

The
Business
Book

Shared

Visions,

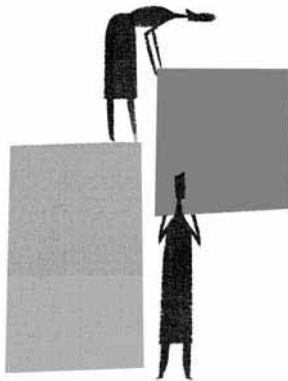
New

Pathways

2004 NCSBN
Annual Meeting
Kansas City, MO
August 3-6, 2004

National
Council
of State
Boards of
Nursing, Inc.

2004 NCSBN Annual Meeting



Section I: 2004 NCSBN Annual Meeting

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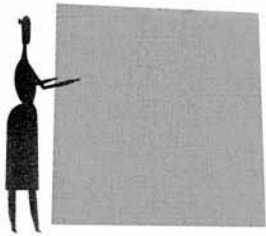
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Mission

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

Vision

Building regulatory expertise worldwide.

Values

Integrity: Doing the right thing for the right reason through informed, open and ethical debate.

Accountability: Taking ownership and responsibility for organizational processes and outcomes.

Quality: Pursuing excellence in all endeavors.

Vision: Using the power of imagination and creative thought to foresee the potential and create the future.

Collaboration: Forging solutions through the collective strength of internal and external stakeholders.

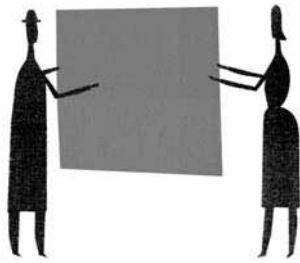
Purpose

The purpose of NCSBN is to provide an organization through which 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.

NCSBN's programs and services include developing the NCLEX-RN® and NCLEX-PN® examinations, performing policy analysis and promoting uniformity in relationship to the regulation of nursing practice, disseminating data related to the licensure of nurses, conducting research pertinent to NCSBN's purpose, and serving as a forum for information exchange for members.

SECTION I

2004 NCSBN Annual Meeting



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Business Agenda of the 2004 Delegate Assembly

Tuesday, August 3

9:00 - 9:40 am

Opening Ceremony

- Introductions
- Announcements

Opening Reports

- Credentials Committee
- Rules Committee

Adoption of Agenda

Report of the Committee on Nominations

- Presentation of the 2004 Slate of Candidates
- Nominations from Floor
- Approval of the 2004 Slate of Candidates

President's Address

Executive Director's Address

Thursday, August 5

2:45 - 4:30 pm

Examination Committee Report

- 2005 NCLEX-PN® Test Plan

Practice, Regulation & Education Committee Report

- Model Nursing Practice Act and Model Administrative Rules

Election Results for Officers, Directors and Committee on Nominations

Friday, August 6

9:00 am - 12:00 pm

Board of Directors' Report

- Strategic Initiatives for fiscal years 2005 through 2007

New Business

- Resolutions Committee

Closing Ceremony

Adjournment

Special Note

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





Standing Rules of the Delegate Assembly

1. Credentialing Procedures and Reports

- A. The President shall appoint the Credentials Committee, which is responsible for registering and accrediting delegates and alternate delegates.
- B. Upon registration, each delegate and alternate shall receive a badge and the appropriate number of voting cards authorized for that delegate. 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 registered alternate may substitute for a delegate provided the delegate turns in the delegate badge and voting card(s) to the Credentials Committee at which time the alternate is issued a delegate badge. The initial delegate may resume delegate status by the same process.
- D. The Credentials Committee shall give a report at the first business meeting. The report will contain the number of delegates and alternates registered as present with proper credentials, and the number of delegate votes present. At the beginning of each subsequent business meeting, the committee shall present an updated report listing all properly credentialed delegates and alternate delegates present, and the number of delegate votes present.

2. Meeting Conduct

- A. Meeting Conduct
 1. Delegates must wear badges and sit in the section reserved for them.
 2. All attendees shall be in their seats at least five minutes before the scheduled meeting time.
 3. There shall be no smoking in the meeting room.
 4. All cellular telephones shall be turned off or turned to silent vibrating mode. An attendee must leave the meeting room to answer a telephone.
 5. A delegate's conversations with nondelegates during a business meeting must take place outside the designated delegate area.
 6. All attendees have a right to be treated respectfully.

3. Agenda

- A. Business Agenda
 1. The Business Agenda is prepared by the President in consultation with the Executive Director and approved by the Board of Directors.
- B. Consent Agenda
 1. The Consent Agenda contains agenda items that do not recommend actions.
 2. The Board of Directors may place items on the Consent Agenda that may be considered received without discussion or vote.
 3. An item will be removed from the Consent Agenda for discussion or vote at the request of any delegate.
 4. All items remaining on the Consent Agenda will be considered received without discussion or vote.



4. Motions or Resolutions

- A. Only delegates, members of the Board of Directors, and the Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the bylaws of the National Council of State Boards of Nursing, Inc. (NCSBN).
- B. All motions, resolutions and amendments shall be in writing and on triplicate motion paper signed by the maker and a second. All motions, resolutions and amendments must be submitted to the Delegate Assembly Chair and the Parliamentarian. All resolutions and nonprocedural main motions must also be submitted to the Chair of the Resolutions Committee before being presented to the Delegate Assembly.
- C. The Resolutions Committee, according to its Operating Policies and Procedures, shall review motions and resolutions submitted before Wednesday, August 4, 2004, at 12 pm. Resolution or motion makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.
- D. The Resolutions Committee will convene its meeting on Wednesday, August 4, 2004, at 4 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion maker. The Resolutions Committee shall meet with the resolution or motion maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its Operating Policies and Procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.
- E. If a member of the Delegate Assembly wishes to introduce a nonprocedural main motion or resolution after the deadline of 4 pm on Wednesday, August 4, 2004, the request shall be submitted under New Business; provided that the maker first submits the resolution or motion to the Chair of the Resolutions Committee. All motions or resolutions submitted after the deadline must be presented with a written analysis that addresses the motion or resolution's consistency with established review criteria, including, but not limited to, the NCSBN mission, purpose and/or functions, strategic initiatives and outcomes; preliminary assessment of fiscal impact; and potential legal implications. The member submitting such a motion or resolution shall provide written copies of the motion or resolution to all delegates. A majority vote of the delegates shall be required to grant the request to introduce this item of business. [The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.]

5. Debate at Business Meetings

- A. Order of Debate: Delegates shall have the first right to speak. Nondelegate members and employees of Member Boards including members of the Board of Directors may speak only after all delegates have spoken.
- B. Any person who wishes to speak shall go to a microphone. When recognized by the Chair, the speaker shall state his or her name and Member Board or organization.
- C. 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.



- D. A red card raised at a 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. Any of these motions takes priority over regular debate.
- E. A timekeeper will signal when the speaker has one minute remaining, and when the allotted time has expired.

6. Nominations and Elections

- A. A delegate making a nomination from the floor shall have two minutes to list the qualifications of the nominee. Written consent of the nominee and a written statement of qualifications must be submitted to the Committee on Nominations at the time of the nomination from the floor.
- B. Electioneering for candidates is prohibited except during the candidate forum.
- C. The voting strength for the election shall be determined by those registered by 5 pm on Wednesday, August 4, 2004.
- D. Election for officers, directors and members of the Committee on Nominations shall be held Thursday, August 5, 2004, from 7:45 to 8:45 am.
- E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall immediately announce run-off candidates and the time for the run-off balloting.

7. Forums

- A. Scheduled Forums: The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly. Forum facilitators will give preference to voting delegates who wish to raise questions and/or discuss an issue. Guests may be recognized by the Chair to speak after all delegates, nondelegate members and employees of Member Boards have spoken.
- B. Open Forum: Open forum time will be scheduled to promote dialogue and discussion on issues by all attendees. Attendee participation determines the topics discussed during an Open Forum. The President will facilitate the Open Forum.
- C. To ensure fair participation in forums, the forum facilitators may, at their discretion, impose rules of debate.





Annual Meeting Schedule

TUESDAY, AUGUST 3, 2004

8:00 am – Registration

8:00 - 8:50 am – NCSBN Delegate Orientation

NCSBN Members & Julia Von Haam, Parliamentarian

Are you representing your state as a delegate? Please join us for a review of the parliamentary procedures required for voting on Delegate Assembly business.

9:00 - 9:40 am – Delegate Assembly: Opening Ceremony

9:00 - 4:30 pm – Exhibit Showcase

Stop by the Exhibit Showcase to learn about products and information pertinent to the boards of nursing!

9:40 - 9:55 am – President's Address

Donna Dorsey, MS, RN, FAAN, NCSBN President

9:55 - 10:10 am – Executive Director's Address

Kathy Apple, MS, RN, NCSBN Executive Director

10:10 - 10:30 am – Finance Committee Forum

Sandra Evans, MAEd, RN, NCSBN Treasurer

Robert Clayborne, MBA, CPA, NCSBN Director of Finance

10:30 - 11:00 am – Break

11:00 am - 12:00 pm – Candidate Forum

Gino Chisari, MSN, RN, Chair, Committee on Nominations

Shirlie Meyer, RN, Vice Chair, Committee on Nominations

Support NCSBN and your fellow NCSBN members: come to the Candidate Forum to hear from the nominees for NCSBN elected office!

12:00 - 1:30 pm – Lunch

1:30 - 2:30 pm – Examination Committee Forum

Anita Ristau, RN, MS, Chair, NCSBN Examination Committee

Casey Marks, PhD, NCSBN Director of Testing Services

2:30 - 2:45 pm – Cookie Break

2:45 - 4:00 pm – Board of Directors Forum

The NCSBN Board of Directors will discuss the proposed FY05-FY07 NCSBN Strategic Plan.

4:00 - 5:00 pm – Breakout Session: Advanced Practice

Kathy Thomas, MS, RN, Chair, NCSBN APRN Advisory Panel

Nancy Chornick, PhD, RN, CAE, NCSBN Director of Credentialing

Session will present current and emerging issues related to advanced nursing practice.

4:00 - 5:00 pm – Breakout Sessions: NCSBN Research Services Update

Lynda Crawford, PhD, RN, CAE, NCSBN Director of Research Services

June Smith, PhD, RN, NCSBN Associate Director of Research Services

Session will cover current NCSBN research.



4:00 - 5:00 pm – Breakout Session: Pearson VUE Best Practices

Pearson VUE staff will present lessons learned regarding best practices in the processes and services provided to the NCSBN membership.

6:00 - 9:00 pm – Benjamin Ranch Reception: Hosted by the Missouri and Kansas State Boards of Nursing

Join us down at the ranch for a warm, wonderful evening of barbecue and music! Round trip transportation will be provided. Buses will depart the Westin Crown Center at 5:30 pm.

WEDNESDAY, AUGUST 4, 2004

8:00 - 9:00 am – Registration and Continental Breakfast

9:00 - 4:30 pm – Exhibit Showcase

Stop by the Exhibit Showcase to learn about products and information pertinent to the boards of nursing!

9:00 - 10:15 am – Keynote Presentation: Leadership Lessons From the Jazz Masters

Keynote Speaker – John Hasse

10:15 - 10:35 am – Break

10:35 am - 12:00 pm – Breakout Session: AACN

American Association of Colleges of Nursing (AACN)

AACN staff will present information regarding the proposed new entry into the professional practice role of the clinical nurse leader.

10:35 am - 12:00 pm – Breakout Session: Nursys® Update

Angela Diaz-Kay, MBA, Director of Information Technology

Update on the Nursys database and answer questions from the membership.

10:35 am - 12:00 pm – Breakout Session: Practice Breakdown

The Practice Breakdown Focus Group presentation will address the Institute of Medicine (IOM) recommendations to NCSBN and the practice breakdown workplans for the next phase of research study, data collection strategies and other resources based on TERCAP.

12:00 - 2:00 pm – Area Lunch & Meeting

NCSBN AREA LUNCHEONS ARE OPEN TO NCSBN MEMBERS AND STAFF ONLY.

The purpose of NCSBN Area Meetings is to facilitate communication and encourage regional dialogue on issues important to NCSBN and its members.

- Area I Luncheon Meeting
- Area II Luncheon Meeting
- Area III Luncheon Meeting
- Area IV Luncheon Meeting

12:00 - 2:00 pm – External Organizations Lunch & Meeting

NCSBN guests are invited to attend this lunch meeting in lieu of the Area Lunches and Meetings to discuss issues of mutual concern with NCSBN staff.

2:00 - 2:30 pm – Haagen-Dazs Ice Cream Break

2:30 - 4:00 pm – Practice, Regulation & Education (PR&E) Committee Forum

Cookie Bible, APN, Chair of the PR&E Committee

Barbara Newman, RN, MS, Chair of the PR&E Model Revisions Subcommittee

The proposed revision to the Model Practice Act and the Model Rules will be presented.

**4:00 - 5:00 pm – Breakout Session: Commission on Graduates of Foreign Nursing Schools (CGFNS)**

Barbara Nichols, DHL, MS, RN, FAAN, Chief Executive Officer of CGFNS
Update on CGFNS services and answer questions from the membership.

4:00 - 6:00 pm – Resolutions Committee Meeting

Charles Alexandre, MSN, RN, Chair of the NCSBN Resolutions Committee
The committee will review all new resolutions.

6:00 - 8:00 pm – Nurse Licensure Compact Administrators (NLCA) Dinner

OPEN TO NLCA MEMBERS ONLY PLEASE.

This is a business meeting of the Nurse Licensure Compact Administrators (NLCA).

THURSDAY, AUGUST 5, 2004**7:45 - 8:45 am – Elections****8:00 - 9:00 am – Registration and Continental Breakfast****9:00 - 10:00 am – Open Forum**

This forum gives delegates and members the opportunity to ask questions and discuss any items pertinent to the business agenda.

10:00 - 10:15 am – Break**10:15 am - 12:00 pm – Building Bridges Networking Groups**

OPEN TO NCSBN MEMBERS ONLY.

Session topics include:

- Board Presidents
- Executive Officers
- Board Members
- Education
- PN/VN Issues
- Practice/Discipline

12:00 - 2:30 pm – Awards Luncheon**2:30 - 2:45 pm – Refreshment Break****2:45 - 4:30 pm – Delegate Assembly: Second Meeting****FRIDAY, AUGUST 6, 2004****8:00 - 9:00 am – Registration and Continental Breakfast****9:00 - 10:15 am – Delegate Assembly: Third Meeting****10:15 - 10:35 am – Break****10:35 am - 12:00 pm – Delegate Assembly: Closing Ceremony**

SCHEDULE SUBJECT TO CHANGE.





Summary of Recommendations to the 2004 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors; Examination Committee; Practice, Regulation & Education Committee; and the Committee on Nominations propose to the 2004 Delegate Assembly. Additional recommendations may be brought forward during the 2004 Annual Meeting.

BOARD OF DIRECTORS

1. Adopt the proposed Strategic Initiatives for fiscal years 2005 through 2007.

Rationale

The Board of Directors developed the proposed 2005-2007 Strategic Initiatives through a facilitated strategic planning process and based the initiatives on the suggestions from Member Boards during the 2004 Midyear Meeting. The proposed plan identifies critical strategic initiatives for the next three years related to NCSBN's mission and vision.

Fiscal Impact

The strategic initiatives will serve as a basis for allocating financial resources for the next three years. Annual operating budgets will be developed to fund strategic and tactical objectives designed to carry out the strategic plan.

2. Recommend adoption of revised Model Nursing Practice Act and Model Administrative Rules.

Rationale

This is the third major revision of the Model Nursing Practice Act and Model Nursing Administrative Rules. The Practice, Regulation & Education Model Rules Revision Subcommittee has spent three years reviewing, researching, drafting and refining the revised models for presentation to the 2004 Delegate Assembly. In completing this project, the subcommittee has consulted with other NCSBN committees, NCSBN staff, Member Boards and interested external groups.

In the early years of the National Council of State Boards of Nursing, Member Boards expressed the need for a Model Nurse Practice Act. The 1982 Delegate Assembly adopted the first Model Nursing Practice Act. Model Nursing Administrative Rules followed in 1983. The model rules served to clarify and make more specific the model act. The model act and rules were revised in 1988 and 1993-1994.

As nursing education, practice and policy evolves, so must the laws and rules that regulate nursing. New concepts, such as the Nurse Licensure Compact, have been incorporated into this revision. The document has been developed as an electronic resource; once adopted, it will be available on the NCSBN Web site. The models have been prepared in a format that tracks the act on one side and the rules on the other, allowing the user to see how the statutes and rules work together. The subcommittee's vision is a living document, reviewed and revised to respond to the changes in nursing and the health care environment. These models are intended to serve as a guide to states in considering revision to their Nurse Practice Acts.

Fiscal Impact

Incorporated into FY05 budget.



COMMITTEE ON NOMINATIONS

3. Adopt the 2004 Slate of Candidates.

Rationale

The Committee on Nominations has prepared the 2004 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information and personal statement for each candidate follows in the Business Book under the Report of the Committee on Nominations. Candidates will present himself or herself at the Candidate's Forum on Tuesday, August 3, 2004, from 11:00 am – 12 pm.

Fiscal Impact

Incorporated into FY05 budget.

EXAMINATION COMMITTEE

4. Adopt the proposed changes to the *NCLEX-PN® Test Plan*.

Rationale

The Examination Committee reviewed and accepted the *Report of Findings from the 2003 PN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (Smith & Crawford, 2003) as the basis for recommending revisions to the *2005 NCLEX-PN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from the Member Boards of Nursing, the professional judgment of the Examination Committee and review by legal counsel provide support for the recommendation to the Delegate Assembly to adopt the proposed changes to the *NCLEX-PN® Test Plan*.

Fiscal Impact

Incorporated into FY05 budget.



Report of the Committee on Nominations

Recommendations to the Delegate Assembly

Adopt the 2004 Slate of Candidates.

Rationale

The Committee on Nominations has prepared the 2004 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information for each candidate follows. Each candidate will present himself or herself at the Candidate's Forum on Tuesday, August 3, 2004.

Background

Per the bylaws, the Committee on Nominations considers the qualifications of all nominees for officers and directors and presents a qualified slate of candidates for vote at the Annual Meeting. The committee's report is read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name is placed in nomination without the written consent of the nominee.

Highlights of FY04 Activities

The committee discussed how to get more members to submit nomination forms. The committee also discussed methods for members to participate as volunteers onsite at NCSBN meetings as greeters, hosts for first-time attendees or registration workers.

The committee stressed identifying possible candidates by promoting NCSBN elected office on the network calls for education, policy and discipline. The committee also promoted running for elected office on the Board of Director's Member Board dial-in conference calls.

The committee created a new candidate brochure, Make Your Mark, with the assistance of the NCSBN Communications Department.

The committee discussed obtaining leadership training via publications or by attending a seminar geared at leadership development hosted by an outside vendor.

The committee discussed future leaders and NCSBN's current mentorship programs, member orientation and leadership initiatives. Committee members discussed the importance of committees naming vice chairs at the outset of the fiscal year for continuity and to reinforce future leaders. The committee was successful in having staff create an NCSBN chair e-mail group to aid in recruitment.

The committee also discussed the true time commitment for a prospective board member and intends to speak to the Board about the liaison role and representative function at outside meetings as a reason for low returns on nomination forms.

The committee requested that NCSBN staff obtain candidate pictures for inclusion on the NCSBN Web site and Business Book. The committee also requested that staff include in the Candidate Forum procedure that the Nominations Chair may approach the second lectern to end a candidate's speech that runs over the allotted time.

