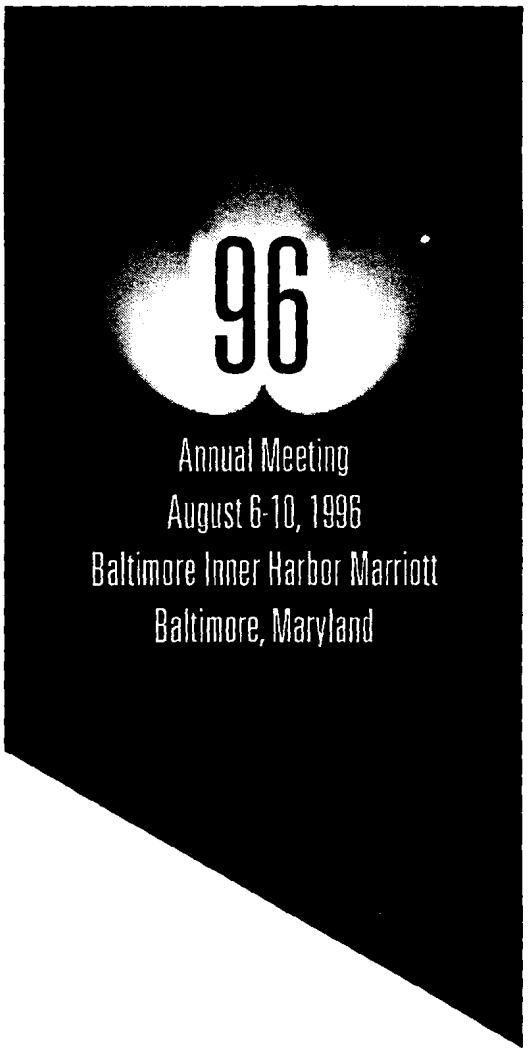


1996 Book of Reports

NATIONAL COUNCIL

National Council of State Boards of Nursing, Inc.
676 North St. Clair, Suite 550
Chicago, Illinois 60611-2921

Table of Contents

Annual Meeting Schedule

Incidental meeting rooms are available throughout the week and may be reserved by calling Sue Davids at the National Council prior to the meeting or via sign-up sheets located at the registration desk on-site. Incidental meeting rooms will be allocated on a first-come, first-served basis.

Monday
August 5

7:30 a.m. - 8:00 a.m.
Registration for Dialogue on Discipline
Grand Foyer

8:00 a.m. - 5:00 p.m.
Dialogue on Discipline
Salon D, E, F

Tuesday
August 6

8:00 a.m. - 9:00 a.m.
11:30 a.m. - 5:00 p.m.
Registration
Grand Foyer

8:30 a.m. - 11:30 a.m.
Executive Officers' Networking Session
East Ballroom

11:30 a.m. - 1:00 p.m.
Lunch Break

1:00 p.m. - 2:30 p.m.
Concurrent Educational/Research Sessions
- Nurse Delegation in Washington State
- Regulation of Unlicensed Assistive Personnel
- The Only Thing That Stays the Same is Change
- Perspectives on Continued Competence, Part I

East Ballroom, Stadium 1-2, 3, 4

2:30 p.m. - 3:00 p.m.
Poster Session
Refreshment Break
Stadium Ballroom Foyer

3:00 p.m. - 4:30 p.m.
Concurrent Educational/Research Sessions
- One Strike, Two Strikes—Out! How State Boards of Nursing Handle Relapse
- Regulatory Framework of a Delegation Systems Model
- RN Competency Assessment: Disturbing Findings
- Perspectives on Continued Competence, Part II

East Ballroom, Stadium 1-2, 3, 4

4:30 p.m. - 5:00 p.m.
Poster Session
Stadium Foyer

5:00 p.m. - 6:30 p.m.
Early Bird Social (cash bar)
Salon A, B, C

Wednesday
August 7

7:30 a.m. - 2:00 p.m.
Registration
Grand Foyer

8:00 a.m. - 9:00 a.m.
Orientation
Stadium 1

9:00 a.m. - 10:30 a.m.
Networking Groups
- Executive Directors
- Board Members
- Board Staff-Education
- Board Staff-Practice/Discipline
Stadium 1, 2, 3, 4-5

10:30 a.m. - 11:00 a.m.
Coffee Break
Stadium Foyer

11:00 a.m. - 12:00 p.m.
Special Interest Groups (SIGS)
- Chemically Impaired Nurses
- LPN/VN Issues
- Member Board Presidents
- Public Policy Issues
Stadium 1, 2, 3, 4-5

12:00 p.m. - 1:30 p.m.
Lunch Break

1:30 p.m. - 3:00 p.m.
Guest Speaker
Jay H. Sanders, M.D.
Eminent Scholar of Telemedicine
Medical College of Georgia
"Legal and Regulatory Barriers to Telemedicine's Implementation"
Grand Ballroom

3:15 p.m. - 4:30 p.m.
Open Dialogue on APRN Issues
Grand Ballroom

7:00 p.m. - 11:00 p.m.
Science and Sensaround, Maryland Science Museum
Hosted by the Maryland Board of Nursing

[illegible]
August [illegible]

8:00 a.m. - 2:00 p.m.
Registration
Grand Foyer

8:00 a.m. - 9:00 a.m.
Breakfast with The Chauncey Group/Sylvan Prometric
Stadium 1, 2, 3

9:00 a.m. - 12:00 p.m.
Forums (•)
Grand Ballroom

• Discipline Issues
  - Sexual Misconduct
  - Advisory Opinions/Rulings
  - Complex Discipline

• Chemically Impaired Nurse Issues Study Results

10:15 a.m. - 10: 45 a.m.
Coffee Break
Grand Foyer

• Unlicensed Assistive Personnel Issues

• Computerized Clinical Simulation Testing

• Nursing Practice and Education Issues
  - PN Scope of Practice
  - Professional Accountability
  - Education Needs Assessment

12:00 p.m. - 1:30 p.m.
Lunch Break

1:30 p.m. - 5:00 p.m.
Forums (•)
Grand Ballroom

• Telecommunications Issues

• Nursing Regulation Issues
  - Response to Pew
  - Regulatory Models

• Licensure Verification

3:00 p.m. - 3:30 p.m.
Refreshment Break
Grand Foyer

Thursday
August 8, cont'd

(Forums, cont'd)

- Continued Competence

- Advanced Practice Issues
  - CNS Status re: Regulation
  - FNP Project
  - NP Certification

5:00 p.m. - 6:30 p.m.
Reception (by invitation only)
Past/Present National Council Board Members

Friday
August 9

8:00 a.m. - 10:00 a.m.
Registration
Grand Foyer

8:00 a.m. - 9:00 a.m.
Breakfast with ASI/TPC
Stadium 1, 2, 3

9:00 a.m. - 10:00 a.m.
Delegate Assembly*
Grand Ballroom

10:00 a.m. - 10:30 a.m.
Coffee Break
Grand Foyer

10:30 a.m. - 12:30 p.m.
Delegate Assembly*
Grand Ballroom

12:30 p.m. - 2:00 p.m.
Area Luncheons
Stadium 1, 2, 3, 4-5

2:00 p.m. - 4:00 p.m.
Candidates' Forum
Grand Ballroom

4:00 p.m. - Eve
Resolutions Committee Meeting
B&O Railroad Room

Saturday
August 10

7:30 a.m. - 9:00 a.m.
Registration
Grand Foyer

7:30 a.m. - 8:30 a.m.
Elections
Patapsco/Severn

9:00 a.m. - 10:30 a.m.
Forums
- Resolutions - New Business
- Board of Directors
Grand Ballroom

10:30 a.m. - 10:45 a.m.
Coffee Break
Grand Foyer

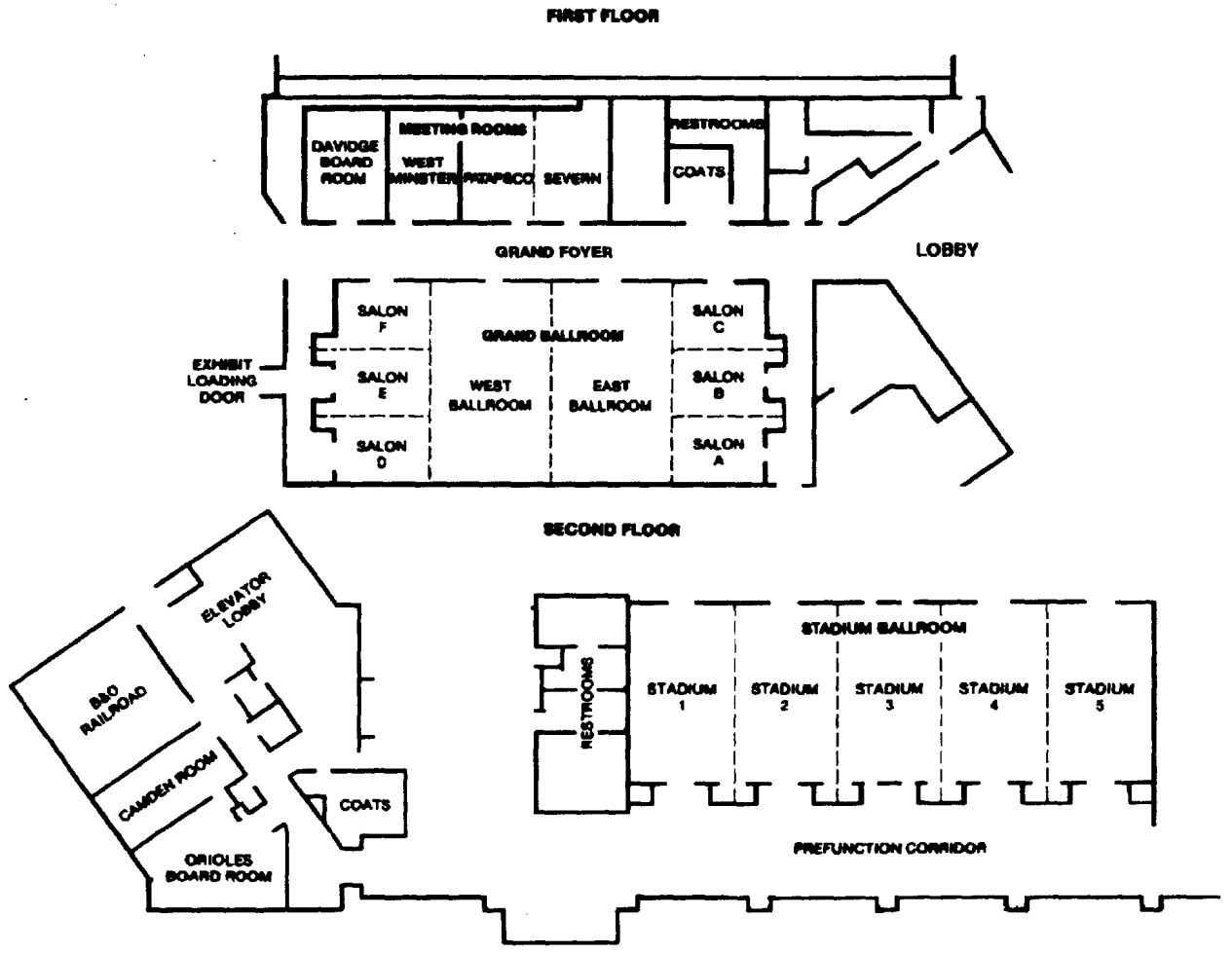
10:45 a.m. - 12:15 p.m.
Delegate Assembly*
Grand Ballroom

12:15 p.m. - 1:45 p.m.
Awards Luncheon
Stadium 1-5

2:00 p.m. - 5:00 p.m.
Delegate Assembly*
Grand Ballroom

*Business conducted during the Delegate Assembly will be continuous, advancing through the agenda as time and discussion permits.

Floor Plan of the Baltimore Marriott Inner Harbor



Business Agenda of the 1996 Delegate Assembly

SPECIAL NOTE
Business conducted during the Delegate Assembly will be continuous, advancing through the agenda as time and discussion permits.

Friday, August 9
9:00 am–12:30 pm

Resource Materials and Forums

- **Opening Ceremonies** ..... Orientation/Parliamentary Review, Wednesday, 8:00 – 9:00 am
  - Introductions
  - Announcements

  Forums, Thursday, 9:00 am – 12:00 pm

- **Opening Reports** ..... **Tab 2**
  - Credentials Committee
  - Rules Committee ..... Tab 2

- **Adoption of Agenda** ..... **Tab 2**

- **Report of the Committee on Nominations** ..... **Tab 3**
  - Slate of Candidates ..... Tab 3, page 2
  - Nominations from Floor

- **President's Address**

- **Officers' Reports** ..... **Tab 4**
  - Treasurer's Report—Audit ..... Tab 4, page 3

- **Report of Staff** ..... **Tab 5**
  - National Council Administrative Staff & Organization Charts .... Tab 5, page 9

- **Examination Committee Report** ..... **Tab 6**
  - Testing Subcommittee Regarding Assessment ..... Tab 6, page 7

  Forums, Thursday, 9:00 – 12:00 pm

- **Report of Test Services** ..... **Tab 7**
  - The Chauncey Group/Sylvan Prometric ..... Tab 7, page 1
  - The Psychological Corporation/Assessment Systems, Inc. ..... Tab 7, page 17
  - National Board of Medical Examiners ..... Tab 7, page 25

- **Finance Committee Report** ..... **Tab 8**

- **Nursing Practice and Education Committee Report** ..... **Tab 9**
  - Complex Discipline Cases Subcommittee ..... Tab 9, page 23
  - Continued Competence Subcommittee ..... Tab 9, page 41
  - Subcommittee to Analyze Clinical Experiences ..... Tab 9, page 55

  Forums, Thursday, 9:00 am – 12:00 pm, and 1:30 am – 5:00 pm

Saturday, August 10
10:45 am–12:15 pm
2:00 pm–5:00 pm

Resource Materials and Forums

■ **Election of Officers & Committee on Nominations**	Candidates' Forum, Friday, 2:00 – 4:00 pm *(Elections: 7:30 – 8:30 am, Saturday, in the Regent Room)*
■ **Board of Directors' Report**	**Tab 10**
Including Reports of Task Forces and Focus Groups	
Related to Goal I—Licensure and Credentialing	
• Advanced Practice Registered Nurse Coordinating Task Force	Tab 10-A
• Computerized Clinical Simulation Testing Task Force	Tab 10-B
• Licensure Examination Comparison Task Force	Tab 10-C
• Licensure Verification Task Force	Tab 10-D
• NCLEX™ Evaluation Task Force	Tab 10-E
• Nurse Aide Competency Evaluation Program Task Force	Tab 10-F
• Research Advisory Panel	Tab 10-G
• Unlicensed Assistive Personnel Task Force	Tab 10-H
Related to Goal II—Nursing Practice	
• Chemically Impaired Nurse Issues Task Force	Tab 10-I
• Disciplinary Investigators' Program Task Force	Tab 10-J
• Nursing Regulation Task Force	Tab 10-K
• Sexual Misconduct Focus Group	Tab 10-L
• Task Force to Analyze Advisory Opinions/Rulings	Tab 10-M
• Telecommunications Issues Task Force	Tab 10-N
Related to Goal IV—Information	
• Communications Evaluation Task Force	Tab 10-O
• Educational Programs Task Force	Tab 10-P
• Information Services Evaluation Task Force	Tab 10-Q
• Nurse Information System Task Force	Tab 10-R
Related to Goal V—Organization	
• Long Range Planning Task Force	Tab 10-S
• Special Services Division	Tab 10-T
	Forums, Thursday, 9:00 am – 12:00 pm, and 1:30 – 5:00 pm
■ **New Business**	
• Resolutions Committee Report	Tab 11
	Forums, Saturday, 9:00 – 10:30 am
■ **Adjournment**	

Standing Rules of the Delegate Assembly

1. Procedures

A. The Credentials Committee, directly after the opening ceremonies of the first business meeting, shall report the number of delegates and alternates registered as present with proper credentials, and the number of delegate votes present. The committee shall make a supplementary report after the opening exercises at the beginning of each day that business continues.

B. Upon registration:

1. Each delegate and alternate shall receive a badge which must be worn at all meetings.

2. Each delegate shall receive the appropriate number of voting cards. Delegates authorized to cast one vote shall receive one voting card. Delegates authorized to cast two votes shall receive two voting cards. Any transfer of voting cards must be made through the Credentials Committee.

C. A member registered as an alternate may, upon proper clearance of the Credentials Committee, be transferred from alternate to delegate. The initial delegate may resume delegate status upon clearance by the Credentials Committee.

D. Members shall be in their seats at least five minutes before the scheduled meeting time. Delegates shall sit in the section reserved for them.

E. There shall be no smoking in the meeting rooms.

F. The Board of Directors may place reports on the consent agenda that do not contain recommendations and can be considered received without discussion. An item will be removed from the consent agenda at the request of any delegate. All items remaining on the consent agenda will be considered received without a vote.

2. Motions

A. The Board of Directors, National Council Committees, and delegates representing Member Boards shall be entitled to make motions. Motions proposed by the Board of Directors or National Council Committees shall be presented by the board or committee directly to the Delegate Assembly.

B. Motions and resolutions submitted prior to Friday, August 9, at 2:00 p.m., shall be reviewed by the Resolutions Committee according to its Operating Policies and Procedures. Motions and resolutions submitted after the deadline shall be submitted directly to the Delegate Assembly during New Business. All motions and resolutions so submitted will be presented with written analysis of consistency with National Council mission, goals, and objectives; assessment of fiscal impact; and potential legal implications. The Resolutions Committee will meet on Friday, August 9, at 4:00 p.m., with the motion maker(s).

C. The Resolutions Committee shall prepare suitable motions to carry into effect resolutions referred to it, and shall submit to the Delegate Assembly, with a fiscal impact statement, these and all other motions referred to the committee.

D. All motions and amendments shall be in writing on triplicate motion paper signed by the maker and shall be sent to the chair prior to being placed before the Delegate Assembly.

3. Debate

A. Any representative of a Member Board wishing to speak shall go to a microphone.

B. Upon recognition by the chair, the speaker shall state his/her name and Member Board.

C. Members and employees of Member Boards may speak only after all delegates who wish to speak on the motion have spoken. Guests may be recognized by the chair to speak after all delegates, members and employees of Member Boards wishing to speak, have spoken.

D. No person may speak in debate more than twice on the same question on the same day, or longer than four minutes per speech, without permission of the Delegate Assembly, granted by a majority vote without debate.

E. A red card raised at the microphone interrupts business for the purpose of a point of order, a question of privilege, orders of the day, a parliamentary inquiry or an appeal.

F. A timekeeper will signal with a red card when the speaker has one minute remaining, and a buzzer will sound when the allotted time has expired.

4. Nominations and Elections

A. A delegate making a nomination from the floor shall be permitted two minutes to give the qualifications of the nominee and to indicate that written consent of the nominee and a written statement of qualifications have been forwarded to the Committee on Nominations. Seconding speeches shall not be permitted.

B. Electioneering for candidates is prohibited in the vicinity of the polling place.

C. The voting strength for the election is determined by those registered by 8:30 a.m. on the day of the election.

D. Election for officers and members of the Committee on Nominations shall be held Saturday, August 10, 1996, from 7:30 a.m.-8:30 a.m.

E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall announce the time for repeated balloting immediately after the original vote is announced.

Summary of Recommendations to the 1996 Delegate Assembly

To provide an overview, the recommendations to be presented to the 1996 Delegate Assembly for consideration are listed below. These recommendations were received by May 8, 1996, the deadline for publication in the 1996 *Book of Reports.* Additional recommendations may be considered during the 1996 Annual Meeting.

Committee on Nominations

1. Adoption of the 1996 Slate of Candidates.

Treasurer

1. That the auditor's report for October 1, 1994, through September 30, 1995, be approved as presented.

Testing Subcommittee Regarding Assessment

1. That the term used to categorize assessment-related activities performed by LPN/VNs be 'data collection.' The term data collection is defined as: The LPN/VN collects information, observes the client, records and reports to the appropriate person (e.g., registered nurse, physician) signs and symptoms and other pertinent data which may indicate that the client's condition deviates from normal and/or that there is a change in the client's condition. LPN/VNs contribute to the assessment of clients through data collection. The term 'contribute to' denotes an active role on the part of the LPN/VN based on the LPN/VN's knowledge, skills and abilities.

Nursing Practice and Education Committee

1. That the definition of competence, standards for competence and position statement regarding competence developed by the Continued Competence Subcommittee be adopted as a position of the National Council. (See the report in Tab 9, page 41.)

Board of Directors

1. That the recommended revised mission statement of the National Council, as presented, be forwarded to the 1996 Delegate Assembly for adoption.

   The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

2. That the Delegate Assembly authorize the Board of Directors to give final approval of the Family Nurse Practitioner Curriculum Guidelines and Regulatory Criteria for Evaluating Family Nurse Practitioners (FNPs) Applying for Prescriptive Authority and, with prior opportunity for review and comment by Member Boards, indicate organizational support as a model for use by Member Boards.

3. That the Delegate Assembly approve the National Council response to the Pew Health Professions Taskforce on Health Care Workforce Regulation report, *Reforming Health Care Workforce Regulation.* (See Nursing Regulation Task Force report behind Tab 10-K.)

Report of the Committee on Nominations

Committee Members
Harriet Johnson, NJ, Area IV, *Chair*
Louise Dean, AK, Area I
Bobbie Johnson, GA-PN, Area III
Dorothy Zook, KS, Area II

Staff
Christopher T. Handzlik, *Integrated Media Manager*

Relationship to Organization Plan
Goal V ..... Implement an organizational structure that uses human and fiscal resources efficiently.
Objective C..... Maintain a system of governance that facilitates leadership and decision making.

Recommendation(s)
No recommendations.

Highlights of Activities

- **Preparation of Slate**
  By the February 16, 1996, deadline, a total of 13 individuals had submitted completed nomination forms for consideration for the 1996 Slate of Candidates. The committee extended the deadline to allow for additional nominations to be submitted. The committee finalized the slate by telephone on April 16, 1996. The list of slated candidates was published in the April 19, 1996, *Newsletter*. Full biographical information for each candidate was published in the May 17, 1996, *Newsletter* in addition to being included within this report.

- **Exploration of Promotional Possibility**
  The committee investigated the possibility of producing a video for the purpose of increasing nominations for National Council office by communicating the roles of the Board of Directors and the Committee on Nominations to members and staff of Member Boards. Because of the expense involved in contracting with a video production studio for such a project, in-house video production possibilities were explored. An initial target date for the release of the video is Fall 1997.

Meeting Dates
- October 30, 1995
- March 18-19, 1996
- April 16, 1996, *telephone poll*

Recommendation(s)
No recommendations.

Slate of Candidates

The following is an overview of the slate developed and adopted by the Committee on Nominations. More-detailed information on each candidate is provided in the subsequent pages of this report. This detailed information is taken directly from candidates' nomination forms. Each candidate will have an opportunity to expand on this information during the Candidates' Forum, scheduled to be held Friday, August 9, 1996, from 2:00 p.m. to 4:00 p.m.

President

Thomas A. Neumann	Wisconsin	Area II
Toma A. Nisbet	Wyoming	Area I

Vice-President

Roselyn Holloway	Texas-RN	Area III
Margaret Howard	New Jersey	Area IV

Treasurer

William F. Greiner	New York	Area IV
Charlene Kelly	Nebraska	Area II

Director-at-Large (two positions)

Leona Beezley	Kansas	Area II
Gregory Howard	Alabama	Area III
Laura Poe	Utah	Area I
Anna F. Yoder	Massachusetts	Area IV

Committee on Nominations

Area I

Louise Dean	Alaska
Helen Zsohar	Utah

Area II

Margaret M. Kotek	Minnesota
Dorothy Zook	Kansas

Area III

Mattie L. Caldwell	Louisiana-RN
Billie R. Rozell	Alabama

Area IV

Ronald S. Ellis	New York
Deborah J. Feldman	Maryland

DETAILED INFORMATION, as taken directly from nomination forms and organized as follows:

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Present employer
4. Educational preparation
5. Offices held or committee membership, including National Council activity
6. Professional organizations
7. Date of term expiration and eligibility for reappointment
8. Personal statement

President

1. **Thomas A. Neumann, Wisconsin, Area II**

2. Administrative Officer, Wisconsin Department of Regulation and Licensing

3. Wisconsin Department of Regulation and Licensing

4. University of Minnesota, Nursing, MS, 1982
   University of Wisconsin-Madison, Nursing, BS, 1977
   University of Wisconsin-Madison, Education, BS, 1972

5. National Council
   - Board of Directors, Vice-President, 1994-1996
   - Board of Directors, Area II Director, 1992-1994
   - Nursing Practice and Education Committee, Chair, 1989-1992
   - Nursing Practice and Education Committee, 1988-1992
   - Delegate, 1986-1992
   - Resolutions Committee, 1988

   Wisconsin Governor's Nursing Education Coordinating Council, 1989-1991
   Wisconsin Board of Nursing
   - Education and Licensure Committee, 1986-present
   - Practice Committee, 1986-present

6. Minnesota League for Nursing (past member)
   National League for Nursing (past member)
   Phi Kappa Phi Honor Society
   Sigma Theta Tau International Honor Society of Nursing

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. This is my tenth year of involvement and commitment with the National Council. I served on the Board of Directors for the past four years and feel that I have a solid, workable understanding of the organization as a whole. Therefore, I feel able to provide competent leadership in meeting Member Board needs according to the Organization Plan. While collaboration with other organizations is essential, the National Council must maintain its unique regulatory focus and respond to the related needs of its Member Boards.

   I believe priorities are providing assistance to Member Boards in responding to the Pew recommendations and addressing the myriad of issues constantly before them regarding health care reengineering, redesign and reform. These include testing for entry-level and continued competence, advanced nursing practice, delegation, overlapping scopes of practice, and survival in a rapidly changing world of regulation.

President

1. **Toma A. Nisbet, Wyoming, Area I**

2. Executive Director, Wyoming Board of Nursing

3. Wyoming Board of Nursing

4. Northern Illinois University, Nursing-Public Health and Administration, MS, 1973
   Northern Illinois University, Nursing, BSN, 1969
   St. Mark's Hospital School of Nursing, Nursing, Diploma, 1967

5. National Council
   Delegate, 1988-1996
   Education Program Task Force, 1994-1996
   Examination Committee-Alternate, 1994-1996
   Administration of Examination Committee, 1990-1994
   Committee on Nominations, 1991-1992
   Greater Rockford Chapter for National SIDS
   Board of Directors, 1979-1985
   Illinois Public Health Association
   Resolutions and Program Committees, Vice-Chair, 1982-1983
   Wyoming Board of Nursing Home Administration
   Vice-Chairman, 1990-1996
   Secretary, 1988-1989
   Wyoming's Long Term Care Task Force
   Member and Chief Staffer, 1987-1988
   YWCA-Rockford, IL
   Board of Directors, 1984-1985

6. American Nurses Association
   American Public Health Association
   Wyoming Commission on Nursing and Nursing Education
   Wyoming Organization of Nurse Executives
   Wyoming Advanced Practitioners of Nursing Organization
   ZONTA

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. First, my experiences in practice, education, consultation, administration and regulation have prepared me to be an effective delegate, committee member, and consensus builder within the National Council structure.

   Second, those roles, my pragmatism, my humor, and your guidance will assist me in navigating the "paradigm shoves" that face nursing regulation and professional practice, if selected as your President.

   Last, I am honored that my name has been placed on the ballot for President of the National Council. I am also pleased that you have a slate of qualified and committed candidates from which to make your selection. Thank you for this opportunity.

Vice-President

1. **Roselyn Holloway, Texas-RN, Area III**

2. Board Member, Texas Board of Nurse Examiners

3. Methodist Hospital School of Nursing, Lubbock, TX

4. Madonna University - Transcultural Nursing, post graduate hours
   University of Texas-El Paso, Nursing, MSN, 1984
   Methodist Hospital School of Nursing, Lubbock, TX, Basic Nursing Diploma, 1980
   Huntingdon College, Montgomery, AL, Biology, BA, 1962

5. National Council
   Board of Directors, Director-at-Large, 1994-1996
   Concepts of Care
   Advisory Board (home health), 1996
   Jim Burkenholder Family Learning Center
   Board of Directors, 1994-1996
   Texas Nurses Association
   Council on Education, 1990-1994
   Nominations Committee, District 18, 1991-1992
   Finance Committee, 1991
   Transcultural Nursing Society
   Treasurer, 1992-1994

6. American Nurses Association
   Texas Nurses Association
   Transcultural Nursing Society

7. Date of expiration of term: 1/99
   Eligible for reappointment: Yes

8. As Vice-President, I will bring to the National Council's Board of Directors experience from having served the past two years as Director-at-Large. During this time, I have had many opportunities to not only serve the National Council, but to become vested in the organization. I envision the role of the Vice-President as one that is clear and challenging; one that will honor the past and prepare for the future by responding to the external strength of the Member Boards contributing to the ongoing process of Board business. Big issues certainly challenge the National Council at this time: reform of health care, determining the policy arenas in which we should be proactive, achieving international leadership and bringing the big picture of the National Council's advocacy role into focus. Only an informed and proactive board can ensure an organization that will fulfill its mission.

Vice-President

1. **Margaret Howard, New Jersey, Area IV**

2. Field Representative, New Jersey Board of Nursing

3. New Jersey Board of Nursing

4. Seton Hall University, Nursing, MSN, 1979
   Seton Hall University, Nursing, BSN, 1968
   All Souls Hospital, Nursing, Diploma, 1960

5. National Council
   Educational Programs Task Force, Chair, 1994-present
   Communications Committee, Member, 1990-1992
   Communications Committee, Chair, 1993-1994
   Examination Committee, Alternate, 1989-1992
   St. Francis Counseling Service
   Board of Directors, 1992-present
   Seton Hall University
   Nursing Alumnae Board of Directors, 1986-1996
   University Alumnae Board of Directors, 1990-1992
   Sigma Theta Tau
   Program Committee, 1984-1986

6. Seton Hall University
   College of Nursing Alumni
   Sigma Theta Tau, 1980-present

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. I believe my experience as a practice and education consultant for the board of nursing for the past 15 years has given me a great opportunity to be exposed to the regulatory process and to be cognizant of the responsibility boards have to protect the health, safety and welfare of consumers during this time of rapid health care reform.

   My participation as a member and chair of National Council committees has afforded me the opportunity to be closely involved with the activities of the National Council and the Board of Directors. I believe that I could make a positive contribution to the Board of Directors during a time that the National Council will be addressing health care reform issues that will impact the public.

Treasurer

1. **William F. Greiner, New York, Area IV**

2. Chair, New York State Board of Nursing

3. Hudson River Psychiatric Center, Poughkeepsie, NY

4. Long Island University, Health Care Administration, MPA, 1985
   Russell Sage College, Nursing, MS, 1973
   University of Bridgeport, Nursing, BS, 1966
   Rockland State Hospital School of Nursing, Professional Nursing, Diploma, 1959

5. National Council
   Task Force to Identify Core Competencies for Nurse Practitioners, 1994-1995
   New York State Board of Nursing
   Conduct Committee, current
   Licensing and Examination Committee, current
   Practice Committee, current
   New York State Nurses Association
   Vice-President, 1984-1986
   Director, 1980-1984
   Delegate to ANA, 1981-1988, 1994-1995

6. American Psychiatric Nurses Association
   New York State Nurses Association
   Nursing Organization Liaison Forum (NYS)
   Sigma Theta Tau

7. Date of expiration of term: 8/98
   Eligible for reappointment: No

8. I have been an eight-year, active member of the New York State Board of Nursing and am the current chair fulfilling a second term. I am currently participating on two separate State Education Department committees focusing on disciplinary reform. As a former principal of a diploma school of nursing, a former director of nursing, and former federal grant manager for a mental health nurse practitioner program, financial management and experience has been, and continues to be, a skill advantageous to me. The various recommendations of the Pew Commission, whether or not endorsed by National Council, will all have financial implications for National Council. I believe that my professional nursing experience, nursing education experience, six years on the New York State Nurses Association's Board of Directors, National Council Area IV and Delegate Assembly experience, and my role as board member and chair over eight years will assist me in the role of treasurer.

Treasurer

1. **Charlene Kelly, Nebraska, Area II**

2. Executive Secretary, Nebraska Board of Nursing

3. Nebraska Department of Health, Professional and Occupational Licensure

4. University of Nebraska, Community and Human Resources, PhD, 1986
   University of Nebraska, Maternal/Child Nursing, MSN, 1976
   University of Nebraska, Nursing, BSN, 1971

5. National Council
   Treasurer, 1993-present
   Finance Committee, 1990-present
   Resolutions Committee, 1991-1993
   Election Committee, 1990
   Communications Committee, 1989-1990
   Nebraska Nurses Association (District II)
   Nominations Committee, 1996
   Sigma Theta Tau, Gamma Pi Chapter
   President, 1985

6. American Nurses Association
   Nebraska Nurses Association
   Sigma Theta Tau, Gamma Pi Chapter

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. It has been my pleasure to serve for six years on the Finance Committee, the last three years as treasurer. These six years have seen much growth in the National Council in terms of depth and scope of activities, numbers of staff and net worth. These have been years of plentiful resources.

   Now we see before us the prediction of leaner years ahead. Current projects continue to need substantial funding. New projects will also require considerable expenditures to bring them to completion. At the same time, we predict

a shrinking candidate pool. Recent efforts by the Finance Committee toward neutralizing the effects of these predictions have included participation in the development of the Special Services Division (SSD), contracting with an investment advisor, and a small research project to more accurately project the numbers of candidates for the upcoming years. As treasurer, I will continue my efforts to promote the financial health of the National Council.

Director-at-Large

1. **Leona K. Beezley, Kansas, Area II**

2. Board Member, Kansas State Board of Nursing

3. Director of Nursing, Neosho County Community College

4. Kansas University, Nursing, MSN, 1990
   Kansas State University, Education, MS, 1980
   Pittsburg State University, Pittsburg, KS, Nursing, BSN, 1975

5. American Nurses Association-Kansas State Nurses Association, 1967-present
   District Secretary-Treasurer
   Finance Committee, Chairman
   Program and Workshop Committee
   Bylaws and Resolutions Committee
   Nominating Committee
   Sigma Theta Tau, Gamma Upsilon Chapter, 1978-1989
   Sigma Theta Tau, Delta Chapter, 1990-present
   Kansas Council of ADN Educators
   Secretary, 1991-present
   Kansas Association of Home Care, 1979-1983
   Board Member, President, Vice-President

6. KCAONE
   National League for Nursing
   Sigma Theta Tau
   American Nurses Association
   Kansas State Nurses Association

7. Date of expiration of term: 7/99
   Eligible for reappointment: Yes

8. I believe that I can contribute to the achievement of the National Council's goals due to my knowledge base and 18 years' involvement in nursing education. I feel I have good people and communication skills and am aware of many issues facing nursing education and practice today. I am a leader and decision-maker at my place of employment. Facing tough issues is not something that I avoid. I do require facts, figures and rationale before I make decisions.

   The National Council needs to always keep as its main concern, public safety by being proactive not reactive to the health care issues. The National Council needs to set standards, so that individual states may use them to help them determine how to handle the issues facing them. They also need to keep well informed of the fast-paced changes occurring as part of health care reform, including the various "big industry" tactics to control nursing practice.

Director-at-Large

1. **Gregory Howard, Alabama, Area III**

2. Board Member, Alabama Board of Nursing

3. Tuscaloosa V.A. Medical Center, Tuscaloosa, AL

4. Shelton State Technical School, LPN, 1982
   Stillman College, 1965-1967

5. National Council
   Committee on Nominations, 1993-1994
   Alabama Board of Nursing
   Advanced Practice Task Force, 1995-present
   Secretary, 1995
   Continuing Education Committee, 1991-present
   Continuing Education Committee, Chair, 1994-present
   Education Committee, 1991-present
   Alabama Federation of Licensed Practical Nurses, Inc.
   First Vice-President, 1995
   Delegate, 1994
   Men's Committee, Chair, 1993-1994
   Director, 1993
   Program Committee, Chair, 1991-1993
   Alabama Federation of Licensed Practical Nurses, Inc., Division 10
   President, 1996
   Ways/Means Committee, 1995
   First Vice-President, 1994-1995
   Treasurer, 1992-1994
   AmeriCorps BAD
   Volunteer to evaluate skills of their workers, 1996
   Mystic Krewe of the Druids
   Vice-President, 1996
   National Federation of Licensed Practical Nurses, Inc.
   State Board of Nursing Committee, 1995
   Delegate, 1993-1994
   Nurses' Day, 1993-1994
   Tuscaloosa VA Medical Center
   LPN Performance Standards Board, 1993-1996
   World AIDS Day Committee, 1995

6. Alabama Federation of Licensed Practical Nurses, Inc.
   Alabama Federation of Licensed Practical Nurses, Inc., Division 10
   National Federation of Licensed Practical Nurses, Inc.

7. Date of expiration of term: 12/99
   Eligible for reappointment: No

8. I am seeking the position of Director-at-Large. As a licensed practical nurse, it is my opinion that I will bring a unique outlook laced with a variety of experiences to the governing body of the National Council. I am aware of the National Council's mission, which is to promote public policy related to the safe practice of nursing in the interest of public welfare. It is with that mission in mind that I participate in the licensing and regulatory activities of nursing.

My experiences of being a board member, a member of my professional organization and on committees with my job, have provided me the opportunity to develop at a level that will enhance the role of Director-at-Large, if elected. Knowing the role that National Council plays in the regulatory arena and the prestige of this body, it would be my honor to serve in the position of Director-at-Large.

Director-at-Large

1. **Laura Poe, Utah, Area I**

2. Executive Administrator, Utah State Board of Nursing

3. Utah State Board of Nursing

4. Brigham Young University, Nursing Education and Administration, MS, 1988
   Brigham Young University, Nursing, BS, 1986

5. National Council
   Information Services Evaluation Task Force, 1995-1996
   Executive Officer Orientation Task Force, 1994-1995
   Utah State Board of Nursing
   Entry into Practice Task Force, 1985-1986
   Utah Nurses Association/Utah Board of Nursing
   Nurse Practice Act Task Force, 1991-1992
   Utah Nurses Association
   Government Relations Committee, 1984-1995

6. Nursing Leadership Forum
   Phi Kappa Phi
   Sigma Theta Tau
   Utah Nurses Association

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. My first exposure to the National Council was the 1993 Annual Meeting. I was impressed with how well the National Council ran. Most impressive was the camaraderie among those in attendance. It didn't take long to understand why the National Council was successful. We all share a common bond, the regulation of nursing practice in the best interest of public welfare.

   Issues discussed at that first meeting are those we grapple with today: advanced practice and delegation. As technology expands and the health care system is reformed, the traditional role of "the nurse" is being challenged, a challenge that the nursing regulatory community must face. As a member of the Board of Directors, I will bring a quick wit and logical mind. I have the knowledge, common sense, and support to get the job done. I support the goals of the National Council and will continue to work toward their achievement.

Director-at-Large

1. **Anna F. Yoder, Massachusetts, Area IV**

2. Chair, Massachusetts Board of Registration in Nursing

3. Beth Israel Hospital, Boston, MA

4. Boston University, Rehabilitation Nursing, MS, 1972
Elizabethtown College, Post-Nursing Degree Program, BS, 1961
Harrisburg Hospital, Nursing, Diploma, 1959

5. National Council
Area IV Meeting Planning Committee, 1996
NACEP Task Force, 1993-present
Invitational Symposium - Rethinking Licensure and Regulation, 1995
American Nurses Association
Delegate, House of Delegates, 1980-1988, 1993-1995
Massachusetts Nurses Association, District 5, Inc.
President, 1987-1991
Board of Directors, 1976-1979
Massachusetts Nurses Association
Council on Professional Nursing Practice, 1976-1983
Council on Professional Nursing Practice, Chair, 1979-1983
Nursing Practice Act Committee, 1983-1985, 1987-1992
Massachusetts Organization of Nurse Executives
Committee on Government Affairs, 1988-present
Committee on Government Affairs, Chair, 1991-1993

6. American Organization of Nurse Executives
Massachusetts Nurses Association
Massachusetts Organization of Nurse Executives
Massachusetts Public Health Association
Sigma Theta Tau, Theta Chapter-at-Large

7. Date of expiration of term: 2/98
Eligible for reappointment: No

8. Throughout my nursing career, I have been a leader and active participant in professional organizations. My commitment to the mission and goals of National Council is an extension of that involvement into the area of public policy. I have a broad understanding of the changing health care environment, along with skills in networking, negotiation and consensus building which are essential to the work of National Council now and into the future. The National Council plays a vital role in assisting Member Boards to continue their mission of public protection in an environment clamoring for less regulation and government control. Priorities should include: 1) leadership in formulating policy which assists Member Boards to ensure public safety by regulating nursing education and practice in the most rational, effective and cost-efficient way; and 2) collaboration with other regulatory bodies which license health professionals to avoid duplication and/or conflict in policies aimed at public protection.

Committee on Nominations

Area I

1. **Louise M. Dean, Alaska, Area I**

2. Chair, Alaska Board of Nursing

3. University of Alaska, Anchorage, AK

4. Alaska Pacific University, Business Administration, MBA, 1996
Alaska Pacific University, Management, BA, 1990
University of Alaska, Accounting, AAS, 1982
Fairbanks, Business Supervision, AAS, 1982

5. National Council
   Committee on Nominations, 1995-1996
   Anchorage Community College
   Instructional Programs Criteria Evaluation Committee, 1986
   Classified Employees Advisory Council, 1984-1986
   Classified Employees Advisory Council, Chair, 1985-1986
   University of Alaska
   Grievance Council, Technical Assistant, 1996
   Selection Review Committee, 1987-1988
   Classified Advisory Council, Chair, 1986-1987
   Statewide Compensation Management Team, 1986
   University of Alaska Statewide Assembly
   Ad Hoc Colgate Committee, 1986
   Ad Hoc Compensation and Benefits Committee, 1984

6. None

7. Date of expiration of term: 3/98
   Eligible for reappointment: No

8. I have had the opportunity to attend four Area Meetings and three Delegate Assemblies. I have had the opportunity to meet individuals from all areas and get an idea for potential nominees. I have several years' experience working with committees dealing with regulation and governance. I am currently serving my sixth year on the Alaska Board of Nursing and my fourth year as chair. I understand group dynamics, communication and the importance of objectivity.

   My current experience with the Committee on Nominations will enable me to contribute to the achievement of the National Council's goals by working with committee members in objectively providing the delegates with a slate of candidates who will best serve the respective Areas and the National Council. This will be important as the National Council deals with UAPs and consumer protection priorities.

Area I

1. **Helen Zsohar, Utah, Area I**

2. Board Member, Utah State Board of Nursing

3. University of Utah, Salt Lake City, UT

4. Arizona State University, Education, PhD, 1982
   University of Texas, Nursing, MSN, 1971
   University of Texas, Nursing, BSN, 1967

5. Utah State Board of Nursing
   Education Peer Review, 1987-1991, 1994-present
   Probation Peer Review, 1994-present
   Chair, 1990-1991

6. American Nurses Association
   Sigma Theta Tau

7. Date of expiration of term: 6/99
   Eligible for reappointment: Yes

8. I have been active in regulatory issues in Utah since 1987 when I was first appointed to the board of nursing. My continuing work with the board reflects a personal and professional commitment to advance the nursing profession as a profession which is truly accountable to public health, welfare and safety. I would like to reflect that commitment at the national level through participation on the Committee on Nominations.

Area II

1. **Margaret Kotek, Minnesota, Area II**

2. Board Member, Minnesota Board of Nursing

3. College of St. Catherine, Minneapolis, MN

4. University of North Dakota, Adult Health Nursing, MS, 1992
   College of St. Catherine, Nursing, BS, 1968

5. National Council
   Licensure Examination Comparison Task Force, 1995-1996
   Grand Forks Technical College
   LPN Advisory Committee, 1981-1991
   Minnesota Board of Nursing
   Education Committee, 1995
   Public Policy Committee, 1995
   Minnesota Community College
   Bush Grant Critical Thinking Interview Process, 1992-present

6. None.

7. Date of expiration of term: 12/99
   Eligible for reappointment: Yes

8. The Pew Commission has challenged public regulation of health care to be accountable and provide appropriate standardized regulation that is flexible, effective and efficient. Increased public representation and meaningful participation on regulatory boards has been recommended to accomplish these reforms.

   I wish to be part of the process on the Committee on Nominations to define diverse leadership, both public and professional that will guide us in identifying and eliminating unnecessary regulatory barriers to safe health care. I have participated at Area and Annual Meetings, as well as the National Conference on Crafting Public Protection for the 21st Century. This involvement has provided multiple opportunities to observe current leadership and identify what is necessary for the National Council in the future.

   The Committee on Nominations has a major responsibility to find the leaders who will best move the National Council toward the 21st Century. I believe I am prepared to meet this expectation.

Area II

1. **Dorothy Zook, Kansas, Area II**

2. Board Member, Kansas State Board of Nursing

3. Office of Dr. Paul Kauffman, Hesston, KS

4. McPherson School of Practical Nursing, 1969

5. National Council
   Committee on Nominations, 1995-1996
   Kansas State Board of Nursing
   Continuing Education, 1989-1996
   Hearing Panel, 1989-1991, 1996
   Practice Committee, 1993-1996
   Vice-Chair, 1993-1995
   Kansas Federation of Licensed Practical Nursing
   First Vice-President, 1993-1996
   Member, 1969-1996
   Delegate, 1994
   Tri-County LPN Association, 1969-1996
   President, 1993-1996

6. Kansas Federation of Licensed Practical Nursing
   National Federation of Licensed Practical Nursing

7. Date of expiration of term: 6/97
   Eligible for reappointment: No

8. As an experienced licensed practical nurse for 27 years, I have been a leader and active participant in professional organizations. I am aware of National Council's mission and goals which is to promote public safety related to safe practice of nursing. The National Council plays a vital role in assisting Member Boards to continue their mission of public protection. My priority is to help find good leadership for National Council by being on the Committee on Nominations. The issues and priorities: health care reform, both legislatively and institutionally; delegation to unlicensed personnel, and the role of RNs and LPNs in the health care setting.

Area III

1. **Mattie L. Caldwell, Louisiana-RN, Area III**

2. Nursing Consultant for Education, Louisiana State Board of Nursing

3. Louisiana State Board of Nursing

4. University of Southern Mississippi, Adult Education/Research, PhD, 1985
   University of Texas at Austin, Psychiatric/Mental Health/Education, MSN, 1972
   Northwestern State University of Louisiana, Nursing, BSN, 1968

5. Council of Administrators of Nursing Education
   Articulation Committee, Chair, 1991
   Lafourche Parish Council on Aging
   Consultant and Provider of Continuing Education, 1987-1989
   Louisiana Organization for the Advancement of AD Nursing
   Vice-President, 1990-1992
   Louisiana State Nurses Association
   Continuing Education Committee, 1988-1991
   Commission on Nursing Education, Chair, 1989-1991
   DNA Delegate for Alexandria, 1988-1989
   Convention Program Committee, 1988-1989
   New Orleans District Nurses Association
   Development and Research Committee, Chair, 1993-1995

Sigma Theta Tau, Beta Chi Chapter
Charter President, 1976-1978
Chair, Steering Committee, 1974-1976
Thibodaux DNA
Convention Delegate Board of Directors, 1985-1989
Publicity and Program Committee, Co-Chair, 1985-1989
Research Conference Group, Secretary, 1988-1989

6. American Nurses Association
Sigma Theta Tau, Beta Chi Chapter

7. Date of expiration of term: (NA)
Eligible for reappointment: (NA)

8. The qualities and skills that I will bring to the Committee on Nominations of the National Council are prior experiences in nursing education for 20 years, four years of staff experience with the Louisiana State Board of Nursing (LSBN), and participating in National Council Area III Meetings. Areas of responsibilities with the LSBN have included Continuing Education Program Manager and Licensure Consultant, and currently, Education Consultant. The National Council must take a strong leadership role in addressing the future role of boards of nursing in ensuring safe and effective nursing care to meet the health needs of the public. The recommendations of the Pew Commission, as well as the growth of "for-profit health care delivery systems," will certainly challenge the National Council and Member Boards. As a member of the Committee on Nominations, I will seek individuals who can assist the National Council in moving forward and achieving its goals.

Area III

1. **Billie R. Rozell, Alabama, Area III**

2. Board Member, Alabama Board of Nursing

3. The University of Alabama in Huntsville, Huntsville, AL

4. The University of Alabama-Birmingham, Community Health, DSN, 1982
The University of Alabama-Birmingham, Community Health, BSN, MSN, 1973, 1974
St. Mary's School of Nursing, Nursing, Diploma, 1959

5. Alabama Commission on Nursing
President, 1988-1990
Collaboration Committee, Chair, 1985
Alabama Health Care Reform Task Force
Cost Containment Committee, Chair, 1993-present
Alabama Health Professions Council
Charter Member, Board of Directors/Executive Council, 1989-present
Alabama League for Nursing
Nominating Committee, 1990-1994
Alabama Office of Rural Health
Advisory Board, 1995-present
Alabama State Commission of Public Health
Board member/Chair, 1986-1994
Subcommittee chair, 1993-1994
Alabama State Council on Prevention of Disease and Medical Care
Chair, 1986-1994
American Rural Health Association
Board of Directors, 1985-1987

Journal of Rural Health
Manuscript Reviewer, 1992-present
National Rural Health Association
Research Program Steering Committee, 1987

6. Alabama State Nurses Association
American Nurses Association
National League for Nursing

7. Date of expiration of term: 3/99
Eligible for reappointment: Yes

8. The work of the Committee on Nominations is pivotal to achieving the strongest possible National Council. There are three major areas of qualities and skills that I will bring to the Committee on Nominations: 1) I have been a member of a national and several state boards of directors, some with regulatory authority. I understand the importance of balance and the need for a good "fit" among board members for decision-making; 2) I have served as chair of a nominating committee and am aware of the many processes and complexities by which individual qualifications can be assessed; and 3) I have demonstrated at the local, state, and national levels the ability to work with others to maintain focus on organizational goals. I understand the needs of the Board of Directors in making policy decisions, and want to assist in creating the best possible slate of candidates for 1997.

Area IV

1. **Ronald S. Ellis, New York, Area IV**

2. Member-at-Large, New York State Board of Nursing

3. Lehman College of C.U.N.Y., Bronx, NY

4. Columbia University, Science Education, EdD, 1973
Columbia University, Science Teaching, MA, 1966
Hunter College-C.U.N.Y., Chemistry, BA, 1963

5. National Council
Communications Committee, 1991-1992
National Science Teachers Association
Awards and Recognition, 1986-1988

6. Association for the Education of Teachers in Science
National Science Teachers Association
New York Academy of Science

7. Date of expiration of term: 6/00
Eligible for reappointment: No

8. I seek nomination as either Director-at-Large or member of the Committee on Nominations. I served the New York State Board of Nursing since July of 1990. I have participated in an average of two to three disciplinary and/or moral character hearings per month. I served on the Licensure and Examination Committee, the Long Range Planning Committee, the Bylaws Committee, the Nominations Committee and the Professional Conduct Committee. Currently, I am Member-at-Large. I have also served the National Council as a member of the Communications Committee.

As a consumer member, I am concerned about who will provide quality health care. Nursing must provide a steady stream of highly qualified professionals to meet the need for quality health care in all contexts. The licensing boards must be able to prevent the encroachment of unlicensed personnel upon the practice of nursing without diminishing the quality of care provided to any patient.

Area IV

1. **Deborah J. Feldman, Maryland, Area IV**

2. Nursing Education Consultant, Maryland Board of Nursing

3. Maryland Board of Nursing

4. University of Mississippi, Nursing Education and MCH, MN, 1976
   Mississippi University for Women, Nursing, BSN, 1975
   Mississippi State College for Women, Nursing, ADN, 1973

5. National Council
   NCLEX™ Evaluation Task Force, Chair, 1994-present
   Administration of Examination Committee, 1989-1994
   Maryland Nurses Association
   Cabinet on Education and Practice, 1982-1990
   Maryland State
   PN-ADN Validation Committee, 1987-present
   State of Maryland Governor's Task Force on Valid Criteria, 1985-present

6. American Nurses Association
   National League for Nursing
   Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. This is a time of great change in nursing and in health care. It is essential that the National Council maintain its leadership posture and take a proactive position on the many issues affecting the practice and education of nurses. In order to do this, we must continue to elect officers who have a vision for the organization's future and the ability to provide leadership to our geographically diverse membership. My work with the National Council on the Administration of Examination Committee and as Chair of the NCLEX™ Evaluation Task Force has given me familiarity with the members of the organization and would enable me to be an effective member of the Committee on Nominations.

Report of the President

Marcia M. Rachel, PhD, RN, President
Executive Director, Mississippi Board of Nursing

As I reflect on the past year's accomplishments and activities, it becomes more and more difficult for me to focus on any one event. Rather, I continue to be amazed and overwhelmed by the many projects and issues which have been addressed within the National Council. It is quite impressive to realize that, in an organization whose potential membership is rather small (61 Member Boards, their board members and staff), we have over 130 volunteers who are actively involved in elected or appointed positions and another 120 or so in the volunteer pool who have offered their commitment and dedication which permeates our membership—a membership whose primary interest is public protection. Fortunately, we have a membership of volunteers who represent diverse backgrounds and interests. While this makes for some interesting and lively discussions, it also assures us that our decisions will be the result of looking at an issue from all sides and perspectives, and it assists us in being able to divert and remove any self-serving, personal opinions and replace them with the best interest of the public.

As you read through this *Book of Reports*, you will find the theme of public protection evidenced throughout each of the reports. This was no accident. Committees, task forces, and focus groups agonized through many meetings, conference calls, and reports before reaching a decision they felt was best for our members in their public protection role. I ask that you read and consider the reports from that same perspective. It is one on which we cannot compromise.

Finally, thanks to each of you for the support, assistance, encouragement and opportunities which you have provided me during my tenure as President. Dr. Jennifer Bosma and her staff at National Council are an assembly of the best of the best. They have provided information, expertise, documents, technical support and assistance during times when I knew I needed help and during times when I should have known. The members of the Board of Directors have tolerated my way of chairing meetings, have taken their elected positions and responsibilities seriously, and have represented the membership well. Because of their participation and input, we have been able to announce each decision with confidence, knowing that the issue was thoroughly discussed, considered and addressed. The Board Members and Staff of the Mississippi Board of Nursing have been extremely supportive of my role with National Council and have made tremendous adjustments to accommodate it. My assistant, Nancy Herrin, has helped me keep my life organized and manageable and I am grateful to her. And finally, my family has graciously given up much of their time with me in order for me to participate as I needed. Although I have heard the question "How much longer?" a time or two, I have never had a guilt trip left at my feet. My husband, Steve, and my children, Chris and Becky, are truly God's gift to me and I appreciate their support during the last two years.

Report of the Vice-President

Tom Neumann, MSN, RN, Vice-President
Administrative Officer, Wisconsin Department of Regulation and Licensing

As Vice-President of the National Council of State Boards of Nursing, I participated in all Board of Directors meetings and conference calls during this past year. I represented the National Council at the CLEAR Annual Meeting in San Antonio, Texas, in September 1995.

During National Council Board meetings, I participated in discussions addressing continued monitoring of computerized adaptive testing (CAT) implementation for the NCLEX™, use of non-U.S. sites for administration of CAT, certification exams for advanced nursing practice, progress regarding CST® and NIS, recommendations presented by the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation, and reports from the variety of committees, subcommittees, task forces, and focus groups. The National Council of State Boards of Nursing continues to be at the forefront providing leadership in the regulation of nursing through its Member Boards, the Board of Directors and National Council staff. During the time ahead, it is imperative that we speak with a unified voice about our mission, purpose and organization plan as we are called upon to respond to challenges regarding the need for the regulation of nursing as it is currently done in the interest of public protection.

I wish to again sincerely thank all of the board members, staff, and others from the National Council jurisdictions who have participated in National Council activities this year, whether on committees, subcommittees, task forces, focus groups, panels, or in other meetings addressing National Council issues. Your interest and commitment contribute to the integrity and leadership of the organization.

Thank you for the opportunity to serve you during the past two years as Vice-President on the Board of Directors. It is always a pleasure to confer with my colleagues in regulation about the challenging, changing issues facing us.

Report of the Treasurer

Charlene Kelly, PhD, RN, Treasurer and Chair, Finance Committee
Executive Secretary, Nebraska Board of Nursing

Relationship to the Organization Plan

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective B ..... Maintain a sound resource management system for National Council.

Recommendation

1. **That the auditor's report for October 1, 1994, through September 30, 1995, be approved as presented.**

Rationale

The audit was completed in December 1995. The auditors found no irregularities in the financial statements and expressed an unqualified opinion.

The National Council of State Boards of Nursing, Inc., remains financially strong. Revenue has continued to exceed expenditures. The financial forecast, based on a projected decline in the number of candidates, anticipates that annual revenue may not continue to be sufficient to cover anticipated expenses resulting in a need to utilize funds from the undesignated fund balance.

The National Council is taking steps to protect the financial position of the organization. The National Council has secured the services of an investment advisor to maximize our investment income. All groups associated with the National Council have been encouraged to use their budget dollars wisely. Systems have been put in place to find ways to carry out activities for Member Boards, as directed by Delegate Assembly, in the most cost efficient methods. And finally, careful assessment and consideration needs to be given to the immediate and long-term fiscal effects of proposed projects.

During the past year, I attended all meetings and conference calls of the Board of Directors. I also chaired the Finance Committee.

I would like to thank Tom Vicek and Jennifer Bosma for their assistance and guidance. The information they provide is invaluable and provides the basis for financially sound decision-making.

National Council of State Boards of Nursing, Inc.
Report of Independent Auditors

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

We have audited the accompanying balance sheets of National Council of State Boards of Nursing, Inc., as of September 30, 1995 and 1994, and the related statements of revenue and expenses, changes in fund balances, and cash flows for the years then ended. These financial statements are the responsibility of management of National Council of State Boards of Nursing, Inc. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our 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., at September 30, 1995 and 1994, the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young LLP
December 8, 1995

National Council of State Boards of Nursing, Inc.
Balance Sheets

	September 30 1995	1994
Assets		
Current assets:		
Cash and cash equivalents	$ 83,001	$ 979,443
Accounts receivable	493,715	831,058
Examination fees due from Member Boards	181,530	341,160
Accrued interest, prepaid expenses, and other	398,320	240,894
Total current assets	1,156,566	2,392,555
Investments, at cost	11,510,839	10,146,747
Property and equipment:		
Furniture, fixtures, and leasehold improvements	200,559	185,378
Equipment and computer software	1,115,061	840,072
	1,315,620	1,025,450
Less: Accumulated depreciation	821,427	581,641
	494,193	443,809
	$13,161,598	$12,983,111
Liabilities and fund balances		
Current liabilities:		
Accounts payable	$ 1,420,509	$ 3,436,238
Examination fees due to Member Boards	–	182,016
Accrued salaries and payroll taxes	272,297	223,097
Total current liabilities	1,692,806	3,841,351
Deferred revenue:		
Examination fees collected in advance (net of prepaid processing fees of $1,715,484 in 1995 and $1,692,120 in 1994)	848,032	831,720
Fund balances:		
Unrestricted:		
Undesignated	9,361,702	6,500,506
Designated	1,259,058	1,790,128
	10,620,760	8,290,634
Restricted	–	19,406
	10,620,760	8,310,040
	$13,161,598	$12,983,111

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statements of Revenues and Expenses

	Year ended September 30	
	1995	1994
Revenue—Unrestricted funds		
Examination fees	$17,329,410	$14,484,046
Less: Cost of development, application, and processing	11,886,065	9,807,274
Net examination fees	5,443,345	4,676,772
Member Board contracts	183,000	183,000
Communication projects	141,640	171,850
Annual Meeting	79,990	63,530
Computerized Adaptive Testing (CAT) income	–	12,429
Nurse aide competency evaluation program (NACEP)	418,832	428,447
Investment income	620,821	470,120
Net examination fees and other revenue—Unrestricted funds	6,887,628	6,006,148
Program and organizational expenses—Unrestricted funds		
Member Board contracts	1,743	9,755
Communication projects	195,543	151,521
Annual meeting	102,573	85,153
Nurse aide competency evaluation program (NACEP)	15,295	18,226
Job analysis studies and other research	106,944	65,430
Computerized Adaptive Testing (CAT)	–	759,947
Role delineation study	257	4,151
Computerized clinical simulation testing (CST®)	225,032	260,428
Nurse information system (NIS)	44,453	27,998
Special services division	89,293	–
Chemically impaired nurses research study	87,957	–
Board meetings and travel	78,744	93,651
Other committee expenses	177,354	232,243
Total program and organizational expenses—Unrestricted funds	1,125,188	1,708,503
Administrative expenses—Unrestricted funds		
Staff salaries and benefits	$ 2,371,915	$ 2,015,413
Professional fees	230,439	85,766
Office supplies	187,774	198,266
Insurance	41,240	32,363
Rent and utilities	234,982	256,801
Equipment maintenance and rental	122,289	85,058
Depreciation	231,338	240,394
Miscellaneous	12,337	14,165
Total administrative expenses—Unrestricted funds	3,432,314	2,928,226
Total expenses—Unrestricted funds	4,557,502	4,636,729
Revenue in excess of expenses—Unrestricted funds	2,330,126	1,369,419
Restricted grant revenue		
Nurse information system (NIS)	348,701	62,203
Effectiveness of Disciplinary Action Study	5,506	–
	354,207	62,203

National Council of State Boards of Nursing, Inc.
Statements of Revenues and Expenses (continued)

Expenses related to restricted grants		
Computerized clinical simulation testing (CST®)	–	1,750
Nurse information system (NIS)	368,107	217,165
Effectiveness of Disciplinary Action Study	5,506	–
	373,613	218,915
Expenses in excess of revenue–Restricted funds	(19,406)	(156,712)
Revenue in excess of expenses	$ 2,310,720	$ 1,212,707

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statements Of Changes In Fund Balance

	Unrestricted											Restricted			
	Undesignated	Designated for Computerized Adaptive Testing (CAT)	Designated For Crisis Mgmt.	Designated for Working Capital Reserve	Designated for Role Delineation	Designated for Computerized Clinical Simulation Testing (CST®)	Designated for Self-Insurance	Designated for Nurse Information System (NIS)	Designated for Special Services Division	Designated for Chemical Dependency	Total Unrestricted Fund	Computerized Clinical Simulation Testing (CST®)	Nurse Information System (NIS)	Effectiveness of Disciplinary Action Study	Total
Fund balance at October 1, 1993	$2,801,952	$1,683,035	$121,836	$1,094,725	$151,471	$854,992	$100,000	$113,204	$ -	$ -	$6,921,215	$1,750	$174,368	$ -	$7,097,333
Transfer to Board-designated funds	(963,038)	-	-	-	-	108,038	-	-	600,000	255,000	-	-	-	-	-
Transfer to undesignated funds	2,252,078	(935,517)	(121,836)	(1,094,725)	-	-	(100,000)	-	-	-	-	-	-	-	-
Revenue in excess of (less than) expenses	2,409,514	(747,518)	-	-	(4,151)	(260,428)	-	(27,998)	-	-	1,369,419	(1,750)	(154,962)	-	1,212,707
Fund balances at September 30, 1994	6,500,506	-	-	-	147,320	702,602	-	85,206	600,000	255,000	8,290,634	-	19,406	-	8,310,040
Transfer to Board-designated funds	(62,983)	-	-	-	-	62,983	-	-	-	-	-	-	-	-	-
Transfer to undesignated funds	147,063	-	-	-	(147,063)	-	-	-	-	-	-	-	-	-	-
Revenue in excess of (less than) expenses	2,777,116	-			(257)	(225,030)	-	(44,453)	(89,293)	(87,957)	2,330,126	-	(19,406)	-	2,310,720
Fund balances at September 30, 1995	$9,361,702	$ -	$ -	$ -	$ -	$540,555	$ -	$40,753	$510,707	$167,043	$10,620,760	$ -	$ -	$ -	$10,620,760

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statements of Cash Flows

	Year ended September 30 1995	1994
Operating activities		
Revenue in excess of expenses	$2,310,720	$1,212,707
Adjustments to reconcile revenue in excess of expenses to net cash provided by operating activities:		
Depreciation	243,265	240,394
Changes in operating assets and liabilities:		
Accounts receivable and examination fees due from Member Boards	496,973	(887,869)
Accrued interest, prepaid expenses, inventories, and other	(157,428)	81,881
Accounts payable	(2,015,729)	765,487
Due to Member Boards	(182,016)	(54,265)
Accrued salaries and payroll taxes	49,200	(34,395)
Deferred revenue, net	16,314	(425,685)
Net cash provided by operating activities	761,299	898,255
Investing activities		
Net additions to property and equipment	(293,649)	(93,754)
Increase in investments, net	(1,364,092)	(634,380)
Net cash used in investing activities	(1,657,741)	(728,134)
Increase (decrease) in cash and cash equivalents	(896,442)	170,121
Cash and cash equivalents at beginning of year	979,443	809,322
Cash and cash equivalents at end of year	$ 83,001	$ 979,443

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Notes to Financial Statements
September 30, 1995 and 1994

1. Organization and Operation

National Council of State Boards of Nursing, Inc. (National Council) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of the National Council is to serve as a charitable and educational organization through which state boards of nursing act on matters of common interest and concern affecting the public health, safety, and welfare, including the development of licensing examinations in nursing. The National Council is a tax-exempt organization under Internal Revenue Code Section 501(c)(3).

2. Summary of Significant Accounting Policies

Examination Fee—Examination fees collected in advance, net of processing costs incurred, are deferred and recognized as revenue at the date of the examination.

Grant Revenue—Restricted funds are recognized as revenue at the time they are received.

Cash Equivalents—Cash equivalents consist of money market funds.

Services of Volunteers—Officers, committee members, the Board of Directors, and other nonstaff associates assist the National Council, without remuneration, in various program and administrative functions. No value has been ascribed for such voluntary services.

Pension Plan—The National Council maintains a defined-contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The National Council's policy is to fund pension costs accrued. Pension expense was $162,513 and $161,630 for the years ended September 30, 1995 and 1994, respectively.

Property and Equipment—Property and equipment are stated on the basis of cost. Provisions for depreciation are computed using the straight-line method over the estimated useful lives of the assets.

Investments—Investments are carried at cost. Investments consist of the following at September 30:

	1995		1994	
	Cost	Market Value	Cost	Market Value
U.S. government and government-backed obligations	$ 9,510,839	$ 9,443,635	$ 8,146,747	$ 8,015,311
Certificates of deposit and other	$ 2,000,000	2,000,000	2,000,000	2,000,000
	$11,510,839	$11,443,635	$10,146,747	$10,015,311

Board-Designated Funds—The Board of Directors has designated certain funds to be used for specific projects. These projects include the development of a role delineation research study, computerized clinical simulation testing (CST®), Nurse Information System (NIS), special services division, and chemical dependency study. These funds are reflected as designated unrestricted funds in the accompanying financial statements.

Restricted Funds—In 1993, the National Council was awarded a restricted grant from the Robert Wood Johnson Foundation to support the establishment of a national Nurse Information System. The grant, amounting to $530,110 was fully received by the end of fiscal year 1995. Of this amount, the National Council has received $175,298 in fiscal year 1995, $62,203 in fiscal year 1994, and $292,609 in fiscal year 1993.

In 1995, the National Council was awarded an additional $499,995 from the Robert Wood Johnson Foundation which will be fully received by January 31, 1997. Of this amount, the National Council has received $100,726 in fiscal year 1995.

Reclassifications—Certain amounts in the 1994 financial statements have been reclassified to conform to the 1995 presentation.

3. Commitments

The National Council leases office space under an operating lease arrangement.

Future noncancelable rental commitments as of September 30, 1995, are as follows:

1996	$242,862
1997	247,721
1998	252,674
1999	257,730
2000	262,882

During fiscal 1990, the National Council entered into a software license and maintenance agreement with the National Board of Medical Examiners. In consideration for the provision of this agreement, the National Council is obligated to pay a base annual fee of $50,000, subject to inflation adjustments. The National Council has the option of terminating this agreement provided that notice is given 18 months prior to termination.

Report of the Area I Director

Joey Ridenour, MN, RN, Area I Director
Executive Director, Arizona State Board of Nursing

This has been an exciting first year representing Area I on the Board of Directors of the National Council of State Boards of Nursing. I have attended and been active in all the Board of Directors' meetings and conference calls. In addition, I represented the National Council at the 1995 National Organization for Associate Degree Nursing Convention (NOADN) Conference in October 1995, and the American Organization of Nurse Executives (AONE) Annual Meeting in Boston, Massachusetts, April 14-17, 1996.

The 1996 Regulatory Day of Dialogue and Area I Meeting were held in beautiful Santa Fe, New Mexico, on March 28-29, 1996. The topics selected by Area I jurisdiction included:

- Pew Recommendation and Strategies: Dr. Jennifer Bosma shared progress on the Pew Health Commission Taskforce's 10 recommendations and challenged the attendees to make a difference in influencing the direction of regulation in the future.

- Delegation and Supervision in the Work Setting: Marilyn Washburn and Ruth Hansten shared that "the hardest aspect of delegation is clarifying the RN role."

- Computerized Clinical Simulation Testing (CST®): Dr. Debra Brady, Chair of the CST Task Force, discussed the purpose and concepts of CST and projected timelines of this exciting new tool to evaluate competencies.

- Telecommunications: Lonna Burress, Chair of the Telecommunications Task Force, energized and challenged the participants to "build bridges" to apply the new technologies available and anticipate their regulatory implications.

- Nursing Regulation Task Force: Libby Lund shared progress on potential models for nursing regulation.

- Licensure Verification Task Force: Susan Woodward shared new and exciting computer programs potentially accessible to Member Boards via NCNET.

- Continued Competence Task Force: Teresa Bello-Jones provided an update on the definition of competency and application in the context of protection of the public.

- An afternoon session was designated for an Area I roundtable discussion.

Thanks are extended to the New Mexico Board of Nursing for their gracious hospitality and to California for their invitation to host the 1997 Area I Meeting.

I want to offer my sincerest thanks and congratulations to Area I Board Members, staff and others who are providing the way through leadership as we evolve into a "new order" of regulation. We know there is no precedent for the future, so creating the new system is challenging. I appreciate your continued support.

Report of the Area II Director

Linda Peterson Seppanen, PhD, RN, Area II Director
Board Member, Minnesota Board of Nursing

As Area II Director of the National Council of State Boards of Nursing, I was an active participant in Board of Directors' meetings and conference calls this past year. I represented the National Council at the NLN Council of Baccalaureate and Higher Degree Programs meeting in Milwaukee, Wisconsin, last fall.

The Regulatory Day of Dialogue and Area II Meeting were held at the Radisson Hotel in Chicago, Illinois, on March 22-23, 1996. There were about 75 participants with all jurisdictions represented. The Illinois Department of Professional Regulation served as a gracious host, sharing a lovely taste of Italian cuisine with our membership on Friday night. About 50 attended an Open House which included various demonstrations and displays at the National Council office on Friday afternoon.

The Regulatory Day of Dialogue, titled, "Reform: Regulation for the 21st Century," focused on: 1) a review of the Pew Health Commission Taskforce recommendations, responses received thus far, and plans for the future; 2) an analysis of those recommendations that mainly apply to nursing, according to individual boards of nursing, other boards, and National Council of State Boards of Nursing; 3) a discussion of reform activities from a national perspective; and 4) an overview of an electronic licensure verification system and communication system. The discussion addressed the question: Do we want a system of licensure where any Area II safe, competent nurse can practice in any Area II state? Categories for consideration include initial licensure, renewal of licensure, and endorsement. Characteristics of such a system were identified along with barriers to the process. This discussion was carried over into the Area II Meeting the next day.

During the Area II Meeting, reports were presented about National Council committees and staff activities and by The Chauncey Group and Sylvan Prometric. Discussion followed each presentation. Area-specific concerns and issues primarily focused on ways to facilitate initial licensure, renewal, and endorsement for safe, competent nurses within the Area II jurisdictions. Representatives from three groupings of contiguous states will explore ways to remove barriers or hurdles to mobility, will consult with each other, and will report at the Area II meeting in Baltimore, Maryland, in August 1996. Written reports of the activities of the past year by each Member Board were distributed to participants.

The 1997 Area II Spring Meeting will be hosted by the West Virginia Boards of Nursing in Charleston, West Virginia, with the South Dakota Board of Nursing hosting in 1998, and the Ohio Board of Nursing hosting in 1999.

I want to thank all the Area II board members and staff who have participated in National Council activities this past year. Your efforts make this organization a dynamic and responsive voice in regulatory matters.

Thank you for the opportunity to serve as Area II Director. I appreciate your willingness to share ideas and opinions with me and your ability to get things done. It continues to be a challenging, stimulating, and rewarding experience.

Report of the Area III Director

Nancy K. Durrett, MSN, RN, Area III Director
Executive Director, Virginia Board of Nursing

As Area III Director of the National Council of State Boards of Nursing, I have participated in all the Board of Directors' meetings and conference calls. I served as the Board liaison to the Long Range Planning Task Force. Additionally, I represented the National Council at the Citizen Advocacy Center Annual Meeting in San Diego, California, and at the meeting cosponsored by the Citizen Advocacy Center and the National Council in Washington, D.C.

The Area III Meeting and Regulatory Day of Dialogue, hosted by the Texas Board of Nurse Examiners and the Texas Board of Vocational Nurse Examiners, were held on April 11-12, 1996, in Austin, Texas. Thanks are extended to the members and staff of both boards for their gracious hospitality.

The Regulatory Day of Dialogue featured an address by Marcella McKay, Vice-President for Nursing and Professional Services, Mississippi Hospital Association, former member of the National Council's Board of Directors, who discussed strategies for boards of nursing in the changing health care environment. A panel discussion followed. The afternoon session included a presentation on the work of the Kentucky Board of Nursing on continued competence. The planning committee was chaired by Judi Crume, AL, and included Shirley Camp, GA-RN; Ann Ferguson, OK; and Linda Thomas, KY.

The Area Meeting had 80 participants with all Area Member Boards represented. A variety of National Council committees and task forces reported on their work. A discussion of Area-specific issues followed. Written reports of the activities of the past years by each Member Board were distributed.

The 1997 meeting will be hosted by the Alabama Board of Nursing.

Area III board members and staff continue to make significant contributions to the National Council through their participation in committees, task forces, focus groups and other activities. Area III always has more volunteers than there are positions to fill. Your willingness to volunteer your time and expertise is very much appreciated.

Thank you for the opportunity to serve you as the Area III Director. Please continue to share your ideas and suggestions with me.

Report of the Area IV Director

Marie T. Hilliard, PhD, RN, Area IV Director
Executive Officer, Connecticut Board of Examiners for Nursing

Representing Area IV on the Board of Directors of the National Council of State Boards of Nursing has been an exciting challenge for me. During these months, many of you seem to be experiencing some regulatory upheaval. As I stated in my report to you last year, we were at a crossroad and difficult choices must be made, impacting the public's health and safety. How fortunate we are that we have the support of each other through the National Council of State Boards of Nursing. It has become very evident to me that the challenges that many of us are facing are challenges that are being replicated from jurisdiction to jurisdiction. That is why it is important for each of us, if at all able through the support of our jurisdictions, to be present at our Annual Meeting. This year's Area IV Meeting provided each of us with the opportunity to dialogue with all but one of our Member Boards and access the support to handle the challenges that we face. We are grateful to the Delaware Board of Nursing for its exceptional handling of our meeting and to Marie Fisher of the Maine State Board of Nursing for her very informational Regulatory Day of Dialogue Program: "Unlicensed Assistive Personnel in Today's Health Care World."

The National Council of State Boards of Nursing remains active in representing our concerns in the national and international arena. Members of the Board of Directors have represented all of us in an excellent manner at numerous professional meetings. We were, indeed, fortunate to have the National Council/CAC Joint Conference, "Crafting Public Protection for the 21st Century," (Pew Report) in Washington, D.C. The impact of that meeting continues to be felt. There have been requests made of the National Council to respond to the Pew Report. While our formal response cannot be made until after the Delegate Assembly has approved such a response, I commented on behalf of the National Council at the National League for Nursing Council of Diploma Programs Annual Meeting in Philadelphia, Pennsylvania, in May of this year. Also, I represented you at the National League for Nursing Council of Associate Degree Programs and Council of Practical Nursing Programs Annual Meeting, in April, in Atlanta, Georgia. In the fall of 1994, I represented you at the Institute of Medicine in Washington, D.C., at hearings regarding "The Adequacy of Nurse Staffing." This year, a handful of the many persons invited to present testimony at the Institute of Medicine were invited for a pre-press release briefing, with opportunity for questions and answers. You will be happy to know that the National Council was included in that very small group of persons/organizations invited to attend the briefing. By now, you should all have access to the report from the Institute of Medicine. Clearly, our concerns for the inadequacy of data supporting a move into health care redesign have been justified. I continue to serve on the Research Advisory Panel, as Board of Directors liaison. As can be seen from the aforementioned comments on the Institute of Medicine study, our need to respond with factual information, to inquiries impacting the health and welfare of the public, has never been greater. To this end, the Research Advisory Panel has a critical role to fulfill, and is well prepared to fulfill it.

I am grateful to all of you for allowing me to assist, in the best way that I am able, in addressing our critical mission as the National Council of State Boards of Nursing.

Report of the Director-at-Large

Roselyn Holloway, MSN, RN, Director-at-Large
Board Member, Texas Board of Nurse Examiners

Thank you for the opportunity to serve as one of the Directors-at-Large for the National Council of State Boards of Nursing for the past year. It has been an honor.

The following is a summary of my year of service:

- Attended all meetings of the Board of Directors at the National Council, Chicago, Illinois.
- Attended the Area III Meeting in Austin, Texas, in April 1996.
- Represented the National Council at Sigma Theta Tau International Biennial Convention in Detroit, Michigan, in November 1995. The five-day convention presented a glimpse of nursing education's future with emphasis on distance teaching/learning and also insights into research of leadership in the federal policy areas.
- Represented the National Council at the 20th Annual Federation of Associations of Regulatory Boards in Salt Lake City, Utah, in February 1996. The theme of the forum was "Regulatory Reform or Reaffirmation?" The most pressing issues in professional regulation were presented in the three-day forum.
- Attended the Nursing Regulation Models Conference at the National Council in Chicago, Illinois, in June 1996, along with all members of the National Council's Board of Directors.
- Participated on the Board of Directors' Continuing Education Committee for planning offerings to Member Boards. (National Council's and CAC's jointly sponsored conference regarding the Pew Health Commission Taskforce recommendations in Washington, D.C., in December 1995.) Also, established the ***Institute for the Promotion of Regulatory Excellence,*** whose purpose is professional development for Member Boards. The Institute will develop and offer educational materials and programs in accordance with Member Boards' needs.

I appreciate all of your support for the National Council and your efforts in the workings of the Board serving as task force members and members of committees. It is your efforts that make the National Council a great organization of nursing.

It has been an honor to serve on the National Council as Director-at-Large. Thank you.

Report of the Director-at-Large

Janet Wood-Yañez, LVN, Director-at-Large
Board Member, Texas Board of Vocational Nurse Examiners

Since the 1995 Delegate Assembly, I have participated as Director-at-Large in the following activities:

- Attended the Post-Delegate Assembly Board of Directors' meeting in St. Louis, MO, August 1995.
- Participated in the Board Retreat in Chicago, IL, in October 1995.
- Attended the following Board meetings:
  October 1995
  May 1996
  June 1996
- Participated in several conference calls.
- Represented the National Council and Texas Board of Vocational Nurse Examiners at Area III Meeting, Austin, TX, April 1996.
- Attended the Nursing Regulation Models Conference in June 1996 in Chicago, IL.
- Appointed by the President to a committee to establish continuing education for Member Boards titled, "The Institute for the Promotion of Regulatory Excellence."
- Represented the National Council at the 46th Annual Convention of the National Federation of Licensed Practical Nurses, Inc., September 1995, in Colorado Springs, CO.
- Represented the National Council at the 55th Annual Convention of the National Association of Practical Nurse Education and Services, Inc., April 1996, in Little Rock, AR.

It became evident to me early how all Member Boards, committee and task force volunteers, National Council staff and members of the Board of Directors have a difficult and challenging decision process at hand. Over the past year, I have always tried to keep in mind the National Council's mission statement, "To promote public policy related to the safe and effective practice of nursing in the interest of public welfare" in all Board actions I participated in.

It has been my extreme pleasure to serve the National Council as one of its Directors-at-Large. I thank you from the bottom of my heart. It was an experience I will never forget.

Report of Staff Activities

Jennifer Bosma, PhD, CAE, Executive Director

In its oversight of the affairs of the organization, the Board of Directors identifies tactics which will lead to accomplishment of the mission, goals and objectives of the National Council. This report is an accounting of staff work focusing on Board-assigned tactics for this past year. For ease of reading, it is organized by program area.

A staff organization chart (Attachment A) accompanies this report. Description of staff responsibilities is found behind Tab 14, Orientation Manual, in this *Book of Reports*.

Testing Programs

National Council Licensure Examinations (NCLEX™)

Program Purpose: To provide a legally defensible, psychometrically sound, and progressive entry-level licensure examination with timely and appropriate information flow; to anticipate Member Board support needs and provide appropriate levels of support.

Supporting activities:

- Monitored the second year's implementation of computerized adaptive testing (CAT) for the NCLEX to approximately 190,000 candidates
- Recruited, screened, and confirmed the attendance of 144 item writers, 55 item reviewers, and 9 Panel of Judges members to fill 24 test development sessions
- Worked with The Chauncey Group to continue publication of the *NCLEX™ Program Reports* to over 780 subscribers
- Worked with The Chauncey Group to implement the new *NCLEX-PN™ Test Plan*
- Worked with the NCLEX Evaluation Task Force to complete the first NCLEX program evaluation

Nurse Aide Competency Evaluation Program (NACEP™)

Program Purpose: To provide a legally defensible, psychometrically sound nurse aide competency evaluation in a competitive environment.

Supporting activities:

- Began working with The Psychological Corporation (TPC) and Assessment Systems International (ASI), after their merger, to transition the operational NACEP program testing services to ASI
- Negotiated a new long-term contract with TPC/ASI to provide nurse aide testing services
- Worked with TPC and ASI to provide the NACEP to 21 states and territories for the testing of over 56,000 nurse aides, primarily in long-term care
- Sponsored the Seventh Nurse Aide/Assistant Conference in Baltimore, Maryland, which was attended by state and federal regulators, educators and others interested in nurse aides/assistants
- Published *Insight: Newsletter on Nurse Aides and Assistive Personnel* three times annually, with circulation to over 1,000

Other services:

- Worked with the APRN Task Force to implement the benchmark process for the nurse practitioner certifying agencies as directed by the 1995 Delegate Assembly

Nursing Practice and Education Programs

Models and Positions

Program Purpose: Through information and analyses provided, Member Boards are assisted in promoting consistency in licensing requirements. Information analyses as well as models, other resources and a process for evaluating the usefulness of various documents are provided.

Supporting activities:

- Participated in the analysis of readership survey response regarding publications related to nursing practice and education
- Assisted in the design and data analysis of the Functional Abilities Validation Study, and the formulation of recommendations regarding safe competent practice

Continued Competence

Program Purpose: Development of renewal and reinstatement processes that encompass both competency assessment and strategies to attain/maintain continued competence will assist boards in demonstrating the need for and effectiveness of regulation.

Supporting activities:

- Provided staff support for the Continued Competence Subcommittee as it developed resources for use by Member Boards

Monitoring the Practice Environment

Program Purpose: Changes in the health care environment are the driving factors in changes in practice, roles and education. Monitoring and analyzing the environment, and sharing information are the first steps in identification of the critical issues that will impact nursing regulation.

Supporting activities:

- Participated in the development and implementation of approaches for more timely and effective monitoring of issues and trends related to the work of the National Council
- Monitored nursing practice issues and their impact on the regulation of nursing practice

Resources Regarding Practice

Program Purpose: To provide documents and other resources which provide assistance, support and guidance regarding the regulation of nursing practice.

Supporting activities:

- Provided staff support for the Nursing Practice and Education Committee, in their coordination role and their work related to professional accountability
- Provided staff support for the Task Force on Advisory Opinions/Rulings as it explored approaches for responding to practice issues

Discipline-related Research

Program Purpose: Providing information, analyses and standards regarding the enforcement of safe nursing practice.

Supporting activities:

- Progressed toward completion of the study of discipline effectiveness, funded by HRSA
- Began collection of discipline cases involving sexual misconduct for future research study

Disciplinary Data Bank

Program Purpose: To provide information regarding disciplinary action taken in other jurisdictions to assist Member Boards in identifying individual seeking the "geographic cure" for licensure difficulties, and to strengthen the safety net in place to protect the public from unsafe and incompetent professionals. Other discipline resources assist the boards to attain the necessary balance between allowing individuals to practice a chosen profession and the need to protect the public from unsafe licensees.

Supporting activities:

- Managed Disciplinary Data Bank (DDB) services
- Obtained authorization from boards of nursing regarding expanded access to selected DDB data
- Explored options for collaboration with the National Practitioner Data Bank to facilitate Member Board reporting when required
- Provided staff support for the Nursing Investigators Program and the Disciplinary Investigators Task Force

- Provided staff support for the Complex Discipline Cases Subcommittee and the Sexual Misconduct Task Force as they developed resources for Member Board use

Monitoring the Education Environment
Program Purpose: Changes in the health care environment are the driving factors in changes in practice, roles and education. Monitoring and analyzing the environment, and sharing information are the first steps in identification of the critical issues that will impact the regulation of nursing education.

Supporting activities:
- Monitored nursing education issues and trends related to nursing regulation
- Kept Member Boards apprised of problems with identified foreign nursing education programs

Resources Regarding Education
Program Purpose: To provide documents and other resources which provide assistance, support and guidance regarding the regulation of nursing education.

Supporting activities:
- Conducted review of Member Board education rules, compared to *Model Nursing Administrative Rules*, for use by the Nursing Practice and Education Committee
- Conducted survey of users to evaluate the Education Surveyors Modules and found 39 boards responded; 20 have used the Modules; most common usage was staff development; 17 found Modules useful or very useful; 19 did not use modules; 17 indicated they were not needed; six plan to use in future
- Provided staff support for the Subcommittee to Analyze Clinical Experiences
- Explored options for obtaining information regarding accommodations to nursing students while in their program of study
- Served as member of the National Practitioner Data Bank Executive Committee

Public Policy Programs

Policy Analysis
Program Purpose: To promote the mission of the National Council by providing ongoing analysis of health care, health care reform, environmental and regulatory issues with primary focus on the impact on Member Boards.

Supporting activities:
- Systematically reviewed state and federal legislation to identify implications for nursing regulation
- Developed system to monitor health care literature to determine impact of changes in the health care and technology environments on nursing regulation
- Developed *Policy Currents* to provide Member Boards with summary of state legislative information
- Developed organizational structure for networking with essential regulatory policy makers
- Facilitated internal public policy team activities to provide evaluation and analysis of regulatory and health care issues

Nursing Regulation
Program Purpose: To develop strategies and resources to support Member Boards in implementing their role regulating nursing.

Supporting activities:
- Provided staff support to Nursing Regulation Task Force which coordinated organizational analysis of and response to the Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation
- Conducted first national intraprofessional conference to analyze the impact of these recommendations for nursing regulation
- Elicited responses from nurses across the country about the "Essence of Nursing"
- Participated in development of strategy to identify and validate regulatory outcomes
- Conducted extensive analysis of all existing models of regulation and identified components as a basis for a proposed, revised model for nursing regulation

NAFTA/Trilateral Initiative
Program Purpose: To participate in trilateral collaborative nursing activities related to nursing licensure, regulation and standards of practice.

Supporting activities:
- Based on agreed upon outline, prepared paper with in-depth description of the nursing regulatory system in the United States
- Coordinated trilateral efforts to ensure preparation of comparable papers describing Canadian and Mexican nursing regulatory systems
- Met with staff of the U.S. Trade Representative's Office and continued to monitor implementation of NAFTA
- Participated in international conference on Trade Agreements, Higher Education, and the Emergence of Global Professions: the Quality Dimension

Unlicensed Assistive Personnel
Program Purpose: To provide resources for Member Boards with varying degrees of responsibilities for regulating unlicensed assistive personnel.

Supporting activities:
- Provided staff support to Unlicensed Assistive Personnel Task Force for development of paper on *Delegation: Concepts and Decision Making Process*, draft sample curriculum for educating professional nurses and unlicensed assistive personnel regarding delegation, and draft decision tree for regulation of unlicensed assistive personnel
- Developed draft current scenarios for use and regulation of unlicensed assistive personnel across the continuum of care

Telecommunications Issues
Program Purpose: To provide guidelines on regulatory issues related to jurisdictional telecommunications practice.

Supporting activities:
- Provided staff support for the Telecommunications Task Force
- Initiated review of literature and Internet for information on the use of telecommunications technology in the provision of nursing care
- Monitored the developments in telecommunications technology and the potential impact on nursing regulation
- Conducted survey to collect information from Member Boards on the pervasiveness of the practice of nursing via telecommunications technology in their respective jurisdictions
- Attended conferences relevant to the topic of telecommunications technology and the growth and development of the provision of care via this technology
- Developed *Telecommunications Hotline* to disseminate to Member Boards pertinent information related to telecommunications technology

Advanced Nursing Practice
Program Purpose: To identify actual and potential regulatory needs of Member Boards related to the advanced practitioner.

Supporting activities:
- Monitored issues related to advanced practice and education
- Provided staff support to APRN Coordinating Task Force, including:
- Reviewed and analyzed the National Association of Nurse Practitioners in Reproductive Health (NANPRH) Standards of Practice and Education
- Reviewed the National Organization of Nurse Practitioner Faculties (NONPF) Curriculum Guidelines
- Developed and conducted survey to gather information from Member Boards on the regulatory status of the CNS and potential merging of advanced practice roles
- Conducted literature search on the role of the Clinical Nurse Specialist to identify current educational preparation and practice pattern of the CNS

- Participated in development of the benchmarking process for NP Certifying Organizations and in the negotiation process

Research Programs

Job Analysis Research

Program Purpose: Support validity arguments for NCLEX-RN, NCLEX-PN, and NACEP.

Supporting activities:

- Completed revision of methodology for performing Registered Nurse job analysis study
- Initiated Registered Nurse job analysis study in May 1996

Chemical Dependency Regulatory Research

Program Purpose: To provide Member Boards with data that informs jurisdiction-level policy decisions; to provide National Council with data that informs development and provision of resources for Member Boards.

Supporting activities:

- Prepared all data collection instruments
- Recruited a seventh Member Board to obtain their participation/cooperation in the study
- Completed recruitment of subjects from seven jurisdictions
- Initiated six months of data collection activities in November 1995
- Performed data analysis

Family Nurse Practitioner Pharmacotherapeutics and Prescriptive Privileges Project

Program Purpose: To develop pharmacotherapeutic curriculum guidelines to promote curricular standardization; to develop criteria that Member Boards can use to evaluate competence of family nurse practitioners applying for prescriptive privileges.

Supporting activities:

- Received award on October 1, 1995, of a $249,000 contract over 15 months funded jointly by the Division of Nursing (Bureau of Health Professions, Health Resources and Services Administration) and the Agency for Health Care Policy and Research (Health Resources and Services Administration, US Department of Health and Human Services)
- Subcontracted to the National Organization of Nurse Practitioner Faculties the curriculum development component
- Prepared draft documents for review, for which opportunity for discussion and critique will be provided during the National Council's 1996 Annual Meeting

Other services:

- Prepared and disseminated a request for proposals for the performance of a job analysis study of entry-level nurse practitioners
- Provided consultative support services to committees, task forces, and staff regarding survey development and data analysis
- Performed electronic literature searches for Member Boards and provided consultation regarding research projects
- Performed data analysis and prepared report summarizing findings of the Organization Plan Objective Importance Study; prepared survey tools and protocol for Organization Plan Objective Effectiveness Study and Trend Analysis Study
- Completed data analysis for the Functional Abilities Study
- Compiled and condensed characteristics of and indicators of an effective regulatory system in preparation for a validation study
- Assisted in joint planning sessions with the American Academy of Nursing for an invitational meeting, "Forging the Future Health Care Work Force: Regulation, Education & Practice"

- Represented the National Council at the National Nursing Research Roundtable and the Interagency Conference on Nursing Statistics
- Provided staff services supporting program development for the conference, "Alternative to License Discipline Programs for Chemically Impaired Nurses"

Computerized Clinical Simulation Testing (CST)® Project
Program Purpose: To provide an authentic assessment of nursing competence.

Supporting activities:
- Collaborated with National Board of Medical Examiners (NBME) in development of the new CST system; continued development of NIRS©, the database which underlies CST cases; developed a new computer user interface; formatted and tested the nursing activity and default client response components of the NIRS; initiated the entry of four CST cases and scoring keys into the new system
- Formed a CST Coordinating Group which consists of two staff from the Research Services Department and two staff from the Testing Services Department to oversee the direction of the CST Project. A major focus this year has been the refinement of the CST Research Plan in preparation for review by the CST External Research Review Panel
- Held a symposium, *Nursing Practice in the 21st Century: Rethinking Licensure and Regulation*, to elicit from a group of nurse visionaries a forecast about the future of nursing that would provide direction in the area of licensing examinations content
- Held a symposium, *Scoring of Performance Assessments*, to elicit, from a panel with expertise in performance assessment scoring and standard setting, information that could be applied to the scoring of CST

Nurse Information System (NIS)
Program Purpose: To establish an unduplicated master list of all nurse licensees.

Supporting activities:
- Worked with Strategic Technology Resources (STR) to develop NIS software
- Finalized data completeness and logical consistency checks that will be used to maintain data integrity within NIS
- Sent scan forms to 13 Member Boards, with a total number of over 900,000 active licensees, that have agreed to use the scan form
- Received and scanned 28,373 scan forms during the period May 1995 through May 1996
- Began task of verifying data integrity of scan files; hand edited over 54,500 records
- Continued to work with Member Boards to encourage participation
- Reviewed all restrictions Member Boards have placed on National Council's release of licensee data in order to standardize the data release rules and compile in a supporting NIS database to form the basis of the NIS data security plan

Communications Programs

Publications and Interorganizational Communications
Program Purpose: To gain national-level government, private sector and media connections and influence that work to enhance the image and public perception of the value of nursing regulation.

Supporting activities:
- Introduced a monthly attachment to the bi-weekly *Newsletter* that focuses on health care legislation and related emerging and current public policy topics, titled *Policy Currents*
- Published four editions of *Issues*, three editions of *Insight: Newsletter on Nurse Aides and Assistive Personnel*, and a special publication of the proceedings from the jointly sponsored conference with the Citizen Advocacy Center, *"Crafting Public Protection in the 21st Century: The Role of Nursing Regulation"*
- Published, and made available for sale, a number of publications including the *NCLEX-PN™ Test Plan, Guidelines for NCLEX-PN™ Item Writers*, an update to *The NCLEX™ Process*, and self-study learning modules for education program site surveyors

- Published a resource packet of information to support Member Board needs when responding to questions about the Pew Taskforce on Health Care Workforce Regulation report
- Published and coordinated the supply to Sylvan Technology Centers of an exit brochure about the NCLEX™ that is given to each candidate following their testing session
- Published a variety of informational brochures for the NCLEX™ and CST® programs
- Produced a video describing the National Council and its purpose, mission and programs for use by Member Boards and for the purpose of orienting new committee volunteers

Meetings

Program Purpose: To provide opportunities for Member Boards to act and counsel together on matters of common interest regarding the role of nursing regulation in public protection.

Supporting activities:

- Planned and implemented the meeting logistics for the Annual Meeting, four Regulatory Days of Dialogue, four Area Meetings, an Advanced Practice Roundtable, and a national nurse aide conference, including the submission of continuing education units where requested
- Planned and conducted a joint conference on the role of nursing regulation in the 21st century with the Citizen Advocacy Center, held in Arlington, Virginia
- Received approval from the Alabama Board of Nursing as a continuing education unit (CEU) provider and developed all related policies and procedures for CEU approval of educational offerings
- Coordinated eight educational sessions and a poster session for the 1995 Annual Meeting; published and distributed the 1996 Call for Papers to all 1995 meeting attendees and educators nationwide
- Coordinated communications among National Council volunteers, travel agency, corporate hotel and office staff regarding committee meetings
- Negotiated and secured hotel contracts for National Council's 1998 Annual Meeting and 1996 Area Meetings

Information Resources

Program Purpose: To build an information access highway to Member Boards and others who could use the information for promotion of safe and effective nursing practice and the protection of the public.

Supporting activities:

- Developed three World Wide Web sites for use by Member Boards, National Council staff and the general public, respectively, and that serve as the foundation of all NCNET services
- Acquired and secured a T1 (high speed) connection to the Internet to facilitate Member Board access to NCNET services and public access to National Council information and resources
- Electronically scanned National Council documents for inclusion in a comprehensive electronic text search database available via NCNET (the name of the service is EDWARD), including Delegate Assembly minutes, Board of Directors minutes, National Council news releases, every edition of *Emerging Issues*, concept papers, position papers, and articles from every edition of *Issues*
- Developed and presented at all Area Meetings a software prototype for a proposed electronic licensure verification information system (ELVIS)
- Assigned personal NCNET logins and passwords to the executive officers of each Member Board
- Purchased and installed an optical scanning system to facilitate document storage and enhance document retrievability
- Continued refinements to the electronic irregularity reporting (EIR) system and National Council's electronic disciplinary data bank (DDB)
- Transitioned to Microsoft Office software products to enhance consistent and efficient work performance at the National Council office

Other services:

- Responded to requests from 12 Member Boards for Resource Network services
- Exhibited National Council services at 13 meetings of nursing and regulatory groups

Governance

Program Purpose: To ensure that boards of nursing, as "owners" of the organization, exert the key leadership and to ensure that the needs of the members are served.

Supporting activities:

- Coordinated liaison meetings with identified organizations (American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, Commission on Graduates of Foreign Nursing Schools, Division of Nursing, National Association for Practical Nurse Education and Service, National Federation of Licensed Practical Nurses, National League for Nursing, National Organization for Associate Degree Nursing, and Joint Commission on Accreditation of Healthcare Organizations)
- According to direction provided by the Executive Officers' Network, implemented the first annual orientation program for new executive officers
- Provided staff support to the Board of Directors and administrative liaisons to all committees and special committees
- Provided beginning-of-year all-staff retreat, mid-year updates, and orientation for new employees

Special Services Division (SSD)

Program Purpose: Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

Supporting activities:

- Submitted business plans for the Certification Examination for Practical and Vocational Nurses (CEPN-LTC™) and Nursing Educator Workshops; both plans were reviewed by the CEO and approved for implementation
- Implemented year-round delivery of the CEPN-LTC through ASI testing centers
- Conducted pilot presentations of Nursing Educator Workshops, in Chicago and Washington, D.C.
- Complied fully with SSD Administrative Guidelines

Executive and Administrative Services

Planning and Evaluation

Program Purpose: To support the governance of the National Council in identification and accomplishment of significant ends related to public protection through nursing regulation.

Supporting activities:

- Planned and implemented a study to obtain National Council membership input regarding the relevance of the National Council's Mission Statement and the importance of its objectives relative to boards of nursing performing their functions
- Maintained a cumulative organizational assessment in four major areas: outcomes evaluation, performance appraisal, structure/documents assessment, and future needs assessment; the organizational assessment activities were augmented for each Board of Directors meeting, with a final summary produced at the end of the fiscal year
- Provided records of progress toward accomplishment of all FY96 tactics in the Organization Plan for each meeting of the Board of Directors
- Coordinated short-term planning with the aim of maintaining congruence with the Organization Plan, vision, and projected availability of resources
- Coordinated long-term planning to ensure focused movement over the next five years

Resource Management

Program Purpose: To maintain sound financial and human resource management systems for the National Council.

Supporting activities:

- Issued financial statements by organization plan objective as well as by responsibility center.

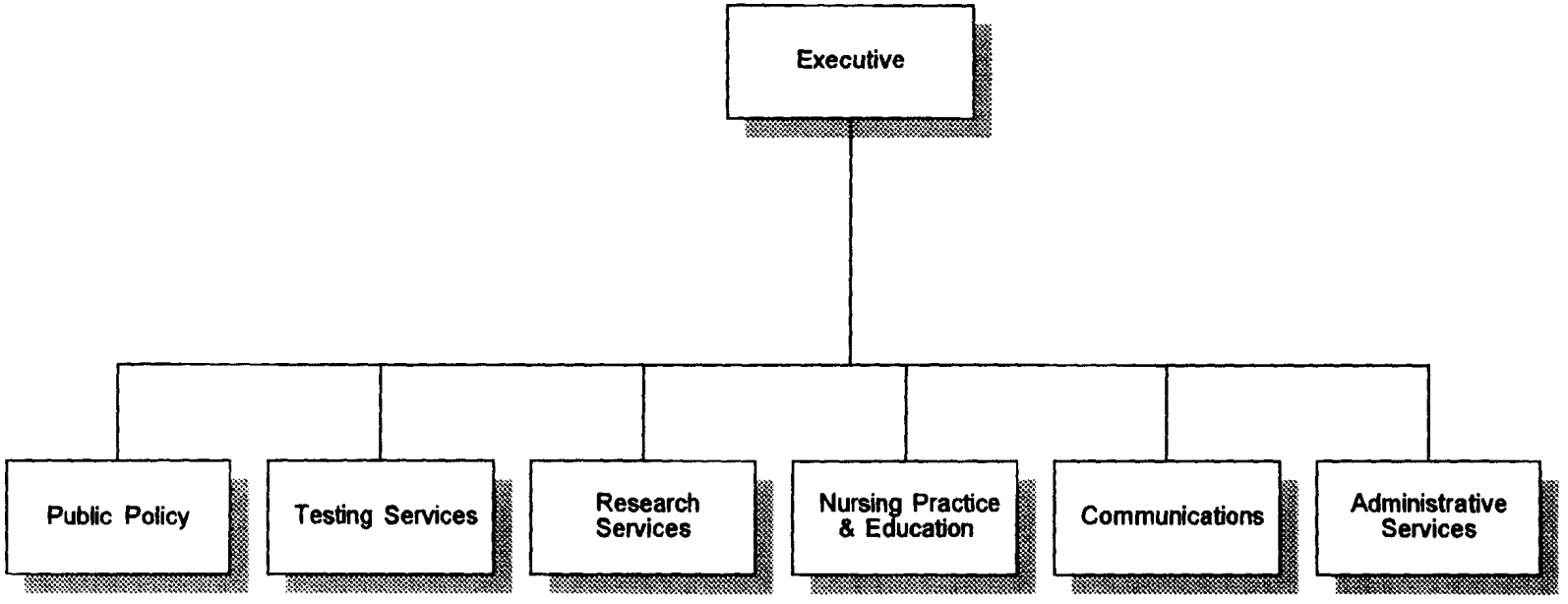
- Reviewed and revised the National Council's hiring, staff orientation, staff development, and compensation systems

The staff of the National Council count it a privilege to work with an organization so committed to goals of safe and effective care for consumers. Working with Member Boards to meet the challenges of our changing environment is both stimulating and rewarding.

National Council Administrative Staff

Jennifer Bosma, Ph.D., C.A.E.	Executive Director
Doris Nay, M.A., R.N.	Associate Executive Director
Anna Bersky, Ph.D., R.N.	CST Project Director
Jodi Borger	NCLEX™ Administrative Assistant
Sandra Brooks	Administrative Assistant
Valerie Brown, BSN, RN	Research Database Coordinator *(beginning February 1996)*
Delores Caruso	Staff Accountant
Nancy Chornick, Ph.D., R.N.	NCLEX™/SSD Coordinator
Darcy Colby	Marketing Assistant *(beginning November 1995)*
Diane Creal, M.S., R.N.	Practice & Policy Associate
Susan Davids, C.M.P.	Meetings Manager
John Ditzel	Software Trainer/Help Desk Coordinator
Heather Freise	Communications Manager *(beginning June 1996)*
Ellen Gleason, M.S.I.R., M.S.O.D.	NACEP Manager
Barbara Halsey, M.B.A.	NCLEX™ Administration Manager
Christopher T. Handzlik	Integrated Media Manager
Carol Hartigan, M.A.	NCLEX™ Contract Manager
Linda Heffernan, J.D., M.S.N., R.N.	Nursing Practice and Education Associate
Carolyn Hutcherson, M.S., R.N.	Senior Policy Analyst
Peggy Iverson	NIS Administrative Assistant
Ellen Julian, Ph.D.	Psychometrician
June Krawczak, Ed.D., R.N.	CST Project Associate
Philip J. LaForge, M.B.A.	Marketing Manager
Craig S. Moore, M.S.T.S.	Network Administrator
Melanie Neal, M.A.	NIS Project Manager
Bryan M. Newson	Software Engineer/Database Manager
Lea Newson	Communications Administrative Assistant
Kerry Nowicki	Communications Manager *(through March 1996)*
Vickie Sheets, J.D., R.N.	Director for Nursing Practice and Education
Ruth Spiro, M.B.A.	Testing Administrative Coordinator
Thomas Vicek, M.B.A., C.P.A.	Director of Administrative Services
Ann Watkins	Executive Secretary
Anne Wendt, Ph.D., R.N.	NCLEX™ Content Manager
Susan Woodward	Director of Communications
Carolyn J. Yocom, Ph.D., R.N., F.A.A.N.	Director of Research Services
Anthony R. Zara, Ph.D.	Director of Testing Services

National Council of State Boards of Nursing
Organizational Chart - Departments



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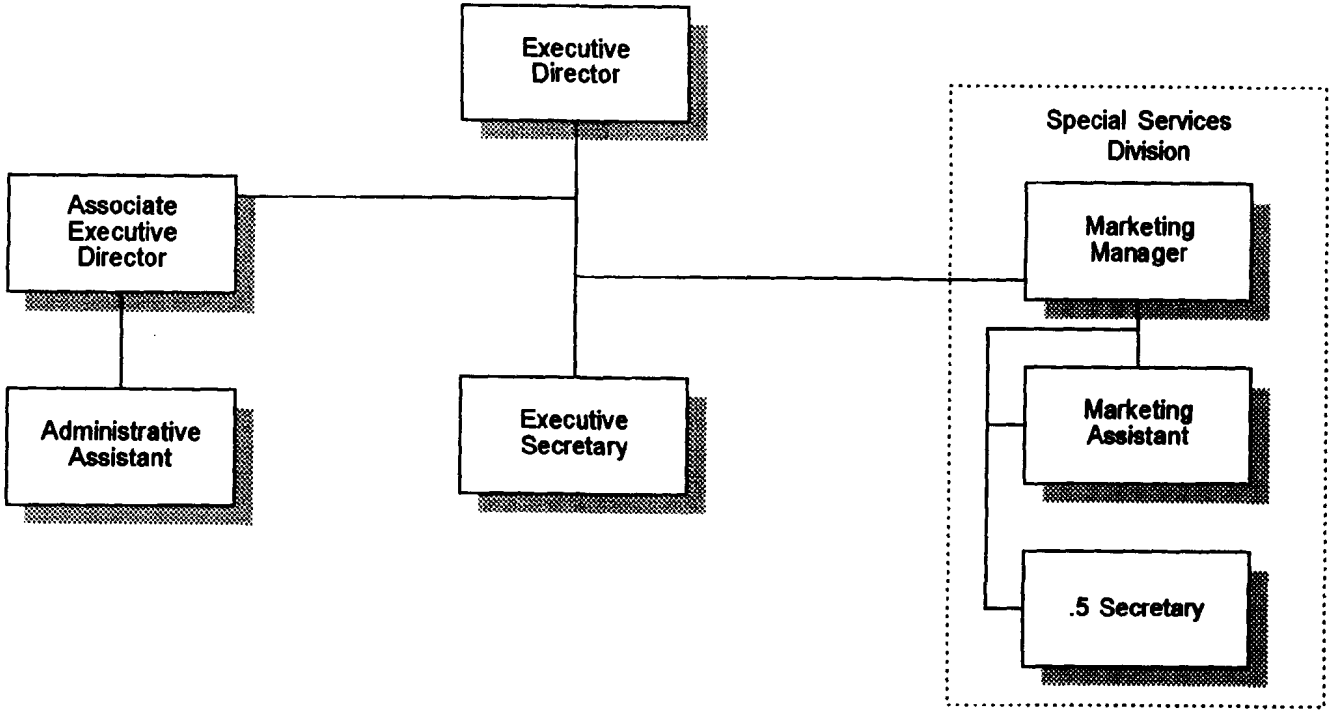
National Council of State Boards of Nursing
Organizational Chart - Executive/SSD



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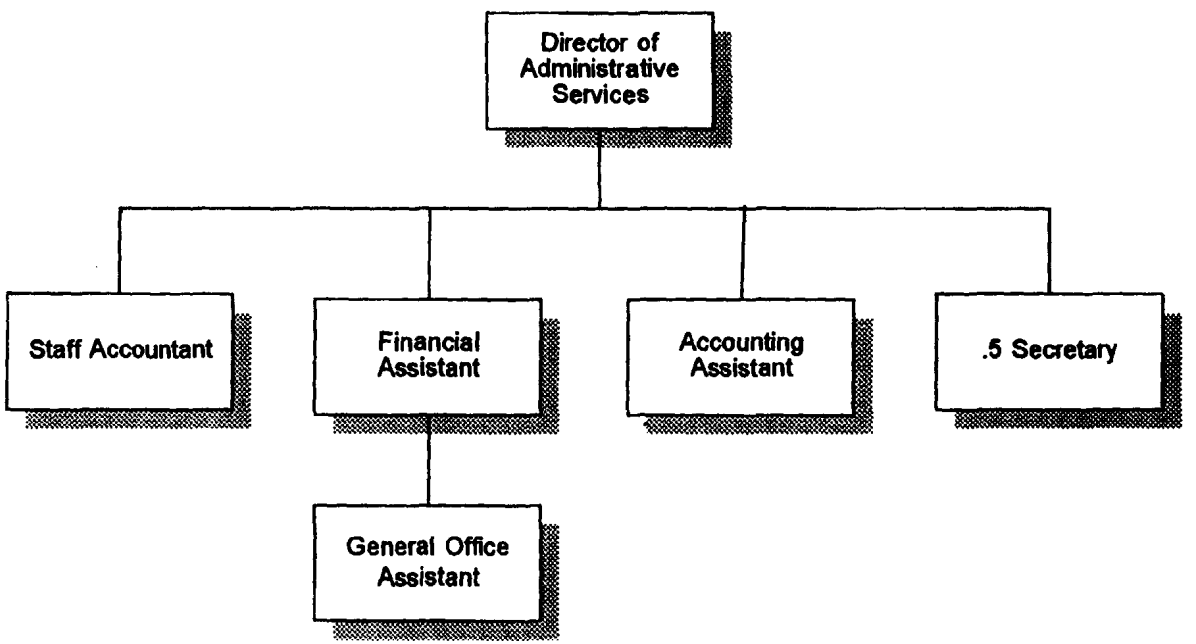
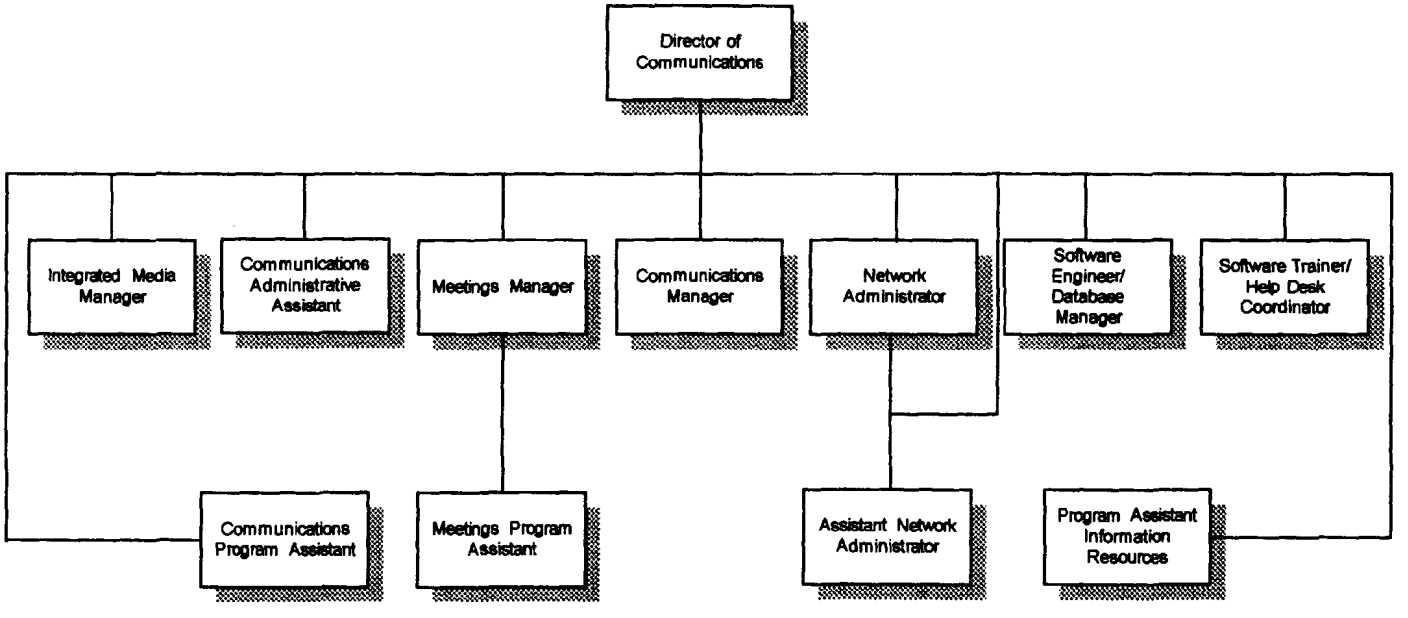
National Council of State Boards of Nursing
Organizational Chart - Administrative Services



National Council of State Boards of Nursing
Organizational Chart - Communications



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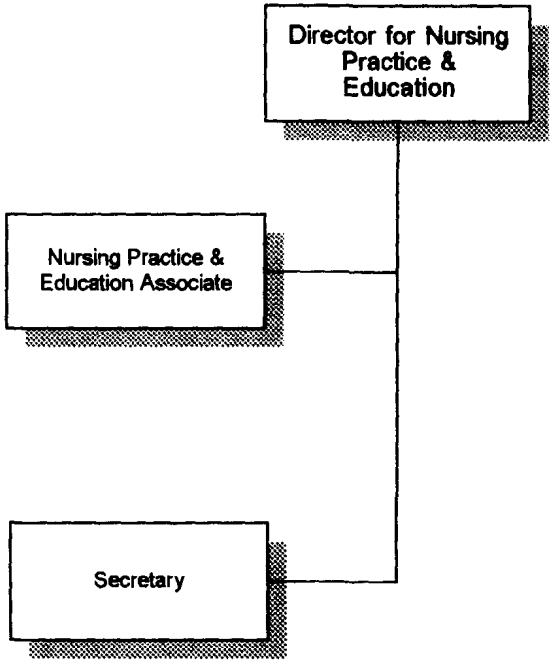
National Council of State Boards of Nursing
Organizational Chart - Nursing Practice & Education



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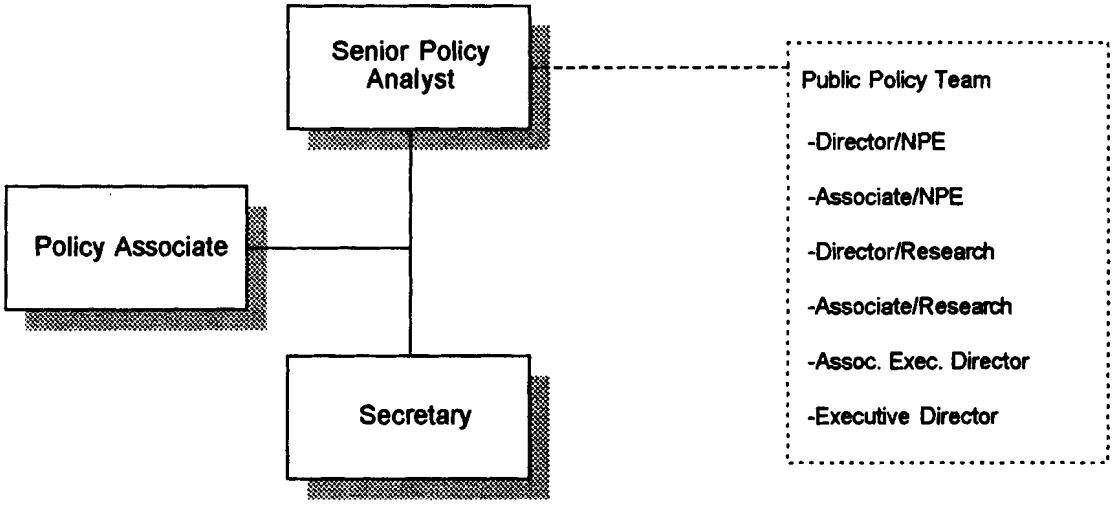
National Council of State Boards of Nursing
Organizational Chart - Public Policy



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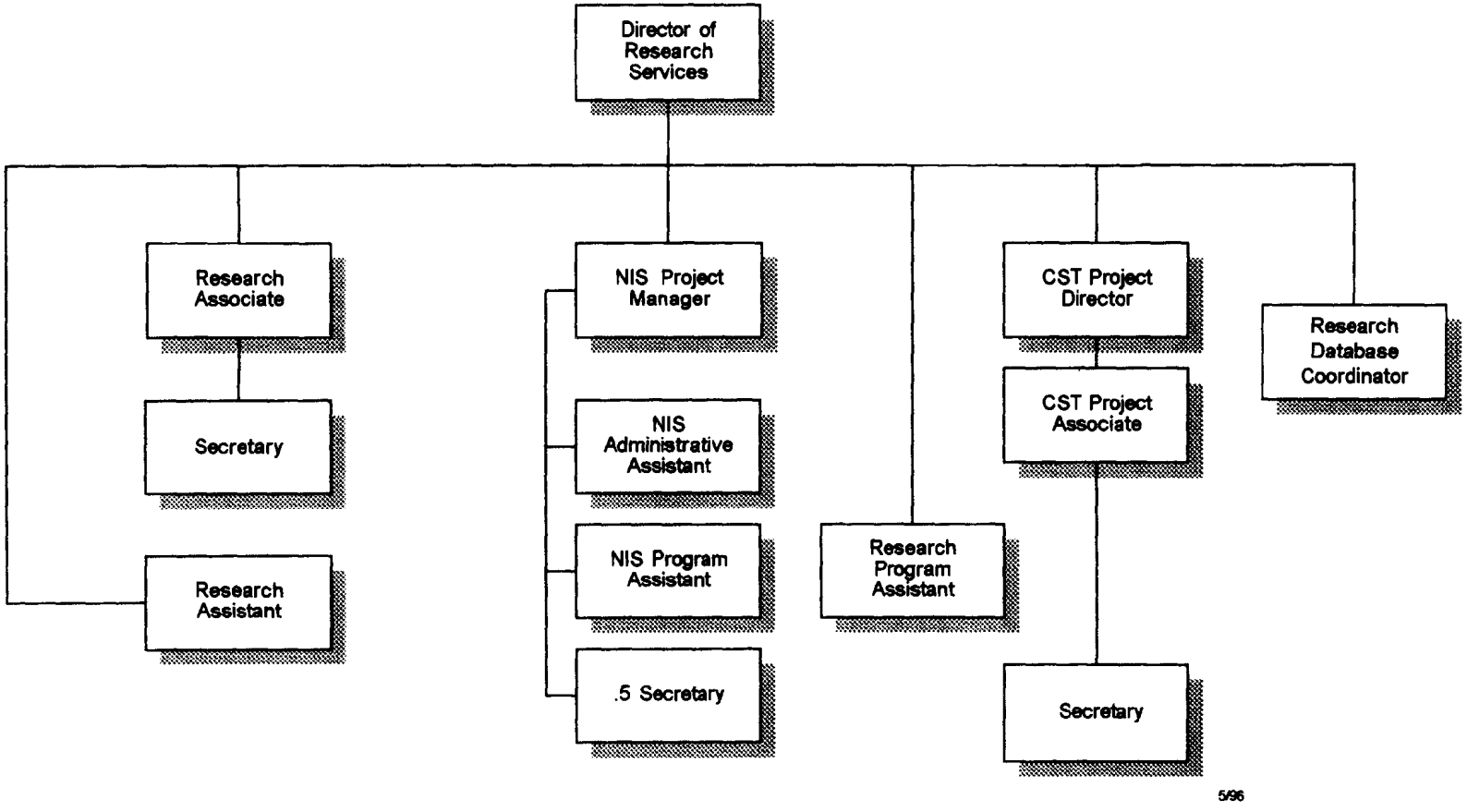
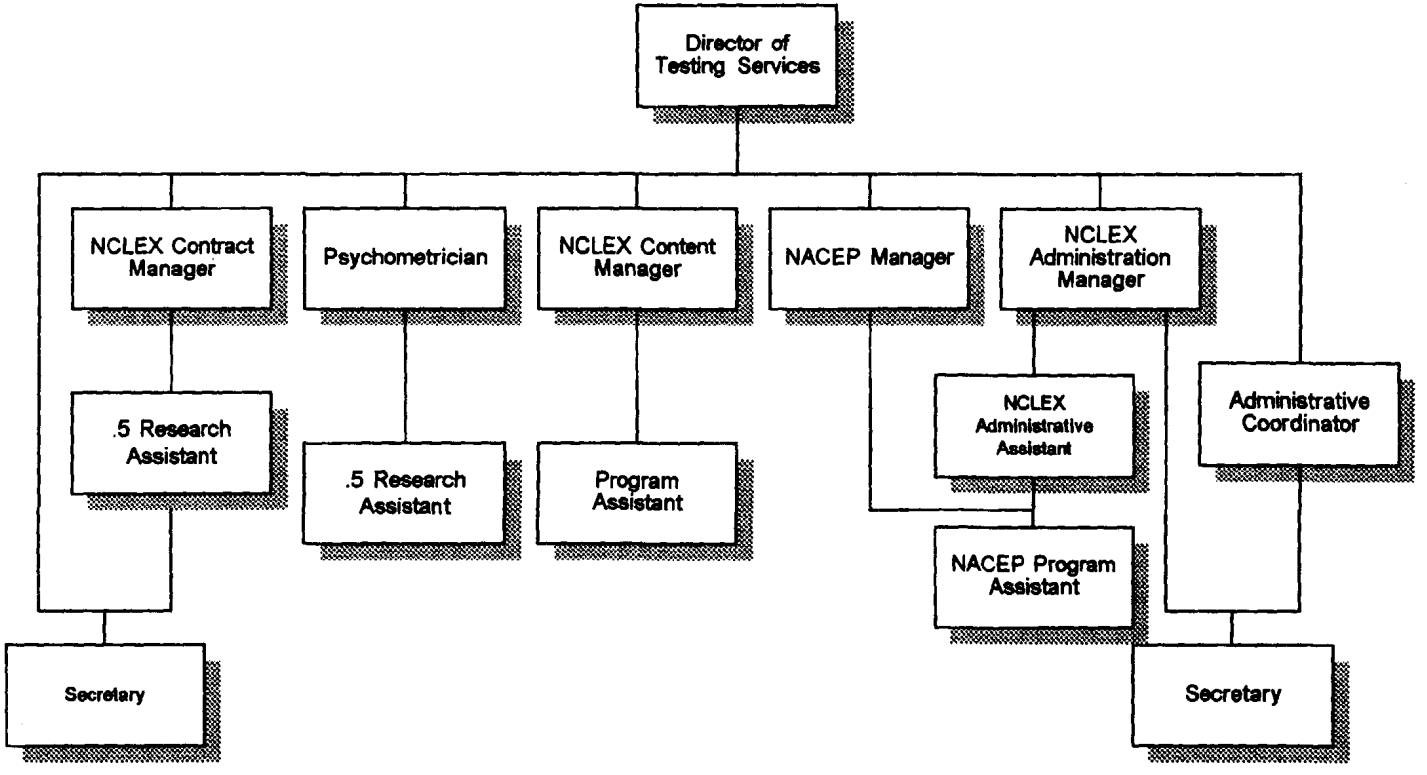
National Council of State Boards of Nursing
Organizational Chart - Research



National Council of State Boards of Nursing
Organizational Chart - Testing



Report of the Examination Committee

Committee Members

Renatta Loquist, SC, Area III, *Chair*
Susan Boone, OH, Area II
Julie Campbell-Warnock, CA-RN, Area I
Cora Clay, TX-VN, Area III
Constance Connell, AZ, Area I
Belle Cunningham, AK, Area I
Sheila Exstrom, NE, Area II
Helen Kelley, MA, Area IV
Carol McGuire, KY, Area III
Lynn Norman, AL, Area III
Carol Silveira, MA, Area IV
Milene Sower, NY, Area IV

Alternate Committee Members

Joan Bouchard, OR, Area I
Shirley Brekken, MN, Area II
Karen Brumley, CO, Area I
Teofila Cruz, GU, Area I
Terry DeMarcay, LA-PN, Area III
Donna Dorsey, MD, Area IV
Faith Fields, AR, Area III
Harriet Johnson, NJ, Area IV
Toma Nisbet, WY, Area I
Carol Osman, NC, Area III
Cynthia Purvis, SC, Area III
Richard Sheehan, ME, Area IV
Rosa Lee Weinert, OH, Area II

Staff

Jodi Borger, *NCLEX Administrative Assistant*
Barbara Halsey, *NCLEX Administration Manager*
Carol Hartigan, *NCLEX Contract Manager*
Ellen Julian, *Psychometrician*
Anne Wendt, *NCLEX Content Manager*
Anthony Zara, *Director of Testing Services*

Relationship to Organizational Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B. ..... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation(s)

The committee received a report in May 1996 concerning the findings of the Subcommittee on PN Assessment. Because the findings of this subcommittee offered no substantive change to the earlier findings of the committee, the report was endorsed as written.

Highlights of Activities

Implementation of New *NCLEX-PN™ Test Plan*

The committee appointed a Panel of Judges which used the new *NCLEX-PN™ Test Plan* in its criterion-referenced standard setting process in February 1996. The Board of Directors' adjustment of the PN/VN passing standard will be implemented with the test plan change in October 1996. This timeline allows information about the new PN/VN passing standard to be communicated to all relevant individuals and agencies.

Item Development

Developed and Monitored Policies and Procedures

The committee reviewed and monitored the effectiveness of all examination-related policies and procedures. Revisions were made in pertinent procedures to reflect processes changed and refined during the second year of computerized adaptive testing for NCLEX™.

Conducted Committee Item Review Sessions

Last year, the committee was interested in preserving consistency in the manner in which NCLEX items were reviewed before becoming operational. Each new item and 25 percent of the base pool are reviewed annually (over the course of five meetings). Throughout this year, the committee continued last year's methodology of reviewing new items only after they have been tried out and have accompanying statistics. All nurse members of the committee reviewed the items in one group and all decisions regarding coding or operational definitions were made by the entire group. The use of Examination Committee (EC) Alternates to assist in the item review process has been significantly diminished. This item review process has greatly enhanced the consistency of decisions, but contributes to a heavy item review workload, given the rapid item development rate dictated by the test service contract.

Monitored Item Production

The Chauncey Group's item development roll-out plan to meet the goal of three optimal item pools has increased in urgency. Given the current rate of new item production and survival as well as the attrition rate of items from the base pool (primarily due to currency), a significant net gain in new NCLEX items has not been realized. To address this issue, a six-member NCLEX Strike Force of key test development staff from National Council and The Chauncey Group was convened. This group is exploring alternative methods for item creation in addition to the scheduled item development workshops planned for the next year. The Examination Committee approved the pilot testing of several supplemental strategies for item development. As each strategy is phased in through pilot testing, outcomes will be evaluated on an ongoing basis by the committee.

In addition to increasing the number of traditional item writing sessions held each year, making changes in the structure of the item writing workshops to increase the time available for writing, and initiating item development at home by experienced item writers, supplemental strategies of "cloning" of items and expert nurse item writers developing items from critical incidents submitted by nurses have also been approved. The committee approved the use of targeted faculty item development workshops (at least one in each of National Council's geographic Areas) to increase participation in item development. Following a one-day presentation on item development, interested individuals who meet the National Council criteria for item writing will have the opportunity to develop and submit items in a structured setting.

In an attempt to reach more staff nurses, a call for critical incidents from front line nurses is being planned. Although a job analysis survey is conducted every three years, the committee has long been interested in developing a plan to obtain a "snapshot" of the rapid changes in the health care delivery system occurring between formal job analysis periods. The committee believes that a nationwide call for critical incidents will help to identify changes in practice, settings and other trends, thus increasing the fidelity of the examination to today's quickly evolving practice.

Evaluated Item Development Process and Progress

The committee evaluated the ETS/Chauncey Group item writing and item review sessions for process and productivity. From April 1995 through March 1996, RN item writers produced 1,791 items in six workshops. For the same time period, a series of six PN sessions were held, resulting in 1,564 items. From June 1995 through March 1996, RN item reviewers approved 1,355 of 1,523 items, resulting in an 89% survival rate. PN item reviewers approved 1,026 of 1,112 items, resulting in a 92% survival rate. Committee representatives monitored the item development sessions when possible in order to provide feedback to The Chauncey Group.

The Examination Committee provides the final review and approval of every item before it is included in a real pool. From May 1995 through December 1995, 885 of 1,019 RN items were approved by the EC, resulting in an 87% survival rate. During the same period, the EC approved 928 of 1,024 PN items, a 91% survival rate.

The survival rate from the Examination Committee review of approximately 25% of the base pool was 80% for RN items and 75% for PN items. The committee received a report and timeline on Chauncey's plan for securing two current updated validations for each base pool item. The Chauncey Group estimates that all RN items will have two current updated validations within the next 18 months and all PN items will have two current updated validations within the next year. The committee reviewed a random selection of 120 item validations for NCLEX-RN and NCLEX-PN items and noted that the validations were accurate and sufficient

To facilitate the item development process, the committee reviewed and approved revised *Guidelines for NCLEX-RN™ Item Writers* and *Guidelines for NCLEX-PN™ Item Writers*; and approved additions to the Operational Definitions during the item review portion of each committee meeting.

As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX items and examinations; particularly review of RN and PN items that were designated by Member Boards as inconsistent with state statutes and/or not reflective of entry-level practice. The committee directed The Chauncey Group to develop a cumulative list of those concepts which were designated as inconsistent with state statutes.

A subgroup of the committee, the Workgroup on Conceptual Framework, Job Analysis/Task Statements and Test Plan, was formed to provide the Examination Committee with a structured method for providing input into the NCLEX test plan development process. The committee met with the Research Department to discuss the calculation of importance weight data for the 1996 RN Job Analysis Study. The committee reaffirmed a previous decision that both frequency and criticality continue to be considered in calculating the importance weights of task statements. For the 1996 RN Job Analysis, the timing definition for entry-level practice will remain at six months. The committee also received clarification of the job analysis pilot study methodology, and made suggestions for changes to the job analysis questionnaire.

Psychometric Issues

Monitored Examination Analysis

The committee periodically evaluated the NCLEX by reviewing reports on item and candidate performance, including item exposure rates, overlap among the items seen by different candidates, non-test plan content coverage, questioned or challenged items, precision of competence estimates and pass/fail decisions, and passing rates and examination-completion rates for many subgroups of candidates. These reports support that the NCLEX meets National Council and industry-wide quality standards.

Monitored the Development of Two Parallel Operational Item Pools

The committee continued to monitor the ongoing process for configuring and implementing two parallel RN and PN item pools. Each year, two pools are created to be parallel in terms of the following variables: (1) Nursing Process, (2) Client Needs, (3) Client Needs Subcategory, (4) Intersections of Nursing Process and Client Needs, (5) Examination Committee review status, (6) CTB-produced items, (7) Case-bound and time-sensitive items, (8) Item difficulty, (9) Point-biserial correlations, and (10) NCLEX Program Report Codes (Human Functioning, Health Alterations, Wellness-Illness Continuum and Stages of Maturity).

The group also adopted a new format for an additional item coding scheme that will allow the committee to review the content of items more specifically. Multiple codes can be assigned for each item. For example, an item about both heart disease and cancer would have both diagnoses listed in the diagnosis field. The list of codes will

evolve over time, and the committee will document and update the list on a regular basis. The approved framework for content coding includes medical diagnosis, treatments/procedures, and drug classifications.

The committee determined that both the RN and PN pools should continue to be rotated semiannually for the period of April 1996 through March 1997, as they were during the first two years of CAT administration of NCLEX.

NCLEX Administration

- **Interstate Sharing of Candidate Data**

  With the inception of CAT and a central candidate database, came opportunities to better assist Member Boards in the interstate transfer of candidate information. Although there are associated statutory issues, and some states are not authorized to release this type of information, 42 Member Boards (69%) have elected to share candidate data, 10 Member Boards (16%) have chosen not to authorize data sharing, and nine Member Boards (15%) remain in the default category (no sharing).

- **Directed MBOS Fixes and Enhancements**

  The Examination Committee surveyed Member Boards for input into the desirability of certain MBOS enhancements which would improve the ease of use and accuracy of the system. Based on this information and on the availability of budgeted National Council funds, the committee prioritized and authorized program changes for the future versions of the software.

- **Monitored Procedures for Candidate Tracking; Candidate Matching Algorithm**

  Due to the importance of candidate tracking, the status and effectiveness of the candidate matching algorithm continues to be a standing agenda item for the Examination Committee. The Chauncey Group has developed a new procedure to correct matching errors on a weekly basis.

- **Monitored Electronic Irregularity Reports and Site Compliance**

  The committee received reports on Electronic Irregularity Report (EIR) summaries and reports on item content EIRs. The committee has continued to review site compliance reports filed by Member Boards and National Council staff, written and telephone complaints from candidates, Member Boards, schools of nursing, legislators, and other stakeholders to determine that the Sylvan sites and ETS corporate sites are in compliance with existing procedures and security requirements.

  The committee communicated its concerns about a perceived increase in software and hardware problems to Sylvan and The Chauncey Group. One more serious issue was a system slow-down at some centers which caused a delay between pushing a key on the keyboard and the resulting action on the screen. Sylvan reported that this was caused by the file server continuously running for a long period of time. All file servers have been "downed" and reinitialized to correct this problem. A policy for "downing" all file servers every 60-180 days, depending on testing volumes, has been implemented by Sylvan.

- **Monitored Testing Compliance According to the Americans with Disabilities Act (ADA)**

  All approved requests for ADA modifications continue to be routed to a single individual at the Sylvan National Registration Center (NRC) so that these candidates can be carefully monitored to prevent scheduling, noncompliance or legal complaints. This process has continued to provide consistency in the scheduling of candidates and the provision of modifications as requested. As of April 1, 1996, a revised version of the test administration software was initiated which permits the software to administer the breaks for candidates with a special accommodation for extra time. Prior to April 1, the Test Center Administrator was required to initiate the breaks for candidates with extra time. This change should increase the consistency of the process for all ADA candidates.

- **Natural Disaster Policy**

  The committee received a report on the conference call of the Executive Officers' Networking Subgroup in which the Natural Disaster Policy was discussed. The committee approved changes to the Natural Disaster

procedure as suggested by the subgroup and revised by the committee. This issue was presented at Area Meetings to solicit more feedback from Member Boards and present data on how the policy has been implemented. A new procedure was distributed to Member Boards in the Updates to the 1996 NCLEX Manual for Member Boards.

- **Computerized Clinical Simulation Testing**

  The committee met with members and staff from the Computerized Clinical Simulation Testing (CST®) Task Force to discuss the direction of CST and how to best work together on the project. The committees discussed such issues as the responsibilities of Member Boards with respect to entry into practice, mechanisms and organizations available to assist with those responsibilities, the purpose of entry-level licensing examinations, nursing competencies each examination methodology should assess, attributes of multiple-choice versus CST assessment, and the particular strengths and weaknesses of each of these examination mechanisms. The committees have formed a workgroup consisting of three members from each committee to work on directional and policy issues related to CST.

- **Future Considerations**

  Large-scale item development will continue throughout FY97, including the supplemental strategies, to move toward the creation of three optimal NCLEX-RN and NCLEX-PN item pools. Working with the CST Task Force, enhanced item coding, further improvement in procedures for meeting the needs of ADA candidates, further enhancements to MBOS, and the continued accuracy of the candidate database and matching algorithm remain high priority items for the committee in the coming year.

Meeting Dates

- October 20-25, 1995
- December 9-14, 1995
- February 15-20, 1996
- May 2-7, 1996
- July 8-12, 1996

Recommendation(s)

The committee received a report in May 1996 concerning the findings of the Subcommittee on PN Assessment. Because the findings of this subcommittee offered no substantive change to the earlier findings of the committee, the report was endorsed as written.

Report of the Testing Subcommittee Regarding Assessment

Subcommittee Members

Terry DeMarcay, LA-PN, Area III, *Chair*
Elaine August, WI, Area II
Jill DeGregorio, RI, Area IV
Marla Embry, AZ, Area I
Pan Pitchford, MS, Area III
Ann Shuman, CA-RN, Area I

Staff

Nancy Chornick, *NCLEX/SSD Coordinator*

Relationship to Organizational Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ..... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation to the Examination Committee

1. **That the term used to categorize assessment-related activities performed by LPN/VNs be 'data collection.' The term data collection is defined as: The LPN/VN collects information, observes the client, records and reports to the appropriate person (e.g., registered nurse, physician) signs and symptoms and other pertinent data which may indicate that the client's condition deviates from normal and/or that there is a change in the client's condition. LPN/VNs contribute to the assessment of clients through data collection. The term 'contribute to' denotes an active role on the part of the LPN/VN based on the LPN/VN's knowledge, skills and abilities.**

Rationale

After reviewing the survey data, the subcommittee concluded that the issue of assessment by LPN/VNs is made confusing with the inconsistent use of the term *assessment*. Twenty-four Member Boards reported not having definitions for the term, and for the 21 Member Boards that reported having definitions, there is a range from describing assessment as a holistic process to defining it as simply reporting data.

However, a comparison between those Member Boards which do not permit LPN/VNs to assess and those Member Boards which do permit LPN/VNs to assess indicates that the majority of Member Boards are fairly consistent in what LPN/VNs are allowed and not allowed to perform. Usually LPN/VNs are allowed to contribute or participate in assessing clients. The most frequently reported assessment-related activity permitted by all Member Boards is the collection of data. The most frequently reported assessment-related activity not permitted by all Member Boards is the independent synthesis of data resulting in a nursing diagnosis.

In terms of practice, the job analysis data indicate that there appears to be a consistent performance of assessment-related activities among LPN/VNs across all Member Boards.

The subcommittee considered other possible terms to describe the activity assessment-related activities performed by LPN/VNs. After considering all of the data, the subcommittee concluded that the term 'data collection' was the most appropriate term. In order to assure that the term is used in a consistent manner, the subcommittee developed a definition for the term of data collection.

Background

The Board of Directors appointed a subcommittee of the Examination Committee to complete the following charge:

"Investigate the scope of LPN/VN nursing practice as it relates to assessment of the client and propose an alternative term for the data collection phase of the nursing process to the 1996 Delegate Assembly which is consistent with the scope of practice of all Member Boards."

Highlights of Activities

The subcommittee met two times. On January 29, 1996, the subcommittee conducted its first meeting via telephone conference call. In order to complete the charge, the subcommittee determined that the following questions needed to be answered: (a) Which Member Boards do not allow LPN/VNs to assess, how do they define assessment and what activities are LPN/VNs permitted to perform?; (b) Which Member Boards allow LPN/VNs to assess and what activities underlay the meaning of the term assessment to these Member Boards?; and (c) What activities are being performed by LPN/VNs?