Committee Members

Gino Chisari, MSN, RN, Chair
Massachusetts, Area IV

Shirlie Meyer, RN, Vice Chair
Idaho, Area I

Karla Bitz, MGMT, BSN, RN
North Dakota, Area II

Betty Sims, MSN, RN
Texas, Area III

Staff

Kathy Apple, RN, MS
Executive Director

Chrissy Ward, Executive Office
Relations Manager

Beth DeMars, Meetings Coordinator

Relationship to Strategic Plan

Strategic Initiative 5 Governance & Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome B

Sound organizational governance advances the NCSBN mission and vision.

Meeting Dates

October 23-24, 2003

December 3, 2003

January 6, 2004

March 3, 2004

April 28, 2004



Future Activities

Candidate Forum August 3, 2004

Attachments

A. Slate of Candidates

The committee discussed a suggestion to change the Candidate Forum to a debate and to require letters of recommendation to support nomination submissions. The committee voted against both, due to the length of time a debate would add to the proceedings and the barrier a letter of recommendation would add to the open nomination process.

The committee revised the Nomination Form and established qualifying criteria for candidates. The committee has also added an interview element to this year's process.

The committee deleted the requirement for a 150-word essay on the Nomination Form replacing the essay requirement with qualifying questions. The committee also deleted previous education and employment history. The board member eligibility term requirements were strengthened.

The committee created three new policies to aid future nominating committees: Preparation of Ballot; Calendar of Activity; and Candidate Forum.

The committee proposed four recommendations for possible Bylaw revision:

1. Delete requirement that Nominations observe Board proceedings at first meeting.
2. Delete requirement that members of Nominations are not eligible for board service until one year following their final year of service to Nominations.
3. Request that Areas be dissolved to allow for a larger number of qualified applicants for both Board and Nominations groups.
4. Ability to name own chair/vice chair.

The committee interviewed all candidates by phone with the exception of two candidates who were present in the office for other NCSBN matters and one candidate who was not available by phone. The committee received positive feedback on changes they have made to the nomination process. Candidates noted that the revision to the two questions that candidates must respond to in writing, were thought provoking and helpful.

The committee had a substantial conversation regarding how to support creativity on the part of candidates during the Candidate Forum. It was decided that the committee should continue this discussion beginning at the first meeting after 2004 Delegate Assembly and that it would be unfair to current candidates to change the forum guidelines at this time.



COMMITTEE ON NOMINATIONS – ATTACHMENT A

2004 Slate of Candidates

The following is the slate of candidates developed and adopted by the Committee on Nominations. Each candidate profile is taken directly from the candidate's nomination form. The Candidate Forum will provide the opportunity for candidates to address the 2004 Delegate Assembly on Tuesday, August 3, from 11:00 am - 12:00 pm.

Board of Directors

PRESIDENT

Donna M. Dorsey, Maryland, Area IV	20
Marcia Hobbs, Kentucky, Area III	22
N. Genell Lee, Alabama, Area III	24

VICE PRESIDENT

Sheila M. Exstrom, Nebraska, Area II	26
Polly Johnson, North Carolina, Area III	28

TREASURER

Sandra Evans, Idaho, Area I	30
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DIRECTOR-AT-LARGE (TWO POSITIONS)

Lanette L. Anderson, West Virginia-LPN, Area II	31
John M. Brion, Ohio, Area II	32
Rula Harb, Massachusetts, Area IV	33
Marjesta K. Jones, Alabama, Area III	34
Constance B. Kalanek, North Dakota, Area II	35

Committee on Nominations

AREA III

June Bell, Kentucky, Area III	38
Karen Taylor, Arkansas, Area III	39

AREA IV

Mary E. Bowen, Pennsylvania, Area IV	40
Anita Paris, New Hampshire, Area IV	41

Detailed Information on Candidates

Information is provided on each candidate in the following pages (taken directly from nomination forms) and organized as follows:

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Date of term expirations and eligibility for reappointment
4. Professional/Regulatory/Community Involvement including Service on NCSBN committee(s)
5. Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.
6. Describe how you will advance the mission, vision and strategic initiatives of NCSBN.



Date of expiration of term: N/A

Eligible for reappointment: N/A

President

Donna M. Dorsey, MS, RN, FAAN

Executive Director, Maryland Board of Nursing, Area IV

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

NCSBN

President, 2002-2004

Treasurer and Finance Committee Chair, 1987-1991

Examination Negotiating Team, 1992, 1993, (NACEP 1997, 1999)

Bylaws, 1984-1986

Examination Committee Team 2, 1992

Examination Committee, 1994-1996

Resolutions Committee, 1994

CORE, 1999-2002

Awards Committee, 2000-2002

Disaster Planning Task Force, 2002

Nurse Licensure Compact Administrators Vice Chair, 1999-2002

American Red Cross

Senior Advisor to the Chief Nurse, 1999-present

National Chairman of Nursing, 1995-1999

Central Maryland Chapter American Red Cross

Vice Chair of the Board, 2002-2004

Maryland Nurses Association

Finance Committee, 1999-2002

JCAHO National Nursing Advisory Committee, 2002-present

Maryland Commission on the Crisis in Nursing Vice-Chair, 1999-present

Advisory Board Center for Workforce Development, University of Maryland, 2002-2004

National Nursing Workforce Clearing House National Advisory Board, 2002-2005

International Nursing Coalition for Mass Casualty Education, 2000-Present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

The long-term impact of the nursing shortage will require new models of nursing practice, which will have a direct impact on regulation. Already we have begun to see increased use of assistive personnel, calls for increased delegation and requests for changes in scope of practice. For regulators these issues raise a number of questions. What are the public protection implications? Who should be regulated? What kind of regulation is needed? These are just a few of the questions. National Council can be instrumental in helping to answer these questions. Using the collective wisdom of the membership, task forces can work to answer specific questions. The Council's research is positioned to identify the major regulatory concerns and provide information allowing for research-based decision



making by Member Boards. Through CORE, best practices can be identified. National Council can provide Member Boards with information that will assist with legislative challenges. In addition, National Council would monitor legislation and policy proposals on the national level and take action to bring forth the position of the Member Boards in order to stem actions that would be negative to public protection. NCSBN can leverage its relationships with other organizations to develop coalitions where needed and negotiate where differences exist. These are the kinds of activities that together make a positive impact on a regulatory challenge such as new models of nursing practice and provide each member board with the tools for effective regulation.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

Leadership, communication, negotiation and collaboration are some of the skills I bring to the table. I view the role as President as that of a leader who guides the Board and organization in assuring that the decisions made are mission based and consistent with the organization's values and vision. Communication is key. Secrets are not healthy for any organization. They impede the ability to move the mission and strategic initiative forward. An organization can only grow through full open discussion and a trusting environment. My goal is to assure that the organization continues to grow and thrive. This does not mean we all have to agree all of the time. We need to be comfortable disagreeing and allowing all sides to be heard.

The strategic initiatives will provide focus. The Balanced Scorecard will assist in evaluation of the progress in reaching the identified strategic objectives for the year. I will monitor the progress and be prepared to work with the Board to take any action that would assure success in meeting the objectives.

Dealing with hard issues both internally and externally is important to assure NCSBN remains mission focused. I believe I can effectively address the hard issues to the benefit of the Council. I am also positioned to continue the development of relationships and collaborations with external groups and individuals who can benefit the organization in meeting its goals.

As President one should lead with a steady hand and straightforward approach to accomplish the goals of the Council. That is what I strive to do in leading NCSBN.



Date of expiration of term: 06/30/06

Eligible for reappointment: Yes

President

Marcia Hobbs, RN, DSN

Board Member, Kentucky Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Regulatory Involvement

NCSBN

Vice President, 2001-present

Board of Directors Liaison: Examination Committee, Regulatory Credentialing Program

Development Task Force

NCSBN Board of Directors' Representative, ANA Call to the Profession, 2001

AONE Annual Meeting, 2002, 2004

National Telemedicine Conference, 2002

NLN Educational Summit, 2002

NLN Education Standards "Think Tank," 2003

ANA Convention, 2004

NSNA Annual Convention, 2003

Delegate Assembly Attendee, 1999-present

Area Meeting Attendee, 1997-2000

Midyear Meeting, 2001-2003

Kentucky Board of Nursing - Appointed 1998, Reappointed 2002

President, 2001

President-Elect, 2000

Secretary, 1999

Chair, Education Committee, 2001-present (Member since 1996)

Chair, Credentialing Review Panel, 2001-2003

Member: UAP Task Force, Initial Competency Task Force,
Continued Competency Task Force

Baccalaureate and Higher Education Representative, 2000-present

Strategic Planning Work Group, Chair, 2000

KBN Connection Editorial Panel, 1999

Professional Involvement

ANA - KNA District Secretary; TNA - State Board of Directors, 1990-1991

District offices, President, Treasurer, Legislative Liaison, Second Vice-President

STTI, President, Delta Epsilon Chapter, 1994-1996, 1998-2000

President-Elect, Delta Epsilon Chapter, 1993, 1996-1997

Delegate to International Convention, 1993, 1995, 1997, 1999

CCNE - Accreditation Visitor and Team Leader, 1998-present



NLN

Sigma Xi

Army Nurse Corps (Reserves), Retired Lieutenant Colonel

Community Involvement

Alpha Chi Faculty Advisor, 1995-present

Purchase AHEC Advisory Board, 1992-present

Calloway County American Red Cross Board of Directors, 1993-2003

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

A major challenge currently facing nursing is that of maintaining states' rights to protect the public in the U.S. while being involved with the globalization of the profession. NCSBN serves as a collective voice for the Member Boards, yet has the unique and crucial opportunity to be "at the table" during discussions and decisions regarding the nursing profession and the international community. No other national body has the regulatory message and research that NCSBN can offer which influences these decisions. It is essential that NCSBN is at the forefront of national and international activities.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I believe that having participated in the development of the updated mission, vision and strategic initiatives give me an internalization of these statements - they aren't simply words printed in the program or on the boardroom wall. I believe that I have the integrity, a continual ability to keep learning and listening, and the relationship skills that can foster collaboration among us, with our professional colleagues, and with various stakeholders. No one person can accomplish the mission, vision and strategic initiatives alone – it is my belief that I can lead this organization to collectively do so.



Date of expiration of term: N/A

Eligible for reappointment: N/A

President

N. Genell Lee, RN, MSN, JD

Executive Director, Alabama Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Executive Officer, Alabama Board of Nursing, September 1999-present

NCSBN Finance Committee, 2002-present

NCSBN Bylaws Committee, 2001

Member, Emergency Nurses Association

Consulting Editor, Journal of Emergency Nursing

Member, Editorial Board, International Journal of Trauma Nursing, 1994-1999

Legal Editor, American Journal of Nursing, 2000

Adjunct Faculty, School of Nursing

University of Alabama, February 1981-August 1992

California State University at Long Beach, November 1987-December 1989

University of California, Los Angeles, August 1984-December 1989

Editor, *Flight Nursing: Principles and Practice*. St. Louis: The C.V. Mosby Company, 1991. (Project completed on behalf of the National Flight Nurses Association).

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

A major challenge facing nursing regulation is how to manage information, communicate effectively and maintain standards to protect the public. The public expects boards of nursing to provide a quality, cost-effective, technologically advanced and evidence-based product or outcome. NCSBN is in a unique position to offer credible information that has been analyzed and synthesized to Member Boards and the public. How does that influence outcome? Learning from each other...what works, what doesn't...what is the political landscape...what are the possibilities...dream big but realistically.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

The President of NCSBN is similar to a symphony orchestra conductor. It doesn't really matter who the conductor is if the members of the orchestra are not playing in tune, not using the same sheet music, or not using the correct instrument. My focus would be guiding the Board members and staff to critically assess and evaluate the mission, vision and strategic initiatives each time an NCSBN program or activity is reviewed, requests are received or the Delegate Assembly provides a different direction.



I am focused on evidence-based decision making and expect analyses of recommendations prior to reaching a conclusion. I am also focused on the financial health of NCSBN and would like to see stronger links between the mission, vision, strategic initiatives and the finances. A performance-based budget model may be effective in evaluating revenues and expenditures associated with NCSBN programs and activities.

The diversity of the Member Boards provides an interesting dilemma in assuring that everyone has an equal voice. A major challenge is how to hear each voice and make decisions based on all the available evidence.



Date of expiration of term: N/A

Eligible for reappointment: N/A

Vice President

Sheila M. Exstrom, RN, BSN, MA, PhD

Board Staff, Nebraska State Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Nebraska Nurses Association

President, 1974-1978

Secretary, 1972-1974

Board of Directors, 1970-1978

District President, 1970-1972

Delegate-at-Large to the American Nurses Association Convention, 1974, 1978, 1980.

Numerous times have served as a Delegate to the Nebraska Nurses Association Conventions

Immanuel Hospital School of Nursing Alumnae Association, President

Sigma Theta Tau-Gamma Pi Chapter - have served on a variety of committees

Clinical Preceptor for students pursuing a Master's degree in Patient Care Administration, Independent Study Program, University of Minnesota, 1982-1987

Consultant, Friesen International, Incorporated, 1975-1980

Adjunct instructor, MSN program at Clarkson College (teaching nursing administration)

Adjunct instructor, MSN program at Nebraska Wesleyan University (teaching curriculum development)

Part-time instructor, Nurse Aide Training program, Southeast Community College, Lincoln

Board Member, Current Secretary, Woodhaven Homeowners Association

Various teaching and committee activities with the First Lutheran Church

Technical Advisor to the Academy Award winning movie "Terms of Endearment," 1981

Active Membership and involvement with:

American Nurses Association

American Red Cross (nurse pin #249210)

American Heart Association

Midland Lutheran College Alumnae Association

Lincoln General Hospital Auxiliary

Nebraska League for Nursing

Nebraska Assembly of Nursing Deans and Directors

Nursing Leadership Coalition

NCSBN activities include:

Member, Subcommittee on Nurse Shortage, 1989

Chair, Subcommittee to Study Regulatory Implication of Changing Models of Nursing Education, 1991

Member, Administration of Examination Committee, 1992-1993

Member, Examination Committee, 1995-2005



Member, Computer Simulated Testing Subcommittee, 1996-1999

Member, Negotiating Committee with testing service, 1997

Member, Subcommittee to compare NCLEX-RN and Canadian Nurse Examination, 1999-2001

I have served as a delegate and/or alternate delegate to numerous meetings of the NCSBN House of Delegates. Have also served in various roles such as election committee or as a page at some meetings of the house of delegates when attending as a nondelegate.

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

I think that the major role of NCSBN is to assist in the standardization of many of the activities that state boards of nursing are involved with and this NCSBN is doing by providing a national examination, by implementing the core requirements for licensure, by the establishment of the nursing compact and by the implementation of the Nursys system for consolidating licensure and disciplinary information. Continued refinement and enhancement of these activities must occur and, in my opinion, should go even further. As globalization is so prominent in so many aspects of our lives I think that some of the NCSBN activities, should they be available in a more global arena, would have a positive outcome on some of the major challenges that are currently facing nursing regulators. Foreign administration of the NCLEX exams may be the initial step. How much easier it will be for the candidates, the boards of nursing and the health care agencies if, for example, Canadian nurses can take the NCLEX exam in Canada and therefore make entry into the states much smoother and at the same time assure the boards of nursing that the competency examination is the same one as used here.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I think that as a board member the primary method that I would use to promote the mission, vision and strategic initiatives of NCSBN would be to oversee the activities of the various units of the organization to assure that they are related to the mission of the organization and to assure that they are performed or developed at the level of excellence. This awareness would be a part of each discussion, deliberation and vote that I would be making.

Board members also have the responsibility to provide the organization with executive staff and financial resources to implement the strategic initiatives as adopted by the member constituents.

I think that I have already mentioned about how I think these activities should take on a broader, more global influence. Another role of the board is to maintain and enhance the internal communications and relationships with the membership boards as well as with other health care provider licensing organizations and other nursing organizations. I think these relationships are important at not only the staff level of organizations working together, but also at the board level. I believe that I have good communication skills built on honesty, cooperation and respect, and always working for win-win situations.

This is how I see I would advance the mission, vision and strategic initiatives of NCSBN.



Date of expiration of term: N/A

Eligible for reappointment: N/A

Vice President

Polly Johnson, RN, MSN

Executive Director, North Carolina State Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Selected Current Statewide Activities:

NC Center for Nursing Advisory Council, 1997-present

NC Center for Nursing Workforce Planning Committee, 2003-present

Chaired NC Nursing Centennial Celebration Committee, 1998-2003

Office of Emergency Services Hospital Bioterrorism Preparedness Task Force, 2002-present

NCNA Professional Practice Advocacy Coalition, 2000-present

NC Institute of Medicine, Nursing Workforce Taskforce, 2002-present

President and Founding Member, Foundation for Nursing Excellence, 2002-present

Member, NCNA, NC Association of Nurse Leaders

National Activities:

Nurse Licensure Compact Administrators, 2000-present

Institute of Medicine's Committee on Health Professions Education Summit, January 2002-May 2003

NCSBN Board of Directors, Director-at-Large, 2002-2003

NCSBN Committees:

UAP Task Force, 1996-1999, Chair, 1998-1999

Resolutions Committee, 2000, 2001, 2002

Advisory Panel, Commitment to Excellence in Regulation, 2000-present

Area III Program Planning Committee Chair, 1998

Pilot State Participant: Nursys and Commitment to Excellence Project

Representative to National Coordinating Council for Medication Error Reporting and Prevention, 2003-present

Citizens Advocacy Center:

Pilot State Participant and Member of Advisory Panel for Practitioner Remediation and Enhancement Partnership (PREP) Project, 2001-present

International Activities:

Participant, Fifth International Conference on Regulation of Nursing and Midwifery, 2001

Presenter, International Congress of Nurses, 2001

Presenter, Sixth International Conference on Regulation of Nursing and Midwifery, 2003



Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

As we face the challenge of a shrinking workforce in a very complex health care delivery environment, regulatory bodies must be able to assure the public that licensees are competent to practice throughout their careers. NCSBN is building a research base of evidence regarding the essential competencies for both entry to practice and continued licensure for RNs and LPN/VNs. Drawing on its own research findings as well as the work of other experts in health care regulation, NCSBN will continue to refine its exam for initial licensure while developing an evidence-based model for the periodic demonstration of continued competence by licensed nurses. This model can then be used by Member Boards to assure the public of their commitment to enhancing patient safety and improving the quality of health care in America through the demonstration of competence upon entry to practice and periodically throughout one's nursing career.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

As a Board member, I will continue to be committed to helping steer the course of National Council to achieve our mission and vision through setting policies, assuring that our resources are appropriately allocated, and being involved in ongoing evaluation and refinement of our strategic activities. Being a Board member requires thoughtful study and consideration of those environmental factors at the global, national and state levels that impact our work as the National Council and its Member Boards. It requires a commitment to a deliberative decision-making process that values diversity of opinions as the Board seeks the right path to take. It also requires flexibility and creative visioning to reset our course when necessary to advance regulatory excellence. I will bring my knowledge of and commitment to the National Council along with my visionary, analytical and interpersonal skills to enhance the collective work of the Board of Directors. I am proud of the work we do and it would be a great privilege for me to serve as the Vice President of the National Council.



Date of expiration of term: N/A

Eligible for reappointment: N/A

Treasurer

Sandra Evans, BSN, MAEd, RN

Executive Director, Idaho Board of Nursing, Area I

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Member, Idaho Nurses Association/American Nurses Association, 1979-present

INA Continuing Education Approval Board, 1985-present

Member, Sigma Theta Tau, Mu Gamma Chapter, 1987-present

Member, Idaho Commission on Nursing and Nursing Education, 1979-present

Chair, 1987-1989

Chair, Data Collection/Analysis Task Force, 1999-2004

Member, Soroptimist International of Boise, 1980-present

National Council of State Boards of Nursing:

Treasurer, 2002-2004

Member, Communications Evaluation Task Force, 1997

Member, Finance Committee, 1996-present; Chair, 2002-present

Member, MSR Operations and Fiscal Work Group, 1999

Member, Resolutions Committee, 2002-present

Member, Nurse Licensure Compact Administrators, 2001-present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

Expectations of our society for efficiency and accountability in health care, including health care regulation, are forcing boards of nursing to critically look at how we conduct our day to day business as well as how we might work together to anticipate and address challenges in our future.

Nursing regulation issues are no longer confined to concerns within the boundaries of our individual states or, in fact, those of the U.S. In order to keep pace with our rapidly changing world, it is incumbent on each of us to transition to a global perspective of health care regulation, rather than to continue to operate as we have historically. It is NCSBN that can and will ensure our influence in the global health care market toward maintaining our commitment to the highest standards necessary for public protection.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

As Treasurer, I am committed to closely examining internal and external forces that affect NCSBN and its financial strategies; evaluating the efficiency of existing financial resources and exploring potential new sources of revenue; and analyzing the cost and effectiveness of ongoing and proposed programs and initiatives. I am confident that we can assist in accomplishing the vision of NCSBN, by exercising prudence in decision making regarding the financial position of this organization.



Director-at-Large

Lanette L. Anderson, RN, BSN, JD

Executive Secretary, West Virginia-LPN Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

NCSBN Activities:

- Bylaws Committee, 1993-1994
- Complex Discipline Cases Subcommittee, 1996
- Finance Committee, 1998-2001
- Commitment to Excellence Pilot Participant, 1999-2002
- CORE Advisory Panel, 2002-2004
- Institute of Regulatory Excellence Fellow, 2004

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

Changes, and therefore challenges, in today's health care environment are prolific. One significant challenge is the change in the utilization of practical nurses and UAPs to provide patient care. NCSBN has taken an important step in evaluating this issue with the formation of a PN Focus Group to discuss the results of the *2003 LPN/VN Practice Analysis*. Further discussion of this topic relating to UAPs can also provide important guidance to nursing regulators.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

My 12 years of involvement in NCSBN activities have been of immeasurable value to me. If chosen to serve on the Board of Directors, I will encourage others, particularly those new to the organization, to take advantage of the numerous opportunities to serve on committees, task forces, etc., and to generally take advantage of the many resources that NCSBN has to offer to Member Boards. I feel that my service will also demonstrate active representation for practical nursing in addition to that of the nursing profession as a whole.



Date of expiration of term: N/A

Eligible for reappointment: N/A



Date of expiration of term: N/A

Eligible for reappointment: N/A

Director-at-Large

John Brion, RN, MS, PhD Candidate

Executive Director, Ohio Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Governor’s Taskforce on Healthcare Workforce Shortage, 2002-2004

Nursing Reimbursement Study Council, Subcommittee on Regulatory Reform, 2004

NCSBN Subcommittee on International Nurse Issues, 2004

NCSBN Institute on Regulatory Excellence (Fort Worth, Texas), 2004

Graduate Student (Nursing) Preceptor, Capital University, Columbus, Ohio, 2003

Joint Regulatory Board Best Practices Committee, 2003

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

U.S. and global health care are currently viewed by many as being in states of crisis and chaos. While this may be true on some levels, the situation can certainly be reframed as one of challenge and opportunity. Never before has nursing been so visible and a topic of public discussion. The profession stands at a pivotal point, faced with a tremendous shortage but, more than ever before, producing practitioners who are more comprehensively prepared to meet the health care needs of our nation. It is vital that nursing regulation plays a key role in assuring that standards are not lowered for the mere purpose of increasing numbers while assuring that nurses are empowered to practice according to their level of preparation. From an international perspective, NCSBN is poised to take a leading role in the standardization of nursing education, credentialing and regulation. By helping to increase the minimum standards expected for both education and practice on the global level, NCSBN will continue to be a vital force in assuring the ongoing availability of highly qualified nurses throughout the world.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

As a professional nurse, I am first and foremost a patient advocate. As a nurse regulator, I advocate for patients by helping to assure access to nursing care that is safe and effective as defined by law. I will maintain a focus of patient advocacy as a member of the Board of NCSBN, remembering that the ultimate purpose of all we do is patient access to safe and effective nursing care. I offer my knowledge, skills and abilities in the support of fellow Board members, National Council staff and Member Boards toward assuring that safe and effective nursing care is available to all. I would welcome the opportunity to work with National Council and its Member Boards in their role as nursing regulators and patient advocates.



Director-at-Large

Rula Harb, MS, RN

Board Staff, Massachusetts Board of Nursing, Area IV

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

National Council Examination Committee, 1998, 2000

National Council Examination Committee, 2002, 2004

Massachusetts Center for Nursing Board of Directors, 2003, 2004

State activities on committees and advisory groups related to:

- Workforce development initiatives
- Promulgation of regulations
- Complaint resolution process
- Substance abuse and rehabilitation program
- Approval of nursing education programs
- Process improvement
- Performance excellence

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

Providing and maintaining an adequate supply of competent nurses is a critical challenge. NCSBN, through an ongoing analyses and review of trends impacting public protection, health care and nursing environments, can influence a positive outcome to the workforce issues that affect the regulation of nursing education and practice. NCSBN, through its commitment to developing technology solutions and databases, can maximize the use of innovative strategies to collect workforce information that will inspire change and regulatory efficiency.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I will advance the mission and vision of NCSBN through my personal commitment to regulatory excellence and my promise to responsibly implement NCSBN strategic initiatives. I will collaborate with Member Boards to understand and represent their perspectives when issues are being deliberated. I will be diligent in maintaining fair and rigorous entry-level competency assessment as directed by the Delegate Assembly. My respect for the integrity of the NCLEX Examination will allow me to investigate future enhancements that will continue to provide you with “state of the art” entry-level nurse licensure examinations.

Thank you for the opportunity to submit my application for your review. I will be most honored to serve as your Director-at-Large.



Date of expiration of term: N/A

Eligible for reappointment: N/A



Date of expiration of term: 12/31/06

Eligible for reappointment: No

Director-at-Large

Majesta K. Jones, LPN

Board Member, Alabama Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Director-at-Large, Board Member, National Council of State Boards of Nursing

Board Member, Alabama Board of Nursing

Member, National Federation of Licensed Practical Nurses, Inc.

Member, Alabama Federation of Licensed Practical Nurses, Inc.

Member National Education Association (ESPO)

Member, Alabama Education Association (ESPO)

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

The shortage of nurses today at all levels from the highest pinnacle of education to the lowly nurse at the bedside presents a challenge to us all because we are all affected by this in some way. Today we find the situation of too many patients and not enough practitioners, too many treatments and not enough time treat and the list could go on and on. This then leaves a load of errors that must be dealt with by us, the regulators, who themselves are growing weary.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I take my profession very seriously and try to uphold the pledge I took many years ago as a light to lead me as I go through my professional day and beyond. To serve and protect the public as I would like to be served and protected is my personal creed. The mission statement of NCSBN may not say that as you read it, but I feel that is the true essence of what it means.



Director-at-Large

Constance B. Kalanek, PhD, RN

Executive Director, North Dakota Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

National Committees:

National Council of State Boards of Nursing

Executive Officers Network, Member

Executive Officer Network Group Leadership Development Seminar, April 28-29, 2003 and April 22-23, 2004 (planning committee)

Commitment to Ongoing Regulatory Excellence Research Project, 2002-2004

Resolutions Committee, 2003-2005

Nurse Licensure Compact Administrators, Member, July 1, 2002

Practice, Education and Regulation Task Force, Chair, Work completed August 12, 2002

Nursing Practice and Education Consortium, Member, 2001

Nurse Week Executive Advisory Board, Member, 2000-2001

State Committees:

Patient Quality Care Task Force, Steering Committee, 2000-2002

ND Statewide Curriculum Task Force, 2000-2001

Multistate Licensure Advisory Committee, 1999 – complete

Preparation of Joint Recommendation on Med. Administration NDDHS, 2000

Nursing Practice Committee, 2000-present

ND Center for Health Workforce Data – Nursing Needs Study, ongoing

ND Health Practitioner Workforce Coalition, ongoing

Professional Memberships and Offices Held:

American Nurses Association, 1981-2002

Certification, Maternal – Child Nurse, 1987-1998

American Nurses Credentialing Center – Commission on Accreditation, Category Alternate, 1997

ANCC Item Writer for Prenatal Certification Examination

ANA Institute of Constituent, Members on Nursing Practice, Representative for North Dakota, 1992-1994

American Society of Psychoprophylaxis in Obstetrics, 1975-1990

Certified Childbirth Educator, 1975-1990



Date of expiration of term: N/A

Eligible for reappointment: N/A



Badlands Childbirth Educators, Treasurer/Member, 1975-1990
North Dakota Nurses Association, District #10, 1980-1990
Continuing Education Committee
Professional Affairs Committee
Government Relations Committee, Chairperson
Nominating Committee
NDNA Delegate, 1987, 1989
NDNA Alternate Delegate, 1984, 1986
North Dakota Nurses' Association District #6, 1990-2002
Continuing Education Committee, Nursing Education Representative, 1996-1998
NDNA Research/Education Council, 1996-1998
NDNA Women, Infants and Children Interest Group, 1996-1998
Refresher Course Task Force, 1988-1998
IV Therapy Committee, 1987-1998
NDNA District #6 Delegate, 1991, 1992, 1994, 1996
Statewide Task Force on Impact of Entry into Practice, Chairperson, 1991-1994
Congress on Education and Practice, Chairperson, 1987-1993
Government Relations Committee, 1984-1992
Membership Committee, 1984-1990
Delta Kappa Gamma International Society, 1986-1990
Northern Rocky Mountain Educational Research Association, 1996-present
Sigma Theta Tau International Honor Society of Nursing, 1988-present
Kappa Upsilon Chapter
STT Workshop Planning Committee, 1996-1997
North Dakota Board of Nursing, Ad hoc Committee on Revision for Rules for IV Therapy for LPNs, 1997
NCSBN appointed alternate, Case Development Committee, 1996-1997

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

NCSBN is facing many challenges nationally and internationally with a nursing shortage of critical proportions. The leadership of NCSBN will be expected to initiate at all levels significant policy development to fill the need for practicing RNs and LPNs for our health care delivery system. Policy development needs to include development of nursing education curricula for this century, which leads to standardization of scopes of practice, identification of the significant role of ancillary personnel and competency issues relevant to the foreign-educated nurse.



The National Council of State Boards of Nursing has become a leader in conducting research on practice. As we all know, research can influence the face of practice and education. Thus, all policy development and action of the Council must be grounded in the use of the research.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

My first response to this question is “I cannot do it alone.” To advance the mission of NCSBN requires a collaborative effort of visionary leaders. The Council in conjunction with Member Boards must focus on problem solving, team building and a proactive approach to leadership.



Date of expiration of term: 7/1/2004

Eligible for reappointment: Yes

Committee on Nominations Area III

June Bell, BSN, RN, BC

Board Member, Kentucky State Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Past President, Kentucky Board of Nursing, Current Vice President

Delegate, NCSBN, 7 years

Current member, Awards Panel

Executive Director Search Committee

2 terms Nominating Committee, 1 as Chair

ANCC, Content Expert Panel – Second appointment

Citizen Member, Foster Care Review Board

Noon Optimist Club (civic)

Vice President, Jabez Therapeutic Riding Club

Advisory Board, 5-6 Elementary School Resource Center

Member, ANA, KNA District #8-President X 2

National Association of Catholic Nurses

Sigma Theta Tau

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

NCSBN is in a position to assist Member Boards in an issue that is high priority to nurses everywhere – unlicensed personnel. Nurses want to know how to assure patient safety through their delegation and supervision of these unlicensed persons. This is not a state issue; it is a global issue. The very lives of patients depend on those who are caring for them. NCSBN is the repository of a wealth of research material, data and information that will help set a standard for the education, regulation and discipline of those persons assisting the nurse in caring for patients.

Describe how you will advance the mission, vision and strategic initiatives of the NCSBN.

By serving on the Nominating Committee, I can help facilitate a slate of officers that is outstanding in its vision and willingness to keep NCSBN in the forefront of nursing regulation both now and in the future. We are only as good locally, nationally and internationally as those we choose to lead us. Our strength is a strong foundation already laid by those who generously gave of their time and talent to get us where we are today. I want to be a part of that dynamic force. I have that same willingness, time and energy to serve as those who went before me. If elected, I can and will continue to promote the ideals and challenges of nursing regulation facing the nursing profession today throughout the world.



Committee on Nominations Area III

Karen Taylor, LPN

Board Member, Arkansas Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Arkansas State Board of Nursing, Board Member, 1998-present

Board Treasurer, 1999-2000

Board Vice President, 2001-2002

Board Secretary, 2003-2004

Chair, Administrative Committee, 2002-2004

Chair, Finance Committee, 1999-2000

National Council of State Boards of Nursing Annual Meeting, Delegate, 2000-2003

National Council of State Boards of Nursing Midyear Meeting, Attendee, 2003-2004

NCLEX Item Reviewer, twice

Board of Directors, Arkansas State Hospice & Palliative Care

Central Region Manager, 2002-present

Facilitator, American Cancer Society, Life After Loss

Member, Case Management Society of America, 1997-present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

One of the biggest challenges today for nursing as well as regulation is the shortage of qualified nurses. NCSBN's work through the Practice, Regulation and Education Subcommittee on Unlicensed Assistive Personnel will help Member Boards make decisions regarding use of this level of provider. NCSBN and boards of nursing allowing NCLEX for Visa Screen allows practicing foreign-educated nurses to stay in the country. Allowing the NCLEX to be administered in other countries will decrease a barrier to licensure in the states. NCSBN's mission to assist Member Boards is carried out in such a way that there are positive outcomes for meeting the demands of the nursing shortage.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I have been a member of the Arkansas State Board of Nursing for six years and have served on other public boards as well. I understand the workings and impact of regulatory organizations. My broad-based clinical expertise spanning 24 years in a variety of settings has enabled me to be involved with many aspects of nursing practice. I have grown personally and professionally during my tenure at the board. Having attended numerous NCSBN meetings, I have gotten to know many of the leaders and potential leaders in the organization. The knowledge of those with potential will advance the mission, vision and strategic initiatives of NCSBN through being able to channel those individuals into elected office. My strengths are integrity, endurance, honesty and dependability. I am assertive enough to contact individuals to run for office, research the subjects at hand and offer my knowledge. If given the opportunity to serve on the nominating committee, I will give my all to the position and am excited about being a part of the solution to the challenges facing this organization.



Date of expiration of term: 10/01/06

Eligible for reappointment: Yes



Date of expiration of term: 10/23/09

Eligible for reappointment: Yes

Committee on Nominations Area IV

Mary E. Bowen, CRNP, DNS, JD, CNAA

Board Member, Pennsylvania State Board of Nursing, Area IV

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Past Secretary, Arizona State Nurses Association, Tucson

Past Vice President and Delegate, Mississippi State Nurses Association, Gulf Port

Current Associate Professor, Director of Graduate Nursing Programs and Vice Chair, Thomas Jefferson University

Current Vice President, Sigma Theta Tau, International Delta Rho Chapter

Current Member, Pennsylvania State Board of Nursing

Current Member, Institutional Review Board, Office of Scientific Affairs, Thomas Jefferson University

Current Volunteer, Thomas Jefferson University, Jeff Hope, FNP for Homeless Women and Children Health

Current Member, American Academy of Nurse Practitioners

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

NCSBN activities will advance optimal health outcomes by leading in the areas of scope of nursing practice, nursing licensure, title protection and setting policy. NCSBN leadership will protect the public from unsafe and incompetent practitioners, and increase health care quality and safety. Standards for certification title protection and licensure of nurses and educational preparation are challenges that NCSBN leaders will provide insight and counsel.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I will provide leadership as a member on the Committee on Nominations by ensuring that national leaders in nursing participate in NCSBN governance structure and provide assurance that highly qualified professionals are nominated for candidacy in governance of NCSBN.



Committee on Nominations Area IV

Anita Paris, RN, MS

Board Staff, New Hampshire State Board of Nursing, Area IV

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Although I am a new staff member at the New Hampshire State Board of Nursing, I have 20 years experience in the nursing profession. I served as a member of the New Hampshire Association of Women's Health, Obstetrics & Neonatal Nursing Advisory Board (AWHONN) and continue to be an ad hoc member. I have participated with the New Hampshire March of Dimes prevention of prematurity campaign and have worked with prenatal clinics throughout the state in promoting prenatal care. I currently work closely with numerous state agencies related to elderly/adult services, and keep abreast of legislative/regulatory sessions associated with nursing care and the safety of the citizens of New Hampshire. Participating on the Committee on Nominations would be my first experience on a National Council committee and I am looking forward to both the challenge and the opportunity.

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

NCSBN Midyear Meeting presented speakers on the challenges related to globalization of the nursing profession. This issue poses significant challenges for nursing regulation and legislation. NCSBN has taken a proactive approach in first, educating members, and in proposing alternatives. In addition, there was discussion regarding customer service and the CGFNS system. The sharing of information and the suggestion plan of action reinforced the need for systems improvement for foreign-educated nurses, which will lead to positive outcomes.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

As one of the NH Board of Nursing staff, I strive to promote the profession of nursing, reinforce the regulations of our Nurse Practice Act, support the nurses in our state and maintain the safety of the citizens of New Hampshire. In reviewing the mission, vision and proposed strategic initiatives, it is evident that participation at all levels is the key to success. I would like to proactively participate and by serving on the Committee on Nominations, I can meet my personal goals as well as the goals of NCSBN.



Date of expiration of term: N/A

Eligible for reappointment: N/A





2004 Report of the Board of Directors

Strategic Planning

This year, the Board of Directors has been immersed in the education and application of the Balanced Scorecard Model of strategic management. This model translates strategy into action. It is a management system that channels the energies, abilities and specific knowledge held by people throughout an organization toward achieving long-term strategic goals. The Balanced Scorecard Model helps organizations translate strategy into operational terms, aligns the organization to the strategy and makes strategy a continual process.

The timing was perfect to implement a new system along with the development of proposed strategic initiatives that will be reviewed and approved by the membership at Delegate Assembly this year. The new strategic initiatives, once adopted by the delegates, will guide the performance of the organization over the next three years.

The Board of Directors has also implemented a number of changes to improve its performance to become a more effective governing body. To this end the Board was able to decrease their meetings to eight, including the post 2003 Delegate Assembly meeting in Alexandria, Virginia, and the pre-2004 Delegate Assembly Meeting in Kansas City, Missouri. Six meetings were held in the Chicago offices of NCSBN.