In order to accomplish this task, two strategies were proposed: (1) survey Member Boards to determine current policies regarding assessment by LPN/VNs; and (2) reanalyze data from the most recent LPN/VN job analysis study to identify current practice patterns of LPN/VNs regarding assessment-related activities.

A survey consisting of nine questions was developed and faxed to Member Boards. The survey asked questions about the scope of LPN/VN practice regarding assessment. Input to the survey was obtained from 52 Member Boards: 46 Member Boards completed and returned the survey and six Member Boards answered selected questions via telephone. Although both RN and LPN/VN boards in two-board states were sent the questionnaire, only the LPN/VN boards responded.

The subcommittee met on March 21-22 to review the data obtained from the survey and the analysis of the LPN/VN job analysis study. Survey results and analysis of the most recent LPN/VN job analysis data were used to answer the original questions identified by the subcommittee. The following information reflects the data received:

1. Determine which Member Boards do not allow LPN/VNs to assess and ask these Member Boards their definition of 'assessment'; determine what they allow LPN/VNs to do in terms of assessment and what they don't allow LPN/VNs to do.

Survey results indicated that:

- Thirteen Member Boards reported that LPN/VNs are not permitted to assess clients.
- Seven Member Boards that do not permit LPN/VNs to assess clients have a definition for the term 'assessment.' The definitions tended to focus on a holistic approach with nursing diagnosis as an integral part of the assessment process.
- Assessment-related activities most frequently permitted by these Member Boards are 'data collection' and 'identification of strengths and weaknesses.'
- Assessment-related activities which LPN/VNs are not permitted to perform most frequently in jurisdictions not permitting LPN/VNs to assess focused on independently determining client needs (i.e., nursing diagnosis, synthesis of data).

2. Determine which Member Boards allow LPN/VNs to assess and determine the activities underlying the meaning of the term 'assessment' to these Member Boards.

Survey results indicated that:

- Twenty-seven Member Boards reported that LPN/VNs are permitted to assess clients in their jurisdictions.
- Fourteen Member Boards permitting LPN/VNs to assess reported having a definition for the term 'assessment.' Although the definitions varied greatly, often terms such as 'they contribute to assessment,' or 'work under the direction of an RN' were included.
- Member Boards allowing LPN/VNs to assess most often identified the following activities which LPN/VNs are permitted to perform: observe, collect data and report.
- These Member Boards identified assessment-related activities which LPN/VNs are not permitted to perform. Although three Member Boards reported that LPN/VNs are permitted to perform all assessment-related activities,

the majority of these Member Boards reported that the LPN/VN could not independently identify a client's needs (i.e., nursing diagnosis, synthesis of data).

3. Determine what is happening in the real world of LPN/VN practice.

Survey results and job analysis data indicate:

- Two Member Boards reported that the nursing process is not taught in LPN/VN educational programs in their jurisdictions. One of the these Member Boards does not permit LPN/VNs to assess clients and the other Member Board permits LPN/VNs to assess clients.
- Data from the 1994 LPN/VN job analysis study indicated that the following activities are being done regardless of whether the Member Boards permitted the LPN/VNs to assess or not:
    1. Obtain client data from family
    2. Determine impact of results of diagnostic tests
    3. Record nursing history data base
    4. Identify client's unmet needs
    5. Determine cause of client's symptoms
    6. Ask client to describe symptoms
    7. Identify client's potential problems
    8. Determine client's strengths and weaknesses
    9. Formulate nursing diagnoses
    10. Collect physical assessment data

  Few differences in the performance of these statements were evident between the jurisdictions that allowed LPN/VNs to assess and those that did not allow LPN/VNs to assess.

Meeting Dates

- January 29, 1996 *(telephone conference call)*
- March 21-22, 1996

Recommendation to the Examination Committee

1. That the term used to categorize assessment-related activities performed by LPN/VNs be 'data collection.' The term data collection is defined as: The LPN/VN collects information, observes the client, records and reports to the appropriate person (e.g., registered nurse, physician) signs and symptoms and other pertinent data which may indicate that the client's condition deviates from normal and/or that there is a change in the client's condition. LPN/VNs contribute to the assessment of clients through data collection. The term 'contribute to' denotes an active role on the part of the LPN/VN based on the LPN/VN's knowledge, skills and abilities.

Future Considerations for the National Council

None.

Report of The Chauncey Group International and Sylvan Prometric

The Chauncey Group International

Effective January 1, 1996, The Chauncey Group International, a wholly-owned subsidiary of Educational Testing Service, was established to enable us to better serve clients in the professions whose needs are different from those of other ETS clients. Total decision-making and operational responsibilities reside in The Chauncey Group. Staff assigned to the NCLEX™ Team have not changed as a result of the transition to The Chauncey Group.

Testing Update

April 1, 1996, marked the two-year anniversary of NCLEX using computerized adaptive testing (CAT). Since April 1994 more than 381,000 NCLEX examinations have been delivered to candidates. To date, we have processed 270,000 scannable registration forms, 54,300 telephone registrations, and 90,000 electronic registration records. This distribution of registration activity has remained nearly unchanged since the start of the program.

The number of calls received at Chauncey has decreased in comparison to past years, with some months showing a significant decrease. Telephone activity for the twelve months ending March 1996 has decreased by ten percent as compared to the same period last year. Since telephone registration activity has remained steady, the reduction has occurred in general inquiry calls. This may indicate that callers are now better informed about the NCLEX program, that printed materials are clearly describing procedures, and that records are being processed rapidly.

The peak period for testing remains May through August. First-time candidates have been able to schedule appointments and test, if requested, within the 30-day testing window. At the busiest time of the summer, most test centers have remained well below 50 percent capacity.

Customer Satisfaction Survey

Each quarter, a random sample of NCLEX candidates using the NCLEX 800 Registration/Inquiry phone number are sent a Customer Satisfaction Survey to evaluate their experiences. The intention of this survey is to measure the perception of our services, to identify areas of weakness based on respondents' written comments, and to address concerns with individual customer service representatives. Responses continue to yield very positive results. Most respondents have answered "yes" to being satisfied with the level of customer service in every category. Free-form comments have been positive about the quality of staff and service.

Printed Information for Candidates

Over the past year, all NCLEX publications that The Chauncey Group produces have been revised in consultation with the National Council and reprinted. Supplies of the NCLEX Candidate Bulletin, the NCLEX-RN™ Program Codes and the NCLEX-PN™ Program Codes have been distributed to boards of nursing. The Scheduling and Taking Your NCLEX, mailed to candidates along with their Authorization to Test, was also revised.

NCLEX™ Program Reports

Two full annual cycles of the *NCLEX™ Program Reports* have been produced and distributed to educational program subscribers. (The *NCLEX™ Program Reports* have replaced the CTB Summary Profiles in providing information to nursing programs about performance of their candidates on the NCLEX.) Each annual cycle covers two cumulative testing periods - April through September and October through March. Subscribers generally receive two reports each year unless all graduates test within one reporting cycle. Included in each Report is information about a program's passing rate for the testing cycle as well as historical passing rate information, candidate performance on the *NCLEX™ Test Plan* dimensions, a program's national and state rank, candidate performance on Categories of Human Functioning, Categories of Health Alterations, A Wellness/Illness Continuum, Stages of Maturity, and Candidate Performance by a Stress, Adaptation, and Coping model.

The *NCLEX™ Program Reports* are based on candidate data that are retained in the NCLEX Data Center at Chauncey and, as such, must rely on accurate gridding by candidates who complete the NCLEX registration form. Although the number of errors has decreased over the past year, there are still errors that occur with gridding of the education program codes. If a candidate grids an incorrect code for the school from which they graduated, yet the code

is a legitimate code that is in the database, the NCLEX database has no way of recognizing the information as incorrect.

Included in each edition of the *NCLEX™ Program Reports* is a thirteen-item Likert-type evaluation form that subscribers are asked to complete and return. Space is also provided for narrative comments to be added. While we have received only a small response rate from subscribers, the responses and comments received have been very positive.

In April, *NCLEX™ Program Reports* subscribers received renewal invoices for the third year of publication. As of March 31, 1996, there were 782 subscribers.

Joint Research Committee

The National Council/Chauncey Joint Research Committee (JRC) is the vehicle through which research is funded for the NCLEX Program. Research projects are funded to address current NCLEX operational issues as well as long-term research issues related to further improving testing for NCLEX and other related testing programs. The JRC consists of eight members: three professional staff representing the National Council, two NCLEX Program staff representing The Chauncey Group International, one ETS researcher, and two external researchers selected jointly by the National Council and Chauncey. The external researchers are Gage Kingsbury from the Portland, Oregon, school system and John Norcini from the American Board of Internal Medicine.

Three JRC reports were presented to the committee for review: 1) "Establishing the comparability of the NCLEX using CAT with traditional NCLEX examinations"; 2) "An investigation of methods for setting the passing standard on the NCLEX-RN using computerized adaptive testing"; and 3) "An investigation of item calibration procedures for a computerized licensure examination." These reports were tentatively approved for publication pending revisions. In addition, six new JRC proposals were funded, two of which will be directed by National Council staff, three of which will be directed by Chauncey Group staff, and one which will be directed by ETS staff. The next meeting of the JRC is scheduled for July 22, 1996.

Collecting Ethnicity and Gender Information from NCLEX Candidates at Test Centers

Currently not all Member Boards are allowed to either collect or pass along to Chauncey ethnicity and gender data from NCLEX candidates. As a result, data used for calculating differential item functioning (DIF) statistics have been restricted and, in some cases, limited the analysis that could be done. In an effort to address this issue and as part of the October 1995 software release for NCLEX, candidates are now asked to respond to three optional background screens to provide ethnicity, gender, and English as a second language data. Data about ethnicity and gender supplement information provided at the time of candidate registration from candidates who do not provide that information and from candidates whose registrations are processed and forwarded by boards of nursing that are prevented from collecting those data. These screens are already providing additional information which will be readily usable for the next DIF Panel Meeting in summer 1996.

Accepting American Express Card Numbers

With the approval of National Council staff, we have modified our registration database system to accept American Express Card numbers for telephone registrations in addition to Visa and MasterCard. Information about this added service was incorporated into the 1996 revision of the NCLEX Candidate Bulletin.

Candidate Calls about Numbers of Items in Their Examination

Staff at all organizations receive calls from candidates questioning the number of items seen in their examination. Generally, calls come following the candidate's receipt of a failing result and a Diagnostic Profile with the candidate indicating that they saw some number of items (both fewer and greater) than the number recorded on the Diagnostic Profile. In all cases when such a complaint is received, the candidate's test record is reviewed and the number of items for which there are responses compared to the Diagnostic Profile. In all cases to date, no discrepancy has been found.

We are planning to implement a software change that will display a confirmation screen at the end of the examination where candidates could verify the number of items seen.

Revision of Acknowledgement Postcard

Since beginning candidate registration, staff have been concerned about the frequency of errors made by candidates in identifying the program code for the educational program from which they graduated. In an effort to increase a candidate's accuracy of the code provided, we revised the acknowledgement postcard that is sent to candidates at the time of their registration and generally before eligibility is determined and the Authorization to Test is sent. (Note that

in cases where we receive electronic registrations for eligible candidates from Member Boards, the acknowledgement postcard is replaced by the Authorization to Test.) The postcards were revised to include the name of the educational program and language that informs the candidate to call Chauncey if the program is not the one from which they graduated. A good measure of the effectiveness of this change has been the decrease in program code errors reported by Member Boards following receipt of each Quarterly Report.

Test Development Activities

■ Item Writing Workshops

For NCLEX-RN, there were six item writing workshops held between April 1995 and March 1996. A total of 74 item writers, representing the practice areas of medical/surgical, psychiatric-mental health, pediatric and obstetrical nursing, developed 1,791 items. For NCLEX-PN, six sessions were held with a total of 52 item writers producing 1,564 items.

The sessions were conducted by members of the Princeton-based and Atlanta-based Chauncey/ETS test development staff. In 1995, item writing workshops were primarily held in either Princeton or Atlanta which facilitated more efficient utilization of staff and increased availability of resources. Item writers represented all four National Council geographic regions at each session. Members of the National Council Examination Committee and National Council staff also audited several of the workshops.

For the next year, six NCLEX-RN and six NCLEX-PN item writing workshops are scheduled. All of the RN workshops are scheduled over the course of the summer, while the PN/VN workshops are scheduled from July 1996 through February 1997.

■ Selecting Item Writers

Potential NCLEX-RN workshop participants who have met National Council criteria for item writers are asked to complete an item writing exercise. This screening instrument includes a letter of explanation and a booklet with information about NCLEX and creating accurate and well-constructed items appropriate for entry-level nursing practice. The potential item writers are asked to develop three items that are linked to specific components of the respective test plans and that are supported in current nursing texts. The nurse test developers review the items and validations for content and technical appropriateness and then recommend writers who meet the criteria to the Examination Committee and the National Council staff. Recommended writers are then approved for attendance at workshops by the Examination Committee.

Over the past few years, recruitment for NCLEX-PN writers has been limited in comparison to the NCLEX-RN, despite the effort exerted by the National Council staff and Member Boards to seek panel members. Potential NCLEX-PN writers do not complete screening exercises. For NCLEX-RN, the number of those who complete the exercises in comparison to the number who submit an application to be a writer is low. Beginning in 1996, screening exercises will be changed to a manual format and will be mailed to item writers to prepare them for attending a meeting. We believe that the new process will expand the pool of potential item writers needed to produce the large volume of items required for the optimal item pools.

■ Item Review Meetings

The six NCLEX-RN Item Review Panels that met between June 1995 and March 1996 approved 1,355 (89%) of the 1,523 items reviewed, while five NCLEX-PN Item Review Panels that met between June 1995 and January 1996 approved 1,026 (92%) of the 1,112 items reviewed. With the exception of one NCLEX-PN meeting held at the Chicago site, all of the other meetings were held either at the Princeton site or the Atlanta site. Each Item Review Panel consisted of participants who represented each of the four National Council geographic areas. Examination Committee members and National Council staff also audited these meetings.

■ Item Review at the Examination Committee Meetings

Newly developed items approved by the Item Review Panels had been presented to the Examination Committee for approval prior to being included in a pretest pool. In February 1995, the Examination Committee

voted to review items only after the items have been pretested. The items in the October 1995 pretest pools are the first set of items that have not been seen by the Examination Committee prior to being pretested. These items will be reviewed in May 1996.

Between May 1995 and December 1995, the Examination Committee approved 885 (87%) of the 1,019 NCLEX-RN and 928 (91%) of the 1,024 NCLEX-PN tryout items for inclusion in a future operational pool. At the July 1995 and February 1996 meetings, the Examination Committee reviewed base pool items for currency. The Committee approved a total of 585 (80%) of the 731 NCLEX-RN and 399 (75%) of the 530 NCLEX-PN items for continued use in the operational pools.

■ Targeting Item Difficulty

The Chauncey NCLEX test development team continues to intensify efforts in targeting item difficulty for the NCLEX pools. Several supplementary approaches have been initiated, including expanding discussion of item difficulty during the didactic portion of item writing workshops and item review meetings; discussing numerous exemplars of difficult items; rewriting items that are based on appropriate content but which have not met NCLEX statistical criteria; and by providing National Council staff with recommendations for extending invitations to experienced item writers for returning to subsequent workshops.

The mean difficulty of the items in the pretest pools for the last four quarters shows an average increase in difficulty for items that have been written over the past year and a half, as compared to the average difficulty of items in the pretest pools for all quarters in the 1994-1995 testing year. This represents an increased effort to produce items that fill those areas of the optimal item pool that have been limited since the inception of CAT.

■ Monitoring

The Chauncey NCLEX test development team recognizes the importance of maintaining the currency of items over time. Ongoing monitoring of the NCLEX-RN and NCLEX-PN operational pools for content accuracy, currency, and appropriateness is done prior to release of the pools in October and April of each year. Items that are flagged for content and sensitivity concerns are presented to the Examination Committee for disposition and, if necessary, removed from the master operational pool.

Items that contain references to time-sensitive content, such as AIDS, tuberculosis, and nursing diagnosis, are coded with a time-sensitive flag in the item banking system for more frequent reviews. Items that contain outdated content are removed from the pool.

Test development staff are reviewing the base pool items on a rotational basis to maintain current validations in appropriate references. Items that are flagged for accuracy or currency concerns during this review process are presented to the Examination Committee for disposition. Many of the items are revised and re-pretested in a future tryout pool.

■ Construction of 1996 NCLEX Item Pools

Prior to configuring the April 1996 NCLEX item pools, a master pool of available items was evaluated. For NCLEX-RN, the master pool consisted of approximately 3,100 items from the pre-CAT administration and 1,245 items developed by ETS/Chauncey. For NCLEX-PN, the master pool consisted of approximately 2,100 items from the pre-CAT administration and 1,560 items developed by ETS/Chauncey. Primarily because of issues of currency and accuracy, there has been a 25% loss in the NCLEX-RN base pool and a 31.5% loss in the NCLEX-PN base pool since April 1995. Items are also removed from the pool after being flagged by statistical analysis. Items that were developed by ETS/Chauncey and were pretested as part of the NCLEX operational pools now make up 33.3% of the NCLEX-RN master pool and 42.7% of the NCLEX-PN master pool.

■ Progress Towards Optimal Pools

At the February 1996 meeting of the Examination Committee, Chauncey staff presented an item pool status report on both the NCLEX-RN and the NCLEX-PN master pools and progress towards meeting the demands of the optimal item pools. National Council and Chauncey staffs are working together as part of the recently created NCLEX Strike Force to evaluate the entire test development process and to propose modifications to the current

procedures. An update on the progress of the Strike Force is presented to the Examination Committee at each meeting.

Face Validity Reviews

The Chauncey test development staff routinely reviews real and simulated examinations based on criteria established by the Examination Committee. The criteria include non-test plan content areas that are not controlled by the selection algorithm, such as maternal/child, infection control, medications, pediatrics, and geriatrics. The review also includes the identification of items based on similar content within an examination.

The actual candidate and simulated examinations reviewed for face validity are generated at five ability levels: low ability; moderately low ability; borderline (pass/fail) ability; moderately high ability; and high ability.

The face validity review of the simulated and real examinations for the October 1995 operational pool and the simulated examinations for the April 1996 operational pool indicated that some content overlap did occur in examinations from each respective pool, with most of the content overlap being noted in the longer exams. With the implementation of the new data base management system and additional coding schemes, content overlap will be reduced, but complete control of the content will not occur without a change in the item selection algorithm.

The category "Prevention and Early Treatment of Disease" under the broad category of "Health Promotion/ Maintenance" continues to be underrepresented in actual and simulated examinations for both NCLEX-RN and NCLEX-PN, though this is more evident in the NCLEX-PN examinations.

Sensitivity Reviews

In-house sensitivity reviews are required for all tests generated at Chauncey. The reviews are based on item-level and test-level concerns and are conducted by trained individuals drawn from across non-NCLEX Chauncey staff. Using guidelines approved by the Examination Committee, the new items for the NCLEX pools undergo a sensitivity review as they are prepared for presentation to an Item Review Panel.

To address test-level concerns such as gender balance and juxtaposition of items, sensitivity reviews are done on the simulated examinations generated for the respective NCLEX pools. The review of the October 1995 and the April 1996 operational pools indicated that the pools are generally in accord with ETS sensitivity guidelines, which Chauncey uses. Two potential issues noted by the sensitivity reviewers, though far less evident with these pools than with the previous pools, were references to "elderly" clients instead of clients with specific ages, and gender references that at times were unnecessary. As the Examination Committee proceeds with its planned systematic review of the existing pool, these sensitivity issues can be easily resolved as editorial changes are made.

NCLEX Differential Item Functioning (DIF) Review Panel Meetings

The first NCLEX-DIF Review Panel Meeting was held on January 26, 1995, in Princeton, New Jersey. Since that time, there have been two additional meetings held, one on August 10, 1995, and another one on January 31, 1996. The NCLEX-DIF Review Panel consists of five members, of which at least one is a male, representatives of three of the ethnic focal groups of NCLEX test takers, one individual with a general linguistic background, and one individual who is currently licensed as a registered nurse.

DIF statistics are computed to compare the performance of females with males and of Whites with other ethnic/ focal groups: Blacks, Hispanics, Asian Indians, Asian Others, Native Americans, and Pacific Islanders. Items are categorized as A, B, or C depending on the level of demonstrated DIF, with category C items containing moderate to large DIF. The category C items are reviewed at a DIF Review Panel Meeting.

The source of the items for review at the August 1995 meeting was the October 1994 operational pools and the October 1994 and January 1995 pretest pools. The panel reviewed a total of 73 RN and 75 PN items from the operational pools and 17 RN and 35 PN from the pretest pools. The panel recommended to the Examination Committe, for review and disposition, referral of seven RN and four PN items from the operational pools and one RN and one PN item from the pretest pools.

The source of the items for review at the January 1996 meeting was the April 1995 operational pools and the April 1995 and July 1995 pretest pools. The panel reviewed 77 RN and 80 PN items from the April 1995 CAT pools and 17 RN and 27 PN items from the tryout pools. The panel recommended referral to the Examination Committee of four RN and six PN items from the operational pools and none from the pretest pools.

The reasons for referral included idiomatic use of language, assumptions regarding the nuclear family and dominant culture, and judgments related to "role-playing" by the nurse in hypothetical situations. The Examination Committee reviewed the items from the August 1995 DIF Review Panel meeting at the October 1995 meeting and the items from the January 1996 DIF Review Panel meeting at their May 1996 meeting. Items were either approved for reuse in the operational pools, held for revision, or removed from the pool.

- **Readability Levels of NCLEX**

The Fry method of determining readability levels was used to calculate the reading levels of the simulated exams from the NCLEX-RN and NCLEX-PN operational pools for October 1995 and April 1996. This method calculates readability based on nonmedical terminology. According to the Fry index, the estimated reading levels of the October 1995 and April 1996 RN operational pools based on the simulations are 7.7 and 7.4, respectively, and the estimated reading levels of the October 1995 and April 1996 PN operational pools based on the simulations are 7.0 and 6.9, respectively. These levels are below the National Council policy for a maximum reading level of tenth grade for NCLEX-RN and of eighth grade for NCLEX-PN.

- **Member Board Reviews**

Each spring and fall, Member Boards have the opportunity to conduct item reviews at Sylvan Technology Centers. Member Boards can review on-line newly developed items that are in the pretest pools and/or simulated examinations for high, medium, and low achievers for both NCLEX-RN and NCLEX-PN.

In the Fall of 1995, 14 Member Boards scheduled review sessions, while 14 Member Boards have scheduled reviews for Spring 1996.

All comments received from a Member Board are forwarded by the National Council to Chauncey test development staff for review. All items referred are re-evaluated for accuracy and currency and brought to the Examination Committee for disposition.

- **NCLEX Item Tracking Database**

To improve the coding and tracking of NCLEX items in order to facilitate test development activities, The Chauncey Group is in the process of developing an item tracking database. A consultant was hired in February 1996 to develop specifications and to design the item database. The database should be completed in July 1996 and entry of additional item codes will begin shortly thereafter.

NCLEX Operations

- **Candidate Matching**

The Examination Committee, National Council staff, and Chauncey staff have worked together to improve the candidate matching procedures over the last year. We have worked in four areas to improve the overall process: 1) we have improved our data editing procedures to maximize the accuracy of the data used to match candidate records; 2) we have improved the candidate matching procedures; 3) we have worked with a few Member Boards whose procedures were contributing to the failure to match candidate records; and 4) we have implemented a weekly procedure that identifies any failures to match before the test is taken to ensure that previously seen items are blocked for repeaters. These efforts have been quite successful in significantly reducing the incidence of non-matched records. In the last scan of the database, there was only one newly detected case of a candidate who had tested again without matching to the prior test record.

- **Data Edits**

In a continuing effort to improve the quality of the data recorded about candidates in the database and distributed to Member Boards, we have enhanced the editing of the data coming into our system. Many of these enhanced edits are the result of efforts to improve the matching of candidate records. In addition, edits for education

program codes and graduation dates have been tightened. These edits have increased the number of cases that are reviewed by staff prior to being loaded into the database. On the assumption that candidates who make errors that are detected by the edit routines are also likely to make errors that cannot be detected by the edits, Chauncey staff also inspect the entire record that is displayed for error resolution. The staff then correct obvious errors in addition to the error that caused the record to be displayed. These changes have enhanced the quality of the information contained in the NCLEX database.

MBOS Change Procedures

Although MBOS has functioned effectively in allowing candidate data to be exchanged between boards of nursing and the Chauncey Data Center, Member Boards have requested that changes and/or enhancements be made. Chauncey and National Council staff maintain a running list of MBOS changes suggested by the Examination Committee, Member Boards, or staff. When a suggested change is added to the list, the entry contains a brief description of the change, the source of the suggestion, and an initial estimate of level of effort required to implement the change. The Examination Committee reviews the suggested changes at each meeting and assigns a priority. Chauncey staff then provide a cost estimate for all entries requested. The Examination Committee and National Council staff identify funds to implement the most desirable changes and authorize Chauncey to proceed. Chauncey staff schedule the change and inform National Council staff and the Examination Committee of the planned release date.

MBOS Releases

Over the past year, MBOS has been enhanced with new releases going to Member Boards in April and October 1995. Enhancements included the option of having two simultaneous open test registrations to allow a candidate to register for both the PN/VN and RN examinations at the same time, printing of mailing labels for candidates that have tested, modification of the Education Program Summary Report to permit users to select only the education programs that are within the Board's jurisdiction, and display of the candidate's most recent address, program code, program name, and date of graduation on the main candidate screen. Changes related to educational program information have been particularly helpful since they facilitate the correction of program codes and graduation dates. By adding this information to the main candidate screen, boards can verify and correct these data while making candidates eligible to test. The improved accuracy of the program code and graduation date data will have a beneficial effect on the Quarterly Reports (aka the Green Sheets) and on the *NCLEX™ Program Reports* provided to subscribing education programs. Other enhancements have been made to the NCLEX Modifications Request Form and the Diagnostic Profile.

National Council staff have conducted a survey of Member Boards about MBOS. The results of the survey were reviewed at the Examination Committee meeting in May 1996. Changes authorized by the Committee will be scheduled for implementation. We expect the next version of MBOS to be released to Member Boards in late Fall 1996.

Member Board Issues in the Exchange of Candidate Registration and Testing Information

Over the past year, the electronic exchange of candidate registrations, eligibility determinations, and testing data between Member Boards and Chauncey has become fairly routine and, for the most part, causes few problems for either the Member Boards or the Chauncey Data Center. We have, however, experienced intermittent problems communicating with some of the island jurisdictions. The problems seem to be caused by telephone systems that are less reliable than we are used to in the continental U.S. and partly by a power-rationing system that causes power outages at unscheduled times. Communication with these boards is monitored and intervention occurs when needed.

Data Sharing Among Boards of Nursing

The lack of information available to a Member Board about candidates educated within its jurisdiction but seeking licensure elsewhere has been a problem for many years. The Board of Directors received a proposal from Chauncey at its August 1995 meeting for a change in the Quarterly Reports (Green Sheets) to alleviate this problem

by adding a table that would provide the missing information if permission is granted by the licensing board. With approval from the Board of Directors, those changes were implemented as Table 4A for the reports produced in early October 1995. As of April 1996, 42 Member Boards have authorized the inclusion in Table 4A of data about their candidates who have been educated out of state.

- **Reporting Options for Member Boards**

In response to requests from several Member Boards, Chauncey proposed to the Examination Committee that boards of nursing be given options to control which paper reports the Member Board wished to receive and how many copies of each report. The Examination Commitee approved the proposal. Member Boards received a survey that asked them to indicate what paper reports they wished to receive as well as the number of copies. A total of 47 Member Boards have responded. Boards of nursing could select to continue to receive three copies of each report. Depending on the specific report, Member Boards have generally reduced the number of reports requested. As a result we are avoiding the production and mailing of unnecessary paper and tailoring the production of paper reports to each Member Board's needs.

- **Quarterly Reports**

Quarterly Reports - formerly "green sheets"- are scheduled to be distributed to each Member Board approximately three weeks following the end of the quarter. Over the past year, changes to the Quarterly Reports requested by the Examination Committee have been implemented, including the addition of a table for data sharing among Member Boards. The new table, Table 4A, has an entry for every candidate educated outside of the license-granting jurisdiction. If the jurisdiction from which the candidate was seeking licensure is participating in data sharing, the entry will show the education program, candidate's name, graduation date, pass/fail status, and the name of the jurisdiction. The Quarterly Reports are being printed on green paper so they can honestly continue to be called the Green Sheets.

Sylvan Prometric Update

Status of Sylvan Technology Centers

The size of the network is virtually unchanged with 210 active testing labs and 1,796 workstations. Prior to implementation of NCLEX using CAT in April 1994, Sylvan agreed to provide 200 sites, housing 1200 workstations, for NCLEX testing within the United States and its territories.

Since implementation, Sylvan has opened three sites, downsized three, and closed eight. When downsizing or closing a site, alternate sites with sufficient capacity to test all candidates existed within a 50-mile district. Prior to finalizing plans to close specific centers, affected Member Boards were contacted to discuss the impact the closure might have on candidates.

Sylvan Learning Systems acquired DRAKE Prometric in the autumn of 1995. "Sylvan Prometric" is the newly formed division of Sylvan Learning Systems. The acquisition will not impact the size of the network providing NCLEX testing until at least 1997. Currently, the DRAKE sites utilize computer systems that are incompatible with Sylvan's and their physical layout does not meet Sylvan's specifications.

Sylvan's March 1996 acquisition of the NASD (National Association of Securities Dealers) sites is expected to impact the size of the current Sylvan network within the next 12 months. We are currently reevaluating the utilization levels of both the Sylvan and NASD sites. We hope to deliver examinations currently administered in NASD sites in Sylvan Technology Centers located in the same market. Additionally, we may be able to offer NCLEX testing in new markets either in NASD sites or by the implementation of new Sylvan Technology Centers.

Site Capacity Issues with Spring and Summer Volumes

Sylvan analyzed 1995 utilization levels during the last quarter of 1995. When analyzing the statistics, peak seasons for various programs and projected volumes based on new clients that have or will begin testing at the Sylvan Technology Centers were considered. The statistical summaries helped determine which specific centers would benefit

from changing the number of testing workstations. Overall, the statistics showed sufficient capacity on a site-by-site basis to comfortably handle the expected 1996 peak testing volumes.

30/45-Day Compliance

During the past year, all NCLEX candidates except one candidate approved for a time and a half examination with a reader and separate room were seated within the 30/45-day compliance period. Candidates who are not seated within the compliant period are sent a refund of their registration fee.

Quality Assurance Update

Sylvan's Quality Assurance Plan (QA Plan) was approved by the Examination Committee in July 1995. Last autumn, Sylvan further enhanced the QA Plan by implementing "trigger point guidelines" to better assess performance on a system-wide and center specific basis. Current monitoring is performed by Sylvan's Client Inquiry Department. As the number of clients served and the size of the network continues to grow, the task of compiling information, analyzing it, and responding to trends becomes more time consuming. Because of this, Sylvan Prometric is currently developing and staffing a separate Quality Assurance Department. This department will be fully operational by June 1996 and its sole objective will be to monitor, maintain, and enhance the quality of the services we provide our clients.

The training and certification processes are also currently being enhanced. A separate Training and Certification Department was formed in January 1996. The goals of this department are to provide and update the tools necessary for center staff to most effectively perform the duties of a Test Center Administrator and to improve the quality of services offered to candidates and center staff at the corporate level. Customer Service seminars are conducted the first week of each month for the Technical Support and National Registration Center staff. All test center administrators are required to pass a certification examination annually. In the past, all center staff were required to take the examination between April and June of each calendar year. In May 1995, the National Council agreed to Sylvan's proposal to change the time frame in which certification occurred. Currently, all test center administrators must certify on or before their certification anniversary date. The change to anniversary date certification has helped Sylvan's certification team focus on each individual's retraining needs prior to recertification. To further assist center staff in the certification process, role play videos that demonstrate and clarify daily center operations are being produced and disseminated to all centers. In addition, Users Groups made up of successful center staff and corporate employees are being formed to share "best demonstrated practices" with all centers.

Update on the Natural Disaster Policy

As of April 18, 1996, a total of 12 Member Boards have declared natural disasters for candidates scheduled to test in 27 different centers on 20 different days since implementation of the Natural Disaster Policy in August 1995. The policy was implemented in 23 cases and not needed in nine cases because the center was closed due to inclement weather.

On September 15, 1995, Hurricane Marilyn devastated the U.S. Virgin Islands. Sylvan Technology Centers ceased operating until electricity and phone lines could be restored. Sylvan contacted candidates with scheduled appointments via U.S. Mail to inform them that the testing centers were not operational. We offered to fly candidates (at Sylvan's expense) to Puerto Rico to test. A number of candidates accepted this offer. The St. Croix center resumed operations in late September. The St. Thomas center resumed operations in late November.

On January 8, 1996, the corporate offices of Sylvan and ETS/Chauncey were unable to open due to the "Blizzard of '96." Technical Support staff supported centers via emergency cellular pagers until they could reach the office later that morning. Over 32 centers from the Midwest to the East Coast, including parts of the South, were unable to open for testing part or all of that week. Approximately 750 candidates were affected by the "Blizzard of '96."

NCLEX Appointment Overlap

In June 1995, the National Council approved a pilot program designed to increase testing availability for NCLEX candidates through overlapping NCLEX appointments 45 minutes. Overall, the program has been highly successful. We have scheduled over 125,000 overlapped appointments since that time and have conclusively determined that one candidate was delayed due to this program. One other case is currently being investigated to determine whether the delay in seating was exacerbated by an overlapped appointment. Generally, NCLEX candidates arrive well ahead of their appointment and begin testing before their appointment time.

Automated Scheduling System

Late summer of 1995, Sylvan began "beta" testing an automatic scheduling system designed to increase candidate satisfaction by allowing them to schedule their appointments virtually 24 hours per day. During a series of "beta" tests, the system was operational only during normal business hours so candidate calls to the system could be monitored by our communications staff. Much insight was provided by candidates as they utilized the system and clarification in scripting resulted. Some software issues that adversely affected center scheduling were identified and have been resolved. Automated scheduling is currently available to NCLEX candidates during normal business hours.

Additionally, the system capabilities are presently being broadened so candidates scheduling appointments for any Sylvan administered examination may be served. Once this process is complete, all candidates will have the opportunity to schedule, reschedule, cancel and confirm appointments as well as obtain directions to the center at which they are testing. We expect full implementation to take place mid-summer 1996. All NCLEX appointments scheduled using the automated scheduling system are tracked for 30/45-day scheduling compliance in the same manner as are appointments made by human registrars.

Scheduling and Testing Candidates with Special Needs

In September 1994, the National Council approved Sylvan's plan to coordinate all scheduling of "special needs" candidates through the Sylvan National Registration Center's "Special Conditions Coordinator" (SCC). The Chauncey Group modified the ATTs that are sent to candidates with special needs requesting they call the Special Conditions Coordinator to schedule their appointments. A procedure was developed by National Council, Sylvan, and Chauncey to ensure each group was fully informed of every candidate's special needs and the Sylvan NCLEX Program Manager began tracking every "special needs" candidate on a weekly basis. Detailed documents are forwarded to applicable centers for each "special needs" testing event.

As requested by the National Council, on April 1, 1996, The Chauncey Group released a significant software enhancement that incorporates computer initiated breaks for candidates approved for extra testing time. This enhancement has been welcomed by Sylvan corporate and center staff as they no longer need to calculate when breaks should occur for this group of candidates. Over time, we expect additional processes that are currently invoked manually to be automated.

Scheduling Member Board Item Reviews

As requested by Member Boards during the 1995 Delegate Assembly's CAT dialogue, dates for the Spring and Autum Member Board Item Reviews are idenfied and published two years in advance. We hope this measure has helped Member Boards to better plan Item Review sessions in conjunction with scheduled board meetings, thus reducing costs and increasing the number of individuals able to participate.

Statistical Topics

- **Standard Setting**

The NCLEX-PN standard setting workshop took place on February 10-13, 1996, in Princeton. There were nine judges that participated in the workshop. All judges were licensed practical nurses with clinical backgrounds in medical-surgical, maternity, gerontological, ambulatory care, and pediatric nursing. Four of the nine judges had experience serving in an instructional or supervisory role to entry-level PNs/VNs. One judge was a member of an ethnic minority group and another was a male. One of the judges was a recently licensed practical nurse. The nine judges were selected to represent the four National Council geographic areas.

There were two different standard setting methods utilized in the standard setting workshop: 1) a modified Angoff standard setting where a 150-question "reference form" was examined; and 2) a standard setting approach called "comparative judgements," where judges evaluated sets of 10 questions that were homogeneous in difficulty (100 questions in total).

A final report detailing the methods and results of the standard setting workshop was submitted to National Council staff in April.

- **Longitudinal Summaries of NCLEX Candidate Performance**

Tables 1 and 2 provide summaries for NCLEX candidate performance for the 1994-95 and 1995-96 testing

years. These data include summaries by three-month intervals as well as cumulative summaries for the testing years running from April through March. Table 1 presents data for the NCLEX-RN and Table 2 presents data for the NCLEX-PN. The tables include a variety of statistics, including number testing, percent passing, average numbers of items taken, percent of candidates taking the minimum and maximum possible numbers of items, average testing time, percentages of candidates taking the mandatory and optional breaks, and the percentages of candidates timing out.

Some highlights of the data summarized in these tables are as follows:

- Approximately 6,200 more NCLEX-RN candidates tested in 1995-96 compared to 1994-95.
- Approximately 10,500 fewer NCLEX-PN candidates tested in 1995-96 compared to 1994-95. However, the 1994-95 volumes for the NCLEX-PN were inflated, especially in the April-June interval, because of testing patterns associated with the transition to CAT.
- The passing rates for NCLEX-RN were relatively stable between 1994-95 and 1995-96. However, the RN passing rates dropped slightly in the last two intervals of 1995-96 with the implementation of the new passing standard.
- The passing rates for NCLEX-PN increased slightly between 1994-95 and 1995-96. This increase may have been related to the fewer numbers of candidates testing.
- For both 1994-95 and 1995-96, the passing rates within specific three-month intervals varied considerably for the NCLEX-RN. The highest passing rates were achieved in April-June and the lowest passing rates were achieved in October-December. These fluctuations appear to be consistent with graduation patterns and expectations of when the better-prepared candidates test.
- In contrast to the NCLEX-RN, the passing rates for the NCLEX-PN were relatively stable across testing intervals, both during 1994-95 and 1995-96. These trends are also consistent with the graduation patterns of PNs, which tend to be evenly spread out across the year rather than peaked in the May-June period that is characteristic of the RNs.

Other variables presented in Tables 1 and 2 tended to be relatively stable between the 1995-96 testing years, and fluctuated across testing intervals according to patterns that were consistent with the ability level of the candidates testing during those intervals. For example, for NCLEX-RN the average numbers of items taken and the average testing times were much greater in the October-December intervals compared to the other intervals. This occurred because candidates were generally of lower ability and thus tended to take longer exams.

One noteworthy statistic in Table 1 was the reduction in the percentages of candidates timing out from 1994-95 (3.9% overall and 1.9% for first-time U.S. educated candidates) to 1995-96 (2.5% overall and 1.6% for first-time U.S. educated candidates). This reduction may be attributed to increased familiarity of candidates with computerized adaptive testing.

Table 1
Longitudinal Technical Summary for NCLEX-RN
Group Statistics for 1995-1996 Testing Year

	Apr 95 - Jun 95		Jul 95 - Sep 95		Oct 95 - Dec 95		Jan 96 - Mar 96		Cumulative 95-96	
	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed
Number Testing	40,836	32,673	48,683	40,268	15,073	5,541	25,794	18,110	130,386	96,592
Percent Passing	84.7	93.1	83.4	89.6	57.4	78.7	74.9	88.5	79.1	90.0
Ave. # Items Taken	113.3	107.5	117.7	114.4	133.9	124.9	119.4	111.7	118.5	112.2
% Taking Min # Items	57.1	61.3	53.4	55.6	42.5	48.2	53.0	58.3	53.2	57.6
% Taking Max # Items	11.2	9.5	12.5	11.5	17.6	14.8	12.7	10.4	12.7	10.8
Ave. Test. Time (Hrs)	1.98	1.82	2.06	1.97	2.46	2.22	2.19	2.00	2.11	1.94
% Taking Mand. Break	27.8	22.4	30.5	27.4	44.2	36.1	34.9	28.2	32.1	26.4
% Taking Opt. Break	1.9	1.1	2.0	1.5	4.6	2.8	3.4	2.2	2.5	1.6
% Timing Out	1.8	1.1	2.1	1.6	4.6	3.6	3.0	1.9	2.5	1.6

Table 1 (continued)
Longitudinal Technical Summary for NCLEX-RN
Group Statistics for 1994-1995 Testing Year

	Apr 94 - Jun 94		Jul 94 - Sep 94		Oct 94 - Dec 94		Jan 95 - Mar 95		Cumulative 94-95	
	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed
Number Testing	30,083	25,948	52,742	44,188	15,548	5,877	25,778	18,232	124,151	94,245
Percent Passing	89.1	93.3	84.1	89.4	63.5	80.0	78.5	90.1	81.6	90.0
Ave. # Items Taken	110.5	105.1	114.4	111.2	133.2	123.1	117.7	111.0	116.5	110.2
% Taking Min # Items	59.4	63.5	55.5	57.9	41.9	48.6	53.4	58.0	54.3	58.9
% Taking Max # Items	10.1	8.5	10.9	10.2	16.0	12.9	11.6	9.8	11.5	9.8
Ave. Test. Time (Hrs)	1.94	1.81	2.07	1.97	2.51	2.23	2.19	2.00	2.12	1.95
% Taking Mand. Break	25.5	21.2	30.4	27.0	45.7	36.3	34.1	27.8	31.9	26.1
% Taking Opt. Break	1.7	1.0	2.0	1.4	4.7	2.9	2.7	1.8	2.4	1.5
% Timing Out	2.1	1.2	2.7	1.8	6.3	4.4	3.6	2.4	3.2	1.9

Table 2
Longitudinal Technical Summary for NCLEX-PN
Group Statistics for 1995-1996 Testing Year

	Apr 95 - Jun 95		Jul 95 - Sep 95		Oct 95 - Dec 95		Jan 96 - Mar 96		Cumulative 95-96	
	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed
Number Testing	11,815	8,733	21,720	18,584	13,398	10,641	10,866	8,157	57,799	46,115
Percent Passing	79.9	90.8	86.5	92.3	81.4	89.7	81.5	91.4	83.0	91.3
Ave. # Items Taken	113.2	107.7	109.0	105.8	114.0	109.9	114.7	108.5	112.1	107.6
% Taking Min # Items	59.0	64.8	63.2	66.2	57.0	61.2	57.2	63.5	59.8	64.3
% Taking Max # Items	16.0	12.6	13.1	11.1	16.3	13.6	16.5	12.5	15.1	12.2
Ave. Test. Time (Hrs)	1.95	1.77	1.81	1.71	1.97	1.83	2.01	1.84	1.91	1.77
% Taking Mand. Break	29.5	22.1	23.5	19.4	30.1	24.5	32.7	25.4	28.0	22.1
% Taking Opt. Break	1.3	0.6	1.0	0.5	1.4	0.8	1.8	0.8	1.3	0.6
% Timing Out	0.8	0.4	0.4	0.2	0.8	0.5	0.8	0.3	0.6	0.3

Table 2 (continued)
Longitudinal Technical Summary for NCLEX-PN
Group Statistics for 1994-1995 Testing Year

	Apr 94 - Jun 94		Jul 94 - Sep 94		Oct 94 - Dec 94		Jan 95 - Mar 95		Cumulative 94-95	
	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed	Overall	1st Time U.S. Ed
Number Testing	18,890	14,958	22,224	18,888	15,490	12,324	11,754	8,474	68,358	54,644
Percent Passing	83.2	90.5	85.3	91.2	79.2	87.8	76.9	88.3	81.9	89.8
Ave. # Items Taken	113.0	107.9	109.2	106.2	116.9	112.8	116.0	110.6	113.2	108.8
% Taking Min # Items	59.7	64.7	63.6	66.5	55.7	59.3	57.1	62.0	59.6	63.7
% Taking Max # Items	15.6	12.3	13.2	11.4	18.4	15.6	17.9	14.3	15.8	13.0
Ave. Test. Time (Hrs)	1.93	1.78	1.83	1.72	2.06	1.92	2.06	1.89	1.97	1.83
% Taking Mand. Break	28.5	22.2	24.4	20.0	33.8	28.1	33.5	26.7	29.2	23.5
% Taking Opt. Break	1.3	0.6	1.1	0.6	1.6	0.9	1.9	1.0	1.4	0.7
% Timing Out	0.7	0.3	0.7	0.4	1.0	0.6	1.2	0.7	0.9	0.5

Annual Report of the NACEP Test Service

Submitted by The Psychological Corporation
Karen Hale, *Program Director Credentialing and Post Secondary Education Measurement*
Herbert Harris, *Program Director Contract Service*
Lucille Dungan, *Business Area Director*
Sue Traweek, *Operation Supervisor*

Highlights of Activities

This has been a unique year for the NACEP program and the partnership between the National Council of State Boards of Nursing and The Psychological Corporation. The magnitude and impact of the changes cannot be addressed simply in highlighting the program activities by functional area since the changes encompass all of them.

- In May, 1996, The Psychological Corporation announced its acquisition of Assessment Systems Incorporated (ASI), located in Philadelphia. As a result of numerous meetings, a restructure of the companies was agreed upon and the decision was made to transition all TPC's credentialing and licensure programs, including the NACEP, to ASI.
- Another result of this program change is that the test development cycle that was to have begun in the fall of 1996 has been canceled. For the balance of this interim period, the TPC client states will continue to administer the current NACEP forms and the ASI nurse aide clients will continue to administer the ASI evaluations. One new format for the nurse aide written and skills evaluations will be developed for use by all client states effective in 1997.
- In 1995, we were pleased to be awarded the contracts for the states of Washington and Florida. The enormous work necessary to successfully bring these programs up ran across all departments and each of their contributions are noteworthy.

Marketing

- One of the largest projects over this report period was the development of an entire series of interrelated marketing materials. Program direction staff met with the marketing staff and outside consultants to familiarize them with the program intricacies in order for them to conceptualize an overall program design. This resulted in a coordinated "look" for the campaign. All of the individual pieces were designed to stand alone as well as fit into a multi-color NACEP folder. Additionally, a transparency overhead presentation was developed as well as posters and boards to be used at conference exhibits. National Council had input into the development of all the pieces and was very pleased with the end product.
- We responded to the National Council's criteria for re-evaluation in preparation for their decision to re-negotiate a new contract or go out for RFP. Again, this was a joint effort across many departments.
- A new oral evaluation report was designed and is now being sent to our client states as part of their standard monthly reports. It provides information on candidates who took the evaluation in oral format, the language of the evaluation, pass/fail by reading comp section, written evaluation section, and total score. The literals of the score reports were also revised.
- Staff attended the annual Area Meetings as well as the Nurse Aide Conference in Baltimore, and the Annual Meeting in August. TPC hosted a reception at the Conference and a breakfast at the Annual Meeting.
- The program director also attended the American Health Care Association conference and personally met with the program director for the Hawaii nurse aide program. TPC also exhibited at the American Association of Homes and Services for the Aging.
- The annual *Book of Reports*, quarterly reports, and semi-annual and annual statistical reports were produced in a timely manner for the National Council.

Contract Services

- Contract services has had a very busy year in handling our client contracts, responding to RFPs and working with our clients on a day-to-day basis.
- The year began with the receipt of many RFPs some of which were quite unique. As a result, we brought staff together from various areas to brainstorm solutions to the requirements presented in the RFPs. These included

Pennsylvania, Connecticut, Massachusetts and Minnesota. We also responded to Colorado and Maryland (for the evaluation and a separate RFP for the registry component). The contracts were awarded as follows: Pennsylvania - ASI (current provider); Connecticut - ASI (current provider); Massachusetts - Red Cross (current provider); and Minnesota - ASI (current provider).

- Contract extensions or renewals included the following: Alaska expanded their contract limits and renewed their contract; Arizona extended their contract and we will be receiving an RFP for the administrative piece; Utah had approached us and has since selected us to provide their testing; Alabama renewed their contract; North and South Dakota also renewed contracts.
- A meeting was scheduled with South Carolina to discuss contract and operational issues as well as a meeting with Colorado to discuss the new on-demand application system.
- Joint visits with TPC and ASI staff were made to Alabama, Colorado, South Carolina and Virginia to discuss the transition of the programs.
- Florida kept staff busy throughout the year. There have been ongoing compliance issues with the test centers and we did have a security incident in Broward County which necessitated a personal trip by the program director to discuss the situation. A candidate took a test booklet home. The booklet was recovered intact. Testing at the site was put on hold while TPC staff investigated the incident. The test center was issued a formal reprimand and advised of proper security procedures. Florida officials were informed of the incident and advised that further incidences might result in closing the test site permanently. We also discussed the merger with Florida officials.
- Another large undertaking was the production of new candidate and sponsor handbooks for our full service and co-op clients. They incorporated the manual skills steps which had not been available for publication previously.

Operations

- This year has been very busy from the perspective of bringing up all of the operational components for Washington and Florida. They resulted in a substantial volume increase of about 35,000 candidates per year or a 45 percent increase in our total volume. Rater training took place in-state for Washington in March and two teams of staff trained Florida raters in June at five locations.
- The IVR (interactive voice response) system was implemented in June. This permits boards of nursing, sponsors, etc., to call in to the 800 number and verify a nurse aide's status automatically. It has been an excellent tool for the information center and our client states.
- Operational staff were also trained and transitioned to take over scoring functions previously performed by Scoreflow personnel. This is yet one more way we have been responsive to means which enable us to decrease processing time.
- The development of the new on-demand application was another major accomplishment for the year. It enables test centers to establish their own testing schedules and reduces application processing time. It was developed for Colorado but will be used in other full service states.
- A more efficient billing system was also developed.

Psychometrics

- During the first quarter of 1995, the '94 Technical Manual was completed which showed a slight upward movement on the percent of candidates passing each evaluation as compared to the 1993 data. This information was presented at the June 1995 Task Force meeting in Chicago. The National Council job analysis was also presented at that meeting, resulting in only minor weight changes being made to the NACEP blueprint.
- A sixth form of the written evaluation was developed and sent to the task force members for a key check and any comments of the items. It went to press in early 1996, a test deck was completed in March and the form was scheduled for the national administration in April 1996. We also began work on the translation of a second form of the Spanish examination which will be available in late spring 1996. It was developed in response to the heavy Spanish speaking candidate population taking the evaluation in Florida. All other test forms were reprinted to ensure meeting candidate volumes since the development of new forms was deferred during this transitional period.
- The pass rate for this reporting period for the written evaluation was 86.5% as compared to 86.4% for the past year. The NACEP has repeatedly demonstrated its stability. For the skills portion, the national pass rate was 93.5% as compared to 93.2% for the prior reporting period. Particularly with the inclusion of Florida in these figures, we have seen a rise in the use of the oral format, including the Spanish version of the evaluation. We administered the oral examination to 2,139 candidates compared to 932 for the last reporting period.

Meeting Dates

- Task Force: June 5-6, 1995
- License Agreement Meeting: June 7, 1995
- Delegate Assembly: August 2-4, 1995

Attachments

Table 1. NACEP Written/Oral Evaluation
Number Tested, Mean Scaled Scored and Percent Passing by State
March 1, 1995 - February 29, 1996

State	Written/Oral		Written		Oral[b]	
	Number Tested	Percent Passing	Number Tested	Percent Passing Score	Number Tested	Percent Passing Score
Alabama	3,610	81.6	3,532	82.5	78	42.3
Alaska	285	90.5	284	90.5	1	100.0
Arizona	3,462	91.4	3,355	92.6	107	52.3
California	35	93.4	35	94.3	[a]	[a]
Colorado	3,906	90.6	3,725	92.3	181	55.8
Delaware	920	82.6	891	84.2	29	34.5
District of Columbia	903	74.1	902	74.1	1	100.0
Florida	10,107	78.7	8,999	81.6	1,108	55.4
Idaho	2,317	94.6	2,275	95.3	42	57.1
Louisiana	808	74.9	783	75.9	25	44.0
Maine	203	96.6	203	96.6	[a]	[a]
Maryland	3,711	82.6	3,647	83.2	64	46.9
Nevada	955	91.1	952	91.2	3	66.7
New Hampshire	92	97.8	92	97.8	[a]	[a]
North Dakota	1,563	94.6	1,537	95.3	26	53.8
Oregon	1,666	94.8	1,639	95.5	27	55.6
Rhode Island	1,851	88.5	1,816	89.2	35	51.4
South Carolina	4,887	78.1	4,744	79.3	143	39.2
South Dakota	1,089	94.3	1,073	94.5	16	81.3
Virgin Islands	29	86.2	29	86.2	[a]	[a]
Virginia	6,769	85.2	6,635	85.9	134	51.5
Washington	5,393	87.1	5,280	88.0	113	46.0
Wyoming	1,045	95.9	1,039	95.9	6	100.0
Total	**55,606**	**85.2**	**53,467**	**86.5**	**1,958**	**52.3**

[a]No oral evaluations administered
[b]Includes Spanish

Attachment B

Table 2. NACEP Manual Skills
Number Tested and Percent Passing by State
March 1, 1995 - February 29, 1996

State	Number Tested	Number Passing	Percent Passing
Alabama	3,204	2,999	93.6
Alaska	270	265	98.1
Arizona	3,460	3,360	97.1
California	37	37	100.0
Colorado	3,612	3,487	96.5
Delaware	808	780	96.5
District of Columbia	666	608	91.3
Florida	5,681	5,064	89.1
Louisiana	685	645	94.2
Maine	216	195	90.3
Maryland	2,894	2,714	93.8
Nevada	1,012	957	94.6
New Hampshire	93	89	95.7
North Dakota	1,574	1,510	95.9
Oregon	1,744	1,625	93.2
South Carolina	4,166	3,713	89.1
South Dakota	1,299	1,212	93.3
Virgin Islands	32	32	100.0
Virginia	6,291	5,933	94.3
Washington	5,333	5,054	94.8
Wyoming	1,049	997	95.0
Total	**44,126**	**41,276**	**93.5**

Annual Report of the National Board of Medical Examiners (NBME) Activities for the Computerized Clinical Simulation Testing (CST®) Project

The following report summarizes CST developmental activities undertaken by the NBME staff through May 1996.

CST Phase II, which began in August 1995, involves the redesign of the CST interface and implementation of test development support systems as described in the 1994 CST User Specification Document. This redesign entails use of MS-Windows for the clinical simulation seen by the examinee and for support database maintenance and case and key authoring used by NBME staff to enter experts' case information into the computer.

I. Support Databases

Support databases refer to information indexed and stored in the computer to help simulate realistically a clinical situation. A careful review of these databases (including files containing the nursing activities and default responses[1]) indicated that a reorganization of some data elements would optimize functionality. The reorganization simplified underlying data structures, eliminated redundant data and regrouped numbering schemes, and merged some nursing activity concepts so that future maintenance will be simpler. This was also done to balance ease of examinee use with quick computer performance (response to examinee actions).

In addition, work was completed on the presentation of default client responses based on different patient conditions (as described in footnote one). This, too, was done in a manner that should simplify future maintenance, optimize system performance and eliminate data redundancy.

Work was also begun on the nursing activity database terms that examinees use when caring for a client within CST. When the examinee types a request for a nursing action, the computer will search the request for key words. Based on a set of computer search rules, it will present the examinee with more detailed options that are close to their request if they asked to do something the computer did not immediately recognize. A prototype has been developed to permit searches for nursing activities in this manner.

II. User Interface Screens

Screen designs for the user interface have been developed and approved by National Council staff. Two screens, *Main* (Client Care screen) and *Vital Signs*, have been redesigned following feedback from National Council staff.

The prototype screens for the simulation interface were completed and presented to National Council staff who approved the basic structure (screen content and format). National Council staff has subsequently reviewed screen text and titles and requested changes that have been implemented. A prototype of the simulation interface screens has been provided to National Council; it is anticipated that, following further feedback from National Council, some final polishing will be required.

III. Data Entry, Case and Key Authoring System Tools

Work has also been completed on the design of the case and key authoring systems in addition to the data entry screens. These screens are the tools used to enter experts' case information into the computer, i.e., case and key authoring; these tools are also used for database maintenance. Implementation of the design of these screens has been completed; these screens are presently being debugged.

Activities May to September 1996

NBME will debug the new case and key authoring tools by entering four cases and keys. Both NBME and National Council will debug the case authoring and key authoring systems, the user interface, and support database content during this time. Following written feedback from National Council, NBME will correct any problems or bugs that

have been identified. It is anticipated that National Council will approve completion of the Phase II activities of the CST Project on or before September 1, 1996.

Phase III Activities

In preparation for the next phase of the project, a price for services has been provided by NBME in response to the National Council's request for Phase III services; a Phase III contract has been prepared by NBME as requested.

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[1] The nursing activity database file contains the nursing activities that the examinee can perform. The default response database file contains responses presented to an examinee following performance of a nursing activity when a case specific response is not needed. Different patient conditions (e.g., gender, age, pregnancy) will evoke different responses. This file also contains responses for activities performed for the patient's family or significant other.

Report of the Finance Committee

Committee Members

Charlene Kelly, NE, Area II, *Treasurer and Chair*
Lorinda Inman, IA, Area II
Barbara Morvant, LA-RN, Area III
Richard Sheehan, ME, Area IV
Jerry Walker, HI, Area I

Staff

Jennifer Bosma, *Executive Director*
Thomas Vicek, *Director of Administrative Services*

Relationship to Organization Plan

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective B ..... Maintain a sound resource management system for National Council.

Recommendation(s)

Recommendations are made throughout the year to the Board of Directors regarding the fiscal impact of proposed activities.

Highlights of Activities

- Reviewed an analysis of various financial ratios comparing the National Council with similar individual organizations and the median ratios of 65 other corporate member associations in the same income range as the National Council.
- Reviewed FY96 budget adjustments resulting from Delegate Assembly action.
- Reviewed and revised the FY1996-2000 Financial Forecast and recommended its approval by the Board of Directors.
- Requested that the Research Department develop and conduct a survey to collect better data for use in making candidate volume projections.
- Interviewed investment advisors and recommended the selection of Becker, Burke Associates, Inc. to the Board of Directors.
- Met with the auditors from Ernst and Young and reviewed the audited FY95 financial statements and management letter.
- Reviewed an Ernst and Young report on ETS internal controls over candidate fees.
- Reviewed the investment advisor's allocation study and recommended allocating up to 15 percent of the National Council's investments to common stocks.
- Reviewed all funding proposals, provided feedback and made recommendations as deemed appropriate.
- Monitored quarterly financial statements, including significant variances from budget.

- Monitored insurance coverage, investments, all expenditures over $15,000, and financial policies.
- Approved the FY97 budget assumptions and FY97-FY00 financial forecast assumptions.
- Reviewed the FY97 budget by Responsibility Center and by Organization Plan objective, including capital acquisitions and presented a tentative budget to the Board at its June meeting. The final budget, with any adjustments based on Delegate Assembly action, will be approved by the Board for implementation October 1, 1996.

Meeting Dates

- October 17, 1995
- January 16, 1996
- April 25, 1996
- June 11-12, 1996

Recommendation(s)

Recommendations are made throughout the year to the Board of Directors regarding fiscal impact of proposed activities.

Report of the Nursing Practice and Education Committee

Committee Members

Dula Pacquiao, NJ, Area IV, *Chair*
Pat Dixon, MO, Area II
Betty Hunt, NC, Area III
Jan Zubieni, CO, Area I

Staff

Linda Heffernan, *Nursing Practice and Education Associate*
Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to the Organization Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective G ..... Promote consistency in the licensure and credentialing process.

Goal II ..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B ..... Provide resources regarding health care issues which affect the regulation of nursing practice.

Bylaws ..... Provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Recommendation to the Delegate Assembly

1. **That the definition of competence, standards for competence and position statement regarding competence developed by the Continued Competence Subcommittee be adopted as a position of the National Council.** **(See the report beginning on page 37.)**

Rationale

The Nursing Practice and Education Committee has been chipping away at the challenges presented by continued competence for many years. The Continued Competence Subcommittee has significantly advanced that work with the development of a definition of competence, competence standards and the attached policy statement which can be used by Member Boards, the National Council and other interested entities to support the attainment, maintenance and advancement of professional competence.

Recommendations to the Board of Directors

1. **That the work of the Complex Discipline Subcommittee be supported and promoted.**

Rationale

The Nursing Practice and Education Committee recognizes that a great deal of Member Board time and resources is devoted to discipline case management. The recommendations proposed by the subcommittee are in keeping with other Nursing Practice and Education projects and the commitment to supporting informed, productive boards of nursing.

2. **That professional accountability behavioral indicators be promoted among Member Boards as an element to be considered when developing tools for post-discipline monitoring.**

Rationale

The Nursing Practice and Education Committee views professional accountability as the *gestalt* for professional nursing practice, the critical foundation for the development of a professional. As such, the behavioral indicators identified provide an important source of information regarding the rehabilitation of a disciplined nurse.

Highlights of Activities

- **Process for Evaluation of Usefulness of National Council Documents**

  One of the Goal I tactics assigned to the Nursing Practice and Education Committee states, "Implement the process for evaluating the usefulness of models and other position papers." This year, the NP&E Committee participated in the development of survey questions regarding the usefulness of models and other position papers that were included in a Communications Department survey of *Issues* readers. The NP&E Committee reviewed the results of the survey. The committee was pleased with the responses as to quality of the documents, but identified that many of the respondents were not aware of the availability of many of the resources. The committee made recommendations to staff regarding where and how National Council documents might be promoted and suggested that staff consider repeating this survey periodically.

- **Professional Accountability Study**

  A tactic under Goal II states, "Assess and analyze selected discipline cases for presence or absence of essential elements of professional accountability." The Nursing Practice and Education Committee used the critical elements of professional accountability and the behaviors that demonstrate the elements identified by the 1995 collaborative work group of educators, practitioners and regulators to design a framework for reviewing disciplinary cases. The committee piloted the framework on a sample of discipline cases. A report of this study is found in Attachment A on page 4.

  The Nursing Practice and Education Committee plans to build upon the committee's current work regarding professional accountability by exploring options to analyze the impact of professional accountability at the interface of graduation and employment. The committee also plans to further integrate the work on competence with their concept of professional accountability. This work will be used to develop proactive strategies to promote professional accountability.

- **Analysis of Nursing Education Rules and Regulations**

  A tactic under Goal III states, "Conduct a comparison of Member Board rules regarding education program approval with National Council model education rules." The Nursing Practice and Education Committee developed a tool for the comparison of education program approval rules. The indicators used by the committee are found in the comment section to the rules for education approval in the *Model Nursing Administrative Rules*.

  The rules from 55 jurisdictions were analyzed. The process for program approval process was very similar across jurisdictions. A diagram of that process was developed. Analysis of the standards for nursing education program approval demonstrated both commonalties and differences. The differences were primarily in the standards for curriculum. A complete report of the findings is found in Attachment B on page 13.

- **Coordination Role**

  The Bylaws of the National Council of State Boards of Nursing state that the Nursing Practice and Education Committee "provides general oversight of nursing practice and education issues by coordinating related subcommittees."

  The Nursing Practice and Education Committee coordinated the work of three subcommittees: the Complex Discipline Cases Subcommittee, the Continued Competence Subcommittee, and the Subcommittee to Analyze Clinical Experiences.

  The Nursing Practice and Education Committee chair was able to meet with chairs of two of the subcommittees, Complex Discipline and Continued Competence, on October 1, 1995, for an orientation and planning meeting. The participating chairs were enthusiastic about this opportunity to discuss their assigned tactics, how these topics were interrelated, and the relationship of these topics to the overall goals of the organization. The establishment of good lines of communication among the chairs facilitated the work throughout the year.

  The Nursing Practice and Education Committee reviewed the final work of the Complex Discipline Cases Subcommittee and the Subcommittee to Analyze Clinical Experiences at its April meeting. The committee supported the recommendations of the Complex Discipline Cases Subcommittee. The Subcommittee to Analyze Clinical Experiences did not make formal recommendations; the Nursing Practice and Education Committee found their model rule language useful and support its being considered during the revision of the *Model Nursing Practice*

Act and *Model Nursing Administrative Rules* planned to begin next year.

The Nursing Practice and Education Committee provided feedback to the Continued Competence Subcommittee regarding the revised definition of competence and competence standards as the subcommittee's work progressed. The committee reviewed the Continued Competence Policy Statement at a May 1, 1996, conference call, and approved the content of the paper and the direction taken by the subcommittee. The Nursing Practice and Education Committee will review the Continued Competence Subcommittee's report regarding the functional ability study and make recommendations for inclusion in the supplement to the *Book of Reports*.

Future Activities

Professional Accountability

- *Behaviors Which Exhibit Professional Accountability Worksheet* will be developed for use as a teaching tool for investigators, to raise awareness of professional accountability elements so that investigators can be cognizant of related information, and add this dimension to their investigative and interview process.
- *Behaviors Which Exhibit Professional Accountability Worksheet* will also be developed for use with students, faculty, licensees, and employers to promote awareness of professional accountability issues.

Continued Competence

- Integrate the work on competence with the concept of professional accountability.
- Develop regulatory guidelines for the use of continued competence resources.
- Identify assessment mechanisms for a variety of uses and investigate their capabilities related to continued competence assessment.
- Explore collaboration opportunities with other health related organizations.

Coordination Role

- Continue to develop the coordination role of the Nursing Practice and Education Committee, not only with Nursing Practice and Education subcommittees, but also to promote communication and collaboration with other task forces and committees regarding nursing practice and education issues.

Meeting Dates

- October 15 - 16, 1995
- February 4 - 5, 1996
- April 21 - 23, 1996
- May 1, 1996 *(telephone conference call)*

Recommendation to the Delegate Assembly

1. That the definition of competence, standards for competence and position statement regarding competence developed by the Continued Competence Subcommittee be adopted as a position of the National Council.

Recommendations to the Board of Directors

1. That the work of the Complex Discipline Subcommittee be supported and promoted.

2. That professional accountability behavioral indicators be promoted among Member Boards as an element to be considered when developing tools for post-discipline monitoring.

Attachments

Attachment A

Professional Accountability: Allowing Holistic Integration of the Many Components of Nursing Practice

Introduction and Purpose

Accountability is a critical characteristic, an attribute of the nursing profession. It is a fundamental value which forms the foundation for the development of a professional. *Professional accountability* is a larger concept, the term that the National Council's Nursing Practice and Education (NP&E) Committee has used to describe the process that allows insight and synthesis, enabling the nurse to successfully integrate the many components of nursing practice so that the outcome is competent practice. Professional accountability encompasses both the process of integration and the context within which the process takes place. Professional accountability forms the *gestalt* for professional practice.

For the past two years, the work of the National Council's Nursing Practice and Education Committee (NP&E) has included efforts to promote professional accountability among nursing students, applicants and licensed nurses. This work continues in the tradition of the 1993 Delegate Assembly resolution which addressed the need for boards of nursing to identify strategies for the prevention of common nursing practice deficiencies. The purpose of this paper is to describe the results of a study conducted by NP&E using a professional accountability framework to review a sample of discipline cases. The cases were analyzed to determine the presence or absence of essential elements of professional accountability. The paper discusses how the committee anticipates that this instrument can be used to design tools to assist in data collection by educators and employers, as well as tools to assist disciplinary investigators to address professional accountability issues in investigations. The results of the pilot were the catalyst for further discussion of the process and the development of visuals to illustrate the committee's concepts. The committee also used the results as a starting point for exploring options to analyze the role of professional accountability at the interface between student level and practice level (i.e., between graduation and first employment as a nurse).

Background and Definitions

In 1993, the Nursing Practice and Education Committee began to envision competence as a concept which encompasses multiple elements including knowledge, skills, abilities and professional accountability. (National Council, 1993) In 1994, the NP&E Committee developed a *Collaboration Model* which featured a cooperative effort between representatives of nursing education, service and regulation to explore a topic and offer strategies for resolving issues and concerns. (National Council, 1994) In 1995, the NP&E Committee applied the *Collaboration Model* to the topic of professional accountability. The process included the following:

- **Phase One: Literature Review on Selected Topic**
- **Phase Two: Selection of an Expert Panel**
  - Assessment of nurses recognized as having a high level of professional accountability - when and how did the nurse learn and incorporate professional accountability as a practice priority, and why does the nurse consider it a practice priority?
  - Identification of roles of nursing educators, nursing service and regulatory boards in promoting professional accountability
  - Development of a plan for implementation and evaluation
- **Phase Three: Report Findings**
- **Phase Four: Evaluation**

The outcome of that work was a report that defined professional accountability, identified the roles of education, service and regulation, and identified critical elements of professional accountability. The definitions identified by 1995 work group included:

- **Professional accountability** is being answerable for decisions and actions (external authority) and is the stimulus that compels a professional to deliver high quality services (internal conscience). Being accountable is demonstrating an obligation or willingness to accept responsibility. Such accountability provides a *gestalt* for practice, a structure that allows the integration of other elements of nursing practice.
- **Critical element** is a basic, essential component.
- **Behavioral indicator** is an observable action or outcome that can be used to illustrate a critical element. (National Council, 1995)

Phase One: Literature Review

Humanity has always struggled with what is right and what is wrong in human conduct. More specifically, "...the professions have always carried distinct moral obligations with respect to public and private decision-making and behavior. What we do as professionals and how we do it, whether in commercial or nonprofit contexts, our sense of integrity, and our regard for self and others, affect the lives of everyone" (Gorlin, 1994, p.v). Accountability is a characteristic of a profession (Gordon, 1989, p.264).

The ANA Code of Ethics states that "[t]*he nurse assumes responsibility and accountability for individual nursing judgments and actions.*" The interpretive statement to this tenet defines accountability as being answerable to someone for one's actions. "Nurses are accountable for judgments made and actions taken in the course of nursing practice" (ANA, 1985). Nurses base their clinical judgments on "consideration of consequences and of universal moral principles, both of which prescribe and justify nursing actions. The most fundamental of these principles is respect for persons" (ANA, 1985). While requirements of an organization's Code of Ethics may exceed the requirements of the law in some jurisdictions, many Nurse Practice Acts in the United States address professional accountability in the context of grounds for discipline and/or standards of practice.

Davis (1993) indicates that higher education has a revived interest in values and ethics, and greater concern regarding the moral development and ethical competency of students. Nursing texts contain chapters on legal and ethical considerations in professional practice. Inherent in the literature is the underlying obligation to be accountable. The purpose of teaching values in education is to focus on the process of inquiry - developing a mode of reasoning and identifying a set of fundamental values that promote effective choice. Morrill (1980) states that students should be challenged to confront standards, analyze differing points of view, assume the role of a person with a contrasting view and wrestle with complex problems with no simple solutions. Such awareness of complex issues and at least beginning experience in analysis would help students better prepare for the ever-changing reality of the health care world.

Gordon (1989) asks, "Why is accountability the byword of the future for the nursing profession?" Accountability adds an element of answerability to responsibility, a formal obligation to disclose one's actions. Gordon defines accountability as the "...state of being responsible and answerable for those behaviors and their outcomes that are included in one's professional role, as reflected in the periodic written reporting of those behaviors and their outcomes" (Gordon, 1989, p. 250). Bergman (1981) considers responsibility, authority, and ability as preconditions to accountability. She states that a person must have "...the ability to decide and act on a specific issue...responsibility to carry out the action... [and] the authority, i.e., formal backing, legal right to carry the responsibility. Then, with...[these]...preconditions, one can be accountable for the action one takes" (Bergman, 1981, p. 54-55). Accountability is a necessary attribute in all those who wish to exercise authority and act autonomously - and this characterizes nurses today" (Gordon, 1989, p. 252).

Gordon also observes that most nurses may think of accountability in the negative, as being blamed or called on the carpet when things go wrong. "Quite the contrary, accountability should be looked at as a highly positive concept, permeated with visions of respect, reward, effectiveness, control, and action" (Gordon, p.261). Accountability should allow for honesty without blame, in the best interest of all (Arnold & Plas, 1993). An example of accountability as a positive concept is found in the work of the Ontario College of Nurses. The College has promoted "reflective practice" - a strong emphasis on the individual's responsibility and accountability for the maintenance of professional competence. Professional accountability, or professional attitude, is a key component of Ontario's ongoing efforts to promote quality assurance.

Professional Accountability Framework

The Nursing Practice and Education Committee also views accountability as a positive attribute, as illustrated in the 1995 NP&E study where work group participants interviewed nurses selected expressly because they were viewed

as extremely accountable for their practice. This year, the NP&E Committee selected elements of professional accountability from its 1995 study to design a framework for analyzing discipline cases. The NP&E Committee reviewed the critical elements and behavioral indicators which were identified by the 1995 collaborative work group, and considered how these might be developed as a framework for review of discipline cases. The critical elements as originally identified were:

1. ***The nurse is responsible for actions, practice and decisions*** - reflecting the need for any professional to accept responsibility for knowing the legal, ethical, and professional parameters of practice, maintaining those boundaries, and acknowledging when a decision or action has not been in the best interest of a client while taking corrective action in the client's behalf.

2. ***The nurse demonstrates honesty and integrity*** - reflecting the fundamental values needed by a professional that permeate all aspects of nursing practice.

3. ***The nurse knows and incorporates professional standards into nursing practice*** - reflecting the need to achieve the necessary knowledge, skills and abilities, so that professional decisions are based on that knowledge and the expectations delineated in professional standards.

4. ***The nurse maintains continued competence*** - reflecting the need to continually learn and apply to practice new knowledge and techniques in the client's interest.

5. ***The nurse is self-reflective, critically reviewing actions, practice and decisions*** - reflecting the need for the nurse to "know thyself" - to be self-reflective, to critically review decisions, actions and practice. The nurse needs to know what she/he knows, know what she/he does not know, recognize when it matters to know, and seek appropriate assistance, supervision and/or counsel.

Development of the Framework

NP&E Committee members discussed each of the identified elements and behavioral indicators to determine which, if any, could be used for a retrospective review of discipline cases. Elements 1, 2, 4 and 5 were selected to be used in the framework. The committee recognized that the core of accountability, which is embedded within each individual, is very difficult to appreciate by objective means. However, the group believed that the element of responsibility included objective aspects of professional standards. Indeed, by the very nature of disciplinary action, one assumes that one or more standards have been breached.

The discipline case review concentrated on the other four elements. The committee members realized that not all behaviors or elements would likely be represented in any one case. The following coding was developed to record the outcomes of a record review for each of the behavioral indicators.

Inconsistent - *demonstrates behavior inconsistent with standard*
Consistent - *demonstrates behavior consistent with standards*
Not referenced (NR) - *no information*
Not applicable (NA) - *does not apply to the situation*

For each element in the framework, NP&E Committee members listed behavioral indicators that were observable by a third party. There were some indicators identified by the work group that were not used in the framework because of the subjective nature of the indicator, e.g., *The nurse internalizes professional standards.* The committee also identified additional indicators to complete the framework. (See Table 1 for a sample worksheet showing the selected elements and indicators.) *Discipline remedy* is defined as the action taken by a board of nursing to correct, rehabilitate or resolve a complaint.

Case Selection

Each committee member was asked to obtain the public documents of a random sample of discipline cases from their jurisdiction that could be used for the case review. The framework was then used by committee members to review the sample of discipline cases.

Application of Framework: Analyzing Discipline Cases

As an alternative to the strictly quantitative and rationalistic method, the committee used a qualitative method which aims for description, analysis and understanding. The work undertaken by the NP&E Committee involved a review of 25 discipline cases. Data were examined for relationships of events from which themes and recurrent patterns were derived.

Missouri Try-out

The first application of the framework for analyzing discipline cases was done by a Member Board. One of the NP&E Committee members shared the draft instrument with the Missouri Discipline Committee, whose members independently reviewed and scored 74 discipline complaints in December 1995. The Missouri group reported back that the interpretation of terms used in the instrument varied among their members (in particular, there was confusion regarding the difference between "not referenced" and "not applicable"). The Missouri Discipline Committee also indicated that the instrument did not "follow well" with their complaints, and thus they were unable to identify either consistent or inconsistent behavioral indicators for 19 (26%) complaints. Some members commented that the framework was "non-contributory" for the discipline process.

Under the responsibility element, the reviewers noted almost as many consistent behaviors as inconsistent behaviors. (It is possible that the tool, worded in positive indices, requires a shift in focus when reviewing cases.) The continued competence section was particularly difficult for them to relate to investigative reports, and they also found it hard to use in chemical dependency cases. Evaluation of honesty and integrity was based only on nurse responses, and the reviewers were often skeptical about the information provided.

The instrument was reported to be most effective in reviewing pure practice issues. The Missouri Discipline Committee suggested that the instrument could be very useful if adopted for monitoring ethical behavior of nurses under discipline order. They also indicated it would be suitable for a facility's internal process of monitoring a nurse's accountability. (Jean Dixon, personal communication, April 22, 1996)

NP&E Pilot

At its February meeting, the NP&E Committee members also used the framework to analyze 25 discipline cases. Each case was independently reviewed by a committee member or staff. A second committee member independently reviewed each case. Any discrepancies in coding results were discussed by the group to arrive at a final determination. The NP&E Committee members debriefed after the experience of using the instrument as part of the evaluation process. (See Table 1.)

Discussion

Table 1 shows the compiled case analysis results. A useable report was a report where there was sufficient information in the fact patterns (i.e., description of the events reported related to the discipline complaint) provided to determine whether the behavior in the case was consistent or inconsistent with the positive behavior indicators included in the framework. Evidence of the following indicators was identified in the fact patterns for 20 or more of the 25 cases:

- Utilizing knowledge to govern actions, decisions and practice.
- Working within identified parameters: legal scope of practice.
- Working within identified parameters: professional standards.
- Acknowledging own behaviors and actions.

Evidence of the following indicators was identified in 15-19 of the cases:

- Performing competently to achieve desired outcome/intended effect.
- Advocating for clients.
- Admitting mistakes.
- Initiating actions to safeguard clients.
- Documenting/reporting by nurse corresponds to observations by others.
- Working within identified parameters: agency policies/procedures.
- Documenting/reporting without intentionally falsifying, omitting or altering information.

Table 1.
Results of Analysis of a Sample of Discipline Cases Using the Professional Accountability Framework

Responsibility	**# Useable reports**	**% Useable**	**Inconsistent**	**% Inconsistent**	**Consistent**	**% Consistent**
The Nurse demonstrates responsibility by:						
Performing competently to achieve desired outcome/intended effect	19	76%	19	100%		
Utilizing knowledge to govern actions, decisions and practice	20	80%	20	100%		
Advocating for clients	15	60%	15	100%		
Intervening as a response to an unexpected outcome	10	40%	10	100%		
Admitting mistakes	19	76%	17	89%	2	11%
Initiating actions to safeguard clients	16	64%	16	100%		
Monitoring performance of delegated tasks	4	16%	4	100%		
Communicating within the health care team	10	40%	10	100%		
Consulting with other nurses and other health care team members	10	40%	10	100%		
Establishing policies/guidelines reflective of legal/professional standards	0		0			
Documenting/reporting by nurse corresponds to observations by others	17	68%	16	94%	1	6%
Presenting reports consistent with client's condition	11	44%	10	91%	1	9%
Documenting/reporting by nurse corresponds to observations by others	14	56%	13	93%	1	7%
Working within identified parameters: legal scope of practice	20	80%	16	80%	4	20%
Working within identified parameters: professional standards	24	96%	24	100%		
Working within identified parameters: agency policies/procedures	18	72%	18	100%		
Honesty/Integrity						
The nurse demonstrates honesty and integrity in practice by:						
Documenting/reporting without intentionally falsify, omitting or altering info	18	72%	17	94%	1	6%
Demonstrating a willingness to pursue solution to problem	10	40%	7	70%	3	30%
Initiating corrective action toward self improvement	8	32%	5	63%	3	7%
Competence						
The nurse promotes continued competence by:						
Assessing self, using legal definition of scope of practice	6	24%	6	100%		
Assessing self, using professional standards	6	24%	6	100%		
Assessing self, using agency policies, procedures and/or guidelines	6	24%	6	100%		
Planning the necessary strategies for attaining competence	2	8%	1	50%	1	50%
Planning the necessary strategies for maintaining competence	1	4%	1	100%		
Planning the necessary strategies for advancing competence	1	4%	1	100%		
Initiating the necessary strategies for attaining competence	2	8%	1	50%	1	50%
Initiating the necessary strategies for maintaining competence	1	4%	1	100%		
Initiating the necessary strategies for advancing competence	1	4%	1	100%		
Evaluating the effectiveness of strategies	1	4%	1	100%		
Professional Self Awareness						
The nurse demonstrates professional self awareness by:						
Acknowledging own behaviors and actions	20	80%	15		5	25%
Asking for assistance appropriately	4	16%	4			
Tracking and documenting professional development and growth	0		0			
Functioning within personal limitations	2	8%	2			

The following indicators were identified in 10-14 of the cases:

- Communicating within the health care team.
- Consulting with other nurses and other health care team members.
- Presenting reports consistent with client's condition.
- Documenting/reporting by nurse corresponds to observations by others.
- Demonstrating a willingness to pursue solution to problem.

The greatest number of behavioral indicators identified referenced the responsibility element. Two indicators were frequently identified under the honesty/integrity element. The only indicator under professional self awareness that was determinable from the fact patterns in a majority of cases was acknowledging own behaviors and actions. The committee found it interesting that two similar indicators, residing under different elements, were found in nearly the same number of cases (*Admitting mistakes,* under the responsibility element, was found in 19 cases, 17 inconsistent and 2 consistent; and *acknowledging own behaviors and actions,* under the professional self awareness element, was found in 20 cases, 15 inconsistent and 5 consistent).

The competence indicators were usually not apparent from the fact patterns or were judged to be non-applicable to the situation. In addition, none of the cases reviewed involved nurses in supervisory roles, which may account for the small number of indicators found involving delegation (only 4) and establishing policies/procedures (0).

Interpretation of Results

The NP&E reviewers had the advantage of being involved in the development of the tool, so that there was a common interpretation of the language used. Clearly, the Missouri experience showed that written instructions, including definitions, would need to be provided if the framework were to be used by other groups. A problem in reviewing some complaints and investigation reports is that they may not include information related to professional accountability issues. Not surprisingly, the framework worked best on practice cases (these cases tended to have lengthier fact).

The NP&E Committee members commented that it was difficult at first not to "read into" the facts. Like the Missouri reviewers, committee members observed that the behavioral indicators listed under the responsibility element were the easiest to find evidence of in the cases. Continued competence indicators were rarely addressed, unless it was the licensee's second time through the system. It was also difficult to identify most of the self awareness indicators. The NP&E Committee concurred with the Missouri Discipline Committee members that the differentiation between "not referenced" and "not applicable" was not always readily apparent, and could be merged into one code.

The committee determined that there is initial support for using the above indicators for evaluating licensees for the responsibility element of professional accountability. The NP&E Committte plans to refine the tool and use the framework to review more cases. The committee will reassess inter-rater reliability and validity of the instrument.

Further Discussion

Possibly the most interesting outcome of the study was the discussion triggered at the committee's last meeting of the year. After the NP&E Committee reviewed the work of its subcommittees and tabulated results of the review of discipline cases, several pieces of a puzzle that has been confounding the committee for some time began to fall into place.

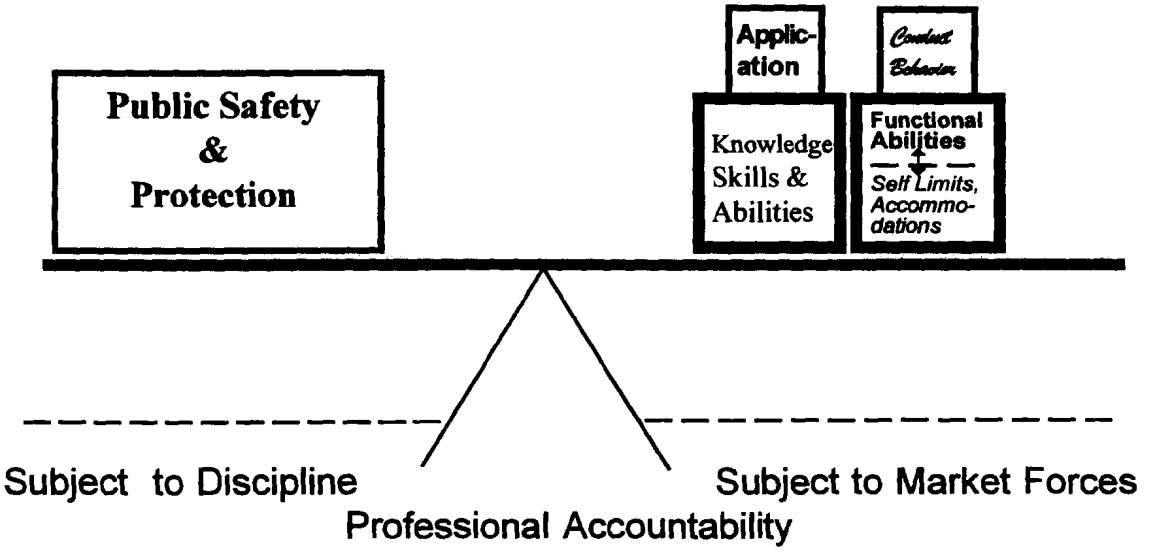
Previous work on competence had raised some "chicken or the egg - which comes first" dilemmas. Is professional accountability a part of competence or is competence a result of professional accountability? In early discussions of the paradigm shift for competence, the NP&E Committee had attempted to use a balance to illustrate how it believed these concepts were interrelated and struggled to fit all the puzzle pieces together - knowledge, competence, professional accountability, functional abilities, conduct/behavior, accommodations for disability, and self limitations.

In its final deliberations of the year, the NP&E Committee also reviewed the work of the Continued Competence Subcommittee and began to re-examine the relationship between professional accountability and competence. Committee members concluded that there is a process by which an individual makes decisions regarding the integration of these "pieces of practice" with the motivation provided by both external authority and internal conscience. The committee calls this *gestalt* or process by which all components are integrated into the context of practice, **professional accountability**, and the end result is **competence**.

Much of the nature of professional accountability is subjective and qualitative. It is difficult to evaluate, especially in a world where we have been conditioned to look for quantitative answers. But professional accountability is an

essential part of nursing practice; indeed, it is the mortar, the glue that holds the whole together. And being able to evaluate the qualitative and subjective may help "tip the scale" to facilitate effective evaluation of a clinical situation. The NP&E Committee developed a visual to illustrate how it has envisioned the totality of nursing practice components which is shown in Figure 1.

Figure 1. **Nurse's Rights and Duties to Practice Profession Based upon Various Components of Practice**



Note that the fulcrum of the diagram's balance is professional accountability, which represents the process of balancing the various components. If any components on the right side are changed in size, there needs to be concomitant change to the remaining components so that the balance can be maintained. The box around knowledge, skills and abilities is drawn in a heavy line to represent that there is a "minimum, essential" aspect of this component, as tested by the NCLEX™ examinations. Similarly, the box labeled functional abilities is drawn with a heavy line. The entire box represents the essential functions, with or without accommodations, needed to safely practice. The interior is divided by a dotted line, with an arrow illustrating that a decrease in functional abilities can be compensated by accommodation and/or self limitations. Finally, because it is not enough just to have the necessary abilities — these skills must be properly applied to be of benefit to the clients — the smaller boxes labeled application and conduct behavior represent the nurse's efforts toward this end. Application comprises both behavior and attitude in utilizing expertise in nursing practice situations. These boxes are drawn with thin outlines to illustrate that these components may vary in response to the individual situation.

The dotted line below the balance allows some "play" in the process. This "play" is the flexible continuum which provides for adaptations by practitioners to maturational, situational, and transitional variables in practice. Should the multiple components shift the balance to the right, public safety would still be maintained. This situation would not be problematic from a regulatory perspective. The horizontal dotted line below the balance on the right side of the diagram represents the effective use of resources. The nurse whose various components far outweigh the minimums needed for public safety might be found by potential employers to be overqualified for an entry position. Thus, market forces might dictate that the nurse be better utilized in a position that would use the additional components more effectively (or, in a period of over-supply, this might not be the case).

On the other hand, should the balance tip to the left so that public safety dips below the point represented by the dotted line, client safety would be at risk because of the failure to achieve the minimum, essential components needed for safe care. Hopefully the individual nurse, or the nurse's employer, would detect the shift, recognize the risk, and take appropriate action to return balance to the situation. The nurse would be subject to disciplinary review should the situation be reported to the board of nursing.

The Nursing Practice and Education Committee members believe that professional accountability enables licensed nurses to detect a shift to the left, like an early warning system, so that nurses can adapt, in the interest of client care. For example, if a nurse has a disability that, as represented in the diagram, makes his/her functional ability side of the box smaller, the balance can be maintained by adjusting the size of the accommodation element, or the self limitation element, or both. Another example would be a nurse put in a situation where he/she recognizes that he/she has a knowledge deficit, e.g., a medical-surgical nurse floated to the obstetrical unit. The nurse should alert supervisors of the lack of knowledge and experience and attempt to resolve the situation. Options should be identified - reassignment to a more congruent practice area, working the shift but limiting activities, not attempting to manage medications or procedures, working in an assistive role. The context of the situation must be evaluated - is it a one-time directive due to exceptional circumstances or is a frequent occurrence that warrants the nurse either obtaining sufficient education, orientation and training to function safely, or to rethink the choice of employment. The latter is a strong statement, but an appropriate consideration in terms of client safety and professional accountability.

A mistake does not necessarily reflect incompetence. Some mistakes are trivial. Nurses make hundreds of decisions a day involving innumerable actions, conversations, and documentations. Unexpected events happen. Nurses do not always work in the best of circumstances., they have "off" days. However, when a pattern of behavior represents a consistent imbalance of the nursing practice components, or when a single mistake exhibits a serious lack of competence, then efforts are needed to re-educate, to rehabilitate, to work to restore the balance.

Future Committee Activities

The committee plans to refine the *Behaviors Which Exhibit Professional Accountability Worksheet,* and pilot the revised framework on additional discipline cases. The committee also plans to explore other regulatory uses for the framework and the behavioral indicators. The committee will discuss with the Research Services Department options for validating the indicators that have been identified by the 1995 workgroup and the NP&E Committee. The NP&E plans to continue its focus on professional accountability and competence, and explore options to analyze the role of professional accountability at the interface of graduation and employment as well as the congruence of minimum, essential knowledge, skills and abilities needed to meet client needs in a variety of settings. The NP&E Committee also plans to explore developing a proposal for a future phenomenological study of discipline cases for further study of the presence or absence of professional accountability elements in discipline cases, and/or as a methodology for analyzing the effectiveness of discipline. This method is envisioned to capture the elusive essence of professional accountability.

References

American Nurses Association, (1985). Code for nurses with interpretive statements. Washington, DC: Author.

Arnold, W. & Plas, J. (1993). The human touch. New York: John Wiley & Sons, Inc.

Bergman, R. (1981). Professional accountability- definition and dimensions. International Nursing Review 28, 53-59.

Davis, M., Johnston, S., DiMicco, W., Findlay, M. & Taylor, J. (1996). The case for a student honor code and beyond. Journal of Professional Nursing, 12, (pp 24-30).

Gorlin, R. (ed.) (1994). Codes of professional responsibility (3rd ed.). Washington, DC: The Bureau of National Affairs, Inc.

Gordon, S. (1989). Accountability in nursing: A many-faceted concept. In S. Leddy & J. Pepper, Conceptual bases of professional nursing (pp. 249-263). Philadelphia: J.B. Lippincott Company.

Missouri Nursing Practice Committee, personal communication, April 22, 1996.

Morrill, R.L. (1980). Teaching values in college. San Francisco: Jossey-Bass.

National Council of State Boards of Nursing. (1993). Report on the pilot of collaboration model for the identification of strategies for the prevention of common nursing practice deficiencies. 1994 Book of Reports. Chicago: Author.

National Council of State Boards of Nursing. (1993). The Nursing Practice and Education Committee's paradigm shift regarding competence...a draft concept for discussion at the Nursing Practice and Education Forum at the 1993 Annual Meeting. 1993 Book of reports. Chicago: Author.

National Council of State Boards of Nursing. (1995). Professional accountability- using the collaboration model for the identification of strategies for the promotion of professional accountability. 1995 Book of Reports. Chicago: Author.

Attachment B

Nursing Education Rules and Regulations: An Analysis

Background

Boards of nursing have their genesis in the regulation of nursing education programs. The role of the board was to provide standards for nursing education and to protect the public from poorly prepared practitioners. In the last several years, there has been much discussion regarding the current role of boards of nursing in the regulation of nursing education programs. Discussion has centered around issues of staff resources, impact of multiple agencies accrediting education programs, identification of the unique role of the board of nursing in the regulation of nursing education, differences and similarities between National League for Nursing (NLN) accreditation and board of nursing approval. Several jurisdictions have moved in the direction of accepting NLN accreditation in lieu of a board of nursing visit for continued program approval.

In 1994, the Nursing Practice and Education (NP&E) Committee revised the *Model Nursing Administrative Rules,* which included Nursing Education Standards. These Rules were adopted by the 1994 Delegate Assembly. As part of the process of revision, the committee shifted the approach to rule development. The committee identified those elements which it considered most important to protect the public health and safety. The elements were developed in the language of the rules as standards, providing a blueprint for regulation. The comments were used to provide indicators for the standards and the specificity that some boards find helpful.

In 1995, the committee compared the Education Standards in the *Model Rules* with the National League for Nursing Criteria and Guidelines for each of the four Councils. The comparison was difficult for several reasons. First, there was no consistent format or framework to the Criteria and Guidelines from the four Councils. Second, each Council articulated its criteria and standards very differently - ranging from very specific and precise requirements in the Licensed Practical/Vocational Program criteria to broad conceptual statements in the Baccalaureate and Higher Degree Program criteria.

The comparison showed similarities as well as differences in the criteria specified by the *Model Rules* and the NLN Criteria and Guidelines. Although the NP&E Committee proceeded with the notion that the *Model Rules* specifically targeted essential criteria for assurance of minimal safe practice and that the NLN Criteria and Guidelines were directed at promoting quality of nursing education programs, this distinction was not clearly evident. In contrast to the *Model Rules* which stipulated the need for the license to practice and recognition of State Nurse Practice Acts, the requirement for licensure to practice was not consistently addressed in faculty or nursing program administrator qualifications in the NLN Criteria and Guidelines.

In comparing the program approval process specified in the NLN Criteria and Guidelines and *Model Rules,* it was apparent that a proactive approval process was required by the *Model Rules* before a program is established. On the other hand, NLN Criteria and Guidelines specify a retroactive program approval process which begins post graduation of the first class of students. Both however, require a continuing approval mechanism to maintain accreditation or approval of the program. Both also stipulate time and opportunity for programs to plan and implement remedies to correct identified deficiencies.

In 1996, the NP&E Committee conducted an analysis of each jurisdiction's education rules compared to the education standards in the *Model Rules.* The indicators listed in the comments to each of the education standards were the points for comparison. The rules from 55 jurisdictions were analyzed: two jurisdictions do not approve/accredit nursing education programs, and rules from four jurisdictions were unavailable for evaluation.

Approval/Accreditation Process

The process for program approval of 55 jurisdictions was reviewed. While there was some minor variation, the process by which boards of nursing approve/accredit nursing education programs is very similar (Figure 1). Most jurisdictions require some form of approval whether through the board of nursing or through another state agency. Programs seeking initial approval must provide the board with a statement of intent to open a program and a proposal.

The proposal includes, but is not limited to, the following: purpose, mission and level of program; documentation regarding present and future need for the program; rationale for establishment of program; analysis of the program's potential effect on existing programs; information regarding the accreditation of the sponsoring/parent institution; an organizational chart showing the relationship between the proposed program and sponsoring/parent institution;

availability of a qualified administrator and faculty and number of budgeted positions; clinical resources; financial resources; and a timetable for planning and initiating the program. Upon approval of the proposal, the program may apply for provisional approval.

Before applying for provisional approval, the program must hire an administrator and submit a written program plan. The board of nursing conducts a site visit and reviews the program plan and application. Following a grant of provisional approval, the program may open. Progress reports are submitted to the board. After graduation of the first class, the program is eligible to apply for full approval. The program must provide a self study based on the standards required by the board and submit to a visit by the board.

The board can grant full approval to programs that demonstrate compliance with the standards for education or conditional approval for a limited time may be granted to a program with provisional or full approval that has now failed to meet board standards. In such cases, the board identifies the deficiencies that must be corrected within a specified length of time. Denial of approval at any level is open to an appeal process which is generally governed by the administrative procedure act of the jurisdiction.

Nursing education programs must demonstrate continuing compliance with board standards on a periodic basis (Figure 2). This process generally involves board review of a self-study report submitted by the nursing education program and a site visit conducted by a board representative. Boards may also review program approval status at the request of a program, after complaints about the program are brought to the attention of the board and/or at the discretion of the board.

Standards of Nursing Education

An analysis of nursing education rules and regulations was conducted, comparing jurisdictional standards to the standards of nursing education in the *Model Rules*. The five standards provided the framework for the analysis. Specific points of analysis were drawn from the indicators provided in the comments.

Standard 1: Organization and Administration

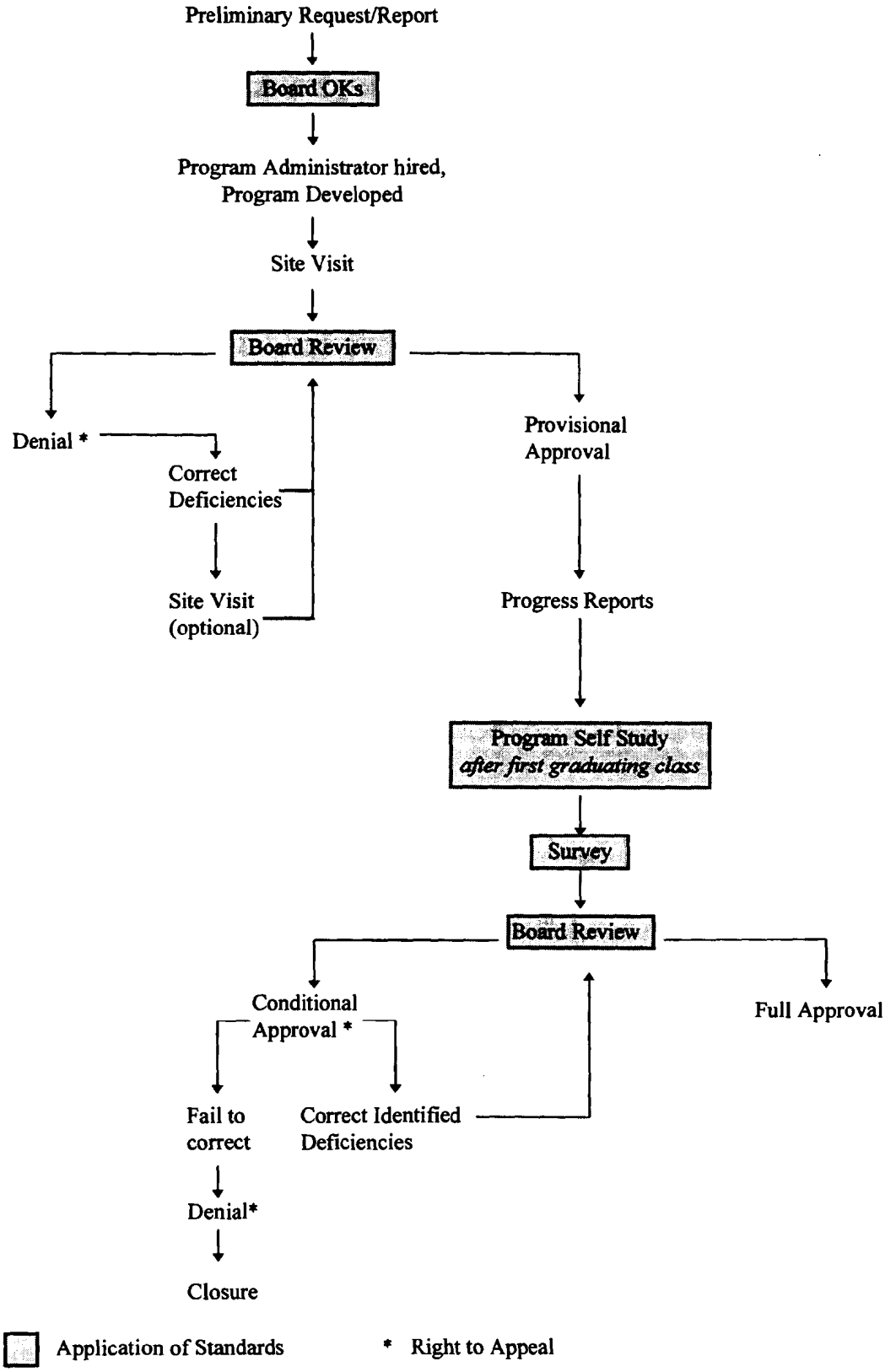
Standard 1 states that the organization and administration of the nursing education program shall be consistent with the law governing the practice of nursing. The NP&E Committee reviewed a total of 55 jurisdictions. In general, the rules and regulations regarding the organization and administration of nursing education programs were fairly consistent with the *Model Rules*. A majority of jurisdictions require written statements about the program's purpose, mission and philosophy, and written policies which are consistent with their parent institutions.

The NP&E Committee noted the following themes:

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 56)*
Accreditation of governing or parenting institution by appropriate agency.	45	82%
Organizational chart depicting: relationship between program and parent institution; relationship between the program and other programs in the same institution; delineation of authority, responsibility and channels of communication.	46	84%
Evidence of financial support and resources to meet the goals of the nursing education program.	48	87%
Achievement of minimum NCLEX™ pass rates for continuing board approval - average range between 75-85%.	27	49%
NLN accreditation or reports accepted for continuing approval in lieu of a site visit.	13	24%

Initial Approval

FIGURE 1



Standard 2: Administrator Qualifications and Responsibilities

Standard 2 states that the administrator of a nursing education program shall be a Registered Nurse (RN), licensed in the state, with the additional education and experience necessary to direct the program preparing graduates for safe and effective practice of nursing. The administrator is accountable for the administration, planning, implementation and evaluation of the nursing education program. The standards suggested a minimum of a master's degree in nursing for Licensed Practical/Vocational Nurse (LPN/VN) programs and a doctoral degree in nursing or a related field for RN programs. Preparation in education and administration, clinical experience and educational experience was suggested.

Registered Nurse Programs - Rules and Regulations from 49 jurisdictions were reviewed.

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 49)*
Delineate different requirements for Administrators of Baccalaureate and Associate Degree or Diploma programs	15	31%
Required earned doctorate for BSN programs	15	31%
Required doctorate for Master's program only	2	4%
Specified the MSN as required	32	64%
Allow Master's in other fields	14	29%
Specify BSN in addition to a Master's degree	7	14%
Specify clinical experience	30	61%
Specify experience in education	31	63%
Specify preparation in education and administration	18	37%

Practical/Vocational Nurse Programs - Rules and Regulations from 50 jurisdictions were reviewed.

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 50)*
Specify Master's in Nursing	27	55%
Specify BSN only	15	31%
Allow BS in other fields	2	4%
Allow progress toward BSN as sufficient	1	2%
No specifications provided	5	10%
Specify clinical experience	39	78%
Specify preparation in education and administration	16	33%
Specify certificate in vocational education	1	2%

If administrative responsibilities were delineated, they were fairly similar: development and maintenance of an environment conducive to the teaching/learning process (39=78%); institutional liaison (33=66%); leadership within the faculty for the development of the curriculum (29=58%); budget (31=63%); faculty recruitment, development, review, retention and promotion (27=54%); board liaison (22=44%); community liaison (8=16%).

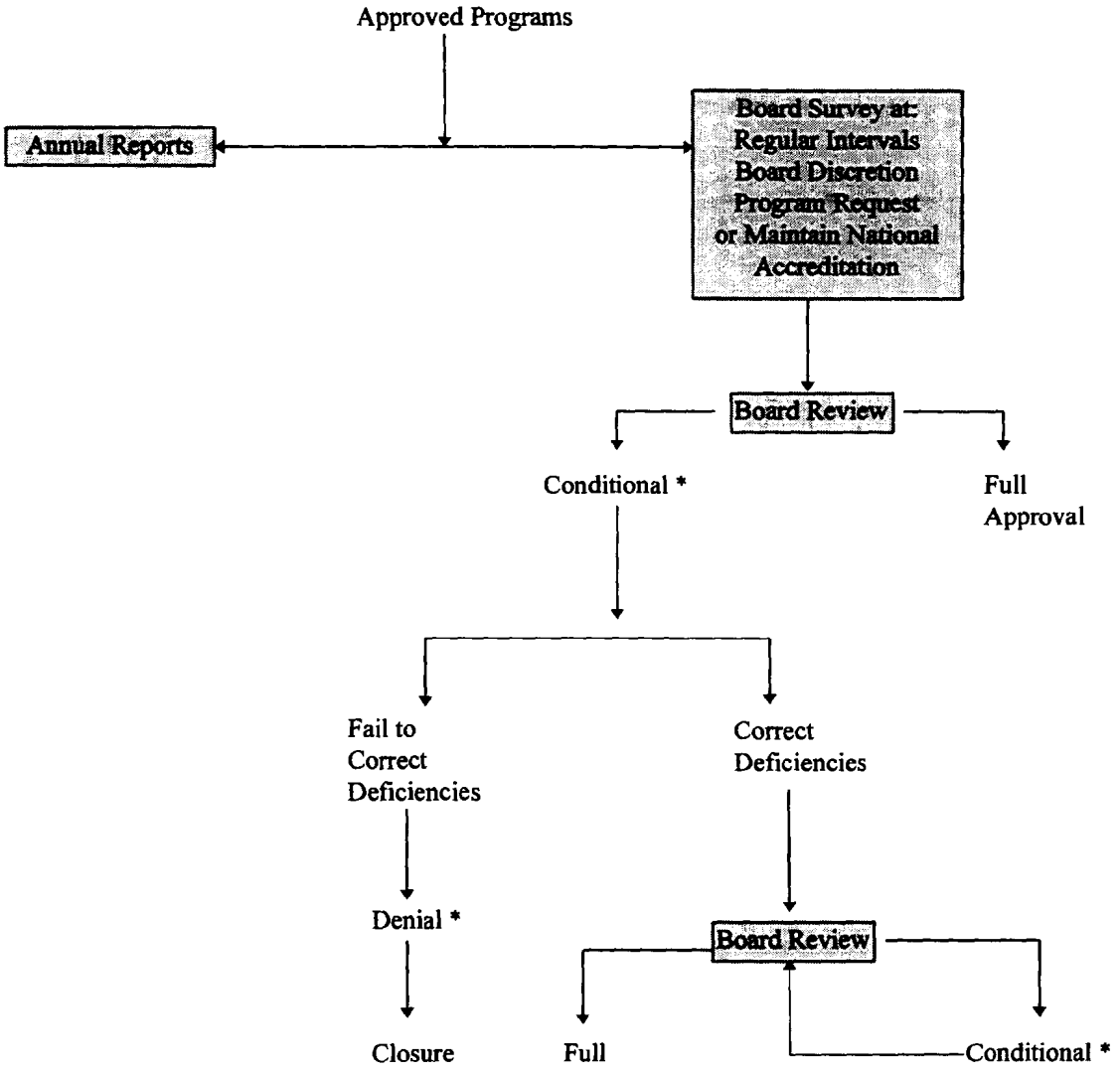
Standard 3: Faculty Qualifications and Responsibilities

Standard 3 states that there shall be sufficient faculty with graduate preparation and nursing expertise to meet the objectives and purposes of the nursing education program. Nursing faculty who teach in a program leading to licensure as a Practical/Vocational Nurse shall have a minimum of a baccalaureate degree. Nursing faculty who teach in programs leading to licensure as a Registered Nurse shall have a minimum of a master's degree in nursing. All faculty, regardless of the program type, shall be currently licensed as a Registered Nurse in the state, have clinical experience relevant to the areas of responsibility, and nursing education experience.

Rules and regulations regarding faculty qualifications and responsibilities for RN programs from 49 jurisdictions were reviewed as well as rules and regulations from 49 jurisdictions regarding LPN/VN programs. All jurisdictions, RN and LP/VN, required all faculty to be licensed in the jurisdiction. A faculty/student ratio was specified in 40 (71%)

Continuing Approval

FIGURE 2



Application of Standards

* Right to Appeal

jurisdictions. Twenty-four (43%) jurisdictions require that all faculty policies and procedures should be available in writing and should include qualifications, rights and responsibilities of faculty members, criteria for evaluation of faculty performance, and promotion and tenure policies.

Registered Nurse Program Faculty

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 49)*
Master's in Nursing required	42	86%
BSN only	6	12%
Provisions for non-qualified faculty to meet requirements	8	16%
Relevant clinical experience required	37	76%
Nursing education experience required	11	22%

Licensed Practical/Vocational Nurse Faculty

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 49)*
BSN degree required	37	76%
MSN required or preferred	7	14%
Provisions for non-qualified faculty to meet requirements	5	10%
Relevant clinical experience required	40	82%
Nursing education experience required	10	20%
Additional academic preparation in education required	6	12%

Faculty responsibilities were delineated in most jurisdictions. These responsibilities include the following:

RESPONSIBILITY SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 56)*
Developing, implementing, evaluating, and updating the purpose, philosophy, objectives and organizational framework	36	64%
Designing, implementing, and evaluating the curriculum	49	88%
Developing, evaluating, and revising student policies	30	54%
Participating in academic advising and guidance of students	26	46%
Providing theoretical instruction and clinical experiences	40	82%
Monitoring instruction provided by preceptors	9	16%
Evaluating student achievement of curricular objectives	46	82%
Providing for student and peer evaluation of teaching effectiveness	16	26%
Participating in activities to maintain nursing competence and professional expertise	32	57%

Standards regarding the use and qualifications of non-clinical faculty were articulated in 23 jurisdictions. Nineteen jurisdictions articulated criteria for the use of preceptors to enhance clinical learning experiences. The criteria for selection of preceptors must be in writing (12); the functions and responsibilities of the preceptor shall be delineated in a written agreement between the preceptor and the nursing education program (9); and the faculty member should retain responsibility for the student's learning experience (13).

Standard 4: Students

Standard 4 stated that students shall be provided the opportunity to acquire and demonstrate the knowledge, skills and abilities for safe and effective nursing practice. All policies relevant to applicants and students shall be available in writing. Students shall be required to meet the health standards required by the clinical agencies, in the interest of client welfare.

The rules and regulations related to students were similar in all jurisdictions. Fifty-one jurisdictions (90%) required that the student policies be in writing and readily available to students and applicants. Policies mentioned were those concerning admission, progression, retention and readmission of students.

Standard 5: Curriculum

Standard 5 states that the curriculum of the nursing education program shall enable the student to develop the nursing knowledge, skills and competencies necessary for the level of nursing practice. The curriculum shall include:

a. content regarding legal and ethical issues, history and trends in nursing, and professional responsibilities;
b. experiences which promote the development of leadership and management skills and professional socialization consistent with the level of licensure;
c. learning experiences and methods of instruction consistent with the written curriculum plan; and
d. courses including, but not limited to:
    1. courses in the biological, physical, social, and behavioral sciences to provide a foundation for safe andeffective nursing practice;
    2. the nursing practice; and
    3. didactic content and clinical experience in the promotion, prevention, restoration, and maintenance of health in clients across the life span and in a variety of clinical settings.

The rules and regulations regarding curriculum were the most varied. Some jurisdictions did not specify any particular content but identified competencies of graduates, or stated that the curriculum should prepare the graduates for the level of licensure, or incorporated the NLN Criteria and Guidelines by reference.

The majority of jurisdictions (50=90%) specified that the curriculum be planned, implemented and evaluated by the faculty with provisions for student input. Forty-two jurisdictions (76%) stated that the curriculum should reflect the organizing framework and objectives of the nursing education program. Twenty-six jurisdictions (47%) required that the curriculum be organized logically and sequenced appropriately. Thirty-eight (69%) specified that the curriculum ensure adequate clinical experience to prepare the student for the safe practice of nursing. Only seven jurisdictions (12%) addressed the facilitation of articulation among programs.

Several trends in curriculum requirements were noted by the NP&E Committee.

STANDARD SPECIFIED	NUMBER OF JURISDICTIONS	PERCENTAGE OF TOTAL *(N = 56)*
Specified content included in nursing curriculum	37	66%
Specified content included in non-nursing support courses	10	18%
Differentiated content for RN and LPN/VN curriculum	31	55%
Differentiated content for BSN and ADN curriculum	18	32%
Additional courses specified for BSN curriculum	11	20%
RN programs - specified hours for nursing courses	6	11%
RN programs - specified hours for non-nursing courses	4	7%
RN programs - specified theory and clinical hours in nursing courses	4	7%
LPN/VN programs - specified hours for nursing courses	9	16%
LPN/VN programs - specified hours for non-nursing courses	1	2%
LPN/VN programs - specified theory and clinical hours in nursing courses	7	3%
LPN/VN programs - specified length of program (hours/days)	5	9%

Generally, if nursing and support course content was identified, the content areas delineated in the *Model Rules* was included. Nursing course content was delineated in terms of clinical areas, e.g. medical, surgical, maternal-child, pediatrics, etc. Non-nursing content specified was in the areas of the behavioral, social and physical sciences.

Differences between RN and LPN/VN curriculum were noted. In contrast to the LPN/VN, RN curriculum provided for greater depth and breadth in both theory and clinical components of content. For example, RN curriculum specified psychiatric/mental health nursing principles and clinical in contrast to principles of mental health in the LPN/VN curriculum. RN curricula emphasized the professional nursing role in the care of clients with complex needs, while the LPN/VN curricula specified care of clients with simple nursing needs and the assistive role provided by practical/vocational nurses to professional nurses. BSN curricula typically specified additional content in community health, research, leadership and management concepts and relevant clinical experiences.

Conclusions

Comparative analysis of the *Model Rules* and the rules and regulations pertinent to nursing education of 55 jurisdictions demonstrated both commonalties and differences. Both delineated the process involved in the regulation of programs as well as standards or outcomes for nursing programs. Standards or outcomes were more clearly and consistently articulated in the *Model Rules*. In many jurisdictions, the standards were implicit in the rules or process of program approval/accreditation.

The process for state approval of new programs is strikingly similar across jurisdictions. Additionally, the process for granting continued approval/accreditation was consistent in a great majority of jurisdictions with some jurisdictions accepting NLN accreditation in lieu of a board visit as the basis for continued approval/accreditation.

Variability in qualifications required for administrators and faculty members were noted. Some jurisdictions required a doctoral degree while others considered this as a preferred qualification in baccalaureate programs. NP&E Committee members thought that this variation was a function of market variability of a qualified pool of applicants for these positions.

Rules and regulations pertaining to curriculum were found to vary greatly among jurisdictions. Stipulations ranged from highly specific content and hours delineation to nonspecific broad themes with specific curricular decisions being left to the nursing education programs by boards of nursing.

The data provide Member Boards with information for comparing their own rules and regulations and expectations of nursing educational programs with those of other jurisdictions. Some norms can be derived from the tabular data which give each Member Board a sense of where it belongs within the range of educational rules and regulations. This process provides a mechanism for boards of nursing to examine their own rules within the context of the *Model Rules* and the norms derived from other jurisdictions. Concomitant to this process are increased dialogue and consultation between boards and formulation of sound rationale for regulations which are unique to each one. Nationwide data can provide boards better understanding of each other's educational programs which forms a logical basis for decisions regarding nursing practitioners across jurisdictions.

Comparative data enhance identification of commonalties and differences in education rules and regulations. This in turn promotes determination of universal and jurisdiction-specific elements of education rules and regulations. Decisions relevant to rules and regulations of nursing education programs can be based on the core components that have been identified by a majority of jurisdictions as well as by a critical examination of each jurisdiction's unique needs and situations. This is fundamental in addressing the needs of a changing demographic of consumers within the context of a global and highly mobile market for nursing practice.

In an era of cost containment and dwindling resources, data from this survey provide some ideas for developing creative regulatory strategies based in experiences of other jurisdictions. Boards can determine areas of duplication in regulations which have been effectively minimized by other states. Through exchange of ideas and experiences, boards can confidently experiment with new strategies which are cost effective in promoting public health, welfare and safety through nursing education.

Report of the Complex Discipline Cases Subcommittee

Subcommittee Members
Ann Torres, AZ, Area I, *Chair*
Lannette Anderson, WV-PN, Area II
Thania Elliott, LA-RN, Area III
Caroline Stellman, MD, Area IV

Staff
Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to Organizational Plan
Goal II ..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective D ..... Provide for Member Board needs related to disciplinary activities.

Recommendations to the Nursing Practice and Education Committee

1. **That two copies of *Discipline Resources Notebook* be distributed to each Member Board, one for the executive officer and an additional copy for the discipline staff.**

   Rationale

   This resource will be helpful to the executive officer who is responsible for all Member Board activities, but it will be most useful to the staff who manage discipline cases on a day-to-day basis. Providing each Member Board with two copies will assure that both the administrative and the discipline staff have ready access to this resource. Board staff are also encouraged to copy portions of the notebook for use by others, e.g., to orient new board members, attorneys, etc.

   Fiscal Impact: Is included in FY96 budget.

2. **That the response to and use of the *Discipline Resources Notebook* be reviewed in early 1997, to provide feedback as to whether or not this is an effective means of meeting Member Board needs, what additional topics ought to be addressed, and to suggest the timing and procedures for updating.**

   Rationale

   This resource is a new approach for meeting Member Board needs related to management of the growing number and complexity of discipline cases. The subcommittee believes it is important to determine whether or not the content and the format provide the working resource that is intended. If useful, plans must be implemented to assure that the information continues to be accurate and that the topics included are timely. If this approach does not meet the intended needs, then another means must be identified and developed.

   Fiscal Impact: Minimal.

3. **That the Complex Discipline Survey conducted in FY96 be revised and repeated in FY98.**

   Rationale

   The subcommittee believes that the data obtained through this new survey instrument will be very useful. The subcommittee also recognizes that the telephone survey was a long and involved process that can be consolidated and streamlined for future use. Discipline is a critical function of licensing boards. Current information is essential to assure that the resources provided by the National Council are accurate and timely.

   Fiscal Impact: To be included in FY98 budget.

4. **That the National Council explore how Member Boards' access to criminal records can be facilitated.**

   Rationale

   Several Member Boards, both in the survey and in contacts with subcommittee members and staff, have indicated the growing need for accurate information regarding criminal convictions of applicants and licensees.

Although many jurisdictions have access to local criminal data, with the mobility of society, there is a need for consistent information at a national level.

Fiscal Impact: Minimal.

5. **That the National Council facilitate national reporting of licensure disciplinary actions.**

Rationale

The National Practitioner Data Bank appears poised to develop plans for implementation of Section Five of P.L. 100-93, which would require reporting of licensure disciplinary actions against other health care practitioners, including nurses, to the National Practitioner Data Bank (NPDB). National Council should take advantage of opportunities to explore collaboration with the NPDB to influence policy decisions regarding how and when nursing actions are reported, as well as to facilitate Member Board compliance with Section Five requirements when implemented.

Fiscal Impact: Minimal.

6. **That the revision of the *Model Nursing Practice Act* and the *Model Nursing Administrative Rules* planned for FY97 include specific suggestions for approaches to informal (disciplinary action without a formal hearing) and alternative resolution (case resolution without formal disciplinary action).**

Rationale

The subcommittee determined that one of the ways many Member Boards are coping with increasing numbers and complexity of discipline cases is through case resolution through informal and alternative approaches. The subcommittee suggests that some practical "how to" provisions in the Model Rules would be very useful for Member Boards considering different approaches to case resolution.

Fiscal Impact: Minimal.

7. **That the National Council develop the following:**

   a. **Model educational materials to assist Member Boards in educating nurses as to their responsibility to report violations to the board of nursing.**
   b. **Model educational materials to raise public (both consumer and legislator) awareness of the purpose and role of nursing regulation related to discipline.**
   c. **Model educational materials to assist consumers in reporting discipline matters to the board of nursing.**

Rationale

Many nurses are not aware of their legal and ethical responsibilities to report violations of the Nursing Practice Act to the board of nursing. Many other nurses are vaguely aware, but are unsure of where to "draw the line" between something that should be reported to the board and something that should be at least attempted to be resolved with the nurse directly and/or with the nurse's employer. The subcommittee suggests that model educational materials could be modified by jurisdictions to meet their particular needs. Similarly, many consumers, including state and federal legislators, are unaware of the board's disciplinary activities and their implications for promoting public safety. The development of materials that could be used and/or modified to meet the specific jurisdictional needs would be very helpful. Finally, with the increase of health care provided in the community setting, it is anticipated that there may be fewer on-site employers (who currently report many complaints to boards) and an increase in the number of consumer complaints. Materials which can help boards promote public awareness of how to get information to the board will assist in developing this source of information regarding nursing practice.

Fiscal Impact: FY97 budget ($9,416 out of pocket and $3,575 staff time)

Background

Previous National Council efforts to develop resources to assist Member Boards in managing disciplinary cases have included the work of the Disciplinary Case Analysis Focus Group (1993), the Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group (1994) and the Sexual Misconduct Task Force (1995). The

Complex Discipline Cases Subcommittee of the Nursing Practice and Education Committee continues to provide resources to assist Member Boards in managing discipline cases.

The subcommittee recognized that discipline cases can be complex - as an individual case is very complicated, involving multiple allegations, situations, settings and individuals. Discipline cases are also complex as to increasing numbers, types of allegations and demands upon limited, and often dwindling, resources. The subcommittee focused on the complexity caused by numbers and demands, and has attempted to develop resources to support boards of nursing as they manage the totality of their caseloads.

Highlights of Activities

- **Coordination with other Nursing Practice and Education Subcommittees**
  Ann Torres, chair, participated in a planning and coordinating meeting with other Nursing Practice and Education Committee subcommittees in October 1995.

- **Complex Discipline Survey**
  Subcommittee members developed and conducted a telephone survey with Member Board staff assigned to conduct discipline activities. The results of the survey are included as Attachment A to this report, on page 25.

- ***Dialogue on Discipline***
  The subcommittee proposed an educational program be held in conjunction with the 1996 Annual Meeting, to provide opportunity for education and extensive networking regarding a variety of discipline topics. The program was selected to be offered in Baltimore, Maryland, on August 5, 1996. The morning program will focus on the implications for the discipline process of the community setting. The afternoon session will be presented by the Sexual Misconduct Task Force, and will focus on the disciplinary guidelines and the educational materials developed to promote awareness of professional boundaries and issues related to professional sexual misconduct. The schedule for the program is found as Attachment B, on page 33.

- ***Disciplinary Resources Notebook***
  The subcommittee developed a *Disciplinary Resources Notebook,* based upon the needs identified from the above survey. This resource will presented for the first time at the *Dialogue on Discipline.* The notebook includes materials developed by the subcommittee, by the Discipline Investigators Task Force, the Sexual Misconduct Task Force, the Chemical Impaired Nurse Issues Task Force, and the Nursing Practice and Education Committee. Selected samples of resources developed by Member Boards are also included in the notebook.

- **Software for Discipline Tracking and Monitoring**
  The subcommittee brainstormed regarding the elements needed for an optimal computer program to assist Member Boards in tracking complaints, investigations, case resolution, after board action monitoring and alternative/diversion program monitoring. Their ideas were shared with the Marketing Manager for possible development by the Special Services Division.

Future Considerations

- Review evaluations from the *Dialogue on Discipline.*
- Promote use of the *Disciplinary Resources Notebook.*
- Develop additional materials to support Member Boards in their discipline process.
- Monitor the numbers and type of discipline cases for issues and trends related to changing and independent practice settings, and the implications for investigating complaints.
- Continue focused activities to develop resources to assist Member Boards in dealing with the increasing number and complexity of discipline cases.

Meeting Dates

- October 23, 1995
- December 14-15, 1995
- February 29 - March 1, 1996
- April 14-15, 1996

Recommendations to the Nursing Practice and Education Committee

1. That two copies of *Discipline Resources Notebook* be distributed to each Member Board, one for the executive director and an additional copy for the discipline staff.

2. That the response to and use of the *Discipline Resources Notebook* be reviewed in early 1997, to provide feedback as to whether or not this is an effective means of meeting Member Board needs, what additional topics ought to be addressed, and to suggest the timing and procedures for updating.

3. That the Complex Discipline Survey conducted in FY96 be revised and repeated in FY98.

4. That the National Council explore how Member Boards' access to criminal records can be facilitated.

5. That the National Council facilitate national reporting of licensure disciplinary actions.

6. That the revision of the *Model Nursing Practice Act* and the *Model Nursing Administrative Rules* planned for FY97 include specific suggestions for approaches to informal (disciplinary action without a formal hearing) and alternative resolution (case resolution without formal disciplinary action).

7. That the National Council develop the following:

   a. Model educational materials to assist Member Boards in educating nurses as to their responsibility to report violations to the board of nursing.
   b. Model educational materials to raise public (both consumer and legislator) awareness of the purpose and role of nursing regulation related to discipline.
   c. Model educational materials to assist consumers in reporting discipline matters to the board of nursing.

Attachments

Attachment A

Complex Discipline Cases Subcommittee Summary of Member Board Survey Results

Subcommittee members developed and conducted a telephone survey with Member Board staff assigned to conduct discipline activities. The survey results are provided (additional board responses will be added and provided in the supplement to the *Book of Reports*).

Table 1. ***Member Board Reported Numbers*** presents information reported by responding boards about the number of complaints they received in a recent twelve-month period (some reported last fiscal year, others last calendar year). The number of licensees in a jurisdiction was obtained from the National Council publication, *1994 Licensure & Examination Statistics.* Member Boards also provided information about the staff available to work with the discipline process in their jurisdiction.

Table 2. ***Informal Processes - Disciplinary Action without Formal Administration Hearing*** presents information reported by Member Boards regarding whether or not informal processes are available in their jurisdictions, a brief description of the process and who is involved in the process.

Table 3. ***Alternative Approaches - Case Resolution without Disciplinary Action*** presents information reported by Member Boards regarding methods to resolve cases with something more than dismissal but less than board action.

Table 4. ***Time Management Tools and Resources*** identify boards which indicated that they have developed resources to support the discipline processes. These tools include: checklists (a few boards also indicated they have developed standard question lists), a system of prioritizing cases, standard forms, standard file formats, tickler systems, scheduling tools, computer tracking, monitoring tools and other approaches to using time and human resources efficiently.

Table 5. ***Member Board Comments*** have been grouped in categories which include: the effects of the changing health care environment on the discipline process, threshold issues, confidentiality issues, investigations (including approaches to specific types of cases), expert witness, case backlogs, unique remedies, board evaluation and other suggestions.

The Complex Discipline Cases Subcommittee will include examples of selected processes and other resources in the *Discipline Resources Notebook* which will be first shared with the participants of the Dialogue on Discipline program scheduled for August 5, 1996, prior to the beginning of the Annual Meeting.

Table 1. Member Board Reported Numbers

Area	Juris	# Complaints	# Licensees	Professional Staff	# Support Staff	Source, # Attorney	Source, # Investigators
1	AK		a				
3	AL		52,213	3	4	3PT	3FT
3	AR	154	40,401	1	1	AG	umbrella
1	AS	0	a	NA	NA	NA	NA
1	AZ	894	48,968	10PT	3	1FT, para	
1	CA-RN	1,028	316,702	1	3+3PT	?	?6
1	CA-VN						
1	CO	326	47,337	2.5	?	?1FT	6
4	CT	115	60,356	3FT, 3PT	see prof staff	Dept PH	Dept PH
4	DC						
4	DE	62	13,447	2PT			
3	FL	850	247,387	4	see prof staff	?	?
3	GA-RN	222	64,070	2	1	AG	umbrella
3	GA-PN	84	27,736	1PT	2PT	AG	umbrella
1	GU						
1	HI	41	15,679	umbrella	——>	——>	——>
2	IA						
1	ID	100	13,902	2PT	1	?	all drug –> Rx
2	IL						
2	IN	70	89,144		1	AG	AG's office
2	KS						
3	KY	424	48,063	2	2	1FT	3FT nurses
3	LA-RN	305	35,927	1	2	1PT	1
3	LA-PN						
4	MA						
4	MD	432	69,296	25%ED+2FT+1PT	2FT+1PT	PTpros, PT-AG*	4
4	ME		20,410	ED	1PT		
2	MI						
2	MN	987	76,291	10+35%	see prof staff	AG	AG's office
2	MO	466		1	1+contract		3FT+7contract
1	MP						
3	MS	528	33,927	3	1+1PT	1FT+AG-PT	3
1	MT	115	12,564	1PT	1PT	1PT	1
3	NC	629	90,343	1	2	?	2
2	ND	50+	6,051	.5FTE+.25FTE		atty/retainer	see prof staff
2	NE	202	7,018	compliance section	compliance	compliance	compliance
4	NH	59	18,650	ED oversight	1	?	2
4	NJ	158	90,648	1	1	?	separate bureau
1	NM	150	17,032	1	1	?	contract out
1	NV	222	12,479	1	2.5	?	2
4	NY	1,677	293,974	8	8	?	55 all professions
2	OH						
3	OK	416	41,348	2(.5)	2	?	1FT+ 2(.5)
1	OR	296	a	1	1	?	3+1 approved
4	PA	301	284,736	1	1	1	?
4	PR						
4	RI						
3	SC	318	37,192	1	?	?	2
2	SD	79	11,870	1	?	?	?
3	TN	310	79,993	1.5	?	AG	umbrella
3	TX-RN	1,641	142,578	1	4	2FT+1PT+para	8
3	TX-VN	1,600	70,892	?	3	?	3
1	UT	?	18,405	umbrella	—>	—>	—>
3	VA	319**	98,204	2	1	?	umbrella
4	VI						
4	VT	89	6,463	1	.5	AG	secy state
1	WA	611	70,143	3	4FT, 1PT	?	5FT, 3PT
2	WI	235	79,271				2FT
2	WV-RN	118	22,014	1	1	AG	0
2	WV-PN	116	7,080	1 does all	0	AG	0
1	WY						

Table 2. Informal Processes - Disciplinary Action Without Formal Administrative Hearing

Area	Juris	Available	Bd Mem Involved	Description of Process	Who Negotiates	Who Writes	Staff Review
1	AK						
3	AL	YES	NO	meeting; pre-hearing rarely	staff		YES
3	AR	YES	NO	pre-hearing conference	staff/atty	atty	YES
1	AS	NO					
1	AZ	YES	NO	nurse makes appt to settle		atty/staff	
1	CA-RN	in develop					
1	CA-VN						
1	CO	YES	?	pre-hearing conference	atty		
4	CT	YES		pre-hearing conference prior to charges	dept atty		YES
4	DC						
4	DE	YES	YES				
3	FL	YES	YES	informal meeting	?	?	?
3	GA-RN	YES	NO	?	atty		?
3	GA-PN	YES	YES	informal meeting	atty/staff		
1	GU						
1	HI	YES	?				
2	IA						
1	ID	YES	NO	pre-hearing conference	atty/staff		
2	IL						
2	IN	YES		negotiated by atty then bd approves	atty		
2	KS						
3	KY	YES	YES	board panel to review case	atty/staff		
3	LA-RN	YES	NO	informal meeting with staff	staff		
3	LA-PN						
4	MA						
4	MD	YES	YES	informal chat, pre-hearing conference	Bd/staff	atty	
4	ME	YES	YES	pre-hearing conference			
2	MI						
2	MN	YES	YES	informal meeting	atty		staff
2	MO	YES		45-day wait period for joint stips	atty		staff
1	MP						
3	MS	YES	?	?	atty/staff		
1	MT	YES	NO	atty meets with nurse	atty		
3	NC	YES	YES	informal meeting	staff	atty	
2	ND	YES			atty		staff
2	NE	YES			AG		staff
4	NH	YES		pre-hearing conference			YES
4	NJ	YES			atty		
1	NM	YES	?	atty meets with nurse	atty		
1	NV	YES	?	?	?	?	YES
4	NY	YES			staff atty		YES
2	OH						
3	OK	YES	YES	informal meeting (vol surrender)	staff	atty	
1	OR	YES				staff	
4	PA	YES	?	?	atty	?	?
4	PR						
4	RI						
3	SC	YES	?	?	staff		
2	SD	YES	NO	informal meeting	atty/staff	staff	
3	TN	YES	YES	meeting	atty	staff	
3	TX-RN	YES*	YES	meeting	?	staff	
3	TX-VN	YES	YES	meeting	?	staff	
1	UT	YES	YES	bd members, atty, staff meet	?	?	
3	VA	YES	YES	informal meeting	atty/staff	staff	
4	VI						
4	VT						
1	WA	YES		brief proceeding to allow appeal denial			
2	WI						
2	WV-RN	YES	YES	informal meeting	atty	staff	
2	WV-PN	YES	NO	not met routinely	staff	staff	
1	WY						

Table 3. Alternative Approaches - Case Resolution Without Disciplinary Action							
Area	Juris	Mediation	Warning Letters	Teaching Conference	Workshops	Diversion	Other
1	AK						
3	AL	YES	YES	YES	occasionally	YES	
3	AR	NO	NO	NO	NO	NO	
1	AS	YES	YES	YES			
1	AZ	NO	YES	NO	YES	YES	
1	CA-RN	YES	YES	NO	NO	YES	
1	CA-VN						
1	CO						
4	CT	YES	YES by dept PH				vol surrender
4	DC						
4	DE	NO	NO	NO	NO	NO	
3	FL	NO	NO	NO	NO	CD diversion	
3	GA-RN	NO	YES	YES	YES (staff)	NO	
3	GA-PN	NO	letter of concern	NO	NO	NO	
1	GU						
1	HI	NO	NO	NO	NO	NO	
2	IA						
1	ID	NO	YES	NO	YES	YES	
2	IL						
2	IN	NO	NO	NO	NO	NO	
2	KS						
3	KY	NO	YES	NO	NO	NO	
3	LA-RN	NO	YES	NO	NO	YES	
3	LA-PN						
4	MA						
4	MD	NO	NO	YES	YES	YES	
4	ME	NO	NO	NO	NO	NO	
2	MI						
2	MN	YES	YES	YES	NO	YES	stip to cease
2	MO	NO	NO	NO	NO	NO	
1	MP						
3	MS	NO	YES	YES	YES	YES	
1	MT	NO	YES	NO	NO	YES	
3	NC	NO	YES	YES	NO	YES	
2	ND		YES			YES	refer adv pro
2	NE		YES			YES	
4	NH	YES	–	–	–	–	
4	NJ	YES	YES				
1	NM	NO	YES	NO	NO	YES	
1	NV	NO	YES	YES	NO	YES	
4	NY	–	–	–	–	–	
2	OH						
3	OK	NO	NO	NO	NO	YES	
1	OR	NO	YES	NO	NO	YES	
4	PA	NO	NO	NO	NO	YES	
4	PR						
4	RI						
3	SC	NO	letter of concern*	NO	NO	NO	
2	SD	NO	YES - self-study courses	YES	YES	YES	
3	TN	NO	YES	NO	NO	YES	
3	TX-RN	NO	YES	YES	YES	YES	
3	TX-VN	NO	YES	NO	NO	YES	
1	UT	NO	YES	YES	NO	YES	
3	VA	NO	memo - drugs	NO	NO	NO	
4	VI						
4	VT						
1	WA	NO	YES	NO	NO	YES	
2	WI						
2	WV-RN	NO	YES	NO	YES	NO	
2	WV-PN	NO	YES	NO	NO	NO	
1	WY						

Table 4. Time Management Tools and Resources

Area	Juris	Checklists	Priority System	Forms	File Formats	Ticklers	Scheduling	Computer Tracking	Monitoring	Other
1	AK									
3	AL		YES		YES			YES - date ###		
3	AR	YES/?list		YES		YES			YES	
1	AS									
1	AZ	YES	YES	YES	YES			YES	YES	
1	CA-RN		YES		YES	YES		YES		
1	CA-VN									
1	CO	YES	YES	YES	YES					
4	CT	YES	YES	YES	YES				YES	
4	DC									
4	DE	NO	–	–	–	–	–	–	–	manual
3	FL	YES		YES	YES	YES	YES			
3	GA-RN	YES				YES		YES - limited ###		
3	GA-PN			YES				###		
1	GU									
1	HI									
2	IA									
1	ID	YES	YES	YES	YES	YES		YES	YES	
2	IL									
2	IN	–	NO	–	–	–	–	YES	–	
2	KS									
3	KY	YES/?list	YES	YES	YES	YES	YES	YES		
3	LA-RN		YES	YES				YES - limited ###	YES	
3	LA-PN									
4	MA									
4	MD	YES	YES	YES	YES	YES	YES	YES	YES	
4	ME	YES	YES							
2	MI									
2	MN	YES	YES	YES	YES	YES	YES	### (in process)		
2	MO	YES	YES	YES	YES	YES		YES	YES	
1	MP									
3	MS	YES/?list	keep flexible	YES					YES	
1	MT	YES	YES	YES	YES	YES		YES	YES	
3	NC	YES	YES - unwritten	YES	YES	YES		YES	YES	
2	ND	YES		YES		YES		YES - limited		
2	NE		YES	YES	YES					
4	NH	–	NO	–	–	–	–	under development	–	
4	NJ	NO	YES - unwritten	YES	YES			YES		
1	NM		YES		YES	YES		YES	YES	
1	NV	YES	YES		YES	YES		YES	YES	
4	NY	YES	YES	YES	YES	YES	–	YES	–	
2	OH									
3	OK	YES	YES	YES	YES			YES	YES	YES - invest training
1	OR		YES		YES				YES	
4	PA									
4	PR									
4	RI									
3	SC		YES	YES	YES			YES	YES	
2	SD	YES		YES		YES	YES	###	YES	YES - menu terms
3	TN	YES	YES	YES		YES				
3	TX-RN	YES	YES	YES	YES	YES	YES	YES	YES	YES - std fines, TC
3	TX-VN	YES/?list	YES	YES	YES	YES	YES	YES	YES	YES - order wksht
1	UT			YES	YES	YES	YES	YES	YES	
3	VA		YES	YES		YES	YES	YES	YES	
4	VI									
4	VT		YES		YES			working on this	YES	
1	WA	YES/?list	YES	YES	YES	YES	YES	YES		
2	WI	YES	YES	YES	YES			YES - dev new	YES	
2	WV-RN		YES	YES	YES			YES	YES	
2	WV-PN		YES						YES	
1	WY									

Table 5. Member Board Comments

Environment Comments

AS ..... need board training
CT ..... more complicated investigations, different requirements in sanctions
GA-RN ... more complicated investigations, APRN problems
ID ..... more practice-related complaints
MD ..... additional resources needed for complaints, monitoring
MN ..... APRN problems, other professions practicing nursing
MS ..... supervising in home care, computerized notes in hospitals
NE ..... additional sources, more complicated investigations, changes in monitoring methods
NJ ..... additional sources of complaints, more complicated investigations, change in monitoring
NY ..... additional sources of complaints, more complicated investigations
ND ..... additional sources, more complicated, changes in monitoring methods
PA ..... additional resources needed for complaints, monitoring
SC ..... more practice issues
TX-VN ... increased workload because of increased public awareness
VT ..... additional sources of complaints
WI ..... additional sources of complaints, more complicated investigations

Threshold Issues

AL ..... distinguish between true violations and employment issues
AZ ..... establish protocols - guide to dismiss
CA-RN ... perennial complainants - try to reduce costs of frivolous cases
CO ..... set standards for abandonment complaints (policy - don't investigate)
CT ..... if case is borderline, seek board opinion in pre-hearing conference
FL ..... most cases to mediation
ID ..... identify cases which would hold up at hearing; negotiate rest
MN ..... require employers to try remedial action first
MS ..... hearing panels to do lower threshold cases
MT ..... considerable, some may be resolved without investigation with informal action
NY ..... presently engaged in raising threshold
ND ..... network with colleagues
SC ..... subcommittee to hear discipline cases, meets separately
SD ..... letters of reprimand and continuing education for borderline cases
TX-VN ... board deals with very serious cases instead of ALJ
TX-RN ... minor incidents, don't have to be reported to board; if three minor incidents in one year
WA ..... adapted criteria for threshold
WI ..... statistical review and discussion regarding the types of cases that result in formal action

Confidentiality Issues - *When does information become public?*

After complaint - **GA-PN, KY** (verifies complaint pending), **MO** (if mandated report), **NY, NC, WV-PN**
After formal charges - **AR, CA-RN, CT, FL, GA-RN, ID, LA-RN, MS, MO, MT** (when investigation complete), **DE, IN, NE, NJ, NM** (if formal hearing), **OK, TN, TX-VN, TX-RN, UT, VT, WA** (respondent discovery), **WV-RN, WI**
At hearing - **ID, , NH, ND**
After board action - **AL, CO, ID, KY, MD, MN, NV, NM, ND, NV, OR, PA** (30 days after), **SC, SD, WA** (public)

Other comments:
AL - concern about limits on sharing how to respond to subpoena; **CT** - investigative file is public after one year or upon dismissal or issuance of charges, whatever first; **FL** - patient records never public without waiver; **GA-RN** - concern after complaint received; **LA-RN** - concern after complaint received; **MS** - want to know before charges; **TX-RN** - can share selectively; **WI** - Wisconsin law presumes records are open unless an exception applies (e.g., protecting the integrity of investigations, confidentiality of treatment records, etc.)