Proposed Strategic Initiatives for FY05-07

1. Facilitate Member Board excellence through individual and collective development. (Member Boards)
2. Promote evidence-based regulation that provides for public protection. (Regulatory Excellence)
3. Enhance the organizational culture to support change and innovation. (PERC)
4. Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers. (Competence)
5. Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues. (Data)
6. Advance NCSBN as a key partner in nursing and health care regulation in the U.S. and internationally. (U.S./International Partner)

Highlights of Business Activities

COLLABORATION WITH EXTERNAL ORGANIZATIONS

- Participated in Nursing's Agenda for the Future.
- Discussed current issues regarding the practice and regulation of clinical nurse specialists with the National Association of Clinical Nurse Specialists.
- Met with Barbara Nichols, CEO and President, Phyllis Kritek, of CGFNS to discuss issues with Member Boards including sharing validation data. President Donna Dorsey and Kathy Apple, executive director, met with the CGFNS Board of Directors to discuss similar issues.
- Approved appointment of Polly Johnson, executive director of the North Carolina Board of Nursing, to be NCSBN's representative to the National Coordinating Council for Medication Error Reporting and Prevention.
- Met with the executive directors of the Ontario and Nova Scotia Colleges of Nursing to

Board of Directors

August 2003 - August 2004

Donna Dorsey, MS, RN, FAAN,
President, Maryland, Area IV

Marcia Hobbs, DSN, RN, Vice
President, Kentucky, Area III

Sandra Evans, MAEd, RN, Treasurer,
Idaho, Area III

Gregory Harris, JD, Area I Director,
Arizona

Mary Blubaugh, MSN, RN, Area II
Director, Kansas

Mark Majek, MA, PHR, Area III
Director, Texas

Myra Broadway, JD, MS, RN, Area IV
Director, Maine

Polly Johnson, MSN, RN, Director-at-
Large, North Carolina, Area III

Marjesta Jones, LPN, Director-at-
Large, Alabama, Area III

Staff

Kathy Apple, MS, RN
Executive Director

Chrissy Ward, Executive Office
Relations/Meeting Manager

Legal Counsel

Thomas Abram
Vedder Price

Attachment

Progress Report



- discuss mutual regulatory issues.
- Met with representatives from the Department of Labor to discuss the current health care worker initiatives.
- Began a dialogue with the American Nurses Association regarding the Nurse Licensure Compact Model.
- Reviewed and supported the National Organization for Nurse Practitioner Faculties Competencies document.
- Met with Dr. David Leach, executive director of the Accreditation Council of Graduate Medical Education, to discuss identification of competencies and competency assessment.
- Accepted a leadership fellow from the Sigma Theta Tau International Omada Board Leadership Program.

MEETING ATTENDANCE BY BOARD OF DIRECTORS AND/OR NCSBN STAFF

- American Association of Nurse Anesthetists
- National Governors Association
- Commission on Graduates of Foreign Nursing Schools Global Alliances Think Tank
- National League for Nursing
- Council on Licensure, Enforcement and Regulation
- National Conference of State Legislators Workforce Meeting
- Joint Commission Nursing Advisory Committee
- Joint Commission's Health Professions Education Meeting
- American National Standards Institute
- American Board of Nursing Specialties
- Nurse Practitioner Database Planning Committee
- National Federation of Licensed Practical Nurses
- AACN - Alliance for Nursing Education
- American Association of Colleges of Nursing
- 2nd International Conference of Evidence-Based Health Care, Teachers & Developers
- National Student Nurses Association
- Sigma Theta Tau International
- National Organization for Associate Degree Nursing
- Department of Labor Healthcare Workforce Development Forum
- Institute for Nursing Healthcare Leadership Conference
- Center for Quality Assurance in International Education
- Friends of the National Institute of Nursing Research
- Third World Congress on Home Care and Hospice
- Federation of Associations of Regulatory Boards
- 6th International Conference on the Regulation of Nursing & Midwifery
- Council of State Governments
- United State Pharmacopoeia (USP) Patient Safety Summit on Transforming to an Error-Free Medication Use Process
- National Coordinating Council of Medication Error Reporting Practices
- Institute of Medicine
- International Society for Quality in Health Care
- National Commission on Nursing Workforce in Long-Term Care
- Accrediting Council for Graduate Medical Education
- Citizen Advocacy Center



- American Medical Association
- American Organization of Nurse Executives
- Federation of State Medical Boards
- National Association of Boards of Pharmacy
- National Association of Clinical Nurse Specialists
- 2004 National Nursing Research Roundtable
- Transforming the Work Environment of Nurses
- Federation of State Medical Boards Workshop on Pain Management

FINANCE

- Reviewed and approved the budget for FY04.
- Reviewed and approved quarterly financial statements.
- Reviewed and discussed long-range forecasts.
- Reviewed and approved current liability insurance coverage.
- Reviewed and approved current investment strategy.
- Approved additional expenditures for an Executive Officer Network Seminar.
- Approved an increase to the Resource Fund from \$20,000 to \$40,000.
- Approved payment for travel expenses and waived registration fees for two delegates from each jurisdiction to attend the 2005 Annual Meeting.

GOVERNANCE & POLICY

- Developed proposed strategic initiatives for FY05-FY07.
- Developed strategic outcomes for FY04.
- On a quarterly basis, reviewed, discussed and approved progress toward achieving the strategic initiatives and outcomes.
- Held a Member Board dial-in opportunity at every meeting of the board to allow for direct communication between the membership and the Board of Directors.
- Conducted an environmental scan at each Board of Directors meeting to monitor current and emerging issues.
- Implemented and assigned board partners for incoming board members.
- Conducted a revised orientation for new board members.
- Appointed chairs, committee members and board liaisons to all FY04 committees.
- Reviewed and discussed the meeting evaluations for the 2003 Delegate Assembly.
- Reviewed and revised the vision statement for NCSBN.
- Conducted a self-assessment of its performance utilizing the consulting services of BoardSource.
- Supported the Northern Mariana Islands Commonwealth Board of Nurse Examiners regarding an Executive Order by the Governor impacting the use of NCLEX.
- Revised policies related to the term length of NCSBN committee members and chairs, committee appointment, and member selection process.
- Revised policy related to publications.
- Revised the meetings policy regarding waivers to NCSBN meetings.
- Developed an executive director succession planning policy for the future.
- Reviewed and approved the 2004 Midyear Meeting agenda.
- Reviewed the evaluations including the results of webcasting from the 2004 Midyear Meeting.
- Conducted a cost analysis of NCSBN summits and other meetings.
- Approved a public policy agenda.



- Reviewed and approved the participation of NCSBN in offering the NCLEX-RN® examination for international nurses already licensed in the United States for purposes of fulfilling *VisaScreen™* requirements.
- Reviewed and discussed the *Implications of Education Levels of Hospital Nurse and Surgical Patient Mortality Study*.
- Discussed the implications of the *Blue Orchid Solutions Proposal* for disciplinary data.
- Reviewed and discussed the outcomes of all FY04 standing and special committees.
- Reviewed and discussed all relevant federal legislation impacting nursing regulation.
- Reviewed and approved the content for the 2003 Annual Report.
- Reviewed the evaluations from the first Institute of Regulatory Excellence on Public Policy.
- Approved recommendations for the 2004 Delegate Assembly.
- Reviewed and commented on proposed federal legislation resulting from the Charles Cullen case.
- Invited the Jordanian Nursing Council to meet with NCSBN in Chicago to share regulatory information.

TESTING

- Approved the 2003 NCLEX-RN Standard Setting Panel of Judges.
- Approved a new passing standard for NCLEX-RN.
- Approved the site selection of the first three countries for administration of NCLEX internationally for the purpose of domestic licensure.
- Approved contract negotiations for additional testing time for NCLEX-RN.
- Approved the current outcome of the study to compare NCLEX-RN to the Puerto Rican Spanish licensure examination.
- Approved an increase to the NCLEX Quick Results fee.
- Reviewed quarterly reports from Pearson VUE.
- Approved the standard setting proposal for the International English Language Testing System.
- Reviewed a proposed policy on the general use of NCLEX Test Plan and Practice Analysis.

PRACTICE, EDUCATION & REGULATION

- Reviewed the 2003 Board Investigator Summit Evaluations.
- Reviewed the proposed clinical nurse leader role model from AACN.
- Revised the charge to the International Nurse Issues Subcommittee.
- Reviewed and approved the proposed revisions to the Model Nurse Practice Act and Model Rules.
- Reviewed the evaluations from the Patient Safety Summit.

INFORMATION TECHNOLOGY

- Evaluated the feasibility of collecting national workforce data through the Nursys database. Directed staff to develop a method of workforce data collection that would be self-sustaining and connected to current licensure data.
- Evaluated the feasibility of collecting and reporting nursing assistive personnel disciplinary data.
- Reviewed and discussed data download requests.
- Reviewed and discussed current issues related to the implementation and status of Nursys.



RESEARCH

- Reviewed the findings from the *Winter 2003 Professional & Practice Issues Survey*.
- Reviewed and approved an evaluation of the Nurse Compact Licensure Model.
- Reviewed the CORE White Paper including dissemination.
- Reviewed the findings of the *2003 Employer Survey*.
- Reviewed the findings of the *2003 PN Practice Analysis* and directed a focus group be facilitated to evaluate the findings for emerging issues.
- Reviewed data analysis from data collected with the TERCAP tool.
- Reviewed the findings from the *2002 RN Practice Analysis Update*.
- Reviewed the 2004-2006 candidate projections.
- Reviewed the findings from the *Spring 2003 Professional & Practice Issues Survey*.
- Reviewed the CORE Aggregate Report.





Board of Directors – Attachment A

Annual Progress Report, October 2003 – May 2004

I. Strategic Initiative: Nursing Competence

NCSBN will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome A. Entry-level nurse competence is assessed by the NCLEX® examinations.

Tactic 1. Develop and administer the NCLEX® examinations.

The Examination Committee continued to monitor item development, psychometrics and examination administration of the NCLEX® examinations through standing and unique reports produced by NCSBN staff and test service.

The Examination Committee completed its annual review and recommendations to the Board of Directors for changes to the examination related policies and procedures.

The Examination Committee recommended a revised *NCLEX-PN® test plan* and sent the plan to Member Boards for review and comment.

The new 45-day retest period policy was implemented.

Tactic 2. Assess and add (if necessary) additional time to the NCLEX-RN® examination.

Based on the recommendation to the Board of Directors from the Examination Committee, the Board, beginning October 1, 2004, approved implementation, pending negotiation of price, with Pearson VUE of additional time to take the NCLEX-RN®. Negotiations were initiated with Pearson VUE and are expected to be completed by the end of the fiscal year.

Tactic 3. Investigate reasons for nonlicensure of nursing school graduates.

The Examination Committee developed and implemented a survey of nursing school graduates who had not taken NCLEX. The results were collected, analyzed and reviewed. A report on the outcome of the survey is included in the Examination Committee 2004 Business Book report.

Tactic 4. Compare equivalency of NCLEX-RN with Spanish language Puerto Rican Nurse Licensure Examination.

With no additional information forthcoming, despite repeated attempts, the Examination Committee filed a report based on available information as part of the 2004 Business Book Report. Based on information received it does not appear that the two examinations are equivalent.

Tactic 5. Implement NCLEX for *VisaScreen™*.

Planning and implementation of an application processing system for international nurses, primarily Canadian nurses, who are currently licensed in the United States, to take NCLEX for *VisaScreen™* requirements was completed. Exam application processing began April 5, 2004.

Background

The annual Progress Report is provided as a summary of the year's activity and accomplishments in the work toward achieving the organization's strategic initiatives.



Outcome B. NCLEX is administered at international sites for purposes of domestic licensure.

Tactic 1. Initiate implementation of the international testing plan for the NCLEX examinations.

Examination Committee reviewed information for initial international testing sites and recommended three countries to the Board of Directors to begin international administration of NCLEX for purposes of domestic licensure.

Tactic 2. Set performance standards for existing English proficiency examinations.

An expert panel was convened to determine performance standards for TOEFL. Subsequently, the Examination Committee recommended a standard for the TOEFL. The outcome report is included in the Examination Committee 2004 Business Book report.

Outcome C. Nurse aide competence is assessed.

Tactic 1. Oversee development of the NNAAP examination.

The NNAAP technical manual was received and reviewed. A complete report has been included in the 2004 Business Book.

Outcome D. Stakeholders are educated about the NCLEX examination program and related products/services.

Tactic 1. Increase NCLEX Program Report subscriptions.

Market definition research was conducted and a new marketing plan for the next subscription cycle is in the planning phase with Pearson VUE.

Tactic 2. Provide content support for the Assessment Strategies Web courses for nurse educators.

Candidate and customer service support has been continuously provided for these courses.

Tactic 3. Increase Member Board enrollment in the NCLEX Results-by-Phone Service.

The phone-based fee increase has been implemented. Thirty-nine of 60 NCSBN Member Boards participate in this service, down one due to the consolidation of Texas boards.

Tactic 4. Increase attendance at the NCLEX Invitational.

The 2004 NCLEX Invitational will be held in San Francisco on September 13, 2004.

Tactic 5. Conduct NCLEX outreach activities for Member Boards, educators, candidates and other stakeholders.

Updated the NCSBN Web site with new NCLEX item information. Exhibited at three conferences for purposes of distributing NCLEX information and recruiting item writers/reviewers.

Outcome E. Research demonstrates relationships of various regulatory approaches to validate continued competence.

Tactic 1. Analyze cross-sectional data obtained from post-entry study to discover how clinical competence evolves.



Cross-sectional data is under analysis for changes in activities/tasks over time. Longitudinal survey #7 has been sent out. The Subject Matter Expert Panel met May 23 and 24, 2004.

Tactic 2. Analyze longitudinal data obtained from years one and two to discover how clinical competence evolves.

Analysis of the longitudinal data is scheduled to begin after completion of cross-sectional analysis.

Outcome F. Issues and trends affecting competency assessment are monitored and responded to as required.

Tactic 1. Determine feasibility of offering NCLEX in additional languages.

Puerto Rico has expressed an interest in NCSBN developing a Spanish language examination within the NCLEX model. Testing experts were consulted to determine the feasibility of a project of this nature. Barriers for a Spanish language licensure examination were identified. The Board of Directors will continue to assess the feasibility of this concept.

Tactic 2. Determine feasibility of developing a continued competency examination for nursing.

Data and possible requirements have been gathered. Completion of a white paper on continued competency is in progress.

Tactic 3. Assess interest in the use of NCLEX and NCLEX services by other countries for purposes of nurse regulation outside of current Member Board jurisdictions.

Jordanian Nursing Council has accepted an invitation to meet with the Board of Directors and NCSBN staff in July 2004.

II. Strategic Initiative: Regulatory Effectiveness

NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome A. Effective strategies are identified to assist Member Boards to respond effectively to critical issues and trends impacting nursing education, practice and regulation.

Tactic 1. Analyze CORE data to identify best practices in nursing regulation.

Aggregate and state-specific reports have been sent out to participating states. Implementation of best practices by individual Member Boards was presented at the 2004 Midyear Meeting. New best practices and standards of excellence have been posted on the NCSBN Web site.

Tactic 2. Establish standards that assure positive outcomes of nursing regulation.

Standards have been incorporated in a new “Best Practices” document, distributed to members at the 2004 Midyear Meeting and posted on the NCSBN Web site.

Tactic 3. Conduct the first year of a two-year study, Regulation of Chemically Dependent Nurses.

IRB approval has been received and participant boards have been invited.



Tactic 4. Share findings from the *Epidemiology of Nursing Error* study and collaborate with stakeholders to prevent or eliminate risk factors in the workplace.

Preliminary data from 79 cases was presented to Practice Breakdown Committee. Data from 102 discipline cases are currently being analyzed.

Tactic 5. Review and update resource manual for Member Boards on the education, immigration and endorsement of international nurses.

International Nurse Issues Subcommittee has been reviewing and updating the resource manual. They also developed a plan for collecting information about credentialing evaluation services and discussed standardized elements of an international nurse credential evaluation.

Tactic 6. Complete revision of the Model Nursing Practice Act and Administrative Rules.

The Practice, Regulation and Education Subcommittee for revision of the Model Rules has revised the language and incorporated membership feedback. The final document will be distributed for external review and comments collected prior to the 2004 Delegate Assembly.

Tactic 7. Gather data about emerging entry-level practice issues. 2003 fall PPI survey being analyzed.

The *Winter 2004 Practice & Professional Issues* will explore the elements of education programs that have an impact on preparation of new graduates to practice safely.

Tactic 8. From the revision of the model rules, develop a position statement on “flexibility” and “consistency” in Nurse Practice Acts and Regulations.

This tactic is addressed within the body of revision to the model act and rules.

Tactic 9. Collaborate with National League for Nursing (NLN) to identify evidence-based indicators of nursing education programs.

NLN was unable to participate in this study. Therefore, the Practice, Regulation & Education Committee has worked with the Research Department to develop a survey that will be sent out to schools of nursing in the fall of 2004, entitled, “Elements of Nursing Education Programs.” These elements will be compared to the competencies of new nurses who have graduated from those same programs. The Practice, Regulation & Education Committee is preparing a working paper, entitled, “A Systematic Review of Research on Outcomes in Nursing Education.”

Tactic 10. Measure outcomes of programs that transition nurses from education to practice.

A formal collaboration with the Vermont Nurse Internship Program (VNIP) has been established and plans have been made to measure outcomes. Outcome measures from other projects and programs will be used to establish an effective regulatory transition model.

Tactic 11. Facilitate networking through the education network calls and educators consultant bulletin board.

Education network telephone conferences have been conducted monthly for education consultants with Member Boards. The education bulletin board has 37 members with 202 posts on four different forums.



Tactic 12. Conduct a Member Board survey on models of licensing for nurses with disabilities.

The survey was sent out to all 60 boards of nursing, with 39 boards of nursing replying to date. Survey summary data is being compiled.

Tactic 13. Initiating and evaluating communication between NCSBN and educators through projects such as direct mailing, etc.

The Leader-to-Leader communication print document has been developed and distributed to all nursing schools. The document has been well received based on comments received from educators.

Tactic 14. Utilize the approval criteria to develop models of collaboration between boards of nursing and accrediting agencies.

A White Paper, “The State of the Art of Approval/Accreditation Processes in Boards of Nursing,” discussing the various models has been developed and approved by the Board of Directors.

Outcome B. Approaches and resources are developed to assist Member Boards in the regulation of advanced practice registered nurses.

Tactic 1. Support productive communication between boards of nursing and APRN certification agencies.

The APRN Advisory Panel has facilitated and reviewed communication and communication strategies between boards of nursing and APRN certification agencies.

Tactic 2. Evaluate the regulatory sufficiency of all APRN certification programs, and provide the information to Member Boards.

Evaluation and comparison of regulatory sufficiency criteria was conducted with the following organizations: the American Association of Critical Care Nurses Certification Corporation; American Nurses Credentialing Center; Pediatric Nursing Certification Board; National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties; and the American Academy of Nurse Practitioners Certification Program.

Tactic 3. Promote communication with APRN stakeholders (e.g., APRN Roundtable, etc).

The annual APRN Roundtable was conducted on May 6, 2004.

Tactic 4. Develop education resources regarding APRN issues.

The Advanced Practice (APRN) Advisory Panel developed an education plan that was approved by the Board of Directors. The plan addressed various methods to keep Member Boards informed of current and emerging advanced practice issues. Resources are under development for implementation of the plan.

Outcome C. Approaches and resources are developed to address issues related to assistive personnel.

Tactic 1. Conduct Nursing Assistive Personnel (NAP) Outcomes study.

In collaboration with the Practice, Regulation & Education Delegation and Assistive Personnel Subcommittee, the Research Department is developing a survey as the first step of the study.



Tactic 2. Identify how nurses work with and through assistive personnel by comparing traditional delegation with what is actually happening in the health care environment.

The Practice, Regulation & Education Subcommittee has been collecting data on the current practice of delegation in addition to conducting a literature review, a review of current state statutes and regulations/rules pertaining to delegation and assistive personnel.

Outcome D. Implementation of the mutual recognition model is supported, monitored and evaluated.

Tactic 1. Track the multi-state discipline cases specific to the Nurse Licensure Compact.

An electronic reporting method with the input of the Nurse Licensure Compact Administrators has been developed for tracking multi-state discipline and was implemented April 1, 2004.

Tactic 2. Support the Nurse Licensure Compact through outreach and advocacy efforts.

The Nurse Licensure Compact (NLC) was supported through ongoing media pitching efforts. Additionally, a new FAQ was developed and reviewed by the Nurse Licensure Compact Administrator group. The NCSBN Web site section was augmented with updated and new information. A fact sheet and Council Connector article are under development.

NCSBN provided support services for current or pending legislation with the New Hampshire, Missouri and the Illinois boards of nursing.

Utah passed the first Advanced Practice (APRN) compact. The compact is not in effect until another board of nursing has adopted the compact.

Outcome E. Discipline resources are developed to support Member Boards in implementation of the discipline process.

Tactic 1. Implement the NCSBN Discipline Resources Plan by:

- a. Facilitating networking through quarterly discipline calls**
- b. Developing two new discipline guidelines.**

Quarterly discipline telephone conference calls were initiated for discipline staff. Up to 80 staff have participated. The 2004 Investigator/Attorney Educational Workshop was scheduled for June 14-16, 2004. The Discipline Resources Advisory Panel developed guidelines addressing investigative report writing, implications of HIPAA, use of expert witness and triage of cases.

III. Strategic Initiative: Public Policy

The NCSBN will analyze the changing health care environment to develop state and national strategies to impact public policy and regulation affecting public protection.

Outcome A. Analysis assists Member Boards in recognizing and understanding trends impacting public protection.

Tactic 1. Federal bills and regulations are identified, analyzed and communicated to Board of Directors and membership.

Staff monitored the House version of the Patient Safety bill, which did pass, but Senate passage of Senate Bill 720 is pending. Information regarding the new *VisaScreen™* federal



rules was widely disseminated including information regarding offering “NCLEX for *VisaScreen*™.” Additionally, NCSBN sent a letter to DHS supporting a delay of *VisaScreen* rules for 18 months, and highlighting that this regulation impacted already licensed and working nurses in the U.S. A new GAO report on screening processes for Virginia facility practitioners was issued in March. NCSBN and Member Boards were consulted in preparation; it supports NCSBN positions on licensure verification. NCSBN submitted comments related to HIPDB practices in support of NCSBN and Member Board efforts to fulfill this requirement.

New Jersey senators will introduced a federal bill regarding reporting of practice violations by employers to NPDB and state boards. NCSBN has met and been consulted on an ongoing basis with key legislative staff. The Board of Directors sent a letter to the New Jersey senators requesting assurance that boards of nursing will not be reporting disciplinary actions to yet another federal database and that the NPDB and the HIPDB will be linked.

Tactic 2. Resources assist Member Boards in understanding public policy trends (policy calls, *Policy Perspectives*, issues alerts, etc.)

Several issue alerts to Member Boards were sent (e.g., Cullen Case statement on employer reporting to boards of nursing, MT opt-out announcement, DoL grant awardees, Department of Commerce released a report from its Office of Technology Policy, examining innovation, demand and investment in telehealth in the U.S. DOC, which cited the NLC and state licensure, Comparison of PR licensure examinations and NCLEX statement, state issues). Issues of *Policy Perspectives* have been distributed to all members. Monthly policy calls were facilitated and have featured a variety of external guests including CGFNS and JCAHO. A statement was issued regarding NCSBN’s position on the PR nurse licensure examination, which had a positive impact, as several states did reconsider pending or possible legislation to accept the PR exam in lieu of NCLEX.

Outcome B. Nursing regulation leadership informs and interacts with policymakers.

Tactic 1. Review for possible endorsement, health care and nursing initiatives and positions that advance public protection.

NCSBN continued to support the Nurse Reinvestment Act funding initiatives through its involvement as a member of the Americans for Nursing Shortage Relief (ANSR) Alliance. NCSBN participated with ANSR in a meeting with the Division of Nursing. NCSBN joined Nurses for a Healthier Tomorrow. Planning was begun by NCSBN and other member coalition-nurse organizations for a reception at the National Conference of State Legislators (NCSL) exhibition to support nursing in July.

Tactic 2. Key relationships are maintained and formed with external organizations affecting public protection and policy.

NCSBN staff have met with the National Association of Hispanic Nurses, Illinois Department of Professional Regulation, National Conference of State Legislators (NCSL), Council on Licensure Enforcement and Regulation (CLEAR), NCC MERP, workforce data Consortium of States Annual Meeting, National Governor’s Association (NGA), American Society of Association Executives (ASAE), American Nurses Association (ANA) and American Hospital Association (AHA) through quarterly conference calls, American Organization of Nurse Executives (AONE), Telehealth Leadership Council, Council of State Governments Suggested State Legislation Committee and Health Policy Task Force, Federation of State Medical Boards, the American National Standards Institute, the USP Patient Safety summit, and the National Association of Boards of Pharmacy. NCSBN staff



members were appointed to the CSG Health Capacity Task Force and Kristin Hellquist was elected to the CLEAR Board of Directors. Vickie Sheets continued as a member of the Board of Directors for the Federation of Association of Regulatory Boards (FARB). NCSBN staff also collaborated with the Department of Labor on the High Growth Job Training Initiative for increasing the nurse supply.

Tactic 3. Outreach strategies reach policymakers regarding NCSBN key messages and provide value to the health care environment.

The Board of Directors approved a public policy agenda and a brochure was developed for distribution. Key organizational messages were part of an ongoing pitching campaign. NCSBN’s external contacts, divided by categories, were transitioned from Access to the long-anticipated contact management system called iMis.

Tactic 4. Increase NCSBN visibility through exhibiting, speaking engagements, sponsorships and invited participation with other key organizations.

A target list was developed for use in identifying the ever-increasing speaking engagements fulfilled by NCSBN staff. Additionally, NCSBN conference sponsorships and NCSBN authored articles were developed and tracked. Key organizations were targeted for NCSBN exhibiting including AONE, NSNA, and AACN.

IV. Strategic Initiative: Information Technology

NCSBN will develop information technology solutions valued and utilized by Member Boards to enhance regulatory efficiency.

Outcome A. Nursys is the comprehensive national database utilized by Member Boards, employers, nurses and the public for timely and reliable licensure information.

Tactic 1. Increase Member Board participation in Nursys® by five.

NCSBN staff have been working with a number of boards of nursing that have expressed interest in submitting licensure data for the purpose of verification. A number of issues have been identified for needing resolution regarding customer service, user friendliness and data accuracy.

Tactic 2. Increase participation in discipline data collection.

NCSBN staff have worked with a number of boards of nursing that do not currently submit disciplinary data to identify ways to assist and support Member Board participation.

Tactic 3. Determine the feasibility of inhouse data collection.

Staff have utilized information from the development of the daily updates project as a foundation for a request for proposals for inhouse data collection. The decision to bring data collection within NCSBN will be made in FY05.

Outcome B. Information technology services are innovative and accessible.

Tactic 1. Develop and implement a nurse imposter alert system.

NCSBN staff have collaborated with the Discipline Resources Advisory Panel to develop plans for an imposter alert system.



Tactic 2. Implement a warm site dedicated to business continuity including disaster preparedness.

NCSBN has researched and selected a site dedicated to business continuity in case of a disaster.

Tactic 3. Complete the feasibility of collecting workforce data.

NCSBN staff members have developed a possible method of national workforce data collection through the Member Board online renewal process. Data would be collected electronically and returned to each participating state and then aggregated nationally for public policy development.

V. Strategic Initiative: Governance & Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome A. Multiple levels of educational programs are accessible to assist in development of core competencies in regulation.

Tactic 1. Implement and evaluate the first annual Institute of Regulatory Excellence: “Public Policy Development: Role Development of Nursing Regulators.”

The first Institute of Regulatory Excellence regarding public policy was held in January 2004, with very positive outcomes.

Tactic 2. Complete a business plan on the value and feasibility of a nursing regulation certification examination.

The Member Board Leadership Development Advisory Panel has been assessing the feasibility of a nursing regulation certification examination. A business plan will be presented to the Board of Directors by the end of the fiscal year.

Tactic 3. Complete content/budget planning for the second annual Institute of Regulatory Excellence: Practice Violations & Discipline.

The content and speakers for the Second Institute of Regulatory Excellence has been developed with feedback provided by the Disciplinary Resources Advisory Panel.

Tactic 4. Complete a logical job analysis of Member Board president and executive officer roles.

The executive officer and president logical job analysis studies will be completed by the end of the fiscal year with core competencies identified. Education topics will be generated from the outcome of these two analyses.

Tactic 5. Convene summits on attorneys and investigators in the discipline process, information technology, patient safety, and UAP (NAP) Conference.

The Investigator/Attorney Workshop was scheduled for June 14-16, 2004, in Philadelphia. The IT Summit was scheduled for May 11-12, 2004, in San Diego. The Patient Safety Summit was conducted November 15, 2003, in Arlington, VA. The UAP (NAP) Conference was scheduled for June 11, 2004, in Austin.



Tactic 6. Promote communication among Member Boards presidents (e.g., electronic bulletin board).

A bulletin board was developed and implemented for use by board presidents. Monitoring of activity was conducted and an evaluation of its effectiveness was conducted as well. It was determined that the bulletin board was not productive and was discontinued.

Tactic 7. Redesign NCSBN 101.

The Member Board Leadership Development Advisory Panel and NCSBN staff actively worked on an easily accessible and comprehensive overview of NCSBN that will be housed on the NCSBN Web site. The goal is to have a program to assist in the orientation of new members or staff to NCSBN.

Tactic 8. Conduct a president and executive officer leadership program at the Midyear Meeting.

The 2004 Midyear meeting included a leadership development program focused on globalization of the nursing workforce. Three expert speakers presented international perspectives. The program received a positive reception from the meeting attendees.

Tactic 9. Provide orientation and mentorship for new executive officers.

A new Executive Officer Orientation will be held on July 14, 2004. The new Executive Officer Mentor Program has been renamed the Executive Officer Coach Program. New Executive officers are assigned a coach with input from the area directors and EO network chair.

Outcome B. Sound organizational governance advances the NCSBN mission and vision.

Tactic 1. Assist the Board of Directors in developing strategic initiatives for FY05-07.

Mark Frigo, PhD, CPA, CMA, facilitated the strategic planning process for the Board of Directors. Dr. Frigo is the director of the Center for Strategy, Execution and Valuation, and the Eichenbaum Foundation Distinguished Professor of Strategy and Leadership in the Kellstadt Graduate School of Business at DePaul University. Dr. Frigo is also a leading expert in strategy design and execution, including balanced scorecard initiatives. The Board of Directors has adopted the Balanced Scorecard Model of strategic management. The planning process facilitated the drafting of strategic initiatives for presentation to the membership and the implementation process of the model within NCSBN.

Tactic 2. Assist the Board of Directors and staff in the implementation of the Balanced Scorecard Model.

Throughout the fiscal year, Dr. Frigo educated the Board of Directors and the NCSBN staff regarding the Balanced Scorecard Model. This included the use of the mission-driven strategy framework and the development and use of balanced scorecard architecture and strategy mapping.

Tactic 3. Revise the vision statement.

The vision statement was revised at the September 2003 Board of Directors meeting. The new vision statement reads, “Building regulatory expertise worldwide.”



Tactic 4. Ensure adequate resources through the development of a long-range financial projection.

Long-range financial projections were developed and continuously presented to the Finance Committee and the Board of Directors.

Tactic 5. Conduct an orientation for new NCSBN Board of Directors members.

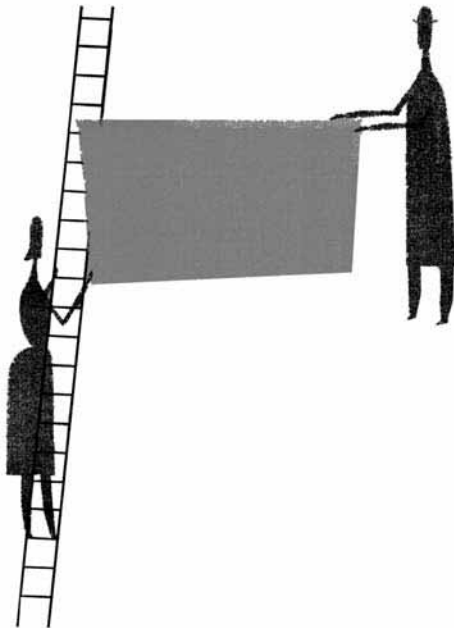
A revised orientation program was provided to the new Board of Directors at the September 2003 meeting.

Tactic 6. Conduct a Board of Directors self-assessment.

A facilitated self-assessment was scheduled for the July 2004 Board of Directors meeting.

Tactic 7. Assist the Board of Directors in the development of a governance model.

The Board of Directors reviewed the essential elements of a governance model at the September 2003 meeting. All essential elements are reflected in the current NCSBN Policy & Procedure Manual. Glenn Tecker was invited to 2004 Midyear Meeting to discuss organizational trust and nimbleness.





SECTION II: COMMITTEE REPORTS
2004 NCSBN Annual Meeting



Committees with Recommendations

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Report of the Examination Committee

Recommendations to the Delegate Assembly

1. Adopt the proposed changes to the *NCLEX-PN® Test Plan*.

Rationale

The Examination Committee reviewed and accepted the Report of Findings from the *2003 PN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (Smith & Crawford, 2003) as the basis for recommending revisions to the *2005 NCLEX-PN Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from the Member Boards of Nursing, the professional judgment of the Examination Committee, and review by legal counsel provide support for the recommendation to the Delegate Assembly to adopt the proposed changes to the NCLEX-PN Test Plan.

Background

As a standing committee of NCSBN, the Examination Committee is charged with providing psychometrically sound and legally defensible entry-level nurse licensure assessments to NCSBN Member Boards. In order to accomplish this outcome, the committee monitors the NCLEX-RN® and NCLEX-PN examination process to ensure policies, procedures and standards utilized by the program meet and exceed guidelines proposed by the testing and measurement industry. The Examination Committee investigates potential future enhancements to the NCLEX examinations and monitors all aspects of the NCLEX® examination process including: item development, examination security, psychometrics and examination administration to ensure consistency with the Member Boards' need for examinations. The Examination Committee approves item development panels and recommends test plans to the Delegate Assembly.

Additionally, the committee oversees the activities of the Item Review Subcommittee, which in turn assists with the item development and review process. Individual Examination Committee members act as chair of the Item Review Subcommittee on a rotating basis. Highlights of the activities of the Examination Committee and Item Review Subcommittee activities follow.

Highlights of FY04 Activities

ENTRY-LEVEL NURSE COMPETENCE IS ASSESSED BY THE NCLEX EXAMINATIONS

NCLEX-PN® Test Plan

At the November 2003 meeting, the Examination Committee reviewed the results of the Report of the Findings from the *2003 PN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (Smith & Crawford, 2003) and used this information to make decisions regarding the categorization of activity statements in order to determine the structure of the test plan. Based on empirical data from the practice analysis study and the expert opinion of the Examination Committee and NCSBN staff, the committee recommended changes to the structure and content distribution of the *2005 NCLEX-PN® Test Plan*. In November 2003, a draft of the revised test plan and related materials were distributed to all Member Boards, members of the Practice Analysis Panel of Experts, and to legal counsel requesting feedback on the proposed changes. The Examination Committee considered all feedback during its April 2004 meeting and a final draft of the proposed *2005 NCLEX-PN® Test Plan* was prepared for consideration by the 2004 Delegate Assembly.

Members

Examination Committee

Anita Ristau, MS, RN, Chair
Vermont, Area IV

Teresa Bello-Jones, JD, MS, RN
California-VN, Area I

Jessie Daniels, MA, BSN, RN
Minnesota, Area II

Claire Doody-Glaviano, MN, BSN, RN
Louisiana-PN, Area III

Sheila Exstrom, PhD, MA, BSN, RN
Nebraska, Area II

Faith Fields, MSN, RN
Arkansas, Area III

Mary Kay Habgood, PhD, MSN, BSN,
RN, Florida, Area III

Rula Harb, MS, RN
Massachusetts, Area IV

Lorinda Inman, MSN, RN
Iowa, Area II

Pamela Randolph, MS, RN, CPNP
Arizona, Area I

Board of Director Liaison

Marcia Hobbs, DSN, RN
Kentucky, Area III

Item Review Subcommittee

Cheryl Anderson, MS, BSN, RN
California-VN, Area I

Louise Bailey, MED, RN
California-RN, Area I

Kathleen M. Breguet, MS, CS, RN
Rhode Island, Area IV

Beverly Foster, PhD, MN, MPH, BSN,
RN, North Carolina, Area III

Karen Gilpin, MSN, CNA, RN
Kansas, Area II

Susan Jones, PhD(c), MSN, RN
Kentucky, Area III

Mary Ann Lambert, MSN, RN
Nevada, Area I

Carmen Lopez Rodriguez, MSN, RN,
CNP, Puerto Rico, Area IV

Maris Lown, MS, RN
New Jersey, Area IV



Item Review Subcommittee

- Teri Murray, PhD, RN
Missouri, Area II
- Renee Olson, LPN
North Dakota, Area II
- Janette Pucci, MSN, RN
Kansas, Area II
- Donna Roddy, MSN, RN
Tennessee, Area III
- Linda Shanta, MSN, RN
North Dakota, Area II
- Nancy L. Smith, PhD, RN, BC, FAANP
Colorado, Area I
- Ellienne Tate, MS, EdD, RN
Louisiana-RN, Area III
- Calvina Thomas, PhD, RN
Arkansas, Area III

Staff

- Casey Marks, PhD, Director of Testing Services
- Kristin Garcia, Testing Services Operations Manager
- Fay Green, NCLEX Administration Coordinator
- Lenore Harris, MSN, RN, AOCN, CNS, NCLEX Content Associate
- Lorraine Kenny, MS, RN, NCLEX Senior Content Associate
- Thomas O'Neill, PhD, Associate Director of Testing Services - Psychometrics
- Kathy Potvin, NCLEX Senior Administration Coordinator
- Michelle Reynolds, MS, Statistician
- Jennifer Tiffen, MS, RN, APN, NCLEX Content Associate
- Michael Tomaselli, NCLEX Administration Manager
- Anne Wendt, PhD, RN, CAE, Associate Director of Testing Services - Content Management

If approved by the Delegate Assembly, it is expected that the 2005 *NCLEX-PN® Test Plan* will be published in early fall of 2004. The implementation date for the new test plan is scheduled for April 2005. The proposed timelines for implementation of the test plan enables Member Boards, NCSBN and Pearson VUE to effectively plan for and communicate the contents of the 2005 *NCLEX-PN® Test Plan* to all interested parties. Additionally, the April date allows for coincident implementation of the 2005 test plan with any change in the NCLEX-PN passing standard. The NCSBN Board of Directors is slated to review the NCLEX-PN passing standard in the fall of 2004.

Continuously Improve Development and Administration of the NCLEX Examinations

Evaluated and Monitored NCLEX Examination Policies and Procedures

The committee evaluated the efficacy of the Board of Directors approved examination related policies and procedures as well as Examination Committee policies and procedures. As an extension of this quality control process, the committee reviewed and adopted necessary modifications and enhancements to the NCLEX Member Board Manual. Revisions were made to pertinent procedures in order to reflect improvements in processes that needed to be changed or refined during the tenth year of the administration of NCLEX via computerized adaptive testing.

Monitored All Aspects of Examination Development

Conducted Committee and Item Review Subcommittee Sessions

In the interest of maintaining consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the Examination Committee continue to chair Item Review Subcommittee meetings. The committee and subcommittee reviewed RN and PN operational and pretest items; reviewed RN and PN alternate items before and after pretesting; and made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes and integrated processes and the NCLEX Style Manual. Assistance from the Item Review Subcommittee continues to reduce the Examination Committee item review workload, facilitating the efforts of the Examination Committee toward achieving defined goals.