Investigation (+'s) and (-'s)

AL..... (+) chief investigator serves subpoenas, investigator assigned geographically; (-) caseload increases practice-related need tracking system for priority
AR ..... (+) have a contract with Pharmacy Board to investigate drug-related cases; (+) call nurses to office to meet with investigator (if no show, "uncooperative behavior" is an additional charge)
CA-RN ... (-) non-nurse investigators need help on nursing issues
CT..... (+) no conflict of interest when complaint investigation/prosecution is separate agency from adjudicator (board), and can move cases quickly that require prompt action to protect the public; (-) Continuing challenge to take prompt action despite volume of impaired nurse cases
GA-PN ... (+) law enforcement experience in investigators
GA-RN ... umbrella agency investigators: (+) outside investigator brings an objective, third-party perspective; (-) don't always see significance of nursing cases
ID..... (+) refers drug cases to Board of Pharmacy; (?) must be written complaints
IN..... (-) complaints sent to AG's office, board does not hear what happens to them, some are dropped without input of board (meeting scheduled to discuss)
MD ..... (+) support staff, board staff devoted to investigations, (+) subpoena; (+) public relations; (+) combination of background; (+) hard copy available immediately??
MN ..... (+) efficient to have board staff obtain records, (-) courts not releasing records without prior payment; would be (+) to have in-house attorney, investigator
MS ..... (+) investigations under the control of the board; (-) can't enter facilities without permission – subpoena takes too long; (-) difficult access to criminal records, search and seizure???; (-) investigators trained in criminal seminars
MO ..... (+) in-services for investigators
NE..... (+) nurses doing nursing investigations; (-) paid for by nursing funds but nursing has no authority over division that administers
NM ..... (-) difficulty getting to agencies for Pds
NY ..... (+) timeliness of case completion, EDP Case Management system provides management with oversight of any case from central office, accountability; (-) biggest challenge is to prevent isolation of field unit from central office
ND ..... Disciplinary Committee reviews all cases, directs investigations; (-) complexity of cases, number of cases vs. amount of staff time, mandatory reporting just enacted, not sure how will affect workload
OK..... (+) RN investigators; (+) autonomous
PA..... (+) umbrella investigators bring a cross knowledge of health care professions
SC..... (-) trying to train non-nurses to work with nursing employers
SD..... (+) private legal counsel; (+) RN investigator; (-) cases more complex, practice, time consuming
TX-RN ... (-) investigator caseload averages 210!; (+) board determine priority criteria
TX-VN ... (-) complexity of cases increasing; (-) more nurses represented by attorneys; (-) no in-house attorney
UT..... (-) investigator caseload too high (60)
WI..... (+) team organization, close working relationships; (-) organizing time to address volume of complaints in timely fashion, many complaints require time-consuming contacts in field

The following boards identify problems with timeliness of investigations: **AZ, CO, NV, NJ, OR, UT, WA, WI**

Investigation Approaches - Practice Cases

AL..... subpoenas to other employers; look for pattern
AZ..... guidelines reporting complaints; contract with hospital to evaluate competency; competency checklist, modified Debrono; paralegals do upfront - subpoenas, witness list, preliminary work-up
CT..... secure witness statements early in process before memories fade or "change," or patients die
FL..... documentation by employers, supervisors
ID..... in between the hardest
KY..... interview witnesses, site visits
LA-RN ... use employers' written evidence, witnesses
MN ..... provide employers help in documenting
MS ..... witness observations
MT..... can use experts at beginning sometimes
NV ..... patterns, standards of practice

NJ ..... investigators need to be more conversant with boards
NY ..... standardized methods of investigation, input from board, standardized report writing
ND ..... network with colleagues
OK ..... objective facts; agency policy and procedures; standards; talk to other nurses; patterns; patient outcomes; does nurse recognize problem?
OR ..... educate attorneys, hearing officers
SD ..... use expert witnesses to review information
TX-VN ... identify patterns of behavior; repeated counseling; job hopping
VA ..... past employment records, patient medical records
WV-RN .. talk to other nurses; documentation to support complaint
WI ..... board must make clear their standard; random case review (i.e., peer review); interaction with other agency performing on-site surveys of nursing care; impose sanctions that include orders for regular reports from therapists

Investigation Approaches - Abuse and Neglect

AZ ..... psychological evaluations; advocate for witnesses in abuse cases
CT ..... secure witness statements early in process before memories fade or "change," or patients die
FL ..... documentation employers, supervisors
ID ..... need credible witnesses, evidence
KY ..... interview witnesses; visit facility
MN ..... obtain information about facility from state licensing agency
NE ..... facilities usually do thorough internal investigations, often very helpful; written statements
NV ..... eye witnesses, evaluate credibility (including therapist), verify facts
NJ ..... education of involved parties
NY ..... standardized methods of investigation; input from board, standardized report writing
ND ..... network with colleagues
OK ..... interviews; look for other surveys
OR ..... don't find as difficult as practice issues
SD ..... work with health department
TX-VN ... identify patterns, counseling, job hopping
TX-RN ... educate facility how to investigate, pictures
VA ..... employment history, see if pattern
WV-PN .. work with health department

Dual Diagnoses Approaches

AL ..... may not docket, as for MD statement, approve if no danger (alternative program)
AZ ..... increasing numbers of complaints, recommend nondisciplinary approach or limited license
CT ..... review very carefully for appropriate remedy
FL ..... IPM
ID ..... non-practicing status
KY ..... MH, CD evaluations
LA-RN ... MH, CD evaluations
MD ..... not discipline, refer to rehab
MS ..... wants suggestions how to manage
NE ..... referred for evaluation
NV ..... increasing numbers of complaints, recommend nondisciplinary approach
NM ..... handle like other allegations
ND ..... network with colleagues
OK ..... ask nurse for evaluation, seek voluntary surrender if recommended
OR ..... refers to nurse monitoring program
SD ..... more MH complaints, would like to transfer these to diversion program
TX-RN ... TPAPN
TX-VN ... peer assistance referral
UT ..... has only had two cases

VA ..... AED assists board members, participates in hearing
WV-RN .. MH, CD evaluations
WV-PN .. MH, CD evaluations

Use of Expert Witnesses

Outside experts - AR (toxicologist), **CA-RN, CO, CT, FL, GA-RN, GA-PN, ID, KY, MD, MN, MS, MO, MT, NV, NY, OK, NE, NJ, OR, PA** (lawyers?), **SD, TX-RN, UT, VT, WA, WV-RN, WI**
Board members/staff - AL, AZ, CT, MD, MO, OK, SC, TX-RN, VT
ND - depends on how expert define - use witnesses pertinent to the case (e.g., nurse manager, law enforcement, etc.)
WI - has expert witness checklist

How do you deal with case backlogs?

AL ..... workday" to resolve old cases, all staff involved
AZ ..... limit investigator responsibilities, full-time investigators, guidelines for "that's enough"
CO ..... regroup, problem solve, routine meetings, staff meet with board to set goals
CT ..... work faster and smarter, streamline procedures without compromising quality
GA-RN ... oldest cases first, top priority cases first
GA-PN ... need automated tickler system
ID ..... help! look for options for less serious cases
KY ..... prioritze cases, ongoing communication with complainant
MD ..... increase informal hearings, better guidelines, complaint form for investigations
MN ..... periodic review and re-classification
MS ..... consolidate cases in geographic area for investigations, use telephone contacts (vs. field), add day of hearings to board meeting
MT ..... contract for additional investigators
NV ..... prioritize, one case at a time
NJ ..... have more than one meeting a month
NY ..... 1980, special unit created to deal with a backlog
ND ..... network with colleagues
OK ..... part-time on priority cats, 15% time on old cases, investigation staff meet on closing cases
OR ..... need more investigators
SC ..... use back-up investigators
SD ..... set priorities for cases and commit to certain turnaround times to board
TN ..... extra board meeting for hearing (if attorneys available)
TX-RN ... Hell week" when investigators come in to resolve old complaints (attorneys, staff)
TX-VN ... work weekends, lunches, evenings and breaks
UT ..... settlement helps, backlog with AG
VA ..... board members hold more days of informal conferences
VT ..... follow ancient Icelandic proverb: *"Run in circles, yell and shout"*
WA ..... accept situation, try to respond
WV-RN .. involve everyone in discipline and divide workload
WI ..... brainstorm with staff regarding ways to improve productivity, prioritize existing cases, review with Board possibility of closing older cases

Suggestions for Unique Remedies

Board appearances - **FL**
More training, authorize for overtime, cross train - **CA-RN, CT**
Settlement agreements! - **NM**
Cite conditions in reinstatement - **ID**
****Community service*** - **AZ, MN**
Fines - **AL, AR, AZ** (fraud, lapsed license), **FL, GA-RN** (practice without license), **GA-PN** (practice without license), **KY** (up to $10,000), **LA-RN, MS, MD** (up to $5,000, payment schedule), **MN, MO, MT, OR** (practice without license), **NJ** (fraud, unlicensed practice, up to to $500 for each six months not renewed)
Impose order rather than stay - **NC, NY** (up to $10,000 per violation), **IN** (restitution)

Look at diversion program elements to use in discipline orders - **AZ**
Motion worksheet - **MS, TX-VN, LA-RN, TX-RN, MD**
****Monitoring Fee*** - **WV-PN** (TX-VN considering)
Order CD into Tx (alternate program) - **TN**
Recoup costs - **MN, AR, SD, FL, KY, NC, SC** (disciplinary fund), **WA, NV, MT, ID, CA-RN**
Reinstatement fees - **AZ, NM**
Restitution - **MN**
Standard guidelines - **CA-RN, WA**
Stayed suspension - **FL**
Suspend until finish drug rehab, then supervised practice - **UT**
Timely contracts - **CO**
Tolling probation - **FL**
Use two attorneys - **MT**

Pew Implications - Does board have process for evaluation?

AZ..... criteria priority, educate public in reporting; creative nondisciplinary for at-risk populations
CT..... ongoing, critical evaluation because board is separate entity from Dept. of Public Health, checks and balances
ID..... manage with limited resources
MS..... sharing forms, true list of contacts with direct numbers
MO..... case by case, at board meetings
NV..... annual review, sentencing guidelines
NC..... has process to evaluate components
OK..... agency evaluation every six months
PA..... tatistics, evaluate process
SD..... process annual review
TN..... concern about felons as students, nurses have cases, orders to ratify
TX-RN ... time limit on cases, efficiency
TX-VN ... summary suspensions, deny all felons
UT..... quality interviews
WI..... board is presenting reviewing

Other Suggestions

AL..... actions in Newsletter, notify complainants, need updated computer system for tracking, use Social Security number
AR..... check NCIT for felons
CT..... makes mandatory reports regarding drug diversion to Drug Control Divions of Dept. of Consumer Protection, sometimes roles overlap
GA-RN ... deny licensure, how to limit practice while appealing
IN..... now charge $3.00 per licensee for impaired nurses, program to start in future
NY..... written procedures for much of what is done in investigation

Attachment B

The Dialogue on Discipline Program Schedule

7:30 a.m. - 8:00 a.m Registration

Morning Session - *Our Challenge: From Institution to Community*

8:00 a.m. - 8:15 a.m. Introduction, Expectations for the Dialogue - Ann Torres

8:45 a.m. - 9:15 a.m. Overview: The Community Setting and Implications for Discipline - Donna Dorsey

9:15 a.m. - 9:35 a.m. The Complaint Process, Priority of Cases, Threshold Issues - Jane Werth

9:35 a.m. - 10:30 a.m. Investigating in the Community - Claire Delaney and Donna Mooney

10:30 a.m. - 10:45 a.m. Break

10:45 a.m. - 11:05 a.m. Alternative Approaches to Discipline - Anthony Diggs

11:05 a.m. - 11:25 a.m. Innovative Remedies that Work in the Community Setting - Diana Vander Woude

11:25 a.m. - 11:35 a.m. *The Discipline Resource Notebook* - Vickie Sheets

11:35 a.m. - 12:15 p.m. Case Study; Panel Question and Answer Session

12:30 p.m. - 1:45 p.m. Luncheon - "Changing Focus" - Donna Mooney

Afternoon Session - *Sexual Misconduct: The Challenge Continues*

2:00 p.m. - 2:45 p.m. Overview of Professional Sexual Misconduct and Boundary Issues - Jean Stevens and Neysa Somple

2:45 p.m. - 3:00 p.m. *Preventing Professional Sexual Misconduct: A Resource Packet for Member Boards* - Vickie Sheets

3:00 p.m. - 4:15 p.m. Case Study - small group work, facilitated by the Sexual Misconduct Task Force

4:15 p.m. - 4:50 p.m. Case Study Reports and Dialogue - Small groups report back, moderated by Jean Stevens

4:50 p.m. - 5:00 p.m. Wrap-up; Considerations for Future Programs

Attachment C

Framework for *Disciplinary Resources Notebook*

The following is the outline for the Disciplinary Resources Notebook which the Complex Discipline Cases Subcommittee will first distribute at the *Dialogue on Discipline* educational program, scheduled for August 5, 1996. In addition to distributing a copy to the participants of the Dialogue, the subcommittee will have copies available for review at the Annual Meeting. Later in August, two copies of the notebook will be sent to each Member Board (one for the Executive Officer, one for the board staff who work with discipline cases).

Each Roman numeral category listed below will be a divider in the notebook. Each category will include an introductory section which will provide related information from the Complex Discipline Cases Member Board survey, to report what the responding Member Boards are doing in the identified area. Each category will also include samples of different approaches from selected boards.

I. **Introduction** - purpose, history, suggestions for use

II. **Case Receipt/Investigation**
- A. Complaint Policies
  - 1. Threshold Issues
  - 2. Assignment of Priority to Complaints/Cases
  - 3. Confidentiality
- B. Investigation
  - 1. Telephone interviews
    - a. Pro/Cons
    - b. Criteria
  - 2. Expert Checklist
  - 3. Other

III. **Time Management Tools**
- A. Checklists
- B. Question lists
- C. Forms
- D. Monitoring
- E. Computer Aids
- F. Other

IV. **Alternative Approaches to Case Resolution (resolution without board action)**
- A. Mediation
- B. Warning Letters
  - 1. Benefits v. Due Process Concerns
  - 2. Samples
- C. Conference/Teaching Conferences/Continuing Education
- D. Self Study Courses/Continuing Education
- E. Voluntary Surrender - Pros and Cons
- F. Other

V. **Material from Chemically Impaired Nurse Issues Task Force on Alternative/Diversion Programs**

VI. **Materials from the Nursing Investigators' Program**

VII. **Materials from the Sexual Misconduct Task Force**

VIII. Informal Processes (board disciplinary action without a formal hearing)
- A. Pros and Cons of Informal Processes
- B. Sample approaches as to how to reach settlement without a hearing

IX. Remedies
- A. Harm Index
- B. Motion Worksheet
- C. Sample Language for Innovative Elements
- D. Sanction Guidelines
- E. Other

X. Fines, Cost Recovery and Fees
- A. Sample Fine Schedules
- B. Monitoring Fees
- C. Reinstatement Fees
- D. Fee Scale
- E. Other

XI. Return to Practice
- A. Reinstatement Criteria
- B. Competence Issues
- C. Monitoring
- D. Other

XII. Proactive Strategies to Decrease Need for Discipline
- A. Educational Materials - students, licensees
- B. Educational Materials - employers
- C. Workshops
- D. Other

XIII. Other Resources
- A. "How to Make a Complaint" - targeted for public
- B. Materials for Attorney/Hearing Examiner Education
- C. Other

XIV. Directory of Board Discipline Staff

Continued Competence Subcommittee

Subcommittee Members
Shirley Brekken, MN, Area II, *Chair*
Teresa Bello-Jones, CA-VN, Area I
Marjorie Bronk, TX-VN, Area III
Lynn Walsh, DE, Area IV

Staff
Linda F. Heffernan, *Nursing Practice and Education Associate*
Vickie R. Sheets, *Director for Nursing Practice and Education*

Relationship to the Organizational Plan
Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective G ..... Promote consistency in licensure and credentialing.
Objective H ..... Identify the role of a board of nursing related to continued competence.

Recommendation to the Nursing Practice and Education Committee

1. **That the Nursing Practice and Education Committee present the position statement regarding Competence developed by the Continued Competence Subcommittee to the 1996 Delegate Assembly for adoption.**

Rationale

The importance of competence has been identified by many groups - individual Member Boards, previous Nursing Practice and Education Committees, Citizen Advocacy Center and the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation, to name a few. Boards have a responsibility to assure the public that the practitioners who they license have the educational and professional qualifications necessary for safe practice and that they practice competently. Defining competence, developing standards regarding competence, and articulating a position statement regarding the use of these standards are important steps toward supporting Member Boards' efforts to promote quality and public safety through the regulation of nursing in the evolving health care environment. Delineating the requirements for licensure at entry into practice, renewal, reentry into practice and return to practice after discipline is foundational to regulatory role in the assurance of competence.

Highlights of Activities

- **Definition of Competence and Standards for Competence**

A tactic under Goal I charges, "develop a position statement regarding continued competence." The Continued Competence Subcommittee determined that foundational to a position statement is a definition of competence as well as standards of competence. At the 1995 Delegate Assembly, the subcommittee presented a definition of competence and Standards for Competence. The subcommittee refined the definition of competence, based on input received from Member Boards at the Delegate Assembly and the Area Meetings, as well as input from the Nursing Practice and Education Committee. (See Attachment A)

The subcommittee considered the recommendations of the Pew Health Professions Commission Taskforce in *Reforming Health Care Workforce Regulation* regarding competence and continued competence. In addition, the subcommittee considered the questions raised by Citizen Advocacy Center in its publication, *The Role of Licensing in Assuring the Continuing Competence of Health Care Professionals.* These considerations guided the subcommittee in the development of the Standards for Competence.

Three principles guided the development of standards. Standards must be: 1) objective; 2) transparent; and 3) competence-related. Standards must be measurable in an operationally well defined and verifiable, not subjective manner. Standards are transparent when their meaning and intent are understood by all parties. The standards must be competence related, implying that the practitioner is competent if he/she meets the standard and a practitioner is incompetent if he/she fails to meet the standard.

The revised Standards for Competence are found in Attachment A.

- **Development of Indicators for Standards for Competence**

  The Continued Competence Subcommittee developed behavioral indicators for the Standards for Competence. The indicators provide a means to measure or determine if a practitioner meets or fails to meet a Standard for Competence. The indicators are found in Attachment A.

- **Development of Position Statement regarding Competence**

  A tactic under Goal I states, "Develop position statement regarding continued competence." The subcommittee developed a position statement defining the role of regulation in the assurance of competence of nursing licensees at entry into practice, renewal, reentry into practice, and after discipline. The subcommittee also outlined the responsibilities of individual licensees, employers, educators, and consumers related to competence evaluation and assurance.

  The position statement is found in Attachment B.

- **Functional Abilities Study**

  A tactic under Goal I states, "Evaluate results of validation study regarding functional abilities and make recommendations." The National Council research staff conducted a study to identify the functional abilities that a nurse must possess in order to function in the nursing role in a variety of employment settings. The information obtained will be used to assist Member Boards in the evaluation of candidates for licensure.

  Data were collected via questionnaire from 3,660 registered nurses and licensed practical/vocational nurses. The sample was representative of nurses practicing in urban and rural communities, and large and small jurisdictions from the four geographic areas of the National Council. The questionnaire used in the study requested participants to describe their work setting, position, level of involvement in the delivery of nursing care, and whether the ability to perform each of the 98 listed functional abilities was essential to the safe performance of their job. Participants were also requested to report the presence of a physical or mental disability and the types of accommodations used in order to safely perform in the work setting.

  Data analysis is currently underway. The subcommittee will meet one more time via conference call to review the study and prepare the report. The report will be provided to Member Boards in a supplemental mailing.

- **Education Session at Annual Meeting**

  A tactic under Goal I states, "Investigate mechanisms for evaluating continued competence." At the request of the Institute for the Promotion of Regulatory Excellence, an educational offering on continued competence was developed by the Continued Competence Subcommittee for presentation at the Annual Meeting. The subcommittee planned a for a panel of speakers to address various mechanisms of competence assessment. The purpose of the educational offering is to provide Member Boards with knowledge of the choice of mechanisms available.

Meeting Dates

- October 30-31, 1995
- February 12-14, 1996
- April 1-3, 1996
- May 25, 1996 *(telephone conference call)*

Recommendation to the Nursing Practice and Education Committee

1. That the Nursing Practice and Education Committee present the position statement regarding Competence developed by the Continued Competence Subcommittee to the 1996 Delegate Assembly for adoption.

Attachments

Attachment A

Definition of Competence and Standards for Competence

Definition of Competence

Competence is the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety.

Standards For Competence

Standard 1

Apply knowledge and skills at the level required for a particular situation.

- Determines actions needed to achieve desired outcomes
- Performs nursing activities in a safe/effective manner
- Demonstrates current knowledge necessary to provide safe client care
- Delegates in accordance with established guidelines
- Collaborates with appropriate professionals to attain client health care outcomes

Standard 2

Demonstrates responsibility and accountability for practice and decisions.

- Exhibits ethical behavior
- Assures client welfare prevails
- Establishes and maintain therapeutic boundaries
- Limits practice to current knowledge, skills and abilities
- Clarifies expectations of the role
- Intervenes when unsafe nursing practice occurs
- Practices within the legal authority granted by the jurisdiction
- Implements professional development activities based on assessed needs

Standard 3

Restrict and/or accommodate practice if cannot safely perform essential functions of the nursing role due to mental or physical disabilities.

- Identifies abilities necessary to perform the essential functions of the nursing practice role
- Implements accommodations when needed
- Safely performs essential functions of the nursing practice role
- Limits practice when accommodations are not sufficient to enable safe performance of essential functions of the nursing practice role

Attachment B

Assuring Competence: A Regulatory Responsibility A Proposed Position Statement

As the pace of technological and scientific development accelerates, one of the greatest challenges to health care professionals is the attainment, maintenance and advancement of professional competence in an evolving health care environment. Licensing boards have a role in assuring the public of the competence of licensees, but what should that role be? Who else is accountable for aspects of competence? What is meant by *competence*? And what is the standard to which a licensee is to be held for *continued competence*? Increasingly, licensing boards are challenged to provide assurance to the public that licensees meet minimum levels of competence throughout their careers, not only at the time of entry and initial licensure.

Background

The National Council of State Boards of Nursing has long acknowledged continued competence as a dominant regulatory issue for boards of nursing. In 1985, the National Council published a position paper on continued competence. *A Conceptual Framework for Continued Competence* (1991) considered the measurement of competence from empirical and standard-setting perspectives.

In 1993, the Nursing Practice and Education Committee presented a *Paradigm Shift Regarding Competence.* The new paradigm advanced the licensee's responsibility for individual competence. The board of nursing role was envisioned as that of a collaborator with licensees and employers. The licensee's responsibility for self assessment and self limitation of practice was the focal point of the plan to facilitate collaboration. The plan included consideration of a nondisciplinary process that would enable licensees who have or who acquire a disability to practice through accommodation rather than sanction. In 1994, the Nursing Practice and Education Committee incorporated some of the concepts proposed in the *Paradigm Shift* into the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

At the 1995 Annual Meeting, the Essential and Continued Competence Subcommittee presented a Definition of Competence, Standards for Competence, Model for Individual Competence Evaluation and a paper entitled: *Developing a Model for Nursing Competence: A Working Draft.* The National Council Board of Directors charged the Continued Competence Subcommittee of the Nursing Practice and Education (NP&E) Committee to identify the responsibility and role of a board of nursing related to continued competence.

The pioneering work of the NP&E Committee and the Continued Competence Subcommittee on the subject of competence is validated by the recommendations from the Pew Health Professions Commision's Taskforce on Health Care Workforce Regulation which were recently published. In the fall of 1995, it became increasingly clear that competence assurance had moved from a concept that was under study to an issue that sits squarely in front of regulators and regulatory agencies. The Pew publication, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, clearly articulates several recommendations regarding competence. Those recommendations are: *(2) States should standardize entry-to-practice requirements and limit them to competence assessments for health professionals....; (3) States should base their practice acts on demonstrated initial and continued competence...; (7) States should require each regulatory board to develop, implement, and evaluate continuing competence requirements to assure the continuing competence of regulated health care professionals...; and (8) States should maintain a fair, cost-effective, and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health... .*

In addition, the Citizen Advocacy Center (CAC) published *The Role of Licensing in Assuring the Continuing Competence of Health Care Professionals.* In this resource guide, CAC asked the question: "Can the public be confident that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent years and decades after they have been in practice?" The response given by CAC was: "No," raising policy issues that health professional licensing systems need to address. Boards have a role in assuring that health professionals meet minimum standards of competence throughout their professional lives.

The subcommittee considered the input received from participants in the 1995 Annual Meeting as well as the recommendations and comments from Pew and CAC as it refined the Standards for Competence and developed a position statement.

Developing a Regulatory Model

The primary obligation of regulatory boards is protection of the public health, welfare, and safety. Inherent in that obligation is meeting the expectation of the public that licensed practitioners have met the educational and professional qualifications for practice, and that they practice competently and safely.

Boards of nursing are responsible for assuring the competence of the practitioners they regulate. Boards carry out that responsibility by determining and enforcing standards for competence that are apparent, objective and competence-related. The process of competence assurance may be viewed in the context of risk management, i.e., having in place the mechanisms to reduce the risk of harm to public health, welfare and safety.

The Great Debate

A significant issue widely debated is one which pertains to all professions and is not reflected in the Pew documents. That issue is the inherent change in practice from the new graduate, entry level, generalist level to a focused-practice competence level. Nursing careers take widely divergent paths. Practice foci vary by setting, types of clients, disease conditions, therapeutic modalities or level of health care delivery. Nurses work at all points of service in the health care system. The debate centers on the question, *to what standard is the licensee held for continuing competence?*

The Continued Competence Subcommittee identified three possibilities:

- *a standard based upon the current entry-level competency for the profession*
- *a standard based on a generalist core competency for the profession*
- *a standard based on competence needed for safe and effective practice in the focused area of practice*

From the perspective that the renewed license is no different in what it authorizes and represents to the consumer than the initial license, the entry-level competency standard makes sense. For some types of practice roles, repeated validation of a focused area of practice will suffice, while in other instances, validation of progressive breadth and depth of competence is required. For example, the Emergency Medical Technician, who has a very focused role, may be called upon for any EMT skills on any day, in any situation. So periodic validation of the same knowledge and skills is appropriate. But for a profession with more breadth in knowledge, skills, and scopes of practice, and for a profession that may practice in a variety of settings, validation of entry-level skills only may be shortsighted.

To benefit the consumer, it makes sense for the board to focus on assuring that a practitioner's knowledge and skills in the current area of practice are sufficient such that safe and competent care is delivered. It is a questionable use of time and resources to focus on practitioners acquiring knowledge and skills unrelated to daily practice. Requirements that have no relation to daily practice become an academic exercise, and may even detract from advancement of needed knowledge and skills.

Public Expectations

The public expects safe and competent nursing care. Competent nursing practice takes place when the nurse chooses to implement the right action at the right time. Further, the public expectation is that the nursing care is skillful and is directed to the welfare of the consumer of the services. The public believes that a board of nursing is responsible to assure that practitioners have the educational and professional qualifications to do so. These expectations pose a significant challenge to boards of nursing. One way to assure public expectations are congruent with the jurisdictional statutes and rules is to communicate the substance of practice acts and standards for competence to the public, in a manner that is clear and readily accessible (e.g., to advise that continued competence is evaluated in the focused area of practice).

Board of Nursing Role

Boards are accountable to the public; that is, are answerable to the consumers of the services provided by the practitioners regulated by the board. Boards license individuals, define a scope of practice and identify standards of practice. They provide the consumer with standards to measure the performance of the practitioner and to identify behaviors or incompetent practice which should be reported to the Board.

Public accountability requires regulatory boards to provide assurance to the consumer that practitioners who do not meet the standards for competence will be disciplined in a timely, cost-effective manner, and that information regarding disciplinary action is readily available.

Building a Regulatory Model for Competence Assurance

The implementation of a regulatory model for competence may facilitate a regulatory board's efforts to meet these identified responsibilities. The foundation for a model for competence assurance requires:

- articulating a definition of competence;
- setting standards of competence to compare and evaluate the practice of individual practitioners;
- identifying behaviors which demonstrate competence; and
- implementing a system to discipline individuals who fail to meet the standards for safe and effective practice.

Operationalizing the following premises facilitates the development of a regulatory model for assuring competence by the regulatory board to:

1. Boards determine and enforce competence requirements:
   a. at initial entry to the practice role,
   b. for continuing authority to practice at renewal,
   c. at re-entry to practice after an absence,
   d. after disciplinary action.
2. Requirements for competence assurance include competence development, competence assessment and competence conduct.
3. Boards implement a timely, fair, and efficient disciplinary process to restrict incompetent nurses from practice.
4. Boards are accountable to the public to hold individual practitioners accountable for their own practice.
5. Accountability for competent practice involves individual practitioners, regulatory boards, employers, educators and consumers.

Definition of Competence

Defining competence is difficult because of the complexity of the concept. A beginning practitioner is a generalist. An experienced practitioner has developed expertise in a particular area of practice. Is the expectation of competence the same for both? Should the definition of competence be inclusive of both? A definition of competence which is applicable to all practitioners at every level of practice provides regulatory boards with a means to offer assurances to the public that practitioners are held to a standard specifically relevant to the individual's scope of practice.

Competence is defined as the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare.

Standards for Competence

Standards for Competence must be applicable to every nurse in every practice role and address the continuum of practitioner experience, i.e., competence at entry, continued competence, competence upon re-entry and after disciplinary action. Standards for competence establish a framework for regulatory boards to implement a licensure system that is directed at assuring competence.

The identification of particular behaviors, which are indicators of performance, facilitates the determination of competent practice. Such indicators provide a basis for competence assessment. The challenge is to specify expectations that are reasonable, enforceable, and essential to safe and effective practice along the novice-to-expert continuum. See Figure 1 for Standards for Competence and behavioral indicators.

Figure 1: Standards for Competence

The nurse is expected to:

1. **Apply knowledge and skills at the level required for a particular situation.**

   Indicators
   - Determines actions needed to achieve desired outcomes
   - Performs nursing activities in a safe/effective manner
   - Demonstrates current knowledge necessary to provide safe client care
   - Delegates in accordance with established guidelines
   - Collaborates with appropriate professionals to attain client health care outcomes

2. **Demonstrate responsibility and accountability for practice and decisions.**

   Indicators
   - Exhibits ethical behaviors
   - Assures client welfare prevails
   - Establishes and maintains therapeutic boundaries
   - Limits practice to current knowledge, skills and abilities
   - Clarifies expectations of the role
   - Intervenes when unsafe nursing practice occurs
   - Practices within the legal authority granted by the jurisdiction
   - Implements professional development activities based on assessed needs

3. **Restrict and/or accommodate practice if cannot safely perform essential functions of the nursing role due to mental or physical disabilities.**

   Indicators
   - Identifies abilities necessary to perform the essential functions of the nursing practice role
   - Implements accommodations when needed
   - Safely performs essential functions of the nursing practice role
   - Limits practice when accommodations are not sufficient to enable safe performance of essential functions of the nursing practice role

Demonstrating Competence

The identification of requirements for licensure which the practitioner is expected to meet at specific identified points in the licensing process assists the regulatory board to develop a competence-based licensing system. Standards for Competence are the basis for these requirements. Requirements are established for licensure at: entry into practice; continuing authority to practice at renewal; re-entry into practice after an absence; and after disciplinary action.

Requirements for competence assurance include competence development, competence assessment and competence conduct (See Figure 2). **Competence development** is the method by which a practitioner gains, maintains, or refines practice knowledge, skills and abilities. This development can occur through formal education program, continuing education, or clinical practice, and is expected to continue throughout the practitioner's career.

Competence assessment can be accomplished through a variety of mechanisms - peer review, professional portfolio, professional certification, testing, re-testing, etc. Assessment can occur at every license renewal or through random audits. In addition, identified "triggers" could be used by a board to target practitioners who merit additional assessment. Such "triggers" could include: a practitioner in an independent or isolated practice; multiple jobs in a short period of time; prior discipline; etc.

Competence conduct refers to health and conduct expectations which may be evaluated through reports from the individual practitioner, employer reports, and discipline checks. Part of competence conduct is assurance that licensees possess the functional abilities to perform the essential functions of the nursing role.

Figure 2. Licensure Competence Requirements

	Competence Development	Competence Assessment	Competence Conduct
Initial Entry	Graduation from an Approved Program	NCLEX™	Board review upon application Discipline check
Continuing Authority to Practice at Renewal	Verified Practice during authorization period	Subject to random/targeted group assessment - Board identified mechanism e.g. Peer Review, Professional Certification, Professional Portfolio, Testing, Retesting	Board review upon application Discipline check
Re-Entry to Practice after Absence	Refresher education	Re-test e.g., NCLEX	Board review upon application Discipline check
After discipline	Board identified mechanism e.g., continuing education	Board identified mechanism	Board review upon application Discipline check

The specific details of each requirement may be developed by the regulatory board in compliance with individual statutory parameters. Competence requirements must be clearly communicated to practitioners.

Removing Incompetent Practitioners

Disciplining practitioners who are incompetent, violate the practice act, or do not meet the established requirements to demonstrate competence is required in a regulatory model to assure competence. Providing consumers and employers with standards for competence so they may identify behaviors or incompetent practice which should be reported to the board will facilitate the board's ability to take disciplinary action. A system which provides the public with information about filing complaints and the final disposition of those complaints enhances consumer faith in the regulator's role.

Collaboration to Assure Competence

Promotion of professional competence requires a collaborative approach, involving the board of nursing, individual nurses, employers and educators. Boards determine and enforce continued competence requirements which are administratively feasible, cost-effective and equitably applied. A major concern for licensing boards when considering their role is that of resources, and how to select activities which bring the most value to the public. Who pays? Is the additional cost "bearable" by the health care system? How would it be distributed? Should boards attempt to deal with all licensees on a regular basis, while recognizing that this often means a shallow, superficial sweep? Or would a more effective approach be to do significant and meaningful interactions with a selected group of licensees?

One possibility for identification of the selected group could be random review of licensees. As described earlier, "triggers" for competence assessment might be identified, e.g., nurses changing their practice focus, nurses working in high risk areas, or nurses working in isolation. The latter notion has appeal, if objective and relevant triggers can be identified. Such triggers cannot be developed in isolation: the "stakeholders" must be involved.

Other parties have a role in the determination of competence development and assessment, including the recognition of incompetence. While licensure assures the public and employers that practitioners have attained requirements for competence, employers determine whether or not the practitioner can perform the job. Additionally, those who delegate functions or tasks to the practitioner are accountable for that delegation and the determination of whether or not the practitioner can safely and effectively perform the delegated function.

Educators differ from regulators and employers in that their public is prospective practitioners and future consumers of their services. Their role is that of competence development, to provide the learner with opportunity to develop the knowledge and skills necessary for safe and effective practice, and to collaborate with consumers and employers to determine what knowledge and skills are needed for the practice role. Educators also provide continuing education to enhance and expand the knowledge and skills of licensed practitioners.

The individual nurse must be accountable for practice. One of the competence standards states that the nurse *shall demonstrate responsibility and accountability for practice and decisions.* A behavioral indicator of this standard is that the *nurse implements professional development activities based on assessed needs.* Individual practitioners are expected to achieve, evaluate and maintain competence in nursing practice. The individual competence evaluation provides a framework for the evaluation of individual competence for the current or prospective practice role (see Attachment I). Individuals are also expected to participate in the evaluation of the competence of colleagues and peers to assure that all practitioners are competent.

Competence Accountability

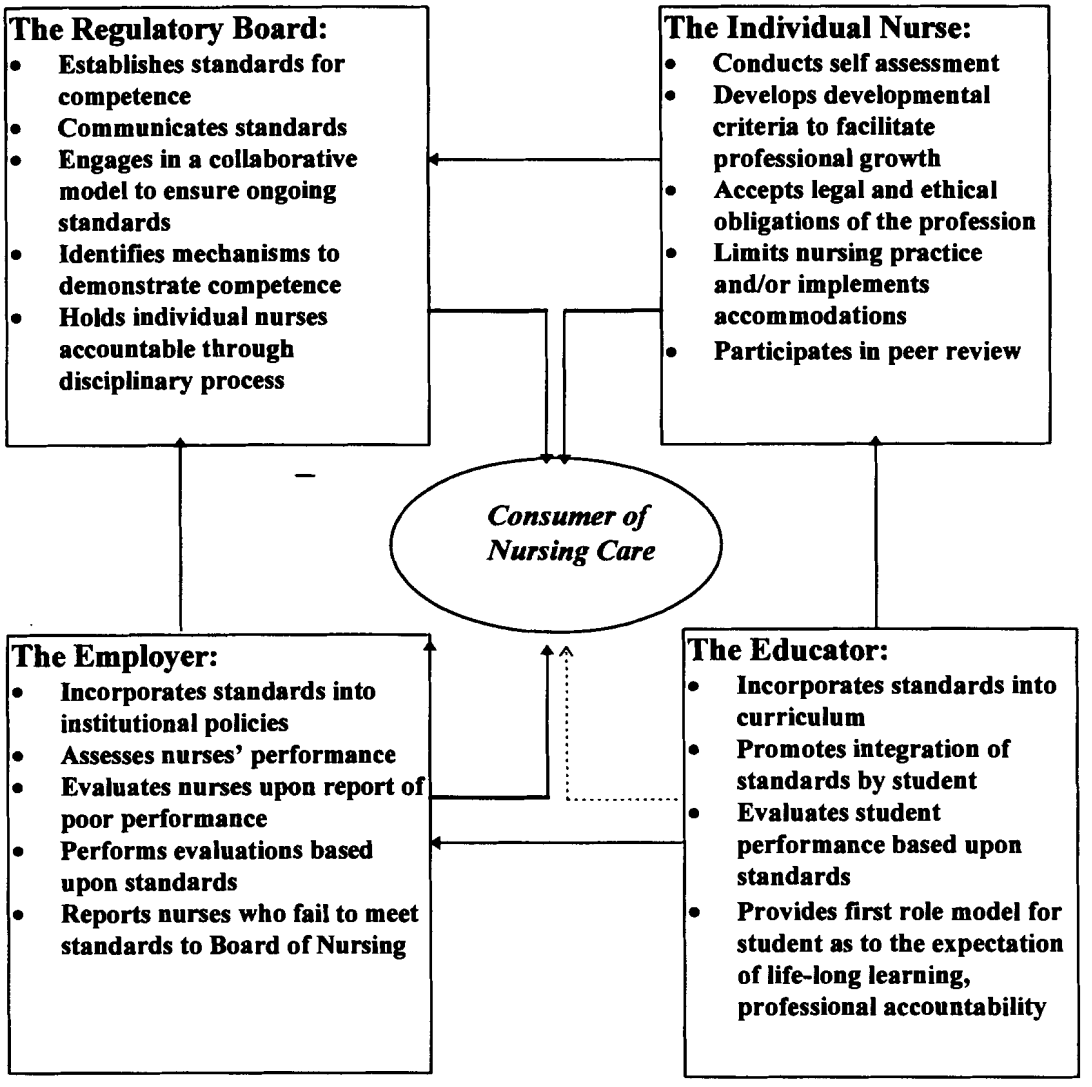
While regulatory boards are not required to provide a model for educators and employers, collaboration with them and other interested parties facilitates a clear understanding of role expectations in competence development, competence assessment and competence conduct. Such efforts must always be directed toward public health, welfare and safety (see Figure 3).

Conclusions

The Continued Competence Subcommittee believes that this policy statement which incorporates a *definition of competence, standards for competence and a model for competence assurance,* will assist boards of nursing in assuring the public that licensed practitioners maintain competence throughout their professional careers. Assuring continued competence is complicated in a profession with varying scopes, levels and settings of practice. The proposed Subcommittee Model addresses both universal and specific validation of competencies at specified points of practice. Additionally, the Model allows for individualized competency assessment precipitated by "triggers" at any point in an individual's nursing career. Both mechanisms provide the necessary safeguards to the consumers by mandatory checkpoints for competence assurance in every practitioner's life as a nurse and the highly individualized, randomly triggered competence checks that are situationally determined. The Model underscores the collaborative nature of assuring competence from key players in the health care delivery system.

This Regulatory Model for Competence Assurance can serve as an effective means for a regulatory board to meet its obligation to protect the public health, welfare and safety by assuring that practitioners are competent to deliver safe and effective care.

Figure 3. Competence Accountability



Actions of boards of nursing that assure competence to the public:

1. Establish competence requirements for safe and effective practice.
2. Communicate standards to the consumers, nurses, nursing educators, employers and other regulators.
3. Hold individual nurses accountable for continued competence.
4. Engage in collaborative activities with nurses, educators, employers, and consumers to ensure nurses practice safely and effectively.
5. Identify a variety of techniques nurses may employ to demonstrate competence.
6. Discipline nurses who fail to meet standards for safe and effective practice.
7. Inform the public of disciplinary actions taken against nurses.
8. Establish nondisciplinary model to monitor and/or limit the practice of nurses who demonstrate inability to carry out essential nursing role functions.

Attachment I
Individual Competence Evaluation

Preface

The Standards for Competence provide the guidelines for individual nurses to achieve, evaluate, and maintain competence in nursing practice. Individual nurses are expected to evaluate knowledge and skills in relation to the expectations of the current or prospective nursing practice role. Competence should be evaluated on a regular basis. In addition, competence should be evaluated when practice circumstances change, e.g., change in job or clinical setting or in response to practice related concerns.

The Individual Model may be used by boards of nursing, employers, educators, and consumers as well as the individual nurse.

Expected Behaviors

The nurse is expected to:

1. **Apply knowledge and skills at the level required for a particular practice situation.**

   a. Identify role expectations (Determine the knowledge and skills needed for the role).
   Sources
   - position description
   - review of literature
   - networking (talk to someone doing the role)
   - observe and/or shadow another nurse (mentor, preceptor)

   b. Determine individual level of knowledge and skills needed for the role.
   Sources
   - skill inventory
   - assessment test
   - cognitive appraisal
   - peer review

   c. Identify strengths and learning needs.
   Source
   - cognitive comparison of role expectations and individual abilities

   d. Develop and implement a learning plan (Identify and carry out learning activities needed by the learner).
   Sources
   - job or role orientation
   - formal or continuing education
   - independent study
   - refresher course
   - precepted learning experience
   - simulated learning experience
   - other experiential learning

   e. Evaluate the effectiveness of learning and its impact on the practice role.
   Sources
   - reassessment (formal or informal)
   - testing
   - peer review
   - performance evaluation

2. Exercise sound nursing judgment.

   a. Synthesize knowledge and skills relevant to client needs in carrying out the nursing role.
   b. Delegate nursing activities appropriately.
   c. Identify cause and effect relationships.
   d. Recognize limits of knowledge and skills.
   e. Use resources appropriately.
   f. Monitor outcomes.

3. Employ personal principles reflective of professional, ethical and legal standards of practice.

   a. Articulate an awareness of regulatory, professional and ethical standards.
      Sources
      - *Nursing Practice Act*
      - American Nurses Association *Code of Ethics*

4. Assure that client welfare prevails.

   a. Articulate respect for the social, cultural and spiritual diversity of clients.
   b. Maintain therapeutic boundaries.
   c. Assure that clients needs are articulated.

5. Enable client participation in health care decisions and outcomes.

   a. Facilitate client decision-making by providing information.
   b. Facilitate the identifying of choices and possible outcomes.
   c. Support client decisions.

6. Participate in professional development activities which support the nursing knowledge and skills needed for safe and effective practice.

   a. Develop professional growth and development criteria recognizing individual level of experience.
   b. Conduct regular evaluation of professional development needs (see Standard 1).
   c. Select professional development activities based upon identified needs.
   d. Review own professional development portfolio.

7. Collaborate with appropriate professionals to attain desired client health care outcomes.

   a. Differentiate nursing functions from functions of other providers.
   b. Communicate with the health care team.
   c. Assess the effectiveness of referrals.
   d. Monitor outcomes by assessment of the impact of collaboration on health promotion, maintenance, illness prevention for the client.

8. Recognize the relationship of personal cognitive and functional abilities to safe and effective practice.

   a. Identify abilities necessary for the essential functions of a nursing practice role.
   b. Identify accommodations needed to ensure safe and effective practice.
   c. Limit practice based on abilities and accommodations.

9. Demonstrate responsibility and accountability for nursing practice decisions and actions.

   a. Identify the legal and ethical obligations of the profession.
   b. Answer for one's own actions and decisions.

Supporting Bibliography

American Organization of Nurse Executives. (1994). Differentiated Competencies for Nursing Practice. Nursing Management, 24(9), 34-35.

Benner, Patricia. (1982, May). Issues in Competence-Based Testing. Nursing Outlook, 303-309.

Benner, Patricia. (1984). From Novice to Expert. Menlo Park: Addison-Wesley.

Black, Henry C. (1979). Black's Law Dictionary. St. Paul: West Pub. Co.

Coghlan, Anne. (1996, February). Supporting Quality Care Through Professional Accountability. Communiqué, 4.

Curtin, Leah L. (1995). Your License and Mine. Nursing Management, 26(12), 7-8.

de Tornyay, Rheba. (1992). Reconsidering Nursing Education: The Report of the Pew Health Professions Commission. 31(7), 296-301.

Division of Practical Nursing Programs. (1979). Competencies of Graduates of Educational Programs in Practical Nursing. New York: National League for Nursing.

Ehrl, Diana. (1994). Regulating Health Care Professionals: An Overview. Council on Licensure Enforcement and Regulation Resource Brief, 4.

Finnocchio, Len. (Speaker). (1994). Professional Regulation: Removing Unjustified Practice Barriers. Washington, DC: Citizen Advocacy Center.

Ford, Joan S. &: Profetto-McGrath, Joanne. (1994). A Model for Critical Thinking Within the Context of Curriculum as Praxis. Journal of Nursing Education, 33(8), 341-344.

Friss, Lois. (1977, October). What Do Nurses Do?. Journal of Nursing Administration, 24-28.

Helms, Lelia B. & Weiler, Kay. (1993). Disability Discrimination in Nursing Education: An Evaluation of Legislation and Litigation. Journal of Professional Nursing, 9(6), 358-366.

Joel, Lucille A. (1995). Your License to Practice: Variations on a Theme. American Journal of Nursing, 95(11), 7.

Johnson, Joy L. (1994). A Dialectical Examination of Nursing Art. Advances in Nursing Science, 17(1): 1-14.

Kaiser, Katherine L. & Rudolph, Elizabeth J. (1996). In Search of Meaning: Identifying Competencies Relevant to Evaluation of the Community Health Nurse Generalist. Journal of Nursing Education , 35(4), 157-162.

Kane, M. (1992). The Assessment of Professional Competence. Evaluation and the Health Professions. 15 (2). 163-182.

Kataoka-Yahiro, Merle & Saylor, Coleen. (1994). A Critical Thinking Model for Nursing Judgment. Journal of Nursing Education, 33(8), 351-356.

Magilvy, Joan K. & Mitchell, Andrea C. (1995). Education Needs of Nursing Students with Special Needs. Journal of Nursing Education, 34(1), 31-36.

McCrone, Eric. (1994, August). Quality Assurance: Council Moves to Revise Standards of Practice. Communiqué, 9-11.

Supples, Joanne M. (1993). Self-regulation in the Nursing Profession: Response to Substandard Practice. Nursing Outlook, 41 (1), 20-24.

Swankin, David A. (1995). The Role of Licensing in Assuring the Continuing Competencies of Health Care Professionals: A Resource Guide. Washington DC: Citizen Advocacy Center.

U.S. Department of Health and Human Services. (1981). Perspectives on Health Occupational Credentialing: A Report of the National Commission in Health Certifying Agencies. Washington, DC: Author.

Vedder, Price, Kaufman & Kammholz. (1994). Update on Legal Obligation of Employers Under the Americans with Disabilities Act. Labor Law, 14(3). Chicago, IL: Author.

Wansbrough, Gillian. (1996, February). All Aboard for 1997: CNO Embarking in Quality Assurance Program. Communiqué, 14-18.

Wansbrough, Gillian. (1996, February). Quality Assurance in Action. Communiqué, 19-23.

Watson, Pamela G. (1995). Nursing Students with Disabilities: A Survey of Baccalaureate Nursing Programs. Journal of Professional Nursing, 11(3), 147-153.

Subcommittee to Analyze Clinical Experiences

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Relationship to the Organizational Plan

Goal III ..... Provide information, analyses and standards regarding the regulation of nursing education.
Objective B ..... Provide resources regarding issues that affect the regulation of nursing education.

Recommendation to the Nursing Practice and Education Commitee

1. **Incorporate the proposed rules and guidelines for Selection of Settings for Student Experiential Activities, Faculty Responsibilities in the Selection and Supervision of Clinical Experiences, and Selection and Roles of Preceptors in the revision of the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.**

Background

The Subcommittee to Analyze Clinical Experiences identified four areas of focus for its work: education for changing roles of nursing in health care delivery; clinical site; safe supervision of students and the use of preceptors; and meeting clinical outcomes. Member Boards were surveyed regarding their regulations on selection of clinical sites, use of preceptors and supervision of clinical learning experiences. Thirty-two Member Boards responded to the survey. In addition, rules and regulations from 30 jurisdictions were reviewed.

Assumptions of Subcommittee

The subcommittee believes that student learning is enhanced through the use of a variety of clinical experiences. Supervision by faculty or preceptors ensure that students are practicing safely. In addition, it allows for timely evaluation of student achievement of clinical learning objectives. Preceptorial experiences are designed to meet specified criteria, student learning needs and program/course objects. These experiences may occur within traditional health care settings, in community agencies, or community-based settings.

Broad, yet succinctly stated regulations, which focus on the safety of clients and client needs, accomplish two objectives: increase access to student learning opportunities; and increase the depth and breadth of experiences which reinforce or expand upon students' and graduates' ability to demonstrate core nursing competencies. These core nursing competencies can be identified through an assessment of community needs. Education programs prepare graduates who are safe entry-level practitioners, able to assist their community in meeting defined health care needs. This is accomplished through community and educational partnerships.

Review of Data

In reviewing regulations and responses regarding clinical learning experiences and use of preceptors, the committee found that regulations varied from having no regulations to very detailed and specific regulations. According to *Member Board Profiles*, 30 jurisdictions approved/accredited clinical education facilities used by programs. Twenty-five boards of nursing conduct on-site visits of clinical education facilities. Others held faculty and programs accountable for selection. Mechanisms for board oversight varied from clinical site approval based on reports from the education program to requirements for board visits to establishing accountability parameters for decision-making and site selection and evaluation.

Requirements for levels of RN staffing; required presence of RN during student learning activities; allowing only RN preceptors; requiring specific patient and/or staffing levels; facility policies; and acuity level of clients can potentially limit access to and use of non-institutional, community based settings. Rules of this type may create situations where boards of nursing become responsible for education program activities, rather than the faculty and

education programs being held accountable for their own planning and decision-making.

The subcommittee was cognizant of the safety concerns which were the likely impetus for these regulations, but believes that safety concerns can be adequately addressed without some of these restrictions. For example, a home health experience could be supervised by a physical therapist or an occupational therapist just as effectively as a registered nurse, if the supervisor and student are properly prepared by the faculty and the learning outcomes clearly identified.

Some of the regulations succinctly state the faculty and education program responsibilities for designing curricula which provide students with sufficient opportunities to safely practice and demonstrate competencies central to the program goals and course objectives. Specific clinical settings were rarely identified in regulatory language. The supervision of students by faculty or faculty extenders, such as preceptors, was consistently spelled out in rule form.

Guidelines were frequently used to implement rules and provide parameters for decision-making by faculty and institutions. These guidelines also ranged from highly detailed to broadly stated.

Common to all regulations reviewed were the concepts of faculty responsibility and accountability for:

1) ensuring public safety
2) planning, implementing, evaluating experiential activities of students

Few boards communicated the expectation and accountability of faculty to collaborate with facilities and clinical experts in the community to enhance opportunities for students to apply theory to practice and demonstrate competencies appropriate to the students' level of preparation.

Development of Rules and Guidelines

The subcommittee developed model rules and guidelines for the Selection of Clinical Sites, Faculty Responsibilities, and Selection and Roles of Preceptors (Attachment A). In developing the rules and guidelines, the subcommittee considered the concerns raised by the Pew Health Professions Commission in *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*, specifically the need to better prepare practitioners for the rapidly changing health care delivery environment. The subcommittee determined that the proposed rules and guidelines are responsive to the concerns raised.

The subcommittee believes that the proposed rules and guidelines support the "rediscovery" of the historical roots of nursing in the community. Students can safely provide direct nursing care and meet learning outcomes in community-based settings through careful planning and supervision. Preceptorial learning activities encourage faculty and programs to increase their involvement with the community. Through the expanded use of community-based settings, faculty and students will increase their involvement in carrying out health promotion/disease prevention activities. In addition, community-based experiences will better prepare graduates to deliver nursing care in culturally diverse communities while increasing health care availability to the disadvantaged populations in the community.

The proposed rules and guidelines encourage faculty collaboration with other professionals in the teaching/learning process. As faculty become more collaborative through interaction with diverse health care professionals, they position themselves to prepare students to safely practice nursing in a rapidly evolving health care environment. Through collaboration, faculty become more familiar and skilled in community-based settings and are able to facilitate student learning experiences more effectively.

The subcommittee believes that each clinical education setting must be evaluated within the context of client health, welfare and safety. The education program faculty is responsible for the selection of student clinical learning experiences based on an evaluation of the appropriateness of the experience in meeting identified course objectives and curriculum outcomes. The knowledge and skill level of the student, the acuity of the client population, the experience of the clinical staff with students as well as the availability of support resources are factors that should be evaluated in selecting clinical learning experiences. Learning experience settings should be appropriate for the level of practitioner being prepared.

Meeting Dates

- November 14, 1995 *(telephone conference call)*
- November 27, 1995 *(telephone conference call)*
- March 8-9, 1995

Recommendation to the Nursing Practice and Education Committee

1. Incorporate the proposed rules and guidelines for Selection of Settings for Student Experiential Activities, Faculty Responsibilities in the Selection and Supervision of Clinical Experiences, and Selection and Roles of Preceptors in the revision of the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

Attachments

Attachment A

Proposed Model Rules and Guidelines

Selection of Settings for Student Experiential Activities

Model Rule

1. Selection of settings shall be based on identified course objectives and curriculum outcomes.
   a. Faculty are accountable for establishing criteria for learning experiences. These criteria shall be in writing and regularly evaluated by faculty .
   b. Faculty are responsible for the selection and evaluation of clinical experiences.

2. There shall be a written agreement between the educational program and the cooperating agency which identifies the roles and responsibilities of the educational program, clinical agency, faculty, and student.

3. Settings used for student learning should be approved by the appropriate licensing, certifying or accrediting agency.

Model Guideline

Parameters for Selection of Settings for Student Experiences

1. The selection of student clinical learning experiences should be based on an evaluation of:
   a. The appropriateness of the experience in meeting identified course objectives and curriculum outcomes
   b. The knowledge and skill level of the student, the acuity of the client population, and the experience of the clinical staff with students
   c. The availability of support resources

2. Learning experience settings should be appropriate for level of practitioner being prepared.

3. Joint annual evaluation of effectiveness of student learning experiences should include:
   a. Faculty
   b. Preceptor
   c. Student
   d. Facility

4. Factors to be considered when developing criteria for selection of experiential learning settings include, but are not limited to:

   a. The role of nursing in the setting
   b. Opportunity for the student to practice nursing safely
   c. Ability of faculty to provide adequate and safe supervision of student practice
   d. Diversity of population served
   e. Willingness of setting to accommodate student experience
   f. Number of other programs/students using the setting
   g. Interdisciplinary nature of site
   h. Location and accessibility of the setting
   i. Physical safety of students

Faculty Responsibilities in the Selection and Supervision of Clinical Experiences

Model Rule

Faculty is accountable for directing and evaluating students during learning experiences.

1. Faculty plans, implements and evaluates student learning experiences in selected affiliate agencies consistent with the students' level of preparation, course objectives and curriculum outcomes.

2. Faculty is accountable for evaluating student accomplishment of learning objectives.

3. The degree of faculty supervision is defined by the client safety needs, level of student skills, knowledge and ability and the availability of support resources.

Model Guideline

1. When planning for student learning experiences, faculty should consider health, safety and welfare of clients as a priority.

2. In selecting learning experiences, faculty are responsible for:

   a. Evaluation of knowledge and skill level of student, acuity of client population, experience level of staff, and availability of support services
   b. Evaluation of appropriateness of clinical experience for meeting identified course objectives and curriculum outcomes
   c. Establishing relationship with clinical agency
   d. Establishing relationship with preceptor or clinical extenders
   e. Orientation of students to facility, role expectations, and learning objectives
   f. Orientation of facility and preceptors which includes:
      Roles and responsibilities of facility, faculty, preceptors and students
      Knowledge and skill level of students
      Course objectives and curriculum outcomes
      Accountability and responsibility of faculty and students related to competence
      Monitoring that all the parties are meeting agreements

Faculty are responsible for guiding, monitoring, and evaluating student learning.

   a. Faculty directly supervise student in providing direct care to clients
   b. *Direct Supervision* means that the supervisor is physically present and immediately accessible. This can be accomplished by faculty directly or through the use of a preceptor
   c. Faculty shall be readily available to students/preceptors during preceptorial learning activities. Ready availability to preceptor and student/facility can/may be accomplished by phone/pager after evaluation of the clinical situation

4. Faculty should be competent in the practice area.

Selection and Responsibilities of Preceptors

Model Rule

1. Criteria for selection of preceptors shall be written and consistent with meeting program outcomes for students.

2. There shall be a written agreement between nursing program and preceptor which identifies the roles and responsibilities of faculty, preceptor, student, and clinical facility.

3. Preceptor shall have:
   a. a current license appropriate to their profession
   b. expertise in the clinical area being precepted, and
   c. hold the same or higher education credential than the student being precepted.

Definitions

Preceptor - registered or professional health care professional who serves as a facilitator of student learning experience in the practice setting.

Preceptorial learning activities - Those learning experiences which are provided under the direct leadership and supervision of a preceptor who is not a member of the nursing education program's faculty.

Model Guideline

1. Responsibilities of preceptor includes:
   a. Guiding and monitoring student learning activities
   b. Facilitating student learning
   c. Evaluating student performance in relation to clinical learning objectives. The learning objectives are established collaboratively by the faculty, student and preceptor
   d. Collaborating with faculty and students to review the progress of the student toward meeting clinical learning objectives

2. A preceptor is responsible for directly facilitating learning activities of no more than ( ) students at one time, based on an assessment of the clinical situation and safety needs of the clients.

3. Each student shall have a designated faculty member who is responsible for the coordination of learning activities.

4. Communication and collaboration between faculty and preceptor is ongoing throughout the clinical experience. The faculty is responsible for assuring that this collaboration is facilitated.

5. Preceptorial experiences occur after the student has received basic theory and clinical experiences necessary to safely provide care to clients (within an individual course or within the total curriculum).

Selected Bibliography

American Association of Colleges of Nursing. (1993). Nursing Education' Agenda for the 21st Century. Washington DC: Author.

Bellack, Janis P. (1995). Guest Editorial: Educating for the Community. Journal of Nursing Education. 34(8), 342-343.

Buls, Patricia, & Leake, Penny Y. (1995). Student Home Care Program: A Real Taste of Home. Journal of Nursing Education. 34(8), 372-374.

Buttriss, Grace, Kuiper, RuthAnne, & Newbold, Betty. (1995). The Use of a Homeless Shelter as a Clinical Rotation for Nursing Students. Journal of Nursing Education. 34(8), 375-377.

Conway-Welch, Colleen & Norman, Linda. (1995). Health Care Reform and Managed Care: Challenges for Nursing Education. Quality Management in Health Care. 4(1), 34-39.

Coudret, Nadine A., Fuchs, Pennae L., Roberts, Cynthia S. Suhrheinrich, Joy A. & White, Ann H. (1994). Role Socialization of Graduating Student Nurses: Impact of a Nursing Practicum on Professional Role Conception. Journal of Professional Nursing, 10(6), 342-349.

Erkel, Elizabeth A., Nivens, Anita S., & Kennedy, D. Elizabeth. (1995) .Intensive Immersion of Nursing Students in Rural Interdisciplinary Care. Journal of Nursing Education. 34(8), 359-365.

Faller, Helen S., Dowell, Marsha A., Jackson, M. Adrienne. (1995). Bridge to the Future: Nontraditional Clinical Settings, Concepts and Issues. Journal of Nursing Education. 34(8), 344-349.

Gauthier, Mary A., & Matteson, Peggy. (1995). The Role of Empowerment in Neighborhood-Based Nursing Education. Journal of Nursing Education. 34(8), 390-395.

Kelley, Barbara E. (1995). Community-Based Research: A Tool for Community Empowerment and Student Learning. Journal of Nursing Education. 34(8), 384-389.

Laschinger, Heather K. & Weston, W. (1995). Role Perceptions of Freshman and Senior Nursing and Medical Students and Attitudes Toward Collaborative Decision Making. Journal of Professional Nursing. 11(2), 119-128.

Lindeman, Carol A. (1995). Nursing Education in Changing Times. NLN Research and Policy Prism. 3(1), 1.

Nugent. Katherine E. & Lambert, Vickie A. (1994). Empowering Faculty Through Intrapreneurship: A Change Model. Journal of Nursing Education, 33(5), 226-229.

Oermann, Marilyn. (1994). Reforming Nursing Education for Future Practice. Journal of Nursing Education. 33(5), 215-219.

Peters, Rosalind M. (1995). Teaching Population-Focused Practice to Baccalaureate Nursing Students: A Clinical Model. Journal of Nursing Education. 34(8),378-383.

Pew Health Professions Commission. (1995). Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century. San Francisco, CA: UCSF Center for the Health Professions.

Ploifroni. E. Carol, Packard, Sheila A., Shah, Helen S. & MacAvoy, Suzanne. (1995). Activities and Interactions of Baccalaureate Nursing in Clinical Practica. Journal of Professional Nursing. 11(3), 161-169.

Tagliareni, M. Elaine & Murray, Joyce P. (1995). Community-Focused Experiences in the ADN Curriculum. Journal of Nursing Education. 34(8), 366-371.

Tenn, Louise. (1995). Primary Health Care Nursing Education in Canadian University Schools of Nursing. Journal of Nursing Education. 34(8), 350-358.

Selected State Rules and Regulations

Supplemental Report of the Continued Competence Subcommittee

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Additional Recommendations to the Nursing Practice and Education Committee

1. **Disseminate and promote the Functional Abilities Study.**

Rationale

The Functional Abilities Study identifies the "core" functional ability activities/attributes essential for an individual to perform nursing activities in a safe and effective manner. Boards of nursing may use this information when considering the eligibility of an individual for initial or continuing licensure. However, the presence of a disability that impacts an individual's ability to demonstrate competence in these areas should not be considered in isolation from the accommodations that can be used to compensate for a noted "deficiency."

The report is viewed by the subcommittee as augmentation to other National Council studies, particularly, the Job Analysis Studies, Role Delineation Study, and the Readability Levels of Clinical Nursing Documents. Together, these studies frame a picture of the roles and expectations of practicing nurses as well as the abilities needed to fulfill those roles. The Functional Abilities Study will provide boards with a resource to assist in making licensure decisions through the identification of "core abilities." This identification may facilitate boards in making an informed analysis of a licensure applicant with a disability.

2. **Development of guidelines for implications of the Functional Abilities Study.**

Rationale

The Continued Competence Subcommittee believes that the information in this report will assist Member Boards in their evaluation of nurses with disabilities, many of whom could function safely and effectively in selected employment settings/environments and/or in selected positions. The development of guidelines, which encompass all the other documents identified above, would both promote the use of the results of the Functional Abilities Study and will assist in the judicious use of the information.

3. **Consider the implications of the Functional Abilities Study for the *Model Act* and *Rules* revision.**

Rationale

The Continued Competence Subcommittee believes that review of the information in this report should be one of the activities completed in the revision of the *Model Nursing Practice Act* and *Model Administrative Rules for Nursing*, an activity planned for next year. The *Models* currently contain a nondisciplinary approach for licensure of nurses with disabilities, and the Functional Abilities Report may be used to support that approach or as a basis for identifying other approaches for Member Boards to use in making licensure decisions.

Future Activities for the National Council

The Continued Competence Subcommittee recommends that, in addition to distribution, these documents will be promoted as resources both for boards of nursing and other interested parties. Guidelines for implications of the Functional Abilities Study could be developed next year as part of the Nursing Practice and Education Committee's

further work on continued competence. The subcommittee would also recommend that its work on competence as well as the implications of the Functional Abilities Study be reviewed by the Nursing Practice and Education subcommittee which will revise the *Model Act* and *Rules*, as they approach synthesizing the many elements of work to support regulation that have been developed by a variety of National Council committees in the past few years..

Additional Recommendations to the Nursing Practice and Education Committee

1. Disseminate and promote the Functional Abilities Study.
2. Development of guidelines for implications of the Functional Abilities Study.
3. Consider the implications of the Functional Abilities Study for the *Model Act* and *Rules* revision.

Attachment

Attachment C

Validation Study: Functional Abilities Essential for Nursing Practice

NOTE: Page numbers for this document appear at the bottom of each page.

VALIDATION STUDY:

FUNCTIONAL ABILITIES ESSENTIAL FOR NURSING PRACTICE

Carolyn J. Yocom, PhD, RN, FAAN

1996

EXECUTIVE SUMMARY

Validation Study: Functional Abilities Essential for Nursing Practice

To practice nursing, a licensee must possess a multitude of knowledge, skills and abilities (KSAs) in order to provide safe and effective client care. These KSAs can be dichotomized into two groups: domain specific (i.e., specific to the practice of nursing) and non-domain specific. Historically, boards of nursing have relied on two major sources of information to evaluate the competence of licensure applicants regarding the domain specific KSAs: (1) documentation from nursing education programs that graduates have demonstrated satisfactory levels of competence and (2) performance on standardized objective tests (i.e., NCLEX™). Based on their successful completion of a basic nursing education program, it has also been assumed that graduates demonstrate competence regarding the non-domain specific KSAs.

The initial and/or continued competence of persons with disabilities to practice nursing has been debated for many years. In fact several boards of nursing have a mechanism whereby a limited license may be issued to individuals whose ability to practice is impacted by the presence of a disability. A board's mandate to protect the public and the issue of competence was heightened with passage of the Americans with Disabilities Act (ADA). Subsequently, questions were raised regarding (1) the types of functional ability activities/attributes (non-domain specific) a nurse must possess in order to practice safely and effectively and (2) the types of compensatory accommodations used by nurses with disabilities.

The primary purpose of this study was to obtain validation of the essential non-domain specific functional abilities that a nurse must possess in order to perform nursing activities in a safe and effective manner. Data were provided, in response to a mailed questionnaire, by 3,660 RNs and LPN/VNs representative of all geographic regions of the United States. Based on previous National Council research, the demographic characteristics of this study's participants and their work environment characteristics indicate they are representative of the nursing population. Study participants identified which of 98 descriptive activities/attributes, grouped within sixteen functional abilities, were essential for the performance of nursing activities. An essential activity/attribute was one identified by 95% or more of the respondents in an analysis group.

Core essential activities/attributes vary by level of licensure. The outcomes of data analysis indicate that selected activities/attributes of all sixteen functional ability groups are essential for the delivery of safe and effective client care. In addition, there are "core" activities/attributes that transcend the employment setting and/or job position of a nurse in a specific licensure category. A "core" group of 27 essential activities/attributes were identified for LPN/VNs providing direct client care. These were distributed across the following functional ability groups: *Fine Motor Skills, Physical Endurance, Mobility, Hearing, Visual, Tactile, Reading, Arithmetic Competence, Emotional Stability, Analytical Thinking, Interpersonal Skills* and *Communication Skills.* These essential activities/attributes are almost evenly divided between those representing psychomotor skills/abilities and the senses and those representing psychosocial skills and higher cognitive functioning.

In contrast, for RNs providing direct or indirect client care, a "core" group of 17 essential activities/attributes were identified. These represent the following eight functional ability groups: *Fine Motor Skill, Hearing, Arithmetic Competence, Emotional Stability, Analytical Thinking, Critical Thinking, Interpersonal Skills,* and *Communication Skills.* All but two of the activities/attributes represent psychosocial skills and higher cognitive functioning abilities. With some exceptions, this pattern is also evident in the data provided by RNs providing direct client care when they are examined according to position title or by employment setting. Registered Nurses in direct care positions also identified essential activities/attributes in the following ability groups: *Mobility, Visual* and *Reading*. Therefore, the "core" activities/attributes of functional abilities vary according to a licensee's scope of practice.

Additional essential activities/attributes vary by level of involvement in client care, job position, and work setting. The level of involvement in care provision (direct, indirect), job position, and employment setting have an impact on the types of additional functional ability activities/attributes that are essential for the delivery of safe and

effective client care. A majority of these activities/attributes essential in unique settings or positions represent psychomotor skills/abilities, the senses, and arithmetic competence. Secondly, there is generally a large proportion that are common to a majority, but not all, of either the job position groups or the employment setting groups. Lastly, there is a small proportion of essential activities/attributes that are unique to a specific job position or employment setting.

Disabilities. The greatest proportion of reported disabilities involved neuro-musculo-sketetal system problems and within this group, the majority are back-related problems. The predominant accommodations for participants identifying the presence of a disability were work load and/or work schedule adjustments, the provision of assistance by other staff, or effecting a change in employment status or location. The primary accommodation for those with a hearing impairment was the use of hearing aides or other amplification devices. The primary accommodation for those with a visual impairment was the use of corrective lenses to correct for nearsightedness. Depending upon its severity and impact on the ability to function, the reported disability may or may not be covered under the ADA and therefore, may or may not trigger a legal requirement for an accommodation.

Implications. This study identifies the "core" functional ability activities/attributes essential for an individual to perform nursing activities in a safe and effective manner. Boards of nursing may use this information when considering the eligibility of an individual for initial or continuing licensure. However, the presence of a disability that impacts an individual's ability to demonstrate competence in these areas should not be considered in isolation from the accommodations that can be used to compensate for a noted "deficiency." Secondly, this information may be found useful by individuals considering nursing as a career and by nurse educators evaluating both applicants for admission and students enrolled in their programs.

Additionally, identification of both "core" and "non-core" essential functional ability activities/attributes, as delineated by job position and by employment setting, provides guidance to boards of nursing in their consideration to restrict a nurse's authority to practice nursing by limiting scope, setting, or type of nursing role and activities. In both instances, the nature of the specific disability, and the degree of compensation, if any, from the use of special accommodations must be considered. The position-specific and employment setting-specific lists of activities/attributes can be a valuable resource during career counseling opportunities - both with prospective licensees and with licensees who acquired a disability following initial licensure. A further implication for boards of nursing imposing limitations, involves policy determination - whether or not such limitations should be imposed by disciplinary or non-disciplinary methods.

Within each jurisdiction, the board of nursing has a legislative mandate to protect the public from incompetent providers of nursing care. When evaluating the competence of licensure applicants and licensees, the board cannot neglect or dismiss this mandate. While several boards have taken various positions on the use of limited licenses, this study does not advocate one position or another on this policy issue. It is hoped that the judicious use of the information reported in this report will assist them in their evaluation of nurses with disabilities, many of whom could function safely and effectively in selected employment settings/environments and/or in selected positions.

Acknowledgments

We gratefully acknowledge the contributions of the licensed practical/vocational nurses and registered nurses, from throughout the United States, who participated in this study. The information they have provided will assist boards of nursing and others with an interest in the non-domain specific, functional ability activities and attributes essential to the performance of nursing activities in a safe and effective manner.

Additional individuals have contributed to the performance of this study. The members of the National Council of State Boards of Nursing's Continued Competence Subcommittee provided input on instrument development and the establishment of data analysis decision rules. They also critiqued drafts of the final report. These members are: Shirley Brekken (MN), Chair; Teresa Bello-Jones (CA-VN); Marjorie Bronk (TX-VN); and Lynn Walsh (DE). The following members of the Job Analysis Monitoring Panel provided valuable advice regarding study design and analysis: Ms. Angeline Jacobs, Professor Emeritus, Azuza Pacific College, Azuza California; Dr. Michael Kane, Professor, Department of Kinesiology, University of Wisconsin, Madison, Wisconsin; and Dr. Mark Raymond, Director of Psychometric Services, The American Registry of Radiologic Tecnologists, St. Paul, Minnesota.

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Validation Study: Functional Abilities Essential for Nursing Practice

In response to the Americans with Disabilities Act (ADA), the National Council of State Boards of Nursing initiated a series of studies to identify competencies that a nurse must possess, in addition to those nursing knowledge, skills and abilities evaluated via a licensing examination, in order to function safely and effectively in a variety of employment settings. The information obtained will assist Member Boards of Nursing in their evaluation of candidates for licensure.

Two types of studies were initiated. One study, *Readability Levels of Clinical Nursing Documents* (Yocom, 1993), was performed to identify the reading grade level of material contained in client charts, nursing care plans, and selected reference materials. A second initiative, consisting of three related studies, addressed non-domain specific abilities essential to the practice of nursing. The first study (Chornick, 1993a) used a panel of experts to identify a list of functional abilities (e.g., fine motor skills, hearing, visual, smell, etc.) and nursing-related activities for each identified ability. In the second study (Chornick, 1993b), nursing administrators from a sample of 264 agencies representing three types of health care settings (acute care, long term care and home health) were asked to complete a questionnaire. A major component of the questionnaire included the list of functional abilities and related nursing activities identified by the expert panel. Each respondent was requested to indicate which activities were essential for nurses to perform in order to practice safely and effectively within the facility. Results indicated that the performance of relatively high numbers of activities representative of each functional ability were essential for nursing practice. Also, no additional functional abilities considered essential for practice were identified.

The current study is the third in this series. Its purpose is to use job incumbents to evaluate the validity of the results obtained in the previous studies and to further elucidate activities/attributes representative of the postulated functional abilities.

METHODOLOGY

Design and Sample Selection

The target population was all licensed practical/vocational nurses (LPN/VNs) and registered nurses (RNs) practicing in the United States and its territories. The sample for the study was randomly selected, using a one of n approach, from among all licensed nurses (RNs and LPN/VNs) listed on data tapes supplied by 28 jurisdictions (states) to the National Council for use in development of the Nurse Information System (NIS) data base. The sampling frame was constructed so that it consisted of one sub-group for each of the 28 jurisdictions. Collectively, the sample represents nurses practicing in urban and rural jurisdictions representative of large and small states and all four geographic regions of the United States.

Experience gained in the performance of a previously completed role delineation study (Yocom & Chornick, 1995) was used to estimate the sample size needed for the current study. In the role delineation study, LPN/VNs and RNs were requested to complete a questionnaire. Of that study's original sample, 24 percent returned questionnaires that were considered useable for data analysis. Most of the attrition was due to non-response (approximately 50%), or to respondents not working in nursing or not directly caring for clients 20 or more hours per week. Therefore, it was estimated that a sample size of 10,000 would be required to provide an analysis file containing a minimum of 2,400 respondents who were actively employed in nursing and providing direct nursing care.

Instrument Development

A self-administered questionnaire was developed for use in this study. Questions addressing demographic characteristics and work environment were modifications of those used in the role delineation study (Yocom and Chornick, 1995). The main section of the questionnaire contained a list of 98 activities or attributes representing 16 functional abilities (See Table 1). These sixteen functional abilities were identified based upon the prior work of the National Council in this area (Chornick, 1993a, 1993b) and that of the Southern Council on Collegiate

Table 1. Sixteen Categories of Functional Abilities

Category	Description
Gross Motor Skills	Gross motor skills sufficient to provide the full range of safe and effective nursing care activities.
Fine Motor Skills	Fine motor skills sufficient to perform manual psychomotor skills.
Physical Endurance	Physical stamina sufficient to perform client care activities for entire length of work role.
Physical Strength	Physical strength sufficient to perform full range of required client care activities.
Mobility	Physical abilities sufficient to move from place to place and to maneuver to perform nursing activities.
Hearing	Auditory ability sufficient for physical monitoring and assessment of client health care needs.
Visual	Visual ability sufficient for accurate observation and performance of nursing care.
Tactile	Tactile ability sufficient for physical monitoring and assessment of health care needs.
Smell	Olfactory ability sufficient to detect significant environmental and client odors.
Reading	Reading ability sufficient to comprehend the written word at a minimum of a tenth grade level.
Arithmetic	Arithmetic ability sufficient to do computations at a minimum of an eighth grade level. It includes the following three concepts: ***Counting***: the act of enumerating or determining the number of items in a group. ***Measuring***: the act or process of ascertaining the extent, dimensions or quantity of something. ***Computing***: the act or process of performing mathematical calculations such as addition, subtraction, multiplication and division.
Emotional Stability	Emotional stability sufficient to assume responsibility/accountability for actions.
Analytical Thinking	Reasoning skills sufficient to perform deductive/inductive thinking for nursing decisions.
Critical Thinking Skill	Critical thinking ability sufficient to exercise sound nursing judgment.
Interpersonal Skills	Interpersonal abilities sufficient to interact with individuals, families and groups respecting social, cultural and spiritual diversity.
Communication Skills	Communication abilities sufficient for interaction with others in oral and written form.

Education for Nursing (1993). A major difference between this questionnaire and the one used for the second study was the text used to describe the activities/attributes associated with each functional ability. In the previous study, the descriptions were stated in terms of nursing activities, such as "Operating fire extinguisher," "Transferring/ambulating patient with or without mechanical assistance," "Positioning Clients," etc. For the current study, the statements were revised to more closely reflect the functional ability needed to perform the nursing activities. For each activity/attribute listed, participants were asked to indicate if it was essential for them to be able to perform or possess it in order to provide minimally safe and effective care to their clients.

Content validity was established by a review of the literature, review by nursing experts (registered nurse staff of the National Council and members of its Continued Competence Subcommittee) and by external reviewers with expertise in reading skills, occupational skill development and performance, critical and analytical thinking, emotional stability and mathematics. Overall reliability of the questionnaire using Cronbach's alpha was .95. The standardized alpha coefficients for the 16 functional ability groupings (subscales) ranged from .49 to .88. Those subscales with alphas below .70 (*Physical Endurance, Hearing, Reading, Interpersonal Skills*, and *Communication Skills*) were examined further in an attempt to identify the source of the low coefficients. Several factors may have contributed to this finding. Included are the lack of variability in responses (i.e., practically all respondents reported all activities/attributes included in a subscale were essential [e.g., *Communication Skills*] and the inclusion of activities/attributes that are widely disparate while still an example of the targeted functional ability [e.g., *Physical Endurance* - "Standing" vs. "Sustaining repetitive movements"]). However, an analysis of activity/attribute statements included in one subscale, *Reading*, indicated several were misclassified. These statements were: "Read and understand columns of writing (e.g., flow sheets, charts)"; "Read digital displays"; and "Read graphic printouts."

In a further attempt to delineate the subscale structure of the instrument, the data were submitted to a factor analysis. The resulting six-factor solution supported the activity/attribute statement groupings of all subscales except *Reading*. (Several subscales were included in each of the six factors [e.g., *Physical strength* and *Physical endurance* loaded on one factor]). Three activity/attribute statements originally included in the *Reading* subscale loaded on the sixth factor with statements included in the *Arithmetic Competence* group ("Calibrate equipment"; "Convert numbers to and/or from the Metric System"; and "Read graphs [e.g., vital sign sheets]"), thus suggesting their placement in this group. Appendix A contains a list of all activity/attribute statements grouped according to their final assignment to a subscale.

Data Collection

A multi-phase mailing process was used to collect data. The mailing process was originally designed to include: (1) a preletter informing participants of their selection for inclusion in the study, the study's purpose, the importance of their participation and a return postcard to indicate their willingness to participate; (2) a questionnaire with a cover letter and return envelope, and (3) a reminder postcard. The first mailing (pre-letter and return postcard) was sent to 10,000 nurses during the second week of September, 1995. It consisted of the cover letter explaining the study and the return postcard. By the first week of October, only 1,550 postcards were returned (17.8%, taking into account bad addresses). Phone calls from recipients indicated there was some concern regarding the consequences of completing the questionnaire (e.g., "Will I lose my license if I fill out the questionnaire?").

Based on the information obtained from these phone calls and the poor response rate, the methodology used to recruit participants was reconsidered. A second sample of 8,000 nurses was drawn from the 28 data tapes. This number was selected based on the **estimated** total number of respondents agreeing to participate as a result of the postcards received following the first mailing (n=2,000) and the total number of questionnaires available (n=10,000).

Revisions were made in the content of the initial set of materials sent to prospective participants included in the second sample and in the mailing schedule. In contrast to the protocol used for the first sample, all prospective participants in this phase of the study received, in one mailing, the questionnaire, a revised cover letter requesting

participation, and an envelope for return of the completed questionnaire. This approach allowed potential participants to review the questionnaire prior to committing to the project. Measures that would be taken to assure the confidentiality of responses were stressed in the revised cover letter. In addition, all individuals included in the first sample who returned postcards indicating a willingness to participate in the study were sent a questionnaire, cover letter and return envelope. Participation was promoted through the use of a reminder post card sent to all prospective participants one week after their questionnaires were mailed.

The following table illustrates how data collection was operationalized:

Table 2. Mailing schedule and contents for individuals selected for study participation.

	Original Sample (n=10,000)	Second Sample (n=8,000)
First Mailing	A cover letter requesting participation. Return postcard indicating whether recipient would participate	
Second Mailing	Cover letter Questionnaire Return envelope	Revised cover letter Questionnaire Return envelope
Third Mailing	Reminder postcard	Reminder postcard

Confidentiality

All potential participants were promised confidentiality with regard to their participation and their responses. Pre-assigned code numbers were used to facilitate cost-effective follow-up mailings and for merging data files generated from scannable and non-scannable data. However, the files containing mailing information and code numbers were kept separate from the data files.

Response Rate and Representativeness of the Respondent Group

Questionnaires were sent to 10,000 of the 18,000 individuals selected for participation in the study. Of these 10,000, a total of 3,660 were returned. Following adjustment for bad addresses (12.7%), the effective sample size was 15,712, thus reflecting an overall response rate of 23.3 percent.

Because the response rate was low, a telephone survey was initiated to (1) determine the reason for non-participation among those in the first sample (n=10,000) and (2) evaluate the representativeness of respondent characteristics versus those of non-respondents from the first sample. The telephone numbers of one hundred individuals, selected at random from among those included in the original (first) sample were obtained via directory assistance. Telephone calls were made on weekends and evenings, in mid-January 1996, in an attempt to reach the greatest number of individuals. A structured interview was conducted, using a prepared script, with the first 50 individuals who agreed to speak with us. Only one person refused to be interviewed when the purpose of the call was explained. Of the 50 interviewees, the stated reason for not participating fell within two categories: (1) never got around to completing/returning the postcard indicating an interest in participating, or (2) did not remember receiving the letter asking them to participate in the study.

All 50 interviewees agreed to (1) answer questions requesting demographic information and (2) for 17 activities/ attributes representing the 16 groups of functional abilities, to identify if they were essential for the performance of their job. The 17 activity/attribute statements were selected by National Council staff on the basis of their perceived importance to the safe and effective practice of nursing. Comparisons of the demographic characteristics and responses to 17 statements for the telephone survey participants and the participants in the mail survey were performed using the Chi square statistic. There were no statistically significant differences between the two groups (the data used in these analyses are reported in Appendix A). Based on these results, it was concluded that there were no differences between the respondent and non-respondent groups.

DATA ANALYSIS

All returned questionnaires were electronically scanned and database files were created. During the scanning process, all rejected questionnaires were reviewed and, if a definitive response could be ascertained, the data were hand entered. In addition, all write-in responses to requests for specific information were compiled, coded and entered into a database. Prior to beginning data analysis procedures, frequency distributions were used to check for and eliminate any out-of-range values.

An examination of the frequency distributions for responses to three key questions revealed that high percentages of participants (over 5%) responded "Other" and then wrote in a response. The three questions were ones designed to identify a participant's level of involvement in the delivery of client care (9%), their principal nursing position (16%), and their work setting (18%). Therefore, the write-in responses were reviewed and either assigned to an existing response category or a new one was identified. Responses to two additional open-ended questions (i.e., those describing existing physical or mental disabilities and the types of compensatory accommodations used in the work setting) were reviewed and, based on a content analysis, categorized to facilitate reporting.

In keeping with the purpose of this study, that is, to identify the functional abilities essential for a nurse to possess in order to provide safe and effective care to clients, several data analysis decision rules were established. These rules and the rationale for their establishment were:

1. Data contributed by registered nurses (RNs) will be analyzed separately from that contributed by licensed practical/vocational nurses (LPN/VNs). *Rationale*: Separate scopes of practice may have an impact on the types of functional abilities essential to job performance.

2. Data analysis will be confined to only that contributed by individuals involved in the provision of direct client care (e.g., physical care, telephone triage, etc.) and indirect client care (e.g., administration, research, insurance case management, etc.). Data contributed by those reporting they assist with the direct delivery of care will not be used. *Rationale*: The activities/attributes of individuals "assisting with direct care" may be confounded by variations in roles and in the level of assistance required by the person being assisted.

3. Within level of care involvement (direct, indirect), job position and work setting variables will be used to determine which functional ability activities/attributes are essential. *Rationale*: Practice characteristics vary based on type of position (e.g., administrator vs. staff nurse) and work setting (e.g., critical care unit vs. outpatient clinic) and therefore the activities/attributes of functional abilities essential to job performance may vary.

4. Essential functional ability activities/attributes will be defined as those identified by 95% or more of the respondents in an analysis group. *Rationale*: Established based on the dictionary definition of essential which states: "basic or indispensable; necessary" (American Heritage Dictionary, second college edition, 1982; Boston: Houghton Mifflin Company) while still allowing for sampling error.

5. Analysis groups shall contain data from a minimum of 30 respondents. *Rationale*: The standard error of a sample proportion = .95 with sample size = 30 is .04. Therefore, a 95 percent confidence interval (one-tailed) for the lower boundary of the true population proportion includes the value, .88, one considered sufficiently stringent for this study.

A description of study participants and the outcomes of data analysis procedures are reported in the next section.

RESULTS

This section provides a general description of the demographic characteristics of study participants, their work environment, involvement in the provision of client care, and the functional ability activities/attributes essential for the performance of their jobs. A functional ability activity/attribute had to be identified by a minimum of 95

percent of the study participants within an analysis group in order to be designated as "essential" for the delivery of safe and effective client care.

Demographic Characteristics

A total of 3,660 individuals participated in the study. Of these, 2,677 (73.1%) were RNs and 969 (26.5%) were LPN/VNs. Fourteen (0.4%) individuals did not identify their licensure status.

Study participants were predominantly female (95.9%). The racial ethnic makeup of the group is reported in Table 3. Comparison of the demographic characteristics of study participants with those of RNs and LPN/VNs participating in a role delineation study (Yocom & Chornick, 1995) revealed similar characteristics thus supporting the representativeness of the current sample.

Table 3. Racial/ethnic characteristics of study participants.

	Total Group (n=3,660)*		RNs (n=2,677)		LPN/VNs (n=969)	
Racial/Ethnic Group	n	%	n	%	n	%
Native American	39	1.10	25	1.00	14	1.50
Asian Indian	6	0.20	5	0.20	1	0.10
Pacific Islander	4	0.10	4	0.20	0	0.00
Other Asian	39	1.10	35	1.30	4	0.40
Black/African-American	164	4.60	78	3.00	84	8.80
Hispanic	76	2.10	44	1.70	32	3.40
White, not Hispanic	3234	90.10	2424	92.00	806	84.80
Other	28	0.80	19	0.70	9	0.90
Missing	70		46		24	

* Includes 14 individuals not identifying license type

Work Environment

Study participants were requested to provide information describing their work environment in terms of: work setting, position title, shift, hours worked and involvement in the provision of client care.

Setting. The distribution of reported employment settings for the total group and for RNs and LPN/VNs is reported in Table 4. The greatest proportions of RNs reported employment in medical-surgical units (23.3%), intensive care units (13.7%) and skilled care facilities (13.0 %). In contrast, while a similar proportion of LPN/VNs also reported employment in medical-surgical units (28.3%), significant numbers were also employed in long term care settings (intermediate care - 23.2%; skilled care - 35.2%).

Position title. Participants were requested to identify the title of their principle nursing position. This information is provided in Table 5. The greatest percentages of RNs (50.7%) and LPN/VNs (63.2%) reported employment as staff nurses. In addition, employment as a charge nurse represented the second most frequently identified positions for both groups, 26.7% for RNs and 28.2% for LPN/VNs.

Table 4. Employment settings of study participants.

Employment Setting	Total (n=3660)**		RN (n=2677)		LPN/VN (n=969)	
	#	%	#	%	#	%
Acute Care						
Anesthesia	54	1.5	52	1.9	2	0.2
Emergency Room	283	7.7	235	8.8	48	5.0
Intensive Care	405	11.1	366	13.7	38	3.9
Labor & Delivery	205	5.6	169	6.3	35	3.6
Medical-Surgical	900	24.6	625	23.3	274	28.3
Nursery	208	5.7	155	5.8	52	5.4
Operating Room	234	6.4	197	7.4	36	3.7
Pediatrics	249	6.8	165	6.2	84	8.7
Psychiatric	222	6.1	159	5.9	62	6.4
Recovery Room	157	4.3	133	5.0	23	2.4
Hospital (non-specific)	105	2.9	65	2.4	40	4.1
Long Term Care Setting						
Intermediate	398	10.9	172	6.4	225	23.2
Residential	258	7.0	111	4.1	147	15.2
Skilled Care	691	18.9	347	13.0	341	35.2
Nursing Home (non-specific)	53	1.4	13	0.5	40	4.1
Community/Home Care Settings						
Business/Industrial Facility	157	4.3	116	4.3	41	4.2
Client's Home	465	12.7	325	12.1	140	14.4
Outpatient Clinic	309	8.4	242	9.0	67	6.9
Outpatient Surgery	137	3.7	110	4.1	27	2.8
Physician's Office	330	9.0	189	7.1	140	14.4
School	160	4.4	133	5.0	26	2.7
Other	203	0.1	171	6.4	35	3.6

* Includes 14 individuals not identifying license type

** All percentages sum to greater than 100% since participants could indicate any setting where they were employed at least one-third of the time.

Table 5. Title of principle nursing position.

	Total Group (n=3660)**		RNs (n=2677)		LPN/VNs (n=969)	
Position title	#	%*	#	%	#	%
Administrator	157	4.3	138	5.2	19	2.0
Advanced practice	236	6.4	227	1.0	9	0.9
Case manager	25	0.7	24	0.9	1	0.1
Charge nurse	991	27.1	716	26.7	273	28.2
Home health/community health	491	13.4	368	13.7	123	12.7
Instructor/educator	331	9.0	284	10.6	45	4.7
Researcher	57	1.6	49	1.8	8	0.8
School nurse	113	3.1	95	3.5	18	1.9
Staff nurse	1972	53.9	1356	50.7	612	63.2
Supervisor	402	11.0	328	12.3	74	7.6
Utilization review/quality assurance	196	5.4	164	6.1	32	3.3
No position title	69	1.9	25	0.9	42	4.3
Other	181	4.9	158	5.9	48	5

* Includes 14 individuals not identifying license type

** All percentages sum to greater than 100% since participants could indicate more than one response

Shift/Hours worked. The number of hours worked per day and the shift assignment reported by study participants are reported in Table 6. The majority of participants worked eight hours per day on the day shift.

Table 6. Work hours of study participants.

	Total Group (n=3660)		RNs (n=2677)		LPN/VNs (n=969)	
	#	%	#	%	#	%
Work Hours						
Number of hours per day:						
8 hour shift	2473	67.6	1729	64.6	739	76.3
10 hour shift	182	5.0	273	10.2	84	8.7
12 hour shift	667	18.2	629	23.5	203	20.9
24 hour on call	199	5.4	239	8.9	42	4.3
Shift						
Days	1279	34.9	1486	55.5	491	50.7
Evenings	519	14.2	471	17.6	294	30.3
Nights	577	15.8	413	15.4	227	23.4
Rotating	237	6.5	182	6.8	71	7.3
Other	549	15.0	423	15.8	123	12.7

* Sums to more than 100% because participants could select more than one response

Involvement in client care. Participants were requested to indicate which of three levels of involvement in client care they engaged in. Alternatively, response options were also provided for those not in clinical practice or, if none of the provided categories "fit," to write in a response. The range of participant responses is provided in Table 7.

Table 7. Level of participant involvement in client care.

Level of involvement	Total Group (n=3,660) * #	%	RNs (n=2,677) #	%	LPN/VNs (n=969) #	%
Perform direct care	2694	77.3	1925	75.1	769	84.1
Assist with direct care	161	4.6	137	5.3	24	2.6
Perform indirect care	396	11.4	358	14.0	38	4.2
Not in clinical practice	102	2.9	52	2.0	48	5.3
Other	130	3.7	91	3.6	35	3.8
(Missing)	(177)		(114)		(55)	

* Includes 14 individuals not identifying license type

Generalizability of Findings

Comparison of the demographic characteristics and the work environment of study participants with those of RNs and LPN/VNs who participated in a role delineation study (Yocom & Chornick, 1995) revealed similar characteristics thus supporting the representativeness of the data and therefore the generalizability of the findings.

Functional Abilities Essential for Safe and Effective Client Care

Participants were requested to review a list of 98 activities/attributes, grouped within sixteen functional abilities (see Table 1 and Appendix A), that may or may not be essential for a nurse to possess in order to provide safe and effective care to clients. For each activity/attribute, participants indicated if it was essential or not essential to job performance. The data analysis outcomes for the LPN/VN group are presented first, followed by those for the RN group. The following framework will be used to present the results.

I. LPN/VNs (Direct care only)
   - A. Position
     1. Activities/attributes common across all positions
     2. Activities/attributes unique to specific positions
   - B. Setting
     1. Activities/attributes common across all settings
     2. Activities/attributes unique to specific settings
   - C. Core - activities/attributes common across all roles and settings

II. RNs (Direct and indirect care)
   - A. Position
     1. Activities/attributes common across all direct care positions
     2. Activities/attributes unique to specific direct care positions
     3. Activities/attributes common across all indirect care positions
     4. Activities/attributes unique to specific direct care positions
     5. Core - activities/attributes common across all direct and indirect care positions

B. Setting
   1. .Activities/attributes common across all settings (direct care)
   2. Activities/attributes unique to specific settings (direct care)
   3. Activities/attributes common across all settings (indirect care)
   4. Activities/attributes unique to specific settings (indirect care)
   5. Core - activities/attributes common across all settings (direct and indirect care)

C. Core - activities/attributes common across all direct and indirect care positions and all settings

I. Functional Ability Activities / Attributes Essential for Practice as a Licensed Practical/Vocational Nurse

The Licensed Practical/Vocational Nurse participants were grouped based on their level of involvement in the delivery of nursing care (i.e., direct or indirect). Thereafter, the percent indicating that a specific functional ability activity/attribute was essential to job performance was calculated based on their position and work setting. For each group composed of 30 or more individuals, the activities/attributes identified as essential by 95 percent or more were identified. The outcomes of these analyses are reported below. As previously reported in Table 7, very few participants (i.e., 38) reported they were involved in the provision of indirect care. Therefore, since their further division by position or by work setting resulted in group sizes too small to meet the reporting criteria, information will be provided for only those LPN/VNs engaged in direct care activities.

A. Job Position (Direct Care). Five groups of LPN/VNs involved in the provision of direct client care, classified according to their position titles, collectively identified 36 common functional ability activities/attributes as essential to the performance of their jobs. The five positions were those of supervisor (n=49), charge nurse (n=219), staff nurse (n=541), office nurse (n=31) and home health/community health nurse (n=102). The essential activities/attributes, reported in Table 8, represent 13 of the 16 functional ability categories. The categories not represented are Gross Motor Skills, Smell, and Critical Thinking.

Table 8. Common functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care as a supervisor, charge nurse, staff nurse, office nurse and home health nurse.

Activity/Attribute	Functional Ability
Pick up objects with hands	Fine Motor Skills
Grasp small objects with hands	
Write with pen or pencil	
Pinch/pick or otherwise work with fingers	
Twist (with hands)	
Squeeze (with fingers)	
Maintain physical tolerance	Physical Endurance
Move light objects weighing up to 10 lbs.	Physical Strength
Bend	Mobility
Stoop/squat	
Move quickly	
Walk	
Hear normal speaking level sounds	Hearing
Hear faint body sounds	
See object up to 20 inches away	Visual
Distinguish color intensity	
Feel vibrations	Tactile
Read and understand printed documents	Reading

Table 8. Common functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care as a supervisor, charge nurse, staff nurse, office nurse and home health nurse. (cont.)

Read and understand columns of writing	Arithmetic Competence
Use measuring tools	
Provide client with emotional support	Emotional Stability
Adapt to changing environment/stress	
Deal with the unexpected	
Focus attention on task	
Monitor own emotions	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Prioritize tasks	
Use long term memory	
Use short term memory	
Respect differences in clients	Interpersonal Skills
Establish rapport with clients	
Establish rapport with co-workers	
Explain procedures	Communication Skills
Interact with others	
Speak on the telephone	

Additional essential functional ability activities/attributes unique to LPN/VNs functioning in any one or more of the five positions were identified. This information, reported in Table 9, reveals that the activities/attributes essential to LPN/VN performance in a supervisor or charge nurse position are very similar. In contrast, the activities/attributes identified by those in staff nurse, office nurse or home health/community health nurse positions are diverse. It is interesting to note that, with one exception, "Stand (e.g., at client side during surgical or therapeutic procedure)," an activity/attribute identified as essential by either office nurses or home health/community health nurses was also identified by staff nurses.

Table 9. Additional functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care as a supervisor, charge nurse, staff nurse, office nurse or home health nurse.

Activity/Attribute	Supervisor	Charge Nurse	Staff Nurse	Office Nurse	Home Health/ Community
Carry equipment/supplies (PS*)	■	■	■	■	
Twist (body) (Mo)	■	■	■		■
See objects up to 20 feet away (Vi)	■	■	■		■
Distinguish color (Vi)	■	■	■	■	
Detect temperature (Ta)	■	■	■		■
Feel differences in surface characteristics (Ta)	■	■	■		■
Detect odors from client (Sm)	■	■	■		■

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

Table 9. Additional functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care as a supervisor, charge nurse, staff nurse, office nurse or home health nurse. (cont.)

Activity/Attribute	Supervisor	Charge Nurse	Staff Nurse	Office Nurse	Home Health/ Community
Read measurement marks (AC)	■	■	■	■	
Write numbers in records (AC)	■	■	■	■	
Perform multiple responsibilities (ES)	■	■	■	■	
Evaluate outcomes (AT)	■	■	■		■
Problem solve (AT)	■	■	■		■
Synthesize knowledge and skills (CT)	■	■	■		■
Sequence information (CT)	■	■	■		■
Teach (Co)	■		■	■	■
Give oral reports (Co)	■	■	■	■	
Hear auditory alarms (Au)	■	■	■		
Use depth perception (Vi)	■	■	■		
Use peripheral vision (Vi)		■	■	■	
Feel differences in sizes, shapes (Ta)	■	■	■		
Detect smoke (Sm)	■	■	■		
Read digital displays (AC)	■	■	■		
Count rates (AC)	■	■	■		
Add, subtract, multiply, divide (AC)	■	■	■		
Handle strong emotions (ES)	■	■	■		
Convey information through writing (Co)	■	■	■		■
Squeeze with hands (PS)	■	■			
See objects more than 20 feet away (Vi)	■	■			
Detect gases or noxious smells (Sm)	■	■			
Establish therapeutic relationships (ES)	■	■			
Identify cause-effect relationships (CT)	■	■			
Stand and maintain balance (GMS)		■			
Reach below waist (GMS)		■			
Stand (during procedure) (PE)				■	
Hear faint voices (He)	■				
Read graphs (e.g., vital signs) (AC)		■			
Compute fractions (AC)	■				
Direct activities of others (Co)	■				

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

B. Employment Setting (Direct Care). The responses of LPN/VNs employed in fourteen settings were selected for analysis. Preliminary analysis of the data revealed that the fourteen settings could be collapsed into seven, each with a minimum group size of 30, due to a high degree of conformity in responses. These seven settings are:

Critical Care (includes data from individuals employed in Intensive Care Units and Emergency Rooms) (n=67)

Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units) (n=361)

Psychiatry (n=49)
Long Term Care (Residential Care, Intermediate Care, Skilled Care, and "Nursing Home") (n=600)
Home Health/Community Health Care (n=111)
Outpatient Clinics (n=61)
Physician's Office (n=117)

The essential activities/attributes commonly identified by 95 percent or more of LPN/VNs employed in these settings, represent 13 of the 16 functional ability categories (See Table 10). The categories not represented are those of Gross Motor Skills, Physical Strength, and Critical Thinking.

Table 10. Common functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care in critical care, acute care, long term care, psychiatry, home health, outpatient clinics, and physician's offices.

Activity/Attribute	Functional Ability
Pick up objects with hands	Fine Motor Skills
Grasp small objects with hands	
Write with pen or pencil	
Pinch/pick or otherwise work with fingers	
Maintain physical tolerance	Physical Endurance
Bend	Mobility
Move quickly	
Walk	
Hear normal speaking level sounds	Hearing
Hear faint body sounds	
See object up to 20 inches away	Visual
Feel vibrations	Tactile
Detect odors from client	Smell
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Tell time	
Use measuring tools	
Provide client with emotional support	Emotional Stability
Adapt to changing environment/stress	
Focus attention on task	
Monitor own emotions	
Process information	Analytical Thinking
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Respect differences in clients	Interpersonal Skills
Establish rapport with clients	
Explain procedures	Communication Skills
Interact with others	
Convey information through writing	

Additional essential functional ability activities/attributes unique to LPN/VNs functioning in any one or more of the seven work settings were identified. This information, reported in Table 11, reveals that the activities/attributes essential to LPN/VN performance in the Acute Care and Long Term Care settings are the most similar. In addition, the essential activities/attributes identified for these two settings are also common to those identified as essential in the Critical Care settings. Greater diversity is seen in the essential activities/attributes identified for Psychiatry, Home Health/Community Health, Outpatient Clinic and Physician's Office. However, what is remarkable is that with one exception, "Defend self against combative client" (Psychiatry), an activity/attribute essential for providing safe and effective care in one or more of these four units is also essential in a Critical Care unit.

Table 11. Additional functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care in critical care, acute care, long term care, psychiatry, home health, outpatient clinic, or physician's office.

Activity/Attribute	Critical Care[1]	Acute Care[2]	Long Term Care[3]	Psychia-try	Home Health/ Comm.	Outpatient Clinics	Physician's Office
Twist (with hands) (FMS*)	■	■	■	■		■	■
Move light objects weighing up to 10 lbs (PS)	■	■	■		■	■	■
Carry equipment/supplies (PS)	■	■	■	■		■	■
Stoop/squat (Mo)	■	■	■		■	■	■
Use peripheral vision (Vi)	■	■	■	■		■	■
Distinguish color intensity (Vi)	■	■	■		■	■	■
Detect temperature (Ta)	■	■	■		■	■	■
Read digital displays (AC)	■	■	■	■		■	■
Read measurement marks (AC)	■	■	■	■		■	■
Perform multiple responsibilities concurrently (ES)	■	■	■	■		■	■
Transfer knowledge from one situation to another AT)	■		■	■	■	■	■
Synthesize knowledge and skills CT)	■	■	■	■	■		■
Establish rapport with co-workers (IP)	■	■	■	■		■	■
Speak on the telephone (Co)	■	■	■	■		■	■
Reach below waist (GMS)	■	■	■	■		■	
Squeeze (with fingers) (FMS)	■	■	■			■	■
Twist (body) (Mo)	■		■		■	■	■
See objects up to 20 feet away (Vi)	■	■	■	■			■
Feel differences in surface characteristics (Ta)	■	■	■	■	■		

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical care: Intensive Care units and Emergency Rooms
[2] Acute care: Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units
[3] Long term care: Residential Care, Intermediate Care, Skilled Care, and "Nursing Home"

Table 11. Additional functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care in critical care, acute care, long term care, psychiatry, home health, outpatient clinic, or physician's office . (cont.)

Activity/Attribute	Critical Care[1]	Acute Care[2]	Long Term Care[3]	Psychia-try	Home Health/ Comm.	Outpatient Clinics	Physician's Office
Add, subtract, multiply, divide (AC)	■	■	■			■	■
Write numbers in records (AC)	■	■	■	■			■
Deal with the unexpected (ES)	■	■	■	■	■		
Evaluate outcomes (AT)	■	■	■	■	■		
Identify cause-effect relationships (CT)	■	■	■	■	■		
Teach (Co)	■	■		■		■	■
Give oral reports (Co)	■	■	■	■	■		
Hear auditory alarms (He)	■	■	■	■			
Feel differences in sizes, shapes (Ta)	■	■	■			■	
Detect smoke (Sm)	■	■	■		■		
Read graphs (e.g., vital signs (AC)	■	■	■		■		
Handle strong emotions (ES)	■	■	■	■			
Sequence information (CT)	■	■		■			■
Stand and maintain balance (GMS)	■	■					■
Push or pull 25 lbs (PS)	■	■	■				
Reach above shoulders (GMS)	■	■					
Stand (during procedure) (PE)	■						■
Lift 25 lbs. (PS)	■	■					
See objects more than 20 feet away (Vi)	■		■				
Compute fractions (AC)	■	■					
Move within confined spaces (GMS)	■						
Sustain repetitive movements (PE)	■						
Support 25 lbs. weight (PS)	■						
Defend self against combative client (PS)				■			

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical care: Intensive Care units and Emergency Rooms
[2] Acute care: Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units
[3] Long term care: Residential Care, Intermediate Care, Skilled Care, and "Nursing Home"

Table 11. Additional functional ability activities/attributes essential to the performance of LPN/VNs providing direct client care in critical care, acute care, long term care, psychiatry, home health, outpatient clinic, or physician's office. (cont.)

Activity/Attribute	Critical Care[1]	Acute Care[2]	Long Term Care[3]	Psychia-try	Home Health/ Comm.	Outpatient Clinics	Physician's Office
Read graphic printouts (AC)	■						
Calibrate equipment (AC)	■						
Convert numbers to and/or from the Metric system (AC)	■						
Negotiate interpersonal conflict (ES)	■						

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

C. Core Functional Ability Activities/Attributes Essential for LPN/VN Practice. Finally, the lists of functional ability activities/attributes identified as essential by 95 percent or more of LPN/VNs employed in five positions and across seven groups of employment settings were compared to identify a core set of essential functional ability activities/attributes. These commonly identified activities/attributes, reported in Table 12, represent 12 groups of functional abilities (all except Gross Motor Skills, Physical Strength, Smell, and Critical Thinking).

Table 12. Core functional ability activities/attributes essential for safe, effective LPN/VN practice.

Activity/Attribute	Functional Ability
Pick up objects with hands	Fine Motor Skills
Grasp small objects with hands	
Write with pen or pencil	
Pinch/pick or otherwise work with fingers	
Maintain physical tolerance	Physical Endurance
Bend	Mobility
Move quickly	
Walk	
Hear normal speaking level sounds	Hearing
Hear faint body sounds	
See object up to 20 inches away	Visual
Feel vibrations	Tactile
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Use measuring tools	
Provide client with emotional support	Emotional Stability
Adapt to changing environment/stress	
Focus attention on task	
Monitor own emotions	

Table 12. Core functional ability activities/attributes essential for safe, effective LPN/VN practice.

Activity/Attribute	Functional Ability
Process information	Analytical Thinking
Prioritize tasks	
Use long term memory	
Use short term memory	
Respect differences in clients	Interpersonal Skills
Establish rapport with clients	
Explain procedures	Communication Skills
Interact with others	

II. Functional Ability Activities / Attributes Essential for Practice as a Registered Nurse.

The Registered Nurse participants were grouped based on their level of involvement in the delivery of nursing care (i.e., direct or indirect). Thereafter the percent indicating that a specific functional ability activity/attribute was essential to job performance in their position and in their employment setting was calculated. For each group composed of 30 or more individuals, the activities/attributes identified as essential by 95 percent or more were identified. The outcomes of this analysis are reported below, first for those involved in the provision of direct client care and then for those providing indirect client care.

A. Job Position (Direct Care). Nine groups of RNs involved in the provision of direct client care, classified according to their position titles, identified 36 common functional ability activities/attributes as essential to the performance of their jobs. The nine positions were those of supervisor (n=178), charge nurse (n=635), nurse educator (n=107), advanced practice registered nurse (n=166), staff nurse (n=1275), school nurse (77), office nurse (n=39), home health/community health nurse (n=270) and utilization review/quality assurance (UR/QA) (n=55). These essential activities/attributes, reported in Table 13, represent 11 of the 16 functional ability categories. The categories not represented are those of Gross Motor Skills, Physical Endurance, Physical Strength, Tactile, and Smell.

Table 13. Common functional ability activities/attributes essential to the performance of RNs providing direct client care as a supervisor, charge nurse, nurse educator, advanced practice registered nurse, staff nurse, school nurse, office nurse, home health/community health nurse and in a utilization review/quality assurance position.

Activity/Attribute	Functional Ability
Pick up objects with hands	Fine Motor Skills
Grasp small objects with hands	
Write with pen or pencil	
Pinch/pick or otherwise work with fingers	
Twist (with hands)	
Walk	Mobility
Hear normal speaking level sounds	Hearing
See object up to 20 inches away	Visual
Distinguish color intensity	

Table 13. Common functional ability activities/attributes essential to the performance of RNs providing direct client care as a supervisor, charge nurse, nurse educator, advanced practice registered nurse, staff nurse, school nurse, office nurse, home health/community health nurse and in a utilization review/quality assurance position. (cont.)

Activity/Attribute	Functional Ability
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Tell time	
Use measuring tools	
Add, subtract, multiply, divide	
Write numbers in records	
Provide client with emotional support	Emotional Stability
Adapt to changing environment/stress	
Focus attention on task	
Monitor own emotions	
Perform multiple responsibilities	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Identify cause-effect relationships	Critical Thinking
Sequence information	
Respect differences in clients	Interpersonal Skills
Establish rapport with clients	
Establish rapport with co-workers	
Teach	Communication Skills
Explain procedures	
Interact with others	
Speak on the telephone	
Convey information through writing	

Additional essential functional ability activities/attributes unique to RNs functioning in any one or more of the nine positions were then identified. This information, reported in Table 14, reveals that the activities/attributes essential to RN performance as a charge nurse, staff nurse or in a UR/QA position are the most similar. The greatest diversity is seen in the essential activities/attributes identified by office nurses. The essential activities/attributes identified by supervisors, nurse educators, APRNs, school nurses and home health/community health nurses all contain common elements.

Table 14. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care as a supervisor, charge nurse, nurse educator, advanced practice registered nurse (APRN), staff nurse, school nurse, office nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position.

Activity/Attribute	Super-visor	Charge Nurse	Nurse Educa-tor	APRN	Staff Nurse	School Nurse	Office Nurse	Home Health/ Comm.	UR/QA
Maintain physical tolerance (PE*)	■	■	■	■	■	■	■		■
Feel vibrations (Ta)	■	■		■	■	■	■	■	■
Establish therapeutic relationships (ES)	■	■	■	■	■	■		■	■
Deal with the unexpected (ES)	■	■	■	■	■	■		■	■
Evaluate outcomes (AT)	■	■	■	■	■	■		■	■
Synthesize knowledge and skills (CT)	■	■	■	■	■	■		■	■
Give oral reports (CO)	■	■	■	■	■	■		■	■
Move light objects weighing up to 10 lbs (PS)	■	■	■		■	■		■	■
Hear faint body sounds (He)		■		■	■	■	■	■	■
Read measurement marks (AC)		■	■		■	■	■	■	■
Handle strong emotions (ES)	■	■	■	■	■		■		■
Carry equipment/supplies (PS)	■	■	■		■		■		■
Bend (Mo)	■	■			■	■		■	■
Move quickly (Mo)	■	■	■		■	■			■
Negotiate interpersonal conflict (IP)	■	■	■		■		■		■
Feel differences in sizes, shapes (Ta)	■	■			■			■	■
Direct activities of others (Co)	■	■				■	■		■
Stand and maintain balance (GMS)		■			■			■	■
Reach below waist (GMS)		■			■	■			■
Squeeze (with fingers) (FMS)		■			■	■	■		
Stoop/squat (Mo)		■			■		■		■
Hear auditory alarms (He)	■	■			■	■			■
See objects up to 20 feet away (Vi)	■	■			■	■			
Detect temperature (Ta)		■			■	■			■
Count rates (AC)		■			■		■		■
Influence people (Co)	■			■		■		■	
Feel differences in surface characteristics (Ta)		■				■			■
Detect odors from client (Sm)		■				■			■
Read digital displays (AC)		■			■		■		
Use depth perception (Vi)							■		■
Use peripheral vision (Vi)		■							■

Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

Table 14. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care as a supervisor, charge nurse, nurse educator, advanced practice registered nurse (APRN), staff nurse, school nurse, office nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position. (cont.)

Activity/Attribute	Super-visor	Charge Nurse	Nurse Educa-tor	APRN	Staff Nurse	School Nurse	Office Nurse	Home Health/ Comm.	UR/QA
Read graphs (e.g., vital signs) (AC)		■			■				
Compute fractions (AC)		■			■				
Use upper body strength (PS)		■							
Squeeze with hands (PS)		■							
Detect smoke (Sm)		■							

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

Job Position (Indirect Care). Five groups of RNs involved in the provision of **indirect** client care, classified according to their position titles, identified 23 common functional ability activities/attributes as essential to the performance of their jobs. The five positions were those of nursing service administrator (n=102), supervisor (n=129), charge nurse (n=30), home health/community health nurse (n=53) and utilization review/quality assurance (n=81). The essential activities/attributes identified by this group, reported in Table 15, represent nine of the 16 functional ability categories. The categories not represented are: Gross Motor Skills, Physical Endurance, Physical Strength, Mobility, Visual, Tactile, and Smell.

Table 15. Common functional ability activities/attributes essential to the performance of RNs providing indirect client care as a nursing service administrator, supervisor, charge nurse, home health/community health nurse and utilization review/quality assurance.

Activity/Attribute	Functional Ability
Write with pen or pencil	Fine Motor Skill
Hear normal speaking level sounds	Hearing
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Tell time	
Adapt to changing environment/stress	Emotional Stability
Focus attention on task	
Monitor own emotions	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	

Table 15. Common functional ability activities/attributes essential to the performance of RNs providing indirect client care as a nursing service administrator, supervisor, charge nurse, home health/community health nurse and utilization review/quality assurance. (cont.)

Activity/Attribute	Functional Ability
Identify cause-effect relationships	Critical Thinking
Synthesize knowledge and skills	
Sequence information	
Establish rapport with clients	Interpersonal Skills
Establish rapport with co-workers	
Interact with others	
Speak on the telephone	Communication Skills
Convey information through writing	

Additional essential functional ability activities/attributes unique to RNs providing indirect client care and functioning in any one or more of the five positions were identified. This information, reported in Table 16, reveals that the activities/attributes essential to RN performance in the role of nursing service administrators, supervisors and charge nurses are very similar in contrast to those identified by home health/community health nurses or those in utilization review/quality assurance positions.

Table 16. Additional functional ability activities/attributes essential to the performance of RNs providing indirect client care as a nursing service administrator, supervisor, charge nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position.

Activity/Attribute	Adminis-trator	Supervisor	Charge Nurse	Home Health/ Comm.	UR/QA
Walk (Mo*)	■	■	■	■	
See object up to 20 inches away (Vi)	■	■	■	■	
Perform multiple responsibilities (ES)	■	■	■	■	
Influence people (Co)	■	■	■		■
Pick up objects with hands (FMS)	■	■	■		
Grasp small objects with hands (FMS)	■	■	■		
Explain procedures (Co)	■	■	■		
Direct activities of others (Co)	■	■	■		
Maintain physical tolerance (PE)		■	■		
Provide client with emotional support (ES)		■	■		
Deal with the unexpected (ES)	■	■			
Plan/control activities for others (CT)	■	■			
Teach (Co)	■			■	
Give oral reports (Co)		■	■		

Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

Table 16. Additional functional ability activities/attributes essential to the performance of RNs providing indirect client care as a nursing service administrator, supervisor, charge nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position.(cont.)

Activity/Attribute	Administrator	Supervisor	Charge Nurse	Home Health/ Comm.	UR/QA
Hear auditory alarms (He)			■		
Distinguish color (Vi)			■		
Read digital displays (AC)		■			
Establish therapeutic relationships (ES)		■			

Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

Core Functional Ability Activities/Attributes Essential for RN Practice, by type of position. The lists of functional ability activities/attributes identified as essential by 95 percent or more of RNs working in any of the nine positions and involved in the provision of direct or indirect care were compared to identify a core set of activities/attributes. These 22 common activities/attributes, reported in Table 17, represent nine groups of functional abilities (all except Gross Motor Skills, Physical Endurance, Physical Strength, Mobility, Visual, Tactile, and Smell).

Table 17. Core functional ability activities/attributes essential to the performance of RNs providing direct or indirect client care as a nursing service administrator, supervisor, charge nurse, nurse educator, advanced practice registered nurse (APRN), staff nurse, school nurse, office nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position.

Activity/Attribute	Functional Ability
Write with pen or pencil	Fine Motor Skill
Hear normal speaking level sounds	Hearing
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Tell time	
Adapt to changing environment/stress	Emotional Stability
Focus attention on task	
Monitor own emotions	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Identify cause-effect relationships	Critical Thinking
Sequence information	
Establish rapport with clients	Interpersonal Skills
Establish rapport with co-workers	
Interact with others	

Table 17. Core functional ability activities/attributes essential to the performance of RNs providing direct or indirect client care as a nursing service administrator, supervisor, charge nurse, nurse educator, advanced practice registered nurse (APRN), staff nurse, school nurse, office nurse, home health/community health nurse or in a utilization review/quality assurance (UR/QA) position. (cont.)

Activity/Attribute	Functional Ability
Speak on the telephone	Communication Skills
Convey information through writing	

B. Employment Setting (Direct Care). The responses of RNs employed in nineteen settings were selected for analysis. Preliminary analysis of the data revealed that the nineteen settings could be collapsed into twelve, each with a minimum group size of 30, due to a high degree of conformity in responses. These twelve settings are:

Critical Care (includes data from individuals employed in Intensive Care Units, Post-Anesthesia Recovery, and Emergency Rooms) (n=577)
Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units) (n=811)
Anesthesia (n=39)
Surgery (Inpatient and Outpatient Operating Rooms) (n=262)
Psychiatry (n=119)
Long Term Care (Intermediate Care and Skilled Care) (n=317)
Residential Care (n=76)
Home Health Care (n=111)
Occupational Health (n=47)
Outpatient Clinics (n=61)
Physician's Offices (n=117)
School Health (n=87)

The essential activities/attributes commonly identified by 95 percent of RNs employed in these settings, reported in Table 18, represent 10 of the 16 functional ability categories. The categories not represented are those of Gross Motor Skills, Physical Endurance, Physical Strength, Mobility, Tactile, and Smell.

Table 18. Functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices and school health.

Activity/Attribute	Functional Ability
Pick up objects with hands	Fine Motor Skills
Grasp small objects with hands	
Write with pen or pencil	
Hear normal speaking level sounds	Hearing
See object up to 20 inches away	Visual
Read and understand printed documents	Reading
Read and understand columns of writing	Arithmetic Competence
Tell time	
Write numbers in records	
Provide client with emotional support	Emotional Stability

Table 18. Functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices and school health. (cont.)

Activity/Attribute	Functional Ability
Adapt to changing environment/stress	
Deal with the unexpected	
Focus attention on task	
Monitor own emotions	
Perform multiple responsibilities	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	Analytical Thinking (cont.)
Use short term memory	
Sequence information	
Synthesize knowledge and skills	Critical Thinking
Respect differences in clients	
Establish rapport with clients	Interpersonal Skills
Establish rapport with co-workers	
Explain procedures	Communication Skills
Give oral reports	
Interact with others	
Convey information through writing	

Additional essential functional ability activities/attributes unique to RNs employed in any one or more of the twelve work settingswere identified. Examination of this information, reported in Table 19, reveals several patterns in the activities/attributes essential to RN performance in various settings. Similar activities/attributes were identified by RNs in three different types of settings: (1) critical care, anesthesia and surgery; (2) acute care and long term care; and (3) residential care and home health/community health. Greater diversity is seen in the essential activities/attributes identified by RNs providing direct care in psychiatry, occupational health, outpatient clinics, physician's offices and school health.

(Text continues on page 29)

Table 19. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices or school health. settings.

Activity/Attribute	Critical Care[1]	Acute Care[2]	Anes-thesia	Surgery (OR)[3]	Psychi-atry	Long Term Care[4]	Residen-tial Care	Occupa-tional Health	Home Health/ Comm.	Outpatient Clinic	Physician's Office	School
Pinch/pick or otherwise work with fingers (FMS*)	■	■	■	■	■	■	■		■	■	■	■
Use measuring tools (AC)	■	■	■	■		■	■	■	■	■	■	■
Identify cause-effect relationships (CT)	■	■	■	■	■	■	■	■	■	■		■
Speak on the telephone (CO)	■	■		■	■	■	■	■	■	■	■	■
Twist (with hands) (FMS)	■	■	■	■		■	■		■	■	■	■
Maintain physical tolerance (PE)	■	■	■	■	■	■	■	■			■	■
Move quickly (Mo)	■	■	■	■	■	■	■	■			■	■
Walk (Mo)		■		■	■	■	■	■	■	■	■	■
Read measurement marks (AC)	■	■	■	■		■	■		■	■	■	■
Establish therapeutic relationships (ES)	■	■	■	■	■	■	■	■	■	■		
Teach (Co)	■	■			■	■	■	■	■	■	■	■
Feel vibrations (Ta)	■	■	■	■		■	■		■		■	■
Add, subtract, multiply, divide (AC)	■	■	■	■		■			■	■	■	■
Negotiate interpersonal conflict (IP)	■	■		■	■			■	■	■	■	■
Move light objects weighing up to 10 lbs (PS)	■	■	■	■		■	■		■			■

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical Care (Critical Care (Intensive Care units, Post-Anesthesia Recovery, and Emergency Rooms)

[2] Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units)

[3] Surgery (Inpatient and Outpatient Operating Rooms)

[4] Long Term Care (Intermediate Care and Skilled Care)

Table 19. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices or school health. settings. (cont.)

Activity/Attribute	Critical Care[1]	Acute Care[2]	Anes-thesia	Surgery (OR)[3]	Psychi-atry	Long Term Care[4]	Residen-tial Care	Occupa-tional Health	Home Health/ Comm.	Outpatient Clinic	Physician's Office	School
Bend (Mo)	■	■		■		■	■		■		■	■
Hear faint body sounds (He)	■	■	■			■	■		■		■	■
Distinguish color intensity (Vi)	■	■	■	■		■	■		■			■
Handle strong emotions (ES)	■	■		■	■	■	■	■	■			
Hear auditory alarms (He)	■	■	■	■	■	■	■					
Detect temperature (Ta)	■	■	■	■		■	■		■			
Feel differences in surface characteristics (Ta)	■	■	■			■	■		■			■
Feel differences in sizes, shapes (Ta)	■	■	■	■		■	■		■			
Count rates (AC)	■	■	■	■		■	■		■			
Direct activities of others (Co)	■					■		■	■	■	■	■
Stand and maintain balance (GMS)	■	■		■			■	■	■			
Squeeze (with fingers) (FMS)	■	■	■	■		■	■					
Carry equipment/supplies (PS)	■	■		■		■			■		■	
Stoop/squat (Mo)	■	■		■		■			■		■	
Influence people (Co)							■	■	■	■	■	■
Twist (body) (Mo)	■	■	■	■		■						
Read digital displays (AC)	■	■	■	■							■	
Detect smoke (Sm)		■	■		■	■						

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical Care (Critical Care (Intensive Care units, Post-Anesthesia Recovery, and Emergency Rooms)

[2] Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units)

[3] Surgery (Inpatient and Outpatient Operating Rooms)

[4] Long Term Care (Intermediate Care and Skilled Care)

Table 19. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices or school health. settings. (cont.)

Activity/Attribute	Critical Care[1]	Acute Care[2]	Anes-thesia	Surgery (OR)[3]	Psychi-atry	Long Term Care[4]	Residen-tial Care	Occupa-tional Health	Home Health/ Comm.	Outpatient Clinic	Physician's Office	School
Read graphs (e.g., vital signs) (AC)	■	■	■	■								
Use upper body strength (PS)	■			■		■						
Use peripheral vision (Vi)			■	■		■						
Compute fractions (AC)	■	■	■			■	■					
Reach above shoulders (Mo)	■	■	■	■								
Reach below waist (Mo)	■	■	■	■								
Stand (during procedure) (Mo)	■	■		■							■	
Squeeze with hands (PS)	■		■	■		■						
See objects up to 20 feet away (Vi)	■	■			■	■						
Use depth perception (Vi)	■		■	■					■			
Detect gases or noxious smells (Sm)		■	■	■								
Push or pull 25 lbs (PS)	■			■								
Read graphic printouts (AC)	■		■									
Lift 25 lbs. (PS)	■			■								
Hear in situations when not able to see lips (He)			■	■								
Measure time (AC)	■		■									

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical Care (Critical Care (Intensive Care units, Post-Anesthesia Recovery, and Emergency Rooms)

[2] Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units)

[3] Surgery (Inpatient and Outpatient Operating Rooms)

[4] Long Term Care (Intermediate Care and Skilled Care)

Table 19. Additional functional ability activities/attributes essential to the performance of RNs providing direct client care in critical care, acute care, anesthesia, operating rooms, psychiatry, long term care, residential care, home health, occupational health, outpatient clinics, physician's offices or school health. settings. (cont.)

Activity/Attribute	Critical Care[1]	Acute Care[2]	Anes-thesia	Surgery (OR)[3]	Psychi-atry	Long Term Care[4]	Residen-tial Care	Occupa-tional Health	Home Health/ Comm.	Outpatient Clinic	Physician's Office	School
Plan/control activities for others (CT)							■	■				
Move within confined spaces (GMS)				■								
Sustain repetitive movements (PE)	■											
Defend self against combative client (PS)					■							
Hear faint voices (He)			■									
Use a calculator (AC)								■				
Calibrate equipment (AC)			■									
Convert numbers to and/or from the Metric system (AC)			■									

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength; Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Critical Care (Critical Care (Intensive Care units, Post-Anesthesia Recovery, and Emergency Rooms)

[2] Acute Care (Medical-Surgical, Pediatric, Labor and Delivery, and Nursery units)

[3] Surgery (Inpatient and Outpatient Operating Rooms)

[4] Long Term Care (Intermediate Care and Skilled Care)

Employment Setting (Indirect Care). Four groups of RNs reporting involvement in the indirect provision of care to clients and classified according to their employment setting, collectively identified 24 common functional ability activities/attributes as essential to the performance of their jobs. The four employment settings were: acute care (n=118), skilled care (n=67), occupational health (n=41), and home health/community health (n=42). These essential activities/attributes, reported in Table 20, represent eight of the 16 functional ability categories. The categories not represented are those of Gross Motor Skill, Physical Endurance, Physical Strength, Mobility, Visual, Tactile, Smell, and Reading.

Table 20. Functional abilities/attributes essential to the performance of RNs providing indirect care in acute care, skilled care, occupational health, and home health/community health care settings.

Activity/Attribute	Functional Ability
Write with pen or pencil	Fine Motor Skill
Hear normal speaking level sounds	Hearing
Read and understand columns of writing	Arithmetic Competence
Tell time	
Monitor own emotions	Emotional Stability
Perform multiple responsibilities	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Identify cause-effect relationships	Critical Thinking
Synthesize knowledge and skills	
Sequence information	
Negotiate interpersonal conflict	Interpersonal Skills
Respect differences in clients	
Establish rapport with clients	
Establish rapport with co-workers	
Explain procedures	Communication Skills
Interact with others	
Speak on the telephone	
Convey information through writing	

Additional essential functional ability activities/attributes unique to RNs providing indirect client care while employed in any one or more of the four work settings were identified. This information, reported in Table 21 reveals that the activities/attributes essential to practice in acute care, long term care and home health/community health care settings are very similar to each other. This is in contrast to the additional activities/attributes identified by those employed in an occupational health care setting.

Table 21. Additional functional ability activities/attributes essential to the performance of RNs providing indirect client care in acute care, skilled care, occupational health and home health/community health care settings.

Ability statement RN setting (indirect)	Acute Care[1]	Skilled Care	Occupational Health	Home Health/ Community
Pick up objects with hands (FMS*)	■	■		■
Grasp small objects with hands (FMS)	■	■		■
Walk (Mo)	■	■		■
See object up to 20 inches away (Vi)	■	■		■
Read and understand printed documents (Re)	■		■	■
Write numbers in records (AC)	■	■		■
Adapt to changing environment/stress (ES)	■	■		■
Deal with the unexpected (ES)	■	■		■
Focus attention on task (ES)	■	■		■
Give oral reports (Co)	■	■		■
Negotiate interpersonal conflict (IP)	■	■		■
Influence people (Co)	■	■		■
Direct activities of others (Co)	■	■		■
Maintain physical tolerance (PE)	■	■		
Read graphs (AC)	■	■		
Establish therapeutic relationships (ES)		■		■
Provide client with emotional support (ES)		■		■
Handle strong emotions (ES)	■			■
Plan/control activities for others (CT)	■			■
Teach (Co)	■			■
Hear auditory alarms (He)		■		
See objects up to 20 feet away (Vi)		■		
Use measuring tools (AC)				■
Read measurement marks (AC)				■
Add, subtract, multiply, divide (AC)				■

*Key: GMS = Gross Motor Skills; FMS = Fine Motor Skills; PE = Physical Endurance; PS = Physical Strength, Mo = Mobility; He = Hearing; Vi = Visual; Ta = Tactile; Sm = Smell; Re = Reading; AC = Arithmetic Competence; ES = Emotional Stability; AT = Analytic Thinking; CT = Critical Thinking; IP = Interpersonal Skills; CO = Communication Skills.

[1] Acute Care (Medical-Surgical, Pediatrics, Labor and Delivery, and Nursery units)

Core Functional Ability Activities/Attributes Essential for RN Practice, by Type of Employment Setting. The lists of functional ability activities/attributes identified as essential by 95 percent or more of RNs working in any of the twelve employment settings and involved in the provision of direct or indirect care were compared to identify a core set of activities/attributes. These 21 commonly identified activities/attributes, reported in Table 22, represent eight categories of functional abilities. Those not represented are: Gross Motor Skills, Physical Endurance, Physical Strength, Mobility, Visual, Tactile, Smell, and Reading.

Table 22. Core functional ability activities/attributes essential to the performance of RNs providing direct or indirect care across multiple work settings and job positions.

Activity/Attribute	Functional Ability
Write with pen or pencil	Fine Motor Skill
Hear normal speaking level sounds	Hearing
Read and understand columns of writing	Arithmetic Competence
Tell time	
Monitor own emotions	Emotional Stability
Perform multiple responsibilities	
Transfer knowledge from one situation to another	Analytical Thinking
Process information	
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Synthesize knowledge and skills	Critical Thinking
Sequence information	
Respect differences in clients	Interpersonal Skills
Establish rapport with clients	
Establish rapport with co-workers	
Interact with others	Communication Skills
Explain procedures	
Convey information through writing	

C. Core Functional Ability Activities/Attributes Essential for RN Practice. Finally, the lists of functional ability activities/attributes identified as essential by 95% or more of RNs working in any employment setting, employed in any position, and involved in the provision of either direct or indirect client care were compared to identify a core set of essential activities/attributes. These 17 commonly identified activities/attributes, reported in Table 23, represent eight categories of functional abilities. Those not represented are: Gross Motor Skills, Physical Endurance, Physical Strength, Mobility, Visual, Tactile, Smell, and Reading).

Table 23. Core functional ability activities/attributes essential to the performance of RNs providing direct or indirect care in multiple work settings and job positions.

Activity/Attribute	Functional Ability
Write with pen or pencil	Fine Motor Skill
Hear normal speaking level sounds	Hearing
Read and understand columns of writing	Arithmetic Competence
Tell time	
Monitor own emotions	Emotional Stability
Transfer knowledge from one situation to another	Analytical Thinking
Process information	

Table 23. Core functional ability activities/attributes essential to the performance of RNs providing direct or indirect care in multiple work settings and job positions. (cont.)

Activity/Attribute	Functional Ability
Evaluate outcomes	
Problem solve	
Prioritize tasks	
Use long term memory	
Use short term memory	
Sequence information	Critical Thinking
Establish rapport with clients	Interpersonal
Establish rapport with co-workers	
Interact with others	Communication
Convey information through writing	

Participant's Disabilities

Seven percent (n=256) of all respondents reported the presence of a current physical and/or mental disability. Documentation regarding the type of disability was provided by 251 participants. This information and how they accommodated for the disability were reviewed and classified to facilitate analysis. The results of this classification are summarized in Table 24. The majority (55%, n=129) of the reported disabilities involved neuro-musculo-skeletal disorders. Of these, 55 were back-related problems. The predominate accommodations identified by participants were work load and/or work schedule adjustments, the provision of assistance by other staff, or effecting a change in employment status or location (e.g., retired, disability leave, change in position). The primary accommodation for those with a hearing impairment was the use of hearing aides or other amplification devices. The primary accommodation for those with a visual impairment was the use of corrective lenses to correct for nearsightedness.

Table 24. Types of disabilities and accommodations used reported by study participants (n=251).

Classification	Number	Percent	Accommodations
Cancer	2	1%	Work load and work hours adjusted
Cardiovascular disorder	10	4%	Work load and work hours adjusted; retired; change job position
Circulatory problem (lymphedema)	1	0%	Change job position
Cognitive disorders (attention deficit; dyslexia; closed head injury)	10	4%	Organization of tasks; dependence on other staff to assist as necessary
Diabetes	10	4%	Consistent meal times; same shift at all times
Fatigue	4	2%	Adjust work schedule (i.e., number of days)
Urinary disorder	1	0%	Limit fluid intake
Hearing disorder	18	7%	Hearing aides; Doppler for taking BPs; amplification (telephone & stethoscope)
Immune disorder (Lupus, etc.)	5	2%	Reduce work hours and/or stress; resign

Table 24. Types of disabilities and accommodations used reported by study participants (n=251).

Classification	Number	Percent	Accommodations
Neurological disorder (seizure disorder; Menierre's; Tourette's; multiple sclerosis)	9	4%	Medication; reduced work hours
Neuro-muscular-skeletal disorder	(129)	(51%)	
Back	55	22%	Assistance with lifting; frequent change of position; change job position (no patient care or lifting)
Hands	8	3%	Assistance from staff; rest periods
Lower extremity	25	10%	Elevators; assistance from other staff
Neck	4	2%	Limit physical activity
Upper extremity	3	1%	Assistance from other staff
Undifferentiated/other	32	13%	Rest periods, assistance from other staff; change job position
Obesity	1	0%	None
Olfactory disorder	1	0%	None
Psychiatric disorder (Depression, Bi-Polar personality, etc.)	10	4%	None (take medication)
Respiratory disorder (Asthma)	6	2%	Avoid strong odors; change job position
Visual disorder (blind one eye, color blind; nearsightedness; chronic uveitis	28	11%	Corrective lenses; read color coded materials carefully; restrict driving hours.
Unclassified	6	2%	

DISCUSSION

To practice nursing, a licensee must possess a multitude of knowledge, skills and abilities (KSAs) in order to provide safe and effective client care. These KSAs can be dichotomized into two groups: domain specific (i.e., specific to the practice of nursing) and non-domain specific. Historically, boards of nursing have relied on two major sources of information to evaluate the competence of licensure applicants regarding the domain specific KSAs: (1) documentation from nursing education programs that graduates have demonstrated satisfactory levels of competence and (2) performance on standardized objective tests (i.e., NCLEX™). Based on their successful completion of a basic nursing education program, it has also been assumed that graduates also demonstrate competence regarding the non-domain specific KSAs.

The initial and/or continued competence of persons with disabilities to practice nursing has been debated for many years. In fact several boards of nursing have a mechanism whereby a limited license may be issued to individuals whose ability to practice is impacted by the presence of a disability. A board's mandate to protect the public and the issue of competence was heightened with passage of the Americans with Disabilities Act (ADA). Subsequently, questions were raised regarding (1) the types of functional ability activities/attributes (non-domain specific) a nurse must possess in order to practice safely and effectively and (2) the types of compensatory accommodations used by nurses with disabilities.

The primary purpose of this study was to obtain validation of the essential non-domain specific functional abilities that a nurse must possess in order to perform nursing activities in a safe and effective manner. Data were provided, in response to a mailed questionnaire, by 3,660 RNs and LPN/VNs representative of all geographic regions of the United States. Based on previous National Council research, the demographic characteristics of this study's participants and their work environment characteristics indicate they are representative of the nursing population.

Study participants identified which of 98 descriptive activities/attributes, grouped within sixteen functional abilities, were essential for the performance of nursing activities. Factors considered during data analysis were level of licensure (RN, LPN/VN), level of involvement in client care (direct, indirect), position title and employment setting. In addition, two constraints (minimum analysis group size (n=30); percent of respondents indicating an activity/attribute was essential (≥95%)) were placed on the data during the analysis phase.

Limitations. A limitation of this study is that the activities/attributes identified were self-reported and are subject to the bias of the individual's perception of what functions are essential to a particular nursing role. Additionally, the study does not address whether reported disabilities were evident at the time of initial licensure or occurred later in the nurse's career.