As the item pools continue to grow, review of operational items is critical to assure that the item pools reflect current entry-level nursing practice. To this end, the number of Item Review Subcommittee meetings has increased from four to five. In addition, the length of the meeting has increased from three and a half days to four and a half days and the number of volunteers serving on the subcommittee has increased to 17. Orientation to the work of the subcommittee occurs annually as well as at each meeting.

Monitored Item Production

Under the direction of the Examination Committee, RN and PN pretest items were written and reviewed by NCLEX Item Development Panels (see charts on page 66). A total of six NCLEX item review panels reviewed NCLEX-RN and NCLEX-PN pretested items, and a total of four RN and PN master pool review panels reviewed either RN or PN operational items. In addition, the Item Review Subcommittee reviewed real examinations for face validity and provided reports to the Examination Committee. As part of the contractual requirements with test service, items that use alternate formats have been developed and deployed in item pools. Information about which item formats are in use and which formats are under consideration has been made available to Member Boards and candidates in the NCLEX Candidate Bulletin and on the NCSBN Web site.



Evaluated Item Development Process and Progress

The committee evaluated item development sessions conducted by test service. Committee representatives attended and monitored each of the item development sessions and provided feedback to the committee and test service. Overall, panelists and Examination Committee representatives in attendance have rated item development sessions favorably.

NCLEX-RN® Detailed Test Plan

The Examination Committee reviewed and approved the National Council of State Boards of Nursing *Detailed Test Plan for the NCLEX-RN® Examination*. In February 2004, the detailed test plan was made available to the public and distributed to Member Boards.

Monitored the Development of Operational NCLEX Item Pools

The Examination Committee monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involved only a few variables. However, the quality control checks performed afterward were based upon many variables, both clinical and psychometric. The resulting operational item pools were evaluated extensively with regard to these variables and were found to be within operational specifications.

To ensure that operational item pools and the item selection algorithm were functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan subcategory. It was concluded that the operational item pools and the item selection algorithm were acting in concert to produce exams that were within NCSBN specifications and comparable to exams drawn from previous NCLEX item pool deployments. These conclusions were reinforced by replicating the analyses using actual candidate data. The Examination Committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Member Board Review of Items

Every spring and fall, each Member Board has the opportunity to conduct a Member Board item review. Member Board item review includes reviewing and commenting on newly developed items and simulated operational examinations at Pearson Professional Centers during specific predefined time periods. Boards refer an item for Examination Committee review for one of the following reasons: “not entry-level,” “against the nurse practice act” or for “other reasons.” Staff provides the committee with feedback on all items queried. Items referred as “not entry-level” are seen by an additional NCLEX Item Review panel prior to committee review. The committee responded to all Member Board questions and concerns regarding NCLEX examination items and simulated examinations at the meetings following Member Board review, which traditionally takes place in October and April of each year.

In the spring of 2003, eight Member Boards reviewed and referred items to the Examination Committee. In the fall of 2003, five Member Boards reviewed and referred items to the Examination Committee. The Examination Committee continues to strongly encourage all Member Boards to take advantage of the semiannual opportunities to review NCLEX items.

Item-Related Incident Reports

Occasionally, candidates comment on items seen at Pearson Professional Centers. When this occurs, the candidate files an electronic Incident Report (IR) with Pearson VUE and NCSBN staff investigates the item-related incident. At the November 2003 committee meeting, six PN items and three RN items were reviewed with all but one item being

Relationship to Strategic Plan

Strategic Initiative 1 Nursing Competence.

NCSBN will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome A

Entry-level nurse competence is assessed by the NCLEX® examinations.

Outcome B

NCLEX is administered at international sites for purposes of domestic licensure.

Outcome D

Stakeholders are educated about the NCLEX examination program and related products/services.

Meeting Dates

Examination Committee

November 5-7, 2003
November 24, 2003 (Conference Call)
January 28-29, 2004
April 26-28, 2004
July 2004 (Conference Call)

Item Review Subcommittee

December 3-6, 2003
March 16-19, 2004
May 18-21, 2004
July 12-16, 2004
August 23-27, 2004



Attachments

- A. Proposed 2005 NCLEX-PN Test Plan (Strikethrough Copy)
- B. Proposed 2005 NCLEX-PN Test Plan (Clean Copy)
- C. TOEFL Passing Standard Report
- D. Criteria Matrix for International Administration of the NCLEX Examinations
- E. Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX)

retained. At the January 2004 committee meeting, the committee retained all six PN items and fourteen RN items reviewed.

NCSBN Item Development Sessions Held at Pearson VUE

RN Item Development Sessions Productivity Comparison					
Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed
April 02 - March 03	4	47	2,611	7	1,542
April 03 - March 04	2	23	1,097	5	1,446

LPN/VN Item Development Sessions Productivity Comparison					
Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed
April 02 - March 03	3	33	1,476	6	1,547
April 03 - March 04	2	24	968	5	1,611

Joint Research Committee (JRC)

The JRC is a small group of NCSBN and Person VUE staff along with a selected group of prestigious testing industry experts that reviews and conducts psychometric and test development related research for the NCLEX Examinations. In the last year, the JRC funded research to document the principles of good human-computer interface designs for computerized examinations and find ways to increase the effectiveness of the NCLEX examination tutorial while simultaneously decreasing the required administration time. The JRC has also sponsored a qualitative study of the alternate item formats. This study described the reasoning processes that examinees used to answer these questions and determined if the different formats required the candidate to use a higher level of cognitive processing than is required with a matched multiple choice format item. In other discussions, regarding alternate item formats, the JRC provided expert advice on interface design for alternate items.

Additional research has addressed methodologies to achieve current levels of precision for item calibrations using fewer candidates. Other initiatives in progress include investigations to determine optimal pool configuration given item exposure constraints and ways to examine nonuniform differential item functioning. The JRC has also contributed ways to detect changes in item parameters over time, which is known as item drift. Discussions with the JRC have assisted NCSBN and Pearson staff with internal research projects on these and other psychometric and content development topics.

Monitored all Aspects of Examination Administration

Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm

The Examination Committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semiannual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months. The most recent check covered the period from April 1, 2003 through September 30, 2003, and compared over 110,000 candidate records. The check results revealed that there were no duplicate candidate records and that no repeat candidate records were treated by the system as separate individuals.

This check serves as an important reminder to each board of nursing to carefully review candidate records for accuracy at the time of eligibility declaration. Accumulated



candidate registration records are required in order to properly enforce the waiting period between examinations and provide blocking files for previously seen items.

Candidate Tutorial

The NCLEX candidate tutorial was modified to allow candidates the opportunity to become familiarized with the look and feel of alternate item formats before experiencing them in the examination. The tutorial is modified whenever new alternate formats are added to the examination or existing formats change. The current version of the NCLEX candidate tutorial is available on the NCSBN Web site, so that candidates may see the new items before arriving at the test center for their examination appointment.

Monitored the Security of the NCLEX Examination Administrations and Item Pools

The Examination Committee monitored investigations of potential security incidents, reviewed final reports from test service, and made determinations and recommendations regarding security of the NCLEX examination administrations and item pools. For FY04, no incidents occurred that compromised NCLEX examination administration or the security of item pools. Pearson VUE will continue to vigorously monitor and insure NCLEX examination security.

Compliance with the 30/45 Day Scheduling Rule

The Examination Committee monitors compliance with the 30/45-day scheduling rule. For the period of April 1, 2003 to September 30, 2003, there were 50 candidates scheduled out of compliance, out of 110,774 candidates testing. The majority of the violations occurred early in 2003 at the test center in Saipan. The volume more than tripled for this center due to a change in regulations by U.S. Customs and Immigration regarding new entry restrictions for foreign candidates into Guam thereby affecting access to the Pearson Professional Center located there. To remedy this problem, test service built a new center in Saipan to accommodate the additional candidates. There were no 30/45-day scheduling violations recorded after July 2003. A dedicated department at Pearson VUE continues to analyze center utilization levels in order to project future testing volumes and meet the testing needs of all of their testing clients. As an early indicator of center usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites go over 60% capacity levels.

Responded to Member Board Inquiries Regarding NCLEX Examination Administration

As part of its activities, the committee and NCSBN Testing Services staff responded to Member Boards' questions and concerns regarding administration of the NCLEX examinations. The Examination Committee has continued to follow up on posttest service transition activities and has responded to various inquiries regarding system enhancements.

Time Length for the NCLEX-RN

The Examination Committee recommended to the NCSBN Board of Directors a proposal to extend the time limit for the NCLEX-RN examination from the current limit of five hours to six. The recommendation is based on the increasing number of candidates, approximately 6% of the total RN candidate population over the evaluation period, who are running out of time. Further rationale includes the expectation that future enhancements, such as alternate item formats, will require more time for completion. A recommendation to change the NCLEX-RN time limit will prevent an increasing number of RN candidates from running out of time for test administration and allow candidates to have their competency assessed by the optimal passing rule (the 95% Confidence Interval Rule).

Presently, the committee does not recommend a change to the NCLEX-PN time limit due to



the substantially shorter maximum-length examination (205 for the NCLEX-PN in contrast to 265 for the NCLEX-RN) and the relatively small number of candidates (1.5% of the total NCLEX-PN testing population) who ran out of time in 2003.

The Board of Directors approved the Examination Committee recommendation for additional time for the NCLEX-RN. Pending the negotiation with test service regarding the cost of the additional time, the extra hour is expected to be added to all NCLEX-RN examinations beginning October 1, 2004. There will be no increase in the candidate examination fee for this additional time.

Investigate Reasons For Nonlicensure Of Nursing School Graduates

The Examination Committee investigated the reasons why nursing school graduates from the 2000 calendar year have not taken the NCLEX-RN or NCLEX-PN examination. This study was designed to investigate the reasons why candidates who complete their nursing education, submit a registration for the NCLEX examination yet never take an NCLEX-RN or NCLEX-PN examination. It was anticipated that the results of the study would provide information that might positively impact the nursing shortage.

A literature review in the subject areas of medicine, nursing and education using several key words such as licensure, nursing education, job satisfaction, attrition, retention, and testing was conducted. This search generated approximately 150 citations. Most of the citations identified were not relevant to the research question. No studies were found that discussed reasons for nonlicensure of nursing school graduates. Furthermore, no studies addressed graduates of LPN/VN programs. Anecdotal information from several boards of nursing indicates that some of the reasons for graduates registering but not testing are fear of failure and lack of a monetary incentive since graduates in some jurisdictions can work under a temporary permit for extended periods of time.

A survey was developed based on review of appropriate literature and expert opinion. The survey was sent to all candidates (RN and PN) who registered to take the NCLEX examination in the year 2000 and as of January 2003 had yet to take the exam. The initial survey was sent to 2,022 nonlicensed candidates who applied for, but never took either the NCLEX-RN or NCLEX-PN examinations. Unfortunately, the response rate for the survey was less than 10% of the sample and the returned surveys were not representative of the sample. The Examination Committee decided to continue additional data collection in FY04, based on a refined survey tool.

Data collection using a revised survey, entitled *A Survey of Reason for Not Taking the National Nurse Licensure Examination (NCLEX®)*, began in December 2003. In addition to the paper version of the survey, an internet-based survey was created to allow electronic submission responses.

The paper version of the 2004 survey was sent to 2,898 candidates with domestic (U.S.) addresses. A postage-paid envelope and instructions on how to proceed with electronic submission, if preferred, was included in the mailing. Additionally, 1,852 candidates with international addresses were also asked to participate in the survey process. A letter was sent detailing the process for using the internet-based survey. As an incentive to increase the response rate, participants were offered the opportunity to be entered into a drawing to win one of two free online continuing education (CE) courses from NCSBN Learning Extension.

As of April 15, 2004, the final response rate of approximately 15% was tabulated based on 578 total responses from 3,759 total addresses (2,096 domestic and 1,663 international). Of the 578 total responses, 405 were from domestic addresses (32 online, 373 by mail) for a domestic response rate of 19% and 173 responses were from international addresses (172 online, 1 by mail) for an international response rate of 10%.



In an effort to determine how representative the responders were of the entire population, a comparison was performed of responders by RN/PN examination registration, U.S./internationally-educated with nonresponders by RN/PN examination registration and U.S./internationally educated. Based on the results, it was determined that the respondents to the survey were representative of the population as a whole.

With the representation of the population determined, the data was then sorted to create a subpopulation with the characteristics appropriate to this study. On the first sort of data, all respondents currently licensed in the U.S. to practice nursing were deleted. The original sample was chosen from those candidates who registered in 2001 but had not yet taken the NCLEX by December 2003 (first mailing). The next sort was to remove candidates who reportedly had not completed requirements for graduation and were therefore unable to take the licensure exam. These candidates apparently paid their fees, but had either not completed all required course work for graduation or may have not passed a predictor examination required by their educational program. The completion of these sorts created a total subpopulation of 357 candidates, decreased by 214 from the original number of survey responses.

In order to determine why this group did not complete the process for licensure, the responses to the survey question: “Which of the following choices best describes your reason(s) for delaying or not taking the NCLEX® examination?” were tabulated. The respondents were asked to select all that applied and therefore had multiple responses. A significant number of candidates wrote comments in the last portion of the questions that listed ‘Other, please specify.’ Upon review of the written comments, it was determined that the comments were reiterations of the reasons listed in the question. Therefore, when possible, the responses were recategorized into the appropriate category. The remaining 24 respondent comments referred to financial burdens as a result of taking and failing qualifying exams (such as TOEFL) or the NCLEX itself as a reason for not taking NCLEX. These responses/comments on financial burden are listed at the bottom of Table 1 as a separate and additional category. Table 1 provides the respondents’ answers as to the reason for delaying/not taking the NCLEX examination.



Table 1. Reason(s) for delaying or not taking the NCLEX examination

Question #4 Reasons for delaying (Select all that apply)	RN (n=271)		PN (n=86)	
	U.S. Educated (n=28)	Internationally Educated (n=243)	U.S. Educated (n=49)	Internationally Educated (n=37)
1. Board of Nursing did not make me eligible	4% (n= 2)	7% (n= 29)	6% (n= 5)	8% (n= 6)
2. CGFNS	0% (n= 0)	9% (n= 38)	0% (n= 0)	14% (n= 10)
3. Can work using permit or endorsement	0% (n= 0)	.5% (n= 2)	0% (n= 0)	0% (n= 0)
4. Can't apply for licensure – legal reasons	2% (n= 1)	2% (n= 9)	3% (n= 3)	0% (n= 0)
5. Can't pass TOEFL, TOEIC or TSE	0% (n= 0)	4% (n= 16)	0% (n= 0)	6% (n= 4)
6. Physical/Mental disability	6% (n= 3)	1% (n= 4)	2% (n= 2)	0% (n= 0)
7. Increasing family responsibilities	10% (n= 5)	3% (n= 11)	3% (n= 3)	7% (n= 5)
8. Continue Education	2% (n= 1)	2% (n= 8)	5% (n= 5)	4% (n= 3)
9. Difficulty obtaining work visa	2% (n= 1)	9% (n= 41)	0% (n= 0)	1% (n= 1)
10. Not confident in ability to pass exam	25% (n= 13)	11% (n= 50)	27% (n= 25)	6% (n= 4)
11. Employed outside of nursing	6% (n= 3)	4% (n= 17)	3% (n= 3)	1% (n= 1)
12. Financially independent/ do not need to work	4% (n= 2)	.5% (n= 2)	0% (n= 0)	3% (n= 2)
13. General Test Anxiety	15% (n= 8)	6% (n= 28)	15% (n= 14)	4% (n= 3)
14. Non-U.S. transcript/program evaluation incomplete	0% (n= 0)	5% (n= 23)	1% (n= 1)	10% (n= 7)
15. Not enough time to prepare	6% (n= 3)	18% (n= 80)	9% (n= 8)	15% (n= 11)
16. Registration or ATT expired	15% (n= 8)	11% (n= 49)	14% (n= 13)	14% (n= 10)
17. Relocated and can't take the test/work	4% (n= 2)	3% (n= 12)	1% (n= 1)	3% (n= 2)
18. No longer interested in nursing as career	0% (n= 0)	0% (n= 0)	2% (n= 2)	1% (n= 1)
* Financial reasons/ can't afford all of the fees	0% (n= 0)	4% (n= 17)	7% (n= 6)	1% (n= 1)
Total responses	52	436	91	71



The following information is summarized from Table 1.

U.S.-educated RNs (n=28), listed the following reasons for delaying/not taking NCLEX:

- Not confident in my ability to pass exam – 25% (n=13)
- General test-taking anxiety – 15% (n=8)
- Registration/ATT expired – 15% (n=8)
- Increased family responsibilities – 10% (n=5)

The internationally educated RNs (n=243) listed the following reasons, with 17 respondents note the unasked category of ‘Financial Reasons’:

- Not enough time to prepare – 18% (n=80)
- Not confident in my ability to pass exam – 11% (n=50)
- Registration/ATT expired – 11% (n=49)

The U.S.-educated PN respondents (n=49) listed the following reasons to the delaying/not-taking question including six respondents in the ‘financial reasons’ category:

- Not confident in my ability to pass exam – 27% (n=25)
- General test-taking anxiety – 15% (n=14)
- Registration/ATT expired – 14% (n=10)

Finally, the internationally educated PN respondents (n= 37) noted the following reasons:

- Not enough time to prepare – 15% (n=11)
- CGFNS – 14% (=10)
- Registration/ATT expired – 14% (n=10)
- Non-U.S. transcript/program evaluation incomplete – 10% (n=7)

The results of this study suggest some common themes as to why a presumably motivated candidate population, identified as such due to the completion of formal education and initiation of the licensure application process (including NCLEX registration and payment of all applicable fees), fails to follow through on the nurse licensure process. There appears to be little differentiation between reasons for nonlicensure for RNs and PNs. However, there seem to be somewhat different reasons for U.S. and internationally educated candidates.

In general, U.S.-educated candidates selected reasons for not taking the NCLEX examination that were related to their self-perceived ability to pass the NCLEX examination. Internationally educated candidates, while to some degree concerned about their ability to pass the NCLEX, seem to select reasons that are more structural or process related rather than personal in nature.

Responses such as ‘not having enough time to prepare,’ ‘CGFNS,’ ‘expirations of ATT’s’ and ‘financial considerations’ suggest that because the process for an internationally educated candidate takes longer, is more expensive, and in general requires more attempts than a U.S.-educated candidate; that those candidates, who are not initially successfully, may give up more readily than a U.S.-educated candidate. Based on the reasons selected by the internationally prepared candidates, it could be that this group needs more information about, and familiarity with, the process and requirements for licensure.

Since the time of this study many Boards of Nursing have made changes to the NCLEX registration and licensure application processes that may help both international- and U.S.-educated qualified candidates enter the profession in less time than is currently required. Examples of these changes include reduction of wait time between NCLEX administrations, online initial licensure applications and acceptance of additional English



proficiency examinations. Other initiatives such as international availability of the NCLEX examinations, unified cut scores for English proficiency examinations and multiple methods for educational credentials review may make the total licensure process even more efficient for all candidates.

The conclusions of this study are limited to a small section of candidates who show interest but do not enter the nursing profession. The findings and the relatively low number of prospective nurses impacted, suggest that there are few, if any, specific recommendations that can be made to boards of nursing that will encourage candidates to take the licensure examination and thus reduce the nursing shortage.

Investigate the Feasibility of Increasing Frequency of NCLEX Administrations

Effective January 1, 2004, NCSBN policy was amended to permit candidates to test as often as once every 45 days or eight times per year, unless limited to fewer retakes by the desired jurisdiction of licensure. This policy allows candidates to be exposed a maximum of four times to any one operational item pool. Member Boards can make retesting time periods longer, but not more frequently, than NCSBN policy. Starting with the October 2003 deployment, the number of items in an operational pool was increased to accommodate this more frequent retake policy.

Compare Equivalency of NCLEX-RN with Spanish Language Puerto Rican Nurse Licensure Examination

The Examination Committee was charged to conduct a comparison study with Puerto Rico regarding the NCLEX-RN and the Spanish language Puerto Rican Nurse Licensure Examination as part of the FY04 strategic initiatives. NCSBN has attempted to do a comparison of the NCLEX-RN and Puerto Rico Board of Nursing Registered Nurse Licensure Examinations to determine if the examinations can be considered equivalent for licensure purposes in the United States for the last three years. NCSBN began this comparison study in 2002, but to date still have not received the information requested from the Puerto Rico Board of Nursing necessary to complete the study in the manner intended.

In lieu of a completed study, this report is provided as guidance to Member Boards of nursing that may be in the process of independently investigating the utility of using the Puerto Rican Nurse Licensure examinations. Despite the lack of complete information, the following identified issues signify nontrivial differences between the NCLEX and the Puerto Rican examination, which fail to support a position of equivalency between the two examinations.

Different Languages

The Puerto Rican examination is produced and predominantly administered in Spanish and the NCLEX-RN is produced exclusively in English. Testing standards and guidelines developed by the following organizations: International Test Commission (ITC); National Organization for Competency Assurance (NOCA); American Educational Research Association (AERA); American Psychological Association (APA); National Council on Measurement in Education (NCME); and Council on Licensure, Enforcement, and Regulation (CLEAR). All strongly warn against treating results from tests given in different languages as equivalent in light of substantive difference in content interpretation due to language differences.

Scope of Practice Represented

The content of the Puerto Rican nurse licensure examinations are based only on nursing practice in Puerto Rico. The NCLEX-RN is based on a practice analysis that assesses entry-level nursing knowledge, skills and abilities representative of practice in all states and



territories including Puerto Rico. To the extent entry-level practice in Puerto Rico differs from other areas in the U.S., the Puerto Rican examination may be inappropriate for licensure outside Puerto Rico. To date, it has been impossible to establish the level of congruence between the scopes of practice in Puerto Rico and the United States. This may be particularly important given that Puerto Rico administers two RN examinations; NCSBN has not been given a clear description as to how they differentiate educational preparation or how they lead to distinct levels of RN licensure.

Examination Validity/Legal Defensibility

The basis for fair and appropriate test usage for licensure and certification examinations rests on the establishment of examination validity. Examination validity assures that the examination measures what it is intended to measure. In the case of the NCLEX-RN examination, it is intended to measure minimum competency in entry-level RN practice. To insure that the test measures the knowledge, skills and abilities necessary to practice safely and effectively, the test plan or test blueprint is based on a practice analysis of entry level RNs that identifies the necessary knowledge, skills and abilities. NCSBN conducts a practice analysis once every three years for the NCLEX-RN. A practice analysis is not conducted for the Puerto Rico examinations. NCSBN also do not know the process by which Puerto Rico exam items are constructed, reviewed and validated.

Psychometric Soundness

In addition to validity, an exam must be reliable. Exam reliability simply means that the exam will yield closely similar evaluations of a candidate's ability over repeated administrations with some degree of statistical certainty. In the case of the NCLEX-RN, the reliability coefficient or decision consistency index is in excess of .90 (with a range between 0 and 1.00). This is the level recommended, by psychometric standards, for reliability coefficients for licensure and certification examinations. NCSBN does not know the reliability coefficients for the Puerto Rican examinations or even if they are computed. Furthermore, reliability estimates are sample depended and even if it were known what the coefficients were, they would not necessary be predictive for candidate populations outside Puerto Rico.

Number of Examinations

The NCLEX-RN is a single examination utilized by all 55 Boards of Nursing for purposes of assessing competence for Registered Nurse Licensure (a single level of licensure). As mentioned above, the two examinations in Puerto Rico are used dependent on level of registered nurse education upon entry into practice for two distinct levels of licensure. It is unknown how or if, the single level of RN licensure is comparable to the bifurcated licensure model utilized in Puerto Rico.

Examination Security and Integrity:

Given their important role in public safety, it is essential that the integrity and security of licensure examinations be maintained. There are two essential items to preserving exam integrity and security:

- (1) Exams must be administered and scored in a secure environment with adequate checks on candidate identification.
- (2) Exam items must not be over exposed through exam form rotation and limitations on repeat examinations.

NCSBN does not have sufficient information on the procedures for administration of the Puerto Rican examinations to determine if they are sufficient to ensure the integrity of the examinations.



Examination Difficulty

A final key indication of exam comparability is the passing rates for the two examinations. To make a direct comparison, results from pairs of candidates who took both examinations would be required. Despite this information being available, the results in Tables 1 and 2 show that candidates from Puerto Rico pass the NCLEX-RN at a significantly lower rate than candidates from other parts of the U.S. The large difference in pass rates strongly suggests that the exams are of substantially different difficulty. While there may be many factors contributing to this difference in passing rates, the extreme differences do suggest that the standard that candidates need to achieve to demonstrate competence for entry-level RN practice is lower for the Puerto Rican examination than it is for the NCLEX-RN.

Table 1 RN Pass Rates for Reference Group, All others and Total for 1998-2003

National and Puerto Rico (by juris of licensure)

YEAR	National						Puerto Rico					
	Ref Group		All Others		Total		REF GROUP		ALL others		TOTAL	
	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing
1998	83,238	85.0%	33,472	39.2%	116,710	71.9%	53	9.4%	21	9.5%	74	9.5%
1999	76,607	84.8%	36,580	41.5%	113,187	70.8%	43	14.0%	27	14.8%	70	14.3%
2000	71,499	83.8%	37,213	40.0%	108,712	68.8%	71	9.9%	31	19.4%	102	12.7%
2001	68,761	85.5%	39,709	41.5%	108,470	69.4%	54	9.3%	33	12.1%	87	10.3%
2002	70,684	86.7%	43,223	44.7%	113,907	70.7%	41	7.3%	30	10.0%	71	8.5%
2003	76,726	87.0%	48,013	45.7%	124,739	71.1%	21	14.3%	22	22.7%	43	18.6%

Table 2 RN Pass Rates for Reference Group, All others and Total for 1998-2003

National and Puerto Rico (by juris of education)

YEAR	National						Puerto Rico					
	Ref Group		All others		Total		Ref Group		All Others		Total	
	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing	# testing	% passing
1998	83,238	85.0%	33,472	39.2%	116,710	71.9%	130	16.2%	167	14.4%	297	15.1%
1999	76,607	84.8%	36,580	41.5%	113,187	70.8%	145	12.4%	171	16.4%	316	14.6%
2000	71,499	83.8%	37,213	40.0%	108,712	68.8%	213	10.8%	216	19.0%	429	14.9%
2001	68,761	85.5%	39,709	41.5%	108,470	69.4%	177	14.1%	231	16.5%	408	15.4%
2002	70,684	86.7%	43,223	44.7%	113,907	70.7%	185	18.4%	208	18.8%	393	18.6%
2003	76,726	87.0%	48,013	45.7%	124,739	71.1%	183	16.9%	242	17.4%	425	17.2%

Because of the above-cited open issues and lack of data, NCSBN cannot provide a definitive assessment of whether the Puerto Rico examinations are substantially equivalent to the NCLEX-RN examination. However, information collected to date does not support a determination of equivalency between the NCLEX-RN and Puerto Rico Board of Nursing Registered Nurse Licensure Examinations. At this time, the Examination Committee cannot complete the comparison between the two examinations. Until the requested information from Puerto Rico is remitted to committee, this report will stand as the committees' position regarding the equivalency between the two examinations.



Set Performance Benchmarks for Existing English Proficiency Examinations

The Test of English as a Foreign Language (TOEFL) is a test of English proficiency that is commonly used by boards of nursing as one of the requirements for obtaining a nursing license. However, the TOEFL yields a score, not a pass-fail decision. Therefore, each jurisdiction that uses the TOEFL also has to set a passing standard that represents minimum English language competence to allow for safe and effective nursing practice.

Given the number of international nurses that seek licensure in the United States, defining a legally-defensible passing standard, documenting the procedures used to identify that standard, and making it available to boards of nursing and other interested parties would be a benefit to the Member Board jurisdictions. To that end, the Examination Committee was charged with developing a recommended minimum passing score for the TOEFL.

A recommended passing standard should reflect the level of English language proficiency, as measured by TOEFL, believed necessary for entry-level nurses to possess in order to be able to perform important nursing responsibilities safely and effectively. It would be recommended that foreign nurse candidates should at least meet this standard before they would be issued a license. It is important to note that the standard is intended to reflect the minimum level of English proficiency necessary for safe and effective entry-level practice, not the level of proficiency necessary for nurse candidates to pass the NCLEX examination.

On December 7-8, 2003, a 25-member panel met in Chicago to engage in a standard setting exercise for the TOEFL examination. The members of this panel included: nurses who speak a primary language other than English and have taken the TOEFL, nurses who work with clients who speak a primary language other than English, clinical nurse supervisors of nurses who speak a primary language other than English, nursing regulators, a nursing educator and a public member.

First, the panelists participated in a discussion of how much English proficiency was required to safely and effectively perform the activities of nursing. There was also a discussion about English proficiency and the TOEFL. Next, each participant was asked to respond to a computerized sample test as if she were a minimally competent candidate and then select a writing sample that is typical of a minimally proficient candidate. Subsequently, each participant received an ability estimate based upon those responses. These ability estimates were summarized and formed the basis for the panel's series of recommended standards.

After reviewing the results of the study and the possible standards recommended by the 25 member panel, the Examination Committee recommended that a score of 220 on the computerized TOEFL (560 on the written TOEFL) be required to demonstrate the minimum degree of English proficiency necessary to be a safe and effective entry-level nurse. The full study is provided as an attachment to this to this report.

The committee expects this tactic to continue in FY05 with the International English Language Testing System (IELTS) English proficiency examination. A recommended standard for the IELTS examination will be presented to the Delegate Assembly at the 2005 Annual Meeting.

NCLEX is Administered at International Sites for Purposes of Domestic Licensure

NCSBN International NCLEX Initiative

Pursuant to Strategic Initiative 1.B.1 of the FY02-FY04 NCSBN Strategic Plan, the NCLEX is administered at international sites for purposes of domestic licensure, the Examination



Committee was charged with the initiation of the International Testing Plan for the NCLEX Examinations during FY04.

NCSBN defined the NCLEX international testing initiative as:

“International testing is the administration of current NCLEX-RN and NCLEX-PN examinations in Pearson Professional Testing Centers located outside Member Board jurisdictions, for purposes of licensure in Member Board jurisdictions. No part of this specific recommendation regarding international administration will contradict or circumvent any current Member Board licensure processes or requirements. This specific recommendation regarding international administration does not address the administration or modification of the NCLEX examinations for purposes of licensure, or any other purpose, for Boards of Nursing, or any similar regulatory body, outside current Member Board jurisdictions. Candidate examination fees for examination administrations outside Member Board jurisdictions will be set to reflect the costs of the examination administration in international jurisdictions. Domestic NCLEX candidate fees will not be increased to accommodate costs associated with international administration.”

Utilizing the security and location selection criteria that were accepted and approved by NCSBN in 2002, the Examination Committee has selected the United Kingdom (England), Hong Kong and South Korea as the three initial countries for international testing locations. It is important to note that these countries were selected because they rated highly across all criteria under consideration.

Based on all current NCLEX examination program policies and procedures, including all current security protocols, the Examination Committee intends to proceed with administration of NCLEX-RN and NCLEX -PN examinations in testing centers in these three countries, for purposes of licensure within Member Board jurisdictions with the following conditions:

- International NCLEX administration will begin in January 2005.
- International NCLEX Examination fees will be established by the NCSBN Board of Directors for examination administration outside Member Board jurisdictions.
- Three or fewer locations will be utilized as the initial set of international administration locations to pilot the initiative.
- Utilizing standards and criteria for NCLEX administration performance, international testing locations may be added or removed during FY05.
- In all circumstances, international testing will not be implemented if all security policies and procedures currently used are not employed.

Supplementary information on the selection criteria is presented in Attachment D of this report. Additional information on the selection of these initial countries will be presented at the Examination Committee forum at the 2004 Annual Meeting.

Stakeholders are educated about the NCLEX examination program and related products/services.

Presentations

NCSBN Testing Services staff conducted more than 15 NCLEX informational presentations. Additionally, staff has exhibited at 10 conferences during FY04. These opportunities assist NCSBN's Testing Services Department to educate stakeholders as well as recruit for NCSBN Item Development panels.

Video

The “Understanding the NCLEX Examinations” video, produced and distributed last fiscal year, continues to be a frequently requested product from NCSBN Testing Services. The



video is a key educational piece to inform interested segments of the public, such as educators and candidates, about all aspects of the NCLEX Examination Program.

Publications

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process.

NCLEX Invitational

For the past four years, NCSBN Testing Services staff has coordinated and hosted an NCLEX Invitational in order to provide member boards, educators and other stakeholders an opportunity to learn about the NCLEX Program. As part of the FY04 strategic initiatives, staff was charged to improve delivery of the NCLEX Invitational and increase attendance. On September 26, 2003, 250 attendees participated in the 2003 NCLEX Invitational at the Wyndham Tremont in Boston, Massachusetts. Feedback from attendees was positive and constructive. For FY05, the NCLEX Invitational will be held September 13, 2004 in San Francisco at the Fairmont Hotel. The theme of the Invitational is components for success. Presentations will include, in addition to standard NCLEX information, additional information about international testing and alternate item formats.

NCLEX Program Reports

The committee monitored production of the NCLEX program reports. NCLEX program reports were modified to reflect operational test plan and passing standard changes made to the examination during the course of the year. NCLEX program reports were distributed to subscribing nursing education programs during the current fiscal year in October 2003 and April 2004.

During this time, NCSBN staff performed a market definition analysis to assess how much improvement in subscriptions could be reasonably expected by improving our marketing strategies. The results suggest that there will be an increase of programs subscribing to the product. Presently, 32%-44% of RN programs and 13%-17% of PN programs subscribe. Strategies to increase subscriptions will be investigated in FY05.

NCLEX Quick Results

The NCLEX Quick Results service allows candidates to access their unofficial NCLEX results two full business days after their examination administration. This service is provided by Pearson VUE and is accessible to candidates by telephone or Internet for a nominal charge. State boards of nursing must sign up to participate in the NCLEX Quick Results service. Over 54,000 candidates (31,000 on the Web and 23,000 on the phone) used NCLEX Quick Results service between April and September 2003. Currently, 39 of 60 state boards of nursing participate in the NCLEX Quick Results service, the highest level of member board participation since the establishment of the product offering.

Future Activities

- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate enhancements to NCSBN examination process.
- Evaluate NCLEX Outreach initiatives.
- Administer NCLEX examination in international locations.
- Research and recommend English-as-a-second language competency examinations and valid passing standards.



Attachment A

Proposed 2005 Test Plan - Strikethrough Copy

1 NCLEX-PN® Test Plan

2 ~~TEST PLAN FOR THE~~

3 ~~NATIONAL COUNCIL LICENSURE EXAMINATION~~

4 ~~FOR PRACTICAL/VOCATIONAL NURSES~~

5 ~~(NCLEX-PN® EXAMINATION)~~

6 Test Plan for the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN®
7 Examination)

9 INTRODUCTION

10 Introduction

11
12 Entry into the practice of nursing in the United States and its territories is regulated by the licensing authorities
13 within each jurisdiction. To ensure public protection, each jurisdiction requires a candidate for licensure meet
14 set requirements that include to passing an examination that measures the competencies needed to practice
15 safely and effectively as a newly licensed, entry-level practical/vocational nurse. The National Council of State
16 Boards of Nursing, Inc. (NCSBN), develops a licensure examination, the National Council Licensure Examination
17 for Practical/Vocational Nurses (NCLEX-PN® Examination), which is used by state and territorial boards of nursing
18 to assist in making licensure decisions.

19
20 ~~The initial~~ Several steps occur in the development of the NCLEX-PN® Examination. The first step is the
21 ~~preparation~~ conducting a practice analysis that is used to collect data on the current practice of entry-level
22 ~~practical/vocational nurses~~ of a test plan to guide the selection of content and behaviors to be tested. In this
23 plan, provision is made for an examination reflecting entry level practical/vocational nursing as identified in the
24 study entitled *Linking the NCLEX-PN® National Licensure Examination to Practice: 2000 Job Analysis of Newly*
25 *Licensed Practical/Vocational Nurses in the U.S.* (Smith, Crawford, & Gawel, 2000), *(Report of Findings from the*
26 *2003 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* [Smith & Crawford, 2003]). The
27 activities were analyzed in relation to: (1) the frequency of their performance, (2) their impact on maintaining
28 client safety and (3) the settings in which they were performed. Newly licensed practical/vocational nurses are
29 asked about the frequency and priority of performing more than 150 nursing care activities. The activity
30 statements are then analyzed in relation to the frequency of performance and the impact on maintaining client
31 safety. This analysis guides the development of a framework for entry-level nursing practice that ~~delineates~~
32 incorporates specific client needs as well as processes that are fundamental to the practice of nursing. The next
33 step is writing the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested.
34 Variations in each jurisdiction's laws and regulations guide are considered in the development of the test plan.

35
36 The *NCLEX-PN® Test Plan* derived from this framework provides a concise summary of the content and scope of
37 the examination. ~~The plan also~~ It serves as a guide for both examination development as well as and candidate
38 preparation, as well as a guide for feedback for the unsuccessful candidate. Each NCLEX-PN examination is ~~B~~
39 based on the test plan. Each unique NCLEX-PN® examination reflects assesses the knowledge, skills and abilities
40 that are essential for the practical/vocational nurse ~~to master in order~~ to meet the needs of clients who require
41 the promotion, maintenance and/or restoration of health. The following sections describe beliefs about people,
42 nursing and clients that are integral to the examination, ~~the~~ cognitive abilities that will be tested in the
43 examination, and the categories and specific components parts of the *NCLEX-PN® Test Plan*.

45 BELIEFS

46 Beliefs

47
48 Beliefs about people and nursing ~~underlie~~ influence the *NCLEX-PN® Test Plan*. People are finite beings with
49 viewed as having varying capacities to function in society. They are unique individuals defining their who have
50 defined own systems of daily living which that reflect their values, cultures, motives and lifestyles. Additionally,
51 they are viewed as people have ing the right to make decisions regarding their health care needs and participate
52 in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individuals,
53 families/ and significant others) ~~to~~ achieve an optimal level of health in a variety of settings.



55 Nursing is both an art and a science. It is a learned profession based on an understanding of the human condition
 56 across the life span and the relationships of an individual with others and within the environment. ~~that~~
 57 integrates concepts from the liberal arts, and the biological, behavioral and social sciences. The nature of
 58 nursing is dynamic and continually evolving. Nursing practice is founded on a professional body of knowledge
 59 that integrates concepts from the biological, behavioral and social sciences. The goal of nursing in any setting is
 60 to promote comfort and quality health care. ~~health and~~ The nurse assists individuals throughout their life spans to
 61 attain an optimal level of functioning by responding to their needs, conditions ~~or~~ and events that result from
 62 actual or potential health problems (American Nurses Association, 1995). The domain of nursing and the relevant
 63 knowledge, skills and abilities exist along a continuum and are organized and defined by professional and legal
 64 parameters.