Core essential activities/attributes vary by level of licensure. The outcomes of data analysis indicate that selected activities/attributes of all sixteen functional ability groups are essential for the delivery of safe and effective client care. In addition, there are "core" activities/attributes that transcend the employment setting and/or job position of a nurse in a specific licensure category. As reported in Table 12, a "core" group of 27 essential activities/attributes were identified for LPN/VNs providing direct client care. These were distributed across the following functional ability groups: *Fine Motor Skills, Physical Endurance, Mobility, Hearing, Visual, Tactile, Reading, Arithmetic Competence, Emotional Stability, Analytical Thinking, Interpersonal Skills* and *Communication Skills.* These essential activities/attributes are almost evenly divided between those representing psychomotor skills/abilities and the senses and those representing psychosocial skills and higher cognitive functioning.

In contrast, for RNs providing direct or indirect client care (see Table 23) a "core" group of 17 essential activities/attributes were identified. These represent the following eight functional ability groups: *Fine Motor Skill, Hearing, Arithmetic Competence, Emotional Stability, Analytical Thinking, Critical Thinking, Interpersonal Skills,* and *Communication Skills.* All but two of the activities/attributes represent psychosocial skills and higher cognitive functioning abilities. This pattern is also evident in the data provided by RNs providing direct client care when they are examined according to position title (Table 13) or by employment setting (Table 17). Therefore, the "core" activities/attributes of functional abilities vary according to a licensee's scope of practice.

Additional essential activities/attributes vary by level of involvement in client care, job position, and work setting. The level of involvement in care provision (direct, indirect), job position, and employment setting have an impact on the types of additional functional ability activities/attributes that are essential for the delivery of safe and effective client care. This is clearly demonstrated in Tables 9, 11, 14, 16, 19, and 21. Examination of the information reported in these tables reveals the emergence of a series of common elements. First, a majority of the activities/attributes represent psychomotor skills/abilities, the senses, and arithmetic competence. Second, there is generally a large proportion of essential activities/attributes that are common to a majority, but not all, of either the job position groups or the employment setting groups. Lastly, there is a small proportion of essential activities/attributes that are unique to a specific job position or employment setting.

Disabilities. The types of self-defined disabilities reported by a subset of 256 study participants provides insight into the range of disabilities manifested and compensatory accommodations used to compensate for the disability. Depending upon its severity and impact on the ability to function, the reported disability may or may not be covered under the ADA and therefore, may or may not trigger a legal requirement for an accommodation.

The greatest proportion of reported disabilities involved neuro-musculo-skeletal system problems and within this group, the majority are back-related problems. The incidence of back-related injuries as an occupational hazard is well documented in the literature, most recently in the Institute of Medicine's study, *Nursing staff in hospitals and nursing homes. Is it adequate?* (Wunderlich, Sloan, & Davis, 1996). The predominate accommodations identified by participants identifying the presence of a disability were work load and/or work schedule adjustments, the provision of assistance by other staff, or effecting a change in employment status or location. The primary accommodation for those with a hearing impairment was the use of hearing aides or other amplification devices. The primary accommodation for those with a visual impairment was the use of corrective lenses to correct for nearsightedness.

Implications. This study identifies the "core" functional ability activities/attributes essential for an individual to perform nursing activities in a safe and effective manner. Boards of nursing may use this information when considering the eligibility of an individual for initial or continuing licensure. However, the presence of a disability that impacts an individual's ability to demonstrate competence in these areas should not be considered in isolation from the accommodations that can be used to compensate for a noted "deficiency." Secondly, this information may be found useful by individuals considering nursing as a career and by nurse educators evaluating both applicants for admission and students enrolled in their programs.

Additionally, identification of both "core" and "non-core" essential functional ability activities/attributes, as delineated by job position and by employment setting, provides guidance to boards of nursing in their consideration to restrict a nurse's authority to practice nursing by limiting scope, setting, or type of nursing role and activities. In both instances, the nature of the specific disability, and the degree of compensation, if any, from the use of special accommodations must be considered. The position-specific and employment setting-specific lists of activities/attributes can be a valuable resource during career counseling opportunities - both with prospective licensees and with licensees who acquired a disability following initial licensure. A further implication for boards of nursing imposing limitations, involves policy determination - whether or not such limitations should be imposed by disciplinary or non-disciplinary methods.

Within each jurisdiction, the board of nursing has a legislative mandate to protect the public from incompetent providers of nursing care. When evaluating the competence of licensure applicants and licensees, the board cannot neglect or dismiss this mandate. However, it is hoped that the judicious use of the information reported in this report will assist them in their evaluation of nurses with disabilities, many of whom could function safely and effectively in selected employment settings/environments and/or in selected positions.

REFERENCES

Chornick, N. (1993a). Report to the Nursing Practice and Education Committee: Meeting of the advisory panel on essential competencies. Chicago: National Council of State Boards of Nursing.

Chornick, N. (1993b). *Non-nursing essential competencies of nursing practice*. Chicago: National Council of State Boards of Nursing.

Southern Council on Collegiate Education for Nursing (1993, March). *Red alert: The Americans with Disabilities Act - Implications for nursing education*. Atlanta: SCCEN.

Wunderlich, G., Sloan, F, & Davis, C. (Eds.) (1996). *Nursing staff in hospitals and nursing homes. Is it adequate?* Washington, DC: National Academy Press.

Yocom, C. (1993). *Readability levels of clinical nursing documents*. Chicago: National Council of State Boards of Nursing.

Yocom, C. & Chornick, N. (1995). *Role delineation study: Nursing activities performed by nurse aides, licensed practical/vocational nurses, registered nurses and advanced practice registered nurses*. Chicago: National Council of State Boards of Nursing.

Appendix A

Functional Ability Categories and representative activities/attributes

Gross Motor Skills
- Move within confined spaces
- Sit and maintain balance
- Stand and maintain balance
- Reach above shoulders (e.g., IV poles)
- Reach below waist (e.g., plug electrical appliance into wall outlets)

Fine Motor Skills
- Pick up objects with hands
- Grasp small objects with hands (e.g., IV tubing, pencil)
- Write with pen or pencil
- Key/type (e.g., use a computer)
- Pinch/pick or otherwise work with fingers (e.g., manipulate a syringe)
- Twist (e.g., turn objects/knobs using hands)
- Squeeze with finger (e.g., eye dropper)

Physical Endurance
- Stand (e.g., at client side during surgical or therapeutic procedure)
- Sustain repetitive movements (e.g., CPR)
- Maintain physical tolerance (e.g., work entire shift)

Physical Strength
- Push and pull 25 pounds (e.g., position clients)
- Support 25 pounds of weight (e.g., ambulate client)
- Lift 25 pounds (e.g., pick up a child, transfer client)
- Move light objects weighing up to 10 pounds (e.g., IV poles)
- Move heavy objects weighing from 11 to 50 pounds
- Defend self against combative client
- Carry equipment/supplies
- Use upper body strength (e.g., perform CPR, physically restrain a client)
- Squeeze with hands (e.g., operate fire extinguisher)

Mobility
- Twist
- Bend
- Stoop/squat
- Move quickly (e.g., response to an emergency)
- Climb (e.g., ladders/stools/stairs)
- Walk

Hearing
- Hear normal speaking level sounds (e.g., person-to-person report)
- Hear faint voices
- Hear faint body sounds (e.g., blood pressure sounds, assess placement of tubes)
- Hear in situations when not able to see lips (e.g., when masks are used)
- Hear auditory alarms (e.g., monitors, fire alarms, call bells)

Visual
- See objects up to 20 inches away (e.g., information on a computer screen, skin conditions)
- See objects up to 20 feet away (e.g., client in a room)
- See objects more than 20 feet away (e.g., client at end of hall)
- Use depth perception
- Use peripheral vision
- Distinguish color (e.g., color codes on supplies, charts, bed)
- Distinguish color intensity (e.g., flushed skin, skin paleness)

Appendix A

Functional Ability Categories and representative activities/attributes (cont.)

Tactile
- Feel vibrations (e.g., palpate pulses)
- Detect temperature (e.g., skin, solutions
- Feel differences in surface characteristics (e.g., skin turgor, rashes)
- Feel differences in sizes, shapes (e.g., palpate vein, identify body landmarks)
- Detect environmental temperature (e.g., check for drafts)

Smell
- Detect odors from client (e.g., foul smelling drainage, alcohol breath, etc.)
- Detect smoke
- Detect gases or noxious smells

Reading
- Read and understand written documents (e.g., policies, protocols)

Arithmetic Competence
- Read and understand columns of writing (flow sheet, charts)
- Read digital displays
- Read graphic printouts (e.g., EKG)
- Calibrate equipment
- Convert numbers to and/or from the Metric System
- Read graphs (e.g., vital sign sheets)
- Tell time
- Measure time (e.g., count duration of contractions, etc.)
- Count rates (e.g., drips/minute, pulse)
- Use measuring tools (e.g., thermometer)
- Read measurement marks (e.g., measurement tapes, scales, etc.)
- Add, subtract, multiply, and/or divide whole numbers
- Compute fractions (e.g., medication dosages)
- Use a calculator
- Write numbers in records

Emotional Stability
- Establish therapeutic boundaries
- Provide client with emotional support
- Adapt to changing environment/stress
- Deal with the unexpected (e.g., client going bad, crisis)
- Focus attention on task
- Monitor own emotions
- Perform multiple responsibilities concurrently
- Handle strong emotions (e.g., grief)

Analytical Thinking
- Transfer knowledge from one situation to another
- Process information
- Evaluate outcomes
- Problem solve
- Prioritize tasks
- Use long term memory
- Use short term memory

Critical Thinking
- Identify cause-effect relationships
- Plan/control activities for others
- Synthesize knowledge and skills
- Sequence information

Appendix A

Functional Ability Categories and representative activities/attributes (cont.)

Interpersonal Skills
- Negotiate interpersonal conflict
- Respect differences in clients
- Establish rapport with clients
- Establish rapport with co-workers

Communication Skills
- Teach (e.g., client/family about health care)
- Explain procedures
- Give oral reports (e.g., report on client's condition to others)
- Interact with others (e.g., health care workers)
- Speak on the telephone
- Influence people
- Direct activities of others
- Convey information through writing (e.g., progress notes)

Appendix B

Comparison of Demographic Characteristics and Responses to Selected Functional Ability Activities/Attributes: vs. Mail Survey Respondents vs. Telephone Survey Participants (Non-respondents)

Characteristic	Mail Survey	Telephone Survey	X^2	Characteristic	Mail Survey	Telephone Survey	X^2
	%	%			%	%	
Gender:				Feel differences in surface			
Female	96	98	ns*	characteristics (yes)	90	93	ns
Male	4	2		(no)	10	7	
License type:				Detect odors from			
RN	73.1	65	ns	client(yes)	91	83	ns
LPN/VN	26.9	35		(no)	9	17	
Race/Ethnicity:				Read and understand printed			
White	90	91	ns	documents (yes)	99	100	ns
Minority	10	9		(no)	1	0	
Activities/Attributes:				Add, subtract, multiply, divide (yes)	96	100	ns
Stand and maintain balance (yes)	93	90	ns	(no)	4	0	
(no)	7	10					
				Deal with the unexpected (yes)	98	100	ns
Pinch/pick up with fingers (yes)	96	93	ns	(no)	2	0	
(no)	4	7					
				Prioritize tasks (yes)	99	100	ns
Maintain physical tolerance (yes)	97	97	ns	(no)	1	0	
(no)	3	3					
				Identify cause-effect relationships (yes)	96	100	ns
Support 25 lb. Weight (yes)	81	86	ns	(no)	4	0	
(no)	19	14					
				Establish rapport with clients (yes)	99	100	ns
Stoop/squat (yes)	93	86	ns	(no)	1	0	
(no)	7	14					
				Give oral reports (yes)	97	97	ns
Hear faint body sounds (yes)	92	90	ns	(no)	3	3	
(no)	8	10					
Distinguish color (yes)	94	90	ns				
(no)	6	10					

* X^2 non significant at .05

Report of the Board of Directors

Board Members

Marcia M. Rachel, MS, Area III, *President*
Tom Neumann, WI, Area II, *Vice-President*
Charlene Kelly, NE, Area II, *Treasurer*
Joey Ridenour, AZ, *Area I Director*
Linda Seppanen, MN, *Area II Director*
Nancy Durrett, VA, *Area III Director*
Marie Hilliard, CT, *Area IV Director*
Roselyn Holloway, TX-RN, Area III, *Director-at-Large*
Janet Wood-Yañez, TX-VN, Area III, *Director-at-Large*

Staff

Jennifer Bosma, *Executive Director*
Doris Nay, *Associate Executive Director*

Tactics

Under the National Council's Organization Plan, the Board of Directors is responsible for tactics relating to governance, including:

- Identify needs for, create and provide guidance to task forces and other committees to address specific topics important to the National Council's mission.
- Assess organizational coordination and effectiveness.

The recommendations and activities which follow stem from the Board's fulfillment of those responsibilities during the past year.

Recommendations

The Board forwards to the Delegate Assembly for its consideration the following recommendations brought by task forces with the support of the Board:

Long Range Planning Task Force: *Mission Statement*

1. **That the recommended revised mission statement of the National Council, as presented, be forwarded to the 1996 Delegate Assembly for adoption.**

   The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

   (See task force report under Tab S.)

Advanced Practice Registered Nurse (APRN) Coordinating Task Force: *FNP Guidelines & Criteria*

2. **That the Delegate Assembly authorize the Board of Directors to give final approval of the Family Nurse Practitioner Curriculum Guidelines and Regulatory Criteria for Evaluating Family Nurse Practitioners (FNPs) Applying for Prescriptive Authority and, with prior opportunity for review and comment by Member Boards, indicate organizational support as a model for use by Member Boards.**

   (See task force report under Tab 10-A.)

Future Recommendations

Nursing Regulation Task Force: Response to Pew Commission Task Force

The Nursing Regulation Task Force is preparing a draft National Council response to the Pew Health

Professions Commission's Regulation Task Force for the Board's review at its June 26-28 meeting. If approved by the Board and adopted by the Delegate Assembly, the response will be communicated in the appropriate format to Pew prior to the December 1996 deadline, and will be disseminated for information to organizations with mutual interests in nursing and regulation.

Nursing Regulation Task Force: Regulatory Models

It is anticipated that materials for discussion of a revised nursing regulation model(s) will be developed during and following the Nursing Regulation Models Conference on June 9-10. The Nursing Regulation Task Force and Board of Directors will make specific recommendations, as warranted, to the Delegate Assembly in the supplemental report to the *Book of Reports* issued in July.

APRN Coordinating Task Force: Nurse Practitioner Certification Examination Programs

The Board of Directors disseminated to all Member Boards in April a chronology of events, including all relevant correspondence, detailing the collaboration activities it undertook over the past year in response to the 1995 Delegate Assembly motion:

> *The National Council will collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations which are sufficient for regulatory purposes. Benchmarks for progress shall be established and evaluated by the Board of Directors. The Board of Directors shall report to the 1996 Delegate Assembly with specific recommendations regarding future actions including the potential creation of a core-competency examination. If, at any time, the Board of Directors determines that significant progress is not being made, the Board is authorized to conduct a job analysis of entry-level nurse practitioners.*

A job analysis was initiated in April, 1996, due to lack of significant progress in the collaboration with the nurse practitioner certifying organizations. The results of the first phase of the job analysis will be reported to the APRN Coordinating Committee and Board shortly before the Annual Meeting. Specific recommendations will be made to the Delegate Assembly, as warranted, following that report. Time will be provided for discussion during the Forum.

Major Accomplishments of the Board of Directors in FY96

Goal I. Licensure and Credentialing

- Monitored the second year of computerized adaptive testing for NCLEX™; directed a comprehensive evaluation of the services of the Chauncey Group International in preparation for the Delegate Assembly's consideration of the next test service contract in 1997. Compilation of the responses is attached (Attachment A). Additionally, CGI submitted a detailed self-evaluation (Attachment B).
- Re-evaluated the passing standard for the NCLEX-PN™, considering the recommendation of the panel of judges and other relevant data, and raised the standard from -0.56 to -0.51 (approximately equal in magnitude to prior changes in the standard).
- Provided input and direction to the CST® Task Force and Examination Committee regarding future policy development related to the potential use of CST in NCLEX-RN™.
- Directed negotiations with The Psychological Corporation and Assessment Systems International regarding provision of a competency evaluation for nurse aides (per OBRA 1987), resulting in a new ten-year agreement for a combined program with ASI.
- Extensively discussed with four nurse practitioner certification organizations regarding a document review and site visit process which would produce information for Member Boards regarding the sufficiency of these examinations when used for regulatory purposes. Upon failure of the discussions to progress toward any actual review, initiated a job analysis of entry-level nurse practitioners.
- Concurred with the APRN Coordinating Task Force that a job analysis of Clinical Nurse Specialists (CNS) be deferred until a later time; and that Member Boards be encouraged to actively promote the use of similar criteria for the recognition of CNSs and Nurse Practitioners.
- Approved for dissemination the final *Delegation: Concepts and Decision-Making Process* developed by the Unlicensed Assistive Personnel Task Force.

- Provided feedback to continued competence subcommittee regarding development of competence definition, standards, and policy statement, and supported the position paper proposed by the subcommittee for Delegate Assembly adoption.
- Created special committees to deal with NCLEX evaluation, "assessment" terminology with respect to NCLEX-PN, Nurse Aide Competency Evaluation Program (NACEP), APRN issues, unlicensed assistive personnel issues, CST research and development, licensure verification, and licensure examinations comparison (subsequently deferred due to issue related to the Canadian Nurses Association Testing Service).

Goal II. Nursing Practice

- Endorsed the NP&E/Complex Discipline Subcommittee's suggestion for a day of dialogue on disciplinary topics at the Annual Meeting, and the development of a notebook of resources; supported the subcommittee's recommendations to the Board (see subcommittee report under Tab 9).
- Approved the offering of the Nurse Investigators Program upon request by Member Boards with instructor training, as needed, in preparation for program delivery. The Board decided to offer the Nurse Investigators Program in conjunction with the 1997 Annual Meeting rather than 1996, to allow the Day on Discipline to be offered in 1996.
- Directed implementation of offering Disciplinary Data Bank Access to certifying and government agencies and explored potential collaboration with the National Practitioner Data Bank, to facilitate Member Board reporting to the NPDB when implemented.
- Approved topics identified by the Discipline Investigators Task Force for future development of discipline resource modules.
- Created special committees to deal with chemically impaired nurse issues, complex discipline cases, continued competence, disciplinary investigators education, sexual misconduct issues, advisory opinions/rulings, and practice-related telecommunications issues.

Goal III. Nursing Education

- Participated in meetings, as invited, by the National Organization of Nurse Practitioner Faculties (NONPF) related to improving consistency in the education of nurse practitioners; supported NONPF's curriculum guidelines for nurse practitioner education.
- Created a special committee to analyze clinical experiences and supported the subcommittee's recommendations (see report under Tab 9).

Goal IV. Information

- Represented the National Council at 22 meetings of organizations with related areas of interest.
- Met with chief elected and staff officers of the American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, Commission on Graduates of Foreign Nursing Schools, National Association for Practical Nurse Education and Service, National Federation for Licensed Practical Nursing, National League for Nursing, and National Organization for Association Degree Nursing for liaison purposes. In addition, representatives of the boards of the AACN and NLN came to a Board of Directors meeting for "board-to-board" dialogue concerning mutual interests in serving the nursing education community and the public at large.
- Created the Institute for the Promotion of Regulatory Excellence for the purpose of serving the education needs of Member Boards; appointed a committee of the Board to direct the Institute's activities (see Attachment C).
- Created special committees to deal with communications evaluation, Annual Meeting educational programs selection, information services evaluation, Nurse Information System (NIS) policies, and research agenda (see report under Tab 10-G).

Goal V. Organization

- Focused on the National Council's Organization Plan (mission, goals and objectives). Directed that the National Council take a leadership role in discussions of nursing regulation, including sponsorship of various meetings (Nursing Leadership symposium on October 1; "Crafting Public Protection for the 21st Century: The Role of

(Nursing Leadership symposium on October 1; "Crafting Public Protection for the 21st Century: The Role of Nursing Regulation" conference with Citizen Advocacy Center on December 4-5; an invitational planning conference with the American Academy of Nursing on February 23-25; and the Nursing Regulation Models conference for Member Boards on June 9-10). Additional breadth was given to regulatory discussions through organizational participation in the Interprofessional Workgroup on Health Professions Regulation, which incorporated 15 health care professions in discussions about response to the Pew Taskforce's recommendations on regulation and possible collaboration on future projects.

- Appointed 129 individuals representing 38 boards of nursing to 28 committees and special groups to accomplish 104 tactics; in addition to special committees reported under Goals I-IV above, special committees were appointed to address long range planning and nursing regulation.
- Maintained the coordination, accountability, and support of all committees, task forces, focus groups, and staff for performance of tactics assigned, through quarterly reviews of progress.
- Planned agendas for and conducted Area Meetings and Annual Meeting.
- Maintained general oversight of the Special Services Division.
- Approved and monitored current year fiscal operations and the implementation of the annual budget.
- Created, updated, and maintained appropriate policies for the governance of the organization.
- Assessed the organization's performance in terms of outcomes, processes, structure, and future needs.
- Evaluated the performance of major contractors, committees, the executive director, and the Board itself.

Meeting Dates

- August 6, 1995, *post Delegate Assembly*
- October 19-20, 1995
- November 21, 1995 *(telephone conference call)*
- March 5, 1995 *(telephone conference call)*
- April 8, 1996 *(telephone conference call)*
- May 8-10, 1996
- May 29, 1996 *(telephone conference call)*
- June 26-28, 1996

Attachments

Attachment A

Chauncey Group/Sylvan Prometric Evaluation

Background

In August 1992, the Delegate Assembly selected ETS (now The Chauncey Group International) and SLS (now Sylvan Prometric) as test service providers for the NCLEX™ for the period of April 1, 1994, through September 30, 1999. In order to provide for a sufficient timeline to facilitate a smooth transition to a possible new vendor, next August, the Delegate Assembly will be asked to determine whether to approve a new contract with the Chauncey Group/Sylvan for the next contract period (1999 to 2002 or later) or to begin the Request for Proposals (RFP) process for selecting an NCLEX testing services vendor.

Evaluation Methodology

The tactic to conduct the test service evaluation was assigned to staff to complete as part of the 1995 Organization Plan. This is different than for previous test service evaluations which were conducted by committees. It was believed that the timing of this evaluation was such that the process would be largely data driven and that membership input would be solicited throughout the process. Also, the NCLEX Evaluation Task Force is completing its charge for this August and some of their findings about the NCLEX program can be used to additionally inform this evaluation.

Staff began the evaluation process with a review of the 1989 Test Service Evaluation Committee's survey instrument (which was a modification of the 1985-1986 Test Service Evaluation Committee's instrument) and made additions and modifications. The Chauncey Group/Sylvan was provided with a draft of the survey which they were invited to review and provide comments. Their comments were taken into account in development of the final survey form and their question additions were included mostly verbatim (these are the 5-point scale items referenced below). Staff also reviewed the final report of the 1989 Test Service Evaluation Committee and materials from the 1986 Committee to get a flavor of how these big evaluations were conducted in the past.

The survey instrument was distributed to: (1) all Member Boards, (2) Examination Committee (EC) members, (3) Board of Directors members, (4) appropriate National Council staff, (5) legal counsel, and (6) the Chauncey Group/ Sylvan for their evaluations. The instrument was tailored for each evaluator group so that they received only questions with which they would have a reasonable likelihood of having direct experience. Previous evaluations have also included item writers and item reviewers; they were not surveyed for this evaluation because each panel member completes a survey after their service.

The survey results were compiled and entered into a database and spreadsheet for analysis. The results form the basis of this report. To provide a framework for the results, and to replicate an activity of the 1989 Evaluation Committee, survey respondents were asked to rank six major service areas in order of importance to the mission and goals of the National Council. The rankings of the services were:

Services	Member Boards	Board	EC	Staff
Test Development	1	1	1	1
Test Administration	2	2	2	2
Data Services	3	3	3	4
Candidate Customer Service	4	4	6	5
Test Service Staff	5	6	4	3
Reports	6	5	5	6

There was a definite break between the top three and bottom three service areas for Member Boards.

Results

As of April 15, the survey was returned by: 48 Member Boards, 5 Board of Directors members, 7 Exam Committee members, 7 staff (and legal counsel), and Chauncey/Sylvan.

The performance of Chauncey/Sylvan as test service was evaluated for each of the six major areas of service, within the context of this importance ranking framework. Groups without opportunity to observe a particular service area generally did not receive questions about that service on the survey. In reporting the results, the overall averages of the involved groups on items relating to each service will be described. This average is necessarily affected by the number of evaluators in each category who responded to the item. Thus, items which Member Boards responded to would be largely affected by the aggregate Member Board rating. The reported overall averages include Chauncey/ Sylvan's self review ratings; their evaluation form is Attachment B behind this tab.

The survey response scale was coded with 1 indicating low satisfaction, 2 = moderate satisfaction, and 3 = high satisfaction. To facilitate interpretation of the results, items with average scores ≥ 2.7 are described as "high satisfaction"; from 2.31 to 2.69 as "moderate satisfaction"; items with average scores between 2.0 and 2.3 indicate "needing improvement"; items with average scores < 2.0 indicate "problem areas." These designations were also used in the 1989 test service evaluation, but with the designators being applied a bit more harshly than they were here (e.g., high was for scores > 2.8; needing improvement was indicated for scores between 2.0 and 2.49). With Chauncey and Sylvan's opportunity to provide service only possible over a scant two years, the more lenient scale described above was applied for this evaluation.

Overall, 25 items achieved a high satisfaction rating; 60 earned moderate satisfaction; 28 earned a needing improvement rating; and 4 were designated as problem areas out of the 117 items on the three-point response scale. Comments are incorporated when appropriate to elaborate on the reasons for lower ratings. As in the 1989 report, specific comments on highly or moderately rated items are not incorporated in this report. This should not be interpreted to mean that only negative comments were made; in fact, many areas were rated highly and positive comments made.

Test Development. For items that can be reasonably categorized as Test Development (including some questions about research areas), four reflect high satisfaction (#8 - security procedures for exam development, #22 - quality of preconference materials for Item Review meetings, #24 - arrangements for Item Review conferences, and #26 - ETS coordination of MB tryout item review). Member Boards also rated their participating nurses' satisfaction in the item writing and item review workshops as 4.36 (1=low to 5=high satisfaction).

Ten items reflect services needing improvement:
#12 - frequency, duration, and location of item-writing conferences sufficient to accomplish necessary item writing and item review to build up to three optimal NCLEX item pools,
#14 - detailed item-writing assignments prepared jointly by the Exam Committee and Chauncey staff,
#15 - item-writing training materials/item-writer screening tool,
#19 - Chauncey review of items for agreement with exam specifications sound measurement characteristics, and grammatical correctness,
#21 - assistance to National Council in selection of Item Reviewer (IR) panel members,
#25 - effectiveness of IR procedures,
#27 - annual item pool inventory report,
#29 - the construction of item pools (including adherence to specifications, equivalent content distribution, readability level, difficulty level, discrimination level, and reliability),
#64 - person-fit analyses (identifying patterns of anomalous responses), and
#81 - annual research meeting.

Member Boards also rated very lowly the various aspects related to Member Board review of newly written items with none of the services being rated higher than 1.92 (ease of accessing items) on a 1=low to 5=high scale.

Two service areas reflect problem areas (#17 - effectiveness of item writing workshop procedures = 1.75 overall average [Board of Directors' average - 1.0; EC - 2.0; staff - 1.0], and #67 - Chauncey role in facilitating functioning of the Joint Research Committee = 1.91 overall average [Board average-2.0; EC-2.0; staff-1.67]). Note that Member Boards were not asked either #17 or #67. The evaluator comments on item #17 generally refer to the slow progress in working towards producing three optimal item pools as agreed-to in the contract. Chauncey's self evaluation on items #17 and #67 was 2.0 for each.

Test Administration. For items that can be reasonably categorized as Test Administration, seven reflect high satisfaction:
#9 - security of item pools and rotation,
#111 - ability to meet 30/45-day rule,
#122 - procedures for ADA modifications,
#123 - approved procedures are correctly implemented,
#125 - timeliness of transmitting candidate NCLEX data to Chauncey,
#128 - Sylvan coordination of Member Board exam reviews, and
#130 - Sylvan coordination of Member Board tryout item review.

Six reflect service areas needing improvement:
#114 - procedures for responding to a crisis before, during, and after the administration of an examination,
#116 - efficacy of the training and certification program for Test Center staff,
#118 - examinations are successfully restarted following software/hardware problem identification and correction,
#119 - quality and timeliness of technical support services for centers,
#124 - procedures for responding to and recording test administration problems (EIRs) by Test Center staff, and
#127 - responsiveness to providing data in response to candidate investigations (including timeliness and quality).

Member Boards rated the quality of EIRs in solving candidate issues as 3.40 on a 5-point item (1=low to 5=high).

One service area reflects a problem area (#117 - examinations are delivered without hardware/software problems = 1.97 average overall). [Member Board average - 2.02; Board of Directors - 1.75; EC - 1.86; staff - 1.8]. Evaluator comments for item #117 commonly refer to the number of restarts to which candidates are subjected and the number of hardware and software problems as reflected in the EIRs. Chauncey's self evaluation for item #117 was 2.0.

Data Services. For items that can be reasonably categorized as Data Services, seven areas reflect high satisfaction:

#39 - Test Center Administrators' Manual,
#42 - usefulness and clarity of the ATT document,
#46 - adequacy of possible modifications for disabled candidates,
#51 - procedures for exam reviews by Member Boards,
#94 - the options available for handling registrations from licensure candidates (direct registration, and board-processed),
#95 - responsiveness of Chauncey registration staff to requests for information, and
#97 - interpersonal relations between registration staff and National Council.

Eight items reflect service areas needing improvement (#90 was not asked of Member Boards):
#43 - procedures for revising exam-related materials,
#44 - procedures for ordering Candidate Bulletins (including overage policy and responsiveness to late orders),
#48 - procedures for analyzing possible cheating behavior through manual and electronic review (including turnaround time),
#49 - procedures for responding to a crisis before, during, and after the administration of an examination,
#52 - procedures for exam reviews by candidates (including cost and turnaround time),
#85 - the design of the computer system and programs to implement the candidate registration process (including the matching algorithm, but not MBOS),
#90 - the quality of Chauncey financial reporting regarding NCLEX candidate volumes and fees, and
#92 - the procedures for correcting candidate data (for program, foreign educated, and initial/repeat, etc.) with respect to both timeliness and format.

One service area reflects a problem area (#50 - procedures for item deletions = 1.71 average overall). [Board average - 2.0; EC - 2.13; staff - 1.0]. Member Boards were not asked #50. The comments on this item refer to the time lag being too long to remove a flawed item from the field and that some items come to the EC that should already have been removed from the item pools. Chauncey's self evaluation on item #50 was 2.0.

Candidate Customer Service. For items that can be reasonably categorized as Candidate Customer Services, two reflect high satisfaction (#122 - procedures for modifying NCLEX administration for disabled candidates; and #123 - approved modifications for ADA candidates are correctly implemented). These questions also were included in the Test Administration section and they were answered by Member Boards. Member Boards rated their level of satisfaction with the service provided when contacting ETS to resolve a problem as 4.47 (1=low to 5=high).

Two items reflect service areas needing improvement (#118 - Examinations are successfully restarted following software/hardware problem identification and correction; and #127 - responsiveness to providing data in response to candidate investigations, including timeliness and quality). These questions also were included in the Test Administration section and they were answered by Member Boards. Member Boards rated their impressions of candidates satisfaction with the service provided when candidates call ETS as 3.79 on a 5-point item (1=low to 5=high).

Reports. For items that can be reasonably categorized as reports: One reflects high satisfaction (#61 - accuracy of reports). Member Boards also rated timeliness of electronic results transmission as 4.55 (1=low to 5=high).

Two items reflect service areas needing improvement, #56 - Individual Candidate Results Report (including photograph quality) and #57 - diagnostic profiles. Evaluator comments on item #56 uniformly discuss the lack of quality photographs. Participant comments on #57 reflect candidate confusion over interpretation of the profiles and the lack of sufficient information to aid studying for retakes. Member Boards also rated timeliness of paper results receipt as 3.78 on a 5-point item (1=low to 5=high).

Test Service Staff. For items that can be reasonably categorized as test service staff, five reflect high satisfaction (#5 - availability of Chauncey staff for National Council meetings, #71 - facilitation of visits to Chauncey headquarters and Sylvan sites, #72 - expertise of psychometric staff, #107 - availability of Sylvan staff for National Council meetings, and #108 - interpersonal relations between Sylvan and National Council representatives). All of these items were included in the Member Boards' evaluation form. Member Boards rated the responsiveness of Sylvan staff in responding to inquiries as 4.14 (1=low to 5=high).

Two items reflect service areas needing improvement (#7 - manner in which ETS staff changes were handled [e.g., how communicated, advise sought], and #104 - level of expertise of Test Center staff [e.g., adherence to policies, training, responsiveness to problems]).

Overall Rating Items. There were four questions on the survey which sought to elicit global evaluations of the testing service providers and the NCLEX. The rating for Chauncey on item #102 - overall performance = 2.65 (3 = high satisfaction; 2 = moderate satisfaction). Sylvan's rating on item #135 - overall performance = 2.57. The rating for Chauncey/Sylvan combined on item #137 - how satisfied are you with the services provided by Chauncey and Sylvan = 4.19 (on a 1 to 5 scale). The average rating for the NCLEX on item #136 - how well is the computer-delivered NCLEX satisfying your needs to support the licensing of nurses in your jurisdiction = 4.83 (on a 1 to 5 scale).

Summary. For the service area ranked highest by all participants, Test Development, four items were judged to provide high satisfaction, ten were needing improvement, and two reflected problem areas. The next highest ranked service area, Test Administration, showed seven items with high satisfaction, six needing improvement, and one problem area. For Data Services, seven items were high satisfaction, eight needing improvement, and one problem area. In the area of Candidate Customer Services, two items showed high satisfaction and two reflected needing improvement. For Reports, one item showed high satisfaction and two reflected needing improvement. For Testing Service Staff, five items earned high satisfaction, two showed needing improvement.

Service Areas	High Satisfaction	Needing Improvement	Problems
Test Development	4	10	2
Test Administration	7	6	1
Data Services	7	8	1
Candidate Customer Service	2	2	0
Reports	1	2	0
Test Service Staff	5	2	0

Future Activities

The future activities relating to acquiring testing services for the next contract period (post-September 1999) are dependent on the actions of the 1996 Delegate Assembly. Tactics in the FY97 Organization Plan have been drafted and budgeted to correspond with either of two decisions: (1) negotiation of a new contract with Chauncey, or (2) development and distribution of an RFP for testing services.

Also in the FY97 Plan are associated task forces to assist with the necessary activities for either delegate decision. Should the Delegate Assembly choose to negotiate a new contract with Chauncey/Sylvan, a Negotiation Team has been planned for; should the delegates decide to let an RFP, a Proposal Evaluation Team has been planned for.

Attachment B

Test Service Evaluation Questionnaire

Date submitted: March 1, 1996

Note: Ratings for each statement are indicated by parentheses.

Staff Form

Directions: Please rate ETS/Chauncey Group (still ETS for this form) and/or Sylvan's performance (as applicable) on each service, deliverable, or procedure by circling one of the ratings in the column on the right. If you do not have adequate involvement in the activity or function to provide a fair assessment, please mark that item not applicable (N/A). Space has been provided should you wish to make explanatory comments. Use the time period from September, 1992 to the present for all assessments.

This survey has been customized for the specific respondent groups. Please disregard the item code numbers in parentheses. Also, some items have been included to provide requested feedback to ETS/Chauncey and Sylvan; they are interspersed and may have a slightly different format.

Degree of Satisfaction		
Key: H = high	**M = moderate**	**L = low**

Degree of Satisfaction

I. TEST SERVICE (ETS/Chauncey Group)

TEST SERVICE STAFF

(please note that Sylvan staff will be evaluated in Section II.)

(1) Overall level of expertise of ETS staff (H) M L N/A

Comments:

The major responsibilities for the daily operation of the NCLEX Program rest with a large number of Chauncey/ETS staff with expertise in areas ranging from computer systems and customer service to test development and psychometrics. In addition to these individuals, many other Chauncey and ETS staff from across both organizations are involved in the many activities required to maintain a daily testing program. In addition, when other needs arise we are able to supplement the "regular" NCLEX staff with access to colleagues within Chauncey and ETS.

(2) Responsiveness of ETS staff to requests for information (including timeliness, follow-through, depth) H (M) L N/A

Comments:

Requests for information, in particular requests from Member Boards, take high priority and are, in most cases, addressed promptly. In many situations, requests can be met within the same day of the request. However, investigations into candidate issues may require time for data gathering, reporting of findings,

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

and resolution, especially when multiple decisions-makers are involved. In those cases, we provide status updates until resolution is reached. Our responsiveness to requests for information from NCSBN staff has not always been as prompt as we would like. On occasion, we have not met deadlines for submission of reports. We will continue to try to improve our timeliness.

(3) Responsiveness of ETS staff to requests for services (including timeliness, follow-through, depth) H (M) L N/A

Comments:
Candidate issues related to NCLEX administration take the highest priority and are resolved promptly. Requests for other services or program enhancements are responded to as quickly as possible, given competing priorities and available resources. As with requests made by NCSBN for information, we have set as a goal to improve our timeliness in responding to requests for services.

(4) Communication between ETS and Council representatives (including staff, Board, Member Boards, Committees) H (M) L N/A

Comments:
It took some time for ETS/Chauncey staff to get to know Council Staff and to become familiar with their needs. We believe communications between staffs have improved significantly in the past year. We recognize the importance of keeping the National Council informed and updated and strive to do so. In all of our communications with Member Boards and Committee members, we strive to be responsive, accommodating, and timely.

(5) Availability of ETS staff for National Council meetings (H) M L N/A

Comments:
Chauncey staff regularly attend Examination Committee meetings, Area Meetings, Delegate Assembly, monthly staff meetings, and other meetings to which we are invited to participate.

(6) Interpersonal relations between ETS staff and Council (including staff, Board, Member Boards, Committees) H (M) L N/A

Comments:
We began the NCLEX program by having one contact person at Chauncey communicate with one contact person as NCSBN. While that approach may have been the best way to start a new program, we soon realized that direct communications among all staff would be more productive and responsive. The focus for staff interactions has changed from a single contact person at each organization to direct contacts between persons sharing similar responsibilities - for example, test development staff at Chauncey talk directly with test development staff at NCSBN. This change has been both positive and effective and, we believe, has enhanced interpersonal relations. Generally, staff communicate daily either by phone or e-mail and must often deal with difficult and sensitive issues quickly. We have enjoyed our

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

interactions with Member Board staff and believe our interpersonal relations with them to be very positive.

(7) Manner in which ETS staff changes were handled (H) M L N/A
(e.g., how communicated, advise sought)
Comments:
The majority of the Chauncey staff who began NCLEX implementation are still an active part of the program staff today. There has been only one change in key staff since the program began; we have appreciated the input received from the National Council about the criteria to be considered when selecting a replacement and about candidates being considered. Also, several new positions have resulted in additional staff for the program. When Chauncey staff are hired, NCSBN staff and Member Boards, when appropriate, are informed of the change and in-person introductions made at the first available opportunity.

SECURITY PROVISIONS

(8) Development of and adherence to security procedures (H) M L N/A
with respect to exam development
Comments:
Security has been maintained during all test development activities including item writing, item review, in-house editing, item bank maintenance, and Examination Committee review. There have no incidences of security breaks in test development activities. Items are stored securely and are tracked in each stage of the development process.

(9) Development of and adherence to security procedures (H) M L N/A
with respect to item pools and their rotation in the field
Comments:
There has been no incidence of a security break impacting the item pool during rotation of the item pools or during the time the pools are in the field. There have been two incidences where candidates' actions regarding recording items on scratch paper were investigated but no evidence was found in either case that supported a security break or a serious threat to the integrity of the item pools.

(10) ETS cooperation in investigations of potential security breaks H (M) L N/A
(timeliness of reporting, correction of problem)
Comments:
In the most serious case investigated, ETS's Office of Test Security conducted an extensive investigation into a candidate taking scratch paper from the test center. That investigation lasted several days during which time the candidate's test result was put on hold and the Board of Nursing notified of the action. In

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

another case where a test center was broken into, the investigation included interactions with the local police. Both cases were resolved. We continue to work with the ETS Test Security office to conduct investigations in a more timely way.

(11) Support of Crisis Management Planning (H) M L N/A
Comments:

Fortunately, we have not had an occasion where we have had to use the Crisis Management Plan. We are planning some major security enhancements in the near future which will significantly strengthen the systems currently in place.

TEST DEVELOPMENT

(12) Frequency, duration, and location of item-writing conferences and Item Reviewer meetings (sufficient to accomplish necessary item writing and item review to build up to three optimal NCLEX item pools) H (M) L N/A
Comments:
ETS/Chauncey had anticipated that approximately 5 item writing workshops and 5 item review panels for both NCLEX-RN™ and NCLEX-PN™ each year would produce sufficient numbers of items to meet the expectations of the optimal item pool. Item development for NCLEX proved to be a massive project and it became evident that the original expectation for session productivity could not be achieved as less than projected numbers of items were being produced. The demands to develop items within a specific difficulty range also proved to be a great challenge. ETS/Chauncey have initiated a variety of activities to increase item production. As part of the Test Development Strike Force (which consists of NCSBN and Chauncey staff charged with the task of evaluating the entire test development process), the entire format and frequency of item writing workshops and item review panels are being evaluated and suggested changes will be made and implemented.

For the remainder of 1996 and into 1997, 6 item writing workshops and 6 item review panels per pool have been scheduled. More review panels will be scheduled if supplemental item writing activities produce sufficient numbers to warrant them. This will be evaluated by Chauncey staff in cooperation with NCSBN staff.

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(13) Assistance to Council in selection and screening of item writers (H) M L N/A
Comments:
ETS/Chauncey test development staff participate on a frequent basis with the screening of potential NCLEX-RN item writers. At least 10, and frequently more, sets of exercises per session, totaling more than 120 sets per year, are reviewed and rated by Chauncey staff according to a predetermined format. Recommendations are made to NCSBN staff based upon the individual's performance on the screening exercise. Potential NCLEX-PN item writers are not screened in this manner because of a limited number of available item writers. As part of the Test Development Strike Force, the screening exercise will be modified into a tool to prepare item writers for workshop activities.

(14) Detailed item-writing assignments prepared jointly by the Exam Committee and ETS staff (to provide direction to the Item Writers) (H) M L N/A
Comments:
ETS/Chauncey staff has worked with NCSBN staff to develop guidelines for item writers that will provide them with detailed specifications for writing items. Currently information available about item content is limited to the components of the test plan: Client Needs and Nursing Process. This information can be cross-tallied with statistical information to provide a distribution of test plan across five ranges of difficulty. Lists describing specific content areas to avoid have been developed by ETS/Chauncey test development staff as the process as evolved over the last two years. Chauncey, National Council staff and the Examination Committee have recognized that a more detailed description of item pool content needs is required to provide the item writers with a detailed assignment. Chauncey is currently developing a more comprehensive data bank that will allow us to code items on several content strands, such as medical diagnoses, drugs and treatments. These item coding schemes will make it easier to provide detailed assignments to item writers

(15) Item-writing training materials/item-writer screening tool (H) M L N/A
Comments:
Item writer guidelines have been prepared jointly by NCSBN staff and Chauncey staff that assist item writers with their item development. The guidelines reflect the test plan and provide directions to the item writer. The rules for writing acceptable stems and options are presented with examples. Feedback from the item writers is that these guidelines are very helpful and provide them with a tremendous amount of useful and pertinent information. Materials are reviewed and revised every two years to reflect the most current test plan and item development information.

Item screening materials are used to screen NCLEX-RN item writers. It has been recognized by both National Council and Chauncey staff that the screening exercises are not always valuable in predicting the potentially successful item writer. Chauncey staff is working with National Council staff as part of the Strike Force to re-evaluate these exercises and their predictability.

5-All

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(16) Training/feedback provided to item writers (H) M L N/A

Comments:

Chauncey staff are readily available throughout the item writing workshops to provide frequent consultation to item writers about their items. Staff assist them with revising the item and with increasing the potential difficulty level of the item. At the end of each day of the workshop, the items are reviewed by Chauncey staff and some of them are discussed with the group the next day. This enhances the item writer's ability to develop acceptable items. Evaluations from participants have demonstrated an increasingly positive rating about the experience--over 90% rate the sessions and the staff as being above average. Chauncey staff then evaluate the contributions of the participants and provide NCSBN with this evaluation that is used for future reference when selecting individuals who should return to another session.

(17) Effectiveness of item-writing workshop procedures (evidenced by productive, high-quality sessions) H (M) L N/A

Comments:

Based on experience with other testing programs, ETS/Chauncey had predicted that item productivity would yield approximately 50 items per writer per workshop. But productivity at the item writing workshops has not been at the level expected at the start of the contract and varies greatly among the writers and the workshops. Item writers produce on average about 25 items per person, though frequently there are some who produce less than 15. Even for those who produce a large volume, the quality is not always at the level that is desired.

In an effort to increase both quantity and quality of items produced at workshops, Chauncey staff is beginning to reorganize the teaching methods used at item writing workshops. Following an orientation to the item development process, staff are working with 3 to 4 item writers who write items as a group. This is being done for a half day to assist the participants in starting the item writing activity. Though this is a recent change, initial feedback from the item writers is quite positive. Some would even prefer to work in a group for the whole session.

Chauncey and NCSBN staff are investigating a variety of supplemental item development activities, including revising old items with poor statistics, cloning of items, and having item writers develop items at home. Items will be tracked according to their origin so that each supplemental method can be evaluated for effectiveness.

(18) Arrangements for item-writing workshops (coordination, travel, accommodations, meal allowance, hospitality, (H) M L N/A

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

and work environment)
Comments:
All travel arrangements and accommodations for item writing workshops are arranged efficiently by Chauncey staff. Effort has been exerted to keep out-of-pocket expenses for participants to a minimum, as most of their travel-related needs and meals are provided by Chauncey. Feedback from the item writers reflects their overall positive satisfaction with the arrangements and service provided.

(19) ETS review of items for agreement with exam specifications sound measurement characteristics, and grammatical correctness (H) M L N/A
Comments:
Since the inception of the contract, ETS/Chauncey has been responsible for reviewing large numbers of items that include the thousands of RN and PN items in the original base pool of items transferred to ETS, approximately 1,000 RN and 800 PN base pool items that are reviewed for currency each year and several hundreds of items that are being prepared for item review and for inclusion in the operational pools each year. On several occasions, a few items with flaws were not identified during these screenings and had to be removed from the operational pool. ETS/Chauncey has accepted the request by NCSBN and the EC to include validation of an incorrect distractor in addition to the support for the correct answer and have applied this not only to new items but to the currency validation of base pool items.

Recognizing this difficulty, ETS/Chauncey has expanded their staff of experienced nurse collaborators who are specialists in selected areas of nursing practice and who review items for accuracy and currency. All items are reviewed by editors to assure that they are in agreement with grammatical correctness and test specifications.

(20) ETS review of items for ethnic and gender bias (H) M L N/A
Comments:
ETS/Chauncey has done very well in reviewing items for ethnic and gender bias. Test development staff have become well versed in bias review; few items are flagged by the sensitivity bias review for potential problems.

(21) Assistance to Council in selection of Item Reviewer panel (IR) members (H) M L N/A
Comments:
ETS/Chauncey's involvement in the selection of item reviewers has generally involved discussion with NCSBN staff of individuals who might be asked to return to a second session. Item reviewers are evaluated by Chauncey staff after each session and recommendations are made about those individuals who would be valuable to have return at another time. The evaluations of item review members are used by NCSBN staff in determining the selection of subsequent panels.

7-All

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(22) Quality of preconference materials for IR members (H) M L N/A
Comments:
Item review members are sent materials about the item review process and the feedback from them is that these materials are very helpful in preparing them for the panel sessions. Manuals for Item Review Panels for NCLEX-RN and NCLEX-PN have been developed by ETS/Chauncey in cooperation with NCSBN staff and are reviewed and revised every two years.

(23) Effectiveness of training provided to IR members (H) M L N/A
Comments:
Item Review members have consistently reported that the orientation program provided on the first day of the session is extremely beneficial in initiating the review process. At this orientation, Chauncey staff explore the members' role as reviewers and discuss the procedures involved in the session in detail. Feedback on the evaluation forms from the members indicates that over 90% of the participants rate the quality of the session and the expertise of the staff as being above average.

(24) Arrangements for IR conferences (coordination, travel, hotel, meal allowance, hospitality, and work environment) (H) M L N/A
Comments:
ETS/Chauncey makes all arrangements for the item review panels in an efficient and timely manner. As with the item writing workshop sessions, out-of-pocket expenses for the participants are kept to a minimum. Evaluations from participants overwhelming indicates their satisfaction with our accommodations and service.

(25) Effectiveness of IR procedures (H) M L N/A
Comments:
A panel of five item reviewers is convened; each reviewer is experienced clinically in a specific area of nursing practice. Item reviewers read and discuss each item together and textbooks are available if needed for their review. Evaluations from item reviewers has also been consistently positive.

(26) ETS's coordination of Member Board review of experimental items (H) M L N/A
Comments:
Twice a year, Member Boards are invited to review pretest pools for both NCLEX-RN and NCLEX-PN. These review sessions are scheduled by Chauncey at a Sylvan test center that is convenient for the Member Board.

(27) Annual item pool inventory report (H) M L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Each year in February, the RN and PN pools are inventoried to tally the number of items in each part of the test plan and in each of five ranges of item difficulty. Actual numbers of available items in the master pools is compared to the optimal numbers of items required for three operational pools. These frequencies provide guidance for evaluating the status of the pool and for identifying deficient areas in need of development.

(28) Maintenance of the NCLEX item banks (text and statistics) H (M) L N/A

Comments:

NCLEX items have been maintained in ETS' Test Development/Document Creation (TD/DC) data bank. This bank allows for the inclusion of the item text, test plan codes, status codes, textbook validation. and statistical information. But ETS/Chauncey has recognized that the TD/DC system is inadequate in handling the large scope of information that is needed to satisfy a variety of data needed for test development. For instance, there is a need to be able to code items for specific content areas that are outside of the framework of the test plan, which would be useful for developing specific item writing assignments, for selecting content-diverse operational pools, for separating items with similar content into different pools, and for reducing the amount of overlap in real exams.

In an effort to improve the maintenance of the item bank, Chauncey is currently in the process of developing a new data base management system that will increase the amount and type of information that can be stored about each item in the bank. Of particular concern to the Examination Committee is the need to have a more specific coding scheme that can be used to evaluate the types of items in the current pool and to identify content areas for further item development. It is expected that this system will be operative by July 1 at which time items will be re-evaluated for new codes.

(29) The construction of item pools (including adherence to specifications, equivalent content distribution, readability level, difficulty level, discrimination level, and reliability) H (M) L N/A

Comments:

Item pools are constructed using automated procedures based on a large number of content and statistical rules. Simulations have documented the equivalence of the item pools. The depth of the pools have increased in the past two years; however, they are still not optimal. We are implementing new procedures for pretest pool construction so that content within each pretest pool will be more representative of the entire NCLEX Test Plan rather than restricted to specific content areas.

(30) Relevance of items to current, entry-level practice (H) M L N/A

Comments:

Items are reviewed on numerous occasions for currency and relevance for entry-level practice at item review panels, Chauncey staff reviews, Member Board reviews, and Examination Committee reviews.

Degree of Satisfaction Key: H = high M = moderate L = low

Degree of Satisfaction

(31) Implementation of new RN test plan (including review of item pool recoding of items, writing of new items, revision of report formats) (H) M L N/A
Comments:
In preparation for the new RN test plan that was implemented in October, 1995, Chauncey staff completely recoded the item pool according to the new scheme. Item writing workshops began developing items according to the new RN test plan about one year prior to its implementation.

(32) Assistance in development of the new NCLEX-PN Test Plan (H) M L N/A
Comments:
Currently, staff are in process of recoding the PN item pool for the new test plan to be implemented in October 1996. Test development staff reviewed and critiqued the draft of the test plan as requested by NCSBN staff.

(33) Has your Board of Nursing participated in a Member Board review of newly-written items or simulated examinations at a test center?

YES ___ NO ___ If NO, skip to question #34. (N/A)

On a scale of 1 to 5, please rate the following services used for Member Board item reviews at test centers (1 = low rating, 5 = high rating):

scheduling of Member Boards reviews _____
ease of accessing items _____
ability to review and critique items _____
procedure for completing review and submitting comments _____

(34) Based on comments from nurses from your jurisdiction that have attended item writing or item review workshops, please rate on a sale of 1 to 5 the level of satisfaction from attending the workshop. (N/A)

OPERATIONAL SERVICES

(35) On a scale of 1 to 5, how well does MBOS satisfy your need to manage data about NCLEX candidates?
____5_____ (1 = low rating, 5 = high rating)

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Information about all registered candidates is available in MBOS and can be viewed on the screen or in a variety of reports. The information is updated when candidates are authorized, make appointments or take the NCLEX. Candidates can be made eligible and changes can be made to candidate data, both of which are transmitted to the NCLEX Data Center. Staff at Member Boards have learned to use MBOS effectively. Most calls to the MBOS Helpline are routine, e.g., forgotten passwords.

(36) The usability of the non-MBOS system to communicate with ETS (H) M L N/A
Comments:
All Boards except North Carolina use expEDIte/PC, the same software as the MBOS users use, to communicate data to the Data Center, so communication is the same for MBOS and non-MBOS Boards. This communication is functioning effectively. North Carolina uses software on the AS-400 mini-computer. After a few start-up issues due to the uniqueness of their set-up, we have experienced very few problems interacting with NC.

Although the communication system has operated effectively, several non-MBOS Boards have had difficulty programming their internal systems to accept and process transactions from the Data Center and to send appropriate transactions to the Data Center.

(37) The quality of the MBOS documentation (manual) H (M) L N/A
Comments:
The MBOS User Manual has been adequate but could be improved. However, we have the impression that MBOS is easy enough to use and the on-screen prompts are helpful enough that most users rarely refer to the User Manual. The User Manual is a basic entry-level document and most users have progressed beyond that point. The MBOS Helpline has not received calls from MBOS users complaining about the User Manual.

(38) On a scale of 1 to 5, how do you rate the support you have received from the MBOS Helpline? __5__
(1 = low rating, 5 = high rating)
We have been told by Member Board staff at Area Meetings and Delegate Assemblies that they have been pleased by the support that they have received when they have had to call the MBOS Helpline. The Helpline is staffed from 8 AM until 8 PM. From 8 AM to 6 PM, there are usually three people available to respond to Helpline calls with the evening shift supervisor covering from 6 to 8 PM. After hours callers may leave a voice-mail message which will be responded to the next day.

Please make additional comments about MBOS. Please include what you like best about MBOS as well as any improvements or enhancements you suggest.

(39) Test Center Administrators' Manual (H) M L N/A

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Comments:
The TCA Manual has effectively communicated the National Council's expectations to the test center administrators and has served as a resource for information about NCLEX policies and procedures. It is updated annually following review by Council, Sylvan, Chauncey and ETS staff.

(40) NCLEX Candidate Bulletin (H) M L N/A
Comments:
There have not been any systematic candidate misunderstandings that can be attributed to the Candidate Bulletin. In fact, call volumes about topics such as registration and procedural issues have decreased over the past year. Candidates have been successfully registering for the NCLEX based on the information provided in the Bulletin. The Bulletin has recently undergone its third revision and reprinting since CAT began.

(41) Scheduling and Taking Your NCLEX Bulletin (H) M L N/A
Comments:
Candidates have generally understood how to make appointments and what they must do on the day of the test. Revisions to this document have been minor including the section regarding forms of acceptable identification which must be presented at the test center.

(42) Usefulness and clarity of the ATT document (H) M L N/A
Comments:
The ATT has served its function well as evidenced by very few revisions during the past two years. An alternate version of the ATT is produced for ADA candidates to provide specific instructions for scheduling their examination. Duplicate ATTs are provided on request without charge and the envelopes are addressed by hand on occasion to ensure delivery.

(43) Procedures for revising exam-related materials H (M) L N/A
Comments:
The procedures for revising exam related materials involve staff from the National Council, Chauncey, Sylvan and ETS. While the coordination of reviews and revisions has improved, there is room for further improvement in the coordination of these activities.

(44) Procedures for ordering Candidate Bulletins (including overage policy and responsiveness to late orders) H (M) L N/A
Comments:
Annual supplies of Bulletins are provided to Boards from the printer in a bulk shipment. The quantity is determined by past usage. Requests for supplementary shipments are delivered within three weeks via UPS ground delivery. In cases of emergency, a supply of Bulletins is shipped via Federal Express for two

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

day delivery. Follow-up via NCNET may help Member Boards May help identify delayed shipments early enough to take timely corrective action. We are working toward refining the ordering and distribution process for Bulletin shipments so as to accommodate each Member Board's schedule rather than automatic annual shipments.

(45) Procedures for modifying the examination for disabled candidates (H) M L N/A
Comments:
After a less than ideal start-up, the examining of disabled candidates has been handled effectively due to careful monitoring and individualized instructions to center staff for these candidates. When the Data Center receives information that a candidate has requested special conditions, an entry is made into a database developed expressly for tracking ADA candidates. The Data Center also communicates with Sylvan staff so that they can be prepared to process the requested modifications when approved by the National Council. Systems changes are currently underway for release in April 1996 that will provide system-managed breaks for candidates with extended time tests.

(46) Adequacy of possible modifications for disabled candidates (H) M L N/A
Comments:
Most modifications requested are provided routinely. Occasionally a request is received that is not satisfied by any of the modifications that are in place. On those occasions, the candidate (and sometimes her advocate) work with ETS experts in testing the handicapped and, in consultation with the Member Board and the Council, an appropriate accommodation is designed. In all cases, an accommodation has been provided that is psychometrically sound and acceptable to the candidate.

(47) Procedures for examination data transfer to Member Boards (H) M L N/A
Comments:
Most Member Boards transfer data to and from the Data Center routinely every night. Initially there were no automated systems to detect procedural errors in the transfer of data. But since those systematic checks on the transfer have been implemented and the Boards have become more experienced in operating the system, there have been few problems with data transfers. The Boards located on the distant Pacific islands continue to have occasional difficulties in their communications due to power and telephone service instability.

(48) Procedures for analyzing possible cheating behavior through manual and electronic review (including turnaround time) H (M) L N/A
Comments:
Cases of possible cheating have been handled promptly and effectively (See the section titled Security Provisions - items 8 through 11). However, some repeating candidates whose results were very different

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

from prior results (large score differences) have been held longer than is desired while the signature logs are retrieved from the center for comparison of the signatures from the two examinations.

(49) Procedures for responding to a crisis before, during, and after the administration of an examination — H (M) L N/A

Comments:
Staff at Sylvan, Chauncey and ETS have responded promptly on those fortunately rare occasions when a crisis has occurred. Unfortunately there have been times when our focus on resolving the crisis has meant that we have not communicated as promptly with the National Council and the affected Member Board(s) as we should have. (See item 4)

(50) Procedures for deletion of items with unacceptable psychometric properties (including speed of ETS' action) — H (M) L N/A

Comments:
At the start of computer-based testing for NCLEX, our procedures for deleting items from an active pool were not fully documented. This resulted in some delays. They have since been documented with clear responsibilities and deadlines for every step. Since that time, the process for deleting items (i.e., releasing a Problem Item Notice or PIN) has begun promptly. Most centers receive and install the PIN the day after it is released, but for a few centers it takes longer than is desirable. We continue to work to speed the distribution of PINed items to all centers.

(51) Procedures for exam reviews by Member Boards — (H) M L N/A

Comments:
Member Boards may request examination reviews twice yearly at a local test center. Both simulated examinations at different ability levels and pre-test items are available for review. Approximately 14 to 18 Member Boards choose to review items during each review session.

(52) Procedures for exam reviews by candidates (including cost and turnaround time) — (H) M L N/A

Comments:
Candidate reviews have been scheduled with reasonable lead times considering the need to also schedule Member Board participation and test center time that will not impact NCLEX (or other) scheduled examinations. The cost is high and so is the price to the candidate. To date, only 16 candidates have requested review sessions.

(53) On a scale of 1 to 5, how satisfied are you with quarterly Examinee Exit Evaluations? __5___
(1 = low rating, 5 = high rating)

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Using newly developed analytical reports, the Examinee Exit Evaluations have been very useful in identifying centers whose performance falls outside the expected parameters or varies significantly from the norm set by test centers as a whole. Some of the questions have been revised to improve clarity.

NCLEX REPORTS

Please indicate the degree to which you believe the following reports provide clear, timely, and useful information to Member Boards and/or candidates

(54) On a scale of 1 to 5, how well do the Quarterly Reports ("Green Sheets") satisfy your needs for summary information about NCLEX candidates? __4___ (1 = low rating, 5 = high rating)
With the addition of four quarters and a rolling annual total to Table 1 and the addition of Table 4-A which implemented data sharing among Boards, the current Quarterly Reports provide more information than was provided by the versions from the paper and pencil test. We continue to make changes and enhancements at the request of the Member Boards and the Examination Committee.

Please make additional comments about the Quarterly Reports. Please include what you like best about the Quarterly Reports as well as any improvements/enhancements suggested.

(55) Jurisdiction Program Summary Reports (Table 4 of Green Sheets) H (M) L N/A
Comments:
Table 4 of the Quarterly Reports has been a source of some frustration for Member Boards and education programs. The sources of the frustration were inaccurate data provided by candidates on their registration forms (errors in program code and graduation dates) and the fact that candidates are included in Table 4 when educated within the jurisdiction even though they have applied for licensure from another Board. The former problem has been addressed by improving the edit rules and by adding the program code, program name and graduation date to the main candidate screen in MBOS so Boards can verify the accuracy of those data when making candidates eligible. The second problem has been addressed by the initiation of Table 4-A which provides data about candidates seeking licensure outside the educating jurisdiction to the extent that the licensing jurisdiction permits the sharing of data.

(56) Individual Candidate Results Report (including photograph quality) H (M) L N/A
Comments:
There have been no reported problems with the paper Candidate Results Reports. The photo images are of uneven quality, most are fine but a few are not as clear as we would like. The NCLEX Operations staff monitor the quality of the photo images daily and notify Sylvan of centers that are producing

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

unacceptable photo images. The recently introduced options on the number of copies of reports has been a useful enhancement.

(57) Diagnostic Profiles for Failing Candidates H (M) L N/A
Comments:
Some candidates were confused by the first version of the Diagnostic Profile. The revised version appears to have reduced the confusion, but a few candidates are still not clear about how to interpret the Diagnostic Profile. We continue to work with the National Council to find better ways to interpret the examination results to candidates who fail the examination.

(58) On a scale of 1 to 5, how do you rate the timeliness of the receipt of the electronic transmission of results of NCLEX examinations? __5___ (1 = low rating, 5 = high rating)
With the exception of office closings (due to holidays or weather) and a couple of instances of the Data Center not having the data ready on schedule, the electronic transmissions have gone out to the Boards night after night without interruption.

(59) On a scale of 1 to 5, how do you rate the timeliness of the receipt of the paper results of NCLEX examinations? __4___ (1 = low rating, 5 = high rating)
The paper results are packaged and mailed every afternoon. However, we have heard from some Member Boards that the paper reports are not received on a regular daily basis. For example, a Member Board may tell Chauncey staff that they received the reports for a test date before receiving reports for a prior test date, or that they receive reports only two or three times per week instead of daily. These anomalies in the receipt of the paper reports are being investigated. We continue to investigate uneven receipt of hardcopy (paper) reports and to look for ways to improve the reliability with which they are received by the Boards.

(60) On a scale of 1 to 5, how do you rate the format and content of the paper results reports? __4___
(1 = low rating, 5 = high rating)
The results reports contain all the information needed in an easy to use format and contain the name and address in a location that fits a standard window envelope. The quality of the photo images needs to be more consistent.

Please make additional comments about examination results. Please include what you like best about results reporting as well as any improvements/enhancements suggested.

(61) Accuracy of reports (H) M L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Chauncey has received no allegations of inaccurate data in NCLEX reports. There have been instances in which the wrong candidate's photo image appears on a Results Report. This is due to a procedural error at the test center. The incidence of wrong photo images on reports has declined sharply and is currently a very rare event. The accuracy of the reports are dependent on the accuracy of the data provided by the candidates. We have improved our data editing procedures and have increased the number of candidate records that are manually reviewed and corrected.

(62) Ease of understanding and interpreting reports (H) M L N/A
Comments:
.We have not heard from Boards about any difficulties in understanding or interpreting the reports provided.

STATISTICAL ANALYSES

Please indicate the degree to which you believe the following analyses and resulting reports provide clear and useful information to National Council, Member Boards and/or candidates

(63) Standard statistical analyses (including item difficulty, discrimination, reliability, Rasch scale values, Rasch fit statistics, equating procedures) (H) M L N/A
Comments:
Statistical analyses have included extensive simulations of CAT as well as detailed technical analyses that are issued on a quarterly basis. Simulations have been run for operational pools to assess the face validity as samples of examinations and to develop the scripts for Member Board reviews. National Council staff have had significant input on the format and content of the statistical reports produced for the Council.

(64) Person-fit analyses (identifying patterns of anomalous responses) (H) M L N/A
Comments:
Person-fit statistics are calculated for all candidates and extreme cases are put on hold until for further investigation has been completed. Research is in progress to explore new methods for doing person-fit analyses.

(65) Item differential performance analyses (Mantel-Haenszel) (H) M L N/A
Comments:
Research was carried out prior to the implementation of CAT to establish and evaluate appropriate DIF procedures. Analyses are carried out on a semi-annual basis leading to a review meeting of the DIF panel to inspect the items identified by the DIF analysis as requiring further scrutiny. Feedback from EC members and Council staff who have attended DIF panel meetings has been very positive. Modifications

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

to the procedures and systems enhancements (e.g., collecting ethnicity data during testing) have been implemented to increase the numbers of items analyzed.

RESEARCH, EVALUATION, AND EDUCATION

(66) ETS support in providing current research findings regarding test methodology (H) M L N/A

Comments:
ETS and Chauncey research has contributed to the development of the NCLEX DIF procedures, the methods used to create parallel pools, the methodology and computer programs for CAT simulations, and to ongoing research on CAT item calibration. In addition, ETS research staff contributed resources and expertise to the design and execution of the NCLEX Beta Test comparability study.

(67) ETS role in facilitating the functioning of the JRC H (M) L N/A

Comments:
ETS and Chauncey staff have played key roles in establishing the Joint Research Committee and in its ongoing operations. Since staff were focused on the NCLEX operational program, the JRC got off to a slower start than had been hoped. Although research efforts to date have concentrated on applied psychometric problems, plans for more long range projects (such as research on alternative item types that could be included in CAT) are starting to be made.

(68) Effectiveness of JRC structure to get important NCLEX research conducted (H) M L N/A

Comments:
The JRC structure has provided an efficient mechanism to get important NCLEX research conducted. In the first year of implementation, research projects on CAT standard setting, CAT item calibration, prediction of item difficulty, and CAT person fit procedures were funded.

(69) Monitoring the integrity of measurement principles applied to NCLEX (e.g. dimensionality, scale drift, IRT model) (H) M L N/A

Comments:
In late 1994 the NCLEX program was audited through the ETS auditing process, which included an evaluation of the measurement principles and procedures utilized with the program. This audit process confirmed the overall integrity of the program, as well as providing suggestions for enhancing psychometric procedures. Recognizing the NCLEX program as a new program using new CBT procedures, the auditors were particularly complimentary about the thoroughness with which the audit guidelines were met.

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(70) Compilation of data at Member Boards' request (H) M L N/A
Comments:
The NCLEX program has been responsive in directly compiling data at Member Boards' requests or assisting Council staff in responding to Member Board requests. MBOS data damaged by error made by a Member Board was rebuilt by Chauncey and ETS staff and promptly reinstalled. Requests have been honored promptly and accurately.

(71) Facilitation of visits to ETS headquarters and SLS sites (H) M L N/A
Comments:
ETS has encouraged visits by Council staff and Member Boards to their headquarters and to SLS sites. SLS held open houses at many test centers so that Board members and staff could visit a test center. EC members and National Council staff have been invited and have met at ETS and Chauncey offices.

(72) Expertise of psychometric staff (H) M L N/A
Comments:
ETS and Chauncey staff have a high level of expertise which has been used in developing innovative methods to accomplish psychometric analyses for the program.

(73) NCLEX Quarterly Technical Reports (H) M L N/A
Comments:
The NCLEX Quarterly Technical Reports provide a comprehensive summary of information about each testing quarter as well as comparisons to past quarters and annual results. These Reports are reviewed at EC meetings and have been evaluated as thorough. Data are used for addressing questions and decision making.

(74) Item Differential Performance Reports (H) M L N/A
Comments:
NCLEX DIF reports are thorough, have been completed in a timely manner, and have provided important information for the DIF review meetings. The DIF procedures developed for linear (e.g., paper and pencil) tests are inappropriate for CAT so staff have developed new procedures to apply to the NCLEX.

(75) Person-Fit Analysis Reports H M L (N/A)
Comments:
Person-fit statistics are used in reviewing individual candidates' results but are not summarized in any regularly-produced report.

(76) Effectiveness of standard-setting procedures (H) M L N/A

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Comments:
An extensive research project was conducted as part of the RN standard setting in 1995. Both this standard setting and the PN standard setting in 1996 have been thorough, well documented, and evaluated favorably by the participants.

(77) Usefulness of reports and recommendations pertaining to standard setting (H) M L N/A
Comments:
Reports and recommendations pertaining to standard setting have been timely and thorough. These reports provide the basis for information provided to the Board of Directors for the setting of passing standards.

(78) ETS Annual Report (H) M L N/A
Comments:
Each year Chauncey and Sylvan staff take the opportunity to summarize the program activities and accomplishments. This comprehensive report is submitted for the Annual Book of Reports. We know that the report is reviewed since we generally receive questions from Member Boards following the distribution of this report.

(79) ETS Quarterly Reports (H) M L N/A
Comments:
Chauncey and Sylvan staff submit reports of activities and accomplishments to the NCSBN Board of Directors for each meeting held. We have responded to requests for format changes and topics for inclusion from National Council staff.

(80) Additional written reports/oral presentations for committees, Board of Directors, Area Meetings, and Delegate Assembly (H) M L N/A
Comments:
NCLEX program staff have been responsive in providing written reports and oral presentations as requested. We have not always made the deadlines for EC mailings and hotel packets. We will continue to work to improve in this area. Committee meetings have consistently been staffed by the most senior staff members. The Delegate Assembly has been well attended and staff have consistently been willing to embarrass themselves at the annual ETS breakfast.

(81) Annual research meeting H (M) L N/A
Comments:
ETS staff have used the Annual Research meeting to work with National Council staff to establish research priorities for the JRC. Future Annual Research meetings will focus on exploring the research needs of NCLEX.

Degree of Satisfaction Key: H = high M = moderate L = low

Degree of Satisfaction

(82) Annual contract evaluation meeting (H) M L N/A
Comments:
The contract evaluation meeting has provided ETS and National Council staff with opportunities to step back from the day-to-day issues and look at the "big picture". Both National Council and Chauncey staff have been open in discussing topics related to the contract evaluation and the meetings have been beneficial to the Chauncey staff in planning future work activities.

(83) Participation in education workshops at the request of Member Boards H M L (N/A)
Comments:
No education workshops have been held. However, discussions with National Council staff have taken place to plan an educational session for Member Board staff.

(84) Additional educational services (including Invitational Conferences and other conference presentations) (H) M L N/A
Comments:
ETS staff have been proactive in setting up symposiums at the AERA conference and in presenting research related to computerized adaptive testing and the NCLEX at other national conferences (e.g., CLEAR.).

REGISTRATION ISSUES

(85) The design of the computer system and programs to implement the candidate registration process (including the matching algorithm, but not MBOS) H (M) L N/A
Comments:
The computer systems have been constantly revised to improve their functionality and efficiency. As problems have been encountered and resolved, the computer systems have been enhanced to prevent the problem in the future or to automate the process of recovery. The matching algorithm is a good example. The algorithm itself has had only a few changes. But changes have been made to edit programs to improve the quality of the data used by the algorithm, the displays of data for the clerical review of uncertain cases has been improved, and the clerical procedures have been refined, all of which have brought us to the point where a scan of the database for duplicate candidate records detected only one case from some time ago.

(86) The functioning of the telephone registration system (H) M L N/A

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Comments:
Since the inception of NCLEX using CAT, over 50,000 telephone registrations have been taken by NCLEX Operations. Telephone registrations, which take about 4 minutes each, account for about 13% of all registrations. Our quarterly customer satisfaction surveys show that 96% of respondents answer yes to a question asking if the telephone registration system was easy to use.

(87) The level of cooperation between the Council and ETS in resolving problems with registration including the matching algorithm (H) M L N/A
Comments:
Council staff, the Examination Committee and Chauncey/ETS staff have worked together to identify issues and to suggest enhancements to the registration (and indeed to all Data Center) systems. All the enhancements are assigned a priority and are implemented as soon as possible.

(88) The process for delivering and updating magnetic and hard copy of NCLEX data (H) M L N/A
Comments:
The process for delivering magnetic NCLEX data operates smoothly day in, day out. Magnetic (or electronic) NCLEX data emanating from the registration process are sent nightly to Member Boards. There is no hard copy resulting from registrations per se. When eligibilities are received by the Data Center, they are processed and the result is both an electronic transmission to the Member Board and to Sylvan and a hard copy (the ATT) which is mailed to the candidate. This process occurs daily with the ATTs going into the mail one or two days after receipt of eligibility from the Member Boards. We had one deviation from that schedule in late December 1995 when ATTs were not produced. We have tightened our procedures to detect times in the future when ATTs are not printed.

(89) The procedures for processing candidate registrations and fees (H) M L N/A
Comments:
Over 360,000 registration have been processed since February, 1994. The bulk of the registrations, those that do not require special handling, are processed within 48 to 72 hours of receipt. Instructions in the Bulletin provide detailed instructions for correctly completing the registration form. An extensive data editing procedure is used to ensure that accurate data are entered into the NCLEX database. Member Boards have commented that the quality of the data they receive has improved as the improved editing procedures have been implemented. The matching algorithm and the clerical review match the registrations for repeaters with their database records from prior administrations of the examination.

(90) The quality of ETS financial reporting regarding NCLEX candidate volumes and fees H (M) L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Financial reports are provided monthly. There have been some early issues surrounding the reconciliation of the Counts of registrants provided by Chauncey with the funds transferred to the National Council account, but those issues have been resolved. There have been concerns about differences between financial information provided by LGR and Chauncey. The most recent communication on this topic indicates that LGR and Council staff have accepted the Chauncey data as accurate.

(91) The registration form (content and composition) (H) M L N/A
Comments:
The fact that the registration form used in February 1994 has been reviewed by both Chauncey and National Council and has had almost no change since then is an indication that it is working well.

(92) The procedures for correcting candidate data (for program, foreign educated, and initial/repeat, etc.) with respect to both timeliness and format H (M) L N/A
Comments:
From the beginning, the Acknowledgment postcard has been an effective means of informing candidates about their name and address as recorded in the database and gives candidates an opportunity to correct these data. The name of the education program was been added to the postcard in 1995 to allow candidates to inform us of corrections to that data also. Meanwhile, the address, program code, program name and graduation date have been added to the main candidate screen in MBOS so that Boards can now confirm the accuracy of those data when making candidates eligible. Initially the designation of first time or repeater was based purely on candidate reported data. Once the database contained adequate historical data, edits were added to overrule the candidate reported data when the database substantiated the overruling.

(93) The procedures for verifying the receipt of Candidate Bulletins to Member Boards H (M) L N/A
Comments:
Member Boards receive prior notice of the shipment of Candidate Bulletins and notify Chauncey if the shipment is delayed or not delivered. Many Member Boards order and acknowledge Bulletin shipments through NCNET. Our goal is to determine what method of acknowledgment works best for each Member Board.

(94) The options available for handling registrations from licensure candidates (direct registration, and board-processed) (H) M L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Several options exist and have been implemented. Most Boards ask candidates to register directly with Chauncey. Although most of those Boards wait to receive a registration record from Chauncey prior to declaring eligibility, three Boards have opted to send eligibilities prior to receiving the registration record. Four states register candidates in jurisdiction-specific systems and transmit the resulting eligible registrations to Chauncey. As these comments indicate, Chauncey has implemented a flexible variety of ways in which Member Boards can interact with the Data Center. All of these ways are working effectively.

(95) Responsiveness of ETS registration staff to requests for information (H) M L N/A
Comments:
Up to four supervisory staff are available via an 800 number to answer requests for information from Member Boards. Responding to requests for information from Member Boards is always a high priority for NCLEX staff. Member Boards have commented favorably during phone calls or in person at various meetings about the helpfulness of the NCLEX staff and their timeliness in providing data.

(96) Communication between registration staff and Council representatives (including staff, Board, Member Boards, Committees) (H) M L N/A
Comments:
The phones are covered from 8 am to 8 PM and messages left in the voice mail system will be responded to the next business day. In addition, Boards and National Council communicate with NCLEX staff via email and fax. We place a high priority on responding to all communications from Boards and Council staff.

(97) Interpersonal relations between registration staff and Council representatives (including staff, Board, Member Boards, Committees) (H) M L N/A
Comments:
Chauncey registration staff communicate frequently, even daily, with Council staff, and communicate frequently with Member Boards via special access 800 telephone number. As a result we feel we know, are known to, and maintain friendly relationships with all these constituencies of the NCLEX program. We have received several positive comments from Member Boards and Council staff about the helpfulness of the registration staff.

TIMETABLES

(98) The adherence of ETS to the mutually specified timetables H (M) L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Although we have tried to meet the most critical deadlines, we face daily demands that, on occasion, prevent us from accomplishing all we had hoped to accomplish on that specific day. We have certainly encountered delays in providing work copies (for EC) for NCSBN review. We want to improve our performance in this area.

CUSTOMER SERVICE

(99) On a scale of 1 to 5, what is your level of satisfaction with the service provided when you have contacted ETS to ask a question or to resolve a problem? __5___ (1 = low rating, 5 = high rating)

This rating is based on comments from Member Board staff during telephone conversations, at Area Meetings and the Delegate Assembly.

(100) On a scale of 1 to 5, rate your impressions of your candidates' satisfaction with the service provided when candidates call ETS. __5___ (1 = low rating, 5 = high rating)

This rating is based on the responses to the quarterly satisfaction survey that is mailed to a sample of candidates who have had contacted us.

Please make additional comments about ETS' customer service. Please include what aspects of customer service have served you well as well as aspects of any improvements you suggest.
From the outset, NCLEX staff have made customer service a priority. Our telephone staff are trained in providing good customer service and are provided with manuals and scripts so as to ensure that correct information about the program is provided whenever customers contact the NCLEX staff. One area of improvement will be to do a better job of alerting National Council staff and Member Boards when a customer's contact indicates that they may also contact either of those bodies. Our customer satisfaction surveys show positive responses of the 90% and above, with 94% responding yes to the question about overall satisfaction.

INDEMNITIES

(101) The provision for cooperation with respect to claims (H) M L N/A
Comments:
To our knowledge, there have been no legal actions brought against the NCLEX program. In 1994 an item rescore resulted in payment of lost wages to two candidates whose test results changed from fail to pass. Working together the two Boards of Nursing, ETS/Chauncey, and the National Council resolved this issue promptly and without further consequence.

Degree of Satisfaction Key: H = high M = moderate L = low

Degree of Satisfaction

OVERALL PERFORMANCE

(102) Overall performance of ETS (H) M L N/A

Comments:

Implementation of NCLEX using CAT has been challenging yet rewarding for all Chauncey/ETS staff. As the first large-scale licensure program to move in a single effort from paper-and-pencil testing to computerized adaptive testing, there have been many "firsts" encountered along the way. Processes have been created or, in some cases, adapted for NCLEX. The transition from a paper-and-pencil test to a computer-administered CAT, from testing four times per year to testing every working day, from Board administered tests to vendor administered tests has been accomplished with a remarkable lack of disruption. Folks that were dubious about the plan to move to computer-based testing are no longer doubters.

A daily testing program provides a unique set of needs. Issues arise that must be addressed immediately while still providing the complement of daily services required to keep the program operational. We believe we are meeting this challenge. Our goal is to be responsive to needs and to adapt to meet those needs.

Our strengths rest in our commitment to NCLEX and our strong desire to make this program as successful as possible. To achieve that end, we benefit from the vast resources available within the Chauncey Group, ETS, and Sylvan Prometric available to create unique approaches to issues as they arise.

II. ADMINISTRATION SERVICE (Sylvan)

ADMINISTRATION SERVICE STAFF

(103) Level of expertise of Sylvan staff (H) M L N/A

Comments:

Sylvan corporate staff, specifically the Program Manager, Client Inquiry, National Registration and Technical Support staff members that work directly with the NCLEX program, possess a high level of expertise in NCLEX policies and procedures. All others know how to obtain NCLEX specific information.

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(104) Level of expertise of Test Center staff (e.g., adherence to policies, training, responsiveness to problems) H (M) L N/A

Comments:

Overall, center staff are knowledgeable of and correctly follow NCLEX policies and procedures the vast majority of the time. Of the 344,163 candidates responding to the NCLEX Examinee Evaluation between April 1994 and December 1995, 267,521 voiced a specific opinion about the knowledge level of the center staff. Approximately 95% (253,739 candidates of those responding) felt the center staff was very knowledgeable; 13,314 (4.98%) felt the staff was somewhat knowledgeable and 468 (.17%) felt the staff was not knowledgeable. Sylvan strives to ensure all staff is knowledgeable all of the time but also realizes candidate perception is sometimes skewed negatively when technical difficulties beyond the staff's control arise. Additionally, we recognize the occasions when specific individuals have provided candidates with incorrect information or have not followed the specified policies and procedures.

(105) Responsiveness of Sylvan staff to requests for services (H) M L N/A

Comments:

Sylvan is very responsive to all requests for information and services from National Council and Member Boards. Member Board requests we have granted include furnishing a listing of center schedules for site visits, analysis of center performance over time and implementation of the natural disaster plan.

(106) Communication between Sylvan and Council representatives (including staff, Board, Member Boards, Committees) H (M) L N/A

Comments:

The Program Manager acts as the primary contact for NCSBN and Member Boards and the conduit through which most communications with Sylvan flow. When she is unavailable, her voice mail directs callers to contact Sylvan's corporate offices for immediate assistance. While most communications have been smooth, occasional misunderstandings and technical difficulties delay response times and sometimes result in incorrect information being forwarded. Immediate follow up action is taken when problems like these arise.

(107) Availability of Sylvan staff for National Council meetings (H) M L N/A

Comments:

At least one Sylvan staff member attends each Exam Committee meeting, staff meeting, Area Meetings and Delegate Assembly. Most EC and staff meetings are attended by both the NCLEX Program Manager and Director of Operations.

(108) Interpersonal relations between Sylvan staff and Council representatives (including staff, Board, Member Boards, Committees) (H) M L N/A

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Comments:
Sylvan views their relationship with NCSBN and Member Boards as a partnership and encourages input from them to solve specific problems and further enhance our services to them and the NCLEX candidates.

(109) Way in which Sylvan staff changes were handled (H) M L N/A
Comments:
Sylvan initially proposed serving Member Board needs via Regional Consultants. As the program unfolded, Sylvan dedicated the NCLEX Program Manager to serve as the primary contact for Member Boards and National Council Staff.

(110) On a scale of 1 to 5, how do you rate the responsiveness of Sylvan staff in responding to your inquiries about candidate complaints and site issues? __4___ (1 = low rating, 5 = high rating)
Sylvan strives to provide a preliminary response to all complaints within 72 hours of their receipt. Many issues are resolved in less time but some take longer due to their complexity and the need for discussions with a specific center staff member. Concerns raised during site visits are forwarded to Sylvan by NCSBN and are investigated and responded to in writing within 30 days.

ADMINISTRATION ISSUES

(111) Ability to schedule candidate examinations within 30 or 45 days (as required by contract) (H) M L N/A
Comments:
Since implementation in April 1994, all candidates but 8 in Arkansas in the spring of 1994 and 6 candidates in the Virgin Islands in January 1995 were seated within 30/45 day compliance. In both cases, Sylvan was unable to seat candidates within the 30/45 day compliance because our centers were not operational.

(112) Sylvan and Test Center adherence to National Council security measures for NCLEX administration (H) M L N/A
Comments:
Sylvan monitors EIRs, complaint letters and Examinee Exit Evaluations to ensure compliance with all security measures. Network wide, center staff always strive to adhere to NCSBN security measures by reporting security issues to the Technical Support Hotline and filing EIRs upon identification. One notable case involved a candidate who attempted to bribe the staff in hopes of passing the NCLEX. The National Council and affected Member Board were immediately informed of the situation and the candidate was apprehended. Occasionally, a test center administrator fails to adhere to one or more of

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

the security measures. When this occurs, Sylvan investigates the incident, provides retraining and reprimands the staff member, when applicable. Some examples that prompt intervention include failing to view an visitor's authorization letter or identification, inconsistent proctoring or staffing and allowing candidates failing to bring their ATT to test without successfully matching all secondary match criteria.

(113) Sylvan cooperation in investigations of potential security breaks (timeliness of reporting, correction of problem) (H) M L N/A

Comments:
Investigations relating to security breaks are escalated to the NCLEX Program Manager, Director of Operations and the ETS Office of Test Security and are considered to be of the highest priority for timely resolution.

(114) Procedures for responding to a crisis before, during, and after the administration of an examination H (M) L N/A

Comments:
Sylvan has a crisis plan in place that has worked well since implementation of the NCLEX. The Blizzard of '96 afforded us the opportunity to test our procedures relating to weather crises. The Sunday before the blizzard shut down the upper East Coast, technical support staff were asked to move into a hotel near the corporate offices to increase their chances of being able to travel to work on Monday morning. They supported center staff from the hotel on Monday and were able to travel into work on Tuesday. They remained stationed at the hotel through Friday.

(115) Sylvan responsiveness to corrective actions suggested by concerns raised by National Council and site visitors (H) M L N/A

Comments:
EIRs, technical support records, candidate complaints, site visits and Member Board and Council input all help us to identify areas where improvements are warranted. If a problem appears to be widespread, communiqués are sent to the entire testing network. If a problem is specific to a center, the Client Inquiry staff or NCLEX Program Manager contacts the center to discuss the concern and to provide guidance for dealing with a similar event in the future.

(116) Efficacy of the training and certification program for Test Center staff H (M) L N/A

Comments:
Center staff are trained on the basics of the NCLEX and must pass the certification exam prior to serving as a test center administrator. Subsequent training is performed on the job and through communication with Sylvan's corporate headquarters via communiqué and telephone. Plans to enhance the quantity and quality of training are currently being implemented by Sylvan's new Training Director. A series of videos focusing on maximizing daily operations and improving customer service are being produced. Users

Degree of Satisfaction		
Key: H = high	M = moderate	L = low

Degree of Satisfaction

groups made up of center staff will further help us identify and disseminate best demonstrated practices to all centers.

(117) Examinations are delivered without software/hardware problems H (M) L N/A
Comments:
Hardware problems have been minimal in the last 2 years. In February, we isolated and began remedying a problem caused by the constant running of the file server. Software issues relating to the test administration software are not within Sylvan's purview. Scheduling errors are seldom caused by software malfunctions but rather human error. In August 1994, the National Registration Center (NRC) began utilizing a written script requesting candidates repeat back appointment date, time and location to the registrar prior to ending the call. This has virtually eliminated scheduling errors that occur when candidates call the NRC. We continue to encourage center staff to utilize the script to further minimize communication errors when scheduling candidate appointments.

(118) Examinations are successfully restarted following software/hardware problem identification and correction H (M) L N/A
Comments:
The procedures for restarting an exam that has been interrupted due to a power outage or technical problem are very clear and easy to perform by the center staff. Successful restarts are dependent upon the test administration software allowing the restart. Additionally, restarts for special needs candidates approved for extra time and additional breaks are planned in advance. Restarts for special needs candidates do not signify a problem, rather that the exam has been administered as directed. Candidates whose exams must be restarted due to power outages and technical problems are offered the opportunity to reschedule their exam if it cannot be restarted in 30 minutes. The majority of candidates choose not to reschedule their appointment once their exam has begun because doing so requires a new ATT be produced and sent by Chauncey and the candidate must take an entirely new examination.

(119) Quality and timeliness of technical support services for centers H (M) L N/A
Comments:
In 1995, the Technical Support Department averaged less than 55 seconds to answer Hotline calls (for all testing programs), and a call back occurs within an average of 4 minutes for calls classified as emergency calls. On average it takes of about 29 minutes to respond to, diagnose and resolve problems identified as emergencies. For non-emergencies, the call back occurs on average in about 7 minutes and it takes an averaged 42 minutes to respond to, diagnose and resolve non-emergency issues. Emergencies always receive the highest priority and are defined as problems that delay or interrupt candidate testing.

(120) Timely replacement of faulty equipment (H) M L N/A
Comments:

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

Isolating reported problems sometimes poses a challenge due to the lack of technical expertise of the staff reporting the problem and the intermittent and elusive nature of some problems. Faulty hardware is generally replaced within 24 hours of positive identification and isolation of the problem and determination that it cannot be fixed remotely by the Technical Support staff. We do acknowledge that in the past, repair or replacement of Image Capture cameras sometimes took longer than 24 hours requiring center staff to take Polaroid pictures of candidates. Faulty Image Capture cameras are now repaired or replaced within 24 hours.

(121) Quality of National Registration Center services (centralized scheduling) (H) M L N/A
Comments:
The National Registration Registrars utilize a written script when scheduling candidates. The script was enhanced in August 1994 to ask candidates to verbally confirm appointment date, time and location prior to ending the call. This measure has significantly decreased the number of candidates arriving to test on the wrong day.

(122) Procedures for modifying NCLEX administration for disabled candidates (H) M L N/A
Comments:
In late 1994, a process was developed whereby Sylvan's Program Manager reconciles special accommodations information received from NCSBN and Chauncey on a weekly basis. Monitoring the status of every ADA candidate promotes discussion between the organizations when highly unusual accommodations are requested and ensures each candidate receives the accommodations that have been approved by their Board of Nursing.

(123) Approved modifications for ADA candidates are correctly implemented (H) M L N/A
Comments:
Center staff utilize written step-by-step instructions when administering examination sessions for special needs candidates. The Technical Support Team is in possession of all special needs documents and is informed of all upcoming ADA appointments beforehand so they can best assist center staff if procedural questions or technical problems arise.

(124) Procedures for responding to and recording test administration problems (EIRs) by Test Center staff H (M) L N/A
Comments:
Center staff have become very good at reporting most test session irregularities. We are working to provide additional direction on the need to document any and all concerns and comments candidates make as well as documenting problems that are reported to Technical Support and resolved immediately or that have been reported previously.

Key:	Degree of Satisfaction H = high M = moderate L = low

Degree of Satisfaction

(125) Timeliness of transmitting candidate NCLEX data to ETS (H) M L N/A
Comments:
NCLEX data is transmitted to Sylvan's central database as soon as the examination has been completed. The central database then transmits the EPRs to Chauncey at various time intervals throughout the day and evening.

(126) Timeliness of communicating EIR data (H) M L N/A
Comments:
Each evening EIR data are transmitted to the Chauncey Group and NCSBN simultaneously. EIR data are transmitted to Member Boards by NCSBN.

(127) Responsiveness to providing data in response to candidate investigations (including timeliness and quality) H (M) L N/A
Comments:
The Client Inquiry Department investigates candidate complaints and responds to NCSBN inquiries. Current communication channels between the Client Inquiry Department and NCSBN are indirect. NCSBN has agreed to add the Client Inquiry Department to their distribution list. This measure will decrease the time lag caused by transmitting messages through the Program Manager or Chauncey.

(128) Sylvan's coordination of exam reviews by Member Boards (H) M L N/A
Comments:
Member Board Item Reviews are scheduled and confirmed in advance. As requested by Board Members at the 1995 Delegate Assembly, we have published review dates for 1996 and 1997 to assist Member Boards in coordinating board meetings around Item Reviews.

(129) Sylvan's coordination of exam reviews by candidates (including cost and turnaround time) (H) M L N/A
Comments:
Candidate Review and Challenges are considered special events and are coordinated by the NCLEX Program Manager. The Program Manager works directly with the Board of Nursing to coordinate a date, time and location that is most convenient for the Board.

(130) Sylvan's coordination of Member Board review of experimental items (H) M L N/A
Comments:
Member Board review of simulated examinations and experimental items takes place during the same sessions. See comments under question #128.

Degree of Satisfaction Key: H = high M = moderate L = low	Degree of Satisfaction

(131) Timeliness and quality of Sylvan reports to National Council (H) M L N/A
Comments:
In 1995, Sylvan and National Council developed a report schedule for a variety of summary reports. Additionally, Sylvan provides drafts of all reports that will be furnished to the Board of Directors and Member Boards for input prior to finalization.

(132) On a scale of 1 to 5, how do you rate the quality of service your candidates receive at the testing centers?
___5__ (1 = low rating, 5 = high rating)
We believe the service we have provided to candidates has been very high based on the compilation of responses to the April 1994 - December 1995 NCLEX Examinee Evaluations. Over 95% of candidates responded favorably to questions concerning check-in procedures, knowledge and professionalism of the center staff with the highest rating achieved on professionalism of staff (99.13%). Over 90% of candidates responded favorably to our scheduling processes, ability to locate the testing center and the lighting inside the testing lab. The least favorable responses related to noise, both inside and outside the testing room with an average rating of approximately 86% reporting the testing room was quiet. Sylvan continues to search for ways to further reduce noise levels or create white noise that will mask noises that cannot be eliminated like keyboard noises and those caused by candidates such as coughing, writing and entering and exiting the testing room.

(133) Please choose the answer that best describes the amount and quality of information Sylvan Technology Center staff provide to testing candidates.

Just the right amount of correct information _____ (N/A)
Not enough information _____
Too much information _____
Incorrect information _____

(134) On a scale of 1 to 5, how do you rate the quality of EIRs written in helping you resolve candidate issues?
___4__ (1 = low rating, 5 = high rating)
The quality of EIRs filed has improved significantly since implementation. National Council and Member Board input has been instrumental in determining when EIRs should be filed and what level of detail is needed to best assist Member Boards when working with candidates. Sample EIRs have been forwarded to center staff and are included in the 1996 NCLEX Test Center Administrator's Manual to help them better understand what details are needed.

Degree of Satisfaction		
Key: H = high	**M = moderate**	**L = low**

Degree of Satisfaction

Please make additional comments about ways that Sylvan might improve the services offered to Member Boards and/or candidates? Please include what you think works as well as any improvements or enhancements suggested.

Sylvan continually strives to improve the services we offer Member Boards and candidates. A variety of software enhancements are scheduled to be implemented in late 1996. Two significant enhancements include allowing us to automatically capture detailed information about center closures and disallowing center staff from scheduling candidates approved to test with special accommodations. The automated scheduling system that we began testing last summer will shortly become fully operational allowing candidates to schedule, reschedule, cancel and confirm appointments virtually 24 hours per day.

OVERALL PERFORMANCE

(135) Overall performance of Sylvan (H) M L N/A

Comments:

Implementation and successful coordination of the NCLEX CAT has been challenging and enlightening for the Sylvan corporate and center staff. In the last two years, we have found new challenges and better ways of serving our NCLEX candidates and Member Boards. As we work with the individual boards, National Council, ETS, Chauncey and center staff, we consistently challenge ourselves to approach each new opportunity creatively, always focusing on how changes will affect all parties, including the candidates.

Our strengths lie in the dedication of our corporate and center staffs to making this program as successful as possible. Our corporate staff is dedicated to providing more and better tools to help the center staff better satisfy the needs of all candidates. The ability of our center staff to provide quality testing services in a friendly, comfortable and professional atmosphere on a daily basis and sometimes under tremendous pressure is noteworthy.

III. ADDITIONAL COMMENTS

Note: This section is not applicable for The Chauncey Group and Sylvan Prometric.

Degree of Satisfaction		
Key: H = high	**M = moderate**	**L = low**

Degree of Satisfaction

(136) On a scale of 1 to 5, how well is the computer-delivered NCLEX satisfying your needs to support the licensing of nurses in your jurisdiction? _____ (1 = low rating, 5 = high rating)

(137) On a scale of 1 to 5, how satisfied are you with the services provided by ETS and Sylvan? _____ (1 = low rating, 5 = high rating)

(138) Please make additional comments about the performance of ETS not covered above

(139) Please make additional comments about the performance of Sylvan not covered above.

(140) Additional comments about computer-delivered NCLEX. Please include what you like the best about the computer-delivered NCLEX and what aspect of the computer-delivered NCLEX is most in need of improvement.

(141) Please list any additional services or procedure modifications that are of high priority to you at this time and indicate the rationale for the request.

Please specify who participated in the response to this survey (by title):

Degree of Satisfaction Key: H = high M = moderate L = low

Degree of Satisfaction

Jurisdiction:

Please rank order (1 - 6, with 1 as highest, 6 as lowest) the following areas of testing service in terms of importance to the National Council mission and goals:

_____ Candidate customer service

_____ Data services (registration, MBOS)

_____ Reports

_____ Test administration

_____ Test development

_____ Test service staff (SLS and ETS)

Attachment C

Report of the Institute for the Promotion of Regulatory Excellence Board Committee

Committee Members

Tom Neumann, WI, Area II, *Vice-President, Chair*
Charlene Kelly, NE, Area II, *Treasurer*
Roselyn Holloway, TX-RN, Area III, *Director-at-Large*
Janet Wood-Yañez, TX-VN, Area III, *Director-at-Large*

Staff

Lea Newson, *Administrative Assistant, Communications*
Susan Woodward, *Director of Communications*

Relationship to the Organization Plan

Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ..... Facilitate communication between National Council, Member Boards and related entities.

Recommendations to the Board of Directors

Recommendations were made over the course of the year that helped to identify educational offerings for Member Boards.

Highlights of Activities

- **Creation of the Institute for the Promotion of Regulatory Excellence**

  During its October meeting, the Board committee defined National Council's continuing education program, named the program the "Institute for the Promotion of Regulatory Excellence," reviewed its responsibilities in the development of the program, and created a Member Board Needs Survey that was distributed to all boards of nursing and returned with responses. The committee decided that the objective of the Institute for the Promotion of Regulatory Excellence would be to provide educational offerings for Member Boards (board members and staff) that expand and enhance the knowledge of issues and activities that impact the regulation of nursing. The Board of Directors required the committee to act as the coordinating group for the program, reporting to the Board, with the following responsibilities:

  - survey Member Board needs/ distribute Call for Topics to National Council committees/task forces;
  - identify/prioritize needs;
  - match needs with proposals;
  - identify delivery method;
  - choose educational offerings according to needs;
  - refer topics to appropriate structural units (e.g., task forces) for program development;
  - conduct evaluation activities;
  - assure quality of program;
  - deal with emerging issues; and
  - budget annually.

  The committee developed criteria for the selection and evaluation of offerings, and defined the role of continuing education credit in the implementation of the program. Educational offerings will be selected on the basis of whether the offering is based on a Member Board needs assessment; offers an educational opportunity;

a structured learning experience; requires an investment of time and money; and is deliverable to the majority of Member Boards. Attendance and participant evaluations will be used to evaluate offerings. The committee also decided that Member Board need would be the driving force behind the program, not the amount of continuing education credit offered.

- **Joint Conference with the Citizen Advocacy Center**

  On December 5, 1995, over 225 persons attended the joint conference sponsored by the National Council and the Citizen Advocacy Center titled, "Crafting Public Protection for the 21st Century: The Role of Nursing Regulation." The conference, recommended in June 1995 by the Board committee, was well received and attendee evaluations indicated a successful meeting.

- **Selection of Offerings based on Member Board Needs Survey**

  The committee reviewed results from the 1996 Member Board Needs Survey and the Call for Topics during its January meeting. The committee identified that topics of most interest to Member Boards were "Political Climate and Impact on the Functioning of Boards of Nursing," "Turf Issues - Overlapping Scopes of Practice," and "Delegation." Indicated as the most preferred delivery method for educational offerings was "as part of the Annual Meeting." In addition, the committee noted that many boards suggested that topics related to continued competence would be of interest.

  The committee agreed that Member Boards' continuing education needs, as identified in the needs survey, were partially met in 1995 with regard to the topic "Political Climate and the Impact on the Functioning of Boards of Nursing." Based on its review of the survey and of various proposals in FY96, the committee recommended to the Board of Directors that an offering on continued competence be developed by the Essential and Continued Competence Subcommittee and offered as a concurrent educational session to be held at the 1996 Annual Meeting; and that the educational offering, "A Day of Discipline" as proposed and developed by the Complex Discipline Cases Subcommittee, be held on August 5, 1996, in conjunction with the 1996 Annual Meeting. Both recommendations were approved by the Board of Directors at its January meeting. At its May meeting, the Board of Directors also approved the committee's recommendation that a public policy conference be offered as an educational offering during FY97. The committee will continue to look for ways to incorporate other top topics identified in the survey in future educational offerings.

Future Activities

In accordance with its responsibilities, the committee will continue to review educational proposals, survey Member Board needs and recommend educational offerings to be offered by the Institute for the Promotion of Regulatory Excellence. In June, the committee will meet to revise the Member Board Needs Survey for distribution in October 1996.

Meeting Dates

- October 17, 1995
- January 16, 1996
- May 7, 1996

Recommendations to the Board of Directors

Recommendations were made over the course of the year that helped to identify educational offerings for Member Boards.

Supplemental Report of the Board of Directors

Board Members

Marcia M. Rachel, MS, Area III, *President*
Tom Neumann, WI, Area II, *Vice-President*
Charlene Kelly, NE, Area II, *Treasurer*
Joey Ridenour, AZ, *Area I Director*
Linda Seppanen, MN, *Area II Director*
Nancy Durrett, VA, *Area III Director*
Marie Hilliard, CT, *Area IV Director*
Roselyn Holloway, TX-RN, Area III, *Director-at-Large*
Janet Wood-Yañez, TX-VN, Area III, *Director-at-Large*

Staff

Jennifer Bosma, *Executive Director*
Doris Nay, *Associate Executive Director*

Recommendations

The Board forwards to the Delegate Assembly for its consideration the following recommendation brought by the Nursing Regulation Task Force with the support of the Board:

1. **That the Delegate Assembly approve the National Council response to the Pew Health Professions Taskforce on Health Care Workforce Regulation report, *Reforming Health Care Workforce Regulation.* (See Nursing Regulation Task Force report behind Tab 10-K.)**

   If adopted by the Delegate Assembly, this response will be forwarded in the appropriate format to the Pew Commission for inclusion among the solicited responses. It will also be disseminated for information to organizations with mutual interests in nursing and regulation.

Board Action at June 26-28 Meeting

The Board of Directors also considered the Nursing Regulation Task Force's request for direction regarding development of potential future regulatory models. Materials developed subsequent to the discussions at the Member Board conference on regulatory models, June 9-10, were reviewed and the Board provided feedback to the Task Force. The Board approved funding for a mid-July Task Force meeting combined with another Member Board focus group. Member Boards will receive materials describing the continuing development of models prior to the Annual Meeting. Forum time has been identified for further discussion of the regulatory models at the Annual Meeting. The Nursing Regulation Task Force and the Board of Directors, at their next meetings (July 16 and August 3-4, respectively), will further consider potential recommendations for discussion and action by the delegates at the Annual Meeting. The forum on the afternoon of Thursday, August 8, will include this topic.

The Board received the report of the Information Services Evaluation Task Force (Tab 10-Q). The Board endorsed the task force's recommendations that the National Council continue to advance, with high priority, its presence on the Internet. The task force in FY97 will be known as the "Strategic Technology and Information Management Task Force." At the post-Delegate Assembly Board meeting, the Board will consider the number of meeting times for the task force as it finalized the tactics and budget for FY97.

Future Board Considerations

The Board will also discuss, with the APRN Coordinating Task Force, the results of Phase I of the Nurse Practitioner job analysis and the recent commitments by Nurse Practitioner certifying organizations for third party review of the sufficiency of certification examinations for regulatory purposes. This discussion is anticipated to occur at the Board meeting on August 4, and will be reported during the Annual Meeting. Opportunities for discussion of APRN issues will be offered on the afternoons of Wednesday, August 7, and Thursday, August 8, at the Annual Meeting.

Report of the APRN Coordinating Task Force

Task Force Members
Kathy Thomas, TX-RN, Area III, *Chair*
Kathy Apple, NV, Area I
Elizabeth Lindberg, MA, Area IV
Jacqueline Waggoner, IL, Area II

Staff
Diane Creal, *Policy and Practice Associate*
Carolyn Hutcherson, *Senior Policy Analyst*

Relationship to Organization Plan
Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E ..... Provide a comprehensive approach for the regulation of advanced nursing practice.

Recommendations to the Board of Directors

1. **That a job analysis for the Clinical Nurse Specialist is deferred until a later time.**

   Rationale
   Preliminary results from the data collected on the regulatory status of the Clinical Nurse Specialist indicate that further monitoring of the role is required. Obtaining information on the practice and education of the Clinical Nurse Specialist was difficult, in part, because of the redefining of the role. Additional monitoring of the evolving role of the Clinical Nurse Specialist and the regulatory implications of the changing role is required before recommending a job analysis be initiated.

2. **That the Member Boards be encouraged to actively promote the use of similar criteria for recognition of Clinical Nurse Specialists and Nurse Practitioners.**

   Rationale
   Specific recommendations for criteria for regulation include: Master's degree (consistent with *Model Nursing Practice Act*); specific educational preparation in role and specialty (consistent with American Association of Colleges of Nursing's *Essentials of Graduate Education* and the National Organization of Nurse Practitioner Faculty *Curriculum Guidelines*); standardized curriculum; and passing score on an entry-level competency exam (regulatory assurance of competency).

3. **That the Delegate Assembly authorize the Board of Directors to give final approval of the Family Nurse Practitioner (FNP) Curriculum Guidelines and Regulatory Criteria for Evaluating Nurse Practitioners Applying for Prescriptive Authority and, with prior opportunity for review and comment by Member Boards, indicate organizational support as a model for its use by Member Boards.**

   Rationale
   The need for commonly agreed upon evaluation criteria for FNPs applying for prescriptive authority and for curriculum guidelines in the area of pharmacology is critical given current trends toward greater utilization of FNPs for the provision of primary care in community-based health care delivery settings. In order to fully maximize their potential for providing competent primary health care for all types of clients, including those in underserved populations, FNPs must possess sufficient knowledge of pharmacology, other related sciences and relevant state and federal laws. Consistency in regulatory agencies' evaluation criteria and requirements would, in addition to promoting inter-state mobility of FNPs, also help promote other health care provider groups' and the public's understanding, acceptance and utilization of the contributions FNPs can make to the delivery of quality health care, and promote public protection through the standardization of educational preparation.

Member Boards will have received draft documents prior to the Annual Meeting for review and comment. An opportunity for discussion will be provided at the Annual Meeting. Because the projected final date of completion for the FNP project is February 1997, it would be of benefit to Member Boards if the approval process was not delayed until the 1997 Delegate Assembly.

4. **Following receipt of Phase I of the Nurse Practitioner job analysis, the task force will review the results and make recommendations to the Board of Directors regarding future National Council activities.**

Background

Per the 1995 *Book of Reports*, the Task Force to Study the Feasibility of a Core Competency Exam for Nurse Practitioners recommended that the National Council proceed with "the development of an entry-level core competency examination for nurse practitioners." The Nurse Practitioner specialty certification organizations requested that they be allowed to demonstrate the feasibility of utilizing their tests for regulatory purposes. A vote at the 1995 Delegate Assembly resulted in the following resolution: *"Collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations which are sufficient for regulatory purposes. Benchmarks for progress shall be established and evaluated by the Board of Directors. The Board of Directors shall report to the 1996 Delegate Assembly with specific recommendations regarding future actions including the potential creation of a core-competency examination. If, at any time, the Board of Directors determines that significant progress is not being made, the board is authorized to conduct a job analysis of entry-level nurse practitioners."* The APRN Coordinating Task Force was charged with this tactic. A chronology of the collaboration activities and correspondence was distributed to Member Boards in April, at the time it was determined by the Board of Directors that significant progress had not been made and a job analysis should be performed.

Highlights of Activities

- **Review of the National Organization of Nurse Practitioner Faculties (NONPF) Curriculum Guidelines**
  The APRN task force reviewed the NONPF Curriculum Guidelines and reported its conclusions to the Board of Directors, resulting in a letter of strong support for Member Board use of the guidelines as a method of promoting consistency in licensing and credentialing.

- **Review of the National Association of Nurse Practitioners in Reproductive Health (NANPRH) Standards of Practice & Education**
  The task force reviewed the NANPRH standards of practice which were submitted to National Council with the request for an official letter of endorsement, and reported its conclusions to the Board of Directors.

- **Nurse Practitioner Certifying Body Activities**
  Events and discussions surrounding the collaborative activities between the National Council and the nurse practitioner certifying organizations are outlined in a chronology of events (Attachment A). A request for proposals (RFP) for a job analysis of entry-level nurse practitioners was initiated and a resulting job analysis will be reported (Phase I) to the delegates at the Annual Meeting. The APRN Coordinating Task Force will be forwarding a recommendation to the Board of Directors as the results of the job analysis become available.

- **Regulatory Issues for Advanced Practice Nursing**
  Monitoring of issues related to advanced practice and education as well as the potential merging of the nurse practitioner and clinical nurse specialist roles was ongoing. From a regulatory perspective, distinguishing primary care versus acute care and specialty versus advanced practice were identified issues which Member Boards face on a consistent basis. Resource documents will be developed to assist Member Boards with these issues.

- **Regulatory Status of the Clinical Nurse Specialist (CNS)**
  The initial work of the task force centered on data collection regarding the status of the CNS from a regulatory, educational, certification and practice perspective. Numerous issues related to the regulation of CNS practice were identified and discussed. A survey to Member Boards was developed and articles on the role confusion/merger of the CNS were obtained and discussed (Attachment B). Regulatory issues were identified for the CNS.

Future Considerations for the National Council

- Continue to monitor all issues related to advanced practice and education
- Continue to monitor the merging of the nurse practitioner and clinical nurse specialist roles
- Continue to monitor the regulatory implications of the advanced practice role and potential merging of roles
- Continue to develop strategies for uniform regulation of advanced practice nurses
- Continue to monitor impact of changes in advanced practice on Member Boards

Meeting Dates

- September 20-22, 1995
- January 24-26, 1996
- March 25-27, 1996
- May 16-18, 1996

Recommendations to the Board of Directors

1. That a job analysis for the Clinical Nurse Specialist is deferred until a later time.

2. That the Member Boards be encouraged to actively promote the use of similar criteria for recognition of Clinical Nurse Specialists and Nurse Practitioners.

3. That the Delegate Assembly authorize the Board of Directors to give final approval of the Family Nurse Practitioner (FNP) *Curriculum Guidelines* and Regulatory Criteria for Evaluating Nurse Practitioners Applying for Prescriptive Authority and, with prior opportunity for review and comment by Member Boards, indicate organizational support as a model for its use by Member Boards.

4. Following receipt of Phase I of the Nurse Practitioner job analysis, the task force will review the results and make recommendations to the Board of Directors regarding future National Council activities.

Attachments

Attachment A

Chronology of NP Certification Review Events June 1995 to March 1996

June, 1995	National Council (NC) sponsors Advanced Practice Leadership Roundtable, at which the recommendation of the National Council Task Force to Study the Feasibility of a Core Competency Examination for Nurse Practitioners is discussed.
July, 1995	National Council representatives attend special meeting of NP certification organizations called in conjunction with Keystone NP conference; purpose is to "achieve the goal of effectively responding to NCSBN's concerns."
August, 1995	NP Certification organization representatives attend National Council Delegate Assembly, provide a document intended to address the questions raised about the regulatory sufficiency of NP examinations, and lobby the Delegate Assembly for time to work out a mutually agreeable alternative. Delegate Assembly adopts a motion that "the National Council will collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations which are sufficient for regulatory purposes. Benchmarks for progress shall be established and evaluated by the Board of Directors. The Board of Directors shall report to the 1996 Delegate Assembly with specific recommendations regarding future actions including the potential creation of a core-competency examination. If, at any time, the Board of Directors determines that significant progress is not being made, the board is authorized to conduct a job analysis of entry level nurse practitioners." A letter is sent to certification organizations laying out National Council's proposed process for document review and site visits, and calling a meeting for September 20, 1995.
September, 1995	All NP certification organizations send representatives to the September 20 meeting at the National Council. (A memo of September 19 from the certifying organizations requests criteria for determining psychometric soundness and legal defensibility.) During the meeting, the process described in the letter is reviewed and discussed (no substantial alternatives are proposed other than the possible need for a resolution-of-differences-regarding-conclusions process). The certifying organizations expressed a need for more specificity regarding the documents to be provided and a detailed list was generated at the meeting. Each organization identified a target timeframe for its site visit, and an overall timeframe for review of documents, site visits, report generation and review, and finalization was agreed upon.
October 10, 1995	National Council sends a letter confirming outcomes of the meeting to all organizations, including timeline for entire process through reporting, the 11 areas to be reviewed and a list of relevant source materials in each area.
October 19, 1995	National Council Board of Directors finds progress to date acceptable.
October 27, 1995	The first correspondence from one of the certifying organizations is received (NCC); it contains dates and procedures (including a confidentiality agreement) for the organization's site visit. The procedures (e.g., restricting access to some materials to on site and limiting parties participating in the process) are significantly different than those discussed on September 20, and seriously reduce the likelihood that the document review and site visit will be able to fulfill their intended purpose. Over the next several weeks, correspondence is exchanged with NCC.

November 21, 1995 — National Council Board of Directors receives an update on the process and determines that it is proceeding as planned "with minor issues to be worked out with a few certifying agencies." Board suggests executive director meet face-to-face with NCC executive director.

November 29, 1995 — Executive directors of NCC and National Council meet and reach the following conclusions:
1) NCC will review a confidentiality agreement proposed by National Council.
2) National Council will develop definitions of terminology to clarify issues such as legal defensibility. Furthermore, Ms. Burns found the draft checklist for document review and site visit list helpful and encouraged that it be shared with the other organizations.

December 22, 1995 — National Council sends correspondence to all certifying organizations; including the checklist and "chapter one" of the final report (which defines the purpose, key terminology such as legal defensibility and regulatory sufficiency, and the industry standards to be used in the review process and report.

December 28, 1995 — Certification organizations send correspondence to National Council expressing a number of unresolved issues. Concerns to the certification organizations are reflected in the following excerpts from their correspondence: "A significant level of uncertainty continues to exist regarding the purpose, process, criteria for review, and standard of acceptability." The correspondence concludes with the following: "Due to the lack of resolution of these key issues, we believe that plans for site visits need to be deferred until further discussion and clarification have occurred. In addition, we request that written assurances to all the parties' satisfaction be given, that NCSBN will not develop or administer a generic or specialty examination for nurse practitioners, based in any respect upon its review of our organizations." National Council suggests a conference call for discussion.

January 17, 1996 — Marcia Rachel, Jennifer Bosma, and Anthony Zara speak with NP certification organization representatives by conference call; major unresolved issues identified by certification organizations are how to assure that National Council will not use organizations' materials in creating a new examination and the criteria to be used by National Council for the review and reporting to Member Boards. Conference call is reported to National Council Board of Directors, meeting on this date, who agree that it is not within the Board's purview to agree to the certifying organizations' request that National Council make a commitment not to engage in the preparation of any NP examinations for a specified period of time, and set a March 1 deadline for a face-to-face meeting by which an acceptable procedure must be identified.

January 19, 1996 — Certification organizations send letter reflecting their understanding of conference call conclusions; variation in understanding is evidenced by their conclusion that National Council had agreed to "provide the certification organizations with a specific, written description of perceived insufficiencies of current examinations and/or certification processes." National Council representatives articulated that a list of specific cases of concern would be counterproductive to an objective, comprehensive assessment of NP certification programs compared to industry standards.

January 24, 1996 — Certification organizations meet; telephone contact is initiated by National Council with representatives of the organizations prior to and on the day of the meeting in an attempt to ensure accurate, comprehensive and timely communication. A February 26 meeting with National Council is agreed to by phone.

February 23, 1996 — Certification organizations send correspondence emanating from their January 24 meeting, stating a review mechanism, standards, and report components acceptable to them including: new limitations to job analysis (executive summary only); limitations on notes made on-site (e.g., no written record related to documents not in public domain); and reiterating requests

for specific insufficiencies and for commitment not to develop or administer a generic or specialty exam for nurse practitioners.

February 26, 1996 — Marcia Rachel and Carolyn Hutcherson attend meeting with certification organization representatives on behalf of National Council.

March 1, 1996 — Certification organizations send correspondence regarding outcomes of February 26 meeting. New issues are identified in the following excerpt from the correspondence: "We think it important, however, to reserve the right of the certifying organizations, within the boundaries described above, to modify a draft report prepared by the staff of the National Council in any way they deem appropriate at their sole discretion. We are also seeking the agreement of the National Council to make verbal reports to members based solely on the written report of the results of the review that has been approved in advance in writing by the certifying organizations". Furthermore, a proposal for a new document, a "memorandum of agreement," was made by the certification organizations.

March 5, 1996 — National Council Board of Directors reviews progress during conference call meeting. The Board of Directors specified that procedures and a timeline identifying agreed upon dates must be forwarded to National Council by March 13, 1996. Board's decisions are communicated to certification organizations in letter.

March 13, 1996 — Certification organizations reply, sending proposed memorandum of agreement and confidentiality agreement with substantial changes from terms proposed by National Council. The counterproposal by the certification organizations included: to keep the memorandum of agreement itself confidential; to bind all National Council persons including volunteers to confidentiality regarding the reports; and to return all documents prior to report completion and presentation at the Annual Meeting.

March 15, 1996 — Jennifer Bosma sends initial reply stating the unacceptability of the certification organizations having the right to make modifications in the final report "in any way they deem appropriate at their sole discretion." By telephone conversation, certification organizations agree to consider alternatives to the objectionable provision concerning the reports and propose a meeting in Chicago on March 20 to "attempt to resolve remaining issues related to both proposed agreements."

March 18, 1996 — Jennifer Bosma relates proposed alternative reporting mechanism to Mary Jean Schumann by telephone (i.e., that a certification organization which upon reviewing the draft report has serious unresolvable concerns about its contents, will have the option to decline publication of any report with that action reported to the delegates); and supports idea of meeting March 20, provided that there is a viable proposal "on the table" beforehand for the approval of reports and all participants understand that all issues must be resolved at this meeting in order to proceed further with the collaborative process. Mary Jean Schumann requests that the proposed alternative be put in writing by National Council, as well as the other points of objection. Jennifer Bosma prepares memo describing points of objection and faxes to Mary Jean Schumann that evening.

March 19, 1996 — Legal counsel prepares language for reporting alternative, which is transmitted by Tony Zara to certification organizations. Mary Jean Schumann requests that any additional points raised in legal review be transmitted to them in writing and suggests that we handle discussions on Wednesday via conference call rather than face-to-face meeting.

March 20, 1996 — After receiving legal counsel review of proposed agreements and suggested minor changes, Jennifer Bosma prepares letter and faxes it to certification organizations in morning. Certification organizations, via MJ Schumann, indicate that they wish to delay start of conference call to

have opportunity to consider the legal review comments. MJ Schumann calls near end of day to say they are preparing a written response which will be delivered the next morning.

March 21, 1996 — Written response of certifying organizations is received. It continues to bind volunteers to confidentiality, newly limits report distribution to "official representatives of each state Board of Nursing registered and in attendance at the 1996 NCSBN Annual Meeting," and provides that the only information to be shared if and when a certification organization declines publication of its report is "the parties could not reach mutual agreement regarding the content of the report." A new sentence limiting report content is included: "The draft report shall not include any information that adversely affects the legal defensibility or integrity of any test or testing process." Marcia Rachel indicates desire to confer with Board of Directors on March 22.

March 22, 1996 — President polls Board of Directors, which reaches decision to initiate job analysis.

March 25, 1996 — Decision of the Board of Directors is communicated to certification organizations. Basis cited is **lack of significant progress** in collaborating with certification organizations toward legally defensible and psychometrically sound nurse practitioner exams sufficient for regulatory purposes. Specific barriers include the limitations on reporting the findings and on the ability to openly discuss the findings and process used.

March 28, 1996 — Correspondence received from certification organizations expressed that they are "at a loss to understand how Council has reached the conclusions implicit in Paragraph 3 of your letter" (dated March 25) and "remain open to dialogue if the National Council believes this would be beneficial."

March 29, 1996 — Request for proposals (RPF) for the performance of an entry-level nurse practitioner job analysis study is issued.

April 4, 1996 — Board of Directors reviews correspondence from certification organizations and the APRN Task Force comments and recommendations. Directs correspondence replying to March 28 letter reiterating National Council commitment to job analysis, and offering opportunity for any NP certification organization to approach the National Council for further dialogue.

May 8, 1996 — Board of Directors awards the contract for the performance of an entry-level nurse practitioner job analysis study to the Chauncey Group International. A preliminary report of Phase I (logical job analysis) will be given at National Council's Annual Meeting, August 6-10, 1996, in Baltimore.

ATTACHMENT B

Member Board Requirements for Legal Recognition as a Clinical Nurse Specialist (CNS) — Summary Report 1996

1) Are Clinical Nurse Specialists (CNS) regulated as advanced practice registered nurses in your state? (n=40, out of 56 Member Boards regulating registered nurses)
   25 Yes 15 No (go to question 7)

   — If yes, please identify which type of CNSs (check all that apply) (n=25)
   15 psych and/or mental health
   9 no designation
   10 others (please specify) _____

2) What approach is used to regulate CNSs? (n=25)
   9 Licensure
   3 Certification
   6 Letter of Recognition
   7 Other (please specify) _____

3) Does authorization from the Board of Nursing grant the use of a CNS title? (n=25)
   15 Yes 10 No

   — If yes, please specify _____

   — If no, how do you advise CNSs regarding use of the title CNS? (please explain)
   _____

4) Does authorization from the Board of Nursing grant a scope for CNS practice? (n=25)
   14 Yes 11 No

   — If no, how do you advise CNSs regarding scope of practice? (please explain)
   _____

5) What is the minimum level of education required for legal recognition as a CNS? (check one) (n=25)
   0 Baccalaureate
   7 Masters Degree
   12 MS in Nursing
   5 Other (please specify) _____
   1 N/A

6) Please indicate which additional criteria are required for recognition as a CNS: (n=25)
   11 MS in specialty area

   — If yes, must it be in the CNS's selected area of practice
   7 Yes 4 No

   1 Other post baccalaureate education
   20 Certification by a national certifying body in a specialty area
   1 Formal preceptorship
   Other (please specify) _____

7) Does the Board of Nursing establish educational criteria for the CNS programs? (n=40)
7 Yes 33 No

— If yes, are minimum requirements specified for the length of CNS programs? (n=7)
3 Yes 4 No

— If yes, please specify minimum number of hours, months, etc._____

— If no, requirements are recognized by: (n=33)

*education program	Yes 6	No 27
*national certifying body	Yes 12	No 11
*other (please specify)	_____	

8) Does your board review the curriculum content of CNS educational programs? (n=40)
7 Yes 33 No

— If yes, which of the following content is required: (check all that apply) (n=7)

3 Advanced Pharmacology	Number of hours required _____
2 Advanced Physical Assessment	Number of hours required _____
2 Pathophysiology	Number of hours required ____
2 Psychopathophysiology	Number of hours required _____
3 Preceptorship	Number of hours required _____

— Do you specify preceptor qualifications? (n=40)
4 Yes 36 No
— If yes, which are required (check all that apply) (n=4)
1 Experienced CNS
2 Physician
1 Nurse Practitioner
Other (please specify) _____

— Must the preceptorship be a part of the formal curriculum? (n=40)
5 Yes 35 No

— If yes, which of the following scenarios are accepted (check all that apply) (n=5)
3 Concurrent with didactic
2 After conclusion of didactic
2 As specified by educational program
2 As specified by certifying body

9) Are the educational standards for the nurse practitioner and CNS the same in your state? (n=40)
9 Yes 31 No

10) Are you considering rule changes which require the same criteria for CNS and nurse practitioner board recognition? (n=40)
6 Yes 34 No

11) Are CNSs eligible for prescriptive authority? (total n=40)
18 Yes 22 No

— If yes, what criteria are required for eligibility for CNS prescriptive authority (check all that apply) (n=18)
11 Specialty education in master's program
14 Additional pharmacology courses
4 Continuing Education
Other (please specify) _____

Attachment C

Clinical Nurse Specialists: A Regulatory Profile

The advent of managed care and subsequent restructuring of the health care system have brought practice and regulatory issues facing advanced practice nurses to the forefront. Furthermore, while nurse practitioners (NPs) continue to struggle with issues related to prescriptive authority, independent practice and reimbursement, clinical nurse specialists (CNSs) are experiencing the restructuring of their very role. Historically, CNSs have practiced in the acute care setting and as the practice setting shifts from acute care to the community, the role of the CNS is tenuous, at best. The question then becomes: what is happening to the role of the CNS—from a regulatory perspective?

At National Council's August 1995 Delegate Assembly, a resolution was passed to "gather data to reveal the current state of the regulation of the clinical nurse specialist" to assist Member Boards with identification related to the regulatory needs of the CNS. In response to this resolution, the APRN Coordinating Task Force of the National Council of State Boards of Nursing developed a framework for analysis of the issue. The education, certification, practice, and regulation of the CNS were identified as key areas to explore in the quest for capturing a current picture of the role of the CNS from a practice and regulatory perspective. Are CNSs regulated as advanced practice nurses? Is the scope of CNS practice changing? Are there standard criteria for regulating NPs and CNSs? Are the educational standards the same for CNSs and NPs? Is there a need for standard regulatory criteria to ensure protection of the public? Are the roles of the CNS and NP merging? These are just a few of the questions that provided the framework for exploring the current practice and regulatory environment of the CNS.

Introduction and Background

Advanced practice registered nurse (APRN) is an umbrella term used to describe categories of registered nurses who have gone beyond the basic nursing education and engage in clinical practice beyond the basic nursing practice. The categories of nurses generally accepted as APRNs include clinical nurse specialists, nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists (American Nurses Association, 1993; National Council of State Boards of Nursing, 1994). However, in the regulatory arena, the types of APRNs who are *legally authorized* to practice beyond the nurse practice act as advanced practice registered nurses vary. At issue, is the regulatory status of the CNS across the nation.

Issues Specific to CNS Regulation

There are several key factors related to the CNS role which are causing the regulatory community to pause. First and foremost, the scope of CNS practice is changing. The continued movement towards emphasis on primary care versus acute care and the change in settings from acute care to community-based care has afforded the CNS an opportunity to have increased responsibility in the medical management of patients. Additionally, there has been a proliferation of very sub-specialized practice (e.g., transplantation, infertility, etc.) as well as an increase in the number of CNSs who are seeking prescriptive authority. The increased responsibility for medical management of patients, the proliferation of subspecialties and prescriptive authority for CNSs begs the fundamental question of whether educational preparation matches current CNS scope of practice? Does the coursework of the CNS include subjects such as advanced physical assessment, pharmacotherapeutics, diagnosis and management of medical problems with pharmaco and non-pharmacotherapeutic treatments? Furthermore, not all boards of nursing recognize and grant legal authority for the CNS to practice beyond the basic nurse practice act. If the scope of CNS practice is changing to this extent described above, legal authority to practice beyond the basic nurse practice act is required. These scenarios pose unique challenges to the regulatory community and require additional deliberations.

Clinical Nurse Specialist Education

Curricular Content

It is widely recognized and accepted that the CNS is generally educated and prepared at the graduate level, whereas the NP has a variety of entry levels into advanced practice (e.g., post-basic education certification programs, graduate level). Since 1990, studies conducted on the differences in core curriculum between the NP and CNS have found more

similarities than differences (Elder & Bullough, 1990; Forbes, Rafson, Spross, & Kozlowski, 1990; Price, Martin, Newberry, Zimmer, Brykczynski, & Warren, 1992). However, the major differences between the curricula were in the following substantial components: pharmacology, primary care, physical assessment, health promotion, nutrition, and history taking (Elder & Bullough, 1990; Forbes et al, 1990; Schroer, 1991). Understandably, the abovementioned areas were generally included in curricular content for the NP rather than CNS programs.

In 1992 a report titled "*Survey of Certified Nurse Practitioners and Clinical Nurse Specialists: December 1992*" was conducted for the Division of Nursing and served as an additional source of information for purposes of exploring the educational preparation of the CNS. The *population* for the study was "all nationally certified or state recognized nurse practitioners and clinical nurse specialists in the United States who obtained their certification/recognition from a national certifying body or a state that required a master's degree in nursing as part of the certification/recognition requirements" (n=37,963). The estimated number of NPs reported in this study was representative of all nationally or state certified/recognized NPs. The estimated number of CNSs represents *only* those for whom the certification/ recognition process requires a master's degree in nursing. Surveys were mailed to 4,000 eligible certified nurses, with a 69 percent response rate. Results of the study are reported based on the estimated population and sample.

According to the 1992 Division of Nursing survey, 65.1 percent of the estimated population were educated in NP programs only, 19.5 percent in CNS programs only, and 15.4 percent as both NPs and CNSs. Of the certified nurses who attended CNS programs, the majority (99.5 percent) were educated at the master's level. Less than one percent (0.5 percent) were educated in doctoral programs. In contrast, the majority (55.6 percent) of certified nurses educated exclusively as NPs were educated in certificate programs, and 40.1 percent were educated in master's degree programs.

As of December 1995, information received from the American Association of Colleges of Nursing (AACN) indicated that approximately 178 programs in the United States offer master's level CNS programs. In an attempt to determine the curricular content of CNS programs, eight institutions offering CNS programs were selected from this list. The eight institutions were selected based on area representation and included; University of Florida, Pennsylvania State University, University of Texas at Austin, Hunter College (New York), University of Colorado, University of Iowa, University of Washington, and South Dakota State University. Information was requested on admission and education requirements as well as terminal objectives. Because of the wide variation in the information submitted, a formal analysis was not feasible; however, some interesting details were extrapolated. For instance, the University of Florida indicated that it anticipated all clinical tracks will be NP programs by fall 1996. Pennsylvania State University indicated that its graduate faculty was revising the curriculum for CNS programs to meet "current AACN guidelines," and the new curriculum would be available by spring semester 1997. The American Association of Colleges of Nursing (AACN) *Essentials of Master's Education for Advanced Practice Nursing* document contains both essential core content for all master's educated nurses and essential core content for all advanced practice nurses in direct care roles. And finally, Hunter College in New York responded that it was unable to send information because the faculty was reviewing the curriculum of all CNS programs with the intent of modification. Although the task force was unable to formulate any conclusions from this information, the modifications and anticipated changes of the educational programs do lend support to the hypothesis that the role and scope of practice of the CNS is changing. The question is whether the CNS will remain a unique role, be phased out entirely, or merge with the NP role?

Clinical Nurse Specialist Certification

Certification is a word which has a propensity to cause confusion because it is used in different ways to mean different things. In the *regulatory arena*, certification is the term often used by boards of nursing when granting legal authority for advanced nursing practice. Some states also use recognition and licensure in the same manner. Conversely, certification is used within the *profession* to indicate specialized knowledge or excellence in practice and, in and of itself, provides no legal authority for advanced nursing practice. The confusion arises because some boards of nursing accept certification by a board-approved national certification organization as fulfillment of one of the prerequisites for legal recognition. Any title, even if issued by a national certification organization, only carries legal status if that title is recognized or authorized by the state board of nursing. Clearly, the area of national certification and/or state recognition is confusing, at best. Currently, it appears that the American Nurses Credentialing Center (ANCC) may be the only national certifying body for CNSs which is generally recognized by boards of nursing.

While limited data were available regarding CNS certification, the 1992 Division of Nursing report did contain some data regarding national certification and state recognition. Results of this report revealed that, of the total estimated

population of certified nurses, approximately 10,217 of the total were nationally certified or state recognized as CNSs. An estimated 7,988 CNSs were nationally certified (44 percent) or state recognized (20.8 percent) only as CNSs. The remaining (35.2 percent) held national certification and state recognition. However, an estimated 2,219 nurses certified as both NPs and CNSs were most likely to be *state recognized* as CNSs (74.8 percent) and *nationally certified* as nurse practitioners (66.1 percent). Again, remember that national certification does not necessarily equate with state recognition.

Clinical Nurse Specialist Practice

The literature largely supports the premise that the core role components of the CNS consist of expert clinician, consultant, researcher, and educator (Crigler, Hurt, Burge, Kelly, & Sanborn, 1984; Elder & Bullough, 1990; Schroer, 1991; Sparacino, 1992). While the core components of the role appear clear, the actual CNS practice as it relates to educational preparation and legal use of the CNS title as it relates to additional legal authority are ambivalent, at best. Furthermore, job titles may be clinical specialist (CS) or clinical nurse specialist (CNS) without any requirement for advanced education or certification.

Position/Title

The 1992 Division of Nursing survey of certified NPs and CNSs was the major source of information for this issue. The survey revealed that 76.8 percent of the total NPs and CNSs were employed in advanced practice roles where they held the role title of NP or CNS. An estimated 21,892 certified nurses (75.2 percent) were employed in patient care roles with the position title NP, and an additional 5,868 certified nurses (20.1 percent) were employed in patient care roles with the position title CNS. However, in some cases, the title and educational preparation were not consistent. Among nurses who were employed full time and reported their practice role title, an estimated 326 individuals were educated exclusively as NPs and were certified as NPs, but had the role title CNS. An estimated 246 nurses who were educated exclusively as NPs, were employed with the role title NP but were certified as CNSs. Furthermore, an estimated 86 nurses were educated and certified exclusively as CNSs but had the practice role title NP, and an estimated 130 nurses were educated as CNSs and held the position title CNS but were certified as NPs. This report provides concrete data to illustrate the inconsistency in the education, certification, titling, and use of APRNs to date.

Regulation of the Clinical Nurse Specialist

In November 1995, the APRN Coordinating Task Force developed a survey to collect data on the current regulatory status of the CNS from a national perspective. After refinement of the tool, the survey was sent to 56 boards of nursing, which were asked for completion and return of the survey by January 31, 1996 (Attachment B, page 9 behind this Tab). In all, 40 boards of nursing responded to the request, reflecting a 71.4 percent response rate. Two boards responded after the results were compiled so their responses are not reflected.

Survey Results

- Of the 40 boards of nursing that responded to the survey, 25 (62.5 percent) regulate CNSs as APRNs in their state.
- Of states that regulate CNSs as APRNs, 36 percent regulate by licensure, 12 percent by certification, 24 percent by letter of recognition, and 28 percent by another method (nonspecified).
- 60 percent of the respondents who regulate CNSs indicated that authorization from the board of nursing grants the use of a CNS title, and 56 percent indicated that authorization by the board of nursing grants a scope for CNS practice.
- The minimal level of education required for legal recognition as a CNS varies. Of respondents that regulate CNSs, 28 percent require a master's degree, 48 percent require an MS degree in Nursing, 20 percent indicated other educational requirements (nonspecified) and 4 percent indicated that it was non-applicable.
- Additional criteria required for legal recognition as a CNS included an MS degree in specialty area (44 percent), certification by a national certifying body in a specialty area (80 percent), formal preceptorship (4 percent), and other post baccalaureate education (4 percent).
- 18 percent indicated that their board of nursing *established* educational criteria for CNS programs.
- 18 percent of the respondents indicated that their board of nursing *reviewed* the curricular content of CNS educational programs.
- 23 percent indicated that the educational standards for the NP and CNS were the same. Fifteen percent of the boards of nursing responded that they were considering rule changes that would require the same criteria for CNS and NP board recognition.

Finally, boards of nursing were asked to identify current issues related to the practice and/or regulation of CNSs in their respective state (e.g., education, scope of practice, credentialing, reimbursement). The following is an summarized list of comments:

- (AR) Should all CNSs be eligible for prescriptive authority?
- (MN) What is their scope of practice? How does it differ from NP's? Reimbursement is a professional issue.
- (AZ) The CNSs asked for rules so they can get reimbursed.
- (FL) Applicants who hold bachelor's degrees in nursing and master's degrees in psych/mental health counseling (that included experience in case management) and who can document that they successfully completed coursework in physical assessment, pathophysiology, and pharmacology can be considered on an individual basis or can be considered if they passed a national certification exam.
- (GA) Georgia Board of Nursing's issues relate to guidelines for new groups (other than CNSs) seeking advanced practice status.
- (CA) We have a bill pending in legislature.
- (WA) The blending of CNS and NP roles is of concern. Subcommittee of the commission is beginning discussions.
- (SD) Obtaining Medicare, Medicaid provider numbers.
- (NH) Lack of similarity in programs. No common standards.
- (ND) P/MH CNS receives third-party reimbursement at a lower rate than other APRNs.
- (ID) Legislation may be introduced this session to change the definition of "nurse practitioner" to advanced practice nurse and to include CNS.
- (MO) CNSs in subspecialties who are without certifying body (e.g., peds); concerns about pursuing college practice and delegated RN authority and not having pharmacology course other than mental health professionals.
- (NE) CNSs would like an "expanded scope" to include management of chronic illness and prescription.
- (NV) CNS is working adequately for what the designed role "was," but the possibility of CNS diagnosis, treatment and prescribing illness and having limited scope of practice that was similar to medicine was not in the design.
- (TX) Educational preparation for medical aspects of care and prescriptive authority. Lack of standards for education. Lack of certification examinations for all specialties scope of practice — they are being recruited for primary practice positions
- (UT) Blurring of the role between nurse practitioner and CNS.

Future CNS-Related Activities

The APRN Coordinating Task Force has proposed that Member Boards are identifying that the CNS role and scope of practice is changing. CNSs are assuming an increased responsibility of medical management of patients. While this may fulfill a need of the health care delivery system, what are the regulatory implications? As Nevada identified in their response to state-specific issues: CNS is working adequately for what the designed role "was," but the possibility of CNS diagnosis, treatment and prescribing illness and having limited scope of practice that was similar to medicine was not in the design.

Secondly, there appears to be an "informal" merging of the CNS and NP roles. This conclusion is validated in several state responses to state-specific issues. For example, Utah indicated that there is a blurring of the role between nurse practitioner and CNS. Nebraska responded that CNSs would like an "expanded scope" to include management of chronic illness and prescription (similar to the role of the NP). Minnesota asks, what is their scope of practice? How does it differ from NPs'? The regulatory implications to an informal or formal merging of the CNS and NP roles are significant. The establishment of standard criteria for regulation of CNSs and NPs becomes a fundamental question which needs to be addressed. If, in fact, the purpose of regulation and the concomitant establishment of standards is to protect the public, is the current regulatory system allowing the regulatory community to realize that objective? Additionally, does the current system of regulation/recognition limit interstate mobility? Clearly, with the advancement of technology and the onset of telecommunications technology in the provision of nursing care, similar standards for the regulation of advanced practice nurses would facilitate mobility of the APRN and ensure a consistent level of protection for the citizens of the states.

The APRN Coordinating Task Force has recognized what has been reinforced by this study of the issues is that the CNS role is in flux. Additionally, changes to the structure of the health care delivery system as well as the role of all APRNs are occurring rapidly. Continued monitoring, identification and analysis of the trends is imperative to the regulatory community.

References

American Nurses Association. (1980). A Social Policy Statement. Kansas City, MO: Author.

American Nurses Association. (1993). Advanced practice nursing: A new age in health care. (pp.1-5). Washington, D.C.: American Nurses Association.

Crigler, L., Hurt, L., Burge, S., Kelly, G., & Sanborn, C. (1984). Quantifying the clinical nurse specialist role: a pilot study. Virginia Nurse, 53, 3, 37-42.

Division of Nursing Bureau of Health Professions Health Resources and Services Administration. (1992). Survey of Certified Nurse Practitioners and Clinical Nurse Specialists: December 1992. Washington, D.C.

Elder, R. & Bullough, B. (1990). Nurse practitioners and clinical nurse specialists: Are the roles merging? Clinical Nurse Specialist, 4, 2, 78-84.

Forbes, K., Rafson, J., Spross, J. & Kozlowski, D. (1990). The clinical nurse specialist and nurse practitioner: core curriculum survey results. Clinical Nurse Specialist, 4, 2, 63-66.

Montemuro, M. (1987). The evolution of the clinical nurse specialist: response to the challenge of the professional nursing practice. Clinical Nurse Specialist, 1, 3, 106-110.

Price, M., Martin, A., Newberry, Y., Zimmer, P., Brykczynski, K. & Warren, B. (1992). Developing national guidelines for nurse practitioner education: An overview of the product and the process. Journal of Nursing Education, 31, 1, 10-15.

Ray, G. & Hardin, S. (1995/February). Advanced practice: playing a vital role. Nursing Management, 45-47.

Schroer, K. (1991). Case management: clinical nurse specialist and nurse practitioner, converging roles. Clinical Nurse Specialist, 5, 4, 189-194.

Sparacino, P. (1992). Advanced practice: the clinical nurse specialist. Nursing Practice, 5, 4, 2-4.

Bibliography

Chase, L., Johnson, S., Laffoon, T., Jacobs, R. & Johnson, M. (1996). CNS role: An experience in retitling and role clarification. Clinical Nurse Specialist, 10, 1, 41-45.

Cronenwett, L. (1995). Molding the future of advanced practice nursing. Nursing Outlook, 43, 3, 112-118.

Davies, B. & Hughes, A. (1995). Clarification of advanced nursing practice: Characteristics and competencies. Clinical Nurse Specialist, 9, 3, 156-166.

Fenton, M.V., & Brykczynski, K.A. (1993). Qualitative distinctions and similarities in the practice of clinical nurse specialists and nurse practitioners. Journal of Professional Nursing, 9, 313-326.

Forbes, K. (1991). Is education keeping pace with health care? Clinical Nurse Specialist, 5, 49,-50.

Frik, S.M., & Pollock, S.E. (1993). Preparation for advanced nursing practice. Nursing & Health Care, 14, 4, 190-195.

Haber, J. (1995). Regulating advanced practice. Perspectives in Psychiatric Care, 31, 1, 5-7.
Koerner, J. (1992). Differentiated practice: The evolution of professional nursing. Journal of Professional Nursing, 18, 6, 335-341.

Micheels, T., Wheeler, L. & Hays, B. (1995). Linking quality and cost effectiveness: Case management by an advanced practice nurse. Clinical Nurse Specialist, 9, 2, 107-111.

O'Malley, J. (1995). Who is the advanced practice nurse? Seminars for Nurse Managers, 3, 2, 81-83.

Payne, J. & Baumgarter, R. (1996). CNS role evolution. Clinical Nurse Specialist, 10, 1, 46-48.

Pearson, L. (1995). Annual update on how each state stands on legislative issues affecting advanced nursing practice. Nurse Practitioners, 20, 1, 13-22.

Steel, J. (1994). Advanced nursing practice. AACN Clinical Issues, 5, 1, 71-76.

Watson, J. (1995). Advanced nursing practice...and what might be. N&HC: Perspectives on Community, 16, 2, 78-83.

Report of the Computerized Clinical Simulation Testing (CST®) Task Force

Task Force Members
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Dorothy Fiorino, OH, Area II
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Vickie Lambert, GA-RN, Area III
Adrienne Murano, NY, Area IV

Staff
Anna Bersky, *CST Project Director*
June Krawczak, *CST Project Associate*

Relationship to the Organization Plan
Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective C ..... Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Recommendations to the Board of Directors
No recommendations.

Background of CST Project

Computerized Clinical Simulation Testing for nursing competence has been under research and development in collaboration with the National Board of Medical Examiners (NBME) since 1988. It is believed that CST permits a more authentic assessment of examinee application of the clinical decision-making process to the management of client care. In CST there are no testing cues in the form questions or answer options. This testing methodology uses patient scenarios that are based on real life situations and requires the use of free-text entry for the specification of client care activities. At the beginning of each clinical encounter, the examinee is presented with a brief description of the client situation. The examinee then proceeds to the "Client Care" screen where requests for nursing activities can be specified. From this screen, requests for chart review are specified by selecting the desired chart component. Requests for nursing assessments and interventions are specified by typing the desired nursing action into the free-text entry box labeled patient or into the box labeled family/significant other. When a free-text request is entered, a 30,000+ term nursing activity database is searched for an alphabetical match to the request. When a match is found and confirmed, a client response is presented and simulation time moves forward. In addition to the interactive nature of CST, the simulations are also dynamic, in that client condition changes over time, both in response to nursing action (or non-action) and as the underlying health problem unfolds. Because of the temporal nature of CST, examinee actions can be evaluated based not only on the level of correctness of action, but also on the timing and sequence, or prioritization, of actions.

Phase I (1988 - 1993) of the CST Project included the initial development of CST. Field and pilot study results provided preliminary evidence that CST is feasible to develop and administer, and that it is a potentially valid and reliable exam. In 1991, the National Council's Delegate Assembly directed that the investigation of CST as a potential component of the NCLEX-RN™ continue. Phase II of the CST Project (1994 - 1996) has included the development and programming of the specifications of a new simulation system, and enhancement of the Nursing Information Retrieval System (NIRS®), the relational database of nursing and medical information which underlies the CST system and contributes to the efficiency and flexibility of case and scoring key development and exam administration. Phase III of the CST Project (1996 - 1999) includes CST case and scoring key development and a pilot study designed to evaluate the psychometric soundness and legal defensibility of CST as a potential component of the NCLEX-RN. In 1999, the results of the pilot study will be reported to the Delegate Assembly, who will make a decision regarding the use of CST as a component of the NCLEX-RN. During Phase III of the project, other Member Board uses of CST such as education and the evaluation of continued competence will also be explored.

Highlights of Activities

- **CST Research Plan and Pilot Study**
  Initiated implementation of the CST Pilot Study plan. In February 1996, a mailing sent to all Member Boards described the requirements for, and solicited participation in, the CST Pilot Study. It is anticipated that board selection for participation will occur in June 1996.

  During its February 1996 meeting, the CST Task Force met with the Examination Committee (EC) to determine how the two groups should work together to address CST content and scoring policy-related issues. The CST Task Force and the EC formed a work group consisting of three members each from the CST Task Force and the EC to consider these issues. The CST/EC work group will have its first meeting in July 1996.

- **Member Board Use of CST (for applications other than initial licensure)**
  Initiated implementation of the plan for exploring Member Board use of CST. In February 1996, a mailing sent to all Member Boards described the requirements for, and solicited participation in, exploration of Member Board use of CST. It is anticipated that the selection of boards of nursing for participation will occur by January 1997.

- **CST Case Development Committee (CDC) and Scoring Key Development Committee (SKDC)**
  Recruitment for CDC and SKDC members was initiated in February 1996. Twelve members and two alternates have been appointed to the CST CDC, which will begin work in the Fall of FY97. Selection of SKDC members is in progress.

Future Activities

- Initiate CST case development and continue refinement of research plan and procedures for evaluating the content validity of CST.

- Recruit schools of nursing to participate in the CST Pilot Study (Fall 1996) and identify participating schools by February 1997.

- Begin CST case development in November 1996.

- Develop scoring keys for CST cases and refine research plan for evaluating psychometric soundness of CST.

- Explore Member Board use of CST.

Meeting Dates

- November 3 - 4, 1995
- February 15 - 17, 1996
- April 28 - 29, 1996
- May 22, 1996 *(telephone conference call)*

Recommendations to the Board of Directors

No recommendations.

Report of the Licensure Examination Comparison Task Force

Task Force Members
Frazine Jasper, NV, Area I, *Chair*
Joyce Johnston, PA, Area IV
Margaret Kotek, MN, Area II
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Staff
Anthony Zara, *Director of Testing Services*

Relationship to Organization Plan
Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ..... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendations to the Board of Directors
No recommendations.

Highlights of Activities
The expected outcomes for this task force were to develop a formal contrast and comparison of the Canadian Nurses Association (CNA) and National Council entry-level nursing competencies, share information about test development, and develop and increasingly collaborative relationship. Early in the process, the Canadian Nurses Association Testing Service (CNATS) shared some information about activities in Canada that affected this year's projected workflow. CNATS expressed interest in working collaboratively on the examination comparison, but they did not believe that this year was the best time to begin such an undertaking. First, CNA's Executive Director relinquished her duties during February 1996 (to take the Executive Director post at the International Council of Nurses) and a new Executive Director was hired. CNA is also in the middle of a large National Nursing Competency Project to develop lists of competencies for the "family of nurses" (practical nurses/nursing assistants, registered nurses, and registered psychiatric nurses), scheduled to be completed during 1996. This project is being conducted with input from the testing staff, but is being directed by another department.

After reports from staff about CNATS' desire to slow down the process and defer collaborative and comparison activities until later this spring, National Council's Board of Directors agreed to lengthen the timeline so that the formal comparison of CNATS and NCLEX™ would be scheduled for completion until sometime next fiscal year. This timing change will preserve National Council's opportunity to work collaboratively with a sister organization in another country to produce a jointly-developed examination comparison and also to continue to develop a collegial and collaborative relationship.

Future Activities
National Council will continue to communicate with CNATS about its examination and will stay informed about its competency project. The timing of specific activities for this task force will be developed after an initial planning meeting with CNATS this fall.

Meeting Dates
None to date in FY96.

Report of the Licensure Verification Task Force

Task Force Members

Mark Majek, TX-RN, Area III, *Chair*
Donna Dorsey, MD, Area IV
Renatta Loquist, SC, Area III
Anita Ristau, VT, Area IV
Mary Schaper, WY, Area I

Staff

Carolyn Hutcherson, *Senior Policy Analyst*
Bryan Newson, *Software Engineer/Database Manager*
Lea Newson, *Communications Administrative Assistant*
Susan Woodward, *Director of Communications*

Relationship to Organization Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective G ..... Promote consistency in the licensure and credentialing process.

Recommendations to the Board of Directors

No recommendations.

Background

As early as 1990, it was determined by legal counsel that *"absent contrary statutory requirements, Member Boards may rely on electronically transmitted information in making endorsement decisions."* Between 1990 and 1995, various projects were undertaken to determine the feasibility of electronic licensure verification. A universal verification form was developed from samples of all Member Board forms, and pilot testing was conducted among eight Member Boards. However, it wasn't until after the implementation of computerized adaptive testing for the NCLEX™, when Member Boards were provided with the same computer hardware and software, that the possibility of electronic licensure verification became more viable.

In August 1995, an overview of electronic licensure verification was presented at the Executive Officers' Network meeting. At that time, the Licensure Verification Task Force identified two possible approaches for developing a system which maximizes the use of technology for transmittal of licensee information. Discussion focused on whether or not all the elements historically requested on licensure verification forms (especially for nurses licensed many years ago) are indeed necessary to grant a license. The executive officers supported a comprehensive analysis of information/data that is needed to grant a license and requested that a study be done in conjunction with the development of an electronic licensure verification system. Strong support was voiced to proceed with study and development of the project.

Highlights of Activities

- **Review of Previous Work**

  At its first meeting in November 1995, the Licensure Verification Task Force reviewed all past activity done toward development of an electronic licensure verification system and discussed results from pilot tests conducted in the early 1990s among eight Member Boards. Member Board data release parameters, as provided via Nurse Information System (NIS) contracts, were reviewed and discussed. Possible roadblocks were identified and discussed, and plans were set in motion to survey Member Boards regarding their current endorsement procedures.

- **Request for Member Board Input**

  In January 1996, the task force requested that each Member Board submit a copy of its licensure verification form and circle the five data elements that the jurisdiction believed most essential for an electronic licensure verification system. By the start of the 1996 Area Meetings in March, the task force had received endorsement

forms from 57 of 61 Member Boards. Based on input received, the task force identified the following data elements (in addition to identifying information such as name, address, birth date, Social Security number, etc.) for inclusion in the preliminary software prototype for electronic licensure verification (listed below in no particular order):

- License ever encumbered
- NCLEX-RN™ and NCLEX-PN™ pass/fail status
- Current license status (active/inactive)
- Type of license issued (RN, LPN/VN)
- Name of education program completed
- Education program graduation date
- Location of education program (city/state)
- License number

With these data elements identified, staff was directed to develop a preliminary software prototype of a user-friendly computer screen that shows what electronic licensure verification might look like. This prototype was shown and explained at all four Area Meetings, with an invitation for further input from Member Boards.

■ **Development of an Electronic Licensure Verification Information System (ELVIS)**

During its April 30–May 2, 1996, meeting, the task force discussed the Area Meeting presentations as well as attendee reaction and feedback. Task force members concluded that attendees at all four Area Meetings had a positive reaction to the concept of ELVIS. In fact, it was perceived that there is an overall sense of wanting to participate and Member Boards are ready. The few suggestions and questions raised by attendees were addressed by the task force and incorporated in its work at this meeting.

Before beginning work on development of ELVIS, the task force also reviewed correspondence received by legal counsel regarding the ownership of NCLEX™ data, reports indicating the status of release of Social Security numbers by Member Boards, information about the exploration of the Special Services Division into plastic license production services, and a verbal report from staff regarding the preliminary discussions of the Nursing Regulation Task Force on development of revised regulation models.

Modifications to the proposed ELVIS computer screens were made, primarily adding date information to various data fields (e.g., date of original and subsequent licensure, date data received by National Council, date of disciplinary action, and date each nurse passed the appropriate nurse licensure examination). Also added were maiden name and mother's maiden name to the possible identifying search data fields. With the form revised (Attachment A), the task force defined the parameters of each data field (Attachment B). These definitions would be shared with Member Boards so that a common understanding of all data that appear in ELVIS would be possible. There was much discussion on the topic of State Board Test Pool Examination (SBTPE) score reporting, as well as education information that resulted in waivers. The task force concluded that anomalies exist and the system would instead be designed for the benefit of the greatest percentage of Member Boards; anomalies would be handled on an individual basis and separate from ELVIS. Task force members also agreed that the National Council will build the best database possible, always striving for completeness and accuracy, but recognized that absolute perfection will never be possible.

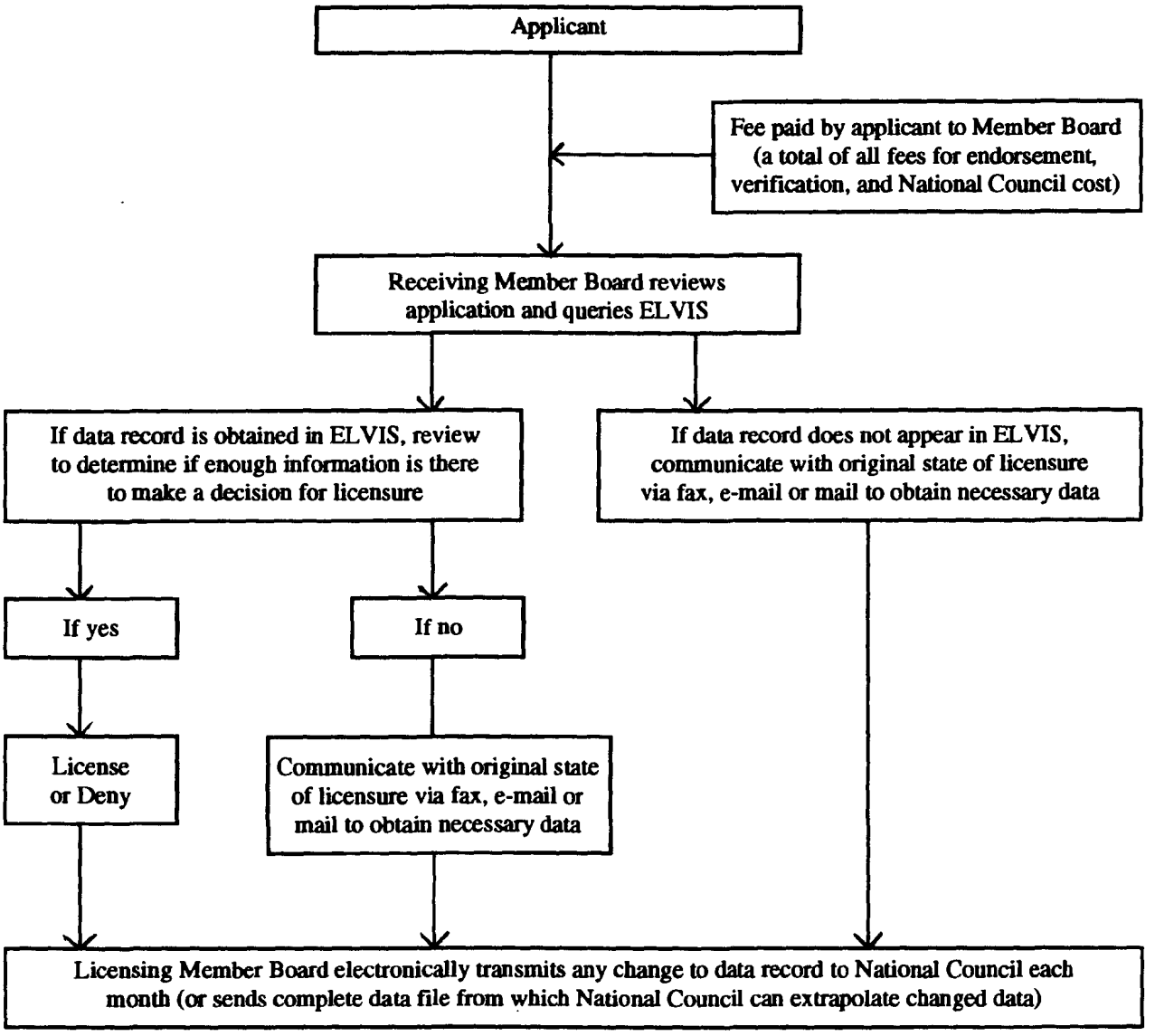
To help determine the extent of the anomalies and possible hurdles, the task force prepared a six-question survey that was mailed to Member Boards in May, asking them to indicate their variances to the passing standards over the years (if any), place a check next to each data element they can electronically provide, indicate whether or not they electronically report to the DDB, and indicate whether or not they can electronically select and transmit only new activity on a data record (instead of the entire record each time).

The task force agreed that a pilot among its members would serve as a good test of a system, for presentation and discussion at the 1996 Annual Meeting. The following pilot timeline was established: May/June—build test database with data from the Chauncey Group, CTB, TX-RN, SC, MD, WY, and VT; July—revise prototype software screens and make them operational with the test data; August—present findings at the 1996 Annual Meeting. Among the questions that will hopefully be answered by the pilot test will be: 1) how many records were complete?, 2) what data elements are missing?, 3) what problems were encountered in matching?, 4) will the link to the DDB work?, and 5) will securing NCLEX data from the Chauncey Group on a routine basis work? The task force plans to conduct a telephone conference call in late July to discuss the pilot and plan for presentation at the Annual Meeting.

The fee schedule was discussed at length, with two models emerging as most viable: 1) invoice Member Boards annually, based on actual endorsements made in the previous year, and 2) set an annual flat fee that is offered on a graduated basis, depending on the number of annual endorsements. Regardless of fee schedule model, the cost to the National Council for maintaining and administering the system must be calculated. The task force

directed that, with the National Council costs in hand, a fee schedule be prepared for distribution at the Annual Meeting that would show the projected fee for each Member Board under each model. This would be among the topics of discussion with Member Boards in August. The task force then tackled development of an endorsement model that depicts data flow (Figure 1).

Figure 1. Endorsement Data Flow Model



It was strongly agreed that, in order to preserve the integrity of the system, ELVIS data shall be updated ONLY via Member Board electronic data submission on a regular schedule. Neither Member Board staff nor National Council staff will be able to enter or change data directly in ELVIS on-line.

Finally, the task force determined that its target outcomes of the meeting with executive directors in August will be: 1) reach consensus among Member Boards on using *only* the data elements on the ELVIS screen for licensure endorsement; 2) reach agreement on the fee schedule model; and 3) reach agreement on the data flow process. The task force plans to request that the executive officers develop a resolution for consideration by the 1996 Delegate Assembly that would direct implementation of ELVIS in FY97 and promote, but not insist on, Member Board participation.

Future Activities

Results of the pilot test will be shared with the membership at the 1996 Annual Meeting. Also at that time, possible data flow and fee models will be discussed. Depending on feedback and results of the 1996 Annual Meeting, the task force will continue its work by immediately determining an implementation timeline and resolving any obstacles to implementation that present themselves along the way.

Meeting Dates

- November 26-27, 1995
- February 26, 1996 *(telephone conference call)*
- April 30-May 1, 1996
- July 29, 1996 *(telephone conference call)*

Recommendations to the Board of Directors

No recommendations.

Attachments

Attachment A

Netscape: Electronic Licensure Verification Information Service (ELVIS)

elvis

Electronic Licensure Verification Information Service (ELVIS)

SSN:

License #:

Juris of License: AL

Last:

First:

Middle:

Birth Date:

Maiden:

Mother's Maiden:

Perform Search

Clear Criteria

Name Information ("*" indicates an alias)

Last	First	Middle	Maiden	Mother's Maiden	Juris	Date of Update
Doe	Jane	A.	Dunn	Smith	IL	5/23/1995
Doe	Jane	Anita	Dunn	-	IN	5/1/1995
Dough	Jane	-	-	-	WVPN	4/23/1995
*Jones	Jane	-	-	-	WVPN	4/23/1995
*Smith	Jane	-	-	-	WVPN	4/23/1995

Social Security Number: 123-45-6789 **Date of Birth:** 1/1/1950

Address Information

Street	City	State	Zip Code	Juris	Date of Update
123 Main Street	Chicago	IL	60611	IL	5/23/1995
123 Main St.	Chicago	IL	60611	IN	5/1/1995
5432 N. Kerrigan St.	Detroit	WVPN	11021	WVPN	4/23/1995

Licensure Information

Juris	License Number	Type	Status	Encumbered?	Orig?	Date of Licensure
WVPN	PN9999	PN	Active	Yes	Yes	8/11/1970
IL	IL09RN	RN	Inactive	No	Yes	1/24/1975
IN	RN0876-3432	RN	Active	No	No	8/28/1978

Disciplinary Information

License Number	Juris	DDB Case Number	Actions	Violations	Date of Action
PN9999	WVPN	A123	• Probation • Fine	• Sale of Drugs	3/15/1972

Nursing Education

Grad Year	Type	Program Name	City	State
1988	RN	Loyola University	Chicago	IL
1980	LPN	City College of Chicago	Chicago	IL

Examination Results

	Date Passed
PN	8/1/1970
RN	12/12/1974

Document: Done.

Attachment B

Electronic Licensure Verification Information System (ELVIS) Data Definitions—Preliminary

Purpose: for licensee identification; for use by Member Boards only

Identifying Data

License number ..... a list of all license numbers from all jurisdictions in which the nurse is licensed

Jurisdiction ..... must match license number

Social Security number ..... if it does not appear, it is not known

Date of birth ..... if it does not appear, it is not known

Licensure Data

Date submitted ..... the date the data was received at the National Council

Original ..... first state of licensure

Inactive ..... any license not active. Includes, but is not limited to, lapsed, delinquent, non-renewed, revoked, suspended, meaning that the person is not licensed to practice.

Nursing Education Data

Graduation year ..... the date the candidate met the jurisdiction's basic education requirements for examination eligibility. If the date does not appear, additional information may be required.

Examination Date

RN ..... if a date appears, the nurse passed an appropriate nurse licensure examination*

1952–1982	Pass all 5 parts of SBTPE with a score of 350 or above
1982–1988	Pass NCLEX with a score of 1,600 or above
1988–Present	Pass NCLEX with a result of pass

LPN/VN ..... if a date appears, the nurse passed an appropriate nurse licensure examination*

1952–1982	Pass both parts of SBTPE with a score of 350 or above
1982–1988	Pass NCLEX with a score of 350 or above
1988–Present	Pass NCLEX with a result of pass

* If the date does not appear, the nurse did not pass a nurse licensure exam at the national passing standard and additional information may be required.

Report of the NCLEX™ Evaluation Task Force

Task Force Members

Deborah Feldman, MD, Area IV, *Chair*
Joan Bouchard, OR, Area I
Faith Fields, AR, Area III
Lori Scheidt, MO, Area II
Rosa Lee Weinert, OH, Area II

Staff

Carol Hartigan, *NCLEX™ Contract Manager*
Anthony Zara, *Director of Testing Services*

Relationship to Organizational Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ..... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendations to the Board of Directors

See end of Summative Report, Attachment A.

Highlights of Activities

The CAT Evaluation Task Force was appointed by the Board of Directors last year to complete planning for and implement an evaluation of the NCLEX program. The conversion of the NCLEX from paper-and-pencil to computerized adaptive testing (CAT) administration was a large national project affecting Member Boards, candidates, educators, National Council and test service staff. The goal of the evaluation was to obtain a global view of a complex National Council program. Last year, the task force identified the seven major areas of NCLEX program evaluation (test development, Member Board processes, candidate registration, NCLEX administration, results reporting, psychometric effectiveness, and customer service), primary and secondary evaluators, and an overall structure for the evaluation. Primary evaluators of the NCLEX program include Member Boards, the Examination Committee, candidates, and National Council staff. Secondary stakeholders identified were nursing educators, nursing service, health care consumers, the regulatory community, the testing service, legal counsel, the psychometric community, legislators, and the general public.

During this year, the task force revised and edited the original draft framework of the Comprehensive NCLEX Program Evaluation Matrix (containing seven major service areas, 28 issues, and 129 specific service categories), determining criterion statements, frequency and modality of each evaluative component, and the appropriateness of the designated evaluators. In a concerted effort to not duplicate existing ongoing efforts, the task force designed the NCLEX program evaluation to include the evaluation mechanisms which are already in place on a fixed schedule, such as the periodic test service reports to the Examination Committee, Board of Directors, and Delegate Assembly. Many of the key areas of NCLEX administration evaluation were dependent on the completion and acceptance by the Examination Committee of the comprehensive Sylvan Quality Assurance Plan, which was approved by the Examination Committee at its July 1995 meeting. Thus, the evaluation matrix is composed of the existing performance criteria (based on the Chauncey/Sylvan contract, Examination Committee policies and procedures, etc.) and key areas of service identified by the task force. The matrix was approved by the Board of Directors at its January 1996 meeting.

In numerous instances, the primary evaluators of an NCLEX program area are the Member Boards. The task force developed and distributed a survey tool for Member Boards to evaluate the NCLEX program that would not be repetitive or burdensome to the membership. The task force also utilized the results of the Test Service Evaluation survey, which was conducted this year. The results of the Member Board NCLEX Evaluation Task Force survey were considered by the task force at its April 1996 meeting, and final revisions were made to the evaluation matrix based on survey results.

The task force presents the first comprehensive evaluation of the NCLEX program in Attachment A. The full NCLEX Program Evaluation Matrix is Attachment B. The task force believes that as more experience with CAT administration of NCLEX has been gained, the frequency, duration and severity of problems in all aspects of the

program have become solved. This trend should continue with even more problems being solved, eliminating the need to continuously evaluate some elements which are currently judged as problems, but which will be satisfactorily resolved as the program progresses.

Future Activities
The task force has completed its charge.

Meeting Dates
- November 2-3, 1995
- April 16-17, 1996
- April 30, 1996 *(telephone conference call)*

Recommendations to the Board of Directors
See end of Summative Report, Attachment A.

Attachments

Attachment A

Summative Evaluation of the NCLEX™ Program

This summative evaluation of the NCLEX was conducted by the NCLEX Evaluation Task Force as part of completing its charge for FY96. It is based on the NCLEX Comprehensive Evaluation Guide matrix, developed by the task force during FY95 and approved by the Board of Directors in January 1996 (Attachment B). This effort reflects the first large-scale evaluation of any National Council program and may be used as a model for other program evaluations.

The general NCLEX program evaluation methodology is outlined in detail in the NCLEX Comprehensive Evaluation Guide (Attachment B). It was specifically designed to utilize existing evaluators and standard NCLEX reporting as much as possible. The task force believed that the primary evaluators of each aspect of the NCLEX program should be the entities that have the most information, accountability, and the most contact with the program. The task force believes little is gained by adding another layer of evaluation process (one step removed from the data) to existing structures. For example, the Examination Committee is designated as the primary evaluator for many of the NCLEX service areas, with its evaluation frequency based on the reporting cycles of the Chauncey Group and National Council staff. The evaluative criteria were developed by the task force to coincide with Examination Committee policies, National Council-Chauncey contract terms, the Sylvan Quality Assurance Plan, and Member Board needs.

Another point for this evaluation is that it has been designed as an NCLEX program evaluation, and not an evaluation of the performance of the testing service, the Chauncey Group/Sylvan Prometric. The testing service evaluation was also conducted this year and can be found under the Board of Directors' report.

The format of this evaluation is that the NCLEX service areas will only be discussed by exception. That is, unless a service area is not meeting the criteria, or unless there is something surprisingly positive to report about a service area, it will not be discussed here. The task force believed that it is Member Boards' expectation that the NCLEX program is generally performing satisfactorily and to report on service areas meeting criteria would not be conducive to concise analysis. The evaluation matrix contains seven major service areas, 28 issues, and 129 specific service categories.

To enhance the available information in some of the evaluation categories, the task force reviewed responses from the Test Service Evaluation Survey. The survey response scale was coded with 1 indicating low satisfaction, 2 = moderate satisfaction, and 3 = high satisfaction. To facilitate interpretation of the results, items with average scores 2.7 are described as "high satisfaction"; from 2.31 to 2.69 as "moderate satisfaction"; items with average scores between 2.0 and 2.3 indicate "needing improvement"; items with average scores < 2.0 indicate "problem areas." These designations were also used in the 1989 test service evaluation, but with the designators being applied a bit more harshly than they were here (e.g., high was for scores > 2.8; needing improvement was indicated for scores between 2.0 and 2.49). With Chauncey and Sylvan's opportunity to provide service only possible over a scant two years, the more lenient scale described above was applied for this evaluation.

Area I, Test Development; Issue A - *Content*

No major problems identified.

Area I, Test Development; Issue B - *Participation*

For this area, it is important that an increased number of item development panel members be recruited from Areas I and IV. More ethnically diverse members should also continue to be sought. The screening instrument used by Chauncey is being reevaluated for its effectiveness as a positive predictor of success for item writers.

Area I, Test Development; Issue C - *Item Development Process*

At this time, the evidence suggests that item production is not proceeding on a pace to meet the contractual goal of producing three optimal item pools for the NCLEX-RN and -PN by September 1999. The task force believes that semiannual reports specifically addressing this contractual term should be produced by Chauncey for the Examination Committee. The percentage of tryout items lost due to unacceptable statistics has not consistently

been less than 28 percent. There does seem to be a reasonable match between item pool needs and item output, but the process of item pool need specifications has not yet been optimized. Chauncey and National Council staff are working toward a more comprehensive item coding scheme to address this need.

Area I, Test Development; Issue D - *Item Pools*

As mentioned above, Chauncey provides several types of item production summaries, but the task force believes that a semiannual report specifically developed to address the issue of progress toward three optimal pools is needed.

Area II, Member Board Processes; Issue A - *MBOS*

No major problems identified; six Member Boards do not use the MBOS system, but have developed state-specific resources.

Area II, Member Board Processes; Issue B - *Communication*

The *Examinee Exit Evaluation* reflects that 95 percent of the NCLEX candidates believe they receive sufficient information to meet their needs. Member Boards answered that 94 percent of the time they receive sufficient information from National Council to meet the needs of their constituents. Thirty-three of 40 (83%) Member Boards reported that they had sufficient information to respond to candidate questions or complaints at least 90 percent of the time. Thirty-five of forty (85%) Member Boards reported that they could find answers to NCLEX questions in the *NCLEX™ Manual* 95 percent of the time.

Area II, Member Board Processes; Issue C - *Interactions with NCLEX System*

Member Boards reported a satisfaction level of 2.4 (with 2=moderate and 3=high) concerning the responsiveness of Sylvan to corrective actions suggested by Member Board or National Council site visitors. Member Boards believe that the procedures for correcting candidate data with respect to timeliness and format need improvement (with a satisfaction level of 2.3). The task force also noted that supplying sufficient qualified readers for meeting ADA candidates' needs remains an issue. The task force noted that approximately half the Member Boards are not providing readers' names to Sylvan (reader lists should be provided annually) and recommends that Sylvan send reminders to Member Boards each January soliciting readers. As of late April, only five Member Boards had more than a three-week span in which they did not access the National Council electronic mail system (and presumably picked up their EIRs).

Area III, Registration; Issue A - *By Telephone*

Regarding this issue, the task force believes that the value to candidates (costs versus benefits) of NCLEX telephone registration could be improved, given the current system of batching approvals and waiting for the credit card number to clear before continuing the process. The task force recommends that Chauncey implement a system in which credit card approvals are available in real time (as is done in all retail establishments) to increase this service's value.

Area III, Registration; Issue B - *By Mail*

No major problems identified.

Area III, Registration; Issue C - *Funds Handling*

On the Test Service Evaluation, the quality of Chauncey's financial reporting concerning NCLEX volumes and fees earned a 2.2 average rating (1=low, 2=moderate, 3=high satisfaction). The lower rating was due to issues of report timing and responsiveness to National Council requests for information.

Area III, Registration; Issue D - *Process*

The task force noted that the matching algorithm (designed to prevent duplicate candidate entries in the database) was not performing to the level expected by National Council early after the implementation of CAT. Since that time, Chauncey and National Council have worked together to significantly improve the algorithm and its associated resolution procedures. Recent update reports as to its functioning have been very satisfactory.

Area III, Registration; Issue E - *Communication*

Member Boards report the procedures for ordering Candidate Bulletins attain a satisfaction level that reflects needing improvement (2.22; with 1=low, 2=moderate, 3=high satisfaction). National Council staff reports that working with Chauncey to develop and update the Candidate Bulletins has been very cumbersome. Consistent red-lining of previous language and the elimination of new errors in the draft text would provide a good start to improving the process.

Area IV, NCLEX Administration; Issue A - *Scheduling*

No major problems identified.

Area IV, NCLEX Administration; Issue B - *ADA Compliance*

Sylvan has assigned one staff person to specifically work with Americans with Disabilities Act (ADA) compliance to assure that candidate service is maintained within legal and contractual requirements. The service provided by the test service has been good in this regard and should continue. The task force recommends that National Council continue to monitor this service area closely.

Area IV, NCLEX Administration; Issue C - *Security*

The task force believes that site proctoring is an issue which requires continual vigilance and high-level attention by Member Boards and National Council. Proctoring compliance has shown improvement since April 1994, but incidents still occur where the NCLEX is administered without two proctors present. The task force believes that the videotaping system has proven useful and is in general performing adequately. However, there has been a surprisingly large number of tapes discovered to be blank or useless after they have been requested for investigation. The task force suggests that Sylvan provide a more systematic retraining of center personnel on the video system to reduce the number of bad tapings.

The task force noted that only a few NCLEX have been administered to candidates who did not provide the approved identification. The task force stresses that because the Member Boards have a legal responsibility to issue licenses only to the correct candidates, a zero tolerance is the only appropriate criterion for site identification errors. National Council staff should continue to monitor the EIRs for this type of error. The task force believes that the quality of the digitized photographs is much too variable and that too many poor quality photos are being produced. General photo quality has not improved much since CAT was implemented. Member Boards have complained about the time lag necessary to retrieve candidate thumbprints and signature logs.

Area IV, NCLEX Administration; Issue D - *EIRs*

The task force found that EIRs seem to be providing consistent information, but that their coding accuracy could use some improvement. There have been EIR transmission irregularities, but they seem to be improving. The task force suggests that Chauncey explore the possibility of developing an on-line system for EIRs providing Member Boards with an option to print only the ones selected. Concerning EIR value, 47 percent of the Member Boards believe they are not fully informed of candidate problems through the EIR system before candidates register their complaints. Some EIRs do not provide enough information or the description of the incident is not sufficiently clear. The task force believes that EIR trends will be more effectively evaluated based on the trigger points (which initiate further Sylvan action) described in the Sylvan Quality Assurance Plan.

Area IV, NCLEX Administration; Issue E - *Sites*

The Sylvan site equipment and maintenance has been very satisfactory. One equipment problem has occurred in which the site file server performance was slowed down due to heavy utilization of the "back-up/hot fix" space (not as a function of candidate volume but as a function of how much time had passed since the servers were "brought down" and restarted). This problem was solved by reallocating the back-up space of each server by bringing it "down" and reinitializing it. To avoid a recurrence, Sylvan has initiated a schedule to "down" all servers every 60-180 days. Less than 100 candidates have been documented as adversely affected by this problem (due to slow keyboard response time) and all have received a free and immediate retest.

A software problem was introduced with the rotation of the tryout item pools in January 1996. Examinations were caused to abnormally terminate when a "turned-off" pretest item was selected for administration. Seventy-four

candidates were affected and were offered free and immediate retests. Also, failure candidates from this group received a voucher from Chauncey to pay for their next examination. In general, EIRs reflecting software errors continue to be generated at a fairly high rate, but these problems are not affecting candidate results.

Concerning the center environment, approximately 10 percent of NCLEX candidates believe that excess noise during their testing session was distracting. Approximately 85 percent characterize themselves as being comfortable in the testing centers.

Site capacity has been very good; NCLEX candidates have been accommodated within the contractual requirements of 30 days (or for repeaters, 45 days). Sylvan notifies National Council when the utilization of any site reaches 80 percent of capacity.

The task force is aware of some anecdotal reports of Sylvan Technical Support providing incorrect information to test center personnel and some delays in Technical Support response times. EIRs reflect a more general site misunderstanding of the distinct roles of the Sylvan Hot Line and Technical Support.

Member Boards and the other test service evaluators have rated the number of NCLEX restarts as a problem area (1.97; with 1=low, 2=moderate, 3=high satisfaction). Neither the number nor rate of restarts has declined since CAT was implemented. The implementation of the Sylvan Quality Assurance Plan should help the problem; it indicates that sites with excessive restarts will be investigated to determine the appropriate remedial action.

The task force recommends that site compliance be continually monitored by Sylvan, Chauncey, and National Council. There have been two instances where sites out of compliance continued to administer the NCLEX for a period of time.

Area IV, NCLEX Administration; Issue F - *Center Personnel*

The Test Service evaluators rated the efficacy of the training and certification program for Sylvan test center staff as needing improvement (2.29; with 1=low, 2=moderate, 3=high satisfaction). Sylvan has been very responsive to staff training needs and has instituted a process to distribute nightly communiqués to all test centers to deliver timely training or remedial information. Proctoring issues were already discussed above.

The task force is aware that there have been some reports of test site personnel providing inaccurate information to candidates. These instances are difficult to quantify; documented problem cases are generally remedied through the transmission of the correct information in the nightly communiqué process.

The test service evaluation showed that the responsiveness of Sylvan in providing information to Member Boards or the National Council in response to candidate inquiries was an area that needed improvement (rated 2.26; 1=low, 2=moderate, 3=high satisfaction).

Area IV, NCLEX Administration; Issue G - *Examinee Exit Evaluations*

The Examinee Exit Evaluation provides an important tool in monitoring sites and it is prominently featured in the Sylvan Quality Assurance Plan as providing trigger points for taking additional action. One question consistently receives a rather low rating from candidates (approximately 10 percent dissatisfied), and that is the use of bifocal glasses interfering with the candidates' ability to read the screen. The task force is not sure exactly what this response means and suggests a clarification of the question is needed. The results could reflect that the problem could be alleviated by making the screens or chairs more adjustable, or by having the site staff provide better instructions as to how to make those adjustments. Either way the task force believes that sites should be flexible enough to accommodate candidates wearing bifocals.

Area V, Results Reporting; Issue A - *Timeliness*

Twelve Member Boards disagreed with the statements that electronic results are received in a timely manner and that paper results are received by the boards in a timely manner. The task force believes the evidence shows that the majority of candidate results for the majority of boards are sent in a timely way, but recommends that Chauncey and National Council follow-up with the dissatisfied boards to determine exactly what problems are being reflected

in these survey results. Ten Member Boards also responded that they are not notified of delays in the release of candidate results by the time they were due. The task force recommends that Chauncey and National Council work together to tighten up the notification process. Eleven boards responded that the receipt of the Polaroid photographs does not occur soon enough the meet the boards' normal results release schedule.

Area V, Results Reporting; Issue B - *Score Holds*

The task force believes that Member Boards are not satisfied with the process of notification of score holds and that resolution reports are also not reported in a timely manner to boards.

Area V, Results Reporting; Issue C - *Accuracy*

The task force notes that the quality of the digitized photographs has improved since CAT was implemented, but that there is still much work to be done before they are uniformly excellent. At the beginning, Chauncey did experience a few problems in getting the right paper results to boards, but this has been much improved since.

Area V, Results Reporting; Issue D - *Aggregate Reports*

The task force notes that customers have been generally very satisfied with the *NCLEX™ Program Reports*; their evaluations have been positive. There is a difficulty, though, in producing corrected reports when programs identify misinformation.

The task force encourages all Member Boards to participate in the data sharing process for NCLEX. Chauncey and National Council have made the process easy and the data is valuable to all Member Boards.

Area V, Results Reporting; Issue E - *Diagnostic Profiles*

There is a legal and ethical need to continue to provide failing candidates with information about their NCLEX performance. Nineteen Member Boards (out of 39 responding to this question) believe that the Diagnostic Profile is not understandable to candidates or other board constituents. The task force believes that this problem has been with NCLEX for many years and is likely due to a lack of understanding of the NCLEX test plans. National Council has provided a telephone script to explain the profiles for Member Boards in the NCLEX Manual. National Council has solicited input on the profiles from Member Boards and others in many forums and continues to seek input to improve this report.

Area VI, Psychometric Effectiveness; Issue A - *Validity and Reliability*

No major problem here.

Area VII, Customer Service; Issue A - *Problem Resolution*

Although these issues take more resources than we would like, and some investigations take more time than would be considered optimal, this program function is being performed generally very well.

Area VII, Customer Service; Issue B - *National Council Customer Service*

Thirty-nine (of 40) Member Boards believe that their concerns are addressed by National Council in a timely manner. The task force believes that overall, National Council is providing good service for the NCLEX program.

Area VII, Customer Service; Issue C - *Contract Compliance*

Chauncey communications with National Council entities are comprehensive and have been improving. National Council and Chauncey/Sylvan staff meet on a monthly basis to discuss the program. National Council and Chauncey/Sylvan are also connected through an efficient electronic mail system; communications between the parties is almost instantaneous. The integrity of Chauncey/Sylvan's reports is very important to the quality of the NCLEX and to the relationship of all parties involved. The task force believes that contract compliance issues are generally good. Information about contract details can be found in the other sections of this report.

Summary

The average rating for the NCLEX for how well the computer-delivered NCLEX is satisfying Member Board needs to support the licensing of nurses in their jurisdiction was 4.83 (on a 1=low to 5=high scale). The task force concurs with this evaluation and believes that NCLEX is meeting Member Board needs. There are some areas where service

could be improved (e.g., item development, proctoring, results reporting, as outlined above), but generally the program is one of which the National Council, Chauncey, and Sylvan can be justifiably proud. The task force believes that the following issues should receive further attention by National Council and Chauncey/Sylvan:

- The task force noted that approximately one-half of the Member Boards are not providing readers' names to Sylvan (reader lists should be provided annually) and recommends that Sylvan send reminders to Member Boards each January soliciting readers.

- The task force recommends that Chauncey implement a system in which credit card approvals are available in real time (as is done in all retail establishments) to increase the service's value.

- The task force recommends that National Council continue to monitor the ADA procedures closely.

- The task force recommends that site compliance be continually monitored by Sylvan, Chauncey, and National Council.

- The task force believes the evidence shows that the majority of candidate results for the majority of boards are sent in a timely way, but recommends that Chauncey and National Council follow up with the dissatisfied boards to determine exactly what problems are being reflected in these survey results.

- The task force recommends that Chauncey and National Council work together to tighten up the score-hold notification process.

Attachment B

NCLEX™
Comprehensive Evaluation Guide

Area: I Test Development
Issue: A *Content*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Face Validity			
EC	Review of selected real exams	Annually	Sample real and simulated examinations will demonstrate coverage of the Test Plan without overlapping content.
EC	During EC Item Review (Item Level)	Quarterly	Sample real and simulated examinations will demonstrate coverage of the Test Plan without overlapping content.
Member Boards	Review of real and simulated exams	Biannually or less frequently	Sample real and simulated examinations demonstrate coverage of the Test Plan without overlapping content.
Based on Job Analysis / Test Plan			
CGI	CGI staff review	At least quarterly at each EC Item Review session, in the case of individual candidate concerns, or concerns arising from Member Board Item Review.	100% of items reviewed are based on the currently applicable Job Analysis Study and Test Plan.
EC	EC Item Review	At least quarterly at each EC Item Review session, in the case of individual candidate concerns, or concerns arising from Member Board Item Review.	100% of items reviewed are based on the currently applicable Job Analysis Study and Test Plan.
Member Boards	Review of real and simulated exams	Biannually or less frequently.	100% of items reviewed are based on the currently applicable Job Analysis Study and Test Plan.
NC staff	NC staff review	At least quarterly at each EC Item Review session, in the case of individual candidate concerns, or concerns arising from Member Board Item Review.	100% of items reviewed are based on the currently applicable Job Analysis Study and Test Plan.
Item Analysis			
CGI	The routine item analysis will include item characteristic curve parameters, response-choice frequencies by ability subgroups and DIF analysis to detect adverse impact on minority subgroups	When at least 500 responses are available for a set of tryout items, a routine item analysis will be run by CGI.	Items with unacceptable statistics or unusual response patterns will be removed from the pool for review by a content specialist. This review may result in discarding or recycling the item. The EC will have final approval of 100% of the items prior to their becoming operational.
EC	Review CGI Summary Reports	Quarterly	Items with unacceptable statistics or unusual response patterns will be removed from the pool for review by a content specialist. This review may result in discarding or recycling the item. The EC will have final approval of 100% of the items prior to their becoming operational.
NC staff	Review and analyze CGI Summary Reports	Quarterly	Items with unacceptable statistics or unusual response patterns will be removed from the pool for review by a content specialist. This review may result in discarding or recycling the item. The EC will have final approval of 100% of the items prior to their becoming operational.
Valid Item Coding			
EC	EC Item Review and Annual CGI Report	At each Item Review Session and as necessary in the case of Test Plan Changes.	100% of the items reviewed are coded based on the appropriate Test Plan category and other categories as specified by EC.

Area: I Test Development
Issue: B *Participation*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Recruiting			
CGI	CGI reviews needs and develops panelist requests, which are forwarded to NC	CGI submits panel requests annually Evaluation of need is ongoing.	A sufficient number of qualified applicants are available for CGI use in screening and selecting qualified panelists.
EC	EC reviews Member Board methods and relative success in recruiting panelists. NC staff assists EC in developing new strategies as necessary.	Recruitment, selection and evaluation are ongoing.	100% of the panels are filled
EC	EC reviews Member Board methods and relative success in recruiting panelists. NC staff assists EC in developing new strategies as necessary	Recruitment, selection and evaluation are ongoing	A sufficient number of qualified applicants are available for CGI use in screening and selecting qualified panelists
Representation: Geographic			
EC	Evaluation of panelist application according to established criteria	Before Item Developers are selected to attend a session	All four Areas of the National Council are represented by item development panelists
NC staff	Evaluation of panelist application according to established criteria.	Before Item Developers are selected to attend a session	All four Areas of the National Council are represented by item development panelists.
Representation: Demographic			
EC	Evaluation of panelist application according to established criteria	Before item developers are selected to attend a session.	Panels represent cultural and ethnic diversity, different practice settings, and a variety of educational settings
NC staff	Evaluation of panelist application according to established criteria	Before item developers are selected to attend a session.	Panels represent cultural and ethnic diversity, different practice settings, and a variety of educational settings.
Representation: Experience			
EC	Evaluation of panelist application according to established criteria	Before Item Developers are selected to attend a session	Panels have an appropriate mix of experienced and novice participants 100% of the time.
NC staff	Evaluation of panelist application according to established criteria	Before Item Developers are selected to attend a session	Panels have an appropriate mix of experienced and novice participants 100% of the time.
Qualifications			
EC	Final screening and selection of panel members	Before Item Developers are selected to attend a session	Item Developers meet the qualifications as stated in National Council policy 100% of the time.
Member Boards	Validation of qualifications through review of Board-specified documentation	Before Item Developers are selected to attend a session	Item Developers meet the qualifications as stated in National Council policy 100% of the time.
NC staff	Review of qualifications and endorsement by Member Board	Before Item Developers are selected to attend a session	Item Developers meet the qualifications as stated in National Council policy 100% of the time.
Screening /Evaluation			
CGI	Applicant's response on screening instrument is evaluated	Screening and evaluation as appear conducted as applications are received	The screening instrument used by CGI is a positive predictor of success of item writers
CGI	Evaluate effectiveness of each panel member	During each item development session	Each panel member makes a positive contribution to the item development process.
EC	Review reports from CGI on panel performance and reports tracking item survival by item writer	Quarterly	Quality item development is meeting targets

Area: I Test Development
Issue: B *Participation*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Member Board Review			
Member Boards	CGI shall submit items selected for experimental testing for review to those Member Boards which so request according to procedures determined by NC with the assistance of CGI Such review shall be limited to the appropriateness of the items for entry level and consistency with laws regulating nursing practice in the Member Board's jurisdiction	Problems identified with items during Member Board review shall be brought to the EC by NC staff for response/disposition	CGI will provide materials for Member Board review in a timely manner
NC staff	CGI shall submit items selected for experimental testing for review to those Member Boards which so request according to procedures determined by NC with the assistance of CGI Such review shall be limited to the appropriateness of the items for entry level and consistency with laws regulating nursing practice in the Member Board's jurisdiction	Problems identified with items during Member Board review shall be brought to the EC by NC staff for response/disposition	NC staff shall respond to the jurisdiction's complaint about an item based on the decision of the EC.

Area: I Test Development
Issue: C *Item Development Process*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Production Rate			
BOD	EC review of Item Pool Development Progress Reports	CGI semi-annual report to EC	No later than the termination date of this agreement, CGI must have developed items sufficient to create three Optimal Item Pools for each examination.
EC	EC review of Item Pool Development Progress Reports	CGI semi-annual report to EC	No later than the termination date of this agreement, CGI must have developed items sufficient to create three Optimal Item Pools for each examination.
NC staff	EC review of Item Pool Development Progress Reports	CGI semi-annual report to EC	No later than the termination date of this agreement, CGI must have developed items sufficient to create three Optimal Item Pools for each examination.
Item Writing			
EC	Monitor accuracy of validations	At each EC meeting	100% of the items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN.
EC	Review panel members' evaluations of sessions	At each EC meeting	100% items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN.
NC staff	Review and approve training materials	Annually	100% items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN.

Area: I Test Development
Issue: C *Item Development Process*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Item Reviews			
EC	Review reports of EC representatives attending item development sessions	At each EC meeting	100% of the items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN.
EC	Review Panel members' evaluations of sessions	At each EC meeting	100% of the items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN
EC	Monitor validations, entry level, currency, etc of items	At each EC meeting	100% of the items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN
NC staff	Review and approve training materials	Annually	100% of the items produced as a result of CGI Item Writing workshops will be Test Plan relevant, entry-level, job-related, of minimal bias, psychometrically sound, targeted to specific difficulty levels. reflect NCLEX style and coded to a specific Test Plan cell and other categories identified in the job analysis and specified from time to time by NCSBN.
% of Items Lost to Statistics			
CGI	Analysis of net items produced	Quarterly report to EC	Items lost to bad statistics are less than 28% for both RN and PN pools.
EC	Analysis of net items produced	Quarterly report to EC	Items lost to bad statistics are less than 28% for both RN and PN pools.
EC Role in Item Development Process			
EC	Self-evaluation and Chair evaluation of committee	Annually	The Examination Committee workload is reasonable for 5, 5 day meetings.
EC	Self-evaluation and Chair evaluation of committee	Annually	Item development process is being implemented effectively.
NC staff	Workload analysis	Annually	Item development process is being implemented effectively
NC staff	Workload analysis	Annually	Item development process is being implemented effectively
Turnaround Time From Item Writing to Pool Inclusion			
EC	Analysis of reports from CGI	Annually	Continued reduction in lag time is achieved.

Area: I Test Development
Issue: C *Item Development Process*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Filling Pool Holes			
EC	Analysis of reports from CGI identifying pool needs	At each EC meeting	There exists a reasonable match between need and output of items.
NC staff	Analysis of reports from CGI identifying pool needs	Ongoing and at each EC meeting	There exists a reasonable match between need and output of items.

Area: I Test Development
Issue: D *Item Pools*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Item Pool Configuration (Equivalent Pool Size)			
EC	Staff review of configuration criteria	Semi-annually	Satisfactory pool equivalence, number of items, able to meet Test Plan, face validity.
NC staff	Staff review of configuration criteria	Semi-annually	Satisfactory pool equivalence, number of items, able to meet Test Plan, face validity.
Moving to 3 Optimal Item Pools			
BOD	Review definition of optimal pool and compare to current pool tallies	Quarterly	Three optimal pools exist by deadline date specified in contract.
EC	Review CGI report on progress toward three optimal item pools	Quarterly	Three optimal pools exist by deadline date specified in contract.
EC	Review definition of optimal pool and compare to current pool tallies	Quarterly	Three optimal pools exist by deadline date specified in contract.
Item Pool Maintenance			
EC	Review policies and procedures re: item pools	Annually	Good item pools, currency, accuracy, readability, reflect NC criteria for items.
NC staff	Review policies and procedures re: item pools	Annually	Good item pools, currency, accuracy, readability, reflect NC criteria for items
Item Pool Storage / Security			
CGI	CGI security audit	Annually	Contractual provisions are met.
NC staff	CGI security audit	Annually	Contractual provisions are met.

Area: II Member Board Processes
Issue: A *MBOS*

Evaluator	Methodology of Evaluation	Frequency	Criteria
MBOS Usability			
EC	Reviews requests for MBOS enhancement and takes action	At each EC meeting	The MBOS Software facilitates Member Boards in their licensure function processes.
Member Boards	Complete Member Board Survey	Occasionally	The MBOS Software facilitates Member Boards in their licensure function processes.
Member Boards	Member Boards identify problems and possible enhancements	Continuous assessment in communications with Member Boards, occasionally by survey, annually at Delegate Assembly	The MBOS Software facilitates Member Boards in their licensure function processes
MBOS Manual			
CGI	Staff review	Annually and with each release	The documentation provided is sufficient to use the software.
Member Boards	Complete Member Board Survey	Annually	The documentation provided is sufficient to use the software
Member Boards	Member Boards identify problems with documentation	Ongoing assessment in communications with Member Boards, and particularly following release of new software	The documentation provided is sufficient to use the software.
NC staff	Staff review	Annually and with each release	The documentation provided is sufficient to use the software.
MBOS Help Desk			
EC	Review results of Member Board Survey	Annually	Problems are solved or questions are answered 90% of the time on the first call.
EC	CGI provides a summary of help desk interventions in a format so that the EC can identify Member Boards needing frequent additional assistance, frequency of occurrence of specific problems, length of time from help call to resolution of problem, and other data so that appropriate intervention can occur	Quarterly	Member Boards needing frequent additional assistance will be identified and action taken to resolve recurring problems.
EC	Review results of Member Board Survey	Annually	Member Boards express satisfaction with MBOS help.
Member Boards	Complete Member Board Survey	Annually	Problems are solved or questions are answered 90% of the time on the first call.
Member Boards	Member Board staff inquiries to help desk	Ongoing	Member Boards needing frequent additional assistance will be identified and action taken to resolve recurring problems.
Member Boards	Complete Member Board Survey	Annually	Member Boards express satisfaction with MBOS help.
NC Staff	Analyze and summarize CGI report	Quarterly	Member Boards needing frequent additional assistance will be identified and action taken to resolve recurring problems.
NC staff	Analyze and summarize Member Board Survey	Quarterly	Problems are solved or questions are answered 90% of the time on the first call.
NC Staff	Analyze and summarize Member Board Survey	Quarterly	Member Boards express satisfaction with MBOS help.
System Security			
Member Boards	Complete Member Board Survey	Annually	Compliance with existing standards

Area: II Member Board Processes
Issue: A *MBOS*

Evaluator	Methodology of Evaluation	Frequency	Criteria
MBOS Performance			
CGI	Annual MBOS Performance report	Annually	The system is "up" 99% of the time
Member Boards	Member Boards identify problems with equipment and maintenance procedures	Ongoing; review of help desk calls and Member Board complaints	The system is "up" 99% of the time
Member Boards	Complete Member Board Survey	Annually	The system is "up" 99% of the time
NC staff	Procedures shall be periodically reviewed by NC Equipment maintenance shall be performed by CGI on a regular basis	Ongoing	The system is "up" 99% of the time

Area: II Member Board Processes
Issue: B *Communication*

Evaluator	Methodology of Evaluation	Frequency	Criteria
To Candidates			
Candidates	Complete Examinee Exit Evaluation	Ongoing Quarterly summary of candidate exit evaluations will be provided for the EC	99% of responding candidates for NCLEX receive sufficient information to meet their needs.
EC	Use of confidential candidate comments Candidate contacts with NC and/or others indicating lack of information available concerning the NCLEX Ongoing evaluation through routine contacts with Member Boards to determine if candidates and schools are finding the information provided to be adequate	Ongoing Quarterly summary of candidate exit evaluations will be provided for the EC	99% of responding candidates for NCLEX receive sufficient information to meet their needs.
Member Boards	Complete Member Board Survey	Annually	99% of responding candidates for NCLEX receive sufficient information to meet their needs.
Member Boards	Use of confidential candidate comments Candidate contacts with NC and/or others indicating lack of information available concerning the NCLEX Ongoing evaluation through routine contacts with Member Boards to determine if candidates and schools are finding the information provided to be adequate	Ongoing Quarterly summary of candidate exit evaluations will be provided for the EC	99% of responding candidates for NCLEX receive sufficient information to meet their needs.
NC staff	Use of confidential candidate comments Candidate contacts with NC and/or others indicating lack of information available concerning the NCLEX Ongoing evaluation through routine contacts with Member Boards to determine if candidates and schools are finding the information provided to be adequate	Ongoing Quarterly summary of candidate exit evaluations will be provided for the EC	99% of responding candidates for NCLEX receive sufficient information to meet their needs.
Constituents; Educators, Legislators, Public, Nurse Executives, AAGs, SNAs			
Member Boards	Member Boards forward complaints from their constituents concerning lack of information	When complaints received	Member Board constituents receive sufficient information from NC to meet the needs of their constituents.
Member Boards	Complete Member Board Survey	Annually	Member Board constituents receive sufficient information from NC to meet the needs of their constituents.
Member Boards	Survey of Member Boards asking how NC can be of assistance to Boards	Annually	Member Board constituents receive sufficient information from NC to meet the needs of their constituents.
Inter-board			
Member Boards	Complete Member Board Survey	Annually	Adequate mechanisms exist for exchange of NCLEX information among Member Boards
Member Boards	Ongoing evaluation through routine contacts with Member Boards to determine if the jurisdiction-to-jurisdiction information flow is adequate to meet their needs	Continual through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards
NC staff	Ongoing evaluation through routine contacts with Member Boards to determine if the jurisdiction-to-jurisdiction information flow is adequate to meet their needs	Continual through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards

Area: II Member Board Processes
Issue: B *Communication*

Evaluator	Methodology of Evaluation	Frequency	Criteria
To and From NC, CGI, SLS (Communication Channels)			
CGI	Ongoing evaluation through routine contacts with Member Boards to determine if the communication among Member Boards and NC, CGI, and/or SLS is adequate to meet their needs	Ongoing through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards, NC, CGI and SLS Communication channels are followed among all entities.
Member Boards	Complete Member Board Survey	Annually	Adequate mechanisms exist for exchange of NCLEX information among Member Boards, NC, CGI and SLS Communication channels are followed among all entities
Member Boards	Ongoing evaluation through routine contacts with Member Boards to determine if the communication among Member Boards and NC, CGI, and/or SLS is adequate to meet their needs	Ongoing through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards, NC, CGI and SLS Communication channels are followed among all entities.
NC staff	Ongoing evaluation through routine contacts with Member Boards to determine if the communication among Member Boards and NC, CGI, and/or SLS is adequate to meet their needs	Ongoing through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards, NC, CGI and SLS Communication channels are followed among all entities.
SLS	Ongoing evaluation through routine contacts with Member Boards to determine if the communication among Member Boards and NC, CGI, and/or SLS is adequate to meet their needs	Ongoing through routine contacts	Adequate mechanisms exist for exchange of NCLEX information among Member Boards, NC, CGI and SLS Communication channels are followed among all entities
Service to Candidates			
Candidates	Provide candidate feedback	Ongoing	When receiving complaints or questions from a candidate, the Member Board has sufficient information available to respond to the issue 90% of the time without having to refer the candidate to another source.
Member Boards	Complete Member Board Survey	Annually	When receiving complaints or questions from a candidate, the Member Board has sufficient information available to respond to the issue 90% of the time without having to refer the candidate to another source
Member Boards	Ongoing evaluation in contacts with Member Boards	Ongoing	When receiving complaints or questions from a candidate, the Member Board has sufficient information available to respond to the issue 90% of the time without having to refer the candidate to another source
NCLEX Manual			
Member Boards	Complete Member Board Survey	Annually	Member Boards can find answers to NCLEX questions in the NCLEX Manual 95% of the time
Member Boards	Solicit feedback on adequacy of updates to Manual, candidate complaints, Ongoing evaluation for revising	Ongoing; Evaluate manual annually for revision	Member Boards can find answers to NCLEX questions in the NCLEX Manual 95% of the time
NC staff	Solicit feedback on adequacy of updates to Manual, candidate complaints, Ongoing evaluation for revising	Ongoing; Evaluate manual annually for revision	Member Boards can find answers to NCLEX questions in the NCLEX Manual 95% of the time

Area: II Member Board Processes
Issue: C *Interactions with NCLEX System*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Eligibility Status			
Member Boards	Self-evaluation	Ongoing	Member Boards make eligibility decisions within 24 hours after application is complete
Eligibility Decisions			
Member Boards	Daily evaluation when using MBOS and/or printing reports	Ongoing	The candidate is sent an eligibility notice by CGI within 24 hours after being made eligible to test by the Board, where applicable.
Site Visit Process			
EC	Review NC report	Quarterly	Testing sites are found to be in compliance with standards during the Member Board visit
Member Boards	Member Boards will visit their examination sites and submit an evaluation to NC	Semi-annually	Testing sites are found to be in compliance with standards during the Member Board visit.
NC staff	Analyze and summarize Member Board site evaluations	Semi-annually	Testing sites are found to be in compliance with standards during the Member Board visit
EIR Use			
NC staff	Evaluate mailbox usage	By exception	90% of Member Boards pick up EIRs daily.
Results Processing			
Member Boards	Self-evaluation	Ongoing	Candidate NCLEX results are mailed out within two weeks of receipt of paper copy 95% of the time.
Data Changes			
CGI	Review accuracy of quarterly reports	Ongoing and by exception	CGI makes corrections to data as requested by Member Boards, which are reflected in quarterly reports.
CGI	Evaluated at test centers when ATT is compared to identification and MBOS data	Ongoing	Existing processes for making candidate data changes facilitate the office workflow. Data changes are made only according to the procedure established in the Test Center Administrator's
Constituents	Review accuracy of quarterly reports	Quarterly	CGI makes corrections to data as requested by Member Boards, which are reflected in quarterly reports.
Member Boards	Review accuracy of quarterly reports	Quarterly	CGI makes corrections to data as requested by Member Boards, which are reflected in quarterly reports.
Member Boards	Daily evaluation by Member Boards when using MBOS and/or issuing licenses	Daily	Existing processes for making candidate data changes facilitate the office workflow. Data changes are made only according to the procedure established in the Test Center Administrator's manual. CGI makes corrections to data as requested by Member Boards, which are reflected in quarterly reports
SLS	Evaluated at test centers when ATT is compared to identification and MBOS data	Ongoing	Existing processes for making candidate data changes facilitate the office workflow. Data changes are made only according to the procedure established in the Test Center Administrator's manual.

Area: II Member Board Processes
Issue: C *Interactions with NCLEX System*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Readers			
Candidates	The effectiveness of the reader is evaluated by the candidate	Whenever a reader is needed	Only qualified readers are used.
Member Boards	The effectiveness of the reader is evaluated by the candidate and the test center staff Only qualified readers are utilized	Whenever a reader is needed	Only qualified readers are used.
Member Boards	Review SLS report on status of each reader	Annually	Jurisdictions and test centers identify a sufficient number of qualified readers to meet ADA candidates' needs.
NC staff	The effectiveness of the reader is evaluated by the candidate and the test center staff Only qualified readers are utilized	Whenever a reader is needed	Only qualified readers are used.
SLS	SLS report on status of each reader	Annually	Jurisdictions and test centers identify a sufficient number of qualified readers to meet ADA candidates' needs
SLS	The effectiveness of the reader is evaluated by the test center staff Only qualified readers are utilized	Whenever a reader is needed	Only qualified readers are used.
SLS	SLS report on status of each reader	Annually	Jurisdictions and test centers identify a sufficient number of qualified readers to meet ADA candidates' needs

Area: III Registration
Issue: A *By Telephone*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Queue Times			
CGI	Telephone queue times for candidate registration are monitored regularly by CGI Appropriate measures are taken to reduce candidate wait time during peak periods (sufficient number of operators)	Ongoing; daily	A sufficient number of operators are handling candidate registrations so that the registration begins within 5 minutes.
NC staff	Periodic reports are received from CGI	Quarterly	A sufficient number of operators are handling candidate registrations so that the registration begins within 5 minutes.
Value (cost vs. benefits)			
Candidates	Provide candidate feedback	Ongoing	Credit cards clear in real time, are not held and batched.
Candidates	Provide candidate feedback	Ongoing	There are perceived advantages to telephone registration processing vs. mail registration processing to justify the additional cost
Data Accuracy			
CGI	Accuracy of candidate registration information obtained by telephone is compared to the accuracy of scanned paper registration	Ongoing	Candidate registration information obtained by telephone and keyed in by operators is no less accurate than information obtained from scannable registration forms.
EC	CGI will evaluate any difference in data accuracy between the two methods and report to the EC annually,	Annually	Candidate registration information obtained by telephone and keyed in by operators is no less accurate than information obtained from scannable registration forms.
Scripts Use			
Member Boards	Simulate candidates asking questions	As necessary	Candidates receive information from prepared and approved scripts without elaboration or improvisation by operators.
Member Boards	Review candidate feedback and investigate complaints of inaccurate information	When received	Candidates receive information from prepared and approved scripts without elaboration or improvisation by operators.
NC staff	Review and analyze candidate feedback and investigate complaints of inaccurate information	When received	Candidates receive information from prepared and approved scripts without elaboration or improvisation by operators.
NC staff	Simulate candidates asking questions	As necessary	Candidates receive information from prepared and approved scripts without elaboration or improvisation by operators.

Area: III Registration
Issue: B *By Mail*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Processing Time			
CGI	Performance report on processing time	Quarterly	95% of registrations are processed within 48 hours.
NC staff	Review and analyze CGI performance report	Quarterly	95% of registrations are processed within 48 hours.
Incomplete Records in Database			
CGI	CGI review of database for record completeness and reports to EC	Annually	100% of incomplete forms are rejected by EC established criteria.
CGI	Incomplete registrations are rejected for human resolution at the time of initial processing	Daily	100% of incomplete forms are rejected by EC established criteria
EC	Review CGI report	Annually	100% of incomplete forms are rejected by EC established criteria.
Data Accuracy			
CGI	CGI develop summary report on the automated reasonability checks	Semi-annually	Reasonability checks are in place and periodically updated
Member Boards	Comparison of CGI data with Member Board data, self-evaluation	Ongoing	Member Boards correct 100% of data errors
NC staff	Review and analyze CGI reports	Semi-annually	Reasonability checks are in place and periodically updated.
Registration Form Quality			
NC staff	Review of accuracy reports for trends	Per reporting cycle	The candidate registration form consistently elicits the desired data.

Area: III Registration
Issue: C *Funds Handling*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Accurate Accounting			
BOD	Review CGI reports	Annually	CGI/NC records match with 100% accuracy
CGI	Internal audit of accounting procedures	Annually	CGI/NC records match with 100% accuracy
Finance Committee	Review NC staff and CGI reports	Quarterly	CGI/NC records match with 100% accuracy
NC staff	Review and analyze CGI informal audit report	Annually	CGI/NC records match with 100% accuracy
NC staff	Review and analyze CGI reports	Annually	CGI/NC records match with 100% accuracy
Timeliness			
CGI	CGI develops timeliness report	Annually	Contract terms for timeliness are met.
Finance Committee	Review CGI report	Annually	Contract terms for timeliness are met
NC staff	Review and analyze CGI report	Annually	Contract terms for timeliness are met.

Area: III Registration
Issue: D *Process*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Abandoned Registrations			
CGI	Prepare CGI report	Annually	Multiple attempts at registration are identified 100% of the time.
Member Boards	Review CGI report	Annually	Multiple attempts at registration are identified 100% of the time.
NC staff	Review and analyze CGI report	Annually	Multiple attempts at registration are identified 100% of the time.
Matching Algorithm			
CGI	Performs periodic scans of the total candidate database to identify duplicate candidates not found by the matching algorithm	As determined by EC	Duplicate candidate registrations will be detected by the matching algorithm before ATTs are issued, 100% of the time.
EC	Review CGI reports of database scans for duplicate candidates	As determined by EC	Duplicate candidate registrations will be detected by the matching algorithm before ATTs are issued, 100% of the time
Member Boards	Evaluate inquiries from other Member Boards and candidates	When received	Duplicate candidate registrations will be detected by the matching algorithm before ATTs are issued, 100% of the time
NC staff	Review CGI reports of database scans for duplicate candidates and analyze for trends	As determined by EC	Duplicate candidate registrations will be detected by the matching algorithm before ATTs are issued, 100% of the time.
ATT Process			
CGI	Prepare report on status	Quarterly	ATTs are mailed within 48 hours of eligibility declaration 100% of the time
Member Boards	Member Boards report by exception	Ongoing	ATT validity dates are accurate 100% of the time
NC staff	Review and analyze reports from CGI and Member Board reports	Quarterly	ATT validity dates are accurate 100% of the time

Area: III Registration
Issue: E *Communication*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Candidate Bulletin			
Candidates	Examinee Exit Evaluation	Ongoing	Candidates have adequate information concerning the NCLEX process
CGI	Review and report rejected applications to EC for trend analysis	Whenever received; compile quarterly summary	Candidate bulletin contains information enabling candidates to complete forms accurately.
EC	Review Member Board Survey results	Annually	Member Boards have sufficient quantities of bulletins to meet candidate requests and statutory requirements.
EC	Review Member Board Survey results	Annually	Member Boards have sufficient quantities of bulletins to meet candidate requests and statutory requirements.
EC	Review CGI report on rejected applications and trends	Quarterly	Candidate bulletin contains information enabling candidates to complete forms accurately.
Legal counsel	Legal review	As changes are made	Candidate bulletin affords legal protection for National Council and Member Boards
Member Boards	Complete Member Board survey re: legal protection, accuracy and usability	Annually	Candidate bulletin affords legal protection, is usable and accurate
Member Boards	Complete Member Board survey re: bulletin supply	Annually	Member Boards have sufficient quantities of bulletins to meet candidate requests and statutory requirements
NC staff	NC internal report	Annually	Candidate bulletin development process is reasonable
Program Code Booklets			
Member Boards	Complete Member Board Survey	Annually	Program Code booklets are accurate and usable
Customer Service			
Candidates	Provide candidate feedback	Whenever received	Candidates receive consistent and correct information from operators/staff.
Candidates	Complete Examinee Exit Evaluation	Every day of testing	Candidates receive prompt, courteous treatment
Member Boards	Review EIRs, candidate complaints	Whenever received	Candidates receive prompt, courteous treatment
Member Boards	Review EIRs, candidate complaints	Whenever received	Candidates receive consistent and correct information from operators/staff.
NC staff	NC staff compares NC/CGI/SLS scripts	Annually	Candidates receive consistent and correct information from operators/staff.
Changes in Registration Process are Communicated to all Parties			
Member Boards	Complete Member Board Survey	Annually	Changes are communicated in a timely way prior to implementation.
NC staff	Project monitoring	Ongoing	Changes are communicated in a timely way prior to implementation.

Area: IV NCLEX Administration
Issue: A *Scheduling*

Evaluator	Methodology of Evaluation	Frequency	Criteria
NRC			
Candidates	Provide candidate feedback	Whenever received	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
CGI	Monitor SLS reports	Quarterly	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
Member Boards	Review EIRs, candidate complaints	Whenever received and as necessary to assure compliance	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
SLS	All NRC Registrars are monitored weekly for call quality Each monitored call is documented by a Team Leader and reviewed with the Registrar	Weekly and as needed if remediation is required	Calls are answered within two minutes. Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
SLS	Secret Shopper program using SLS staff to call the NRC and schedule and appointment while observing and documenting the service provided by the NRC	Periodically	Calls are answered within two minutes Appointments are made correctly 100% of the time. Established procedures and scripts are followed 100% of the time.
Local			
Candidates	Provide candidate feedback	Whenever received	Appointments are made correctly 100% of the time.
CGI	Monitor connection wait time and reports	Quarterly	Established procedures and scripts are followed 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Established procedures and scripts are followed 100% of the time
Member Boards	Review EIRs, candidate complaints	Whenever received and as necessary to assure compliance	Appointments are made correctly 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Appointments are made correctly 100% of the time.
NC staff	Monitor connection wait time and reports	Quarterly	Established procedures and scripts are followed 100% of the time.

Area: IV NCLEX Administration
Issue: B *ADA Compliance*

Evaluator	Methodology of Evaluation	Frequency	Criteria
30/45 day Compliance			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	SLS scheduling is in compliance as designated in the contract.
CGI	Review SLS 30-45 day reports	Monthly	SLS scheduling is in compliance as designated in the contract.
Member Boards	Review trend analysis of Examinee Exit Evaluations	Quarterly	SLS scheduling is in compliance as designated in the contract.
Member Boards	Review EIRs, candidate complaints	Whenever received and as necessary to assure compliance	SLS scheduling is in compliance as designated in the contract.
NC Staff	Examinee Exit Evaluations are monitored for trends	Quarterly	SLS scheduling is in compliance as designated in the contract.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints,	Whenever received and as necessary to assure compliance	SLS scheduling is in compliance as designated in the contract.
NC staff	Review and summarize SLS 30-45 day reports	Monthly	SLS scheduling is in compliance as designated in the contract.
SLS	Self-evaluation of 30-45 day compliance	Monthly	SLS scheduling is in compliance as designated in the contract.
Rescheduling (changing appointments)			
Candidates	Provide candidate feedback	Whenever received	Candidate rescheduling events are performed accurately 100% of the time.
CGI	Monitor SLS reports	Quarterly	Candidate rescheduling events are performed accurately 100% of the time.
Member Boards	Review EIRs, candidate complaints	Whenever received and as necessary to assure compliance	Candidate rescheduling events are performed accurately 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints,	Whenever received and as necessary to assure compliance	Candidate rescheduling events are performed accurately 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Candidate rescheduling events are performed accurately 100% of the time.
SLS	Self-evaluation of rescheduling compliance	Quarterly	Candidate rescheduling events are performed accurately 100% of the time.
Testing Software			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.

Area: IV NCLEX Administration
Issue: B *ADA Compliance*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Site			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Testing of ADA candidates is in compliance with federal requirements 100% of the time
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
SLS	Review and EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Accommodations			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Paper Flow Process			
Candidates	Provide candidate feedback, complete Examinee Exit Evaluation	Every day of testing	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
CGI	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Member Boards	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
NC staff	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
SLS	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.

Area: **IV** NCLEX Administration
Issue: **B** *ADA Compliance*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Scheduling			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
CGI	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
Member Boards	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
NC staff	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time.
SLS	Investigate Member Board and/or candidate complaints	Whenever received and as necessary to assure compliance	Testing of ADA candidates is in compliance with federal requirements 100% of the time

Area: IV NCLEX Administration
Issue: C *Security*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Proctoring			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	NCLEX is administered in compliance with security requirements 100% of the time.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Site Compliance			
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Videos			
CGI	Evaluate availability and usefulness of video	When required for candidate investigation	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Evaluate availability and usefulness of video	When required for candidate investigation	NCLEX is administered in compliance with security requirements 100% of the time.
NC staff	Evaluate availability and usefulness of video	When required for candidate investigation	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Evaluate availability and usefulness of video	When required for candidate investigation	NCLEX is administered in compliance with security requirements 100% of the time.

Area: IV NCLEX Administration
Issue: C *Security*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Identification			
Candidates	Provide candidate feedback, complete Confidential Comment She, Examinee Exit Evaluation	Every day of testing	NCLEX is administered in compliance with security requirements 100% of the time
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Photos			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	NCLEX is administered in compliance with security requirements 100% of the time
CGI	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
Member Boards	Complete Member Board Survey	Annually	NCLEX is administered in compliance with security requirements 100% of the time
NC staff	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
Thumb Printing			
CGI	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Complete Member Board Survey	Annually	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time
NC staff	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Evaluate feedback from Member Boards and/or candidates	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.

Area: IV NCLEX Administration
Issue: C *Security*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Signature Log			
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Complete Member Board Survey	Annually	NCLEX is administered in compliance with security requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Access to Center			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet, Examinee Exit Evaluation	Every day of testing	NCLEX is administered in compliance with security requirements 100% of the time.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	NCLEX is administered in compliance with security requirements 100% of the time.

Area: IV NCLEX Administration
Issue: D *EIRs*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Data Accuracy, Code Usage, and Compliance with Rules			
CGI	Evaluate EIRs for completeness and accuracy of information	Ongoing	EIRs are consistently complete and accurate.
CGI	Monitor SLS reports	Quarterly	EIRs are consistently complete and accurate
Member Boards	Compare number of EIRs received to number of candidate complaints	Ongoing	EIRs are consistently complete and accurate.
Member Boards	Evaluate EIRs for completeness and accuracy of information	Ongoing	EIRs are consistently complete and accurate.
NC staff	Monitor SLS reports	Quarterly	EIRs are consistently complete and accurate
NC staff	Evaluate EIRs for completeness and accuracy of information	Ongoing	EIRs are consistently complete and accurate.
SLS	Perform audits of EIR data accuracy	Monthly	EIRs are consistently complete and accurate.
SLS	Evaluate EIRs for completeness and accuracy of information	Ongoing	EIRs are consistently complete and accurate.
EIR System Design			
CGI	Evaluate flow of EIRs through data system	Ongoing	EIR flow is not interrupted
CGI	Monitor SLS reports	Quarterly	EIR flow is not interrupted
Member Boards	Evaluate flow of EIRs through data system	Ongoing	EIR flow is not interrupted
NC staff	Evaluate flow of EIRs through data system	Ongoing	EIR flow is not interrupted
NC staff	Monitor SLS reports	Quarterly	EIR flow is not interrupted
SLS	Perform audits of EIR system flow	Monthly	EIR flow is not interrupted
SLS	Evaluate flow of EIRs through data system	Ongoing	EIR flow is not interrupted
Value			
CGI	Monitor SLS reports	Ongoing	EIRs are useful in complaint resolution
CGI	Evaluate EIRs as "early warning" notification of examination administration problems	Ongoing	Stakeholders are fully informed of problems by EIR before complaints are received.
Member Boards	Complete Member Board Survey	Annually	EIRs are useful in complaint resolution.
Member Boards	Evaluate EIRs as "early warning" notification of examination administration problems	Ongoing	Member Boards are fully informed of problems by EIR before complaints are received.
NC staff	Monitor SLS reports	Ongoing	EIRs are useful in complaint resolution
NC staff	Evaluate EIRs as "early warning" notification of examination administration problems	Ongoing	Stakeholders are fully informed of problems by EIR before complaints are received.
SLS	Perform audits of EIR usefulness as "early warning" system for Member Boards and other stakeholders	Ongoing	Stakeholders are fully informed of problems by EIR before complaints are received.
SLS	Evaluate EIRs as "early warning" notification of examination administration problems	Ongoing	Stakeholders are fully informed of problems by EIR before complaints are received.

Area: IV NCLEX Administration
Issue: D *EIRs*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Trend Analysis			
CGI	Monitor EIRs to determine trends at testing centers	Ongoing	EIRs serve as accurate indicator of trends in test center performance.
CGI	Monitor SLS reports	Monthly	EIRs serve as accurate indicator of trends in test center performance.
Member Boards	Monitor EIRs to determine trends at testing centers	Ongoing	EIRs serve as accurate indicator of trends in test center performance.
NC staff	Monitor EIRs to determine trends at testing centers	Ongoing	EIRs serve as accurate indicator of trends in test center performance.
NC staff	Monitor SLS reports	Quarterly	EIRs serve as accurate indicator of trends in test center performance.
SLS	Monitor EIRs to determine trends at testing centers	Ongoing	EIRs serve as accurate indicator of trends in test center performance.
SLS	Perform audit of EIR effectiveness in identifying trends in test center performance	Ongoing	Centers whose EIR % (as a percentage of tests delivered) are in the top or bottom 5% of all centers for the month will prompt an investigation of the content of the EIRs received, leading to a recommendation for remediation if deemed necessary. This process is completed monthly. Any center having a significant security breach (any activity requiring a site visit by ETS security staff) will receive an unannounced site visit by Sylvan staff. Centers which have above average numbers of EIRs that are appropriately in categories most likely to suggest problems initiated at the site will prompt an investigation of the contents of the EIRs received, leading to a recommendation for remediation if deemed necessary. This process is completed monthly and covers the 90-day period prior to that month end. Specific categories for this trigger are: (1) THEFT OR VANDALISM - Any occurrences; (4) EQUIPMENT FAILURE - Top 25% of all centers; (5) SOFTWARE PROBLEMS - Top 25% of all centers; (10) IMAGE CAPTURE FAILURE - Top 25% of all centers; (11) VIDEO / AUDIO OPERATIONS - Top 10% of all centers; (12) ADMINISTRATIVE ERROR - Top 25% and bottom 5% of all centers; and (18) ENVIRONMENTAL PROBLEM - Top 10% of all centers.

Area: IV NCLEX Administration
Issue: D *EIRs*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Resolution Quality			
CGI	Evaluate speed and efficacy of resolution of problems identified on EIRs	Ongoing	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
CGI	Monitor SLS reports	Quarterly	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
Member Boards	Evaluate speed and efficacy of resolution of problems identified on EIRs	Ongoing	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
NC staff	Monitor SLS reports	Quarterly	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
NC staff	Evaluate speed and efficacy of resolution of problems identified on EIRs	Ongoing	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
SLS	Evaluate speed and efficacy of resolution of problems identified on EIRs	Ongoing	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required
SLS	Perform audits of resolution time/satisfaction on problem EIRs	Monthly	Problems identified in EIRs are satisfactorily resolved within 30 days, 100% of the time, except in more complex circumstances or if remediation is required

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Equipment			
Candidates	Complete Examinee Exit Evaluation	Every day of testing	Any computer failures are repaired or replaced within 24 hours of detection and diagnosis
Candidates	Complete Examinee Exit Evaluation	Every day of testing	Testing Center equipment meets contractual requirements 100% of the time.
Candidates	Complete Examinee Exit Evaluation	Every day of testing	Computer upgrades are instituted when need exists.
CGI	Monitor SLS Reports	Quarterly	Any computer failures are repaired or replaced within 24 hours of detection and diagnosis
CGI	Monitor SLS Reports	Quarterly	Computer upgrades are instituted when need exists.
CGI	Monitor SLS Reports	Quarterly	Testing Center equipment meets contractual requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Any computer failures are repaired or replaced within 24 hours of detection and diagnosis.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Computer upgrades are instituted when need exists.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Center equipment meets contractual requirements 100% of the time.
NC staff	Monitor SLS Reports	Quarterly	Any computer failures are repaired or replaced within 24 hours of detection and diagnosis.
NC staff	Monitor SLS Reports	Quarterly	Computer upgrades are instituted when need exists.
NC staff	Review and summarize EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing Center equipment meets contractual requirements 100% of the time.
SLS	Perform audits of Test Center equipment functioning	Monthly	Any computer failures are repaired or replaced within 24 hours of detection and diagnosis.
SLS	Perform audits of Test Center equipment functioning	Monthly	Testing Center equipment meets contractual requirements 100% of the time.
SLS	Perform audits of Test Center equipment functioning	Monthly	Computer upgrades are instituted when need exists.

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Software			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	Testing Center software functions correctly 100% of the time.
CGI	Monitor SLS reports	Quarterly	Testing Center software functions correctly 100% of the time.
CGI	Monitor SLS reports	Quarterly	Extensive compatibility testing is done by SLS and CGI to verify that all software used performs as it should on any proposed new hardware.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Extensive compatibility testing is done by SLS and CGI to verify that all software used performs as it should on any proposed new hardware.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Center software functions correctly 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Extensive compatibility testing is done by SLS and CGI to verify that all software used performs as it should on any proposed new hardware.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing Center software functions correctly 100% of the time.
SLS	Perform audits of Test Center software functioning	Monthly, with each new release, and with new hardware	Extensive compatibility testing is done by SLS and CGI to verify that all software used performs as it should on any proposed new hardware.
SLS	Perform audits of Test Center software functioning	Monthly, with each new release, and with new hardware	Testing Center software functions correctly 100% of the time.

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Environment			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Testing Center environment meets contractual requirements 100% of the time.
CGI	Monitor SLS reports	Quarterly	Testing Center environment meets contractual requirements 100% of the time.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Center environment meets contractual requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Center environment meets contractual requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing Center environment meets contractual requirements 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Testing Center environment meets contractual requirements 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Center environment meets contractual requirements 100% of the time.
SLS	Perform periodic video review audits of site compliance	Quarterly	Testing Center environment meets contractual requirements 100% of the time.
Capacity			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.
CGI	Monitor SLS reports	Quarterly	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.
SLS	Perform daily audits of center capacity and institute notification measures when capacity indicates	Daily	Testing center capacity is sufficient to assure contractual (within the 30-45 day scheduling rule) candidate scheduling requirements 100% of the time.

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Location			
CGI	Monitor SLS audits	Quarterly	Testing Centers meet jurisdictional requirements as outlined in the contract.
Member Boards	Review EIRs and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Centers meet jurisdictional requirements as outlined in the contract.
NC staff	Monitor SLS audits	Quarterly	Testing Centers meet jurisdictional requirements as outlined in the contract.
NC staff	Review and summarize EIRs and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Centers meet jurisdictional requirements as outlined in the contract.
SLS	Perform periodic audits of center usage and scheduling difficulty related to location,	Monthly	Testing Centers meet jurisdictional requirements as outlined in the contract.
Findability			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Candidates are able to easily find their Test Center
CGI	Review EIRs, Member Board and/or candidate complaints, Examinee Exit Evaluation and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Candidates are able to easily find their Test Center
Member Boards	Review EIRs, candidate complaints, Examinee Exit Evaluation and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Candidates are able to easily find their Test Center
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, Examinee Exit Evaluation and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Candidates are able to easily find their Test Center
SLS	Review EIRs, Member Board and/or candidate complaints, Examinee Exit Evaluation and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Candidates are able to easily find their Test Center

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
SLS QA Plan			
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS QA plan is reviewed and updated annually. The QA plan is sufficient to provide early warning of testing problems.
EC	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS QA plan is reviewed and updated annually. The QA plan is sufficient to provide early warning of testing problems.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS QA plan is reviewed and updated annually. The QA plan is sufficient to provide early warning of testing problems.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	SLS QA plan is reviewed and updated annually. The QA plan is sufficient to provide early warning of testing problems.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS QA plan is reviewed and updated annually. The QA plan is sufficient to provide early warning of testing problems.
Discipline Process			
BOD	CGI Quarterly Reports	Quarterly	SLS corporate procedure for employee /franchisee is followed 100% of the time
CGI	CGI Quarterly Reports	Quarterly	SLS corporate procedure for employee /franchisee is followed 100% of the time
EC	CGI Quarterly Reports	Quarterly	SLS corporate procedure for employee /franchisee is followed 100% of the time
NC staff	CGI Quarterly Reports	Quarterly	SLS corporate procedure for employee /franchisee is followed 100% of the time
SLS	CGI Quarterly Reports	Quarterly	SLS corporate procedure for employee /franchisee is followed 100% of the time
Tech Support			
CGI	Monitor SLS reports	Quarterly	Testing Centers receive appropriate tech support in a timely way 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Testing Centers receive appropriate tech support in a timely way 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Testing Centers receive appropriate tech support in a timely way 100% of the time.
NC staff	Monitor SLS reports	Quarterly	Testing Centers receive appropriate tech support in a timely way 100% of the time.
SLS	Compile reports utilizing the SLS Automated call tracking system	Quarterly	Testing Centers receive appropriate tech support in a timely way 100% of the time.

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Hotline			
CGI	Monitor SLS reports	Quarterly	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
EC	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
NC staff	Monitor SLS reports	Quarterly	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
SLS	SLS Automated call tracking system	Quarterly	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	100% of the Hotline calls are answered and triaged as emergency or non-emergency within one minute. Emergency calls are returned within 10 minutes. Non-emergency calls are returned within 30 minutes.

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
RESTARTS			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	Restarts are handled according to appropriate procedure 100% of the time.
CGI	Monitor SLS reports	Quarterly	The number of restarts will continually decrease
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Restarts are handled according to appropriate procedure 100% of the time.
NC staff	Monitor SLS reports	Quarterly	The number of restarts will continually decrease
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Restarts are handled according to appropriate procedure 100% of the time.
SLS	Perform audits of restart frequency and precipitating factors	Monthly for the previous 90 day period	Testing Centers having restarts in excess of twice the average for all centers over a 90 day period will prompt the investigation of other trigger points to decide required remedial action.
Delayed Start of Day			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Delayed start of day events are handled according to appropriate procedures 100% of the time.
CGI	Monitor SLS reports	Quarterly	The number of delayed start of day events will continually decrease.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Delayed start of day events are handled according to appropriate procedures 100% of the time.
NC staff	Monitor SLS reports	Quarterly	The number of delayed start of day events will continually decrease.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Delayed start of day events are handled according to appropriate procedures 100% of the time.
SLS	Perform audits of delayed start of day incidents, frequency, and precipitating factors	Monthly for the previous 90 day period	Testing Centers having delayed start of day events in excess of 5% of their testing days in any three-month period (four occurrences in three months) will prompt the investigation of other trigger points to decide required remedial action.
Protocol Followed for Closing a Site			
NC staff	Investigate complaints and Review and analyze SLS reports	As needed	Site closings are conducted in accordance with established procedures 100% of the time
Notification of Site Closing			
Member Boards	Investigate complaints and review SLS reports	As needed	Member Boards and National Council are notified of site closings using established procedures 100% of the time.
NC staff	Investigate complaints and Review and analyze SLS reports	As needed	Member Boards and National Council are notified of site closings using established procedures 100% of the time

Area: IV NCLEX Administration
Issue: E *Sites*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Cessation of Testing When a Site is Out of Compliance			
Member Boards	Investigate complaints and review SLS reports	As needed	No appointments are scheduled and no examinations are administered when a site is out of compliance.
NC staff	Investigate complaints and Review and analyze SLS reports	As needed	No appointments are scheduled and no examinations are administered when a site is out of compliance.

Area: IV NCLEX Administration
Issue: F *Center Personnel*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Training			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
CGI	Monitor SLS reports	Monitor by exception	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
NC staff	Monitor SLS reports	Monitor by exception	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
SLS	Perform audits of training attendance and provide for ongoing training needs assessment	Ongoing	SLS staff receive sufficient training to maintain compliance with NCLEX administration requirements 100% of the time.
Certification			
CGI	Monitor SLS reports	Quarterly	100% of the SLS Test Center Administrators will achieve initial certification and maintain updated annual re-certification.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	100% of the SLS Test Center Administrators will achieve initial certification and maintain updated annual re-certification.
NC staff	Monitor SLS reports	Quarterly	100% of the SLS Test Center Administrators will achieve initial certification and maintain updated annual re-certification.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	100% of the SLS Test Center Administrators will achieve initial certification and maintain updated annual re-certification.
SLS	Perform periodic audit of certification records	Quarterly	100% of the SLS Test Center Administrators will achieve initial certification and maintain updated annual re-certification.

Area: IV NCLEX Administration
Issue: F *Center Personnel*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Staffing			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
CGI	Monitor SLS reports	By exception and quarterly	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
NC staff	Monitor SLS reports	By exception and quarterly	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
SLS	Perform periodic audits of staffing compliance	Intermittently	SLS staffing levels will be in compliance with contractual requirements 100% of the time.
SLS	SLS telephone contacts to a Testing Center will include periodic requests to speak to the backup proctor available during NCLEX testing If the proctor is unavailable, further telephone attempts to contact will be made	Intermittently	Any Testing Center where the backup proctor is unavailable to come to the telephone during two NCLEX sessions within a month period will receive an unannounced site visit during an NCLEX session by Sylvan staff.
TCA Manual			
CGI	Monitor SLS reports	By exception and annually	The TCA Manual will provide sufficient information to facilitate examination administration in full compliance with NCLEX specifications.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	The TCA Manual will provide sufficient information to facilitate examination administration in full compliance with NCLEX specifications.
NC staff	Monitor SLS reports	By exception and annually	The TCA Manual will provide sufficient information to facilitate examination administration in full compliance with NCLEX specifications.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	The TCA Manual will provide sufficient information to facilitate examination administration in full compliance with NCLEX specifications.
SLS	Perform periodic audits and updates of TCA manual	As necessary	The TCA Manual will provide sufficient information to facilitate examination administration in full compliance with NCLEX specifications.

Area: IV NCLEX Administration
Issue: F *Center Personnel*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Information Provided			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
CGI	Monitor SLS reports	By exception	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
NC staff	Monitor SLS reports	By exception	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
SLS	Perform periodic audits of information given to candidates	By exception	SLS personnel will provide accurate, consistent information about the NCLEX to candidates and Member Board visitors 100% of the time.
Performance of Duties			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.
CGI	Monitor SLS reports	Quarterly	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.
NC staff	Monitor SLS reports	Quarterly	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.
SLS	Perform periodic audits of staff performance	As indicated by trigger points	SLS employees perform required duties related to administration of the NCLEX in compliance with established standards and procedures 100% of the time.

Area: IV NCLEX Administration
Issue: F *Center Personnel*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Customer Service			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Candidates will receive excellent customer service from SLS employees according to SLS QA trigger points.
CGI	Monitor SLS reports	Quarterly	Candidates, Member Boards and the NC will receive excellent customer service from SLS employees as indicated in the annual Test Service evaluation.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Member Boards will receive excellent customer service from SLS employees according to SLS QA trigger points.
Member Boards	Complete Member Board Survey	Periodically	NC staff will receive excellent customer service from SLS employees as indicated in the annual Test Service evaluation.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	The NC will receive excellent customer service from SLS employees as indicated in the annual Test Service evaluation.
NC staff	Monitor SLS reports	Quarterly	Candidates, Member Boards and the NC will receive excellent customer service from SLS employees as indicated in the annual Test Service evaluation.
SLS	Perform periodic assessments of customer satisfaction, Confidential Comment Sheets and Examinee Exit Evaluations	As indicated by trigger points	Candidates, Member Boards and the NC will receive excellent customer service from SLS employees as indicated in the annual Test Service evaluation.
30 Minute Rule			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet and Examinee Exit Evaluation	Every day of testing	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time, 100 % of the time.
CGI	Review SLS reports	Quarterly	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time, 100 % of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Whenever received and as necessary to assure compliance	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time.
NC staff	Review and analyze SLS reports	Quarterly	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time, 100 % of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Whenever received and as necessary to assure compliance	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time, 100 % of the time.
SLS	Periodically audit centers for compliance with the 30 minute reschedule rule	By exception	Candidates who must wait 30 minutes or more for their scheduled examination to begin will be offered an opportunity to reschedule for another time, 100 % of the time.

Area: IV NCLEX Administration
Issue: G *Examinee Exit Evaluations*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Evaluation			
Candidates	Complete Examinee Exit Evaluation	Received every day of testing	Centers where examinee exit evaluations vary more than 5% in absolute terms from the same quarter of the previous year on center related performance questions will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary. This process will be completed quarterly. Specific questions monitored are outlined in the SLS QA Plan.
CGI	Review EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint (s) of examinee exit evaluations	Received every day of testing	Centers where examinee exit evaluations vary more than 5% in absolute terms from the same quarter of the previous year on center related performance questions will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary. This process will be completed quarterly. Specific questions monitored are outlined in the SLS QA Plan.
Member Boards	Review EIRs, candidate complaints, and compare to number and chief complaint (s) of examinee exit evaluations	Whenever received	Centers where examinee exit evaluations vary more than 5% in absolute terms from the same quarter of the previous year on center related performance questions will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary. This process will be completed quarterly. Specific questions monitored are outlined in the SLS QA Plan.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint (s) of examinee exit evaluations	Received every day of testing	Centers where examinee exit evaluations vary more than 5% in absolute terms from the same quarter of the previous year on center related performance questions will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary. This process will be completed quarterly. Specific questions monitored are outlined in the SLS QA Plan.
SLS	Review and summarize EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint (s) of examinee exit evaluations	Received every day of testing	Centers where examinee exit evaluations vary more than 5% in absolute terms from the same quarter of the previous year on center related performance questions will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary. This process will be completed quarterly. Specific questions monitored are outlined in the SLS QA Plan.

Area: IV NCLEX Administration
Issue: G *Examinee Exit Evaluations*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Confidential Comment Sheets			
Candidates	Provide candidate feedback, complete Confidential Comment Sheet	Whenever received	Confidential comments received reflect high quality examination processes.
CGI	Review EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint(s) of Confidential Comment Sheets	Whenever received	Confidential comments received reflect high quality examination processes.
CGI	Any site not receiving any Confidential Comment Sheets in a six-month period will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary	Ongoing review	Confidential Comment Sheets are made available to 100% of the candidates.
Member Boards	Review EIRs, candidate complaints, and compare to number and chief complaint(s) on Confidential Comment Sheets	Received every day of testing	Confidential comments received reflect high quality examination processes.
NC staff	Any site not receiving any Confidential Comment Sheets in a six-month period will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary	Ongoing review	Confidential Comment Sheets are made available to 100% of the candidates.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint(s) of Confidential Comment Sheets	Received every day of testing	Confidential comments received reflect high quality examination processes.
SLS	Review EIRs, Member Board and/or candidate complaints, and compare to number and chief complaint(s) on Confidential Comment Sheets	Received every day of testing	Confidential comments received reflect high quality examination processes.
SLS	Any site not receiving any Confidential Comment Sheets in a six-month period will prompt an investigation of other trigger areas for that center to decide what remedial action is necessary	Ongoing review	Confidential Comment Sheets are made available to 100% of the candidates.

Area: V Results Reporting
Issue: A *Timeliness*

Evaluator	Methodology of Evaluation	Frequency	Criteria
48 Hour Electronic Transmission of Candidate Results			
BOD	Review CGI Quarterly Reports	Quarterly	Electronic candidate results are received at the Member Board office within 48 hours of testing.
EC	Review CGI Quarterly Reports	Quarterly	Electronic candidate results are received at the Member Board office within 48 hours of testing.
Member Boards	Generate complaints concerning electronic results not received within 48 hours	Ongoing	Electronic candidate results are received at the Member Board office within 48 hours of testing.
Member Boards	Complete Member Board Survey	Annually	Electronic candidate results are received at the Member Board office within 48 hours of testing.
NC staff	Review complaints from Member Boards concerning electronic results not received within 48 hours	As often as received	Electronic candidate results are received at the Member Board office within 48 hours of testing.
Paper Mailing of Candidate Results			
BOD	Review CGI Quarterly Reports	Quarterly	CGI will mail paper results to Member Boards within 3 days of testing, except in situations which require score holds, 100% of the time.
EC	Review CGI Quarterly Reports	Quarterly	CGI will mail paper results to Member Boards within 3 days of testing, except in situations which require score holds, 100% of the time.
Member Boards	Generate complaints concerning paper results not received	Ongoing	CGI will mail paper results to Member Boards within 3 days of testing, except in situations which require score holds, 100% of the time.
Member Boards	Complete Member Board Survey	Annually	CGI will mail paper results to Member Boards within 3 days of testing, except in situations which require score holds, 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning paper results not received	As often as received	CGI will mail paper results to Member Boards within 3 days of testing, except in situations which require score holds, 100% of the time.
Lost Paper Results Process			
BOD	Review CGI Quarterly Reports	Quarterly	Lost paper results are tracked, retrieved, and replacements sent in a timely fashion, 100% of the time.
EC	Review CGI Quarterly Reports	Quarterly	Lost paper results are tracked, retrieved, and replacements sent in a timely fashion, 100% of the time.
Member Boards	Generate complaints concerning "lost" paper results and procedures to replace hard copy	Ongoing	Lost paper results are tracked, retrieved, and replacements sent in a timely fashion, 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Lost paper results are tracked, retrieved, and replacements sent in a timely fashion, 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning "lost" paper results and procedures to replace hard copy	As often as received	Lost paper results are tracked, retrieved, and replacements sent in a timely fashion, 100% of the time.

Area: V Results Reporting
Issue: A *Timeliness*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Member Board Notification			
Member Boards	Complete Member Board Survey	Annually	Member Boards will be notified of any delay in release of candidate results within 48 hours of testing, 100% of the time.
Member Boards	Generate complaints concerning any candidate results not received	Ongoing	Member Boards will be notified of any delay in release of candidate results within 48 hours of testing, 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning any candidate results not received	As often as received	Member Boards will be notified of any delay in release of candidate results within 48 hours of testing, 100% of the time.
Polaroid Process			
Member Boards	Generate complaints concerning noncompliance with Polaroid process	Ongoing	Polaroid procedure for non-image capture will be followed correctly 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Polaroid procedure for non-image capture will be followed correctly 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning noncompliance with Polaroid process	As often as received	Polaroid procedure for non-image capture will be followed correctly 100% of the time.

Area: V Results Reporting
Issue: B *Score Holds*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Criteria for Holds			
EC	Review score hold criteria and effectiveness in identifying problems	Annually	Score hold criteria reviewed and revised as necessary on an annual basis.
EC	Review complaints from Member Boards concerning candidate results holds not in compliance with criteria for holds	As often as received	Criteria for holds will be maintained, and process of notification of Member Boards will be followed correctly 100% of the time.
Member Boards	Generate complaints concerning candidate results holds not in compliance with criteria for holds	As often as received	Criteria for holds will be maintained, and process of notification of Member Boards will be followed correctly 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning candidate results holds not in compliance with criteria for holds	As often as received	Criteria for holds will be maintained, and process of notification of Member Boards will be followed correctly 100% of the time.
Follow-up on Problem			
Member Boards	Generate complaints concerning lack of follow-up and or communication on resolution of candidate problems	As often as received	Score holds are followed up in a timely fashion, and Member Boards are notified of resolution of candidate complaints in a timely manner 100% of the time.
NC staff	Review and analyze complaints from Member Boards concerning lack of follow-up and/or communication on resolution of candidate problems	As often as received	Score holds are followed up in a timely fashion, and Member Boards are notified of resolution of candidate complaints in a timely manner 100% of the time.

Area: V Results Reporting
Issue: C *Accuracy*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Correct and Usable Photo Image			
Candidates	Provide candidate feedback	Ongoing	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
CGI	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Ongoing	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
Member Boards	Review EIRs, candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Ongoing	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
NC staff	Review and summarize EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards. Analyze for trends and/or problems	Ongoing	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
SLS	Review EIRs, Member Board and/or candidate complaints, and STC Facility Requirements Compliance Checklists completed by Member Boards	Ongoing	Candidate results forms will contain a usable and correct, digitized and discernible candidate photo 100% of the time.
Correct Results			
BOD	Review EIRs and investigative reports concerning candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.
Candidates	Provide candidate feedback	Ongoing	Candidates receive correct results 100% of the time.
CGI	Review EIRs and investigative reports concerning candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.
EC	Review EIRs and investigative reports concerning candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.
Member Boards	Review EIRs and investigative reports concerning candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.
Member Boards	Complete Member Board Survey	Ongoing	Candidates receive correct results 100% of the time.
NC staff	Review and summarize EIRs, investigate candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.
SLS	Review EIRs, investigate candidate, Member Board and/or constituent complaints of "wrong results" received for a candidate	Ongoing	Candidates receive correct results 100% of the time.

Area: V Results Reporting
Issue: D *Aggregate Reports*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Quarterly Reports (green sheets)			
Constituents	Candidate and aggregate data is evaluated for accuracy and completeness	Quarterly	Quarterly reports contain correct information 100% of the time, given the absence of candidate program code errors, etc.
EC	Reviews requests for enhancements to the quarterly report format	Quarterly	Quarterly reports contain correct information 100% of the time, given the absence of candidate program code errors, etc.
Member Boards	Candidate and aggregate data is evaluated for accuracy and completeness	Quarterly	Quarterly reports contain correct information 100% of the time, given the absence of candidate program code errors, etc.
Member Boards	Complete Member Board Survey	Annually	Quarterly reports contain correct information 100% of the time, given the absence of candidate program code errors, etc.
Program Reports (BON, CGI)			
BOD	Provide update in CGI quarterly report to the BOD	Quarterly	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
CGI	Survey subscribers for satisfaction with report content and accuracy	Annually	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
CGI	CGI will keep a running tally of complaints and/or suggestions for enhancements to reports	Ongoing	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
CGI	Provide update in CGI quarterly report to the BOD	Quarterly	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
Constituents	CGI will keep a running tally of complaints and/or suggestions for enhancements to reports	Ongoing	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
Constituents	Survey subscribers for satisfaction with report content and accuracy	Annually	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
Member Boards	Survey subscribers for satisfaction with report content and accuracy	Annually	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
Member Boards	CGI will keep a running tally of complaints and/or suggestions for enhancements to reports	Ongoing	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
NC staff	Provide update in CGI quarterly report to the BOD	Quarterly	Program Reports provide comprehensive information which can be utilized by Programs of Nursing as a diagnostic tool.
Quarterly Technical Reports			
CGI	CGI prepares for review by EC	Quarterly	Technical reports contain adequate information to evaluate the continued psychometric effectiveness of the examination.
EC	CGI prepares for review by EC	Quarterly	Technical reports contain adequate information to evaluate the continued psychometric effectiveness of the examination
NC staff	CGI prepares for review by EC	Quarterly	Technical reports contain adequate information to evaluate the continued psychometric effectiveness of the examination.

Area: V Results Reporting
Issue: D *Aggregate Reports*

Evaluator	Methodology of Evaluation	Frequency	Criteria
State to State			
BOD	Review complaints from Member Boards concerning lack of information about pass-fail status of candidates educated in their jurisdictions	When received	Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.
CGI	Review complaints from Member Boards concerning lack of information about pass-fail status of candidates educated in their jurisdictions	When received	Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.
Constituents	Generate complaints concerning lack of information about pass-fail status of candidates educated in their jurisdictions	When received	Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.
EC	Review complaints from Member Boards concerning lack of information about pass-fail status of candidates educated in their jurisdictions	When received	Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.
Member Boards	Generate complaints concerning lack of information about pass-fail status of candidates educated in their jurisdictions		Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.
NC staff	Review and summarize complaints from Member Boards concerning lack of information about pass-fail status of candidates educated in their jurisdictions	When received	Candidate data sharing among Member Boards will be implemented as fully as possible given statutory limitations.

Area: V Results Reporting
Issue: E *Diagnostic Profiles*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Understandable and Useful			
Candidates	Provide candidate feedback	When received	Diagnostic Profiles will be understandable by candidates and constituents.
CGI	Investigate candidate, Member Board and/or constituent complaints of difficulty in interpretation of candidate results	When received	Diagnostic Profiles will be understandable by candidates and constituents.
CGI	Investigate candidate, Member Board and/or constituent complaints of difficulty in utilizing candidate results as a diagnostic tool to direct preparation for a subsequent examination	When received	Diagnostic Profiles will be useful to candidates and Member Boards.
Constituents	Generate complaints of difficulty in utilizing candidate results as a diagnostic tool to direct preparation for a subsequent examination	When received	Diagnostic Profiles will be useful to candidates and Member Boards.
Constituents	Generate complaints of difficulty in interpretation of candidate results	When received	Diagnostic Profiles will be understandable by candidates and constituents.
EC	Review Member Board Survey regarding usefulness of diagnostic Profiles	Annually	Diagnostic Profiles will be useful to candidates and Member Boards.
Member Boards	Forward candidate and/or constituent complaints of difficulty in utilizing candidate results as a diagnostic tool to direct preparation for a subsequent examination to NC	When received	Diagnostic Profiles will be useful to candidates and Member Boards.
Member Boards	Forward candidate and/or constituent complaints of difficulty in interpretation of candidate results to NC	When received	Diagnostic Profiles will be understandable by candidates and constituents.
Member Boards	Complete Member Board Survey	Annually	Diagnostic Profiles will be useful to candidates and Member Boards.
NC staff	Investigate candidate, Member Board and/or constituent complaints of difficulty in utilizing candidate results as a diagnostic tool to direct preparation for a subsequent examination	When received	Diagnostic Profiles will be useful to candidates and Member Boards.
NC staff	Survey Member Boards regarding usefulness of diagnostic Profiles	Annually	Diagnostic Profiles will be useful to candidates and Member Boards.
NC staff	Investigate candidate, Member Board and/or constituent complaints of difficulty in interpretation of candidate results	When received	Diagnostic Profiles will be understandable by candidates and constituents.

Area: VI Psychometric Effectiveness
Issue: A *Validity and Reliability*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Psychometric Analyses			
BOD	Review CGI reports and research agenda	Quarterly and ongoing	The NCLEX examination is psychometrically sound.
CGI	Review CGI reports and research agenda	Quarterly and ongoing	The NCLEX examination is psychometrically sound.
EC	Review CGI reports and research agenda	Quarterly and ongoing	The NCLEX examination is psychometrically sound.
NC staff	Review and analyze CGI reports and research agenda	Quarterly and ongoing	The NCLEX examination is psychometrically sound.
Research Program			
BOD	Review Joint Research Council reports and research agendas	Semi-annually and as reports are produced	NCLEX remains a high quality, progressive licensure program which meets the changing needs of Member Boards and society.
CGI	Review Joint Research Council reports and research agendas	Semi-annually and as reports are produced	NCLEX remains a high quality, progressive licensure program which meets the changing needs of Member Boards and society.
EC	Review Joint Research Council reports and research agendas	Semi-annually and as reports are produced	NCLEX remains a high quality, progressive licensure program which meets the changing needs of Member Boards and society.
NC staff	Review Joint Research Council reports and research agendas	Semi-annually and as reports are produced	NCLEX remains a high quality, progressive licensure program which meets the changing needs of Member Boards and society.
Legal Defensibility			
BOD	Review legal opinions	As needed	The NCLEX examination is legally defensible
EC	Review legal opinions	As needed	The NCLEX examination is legally defensible
Legal counsel	Review past and provide updated legal opinions	As needed	The NCLEX examination is legally defensible
NC staff	Review legal opinions	As needed	The NCLEX examination is legally defensible

Area: VII Customer Service
Issue: A *Problem Resolution*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Candidate Complains to Member Board			
Candidates	Provide candidate feedback	Whenever received	Candidate complaints to Member Boards are investigated and resolved to mutual satisfaction in a timely fashion.
Member Boards	Receive candidate feedback	Whenever received	Candidate complaints to Member Boards are investigated and resolved to mutual satisfaction in a timely fashion.
Candidate Complains to NC			
Candidates	Provide candidate feedback	Whenever received	Candidate complaints to NC are investigated and resolved to mutual satisfaction in a timely fashion.
Member Boards	Monitor candidate feedback	Whenever received	Candidate complaints to NC are investigated and resolved to mutual satisfaction in a timely fashion.
NC staff	Candidate complaints are investigated, tracked and remediated	Whenever received	Candidate complaints to NC are investigated and resolved to mutual satisfaction in a timely fashion.
Candidate Complains to CGI/SLS			
Candidates	Provide candidate feedback	Whenever received	Candidate complaints to CGI/SLS are investigated and resolved to mutual satisfaction in a timely fashion.
CGI	Candidate complaints are investigated, tracked and remediated	Whenever received	Candidate complaints to CGI/SLS are investigated and resolved to mutual satisfaction in a timely fashion.
Member Boards	Monitor candidate feedback	Whenever received	Candidate complaints to CGI/SLS are investigated and resolved to mutual satisfaction in a timely fashion.
NC staff	Candidate complaints are investigated, tracked and remediated	Whenever received	Candidate complaints to CGI/SLS are investigated and resolved to mutual satisfaction in a timely fashion.
SLS	Candidate complaints are investigated, tracked and remediated	Whenever received	Candidate complaints to CGI/SLS are investigated and resolved to mutual satisfaction in a timely fashion.

Area: VII Customer Service
Issue: B *NCSBN Customer Service*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Exhibiting, Speaking			
BOD	Complete post-presentation evaluations, provide feedback	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
Candidates	Complete post-presentation evaluations, provide feedback	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
Constituents	Complete post-presentation evaluations, provide feedback	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
EC	Review post-presentation evaluations and/or other feedback from attendees	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
Member Boards	Complete post-presentation evaluations, provide feedback	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
Member Boards	Complete Member Board Survey	Annually	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
NC staff	Review post-presentation evaluations and/or other feedback from attendees	Following each event	Exhibiting and speaking opportunities meet organizational objectives for examination information dissemination.
NC to Member Boards			
BOD	Review all complaints received	Whenever received	Member Board NCLEX needs are addressed in a timely manner 100% of the time.
BOD	Review results of Member Board Survey for customer satisfaction	Annually	Member Board NCLEX needs are addressed in a timely manner 100% of the time.
BOD	Review all complaints received		Complaints are addressed in a timely manner 100% of the time.
EC	Review results of Member Board Survey for customer satisfaction	Annually	Member Board NCLEX needs are addressed in a timely manner 100% of the time.
EC	Review all complaints received	Whenever received	Complaints are addressed in a timely manner 100% of the time.
Member Boards	Complete Member Board Survey	As needed	Member Board NCLEX needs are addressed in a timely manner 100% of the time.
Member Boards	Complete Member Board Survey	Annually	Complaints are addressed in a timely manner 100% of the time.

Area: VII Customer Service
Issue: C *Contract Compliance*

Evaluator	Methodology of Evaluation	Frequency	Criteria
Contract Interpretation and Compliance			
BOD	Daily evaluation of test service performance	Ongoing	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
BOD	Formal contract evaluation meeting	Annually	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
EC	Daily evaluation of test service performance	Ongoing	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
EC	Formal contract evaluation meeting	Annually	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
Legal counsel	Formal contract evaluation meeting	Annually	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
Member Boards	Daily evaluation of test service performance	Ongoing	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
NC staff	Daily evaluation of test service performance	Ongoing	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
NC staff	Formal contract evaluation meeting	Annually	Vendor meets terms of contract. Vendor anticipates and meets Member Board and NC needs.
CGI Accountability for Subcontractor			
BOD	Formal contract evaluation meeting	Annually	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
BOD	Daily evaluation of test service performance	Ongoing	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
EC	Daily evaluation of test service performance	Ongoing	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
EC	Formal contract evaluation meeting	Annually	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
Legal counsel	Formal contract evaluation meeting	Annually	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
Member Boards	Daily evaluation of test service performance	Ongoing	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
NC staff	Daily evaluation of test service performance	Ongoing	CGI demonstrates full accountability for the performance of their subcontractor, SLS.
NC staff	Formal contract evaluation meeting	Annually	CGI demonstrates full accountability for the performance of their subcontractor, SLS.

Area: VII Customer Service
Issue: C *Contract Compliance*

Evaluator	Methodology of Evaluation	Frequency	Criteria
CGI Communications to NC			
BOD	Review Quarterly and Annual reports from Test Service	As scheduled	The Test Service provides the information needed for BOD and Member Boards that facilitates decision making.
Member Boards	Review Quarterly and Annual reports from Test Service	As scheduled	The Test Service provides the information needed for BOD and Member Boards that facilitates decision making.
NC staff	Review and analyze Quarterly and Annual reports from Test Service	As scheduled	The Test Service provides the information needed for BOD and Member Boards that facilitates decision making.

Report of the Nurse Aide Competency Evaluation Program (NACEP™) Task Force

Task Force Members
Cindy Lyons, OK, Area III, *Chair*
Dorothy Fulton, AK, Area I
Patricia Hill, ND, Area II
Mary Kinson, NH, Area IV
Orpha Swiger, WV-PN, Area II
Anna Yoder, MA, Area IV
Sarah Greene Burger, DC, *Consultant*

Staff
Ellen Gleason, *NACEP Program Manager*

Relationship to Organization Plan
Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective D ..... Provide a competency evaluation for nurse aides.

Recommendations to the Board of Directors
No recommendations.

Background
In May 1995, the National Council's test service for the Nurse Aide Competency Evaluation Program (NACEP), The Psychological Corporation (TPC), announced that it had acquired Assessment Systems, Inc. (ASI). Over the past year, TPC, ASI and the National Council have met to discuss the merger, negotiate a new contract and plan the future course of NACEP. (More information on the TPC/ASI merger can be found in the Board of Directors' report.) As a result, the NACEP Task Force has not met this year. The National Council Board of Directors and staff would like to thank the members of the task force for their patience during this time of uncertainty and their willingness to serve the National Council and its Member Boards.

Highlights of Activities

- **User Survey**
  The results of the 1996 user survey (Attachments A and B) indicate that user satisfaction has increased over the past year. Few users reported experiencing operational difficulties, and difficulties experienced were resolved by the test service. Several users have indicated that they are looking forward to the possibilities of an electronic application process and testing, which may be offered in the future.

- **Communications**
  The Seventh Nurse Aide Conference was held in Baltimore, Maryland, on May 13-14, 1996, and was attended by over 65 individuals. New advances in training programs, recertification and the nurse aide registry were discussed. In addition, discussions on the impact of nurse aide training and quality of resident life, stress and turnover rates for nurse aides and the increasing use of unlicensed assistive personnel were discussed. The conference concluded with a discussion on the future of nurse aide training and certification.

  Insight—Newsletter on Nurse Aides and Assistive Personnel entered its fourth year of publication. *Insight* is distributed to more than 1,080 individuals in a wide variety of settings including long-term care facilities, home health agencies, training facilities, etc. Future plans include offering more articles related to the use of unlicensed assistive personnel (UAPs) in all settings and more information on state and federal regulation of UAPs.

Future Activities
Future activities of the task force will be determined by the Board of Directors after finalizing negotiations with TPC/ ASI.

Meeting Dates
None.

Recommendations to the Board of Directors
No recommendations.

Attachments

Attachment A

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
NURSE AIDE COMPETENCY EVALUATION PROGRAM
FEBRUARY 1996 USER STATE AGENCY SURVEY - CUMULATIVE RESULTS
N = 22

		SA	A	D	SD	Other*
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	13	8	1		
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	10	11	1		
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	7	13	1		1
4.	NACEP meets all the legal requirements in this jurisdiction:					
	a. for aides employed in long term care.	15	7			
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	9	9	3		1
	c. for aides employed in acute care settings (hospitals).	8	9	3	1	1
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	5	16	1		
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	6	13			3
7.	The test service provides accurate and necessary information regarding the NACEP.	7	12	2		1
8.	The test service answers inquiries from this agency in a reasonable amount of time.	7	13	1		1
9.	Evaluation materials from the test service arrive on time at test sites.	5	15			2
10.	Candidates receive score reports within the time period specified by your contract.	3	14	2		3

11.	The state agency score reports have been received in a timely manner.	2	14	3	1	2
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	4	15	1		2
13.	NACEP security measures are effective.	6	16			
14.	Feedback on the NACEP from nurse aides has been positive.	2	15	3		
15.	Feedback on the NACEP from facilities has been positive.	2	15	4		1
16.	The application process is easy for candidates and sponsors to compete.	2	15	3		2
17.	NACEP is an effective evaluation for home health aides (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as long term care aides.	4	13	2		3
18.	The Nurse Aide Practice Test has been useful.	4	14	1		3

			Yes	No	Other*
22.	In your jurisdiction, are you currently using NACEP to evaluate:				
	a.	aides employed in long term care settings	18	1	2
	b.	aides employed in home health settings	12	6	3
	c.	aides employed in acute care (hospital) settings	11	8	2

		Very Low	Low	Med	High	Very High
26.	Overall, how satisfied is this agency with the Nurse Aide Competency Evaluation Program (NACEP) offered by the National Council of State Boards of Nursing and The Psychological Corporation . Please respond on a scale of 1 to 5, with 1 indicating a very low level of satisfaction.	0	0	5	12	4

No Response = 1

SA = Strongly Agree
A = Agree
D = Disagree
SD = Strongly Disagree

**Other includes responses such as no answer given, not applicable, perhaps, etc.*

Responses to open-ended questions (19-21 and 23-25) are available upon request.

Attachment B

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
NURSE AIDE COMPETENCY EVALUATION PROGRAM
1996 USER STATE AGENCY QUESTIONNAIRE
COMPARISON OF CUMULATIVE RESULTS

		1996	1995	1994
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	3.54	3.40	3.27
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.41	3.25	3.00
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.29	3.20	2.76
4.	NACEP meets all the legal requirements in this jurisdiction:			
	a. for aides employed in long term care.	3.68	3.45	3.45
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	3.29	3.13	3.25
	c. for aides employed in acute care settings (hospitals).	3.14	3.00	2.76
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	3.18	3.14	3.05
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	3.31	3.15	2.90
7.	The test service provides accurate and necessary information regarding the NACEP.	3.24	3.24	3.14
8.	The test service answers inquiries from this agency in a reasonable amount of time.	3.28	3.10	3.09
9.	Evaluation materials from the test service arrive on time at test sites.	3.42	2.83	2.94

Averages calculated - highest possible score = 4.00, lowest possible score = 1.00

10.	Candidates receive score reports within the time period specified by your contract.	3.01	2.89	2.75
11.	The state agency score reports have been received in a timely manner.	2.87	2.79	2.76
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	3.15	2.65	2.86
13.	NACEP security measures are effective.	3.27	3.00	3.09
14.	Feedback on the NACEP from nurse aides has been positive.	2.97	3.00	2.76
15.	Feedback on the NACEP from facilities has been positive.	2.93	2.95	2.70
16.	The application process is easy for candidates and sponsors to complete.	2.95	2.90	2.78
17.	NACEP is an effective evaluation for home health aides (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as long term care aides.	3.10	3.00	2.92
18.	The Nurse Aide Practice Test has been useful.	3.16	3.23	3.31

**Other includes responses such as no answer given, not applicable, perhaps, etc. This type of response was not used in calculating the results for questions 1 through 18.*

Report of the Research Advisory Panel

Panel Members

Mary Pat Curtis, MS, Area III, *Chair*
M. Christine Alichnie, PA, Area IV
Lee Duke, UT, Area I
Marie Hilliard, CT, Area IV
Emily Snider McDowell, WV-RN, Area II

Staff

Carolyn J. Yocom, *Director of Research Services*

Relationship to Organization Plan

Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective D ..... Conduct and disseminate research pertinent to the mission of the National Council.

Recommendations to the Board of Directors

1. **Adoption of research agendas for FY97 and FY98-FY99 (tentative) (see Attachments A and B).**

Highlights of Activities

The Research Advisory Panel met twice, via telephone conference call, in FY96. The responsibilities of the Research Advisory Panel (RAP) are to:

- provide input to the Long Range Planning Task Force and research staff regarding the development of and annual update of a formal, forward-looking research agenda for the National Council (excluding psychometric research regarding the NCLEX™);

- assist representatives of Member Boards in identifying and framing researchable issues; and

- provide input to the Resolutions Committee, the Board of Directors and research staff regarding (1) the advisability of adopting resolutions/motions directing the National Council to conduct a specific research study and (2) the fit of proposed studies within the National Council's research agenda.

The panel's first meeting was devoted to member orientation, a review of FY96 research activities, and the provision of advice to the Chemically Impaired Nurse Issues Task Force and staff regarding approaches that could be used to improve subject recruitment for the chemically impaired nurse study.

A panel member was able to attend three of the four FY96 Area Meetings in order to identify issues raised by Member Board representatives that have implications for the development of a research agenda covering FY97 - FY99. Staff provided input regarding issues raised at the fourth Area Meeting. Issues identified were as follows:

- Delegation and supervision (e.g., in relation to unlicensed assistive personnel and the licensee's level of expertise)
- Impact of telecommunications technology use on the health, safety and welfare of consumers
- Continued competence of licensees
- Scope of practice issues (e.g., distinct vs. overlapping)
- Impact of the Americans with Disabilities Act on disciplinary actions (e.g., need for limited licenses?)
- Impact of regulatory reform

During its second meeting, the panel considered these issues and reviewed information summarizing research needs and projects identified by National Council committees and staff, as reflected in the proposed FY97 Organization Plan tactics. The panel also considered several initiatives currently underway, such as those of the Telecommunications Task Force, the Continued Competence Task Force, the Computerized Clinical Simulation Testing (CST™) project, and

the job analysis studies. In reviewing the issues identified at Area Meetings, the RAP determined that these are addressed in current projects or initiatives (e.g. continued competence, CST, functional abilities study) or in proposed projects (e.g., unlicensed assistive personnel study (Goal I, Objective F), regulatory effectiveness study (Goal V, Objective F)). The impact of telecommunications technology use needs to be considered in the development of the regulatory effectiveness study with input from National Council committees or task forces addressing these issues.

The research agenda for FY97 (Attachment A) and for FY98-FY99 (Attachment B) were identified and a recommendation for their adoption was forwarded to the Board of Directors. The rationale for recommending inclusion of specific research studies and projects in the research agenda are as follows:

- **Job analysis studies, including the definition of entry-level practice** — are essential to the validity of examinations provided by the National Council.

- **Employment trends study** — assists the Examination Committee and others to keep abreast of changes in the employment/work setting characteristics of newly licensed RNs and LPN/VNs.

- **Unlicensed assistive personnel study** — will provide information regarding the congruence between the education, practice and supervision of unlicensed personnel providing nursing services. Information regarding the delegation of nursing activities to UAPs can also be addressed within this study.

- **CST Project** — will provide information regarding the validity and reliability of CST as a potential component of the NCLEX-RN™; has potential use as a means of assessing ongoing competence of licensees.

- **Discipline-related projects** — outcomes of the Chemically Impaired Nurse Study and the Sexual Misconduct Study would both assist Member Boards in identifying appropriate remedies. The disciplinary statistics/trends project will provide valid and reliable information regarding Member Board disciplinary activity and assist in the identification of emerging trends.

- **Regulatory Effectiveness Study** — will provide feedback to regulatory agencies, consumers and others regarding the impact and effectiveness (outcomes) of nursing regulation. For the long-term, benchmarking data can be used as a means for measuring effectiveness.

- **Long Range Planning studies** — studies internal to the organization, examining its Mission, Organization Plan Objectives, and trends and issues impacting Member Boards, will promote organizational and Member Board effectiveness.

The RAP also reviewed the ongoing activities of the research department included in the FY97 Organization Plan that provide support for organizational (a) informational needs, (b) database development and maintenance, and (c) research support and development (see Attachment A). An overview of the timeline for research study performance and other related projects is included in Attachment C.

The RAP also considered the proposed Role Delineation Study and deferred a recommendation on its inclusion in the research agenda (FY97 or later) until after the Annual Meeting. While the study could assist in the identification of overlapping scopes of practice and the whole issue of delegation to and supervision of unlicensed assistive personnel, the continuing upheaval within the health care delivery system and its impact on patterns of employment and utilization of nursing personnel is of concern with respect to its impact on the usefulness of study outcomes.

Future Activities

Members of the Research Advisory Panel will be in attendance at the Annual Meeting to provide assistance to Member Board representatives regarding the identification of research needs and to provide input to the Resolutions Committee and Board of Directors. Prior to the conclusion of FY96, the panel will recommend, as needed, modifications to the FY97 research agenda.

Meeting Dates

- October 12, 1995 *(telephone conference call)*
- April 23, 1996 *(telephone conference call)*

Recommendations to the Board of Directors

1. **Adoption of research agendas for FY97 and FY98-FY99 (tentative) (see Attachments A and B).**

Attachments

Attachment A

Proposed FY97 Research Agenda

Goal I, Objective A:
- Conduct a PN Job Analysis Study using a revised methodology
- Implement a Nurse Aide Job Analysis Study
- Perform periodic assessments of the work environment of newly licensed RNs and LPN/VNs
- Compare practice characteristics of RNs licensed six months or less with those in practice seven to twelve months

Goal I, Objective C:
- Reinstate CST® case development and finalize procedures for introducing CST software into schools
- Reinstate scoring key development and continue to explore procedures for scoring CST
- Initiate pilot study of Member Board uses of CST

Goal I, Objective F:
- Describe and evaluate the congruence between practice, education and supervision of unlicensed assistive personnel who provide nursing related tasks

Goal II, Objective C:
- Conduct secondary analyses of chemically impaired nurse data
- Plan statistical analysis procedures for Disciplinary Data Bank (DDB) data consistent with redesigned data collection procedures
- Conduct a study on sexual misconduct disciplinary cases

Goal V, Objective A:
- Determine effectiveness of National Council in meeting Organization Plan Objectives
- Identify trends and issues impacting the regulation of nursing and the structure and operations of boards of nursing; to identify how National Council can assist Member Boards

Goal V, Objective F:
- Identify regulatory outcome indicators and plan outcomes research study

The following, ongoing activities of the research department included in the FY97 Organization Plan provide support for organizational (a) informational needs, (b) database development and maintenance, and (c) research support and development:

Goal I, Objective A:
- Revise PN job analysis study methodology
- Evaluate alternative methodologies for performance of nurse aide job analysis studies

Goal I, Objective E:
- Complete the Family Nurse Practitioner Pharmacology Project
- Monitor performance of a Nurse Practitioner job analysis study
- Maintain APRN Certification Clearinghouse (Note: placeholder)

Goal IV, Objective B
- Complete data loading, begin full operation of system and refine the Nurse Information System (NIS) plan for future system needs

Goal IV, Objective D

- Update research agenda for the National Council
- Facilitate research activities of Member Boards, committees, staff groups, etc.
- Redesign data collection and reporting methodologies for statistical/informational databases incorporated into Member Board accessible electronic media
- Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions (Note: *Member Board Profiles, Licensure and Examination Statistics*, etc.)

Goal V, Objective D

- Develop proposals to respond to Member Board requests for large-scale, unique services

Attachment B

Preliminary FY98 and FY99 Research Agendas

FY98

Goal I, Objective A:
- Complete Nurse Aide Job Analysis Study
- Perform periodic assessments of the work environment of newly licensed RNs and LPN/VNs

Goal I, Objective C:
- Continue CST® Project (complete case development activities; conduct pilot study; continue exploration of Member Board uses)

Goal I, Objective F:
- If necessary, continue work on FY97 tactic: Describe and evaluate the congruence between practice, education and supervision of unlicensed assistive personnel who provide nursing related tasks (Note: methodology and timeline for study performance not yet identified)

Goal II, Objective C:
- Implement statistical analysis procedures using Disciplinary Data Bank (DDB) data to identify trends and emerging issues
- Continue study on sexual misconduct disciplinary cases

Goal IV, Objective D:
- Implement role delineation study (Note: placeholder; dependent upon timeline decision to be made in late FY96)

Goal V, Objective F:
- Implement regulatory outcomes research study

FY99

Goal I, Objective A:
- Conduct RN Job Analysis Study
- Perform periodic assessments of the work environment of newly licensed RNs and LPN/VNs

Goal I, Objective C:
- Complete CST study and report findings to Delegate Assembly

Goal II, Objective C:
- Continue statistical analysis of Disciplinary Data Bank (DDB) data to identify trends and emerging issues
- Continue study on sexual misconduct disciplinary cases (Note: timeline for study performance dependent upon volume of cases)

Goal V, Objective A:
- Determine relevance of National Council's Mission Statement to Member Boards' needs and purposes
- Determine importance of National Council's Organization Plan Objectives to Member Boards
- Initiate study to determine effectiveness of National Council in meeting Organization Plan Objectives
- Initiate study to identify trends and issues impacting the regulation of nursing and the structure and operations of boards of nursing and to identify how National Council can assist Member Boards

Goal V, Objective F:
- Develop protocol and implement plan for ongoing compilation and reporting of a regulatory effectiveness "report card"

Attachment C

Three-year Overview of National Council Research Agenda: FY97- FY99

Activity	*Frequency*	*FY97*	*FY98*	*FY99*
Job Analysis Studies (JAS)				
Entry-level RNs	Every 3 years			X - May ?
Entry-level LPN/VNs	Every 3 years	X - May		
Nurse Aides	Every 3 years		X - Fall	
Nurse Practitioners	Undetermined	finish		
Employment trends -				
newly licensed RNs and LPN/VNs	Every quarter	X X X X	X X X X	X X X X
Definition of entry-level practice	Proposed	X		
Evaluation of JAS methodology				
Entry-level RNs	Every 3 years		X	
Entry-level LPN/VNs	Every 3 years	X		X
Nurse Aides	Every 3 years	X		
Role Delineation Study	Approx. every 5 years			
Determine methodology		TBD*		
Perform study			TBD*	
UAP study	Proposed			
Determine methodology		X		
Perform study		Start?	Continue?	
Family Nurse Practitioner Pharmacology Project				
Complete project	One-time only	X		
Computerized Clinical Simulation Testing (CST®) Project	Through FY99			
Complete research and development		X	X	X
Delegate Assembly decision				X
Regulatory Effectiveness Study	In development			
Outcome indicators		X		
Plan protocol		X		
Implement			X	
Regulatory "report card"				TBD*
Regulatory Management of Chemically Impaired Nurses	Ongoing			
Secondary data analysis		X		
Disciplinary Statistics/Trends Project	Proposed			
Identify approach/methodology		X		
Implement	(Quarterly)		XXXX	XXXX

Activity	*Frequency*	*FY97*	*FY98*	*FY99*
Sexual Misconduct Study	Proposed			
Data collection		X		
Analysis			X	
Nurse Information System (NIS) Project	Ongoing			
Finish research and development		X		
Implement			X	X
Databases				
Member Board Profiles Update	Full -even years		X	
	Partial -odd years	X		X
APRN regulatory requirements	Update -odd years	X		X
Licensure and Examination Statistics	Annually	X	X	X
Survey databases (Member Board and National Council)	Ongoing	X	X	X
Long Range Planning (organizational)				
Mission Statement Evaluation	Every 3 years			X
Organization Plan Objectives: Importance Study	Every 3 years			X
Organization Plan Objectives: Effectiveness Study	Every 3 years	(finish)		X (start)
Trend Analysis Study				X (start)
Finance Committee				
Graduation statistics (Candidate projections)	Annual	X	X	X

* TBD = To be determined

Report of the Unlicensed Assistive Personnel Task Force

Task Force Members

Harriett Clark, CA-RN, Area I, *Chair*
LaRee Rowan, MN, Area II
Sulinda Moffett, OK, Area II (resigned 3/96)
Edna Fannin, LA-PN, Area III
Marie Fisher, ME, Area IV

Staff

Carolyn Hutcherson, *Senior Policy Analyst (until December 1995)*
Ellen Gleason, *NACEP Program Manager (beginning December 1995)*
Vicky Burbach, *Consultant (beginning December 1995)*

Relationship to the Organization Plan

Goal I ..... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective F ..... Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.

Recommendations to the Board of Directors

No recommendations.

Highlights of Activities

The Unlicensed Assistive Personnel (UAP) Task Force presented a draft delegation paper, *Delegation: Concepts and Decision-Making Process*, to the 1995 Delegate Assembly. The Delegate Assembly authorized the Board of Directors to review and approve the final version of the concept paper. After its meeting in October 1995 and a conference call in November 1995, the task force revised the paper and requested that the Board of Directors review and approve the paper, which it did in December 1995 (Attachment A).

The task force also developed the following documents:

- *Premises* (Attachment B). The UAP Task Force developed premises to state the assumptions that will guide the present and future work of the task force.

- *Use and Regulation of UAP in the Continuum of Care* (Attachment C) was developed by the task force to describe the current services, settings, education preparedness, and level of nursing involvement in UAP utilization. The continuum identifies the gaps in consumer protection within the current system and will guide the future work of the task force. The gaps are:

  - Adequate information regarding UAP education, competencies, and authority is unavailable to consumers.

  - Educational, experiential, and minimum competency standards for UAPs are lacking, making it difficult for nurses to assess UAP qualifications and knowledge with any level of confidence or consistency.

  - Authority for regulation by boards of nursing or any other entity may not exist, with the exception of the Omnibus Budget Reconciliation Act (OBRA) 1987 model. In the OBRA model, multiple regulatory entities may be involved and, therefore, regulatory authority is still unclear.

  - Current regulations do not address the reality of the existing and evolving health care system.

  - Too-specific regulations encourage proliferation of new "titles" to circumvent existing regulation.

- Too-specific regulations create confusion in the education and supervision of multi-skilled workers.
- Non-specific regulations compromise consumer safety.
- Provision of "nursing care" is occurring without licensed nurse delegation and supervision. Large regulatory gaps exists in settings such as:
  - foster homes
  - assisted living
  - schools
  - ambulatory care centers
  - private homes
  - acute care
  - physicians' offices

- *Board of Nursing Enforcement Options in the Utilization of Unlicensed Assistive Personnel* (Attachment D). The task force developed a decision tree to assist Member Boards to identify enforcement options for addressing inquiries and complaints concerning UAPs. Member Boards may have limited resources to pursue inquiries and complaints of unsafe and ineffective care by UAPs. The task force strongly encourages Member Boards to collect data regarding incompetent, ineffective, unsupervised, or illegal care provided by UAPs. When a referral is made to another state agency or to the attorney general or district attorney, Member Boards should follow-up and obtain data regarding referral outcomes. Data collected can be used in a collaborative effort with consumers, other regulatory agencies, and providers to increase access to and delivery of quality care.

- *Delegation Education Outlines* DRAFT (Attachment E). The task force identified education as an important factor in appropriate delegation and supervision of nursing tasks to UAPs. The outline includes content for teaching the principles of delegation to both licensed nurses and UAPs. This is a document in progress.

Meeting Dates

- October 8-9, 1995
- November 3, 1995 *(telephone conference call)*
- December 14-16, 1995
- March 14-16, 1996
- April 29-30, 1996

Recommendations to the Board of Directors

No recommendations.

Future Considerations for the National Council

- Continued development of the *Delegation Education Outlines* for the licensed nurse and the UAP.
- Development of consumer education information regarding UAPs.
- Review and revision of the *Model Nurse Aide Regulation Act* and *Model Nurse Aide Administrative Rules.*

Attachments

Attachment A

NATIONAL COUNCIL

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Delegation: Concepts and Decision-making Process

Introduction

To meet the public's increasing need for accessible, affordable, quality health care, providers of health care must maximize the utilization of every health care worker and ensure appropriate delegation of responsibilities and tasks. Nurses, who are uniquely qualified for promoting the health of the whole person by virtue of their education and experience, must be actively involved in making health care policies and decisions; they must coordinate and supervise the delivery of nursing care, including the delegation of nursing tasks to others.

Issues related to delegation have become more complex in today's evolving health care environment, creating a need for practical guidelines to direct the process for making delegatory decisions. Accordingly, this paper expands and builds upon the National Council's 1987 and 1990 conceptual and historical papers on delegation by presenting a dynamic decision-making process and practical guidelines for delegation.

Purpose

The purpose of this paper is to provide a resource for Boards of Nursing, health policy makers, and health care providers on delegation and the roles of licensed and unlicensed health care workers. The paper emphasizes and clarifies the responsibility of Boards of Nursing for the regulation of nursing, including nursing tasks performed by unlicensed health care workers, and the responsibility of licensed nurses to delegate nursing tasks in accord with their legal scopes of practice. It provides a decision-making tool which can be used in clinical and administrative settings to guide the process of delegation. This paper also describes the accountability of each person involved in the delegation process and potential liability if competent, safe care is not provided.

Premises

The following premises constitute the basis for the delegation decision-making process.

1. All decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety and welfare of the public.
2. Boards of Nursing are responsible for the regulation of nursing. Provision of any care which constitutes nursing or any activity represented as nursing is a regulatory responsibility of Boards of Nursing.

3. Boards of Nursing should articulate clear principles for delegation, augmented by clearly defined guidelines for delegation decisions.
4. A licensed nurse must have ultimate responsibility and accountability for the management and provision of nursing care.
5. A licensed nurse must be actively involved in and be accountable for all managerial decisions, policy making and practices related to the delegation of nursing care.
6. There is a need and a place for competent, appropriately supervised, unlicensed assistive personnel in the delivery of affordable, quality health care. However, it must be remembered that unlicensed assistive personnel are equipped to assist—not replace—the nurse.
7. Nursing is a knowledge-based process discipline and cannot be reduced solely to a list of tasks. The licensed nurse's specialized education, professional judgment and discretion are essential for quality nursing care.
8. While nursing tasks may be delegated, the licensed nurse's generalist knowledge of patient care indicates that the practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated.
9. A task delegated to an unlicensed assistive person cannot be redelegated by the unlicensed assistive person.
10. Consumers have a right to health care that meets legal standards of care. Thus, when a nursing task is delegated, the task must be performed in accord with established standards of practice, policies and procedures.
11. The licensed nurse determines and is accountable for the appropriateness of delegated nursing tasks. Inappropriate delegation by the nurse and/or unauthorized performance of nursing tasks by unlicensed assistive personnel may lead to legal action against the licensed nurse and/or unlicensed assistive personnel.

Definitions

Accountability ..... Being responsible and answerable for actions or inactions of self or others in the context of delegation.

Delegation ..... Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.

Delegator ..... The person making the delegation.

Delegatee ..... The person receiving the delegation. (a.k.a. Delegate)

Supervision ..... The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.

Unlicensed Assistive Personnel (UAP) ..... Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.

Regulatory Perspective: A Framework for Managerial Policies

Boards of Nursing have the legal responsibility to regulate nursing and provide guidance regarding delegation. Registered Nurses (RNs) may delegate certain nursing tasks to Licensed Practical Nurses/Vocational Nurses (LPN/VNs) and unlicensed assistive personnel (UAP). In some jurisdictions, LPN/VNs may also delegate certain tasks within their scope of practice to unlicensed assistive personnel. The licensed nurse has a responsibility to assure that the delegated task is performed in accord with established standards of practice, policies and procedures. The nurse who delegates retains accountability for the task delegated.

The regulatory system serves as a framework for managerial policies related to the employment and utilization of licensed nurses and unlicensed assistive personnel. The nurse who assesses the patient's needs and plans nursing care should determine the tasks to be delegated and is accountable for that delegation. It is inappropriate for employers or others to require nurses to delegate when, in the nurse's professional judgment, delegation is unsafe and not in the patient's best interest. In those instances, the nurse should act as the patient's advocate and take appropriate action to ensure provision of safe nursing care. If the nurse determines that delegation may not appropriately take place, but nevertheless delegates as directed, the nurse may be disciplined by the Board of Nursing.

Acceptable Use of the Authority to Delegate

The delegating nurse is responsible for an individualized assessment of the patient and situational circumstances, and for ascertaining the competence of the delegatee before delegating any task. The practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated. Supervision, monitoring, evaluation and follow-up by the nurse are crucial components of delegation. The delegatee is accountable for accepting the delegation and for his/her own actions in carrying out the task.

The decision to delegate should be consistent with the nursing process (appropriate assessment, planning, implementation and evaluation). This necessarily precludes a list of nursing tasks that can be routinely and uniformly delegated for all patients in all situations. Rather, the nursing process and decision to delegate must be based on careful analysis of the patient's needs and circumstances. Also critical to delegation decisions are the qualifications of the proposed delegatee, the nature of the nurse's delegation authority set forth in the law of the jurisdiction, and the nurse's personal competence in the area of nursing relevant to the task to be delegated.

Delegation Decision-Making Process

In delegating, the nurse must ensure appropriate assessment, planning, implementation and evaluation. The delegation decision-making process, which is continuous, is described by the following model:

I. Delegation criteria
   - A. Nursing Practice Act
     1. Permits delegation
     2. Authorizes task(s) to be delegated or authorizes the nurse to decide delegation
   - B. Delegator qualifications
     1. Within scope of authority to delegate
     2. Appropriate education, skills and experience
     3. Documented/demonstrated evidence of current competency
   - C. Delegatee qualifications
     1. Appropriate education, training, skills and experience
     2. Documented/demonstrated evidence of current competency

Provided that this foundation is in place, the licensed nurse may enter the continuous process of delegation decision-making.

II. Assess the situation
   - A. Identify the needs of the patient, consulting the plan of care
   - B. Consider the circumstances/setting
   - C. Assure the availability of adequate resources, including supervision

If patient needs, circumstances, and available resources (including supervisor and delegatee) indicate patient safety will be maintained with delegated care, proceed to III.

III. Plan for the specific task(s) to be delegated
   - A. Specify the nature of each task and the knowledge and skills required to perform it
   - B. Require documentation or demonstration of current competence by the delegatee for each task
   - C. Determine the implications for the patient, other patients, and significant others

If the nature of the task, competence of the delegatee, and patient implications indicate patient safety will be maintained with delegated care, proceed to IV.

IV. Assure appropriate accountability
   A. As delegator, accept accountability for performance of the task(s)
   B. Verify that delegatee accepts the delegation and the accountability for carrying out the task correctly

If delegator and delegatee accept the accountability for their respective roles in the delegated patient care, proceed to V.

V. Supervise performance of the task
   A. Provide directions and clear expectations of how the task(s) is to be performed
   B. Monitor performance of the task(s) to assure compliance to established standards of practice, policies and procedures
   C. Intervene if necessary
   D. Ensure appropriate documentation of the task(s)

VI. Evaluate the entire delegation process
   A. Evaluate the patient
   B. Evaluate the performance of the task(s)
   C. Obtain and provide feedback

VII. Reassess and adjust the overall plan of care as needed

The Five Rights of Delegation provide an additional resource to facilitate decisions about delegation.

The Five Rights of Delegation

- **RIGHT TASK**
  One that is delegable for a specific patient.

- **RIGHT CIRCUMSTANCES**
  Appropriate patient setting, available resources, and other relevant factors considered.

- **RIGHT PERSON**
  Right person is delegating the right task to the right person to be performed on the right person.

- **RIGHT DIRECTION/COMMUNICATION**
  Clear, concise description of the task, including its objective, limits and expectations.

- **RIGHT SUPERVISION**
  Appropriate monitoring, evaluation, intervention, as needed, and feedback.

Conclusion

The guidelines presented in this paper provide a decision-making process that facilitates the provision of quality care by appropriate persons in all health care settings. The National Council of State Boards of Nursing believes that this paper will assist all health care providers and health care facilities in discharging their shared responsibility to provide optimum health care that protects the public's health, safety and welfare.

Attachment B

Premises
4/30/96

Boards of nursing are responsible for the regulation of nursing. Provision of any care which constitutes nursing or any activity represented as nursing is a regulatory responsibility of boards of nursing. Boards of nursing should be cognizant of evolving changes in health care which impact consumer safety. The UAP Task Force developed the following premises to state the assumptions that will guide the present and future work of the task force:

1. Boards of nursing should be proactively involved and take a leadership role in developing public health policy.

2. Consumer choice is critical. Boards of nursing should take a proactive role in providing information to assist consumers in making informed choices regarding care givers.

3. Boards of nursing should maintain ongoing collaboration with consumers, other regulatory agencies and health care providers to increase access and delivery of quality care.

4. Boards of nursing should take a leadership role in the development of standards for the education and utilization of unlicensed assistive personnel.

5. Boards of nursing should review and revise statutes, regulations, policies and procedures to allow for evolution of changes in health care delivery while maintaining consumer safety.

6. Boards of nursing should take a leadership role in influencing state and federal agencies to make regulatory changes which reflect current health care needs.

7. Boards of nursing should regulate the utilization of any unlicensed person, regardless of title, to whom nursing tasks are delegated.

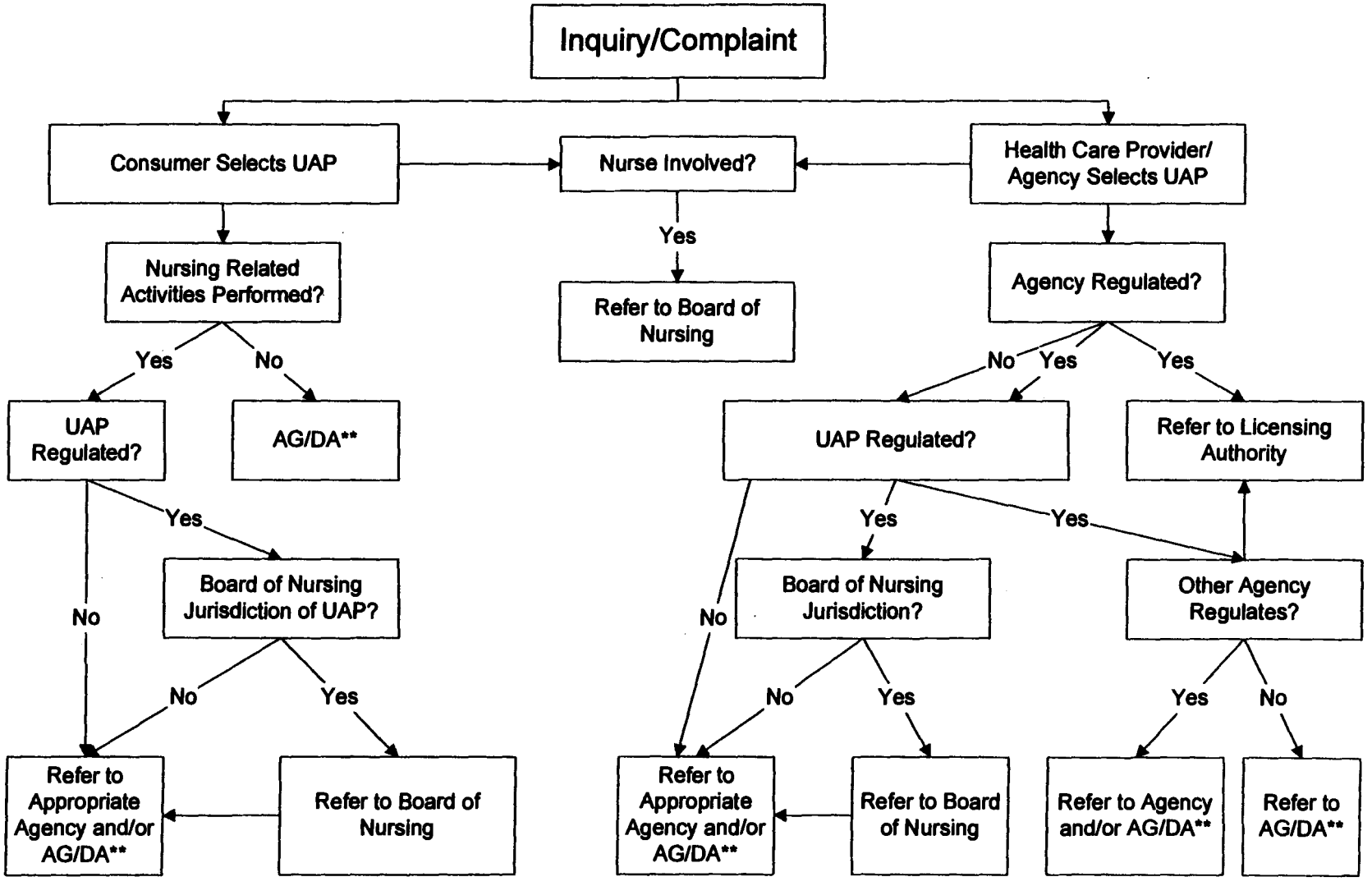
Current Use and Regulation of UAPs in the Continuum of Care Providers

Care Provision

	Category A	Category B	Category C	Category D	Category E	Category F
Settings for Care	Private Homes	Provide services in private homes	Provide services in private homes other than nursing homes, private homes, and hospitals	Provide services in institutional settings care, and private homes through a certified agency	Provide services in nursing homes, acute EMT, Technicians, Medical Assistants	Provide services in regulated settings; ex,
Service Provided by Caregiver	Services determined by client from simple to complex	Clean, cook, shop, etc. - no personal cares	Provide previous cares plus assist with grooming and ADLs	Provide previous services plus medications (usually orals)	Provide ADLs plus more complex nursing tasks as delegated. May provide medications with additional education.	Provides more complex services but usually restricted to particular type or setting
Level of Supervision of Caregiver		May or may not be nursing supervision	May or may not be nursing supervision	May or may not be nursing supervision	Nursing supervision provided	Supervision provided but may or may not be provided by nurses
Education/ Training of Caregiver	Education provided by consumers. May or may not be education provided by nurses	May or may not have nursing instruction	May or may not have nursing instruction	May or may not have nursing instruction	Required nursing instruction	Usually some type of formal instruction; may or may not be provided by nurses
Disciplinary Process	None	None	None	None	Abuse registry - annotation only	May or may not be disciplinary process
Regulation	None	None or through a service agency	None; May be through an agency; no regulation of individual	None; May be through agency; may be as individuals. May regulate through delegation	May be through agency; may be as individuals, may regulate through delegation	May be through agency; may be as individuals

April 1996

BOARD OF NURSING
ENFORCEMENT OPTIONS IN UTILIZATION OF
UNLICENSED ASSISTIVE PERSONNEL (UAP)



Revised 4/96

** AG/DA=Attorney General/District Attorney

Attachment E

DELEGATION EDUCATION OUTLINE (DRAFT)

I - LICENSED NURSE

Purpose: To teach licensed nurses to delegate and utilize information in *Delegation: Concepts and Decision-making Process.* "It is as important to learn the management techniques to deliver and delegate care as it is to master the clinical skills necessary for high-tech/high-touch care." (Burruss, 1993).

A. Content (Based upon *Delegation: Concepts and Decision-making Process*)

1. Terminology (as defined by individual Nurse Practice Acts; include additional terminology specific to each jurisdiction).

   Recommended Definitions:
   a) Accountability - being responsible and answerable for actions or inactions of self or others in the context of delegation
   b) Delegation - transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.
   c) Delegator - the person making the decision
   d) Delegatee - the person receiving the delegation
   e) Supervision - the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel
   f) Unlicensed Assistive Personnel (UAP) - any unlicensed personnel, regardless of title, to whom nursing tasks are delegated

2. Authority
   a) Federal
      i) clarify difference between federal statute and federal regulations
      ii) impact of federal requirements on employment of unlicensed personnel
   b) State statute
      i) Nurse Practice Act of jurisdiction
      ii) other state statutes
   c) State regulation
      i) Board of Nursing regulations
      ii) other state agency regulations
   d) Professional standards
      i) NCSBN
      ii) American Nurses Association and Practical/Vocational nurse associations
      iii) Specialty nursing organizations
      iv) Other
   e) Employer policy
      i) Legal implications
      ii) Coercion; refusal to delegate inappropriately
      iii) Should be actively involved in policy formation

3. Principles of Delegation: Concepts and Decision-making Process
   a) Premises
   b) Five rights
   c) Delegation decision-making process

4. Implementing the Delegation Process
    a) Use the nursing process in making decisions about delegation
    b) Be familiar with applicable statute(s) and regulation(s)
        i) are there any limits to who can receive delegation?
        ii) what can be delegated? Only tasks, not process
        iii) Under what circumstances
    c) Understand the scope(s) of practice for delegator and delegatee
    d) Consider the impact of facility policies and procedures
    e) Determine the qualification and skill level of the delegatee; what is the difference if the delegatee is an LPN or a UAP?
    f) Follow-up! Follow-up! Follow-up!

5. Implications
    a) Patient care outcomes
    b) Public/consumer safety
    c) Consumer choice
    d) Cost containment
    e) Access to health care
    f) Disciplinary action
    g) Career impact
    h) Employer action
    i) Nursing liability

B. Implementation of the teaching outline

1. Teach nurses to be both delegators and delegatees or recipients of assignments
    a) Teach principles of delegation
        i) During the first level of nursing programs
        ii) During orientation as appropriate
    b) Teach criteria to be considered when accepting delegation/assignment

2. Utilize Board of Nursing expertise in teaching delegation to licensed nurses and nursing students

3. Utilize licensed nurse mentor(s) in teaching and role-modeling delegation to nurses

4. Be clear about legal ramifications for licensed nurse, unlicensed assistive personnel and employer

5. Utilize role-playing to assist in application of delegation concepts and principles

C. Evaluation of delegation practices

1. Delegating nurse can verbalize statutory and regulatory authority for delegation

2. Delegating nurse can articulate thought process and information used to arrive at decision to delegate

3. Delegation decisions are clearly grounded in premises as outlined

4. Safe, effective patient outcome can be identified

5. Patient/consumer verbalizes satisfaction with care provided

6. Appropriate documentation has been completed

II - UNLICENSED ASSISTIVE PERSONNEL

Purpose: To teach unlicensed assistive personnel to accept and implement delegated responsibilities. Unlicensed assistive personnel must be able to identify when it is or is not appropriate to carry out a delegated assignment and how to respond in either instance.

A. Content (Based upon *Delegation: Concepts and Decision-making Process*)

1. Terminology (as defined by individual Nurse Practice Acts).

   Recommended Definitions:
   a) Accountability - being responsible and answerable for actions or inactions of self or others in the context of delegation
   b) Delegation - transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.
   c) Delegator - the person making the decision
   d) Delegatee - the person receiving the delegation
   e) Supervision - the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel
   f) Unlicensed Assistive Personnel (UAP) - any unlicensed personnel, regardless of title, to whom nursing tasks are delegated

2. Authority
   - a) Federal
     - i) clarify difference between federal statute and federal regulations
     - ii) impact of federal requirements on employment of unlicensed personnel
   - b) State statute
     - i) Nurse Practice Act of jurisdiction
     - ii) other state statutes
   - c) State regulation
     - I) Board of Nursing regulations
     - ii) other state agency regulations
   - d) Employer policy.
     - i) Is it legal?
     - ii) Who is your boss?
     - iii) Who can delegate to you?
   - e) Nursing and non-nursing UAP
     - i) Delegating
     - ii) Coordinating

3. Delegation Decision-making Process
   - a) Who is UAP supervisor?
     - i) Nurse's authority or responsibility for UAP
     - ii) Other organizational supervision
     - iii) Consumer direction
   - b) Nurse's considerations in deciding to delegate
     - i) delegation criteria
     - ii) assess the situation
     - iii) plan for the specific task(s) to be delegated
     - iv) accountability
     - v) supervise performance of the task
     - vi) evaluate the entire delegation process
   - c) What the UAP must consider in accepting the delegation
     - i) the task delegated: what, where, when, why, how

ii) working within the assigned role
iii) the seriousness of the responsibility
iv) cannot re-delegate to some else
v) cannot do any nursing activity unless directed to do so by a nurse
vi) accountability

d) Five rights of delegation
i) how they apply to the nurse's decision to delegate
ii) how they apply to UAP acceptance of delegation

4. Refusing to accept a delegated task
a) when the UAP should say no to delegation
b) how the UAP can say no to delegation
c) consequences of saying no to delegation
d) consequences of accepting inappropriate delegation
e) reporting inappropriate delegation

5. Delegation follow-up
a) what the patient/consumer should expect from the delegation process
b) what the UAP should expect from the delegating nurse
c) what the delegating nurse should expect from the UAP; when and how the UAP should report back to the nurse
d) documentation of the care provided

B. Implementation of the teaching outline

1. Delegation must be taught by a licensed nurse according to each jurisdiction

2. Be clear about legal ramifications for licensed nurse, unlicensed assistive personnel and employer

3. Utilize role-playing to assist in application of principles related to accepting and refusing delegation, and in application of communicating expectations and providing feedback to delegating nurse

C. Evaluation of delegation practices

1. Verbalize when appropriate to seek direction

2. Articulate thought process on accepting delegation

3. Safe, effective patient outcome can be identified

4. Patient/consumer verbalizes satisfaction with care provided

5. Appropriate documentation has been completed

DELEGATION TO UNLICENSED ASSISTIVE PERSONNEL

BIBLIOGRAPHY

Are unlicensed assistive personnel a threat to staff and patients? (1995). *The Journal of Practical Nursing*, 45 (3), 4-7.

Barter, M. & Furmidge, M. (1994). Unlicensed assistive personnel: Issues relating to delegation and supervision. *Journal of Nursing Administration*, 24 (4), 36-39.

Barter, M., McLaughlin, Frank, E., & Thomas, S.(1994). Use of unlicensed personnel by hospitals. *Nursing Economics*, 12 (2), 82-87.

Burbach, V. (1994). Delegation in nursing. *Issues*, 15 (3), 7-8.

Burruss, R., Ashworth, D., & Arikan, V. (1993). Medication administration by non-RN personnel: A safe and cost-effective response to the RN shortage. *Health Care Supervisor*, 11 (4), 64-74.

Crawley, W., Marshall, R. & Till, A. (1993). Use of unlicensed assistive staff. *Orthopeadic Nursing*, 12 (6), 47-53.

Delegation to assistive personnel can be a complex task for nurses (1994). *Insight: Newsletter on Nurse Aides and Unlicensed Assistive Personnel*, 3 (2), 3.

Eastaugh, S. & Regan-Donavan, M. (1990). Nurse extenders offer a way to trim staff expenses. *Healthcare Financial Management*, 44 (4), 58-62.

Elias, M. (1995, January 20). Caregiving is shifting from RNs to aides, *USA Today*, p 1.

Fuller, K. (Ed) (1994). *Generations: Front Line Workers in Long-Term Care*, 8 (3).

Gardner, D. (1991). Issues related to the use of nurse extenders. *Journal of Nursing Administration*, 21 (10), 40-45.

Gould, R., Thompson, R., Rakel, B., Jensen, J., Hasselman, E. & Young, L. (1996). Redesigning the RN and NA roles. *Nursing Management*, 27 (2), 37-41.

Hansten, R. & Washburn, M. (1994). *Clinical Delegation Skills. A Handbook* for *Nurses*, Gaithersburg, Maryland: Aspen Publishers, Inc.

Hansten, R. & Washburn, M. (1992). Delegation: How to deliver care through others. *American Journal of Nursing*, 92 (3), 87-90.

Harris, M. (1993). Competent, supervised, unlicensed personnel will contribute to high-quality in-home health care. *Home Healthcare Nurse*, 11 (6), 55-56.

Huber, D., Bliegen, M., & McCloskey, J. (1994). Use of nursing assistants: Staff opinions. *Nursing Management*, 25 (5), 34-38.

Jung, F., Pearcy, L., & Phillips, J. (1994). Evaluation of a program to improve nursing assistant use. *Journal of Nursing Administration*, 24 (3), 42-47.

Kane, R., O'Connor, C., & Baker, M. (1995). *Delegation of nursing activities: Implications for patterns* of *long-term care*. Washington, DC: Public Policy Institute, AARP.

Kennerly, S. (1989). Implications of the use of unlicensed personnel: A nursing perspective. *Focus on Critical Care*, 16 (5); 364-368.

Kennerly, S. (1990). The impact of nurse extenders on the curriculum. *Nurse Educator*, 15 (3), 36-39.

King, B. (1995). Working with a new staff mix. *RN*, 58 (16), 38-41.

Kreplik, J. (1995). Unlicensed hospital assistive personnel: Efficiency or liability. *Journal of Health and Hospital Law*, 28 (5); 292-309.

Lengacher, C. & Mabe, P. (1993). Nurse extenders. *Journal of Nursing Administration*, 23 (3), 16-19.

Manthey, M. (1992). Practice partners: Humanizing healthcare. *Nursing Management*, 23 (5), 18-19.

National Council of State Boards of Nursing, Inc. (1990). *Concept Paper on Delegation*, Chicago: author.

National Council of State Boards of Nursing, Inc. (1995). *Delegation: Concepts and Decision-Making Process.* Chicago: author.

National Council of State Boards of Nursing, Inc. (1991) *Nursing Care in the School Setting*. Chicago: author.

Neidlinger, S., Bostrom, J., Stricker, A., Hild, J., & Zhang, J. (1993) Incorporating nursing assistive personnel into a nursing professional practice model. *Journal of Nursing Administration*, 23 (3), 29-37.

Pischke-Winn, K., Catrambone, C. & Minnick, A. (1995). Regulatory requirements and the multi-task worker. *Nursing Management*, 26 (12), 39-41.

Poe, L. & Williams, M. (1995). The process of delegation, from concept to practice. *1995 Concurrent Educational/ Research Sessions*, Chicago: National Council of State Boards of Nursing, Inc.

Schwab, N.& Haas, M. (1995). Delegation and supervision in school settings. *Journal of School Nursing*, 11 (1), 26-33.

Smeltzer, C., Formella, N., & Beebe, H. (1993). Work restructuring: The process of decision making. *Nursing Economics*, 11 (4), 215-222.

Tri Council for Nursing. (1990). *Statement on assistive personnel to the registered nurse*. Washington DC: author.

Vargo, S. (1995). The four basic personality types of nurses. *Journal of Nursing Jocularity*, 5 (2); 22-23.

Report of the Chemically Impaired Nurse Issues Task Force

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Relationship to Organization Plan

Goal II..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective C..... Conduct research on regulatory issues related to disciplinary activities.
Objective D ..... Provide for Member Board needs related to disciplinary activities.

Recommendations to the Board of Directors

No recommendations.

Highlights of Activities

A primary activity of task force members has been to provide consultation and assistance to staff relative to performance of a research study to evaluate the effectiveness of regulatory approaches for the management of chemically impaired nurses. During its first meeting, the task force, in collaboration with the Research Advisory Panel, addressed a less than desirable number of potential study participants representing states using a disciplinary approach. Additional strategies identified included the addition of another jurisdiction (CT) to those already participating in the study (OH, SC, VA, FL, MD, WA).

During its second meeting, the task force reviewed the status of the research study. Considerable time was spent reviewing (a) the status of data collection activities (questionnaires, mailing schedules, procedures), (b) preliminary data analysis results (descriptive statistics compiled from selected questionnaires), and (c) responses on selected sets of questionnaires not yet submitted to data analysis. The task force also discussed mechanisms for retrieving study participant compliance information from the seven jurisdictions involved in the study. Assistance was also provided to staff in the identification of information that could be used to obtain cost data from the participating jurisdictions.

Data collection from study participants will continue through April and May 1996. It is anticipated that sufficient data analysis will be completed to provide the following information during an informational forum at the 1996 Annual Meeting: (1) an overview of selected demographic and substance abuse characteristics of study participants; (2) comparisons of recidivism rates, licensure status and return to work rates; and (3) cost comparisons of a disciplinary approach versus an alternative to discipline approach. The task force will hold one additional meeting this year to review study results and prepare a written research report containing this information. This report will be provided to Member Boards in a supplemental mailing to the *Book of Reports*.

The task force also had responsibility for coordinating a conference, *Alternative to License Discipline Programs for Chemically Impaired Nurses,* offered February 29 - March 1, 1996, in Chicago, to meet needs of (1) staff of alternative to license discipline programs, and (2) representatives of Member Boards interested in establishing alternative to license discipline programs. Based on discussion topics and work groups formed during the Chemically Impaired Nurse Programs Special Interest Group meeting at the 1995 Annual Meeting, a conference agenda was formulated.

Thirty-six registrants representing Member Boards, alternative programs and other groups (i.e., American Association of Nurse Anesthetists, Indiana Nurses' Association Peer Assistance Program) were in attendance, in addition to the task force and its staff and consultant (total attendees = 42). Presentations and discussion focused on the following topics: random drug screening; guidelines for treatment, monitoring, return to practice and practice

restrictions; inter-state mobility issues; data collection and management issues; quality assurance; the development of a survey tool to be distributed to alternative programs; and the National Council's research study. Evaluation forms rated the meeting agenda, content, format and length as good to excellent. Evaluation of individual agenda items indicated almost unanimous agreement that each provided valuable information and adequate time for discussion. Strong support for continuing the conference on an annual basis along with suggested topics were provided by attendees.

Future Activities

Additional analyses of research study data will be competed in FY97. The task force will use the study results as a basis for identifying needed changes to the document, *Model Guidelines: A Nondisciplinary Alternative Program for Chemically Impaired Nurses,* originally adopted by the Delegate Assembly in 1994. The revised document will be submitted to the 1997 Delegate Assembly for consideration.

Meeting Dates

- October 12, 1995 *(telephone conference call)*
- February 27-28, 1996

Recommendations to the Board of Directors

No recommendations.

Attachment

A .....A Comparison of Two Regulatory Approaches to the Management of Chemically Impaired Nurses, *page 3*

Attachment A

A Comparison of Two Regulatory Approaches to the Management of Chemically Impaired Nurses

NOTE: Page numbers for this document appear at the bottom of each page.

INTERIM REPORT:

A COMPARISON OF TWO REGULATORY APPROACHES TO THE MANAGEMENT OF CHEMICALLY IMPAIRED NURSES

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1996

Interim Report:
A Comparison of Two Regulatory Approaches to the Management of Chemically Impaired Nurses

A major consequence of chemical substance abuse among nurses is the dysfunction that interferes with the exercise of judgment. Therefore, a chemically impaired licensee's practice does not exemplify accepted standards and the recipients of nursing care are exposed to the threat of or actual harm. Currently, the predominant approach used by boards of nursing to protect the public's safety is through a process that can result in disciplinary action against a license to practice. Over the past ten years, it has been argued that a nondisciplinary approach can protect the public from unsafe practitioners while promoting treatment and rehabilitation of impaired licensees. A nondisciplinary alternative program offers a confidential, voluntary alternative to license discipline for nurses with a substance abuse/dependency problem. Proponents of this approach also contend that it is more cost effective and successful. While isolated studies of the effectiveness of individual nondisciplinary alternative programs have been undertaken, a search of the literature failed to identify any studies comparing the outcomes and cost effectiveness of these two different approaches. Such evaluation may optimize regulatory approaches for the management of occurrences of recidivism, appropriate licensure status, and factors impacting employment status or conditions. When optimized, board management of chemically impaired nurses will achieve a board's primary goal of safe and effective nursing care for all patients, while also allowing achievement of a secondary goal of returning a knowledgeable, skilled nurse to a productive role in society.

In August 1994, the National Council's Board of Directors authorized performance of a longitudinal study of chemically impaired nurses. The aims of the study are to: (1) describe the physical, psychosocial and psychiatric profiles of chemically impaired nurses; (2) determine if there are any differences in rates of nurse recidivism (implying a potential for public harm), maintenance/re-issuance of unencumbered licenses and return to work of abstinent nurses (implying a potential public benefit) associated with the two different approaches to regulatory management; (3) determine the impact of selected physical, psychosocial and psychiatric factors on rates of nurse recidivism, maintenance/re-issuance of unencumbered licenses, and return to work among the two groups; (4) determine if there are any differences in the costs to nurses and to the boards of nursing based on the type of regulatory management approach used; and (5) identify barriers to and facilitators of nurse rehabilitation as perceived by chemically impaired nurses, boards of nursing, and monitoring program staff. It is anticipated that the results of this study will assist Member Boards and other policy makers in their evaluation of policies and procedures established to protect the public while still promoting the recovery/rehabilitation of licensed nursing personnel.

The following sections of this interim report describe the methodology used to conduct the study, provide descriptive information about the nurse participants and report findings which address two specific issues. These are: (1) differences in rates of recidivism and (2) differences in rates of return to work./retention in the workforce among nurses with a substance abuse history managed via the two approaches. In addition, selected socio-demographic information will also be provided.

METHODOLOGY

This longitudinal study employed a quasi-experimental design using two cohorts of volunteer subjects. One cohort represented registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) who had disciplinary action taken against their licenses in jurisdictions using a traditional, disciplinary approach to the regulatory management of chemically impaired nurses. The second cohort represented RNs and LPN/VNs participating in nondisciplinary alternative programs in jurisdictions providing this option. Both cohorts also included RNs with current or previous legal recognition to practice within the advanced practice registered nurse (APRN) role. For the remainder of this document, the two types of programs/groups will be referred to as the discipline approach/group and the alternative approach/group.

Sample Selection

The population of interest was all chemically impaired nurses who had either been disciplined or admitted to a non-disciplinary alternative program between January 1993 and June 1995. To be eligible for inclusion in the study, nurse participants had to meet the following criteria: (1) 21 years of age or older; (2) diagnosis of a substance abuse disorder (includes the use of alcohol, prescription or recreational drugs); (3) understands written and spoken English at an eighth grade level or higher; (4) had disciplinary action taken against a license to practice as an LPN/VN, RN or APRN, or has voluntarily entered a board of nursing-authorized alternative program in lieu of having disciplinary action taken against a license to practice nursing; and (5) voluntarily agrees to participate in the study. To gain access to this population, a two-stage process, as described below, was used.

Boards of nursing. Seven jurisdictions were selected for participation in the study. The criteria for consideration were: (1) a sufficiently large volume of chemically impaired nurses that could result in approximately 25 - 40 nurse volunteers from within each jurisdiction; (2) willingness to assist in sample selection procedures; (3) willingness to provide background and compliance information about study participants that is within the public domain or if not, as authorized by the participant; and (4) could provide assurance that the principle investigators were exempt from mandatory reporting requirements within the jurisdiction. An additional criterion had to be met by boards representing those providing alternative programs - the programs had to have been in full operation for two or more years and not currently undergoing modification.

Four boards of nursing meeting the above criteria were selected to represent jurisdictions using a disciplinary approach: Connecticut, Ohio, South Carolina and Virginia. Three boards were selected to represent jurisdictions with nondisciplinary alternative programs: Florida, Maryland and Washington.

Nurse participants. Two different procedures were used to recruit study participants. Jurisdictions using a discipline approach provided the investigators with a list of names and addresses of all individuals disciplined during the target period. Each individual was sent a letter explaining the study's purpose and intended use, an overview of the methodology, and measures to be taken to protect the confidentiality of their participation and their responses. Individuals desiring to participate were requested to sign and return a consent form and a data release authorization form. In jurisdictions using the alternative approach, designated board or monitoring program staff were provided with sufficient copies of the study materials, as described above, which they then mailed to program participants. Those desiring to participate in the study were directed to return the signed consent and data release forms directly to one of the investigators.

In an effort to promote participation, letters promoting the study and reinforcing the measures to be instituted to protect the confidentiality of responses were prepared by each board of nursing or its monitoring program's staff. These letters were sent by one of the investigators (discipline approach) or monitoring program staff (alternative approach). Additionally, recipients of the recruitment materials were encouraged to place anonymous calls to a toll-free phone number if they had questions about the study. Potential participants were also informed that those participating for the full six-month period of data collection would be paid a $50 honorarium.

These recruitment efforts, which extended over a six-month time period, resulted in the receipt of 219 signed consent forms. One hundred (46%) were from within the jurisdictions using a discipline approach and 119 (54%) were from within those using an alternative approach. Based on the sensitive nature of the data to be collected, the longitudinal design of the study, and the unknown level of alcohol and drug use among those agreeing to participate, this response was considered sufficiently large enough to withstand a 50% drop-out rate and still have sufficient data for analysis. Prior to beginning the study, a power analysis suggested that a minimum of 25 individuals in each group would be sufficient to determine differences in recidivism rates, licensure status, and return to work rates at the 0.05 level of significance.

Protection of Subjects Rights and Confidentiality Issues

The protocol for study performance, including measures to protect the rights of research participants, was reviewed and found in compliance with accepted standards by the executive director of the National Council of State Boards of Nursing and by the institutional research review board of The George Washington University, Washington, DC.

Several measures were instituted to protect the confidentiality of participant responses and to promote truthful responses. These were as follows:

1. A unique code number was assigned to each participant. The master list of names, addresses and code numbers was kept in a secure, locked cabinet at the Center for Health Policy Research at The George Washington University (GWU). Furthermore, this information will not be shared with Chicago-based project staff at the National Council.

2. Study participants were routinely reminded not to write their names or other unique identifier on any questionnaires or return envelopes.

3. Data will only be reported in the aggregate; exemplars that could result in the potential identification of a study participant will not be used.

4. All communications with participants (e.g., mailing of and receipt of study materials; responding to phone inquiries) were the responsibility of project staff at GWU.

5. Upon completion of data collection activities and the payment of honoraria, the master list of names, addresses, and code numbers will be destroyed.

6. Assurances from participating boards of nursing that project staff at GWU and at the National Council were exempt from mandatory reporting requirements.

DATA COLLECTION

The data collection instruments used in the study, and procedures for data collection and analysis are described below.

Instruments

A battery of questionnaires was used in this study. Those used to collect data for the information reported in this document were either developed specifically for use in this study by project staff or were based on instruments used in previous studies. These instruments were as follows: (1) Demographic and Licensure Information (DLI); (2) Employment History (EH); (3) Current Workplace Description (CWD); (4) Lifetime Substance Abuse (LTS); and (5) Maintenance of Abstinence (MT). (Additional questionnaires designed to collect psycho-social, health, psychiatric and family histories, workplace environment, substance abuse treatment and access to controlled substances were also used in this study.)

Most items in the questionnaires required participants to select one or more options from a list of potential options. If a response of "other" was selected, elaboration was requested. Each copy of a specific questionnaire (e.g., DLI) contained a unique, printed code number to facilitate grouping of each participant's questionnaires post administration.

Evidence in support of the content validity of all questionnaires was established based on a literature review and review by the National Council's Chemical Dependency Issues Task Force, by experts in the treatment of chemically impaired individuals and by individuals conducting substance abuse research. Instruments developed specifically for this study (i.e., DLI, LTS, MT and SAM) were piloted tested using a group of recovering nurses. Based on the level of congruence between written responses and post-administration interviews, minor changes in wording or format were made.

Since a number of items in these questionnaires concerned sensitive issues (e.g., current drug/alcohol use, source of supply, etc.), the validity of participants' responses was a concern. Therefore, in the final data collection period, the following statement was included:

> Since a number of items included in our questionnaires concerned sensitive issues, we need to know how honest you were able to be in your responses. Please indicate on the following scale the extent to which you believe that your responses can be used as valid scientific data.

A seven point response scale (0 = Not at all valid; 6 = Completely valid) was provided.

Data collection

Data were collected over a six-month time period via a series of monthly mailings. Each mailing contained a cover letter, a battery of questionnaires, a postage pre-paid business reply envelope, and a pencil. Reminder post cards were sent to non-respondents to encourage continued participation. All questionnaires sent to a particular participant over the course of the study contained the same code number. If replacement questionnaires had to be sent, the new code number was recorded.

The schedule for questionnaire administration was as follows:

Month #1:	DLI, LTS, MT	Month #4:	MT
Month #2:	EH, CWD, MT	Month #5:	MT
Month #3:	MT	Month #6:	MT, CWD, validity question

Limitations

The limitations of this study are as follows: the quasi-experimental design, the potential for a self selection bias, the inability to control for the impact of possible differences in the administration of the nondisciplinary alternative programs, differences in state laws governing the management of chemically impaired nurses within the discipline jurisdictions, and the inability to measure the severity of alcohol/drug induced impairment and its impact on functionality and recovery.

Data Analysis

Returned questionnaires were either submitted to optical scanning or the data were hand-entered into database files in preparation for analysis. All data files were verified for accuracy. Data analysis procedures included the preparation of frequency distributions, descriptive statistics and inferential statistics (X^2, analyses of variance). A Yates correction for continuity was applied to all 2 x 2 contingency tables submitted to a X^2 analysis. Unless stated otherwise, a .05 level of significance was used. The results of data analysis are reported in the next section.

RESULTS

Information contained in this section of the report will address findings related to two specific questions: (1) Are there any differences in the rates of recidivism among nurses with a substance abuse history managed via disciplinary and alternative approaches? and (2) Are there any differences in the rate of return to work/retention in the work force among nurses with a substance abuse history managed via the disciplinary and alternative approaches? The relationship between continued use of alcohol and/or drugs and work status will also be examined. Prior to presenting these findings, information describing participant attrition rates, selected socio-demographic and work history information about study participants, and replies to the response validity question will be described.

Study Participants

This section provides information about study participants. Included are the distribution of participants and study "drop-outs" by type of regulatory approach used. This is followed by socio-demographic, work history and lifetime substance abuse information about participants in both groups and, where appropriate, the results of statistical comparisons used to determine their level of equivalence at the beginning of the study.

Attrition from study. Signed consents to participate were received from 219 nurses who, in response to a history of alcohol and/or drug use, either had disciplinary action taken against their licenses or were participating in board of nursing-authorized nondisciplinary alternative program. Of these, 46% were from jurisdictions using a discipline approach and 54% were from those using an alternative approach. Five percent (n=10) of those consenting to participate, did not provide any data. An additional 28 percent (n=62) never completed the study. The overall attrition rate was 33 percent, resulting in 147 (discipline group = 65; alternative group = 82) who participated for the full six-month study period (see Table 1). Statistically, X^2 analysis demonstrated no significant differences in the attrition rates calculated at two different times: (1) prior to data collection and (2) during the study.

Table 1. Participant attrition rates.

Participation status	Discipline Group		Alternative Group	
	#	%	#	%
Returned signed consent forms*	100	46%	119	54%
Participants not returning questionnaires at Time 1	7		3	
Participants providing Time 1 data* **	93	44%	116	56%
Participants not providing data one or more times between Time 2 and Time 6	28		34	
Participants providing data throughout the study **	65	44%	82	56%

* ** X^2 = nonsignificant

Description of Participants

Licensure level and status. Participants in the study were licensed at all levels of practice, LPN/VNs, RNs, and/or APRNs. The majority in both the discipline and alternative groups (see Table 2) held or previously held an RN license. A larger proportion of participants in the discipline group were LPN/VNs as compared to the alternative group. Less than 10% of each group contained APRNs. Since participants could select one or more options in order to reflect all levels of licensure, a series of X^2 analyses of the distributions of each specific licensure type within the two groups were performed. Statistically significant differences in the proportions of LPN/VNs (X^2 = 5.51) and RNs (X^2 = 7.36) were demonstrated between the two groups. The average length of time since initial licensure was 13.9 years and 15.8 years for the discipline and alternative groups, respectively. This was not statistically significant.

Statistically significant differences were demonstrated in the license status of participants in the two groups (X^2 = 108.71). Within the alternative group, 68% had an active license while less than 3% had their license suspended or revoked. In contrast, within the discipline group, 9% had an active license while 53% had their license revoked or suspended (see Table 2).

Demographic characteristics. Examination of the demographic characteristics of participants revealed that they were primarily women (85%) and Caucasian (94%). With one exception, there was minimal representation of all minority groups. There were no Asians/Pacific Islanders in either group. Specific racial/ethnic distributions, by type of approach, are reported in Table 3. The distributions of participants, by gender or racial/ethnic background, were examined by X^2 analysis; no statistically significant differences were demonstrated.

Table 2. Level of licensure and license status of study participants.

	Discipline Group		Alternative Group	
Licensure characteristics	#	%	#	%
A. Current level of licensure*	(n= 87)		(n=110)	
Licensed Practical/Vocational Nurse (LPN/VN)**	24	28%	15	14%
Registered Nurse (RN)***	55	65%	90	81%
Advance Practice Registered Nurse (APRN)****	8	9%	5	4%
B. License status at beginning of study*****	(n=77)		(n=106)	
Active license	7	9%	72	68%
Probation	22	29%	4	4%
Limited/Restricted license	7	9%	27	25%
License suspended	32	42%	2	2%
License revoked	9	12%	1	1%

* Participants could select more than one option

** $X^2 = 5.51$, $p < .05$

*** $X^2 = 7.36$, $p<.05$

**** X^2 = nonsignificant

***** $X^2 = 108.71$, $p < .01$

Table 3. Demographic characteristics of study participants.

	Discipline Group		Alternative Group	
Characteristic	#	%	#	%
A. Gender*	(n=83)		(n=108)	
Male	13	16%	17	15%
Female	70	85%	94	85%
B. Race/Ethnicity*				
1. Hispanic	(n=79)		(n=106)	
Yes	0	0%	2	2%
No	79	100%	104	98%
2. Other *	(n=82)		(n=109)	
Native American/Alaskan Native	0	0%	0	1%
Asian/Pacific Islander	0	0%	0	0%
Black/African American	6	7%	3	3%
Caucasian	76	93%	104	95%
Other	0	0%	1	1%

* X^2 = nonsignificant

Table 3. Demographic characteristics of study participants. (cont.)

Characteristic	Discipline Group		Alternative Group	
	#	%	#	%
C. Marital status*	(n=83)		(n=109)	
Single, never married	17	20%	15	14%
Married	37	45%	47	43%
Divorced/Separated	27	33%	45	41%
Widowed	2	2%	2	2%
D. Highest level of educational preparation*	(n=83)		(n=108)	
LPN/VN Diploma/Certificate	22	27%	12	11%
LPN/VN Associate Degree	1	1%	2	2%
RN Diploma	16	19%	22	20%
RN Associate Degree	26	31%	45	42%
RN- Bachelor's Degree in Nursing	10	12%	18	17%
RN - Non-Nursing Bachelor's Degree	0	0%	2	2%
Advanced Practice - Certificate	7	8%	3	3%
Advanced Practice - Master's Degree	0	0%	1	1%
Master's Degree in Nursing	1	1%	1	1%
Non-Nursing Master's Degree	0	0%	2	2%

* X^2 = nonsignificant

The average ages of the two groups of participants were 40.4 (discipline group) and 41.6 (alternative group). A t-test demonstrated no statistically significant age difference between the groups. Participants' marital status is reported in Table 3. The largest proportion within each group were married (45% - discipline approach; 43% - alternative approach. A X^2 analysis demonstrated no statistically significant differences between the two groups. The alternative group had, on average, a higher number of dependents (1.5 children and adults) in contrast to 1.4 dependents for the discipline group.

Educational level. The highest level of education of participants in each group is reported in Table 3. For LPN/VNs, the majority had completed a PN/VN program leading to a certificate or diploma. Within the RN group, the largest proportion had an associate degree in nursing. A majority of the APRNs had completed a certificate program. There were no statistically significant differences between the discipline and alternative groups.

Employment history. The average number of years employed in nursing and in the current/most recent position (see Table 4) for participants in the discipline and alternative groups was not statistically significantly different. Participants were also requested to indicate the work setting, their clinical specialty and their primary job position. This information is reported in Table 4. If necessary, more than one response option could be selected within each list. While participants indicated they were employed in a variety of settings, clinical specialties and positions, the largest proportions within each group indicated employment in acute care settings, and in staff positions. The greatest proportions in specific clinical specialty areas among participants in the discipline group were in geriatrics and critical care. For those in the alternative group, the greatest proportions were in critical care, medical-surgical units and emergency rooms. Ninety-six percent of the discipline group participants and 98% of the alternative group participants were employed in nursing at the time their substance abuse problem was identified.

Table 4. Employment characteristics of study participants

Characteristic	Discipline Group		Alternative Group	
	#	%	#	%
A. Work setting*	(n=58)		(n=90)	
Inpatient acute care (hospital)	33	56%	48	53%
Other hospital setting	6	10%	12	13%
Long term care	20	34%	18	20%
Outpatient clinics	2	3%	7	7%
Home health/Public health/Hospice	3	5%	13	14%
Physician's office	4	6%	4	4%
School/Student health	0	0%	1	1%
Jail/Prison	1	1%	2	2%
Other community based setting	0	0%	1	1%
Independent practice	0	0%	1	1%
Temporary employment agency	1	1%	4	4%
Nursing education	0	0%	1	1%
Insurance company	2	3%	0	0%
B. Clinical specialty*	(n=58)		(n=90)	
General practice	3	5%	13	14%
AIDS	0	0%	3	3%
Critical care	13	22%	18	20%
Drug/Alcohol unit	2	3%	2	2%
Emergency care	5	8%	13	14%
Family health	0	0%	1	1%
Geriatrics	14	24%	6	6%
Labor and Delivery	3	5%	4	4%
Medical/Surgical	7	12%	15	16%
Neonatal	2	3%	1	1%
Obstetrics/Gynecology	2	3%	3	3%
Oncology	3	5%	2	2%
Pediatrics	4	6%	4	4%
Perioperative	2	3%	3	3%
Psychiatry/Mental health	4	6%	6	6%
Public/Community health	1	1%	1	1%
Other	0	0%	12	13%
C. Primary position*	(n=56)		(n=87)	
Staff/General duty	24	42%	52	59%
Nurse administrator/manager	7	12%	7	8%
Nurse consultant	0	0%	1	1%
Nurse educator	1	1%	1	1%
Clinical nurse specialist	0	0%	3	2%
Certified registered nurse anesthetist	3	5%	1	1%
Certified nurse midwife	0	0%	0	0%
Nurse practitioner	1	1%	3	2%
Nurse researcher	2	3%	0	0%
Other	18	31%	19	36%

* Participants could select more than one response option

Drug and alcohol use. Participants were requested to report if they had ever used cigarettes or abused drugs or alcohol. Abuse was defined as, *a pattern of substance use that leads to impairment, as manifested by one or more of the following: (1) failure to fulfill major role obligations (e.g., as a parent, as a nurse); (2) use in situations in which it is hazardous (e.g., on the job, while driving); (3) illegal behavior (e.g., stealing drugs from the workplace, using illegal prescriptions, substituting a non-controlled substance for a patient's dose); or (4) continued use despite social or interpersonal problems caused by the substance.*

The proportions of participants within each group who reported abuse of nine classifications of prescription or recreational drugs are reported in Table 5. There were no statistically significant differences in the proportions of participants within each group reporting use of the following substances: (1) alcohol (2) marijuana, hashish or THC; (3) cocaine or crack; (4) tranquilizers; (5) barbiturates; (6) minor opiates (e.g., Codeine); (7) amphetamines; or (9) inhalants. However, a statistically significant, higher percentage of participants in the alternative group (44%) than in the discipline group (26%) reported the use of major opiates (e.g., Opium, Demerol, Fentanyl) (X^2 = 5.39, $p < 0.03$). The following substances were used by over fifty percent of participants in the discipline group (ranked by percent using, highest to lowest): amphetamines, alcohol, barbiturates, tranquilizers, and marijuana. In contrast, the substances used by over fifty percent of participants in the alternative group (ranked by percent using, highest to lowest) were: barbiturates and amphetamines (tied), and alcohol.

Table. 5. Lifetime substance abuse history of study participants at time of entry into the study.

		Discipline Group		Alternative Group	
Substance		#	%	#	%
1. Alcohol*	(Discipline: n=92; Alternative: n=110)				
Yes		59	64%	73	66%
No		33	36%	37	34%
2. Marijuana*	(Discipline: n=91; Alternative: n=110)				
Yes		48	53%	50	46%
No		43	47%	59	54%
3. Cocaine/Crack*	(Discipline: n=94; Alternative: n=110)				
Yes		34	36%	39	35%
No		60	64%	71	65%
4. Tranquilizers*	(Discipline: n=92; Alternative: n=111)				
Yes		49	53%	46	41%
No		43	47%	65	59%
5. Barbiturates*	(Discipline: n=87; Alternative: n=107)				
Yes		52	60%	79	74%
No		35	40%	28	26%
6. Minor opiates*	(Discipline: n=88; Alternative: n=108)				
Yes		31	35%	53	49%
No		57	65%	55	51%
7. Major opiates**	(Discipline: n=87; Alternative: n=108)				
Yes		23	26%	47	44%
No		64	74%	61	56%
8. Amphetamines *	(Discipline: n=87; Alternative: n=107)				
Yes		62	71%	79	74%
No		25	29%	28	26%
9. Inhalants*	(Discipline: n=92; Alternative: n=107)				
Yes		10	11%	9	8%
No		82	89%	98	92%

* X^2=nonsignificant ** X^2= 15.39, $p<.05$

Drug/Alcohol related legal problems. Participants were requested to indicate whether they had been convicted of a drug/alcohol related crime and if they had been incarcerated as a result of drug/alcohol related charges or convictions. The reason for any convictions and the type of facility in which they were confined was also requested. This information is reported in Table 6. Differences in incarceration rates were not statistically significant. However, a significant difference was demonstrated (X^2 =16.048) between the numbers of participants convicted of drug/alcohol related crimes (discipline group = 48%, alternative group = 19%). For those in the discipline group, the primary reason was the theft or diversion of patient drugs (n=18). In contrast, the primary reason for a conviction among the diversion group was the forgery of prescriptions (n=8).

Table 6. Drug-related convictions and incarceration history of study participants.

	Discipline Group		Alternative Group	
	#	%	#	%
A. Incarcerated due to substance use-related charges/convictions*	(n= 80)		(n=106)	
No	67	84%	98	92%
Yes	13	16%	8	8%
B. Type facility confined to **	(n=13)		(n=8)	
Jail	10	77%	7	87%
Prison	2	15%	2	25%
Home confinement	2	15%	1	12%
C. Convicted of a drug/alcohol-related crime***				
No	41	52%	87	81%
Yes	38	48%	21	19%
D. Reason for conviction**	(n=38)		(n=21)	
Driving under the influence	8	21%	6	29%
Possession for self use	7	18%	6	29%
Dealing/possession with intent to sell	1	3%	2	10%
Theft/diversion of drugs intended for patient use	18	47%	1	5%
Theft of drugs/alcohol from other sources	2	5%	0	0%
Shoplifting	1	3%	3	14%
Theft - other	2	5%	1	5%
Prostitution	1	3%	1	5%
Burglary	1	3%	2	10%
Disorderly conduct	2	5%	1	5%
Assault	0	0%	1	5%
Forgery of prescriptions	5	13%	8	38%
Forgery - other documents, checks, etc.	1	3%	1	5%

* X^2 = nonsignificant

** Participants could select more than one option

*** X^2= 16.048, p<.01

Equivalence of Comparison Groups

Given the quasi-experimental design of this study and the potential for a self selection bias, selected licensure, socio-demographic and substance abuse characteristics of the two groups of participants were examined to determine the degree to which they were equivalent at the beginning of the study. The characteristics of the two groups were statistically equivalent in regard to the following areas: time since initial licensure, gender, race/ethnicity, marital status, educational level, number of years employed in nursing, number of years employed in current or most recent position, incarceration as a result of drug/alcohol related charges or convictions, and, with one exception, the types of substances used/abused.

Differences in the two groups were identified in the following areas: level of licensure (more RNs and less LPN/VNs in the alternative group), license status (higher percentage of active licenses in the alternative group), use of major opiates (higher in the alternative group), and convictions for drug/alcohol related crimes (lower percentage with convictions in the alternative group). The differences in the proportions of RNs and LPN/VNs in the two groups should not have a major impact on the validity of the conclusions that can be drawn from this study with regard to recidivism rates and retention in or return to the workforce since the application of policies and procedures guiding regulatory management does not vary by type of licensure. The differences in license status are expected as a result of the two approaches to regulatory management. One aim of the study is to determine if there is any change in this status at the end of the study. The major contributing factor to the difference in conviction rates is the higher percentage of participants in the discipline group who were convicted of the theft or diversion of drugs from patient supplies. Since conviction for a drug/alcohol related crime does not automatically eliminate chemically impaired nurses from eligibility for admission to the three alternative programs represented in this state, it is impossible, at this time to determine if this difference introduces a systematic bias.

Response Validity

During the final phase of data collection, participants were requested to respond to a question asking them to indicate the extent to which they believed their responses could be used as valid scientific data. A seven point response scale (0 = Not at all valid; 6 = Completely valid) was provided. Responses were received from 143 (97%) of the 147 participants who competed the study. Of these, 107 (75%) indicated their responses were "Completely valid." The remaining responses were either a "4" (n=3) or a "5" (n=29). The thirty-two "4" and "5" responses were equally distributed between the two groups of participants. The mean response for each group was 5.8 and 5.7 for the discipline and alternative groups, respectively. A *t*-test demonstrated no statistical difference between these two values. Based on these results, it was concluded that the data provided by participants in this study are valid and reliable.

Research Question 1:

The first research question was, *Are there any differences in the rates of recidivism among nurses with a substance abuse history managed via disciplinary and alternative approaches?* Participant responses on the six Maintenance of Abstinence questionnaires (MT-1 through MT-6) administered over the course of this study were used to answer this question, which addresses one aspect of the board's responsibility to protect the public from harm.

Upon entry into the study, 185 participants provided information on their level of substance use since the imposition of disciplinary action or entry into an alternative program. Of these,124 (67%) reported continued abstinence. Table 7 provides the distribution, by level of use (abstinence, periodic use, and continuous use), for each of the two groups. A X^2 analysis demonstrated no statistically significant differences between the two distributions. For those reporting periodic use (n= 59), the periods of time between initial abstinence and the last relapse ranged between two years and less than one month. The average number of relapses per participant, by type of approach was 8.3 (range 1 - 99 or more) for those in the discipline group. In comparison, the average number of reported relapses for participants in the alternative group was 2.9 (range = 1 - 20). Prior to entry into the study, the predominate substances were prescription drugs (e.g., narcotics, opiates, etc.) and alcohol. However, reported use of street/recreational drug use, primarily marijuana and crack cocaine, was minimal.

During the remaining five months of the study, abstinence/use data were collected to determine ongoing abstinence/recidivism rates. Of those completing the study, (discipline = 65; alternative = 82), 21 participants (discipline = 10; alternative = 11) reported periodic or continuous use (see table 8). A X^2 analysis demonstrated no statistically significant difference between the recidivism/continuous use rates of the two groups during the five-month period. During this period, prescription drug use versus alcohol and street/recreational drug use was equally divided among the 20 participants identifying the substance used.

Table 7. Distribution of abstinence and drug/alcohol use history among study participants upon entry into the study.

	Discipline Group (n=78)		Alternative Group (n=107)	
Abstinence and drug/alcohol use history	#	%	#	%
Abstinence since license disciplined or entry into alternative program	49	63%	75	70%
Periodic use since license disciplined or entry into alternative program	28	36%	31	29%
Continuous use	1	1%	1	1%

X^2 = nonsignificant

Table 8. Distribution of abstinence and drug/alcohol use among study participants during the study.

	Discipline Group (n=65)		Alternative Group (n=82)	
Abstinence and drug/alcohol use history	#	%	#	%
Abstinence since license disciplined or entry into alternative program	55	85%	71	87%
Periodic use since license disciplined or entry into alternative program	10	15%	11	13%

X^2 = nonsignificant

The abstinence/recidivism data for participants providing data throughout the study period were submitted to a two-way analysis of variance, using a general linear models approach, to explore the interaction between time and group membership. The resulting F-ratios (see Table 9) demonstrate that while the overall model explains a significant proportion of the variance ($F = 10.22$, $p < 0.001$) and significant differences in abstinence/recidivism rates based on group membership ($F=4.47$, $p < 0.05$) and time ($F= 20.95$, $p< 0.001$), the interaction effect was non-significant ($F = 1.07$, $p > 0.05$).

Based on the mixed results of the analyses described above, it can be concluded that, while during the time period of this study the recidivism rates among participants in the alternative group were lower than those in the discipline group, this may be an artifact of the short time frame over which data were collected. Therefore, until additional analyses can be performed that will explore the impact of additional factors (e.g., length of time in recovery, treatment modalities, etc.), a conservative conclusion is that the recidivism rates among alternative program participants are no higher than those in the discipline group.

Table 9. Analysis of variance table: Interaction of time and group membership on abstinence .

Source	D.F.	Sum of Squares	Mean Square	F Value	Pr > F
Model	11	12.13	1.1	10.22	0.0001
Error	844	91.05	0.11		
Corrected total	855	103.18			
$R^2 = 0.118$	C.V> 234.2926	Root MSE = 0.3284	Mean: status at time = 0.14		

Source	D.F.	Sum of Squares	Mean Square	F Value	Pr > F
Time	5	11.3	2.26	20.95	0.001
Group	1	0.48	0.48	4.47	0.0347
Time * Group	5	0.58	0.12	1.07	0.3765

Research Question #2

The second research question was, *Are there any differences in the rate of return to work/retention in the workforce among abstinent nurses with a substance abuse history managed via the disciplinary and alternative approaches?* Participant responses on the current work description questionnaires (CWD-1, CWD-2) were used to answer this question which addresses the potential for returning knowledgeable, useful nurses to a productive role in society. The questionnaires were administered during the second and last data collection periods. Initially, 43% of participants in the discipline group and 75% of those in the alternative group (see Table 10) reported employment in nursing. A X^2 analysis demonstrated that this difference was statistically significant ($X^2 = 18.73$). At the conclusion of the study, a statistically significant greater percent of the alternative group participants (74%), than of those in the discipline group (52%) were employed ($X^2 = 6.61$) (see Table 10).

Table 10. Employment status of study participants

Characteristic	Discipline Group #	Discipline Group %	Alternative Group #	Alternative Group %
A. Employment status at beginning of study*	(n=82)		(n=107)	
Not employed	47	57%	27	25%
Employed	35	43%	80	75%
B. Employment status at end of study**	(n=59)		(n=79)	
Not employed	29	48%	21	26%
Employed	31	52%	60	74%
C. Comparison of employment status at beginning and end of study***	(n=82)		(n=109)	
Not employed at any time	30	51%	19	24%
Employed both times	22	37%	54	68%
Employed at beginning of study but not at the end	4	7%	1	1%
Employed at end of study but not at the beginning	3	5%	5	6%

* $X^2 = 18.73$, $p<.001$ ** $X^2 = 6.61$, $p=.01$ *** $X^2 = 15.67$, $p=.001$

Following elimination of Time 2 data for those who had dropped out of the study, a table was constructed comparing employment status at the beginning and the end of the study (see Table10). A X^2 analysis demonstrated that the distributions were not equivalent (X^2 = 15.67, p< 0.05). Greater percentages of participants in the alternative programs than in the discipline programs were in the work force. This finding is related to the number of participants who had a license to practice nursing at the beginning of the study. Future analyses will be directed towards exploring the change in employment status in relation to any change in licensure status at the conclusion of the data collection period. (This data is not yet available for analysis.)

One additional analysis that was performed examined the relationship between employment status and abstinence/substance use as reported in the second and the sixth data collection periods (see Table 11) . Of the 29 participants in the discipline group who were employed at any time between the two time periods, two reported alcohol/drug use. Of the 60 participants in the alternative group who reported employment during this same time period, four reported alcohol/drug abuse. A X^2 analysis demonstrated no statistically significant differences in these distributions. At this point in our analyses, it is impossible to determine whether any of these nurses were practicing while impaired.

Table 11. Substance use among participants employed in nursing at any time during the study.

	Discipline Group		Alternative Group	
	(n=29)		(n=60)	
Abstinence and drug/alcohol use during employment	#	%	#	%
Abstinence	27	93%	56	93%
Periodic use of alcohol/drugs	2	7%	4	7%

X^2 = nonsignificant

Less than half (43%) of the participants in the discipline group were employed. This is a direct consequence of the nature of disciplinary action taken against their license to practice - either suspension or revocation which removes them from practice, placement on probation, or the imposition of limitations on practice. In contrast, very few participants (<3%) in the alternative group reported that disciplinary action taken against their license resulted in revocation or suspension.

Based on the above analyses, it can be concluded that retention in and/or return to employment in nursing is highest in the alternative group. A small percentage of participants in both groups continued to use alcohol/drugs while employed. While the ideal situation would be one where all nurses with a history of a substance abuse disorder would not practice while impaired, the overall percentage of employed participants reporting continued or periodic use of mind-altering substances was minimal in both groups. This indicates the effectiveness of both approaches in assuring protection of consumers.

SUMMARY AND CONCLUSIONS

The purpose of this interim report is to share selected findings regarding (1) the socio-demographic, licensure, drug/alcohol use characteristics of chemically impaired nurses who have had disciplinary action taken against their licenses or who are participating in a board of nursing-sponsored nondisciplinary alternative program and (2) the impact of regulatory management approach (discipline versus alternative program) on two factors: recidivism rates and retention in or return to the workforce.

Study participants were LPN/VNs and RNs, including APRNs who volunteered to participate in the study. Based on the preliminary findings of this study, the typical nurse participants in both groups can be described as female, Caucasian, 40 to 42 years old, married with 1.4 to 1.5 dependents, had completed an associate degree in nursing (RNs) or PN/VN program diploma/certificate (LPN/VNs), been licensed as a nurse for 14 to 16 years, employed in nursing for 13 to 15 years, and employed in the current or most recent position for three to five years. The most frequently abused prescription and street/recreational drugs were: amphetamines, barbiturates, tranquilizers, alcohol, and marijuana.

The first research question was, *Are there any differences in the rates of recidivism among nurses with a substance abuse history managed via disciplinary and alternative approaches?* Participants in both groups provided information about abstinence/recidivism patterns prior to and during the six-month data collection period. Based on an analyses of this data, it was concluded that the recidivism rates among alternative program participants are no higher than those in the discipline group.

The second research question was, *Are there any differences in the rate of return to work/retention in the workforce among abstinent nurses with a substance abuse history managed via the disciplinary and alternative approaches?* Participants reported their employment status at the beginning and the end of the study. While there was a net loss of four alternative program participants from the workforce and a net gain of one in the discipline group (see Table 11), statistically higher percentages of participants in the alternative group (who provided data at both times) were employed in nursing. An additional analysis demonstrated that two individuals within the discipline group and four within the alternative group were not abstinent while employed. These numbers represent less that 10% of those employed. Based on these results, it was concluded that retention in and/or return to employment in nursing is highest in the alternative group. Furthermore, the small percentage of participants who reported use of alcohol/drugs while employed was equivalent in both groups.

The results of this study must be examined from the perspective of a board of nursing's mandate to protect the public from incompetent providers of nursing care. Historically, boards have dealt with chemically impaired nurses by taking disciplinary action against a license to practice. More recently, a number of boards have established a nondisciplinary alternative program that offers a confidential, voluntary alternative to license discipline for nurses with a substance abuse/dependency problem. In response to the question, "Does a nondisciplinary approach protect the public equally as well as the more traditional approach?, the results of this study demonstrate that the outcomes of both approaches are equivalent in regard to continued use/abuse of alcohol/drugs by nurses with a substance abuse disorder, including among those who have returned to the workforce, deterring recidivism, keeping impaired nurses from practice, and retiring /retaining abstinent nurses in the workforce..

Future work

Additional analyses of the data obtained from study participants will continue. A primary goal is to identify factors that contribute to abstinence/recidivism in order to provide boards of nursing and other policy makers with information that may assist in the development of policies and procedures guiding the management of the chemically impaired nurse. Forthcoming analyses will also address whether the periodic or continuous use of alcohol/drugs reported by the nurses in this study and who are still under the board's jurisdiction was detected; cost factors associated with the two types of programs; and facilitators and barriers to nurse rehabilitation/recovery.

Report of the Disciplinary Investigators' Program Task Force

Task Force Members

Florence Stillman, MO, Area II, *Chair*
Giovanni Di Paola, CT, Area IV
M. Teresa Mullin, VA, Area III
Dianne Wickham, MT, Area I

Staff

Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to Organization Plan

Goal II..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B..... Provide resources regarding health care issues which affect the regulation of nursing practice.

Recommendations to the Board of Directors

That the National Council invest resources to support Member Board disciplinary activities by:

1. **Offering the Nursing Investigators' Program (NIP) in conjunction with 1996 National Council Annual Meeting, to be held in Baltimore, Maryland, in August, 1996.**

2. **Offering the NIP to other National Council groups which request that the program be offered in their jurisdiction or Area and which meet identified criteria.**

3. **Recruiting and training new faculty to present NIP (task force requests an additional meeting to "train-the-trainer").**

4. **Developing a disciplinary resource notebook, which includes materials from the discipline-related committees. (This is same disciplinary resource notebook being developed by the Complex Discipline Cases Subcommittee, the task force is supportive of this idea and has material to contribute.)**

5. **Developing study modules regarding discipline topics, designed for a variety of audiences.**

Background

The 1993 Delegate Assembly adopted a recommendation from the Communications Committee that the Board of Directors determine the methodology to implement educational programs for discipline investigators that best meets the needs of the membership within the National Council's Organization Plan. The Disciplinary Investigators Program Task Force was appointed to work on this project. The first approach to providing educational programs was to pilot a Specialized Healthcare Investigators program, developed in collaboration with CLEAR, and held September 29 and 30, 1994, in conjunction with the CLEAR Annual Conference in Boston. Overall, reaction to the program was positive. After reviewing the CLEAR summary report and evaluating the pilot program, the task force recommended that a modified program, focusing on nursing investigations, be held in conjunction with the 1995 Annual Meeting in St. Louis. The Nursing Investigators' Program (NIP) was held Monday, July 31, 1995, prior to the Annual Meeting. It was a one-day program, costing $115 (price included lunch and materials) and offering continuing education credit for nurses. Thirty-four individuals completed the program.

Highlights of Activities

- **Survey of Nursing Investigators' Program participants**
  At the direction of the task force, staff surveyed the participants of the St. Louis program six months after NIP to determine whether the program had been of assistance in their work. Twenty-four out of thirty-two participants

(75%) responded to the survey. Nineteen respondents (79%) indicated that the completion of the program had been of assistance in their disciplinary work. Twenty-three respondents (96%) indicated that they would recommend the program to others.

- **Evaluation of 1995 Nursing Investigators' Program, held July 31, 1995, in conjunction with the 1995 National Council of State Boards of Nursing Annual Meeting**
  The task force members were more satisfied with the St. Louis program, which focused on nursing, than with the program sponsored jointly with CLEAR, which was multidisciplinary. The revisions to the curriculum (adding a session on chemical dependency and splitting the group into basic and advanced groups for medical documents) worked well. The small group work was refined and better coordinated. The meeting environment was much improved in St. Louis and greatly facilitated the small group work. The materials were improved. Adding the lunch as part of the program provided a wonderful networking opportunity.

  The task force reviewed evaluations and feedback received after the presentation of the programs and compared them to the Boston evaluations. The evaluations were positive overall and continuation of NIP was supported. Based on these ratings, the task force recommends to continue the NIP. (Evaluation summaries, debriefing notes and survey results are available upon request.)

- **Development of criteria for offering the Nursing Investigators' Program upon request**
  These criteria include:
  1. Request shall come from a National Council-related group (Member Board, Area, committee, Board of Directors).
  2. Registration of enough participants to financially break even for costs of meeting, travel of faculty and materials. (Actual number of participants required will vary as to location, but will be approximately 20.)
  3. There are no prerequisites for taking the course.
  4. A faculty to participant ratio of 1:10 is required for effective small group work. If the location is remote, and/or the group is under financial constraints, NIP faculty may work with local board staff to assist with small groups. Time for a training session would need to be incorporated the evening before NIP is offered.

- **Identification of qualifications for faculty and development of a selection process for recruitment and training of program faculty**
  The task force identified the following criteria for faculty selection: combination of education and experience suitable for NIP topics, excellent speaking and interacting skills and recommendation by affiliated board. NIP completion is desirable. The process suggested for selection and training of new faculty includes placing a call in the National Council *Newsletter* for interested individuals to submit resumes, identify areas of expertise and provide recommendation. New faculty would meet with representatives of the task force for training and National Council staff. The meeting would include a discussion of program development, review of the curriculum and opportunities for practice presentations. Planning the role plays and working through the case study would be incorporated. The entire group would contribute to the updating of the program notebook. In the future, "train-the-trainer" sessions could be scheduled annually, and facilitated by current faculty members and National Council staff.

- **Collaboration with other discipline-related committees**
  The task force supported the development of a disciplinary resource notebook by the Complex Discipline Subcommittee, which would include materials from the discipline-related committees.

- **Development of suggested topics for future *Discipline Resource Modules***
  The task force members discussed at length the advantages and disadvantages of the various approaches to discipline education. NIP and other workshops provide the opportunity for face-to-face interactions. Written materials, such as study modules and other printed resources, are better suited to some learning styles. However, independent study loses the interactive dialogue, the opportunity for immediate feedback and answers to questions. The task force members do not think this is an either/or decision. Rather, they believe that opportunities in both workshop and written materials should be provided so that Members Boards have a variety of resources available to meet their individual content, time, and cost needs. The task force identified topics that could be developed to

support Member Boards in their discipline activities and could be offered in addition to NIP. The task force directed staff to share these recommendations with the Institute for the Promotion of Regulatory Excellence and also with the Special Services Division, as they believed several of the topics would be suitable to market to outside agencies and individuals.

Future Activities

The Oregon Board of Nursing has requested that the Nursing Investigators' Program be offered on the west coast, and will host the program sometime in the late summer or early fall of 1996.

Meeting Dates

- January 4-5, 1996

Recommendations to the Board of Directors

That the National Council invest resources to support Member Board disciplinary activities by:

1. **Offering the Nursing Investigators' Program (NIP) in conjunction with 1996 National Council Annual Meeting, to be held in Baltimore, Maryland, in August 1996.**

2. **Offering the NIP to other National Council groups which request that the program be offered in their jurisdiction or Area and which meet identified criteria.**

3. **Recruiting and training new faculty to present NIP (task force requests an additional meeting to "train-the-trainer").**

4. **Developing a disciplinary resource notebook, which includes materials from the discipline-related committees. (This is same disciplinary resource notebook being developed by the Complex Discipline Cases Subcommittee, the task force is supportive of this idea and has material to contribute.)**

5. **Developing study modules regarding discipline topics, designed for a variety of audiences.**

Report of the Nursing Regulation Task Force

Task Force Members

Elizabeth Lund, TN, Area III, *Chair*
Joan Bouchard, OR, Area I *(appointed 3/96)*
Cheryl Graves, NE, Area II
Jenenne Nelson, CO, Area I *(resigned 2/96)*
Carol Osman, NC, Area III
Cynthia VanWingerden, VI, Area IV

Staff

Diane Creal, *Policy and Practice Associate*
Carolyn Hutcherson, *Senior Policy Analyst*

Relationship to the Organization Plan

Goal II ..... Provide information, analyzes and standards regarding the regulation of nursing practice.
Objective B ..... Provide resources regarding health care issues which affect the regulation of nursing practice.

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective F ..... Analyze approaches to the regulation of nursing personnel based on evolving health care and environmental changes.

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective F ..... Analyze approaches to the regulation of nursing personnel based on evolving health care and environmental changes.

Recommendations to the Board of Directors

1. **Approve the National Council response to the Pew Health Professions Taskforce on Health Care Workforce Regulation report *Reforming Health Care Workforce Regulation* (Attachment A).**

Rationale

At the January 17-18, 1996, meeting, the Board of Directors determined that the National Council would prepare an organizational response to the recommendations from the Taskforce on Health Care Workforce Regulation. Using analysis from the Nursing Regulatory Resource Packet and collective analysis by Member Boards to each of the recommendations, a draft organizational response was prepared. This response is included as Attachment A, and is recommended to the Board of Directors to be forwarded to the Delegate Assembly for adoption.

Background

In September 1995, the report of the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation entitled, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, was released. This report focused on ten issues surrounding regulation of health professionals. Since the policy options proposed in the report would have direct impact on the operations of boards of nursing, the Nursing Regulation Task Force coordinated a number of activities to assist Member Boards in responding to this report. A National Council Action Plan was established to include items such as:

1. Initiation of intra-professional as well as cross professional dialogue about regulatory reform.
2. The joint National Council/Citizen Advocacy Center conference discussed below.
3. Development of a Fact Sheet noting Member Board and National Council activities related to issues identified in the report, supplemented by a Member Board Successes Fact Sheet highlighting activities undertaken by boards of nursing to promote effective regulation.

4. Development of a lexicon of terminology used in health care delivery system restructuring.
5. Individual and organization dialogue with Pew representatives
6. Preparation of the Regulatory Resource Packet providing information for Member Board use in evaluating and analyzing the recommendations of the Taskforce on Health Care Workforce Regulation.
7. Collective Member Board dialogue about each of the ten recommendations.
8. Preparation of a comprehensive approach for organizational response to the recommendations.
9. Presentations at health care meetings about regulatory reform in nursing.

2. Provide direction about selection of a revised model for nursing regulation which meets regulatory objective in protecting the public.

Background

■ **Model Development**

In December, 1994, the Nursing Regulation Subcommittee began analysis of several proposed models for nursing regulation. At that time, consideration was given to the Ontario Model, institutional licensure, privatization and a federal model for regulation. As attention focused on developments in telecommunications and technology and creation of multi-state health care delivery systems, frequent attention was drawn to the perceived barriers to full utilization of these systems created by the current state-based health professions licensure system. The Federation of State Medical Boards proposed a model for regulating physicians to accommodate telemedicine.

The Task Force decided to explore whether there were other models of regulation which might be adapted to nursing regulation to ensure protection of the public while allowing some permeability of state boundaries. Elements of 10-12 models were identified including endorsement, reciprocity, the Veterans Administration model, the drivers license model, mutual recognition, federal license, corporate credentialing and long arm statutes. After analysis by the task force, five models (reciprocity, fast endorsement, mutual recognition, federal law and corporate credentialing) were selected for in-depth evaluation. From this analysis, the two major approaches selected for further consideration were fast endorsement and mutual recognition. Although fast endorsement could eliminate delays when nurses need to move rapidly from one practice setting to another, fifty licenses might still be needed for a nurse working with a national health care delivery system. While mutual recognition (the system in place in the European Economic Community and Australia) held some appeal, it was felt that protection of the public would be best served by being able to more closely track the nurse's location and practice setting. The task force agreed that sufficient disciplinary oversight must be maintained so an unsafe practitioner could be removed from practice as quickly as possible. To this end, a hybrid system was developed, calling for creation of a multi-state license (MSL) for persons who met specified criteria. The MSL would allow practice in all participating states. The creation of this additional licensure component framed attention on two major areas of concern - discipline and the impact on board revenue.

■ **Focus Groups**

On May 30, 1996, a disciplinary focus group comprised of nine individuals representing boards of nursing was convened to discuss disciplinary questions related to any model which allows permeable state boundaries. They focused on whether a disciplinary system could be developed to monitor nursing practice when the patient and nurse are in different states. A number of creative options were identified with general enthusiasm that an effective system could be established to ensure protection of the public. On May 31, 1996, a second focus group representing eight boards of nursing met to discuss revenue issues and their impact based on implementation of any model which facilitates permeable state boundaries. This group deliberated about a number of potential revenue options as well as operational changes within board offices. Concerns were expressed about those boards whose revenue expectations and options are impacted by state government and not just the board.

■ **Special Conference**

On June 9-10, 1996, a special conference was held for a representative from each Member Board to participate in dialogue about modification of the current nursing regulatory system to accommodate changes in the health care delivery system and the explosion of telecommunications advances. Special attention was given to use of telephones for nursing practice across state lines. Representatives from 59 jurisdictions participated. Participants explored a number of possible models, discussing options ranging from minor modifications of the current system

to "wiping the slate clean" and reconceptualizing regulation. Consensus emerged that some accommodation of the current system would be necessary to respond to the changing health care environment and to create permeable state boundaries. Consideration was given to establishment of uniform licensing requirements across states. Options for further analysis and planning were identified as well as resources needed by Member Boards to facilitate understanding of the issues and establishment of direction at the annual meeting in August.

■ **External Opportunities**

In January 1996, National Council responded to an invitation by the Federation of State Medical Boards to participate in open dialogue about their proposed model for telemedicine practice by physicians. Several opportunities have arisen for presentation of the National Council perspective on provision of nursing care across state lines, including describing the current system for nursing regulation at a Center for Telemedicine Law meeting. The Federal Office for Rural Health Policy has expressed both interest and support for consideration of nursing's deliberation about future regulatory modifications. Presentations about the potential revision of the regulatory system for nursing were given for the Federal Joint Working Group on Telemedicine and the Congressional Ad Hoc Steering Committee on Telemedicine and Health Care Informatics. That nursing regulators are attempting to propose solutions which maximize public protection and allow permeability of state boundaries is being recognized by policy experts in the public and private sectors.

■ **Future Considerations for National Council Regarding Model Development**

- Continue development of optimal regulatory model(s)
- Continue to identify specific concerns and develop strategies to identify solutions
- Conduct focus groups to critique proposed revised regulatory models
- Solicit feedback from non-nursing state governmental representatives
- Solicit feedback from regulatory leaders in other professions
- Solicit feedback from leadership of other nursing organizations
- Solicit feedback from managed care and other health care delivery system representatives
- Establish workgroups to focus on specific components of a proposed model
- Disseminate information about proposed model for nursing regulation
- Establish timeline for model implementation
- Seek external funding to support efforts related to model development and/or implementation
- Develop language for model practice act and rules to assist boards of nursing with potential transition
- Provide opportunity for dialogue about transition issues and processes
- Collaborate on development of electronic system to support model revisions

Other Activities

■ **National Council/Citizen Advocacy Center Conference**

On December 4-5, 1996, the National Council and Citizen Advocacy Center jointly sponsored a conference entitled, *Crafting Public Protection for the 21st Century: the Role of Nursing Regulation.* Feedback from the 230 participants was uniformly supportive of the leadership role of National Council in sponsoring a public dialogue about the role of regulation in protecting the public as well as identification of potential regulatory modifications to accommodate the rapidly changing workplace. The first day included presentations about the Pew Health Professions Task Force Report, changes in the health care delivery systems and current regulatory approaches interspersed with opportunities for questions and dialogue. A particularly well received presentation was by Joyce Schowalter, Executive Director of the Minnesota Board of Nursing, who challenged participants to be open in evaluating the need for development of new ways to think about protecting the public. The second day featured a combination of speakers, panel presentations and small group work. Group activity centered on identification of outcomes of effective regulation. Participants were challenged to take a leadership role in determining the future of nursing regulation. Proceedings of the conference were incorporated into a special joint National Council/ Citizen Advocacy Center publication distributed in March 1996.

■ **Nursing Is....**

In response to many expressed concerns about the inability of nursing to "capture the essence" of nursing in a brief statement, a survey was prepared for input by nurses to describe the unique essence of nursing. Since many

actual definitions of nursing have been written, the intent was to formulate a description of nursing which could be understood by consumers and describe a unique role for nursing in debates about health care restructuring and redesign. The survey was distributed in Issues and many other nursing publications. Over 500 responses were received and reviewed by the task force. Responses were categorized according to: a) those which captured some element of the uniqueness of nursing, b) those which were particularly poignant, and c) those which represented a regulatory description. While no statement was determined to singularly capture the uniqueness of nursing, 35 statements were determined to capture some element of a unique description. The task force will prepare these statements in survey form for feedback from participants in the first survey. The results of this feedback with anticipated identification of a statement capturing the unique essence of nursing will be disseminated in nursing publications.

- **Regulatory Outcomes**

  Based, in part, on discussion of the principles noted in the introduction of the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation report, stating that regulation of the health care workforce will best serve the public's interest by "promoting effective health outcomes ...", a project was undertaken to identify outcomes of effective regulation. Accompanying the 1995 Nursing Regulation Subcommittee Report were documents created with Member Board input, citing the Fundamental Beliefs about the Regulation of Nursing and the Essential Functions of Regulation. During a number of meetings, opportunity was provided for nurses and others to identify their beliefs about the outcomes of an effective regulatory system. A comprehensive list of potential outcomes has been formulated to serve as the basis for a research project to be undertaken during FY 97 using a Delphi approach. Response will be sought from within the nursing community as well as from stakeholders in nursing regulation.

Meeting Dates

- September 13-14, 1995
- November 13-14, 1995
- December 4-5, 1995 *(Joint Conference, Crafting Public Protection in the 21st Century: The Role of Nursing Regulation)*
- December 12, 1995, *(telephone conference call)*
- February12-14, 1996
- March 10-12, 1996
- March 20, 1996 *(telephone conference call)*
- March 25, 1996 *(telephone conference call)*
- April 27-29, 1996
- May 20, 1996 *(telephone conference call)*
- June 4, 1996 *(telephone conference call)*
- June 11-12, 1996
- July 1, 1996 *(telephone conference call)*
- July 3, 1996 *(telephone conference call)*
- July 15-16, 1996

Recommendations to the Board of Directors

1. Approve the National Council response to the Pew Health Professions Taskforce on Health Care Workforce Regulation report *Reforming Health Care Workforce Regulation* (Attachment A).

2. Provide direction about selection of a revised model for nursing regulation which meets regulatory objective in protecting the public.

Attachments

Attachment A

Response to the Pew Taskforce on Health Care Workforce Regulation

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August 1996

National Council of State Boards of Nursing Summary Points

Regulatory Outcomes

- A validated consensus regarding appropriate regulatory outcomes must precede discussion of what system of health care workforce regulation will best serve the needs of the American public in the 21st century.

Regulatory History and Legal Precedents

- Consideration is needed of the political diversity, historical roots and legal precedents of regulation prior to going forward with systematic revision of the regulatory system. The past should not be allowed to hold back the evolution of regulation, but it needs to be recognized.

Competence

- Competence is not just a collection of skills; it involves cognitive factors; affective and psychomotor elements; and behavior, attitudes, ethics and judgment in the application of professional knowledge, skills and abilities for the benefit of the public.
- Competence assessment is inadequately accomplished by a one-time skills testing mechanism; more effective assessment requires information from multiple sources and periodic demonstration to ensure reliability and validity.
- It makes more sense, in terms of benefit to the consumer, for the professional to focus on assuring that knowledge and skills in the current area of practice are updated (so that safe and competent care is continually enhanced) than to use time and resources updating or acquiring knowledge and skills unrelated to daily practice.
- A more effective approach to assuring continued competence of licensed professionals is to conduct significant and meaningful evaluations with a selected group of licensees (selected randomly or by "triggers" that identify a particular need for competence demonstration) rather than perform a superficial sweep of all licensees.

Overlapping Scopes of Practice

- Health professions overlap both in knowledge base and clinical application. Scopes of practice should delineate the boundaries appropriate for the education and experience of the category of the regulated professional; they should not define exclusive territory for one group, thereby barring other competent professionals from delivering safe and effective care.

Consistent and Easy Data Access

- Licensing boards need consistent and easy access to data sources, including disciplinary data, malpractice payments and criminal records of applicants/licensees, critical for making informed licensure decisions.
- Crimes which have potential impact on the ability of a professional to practice safely or predict how he or she might treat vulnerable patients subject to their care should be considered as part of a credentialing decision.

Discipline Processes

- Informal processes provide cost-effective and expeditious means of resolving disciplinary matters, and enable boards to deal with cases in a more timely manner while still taking action, often stringent, as needed for public protection.

Professional and Public Representation on Licensing Boards

- An additional oversight board with the authority to amend or reject decisions of professional boards simply adds another layer of bureaucracy to the system.
- Both public (*articulating consumer viewpoints and needs*) and professional (*providing professional expertise and judgment*) regulatory board members are needed to bring together the diverse viewpoints necessary to assess issues from every relevant aspect.

Coordination and Collaboration of Regulatory Agencies

- Interdisciplinary activities, reflecting working interrelationships between health care professions, should be promoted to facilitate communication among various groups and to collaborate in efforts to advance public protection.
- Coordination of and enhanced communication among the multiple licensing agencies, the federal, state, and local authorities, and private entities is imperative.

Adequate Funding and Staffing

- Adequate funding and staffing are necessary to assure that any policy implementation is successful. Many boards are currently underfunded, understaffed and short on the technology needed to implement more flexible and efficient regulatory processes. Far more attention needs to be given to funding issues than is acknowledged in the Taskforce's report if regulation is to move to a new level of effectiveness and accountability.

Major Stakeholder Involvement in Reform Efforts

- Any body convened to "codify regulatory terms and language" must reflect the major stakeholders impacted by the language, including the public, regulated health care professions, providers and payers of health care, regulators and legislators.

National Council of State Boards of Nursing Response to the Pew Taskforce Principles and Vision for Health Care Workforce Regulation

The human population at the end of the 20th century is caught in a vortex of technological, economic, demographic and cultural change. There are enormous pressures on the health care industry to reduce costs, and legislative mandates to increase access to health care. The regulatory system, of which licensing boards provide focus for the individual practitioner, serves the important role of advocate for the public welfare in the midst of these competing forces. A revised 21st century regulatory model for the health care professions must be flexible with respect to process but firm with respect to quality of care outcomes.

Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century has focused attention on the fundamental transformation of the health care delivery and financing structures, and its impact upon regulation of the health care workforce. The Taskforce set forth to identify and explore how regulation protects the public, studied the current regulatory structure and determined that it is out-of-step with current needs and expectations. The Taskforce attempted to propose new approaches to regulation to better serve the public's interest.

The establishment of principles is crucial to any reform effort. From the principles must flow measurable outcomes (and effectiveness indicators), clear assignment of responsibilities, and ways to calculate costs. It is our belief that principles should be stated in terms of outcomes. We recognize that this is not an easy task. Who has the understanding of the context and the authority to define the outcomes to which the regulatory system should be held accountable? The consumer, government, regulatory bodies, health care institutions and professionals all have legitimate perspective and interest. The National Council, as an organization of regulatory boards, has begun a process to empirically validate potential regulatory outcomes. We challenge the Pew Health Professions Commission to lend its backing to broadening this effort so that a true consensus can be obtained.

It is our view that the principles for health care professions regulation exist within a context. That context reflects the theoretical and clinical knowledge and experience of a given health care profession as well as the health system of which it is a part. The legal context for regulation includes the tenth amendment to the United States Constitution which reserves to the states those powers not specifically assigned to the federal government. The state's interest in protecting the public relates directly to the assurance that those whom it authorizes to practice the health care professions possess the minimal, essential competence required for their practice to be safe and effective. Competence is not just a collection of skills; it also encompasses the application of knowledge and skills expected for the practice role, for the benefit of patients.

The principles articulated by the Pew Taskforce are clearly desirable and laudable. But they are also so unfocused that they confound the responsibility and accountability of numerous entities.
Within the context described above, the principles stated by the Taskforce go far beyond the contribution that regulatory boards have the authority and resources to make. Thus, they preclude the definition of measurable outcomes and effectiveness indicators, assignment of clear responsibility and identification of costs.

The first principle set forth by the Taskforce is the most problematic. For exactly which health outcomes should nursing boards be holding nurses accountable? There are multiple layers of accountability and confounding of interactions between entities such as nurses, other providers, institutions, payers, and patients. Regulation *must* present barriers to the unsafe and incompetent practitioner. What each nursing board can be held accountable for is focused on the assurance of a competent health care provider and that their law, rules and processes do not unduly inhibit a safe and competent nurse from providing nursing care. Boards can contribute to availability, accessibility and cost effectiveness of nursing care; but the responsibility for these benefits cannot be solely that of regulatory boards.

The third principle focuses on the consumer right to choose their own health care providers from a safe range of options. Who establishes the range of safe options? We agree that consumers should have choice and that the safety of each

potential choice should be assured. But it is apparent that the range of options is much more in the hands of managed care organizations than in the hands of regulatory boards. Yet we see no consideration in the Taskforce's recommendations of the necessity of including managed care in accountability for respecting consumers' rights to choose from a range of safe options.

The inflexibility, irrationality and cost-ineffectiveness of our present health care system is dependent upon many entities and forces outside of regulation. We agree that boards' laws, rules and processes should not impede flexibility, rationality, and cost-effectiveness of the system, other than what is *necessary* to assure that professionals are safe and effective.

We endorse the principles that hold regulatory bodies accountable to the public and that facilitate professional and geographic mobility of competent providers. While boards of nursing have provided education about provider competence as well as incompetence, they recognize the need to increase effectiveness of efforts to reach out to consumers of nursing care and to other groups sharing an interest in promotion of public health and welfare. Boards of nursing have identified the need to revise the current model of regulation to further increase the permeability of state boundaries so that competent nurses are authorized to practice whenever and wherever consumer need and their own personal and professional interests mesh.

The Taskforce has lumped all professions, all agencies into the same amorphous pool. Different groups are at different points in dealing with the many challenges of the evolving health care system. It would have been useful for the Taskforce to employ the principles of benchmarking for identification of successful practices, so those aspects of regulation that are effective could be retained in any new model. But the most serious criticism of the Pew Taskforce report is that even if all the suggested policy options were enacted as stated in the report, the challenges presented by interstate practice and telecommunications would still not be sufficiently accommodated.

We recognize that it is essential that the United States system of regulation, which originated at the end of the 19th century, undergo comprehensive review. The principles by which nursing regulation proposes to devise a new model to protect the public in the 21st century have been defined and endorsed by the Delegate Assembly of the National Council, comprised of the 61 boards of nursing in each U.S. state and territory. Those principles are further described in the final section of this response, describing the means by which implementation of regulatory reform will eliminate unnecessary barriers.

Recommendation #1 - ***States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.***

The premise for this recommendation is logical, and the goal is laudable. Currently, the semantics of regulatory language reflect an "orange and tangerine" phenomenon. Elements may appear in several laws and be very similar, but not quite the same. Consistent definition of terms such as *licensure*, *certification* and *registration* would be beneficial to both health care providers and consumers. In addition to promoting consumers' understanding regarding the level of protection offered by different professional credentials, communication and coordination between boards would be enhanced. Interstate mobility would be facilitated and telecommunications issues would diminished. Getting there, however, is a huge problem.

The chief reservation held by nursing boards is that this goal will be very difficult to achieve (consider how metric conversion has fared in the United States). Such a standardization process would very expensive and consumers would bear the cost. The political battles could be daunting. For example, consider efforts to promote standardization of advanced nursing practice. There exists a *crazy quilt* of approaches to advanced practice regulation from state to state. However, the reasons for the differences are due to the political climate within which the regulation developed. Different groups within jurisdictions are resistant to change, fearing loss of position and opportunity, and they make it very difficult to progress. Multiply this group by the number of professions and special interests, and enormity of the proposed task becomes obvious.

There needs to be consideration of the political diversity, historical roots, and legal precedents of the current language use of language before going forward with standardization.. The past should not be allowed to hold us back, but it has to be addressed to determine how best to achieve consensus on both the content and implementation of standardized language. This task should be approached rationally, not emotionally, but it must be addressed.

Several boards of nursing have been or are currently involved in state-level efforts to standardize language (e.g., Montana, Utah and Texas). A National Council project developing a lexicon of disciplinary terms (and their equivalents from state-to-state) is near completion. These efforts represent useful starting points for broader standardization of regulatory language.

***Policy Options*:** Standardization of regulatory language would require changes in both state and federal law. It would be costly. Although this project seems almost insurmountable when considered as a whole, the possibility of breaking the work into smaller steps with identified priorities and targeted time frames should be achievable. Any body convened to "codify regulatory terms and language" must reflect the major stakeholders impacted by the language, including the public, regulated health professions, providers and payers of health care, regulators, and legislators. Such a body may be able to articulate a model lexicon and identify possible steps in promoting its use, including assistance with application. Involving all players is essential to avoid duplicative efforts or territorial turf battles.

Recommendation #2 - ***States should standardize entry-to-practice requirements and limit them to competence assessments for health professions in order to facilitate the physical and professional mobility of the health professionals.***

Progress has been made in nursing to standardize many requirements for licensure, for example standardized national examinations for LPNs and RNs. Much work is still needed to promote uniformity of requirements for advanced practice nurses. Issues still exist in terms of educational requirements for entry-into-practice for RNs.

The definitions of *competence* and *competence assessment* are crucial to this discussion. Our working definition for competence is *the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare.* Competence assessment should not be limited to an examination to measure sample knowledge and skills. Other means of competence assessment that consider application of knowledge and skills are desirable.

Licensing boards are charged to maintain the balance between the rights of the professional to practice a chosen profession and the board's responsibility to protect the public health, safety and welfare. Often, the professional roles with the most ambiguities and inconsistencies are in the process of evolution and need to be closely critiqued and guided in their development. Boards serve as the advocate for the public in this process.

Knowledge, skills and abilities (KSAs) are essential standards for evaluating the competence of professionals. But competence is broader than KSAs. We believe that competence does not only involve cognitive factors - it also encompasses affective and psychomotor elements. It involves behavior, attitudes and judgment, and physical and sensory capabilities in the application of the professional's KSAs for the benefit of the client.

There are always outliers in any system devised by man. Flexibility should be built into the system, but must be used with care. Boards which abuse their discretion perform a disservice to the public, and diminish the profession which they regulate. There is increased risk of challenge in this litigious society when requirements, reasonable and necessary for the great majority of professionals, are waived in special circumstances. The potential risks and costs of such litigation have to be considered when discretion is exercised.

This recommendation appears to ignore the need to evaluate licensure applicants for criminal records. Such background information should be evaluated by licensing agencies for the benefit of the public. Crimes which have potential impact on the ability to practice a profession safely, or predict how he or she might treat vulnerable clients subject to their care should be considered as part of a credentialing decision. They are indicative of that aspect of competence comprised of affective or behavioral elements.

Policy options: Uniform entry-to-practice standards for specified professional roles is a worthy goal and would promote mobility of professionals and thereby consumers' access to health care. Boards of nursing are involved in the determination of core licensure requirements, promotion of a licensure approach to managing issues such as mobility and telemedicine/telehealthcare, and accreditation standards. Boards of nursing have in place national standardized licensure examinations. Alternative pathways in education, previous experience and a combination of education and experience should only be considered when appropriate safeguards are in place to assure competence. Entry-into-practice standards should continue to address affective and psychomotor aspects of competence as well as cognitive elements.

Recommendation #3 - ***States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the fullest extent of their current training, experience and skills.***

The ultimate goal of regulation is public protection. Boards of Nursing believe that practice acts should provide sufficient authority for boards to regulate those elements of nursing practice necessary to assure safe professionals. These elements include initial and continuing competence, though within a broader definition of competence, such as that described under our comments on Recommendation #2. It is equally important for practice acts to give notice to licensees as to what is unsafe and incompetent practice. The authority and tools to effectively identify and remove unsafe, incompetent practitioners from practice and/or assist them toward rehabilitation of their practice are critical elements in the regulatory scheme.

Health care professions do overlap. There are many health related functions that can be (and in many cases are) performed safely by multiple types of practitioners. Scopes of practice should not be defined as exclusive territory, but rather as delineating the boundaries appropriate for the education and experience of the category of regulated professionals. The challenge here is to articulate regulatory language that is broad enough to reflect the capabilities, breadth and evolution of practice while being specific enough to be meaningful and useful. This is why practice acts must be periodically reviewed and revised to reflect changing knowledge and technologies.

But should a nurse be allowed to become a physician because she has worked with many patients, is extremely knowledgeable, proficient, and experienced? Should a nurse aide be allowed to become a nurse because he has worked in many situations and has learned much from the patients assigned to his care? Solely performing delegated tasks does not prepare an individual for the transition to another role. That is what this recommendation, taken to its broadest interpretation, could mean. Who would be responsible to track individually expanded scopes of practice? Clearly, it is to the benefit of all to facilitate professional growth, development, and role transition. But it should be done within the boundaries of articulated scopes of practice, and meeting requirements for other professions.

The taskforce's options do not address the activities of unlicensed assistive personnel. Since the nature of their work is assistive, the operative principles for safe utilization of these individuals involve appropriate and responsible delegation and supervision by licensed personnel. The licensed person, who has the authority to practice the profession, is accountable for identifying the conditions for safe delegations:

- the Right Task - *one that is delegable for a specific patient*
- the Right Circumstances - *appropriate patient setting, available resources and other relevant factors considered*
- the Right Person - *the right licensed person delegating the right task to the right person to be performed on the right person*
- the Right Direction/Communication - *clear, concise description of the task, including its objective, limits and expectations*
- the Right Supervision - *appropriate monitoring, evaluation, intervention (as needed) and feedback*

Issues related to delegation have become more complex in today's evolving health care environment. Nurses, who are uniquely qualified for promoting the health of the whole person by virtue of their education and experience, must be

actively involved in providing the assessment, evaluation and judgment needed to coordinate and supervise nursing care. Unlicensed assistive personnel cannot be transformed into professionals through delegation.

Policy options: Scopes of practice should reflect the competence of the professional, not serve to restrict other professionals who have demonstrated competence from providing safe and effective care. How competence is defined and demonstrated is critical. Professional licensure assures the consumer that the licensed individual has met specified minimum education as well as other requirements.

Recommendation #4 - *States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.*

Collaboration between health related boards needs to be promoted to assure sharing of critical information, coordination of efforts and timely board actions. Increased public member participation is desirable, but the need for professional members to provide the expertise envisioned within the basic concept of administrative agencies is essential. An oversight board with authority to amend or reject decisions of boards simply adds another layer of bureaucracy to the system.

Policy options: Without outcome data that clearly supports one type of regulatory structure (e.g., umbrella v. independent), consolidation of the structure and functions of boards is an unproven theory. Unless representation on a consolidated boards reflected actual numbers of practitioners, there is a very real danger that those with the biggest wallets and most political influence would prevail, not necessarily to the public's benefit.

Periodic interdisciplinary meetings among boards to discuss issues of common concern have been implemented in some states (e.g., Texas and Minnesota), and provide opportunities for collaboration and cooperation without adding another layer of bureaucracy. Joint statements and guidelines have been useful for the various professions. On a national level, the National Council has facilitated the convening of an Interprofessional Workgroup, comprised of fifteen health professions. This group, in the process of responding to the Pew recommendations, has interacted regarding multiple common issues. Information sharing about similarities and differences in regulatory processes has already occurred, and it is anticipated that collaboration will continue in areas such as continued competence assessment tools, practice issues related to telecommunications, and the identification of regulatory outcomes.

Recommendation #5 - *Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.*

It is an excellent suggestion to better inform consumers. Nurses have long supported such consumer education. The idea of professional profiles is troubling in some respects. Cost is a factor - who will maintain these profiles, and assure their accuracy? How would this information sharing be implemented? Is it duplicative of other current efforts? Would the information be used? Could it be misused?

Policy options: Adequate funding and staffing are necessary to assure any policy implementation is successful. Boards need to share information with legislators regarding the size of their populations, the various settings in which the licensees work, and the potential impact of unsafe practice. Funding is pivotal in the implementation of public communication and accountability. Boards which have accomplished greater public communication have observed significant increases in the number of complaints received. A consequent greater demand is placed on investigative and prosecutorial personnel and other resources.

Recommendation #6 - *Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.*

Data collection for effective workforce planning is in the interest of assuring effective nursing care for consumers. Licensing boards are potentially excellent sources of supply information related to workforce data, but do not have

access to significant demand data. The National Council already provides statistical data regarding licensed nurses in the United States and its territories to the Division of Nursing, Health Resources and Services Administration, US Department of Health and Human Services. The National Council will be better able to provide such information upon completion and implementation of the *Nurse Information System* (NIS), a current project which will provide an unduplicated count of nurses in the United States as well as demographic information regarding those nurses. There have been two significant impediments in the development of NIS which we believe could also impede the realization of the goal embodied in this recommendation. The first is related to resources - computer systems, database creation and maintenance personnel. The second is state laws and policies regarding privacy and confidentiality of data (e.g., social security numbers). Idiosyncrasies in both laws and interpretation of laws have contributed toward impeding the sharing of data.

Policy options: Approaches similar to those indicated under recommendation #1 would also be appropriate for promoting uniformity laws and interpretation of laws related to confidentiality and privacy of data. Legitimate claims to privacy for some data must be recognized. Development of a consistent approach and consensus for implementation will require concerted efforts by high profile policy leaders who can influence the funding as well as develop more rational policy related to data.

Recommendation #7 - *States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.*

As the pace of technological and scientific development accelerates, one of the greatest challenges to health care professionals is the attainment, maintenance and advancement of professional competence in an evolving health care environment. Licensing boards have a role in assuring the public of the competence of licensees, but what should that role be? Who else is accountable for aspects of competence? What is meant by *competence*? And what is the standard to which a licensee is to be held for *continuing competence*?

National Council had been working on this concept long before the publication of Pew recommendations promoted continued competence as an issue. Our working definition for competence is *the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare.* We believe that competence does not only involve cognitive factors - it also encompasses affective and psychomotor elements. We have developed standards for competence which can be used by boards of nursing, individual nurses and employers to compare and evaluate how individual practitioners may demonstrate competence. We are currently developing behavioral indicators that will assist in this process.

There is a "great debate" that is not reflected in the Pew documents, a debate that pertains to all professions in which there is an area of focused practice following entry into the profession as a generalist. Nursing careers take widely divergent paths - practice focus varies by setting, by types of clients, by different disease, therapeutic approach or level of rehabilitation. Nurses work at all points of service in the health care system. The debate centers on the question, *to what standard is the licensee held for continuing competence?* We have identified three possibilities:

- *a standard based upon the current entry-level competency for the profession*
- *a standard based on a generalist core competency for the profession*
- *a standard based on competence needed for safe and effective practice in the focused area of practice*

From the perspective that the renewed license is no different in what it authorizes and represents to the consumer than the initial license, the entry-level standard makes sense. For some health care roles, continual validation of the entry-level role may be most appropriate, e.g., the Emergency Medical Technician, who has a very focused role, and may be called upon for any EMT skills on any day, in any situation.

But for a profession with more breadth in knowledge, skills, and scopes of practice; for a profession that may practice in a variety of settings, "one size does not fit all." Put in terms of benefit to the consumer, it makes far more sense for the nurse to focus on assuring that knowledge and skills in the current area of practice are updated such that safe and competent care is continually enhanced than for the nurse to use time and resources updating or acquiring knowledge

and skills unrelated to daily practice. Requirements that have no relation to daily practice become an academic exercise, and may even detract from advancement of focused knowledge and skills.

Another concern for licensing boards when considering their role is that of resources, and how to select activities which bring the most value to the public. Who pays? Is the additional cost "bearable" by the health care system? How would it be distributed? Should Boards attempt to deal with all licensees on a regular basis, while recognizing that this often means a shallow, superficial sweep? Or would a more effective approach be to do significant and meaningful interactions with a selected group of licensees? One possibility for identification of the selected group would be random review of licensees. Or, "triggers" for competency assessment might be identified, e.g., nurses changing their practice focus, nurses working in high risk areas, or nurses working in isolation. The latter notion has appeal, if objective and relevant triggers can be identified. Such triggers cannot be developed in isolation: the "stakeholders" must be involved.

Nursing Boards can play an important role in assuring competence, but the individual nurse must be accountable for practice. One of our competence standards states that the nurse *shall demonstrate responsibility and accountability for practice and decisions.* A behavioral indicator of this standard is that the *nurse implements professional development activities based on assessed needs.* Promotion of professional competence requires a collaborative approach, involving the individual nurse, the nursing employer and the Board of Nursing.

Policy Options: While it is fashionable at the moment to criticize the "ineffectiveness" of continuing education in assuring continued competence, the problem lies more in the inappropriate selection and lack of outcomes assessment associated with the current implementation of requirements. The "triggers" approach described above, or any other competence mechanism, could become just another ineffective proxy for truly getting at competence if care is not taken to empirically validate their relevance and objectivity.

In view of the complexity of continued competence and the shortcomings of one-shot competence assessment identified under Recommendation #2 above, the option of requiring the regulated health professionals to periodically demonstrate competence through appropriate testing mechanisms is an overly simplistic solution. "Testing" is only one of a variety of means of attempting to measure competence, and may not be the most effective for assuring that nurses practice safely on a continuing basis and/or it may be more expensive than other equally good assessment approaches.

The Interprofessional Workgroup on Health Professions Regulation has afforded opportunities for sharing regarding their perspectives, conceptual developments and work-to-date on continued competence issues. It is hoped that collaboration on answering the questions identified above and developing cost-effective approaches to the assessment of continued competence will continue. Doubtless, funding will be an important factor in the ability to progress rapidly with a challenge of this magnitude.

Recommendation #8 - *States should maintain a fair, cost effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.*

Boards of nursing strive to attain an appropriate balance between formal administrative hearings and informal settlement methods. Due process procedures are provided in both formal and informal resolution of discipline cases. Formal hearings may be the result of the complexity of issues, or the inability to come to resolution. Informal processes provide cost-effective and expeditious means of resolving disciplinary matters, and enable boards to deal with cases in a more timely manner while still taking action, often stringent, as needed for public protection. The use of "alternative-to-discipline" programs is becoming increasingly common, though there is significant ongoing debate about how best to handle confidentiality issues and fulfill the boards' responsibility to the public.

This is a major obligation of boards, and they need adequate support and resources to perform this function. Boards of nursing spend a great deal of time and resources investigating complaints regarding licensed individuals. Individual boards have developed systems of prioritization based on consumer safety criteria and alternative mechanisms for resolution of cases which reduce the administrative and/or punitive burdens of discipline without compromising the safety of consumers. National Council has developed resources to support more effective and efficient discipline, including an empirical study of various approaches to managing nurses with chemical impairment, and a training course for nursing investigators. Nursing boards are ready and willing to continue to participate in such efforts.

Policy options: Boards of nursing continue to explore approaches for dealing with the increasing numbers of complaints. It is essential to identify those cases which pose immediate risk to the public so that emergency action is taken. Alternative approaches to case resolution are being used in some jurisdictions as cost-effective and expedient means of dealing with complaints. In addition to increasing numbers of cases, investigation and identification of innovative remedies that can be used in community and non-traditional settings challenge boards. The need for adequate resources and personnel is critical.

In addition to facilitating the discipline process, boards need to educate consumers, employers, and licensees regarding licensure discipline. Public relations efforts may promote the visibility and recognition of boards as fair and objective forums to resolve complaints regarding professional practice. But boards must also be prepared to handle effectively the additional complaints that such efforts generate.

The matter of public access to disciplinary data is another area in which diverse state laws addressing due process, confidentiality and freedom of information create inconsistencies regarding the timing of information release and the nature of information that can be shared. The National Council has maintained a *Disciplinary Data Bank* (DDB) for over fifteen years which is recognized as an essential tool in sharing information about licensed nurse disciplinary actions and assists in stopping the "geographic cure" (leaving one jurisdiction ahead of the authorities and establishing practice in a new state before information regarding action is available to other jurisdictions). Another information tool is the *National Practitioner Data Bank (NPDB).* At the present time, information related to nurses is limited to malpractice payments and the rare clinical privileges action report. The National Council is working with the Division of Quality Assurance, HRSA (the federal agency which administers the NPDB) to facilitate board of nursing participation upon implementation of the law which will mandate reporting of board of nursing disciplinary actions. The National Council is also exploring facilitation of access by boards of nursing to criminal data regarding applicants and licenses.

Recommendation #9 - ***States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies in order to best protect and promote the public's health.***

Boards of nursing can cite multiple examples of self-evaluation which are performed on a regular basis, e.g., reports to governors and/or legislatures; participation in sunset reviews. Numerous boards undertake strategic planning processes in which they identify needs related to their responsibility to protect the public, goals, objectives and strategies. The process of periodic updating of these plans includes strong evaluative components.

Policy options: There is a need to identify public expectations and concerns so that boards can be responsive. What are the outcomes for which regulation is accountable? Who is qualified to assess their attainment, when, and by what standards? Who pays, for what reason, to what extent? The need for outcomes and criteria to be identified, in a manner which respects the protection of the public cannot be overstated. Agencies need to look inward at their processes but also to look outward for the impact of their regulation on consumers, licensees and the health care system.

Recommendation #10 - *States should understand the links, overlaps, and conflicts between their health care workforce regulatory system and other systems which affect the education, regulation, and practice of health care practitioners to streamline regulatory structures and processes.*

Assessment of the complex system of regulatory boards, agencies and departments, some of which regulate facilities while others regulate individual practitioners, some which regulate the education of practitioners and others which address the practice of a profession, is challenging. Compounding this conglomeration is the overlay of federal, state and local authority and their laws and regulations. Yet another layer is added by the private entities, e.g., accreditation agencies and certifying bodies, which provide additional credentials and/or validation of programs and services.

Examples of partnership-seeking by boards of nursing can be found across the country. Some boards have formed successful partnerships with in-state groups of nurses. Some have sought out boards regulating other health professions. The National Council has received strong encouragement to seek out partnerships with consumer and public interest groups.

Policy options: Coordination of all these systems is sorely needed, and improved communication among these groups is imperative. Education of all involved parties as to the role and function of other agencies would promote understanding of how their agency's work fits into the overall regulatory scheme. Clearly, someone needs to look beyond the trees (individual agencies) to view the forest (the entire regulatory system) as a whole. The impetus for the licensing community to conduct such a comprehensive analysis may well be provided by the challenge of telecommunications. Collaboration among groups to reduce duplicative efforts and, in some cases, resolve conflicts of authority and purpose must be promoted.

Each agency needs to identify the core functions, and ask the questions:

- *What is unique about the contribution of this agency to the promotion of public welfare?*
- *What complementary functions provided by the agency add value to its service?*
- *Is anyone else looking at the same things, in the same way, or could use the same information? If so, could there be coordination and partnership so that a regulated entity is not required to respond to the same request from multiple agencies within the same timeframe?*

Collaborative efforts should be broadened. Staff need adequate time and resources so that they can devote the attention needed by these efforts. This need for resource reflects the same pervasive theme woven throughout this document: adequate funding for human and other resources required to perform and improve regulatory functions and collaborate and communicate so that real progress is made toward the goal of effective streamlining while maintaining quality outcomes.

Barriers and Opportunities for the Implementation of Regulatory Reform

The challenge to craft a regulatory system adequate for the health care needs of the public in the future includes but goes beyond the conceptualization of a new model by and for boards of nursing. Coordination and collaboration with other health care professions is essential to create a regulatory system with rational processes, informed choice by consumers, and accountability by regulatory boards to the public. As referenced previously in this response, National Council has taken a leadership role in facilitating the meeting of representatives from fifteen health professions (the Interprofessional Workgroup on Health Professions Regulation) which has provided a beginning forum to share perspectives, conceptual developments and collaborative efforts regarding multiple common issues. This group, initially called together to respond to the Taskforce's report, has already begun work on the development of sound approaches for assuring continued competence.

To have any hope of attaining the lofty principles set forth by the Taskforce, it will be necessary to bring together those entities having other types of regulatory roles, such as those named in the tenth recommendation: payers, accreditors, professional associations, the legal system, testing agencies, facility regulators and the federal government. What is needed is to think and plan in the future tense. The reconfiguration of regulation for the 21st century requires the identification of what is currently good and make it better; to determine what is not working and change it so it works. Transition must be planned and supported so we can get to the common goal, an effective regulatory system that truly benefits the public good.

This will require dedicated individuals from a cross section of stakeholders, who bring authority as well as a variety of abilities and skills to the process. They will need vision, perspective, political acumen, a knowledge of the past and cultural awareness as well as technological expertise. Individuals with insight, flexibility, communication/negotiation skills and perseverance will build the consensus needed for regulatory reform.

Boards of nursing are willing and committed to pursue needed regulatory reform. We have the talent, the skills, and the dedication to come to the table to pursue true reform that reaches for the Pew vision while maintaining the focus on quality and safety of care. The support of reform at this level needed will include financing, operational change efforts and effective coordination of efforts. We trust that the importance of this effort will not go unrecognized and unsupported by the Pew Health Professions Commission and Pew Charitable Trusts.

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Attachment B

TO: Carolyn Hutcherson

FROM: Arent Fox, Washington, DC, Attorneys at Law:
Robert J. Waters
Lynn Frendt Shotwell

RE: Federal Legislation Governing Health Care

DATE: March 21, 1996

This memorandum provides examples of federal statutes establishing certification and/or quality standards involving health and safety or health care providers. The Congress has usually justified these measures based on the interstate nature of the regulated service or as a requirement for participation in federally sponsored programs such as Medicare. In some situations, Congress has adopted an extremely broad reading of the "interstate" nature of the health service to justify these regulatory requirements. We have attached excerpts of some of these provisions to provide further explanation.

Clinical Laboratory Improvement Amendments of 1988 (CLIA '88)

CLIA '88 establishes a federal certification scheme for all clinical laboratories. Under this law, the Secretary of Health and Human Services is charged with establishing minimum standards governing the qualifications for clinical laboratory personnel, quality control procedures, inspections and the like. Prior to 1988, the federal government regulated only those laboratories that sent specimens across state borders. However, concerns about the poor quality of testing in unregulated laboratories led Congress to revise the definition of a covered laboratory to include all laboratories.

In developing this legislation, the House Energy & Commerce Committee "concluded that each and every laboratory in the nation has an effect on the public health and that each should be regulated under a unified regulatory mechanism." The Committee found that a strong federal role was necessary as state and local oversight had not ensured uniform compliance with the federal standards existing prior to 1988. The Senate Labor & Human Resources Committee concurred in the need for strong federal oversight. The Committee report states that the Committee intended to expand CLIA "to encompass all laboratories which utilize any of the instrumentalities of interstate commerce (telephone, mail, private courier services, etc.) in the ordinary course of business. It is the intention of the Committee that jurisdiction under this act be expanded to the limits allowed by the commerce clause of the Constitution."

The Mammography Quality Standards Act of 1992 (MQSA)

The MQSA directs the Secretary of HHS to develop and enforce quality standards relating to equipment and personnel for all mammography facilities, to set standards for accrediting bodies, and to provide for annual inspections. All facilities providing mammography must be certified as meeting the Secretary's standards. Prior to enactment of the MQSA, a patchwork of federal, state and private voluntary standards were in place and the quality of mammography facilities varied greatly. The House Energy & Commerce Committee report concluded that "though federal, state, and

private efforts have been undertaken to ensure quality, a glaring need exists for comprehensive federal regulation." States may enact additional standards that do not conflict with the MQSA. The House bill was passed over the objections of Rep. Bill Dannemeyer who opposed the bill on the grounds that it allowed "the Federal government to regulate the private practice of medicine."

The Senate Labor & Human Resources Committee concluded that "the operation of mammography facilities has a significant impact on interstate commerce and as such should be federally regulated." It further found that the literature supported the need for national, uniform quality standards.

Occupational Safety and Health Act of 1970 (OSHA).

Through the exercise of its powers to regulate interstate and international commerce, Congress has authorized the Secretary of Labor to set mandatory occupational safety and health standards applicable to businesses affecting interstate commerce. Many of these standards, such as the blood borne pathogens regulation, regulate the conduct of health professionals.

Medicare and Medicaid.

Health care facilities and providers wishing to participate in the Medicare and Medicaid programs must often comply with standards that are more stringent than those imposed at the state level. The Secretary of HHS has established conditions of participation in these programs for hospitals, long term care facilities, home health agencies, and specialized providers such as comprehensive outpatient rehabilitation facilities, rural primary care hospitals, providers of outpatient physical therapy and speech-language pathology services, portable x-ray services, and organ procurement organizations.

The conditions of participation for each of these facilities include personnel requirements. In most instances, personnel must be licensed in accordance with the applicable state laws. However, in some cases, additional requirements are imposed as well. For example, the conditions of participation for outpatient physical therapy centers require that a facility physician have an appropriate state license, 1 year of post-internship training in the management of rehabilitation patients and 1 year of experience in a rehabilitation setting. Likewise, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) established requirements for assuring the quality of care in nursing facilities which are often not regulated under state law. These standards establish minimum training criteria for nurse aides, including the number of hours of training, the subject matter of the training and who may conduct the training.

Implications for Telehealth Licensure Legislation

The primary impediments to federal telemedicine and telehealth licensure laws are likely to be political rather than constitutional. Federal legislation regarding telehealth or telemedicine licensure could be enacted and justified relying on either the interstate commerce clause or as a condition of participation in the Medicare program. Last year, Representative Ron Wyden (D-OR) introduced an amendment to the Telecommunications Bill that read as follows:

No state shall directly or indirectly restrict interstate commerce by prohibiting any licensed physician in such State from conducting a consultation with a licensed health care practitioner in another state using any advanced telecommunications service that is provided by common carrier and that is subject to the jurisdiction of the Commission under this title.

While the Wyden Amendment was ultimately withdrawn, it was clearly focused on interstate transactions and therefore it is arguably even more defensible than other federal health and safety requirements such as those imposed by CLIA or the MQSA. Please note that Rep. Wyden's Amendment originally applied to all licensed health care providers but was amended to include only physicians at the behest of several members.

Please let us know if we can provide you with additional information.

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Attachment C

TO: Carolyn Hutcherson

FROM: Arent Fox, Washington, DC, Attorneys at Law:
Robert J. Waters
Anthony V. Lupo
Lynn Frendt Shotwell

RE: Interstate Licensure and Telehealth

DATE: June 3, 1996

QUESTION PRESENTED

What position have the courts taken on where a telehealth or other transaction occurs when done via electronic telecommunications?

SHORT ANSWER

Little precedent exists as to "where" a transaction occurs when one party is physically located in one state and the other party is in a different state. The question of where the transaction occurs may not be as important as the question of whether the state can find some means to legally justify imposing its regulatory jurisdiction on an out-of-state entity. In many instances, it will be able to do so.

Courts have generally given states broad latitude to regulate out-of-state businesses and professionals maintaining certain contacts with the state or engaging in conduct which impacts residents of the state. In these circumstances, states may require out-of-state residents to comply with licensure requirements which are not more stringent than those imposed upon in-state residents and are not impossible for out-of-state residents to meet.

DISCUSSION

I. Current Licensure Requirements for Telehealth Vary From State to State

To the best of our knowledge, no states have taken a position on the licensure of telehealth professionals other than physicians. Florida, Nevada, Kansas, South Dakota and Texas require out-of-state physicians consulting with in-state patients via electronic means to be fully licensed to

practice medicine. In Florida and Kansas, the state medical boards made this determination. It has been stated that the Florida Board of Medicine voted to require full licensure for out-of-state physicians who render "the primary interpretation of any diagnostic test used for diagnosis and/or treatment of a disease, process or medical condition" at the behest of in-state medical groups. In Texas, South Dakota and Nevada, the legislatures amended the state medical practice acts to clarify the application of the licensure laws to out-of-state telehealth practitioners. The Nevada legislation reversed the position the Nevada Board of Medical Examiners had taken a year earlier that out-of-state radiologists were not required to be licensed in Nevada to read teleradiologic images of patients located in Nevada.

Not all states, however, have taken the position that licensure is required for out-of-state telehealth providers. The Mississippi Attorney General has offered the opinion that an out-of-state teleradiologist is not "practicing medicine" within the state and does not need to be licensed therein.// While these opposite positions may be explained, in part, by the different definitions of "practice of medicine" under current state laws, we do not think that is where the analysis is properly directed. For a state to be entitled to regulate telehealth providers it must demonstrate (1) that it has jurisdiction over the telehealth provider, and (2) that its regulation does not violate the Commerce Clause of the U.S. Constitution. However, when applying these rules of law the courts have often reached what appear to be inconsistent conclusions. An illustration of this is the conflicting results reached by two states dealing with the regulation of mail order pharmacies:

In 1982, the Ohio Attorney General took the position that a mail order pharmacy located in Ohio could fill prescriptions written by providers licensed in other states even where these providers (i.e. midwives) would be unable to write orders for prescriptions if licensed in Ohio. The Attorney General noted that requiring nonresident practitioners to be licensed in Ohio would not protect the life, health or safety of Ohio residents as they would be unlikely to get a prescription from an out-of-state provider. Because no legitimate local interest was being protected, the Attorney General reasoned that it would violate the Commerce Clause for Ohio to require the licensure of nonresident practitioners.

A year later, the Wisconsin Attorney General took the position that out-of-state pharmacies dispensing drugs by mail to Wisconsin residents were required to comply with Wisconsin's regulations regarding the dispensing of prescription drugs. The Attorney General found that Wisconsin had an implied right to regulate these entities where they regularly and continually solicited mail-order sales from Wisconsin residents. Furthermore, the Attorney General concluded that this regulation was a legitimate exercise of Wisconsin's police power to protect public health and welfare, and as such did not unduly burden interstate commerce.

// In a number of conversations with state medical boards, we have learned that many boards would like to take the position that out-of-state physicians need not be licensed to practice telehealth, but feel prohibited to take this position under current statutory law.

Because these decisions offer little guidance on distinguishing when a state can regulate a provider, it is helpful to examine more closely the legal analysis a court will use in determining a state's ability to regulate out-of-state entities.

II. Has the Provider Purposely Availed Itself to the State's Jurisdiction in Such a Way as To Reasonably Expect that the State Could Regulate Its Business There?

To determine whether a state has regulatory jurisdiction over a telehealth provider, it is important to understand where this consultation occurs. A provider may be considered to be conducting business in the provider's home state, the patient's home state, cyberspace or in both states simultaneously.// Determining where the provider is conducting business will affect not only licensure requirements, but choice of law for legal issues, including malpractice liability and contract disputes, confidentiality of patient records and mandatory reporting of certain health information, and perhaps even employment issues.

Before a state can have the power to regulate a provider, (or for that matter anyone else), the state must have legal jurisdiction over the person or entity. Every state has the inherent authority by virtue of its "police power" to regulate internal affairs for the protection or promotion of the health, safety, welfare, and morals of its citizens. The determination of whether a state has jurisdiction over a person or entity will focus on the defendant's contact with the state. If the defendant has sufficient "minimum contacts" with the jurisdiction and a reasonable expectation that it could be regulated there, then the defendant will likely be subject to regulatory jurisdiction.//

// While some commentators have argued for the creation of new laws governing transactions which occur solely in cyberspace, no such body of law has been created which will provide guidance as to the regulation of telehealth. Moreover, placing the consultation in both states simultaneously does not resolve jurisdiction or choice-of-law issues. Thus, while important to consider these possibilities, they will not be further discussed.

// A state may have jurisdiction over a defendant so as to require it to defend itself in that state, while at the same time not having jurisdiction over the defendant to regulate them. *See generally, Quill*, 504 U.S. 298 (Scalia Concurrence) ("I do not understand this to mean that due process standards for adjudicative jurisdiction and those for legislative (or prescriptive jurisdiction) are necessarily identical.") Id. at 320-321.

It has been held that the type of contacts required for regulatory jurisdiction require "the connection between a state and the regulated person be of a more substantial character than the 'minimum contacts' needed to support judicial process running against the person." *Aldens v. La Follette*, 552 F.2d 745, 751 (7th Cir. 1977). On the other hand, it has also been held that "contacts that would justify regulatory provisions as to one type of business might not as to another because of the greater interest of the state in the former than in the latter." *National Liberty Life Ins. Co. v. State*, 62 Wis.2d 347, 215 N.W.2d 26 (1974).

A defendant's presence is not required in a state for a state to have jurisdiction over the defendant.// So long as a "commercial actor's efforts are 'purposely directed' toward residents of another state," the Supreme Court has rejected the argument that the defendant's absence in the jurisdiction could defeat jurisdiction.// In fact, the Supreme Court has held that a state's regulatory jurisdiction could be asserted on the basis of contacts with the state through the United States mail.//

No cases report directly on the issue of whether a state has jurisdiction over an out-of-state provider offering telehealth services to a patient located in that state. However, we believe it is highly likely that most states will argue that they can regulate out-of-state providers that are contacted by patients in their state. Clearly, a state would argue that it has a heightened interest in protecting its citizens in the telehealth situation which would justify the state imposing a regulation over the providers even though there may be a low level of contacts with the state.

In other situations where the contact with the state has been by electronic transmission, at least one court has found that the electronic transmission was not sufficient to confer jurisdiction.// On the other hand, another court has held that an electronic transmission was sufficient for a state to prosecute an out-of-state resident.//

For the purposes of telehealth, the question will likely turn on whether the provider's contacts with the patient are such that it purposely availed itself to the regulatory jurisdiction of that state. This

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// *Burger King Corporation v. Rudzewicz,* 471 U.S. 462 (1985).
// *Quill Corp. v. North Dakota,* 504 U.S. 298 (1992).
// *Travelers Health Assn. v. Virginia ex rel. State Corp. Comm'n,* 339 U.S. 643, 646-650 (1950).
// In *Pres-Kap, Inc. v. System One, Direct Access, Inc.,* 636 So.2d 1351 (Fla. App. 1994), a lawsuit brought in Florida by a Florida online airline reservation database against a user in New York. The New York user's sole contact with Florida was electronic access of the database. The Florida court found it had no specific jurisdiction to exercise personal jurisdiction over the New York user. It held that the New York user could not reasonably anticipate the possibility of defending a suit in Florida.

Moreover, in *Asahi Metal Industry Co., Ltd. v. California,* 480 U.S. 103 (1987), the court held that "the placement of a product into the stream of commerce, without more, is not an act of the defendant purposefully directed toward the forum state . . . [a]wareness that the stream of commerce may or will sweep the product into the forum state does not convert the mere act of placing the product into the stream into an act purposefully directed toward the forum state."
// In *United States v. Thomas,* Case No. 94-20019-G (W.D. Tenn. Jan 27, 1994), a California couple was criminally prosecuted in Tennessee for allowing an undercover law enforcement officer to download indecent information (which was held not to be indecent in California) from the couple's computer into Tennessee. The court reasoned that the couple did not have to allow the information to be downloaded into Tennessee, and, because they allowed the downloading, they subjected themselves to the jurisdiction.

determination may turn on whether the out-of-state provider has purposely committed some act within the state. The extent to which an out-of-state provider takes affirmative action to establish contacts in the state may affect whether the state has jurisdiction. For example, the more frequently a provider originates a transmission into the patient's state, and the efforts the provider makes to solicit referrals from the state will likely be considered by the court as evidence that the provider is availing itself of the state's jurisdiction. Ultimately, the question of jurisdiction will require a balancing of how often and in what context the provider has conducted business in the jurisdiction.

III. May a State Regulate Out-of-State Activities Which Impact the Welfare of Its Residents Without Violating the Commerce Clause?

If the out-of-state provider is considered to have had sufficient minimum contact to give the patient's state jurisdiction, the next question is whether the state regulation is in violation of the Commerce Clause or some other portion of the U.S. Constitution.//

The power to regulate matters affecting the health, safety and welfare of the public has been left to the states. States generally have broad discretion in the use of their police power. While numerous challenges have been brought against states that attempt to regulate out-of-state professionals and businesses//, courts routinely uphold those regulations which have a legitimate local purpose and which are applied in a nondiscriminatory manner.

Some in the telehealth field argue that requiring out-of-state providers to be fully licensed in the patient's home state violates the Commerce Clause.// The Commerce Clause limits the power of the States to erect barriers against interstate trade. However, this limitation is not absolute. States may

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// It is possible that a service provider could have sufficient contacts with the state for purposes of jurisdiction, but not have the types of conduct required by the Commerce Clause. See Quill, 504 U.S. 298 ("...a corporation may have the 'minimum-contacts' with a taxing State as required by the Due Process Clause, and yet lack the 'substantial nexus' with that State as required by the Commerce Clause." *Id.* at 313.

// Challenges have been brought on grounds that state regulations applied against out-of-state persons violate Due Process and Equal Protection guarantees, the right to travel, and other constitutional rights. Because most of these claims were dismissed out-of-hand by the courts and are not readily applicable to telehealth, they are not included in this discussion.

// "The Commerce Clause of the Constitution grants Congress the power '[to] regulate Commerce with Foreign Nations, and among the several states, and with the Indian Tribes.' Art. I, § 8, cl. 3. 'Although the Clause thus speaks in terms of powers bestowed upon Congress, the Court has long recognized that it also limits the power of the States to erect barriers against interstate trade.'" *Maine v Taylor*, 477 U.S. 131 (1986).

regulate matters of "legitimate local concern" even though interstate commerce may be affected.// When examining whether a particular telehealth statute violates the Commerce Clause, courts would engage in a three-prong analysis:

1. Does the challenged statute discriminate against interstate commerce on its face or in practical effect?

2. Does the statute serve a legitimate state purpose?

3. If the statute serves a legitimate state purpose, would alternative means promote this purpose as well without discriminating against interstate commerce?

Statutes that burden interstate transactions only incidentally violate the Commerce Clause if the burdens imposed on interstate trade are "clearly excessive in relation to the putative local benefits."// Courts have upheld statutes requiring out-of-state entities to obtain a license to engage in the selling of insurance//, the practice of accounting//, and the practice of medicine// within the state. In these situations, the court found that the burden of obtaining a license was outweighed by the need to protect important state interests. Because telehealth consultations affect the health and well-being of individuals physically located in the state, states arguably have a "legitimate local interest" in ensuring that out-of-state telehealth providers meet the same standards as individuals licensed within the state. The extent to which a particular telehealth statute imposed burdens on out-of-state

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// *Maine v Taylor*, supra. State of Maine was allowed to prohibit import of baitfish in order to protect the health and integrity of native species.
// *Id.*

// *California v Fairfax Family Fund*, 347 Cal. Rptr. 812 (Cal. Dist. Ct. App. 1964) appeal dismissed, 382 U.S. 1. "The Commerce Clause does not preclude a state from giving needful protection to its citizens in the course of their contacts with businesses conducted by outsiders when the legislation is general in scope, is not aimed at interstate or foreign commerce, and merely involves burdens incident to effective administration."
// *Mercer v Hemmings*, 170 So. 2d 33 (S.Ct. Florida 1964). A state may require a license and a reasonable fee from out-of-state concerns doing business within its borders, as well as conformance with provisions designed to assure their integrity in dealings with citizens, even though such concerns are engaged in interstate commerce. The court reasoned that to allow out-of-state certified public accountants to perform unlimited engagements in the state without regard to the state's standards of proficiency and completely independent of the Board and its licensing requirements, would not only be grossly unfair to resident public accountants, but would inevitably result in a lowering of standards.

// *Slocum v. City of Freedonia*, 134 Kan 853; 8 P.2d 332 (S.Ct. Kansas 1932) A Missouri doctor who saw patients in Freedonia, Kansas one day a week and then shipped medications from his facility in Missouri was practicing medicine in Kansas and was required to obtain a license. The fact that the medications were shipped across state lines did not constitute interstate commerce.

providers and interstate trade would have to be weighed against the benefits of regulation.

Where a statute affirmatively discriminates against interstate trade, the state must demonstrate that the statute serves a legitimate local purpose which cannot be served as well by available nondiscriminatory means.// However, even overt discrimination against interstate trade may be justified where out-of-state goods or services are particularly likely for some reason to threaten the health and safety of a state's citizens and where outright prohibition, rather than some intermediate form of regulation, is the only effective method of protection."// Thus, if a telehealth procedure (i.e. telesurgery) posed greater than normal risks to the public, a state may be justified in strictly regulating it if no other alternative means of regulation would protect the public as well.

State laws which shield in-state industries from economic competition are almost always invalid. Courts will sometimes look to the motivation underlying a law to determine whether the stated reasons for regulation are a pretext for economic protectionism.// To the extent that a licensure law is enacted to protect in-state providers from competition, the law may be subject to legal challenge.

Finally, regulations which impose unduly burdensome requirements on out-of-state residents may be invalidated under the Commerce Clause. The degree of regulation must be proportionate to the evils that exist if the profession is left unregulated. A licensure procedure may not impose charges or expenses greater than reasonably necessary to defray the administrative cost involved nor may it impose residence or other requirements that make it impossible for out-of-state professionals to comply with.// Thus, state licensure requirements which impose residency or unusually high fee for out-of-state providers would likely be unconstitutional.

CONCLUSION

Many telehealth providers argue that they are not physically going into a state when practicing telehealth. Rather, they maintain, the patient is "travelling" to them via the electronic highway. Therefore, they reason, a state should not be able to regulate their telehealth activities any more than states currently regulate situations where patients drive or fly across state borders to see them.

While this argument makes logical sense, there is no law which will compel a state to reach this conclusion. Should a state desire to regulate out-of-state providers who maintain regular contacts with patients in the state, the provider can arguably be required to comply with the same regulations as in-state providers.

Should Congress decide to act in this area, it may preempt state laws that require licensure of out-

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// *Maine v Taylor*, supra.

// *Id.*

// *Quality Brands v Barry*, 715 F. Supp. 1138 (U.S. Dist. 1989) A District of Columbia law requiring liquor sold in the District to be warehoused in the District was motivated solely by economic protectionism and was thus invalid.

// *Mercer v Hemmings*, supra.

of-state telehealth providers. Until such time, states can arguably impose whatever reasonable requirements deemed necessary to protect the health and safety of their citizens.

Report of the Sexual Misconduct Focus Group

Focus Group Members

Jean Stevens, WA, Area I, *Chair*
Neysa Somple, OH, Area II
Judith Ryan, MD, Area IV
Betty Ann Taylor, *Consultant*

Staff

Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to Organization Plan

Goal II..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective D ..... Provide for Member Board needs related to disciplinary activities.

Recommendations to the Board of Directors

1. **That the National Council distribute to Member Boards and promote the use of the educational packets developed to assist in raising awareness regarding professional boundaries and issues regarding professional sexual misconduct.**

   Rationale

   One sexual misconduct case is likely to cause great harm to the client, consume extraordinary resources and damage the credibility of Boards which fail to pursue such cases. Early in their study of the topic of professional sexual misconduct, the focus group members were convinced that boards of nursing need to promote education of students, licensed nurses, and consumers as well as board of nursing members and staff. Raising awareness of the issue may promote earlier detection of serious offenders. Those offenders categorized in the literature as situational offenders and those grouped in the uninformed/naive category may be prevented from "slipping down the slippery slope" by such educational efforts. Boards should attempt to prevent what they can through educational efforts, and intervene when serious predator behavior is identified, to separate that individual from practicing.

2. **That the National Council produce a video addressing professional boundaries for use by Member Boards to orient new board members, staff, investigators and attorneys as well as to educate students, nurses and the public. The focus group suggests that the video be provided to Member Boards as a membership benefit, but also made available for sale to educators, employers and other entities.**

   Rationale

   The importance of professional boundaries must be stressed as a tool to allow safe connection to meet client needs. Boundaries are difficult, complex, and need to be discussed, read about, and carefully considered by students, nurses and employers. A video based on the concept of professional boundaries would be a valuable resource to make available to Member Boards. This is a topic that needs to be presented sensitively, to focus students and licensees on the "Zone of Helpfulness" described in the task force's 1995 paper (underinvolved professionals can harm, also). A video would provide opportunity to approach this topic in a manner that is interesting and stimulating. The focus group predicts that this would be a sought-after product.

Background

The Sexual Misconduct Focus Group began its work in 1995, developing a monograph on *Disciplinary Guidelines to Manage Sexual Misconduct Disciplinary Cases*. The focus group recommended several additional activities to the Board of Directors to add to Member Board resources in this area. The focus group noted that while the numbers of cases involving sexual misconduct is not large, these cases are high profile, high stakes, and very costly for boards of nursing to prosecute. In 1995, the focus group members recommended that the Board also develop educational materials to promote awareness not only of professional sexual misconduct issues, but also of the importance of

maintaining professional boundaries. The Board of Directors charged the focus group to build upon the 1995 work to develop such resources.

Highlights of Activities

- ***Dialogue on Discipline* and *Disciplinary Resources Notebook***
  The focus group members were pleased for the opportunity to collaborate with the Complex Discipline Cases Subcommittee to plan and implement the *Dialogue on Discipline,* and to contribute materials regarding professional boundaries and professional sexual misconduct to the Complex Discipline Cases Subcommittee' *Disciplinary Resources Notebook.*

- **Professional Boundaries Video Concept**
  The focus group proposed the concept and content for a video to be produced by the National Council addressing professional boundaries. This idea was shared with the Special Services Division and is under review as a possible project.

- **Board Educational Packet**
  The main focus for the focus group work this year has been the development of an educational packet for use by Member Boards in raising awareness regarding professional boundaries and professional sexual misconduct issues (see Attachment A). The packets include the 1995 monograph, reference guides (a series of booklets, each targeted for a separate group including board members, board staff, nursing faculty and nursing employers), and two separate brochures, one designed for nurses, the second designed for the public. The focus group hopes that these educational materials will be useful and widely used.

- **Future Considerations**
  A research project analyzing complaints, processes and actions taken in discipline cases reported to the National Council Disciplinary Data Bank with the codes in the sexual misconduct and professional boundaries categories has begun. The results of this study will provide additional information regarding the nature and extent of professional boundary and sexual misconduct cases, the remedies used by boards of nursing, the effectiveness of disciplinary actions. The results will be shared with Member Boards as a resource in the management of this type of complaint.

Meeting Dates

- November 17, 1995
- February 15-17, 1996
- April 19, 1996

Recommendations to the Board of Directors

1. That the National Council distribute to Member Boards and promote the use of the educational packets developed to assist in raising awareness regarding professional boundaries and issues regarding professional sexual misconduct.

2. That the National Council produce a video addressing professional boundaries for use by Member Boards to orient new board members, staff, investigators and attorneys as well as to educate students, nurses and the public. The focus group suggests that the video be provided to Member Boards as a membership benefit, but also made available for sale to educators, employers and other entities.

Attachment

A .....List of Contents for *Preventing Sexual Misconduct: A Resource Packet for Boards of Nursing, page 3*

Attachment A

Preventing Sexual Misconduct: A Resource Packet for Boards of Nursing

The following is a list of educational materials developed by the Sexual Misconduct Focus Group for use by boards of nursing. The focus group will first distribute these materials at the *Dialogue on Discipline* educational program, scheduled for August 5, 1996. Entitled *Preventing Sexual Misconduct: A Resource Packet for Boards of Nursing,* the resource will also be available for review at the Annual Meeting. Later in August, the packets will be sent to each Member Board for use in promoting awareness of professional boundary issues and professional sexual misconduct among a variety of audiences. Several of the documents were designed specifically for the audience named in the title.

Introduction and Suggestions for Use

Disciplinary Guidelines for Managing Sexual Misconduct Cases
The 1995 Monograph which provides the basis for the task force's work.

Quick Reference for Board of Nursing Members
A booklet providing information needed by board members to assist them in reviewing and evaluating cases involving professional boundaries and/or sexual misconduct.

Quick Reference for Board of Nursing Staff
A booklet providing information needed by board staff at all levels, to assist them in receiving complaints and managing cases involving professional boundaries and/or sexual misconduct.

Quick Reference for Nursing Employers
A booklet designed to inform nursing employers regarding professional boundaries and sexual misconduct, the employer's responsibilities, some warning signs of potential problems as well as some preventive strategies.

Quick Reference for Nursing Faculty
A booklet designed to encourage faculty to promote attention to these professional boundaries and sexual misconduct, the employer's responsibilities, some warning signs of potential problems as well as some preventive strategies.

Professional Boundaries - A Nurse's Guide to the Importance of Appropriate Professional Boundaries
A brochure designed for nurses and nursing students regarding professional boundaries.

Expectations - A Consumer's Guide to the Importance of Appropriate Professional Boundaries
A brochure designed for consumers regarding professional boundaries.

What Should I Expect - A Consumer's Guide
A brochure designed for consumers regarding what should be expected from their health care providers.

The Sexual Misconduct Focus Group believes that these educational materials will assist Member Boards to raise awareness among a variety of audiences of the issues surrounding professional boundaries as well as sexual misconduct.

Report of the Task Force to Analyze Advisory Opinions/ Rulings

Task Force Members
Timothy McBrady, ME, Area IV, *Chair*
Mary Hanes Griffith, AZ, Area I
Nathan Goldman, KY, Area III
Alice Enderlin, IL, Area II

Staff
Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to Organization Plan
Goal II ..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B ..... Provide resources regarding health care issues which affect the regulation of nursing practice.

Recommendations to the Board of Directors

1. **That the National Council promote the Decision Tree for Interpreting Scope of Practice Issues and Guidelines for Developing Advisory Opinions.**

   Rationale
   Boards of nursing receive daily inquiries regarding nursing practice issues. Member Boards vary greatly as to the approaches used to respond to such contacts. The Task Force to Analyze Advisory Opinions/Rulings developed a Decision Tree that could used to guide consideration of scope of practice issues. The Decision Tree could be also be used as an educational tool when presenting presentations regarding the regulatory process to a variety of audiences. Although not all boards are authorized to issue Advisory Opinions, the task force has developed guidelines that may be of assistance to jurisdictions which do use the Advisory Opinion.

2. **That the National Council use the Internet (existing Web site) to collect Advisory Opinions, Declaratory Rulings, and other nursing practice related guidelines developed by member boards of nursing.**

   Rationale
   Member Boards are dealing with many of the same practice issues, and could benefit from the expertise and efforts already expended by sister boards. (In other words, why recreate the wheel if someone has already studied an issue? Build upon the existing information and analysis, adding the perspectives of multiple boards.) The task force believes that such collaboration and sharing would enrich the analysis and decision process. The National Council's Web site would provide an existing, centralized, and easily accessed locale for this information to reside.

3. **That the Nursing Practice and Education Committee serve as a clearinghouse to request data and review inconsistent positions, and offer comments and recommendations to the identified Member Boards.**

   Rationale
   One concern identified by task force members regarding increasing access to such practice resources was the possibility of inconsistent information and positions. Recognizing that differences are frequently semantic in nature, or the result of incomplete information, etc., the task force suggests that the Nursing Practice and Education Committee, in its coordination role and with its access to multiple information sources, might well serve to review such inconsistencies and offer comments to the involved boards. The task force viewed this as a way of promoting consistency in the licensing and credentialing process (Goal I, Objective G in the National Council Organization Plan).

Background

The Member Board use of Advisory Opinions and Declaratory Statements was last surveyed in 1990, and reported in 1991. This update on the use of these mechanisms was recommended by the Long Range Planning Task Force in 1995. The task force was charged not only to survey the issuance of but also to analyze the use of such documents.

Highlights of Activities

- **Staff Review of Member Board Statutes and Rules**
  National Council staff reviewed available Member Boards Statutes and Rules to identify those jurisdictions where such opinions/rulings were authorized, in preparation for the task force's meeting.

- **Survey of Member Boards**
  Member Boards were surveyed regarding Advisory Opinion/Declaratory Rulings to collect updated information regarding the use of such opinions/rulings (see Attachment A).

- **Development of Advisory Opinion/Rulings Paper**
  The task force used the collected information to develop a paper which includes a Decision Tree to assist in the analysis of scope of practice questions, a continuum of responses to practice issues, and guidelines for the development and maintenance of advisory opinions/rulings (see Attachment B).

Meeting Dates

- November 6, 1995
- March 6-7, 1996

Recommendations to the Board of Directors

1. That the National Council promote the Decision Tree for Interpreting Scope of Practice Issues and Guidelines for Developing Advisory Opinions.

2. That the National Council use the Internet (existing Web site) to collect Advisory Opinions, Declaratory Rulings, and other nursing practice-related guidelines developed by Member Boards of Nursing.

3. That the Nursing Practice and Education Committee serve as a clearinghouse to request data and review inconsistent positions, and offer evaluation and recommendations to the identified Member Boards.

Attachments

Attachment A

March 1996 Advisory Opinions Survey Results as of 5/6/96

National Council of State Boards of Nursing
Task Force to Analyze Advisory Opinions
Survey Questionnaire
n = 39

The Task Force to Analyze Advisory Opinions has been charged to analyze current board rules and practice regarding the issuance of advisory opinions/rulings in response to practice questions. The purpose of this survey is to collect updated information regarding the use of such opinions/rulings. Feel free to attach additional sheets for your responses and comments. Your answers to the following questions will assist the task force their consideration of this topic.

Section I (for all Boards)

1. Does your Board of Nursing issue some type of practice ruling (e.g., advisory opinions, declaratory statements or some other type of formal statement in response to questions about practice issues?
   23__ Yes, go to questions 5 through 17.
   7__ No, continue with questions 2 through 4.
   1__ **Comment: "We have the authority but have never issued a declaratory order" - CO**

2. If the answer to question #1 is NO, is it because (check all that apply)
   5__ the Board lacks statutory/rule authority
   5__ advice of legal counsel
   1__ have been legally challenged for issuing in past*
   1__ other (please identify specific reasons:
   "A written reply may be provided in response to a particular practice question" - IL

   ***OH: Supreme Court decision specifically on Board of Nursing Practice Statement.**

3. If the answer to question #1 is NO, the Board has never sought such authority because (check all that apply):
   2__ never requested to do so
   4__ advice of legal counsel
   0__ too controversial
   1__ not consistent with Board philosophy
   0__ more trouble than they are worth
   2__ difficult to maintain currency of information
   2__ other (please identify):
   "There has been no current discussion on this issue by the Committee on Nursing." - IL
   "Have a law which affects many which would need to be changed to allow this. Board would love to have authority - difficult to achieve." - OH

4. If the answer to question #1 is NO, how does the Board deal with practice questions that are brought to its attention?
   0__ Board does not respond to practice questions
   6__ Board staff respond by phone only (nothing written)
   2__ Board staff respond by letter
   3__ Board staff respond by letter after Board review/approval

3__ Board has developed other resources for use in disseminating information regarding selected topics - e.g., decision tree (please identify other resources used):
"Board believes health care changes so constantly, declaratory orders not best way to deal with issues." - CO
"Board statement on scope of practice (enclosed)." - GA-RN
"Newsletter articles. Decision tree standards and delegation rules." - OH

If you answered NO to question #1 and have responded to questions #2, 3 and 4, you are done with this survey. Thank you for your participation. Please go to the end of the questionnaire for signature and directions for returning survey.

Section II (additional section for those Boards of Nursing which issue Advisory Opinions or Declaratory Statements)

The Task Force to Analyze Advisory Opinions has developed the following working definition:

Advisory opinion/ruling: *a statement developed by a Board of Nursing to provide guidance, clarification and direction regarding identified issues. Such statements advise without the force and effect of law.*

5. Some Boards of Nursing may use different terms to describe such a statement. Please indicate the language used in your jurisdiction:
   7__ Advisory Opinion
   3__ Declaratory Statement
   15__ Other (please identify):

   Declaratory Order. Informed opinion. Guidelines. Board Opinion. Advisory Ruling. Declaratory Order. Policy Statements. Interpretive Statements. Practice decisions. Statement On...* Board Policy On... Position Statement. Not legally binding but set a precedent. Is an indicator of what Board is likely to find if asked to rule. Advisory Opinion - Also a position statement at times. Relevant past specific decisions of the Missouri State Board of Nursing

   ***"Used to title document developed in response to "hot topic" or frequently asked question. Used infrequently." - MS**

6. Is the task force's definition of *advisory opinion/ruling* consistent with how the term identified in question #5 is used in your jurisdiction?
   19__ YES*
   5__ NO
   If no, please define the term used in your jurisdiction:
   CO: Rule approaches matter as defining law.
   MO: Pursuant to 526.010 (4)(b), the MSBN may issue "an interpretation...with respect to a specific set of facts and intended to apply only to that specific set of facts."
   MS: Stipulations outlined in Board Statements are required.
   TN: Has effect of law.
   IA: Declaratory ruling is binding on the agency and the petitioner and is applicable only in cir. where relevant facts and law are indist. from those contained in petition. As to other persons, a dec. ruling serves only as precedent, is not binding on agencies.

   ***FL: And only applicable to the person asking for the opinion.**

For the purposes of these survey questions, please consider the term, "advisory opinion/ruling" *to be a synonym for the language used in your jurisdiction.*

7. Please identify the source of authority for issuing advisory opinion/ruling (check all that apply):

10__ Statutory, Nurse Practice Act (please provide citation)

AZ: 32-1606(A)(2)
CA-RN: Usually related to B&P 2725 or discipline Section 2561
CO: CRS 12-38-10 8 (1)(j)
ID: 54-1404(3)
KY: KRS 314.131(2)
LA-PN: LRS 961. (2); 969. {(A) + (B), (1) + (4)} (See Law - highlighten) [ed. note: Act is attached to survey]
MA: M.G.L. Chapter 13. 5.14
MO: see attached sample
MS: 73-15-17(a)
NE: Neb. Rev. Stat. 71-1, 132.11(2).
PA: Section 2.1(k)
SC: 40-33-220(3)
TX-RN: Art. 4514, § 1 & 6

6__ Statutory, other provision of state law (please identify and provide citation)

CO: 24-4-10 5 (11)
CT: [ed. note: None cited]
FL: 120.565 FS Declaratory statement by agencies.
IA: Attached Chap. 12. 17A
ME: 5 MRSA Sec. 9001 (State APA).
WI: Board shall "define and enforce professional conduct and unethical practices not inconsistent with the law" (sec. 15.08(5)(b), Stats.)

6__ Nursing rule/regulation (please provide citation)

CA-RN: CCR 1443.5
CO: Chapter VIII
FL: 595-1.016
ME: Chapter 9.
MS: Functions of the Board(A); and Chapter II 1.2 (Unprofessional Conduct) b (Authorized Scope)
VT: Chap I B(2).

1__ Other rule/regulation (please identify and provide citation

HI: 16-201-48, HAR.

2____ Other (please identify) :

SD: Attorney General's Opinion.
TX-VN: Vocational Nurse Act - Sec 5(f.) page 4.

8. What process is used to identify topics for advisory opinions/rulings in your jurisdiction? (check all that apply)

22__ issue brought to Board by licensees (individuals)
20__ issue brought to Board by licensees (nursing organizations)
13__ issue brought to Board by consumers
19__ issue brought to Board by employers*
17__ issue brought to Board by Board staff
14__ issue brought by Board committee
8__ issue brought by other (please identify):

AZ: Any
CO: We do not use the process
CT: Those who request and are granted party status
ID: Physicians
MA: Medical Society (occasionally).
ME: Other Boards, State Agencies, Professional and other Organizations.
MO: See Practice Committee Flow Chart. Issue must be specific.
PA: Other government entities.
WI: Issue brought by other state agencies or by nursing boards in other states
***If licensees**

9. What process is used to develop content for advisory opinions/rulings in your jurisdiction? (check all that apply)

13__ issue researched by Board committee*†
3__ issue researched by Board members
19__ issue researched by Board staff*
15__ outside experts involved to develop content*‡*
12__ other (please identify):

AZ: Issue researched by entity requesting The opinion.
CA-RN: Jurisdictions
CT: Public hearings
FL: Responsibility of person asking opinion.
HI: Advised by Board Council.
IA: Relevant literature, statements from professional nursing organizations. Attorney-general staff as needed.
ID: Info. and research by requests.
KS: Sometimes
LA-PN: all or either
MS: Use NCSBN and other organizations as resource.
NE: Facilities contacted to determine practice standard.
SD: Published Literature, Member Boards rulings.

***KS: 1st/ by staff**
2nd/ content developed by Board Committee.
3rd/ by experts
†MA: Practice Advisory Committee (not a committee of Board members)
‡NE: Includes surveying other states.
SC: Sometimes.
*** MO: May provide relevant data**

10. Who drafts advisory opinions/rulings for the Board in your jurisdiction? (check all that apply)

0____ Board President
8____ Board Committee
0____ Assigned Board member
10____ Executive Director
16____ other professional staff*
7____ Board attorney†
3____ Other (please identify):

AZ: Committee Members
ID: Board.
LA-PN: Usually combination of Staff/Bd/attorney
TX-VN: (Atty General Rep) Atty General assigned to Brd.

*** KS: 1st then to Board Committee.**
† SC: Consulted on regular basis.

11. Who must approve advisory opinions/rulings in your jurisdictions? (check all that apply)

23____ Full Board*
1____ Board President
2____ Board Committee
0____ Executive Director
1____ Other professional staff
3____ Board attorney
0____ Other (please identify):

***MA: majority Board vote.**

12. How are advisory opinions/ruling shared with nurses and the public in your jurisdiction? (check all that apply)
    - 23__ upon request
    - 9__ distributed to selected mailing list (e.g., individuals interested in topic)
    - 7__ distributed to other state agencies*
    - 8__ distributed to nursing organizations*
    - 8__ distributed to hospitals, other nursing employers*
    - 3__ distributed to all licensed nurses in jurisdiction†
    - 0__ distributed to consumers (please identify mechanism for public dissemination)
    - 18__ reported in Board Newsletter‡
    - 2__ accessible electronically, e.g., via Internet**
    - 3__ other (please identify):
        - **AZ: Filed with Secretary of State for Public Access**
          Kept nearby in Board office.
        - **CA-RN: Mailing list of Board Committees**
        - **FL: Representatives from Florida Nursing Association and Florida Hospital Association distribute information following attendance at board meetings.**
        - **LA-PN: To schools with P.N. programs.**

        - ***VT: If Appropriate**
        - **†SC: By newsletter**
        - **‡VT: Selected opinions.**
        - **MS: (includes nsg employers, all licensed ns, state nsg org, other Bds)**
        - ****SC: Soon**
        - ****AZ: Soon**

13. How are advisory opinions/rulings maintained in your jurisdiction? (check all that apply)
    - 23____ paper files
    - 6____ computer disk/tape
    - 5____ computerized database
    - 1____ other (please identify):
        - **MO: Log**

14. How are advisory opinions/rulings used in your jurisdiction? (check all that apply)
    - 22__ to respond to practice questions received by the Board
    - 18__ as handouts distributed during Board of Nursing presentations
    - 16__ as educational resources for educators, students, licensees, consumers, and others
    - 19__ as orientation materials for new board members, staff, attorneys
    - 1__ other (please identify):
        - **FL: They are sent to individuals asking for similar rulings, but cannot be used by them as permission.**

15. What have been the benefits of issuing advisory opinions/rulings?
    - **AZ We think it decreases phone calls**
    - **CA-RN It helps to provide a clear interpretation of the statues and regulations. Responds to a [illegible] environment [illegible]...**
    - **CT More fluid than regs.; usually provide framework, not laundry list**
    - **FL Advises person asking for the statement if they can or cannot perform a certain function. Occasionally results in a change of Board rule.**
    - **HI Consistency, uniformity in interpretation of statutes or rules. Education tool for new members and anyone interested in procedure or actual ruling on specific topic.**
    - **IA Establishes parameters for practice-Facilitates nurses' ability to expand practice.**
    - **ID Nurses like direction from the Board**
    - **KS Saves time; do not have to reproduce in letter form over and over. Consistency.**

LA-PN **Employers feel more secure/ Sometimes licensees feel more secure and confident that they are within scope of practice/ Individuals prefer that Board "authority" has reacted.**

MA **Clarify scope of practice for both RNs/LPNs. Educate individual licensees employers, educators, consumers, about the criteria for making decisions about safe practice.**

ME **NO COMMENT!**

MO **See items checked in #14**

MS **Standardized Reply**
Forces more indepth examination of issue. Therefore, removing or diluting personal opinion/ personal experiences impact.

NE **Assists licensees with decision making regarding practice issues. Provides a service- we do the research.**

PA **None.**

SC **Consistency in interpretation of NPA by all employees and Board members.**

SD **Clarification of scope of practice to nurses and public, provides for evolution of practice in less formal and costly manner than rule promulgation.**

TN **Addresses questions authoritatively.**

TX-RN **They clarify the Board's position on new/emerging issues in nursing practice where the borders of scope of practice are pushed beyond traditional nursing practice.**

TX-VN **Helps to clarify rules and regulations. Clarifies issues for employers and licensees. Assists public (consumers) to know what to expect.**

VT **Consistency, education.**

WI **The Board be more specific/provide more guidance on a particular issue than expressed in rules. The Board may educate a wide audience with a position which is current and crucial to practice in a variety of settings.**

16. Has your Board experienced legal challenges or other problems as a result of issuing advisory opinions/rulings?

21__ NO

2__ YES (please describe in the space provided below):

ID: **Not until we incorporated some decisions or examples of scope in rules, have shared all decisions with the Board of Medicine but they are contesting some- or part of legislative review.**

NE: **Authority to issue opinions was questioned.**

17. If the answer to question #16 is YES, briefly describe how your Board resolved these problems:

ID: **We have a joint meeting scheduled- at direction of Legislative Committee- to review the area in question.**

NE: **Continued to issue them and then put the authority in the statute.**

Additional comments for consideration by the Task Force:

ID: **Once the practice rules are finalized the Board does not plan to issue any further opinions but to help nurses problem solve with provisions in the rules. The Idaho Board has issued practice decisions based on the statutory power "to establish standards of practice." Generated pages of decisions, become cumbersome to man. and restrict. to prac. Have prac. rules in progress, will have criteria/statements.**

LA:PN: **Opinions are limited - 3 -11x7 pages - since 1948. Board tries not to issue unless feels absolutely essential for safety, health and welfare of consumer/ Now confronted with "delegation" issues.**

MA: **The Board has adopted a decision making model (based on models used by other Boards) which the Practice Advisory Committee and Board apply to each other.**

ME: **It would be helpful to have the committee discuss the pros and cons of issuing advisory rulings.**

MO: **See attachments**

NE: **A centralized, computerized data base of opinions available through NCNET would be a wonderful resource.**

PA: **Opinions are more trouble than benefit. Recipients do not know how to use them. "Decision-making model" has been very helpful.**

Board of Nursing: _____
Signature _____
Title: _____ Date: _____

Please return completed questionnaire by March 1, 1996 to:

Vickie Sheets, Director for Nursing Practice and Education
National Council of State Boards of Nursing
676 N. St. Clair Street, Suite 550
Chicago, Illinois 60611-2921

The Task Force Members thank you for your interest and participation.

Percentage Breakdown:

1 = 3%	9 = 23%	17 = 44%	25 = 64%	33 = 85%
2 = 5%	10 = 26%	18 = 46%	26 = 67%	34 = 87%
3 = 8%	11 = 28%	19 = 49%	27 = 69%	35 = 90%
4 = 10%	12 = 31%	20 = 51%	28 = 72%	36 = 92%
5 = 13%	13 = 33%	21 = 54%	29 = 74%	37 = 95%
6 = 15%	14 = 36%	22 = 56%	30 = 77%	38 = 97%
7 = 18%	15 = 38%	23 = 59%	31 = 79%	39 = 100%
8 = 21%	16 = 41%	24 = 62%	32 = 82%	

Task Force to Analyze Advisory Opinions Member Board Survey Summary

Summary of major points from the survey compiled regarding advisory opinions, declaratory statements

Area	Juris.	Issue, Yes	Issue, No	No authority	No per Atty	Advisory Opinions	Declaratory Statement	Other	Agree TF definition	Challenges	Comments
1	AK	X									
3	AL										
3	AR	X						X	X		Position Statement
1	AS					X			X		
1	AZ	X				X			X		
1	CA-RN	X						X	X		
1	CA-VN	X						X		X	Board opinion, policy*
1	CO	X*									*Have never issued
4	CT	X					X		X		
4	DC										
4	DE										
3	FL	X					X		X		
3	GA-RN										
3	GA-PN										
1	GU										
1	HI	X					X		X		
2	IA	X									
1	ID	X								X	
2	IL		X	X							
2	IN										
2	KS	X						X	X		
3	KY	X				X			X	X	
3	LA-RN	X				X	X	X	X		
3	LA-PN	X						X	X		
4	MA	X							X		
4	MD	X						X			Declaratory Ruling*
4	ME	X				X			X		
2	MI		X	X	X						
2	MN		X	X	X						
2	MO	X						X			Relevant Past Bd Decisions
1	MP										

Task Force to Analyze Advisory Opinions Member Board Survey Summary

Summary of major points from the survey compiled regarding advisory opinions, declaratory statements (continued)

Area	Juris.	Issue, Yes	Issue, No	No authority	No per Atty	Advisory Opinions	Declaratory Statement	Other	Agree TF definition	Challenges	Comments
3	MS										
1	MT										
3	NC	X						X			Interpretive Statement*
2	ND	X				X			X		
2	NE	X				X			X		
4	NH									X	
4	NJ										
1	NM		X		X						
1	NV										
4	NY										
2	OH										
3	OK		X		X						
1	OR										
4	PA	X						X	X		
4	PR										
4	RI										
3	SC	X				X			X		
2	SD	X				X			X		
3	TN	X						X			
3	TX-RN										
3	TX-VN	X						X	X		
1	UT		X	X							
3	VA										
4	VI										
4	VT	X						X	X		
1	WA	X				X					
2	WI					X		X	X		
2	WV-RN										
2	WV-PN										
1	WY										

Attachment B

Responding to Practice Inquiries

Introduction and Purpose
Boards of nursing receive hundreds of calls and letters from nurses, employers, other health care providers, insurers, and consumers regarding nursing practice issues. Boards use a variety of methods to respond to these calls, working under different provisions of various jurisdictional law and policies. One formal approach to practice issues is the issuance of an advisory opinion/ruling. The purpose of this paper is to present the results of a study regarding the issuance of advisory opinions/rulings by boards of nursing.

Background
In 1990, the National Council conducted a survey of Member Boards regarding their use of declaratory statements (DS) and advisory opinions (AO). The results of this survey were reported in the 1991 *Book of Reports*. Eleven boards had reported the authority to use both declaratory statements and advisory opinions. Twenty-one boards had indicated authority to issue declaratory statements (the 11 which could issue either DS or AO, plus an additional 10 boards which could issue DS). Twenty-one boards had indicated authority to issue advisory opinions (the 11 which could issue either DS or AO, plus an additional 10 boards which could issue AO). Six boards responded that the terms were interchangeable; 32 boards indicated that they were not.

In the fall of 1995, the National Council Board of Directors appointed a task force to re-look at the use of advisory opinions by boards of nursing. The Task Force to Analyze Advisory Opinions/Rulings was directed to analyze current board rules and practices regarding the issuance of advisory opinions/rulings responding to practice questions.

Data Collection
In order to complete its charge, the task force analyzed information obtained through a literature review, a staff review of the statutes and/or rules of jurisdictions which authorize advisory opinions/rulings and/or declaratory statements/ rulings, a review of case law and the results of a survey of Member Boards.

Literature Review
Most references in the legal literature addressing advisory opinions focused on how the federal judiciary has avoided advisory activity. Since the early days of the republic, there has been a general rule based on policy considerations, against justices and judges issuing advisory opinions (Dahlquist, 1983, p.48). The very nature of the judicial process is characterized by resolution of controversial points of law in the course of deciding disputes - based on a given set of facts, the presentation of competing advocates and the process of adjudication (Jaconelli, 1985, p. 587). But even judiciary decisions, focused on dispute resolution, have a public aspect, "...which looks to the articulation and refinement of rule and principles for the guidance of the community as a whole..." (Jaconelli, 1985, p. 588). Other articles dealing with advisory opinions or declaratory statements were articles that dealt with topics unrelated to the regulation of health care (e.g., tax, patent, federal issues).

Unlike the judiciary branch of government that is identified in the Constitution, administrative law is a branch of civil law that has developed in response to an increasingly complex society. The administrative agency could be described as a hybrid governmental entity, which may be called on to perform functions reflecting all three branches of government: legislative, executive and judicial. Compared to the legislative process or judicial process, the administrative or regulatory process offers more flexibility and the specialized staffing needed to accomplish control of complex activities and functions in order to protect the public. If a field requires specialized knowledge or a field is rapidly changing, legislators may be unable to specify detailed requirements and standards. An agency with flexible decision-making policies and ongoing responsibility for a limited subject matter may be better able to develop sound policy. Regulatory agencies are creations of statute, and agency authority is a delegated authority. The administrative process must aim to maintain flexibility while providing adequate legal procedural checks to prevent unrestrained government power (National Council, 1994).

This administrative response to the evolution of a complex, technical society is also reflected in the need of agencies to inform and educate their constituents and consumers. In many situations, further direction and interpretation of statutes and rules may be requested. Rather than wait for a dispute which requires an agency to react, some agencies have found it useful to suggest efficient ways of complying with agency rules.

Review of Statutes and Regulations

National Council staff reviewed the board of nursing statutes and regulations/rules that had been scanned into the National Council Member Boards' statutes and regulations computer database as of January 1, 1996. Using a WordPerfect word search, the files were reviewed for references to the words *advisory, declaratory,* and *opinion.* The following 18 boards were identified as having language addressing advisory opinions/rulings and declaratory statements: *Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Iowa, Kentucky, Louisiana-PN, Louisiana-RN, Maryland, Michigan, New Hampshire, Nevada, Oregon, South Dakota, Texas-RN, and Washington.*

Review of Case Law

A computerized search for legal cases was conducted. No specific cases on point were discovered in the search.

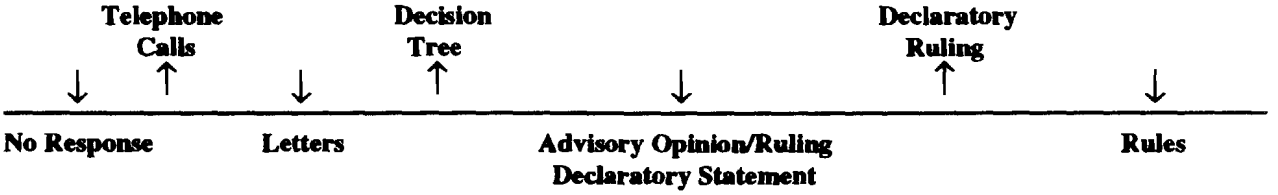
Member Board Survey Results

The task force members assisted in the development of a Member Board survey regarding the use of advisory opinions/ rulings. Thirty-nine Member Boards responded to the questionnaire. The results of the survey are compiled in Attachment A.

Development of a Practice Response Continuum and a Decision Tree

The task force members determined that, in addition to presenting information regarding the use of advisory opinions, they hoped to develop some useful resources for all Member Boards to assist in responding to practice questions. After preliminary review of the survey results, the task force developed a continuum to categorize the variety of approaches used by Member Boards in responding to practice issues. See Figure 1.

Figure 1. A Practice Response Continuum Illustrating Various Approaches to Practice Issues



Definitions

Decision Tree - *a resource developed to assist licensed nurses to interpret the applicability of law and rules to a given practice situation.*

Advisory Opinion/Ruling or Declaratory Statement - *a statement developed by a board of nursing to provide guidance, clarification and direction regarding identified issues. Such statements advise all licensees without the force and effect of law.*

Declaratory Ruling - *an opinion issued by a board of nursing, applicable only to extent of the facts presented in a petition, and binding upon both the board and the petitioner, but not other individuals. Such rulings may predict how a board may rule in similar circumstances but are not binding on future board decisions.*

The continuum represents a number of approaches currently used by Member Boards to respond to practice questions. The level of formality of the responses increases as the reader progresses toward the far right, which is the promulgation

of rules. No Member Board indicated not responding at all to practice inquiries. The survey results indicated that all responding boards do use informal responses by staff via telephone or correspondence.

Seven boards indicated authority to issue advisory opinions. Three boards issue declaratory statements. Fifteen boards indicated that different terms are used to describe such statements. These varied terms include: *Declaratory Order, Informed Opinion, Guidelines, Board Opinion, Advisory Ruling, Policy Statement, Interpretive Statement, Practice Decision, Statement on ..., Board Policy on ..., Position Statement,* and *Relevant Past Decisions of the ... Board.* The most formal approach to a practice concern would be the revision or addition of administrative rules addressing the topic.

From a legal perspective, where a board falls on the continuum is determined by two factors. First, there needs to be enabling authority granted to the board, either in the Nurse Practice Act or the Administrative Procedure Act, or other legislation. The second legal issue is the potential yet unintended binding effect of advisory activity, which can usually be easily dealt with via an appropriate caveat or advisement reiterating the advisory nature of the statement. Many attorneys, possibly in part due to their exposure to judiciary reluctance toward advisory activity, would prefer that their clients not be in the business of issuing statements that are advisory in nature. From a philosophical and policy perspective, it can be informative, instructive and advancing of board objectives to issue such opinions when authorized.

Decision Tree

In addition to developing the continuum, the task force members were aware that some boards have developed and use scope of practice decision trees. These decision trees can be promoted to guide the thought process of nurses who are attempting to resolve scope of practice decisions. Several boards have developed scope of practice guidelines, including: *Arizona, Kentucky, Missouri, Ohio* and *Pennsylvania* (there may be additional boards which have developed similar models but did not mention this on the survey).

While the formats and diagrams illustrating these various boards' approaches to the concept of a scope of practice decision tree differ, all the efforts reflect the desire to provide information to constituents in a manner that promotes individual nurse review and analysis of scope of practice issues. The task force offers this resource to assist Member Boards to deal with practice inquires, both telephone and written. The task force also promotes the Decision Tree as an educational tool for nurses, employers, and students. The Decision Tree, illustrated in Figure 2, was modeled on the work of the Kentucky Board of Nursing.

The first step for a nurse in using the Decision Tree involves consideration of the act to be performed and review of the scope of practice for the nurse's licensure level. The scopes of practice included in the task force's Decision Tree are adopted from the National Council's *Model Nursing Practice Act* and *Model Nursing Administrative Rules*. If an act is not expressly permitted by the scope of practice for the licensure level, e.g., performing brain surgery by an RN, then it is prohibited and the nurse need go no further. If the act clearly falls within the scope, e.g., an LPN performing tracheal suctioning as delegated by an RN team leader, then the nurse proceeds to step 3. If the nurse is unsure just from reviewing the scope of practice, e.g., an RN administering prescribed chemotherapy, the nurse should move to step 2, and review the various standards listed.

Steps 3 and 4 require a nurse to self assess, as to whether the nurse has both the knowledge and the clinical skills needed to perform the acts. If the answer to either question is no, then the act should not be performed until additional knowledge and skills are obtained.

If the nurse determines that he/she has adequate knowledge and skills to perform the act, then step 5 involves the nurse assessing the circumstances. In some situations, this step may reflect a tension between the nurse's perspective of what the reasonable, prudent nurse would do and what the facility expects. Note that the facility/agency policies and procedures are described as "appropriately established." But boards should be cognizant of this potential tension. On one hand, the nurse is asked to self regulate, on the other, is expected to determine whether the agency's expectations are appropriate.

Figure 2. **A Scope of Practice Decision Tree**

Developed to assist licensed nurses to interpret the applicability of law and rules in a given practice situation

1. Describe the act to be performed. Review the scope of practice for your licensure level:

RN

assessment, nursing diagnosis, setting goals, planning care strategies, implementing care, delegating care to qualified others, supervising, evaluating, teaching, managing care, maintaining client safety, collaborating with other health care members.

LPN/VN

contributing to assessment, participating in development of plan of care, implementing aspects of care as directed, maintaining client safety, participating in evaluating care, and delegating to qualified others.

APRN

assessing clients, synthesizing and analyzing data, understanding and applying nursing principals at an advanced level; providing expert teaching and guidance; working effectively with clients, families and other members of the health care team; managing clients' physical and psycho-social health-illness status; utilizing research skills; analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem, and selecting appropriate treatment; making independent decisions in solving complex client care problems; performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures; and recognizing limits of knowledge and experience, planning for situations beyond expertise, consulting with or referring to other health care providers as appropriate.

Is this act expressly permitted or prohibited by the NPA for the license you hold?

UNSURE	WITHIN SCOPE FOR YOUR LICENSE	PROHIBITED
↓	↓	↓
GO TO #2	GO TO #3	**STOP**

2. **Is the act consistent with at least one of the following standards?**

   Board of nursing standards of practice (if promulgated in jurisdiction)
   National nursing organization standards of practice
   Nursing literature and research
   Reasonable, prudent nurse in similar circumstances

   ↓ ↓

   YES **NO** ⟶ **NOT WITHIN YOUR SCOPE OF PRACTICE!**
   Go to #3

3. **Do you personally possess the depth and breadth of knowledge to perform the act safely and effectively, as acquired in a pre-licensure program, post-basic program, continuing education program or structured self-study?**

   ↓ ↓

   YES **NO** ⟶ **STOP!**
   Go to #4 **UNTIL ADDITIONAL KNOWLEDGE GAINED**

4. **Do you personally possess current clinical skills to perform the act safely?**

   ↓ ↓

   YES **NO** ⟶ **STOP!**
   Go to #5 **UNTIL CLINICAL SKILLS ARE ATTAINED**

5. **Is the performance of the act within the accepted "standard of care" which would be provided in similar circumstances by reasonable and prudent nurses who have similar training and experience and consistent with appropriately established facility/agency policies and procedures?**

   ↓ ↓

   YES **NO** ⟶ **STOP!**
   PERFORMANCE OF ACT MAY PLACE BOTH PATIENT/CLIENT AND NURSE AT RISK!
   Go to #6

6. **Are you prepared to accept the consequences of your action?**

   ↓ ↓

   YES **NO** ⟶ **THE ACCOUNTABILITY IS NOT ASSUMED!**
   PERFORM THE ACT* **NOTIFY APPROPRIATE PERSON(S)**

   "*With valid order when necessary, and in accordance with agency policies and procedures*

Suggested Guidelines for Development of Advisory Opinions

According to the survey results, boards of nursing vary considerably regarding the use of advisory opinions. The task force developed suggested guidelines for consideration by boards which do issue this type of statement. Boards of nursing should retain flexibility in process. In some situations, the board may wish to proceed in a different sequence, e.g., a board may request legal opinion prior to writing draft opinion, or may wish to obtain additional public comment prior to issuing opinion.

Practice questions may be submitted to a board from a variety of sources—employers, facilities, agencies, or individuals. Board members may propose a topic for consideration. The *Scope of Practice Decision Tree* and information regarding the board's process for developing advisory opinion can be forwarded to entity, and a board staff member may explain how the Decision Tree can be used to evaluate practice situations. In some situations, the Decision Tree may enable the entity to analyze the practice situation and the question is resolved.

If the Decision Tree does not address the issue sufficiently, then a board advisory opinion is requested. The board, in its discretion, reviews request and determines that a advisory opinion may be needed. Data are collected. This information may be provided by requesting entity, may be obtained by board of nursing staff/members, or expert consultant. Relevant data may include but are not limited to:

- Existing literature, research
- Information on standard of care (local community, region, national)
- Statements and positions of professional organizations, groups
- Information about education and available training
- Description of Decision Tree inadequacy for situation
- Public hearing for interested parties (licensees, consumer input)

Initial review and analysis, and preliminary recommendations may be done by board staff, board consultant, board committee, or other board-appointed group.

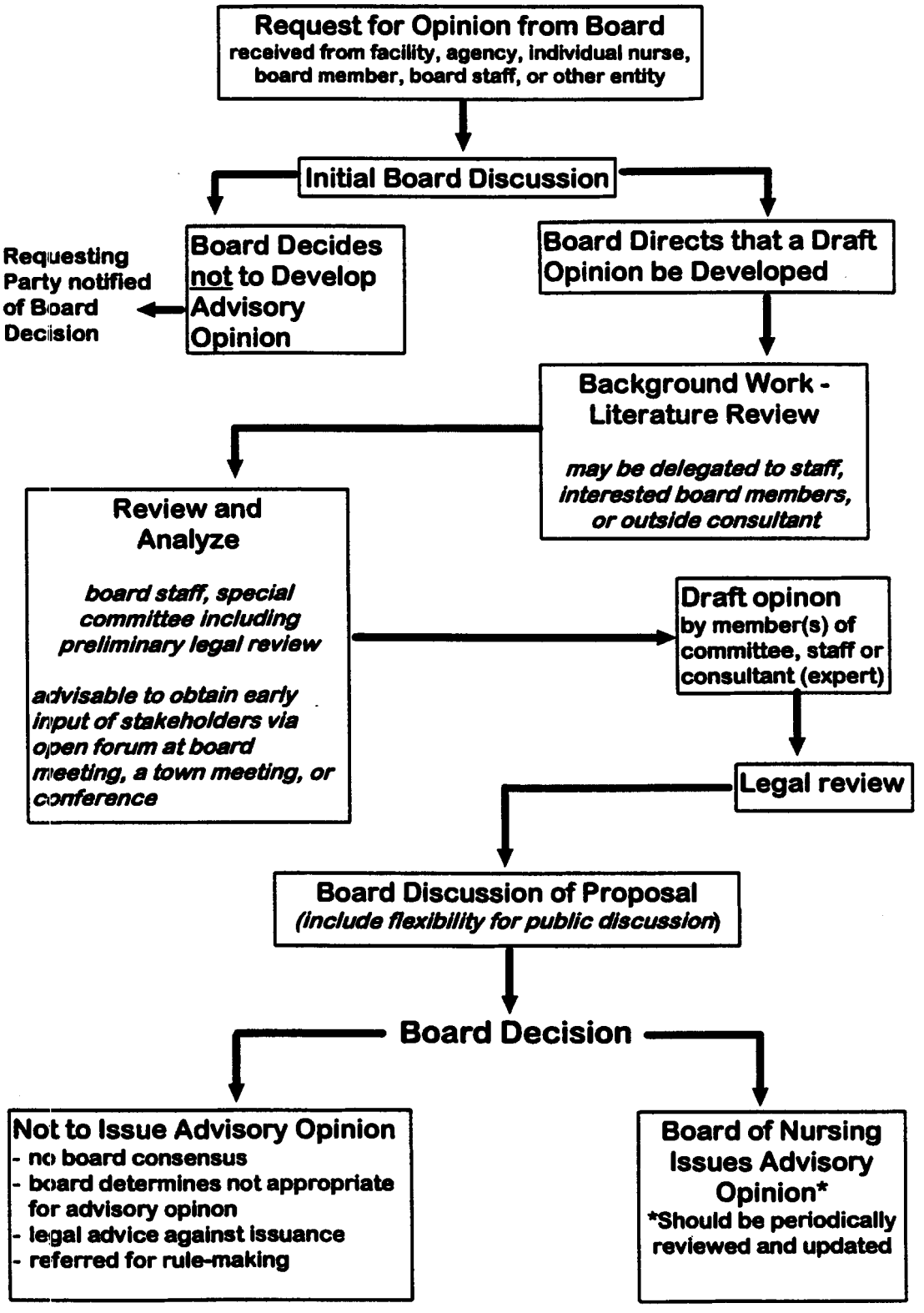
A draft advisory opinion may be prepared by board staff, board consultant, board committee, or other board-appointed group. Legal review should be obtained and any attorney recommendations forwarded to the board.

Board review and discussion, including legal recommendations is the next step. If the proposed advisory opinion is not adopted, the board may recommend any follow-up needed. If the advisory opinion is approved and issued by the board, the board should direct staff as to distribution plan (including submitting document to National Council clearinghouse), suggested uses, promotion and recommend a schedule for future opinion review. The suggested guidelines are illustrated in Figure 3.

The task force recommends that boards maintain their flexibility in the process, and provide adequate opportunity for public input in the process. This may occur both early in the inquiry, when making the determination whether to pursue the study, or obtaining feedback regarding the draft opinion. Involving the stakeholders early and often is an advisable regulatory practice.

As important as care in development of advisory opinions is the maintenance of those opinions. Periodic review of board statements, opinions, guidelines, or whatever the term used by the board, is advisable to assure that the content is timely, accurate and reflective of current board thinking regarding a subject. In this fast-moving and changing health care environment, maintenance becomes a very important consideration. If the board cannot devote the time and resources necessary for maintenance activities, this should be a consideration in the policy determination to issue, even if authorized to do so.

Figure 3. Sample Guidelines for Issuance of Advisory Opinions/Rulings
(For use by jurisdictions which authorize the use of advisory opinions)



Discussion

Many of the contacts between regulatory boards and private parties involve requests for advice. Boards may be asked about agency policies, procedures or interpretations of statute and rules. Boards may also be looked to for technical expertise in the professional field they regulate. Many of these interactions do not rise to the level of requiring advisory opinions or declaratory statements. The most common response to inquiries is to provide information via telephone or correspondence. However, some agencies provide more formal types of advice.

The benefits of issuing advisory opinions/declaratory statements if a board is so authorized include the positive effects afforded by responsiveness to requests and include promotion of voluntary compliance and prevention of violations. Several Member Boards responding to the task force's survey indicated the belief that having such statements available decreased the number of phone calls on particular subjects. Other benefits noted included consistency, uniformity in interpretation, and time savings for board staff. Sometimes the opinions force more in-depth examination of topics. One board indicated that the opinions are "more fluid than regulations" and help in providing a framework.

While providing information and advice is usually perceived as helpful to the public, the biggest question raised by the practice is whether or not the requesting party can rely upon the advice received. What if a nurse were to contact the board and then relied on erroneous information? This could be to the nurse's detriment. How much reliance on staff advice not formally endorsed by the board is reasonable? In such a situation, would the interest of the public outweigh the interest of one individual? And if the advisory opinion is one offered by the board, does that board leave itself to allegations of improper rulemaking?

Some of the advantages of advisory opinions include having consistent, prepared responses to selected practice questions, which can be time-saving for the staff. The task force discussed the possible use of advisory opinions by licensees as an affirmative defense in discipline cases. The board might be challenged if a board determination affects the legal ability of a nurse to practice, e.g., changing requirements to practice. Then the standard ought to go through the statutory rule making process, with all its protections.

Advisory opinions can be useful for speaking to emerging standards, subjects on the cutting-edge. And some of the task force members felt strongly that a citizen ought to be able to call the board for answers.

The considerations against the use of advisory opinions include the time required for development and maintenance. Multiple aspects of nursing practice are constantly changing, requiring frequent updating. It is not inconceivable that a board could adopt an opinion and need to revise it the very next board meeting. The task force members expressed fear of developing a "laundry list" and were concerned that scope of practice questions could haunt the board. In some jurisdictions, attorneys have advised boards against issuing advisory opinions.

The task force identified that a critical concern regarding advisory opinions is the maintenance of those opinions. The group thought it essential that boards that do use such opinions review them frequently for accuracy and currency. An example of a Member Board that has an active and ongoing review of its advisory opinions is Arizona. In 1994-95 the Scope of Practice Committee Project undertook the review and revision of almost 50 Arizona State Board of Nursing opinions issued between 1987 and 1995. The committee determined that over two-thirds of the opinions required revision. Arizona also developed the Arizona State Board of Nursing Inquiry Algorithm to inform facilities of the process of advisory opinion development.

The concern over maintenance of the binding or precedental effect of advisory opinions can be met by a board clearly stating that advisory opinions do not have any such effect. In addition, concern over consistency of advisory opinions can be ameliorated, in part, by not routinely issuing such opinions in response to individual inquiries and reserving them to address issues of wider importance.

Conclusions

There is considerable variation among boards regarding advisory activities. All boards responding to the task force's survey indicated that they respond in some way to practice inquiries, often by telephone conversations or correspondence. For those boards which are authorized and wish to use a more formal means for sharing information that has had the benefit of review and approval by the board of nursing, this paper has offered information, examples and some tools to support this type of board activity.

References

Dahlquist, R. (1983). **Advisory opinions, extrajudicial activity and judicial advocacy: a historical perspective.** Southwestern University Law Review, 14, 46-79.

Jaconelli, J. (1985). **Hypothetical disputes, moot points of law and advisory opinions.** The Law Quarterly Review, 101, 587 - 626.

National Council of State Boards of Nursing, (1994). **Administrative Law** [Handout at Specialized Healthcare Investigators' Program in Boston, MA, September, 1994]

Telecommunications Issues Task Force

Task Force Members
Lonna Burress, NV, Area I, *Chair*
Marilyn Bloss, FL, Area III
Ida Rigley, ND, Area II
Kevin Wilks, RI, Area IV

Staff
Diane Creal, *Policy and Practice Associate*
Carolyn Hutcherson, *Senior Policy Analyst*

Relationship to the Organization Plan
Goal II ..... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B ..... Provide resources regarding health care issues which affect the regulation of nursing practice.

Recommendations to the Board of Directors
No recommendations.

Background
The 1995 Delegate Assembly directed that the National Council "study issues related to telecommunications practice across jurisdictional lines." It quickly became apparent to the task force, which was appointed by the Board of Directors, that the practice of nursing over distance using telecommunications technology was occurring and growing exponentially. The issues that the task force identified and explored are contained in the following report.

Highlights of Activities

- **Research of the Issue**

  The initial activities of the task force centered on researching the topic of telecommunications technology and determining the extent to which this technology impacts the practice and regulation of the profession of nursing. Methodologies for data gathering included: literary searches; Internet searches; Member Board surveys; staff attendance at national telecommunications technology meetings; analysis of regulatory models (actual and potential); and a meeting with the CEO of a company who uses nurses to provide nursing care via telecommunications technology to the elderly in rural Kansas.

  A preliminary literary search on telemedicine yielded 175 articles which were published between 1991-1995, 71 published in 1995 alone. The articles provided information regarding the various applications of telecommunications technology used in the health care arena and the populations most appropriate to the provision of care via this technology.

  An Internet search was also conducted on the subject of telecommunications technology and, more specifically, the subject of telemedicine. An Internet Resource Directory was compiled which contained information on telemedicine resources and services, the Telemedicine Research Center, and the International Telenurses Association. The resources included information on journals on telemedicine as well as information about the American Telemedicine Association (ATA) and the Telemedicine Research Center. Internet searches also yielded information on an organization named the International Telenursing Association (ITA). Through personal communication with the president of ITA, it was discovered that there are over 300 nurses who are members of this organization and the membership continues to grow.

  Further activities of the task force led to the discovery of Linda Roman, CEO of H.E.L.P. Innovations, a company that provides telenursing services to the elderly in the rural areas of Kansas. The task force provided every Member Board with a five-minute video which depicts these services. In a meeting at the National Council, Ms. Roman also outlined ideas for multi-state expansion and identified issues emerging from current state regulatory requirements.

Staff at the National Council attended the Federation of State Medical Boards (FSMB) meeting on issues related to licensure and telemedicine. Physicians, medical board members, attorneys, and the president of the American Telemedicine Association were in attendance to discuss the issues surrounding the use of telecommunications technology in the provision of care. The FSMB clearly identified the development and expansion of telemedicine as an issue which impacts the licensing system and developed proposed model legislation which would address the practice of medicine across state lines. Essentially, the FSMB has proposed that a physician who wants to practice telemedicine across state lines must have a limited license in the state in which he wants to practice. The limited license would allow a physician to practice telemedicine only in that state. Theoretically, if a physician wanted to practice telemedicine on a national level, limited licenses would be required in all states. The use of nurses in the provision of care via telecommunications technology was identified as having potential impact on the profession of medicine. Furthermore, licensure and reimbursement are consistently identified in conferences and articles as the barriers to the development of telemedicine.

In an effort to determine the current status of state laws as they pertain to the practice of telenursing across jurisdictional lines, the task force developed a survey for Member Boards (Attachment A). Initial analysis of the survey yielded at least two important conclusions: 1) there was enormous disparity between states regarding the regulation of nursing practice across state lines; and 2) current state laws in a number of jurisdictions present a barrier to the practice of telenursing. Of the states responding (n=41), 31% require that a nurse take orders only from an authorized provider licensed in the state; 14% forbid taking orders from a provider licensed in another state; 58% have laws which are silent; and 24% permit nurses to take orders from an authorized provider licensed in another state. The survey also revealed that 26% of the respondents were aware of telemedicine projects in their state. In response to the realization that current state laws may be a barrier to the practice of telenursing, the task force explored options for revising the current system to adapt to the telecommunications explosion. Regulatory models such as endorsement, reciprocity, a limited license for telenursing (similar to the Federation of State Medical Boards' model), a national standard implemented at a state level, and a federal model of regulation were researched and discussed.

Identification and Analysis of Issues

Initial analysis of the issues indicated the need to identify the role of the nurse and define the practice of nursing using telecommunications technology. The task force resolved that this concept should be referred to as "telenursing" and proposed the following working definition and description of telenursing:

Telenursing defined *— the practice of nursing over distance using telecommunications technology.*

Telenursing described *— any act in the observation, care and counsel of the ill, injured and infirm in the maintenance of health or prevention of illness of individuals, groups of individuals or the management of health care delivery systems; in the supervising, teaching, directing or delegation of care to other personnel; in the assistance with, implementation of, or correction to the medical treatment plan; or in the nursing treatment and/or health care plan utilizing telecommunications technology.*

Based on the results of the data collection, the task force identified a number of telecommunications technology modalities which are currently used in the practice of telenursing. Examples of the types of technology more commonly used in the practice of telenursing include:

- Telephone
- Facsimile
- Cellular phones
- Video phones
- Computers
- E-mail
- Voice mail
- CD-ROM
- Electronic bulletin board
- Audio tapes
- Audio-visual tapes
- Teleconferencing

- Video conferencing
- On-line services (e.g., America On Line)
- World Wide Web
- Internet
- Interactive television
- Real-time camera
- Still-imaging

The use of the telephone in telephone triaging and checking biometric testing equipment from a distance are probably the most widely recognized example of telenursing. Additional examples of the practice of telenursing using the telephone as the method of telecommunications technology are:

- Obtaining test results (e.g., lab, x-ray)
- Perform patient follow-up activities
- Patient education
- Professional consultations

Although the telephone is arguably the most common method of practicing telenursing, other types of technology such as the use of video conferencing and via two-way interactive television to conduct home visits are becoming more prevalent. Technology such as interactive video, e-mail, and computers have wide applications in the field of telenursing. Examples of nursing using technology in the provision of care include:

- The assignment and performance of home visits using video conferencing (e.g., receipt of assignment, making the visit, charting, follow-up, video/audio equipment assessments)
- Perform home visits via two-way interactive television
- Assist the physician in the implementation of a medical treatment protocol (e.g., x-ray, surgery)
- Participate in consultation (e.g., MD, RN, other professionals, patimnt, family)
- Electronic charting
- Review of the literature to determine national standards of care
- Review treatment standards or protocols

Medical call centers were uncovered as a relatively new phenomenon in the field of telenursing. Medical call centers have nurses and/or clerical professionals direct patients, through the use of technology, to the appropriate level of care before they self-select potentially expensive or unnecessary levels of care. The call centers are typically used by the patient after a local provider's office has closed. Both the various types of technology used, and the use of medical call centers and other settings for telenursing to occur, indicate the growing trend of telecommunications technology in the provision of nursing care and the impact of this technology on the regulation of the profession.

In conjunction with determining the pervasiveness of telenursing, the following concepts for the development of regulation models which would allow for the inevitable explosion of the practice of telenursing were identified and forwarded to the Nursing Regulation Task Force for consideration in the development of future models:

- Port of entry into nursing practice (linked to statutory authority)
- Standardization of all board functions including the acceptance of a single disciplinary decision
- Mechanism for states to remove harmful practitioners and safeguard the consumer

Outcomes of Analysis and Deliberations

In response to the data and information collected between September 1995 and April 1996, the task force developed the following *Statements of Belief* to provide a framework for the development of potential models of regulation that would facilitate the practice of telenursing across jurisdictional lines:

1. The health care delivery system is changing. Nursing will assist consumers to manage their health care at a setting of their choice, utilizing telecommunications technology and nursing science.

2. Telenursing is multidimensional. Practice occurs at the site where the consumer is located, in the interactive space of telecommunications technology, and at the site where the nurse is physically located. Primary discipline occurs at the site where the consumer is located. Any additional authorizing bodies may take disciplinary action.

3. The tele-health system facilitates access to the appropriate resources which include, but are not limited to, telenursing and telemedicine.

4. Current interpretations of the law require licensure of the practitioner in the state where the consumer resides. This presents a barrier to the effective and efficient provision of telenursing.

5. Regulation needs to protect the consumer without stagnation of telenursing care. Nursing boards will fail in their mission to protect the consumer if they fail to remove barriers to access cost-effective, safe, and efficient care.

6. The transition from an industrial-based society to an information-based society is a driving force for the reengineering of the health care delivery system.

7. Failure to accommodate the information revolution could result in federal licensure, corporate credentialing, or some other loss of ability of boards of nursing to protect consumers.

8. The solution must be value added and provide creative, innovative strategies to accommodate the changes—not just new ways to do old things.

9. Systems must go through chaos to change.

10. Telenursing will include multiple levels of providers. Registered nurses will remain responsible and accountable for planning, coordinating, and delegating nursing care.

11. Nurses will adapt their knowledge, skills and abilities to provide care safely and effectively via telecommunications technology. There must be adaptation made for the unstructured environment and the limitation of not being physically present.

Issues Recommended for Review by Boards of Nursing
(Statements are not intended to address all emerging issues and issues will change over time.)

1. It is essential that boards of nursing and nurses recognize that the use of telecommunications technology in nursing practice has moved beyond a simple tool used in providing care to a new, evolving, multidimensional delivery system. This change requires Member Boards to evaluate and take action to promote and protect the consumer's interest.

2. Boards of nursing are faced with the need to legally recognize, accommodate and regulate telenursing activities in ways that protect consumers without undue economic or regulatory burden.

3. Boards of nursing must move immediately to standardize their state practice acts in the areas of requirements for licensure, discipline, practice, education and continued competence.

4. Boards need to move swiftly to evaluate and adopt practice standards related to nurses' roles in telenursing/telemedicine utilization of technology, confidentiality, and storage of electronic medical information, in order to assure the consumer's health, safety and welfare is protected.

5. A standardized regulatory approach should result in a global system that clarifies local and state responsibilities in all provider recipient relationships; allows for nurse ownership of and probability of credentials, assist geopolitical boundaries to become permeable; and supports the consumer's access to the right care, at the right time, by the appropriate provider in the most cost effective manner.

6. The provision of quality telenursing, telemedicine and/or tele-health care requires collaboration among and between licensed qualified providers.

7. Quality assurance and continuous improvement must be integral parts of the emerging delivery system.

8. The final model adopted in response to the changes in the delivery system needs to be *simple, straightforward* and include the following features:
   a) open platform
   b) interactive
   c) mobility
   d) convertibility
   e) connectivity
   f) ubiquitization (technology spreads down through every layer of provider)
   g) global in scope

9. Boards must ensure their legal right to access assumptions included in all treatment protocols so that they may ensure that the systems developed support good outcomes for consumers.

10. Boards must move to require taping, storage and preservation by reasonable means of all therapeutic interactions.

11. Changes in delivery systems will cause changes within Member Board operations.

- **Action Plan**

  In an effort to assist Member Boards with the realization that telenursing was occurring and growing at an exponential rate, the *Telecommunications Hotline* was developed. The objective of the *Telecommunications Hotline* is to disseminate pertinent telecommunications technology or telenursing information to Member Boards in a timely manner. Additionally, articles have been written for the National Council *Newsletter* when appropriate.

Future Considerations for the National Council

- Utilize the information collected in the development of future regulatory models.
- Continue to study developments in telecommunications technology related to the health care delivery system and nursing practice.
- Continue to study the regulatory implications of the developments in telecommunications technology.
- Continue to monitor the impact of the rapid changes occurring in the development of telecommunications technology on Member Boards.
- Continue to disseminate *Telecommunications Hotline,* communicating current developments in the field of telenursing or telecommunications technology.

Meeting Dates

- November 6-7, 1995
- December 13, 1995 *(telephone conference call)*
- February 14-16, 1996
- March 1, 1996 *(telephone conference call)*

Recommendations to the Board of Directors

No recommendations.

Attachments

ATTACHMENT A

Member Board Survey Regarding Practice Across State Lines
November 1995

41 RESPONSES

1) Please check the statement which most accurately describes the law in your state:

   a) The law requires that a nurse take orders only from an authorized provider licensed in the state.
   Yes 13 No 20

   b) The law forbids taking orders from a provider licensed in another state.
   Yes 6 No 21

   c) The law is silent as to a nurse's authority to take orders from a provider licensed in another state.
   Yes 24 No 7

   d) The law permits nurses to take orders from an authorized provider licensed in another state.
   Yes 10 No 12

2) If you answered yes to #1c, would your state deem it legal for nurses to take orders from a licensed provider in another state?

   Yes 16 No 4

3) If answered yes to #1d, are there any conditions or limitations on the authority to take orders from:

Must be a border state	Yes 3 No 9
Must be order from category of provider authorized to prescribe in this jurisdiction	Yes 6 No 5
Other	Yes 4 No 5

4) Has your Board issues rulings or interpretations about this practice?
   Yes 12 No 27

5) Has any other entity in your state issued any rulings or interpretations about this practice?
   Yes 6 No 19

6) Are you aware of any pending activity in this area?

Legislative:	Yes 4 No 33
Attorney General:	Yes 1 No 35
Other Boards:	Yes 5 No 32

7) Are you aware of any telemedicine projects within your state or whether your state is participating in a project?
Yes 11 No 24

8) If yes, is nursing involved in these projects?
Yes 7 No 10

Attachment B

Bibliography

Ball, K. (1994). Riding the superhighway of education with video teleconferencing. Minimally Invasive Surgical Nursing, 8, 3, 114-115.

Blanton, T. & Balch, D. (Sept./Oct., 1995). Telemedicine. The Futurist, 14-17.

DelJunco, R. & Cordray, J. (1996). Telemedicine prospects and perils: Weighing the potentials. Federation Bulletin, 83, 1, 18-22.

Ellenberger, B. (1995). Navigating physician resources on the internet. Canadian Medical Association Journal, 152, 8, 1303-1307.

Granade, P. (1996). Implementing telemedicine on a national basis - a legal analysis of the licensure issue. Federation Bulletin, 83, 1, 7-17.

Granade, P. & Sanders, J. (1996). Implementing telemedicine nationwide: Analyzing legal issues. Defense Counsel Journal, 63, 1, 67-73.

Gurwitt, R. (Oct., 1995). Overload. Governing, 17-23.

Houtchens, B., Allen, A., Clemmer, T., Lindberg, D. & Pedersen, S. (1995). Telemedicine protocols and standards: Development and implementation. Journal of Medical Systems, 19, 2, 93-117.

Jaklevic, M. (March, 1996). Internet technology moves to patient-care front lines. Modern Healthcare, 47-50.

Linder, A. (Oct., 1995). The telemedicine revolution hits home. Healthcare Informatics, 72-76.

Mahmud, K. & Lenz, J. (1995). The personal telemedicine system. A new tool for the delivery of health care. Journal of Telemedicine and Telecare, 1, 1, 173-177.

Mechling, J. (Oct., 1995). Common ground for electronic commerce. Governing, 82.

Nelson, R. & Schlachta, L. (1996). Nursing and telemedicine: Merging the expertise into telenursing. The Journal of the Healthcare Information and Management Systems Society, 9, 3, 17-22.

Puskin, D. & Sanders, J. (1995). Telemedicine infrastructure development. Journal of Medical Systems, 19, 2, 125-129.

Puskin, D., Brink, L., Mintzer, C. & Wasem, C. (1995). Joint federal initiative for creating a telemedicine evaluation framework. Telemedicine Journal, 1, 4, 393-397.

Sandberg, L. (Dec., 1995). Legal and policy issues challenge telemedicine. Health Management Technology, 30-32.

Sanders, J. (1995). Future trends: Telemedicine. Federation Bulletin, 82, 4, 191-197.

Shea, W. (Aug., 1995). Information technology. Group Practice Managed Healthcare News, 14-23.

Stevens, L. (Oct., 1995). Bringing government to people. Governing, 67-76.

Sturgess, G. (1995). Politics and health care: Beyond the federal-state wrangle. Federation Bulletin, 82, 4, 198-202.

Warner, I. (Feb., 1996). Telehealth for home health care. Telehealth, 1-4.

Winn, J. (1995). Endorsement: State vs. National licensure. Federation Bulletin, 82, 9-19.

Weed, L. & Weed, L. (1994). Reengineering medicine. Federation Bulletin, 81, 3, 149-183.

Communications Evaluation Task Force

Task Force Members

Iva Boardman, DE, Area IV, *Chair*
Polly Johnson, NC, Area III
Charles Bennett, CA-VN, Area I
Pat McKillip, KS, Area II

Relationship to Organization Plan

Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ..... Facilitate communication between National Council, Member Boards and related entities.

Recommendations to the Board of Directors

In order to maintain and enhance National Council communications on current regulatory information regarding testing, licensure, public policy, education, unlicensed assistive personnel, and research, the Communications Evaluation Task Force recommends the following:

1. **That the National Council expand the distribution of all National Council communications, targeting employers other than acute care as first priority.**

   Rationale

   Currently, National Council communications are distributed to boards of nursing, board members, nursing education facilities, and some nurse executives. However, the task force notes that the face of the health care workforce and delivery system is shifting. National Council's activities and communications are of interest to all members of the nursing/health care community, including those members not currently reached in areas such as long-term care, home health/rehab institutes, ambulatory care, independent practitioners, occupational settings, and consumers. Initially, these people could be reached by expanding the distribution of *Issues*. Eventually, the task force believes that it would be beneficial to expand the distribution of all National Council communications to reach a wider audience.

2. **That the National Council revise and expand communications processes and content to reflect current and emerging trends and issues.**

   Rationale

   The task force noted that the survey responses included many comments requesting information on current trends in nursing. The task force agreed that if the National Council would be distributing its communications to a wider audience (as requested in recommendation #1) those communications would have to reflect current trends and issues to address readers' information needs. This was brought to the task force's attention by survey responses requesting information on the Pew Commission recommendations, consumer rights, and other current health care trends. Although the task force had some specific suggestions to start the implementation of this recommendation (see suggestions listed below), its recommendation reflects a general policy that should be followed for all communications.

3. **That the National Council establish a formal evaluation process of all National Council communications and a task force be established in FY97 to facilitate the development and implementation of such a process.**

   Rationale

   Currently, there is no system in place that gathers feedback on National Council communications. As National Council communication activities expand and are distributed to a wider audience, feedback is important because it can identify readership, usability and value of each communication vehicle. A task force could establish the process of gathering information and how to use it to evaluate and enhance National Council communications. The

Communications Evaluation Task Force believes that annual evaluations of activities are important in keeping National Council communications on track and valuable to its audience.

Background

The task force created a survey that requested input from readers on all National Council communications. The survey was mailed to a portion of the *Issues* mail list and to boards of nursing (n=5,000). A response of over ten percent was received, which is considered to be a reasonable response rate when weighed against the one-time only survey approach used to minimize expenses while still capturing an overall reflective response. Survey results were tallied (available upon request), and this information was used as a starting point for the task force's meeting. From the survey results, the task force drew the following conclusions:

- *Issues* is the most widely-read communication of the National Council.
- *Issues'* testing and nursing practice and education editions were highly rated; research and the annual meeting editions were poorly rated.
- Those respondents who received brochures gave high rankings to content and value. Many respondents did not know brochures were available.
- Respondents were not well-informed about availability of National Council publications on the full range of subject areas.
- *NCLEX™ Program Reports* were highly rated, but the task force found the abundance of negative comments disturbing.
- Most of the respondents were deans/directors and educators at schools of nursing; boards of nursing had a low response rate.
- Overall, respondents were satisfied with National Council communications.
- Many respondents are interested in receiving more National Council communications and direct mail information on the availability of new communications.

Highlights of Activities

■ **Suggestions for Change:**

In its discussions on the results of the survey, the task force noted some suggestions for change in communications that fall under the general recommendations as follows:

1. *That the National Council expand the distribution of all National Council communications.*

   a. Publish Quarterly Highlights of the *Newsletter*—Many boards include National Council information in their state-level newsletters and use clips from the National Council *Newsletter* as content. By publishing a summary of the National Council *Newsletter* information in a quarterly electronic file, Member Boards would be able to download the information and insert it into their publications as needed.

   b. Expand communications to the consumer audience through development of a brochure regarding the regulatory process and consumer rights.

2. *That the National Council revise and expand communications process and content to reflect current and emerging trends and issues.*

   a. The task force supports the use of electronic communication—communication modes are changing rapidly with the onset of new technologies. The benefits of these new technologies (e.g., rapid transmissions of communications, availability to wide audiences at low cost) make these technologies attractive alternatives to traditional communications. The Communications Evaluation Task Force supports the exploration and use of new technologies.

   b. *Issues* content should be changed to include public policy. Rather than add an additional edition of *Issues*, the task force suggests that the Fall edition's focus (currently Annual Meeting) be changed to Public Policy with the inclusion of a small section on Annual Meeting important events.

c. Align production timelines to ease data collection for research publications. Data collection for *Member Board Profiles* and *Licensure and Examination Statistics* are currently collected on schedules that coincide with periods of heavy activity at the board of nursing level. This results in a slow-down in the data collection process, which in turn delays the publication's release date. The Director of Research Services met with the task force to discuss alternate collection/publication dates for *Member Board Profiles* and *Licensure and Examination Statistics*. The task force recommended an alternate schedule, to be implemented by the Director of Research Services, that may enhance these publications data collection and delivery system.

3. *That the National Council establish a formal evaluation process of all National Council communications and a task force be established in FY97 to facilitate the development and implementation of such a process.*

   a. Provide survey data collected by the Communication Evaluation Task Force to a new task force for background information and discussion.

Recommendations to the Board of Directors

1. That the National Council expand the distribution of all National Council communications, targeting employers other than acute care as first priority.

2. That the National Council revise and expand communications processes and content to reflect current and emerging trends and issues.

3. That the National Council establish a formal evaluation process of all National Council communications and a task force be established in FY97 to facilitate the development and implementation of such a process.

Meeting Dates

- February 8-9, 1996

Future Activities

With this report, the task force has completed its charge for FY96, but has recommended to the Board of Directors that evaluation of communications continue and that a task force be appointed to develop and implement an evaluation process.

Attachment

A .....Communications Evaluation Survey Results, *page 5*

Attachment A

Communications Evaluation Survey Results

Total Response: 470

Which of the following communications have you received directly or as "hand me downs"? (check all that apply)

Issues	97.2%
Brochures	41.6%
Insight	26.7%
Books	13.2%
SNLQ	6.2%
Videos	18.8%

When do you become aware of the availability of National Council publications?

29.4%	1-2 weeks after availability
31.1%	2 weeks - 1 month after availability
20.0%	2+ months after availability

How do you generally hear about National Council publications? (check all that apply)

84.4%	*Issues* announcement or reference
24.3%	Member Board Newsletter article
35.6%	Direct mail
9.0%	National Council's exhibit booth at conventions
20.9%	Word of mouth
1.1%	Other

Would you like to receive direct mail information about National Council publications as they are made available?

90.6% Yes 6.0% No

If National Council publications were available on the World Wide Web, would you be able to access them?

47.3% Yes 47.4% No

Would you prefer an electronic format over a printed format?

7.5%	Yes (prefer electronic)
61.2%	No (prefer printed)
28.5%	Doesn't matter

Does National Council's name on a publication affect your decision to read it?

82.1% Yes 15.1% No

If yes, why? (check all that apply)

75.3%	Reputable source of information
18.3%	Member affiliation
31.1%	Earlier publications proved valuable
1.1%	Other

If no, why? (check all that apply)
0.4% Not aware of National Council's name/reputation
0 Haven't been satisfied with earlier publications
10.0% Purchase only what is necessary (regardless of source)
0.2% Other (please specify)

NEWSLETTERS

ISSUES
Do you receive *Issues*?
95.7% Yes 3.2% No

How much of *Issues* do you read?

All	Half	Scan	None
68.0%	14.7%	15.4%	0.0%

How often do you read the following:	**Always**	**Sometimes**	**Never**
Articles	67.0%	29.6%	0
President's Message	57.1%	37.9%	0.6%
Communications Corner	65.5%	29.6%	0.6%
National Council Updates	81.9%	14.7%	0
Questions & Answers/Letters	56.5%	36.6%	1.3%
Advertisements	26.0%	53.6%	12.6%

***Issues* highlights one of four National Council areas in each edition (Testing, Nursing Practice and Education, Research, Annual Meeting). Were you aware of this?**
59.3% Yes 37.9% No

Is there one topic area that you read more thoroughly than the others?
57.8% Yes 34.7% No

If yes, which one?
38.8% Testing
3.6% Research
0.6% Annual Meeting
35.6% Nursing Practice & Education

Does *Issues* need improvement?
6.0% Yes 58.9% No

If yes, what can *Issues* do to make it more valuable to its readers? (please specify)
- stats on exams; act to nursing dilemma—no jobs; CNAs and HHAs practicing nursing without supervision or penalty; a career that needs an overview
- more headline-type condensed news
- more info on research
- more information on national trends in education and practice
- not sure since to a board of nursing member
- section on dates, new regulations, bibliography section, some humor
- more frequent *Issues* publication
- somewhat
- would like month/year of publication; continue to have latest information available
- unsure
- use bigger fonts for print; include more tables and graphs
- we all need to improve always—nothing specific at this time

- would be difficult because we have so broad an area of interest
- sometimes articles seem to repeat themselves
- clearer explanations in testing and grading; also NP&E simulation
- always give info on how to contact authors or get more information
- sometimes redundant information. edit more
- format presentation
- keep up good communicating
- doesn't look appealing to the eye; research is boring reading; rarely do I find info related to PN education.
- format and size are OK; I would like more information on Pew Commission follow up; also on impact (negative and positive) of unlicensed multicompetency health care provider on nursing
- as a board member, receive prescreened articles only; this is no position to judge entire document
- hard to follow; articles are continued from page to page
- headline or feature most significant practice issues
- I like issues of practice, legal issues the best
- I would like articles to be on consecutive pages instead of skipping 2-3 and having to look for the last paragraph.
- improvements should always be considered
- include all levels, i.e., nursing assistant and practical nurse
- include publication list annually
- indicate focused area
- just continue to keep us informed about national issues
- keep doing as in past
- everything; I'd like to see more news from different state boards

Please rate *Issues* for the value of its information on a scale of 1-5, with 1 being poor and 5 being excellent:
Average rating: 4.16

State Nursing Legislation Quarterly (SNLQ)
Please answer the following only if you are affiliated with a Member Board. If you are not affiliated with a Member Board, skip to "Others."

Do you read *SNLQ* on-line?
2.8% Yes 13.4% No

If yes, is the on-line service informative?
76.9% Yes 15.3% No

Do the legislative summaries provide enough information?
92.3% Yes 0.7% No

If no, why don't you read *SNLQ*?
3.0% I did not know that it is available
2.6% I do not use on-line services often
0 I tried it, but did not find it informative
0.4% I do not have time to read it
1.1% Other (please specify)

— OTHERS --
Were you a past subscriber to *SNLQ*?
10.9% Yes 66.4% No

If yes, have you missed receiving *SNLQ*?
9.6% Yes 4.9% No

Do you currently have a need for information on current legislation about nursing and/or HIV+/AIDS?
55.7% Yes 14.2% No

Is this information addressed by another source?
23.0% Yes 30.4% No

If yes, please specify:
- INA
- Legislative Network for Nurses
- state nursing associations; other
- keeping up on legislative action
- this information is available in many other sources, which is a problem
- journals at hospital library
- state board newsletters, memoranda
- ANA, NJSNA
- AACN, NLN, ANA
- Florida Board of Nursing Consultant, Continuing Education Department of school system
- but need to have multiple resources
- capital update
- journals, NLN
- internal VA communication
- workshops
- Alabama State Nursing Association (sometimes)
- faculty member monthly summary interest provides updates to our faculty (online)
- only as available through board of nursing meetings
- Health Department Epidemiologist
- professional association
- state nursing association
- nursing journals, state newsletters
- ANA Capital Update, AACN Bulletin
- nursing organization, publications (NLN, ANA)
- AACN
- American Red Cross
- Federal Register; Capital Update
- OOPNE
- Florida State Board and FHA
- american nurse
- department of health
- Michigan Nurses Association
- CDC
- director, board of nursing
- state/national nurses association
- faculty on state board
- all professional nursing organizations have this information
- MNA Cabinet
- MN Health department newsletter
- PNA newsletter, legislative update

Would you read *SNLQ* if it were available on the Internet?
30.1% Yes 38.9% No

Would an Internet-accessible version of *SNLQ* be valuable if the bills of only 25 states, as well as federal bills, were represented?
27.7% Yes 34.2% No

Would you be willing to pay a modest fee (under $30 annually) to access *SNLQ* on the Internet?
18.1% Yes 50.0% No

BROCHURES

% received		Rating (4 highest)
12.4%	Your Nursing License is Your Master Key	3.71
70.4%	NCLEX™ Using CAT	3.71
56.9%	NCLEX™ Candidate Information	3.71
13.4%	Nursing Regulation Protecting the Public	3.63
37.1%	Computerized Clinical Simulation Testing	3.56
24.1%	National Council Communications	3.50

Were you aware that National Council has brochures available on these subjects?
39.9% Yes 45.1% No

Would you like to see brochures on additional subjects (not listed)?
19.2% Yes 27.4% No

If yes, please specify:
- overview of National Council to distribute to students
- trends and role in managed care environment
- licensure - educating nurses
- NCLEX CAT outcomes or test results
- implications for the unlicensed healthcare provider
- role of National Council in regulation and legislation
- test item development information for students, public
- information on job placement of graduates with deficient educational preparations
- sexual misconduct
- any, related to mission, goals
- all areas that affect practice; law, education
- graduate data after NCLEX
- models for nursing documents on issues
- implications of managed care
- enrollment and employment trends
- legal issues
- I would like all of the above - the most current publication
- nursing trends
- whatever is of interest to educators
- delegation, differentiation of nursing practice
- legislative issues, National Council information or position statement
- sexual misconduct
- what is National Council: historical, mission, purpose, composition, office meetings, etc.
- nursing regulation, testing
- nursing legislation process
- National Council Communication, Nursing Regulation, Protecting the Public
- ethical issues; retake tips for maximizing NCLEX CAT success
- overview of the professional regulatory process for nurses
- new board member
- something on complaints or how new graduates can protect their license; with downsizing, many are accepting too much responsibility
- legal implications for delegation
- nursing practice changes, advanced practice issues, UAP issues
- activities re: continuing education as a mandate

- changes in nurse practice acts and/or rules and regs for each state
- resources available to Member Boards
- as topics develop
- national health care changes occurring
- I'd like to see the brochures I haven't received
- Pew
- professionalism—attitudes and behavior
- the value of nursing to the public, e.g., protecting public from impostors, etc.
- legal issues affecting practice
- CAT

PUBLICATIONS

I. *Conceptual Framework on Continued Competence* (1991)
Have you received the *Conceptual Framework on Continued Competence?*
4.7% Yes 89.7% No
If no, skip to Section II. If yes, please answer all questions.

What portions of the *Conceptual Framework on Continued Competence* have you used?
72.7% Whole document
4.5% Selected portions (please identify)

Is the information in the *Conceptual Framework on Continued Competence*:
Current? 63% (0 No)
Accurate? 63% (0 No)
Useful? 77% (0 No)

How was the *Conceptual Framework on Continued Competence* used? (check all that apply)
45% Identified possible approaches to issue
31% Stimulated debate
18% Provided support of a board position
49% Provided direction
0 Other (please specify)

Is there something that you wished *Conceptual Framework on Continued Competence* addressed that it did not?
0% Yes

If yes, please specify:
- used to develop legislation
- I worked on nurse practice act reform in Massachusetts
- curriculum
- education in graduate program
- information

Other comments regarding the usefulness of the *Conceptual Framework on Continued Competence:*

II. *Model Legislative Changes and Model Administrative Rules for Advanced Nursing Practice* (1993)
Have you received these *APRN Models*?
9.0% Yes 86% No
If no, skip to Section III. If yes, please answer all questions.

What portions of the *APRN Models* have you used?
60% Whole document
29% Selected portions (please identify)

Is the information in the *APRN Models*:

Current?	83% Yes	2.3% No
Accurate?	83% Yes	0 No
Useful?	86% Yes	0 No

How were the *APRN Models* used? (check all that apply)

69% Identified possible approaches to issue
45% Stimulated debate
23% Provided support of a board position
69% Provided direction
Other (please identify)

Is there something that you wished the *APRN Models* addressed that they did not?

Other comments regarding the usefulness of the *APRN Models*:

III. *Model Nurse Aide Regulation Act and Model Nurse Aide Administrative Rules* (1990)
Have you received these *Nurse Aide Models*?
4.5% Yes 89.6% No
If no, skip to IV. If yes, please answer all questions.

What portions of the *Nurse Aide Models* have you used?
38% Whole document
24% Selected portions (please identify)

Is the information in the *Nurse Aide Models:*

Current?	57% Yes	4.7% No
Accurate?	57% Yes	0 No
Useful?	62% Yes	0 No

How were the *Nurse Aide Models* used? (check all that apply)

33% Identified possible approaches to issue
14% Stimulated debate
10% Provided support of a board position
33% Provided direction
Other (please identify)

Is there something that you wished the *Nurse Aide Models* addressed that they did not?
0% Yes

If yes, please specify:

- haven't had time to read it yet
- education in BSN program
- nice role differentiation between RN and LPN
- information
- classroom information for graduating students; information for faculty
- on nurse practice act reform

Other comments regarding the usefulness of the *Nurse Aide Models*:

IV. *Model Nursing Practice Act* (revised 1993, 1994)
Have you received this *Model NPA*?
11.5% Yes 82.6% No
If no, skip to Section V. If yes, please answer all questions.

What portions of the *Model NPA* have you used?
67% Whole document
17% Selected portions (please identify)

Is the information in the *Model NPA*:

Current?	80% Yes	1% No
Accurate?	78% Yes	1% No
Useful?	87% Yes	0% No

How was the *Model NPA* used? (check all that apply)
55% Identified possible approaches to issue
43% Stimulated debate
28% Provided support of a board position
54% Provided direction
Other (please identify)

Is there something that you wished the *Model NPA* addressed that it did not?
5% Yes

If yes, please specify:

Other comments regarding the usefulness of the *Model NPA*:

V. *Model Nursing Administrative Rules* (revised 1993, 1994)
Have you received these *Model Rules*?
4.1% Yes 90.2% No
If no, skip to Section VI. If yes, please answer all questions.

What portions of the *Model Rules* have you used?
74% Whole document
21% Selected portions (please identify)

Is the information in the *Model Rules:*

Current?	89%Yes	5% No
Accurate?	89% Yes	0% No
Useful?	95% Yes	0% No

How were the *Model Rules* used? (check all that apply)
68% Identified possible approaches to issue
42% Stimulated debate
37% Provided support of a board position
63% Provided direction
Other (please identify)

Is there something that you wished the *Model Rules* addressed that they did not?
0% Yes
If yes, please specify:

Other comments regarding the usefulness of the *Model Rules*:

VI. *Position Paper on the Regulation of Advanced Nursing Practice* (1993)
Have you received the *APRN Position Paper*?
12.8% Yes 81.5% No
If no, skip to Section VII. If yes, please answer all questions.

What portions of the *APRN Position Paper* have you used?
65% Whole document
25% Selected portions (please identify)

Is the information in the *APRN Position Paper*:

Current?	78% Yes	5% No
Accurate?	78% Yes	3% No
Useful?	80% Yes	5% No

How was the *APRN Position Paper* used? (check all that apply)
47% Identified possible approaches to issue
35% Stimulated debate
27% Provided support of a board position
42% Provided direction
Other (please identify)

Was there something that you wished the *APRN Position Paper* addressed that it did not?
2% Yes

If yes, please specify:

Other comments regarding the usefulness of the *APRN Position Paper*:

VII. *Model Guidelines: A Nondisciplinary Alternative Program for Chemically Impaired Nurses* (1994)
Have you received the *Model Guidelines*?
8.5% Yes 84.9% No
If no, skip to Section VIII. If yes, please answer all questions.

What portions of the *Model Guidelines* have you used?
68% Whole document
20% Selected portions (please identify)

Is the information in the *Model Guidelines*:

Current?	78% Yes	0% No
Accurate?	75% Yes	0% No
Useful?	85% Yes	0% No

How was the *Model Guidelines* used? (check all that apply)
63% Identified possible approaches to issue
38% Stimulated debate
28% Provided support of a board position
53% Provided direction
Other (please identify)

Was there something that you wished the *Model Guidelines* addressed that it did not?
0% Yes

If yes, please specify:

Other comments regarding the usefulness of the *Model Guidelines*:

VIII. *The NCLEX™ Process*
Have you received *The NCLEX™ Process*?
33.7% Yes 57.9% No
If no, skip to Section IX. If yes, please answer all questions.

Please rate *The NCLEX™ Process* for its value of information on a scale of 1-5, with 1 being poor and 5 being excellent (circle your choice).
Average rating: 4.26

Was the information in *The NCLEX™ Process*:

Current?	91% Yes	1% No
Accurate?	90% Yes	0% No
Useful?	90% Yes	0.6% No

Would you recommend *The NCLEX™ Process* to a colleague?
88% Yes 0 No
If no, why not? (please specify)

IX. *Test Plan for NCLEX-RN™* and *Test Plan for NCLEX-PN™*
Have you received the *Test Plans*?
64.4% Yes 29.6% No

If yes, which one?
78% NCLEX-RN 39% NCLEX-PN

Please rate the *Test Plans* for their value of information on a scale of 1-5, with 1 being poor and 5 being excellent (circle your choice).
average rating: 4.21

Is the information in the *Test Plans*:

Current?	90% Yes	2% No
Accurate?	90% Yes	0.6% No
Useful?	88% Yes	4% No

Would you recommend the *Test Plans* to a colleague?
87% Yes 3% No

If no, why not? (please specify)
- they are hard to follow in some areas
- necessary for nursing education programs
- vague
- too general too be helpful
- too broad
- too general and broad, doesn't give enough info
- not enough info
- needs more explanation
- yes, I share with students and faculty

X. *NCLEX™ Program Reports*
Do you subscribe to *NCLEX™ Program Reports*?
37.3% Yes 56.4% No
If no, skip to Section XI. If yes, please answer all questions.

Please rate *NCLEX™ Program Reports* for its value of information on a scale of 1-5 (1 = poor, 5 = excellent, circle your choice).
average rating: 4.14

Is the information in the *NCLEX™ Program Reports*:

Current?	60% Yes	2% No
Accurate?	54% Yes	6% No
Useful?	55% Yes	5% No

Have you had problems with your *NCLEX™ Program Reports* subscription?
10% Yes 51% No

If yes, please specify:
- price is very high for a limited budget
- when it transferred to another publisher, were not told of change
- not timely enough and too difficult and expensive to get specific program (institutional) information
- subscription problem first time
- needs more specific information for schools and individuals; not helpful at present
- we haven't received our copy yet
- did not receive-needed follow-up; reporting of graduates not from our program
- order takes a long time to fill; data blank (national/state) when specific program has no grads in a given quarter; we need the data, so many phone calls are required
- somewhat slow in arriving
- did not receive for 199_
- info problems
- It is my understanding they will no longer be available—I liked them!
- grads from 1994 late testers clumped with early 1995 testers in April/September report
- don't subscribe—price is OUTRAGEOUS
- not accurate when candidate lists themselves as a first-time person; skews data
- billing
- needs to identify factoring stats separately; can't be sure reports stats are our stats
- incorrect report of number of grads who actually took NCLEX-RN; one who didn't was counted as a fail
- interrupted
- delays in reports being sent, sent wrong program report, then sent wrong dates
- subscribed in past; very helpful, but grad-date remains a problem
- only received one
- we are multiple campus and don't always give us each campus until reminded
- have not yet received my report but have seen other schools' reports
- when changed publishers there was no information
- very expensive

Do you think *NCLEX™ Program Reports* needs improvement?
19% Yes 30% No

If yes, please specify:
- report should respond to programs with small numbers or recommend not to purchase
- more user-friendly data
- need to be consistent; things are changing with each report
- give some info on floppy, too
- cost is too high, the percentiles are sometimes hard to understand, takes too long to get
- question whether data is always from our graduates
- I wish you could identify graduates by name
- please graph sequentially, not comparing Fall-Fall
- needs to clearly explain data; more explanation of what the results mean

- content area versus nursing process area
- I wish it wasn't so expensive; I'd love to see trend data—program specific
- accurate data
- difficult to determine needed curriculum changes
- problems is that New York does not give names of first-time test takers, so I'm not sure if it is accurate
- dates of issues are confusing
- could get information on more subtopic areas
- don't subscribe—too costly
- The information published was incomplete, apparently due to the small number of graduates sitting for the NCLEX
- hard to interpret—whole issues without content (no takers); TOO EXPENSIVE; DO not like them but hesitant about not receiving them
- not just yet
- It is now difficult to determine how graduates have done in various areas compared to others in a meaningful way; can there be an indication of numbers questions actually answered in each area?
- lower price
- better control of reporting of student results
- more information regarding performance based on demographic data
- statistics are hard to determine; use for curriculum needs
- we have only begun to use—one report only
- better way to let individual schools know how their students are doing
- too expensive for amount of information given
- more specific
- more information administered more frequently
- improvements have been made
- more individual data needed
- explanations need to be clearly stated
- make more program specific ADN versus diploma versus BSN graduate information
- improving timeliness of reports
- it does not totally represent the graduates because not all graduates enter correct code
- reporting should be done more quickly
- very wordy; simpler language
- needs to be more like nurses' review was before CAT
- it would be helpful if reports were published in timing with an academic year rather than a calendar year
- there has been much discussion among the school directors about the inadequacy of these reports
- easier readability
- more useful information; clear directions or help to interpret
- absolutely, I want the areas where the failing candidates had problems
- easier interpretation
- can be confusing—ranking related ties the "per median student" class, and comparisons of like programs—will have 30 of 33 and then 29/32—why do comparable numbers of schools vary?
- nothing obvious springs to mind; it would be nice if the data could be presented more concisely
- information is not easy to find; too many pages that say nothing
- to make useful comparisons, we need to know number of questions per content area; report states more than 10 but if only 11 questions versus 90 questions, makes a difference in interpretation
- need to discuss with someone at NCLEX—results are confusing at this time
- very lengthy
- do not like the large notebook; would prefer small, separate notebook for each year/class

Would you recommend *NCLEX™ Program Reports* to a colleague?
48% Yes 6% No

If no, why not? (please specify)
- too time-consuming; no one wants to read them except me
- because this is the only source we have for rating our program

- there is no other mechanism available to provide reliable/real data
- incomplete information and incorrect program number; personnel seemed unable to correct; too costly
- wouldn't recommend—too costly
- haven't used it long enough
- yes, but with reservation
- no value
- recommend with qualification that report is far less helpful than McGraw-Hill reports
- only if improved
- I use another company!
- reserve discussion until I am not confused about results

XI. *Job Analysis of Newly Licensed Registered Nurses* and *Job Analysis of Newly Licensed Practical/Vocational Nurses*

Have you received the *Job Analysis* publications?
28.1% Yes 65% No
If no, skip to Section XII. If yes, please answer all questions.

Which *Job Analysis* do you use?

RN	PN/VN	Nurse Aide
78%	42%	6%

Please rate the *RN or PN/VN Job Analysis* for its value of information on a scale of 1-5, with 1 being poor and 5 being excellent (circle your choice).
Average rating: 4.07

In general, is the information in the *Job Analysis* publications:
Current? 87% Yes 6% No
Useful? 87% Yes 6% No

Would you recommend *Job Analysis* to a colleague?
83% Yes 7% No

If no, why not? (please specify)
- too general
- more depth needed, more topics
- I would like to receive
- interpretation is questionable
- would like information on getting latest plan
- too vague
- too long; takes too long to get to the point
- nurse aide information not in format to utilize in practice environment; needs follow-up

XII. *Profiles of Member Boards*

Have you received the *Profiles of Member Boards*?
6.4% Yes 85.1% No
If no, skip to EXHIBITING. If yes, please answer the following questions.

Please rate *Profiles of Member Boards* for its value of information on a scale of 1-5, with 1 being poor and 5 being excellent (circle your choice).
Average rating: 4.04

Is the information in the *Profiles of Member Boards*:

Current?	83% Yes	7% No
Accurate?	90% Yes	0% No
Useful?	80% Yes	10% No

Would you recommend *Profiles of Member Boards* to a colleague?
73% Yes 16% No

If no, why not? (please specify)
- information accessible other ways—call Member Board

EXHIBITING

Have you attended a national nursing/regulation meeting/convention in the past year?
39.7% Yes 54.2% No
If no, skip to last section. If yes, please answer the following questions.

While there, have you ever seen National Council's exhibit booth?
70% Yes 28% No

If yes, where? (check all that apply)
16% ANA
47% NLN
13% AACN
2% AONE
1% NAPNES
1% NFLPN
5% NSNA

Other:
- NOADN
- Sigma Theta Tau
- Sigma Theta Tau
- NOADN
- Sigma Theta Tau
- NOADN
- NOADN—Don't forget us!
- National Council Annual Meeting
- Sigma Theta Tau
- CBHDP-NLN Milwaukee
- NOADN
- NOADN
- Mosby conference
- Consumer Advocacy Center
- NPACE

Would you like to see National Council's exhibit at a convention other than those listed above?
24% Yes 43% No

If yes, please specify:
- specialty nursing organizations
- NOADN (listed multiple times)
- N.Y. State Health Occupations Educators Conference, October 1996, Buffalo, New York

- Mosby's
- state board programs
- NONPF
- AVA
- multimedia conference by Stewart Publishing Medical College of Pennsylvania Conferences
- NOADN
- not sure
- ENA Emerging Nurses Association Leadership symposium
- every major conference for nursing, especially nursing education, such as NLN council for research in Nursing Education
- ICN—Vancouver, 1996
- Sigma Theta Tau
- AORN
- specialty organizations
- nursing educators conference at University of Memphis
- NNSDD Conventions

Was the exhibit staff able to answer your questions?
56%Yes 2% No

Did you pick up information?
56% Yes 10% No

TELL US ABOUT YOURSELF
Please answer the following questions to tell us about yourself:
Are you (check all that apply)
81.7% RN
1.7% LPN/VN
0.6% Board staff
7.5% Board member
60.1% Dean/Director
54.8% Educator
2.1% Board executive officer

Other (please specify):
- regional director, P.H.
- previous board member
- consumer member
- director, staff development
- nurse practitioner
- board president
- former board member
- student advanced registered nurse practitioner
- acute care case manager; W/E Nursing Supervisor
- recruiter
- staff nurse
- SNA staff
- board committee member
- Public Member of board of nursing
- CEO, own company
- chairperson
- executive of state nurses association
- former board member

- librarian
- VP nursing
- assistant director
- school librarian
- SNA executive director

In general, how do you hear about the publications you purchase?

42.9% advertisements in nursing journals
78.3% direct mail
35.6% references in journal articles
43.3% word of mouth

Other (please specify)

- material sent to me by colleagues
- item writer
- Internet
- state educators group
- conventions
- board of nursing
- item writer
- convention
- conventions/workshops
- calling National Council
- reprinted by board staff
- Marcia Rachel
- deans and directors council
- *Issues*
- pass-alongs
- college
- colleagues
- state board

How many nursing/regulation publications do you purchase in a year?

7.2% 0
56.1% 1-4
21.7% 5-10
6.8% 11+

What other types of informational communications would you like to see from the National Council?

- develop a video on delegation; most practice acts now include this, but most nurses have never been taught how/when/why to delegate
- procedures/practices that may be rule role questionable with specific requirements, e.g., insertion of PEG tube (req.) administration of chemotherapy (req.)
- changes in nursing; trends in health care; new advancements in nursing responsibility
- I would like to receive information on all of the publications you have asked about in this survey!
- improve the *NCLEX Program Reports*; for the money, they are a rip-off!
- would purchase more National Council communications if I knew they were available
- information regarding impact of institutional licensure and Pew Commission Board recommendations
- current change being proposed and National Council's response—for example, institutional licensure being proposed by Pew, what is National Council's response; other legislation
- a Web page is a great idea; the classroom/office of the future is already here; an important publication such as yours on the Web adds incentive for others to follow
- listing of NLN-approved programs from all the states to the Master level

- articles such as delegation in nursing by V. Burbach are excellent and timely resources; keep up this type of information
- discussion on NAFTA, Pew, etc.
- concern about unlicensed persons
- more information on National Council publications; after leaving the board (member), it is hard to keep up with changes
- would like to see many of these items listed
- information on learning-disabled students and preparing them for NCLEX-RN
- we are a very rural region; the state office receives much of this information
- national and state statistics regarding NCLEX-RN test plan output
- anything that helps our educational programs keep current, relevant, etc.
- simulation, full explanation on item-writing, item evaluation
- I would like to be placed on mailing list for all publications; I really enjoy *Issues*, and would like to receive more National Council information
- job analysis projections
- none—I am inundated already with information
- meets my needs as is
- how do I receive all of these publications; they sound great!
- I would like to receive a brochure of National Council publications? I was not aware of publications available; I would also like information about membership
- advance notice on forthcoming changes in NCLEX-RN
- job analysis for RN and LPN model nurse aide regulation model guidelines
- 1. Suggestions for nursing curriculum content related to board activities
  2. video of examples of board meetings
  3. video of reg. process in substance abuse
  4. video depicting interrelationship of National Council-state boards of nursing-NLN-ANA-NSNA
- trends in item writing content so professors can develop questions that are similar in style
- not sure what available from National Council
- legal issues, definitions of scope of practice, some information regarding displacement of RN/education of work force/substitution with auxiliary staff; more encouragement towards autonomy and independent practice
- mini legislative update in *Issues*
- more definitive information regarding performance of candidates on NCLEX-RN
- strategies to assist students in taking the exam right away and not delay appointments
- analysis of multiskilling and public safety issues
- information advertising your publications separate from *Issues*
- appreciate being on mailing list; *Issues* has been very valuable and would like others
- more information regarding VN board; results and any changes in how passing rates are determined and what are criteria for test questions included, e.g., recency of information, sources of information, universality of test items
- basically, less-fragmented information
- system by which schools of nursing can obtain pass rate of graduates in timely fashion no matter where the graduate sits for the NCLEX-RN
- trends in education and practice are most useful at this time; think you cover it well
- national trends in nursing
- nurse practice changes, nursing practice models, stand on advanced practice and use of UAPs; differentiated roles of LPN, ADN, BSN, Master's
- listing of area educational programs available
- need to have people writing with current information at hand; things in small hospitals remain the same but new technology in the larger facilities may have some students not getting questions right

Comments:

- have not yet received our first [NCLEX Program] report
- thank you for your interest
- most [of the publications purchased are] supplied by state board
- no easy access [to SNLQ on the Internet]

- I like to keep current [on legislation about nursing and/or HIV/AIDS; not aware that NC has brochures available on all subjects]; we just subscribed have not received yet [NCLEX Program Reports]
- I appreciate pertinent information on NCLEX to share with students; I have often found useful material in *Issues* which I share as well
- I chose not to order program reports due to cost; we used to subscribe to the report publication but found it to have limited usefulness
- [not aware of brochures available] for those checked 'No'
- I would like back issues of materials not received which have been identified in this survey
- I frankly cannot remember which I have seen/used
- requested information on [Job Analysis] price, etc., July 20, 1995: no response
- would like access to some brochures we do not receive
- You are doing a great job; don't get discouraged!
- much of the information you have requested is not available at this time for me to review and answer appropriately; I enjoy *Issues*; it needs to be concise and limited to current topics
- I found this survey far too detailed to fill out with any accuracy
- please see comments under program reports
- we need all of the information available to serve our membership
- I am sent this survey, yet do not have access to your services/publications; while some SNAs have adversarial relationships, we have a good relationship and I would like to receive more info from National Council; thanks
- I am retired
- this document too long and covered too many subjects; I just couldn't finish it; also, asking questions about 1991 documents and older, too [demanding]—I would have to go to files to find out!!
- I feel the National Council has expanded into areas that are addressed better by the professional organizations; it would appear that the National Council is trying to overstep its authority and will be answerable to no other group
- while the university may receive your publications, I have not routinely received or read same
- thank you
- I believe you stay current; the information is useful; there is no need to request special topics since you usually stay abreast of changes; just keep EQUAL representation of service and education
- please add my name to list of publications specified in this questionnaire; also, send me information on above as how we can receive
- many of the sections do not apply to me directly; as a member of the IdahoBoard of Nursing, I receive the information and work on that at board meetings
- Send all materials available; I use them!
- I don't remember the names of all the publications I've received
- I've enjoyed all the information received
- we must eliminate all nursing programs that water down the quality of professionals; only four-year BS degree programs should exist if we want to elevate our profession to that of equivalent professions; the shortage is over, so we must stress education
- I am new in the position of director of nursing; I would like to receive all your information.
- it is difficult to answer much of this as I receive an incredible amount of nursing information and I really do not remember where I receive it; I refuse to remember because it adds to the "mind clutter" that I do not need
- I am unaware of the total array of communications published
- new board member, not sure of titles, but enjoy what I read
- I am very impressed by the caliber of resources from the National Council
- I am interested in becoming more involved in NLN in a working role
- I appreciate the work and involvement of the National Council; executive staff always most helpful
- I would be interested in a summary of the results of this survey
- no reference to availability on board of nursing; direct address mailing would help
- my interest in National Council activities is simply a way for me to keep up as a former assistant executive director of a state board; even though I'm no longer at the board, I'm still very interested, but *Issues* alone meets my needs; good publication!
- testing needs to be consistent with technology; example: hip fx-nursing core has changed very much at larger hospital—this is just one example of things to come
- would like to receive brochure on publications

- I am new in my role, which influenced my awareness and responses to this survey; in general, I am impressed with the quality and helpfulness of the National Council's information and activities; thanks!
- please consider separate exams for two- and four-year graduates; having the same exam seems unfair to each and to their expected roles upon graduation
- we are an LPN program and only receive *Issues*, which I read and have gotten a lot of information from pertaining to NCLEX-PN
- have purchased the *Regulatory Advanced Practice RNs* and *Role Delineation Study*
- I like reading the articles in *Issues* and *Newsletters*; they are informative and updated; I am glad to see that the National Council is represented and present/involved in various organizations' committees, meetings, programs, etc., especially the Pew Commission

Report of the Educational Programs Task Force

Task Force Members
Margaret Howard, NJ, Area IV, *Chair*
Lucille Baldwin, AL, Area III
Peggy Hawkins, NE, Area II
Toma Nisbet, WY, Area I

Staff
Sue Davids, *Meetings Manager*

Relationship to the Organization Plan
Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation
Objective C..... Facilitate communication between National Council, Member Boards and related entities.

Recommendations to the Board of Directors
No recommendations.

Highlights of Activities
The 1996 Call For Papers was distributed at the 1995 Annual Meeting to all attendees who received a copy of the proceedings book. It was mailed to Member Boards in October and December with the *Newsletter*. It was mailed to every accredited school of nursing across the country in October. Nineteen abstracts were received, with 12 from Member Boards and seven from educators. The task force reviewed all abstracts, selecting six presentations and one alternate to complete the 1996 Educational/Research Sessions.

Proceedings books will continue to be published and one copy distributed to each meeting attendee upon registration.

Volunteer moderators will continue to be sought for the educational/research sessions. Invitations to serve are extended in the spring with the general "Call for Volunteers" in the *Newsletter*.

Based on responses from the 1995 Annual Meeting evaluation, the task force recommended that poster sessions be continued for the 1996 Annual Meeting. Four out of six abstracts selected accepted the invitation.

Future Activities
Distribute the 1997 Call for Papers, and plan and select National Council-sponsored education offerings to be held in conjunction with the 1997 Annual Meeting.

Meeting Dates
- March 4-5, 1996

Report of the Information Services Evaluation Task Force

Task Force Members

Sandra MacKenzie, MN, Area II, *Chair*
JoAnn Allison, NH, Area IV
Marsha Green, OK, Area III
Laura Poe, UT, Area I

Staff

John Ditzel, *Software Trainer/Help Desk Coordinator*

Relationship to the Organization Plan

Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective A ..... Implement a comprehensive repository of information.

Recommendations to the Board of Directors

1. **That the National Council continue to advance, with high priority, its presence on the Internet.**

   Rationale

   There are many stakeholders in the nursing regulation industry: students, nurses, consumers, educators, hospitals etc. Capturing the information created by those sources and leveraging it to best serve the membership is on target with the mission of the National Council. The Internet is the place where that information is traveling. It is there that data will be acquired, managed, and shared. The evolution of NCNET to the Internet is important. NCNET is set of services that allows Member Boards to share information and network with each other to better serve their constituents. By moving to the Internet, the breadth of information and potential deliverable services is greatly increased. With this recommendation, the task force supports the current move to the Internet by the National Council and commends the Board for making it possible.

2. **That the Information Services Evaluation Task Force be an ongoing special committee, which meets three times per year, in order to serve as a Quality Assurance team for strategic National Council information services.**

   Rationale

   New technology fosters information opportunities. What couldn't be done a few years ago, is now achievable. The National Council's growing Information Master Plan (IMP) reflects those growing possibilities and will be ever evolving. The software won't just be developed and the IMP finished. The services described in the IMP are dynamic: some change direction, others are constant, and some may outlive their utility. A mechanism needs to be in place to assure congruency between those dynamic services and the mission of the National Council. The task force believes it should be the mechanism. By meeting on an ongoing basis, the input and scrutiny of the task force is consistently available to help guide the IMP.

3. **The name of the task force be changed from "Information Services Evaluation Task Force" to "Strategic Technology and Information Management Task Force."**

   Rationale

   The task force believed its name did not adequately reflect its charge. "Strategic" was chosen to focus on those information services that are long term and mission driven. "Technology" and "Information" were chosen because they represent the tools and the content of the IMP, respectively, which must be evaluated. "Management" reflects the need to help guide the IMP, and not simply react to it.

Background

The May meeting of this task force was the first and only for this fiscal year. The first order of business was to review the charge from the Board of Directors:

> *"Review of all implemented IMP services to date, including successes/failures, to modify future planning and implementation process that incorporate evolving needs and available technological solutions."*

The two basic elements of that charge are to review what has been done and suggest possible changes. Before the task force could evaluate what has been done, it needed to take a look at the Information Master Plan (IMP) to determine what was promised. Following review of the materials provided by staff, the task force suggested that a single document be prepared that not only reflects the current IMP, but provides a means by which it can be easily modified as information services change over time. That would allow people to read the IMP at any point in time and understand its relevance at that time.

Highlights of Activities

- **Evaluation of Existing Services**

  The task force was pleased with the information services they reviewed and supported the direction already underway on many services. Task force members were shown the three National Council World Wide Web sites: Staff, Member Board, and Public. The services they evaluated were: SAHVI (Storehouse of Administative, Historical and Volunteer Information), EIRs (Electronic Irregularity Reports), Accufacts, EDWARD (Electronic Document Warehousing and Retrieval Database), News, DDB (Disciplinary Data Bank), Inter-Member Board Communication, and NIS (Nurse Information System). The task force's comments regarding those services were provided to the Board of Directors and staff, and will be considered by staff as NCNET services are developed and delivered. While task force members offered their collective input on individual NCNET services, perhaps the most important outcome of their review was their support for the National Council to continue its effort to develop a presence on the Internet. Since the Internet is, arguably, the global standard for information exchange, they believed that the National Council is best equipped to be the focal point on the Web for nursing regulation information.

- **Modify Future Planning and Implementation Process**

  The task force agreed that the process of software development is a complex environment. The goal of that process is to optimally leverage technological and people resources to satisfy information needs. At the National Council, there is a staff of Information Resources (IR) experts who are not nursing regulators and a membership of nursing regulation experts who are not experts regarding computer technology. The IR staff may have great ideas, but those ideas may not be as useful to the membership as might others. On the other hand, the membership may have great ideas, but those ideas may be technically unfeasible.

  The task force believes that a strong, synergistic relationship should be formed between the membership and IR staff. Combining the nursing regulation expertise of the membership with the technology expertise of the IR staff should provide a product that is greater than their individual efforts. The location for this synergy should be the task force; a convention that enables the working dialogue between both parties. With that outcome in mind, the task force recommended that it meet more than one time per year. Over the next few years, the greatest amount of dialogue will empower IR staff to build the most effective information infrastructure. After three or four years, the task force should be able to scale back its efforts to more of a "maintenance mode" as the number of new services developed each year is expected to decrease.

Other Activity

In addition to offering advice on the existing services and recommending a planning/implementation approach, the task force also suggested that IR staff use Total Quality Management techniques to develop software. This was suggested in order to ease the complexity and contribute to the effectiveness of NCNET services.

Future Activities

This task force will continue its work to give valuable Member Board input into the evaluation of NCNET services.

Meeting Dates

- May 13-14, 1996

Recommendations to the Board of Directors

1. That the National Council continue to advance, with high priority, its presence on the Internet.

2. That the Information Services Evaluation Task Force be an ongoing special committee, which meets three times per year, in order to serve as a Quality Assurance team for strategic National Council information services.

3. The name of the task force be changed from "Information Services Evaluation Task Force" to "Strategic Technology and Information Management Task Force."

Report of the Nurse Information System (NIS) Task Force

Task Force Members
Vicky Burbach, NE, Area II, *Chair*
Brenda Butler Smith, VT, Area IV
Anna Ferguson, OK, Area III
Brenda Smith, IN, Area II
Ruth Ann Terry, CA-RN, Area I

Staff
Melanie L. Neal, *NIS Program Manager*
Peggy Iverson, *NIS Administrative Assistant*

Relationship to Organization Plan
Goal IV ..... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective B ..... Establish a nurse information system for use by Member Boards and others.

Recommendations to the Board of Directors
No recommendations.

Highlights of Activities

- **NIS Policy Development**
  The NIS Task Force met in June 1995 and made a recommendation to the Board of Directors regarding NIS pricing policies. The task force did not meet for further policy development in fiscal year 1996, and has not identified the need for additional policies, to date.

Future Considerations for the National Council
Future needs for NIS Member Board input, in areas such as Member Board participation and usefulness of services, will be addressed by focus groups convened for those specific purposes (pending approval of fiscal year 1997 tactics).

Meeting Dates
None in FY96.

Report of the Long Range Planning Task Force

Task Force Members
Leola Daniels, ID, Area I, *Chair*
Nancy Durrett, VA, Area III, *Board of Directors' Liaison*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Sharon Weisenbeck, KY, Area III

Staff
Doris E. Nay, *Associate Executive Director*

Relationship to the Organization Plan

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective A ..... Implement a planning system to guide the National Council.

Recommendation to the Board of Directors

1. **That the recommended revised mission statement of the National Council, as presented, be forwarded to the 1996 Delegate Assembly for adoption.**

   The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

   Rationale
   The mission statement of the National Council of State Boards of Nursing adopted by the Delegate Assembly in 1984 and reaffirmed by the 1990 Delegate Assembly reads:

   The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

   In September 1995, in accordance with its planning schedule, the Long Range Planning Task Force asked executive officers and board members via the *Mission Statement and Objective Importance Survey* to 1) evaluate the mission statement of the National Council, and 2) determine the importance of the objectives identified in the National Council's Organization Plan. At its April meeting, the task force examined the mission statement of the National Council based on review of all of the data received from survey respondents, the Board of Directors and the 1996 Area Meeting participants. The following definitions/statements were used to frame the discussion:
   - The organization plan is comprised of the mission statement, goals and objectives.
   - The mission statement guides organizational activities and identifies its relationship to the public interest, the reason for being.
   - Goals are broad statements that identify major thrusts of the organization which contribute to the achievement of the mission statement.
   - Objectives are courses of action to accomplish the goals.
   - The Articles of Incorporation identify the following purpose of the National Council of State Boards of Nursing: *Educational and charitable purposes including the lessening of the burdens of government by providing an organization through which Boards of Nursing act on matters of common interest and concern affecting the public health, safety, and welfare including the development of licensing examinations in nursing.*

The task force discussed the retention of the term public policy in the proposed mission statement. Among the issues discussed was the general lack of a clear understanding of the term public policy. Also cited was confusion with the "public policy area" of National Council staff, thus seeming to create a need to identify other aspects of National Council activities, e.g., testing, nursing practice and nursing education, research and communications. In addition, the task force noted that *advance* "stresses effective assisting in hastening a process of bringing about a desired end." As the result of this discussion, the term public policy is not included in the proposed mission statement.

The task force also discussed at length the concept that the National Council is *created* by its 61 member boards of nursing; that the organization is not independent of its members. In other words, while there may be a perception by some that the National Council is an organization that exists separately from the 61 member boards of nursing, the task force chose to discuss the mission statement using the premise that the National Council exists because of and on behalf of its membership. Therefore, the task force agreed that the organization's mission should be reflective of that of its members. Experts working with organizational planning recommend that a mission statement be memorable, compelling and forceful.

The task force believes that the mission statement as proposed:

The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

- complements the goals and objectives adopted by the 1994 Delegate Assembly that address examinations, nursing practice, nursing education, research, public policy, and communications;
- does not include implementation methodology;
- is shorter and more concise, being reduced to 32 words from more than 95 words;
- is easy to remember and quote;
- is clear to consumers and the public which we serve; and,
- expresses the uniqueness and direction of the National Council.

The proposed mission statement was presented to the Board of Directors for consideration at its May 8-10, 1996, meeting with the recommendation that it be forwarded to the 1996 Delegate Assembly.

Highlights of Activities

The Long Range Planning Task Force reviewed the results of the *Mission Statement and Objective Importance Survey* completed by executive officers and board members of Member Boards. For each of the 25 objectives in the National Council's Organization Plan, respondents were asked to identify the eight most important and the eight least important objectives in terms of how they assist a Member Board to perform its functions. The methodology used in conducting the survey and the results of the data analysis are found with this report as Attachment A.

The results of the objective importance survey identified the following eight objectives rated as having the greatest importance to boards of nursing (ranked highest to lowest):

Rank

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

1. *Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.*

Goal II. Provide information, analysis and standards regarding the regulation of nursing practice.

2. *Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

3. *Objective G. Promote consistency in the licensure and credentialing process.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

4. *Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

5. *Objective A. Conduct job analysis studies to serve as the basis for examinations.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

6.5. *Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel. (tie)*

Goal III. Provide information, analyses and standards regarding the regulation of nursing education.

6.5. *Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing education. (tie)*

Goal II. Provide information, analysis and standards regarding the regulation of nursing practice.

8. *Objective B. Provide resources regarding health care issues which affect the regulation of nursing practice.*

The objectives rated as having the **least** importance to board of nursing functioning were:

Rank

Goal V. Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

17. *Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.*

18. *Objective B. Maintain a sound resource management system for the National Council.*

19. *Objective D. Provide consultation and services to meet unique Member Board needs.*

Goal II. Provide information, analyses and standards regarding the regulation of nursing practice.

20. *Objective D. Provide for Member Board needs related to disciplinary activities.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

21. *Objective H. Identify the role of a board of nursing related to continued competence.*

Goal IV. Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

22. *Objective D. Conduct and disseminate research pertinent to the mission of the National Council.*

Goal V. Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

23. *Objective A. Implement a planning system to guide the National Council.*

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

24.5. *Objective D. Provide a competency evaluation program for nurse aides. (tie)*

Goal V. Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

24.5. *Objective G. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division. (tie)*

Comparison of the rank-ordered objectives based on executive officers' ratings with those of the total group revealed that while there were some differences in order, there was agreement on seven of the eight top rated objectives. The executive officers' ratings replaced **Goal III.** ***Objective A.*** *Analyze the health care environment for trends and issues affecting the regulation of nursing education,* with **Goal IV.** ***Objective C.*** *Facilitate communication between National Council, Member Boards and related entities,* among the top eight objectives. Although there were several differences in order, there was also good agreement between the top eight ranked objectives based on board members' ratings and those of the total group. The board members' ratings replaced **Goal 1.** ***Objective A.*** *Conduct job analysis studies to serve as the basis for examinations,* with **Goal IV.** ***Objective B.*** *Establish a nurse information system (NIS) for use by Member Boards and others.* Comparison of the executive officers' and board members' importance rankings of the remaining 17 objectives also demonstrates general agreement with regard to placement of objectives within the "low" and "moderate" importance groups.

The task force updated the Long Range Plan Internal Working Document, which is used as a guide for the Long Range Planning Task Force and the Board of Directors. The document contains directional goals and benchmark tactics extending five years into the future for each objective in the Organization Plan. Each year, the Long Range Planning Task Force reviews the document, considers all available resources and prepares an updated plan for consideration by the Board of Directors.

The Long Range Planning Task Force finalized the proposed tactics to implement the Organization Plan in FY97 for presentation to the Board of Directors. The task force, in addition to reviewing the results of the *Mission Statement and Objective Importance Survey,* reviewed the status of the FY96 tactics; the 1995 Environmental Scan reports, prepared by National Council staff, on the topics of society, nursing education, nursing practice, testing/assessment, and regulation/legislation; ideas generated at the 1996 Area Meetings and Regulatory Days of Dialogue; and the recommendations received from National Council committees, special committees and staff. Consistent with the Annual Planning System, the Board of Directors tentatively adopts the tactics to implement the Organization Plan pending Delegate Assembly action/s. The tactics are used to guide the FY97 budget planning.

Future Activities

During FY97, the Long Range Planning Task Force will conduct a survey to determine the effectiveness of the National Council in meeting its objectives; perform a trend analysis survey; and evaluate the effectiveness of the 1994 revision of the bylaws.

Meeting Dates

- February 1-2, 1996
- March 11, 1996 *(telephone conference call)*
- April 22-23, 1996

Recommendation to the Board of Directors

1. **That the recommended revised mission statement of the National Council, as presented, be forwarded to the 1996 Delegate Assembly for adoption.**

   The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

Attachments

A .....Final Report – Relevance of the National Council's Mission Statement and Importance of Organizational Objectives to Member Boards' Performance of Their Functions, *page 5*

B .....Environmental Scan - Executive Summary, *page 25*

Attachment A

FINAL REPORT

RELEVANCE OF THE NATIONAL COUNCIL'S MISSION STATEMENT AND IMPORTANCE OF ORGANIZATIONAL OBJECTIVES TO MEMBER BOARDS' PERFORMANCE OF THEIR FUNCTIONS

The purpose of this study was to obtain membership input regarding the relevance of the National Council's mission statement and the importance of its objectives relative to boards of nursing performing their functions.

METHODOLOGY

Data collection

Data were collected between September and mid-November, 1995, via a questionnaire mailed to (1) the executive officer of each Member Board (n=61) and (2) members of each Member Board (n=596). A cover letter explaining the purpose of the study and the confidentiality of responses accompanied each questionnaire. The return of questionnaires was promoted by the inclusion of a return envelope, articles in the National Council's *Newsletter* and phone calls to Member Boards' executive officers requesting their assistance in promoting board member participation. Replacement questionnaires were supplied upon request.

Instrument description

A three-part questionnaire was used to collect data. Part I contained two questions addressing the relevance of the Mission Statement. Part II contained a list of the 25 objectives included in the FY96 Organization Plan. Study participants were requested to identify the eight most important and the eight least important objectives based on how they assist a Member Board to perform its functions. The one question in Part III requested information about the nature of respondent's affiliation with a board of nursing. Copies of the cover letter and questionnaire are included in Attachment A1 on page 18.

Data preparation

Upon return, questionnaires were screened to determine level of respondent compliance with directions. Those completed according to instructions were either scanned or the data hand entered into database files. Accuracy of data entry was verified prior to proceeding with data analysis. Of the 200 questionnaires returned, 41 contained unusable data for Part II. The primary reason for rejection was respondent failure to follow directions which required that they identify the eight most important and the eight least important objectives.

RESULTS

Questionnaires were returned by 200 individuals for an overall response rate of 30 percent. Respondents represented 55 of the 61 (90%) Member Boards and included 47 of the 61 (77%) executive officers and 153 of 596 board members (26%). The distribution by type of board member is provided in Figure 1 on page 8. Member Board representation by National Council Area designation is reported in Figure 2 on page 8.

Data analysis for Part I (mission statement relevance), Part II (objective importance) and Part III (demographic data) consisted of frequency distributions and the cross tabulation of data based on type of affiliation with a Member Board (executive officer, board member) and Area designation. In addition, total and mean importance ratings were calculated for each of the objectives listed in Part II based on assignment of the following values: 2 = identified as 1 of 8 objectives having the highest importance, 0 = identified as 1 of 8 objectives having the lowest importance, 1 = the 9 remaining "middle importance" objectives.

The results of data analysis are reported for the following groups: (1) total group, (2) executive officers, (3) board members, (4) total group by National Council Area designation, (5) executive officers by National Council Area designation, and (6) board members by National Council Area designation.

Mission Statement Relevance

Study participants responded to two questions related to the Mission Statement: *The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.*

An overwhelming majority (191, 97%) of the 197 respondents answering the question, replied that the Mission Statement reflects activities in which the National Council should continue to engage (See Table 1). Dissenters were one executive officer and two board members in Area I, one executive officer and one board member in Area III, and one board member in Area IV. Likewise, 98.5% (193) of the 196 respondents answering the question, indicated that the services and guidance provided by the National Council were consistent with individual Member Boards' regulatory responsibilities (See Table 2). Negative responses were indicated by one board member in Area I, and by one executive officer and a board member in Area III. See National Council Mission Statement and Objectives Survey - Comments (Attachment A2 on page 21).

Importance of Objectives

The importance of each of the 25 objectives contained in the National Council's FY96 Organization Plan, in terms of how they assist a Member Board to perform its functions was rated by 159 individuals (45 executive officers and 114 board members). The mean importance and total importance ratings are reported in Tables 3 and 4, respectively, for all respondents and separately, by the executive officers and the board members. The objectives were then rank ordered (1 = highest rating, 25 = lowest rating). Rankings for the total group's ratings are reported in Table 5. For comparison, the rankings of the executive officers' and of the board members' ratings are also reported in Table 5. (For reporting purposes, wording of the objectives included in Tables 3 - 10 was shortened; the full text is included in the text of the report and on the questionnaire.)

Based on the responses of the total group, the eight objectives rated as having the **greatest** importance to boards of nursing functions were (ranked highest to lowest):

1. Provide examinations that are based on current accepted psychometric principles and legal considerations.

2. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

3. Promote consistency in the licensure and credentialing process.

4. Provide a comprehensive approach for the regulation of advanced nursing practice.

5. Conduct job analysis studies to serve as the basis for examinations.

6.5. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel. (tie)

6.5. Analyze the health care environment for trends and issues affecting the regulation of nursing education. (tie)

8. Provide resources regarding health care issues which affect the regulation of nursing practice.

The objectives rated as having the **least** importance to board of nursing functioning were:

17. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

18. Maintain a sound resource management system for the National Council.

19. Provide consultation and services to meet unique Member Board needs.

20. Provide for Member Board needs related to disciplinary activities.

21. Identify the role of a board of nursing related to continued competence.

22. Conduct and disseminate research pertinent to the mission of the National Council.

23. Implement a planning system to guide the National Council.

24.5. Provide a competency evaluation program for nurse aides. (tie)

24.5. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division. (tie)

Between these two extremes were the following eight objectives whose rankings indicate they have "**moderate**" importance to Member Board functioning:

9. Establish a nurse information system (NIS) for use by Member Boards and others.

10. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

11. Facilitate communication between National Council, Member Boards and related entities.

12. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

13. Develop and implement a systematic approach for shaping health care policy related to regulation.

14.5. Provide resources regarding issues that affect the regulation of nursing education. (tie)

14.5. Implement a comprehensive repository of information. (tie)

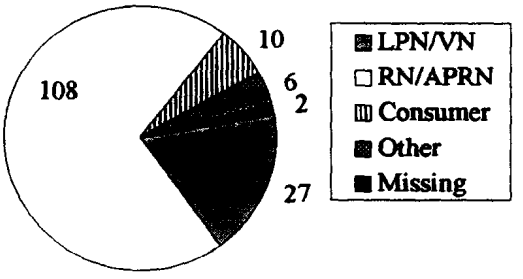
16. Conduct research on regulatory issues related to disciplinary activities.

Comparison of the rank ordered objectives (see Table 5), based on executive officers' ratings with those of the total group, revealed that while there were some differences in order, there was agreement on seven of the eight top-rated objectives. The executive officers' ratings replaced *Analyze the health care environment for trends and issues affecting the regulation of nursing education,* with *Facilitate communication between National Council, Member Boards and related entities,* among the top eight objectives Although there were several differences in order, there was also good agreement between the top eight ranked objectives based on board members' ratings and those of the total group. The board members' ratings replaced *Conduct job analysis studies to serve as the basis for examinations,* with *Establish a nurse information system (NIS) for use by Member Boards and others,* among the

top eight objectives. Comparison of the executive officers' and the board members' importance rankings of the remaining 17 objectives also demonstrates general agreement with regard to placement of objectives within the "low" and "moderate" importance groups.

Data from respondents were also compiled based upon each Member Board's National Council Area designation. The mean and total importance ratings for the total group (n=159) and for respondents within a specific Area designation are reported in Tables 6 and 7, respectively. Table 8 provides a comparison of the objectives' rank order, based on ratings of all respondents within a specific Area and for the total group. Tables 9 and 10 contain, respectively, the mean importance ratings and the objectives' rank order based on the responses of the executive officers and of the board members within each Area designation. Although there are a few exceptions, the data reported in Tables 6 - 10 demonstrate general agreement regarding the level of importance of the National Council's Organization Plan objectives across the four Areas and between executive officers and board members within a specific Area designation.

Figure 1. Distribution of board members



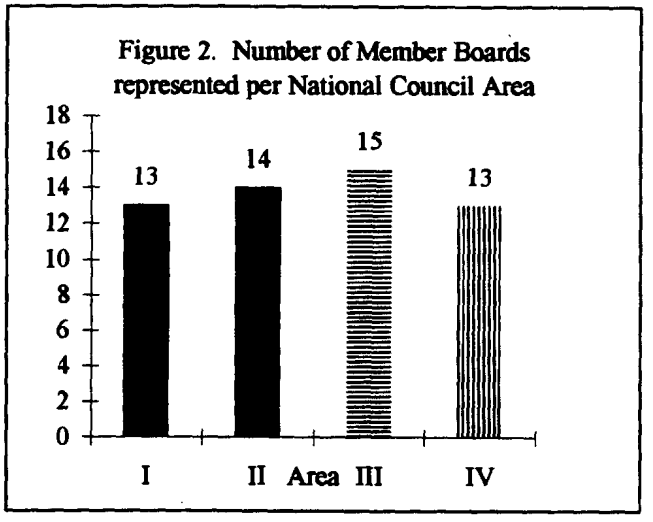


Table 1. Responses of executive officers and board members: Mission statement reflects activities the National Council should continue to engage in.

Group	Area I		Area II		Area III		Area IV		Totals	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Executive officers	12	1	11	0	11	1	9	0	43	2
Board Members	22	2	44	0	41	1	41	1	148	4

Table 2. Responses of executive officers and board members: Services and guidance provided to Member Boards are consistent with the board of nursing's responsibilities.

Group	Area I		Area II		Area III		Area IV		Totals	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Executive officers	13	0	11	0	11	1	10	0	45	1
Board Members	23	1	43	0	41	0	41	1	148	2

Table 3. Objectives - Mean importance ratings: Total sample, executive officers and board members

OBJECTIVES	Mean Rating: Total Sample (N = 159)	Executive Officer (N =45)	Board Member (N =114)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	1.28	1.64	1.14
2. Provide Examinations Based on Psychometric and Legal Considerations	1.75	1.93	1.68
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	0.98	1.00	0.97
4. Provide Nurse Aide Competency Evaluation Program	0.49	0.62	0.44
5. Provide Comprehensive Approach to Regulate Advanced Practice	1.33	1.29	1.35
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	1.21	1.16	1.24
7. Promote Consistency in Licensure and Credentialing Process	1.48	1.24	1.58
8. Identify Role of Board Related to Continued Competence	0.68	0.67	0.68
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	1.53	1.49	1.54
10. Provide Resources RE: Issues Which Affect Regulation of Practice	1.21	1.31	1.17
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	0.84	0.98	0.78
12. Provide for Member Board Needs Related to Disciplinary Activities	0.73	0.80	0.70
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	1.23	1.00	1.32
14. Provide Resources RE: Issues Which Affect Regulation of Education	0.87	0.69	0.94
15. Implement a Comprehensive Repository of Information	0.86	0.71	0.92
16. Establish a Nurse Information System for Use by Boards and Others	1.19	0.93	1.29
17. Communication between NCSBN, Boards and Related Entities	1.11	1.13	1.1
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	0.65	0.87	0.57
19. Implement a Planning System to Guide the NCSBN	0.62	0.71	0.58
20. Maintain a Sound Resource Management System for the NCSBN	0.82	1.02	0.74
21. Maintain Governance System for NCSBN Leadership/Decision-Making	0.82	0.76	0.85
22. Provide Consultation/Services to Meet Unique Member Board Needs	0.77	0.73	0.78
23. Develop/Implement Systematic Approach for Policy Re: Regulation	0.91	0.87	0.93
24. Analyze Regulation Based on Health Care/Environmental Changes	1.12	1.09	1.14
25. Special Services Division to Support Mission and Programs of NCSBN	0.50	0.36	0.56

Key: 0 = least important; 2 = most important

Table 4. Objectives - Importance ratings: Total sample, executive officers and board members

OBJECTIVES	Sum of ratings: Total Sample (n = 159)	Executive Officers (n = 45)	Board Members (n = 114)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	204	74	130
2. Provide Examinations Based on Psychometric and Legal Considerations	279	87	192
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	156	45	111
4. Provide Nurse Aide Competency Evaluation Program	78	28	50
5. Provide Comprehensive Approach to Regulate Advanced Practice	212	58	154
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	193	52	141
7. Promote Consistency in Licensure and Credentialing Process	236	56	180
8. Identify Role of Board Related to Continued Competence	108	30	78
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	243	67	176
10. Provide Resources RE: Issues Which Affect Regulation of Practice	192	59	133
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	133	44	89
12. Provide for Member Board Needs Related to Disciplinary Activities	116	36	80
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	195	45	150
14. Provide Resources RE: Issues Which Affect Regulation of Education	138	31	107
15. Implement a Comprehensive Repository of Information	137	32	105
16. Establish a Nurse Information System for Use by Boards and Others	189	42	147
17. Communication between NCSBN, Boards and Related Entities	176	51	125
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	104	39	65
19. Implement a Planning System to Guide the NCSBN	98	32	66
20. Maintain a Sound Resource Management System for the NCSBN	131	46	85
21. Maintain Governance System for NCSBN Leadership/Decision-Making	131	34	97
22. Provide Consultation/Services to Meet Unique Member Board Needs	122	33	89
23. Develop/Implement Systematic Approach for Policy RE: Regulation	145	39	106
24. Analyze Regulation Based on Health Care/Environmental Changes	179	49	130
25. Special Services Division to Support Mission and Programs of NCSBN	79	16	63

Table 5. Objectives - Comparison of total sample rank order with executive officers and board members

OBJECTIVES	Ranking: Total Sample (n = 159)	Executive Officers (n = 45)	Board Members (n = 114)
Provide Examinations Based on Psychometric and Legal Considerations	1	1	1
Analyze for Trends/Issues RE: Regulation of Nursing Practice	2	3	3
Promote Consistency in Licensure and Credentialing Process	3	6.5	2
Provide Comprehensive Approach to Regulate Advanced Practice	4	4	4
Conduct Job Analysis Studies to Serve as Basis For Exams	5	2	9
Provide Comprehensive Approach for Unlicensed Assistive Personnel	6.5	6.5	7
Analyze for Trends/Issues RE: Regulation of Nursing Education	6.5	12.5	5
Provide Resources RE: Issues Which Affect Regulation of Practice	8	5	8
Establish a Nurse Information System for Use by Boards and Others	9	12.5	6
Analyze Regulation Based on Health Care/Environmental Changes	10	9	10
Communication between NCSBN, Boards and Related Entities	11	8	11
Conduct Research on Computerized Clinical Simulation Testing (CST)	12	12.5	12
Develop/Implement Systematic Approach for Policy RE: Regulation	13	16.5	13
Provide Resources RE: Issues Which Affect Regulation of Education	14.5	22.5	14
Implement a Comprehensive Repository of Information	14.5	20.5	15
Conduct Research on Regulatory Issues RE: Disciplinary Activities	16	12.5	18
Maintain Governance System for NCSBN Leadership/Decision-Making	17	15	16
Maintain a Sound Resource Management System for the NCSBN	18	10	19
Provide Consultation/Services to Meet Unique Member Board Needs	19	19	17
Provide for Member Board Needs Related to Disciplinary Activities	20	18	20
Identify Role of Board Related to Continued Competence	21	22.5	21
Conduct/Disseminate Research Pertinent to NCSBN Mission	22	16.5	22
Implement a Planning System to Guide the NCSBN	23	20.5	23
Provide Nurse Aide Competency Evaluation Program	24.5	24	25
Special Services Division to Support Mission and Programs of NCSBN	24.5	25	24

Table 6. Objectives - Mean importance ratings: Total sample and National Council Areas

OBJECTIVES	Mean Rating: Total Sample (N = 159)	Area I (N=33)	Area II (N=44)	Area III (N =38)	Area IV (N =44)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	1.28	1.21	1.36	1.21	1.32
2. Provide Examinations Based on Psychometric and Legal Considerations	1.75	1.79	1.73	1.76	1.75
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	0.98	1.06	1.02	0.84	1.00
4. Provide Nurse Aide Competency Evaluation Program	0.49	0.67	0.55	0.39	0.39
5. Provide Comprehensive Approach to Regulate Advanced Practice	1.33	1.3	1.45	1.50	1.09
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	1.21	1.18	1.34	1.03	1.27
7. Promote Consistency in Licensure and Credentialing Process	1.48	1.45	1.55	1.53	1.41
8. Identify Role of Board Related to Continued Competence	0.68	0.73	0.66	0.76	0.59
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	1.53	1.36	1.55	1.53	1.64
10. Provide Resources RE: Issues Which Affect Regulation of Practice	1.21	1.3	1.23	1.21	1.11
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	0.84	0.88	1.02	0.82	0.64
12. Provide for Member Board Needs Related to Disciplinary Activities	0.73	0.73	0.68	0.79	0.73
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	1.23	1.18	1.32	1.11	1.27
14. Provide Resources RE: Issues Which Affect Regulation of Education	0.87	1.09	0.91	0.63	0.86
15. Implement a Comprehensive Repository of Information	0.86	0.76	0.77	1.08	0.84
16. Establish a Nurse Information System for Use by Boards and Others	1.19	1.09	1.11	1.26	1.27
17. Communication between NCSBN, Boards and Related Entities	1.11	1.03	1.00	1.13	1.25
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	0.65	0.7	0.66	0.66	0.61
19. Implement a Planning System to Guide the NCSBN	0.62	0.54	0.52	0.47	0.89
20. Maintain a Sound Resource Management System for the NCSBN	0.82	0.88	0.80	0.79	0.84
21. Maintain Governance System for NCSBN Leadership/Decision-Making	0.82	0.82	0.66	0.92	0.91
22. Provide Consultation/Services to Meet Unique Member Board Needs	0.77	0.94	0.64	0.68	0.84
23. Develop/Implement Systematic Approach for Policy RE: Regulation	0.91	0.85	0.95	0.97	0.86
24. Analyze Regulation Based on Health Care/Environmental Changes	1.12	1.18	1.11	1.21	1.02
25. Special Services Division to Support Mission and Programs of NCSBN	0.50	0.27	0.41	0.71	0.57

Key: 0 = least important; 2 = most important

Table 7. Objectives - Importance ratings: Total sample and National Council Areas

OBJECTIVES	Sum of ratings: Total Sample (n = 159)	Area I (n = 33)	Area II (n = 44)	Area III (n = 38)	Area IV (n = 44)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	204	40	60	46	58
2. Provide Examinations Based on Psychometric and Legal Considerations	279	59	76	67	77
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	156	35	45	32	44
4. Provide Nurse Aide Competency Evaluation Program	78	22	24	15	17
5. Provide Comprehensive Approach to Regulate Advanced Practice	212	43	64	57	48
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	193	39	59	39	56
7. Promote Consistency in Licensure and Credentialing Process	236	48	68	58	62
8. Identify Role of Board Related to Continued Competence	108	24	29	29	26
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	243	45	68	58	72
10. Provide Resources RE: Issues Which Affect Regulation of Practice	192	43	54	46	49
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	133	29	45	31	28
12. Provide for Member Board Needs Related to Disciplinary Activities	116	24	30	30	32
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	195	39	58	42	56
14. Provide Resources RE: Issues Which Affect Regulation of Education	138	36	40	24	38
15. Implement a Comprehensive Repository of Information	137	25	34	41	37
16. Establish a Nurse Information System for Use by Boards and Others	189	36	49	48	56
17. Communication between NCSBN, Boards and Related Entities	176	34	44	43	55
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	104	23	29	25	27
19. Implement a Planning System to Guide the NCSBN	98	18	23	18	39
20. Maintain a Sound Resource Management System for the NCSBN	131	29	35	30	37
21. Maintain Governance System for NCSBN Leadership/Decision-Making	131	27	29	35	40
22. Provide Consultation/Services to Meet Unique Member Board Needs	122	31	28	26	37
23. Develop/Implement Systematic Approach for Policy RE: Regulation	145	28	42	37	38
24. Analyze Regulation Based on Health Care/Environmental Changes	179	39	49	46	45
25. Special Services Division to Support Mission and Programs of NCSBN	79	9	18	27	25

Table 8. Objectives - Comparison of total sample rank order with National Council Area rankings

OBJECTIVES	Ranking: Total Sample (n = 159)	Area I (n = 33)	Area II (n = 44)	Area III (n = 38)	Area IV (n = 44)
Provide Examinations Based on Psychometric and Legal Considerations	1	1	1	1	1
Analyze for Trends/Issues RE: Regulation of Nursing Practice	2	3.5	2.5	2.5	2
Promote Consistency in Licensure and Credentialing Process	3	2	2.5	2.5	3
Provide Comprehensive Approach to Regulate Advanced Practice	4	3.5	4	4	10
Conduct Job Analysis Studies to Serve as Basis For Exams	5	6	5	7	4
Provide Comprehensive Approach for Unlicensed Assistive Personnel	6.5	7	6	12	6
Analyze for Trends/Issues RE: Regulation of Nursing Education	6.5	8.5	7	10	6
Provide Resources RE: Issues Which Affect Regulation of Practice	8	5	8	7	9
Establish a Nurse Information System for Use by Boards and Others	9	10.5	9.5	5	6
Analyze Regulation Based on Health Care/Environmental Changes	10	8.5	9.5	7	11
Communication between NCSBN, Boards and Related Entities	11	13	13	9	8
Conduct Research on Computerized Clinical Simulation Testing (CST)	12	10.5	11.5	15	12
Develop/Implement Systematic Approach for Policy RE: Regulation	13	18	14	13	15.5
Provide Resources RE: Issues Which Affect Regulation of Education	14.5	12	15	23	15.5
Implement a Comprehensive Repository of Information	14.5	19.5	17	11	18
Conduct Research on Regulatory Issues RE: Disciplinary Activities	16	15.5	11.5	16	21
Maintain Governance System for NCSBN Leadership/Decision-Making	17	17	20	14	13
Maintain a Sound Resource Management System for the NCSBN	18	15.5	16	17.5	18
Provide Consultation/Services to Meet Unique Member Board Needs	19	14	22	21	18
Provide for Member Board Needs Related to Disciplinary Activities	20	21	18	17.5	20
Identify Role of Board Related to Continued Competence	21	19.5	20	19	23
Conduct/Disseminate Research Pertinent to NCSBN Mission	22	22	20	22	22
Implement a Planning System to Guide the NCSBN	23	24	24	24	14
Provide Nurse Aide Competency Evaluation Program	24.5	23	23	25	25
Special Services Division to Support Mission and Programs of NCSBN	24.5	25	25	20	24

Table 9. Objectives - Mean importance ratings for board members and executive officers, by Area designation

OBJECTIVES	Mean Ratings: Area I Board Memb. (n=20)	Area I Exec. Off. (n=13)	Area II Board Memb. (n=32)	Area II Exec. Off. (n=12)	Area III Board Memb. (n=27)	Area III Exec. Off. (n=11)	Area IV Board Memb. (n=35)	Area IV Exec. Off. (n=9)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	0.80	1.85	1.28	1.58	1.11	1.45	1.23	1.67
2. Provide Examinations Based on Psychometric and Legal Considerations	1.65	2.00	1.63	2.00	1.70	1.91	1.74	1.78
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	0.95	1.23	1.09	0.83	0.81	0.91	1.00	1.00
4. Provide Nurse Aide Competency Evaluation Program	0.50	0.92	0.56	0.50	0.30	0.64	0.40	0.33
5. Provide Comprehensive Approach to Regulate Advanced Practice	1.35	1.23	1.50	1.33	1.52	1.45	1.09	1.11
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	1.20	0.38	1.34	1.33	1.04	1.00	1.31	1.11
7. Promote Consistency in Licensure and Credentialing Process	1.45	1.46	1.66	1.25	1.74	1.00	1.46	1.22
8. Identify Role of Board Related to Continued Competence	0.80	0.62	0.56	0.92	0.74	0.82	0.69	0.22
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	1.25	1.54	1.56	1.50	1.67	1.18	1.60	1.78
10. Provide Resources RE: Issues Which Affect Regulation of Practice	1.35	1.23	1.09	1.58	1.11	1.45	1.17	0.89
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	0.85	0.92	0.88	1.42	0.78	0.91	0.66	0.56
12. Provide for Member Board Needs Related to Disciplinary Activities	0.44	0.85	0.63	0.83	0.85	0.64	0.69	0.89
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	1.30	1.00	1.50	0.83	1.26	0.73	1.20	1.56
14. Provide Resources RE: Issues Which Affect Regulation of Education	1.30	0.77	0.94	0.83	0.70	0.45	0.91	0.67
15. Implement a Comprehensive Repository of Information	0.85	0.62	0.75	0.83	1.22	0.73	0.89	0.67
16. Establish a Nurse Information System for Use by Boards and Others	1.25	0.85	1.25	0.75	1.30	1.18	1.34	1.00
17. Communication between NCSBN, Boards and Related Entities	0.90	1.23	1.03	0.92	1.00	1.45	1.34	0.89
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	0.80	0.54	0.56	0.92	0.48	1.09	0.51	1.00
19. Implement a Planning System to Guide the NCSBN	0.55	0.54	0.50	0.58	0.44	0.55	0.77	1.33
20. Maintain a Sound Resource Management System for the NCSBN	0.70	1.15	0.75	0.92	0.78	0.82	0.74	1.22
21. Maintain Governance System for NCSBN Leadership/Decision-Making	0.80	0.85	0.69	0.58	0.93	0.91	0.97	0.67
22. Provide Consultation/Services to Meet Unique Member Board Needs	1.05	0.77	0.63	0.67	0.70	0.64	0.83	0.89
23. Develop/Implement Systematic Approach for Policy RE: Regulation	1.05	0.54	1.00	0.83	0.81	1.36	0.89	0.78
24. Analyze Regulation Based on Health Care/Environmental Changes	1.24	1.00	1.19	0.92	1.19	1.27	0.97	1.22
25. Special Services Division to Support Mission and Programs of NCSBN	0.35	0.15	0.44	0.33	0.81	0.45	0.57	0.56

Key: = least important; 2 = most important

Table 10. Objectives - Rank order of importance for board members and executive officer, by Area designation

OBJECTIVES	Ranking: Area I Board Memb. (n=20)	Area I Exec. Off. (n=13)	Area II Board Memb. (n=32)	Area II Exec. Off. (n=12)	Area III Board Memb. (n=27)	Area III Exec. Off. (n=11)	Area IV Board Memb. (n=35)	Area IV Exec. Off. (n=9)
1. Conduct Job Analysis Studies to Serve as Basis For Exams	18.5	2.0	7.0	2.5	9.5	3.5	7.0	3.0
2. Provide Examinations Based on Psychometric and Legal Considerations	1.0	1.0	1.0	1.0	2.0	1.0	1.0	1.5
3. Conduct Research on Computerized Clinical Simulation Testing (CST)	13.0	6.5	10.5	15.5	16.0	14.0	11.0	12.0
4. Provide Nurse Aide Competency Evaluation Program	23.0	12.5	22.0	24.0	25.0	21.0	25.0	24.0
5. Provide Comprehensive Approach to Regulate Advanced Practice	3.5	6.5	4.5	5.5	4.0	3.5	10.0	9.5
6. Provide Comprehensive Approach for Unlicensed Assistive Personnel	10.0	24.0	6.0	5.5	11.0	11.5	6.0	9.5
7. Promote Consistency in Licensure and Credentialing Process	2.0	4.0	1.0	7.0	1.0	11.5	3.0	7.0
8. Identify Role of Board Related to Continued Competence	18.5	19.5	22.0	10.0	20.0	16.5	20.5	25.0
9. Analyze for Trends/Issues RE: Regulation of Nursing Practice	7.5	3.0	3.0	3.0	3.0	8.5	2.0	1.5
10. Provide Resources RE: Issues Which Affect Regulation of Practice	3.5	6.5	10.5	2.5	9.5	3.5	9.0	15.5
11. Conduct Research on Regulatory Issues RE: Disciplinary Activities	15.5	12.5	15.0	4.0	18.5	14.0	22.0	22.5
12. Provide for Member Board Needs Related to Disciplinary Activities	24.0	15.0	19.5	15.5	14.0	21.0	20.5	15.5
13. Analyze for Trends/Issues RE: Regulation of Nursing Education	5.5	10.5	4.5	15.5	6.0	18.5	8.0	4.0
14. Provide Resources RE: Issues Which Affect Regulation of Education	5.5	17.5	14.0	15.5	21.5	24.0	14.0	20.0
15. Implement a Comprehensive Repository of Information	15.5	19.5	16.5	15.5	7.0	18.5	15.5	20.0
16. Establish a Nurse Information System for Use by Boards and Others	7.5	15.0	8.0	19.0	5.0	8.5	4.5	12.0
17. Communication between NCSBN, Boards and Related Entities	14.0	6.5	12.0	10.0	12.0	3.5	4.5	15.5
18. Conduct/Disseminate Research Pertinent to NCSBN Mission	18.5	22.0	22.0	10.0	23.0	10.0	24.0	12.0
19. Implement a Planning System to Guide the NCSBN	22.0	22.0	24.0	22.5	24.0	23.0	18.0	5.0
20. Maintain a Sound Resource Management System for the NCSBN	21.0	9.0	16.5	10.0	18.5	16.5	19.0	7.0
21. Maintain Governance System for NCSBN Leadership/Decision-Making	18.5	15.0	18.0	22.5	13.0	14.0	12.5	20.0
22. Provide Consultation/Services to Meet Unique Member Board Needs	11.5	17.5	19.5	20.0	21.5	21.0	17.0	15.5
23. Develop/Implement Systematic Approach for Policy RE: Regulation	11.5	22.0	13.0	15.5	16.0	6.0	15.5	18.0
24. Analyze Regulation Based on Health Care/Environmental Changes	9.0	10.5	9.0	10.0	8.0	7.0	12.5	7.0
25. Special Services Division to Support Mission and Programs of NCSBN	25.0	25.0	25.0	25.0	16.0	24.0	23.0	22.5

NATIONAL COUNCIL

National Council of State Boards of Nursing, Inc.

676 North St. Clair Street
Suite 550
Chicago, Illinois 60611-2921

312 787.6555
FAX 312 787.6898

Long Range Planning Task Force Survey
National Council Mission Statement and Objectives

Directions: 1. Please use a #2 pencil to fill in the appropriate response bubbles and to provide requested information. Unless directed otherwise, indicate the single BEST response to each item. 2. Return the completed questionnaire to: Sandra Brooks, Administrative Assistant, using the enclosed stamped and addressed envelope by October 16, 1995.

PART I Relevance of Mission Statement

1. Does the mission statement of the National Council of State Boards of Nursing, as stated below, reflect activities the National Council should continue to engage in?

   The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

   ○ Yes ○ No

   Comments:

2. Are the services and guidance provided by the National Council consistent with your board's regulatory responsibilities?

   ○ Yes ○ No

   Comments:

PART II Importance of National Council's Organization Plan objectives in terms of how they assist a Member Board to perform its functions.

Directions: 1. Read entire list of 25 objectives. 2. Identify the EIGHT MOST IMPORTANT and the EIGHT LEAST IMPORTANT objectives. 3. Use the following key to indicate your selections: 3 = eight MOST important objectives; 1 = eight LEAST important objectives; 2 = nine REMAINING objectives.

GOAL I Provide Member Boards with examinations and standards for licensure and credentialing.

1. Conduct job analysis studies to serve as the basis for examinations. ③ ② ①
2. Provide examinations that are based on current accepted psychometric principles and legal considerations. ③ ② ①
3. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure. ③ ② ①
4. Provide a competency evaluation program for nurse aides. ③ ② ①
5. Provide a comprehensive approach for the regulation of advanced nursing practice. ③ ② ①
6. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel. ③ ② ①
7. Promote consistency in the licensure and credentialing process. ③ ② ①
8. Identify the role of a Board of Nursing related to continued competence. ③ ② ①

GOAL II Provide information, analyses and standards regarding the regulation of nursing practice.

9. Analyze the health care environment for trends and issues affecting the regulation of nursing practice. ③ ② ①
10. Provide resources regarding health care issues which affect the regulation of nursing practice. ③ ② ①
11. Conduct research on regulatory issues related to disciplinary activities. ③ ② ①
12. Provide for Member Board needs related to disciplinary activities. ③ ② ①

Key: 3 = eight **MOST** important objectives; 1 = eight **LEAST** important objectives; 2 = nine **REMAINING** objectives.

GOAL III Provide information, analyses and standards regarding the regulation of nursing education.

13. Analyze the health care environment for trends and issues affecting the regulation of nursing education. ③ ② ①
14. Provide resources regarding issues that affect the regulation of nursing education. ③ ② ①

GOAL IV Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

15. Implement a comprehensive repository of information. ③ ② ①
16. Establish a nurse information system (NIS) for use by Member Boards and others. ③ ② ①
17. Facilitate communication between National Council, Member Boards and related entities. ③ ② ①
18. Conduct and disseminate research pertinent to the mission of the National Council. ③ ② ①

GOAL V Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

19. Implement a planning system to guide the National Council. ③ ② ①
20. Maintain a sound resource management system for the National Council. ③ ② ①
21. Maintain a system of governance for the National Council that facilitates leadership and decision-making. ③ ② ①
22. Provide consultation and services to meet unique Member Board needs. ③ ② ①
23. Develop and implement a systematic approach for shaping health care policy related to regulation. ③ ② ①
24. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes. ③ ② ①
25. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division. ③ ② ①

PART III Demographic Information

Directions: Please provide the following information so that we can summarize the characteristics of the group that completed this questionnaire. No individual responses will be reported.

Which of the following best describes your relationship with the board of nursing?

- ○ Executive Officer
- ○ LPN/VN Board Member
- ○ RN/APRN Board Member
- ○ Consumer (Public) Board Member
- ○ Other type of Board Member (e.g., physician, attorney, etc.)(describe) _____
- ○ Other (describe) _____

THANK YOU FOR COMPLETING THIS SURVEY.

Attachment A2

Long Range Planning Task Force
National Council Mission Statement and Objectives Survey

Comments
January 10, 1996

PART I Relevance of Mission Statement

Does the mission statement of the National Council of State Boards of Nursing, as stated below, reflect activities the National Council should continue to engage in?

Executive Officer	Board Member	Other	Comments
	X		I believe it would be more effective if it were much shorter.
	X		What values serve as the basis of the mission statement?
	X		Mission statement is not unique. Could apply to many entities. NCSBN need to consider its environment in year 2000 is greatly de-regulated in a global village.
	X		Now more than ever.
	X		Very well stated
		X	Should be one or two sentences - too long.
	X		NCSBN is a dynosauer. Has little relevance to California.
	X		I have a concern however regarding the future of Nursing and the ability of the Boards to affect unity towards this future.
	X		It is too lenghty.
	X		NCSBN tends to be proactive while member boards are reactive.
	X		"... Interest of public welfare through examinations based on current psychometric principles and legal considerations."
	X		It sure helps to have a guide who has input from all the states.
	X		Public Policy needs to be incorporated.
	X		Very good.
	X		Should mention exams - Chief responsibility of NCSBN. Council may offer information- effective "guidance" should be within state NPA/rules.

Long Range Planning Task Force - Part 1 Continued

Executive Officer	Board Member	Other	Comments
	X		Should NC add in its statement about advanced practice and testing along with LPNs in LTC certification and Nurse Aides. Also, look at the global effect NC has on nursing, especially with NAFTA; with CAT, NC can be more global.
X			remove "entry to" and add "beginning entry into minimally compentent"
X			Revise "functions, which include the regulatory entry for the practice of nursing, continuing competence in the practice of nursing education and nursing assistance."
X			It may be time to consider identifying advanced nursing practice in the final sentence as another one for board regulation.
X			Is there a need to mention discipline?
X			What about also including mention about the exam.
X			The word guidance in last sentence not appropriate.
X			I think some boards are moving away from the regulation of nursing education programs.

2. Are the services and guidance provided by the National Council consistent with your board's regulatory responsibilities?

	X		Currently.
X			Continuing competency education.
	X		They seem to be.
	X		NC not fully developed yet.
	X		For the most part.
X			The NP&E Committee's recent work has been outstanding (1995 reports) and are very helpful to our board.
	X		More push for consistency needed. Need for actual leadership/guidance of some Member Boards.
	X		I have not been on the board long enough to answer the question.
	X		Yes, but is NCSBN on a collision course with ANA and/or ANCC?
X			Exam is! Most other services have little significance or better info is available elsewhere.
	X		Why did CAT go to Ireland? Waste of money.

Long Range Planning Task Force - Question 2, Part 1 Continued

Executive Officer	Board Member	Other	Comments
	X		This survey is difficult - because I am well aware of the importance of some functions, and unaware of the scope involving the others - they all sound very focused and pertinent to me - thanks.
	X		Have used National Council resources often - quite helpful!
	X		Monitoring legislation and motives (like CAC & Pew) are good.
	X		One compliments the other and vice versa.
	X		Exams are a must. Research provides valid information so that boards may make informed decisions. NCSBN offers forum for boards to discuss issues that may affect them. NCSBN should offer info, not prescribe policies.
X			Phrase "guidance to its members" - does not reflect autonomy of each BON. Would prefer "assistance or information."
X			Most of the time. When a project or direction is pursued by Council that is not consistent the membership seems to reject it.

PART II Importance of National Council's Organization Plan Objectives in terms of how they assist a Member Board to perform its functions.

Goal 1, Objective E	Provide a comprehensive approach for the regulation of advanced nursing practice	
	X	But not a 2nd license.
X		All of these 25 are important – this was extremely difficult.
Goal 1, Objective H	Identify the role of a Board of nursing related to continued competence.	
	X	Boards of nursing have a duty/role already; measuring competency is the question. NCSBN cannot analyze for boards nor provide standards for regulation.

Attachment B

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

ENVIRONMENTAL SCAN EXECUTIVE SUMMARY

SOCIETY
Jennifer Bosma and Doris Nay

NURSING PRACTICE
Vickie Sheets

NURSING EDUCATION
Linda Heffernan

ASSESSMENT
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PUBLIC POLICY AND NURSING REGULATION
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Preface

The National Council of State Boards of Nursing celebrates its 18th anniversary in 1996. In these 18 years, the environment in which the National Council seeks to fulfill its mission in support of its member boards of nursing has undergone many changes. Through the process of environmental scanning, an attempt was made, in 1995, to survey the current environment and glean projections for the future. An executive summary of each of the environmental scans, (Society; Nursing Practice; Nursing Education; Assessment and Public Policy and Nursing Regulation) are contained in the following documents. A copy of the complete documents will be available in August.

The motive for scanning the aspects of the environment most relevant to the National Council's mission and purpose is to assure that the organization neither overlooks opportunities for greater reach and effectiveness, nor is hindered by unanticipated obstacles which threaten mission accomplishment. While this project was undertaken at the express request of the Long Range Planning Task Force of the National Council, the documents may be useful to other committees, the Board of Directors, and Member Boards.

As with all National Council documents, evaluation by readers is solicited. All evaluations are reviewed and used to assure that future documents will continuously improve in quality and usefulness to our readers. Please forward your comments to the National Council of State Boards of Nursing, 676 North St. Clair, Street, Suite 550, Chicago, Illinois 60611-2921, Attention: Doris Nay, MA, RN, Associate Executive Director, or phone (312) 787-6555 ext. 166, FAX (312) 787-6898 or (email) doris@ncsbn.org.

Society Environmental Scan

Nursing, as a care-giving profession, is profoundly affected by the nature of those to whom care is given. Regulation, which exists for the protection of the public, is shaped by the needs of the public. Thus, any consideration of the environment for nursing regulation has a study of the population of the country as a foundation for all other conclusions. The U.S. population is examined from the perspectives of gender, age, geographic regions, birthrate, immigration and ethnic composition, economic environment, and general health.

The total U.S. population is presently 260 million; with the slowest rate of growth in the nation's history, it is expected to be 270 million by 2000. The median age of the U.S. population in 2000 is expected to be 36 years, and in 2020 it is projected to be 49. The population is aging, with the population over 85 anticipated to grow four times as fast as the total population. Aging will have significant effects on the resources which will be needed to provide help with physical and economic care for those on their own without adequate means of support. In addition, there is a declining proportion of people of working age. It is anticipated that this decline will lead to pressure for changes in the way the labor market operates, including increase in retirement ages, in part-time work, in students working, in returning the unemployed to work, in retraining those with obsolete or surplus skill, in using voluntary and even child labor.

A consensus of experts propose that the population of the U.S. is expected to shift from the present order, (largest to smallest) of South, Midwest, West, Northwest to a pattern in which the West outnumbers the Midwest shortly after the year 2000. Seven states are expected to increase more than 20 percent in population by the year 2000: Nevada, Idaho, Alaska, Utah, Washington, Colorado, and Arizona. Three states are expected to lose population in the same period: Massachusetts, Rhode Island and Connecticut, plus the District of Columbia. However, over a 30-year period, the following eight states are projected to be growth centers: California, Texas, Florida, Washington, Georgia, North Carolina, Virginia, and Arizona (accounting for 60% of total growth, both births and immigration). Approximately 17% of the population move each year; if this percentage holds constant, the number of households moving annually will increase from 40 million in 1990 to 47 million in 2000. People in their 20s are the most likely to move; after age 30, the likelihood of moving declines steadily. A phenomenon of "edge cities" is emerging. Edge cities, located on the fringes of major metropolitan areas, combine features such as inexpensive land and housing and the presence of shopping malls, and appeal to people who will work in the suburbs or "telecommute" to downtown offices.

Birthrates are anticipated to decline gradually through the year 2000. In the recent past birth rates have declined for women aged 20 to 34, but increased for teenagers and women 35 to 39. Currently, about 25% of the population is nonwhite or of Hispanic origin (about 20% of those over age 35 and 33% of those under 35). If current trends continue, minorities will be approaching half of the total U.S. population by 2050. Growth is from births and immigration combined; nearly all non-Hispanic white growth will be from births, while 57% of Asian, 36% of Hispanic, and 20% of Black growth will be from immigration.

The size of the average household has been shrinking. In 2050, if the trend continues, average household size could be 1.9. However, some projections call for a reversal of the trend after 2000 due to slow new-household formation, immigration, and elderly people choosing to live with friends. It is interesting to note that if recent trends continue, one in three households will have a male homemaker by the year 2000. The number of single mothers under age 25 could grow by more than 50 percent between 1990 and 2010; older single mothers could also increase by approximately 24 percent in the same time period. The number of single fathers is expected to grow by 44 percent in the same period. While fewer people over 75 are living with family members (down to 5 percent from 8 percent in 1970), from 20 to 30 percent of workers are providing care to elderly relatives. This group is particularly likely to need paid help. The elderly increasingly desire to live independently of children and other relatives. Whereas in 1990, 9 million adults over age 65 lived alone, that number is expected to increase to 13 million by 2010.

In the job market, four million additional workers are expected to join the health services industry by 2005, bringing the total of workers to 12.5 million; the fastest growth will be in the residential care sector, at 7.3% per year. Home health aides, physical therapists, and medical assistants will be in great demand. Technicians and technologists, such as licensed

practical nurses and radiological technologists, will add large numbers of jobs. Health services manager positions will grow much faster than average, reflecting the overall rate of growth of the health care industry. Use of temporary workers and independent contractors is anticipated to grow, due to the high cost of employee benefits. In fact, jobs will tend to move away from "full time" to a "temporary contract" basis. The nursing workforce is estimated to include 1,850,00 RNs, based on the most recent "National Survey of Registered Nurses," (March 1992). Men constitute 4.3%; approximately 10% come from non-majority racial/ethnic backgrounds; the average age is 43; 72% are married. About 2/3 of RNs currently work in hospitals, but the proportion is larger for younger nurses and smaller for older nurses. Ten percent work in community/public health, 8% in ambulatory settings, 7% in nursing homes, and the remainder in nursing education (2%), student health (2.7%), occupational health (1%) and miscellaneous areas, such as state boards of nursing, health planning agencies and correctional facilities (3%).

One role of government is setting and providing incentives and resources for the achievement of goals for the health of the population. "Healthy People 2000" is a program of the Public Health Service which defines objectives set by decade. The three broad goals are (1) increase the span of healthy life for Americans, (2) reduce health disparities among Americans, and (3) achieve access to preventive services for all Americans. Strategies for attaining the goals are grouped into categories of health promotion, health protection, and disease prevention. The outcome of the current political battles over balancing the federal budget, largely through reduction in federal government entitlements, will have a profound effect on the future role of government.

Among industrialized nations, including the U.S., it is expected that ideas of the appropriate size of the public sector will shift, so that governments will be expected to do less, not more; governments will increasingly be expected to achieve their aims by regulation rather than direct provision of services; and what remains within the public sector will be much more subject to market discipline. Regulatory failure carries economic costs to society, whether from ill-conceived regulation or lack of adequate regulation. Ill-conceived regulation is the result of incompetence or the failure to rescind laws which were brought in for a specific purpose which no longer applies. Balancing popular demand for greater regulation (quality control) with the compliance costs that regulation imposes has been achieved by some governments through sub-contracting regulation to independent, single-function bodies which specialize in regulating a particular area (e.g., Securities and Exchange Commission); this trend is seen as likely to grow.

Thirty-four states have healthier populations in 1994 than they did in 1990, and the overall health of Americans has improved 2.4 percent, based on an index of 17 components that measure lifestyle, access to health care, occupational safety and disability, disease, and mortality. Baby boomers' popularization of healthy lifestyles may reduce rates of chronic disease in old age, reducing use of health services and lengthening average productive lifespan. During the 1980s there were major declines in death rates for three of the leading causes of death among Americans: heart disease, stroke, and unintentional injuries. Infant mortality and deaths from preventable childhood diseases also decreased. Between 1992 and 2040, neurodegenerative disease mortality is expected to increase by 373%, most of the increase attributable to deaths from dementia (the highest among a wide group of diseases studied). Emerging areas of concern among children include increasing abuse (physical, emotional and sexual) and neglect (educational, physical, emotional) and the rise of developmental disorders. The dominant preventable health problems of adolescents and young adults fall into two major categories: injuries and violence that kill and disable before age 25 and emerging lifestyles that affect health status many years later. The leading cause of death is unintentional injuries, 75 percent of which are motor vehicle crashes. Homicide is the second leading cause of death, and first in some racial and socioeconomic groups. In both crashes and homicides, about half are associated with alcohol use. Sectors of society can be effective in creating an environment that facilitates and supports healthful behavior especially when working in minority, rural, and low socioeconomic status populations. Examples include: employer support of smoking cessation, stress management, nutritional and exercise, screening for high blood pressure and cholesterol, and other health-related programs; community groups and churches sponsoring classes and support groups; state agencies initiating community-based prevention programs. People over age 65 need regular primary health care services to help them maintain their health and prevent disabling and life-threatening diseases and conditions, including screenings, immunizations, access to prescription medications, health counseling, and other interventions.

Research indicates that the average health care consumer will spend between $150,000 and $200,000 on health care in his or her lifetime. Consumer demand for health care is changing, causing rapid growth in services such as age-targeted care (pediatric, middle-aged, elder), ethnic-targeted health care, fitness and sports medicine, self-diagnosis and care, preventive

and "quality-of-life" health care, rehabilitation, industrial health.

Within the health care services sector, hospitals are projected to be slowest growing (virtually flat employment) while offices of practitioners, nursing and personal care facilities, and miscellaneous health services are all projected to have growth rates of 3 percent or more making them among the fastest growing industries. Sub-acute care is gaining acceptance as an appropriate level of care. It is seen as an opportunity for hospitals to develop a seamless integrated healthcare system, particularly for patients who have exhausted their inpatient DRGs. Skilled nursing facilities can diversify into sub-acute care, compensating for the continued decrease in average nursing home occupancy rates. The sub-acute health care market segment is projected to grow rapidly in the near future. The urgent need to cut the cost of health care will ensure increased use of home care; more funding for home care and assisted living could slow growth in the nursing-home population. However, even if disability rates were cut in half, twice as many nursing home beds will be needed in 2040.

Technological capabilities are increasingly enabling the provision of health care via telecommunications. Beginning in 1990, the U.S. government has actively fostered research into telemedicine as a means of delivering care into rural or other remote under-served areas in a quality, cost-effective manner. The health services industry is becoming more cost conscious, creating trends such as consolidation of health care institutions into integrated delivery systems; emphasis on preventative health measures; greater use of outpatient treatment; and use of nursing home or sub-acute care as an intermediate point for care delivery between hospital and home. The technologies which will affect the lives of Americans in the next 25 years exist now; determining the direction of technological advance is a guess about complex interactions between "push" in research directions, price of technology, and society's changing wants and needs. "Smart card" technology is predicted to be used for storing personal medical data, credit information, and identification/anti-theft devices. "Smart houses" will likewise have automated functions to increase personal safety, routine chores, and environmental comfort.

For care providers, entrepreneurship is predicted to emerge among nurses due to economic conditions favoring privatization, hospital restructuring, greater emphasis on disease prevention, and advances in nursing knowledge. RNs and LPN/VNs who have been laid off are finding sub-acute care as an alternative place of employment; sub-acute care is generally regarded as requiring interdisciplinary teams including physicians, nurses, and other trained providers. Providers will be responsible not only to individual clients but also to the populations and communities from which clients come. Consequently, health care providers will have to be prepared in educational programs which reinforce across the curriculum a population-based model of clinical practice. To practice appropriately, clinicians will need to be familiar with computer capabilities; software packages will facilitate client care (perhaps through artificial intelligence based software), while simultaneously the need for integrated institutional computer-based data access for quality assurance and fiscal/ operation management will increase. Opportunities to enhance access and cost-effectiveness of health care exist in telemedicine technology; the acceptance of such technology is currently hindered by obstacles including payment for telemedicine services, infrastructure development, legal matters, licensure, and practitioner and patient acceptance.

With new developments and discoveries in technology and science happening today, what could be the impact on the society of the future?

Predictions include:

- Consumers will have easy access to large quantities of health care information
- Consumers will be the drivers, the decision-makers regarding health care
- Many health care services will be delivered to the consumer via telecommunications and robotics
- Health care systems will be global rather than national
- Care will be health care not illness care
- Economics will continue to determine the quantity, quality and setting for the delivery of health care
- The population will be increasingly more diverse

Challenges could include:

- Ethical challenges and difficult choices - how should the technology be used, for whom, when
- Information management - interpreting, evaluating and applying
- Growing chasms between the "haves" and "have nots"
- Emerging illness, resistance to medications, new organisms, new discoveries

- Longer life spans
- New roles for federal, state and local governments
- International and global initiatives
- New health care settings

With these new challenges, developments, and discoveries comes opportunities. This technology revolution is and will continue to influence operations or organizations, providing new opportunities for improving services at lower costs.

What implications does this have for the membership of the National Council, the Member Boards of Nursing? The need to:

- actively monitor the general directions of change (trends)
- early identification of key issues
  - -identify latent concerns that may become issues
  - -separate faddish issues and those likely to have long-lasting effects
- identify forces that could slow, stop or reverse trends

What implications does this have for the National Council?
The need to:

- be on the information highway
- provide Member Boards with services and options for collecting, adding to and delivering information, e.g., video-conferencing, electronic publishing, clearinghouse
- provide early interpretation of implications of issues and actions needed: when, and by whom, e.g., Member Boards, Board of Directors, staff
- provide information early in a form that Member Boards can use to formulate opinions and/or make decisions
- provide for multi-way communications, especially with and among Member Boards
- be responsive to growing technological training needs of Member Boards and National Council staff
- provide for fast decision-making and response
- always maintain quality

Nursing Practice Environmental Scan

Nursing practice in the 1990s is changing and complex. There is renewed emphasis on community-based care, increasing impact from the communication/knowledge explosion and continuous change generated by scientific discovery and technological development.

Who Practices Nursing? A composite picture of the typical RN from the National Sample Survey of Registered Nurses, published in 1992 by the Division of Nursing, is a 43-year-old female, married with children, and employed full-time in a staff level position in a hospital The number of RNs educated in diploma programs was down, but both baccalaureate and associate degree programs showed increasing numbers. Racial/ethnic minorities made up approximately 9% of the RN population while the number of male nurses had increased to 4% of the RN population. Information sources about the numbers and demographics of LPN/VNs continue to be limited.

What is Nursing Practice? Nursing provides many patient services, functions and activities simultaneously. A nurse may conduct a complicated clinical procedure requiring scientific knowledge and technical expertise while simultaneously assessing the patient. The next moment, the nurse may perform a seemingly trivial task. But all of these patient interactions provide the baseline sense of the patient that allows the nurse to recognize when an important change has occurred. This is nursing's beauty and uniqueness. This is also what makes nursing so opaque and complex; difficult to articulate to the public, legislators and other policymakers; and vulnerable to market-driven consultants and administrators.

The vision of the bedside nurse is often idealized, and the nurse who no longer spends time in providing direct care may be accused of no longer being a "real" nurse. But directing care, shaping the environment and mentoring the next generation of practitioners are activities that result in fewer direct care opportunities. Nurses in the 1990s are developing their abilities to work with organizational theory, to work within political realities and to develop scholarship and research skills because caring happens on multiple levels - individual care, population based and system based programs.

Scope of Nursing Practice. One of the challenges to boards of nursing is the all too common lack of knowledge regarding the legal basis for nursing practice. The definition set forth in licensing laws defines both the scope of practice and legal responsibilities and identifies the boundaries within which nursing practice takes place. There are three levels of nursing regulated in the United States. RNs and LPN/VNs are regulated in every state. All but two states have statutory authority for the regulation of advanced nursing practice, and there are legislative efforts underway in both of these jurisdictions.

Continued Competence. Although not a new issue, increased national focus on continued competence has occurred in the past year through the Pew Health Professions Commission Taskforce on Healthcare Workforce Regulation Report. Incompetent performance may be related to insufficient knowledge, skills and abilities, but may also be related to situational factors (practitioner cannot adapt to the practice setting, the practice setting not supporting practice or other relevant conditions) or human factors (related to communication, leadership, problem solving or unstandardized language). Nursing as well as other professions are struggling to assure continued competence. New models, such as self-assessment tests combined with continuing education, portfolio assessment and "cafeteria-style" programs (choosing from several options of education, re-testing, independent study, etc.) are being tried. All these evolving approaches raise questions of effectiveness and costs.

Where and When Does Nursing Practice Take Place? Unlike the physician who may see the patient in the office or briefly visit the patient in the hospital, nurses spend a much higher percentage of time with patients. This provides care opportunities unavailable to providers who only briefly interact with patients. And there are many more nurses and other licensed health care practitioners than physicians and dentists. Nursing care occurs around the clock. Most frequently this kind of extended interaction happens in hospitals or long term care facilities, but also happens in the home and other community settings.

Nurses practice at every level, and in every setting. Ambulatory settings include physician office practice, nurse private practice, community health centers, nurse managed centers, other health centers and clinics, schools, occupational settings, day surgery and surgi-centers. Subacute care provides alternative settings for patients too sick for home but no longer needing acute care.

Hospitals - including community, teaching, and specialty - continue to be needed. The look of hospitals is changing, however, as a major trend in health care is for small hospitals to become part of a multi-institutional system. Many of these acquisitions and mergers have resulted in restructuring and downsizing of all hospital staff, including nurses. Nursing service has the largest number of employees in the hospital, because of round-the-clock, seven-days-a-week staffing needs. Some of the types of settings where nurses work within acute care hospitals include: emergency department, psychiatric, obstetrics/delivery, medical-surgical, operating room and recovery, pediatrics, intensive care and other specialty units.

Governmental health care facilities provide another setting for nursing practice. At least 25 federal agencies are involved in delivering health care services. Some are direct patient care, such as the huge Veterans Administration, the Public Health Service and the Indian Health Service. The Department of Defense provides health care services for the military and their dependents. The government also provides other support services through the Department of Health and Human Services, as well as research and financial support. State and local governments have multiple functions in health care delivery, from state facilities to public health departments.

Long term care facilities provide a variety of services to functionally impaired patients with chronic conditions or who require long-term stays (e.g., rehabilitative care). The cost of long term care is high, and concerns about quality, both of care and of life, has led to both state and federal legislation (e.g., OBRA, 1987). Much of the care is provided by nurse aides, and adequate licensed nurse staffing has long been a concern among both nursing and consumer organizations.

Home health care is needed when a person requires more assistance than can be provided by family or friends. It is a growing industry that has been to a great extent unregulated. Good home care can promote quality of life, and allows a patient to be with family and in a comfortable environment. Family members are in a dual role of recipient and giver of care, an additional challenge for the nurses providing care.

Hospice programs employ a team approach to providing care for the terminally ill. The nurse plays an integral role as the team captain. Hospice is about options and continuity of care, regardless of the setting.

The *1994 Survey of the Nurse Universe*, conducted by Harvey Research Organization, Inc., reported that 54.9% of nurses work in hospitals, 9.5% in nursing home/long term care, 7.1% in physician offices, 5.3% in home health care (community based), 3.1% in extended-care facility/skilled-nursing facilities, 2.2% in home health care (hospital based), 1.9% school, 1.6% mental health, 1.4% public health departments, 1.3% nursing school faculty, 1.0% hospice, 0.8% occupational health and 9.9% other. This survey included both RNs and LPN/VNs.

Selected Factors Impacting Nursing Practice. The changing world and evolving healthcare environment present multiple issues that impact nursing practice.

Changing patient populations - The population is aging, with greater demands for health care, at the same time the pool of potential nursing students is smaller. Changes in the family - one-parent families, smaller family units and increasing numbers of working mothers impact health needs. Ethnic diversity is increasing and requires efforts to appreciate transcultural diversity. There is increasing bifurcation between the haves and the have nots, those with access to information and technology, and those who do not. Social ills such as homelessness, crime, drugs, prostitution, gangs and violence affect the provision of nursing care.

Communication/knowledge explosion - An increasing capacity for human communication has exploded in the last decade. One must not only consider who controls finances, but also who controls information. The Nursing Minimum Data Set (NMDS) and the Nursing Interventions Classification (NIC) are steps toward the implementation of a uniform collection of essential nursing information. The scope of knowledge available through the global information-capacity

created by the marriage of computers and telecommunications technology has made a vast array of resources available to nurses. The challenge for nurses, and all users of the technology, will be to identify criteria for usefulness, to evaluate accuracy of information to validate the reliability of the source and to sort out what is interesting from what is essential information about a subject. Telecommunication is becoming a significant tool for practice. The mode of nursing practice changes, especially related to the use of sensory assessment skills, requires new skills to utilize these tools effectively.

Technology - Nurses today practically need to be engineers; at a minimum they need orientation and training for the various types of technical equipment used in different settings. Technology is a valuable tool to assist in the improvement of patient care, but cannot be a replacement for hands-on care.

Genetic research and scientific discovery - The isolation of DNA made the process of cloning possible, and gene mapping has opened a whole new world of possibilities and complications. Implications for nursing include confidentiality issues, ethical concerns and the need to be knowledgeable about procedures and potential outcomes so that nurses can effectively counsel their patients.

Economics of health care - The reality of our time is competition and the bottomline. Pressures are being placed on nurses and all health care workers to cut costs and increase productivity. Hospitals have been the focus of downsizing. Hospital reorganization can take three approaches: restructuring (changing the architecture of the organization), re-engineering (revamping processes) and job redesign (who should be doing what, when and how). These times of financial woes, downsizing, and redeployment of human resources contribute to a feeling of "standing in quicksand" for many nurses today. The economics of health have led to new terms in nursing terminology, including managed care, case management, patient focused care and critical pathways.

Unlicensed assistive personnel - Nowhere is the impact of economics more apparent than in the use of unlicensed assistive personnel. Much of the downsizing and job redesign approaches involve decreasing the number of more expensive licensed nurses and using more unlicensed assistive personnel. Through careful decision-making and appropriate delegation, the use of assistive personnel can free nurses for activities that require their level of knowledge and expertise. Nurses believe that the decision-making regarding nursing should be made by nurses; each patient and each situation requires professional determination as to whether a function is appropriate for delegation. The challenge is to articulate this need in terms of benefit to the patient, in such a way that it does not appear to be simply "turf protection" on the part of the nurse.

Advanced nursing practice - On the other end of the spectrum is the nurse practicing in an advanced role, as a nurse practitioner, nurse anesthetist, nurse midwife or clinical nurse specialist. These practice roles can provide economical means of expanding access to care. In the past five years, there has been much legislative activity to regulate the advanced practice role and provide authority for practice for Advanced Practice Registered Nurses (APRNs). APRNs are used in all types of settings, often providing primary care. The nursing profession is still challenged by the variability of requirements from jurisdiction to jurisdiction.

Differentiated practice - Nursing is unique among health professions in the diverse educational pathways available, often creating confusion regarding the capabilities of nurses in the workforce. Rather than deal with the complexities of defining roles based on education, many facilities have resulted to the "nurse-is-a-nurse-is-a-nurse" mentality. Efforts to differentiate practice used education and experience to determine levels of practice within a health care organization.

Infectious diseases - Some of the scientific developments in these decade involve both new dangers and old enemies. The World Health Organization estimates some 18 million adults and 1.5 million children are HIV-infected. AIDS is the leading cause of death among adults aged 25 - 44 in the United States. AIDS is a health problem that was initially treated politically, thus making it difficult for health care workers to work with full information in many situations. New infectious diseases and new viruses, unresponsive to current medical therapeutics, are being identified in parts of the world. With the transportation technology shrinking the world, the danger of these new diseases being transported to other population centers is staggering. Old infectious diseases are reappearing, such as tuberculosis. Resistant strains are not controlled with current pharmaceuticals. The implications for nursing include the need to revisit old skills and

approaches to infection control in some situations and to promote diligence in the use of universal precautions, both for the sake of patients entrusted to their care and for the personal safety of health care workers.

Health promotion, prevention, education - Nurses have traditionally been the profession that has focused on health promotion and education. As health care evolves from a sickness model of cure and care to a wellness model of prevention and care, nurses are the logical health care provider to promote optimal health among clients.

Ethical issues and challenges - Nurses become involved with a variety of patient issues that involve thorny ethical dilemmas. Issues such as assisted suicide, confidentiality and privacy concerns, experimental treatment and research, rationing of medical resources, reporting impaired or incompetent colleagues, and treatment versus non-treatment decisions, to name a few examples, may be faced by nurses in their day-to-day practice.

Legal issues - All of the ethical issues listed above also have legal ramifications. Other legal issues in the 1990s facing nurses include delegation and supervision, employment issues, the implications of the Americans with Disabilities Act and selected legal decisions. Taking discipline action against the licenses of unsafe and/or incompetent nurses is one of the most important responsibilities of boards of nursing. Such actions are tracked in the National Council's Disciplinary Data Bank, so that the information is accessible to other nursing boards. As a professional, a nurse may be subject to allegations of malpractice should the nurse's failure to adhere to accepted standards result in harm to a patient. Malpractice payments on the behalf of nurses are reportable to the National Practitioner Data Bank (NPDB). The Health Resources and Services Administration (HRSA), which is the federal administrator of the NPDB, appears poised to implement mandatory reporting of disciplinary actions to the NPDB as well. Both of these data banks serve to promote information sharing that "tightens the safety net" for the public.

Advancing technology, emerging knowledge, and expanding opportunities for communication can be powerful tools, but the tools are as good as the user. The ongoing challenge to nursing is to learn from the past, to select the essential and most useful information and skills from the present, to work within political realities, to promote scholarship and research, and to apply this all on multiple levels, in innumerable settings, so that nursing practice continues to serve its most important consumer, the patient.

Nursing Education Environmental Scan

Nursing education has been experiencing great change in the past few years reflecting the changes in the health care delivery system. A major question facing nursing education programs is: are they preparing competent practitioners or are they even able to? Is it realistic to expect that two to four years of education is sufficient to prepare the student for the rapidly changing workplace? Employers wish to have the new graduate functioning as fully as possible as quickly as possible. New graduates are expected to perform as fully "ripened" professionals. The dichotomy between the expectations of the employment setting and the abilities of the new graduate has been accentuated by the changes in the health care delivery systems.

Employers have blamed nursing education programs for not preparing the graduate for the workplace. Educators have blamed employers for being unrealistic in expectations. No other health care profession expects this of the new graduate without a period of additional training. The conflict in expectations has existed since the decline of apprenticeship programs like the original diploma programs.

Enrollments in RN education programs reached a low point in 1987. Since then, enrollments have increased steadily reaching a high in 1993. However, 1994 data showed that overall enrollments declined, reversing this six-year trend.

In 1994, fall admissions in associate degree and diploma programs declined for the first time in six years. A recent American Association of Colleges of Nursing survey showed that entry-level baccalaureate program enrollments for the 1995-96 academic year dropped 2.6%. However, overall *annual* admissions increased slightly reflecting the smallest increase in the six years.

The numbers of graduations from nursing education programs is still increasing reflecting the upward trend in enrollments of the past few years. This trend is likely to reverse as the number of admissions declines.

The decline in enrollments is believed to be tied to the employment market. In 1990, 83% of respondents to the National League for Nursing Newly Licensed Nurse Survey reported finding their first job before graduation. In 1994, this figure dropped to 64%. In response to questions about their perception of job availability, 63% reported many jobs were available in 1990, compared to 6% in 1994.

Demographics of Nursing Graduates and Students

In 1992, 34% of all nurses had a diploma as their highest educational degree; 28% had an associate degree; and 30% had a baccalaureate degree. About 8% of nurses had a least a master's degree. In addition, about 8% of all nurses were enrolled in a formal education program leading to a nursing or nursing-related degree. Twenty percent of newly licensed nurses in 1992 held college degrees prior to nursing school. Baccalaureate graduates were more likely to have had a degree (20%), compared to associate degree (18.8%) or diploma graduates (15.6%).

Associate degree graduates represent the fastest growing segment of the nursing population. It is predicted that the demand for baccalaureate prepared nurses will continue to outpace the supply. According to Linda Aiken, the rising complexity of care and anticipated reductions in the number of medical residents in hospitals are factors that will increase the demand for the clinical expertise and autonomous decision-making of baccalaureate nurses.

The number of graduate programs has increased, especially the number of nurse practitioner programs. Despite this growth in the number of graduate education programs, the number of graduates is increasing slowly because the typical graduate student needs to work to finance the education and is only able to attend school on a part-time basis.

In 1992, about 8% of the nursing population had a master's degree and about 11,300 nurses had a doctorate. Forty-three percent of master's prepared registered nurses have majored in an advanced clinical practice area. Twenty-two percent majored in education and 24% in administration/supervision. Doctoral degrees were mainly focused on

education (37%) or research (33.5%). There are few doctorates focused on clinical practice or supervision/ administration.

The decrease in the number of graduate students in nursing education as well as the slow production of graduate prepared nurses will have a significant impact on the pool of prepared faculty. Graduates prepared with a clinical focus need assistance to transition to the faculty role and its attendant responsibilities.

The average age of new graduates of nursing education programs has been increasing. The average age of graduates in 1992 was 33.7 years. Diploma graduates averaged 31.3 years; associate degree graduates, 35.7; and baccalaureate graduates, 29.2.

There has been a steady increase in the number of men admitted to nursing education programs to 13.5% overall in 1994. Associate degree programs increased to 14.1% in 1994 from 13.1% in 1993. Baccalaureate and diploma programs remained steady at 12.5% and 13.7% respectively. In general, the percentage of minority admissions has been fairly constant at about 16.2%.

Faculty

In 1992, baccalaureate and higher degree programs reported that about 99% of their faculty have master's degrees in nursing; associate degree programs report 88%: diploma programs report 64%; and practical/vocational programs about 80%. Over 90% of doctoral prepared nurses teach in baccalaureate or higher degree programs. Overall 41% of all nursing faculty have an earned doctorate.

Fewer graduate students are going into teaching and the number of programs preparing teachers is decreasing. In 1978, almost 23% of master's degree graduates prepared for teaching; in 1981, 17%; and in 1991, only 10%. In addition, 35% of students in doctoral study in 1986 or earlier stated they were planning to seek a faculty position. Only 10% of doctoral students beginning graduate study in 1987 or later had the same plans.

Education programs are becoming increasingly reliant on part-time faculty. The number of part-time faculty has increased 15% in the past few years while the number of full-time faculty has decreased 0.9%. Also, in general, 61% of full-time university faculty have a doctoral degree, while only 29% of part-time faculty have doctorates.

The use of preceptors in clinical education to supervise and guide is becoming a common practice. The questions that must be addressed include: the qualifications of the preceptor; the appropriateness of the particular preceptor for the level of education program; supervision of the preceptor; and responsibility of the faculty for evaluation of the student.

Nurse practitioner programs present the question of who should be the preceptor if a nurse practitioner is not available. There are insufficient numbers of nurse practitioners to act as preceptors. Physicians have often been permitted to act as a preceptor. There is controversy as to whether or not a physician assistant should be permitted to act as a preceptor for a nurse practitioner.

Teaching clinical subjects requires the faculty to be clinically competent as well as able to communicate the necessary knowledge and skills to students. This becomes an issue when faculty are prepared in a clinical specialty and have no preparation in education to assist in communication of their knowledge. Faculty in universities are caught between the demands to be clinically competent, as well as maintain or meet scholarship and research expectations. Maintaining clinical competence is particularly important for faculty in nurse practitioner programs. An emerging trend is the encouragement that clinical faculty maintain their competence by participating in clinical practice beyond their clinical teaching. However they may be regarded as less than scholarly by their university counterparts.

Curricular Considerations

Graduates of nursing education programs need to be prepared to meet the needs of increasingly diverse populations served by nurses. Curricula need to address these issues of diversity. Cultural diversity must be included in the course of study including specific health problems, beliefs about health and illness, cultural traditions, etc.

Graduates also need to be prepared to address the issues of the aging population. Physiology and psychology of aging, health issues specific to elderly, death and dying, and specific care needs of the elderly are examples of issues to be included.

Programs should be flexible to meet the needs of the diverse population of students. Mature adult learners have different needs but bring different skills and talents to the program. Minority or disadvantaged students may require support services. Weekend classes, flexible clinical hours, convenient clinical locations, self-paced learning, proficiency and equivalency testing are options that need exploration by faculty. Students should be able to extend time for completion of the program beyond the traditional two or four years. Curricula should be designed so that articulation to another level of nursing is facilitated.

Clinical sites have become a challenge for nursing education programs. Hospitals have fewer beds so fewer students can be accommodated by the facility. Community sites are scarce and the competition for the limited sites is intense. Programs need to become creative is developing appropriate alternative clinical experiences and still meet the objectives and outcomes of the program.

Baccalaureate programs have reported an increase in the use of home care agencies, outpatient centers, mental health facilities, and other community-based sites for clinical training. Baccalaureate programs also reported adding courses or expanding coursework in areas such as health economics, home care, health policy, and care of vulnerable populations.

The explosion in technology creates many challenges in nursing education. New graduates need to be adept at communicating through computer technology. They also need to be able to safely use the technology essential to the delivery of care.

Telecommunication technology is creating a whole new system of health care delivery. Nurses may be caring for clients in remote sites through video and audio technologies. Assessment and decision-making skills will need to be highly developed to facilitate safe and effective care.

Programs need to be flexible so that emerging health issues, technologies, and trends can be addressed in a timely manner.

Summary

The challenge to nursing education programs is to prepare the graduate for the workplace. What the appropriate level of preparation is has been the subject of debate between educators and employers. Skills essential for safe and effective practice should be identified. Skills that provide the graduate with the tools to problem solve, and to identify and find the information, are needed.

"A national nursing shortage does not currently exist, but there is a growing concern in nursing, as in medicine, that the workforce is not optimally trained for the present of future needs of the population." (Aiken)

Assessment Environmental Scan

Assessment - Summary

This is a summary of a more complete environmental scan which was designed to provide a view of the current and upcoming trends in the area of assessment that may impact the National Council both in the near- and longer-term future. Awareness of these issues can provide a platform to prepare for and/or lead important future change. The summary touches on discussions of: (1) content issues, (2) measurement models, (3) measurement methods, (4) environment, and (5) research issues/needs.

Background

The field of licensure/certification assessment has traditionally drawn techniques and standards from the educational/psychological measurement arena. Among the many incremental changes improving the field, two major advances have shaped the current state of the art. In the late 1950s and early 1960s, important advances in measurement theory (item response theory; see e.g., Lord, 1952; Rasch, 1960) changed the landscape for measurement professionals, ushering in a wave of new ideas and paradigms. National Council has been using IRT (the Rasch model) as the organizing framework for the NCLEX™ since 1983.

The second major breakthrough was the application of computer technology to assessment. The history of computers and testing goes back to the mid-1970s with the academic-based research sponsored by the U.S. armed services for their vocational aptitude examinations (see e.g., Weiss, 1981). More recent research has focused on educational and licensure/certification testing and only in the past five or six years have ongoing applications of computer-based testing been put into place (see e.g., Bergstrom & Lunz, 1990). National Council began to research computerized adaptive testing (CAT) as an administration methodology for the NCLEX in 1986, with the program reaching implementation on April 1, 1994. The NCLEX was the first national licensure examination to implement CAT and it remains the largest CAT program in the licensure/certification area.

Content Issues

Job Analyses. National Council conducts extensive triennial job analysis studies to determine specifically what entry-level nurses actually do on the job. There has not been much advancement in the technology or methodology of conducting job analyses in the last several years. Some thought has been given to methodology in terms of gathering the information from the sources that can provide it most accurately. Recent work suggests that the job incumbents, while able to accurately communicate what it is they do on the job, may be unable to accurately assess how important those job functions actually are.

Construct Validation. The Examination Committee has worked to become much more sophisticated in their knowledge about the job analysis methodology which provides them with insights as to its strengths and weaknesses. They have also worked with the Research Department to have considerable input into the design of the job analysis survey instrument. This close involvement facilitates the process of turning raw job analysis task data into a usable NCLEX test plan that reflects the important measurable elements of entry-level nursing.

Measurement Models

Item Response Theory. Many of the current advances in IRT are occurring in the application of the theory rather than in the pure theoretical areas. Current or future NCLEX-based research on item calibration issues, person-fit, and error reliability will be true additions to the field and assist the NCLEX program to provide the best possible measurement.

An interesting future application for National Council is polytomous item response (PIRT) models, which are one potential way to score computerized clinical simulation testing (CST®) assessments. In fact, the richness of the PIRT models directly lend themselves to the assessment richness hypothesized for CST. With CST being a good example, the advancement of computer technology will drive an evolution in the ways examinees can interact with the computer.

Measurement Methods

Multiple-Choice Items. National Council has worked extensively with Chauncey/ETS to refine and improve the item development process. Many NCLEX items are being developed that test higher-order thinking skills such as analysis and synthesis. Chauncey/ETS and National Council have explored the possibility of developing different kinds of NCLEX items (including, for example graphic content, k-choice items, etc.), but the financial responsibilities of this exploration have prevented further development. A subgroup of Chauncey/ETS and National Council staff have been assigned the charge of changing the current test development system so that it is responsive to future needs, including increasing item production, enhancing item content coding, and developing an item development tracking system.

In terms of the delivery of multiple choice items, computerized adaptive testing (CAT) remains on the most current edge. Because National Council implemented CAT for a national licensure examination first, we have received inquiries from many licensure/certification agencies (e.g., National Council of Architecture Registration Boards, National Association of Boards of Pharmacy, American Association of Nurse Anesthetists, Association of State and Provincial Psychology Boards, California Bar Examiners, National Board of Chiropractic Examiners). To keep up with the most current developments and to conduct necessary research, National Council and Chauncey have convened a Joint Research Committee to commission, approve, design, conduct, and fund research related to NCLEX and CAT. JRC-sponsored studies to date include looking at new standard setting methods, item calibration methods, person-fit indices, and the determinants of NCLEX item difficulty.

Performance-Based Assessment. For the last three years, performance assessment (also sometimes referred to as authentic assessment) has reached a level of very intense interest and research in the educational measurement community. The program of the major annual educational measurement conference, sponsored by the American Educational Research Association, included no less than 30 sessions in 1995 and 24 sessions in 1994 featuring work on performance assessment. Performance assessment is the act of measuring cognitive constructs or performance objectives using a more "natural" methodology than multiple-choice questions. Current research is showing it is both theoretically and practically difficult to develop high-quality performance assessments that retain good measurement properties, and that validly combining information from performance assessments and multiple-choice tests remains a challenge.

High levels of both academic and applied research are being conducted on performance assessments. In the licensure and certification areas, performance assessment methods are often conceptualized as an adjunct to existing multiple-choice testing. For example, National Council's CST project is an important research study on applied performance assessment for nurse licensure. The NACEP (as an implemented evaluation tool) also includes a manual skills performance assessment. Although measurement fads drift into and out of fashion, the ideas of performance assessment are truly compelling and seem to have staying power. Alternate methodologies may be able to improve measurement of candidate competence in the near future (e.g., CST).

Technology Advances. As with many aspects of society in general, assessment issues are being affected in important ways by the application of new technology. As this trend continues, it is clear that computerized forms of assessment will become more ubiquitous in school settings and for licensure/certification measurement. This should alleviate any remaining issues that arise for the NCLEX about the "uniqueness" of the computerized testing mode (although not too many complaints have been lodged to date). Extrapolating from the present to potential new assessments based on technology, CST is certainly a step in the right direction. With the idea of making nurse candidate assessment as complete as possible, future CST issues may include: improvement of the stimuli using graphics and sound, methods or equipment for capturing tactile-related competencies, ways to alter the setting (perhaps through a virtual reality mode), ways to capture the candidates' use of entire health care team (new simulation model), etc. Methods for capturing the affective domain of nursing may also be on the horizon (e.g., computerized standardized robotic patients).

Environment

Political. Several of the other environmental scans include political components, but this discussion is limited to issues related to assessment. In the current environment, all health-care providers will soon (if they are not already) be accountable for their additions to good client outcomes and their associated costs. This accountability push would seem

to be a favorable trend for the measurement of nurse candidate competence (emphasizing the licensure function as one of quality control for guaranteeing the public health, safety, and welfare). Having a common examination (NCLEX) and standard also fits well with the current public discourse of removing interstate barriers to competent providers. The federal push for achieving national educational goals and accountability could be read as a pro-assessment trend.

Truth-in-Testing issues generally provide large testing organizations with much reason for concern. The specter of having to release expensive-to-construct, high-security licensure items on a regular basis is frightening. There does not seem to be much headway in pushing for this type of legislation on the state level. New York still has activists who are trying to pass stronger truth-in-testing legislation, but their efforts are sporadic and successful to date. Nationally, we have seen no efforts for any type of federal legislation for truth in testing.

Legal. The legal environment for high-stakes assessment has not changed for the last few years (except for the implementation of the Americans with Disabilities Act, or ADA). No pending or proposed legislation with a large potential impact is in the wings. Detailed ADA issues are still being sorted out in the associated federal and state agencies and in the courts. What has come out of the fighting and is currently clear is that candidates' rights regarding their testing experience and expectations for a "fair" assessment have become increasingly important since ADA was passed. Legal counsel has developed an opinion (disseminated in the *Newsletter*) for Member Boards to use in their decisions on whether or not to grant a modified NCLEX testing session. National Council, Chauncey, and our respective legal counsels have developed a methodology for dealing with very unusual requests that has so far been successful. It sounds simple, but by working directly and openly with the candidates to develop solutions that were mutually acceptable, all sides have been satisfied with the outcomes.

High-Stakes Testing. The environment for high-stakes testing has been pretty positive in the last several years and should continue to be so in the foreseeable future. In fact, initial candidate competence assessments have been so well regarded and seen as successful, that issues of continued competence assurance are again reaching a high level of interest. This issue has been an historic struggle for licensure and certification agencies and no recent research or application leads to the belief that the future will be any easier. As all state professional/occupational regulatory boards are being squeezed for funding and are increasingly needing to justify their functionality in a cost/benefit world, continued competence assessment looms as a currently unprovided but potentially important service for protecting the public health, safety, and welfare.

Research Issues/Needs

CAT. Some of the current NCLEX CAT-related research being conducted under the auspices of the Joint Research Committee was mentioned in an earlier section. Other research needs for NCLEX include investigation of enhanced item selection algorithms, a more in-depth look at the stopping rules, investigation of incomplete exams, stability of the calculated error of measurement, dimensionality studies, and issues of item pool design.

Computerized Simulations. The current research being conducted on computerized simulations is coming from a variety of sources (nursing, medicine, architecture, teaching, pilots) in applied rather than in theoretical settings. Much can be learned from looking at the other professions and studying their approaches to tricky simulation issues since there are many unresolved issues in considering the application of CST for entry-level nurse licensure assessment. Still needing further assessment-type research are issues of case content, timing issues, key validation, scoring, combining case information, and setting standards. National Council sponsored a well-attended symposium this fall to stimulate discussion about simulation scoring issues. This type of cross-disciplinary approach may prove successful in advancing National Council's CST research.

Public Policy and Nursing Regulation Environmental Scan

The purpose of this paper is to explore current policy trends and events which are likely to impact public policy and thus impact nursing regulation; discuss health care delivery system changes which are likely to impact public policy initiatives; and consider identified regulatory problems and concerns which are precipitating calls for regulatory reform. The approach includes a look at today's environment and a look forward.

Public policy, established by an entity with authority to do so, includes those plans, actions, decisions, procedures, or regulations established with the express purpose of promoting the public good. By definition in many states, nursing regulation exists to promote the health, safety and welfare of the public. For nursing, the public may be defined as individual patients or clients, families, communities, and organizations.

Several emerging major political, societal and economic issues have the potential to radically change the underpinnings of this country's relationship with the health care delivery system. As these issues evolve, the impact will be felt by the consumer, the health care provider, the delivery system, employers and educational programs. Three foundational issues are identified and discussed in relation to public policy. These issues include: realignment of state and federal responsibilities; changes emerging from the crisis in health care delivery costs (including managed care, capitation, patient focused care, block grants, waivers and others); and the power of consumers to have a major role in determination of health care services.

In an ideal world, regulatory guidelines are established from public policy based on determination of which regulations promote the public good. Changes in systems can be precipitated by policy forces or by market forces. According to Dr. Ed O'Neill, Executive Director of the Pew Health Professions Commission, current reform in the health care delivery and regulatory systems stems from a market driven rather than policy driven perspective. A brief overview of the report of the Pew Health Professions Taskforce on Health Professions Regulation is included.

Changes in the economic, political and social structure will doubtless continue to impact the phenomenal changes in health care delivery and vice versa. The challenge of regulatory reform is to ensure establishment of sound legal authority for professional practice accompanied by sound disciplinary structures and ensure that only qualified practitioners are licensed and authorized to practice—all while ensuring public protection. Boards of nursing are continuing this important dialogue to effect the changes required by our evolving health care system.

Report of the Special Services Division

Staff

Jennifer Bosma, *Chief Executive Officer*
Philip LaForge, *Marketing Manager*
Nancy Chornick, *NCLEX/SSD Coordinator*
Darcy Colby, *Marketing Assistant*

Relationship to the Organization Plan

Goal V ..... Foster an organizational environment that enhances leadership and facilitates decision decision-making in the nursing regulatory community.

Objective G. ..... Maintain a sound basis to support the mission of the the National Council by providing services or products through the Special Services Division.

Recommendations to the Board of Directors

No recommendations.

Background

The Services Division (SSD) was created by action of the 1994 Delegate Assembly. Its purpose is to advance the mission of the National Council by offering services and products that can contribute income to support programs for Member Boards. During 1996, SSD efforts were concentrated in the research, development and initial marketing of the Certification Examination for Practical and Vocational Nurses in Long-Term Care (CEPN-LTC), Nursing Educator Workshops and a nursing "Care Plan Creator."

Highlights

- **Certification Examination for Practical and Vocational Nurses in Long-Term Care (CEPN-LTC)**
  SSD provides project management services to NAPNES for their long-term care credentialing program.

  - An agreement between NAPNES and SSD was executed by the CEO in March.
  - The CEPN-LTC pilot program was successfully completed on January 24, 1996. Four test sites were used: Albuquerque, New Mexico; Chillicothe, OH; Houston, TX; and; Silver Spring, MD. Staff from the respective boards of nursing proctored the pilot sites; 128 pilot participants were tested.
  - SSD selected Assessment Systems, Inc. (ASI) for year-round exam administration via computer.
  - The first official administration of the exam by ASI took place from May 10 to May 18. Year-round testing will begin on August 8, 1996.
  - Mosby authored a prep book for CEPN-LTC. It was published in March.

- **Nursing "Care Plan Creator" and NIRS**
  SSD is linking with a nursing education publisher to develop software products derived from the Nursing Information Retrieval System (NIRS).

  - The Marketing Manager and CEO made a site visit to Lippincott's headquarters in Philadelphia.
  - A legal agreement to develop NIRS-derived software products has been submitted by SSD to Lippincott for its review.

- **Nursing Educator Workshops**
  SSD is offering nursing educators the opportunity to attend item construction seminars presented by qualified National Council staff and membership.

  - The pilot presentation of "Assessment Strategies for Nursing Educators: Test Development and Item Writing" was held at Oak Brook, IL (west suburban Chicago) on Thursday, January 11, 1996. Sixty-nine nurse educators from various midwestern campuses attended.
  - Evaluations of the pilot presentation were very favorable. A summary evaluation is available upon request.
  - A formal business plan is being constructed to support nursing educator workshops as an ongoing business. It is anticipated that one additional pilot will be presented as part of the project research and development process.

- **NCLEX™ Results Telephone Center**
  SSD explored the concept of providing NCLEX results to candidates over the telephone for a fee.

  - An interest survey was faxed to all Member Boards on October 10, 1995.
  - A reminder memo was faxed on November 28, 1995, to Member Boards that had not responded to the first fax.
  - As of January 16, 1996, 76% of Member Boards (by NCLEX volume) had responded to the interest survey.
  - 41% of respondents indicated a willingness to participate; 59% declined to participate.
  - Respondents that declined to participate most frequently cited the possibility of an unwieldy increase in candidate inquiries as their reason for declining.
  - Because Member Boards expressed concern about the negative impact the "Telephone Center" could have on their day-to-day operations, the project was tabled until a more favorable consensus can be reached.

- **Nurse Information System (NIS)**
  Staff is developing revised conceptual models of the NIS database. Certain new models under consideration do not require marketing of the NIS file for the project to become self supporting. Instead, these models may incorporate electronic licensure verification and the disciplinary data bank into the NIS structure to support operations. These new models will require marketing services of yet to be determined scope. When database development, in its current or some new form, nears completion, marketing plans will be made as appropriate.

Review of Adherence to SSD Administrative Policies/Finances

1. **No revenue generation activity shall detract in any manner from: the protection of the public health, safety, and welfare; the promotion of nursing competence; and the reputation of the National Council.**
   All aforementioned projects have been subjected to this screen. None would result in any compromise.

2. **Consideration shall be given to the consequences of a project for the benefits to National Council which are derived from relationships with other organizations.**
   There have been no projects undertaken that would precipitate adverse consequences to existing National Council relationships.

3. **Before each project is approved for implementation, it must have a business plan which includes at least the following components: Anticipated benefits and consequences of the project, resources needed (money, time, expertise), market analysis, return on investment projections, potential exit strategies, and milestones (financial and other) which must be met for project completion.**
   CEPN-LTC Plan, including financial forecasts, has been reviewed and approved for execution.

4. **Before approving a project for implementation, the governing entity shall direct that the data in the business plan be validated from sources independent of the persons proposing the project (i.e., perform "due diligence"). The larger the investment involved the greater the expectation that these sources will be external to the National Council.**
   There is currently no SSD project "in the pipeline" that would require an investment of enough size to warrant the expense of an outside validation of business plan facts and assumptions at this point. The Administrative Services Director has reviewed the draft financial projections for all projects currently under consideration.

5. **Every approved project should have an anticipated rate of return greater than the return that could be obtained by investing the funds in investment vehicles specified in the organization's investment policies.**
   All projects currently under study are projected to provide returns in excess of rates earned by vehicles specified in National Council investment policies.

6. **If a project involves a market or a technology which is new to the National Council, a joint venture should be considered.**
   ASI was selected to deliver the CEPN-LTC via computer to leverage their economies of scale on test administration.

7. **$600,000 shall be allocated from the National Council's undesignated, unrestricted fund balance for financing potential revenue-generating projects. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.**
   The Board of Directors authorized $194,638 in expenditures and $25,000 in revenue for the FY96 budget. Through March, 1996 SSD has spent $100,769.50 and recognized $26,430.95 in revenue.

8. **Any net revenue over expense generated shall be reviewed annually by the Board of Directors who shall determine the extent to which such funds shall be transferred to the unrestricted/undesignated fund balance. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.**
   No net income has been generated.

Recommendations to the Board of Directors

No recommendations.

Report of the Resolutions Committee/New Business

Task Force Members

Leola Daniels, ID, Area I, *Chair (through April 1996)*
Sharon Weisenbeck, KY, Area III, *Chair (beginning May 1996)*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Lorinda Inman, IA, Area II, *Finance Committee Liaison*

Staff

Jennifer Bosma, *Executive Director*
Doris E. Nay, *Associate Executive Director*

Relationship to the Organization Plan

Goal V. ..... Foster an organizational environment that enhances leadership and facilitates decision- making in the nursing regulatory community.
Objective C ..... Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Recommendations

No recommendations.

Highlights of Activities

- The committee met on Tuesday, April 23, 1996. No resolutions were submitted as of this date. The committee will meet on Friday, August 9, 1996, to review resolutions received by 2:00 p.m. on Friday, August 9, 1996.

- **Resolutions Forum**
  All resolutions received will be presented by the committee as part of the Forum which will be held from 9:00 - 10:30 a.m. on Saturday, August 10, 1996.

Meeting Dates

- April 23, 1996

Summary of 1995 Delegate Assembly Action and Subsequent Implementation

The 1995 Delegate Assembly passed motions directing:

1. **Adoption of the revisions to the *NCLEX-PN™ Test Plan*.**

   The test plan was published and disseminated to Member Boards in November 1995. *Issues*, Volume 16, Number 3, published shortly after the Annual Meeting, highlighted the test plan changes. In May 1996, the Board of Directors re-evaluated the NCLEX-PN passing standard and determined a small increase was necessary to reflect the level of minimum competence for safe and effective practice at entry level. The new test plan and passing standard are both on schedule for October 1996 implementation.

2. **Adoption of the revisions to the National Council's goals and objectives.**

   The revised goals and objectives formed the framework for the FY96 tactics to implement the Organization Plan. The Board of Directors reviews progress on each goal, objective and tactic at every meeting. In addition, Member Boards' ratings of the importance of the objectives, as revised, (see Long Range Planning Task Force report) serve to guide the Board and committees in their efforts this year and in coming years.

3. **That the National Council will collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations which are sufficient for regulatory purposes. Benchmarks for progress shall be established and evaluated by the Board of Directors. The Board of Directors shall report to the 1996 Delegate Assembly with specific recommendations regarding future actions including the potential creation of a core-competency examination. If, at any time, the Board of Directors determines that significant progress is not being made, the Board is authorized to conduct a job analysis of entry-level nurse practitioners.**

   The Board of Directors, using the benchmarks shared with the 1995 Delegate Assembly, established a process for collaboration with the nurse practitioner (NP) certifying organizations. A meeting with all organizations was hosted by the Advanced Practice Registered Nurse (APRN) Coordinating Task Force in September. Document reviews and site visits (one of the benchmarks) were to occur during December–February, but did not due to concerns about confidentiality, report contents and dissemination raised by certifying organizations beginning in late December and continuing through March. When the certifying organizations, at the end of March, continued to insist upon control over contents of the reports and restrictive distribution of reports to Member Boards, the Board determined that significant progress toward examinations sufficient for regulatory purposes had not been made and initiated conduct of a job analysis. Discussions with certifying organizations were left as an open possibility, and at the time of this report, a meeting had been scheduled for May 29 for further discussion with the four NP certifying organizations and their affiliated professional organizations. Further information is reported under the Report of the APRN Coordinating Task Force, and will be provided during forums at the Annual Meeting. Opportunity for discussion and votes on recommendations which the task force and Board will develop for delegates' consideration will be provided.

4. **Adoption of the NCLEX™ Administration Stabilization Criteria and authorized the Board of Directors to apply the criteria to specific geographic sites as the need arises.**

   The Board of Directors evaluated Sylvan center performance against the criteria at its October Board meeting, and again in November when the Examination Committee's review and recommendation were available. Due to some deviations from the criteria, the Board voted to not allow testing in Canadian sites at this time. The Examination Committee and staff have continued to monitor compliance with criteria; no further requests for additional sites have been received from Sylvan.

5. **Authorization of the Board of Directors to review and approve the 1995 draft paper on delegation following revision by the assigned task force.**

   The paper, *Delegation: Concepts and Decision-Making Process*, was completed by the Unlicensed Assistive Personnel Task Force and approved by the Board during a November conference call. The paper was distributed to Member Boards and featured as a pull-out section of *Issues*, Volume 16, Number 3.

6. **When directives of the Delegate Assembly require completion of a project which significantly impacts allocation of resources, the Board of Directors will establish a reasonable timeline for completion of such project. Progress reports are to be given to the Delegate Assembly at identified intervals.**

   No projects of this magnitude have been identified to date.

7. **That the National Council will identify a commonality of language regarding "assessment" as a component of the nursing process which could be incorporated and reflected in the *NCLEX-PN™ Test Plan* after approval by the Delegate Assembly in the normal cycle of test plan revisions.**

   The Board of Directors appointed a subcommittee of the Examination Committee to address this issue. The subcommittee's report and conclusion appears in this *Book of Reports* under Tab 6.

8. **That the National Council will: 1) gather data to reveal the current state of the clinical nurse specialist from a regulatory standpoint, 2) identify regulatory needs of Member Boards with respect to clinical nurse specialists, and 3) initiate relationships with specialty certification organizations for clinical nurse specialists and report back to the 1996 Delegate Assembly.**

   The APRN Coordinating Task Force was charged with this responsibility. A survey of Member Boards was conducted, as well as a review of the literature. The results were shared with the Advanced Practice Leadership Roundtable, attended by representatives of over 20 organizations having interest in APRNs. A report on the status of the clinical nurse specialist appears in this *Book of Reports* under Tab 10-A.

9. **That the National Council will: 1) study the issues related to telecommunications practice across jurisdictional lines, and 2) develop guidelines to assist Member Boards in the regulatory issues related to interjurisdictional telecommunications practice.**

   The Board of Directors appointed a Telecommunications Issues Task Force to address this issue. The task force's report appears in this *Book of Reports* under Tab 10-N.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

Organization Plan

Including
FY96 Tactics

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its Member Boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

Goal I. Licensure and Credentialing

Provide Member Boards with examinations and standards for licensure and credentialing.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

Tactic 1. Implement alternative methodologies for performance of RN and LPN/VN job analysis studies. (Research, Job Analysis Monitoring Panel)

Tactic 2. Conduct an RN job analysis. (Research, JAM)

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

Tactic 1. Maintain and enhance licensure examinations based on current job analysis studies. (Testing, Examination Committee, consultants, legal)

Tactic 2. Develop and implement mechanisms and policies for NCLEX™ content development and develop procedures for decreasing the time from approval to new test plan implementation. (Testing, EC, consultants, legal)

Goal I.B. (continued)

Tactic 3. Develop and implement mechanisms and policies for NCLEX scoring and psychometric performance analysis. (Testing, EC, consultants)

Tactic 4. Assure NCLEX is administered according to approved procedures; review and revise policies. (Testing, EC, consultants)

Tactic 5. Provide quality customer service, including identifying information needs and facilitating development of appropriate communications activities, e.g., NCLEX™ Program Reports. (Testing)

Tactic 6. Continue ongoing NCLEX evaluation processes. (Testing, NCLEX™ Evaluation Task Force)

Tactic 7. Conduct formal ETS/SLS evaluation; develop criteria for negotiation of next test service contract. (Testing, legal)

Tactic 8. Conduct research activities related to the NC/ETS Joint Research Committee. (Testing)

Tactic 9. Provide information about other countries' licensure examinations through developing collaborative relationships, e.g., CNATS. (Testing, Licensure Examination Comparison Task Force)

Tactic 10. Identify a commonality of language regarding "assessment" as a component of the nursing process. (Testing, Testing Subcommittee Regarding Assessment, Subcommittee of EC)

Objective C. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Tactic 1. Initiate CST® case development and continue to refine research plan and procedures for evaluating CST content validity. (Research, CST® Task Force, consultants)

Goal I.C. (continued)

Tactic 2. Develop scoring keys for existing CST cases and refine research plan for evaluating psychometric soundness of CST. (Research, Scoring Advisory Panel, CST® Task Force, consultants)

Tactic 3. Plan for exploring Member Board use of CST for purposes other than initial licensure (e.g., evaluation of continued competence). (Research, CST® Task Force)

Tactic 4. Finalize and initiate implementation of market research plan. (Research)

Objective D. Provide a competency evaluation program for nurse aides.

Tactic 1. Maintain and enhance NACEP™ and related services. (Testing, NACEP™ Task Force)

Tactic 2. Review efficacy of The Psychological Corporation's NACEP marketing plan and effect changes as necessary. (Testing)

Tactic 3. Negotiate new contract with The Psychological Corporation or conduct RFP process for NACEP test service, depending on Board of Director's direction. (Testing, NACEP™ Contract Team)

Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.

Tactic 1. Identify current status of advanced nursing practice regulation as compared to National Council advanced practice models. (NP&E, APRN Coordinating Task Force)

Tactic 2. Coordinate plans and approaches to APRN regulation, including monitoring trends and issues:

- health care environment/work force issues;
- health care reform;
- federal/state legislation; and
- legal decisions affecting APRNs, APRN education and certification. (Public Policy, APRN Coordinating Task Force)

Goal I.E. (continued)

Tactic 3. Maintain APRN Certification Clearinghouse. (Research, legal)

Tactic 4. Collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations which are sufficient for regulatory purposes. (Public Policy, APRN Coordinating Task Force)

Tactic 5. Gather data to reveal the current state of the clinical nurse specialist from a regulatory standpoint. (Public Policy, APRN Coordinating Task Force)

Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.

Tactic 1. Review and revise Nurse Aide Models. (Public Policy, Unlicensed Assistive Personnel Task Force, legal)

Tactic 2. Implement strategies for addressing unlicensed assistive personnel issues for various levels of Member Board involvement. (Public Policy, Unlicensed Assistive Personnel Task Force)

Objective G. Promote consistency in the licensure and credentialing process.

Tactic 1. Monitor issues and trends related to the licensure and credentialing of nurses, planning approaches to those with greatest regulatory impact:

- federal/state legislation including ADA;
- legal decisions affecting licensing and credentialing of nurses;
- endorsement and license verification issues;
- temporary permits; and
- educational and examination requirements. (NP&E)

Tactic 2. Implement the process for evaluating the usefulness of models and other position papers. (NP&E, Nursing Practice and Education Committee)

Goal I.G. (continued)

Tactic 3. Implement licensure verification program to facilitate interstate endorsement. (Public Policy, Licensure Verification Task Force)

Tactic 4. Monitor requirements under NAFTA and other international agreements, including reservations process. (Public Policy)

Tactic 5. Evaluate results of validation study regarding functional abilities and make recommendations. (NP&E, Continued Competence Subcommittee of NPEC, consultants)

Tactic 6. Conduct validation study regarding functional abilities. (Research, Job Analysis Monitoring Panel)

Tactic 7. Study issues related to essential elements for licensure by endorsement (Licensure Verification Task Force).

Objective H. Identify the role of a board of nursing related to continued competence.

Tactic 1. Identify competencies essential for continued licensure. (NP&E, Continued Competence Subcommittee of NPEC, consultants)

Tactic 2. Develop position/policy statement regarding continued competence. (NP&E, Continued Competence Subcommittee of NPEC, consultants)

Tactic 3. Explore and evaluate options for assessing continued competence in multiple nursing settings. (Testing, legal)

Tactic 4. Investigate mechanisms for evaluating continued competence. (NP&E, Continued Competence Subcommittee of NPEC, consultants)

Goal II. Nursing Practice

Provide information, analyses and standards regarding the regulation of nursing practice.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

Tactic 1. Develop approaches for timely and effective monitoring of issues and trends. (NP&E)

Tactic 2. Monitor issues and trends affecting nursing practice, planning approaches to those with greatest regulatory impact:

- case management/effect on health care environment, workforce, etc.;
- community/multiple/changing/nontraditional clinical settings, impact on workforce, environment;
- federal/state legislation, including ADA;
- legal decisions affecting regulation;
- other market trends which impact nursing practice and regulation; and
- multi-skilling and cross-training of health care workers. (NP&E, Nursing Practice Advisory Panel)

Objective B. Provide resources regarding health care issues which affect the regulation of nursing practice.

Tactic 1. Develop documents which provide guidance regarding nursing practice/nursing regulation, including health care reform. (NP&E, consultants, legal)

Tactic 2. Assess and analyze selected discipline cases for presence or absence of essential elements of professional accountability. (NP&E, NPEC)

Tactic 3. Develop strategies to describe the scope of nursing practice and nursing roles to be used as a regulatory definition for nursing. (Public Policy, Nursing Regulation Task Force)

Goal II.B. (continued)

Tactic 4. Analyze current board rules and practices regarding the issuance of advisory opinions/rulings responding to practice questions. (NP&E, consultant, Task Force to Analyze Advisory Opinions/Rulings)

Tactic 5. Study issues related to telecommunications practice across jurisdictional lines. (Public Policy, Telecommunications Issues Task Force)

Objective C. Conduct research on regulatory issues related to disciplinary activities.

Tactic 1. Complete HRSA-funded research project to compare and contrast disciplinary remedies used by Member Boards. (NP&E)

Tactic 2. Implement second year of two-year research project to compare and evaluate the effectiveness of regulatory approaches for the management of chemically impaired nurses. (Research, Chemically Impaired Nurse Issues Task Force, consultants)

Tactic 3. Conduct a study on sexual misconduct disciplinary cases. (Research)

Objective D. Provide for Member Board needs related to disciplinary activities.

Tactic 1. Manage Disciplinary Data Bank services, including promotion of electronic access and reporting, expanded access and quality assurance activities. (NP&E)

Tactic 2. Present nursing investigators' educational program upon request by National Council groups (e.g., Member Board, Area) which meet specified criteria. (NP&E, Disciplinary Investigators' Program Task Force)

Tactic 3. Develop resources assistive to Member Boards in dealing with complex discipline cases. (NP&E, Complex Discipline Cases Subcommittee of NPEC, consultants, legal)

Goal II.D. (continued)

Tactic 4. Develop a Member Board educational packet regarding the continuum of sexual misconduct. (NP&E, Sexual Misconduct Focus Group)

Tactic 5. Sponsor a self-supporting conference addressing issues related to non disciplinary alternative programs for the management of chemically impaired nurses. (Research, Chemically Impaired Nurse Issues Task Force)

Goal III. Nursing Education

Provide information, analyses and standards regarding the regulation of nursing education.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing education.

Tactic 1. Monitor issues and trends for nursing education regulation implications, planning approaches to those with the greatest regulatory impact:

- case management/effect on health care;
- community/multiple/changing/nontraditional clinical settings;
- workforce issues (impact on education);
- federal/ state legislation/initiatives, including ADA;
- legal decisions affecting regulation;
- market demands;
- education issues;
- trends;
- research;
- articulation;
- faculty preparation and shortage;
- curricula in delegation, supervision, nursing management, accreditation;
- challenge of board role in program approval; and
- accommodations granted to students with disabilities. (NP&E, Nursing Education Advisory Panel)

Objective B. Provide resources regarding issues that affect the regulation of nursing education.

Tactic 1. Evaluate educational program for Member Board nursing education program surveyors. (NP&E, consultants)

Tactic 2. Conduct a comparison of Member Board rules regarding education program approval with National Council model education rules. (NP&E, NPEC)

Tactic 3. Analyze current board rules and practices regarding clinical experiences, preceptorships, and/or internships in light of changing nursing roles. (NP&E, consultants, Subcommittee to Analyze Clinical Experiences, Subcommittee of NPEC)

Goal III.B. (continued)

Tactic 4. Facilitate the reporting by schools of nursing of accommodations required by their students [with disabilities] to achieve educational objectives. (NP&E)

Goal IV. **Information**

Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective A. Implement a comprehensive repository of information.

Tactic 1. Develop and implement information services as prioritized by the Information Master Plan. Next 10 services include:

- forms/templates;
- advanced practice certification clearinghouse;
- Board of Directors minutes conversion;
- DDB aggregate reports;
- calendar/scheduler;
- meeting registration;
- Member Board Profiles;
- electronic recruitment/selection/appointment of NCLEX panel volunteers;
- electronic volunteering for committees/special committees; and
- public conference areas. (Communications, NCNET User Group, consultants)

Tactic 2. Plan and conduct comprehensive evaluation of information clearinghouse. (Communications, Information Services Evaluation Task Force, consultants)

Objective B. Establish a nurse information system (NIS) for use by Member Boards and others.

Tactic 1. Complete NIS policy development. (Research, Nurse Information System Task Force)

Tactic 2. Complete development for, maintain and operate NIS; plan for future needs of system. (Research, consultants)

Tactic 3. Design strategies to increase Member Board participation in NIS in order to make system more complete, efficient, and accurate. (Nurse Information System Task Force, Research)

Goal IV.B. (continued)

Tactic 4. Complete development of NIS marketing plan, release product, and begin marketing NIS. (Research, consultants)

Objective C. Facilitate communication between National Council, Member Boards and related entities.

Tactic 1. Maintain and enhance publications and other media communications between and among the National Council and Member Boards. (Communications, Communications Evaluation Task Force)

Tactic 2. Maintain and enhance meeting opportunities between the National Council and Member Boards. (Administration, Area Directors, legal)

Tactic 3. Enhance and promote the public understanding, image and importance of nursing regulation. (Communications, consultants)

Tactic 4. Plan and select National Council-sponsored continuing education programs held in conjunction with the Annual Meeting. (Communications, Educational Programs Task Force)

Tactic 5. Create communications and dialogue opportunities that support and enhance the Executive Officers' Network. (Administration, Executive Officers' Network)

Tactic 6. Continue a program of orientation for Member Board representatives focused on leadership development in nursing regulation and administration. (Communications)

Tactic 7. Hold a visible national event on regulatory issues. (Public Policy)

Tactic 8. Provide a program of continuing education for Member Boards and evaluate the planning process. (Communications, Board of Directors)

Goal IV. (continued)

Objective D. Conduct and disseminate research pertinent to the mission of the National Council.

Tactic 1. Develop a research agenda for the National Council. (Research, Research Advisory Panel, consultants)

Tactic 2. Identify research proposals for which National Council should seek funding. (Research)

Tactic 3. Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions. (Research)

Tactic 4. Compile and disseminate abstracts of completed, ongoing and projected surveys/studies performed by Member Boards and the National Council. (Research)

Tactic 5. Facilitate research activities of National Council's Member Boards, committees, staff groups, etc. (Research)

Goal V. Organization

Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective A. Implement a planning system to guide the National Council.

Tactic 1. Formalize the process for implementing a five-year organizational plan. (Administration, Long Range Planning Task Force)

Tactic 2. Evaluate and recommend revisions, as warranted, to the mission statement of the National Council. (Administration, Long Range Planning Task Force)

Tactic 3. Assess relative importance placed by Member Boards on each objective. (Administration, Long Range Planning Task Force)

Tactic 4. Use environmental data and Member Board input to determine tactics for FY97. (Administration, Long Range Planning Task Force)

Tactic 5. Facilitate intraorganizational coordination. (Administration)

Objective B. Maintain a sound resource management system for the National Council.

Tactic 1. Oversee use of the organization's assets to assure prudence and integrity of fiscal management and responsiveness to Member Boards' needs. (Operations, Finance Committee, auditors)

Tactic 2. Assure that a proposed annual budget is presented to the Board of Directors prior to the beginning of the fiscal year. (Operations, Finance Committee, consultants)

Tactic 3. Maintain financial policies which provide guidelines for fiscal management. (Operations, Finance Committee, consultants)

Goal V.B. (continued)

Tactic 4. Review and revise financial forecast assumptions to maintain a current forecasting model. (Operations, Finance Committee)

Tactic 5. Conduct the organization's financial and business affairs in an efficient and effective manner. (Operations)

Tactic 6. Assure continued high performance information services administration and maintenance, including ongoing systems evaluation. (Communications, consultants)

Tactic 7. Manage human resources to effect the goals of the organization. (Operations, consultant)

Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Tactic 1. Identify needs for, create and provide guidance to task forces and other committees to address specific topics important to the National Council's mission. (Administration, BOD)

Tactic 2. Evaluate current National Council orientation programs for volunteers and staff; based on findings, institute appropriate revisions. (Administration)

Tactic 3. Promote inter-organizational decision making. (Administration)

Tactic 4. Provide and promote leadership activity by and training for Board, committee chairs and staff. (Administration, consultants)

Tactic 5. Assess organizational coordination and effectiveness. (Administration, BOD)

Tactic 6. Maintain internal communications among National Council committees, special committees, consultants, test services, Board of Directors and staff. (Communications)

Tactic 7. Assure a slate of qualified candidates. (Communications, Committee on Nominations)

Goal V. (continued)

Objective D. Provide consultation and services to meet unique Member Board needs.

Tactic 1. Respond to Member Board requests for small-scale, unique resources and/or services via the Resource Network. (Communications)

Tactic 2. Develop proposals to respond to Member Board requests for large-scale, unique services. (Research, Testing)

Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

Tactic 1. Implement an advocacy role for National Council on federal/ national level. (Public Policy)

Tactic 2. Implement a governmental affairs program. (Public Policy)

Tactic 3. Prepare and implement strategies to influence policy issues at the national/federal level. (Public Policy, Policy Issues Advisory Panel)

Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

Tactic 1. Develop and implement a comprehensive system to monitor and identify implications of issues and trends affecting nursing regulation, including periodic dissemination of information and analysis:

- proposed modifications in state organizational and regulatory structure;
- impact on work force, environment;
- state legislative activity;
- federal legislation, including NAFTA, GATS,
- international issues;
- health care reform; and other market trends which impact nursing regulation.

(Public Policy, Policy Issues Advisory Panel, Nursing Regulation Task Force)

Goal V.F. (continued)

Tactic 2. Plan process for future analysis of the benefits and costs of nursing regulation.
(Public Policy, Nursing Regulation Task Force)

Tactic 3. Plan a joint conference with the Citizen Advocacy Center on the topic of "Reforming Professional and Occupational Licensing Regulations: Implications for Nursing Boards."
(Public Policy, Nursing Regulation Task Force)

Tactic 4. Explore regulatory issues emerging from proposals related to cross training multi-skilling of licensed health care providers. (Public Policy, Consultant Groups, Nursing Regulation Task Force)

Tactic 5. Identify and validate indicators of regulatory outcomes for use in evaluating current and proposed regulatory activities. (Public Policy, Panel of Experts, Nursing Regulation Task Force)

Tactic 6. Plan approaches for nursing regulation based on health care delivery system and environmental changes:

- Pew regulation recommendations: analysis and response;
- Model for regulatory redesign.
  (Public Policy, Nursing Regulation Task Force)

Objective G. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

Tactic 1. Stimulate development of services and products, incorporating current and new ideas and efforts of volunteers, staff and potential partners. (Special Services Division)

FY96 Budget - 10/1/95 - 9/30/96
By Organization Plan Goals and Objectives

GOAL I. PROVIDE MEMBER BOARDS WITH EXAMINATIONS AND STANDARDS FOR LICENSURE AND CREDENTIALING.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

Publications Revenue	(4,320)	
Salaries, Benefits, and Taxes	99,802	
Professional/Contractual Fees	28,828	
Travel	3,450	
Printing and Publications	12,372	
Other Expenses	41,742	
Allocation of Administrative Costs	30,070	
Total		211,944

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

NCLEX Revenue	(16,772,000)	
Publications Revenue	(73,882)	
Salaries, Benefits, and Taxes	638,919	
NCLEX Processing Costs	11,864,775	
Professional/Contractual Fees	119,639	
Travel	268,889	
Printing and Publications	81,157	
Other Expenses	66,081	
Allocation of Administrative Costs	163,236	
Total		(3,643,186)

Objective C. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Salaries, Benefits, and Taxes	215,456	
Professional/Contractual Fees	261,800	
Travel	41,028	
Printing and Publications	1,473	
Other Expenses	595	
Allocation of Administrative Costs	75,131	
Total		595,483

Objective D. Provide a competency evaluation program for nurse aides.

Royalty Income	(450,000)
Publications Revenue	(10,470)
Meeting Revenue	(3,500)
Salaries, Benefits, and Taxes	64,032
Professional/Contractual Fees	6,035
Travel	6,550
Printing and Publications	8,766

Other Expenses	5,361	
Allocation of Administrative Costs	12,124	
Total		(361,102)

Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.

Publications Revenue	(400)	
Grant Revenue	(180,827)	
Salaries, Benefits, and Taxes	45,912	
Professional/Contractual Fees	145,879	
Travel	50,327	
Printing and Publications	790	
Other Expenses	13,818	
Allocation of Administrative Costs	11,050	
Total		86,549

Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.

Meeting Revenue	(3,750)	
Salaries, Benefits, and Taxes	7,909	
Professional/Contractual Fees	828	
Travel	16,800	
Printing and Publications	3,195	
Other Expenses	5,700	
Allocation of Administrative Costs	4,598	
Total		35,280

Objective G. Promote consistency in the licensure and credentialing process.

Salaries, Benefits, and Taxes	40,081	
Professional/Contractual Fees	625	
Travel	19,600	
Printing and Publications	7,500	
Other Expenses	1,050	
Allocation of Administrative Costs	9,228	
Total		78,084

Objective H. Identify the role of a board of nursing related to continued competence.

Salaries, Benefits, and Taxes	11,537	
Professional/Contractual Fees	14,973	
Travel	16,550	
Printing and Publications	307	
Other Expenses	10,386	
Allocation of Administrative Costs	7,162	
Total		60,915
GOAL I. TOTAL		**(2,936,033)**

GOAL II. PROVIDE INFORMATION, ANALYSES AND STANDARDS REGARDING THE REGULATION OF NURSING PRACTICE.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

Salaries, Benefits, and Taxes	8,584	
Allocation of Administrative Costs	1,150	
Total		9,734

Objective B. Provide resources regarding health care issues which affect the regulation of nursing practice.

Salaries, Benefits, and Taxes	68,107	
Professional/Contractual Fees	33,794	
Travel	53,000	
Printing and Publications	1,472	
Other Expenses	3,408	
Allocation of Administrative Costs	21,545	
Total		181,326

Objective C. Conduct research on regulatory issues related to disciplinary activities.

Publications Revenue	(2,550)	
Meeting Revenue	(1,500)	
Grant Revenue	(25,000)	
Salaries, Benefits, and Taxes	71,430	
Professional/Contractual Fees	112,671	
Travel	29,365	
Printing and Publications	5,320	
Other Expenses	3,100	
Allocation of Administrative Costs	29,736	
Total		222,572

Objective D. Provide for Member Board needs related to disciplinary activities.

Publications Revenue	(750)	
Income From Services	(500)	
Salaries, Benefits, and Taxes	34,185	
Professional/Contractual Fees	2,128	
Travel	19,000	
Printing and Publications	10,711	
Other Expenses	1,401	
Allocation of Administrative Costs	9,015	
Total		75,190

GOAL II. TOTAL **488,822**

GOAL III. PROVIDE INFORMATION, ANALYSES AND STANDARDS REGARDING THE REGULATION OF NURSING EDUCATION.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing education.

Salaries, Benefits, and Taxes	5,424	
Other Expenses	350	
Allocation of Administrative Costs	774	
Total		6,548

Objective B. Provide resources regarding issues that affect the regulation of nursing education.

Meeting Revenue	(1,500)	
Salaries, Benefits, and Taxes	36,273	
Travel	5,400	
Printing and Publications	3,780	
Other Expenses	1,850	
Allocation of Administrative Costs	6,339	
Total		52,142
GOAL III. TOTAL		**58,690**

GOAL IV. PROMOTE THE EXCHANGE OF INFORMATION AND SERVE AS A CLEARINGHOUSE FOR MATTERS RELATED TO NURSING REGULATION.

Objective A. Implement a comprehensive repository of information.

Salaries, Benefits, and Taxes	171,475	
Professional/Contractual Fees	100,250	
Travel	15,100	
Printing and Publications	10,668	
Other Expenses	131,678	
Allocation of Administrative Costs	57,488	
Total		486,659

Objective B. Establish a nurse information system (NIS) for use by Member Boards and others.

Grant Revenue	(206,395)	
Salaries, Benefits, and Taxes	160,061	
Professional/Contractual Fees	3,353	
Travel	13,288	
Printing and Publications	52,903	
Other Expenses	36,511	
Allocation of Administrative Costs	27,366	
Total		87,087

Objective C. Facilitate communication between National Council, Member Boards and related entities.

Publications Revenue	(2,000)	
Meeting Revenue	(78,375)	
Salaries, Benefits, and Taxes	233,375	
Professional/Contractual Fees	52,631	
Travel	137,765	
Printing and Publications	105,192	
Other Expenses	124,530	
Allocation of Administrative Costs	88,201	
Total		661,319

Objective D. Conduct and disseminate research pertinent to the mission of the National Council.

Publications Revenue	(600)	
Salaries, Benefits, and Taxes	118,550	
Professional/Contractual Fees	45,485	
Travel	22,200	
Printing and Publications	1,657	
Other Expenses	29,130	
Allocation of Administrative Costs	28,966	
Total	245,388	

GOAL IV. TOTAL **1,480,453**

GOAL V. FOSTER AN ORGANIZATIONAL ENVIRONMENT THAT ENHANCES LEADERSHIP AND FACILITATES DECISION-MAKING IN THE NURSING REGULATORY COMMUNITY.

Objective A. Implement a planning system to guide the National Council.

Salaries, Benefits, and Taxes	217,547	
Professional/Contractual Fees	10,658	
Travel	12,200	
Printing and Publications	500	
Other Expenses	900	
Allocation of Administrative Costs	32,405	
Total		274,210

Objective B. Maintain a sound resource management system for the National Council.

Investment Income	(694,000)	
Membership Fee Revenue	(183,000)	
Salaries, Benefits, and Taxes	362,730	
Professional/Contractual Fees	65,382	
Travel	15,500	
Printing and Publications	952	
Other Expenses	1,547	
Allocation of Administrative Costs	47,360	
Total		(383,529)

Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Salaries, Benefits, and Taxes	230,501	
Professional/Contractual Fees	38,325	
Travel	64,650	
Printing and Publications	4,821	
Other Expenses	5,833	
Allocation of Administrative Costs	46,509	
Total		390,639

Objective D. Provide consultation and services to meet unique Member Board needs.

Salaries, Benefits, and Taxes	14,604	
Travel	8,400	
Allocation of Administrative Costs	3,083	
Total		26,087

Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

Salaries, Benefits, and Taxes	20,136	
Professional/Contractual Fees	30,000	
Travel	56,900	
Printing and Publications	4,712	
Other Expenses	4,113	
Allocation of Administrative Costs	9,603	
Total		125,464

Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

Conference Revenue	(68,750)	
Salaries, Benefits, and Taxes	80,625	
Professional/Contractual Fees	10,998	
Travel	26,725	
Printing and Publications	5,600	
Other Expenses	52,518	
Allocation of Administrative Costs	24,279	
Total		131,995

Objective G. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

Other Revenue	(25,000)	
Salaries, Benefits, and Taxes	149,882	
Professional/Contractual Fees	83,142	
Travel	18,400	
Printing and Publications	672	
Other Expenses	411	
Allocation of Administrative Costs	33,714	
Total		261,221

GOAL V. TOTAL		**826,087**
GOAL I. - V. TOTAL		**(81,981)**
SUMMARY		
Total Revenue	**(18,789,069)**	
Less: Total Expenditures	**18,707,088**	
Net (Revenue)/Expenditures	**(81,981)**	

National Council of State Boards of Nursing, Inc.

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the functions and operations of the National Council. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as Board of Directors and committee members.

Following a brief discussion of the National Council's history, this manual will describe the organization's structure, functions, policies, and procedures. More descriptive information on the National Council is available in a published orientation portfolio, available through the communications department.

History

The concept of an organization such as the National Council had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses' Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for persons involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of Nursing also worked with the National League for Nursing Education (NLNE) which, in 1932, became the ANA's Department of Education. In 1933, by agreement with the ANA, the NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, the NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published A Curriculum Guide for Schools of Nursing. Two years later, the NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine scorable form. In 1943, the NLNE Board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the "State Board Test Pool Examination" or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA Board appointed the Committee for the Bureau of State Boards of Nurse Examiners which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that it be replaced by a council. Although council status was achieved, many persons continued to be concerned about potential conflicts of interest and recognized the often heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body.

At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of the ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from the ANA to form the National Council of State Boards of Nursing.

Today, the National Council's membership consists of 61 boards of nursing, including those of the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands. An organizational chart depicting the relationship between the National Council and its Member Boards is attached (Appendix A).

Organizational Mission, Objectives, and Goals

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its Member Boards of nursing on matters of common interest and concern affecting public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

The National Council has several objectives, one of which is to develop and establish policy and procedure regarding the use of licensure examinations in nursing. Another is to identify and promote desirable uniformity in standards and expected outcomes in nursing education and practice as they relate to the public interest. The National Council also seeks to assess trends and issues that affect nursing, disseminate data relating to nurse licensure, and promote continued competence in nursing. To achieve these objectives, it plans and promotes educational programs; it provides consultative services for Member Boards and others; and conducts research that addresses education, practice, and policy-related issues. Strategies for achieving these goals are developed in accordance with organizational objectives and reflect the National Council's mission. The National Council's organization plan adds short-term activities and resources designed to accomplish the long-range goals and objectives. Activities to implement goals are developed, assessed, and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors and committees participate in evaluating the accomplishment of goals and objectives and the directives of the Delegate Assembly.

Organizational Structure and Function

Membership

Membership in the National Council is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by the National Council. At the present time, there are 61 Member Boards including those from the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees, and execution of a contract for using the NCLEX-RN™ and/or NCLEX-PN™.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of the National Council's licensure examinations. Member Boards also receive information services, public policy analyses, and research services. Member Boards who fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

Areas

The National Council's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues, and provide diversity of board and committee representation. Area directors are elected by delegates from their respective Areas through a majority vote of the Delegate Assembly. In addition, there are two directors-at-large who are elected by all delegates voting at the annual meeting. (See Glossary for list of jurisdictions by Area.)

Delegate Assembly

The Delegate Assembly is the legislative body of the National Council and comprises delegates designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates.

The Delegate Assembly meets at the National Council's annual meeting, traditionally held in August. Special sessions can be called under certain circumstances. Regularly scheduled sessions take place in Chicago every third year. In the years between, sessions are held in other cities on a rotation basis among Areas.

At the annual meeting, delegates elect officers and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and approve the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly approves most test-related decisions, including changes in examination fees and test plans.

Officers

Officers of the National Council include the president, vice-president, treasurer, four Area directors, and two directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate or a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice-president, and treasurer are elected for a term of two years or until their successors are elected. The president, vice-president and treasurer are elected in even-numbered years.

The four Area directors are elected for a term of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term.

Officers are elected by ballot during the annual session of the Delegate Assembly. Area directors are elected by delegates from their respective Areas.

Election is by a majority vote. When a majority is not established by an initial ballot, re-balloting takes place between the two nominees with the highest number of votes. In case of a tie on the re-balloting, the choice is determined by lot.

Officers assume their duties at the close of the session at which they were elected. A vacancy in the office of president is filled by the vice-president. Other officer vacancies are filled by Board appointees until the term expires.

Board of Directors

The Board of Directors, the administrative body of the National Council, consists of the nine elected officers. Its primary function is to conduct the business of the National Council between sessions of the Delegate Assembly. The Board authorizes the signing of contracts including those between the National Council and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards, and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to the National Council's purpose, and provision for the establishment and maintenance of the administrative offices.

Meetings of the Board of Directors

Meeting dates for the year are finalized by the Board of Directors during its post-annual meeting Board meeting. All Board meetings are held in Chicago with the exception of the pre- and post-annual meeting Board meetings in those years when the annual meeting is conducted outside of Chicago.

Board officers are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials

are mailed to Board officers two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the biweekly *Newsletter*.

Activities and materials generated during the two-week interval before the meeting are reported or distributed at the next meeting. This limits the flood of last-minute information to be distributed, read and considered during the Board meeting.

The agenda is generally organized around committee and staff reports in the various program areas. Items for Board discussion and action are accompanied by a memo or report which describes the item's background and indicates the Board action needed. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting. A summary of the Board's major decisions is also prepared and mailed to Member Boards for their information prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board officer for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the National Council office and include copies of the articles of incorporation and bylaws, policies and procedures, contracts, organization, budget, test plan, committee rosters, minutes, and personnel manual.

Communications with the Board of Directors

Communication between Board meetings takes place in several different ways. The executive director communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. The executive director and treasurer also discuss the budget on a quarterly basis after the accountant has had the opportunity to compile the necessary financial data. Quarterly reports of major activities are prepared by the executive director and provided to Board officers.

In most instances, the executive director is the person responsible for communicating with National Council consultants about legal, financial, and accounting concerns. This practice was adopted primarily as a way to monitor and control the costs of consultant services.

Conference calls can be scheduled, if so desired by the president. Written materials are generally forwarded to Board officers in advance of the call. These materials include staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board officers use the National Council letterhead when communicating as representatives of the National Council.

Committee on Nominations

National Council delegates elect representatives to the Committee on Nominations. The committee consists of four persons, one from each Area, who may be either board members or staff of Member Boards. Committee members are elected to one-year terms. They are elected by ballot with a plurality vote. The chair is that person who receives the highest number of votes.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director office and for the committee itself and to prepare a slate of qualified candidates. During the Delegate Assembly, additional nominations may be made from the floor.

Committees

Most of the National Council's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Delegate Assembly or Board of Directors. At the present time, the National Council has three standing committees: Examination, Finance, and Nursing Practice and Education.

Committees and special committees are appointed by the Board of Directors to address special issues and concerns. Examples of special committees include the Nurse Aide Competency Evaluation Program Task Force, the Nurse Information System Task Force and the Licensure Verification Task Force.

Committees are governed by specific policies and procedures which may be found in National Council's policy manual. Committee membership is extended to all current members and staff of Member Boards. An effort is made to achieve balanced representation whenever possible, including Area, staff and Board members, registered and practical/ vocational nurses, and consumers. Consultants provide outside expertise to committees as needed, on a one-time or ongoing basis.

A National Council staff member is assigned to serve each committee. Staff work closely with the committee chairs to facilitate committee work and provide support and expertise to committee members, but they have no formal decision-making role. Agendas for the committee meetings are established by the chair. With staff assistance, the chair prepares the agenda, the call to meeting, and any other documents that must be reviewed prior to committee meetings. Staff supervises the mailing of these materials, which are sent to committee members no less than two weeks before the committee meeting.

At the request of committee members, staff will analyze issues and make recommendations in accordance with committee objectives and assumptions.

Examination Committee

The Examination Committee consists of at least six persons, including one representative from each Area. One of these persons must be a licensed practical/vocational nurse. The committee chair must have served on the committee prior to being appointed chair. Alternates to the Examination Committee are generally individuals with prior experience on a testing-related committee. Alternates to the Examination Committee may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member.

The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests research important to the development of licensure examinations.

The Examination Committee provides general oversight of the NCLEX™ process, including examination item development, security, administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test and candidate statistics.

One of the National Council's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is key to this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation. There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills, and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a cut score to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected for this process. They are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a cut score. Taking this outcome along with other data relevant to identification of the level of minimum competence, the Board of Directors sets a passing standard which distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes is the best legal defense available for licensing examinations. For most of the possible challenges that candidates might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

Finance Committee

The Finance Committee is comprised of one representative from each Area and the treasurer, who serves as the chair. The committee's primary purpose is to supervise National Council finances, subject to the Board of Directors' approval. It also reviews financial status on a quarterly basis and provides the Board with a proposed annual budget prior to each new fiscal year.

Nursing Practice and Education Committee

The Nursing Practice and Education Committee consists of at least one representative from each Area. The committee's purpose is to provide general oversight of nursing practice and education regulatory issues. It periodically reviews and revises the *Model Nursing Practice Act* and the *Model Nursing Administrative Rules*, and prepares other position statements and guidelines occasionally for presentation to the Delegate Assembly. It also prepares written information about the legal definitions and standards of nursing practice and education which it disseminates to Member Boards and other interested parties. In the recent past, the committee has had a number of subcommittees to study various issues, e.g., continued competence, complex discipline cases and changing trends in nursing education.

National Council Staff

National Council staff members are hired by the executive director, to whom they report. Their primary role is to implement the Delegate Assembly's policy directives and provide assistance to the Board of Directors and committees.

The National Council staff is organized into departments for the purpose of meeting the organizational objectives. The Testing Services Department exists to accomplish the National Council's primary objective, which is to develop and establish examination-related policy and procedure. Other staff members are assigned to the Departments of: Research Services; Communications; Nursing Practice and Education; Public Policy; Administrative Services; and Executive Staff to assist the National Council to meet its other objectives. A list of staff and their respective titles can be found behind Tab 5.

General Delegate Assembly Information

Agendas for each session are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days before the annual meeting, Member Boards are sent copies of the *Book of Reports*. This document contains annual reports and recommendations from the standing committees, Board of Directors, officers, and executive director, as well as new business submitted by any member or the Board. It also contains the agenda and operating budget, as well as proposed rules for the conduct of Delegate Assembly business.

Prior to the annual session of the Delegate Assembly, the president appoints the Rules, Credentials, Elections, and Resolutions Committees, as well as the Committee to Approve Minutes. Prior to any special session, the president appoints at least the Rules and Credentials Committees. In either case, the president must also appoint a timekeeper, a parliamentarian, and pages.

The purpose of the Rules Committee is to draft, in consultation with the parliamentarian, rules for the conduct of the specific Delegate Assembly. The Credentials Committee's function is to provide delegates and alternates with identification bearing the number of votes to which the individual is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to National Council's goals and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

Minutes of the Delegate Assembly are kept by the executive director, who serves as corporate secretary (beginning with the 1996 Annual Meeting). These minutes are then reviewed, corrected as necessary, and approved by the Committee to Approve Minutes.

The Delegate Assembly, the legislative body of the National Council, as specified in the bylaws, provides direction to:

- approve all new National Council memberships;
- elect officers and members of the Committee on Nominations;
- receive reports of officers and committees and take action as appropriate;
- establish the fee for the NCLEX;
- approve the auditor's report;
- approve policy and position statements;
- adopt the mission, goals and objectives of the National Council;
- approve the substance of all contracts between the National Council and Member Boards and the National Council and test services;
- establish the criteria for and select the NCLEX test service;
- adopt test plans to be used for the development of the NCLEX; and
- transact any other business as may come before it.

General Committee Information

Committee Appointments

The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and to ensure a wide representation of Member Boards, board staff and board members, the following procedure is used.

Individuals who wish to be considered for appointment or reappointment to a National Council committee/special committee submit a Committee Volunteer Information Form. All information from this form, along with information about the number of positions available on each committee, is forwarded to the respective Area director for recommendations for appointment or reappointment. Concurrently, committee chairs are asked to provide input as to whether individuals currently serving on committees should be reappointed. The Area directors recommend the appointment/reappointment of individuals to vacant positions. The Area directors' decisions are based on input received from committee chairs, as well as information obtained from the individuals' volunteer information form.

Prior to the Annual Meeting, the Board of Directors evaluates the qualifications of existing and potential committee chairs, makes tentative appointments for committee chairs, and reviews and tentatively approves the committee/special committee appointments that were recommended by Area Directors. During the Board's post-Delegate Assembly meeting, appointments are finalized after considering the need for additional special committees required to accomplish the directives of the Delegate Assembly.

Committee Minutes

Minutes are taken at every committee meeting including telephone conference calls. Minute-taking is an extremely important responsibility because minutes serve as records of what took place at the meeting. Although minutes can be opposed by oral testimony, they are, in the vast majority of cases, legally binding once they have been adopted and certified. Thus, it is crucial that they accurately reflect the committee's process and outcomes.

Committee minutes are taken by committee members or staff. If no one volunteers to take the minutes, the committee chair may appoint someone to serve as secretary. Whomever takes the minutes should remember to:

- record the date, place, and time of the meeting
- include a statement that the meeting was duly called
- indicate the presiding officer, chair, or committee member
- indicate who served as secretary
- record names of persons present and quorum statistics
- record the reading, correction, and adoption of minutes from the previous meeting
- record the adjournment time
- keep them clear and concise
- not include every routine document
- make amendments to the minutes only with the committee's approval
- initial any amendments

Minutes from National Council Board and committee meetings follow a specific format. With rare exception, they should reflect the topic discussed and the comments and/or actions that followed.

On the advice of legal counsel, the minutes of the discussion should not be laden with unnecessary detail or use a "he said/she said" approach. In other words, it is not desirable for the secretary to transcribe verbatim statements. Only in special circumstances is it necessary to identify individual speakers since the minutes should reflect committee discussion as well as committee action.

Whenever possible, the secretary should leave a handwritten copy of the minutes with the staff person assigned to the committee meeting. The staff person will then have the minutes typed and forwarded to the committee members with the next meeting's agenda. This procedure not only relieves the committee member of an additional burden; it also safeguards the minutes from loss. It also provides the committee chair with information to prepare the next meeting's agenda. In the event that the minutes cannot be left with the staff person, they should be forwarded to the National Council office within two weeks.

Committee Reports

Committee reports are sent to the National Council office no later than three weeks prior to each Board of Directors' meeting. The reports are written by the committee chair who is assisted by the committee staff person. Staff processes the reports and supervises their mailing.

The first page of the report contains committee recommendation(s). Subsequent pages document the committee's activities in either narrative or outline format. Background and rationale for the committee's recommendation(s) should be clearly stated. The report concludes with a reiteration of the committee's recommendation(s), and fiscal impact and legal comments are indicated.

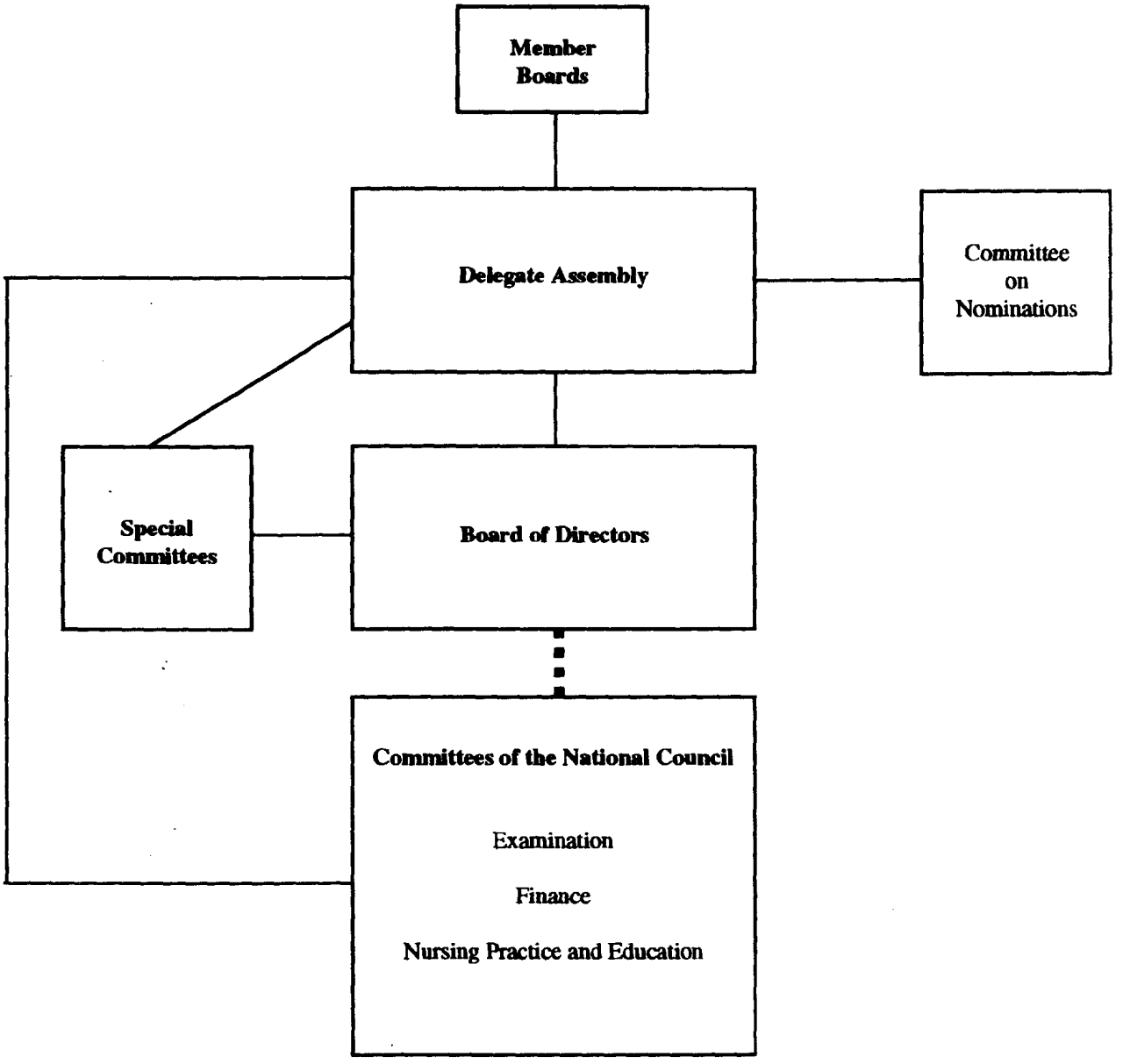
A summary of every committee meeting is reported to the membership via the *Newsletter* that follows the close of the individual meeting.

Appendix A

National Council of State Boards of Nursing, Inc.

Organization

As of June 1, 1996



National Council of State Boards of Nursing, Inc.

BYLAWS

Revision Adopted	8/29/87
Amended	8/19/88
Amended	8/30/90
Amended	8/1/91
Amended	8/5/94

ARTICLE I
Name

The name of this organization shall be the National Council of State Boards of Nursing, Inc., hereinafter referred to as the National Council.

ARTICLE II
Purpose and Functions

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

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

ARTICLE III
Members

Section 1. ***Definition.*** A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory, or political subdivision of the United States of America.

Section 2. ***Qualifications.*** Any state board of nursing that agrees to use one or more National Council Licensing Examinations, hereinafter referred to as the NCLEXÔ, under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council.

Section 3. ***Admission.*** A state board of nursing shall become a member of the National Council and be known as a Member Board upon approval by the Delegate Assembly, as described in Article VII, payment of the required fees and execution of a contract for using the NCLEX.

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

Section 5. ***Fees.*** The annual fee, as set by the Delegate Assembly, shall be payable each July 1.
* *See Proviso number 1.*

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

Section 7. ***Noncompliance.*** Any Member Board whose fees remain unpaid after October 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council shall be subject to immediate review and possible termination by the Board of Directors.

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

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

ARTICLE IV
Officers

Section 1. ***Enumeration.*** The elected officers shall be a president, a vice-president, a treasurer, two directors-at-large, and a director from each Area.

* *See Proviso number 2.*

Section 2. ***Qualifications.*** Members and employees of Member Boards shall be eligible to serve as National Council officers until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 3. ***Qualifications for President.*** The president shall have served as a delegate or a committee member or an officer prior to being elected to the office of President.

Section 4. ***Directors.*** Each Area shall elect a director. Two directors-at-large shall be elected by the Delegate Assembly.

* *See Proviso number 3.*

Section 5. ***Terms of Office.*** The president, vice-president, treasurer and Area directors shall be elected for a term of two years or until their successors are elected. Directors-at-large shall be elected for a term of one year or until their successors are elected. The president, vice-president, and treasurer shall be elected in even-numbered years. The Area directors shall be elected in odd-numbered years. Officers shall assume duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same officer position.

* *See Proviso numbers 4 and 5.*

Section 6. ***Limitations.*** No person may hold more than one elected office at one time. No officer shall hold elected or appointed office or a salaried position in a state, regional or national association or body if such office or position might result in a potential or actual, or the appearance of, a conflict of interest with the National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If a current officer agrees to be presented on the ballot for another office, the term of the current office shall terminate at the close of the Annual Meeting at which the election is held.

Section 7. ***Vacancies.*** A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting.

Section 8. ***Removal from Office.*** A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly. The Board of Directors shall remove any member of the Board of Directors from office upon conviction of a felony. A member of the Board of Directors may be removed by a two-thirds vote of the Board of Directors for failure to perform duties of the office. The individual shall be given 30 days' written notice of the proposed removal.

Section 9. ***Appeal.*** An individual removed from office by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Section 10. ***Responsibilities of the President.*** The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and act as the chief spokesperson for the National Council. The president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 11. ***Responsibilities of the Vice-President.*** The vice-president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting. The vice-president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 12. ***Responsibilities of the Treasurer.*** The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors and Member Boards, and that annual financial reports are presented to the Delegate Assembly. The treasurer shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 13. ***Duties of Area Directors.*** The directors elected from Areas shall preside at Area Meetings of the Member Boards, and shall serve as liaison and resource persons to Member Board members and employees in their respective Areas. The Area directors shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 14. ***Duties of Directors-at-Large.*** Directors-at-large shall perform such duties as shall be assigned to them by the Board of Directors, and act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Article V
Nominations and Elections

Section 1. ***Committee on Nominatlon***

a. ***Composition.*** The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.

b. ***Term.*** The term of office shall be one year. Members shall assume duties at the close of the Annual Meeting Table of Contents

c. ***Election.*** The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. The member receiving the highest number of votes shall serve as chair.

d. ***Limitation.*** A member elected or appointed to the Committee on Nominations may not be nominated for an officer position during the term for which that member was elected or appointed.

e. ***Vacancy.*** A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in whic the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1 of this Article.

f. ***Duties.*** The Committee on Nominations shall consider the qualifications of all nominees for officers and the Committee on Nominations as proposed by Member Boards or by members of the Committee on Nominations, and present a qualified slate of candidates for vote at the Annual Meeting. The committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

Section 2. ***Election of Officers.*** Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest numbers of votes. In case of a tie on the re-balloting,

the choice shall be determined by lot.

ARTICLE VI
Meetings

Section 1. ***Open Meetings.*** All meetings called under the auspices of the National Council shall be open to the public with the following exceptions: (a) meetings of the Examination Committee whenever activities pertaining to test items are undertaken; and (b) executive sessions of the Delegate Assembly, Board of Directors and committees, provided that the minutes reflect the purpose of and action taken in executive session.

Section 2. ***Participation.***

a. ***Right to Speak.*** Members and employees of Member Boards shall be given the right to speak at all meetings called under the auspices of the National Council. Only delegates to the Delegate Assembly, members of the Board of Directors and members of National Council committees shall be entitled to make motions and vote in their respective meetings; provided, however, that the Board of Directors, committees and Member Boards may make motions at the Delegate Assembly.

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

c. ***Electronic Communication and Mail.*** To the extent permitted by law, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

d. ***Committees.*** Committees may establish such methods of conducting their business as they find convenient and appropriate.

ARTICLE VII
Delegate Assembly

Section 1. ***Composition and Term.*** The Delegate Assembly shall be comprised of delegates designated by each Member Board. An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges. A National Council officer may not represent a Member Board as a delegate. Delegates and alternates serve from the time of appointment until replaced.

Section 2. ***Voting.*** Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. ***Authority.*** The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission, goals and objectives, adoption of position statements, and actions at any Annual Meeting or special session. The Delegate Assembly shall approve all new National Council memberships; approve the substance of all NCLEX contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX; select the NCLEX test service; and establish the fee for the NCLEX.

Section 4. ***Annual Meeting.*** The National Council Annual Meeting shall be held at a time and place as determined

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

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

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

ARTICLE VIII
Board of Directors

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

Section 2. ***Authority.*** The Board of Directors shall have general supervision of the affairs of the National Council between the meetings of the Delegate Assembly and shall perform such other duties as are specified in these bylaws. The Board shall be subject to the orders of the Delegate Assembly, and none of its acts shall conflict with action taken by the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly.

Section 3. ***Meetings of the Board of Directors.*** The Board of Directors shall meet in the Annual Meeting city immediately prior to, and following, the Annual Meeting, and at other times as necessary to accomplish the work of the Board. Special meetings of the Board of Directors shall be called by the president upon written request of at least three members of the Board of Directors. Special meetings may be called by the president. Twenty-four hours or more notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

ARTICLE IX
Executive Director

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

Section 2. ***Authority.*** The Executive Director shall serve as the chief staff officer of the organization and shall possess the authority conferred by, and be subject to the limitations imposed by the Board of Directors. The Executive Director shall manage and direct the programs and services of the National Council, supervise all administrative services, serve as corporate secretary, and shall oversee maintenance of all documents and records of the National Council.

Section 3. ***Evaluation.*** The Board of Directors shall conduct an annual written performance appraisal of the Executive Director, and shall set the Executive Director's annual salary.

ARTICLE X
Committees

Section 1. ***Standing Committees.*** Members of standing committees shall be appointed by the Board of Directors.

a. ***Examination Committee.*** The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. At least six alternates shall be appointed, and an alternate may be called on at any time to serve temporarily

as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX process, including examination item development, security, administration, and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly.

b. ***Finance Committee.*** The Finance Committee shall be comprised of one member from each Area and the treasurer, who shall serve as chair. The Finance Committee shall provide general oversight of the use of the National Council's assets to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. The Finance Committee shall maintain financial policies which provide guidelines for fiscal management, and shall review and revise financial forecast assumptions.

c. ***Nursing Practice and Education Committee.*** The Nursing Practice and Education Committee shall be comprised of at least one member from each Area. The Nursing Practice and Education Committee shall provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Section 2. ***Special Committees.*** The Board of Directors shall appoint special committees as needed to accomplish the mission of the National Council. Special committees may be subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. ***Committee Membership***

a. ***Composition.*** Standing committees shall include only current members and employees of Member Boards. Special committees shall include current members and employees of Member Boards, and may include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, consideration shall be given to expertise needed for the committee work, Area representation and the composition of Member Boards. The president, or president's delegate, shall be an ex-officio member of all committees except the Committee on Nominations.

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

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

d. **Committee Functions**

1. ***Budget.*** Standing committees shall submit a budget request for activities prior to the beginning of the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.

2. ***Policies.*** Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.

3. ***Records and Reports.*** Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.

ARTICLE XI
Special Services Division

Section 1. ***Purpose.*** The Special Services Division of the National Council shall be the vehicle for conducting activities which are consistent with the purposes of the National Council and which relate to providing services or products primarily to parties other than Member Boards. This Article shall apply solely to activities within the jurisdiction of the Special Services Division.

Section 2. ***Scope of Activities.*** Activities within the jurisdiction of the Special Services Division shall include the development, promotion and distribution of services and products provided primarily to parties other than Member Boards but shall not include (a) the development of examinations and standards for the governmental authorization for nursing practice in Member Board jurisdictions or (b) the development of standards regarding the regulation of nursing practice and nursing education in Member Board jurisdictions. However, with the prior approval of the Board of Directors, the Special Services Division may develop, promote and distribute services or products which include such examinations and standards at the request of one or more Member Boards and/or certifying bodies other than examinations and standards for the initial entry-level licensure of nurses.

Section 3. ***Management Authority.*** The property and activities of the Special Services Division shall be managed by an Executive who shall be appointed by, and serve at the pleasure of, the Board of Directors and who may, but need not, be the same person who serves as the Executive Director of the National Council. The Executive shall be the chief executive officer of the Special Services Division and, subject to such operating policies and guidelines, including such financial policies and limitations, as may be adopted by the Board of Directors from time to time, shall have full authority to direct the activities of the division and to enter into contracts and make other commitments on behalf of the division, which shall be binding upon the National Council.

ARTICLE XII
Finance

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

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

ARTICLE XIII
Indemnification

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

Section 2. ***Insurance.*** To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him

or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

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

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

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

ARTICLE XIV
Parliamentary Authority

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

ARTICLE XV
Amendment of Bylaws

Section 1. ***Amendment.*** These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly. A two-thirds vote of the delegates present and voting is required to amend the bylaws, providing that copies of the proposed amendments have been presented in writing to the Member Boards at least 45 days prior to the session. Without previous 45-day notice, the bylaws may be amended by a three-quarters vote of the delegates eligible to vote if, at least five days prior to the meeting, notice is given that amendments may be considered at the Annual Meeting or special session.

Section 2. ***Revision.*** These bylaws may undergo revision only upon authorization and adoption by the Delegate Assembly. A committee for revision, authorized by the Delegate Assembly, shall prepare and present the proposed revision. A two-thirds vote of the delegates present and voting is required to adopt the revision, provided that copies of the proposed revision shall have been submitted in writing to the Member Boards at least 45 days prior to the Annual Meeting or special session at which the action is to be taken.

Provisos to National Council of State Board of Nursing Bylaws

1. **Proviso to Article III, Section 5:**
   The annual fee shall be $3000 until determined otherwise by the Delegate Assembly in conjunction with the current contract cycle.

2. **Proviso to Article IV, Section 1:**
   The current secretary shall remain in office until the close of the 1995 Delegate Assembly.

3. **Proviso to Article IV, Section 4:**
   One director-at-large shall be elected at the 1994 Delegate Assembly. Two directors-at-large shall be elected annually at the 1995 Delegate Assembly.

4. **Proviso to Article IV, Section 5:**
   The term of office of the current treasurer shall be extended for one year so that the treasurer shall remain in office until the 1996 Annual Meeting.

5. **Proviso to Article IV, Section 5:**
   Any officer currently in office or elected to office at the 1994 Delegate Assembly may serve up to five consecutive years at the same office position.

Glossary

AACN
American Association of Colleges of Nursing.

AANP
American Academy of Nurse Practitioners.

ACNM
ACNM Certification Council, Inc.

ADA
Americans with Disabilities Act.

ANA
American Nurses Association.

ANCC
American Nurses Credentialing Center.

AONE
American Organization of Nurse Executives.

APN/APRN/ARNP
Advanced Practice Nurse/Advanced Practice Registered Nurse/Advanced Registered Nurse Practitioner. This level of nursing practice is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care.

Area
Designated regions of National Council Member Boards.

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Delaware
Arizona	Iowa	Florida	District of Columbia
California	Kansas	Georgia	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska	North Carolina	New Jersey
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Puerto Rico
N. Mariana Islands	West Virginia	Texas	Rhode Island
Oregon	Wisconsin	Virginia	Vermont
Utah			Virgin Islands
Washington			
Wyoming			

ASI
Assessment Systems, Inc. A wholly owned subsidiary of Havcourt Brace, Inc. The new test service for NACEP (See Psych Corp).

Blueprint
The organizing framework for an examination which includes the percentage of items allocated to various categories.

Board Member
An individual who serves on a board of directors (national level) or a board of nursing (state level).

BOD
Board of Directors of the National Council of State Boards of Nursing.

Bylaws
The laws which govern the internal affairs of an organization.

CAC
Citizen Advocacy Center.

CAT
Computerized Adaptive Testing.

CCNA
Council on Certification of Nurse Anesthetists.

CDC
Case Development Committee. A committee of clinical experts which has the responsibility of developing cases for the Computerized Clinical Simulation Testing (CST®) project.

CEPN-LTC
Certification Examination for Practical Nurses in Long-Term Care.

CGFNS
The Commission on Graduates of Foreign Nursing Schools. (An agency providing credentialing services for foreign educated nurses, as well as a certification program designed to predict success on NCLEX-RN™.)

Chauncey
See The Chauncey Group International, Ltd.

CLEAR
Council on Licensure, Enforcement and Regulation. (An organization of regulatory boards and agencies.)

CNATS
Canadian Nurses Association Testing Service.

CNM
Certified Nurse Midwife.

CNS
Clinical Nurse Specialist.

CON
Committee on Nominations. The elected committee of the National Council responsible for preparing a slate of qualified candidates for each year's elections. The Committee of Nominations' members serve one-year terms.

CRNA
Certified Registered Nurse Anesthetist.

CST®
Computerized Clinical Simulation Testing.

CTB/McGraw-Hill
National Council's test service for the NCLEX™ paper-and-pencil development and administration, 1981-1994.

Decision Consistency
A test statistic that indicates the expected consistency of pass or fail classification decisions across different administrations of the examination. It is concerned only with classification accuracy, not with the precision of the numerical test scores, as is the reliability statistic used with paper-and-pencil examinations.

Delegate Assembly
The policy-making body of the National Council which comprises 61 Member Boards. Each Member Board is entitled to two votes.

Diagnostic Profile
The document sent to failing candidates reflecting their performance on various aspects of the NCLEX test plan.

DIF
Differential item functioning or a measure of potential item bias.

Direct Registration
A method of submitting candidate registrations for NCLEX. Registrations are submitted by candidates, with the $88 fee, directly to The Chauncey Group. The option for telephone registration is available for $97.25.

Disciplinary Data Bank (DDB)
A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards.

EC
Examination Committee.

Education Program Reports
See *NCLEX™ Program Reports.*

EDWARD
Electronic Document Warehousing And Retrieval Database. System to provide guided electronic access to all National Council documents and publications. Nurse practice acts and administrative rules will be made available first, followed by position papers and other frequently requested documents. Part of the Information Master Plan (IMP).

EIRs
Electronic Irregularity Reports. Reports written by the test center staff on the day of testing regarding any irregularities occurring during NCLEX testing. These reports are forwarded by Sylvan overnight to The Chauncey Group and the National Council. The National Council forwards the EIRs to the Member Board where the candidate is seeking licensure.

Electronic Access
Member Boards' direct inquiry of the National Council Disciplinary Data Bank via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

ETS/The Chauncey Group
Educational Testing Service is the parent company of The Chauncey Group. The Chauncey Group is the National Council's test service for NCLEX using computerized adaptive testing, located in Princeton, New Jersey, and engaged in educational and certification testing services.

Experimental Items
Newly written test questions placed into examinations for the purpose of gathering statistics. Experimental items or "tryouts" are not used in determining the pass/fail result.

FARB
Federation of Associations of Regulatory Boards.

Fiscal Year (FY)
October 1 to September 30 at the National Council.

HCFA
Health Care Financing Administration. (A unit of the federal government under the Department of Health and Human Services.)

HRSA
Health Resources and Services Administration. (A unit of the federal government under the Department of Health and Human Services.)

ICN
International Council of Nurses.

ICONS
The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing; the American Association of Critical Care Nurses; the American Organization of Nurse Executives; the American Nurses' Association; the Bureau of Labor Statistics, the Division of Nursing (BHPR, HRSA); the National Center for Health Statistics; the National Council of State Boards of Nursing; the National League for Nursing; and the American Association for Nurse Anesthetists.

IMP
Information Master Plan. Strategy to fulfill the Organization Plan's tactic, "Implement a comprehensive repository of information." The IMP will include electronic submission of information to the Disciplinary Data Bank, the Nurse Information System, electronic archives (see EDWARD), databases of organization-related information (see SAHVI), and other on-line resources for the National Council's Member Boards, staff and other appropriate audiences.

Insight
A triannual newsletter discussing issues related to nurse aides and assistive personnel, delegation to unlicensed assistive personnel and the NACEP.

Issues
A quarterly newsletter published and nationally distributed by the National Council.

Item
A test question.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses. Their use enables many measurement benefits (see Rasch Model).

Item Reviewers
Individuals who review newly written items developed for the NCLEX-RN™ and NCLEX-PN™.

Item Writers
Individuals who write test questions for the NCLEX-RN, NCLEX-PN and NACEP.

JRC
Joint Research Committee. This committee consists of three National Council and three Chauncey or ETS staff members, and two external researchers. The committee is the vehicle through which research is funded for the NCLEX program. Funding is provided jointly by the National Council and The Chauncey Group.

KSA
Knowledge, Skill and Ability statements.

Logit
A unit of measurement used in IRT models. The log transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

LRP
Long Range Planning. (A task force of the National Council.)

MNAR
Model Nurse Administrative Rules. (A publication of the National Council.)

Mantel-Haenszel
A well-accepted statistical procedure used to estimate the differential item functioning or potential bias of test items.

MBOS
Member Board Office System. The software used in many Member Board offices to communicate electronically with The Chauncey Group regarding NCLEX candidates.

Member Board
A jurisdiction having a contract with the National Council to administer NCLEX-RN and/or NCLEX-PN.

MNPA
Model Nurse Practice Act. (A publication of the National Council.)

NACEP™
Nurse Aide Competency Evaluation Program. (Also a task force of the National Council.)

NAPNES
The National Association for Practical Nurse Education and Service.

National Council Organization Plan
Mission, goals and objectives of the National Council as adopted by the Delegate Assembly.

NBME
National Board of Medical Examiners. NBME is currently modifying its computerized clinical simulation testing (CST) software for application to nursing.

NCBPN/N
National Certification Board of Pediatric Nurse Practitioners and Nurses.

NCC
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialities.

NC or NCSBN
Abbreviated form of National Council of State Boards of Nursing, Inc.

NCLEX-RN™
National Council Licensure Examination-Registered Nurse.

NCLEX-PN™
National Council Licensure Examination-Practical Nurse.

NCLEX™ Program Reports
Published by The Chauncey Group twice per year, the *NCLEX™ Program Reports* provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX. Included in the *NCLEX™ Program Reports* is information about a program's performance by the *NCLEX™ Test Plan* dimensions and by content areas. Data about a program's rank nationally and within the program's state are also included.

NCLEX™ Quarterly Reports
The NCLEX™ Quarterly Reports summarize the performance of all first-time candidates educated in a given jurisdiction who were tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates. (Previously known as green sheets.)

NCNET
National Council's electronic network for Member Boards.

Newsletter
A biweekly publication produced by the National Council and distributed to each Member Board. Items included on a regular basis: committee reports; Board of Directors' agendas, major actions and minutes; current updates on policy; report and/or analyses of federal legislation; examination statistics; notice of upcoming events; updates to National Council manuals; solicitations for persons to serve in various capacities; information from the testing department related to the NCLEX; and information related to National Council activities.

NFLPN
National Federation of Licensed Practical Nurses.

NIRS
Nursing Information Retrieval System. A set of databases containing nursing and medical information which are being linked via a simple coding scheme that permits quick and efficient identification and capture of the numerous relationships which exist within and across databases. It is designed to expedite CST case and scoring key development, quality assurance, and the delivery of a CST examination.

NIS
Nurse Information System. A national database being developed by the National Council, containing demographic information on all licensed nurses, an unduplicated count of licensees and serving as a foundation for a variety of services including the disciplinary data bank, licensure verification, and research on nurses. (Also a task force of the National Council.)

NLN
National League for Nursing.

NNRR
National Nursing Research Roundtable.

NP
Nurse Practitioner.

NP&E
Nursing Practice and Education. (A standing committee of the National Council.)

NPDB
National Practitioner Data Bank. A federally-mandated program for collecting disciplinary data regarding health-care practitioners. The NPDB began operation in September 1990, receiving required medical malpractice payment reports for all health care practitioners, and required reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by P.L. 100-93, section five. Implementation of section five is on hold until the NPDB has gained sufficient experience under Title IV to extend services.

OBRA 1987
Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

Ontario Model
Refers to the Regulated Health Professions Act (RHPA), which includes a general act and procedural code that applies to all regulated health professions, as well as 21 profession-specific act. The legislation went into effect on December 31, 1993, and replaced the Health Disciplines Act and various others pieces of legislation.

Pew Charitable Trusts
A national and international philanthropy with a special commitment to Philadelphia, which supports not-for-profit activities in the areas of conservation and the environment, culture, education, health and human service, public policy and religion. The foundation was established by Joseph Pew, owner of Sun Oil Company.

Pew Health Professions Commission
The Pew Health Professions Commission was established in the spring of 1989 and is administered by the University of California at San Francisco, Center for the Health Professions. The mission of the Pew Health Professions Commission is to assist the nation's health professional schools in understanding the changing nature of health care in the United States, what types of health care workers will be needed for the future, and with what skills, and in designing and implementing programs that are capable of educating such professionals.

Pew Taskforce on Health Care
The Pew Health Professions Commission charged the Taskforce on Health Care Workforce Regulation to identify and explore how regulation protects the public's health and to propose new approaches to health care workforce regulation to better serve the public's interest. The task force was comprised of eight individuals with legal, policy and public health expertise.

Psych Corp
The Psychological Corporation. The Psychological Corporation is the parent corporation of ASI. The NACEP test service who is charged to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA). Assessment Systems, Inc., producer of another nurse aide exam, was acquired by TPC in 1995.

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude, and mastery as measured by testing instruments.

Public Policy
Policy formed by governmental bodies and includes all decisions, rules, actions and procedures established in the public interest.

RAP
Research Advisory Panel.

Rasch Measurement Model
The item response theory model used to create the NCLEX measurement scale. Its use allows person-free item calibration and item-free person measurement.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. That is, it assesses the degree to which a test score reflects the person's true standing on the trait being measured. The National Council uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the NACEP. For adaptively administered examinations, such as the NCLEX using CAT, the decision consistency statistic is the more appropriate statistic for assessing precision (see Decision Consistency).

RFP
Request for Proposals.

SAHVI
Storehouse of Administrative, Historical and Volunteer Information. Database to contain comprehensive National Council historical and volunteer information, as well as mailing list data. Part of the Information Master Plan (IMP), scheduled for preliminary availability via the Member Board Web site in 1996.

SKDC
Scoring Key Development Committee. Committee of clinical experts which has the responsibility of developing scoring keys for the Computerized Clinical Simulation Testing (CST) Project.

SSD
Special Services Division. A unit of the National Council which develops services and products, the revenue from which will go to support core programs for Member Boards.

Standard Setting
The process used by the Board of Directors to determine the passing standard for an examination, at or above which examinees pass the examination and below which they fail. This standard denotes the minimum acceptable amount of entry-level nursing knowledge, skills and abilities. The National Council uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is conducted every three years for each NCLEX and whenever the test plan or *NACEP Blueprint* changes.

STC
Sylvan Technology Center.

Submission of Reports
A Member Board, upon taking disciplinary action, submits to the National Council Disciplinary Data Bank biographical data about the nurse and information regarding the grounds for and the disciplinary action taken by the board of nursing.

Summary Profiles
Summary profiles are no longer produced by CTB. They have been replaced by *NCLEX™ Program Reports* produced by The Chauncey Group. See *NCLEX™ Program Reports*.

Sylvan Prometric
The computer-based testing division of Sylvan Learning Systems.

Sylvan Learning Systems
The Chauncey Group's business partner for the delivery of computerized tests. Over 400 Sylvan Learning Centers nationwide form the core of SLS' business. SLS is a publicly-traded corporation headquartered in Columbia, MD.

Sylvan Technology Centers (STCs)
Sylvan Technology Centers are Sylvan Prometric's high-stakes testing centers responsible for the secure delivery of computerized examinations. There are over 250 STCs in North America. The NCLEX using CAT is administered in over 200 STCs located in the United States and its territories.

Test Plan
The organizing framework for NCLEX-RN and NCLEX-PN which includes the percentage of items allocated to various categories.

Test Service
The organization which provides test services to the National Council, including test scoring and reporting. The Chauncey Group, along with Sylvan Learning Systems, is the test service for NCLEX using CAT, and The Psychological Corporation is the test service for the NACEP.

The Chauncey Group
See The Chauncey Group International, Ltd.

The Chauncey Group International, Ltd.
A wholly owned subsidiary of Educational Testing Service (ETS). National Council's test service for NCLEX using computerized adaptive testing, located in Princeton, New Jersey.

TPC
See Psych Corp.

Tri Council for Nursing
Members include the American Association of Colleges of Nursing, American Organization of Nurse Executives, American Nurses Association, and National League for Nursing.

UAP/ULAP
Unlicensed Assistive Personnel.

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. The National Council assures the content validity of its examinations by basing each test strictly on the appropriate test plan (RN or PN) or blueprint (NACEP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.