66 The practical/vocational nurse utilizes uses “specialized knowledge and skills which meet the health needs of
 67 people in a variety of settings under the direction of qualified health professionals” (NFLPN, ~~2003~~1996). The
 68 practical/vocational nurse uses a clinical problem- solving process (the nursing process) to collect and organize
 69 relevant health care data, ~~and~~ assist in the identification of the health needs/problems of clients throughout the
 70 client's life span and contribute to the interdisciplinary team in a variety of settings. The entry-level
 71 practical/vocational nurse, under appropriate supervision, provides competent demonstrates the essential
 72 competencies needed to the care for clients with commonly occurring health problems that have ~~ing~~ unpredictable
 73 outcomes. “Competency implies knowledge, understanding, and skills that transcend specific tasks and is guided
 74 by a commitment to ethical/legal principles” (NAPNES, ~~2003~~1999).

78 **LEVELS-Classification OF COGNITIVE ABILITY of Cognitive Ability Levels**

80 The NCLEX-PN® examination consists of multiple choice items (questions) written at the cognitive levels of
 81 knowledge, comprehension, application and analysis (Bloom et al., 1956).

82 The examination consists of items that use Bloom's taxonomy for the cognitive domain as a basis for writing and
 83 coding items (Bloom et al., 1956; Anderson & Krathwohl, 2001). The practice of practical/vocational nursing
 84 requires the application of all levels of cognitive ability. The majority of items are written at the application or
 85 higher levels of cognitive abilities.

87 **TEST PLAN STRUCTURE**

88 **Test Plan Structure**

89
 90 The framework of Client Needs was selected because it provides a universal structure for defining nursing actions
 91 and competencies for a variety of clients across all settings and is congruent with state laws/rules, and statutes.

93 **CLIENT client NEEDSneeds**

94 Four major categories of Client Needs organize ~~the~~ content of the NCLEX-PN® - Test Plan is organized into four
 95 major Client Needs categories. These client needs Two of the four categories are further divided into a total of six
 96 subcategories:
 97

A. Safe, and Effective Care Environment
▪ 1. Coordinated Care
▪ 2. Safety and Infection Control
B. Health Promotion and Maintenance
3. Growth and Development Through the Life Span
4. Prevention and Early Detection of Disease
C. Psychosocial Integrity
5. Coping and Adaptation



6. Psychosocial Adaptation
D. Physiological Integrity
▪ 7. Basic Care and Comfort
▪ 8. Pharmacological Therapies
▪ 9. Reduction of Risk Potential
▪ 10. Physiological Adaptation

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Integrated Processes INTEGRATED CONCEPTS AND PROCESSES

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

- ~~Clinical Problem-Solving Process (Nursing Process)~~ – a scientific approach to client care that includes data collection, planning, implementation and evaluation.
- ~~Caring~~ – the interaction of the practical/vocational nurse and clients in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired outcomes.
- ~~Communication and Documentation~~ – the verbal and/or nonverbal interactions between the practical/vocational nurse and the clients, families, significant others and members of the health care team. Events and activities associated with client care are validated through a in written and/or electronic records that reflects standards of practice and accountability into in the provision of care.
- ~~Cultural Awareness~~ – the knowledge of and sensitivity to the beliefs and values of the client and nurse, and the integration of such awareness in the provision of nursing care.
- ~~Self-Care~~ – the practice of assisting clients of various abilities to meet their own health care needs, including maintenance of health and/or restoration of function.
- ~~Teaching/Learning~~ – the facilitation of the acquisition of knowledge, skills and attitudes that leads to assist in promoting to a positive changes in behavior.

DISTRIBUTION OF CONTENT

Distribution of Content

The percentage of test ~~questions~~ items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Linking the NCLEX-PN® National Licensure Examination to Practice: 2000 Practice Analysis of Newly Licensed Practical/Vocational Nurses in the U.S.* (Smith, Crawford, & Gawel, 2000). ~~Report of Findings from the 2003 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice~~ (Smith & Crawford, 2003), and ~~Expert judgment was provided by members of the National Council's NCSBN Examination Committee, and by the 2000 Practice Analysis Panel of Experts.~~

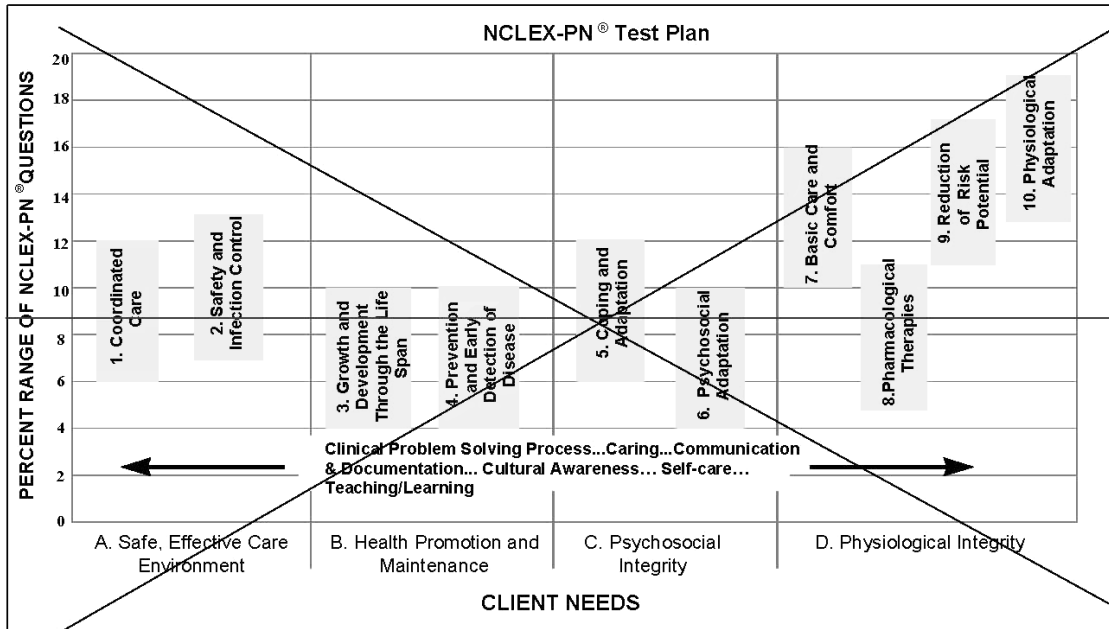
<u>CATEGORIES</u> <u>Client Needs</u>	<u>PERCENTAGE OF Percentage</u> <u>of Items from each</u> <u>Category/Subcategory</u> <u>TEST QUESTIONS</u>
<u>A. Safe and Effective Care Environment</u>	
▪ 1. Coordinated Care	6-12 <u>11-17 %</u>
▪ 2. Safety and Infection Control	7-13 <u>8-14 %</u>
<u>B. Health Promotion and Maintenance</u>	
3. Growth and Development Through the Life-Span	4-10 <u>7-13%</u>
4. Prevention and Early Detection of Disease	4-10 <u>%</u>
<u>C. Psychosocial Integrity</u>	
5. Coping and Adaptation	6-12 <u>8-14 %</u>
6. Psychosocial Adaptation	4-10 <u>%</u>



D. Physiological Integrity

- ~~7.~~ Basic Care and Comfort ~~10-16~~ 11-17%
- ~~8.~~ Pharmacological Therapies ~~5-11~~ 9-15%
- ~~9.~~ Reduction of Risk Potential ~~11-17~~ 10-16%
- ~~10.~~ Physiological Adaptation ~~13-19~~ 12-18%

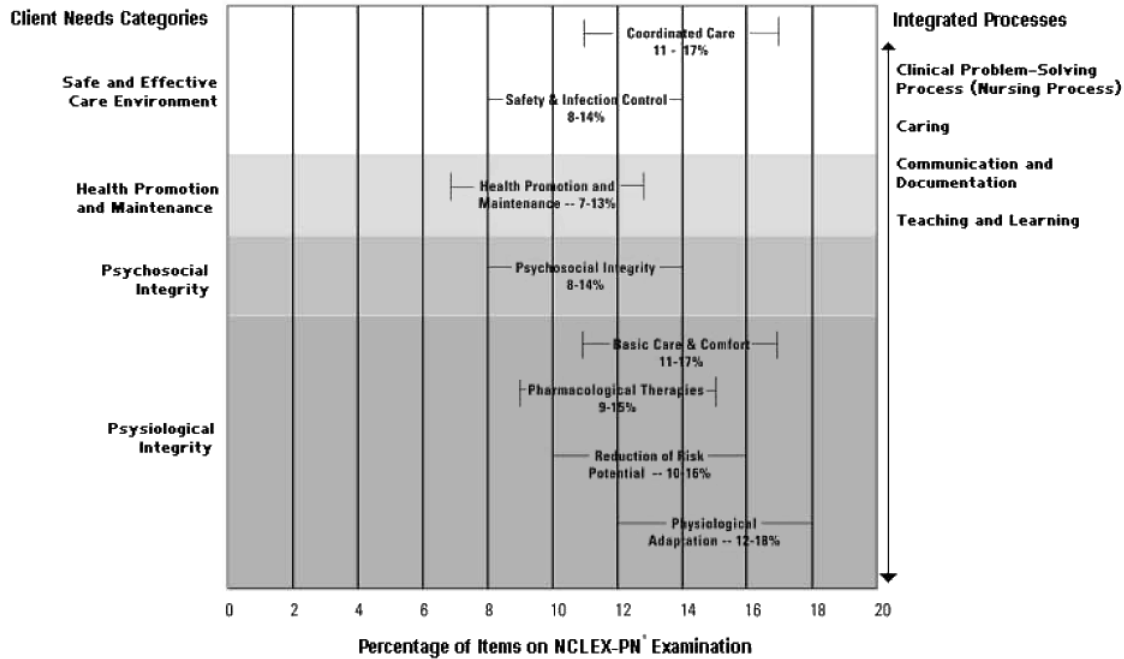
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Distribution of Content for the NCLEX-PN® Test Plan



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OVERVIEW OF CONTENT

Overview of Content

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

A. Safe and Effective Care Environment

The practical/vocational nurse provides nursing care that contributes to the and collaborates with others to enhancement of the health care delivery setting and to protects clients*, family/significant others and other health care personnel through:

- ~~1-~~ *Coordinated Care* – The practical/vocational nurse collaborates with other health care team members to facilitate effective client.

Related content includes, but is **not limited** to:

- Advance Directives
- Advocacy
- Client Care Assignments
- Client Rights
- Concepts of Management and Supervision
- Confidentiality
- ~~Continuous Quality Improvement~~
- ~~Performance Improvement (Quality Assurance)~~
- Establishing Priorities
- Ethical Practice
- ~~Incident/Irregular Occurrence/ Variance Reports (move to “Safety..”)~~
- Informed Consent
- Legal Responsibilities



- Consultation with Members of the Health Care Team
- Continuity of Care
- Referral Processes
- Resource Management

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~~2.1. Safety and Infection Control - The practical/vocational nurse contributes to the protection of clients and health care personnel from health and environmental hazards.~~

Related content includes, but is **not limited to**:

- Accident/Error Prevention
- Internal and External Disaster Plannings
- Handling Hazardous and Infectious Materials
- Home Safety
- Injury Prevention
- Medical and Surgical Asepsis
- Standard-(Universal)-/Transmission-Based/and-Other Precautions
- Use of Restraints/Safety Devices
- Reporting of Incident/Event/Irregular Occurrence/Variance.
- Safe Use of Equipment
- Security Plans

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* Clients are defined as individuals, families and significant others

~~B-Health Promotion and Maintenance~~

~~The practical/vocational nurse provides and assists in directing nursing care that and promotes and maintains health through incorporates ing knowledge of the following areas expected stages of growth and development and prevention and/or early detection of health problems.~~

~~3.Growth and Development Through the Life Span—The practical/vocational nurse assists the client and significant others during the normal expected stages of growth and development from conception through advanced old age.~~

Related content includes, but is **not limited to**:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Data Collection Techniques
- Disease Prevention
- Developmental Stages and Transitions
- Expected Body Image Changes
- Family Interaction Patterns
- Family Planning
- Health Promotion/Screening Programs
- Health Screening
- High Risk Behaviors
- Human Sexuality
- Immunizations
- Lifestyle Choices
- Self-Care

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~~4.Prevention and Early Detection of Disease—The practical/vocational nurse provides client care related to prevention and early detection of health problems.~~

Related content includes, but is **not limited to**:

- ~~Data Collection Techniques~~
- ~~Disease Prevention~~
- ~~Health Promotion Programs~~
- ~~Health Screening~~
- ~~Immunizations~~
- ~~Lifestyle Choices~~

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~~C-Psychosocial Integrity~~

~~The practical/vocational nurse provides nursing care that assists with promotion and supports of the emotional, mental and social well-being of the clients. significant others in the following areas:~~



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~~5. Coping and Adaptation~~ — The practical/vocational nurse promotes the ability of the client and/or significant others to cope, adapt and/or problem solve situations related to illnesses, disabilities, and stressful events.

Related content includes, but is **not limited to**:

- Behavioral Interventions
- Behavioral Management
- Abuse and ~~or Neglect~~ or Neglect
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness
- End of Life ~~Issues~~ Concepts
- Grief and Loss
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Chemical Dependency Substance-Related Disorders
- Suicide/Violence Precautions
- Support Systems
- Therapeutic Communication
- Therapeutic Environment
- Unexpected Body Image Changes

Influences on Health

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~~6. Psychosocial Adaptation~~ — The practical/vocational nurse participates in recognizing and providing care for clients with maladaptive behavior and assists with behavior management of the client with acute and/or chronic mental illness and cognitive psychosocial disturbances.

~~Related content includes, but is not limited to:~~

- ~~• Abuse and Neglect~~
- ~~• Behavioral Interventions~~
- ~~• Chemical Dependency~~
- ~~• Crisis Intervention~~
- ~~• Mental Illness Concepts~~
- ~~• Suicide~~
- ~~• Therapeutic Environment~~

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D. Physiological Integrity

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

~~7. Basic Care and Comfort~~ - The practical/vocational nurse provides comfort to clients and assistance in the performance of their activities of daily living.

Related content includes, but is **not limited to**:

- Assistive Devices
- Elimination
- Mobility/Immobility
- Non-~~pharmacological Pain~~ Comfort Interventions
- Nutrition and Oral Hydration
- Palliative/Comfort Care
- Personal Hygiene
- Rest and Sleep

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~~8. Pharmacological Therapies~~ - The practical/vocational nurse provides care related to the administration of medications and monitors clients who are receiving parenteral therapies.

Related content includes, **but is not limited to**:

- Adverse Effects
- Expected Effects
- Medication Administration
- Pharmacological Actions
- Pharmacological Agents
- Side Effects

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213 9- *Reduction of Risk Potential* – The practical/vocational nurse reduces the client's potential for clients
 214 to developing complications or health problems related to treatments, procedures or existing
 215 conditions.

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 217 Related content includes, but is **not limited** to:

- Potential for Alterations in Body Systems
- Potential Complications of Diagnostic Tests/ Treatments/ Procedures, Surgery and/or Health Alterations
- Diagnostic Tests Laboratory Values
- Therapeutic Procedures
- Vital Signs

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10- *Physiological Adaptation* – The practical/vocational nurse participates in providing care for clients
 with acute, chronic or life-threatening physical health conditions.

Related content includes, but is **not limited** to:

- Alterations in Body Systems
- Radiation Therapy
- Basic Pathophysiology
- Respiratory Care
- Fluid and Electrolyte Imbalances
- Unexpected Response to Therapies
- Medical Emergencies

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ADMINISTRATION OF THE NCLEX-PN® EXAMINATION

Administration of the NCLEX-PN® Examination

227 The *NCLEX-PN® Examination* is administered via to candidates by computer using eComputerized Adaptive
 228 Testing (CAT). CAT is a method for delivering examinations administering tests that uses current computer
 229 technology and measurement theory. An Movement through the examination, including the selection of
 230 answers, was accomplished via a “mouse” for the first time in the April, 2001 administration of the examinations.
 231 A drop-down calculator was also available to candidates for the first time during that testing. extensive multi-step
 232 process is followed in the development of items before they can be used on the examination. Examination items
 233 are primarily four-option and multiple-choice. Other types of item formats may include, but are not limited to,
 234 multiple response, ordered response fill-in-the-blank (e.g. calculation), and hotspot. All item formats, including
 235 standard multiple-choice, may have charts, tables or graphic images.

236 With CAT, each candidate's test examination is unique because it is assembled interactively as the individual
 237 is tested examination proceeds. Each examination item (question) is subjected to an extensive review and pre-
 238 testing process. Those items that have met pre-established criteria may be used in the examination. Computer
 239 technology selects items to administer that match the candidate's ability level. The items, which are stored in a
 240 large item pool, have been The test items, which are stored in a large item pool, are classified by test plan area
 241 and level of difficulty. After the candidate answers each the an item is answered, the computer calculates an
 242 ability-competence estimate based on all earlier answers of the candidate's previous answers. An item
 243 determined to measure the candidate's ability most precisely in the appropriate test plan area is selected and
 244 presented on the computer screen. This process is repeated for each item, creating an examination tailored to
 245 the individual candidate's knowledge and skills while fulfilling all *NCLEX-PN® Test Plan* requirements. The
 246 examination continues with items selected and administered in this way until a pass or fail decision is made.

247 All practical/vocational nurse candidates must answer a minimum of 85 items. The maximum number of
 248 items that a practical/vocational nurse candidate may answer is 205 during a five-hour maximum testing period.
 249 The maximum five-hour time limit to complete the examination includes the tutorial, sample questions and all
 250 breaks. Individuals desiring a copy of this document may download one from the National Council's website:
 251 www.ncsbn.org More information about the NCLEX® examination, including CAT methodology, is listed on the
 252 NCSBN Web site: <http://www.ncsbn.org>.

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Attachment B

Proposed PN/LPN Test Plan – Clean Copy

NCLEX-PN® Test Plan

Test Plan for the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® Examination)

Introduction

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

Several steps occur in the development of the *NCLEX-PN® Test Plan*. The first step is conducting a practice analysis that is used to collect data on the current practice of entry-level practical/vocational nurses (*Report of Findings from the 2003 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* [Smith & Crawford, 2003]). Newly licensed practical/vocational nurses are asked about the frequency and priority of performing more than 150 nursing care activities. The activity statements are then analyzed in relation to the frequency of performance and the impact on maintaining client safety. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes that are fundamental to the practice of nursing. The next step is writing the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are considered in the development of the test plan.

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

Beliefs

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

Nursing is both an art and a science. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and within the environment. The nature of nursing is continually evolving. Nursing



practice is founded on a professional body of knowledge that integrates concepts from the biological, behavioral and social sciences. The goal of nursing is to promote comfort and quality health care. The nurse assists individuals throughout their life spans to attain optimal levels of functioning by responding to the needs, conditions and events that result from actual or potential health problems.

The practical/vocational nurse uses “specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals” (NFLPN, 2003). The practical/vocational nurse uses a clinical problem-solving process (the nursing process) to collect and organize relevant health care data, assist in the identification of the health needs/problems throughout the client’s life span and contribute to the interdisciplinary team in a variety of settings. The entry-level practical/vocational nurse demonstrates the essential competencies needed to care for clients with commonly occurring health problems that have predictable outcomes. “Competency implies knowledge, understanding, and skills that transcend specific tasks and is guided by a commitment to ethical/legal principles” (NAPNES, 2003).

Classification of Cognitive Levels

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

Test Plan Structure

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

Client Needs

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

Safe and Effective Care Environment

- Coordinated Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity

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

Integrated Processes

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

- *Clinical Problem-Solving Process (Nursing Process)* – a scientific approach to client care that includes data collection, planning, implementation and evaluation.
- *Caring* – interaction of the practical/vocational nurse and clients, families, and



significant others in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired therapeutic outcomes.

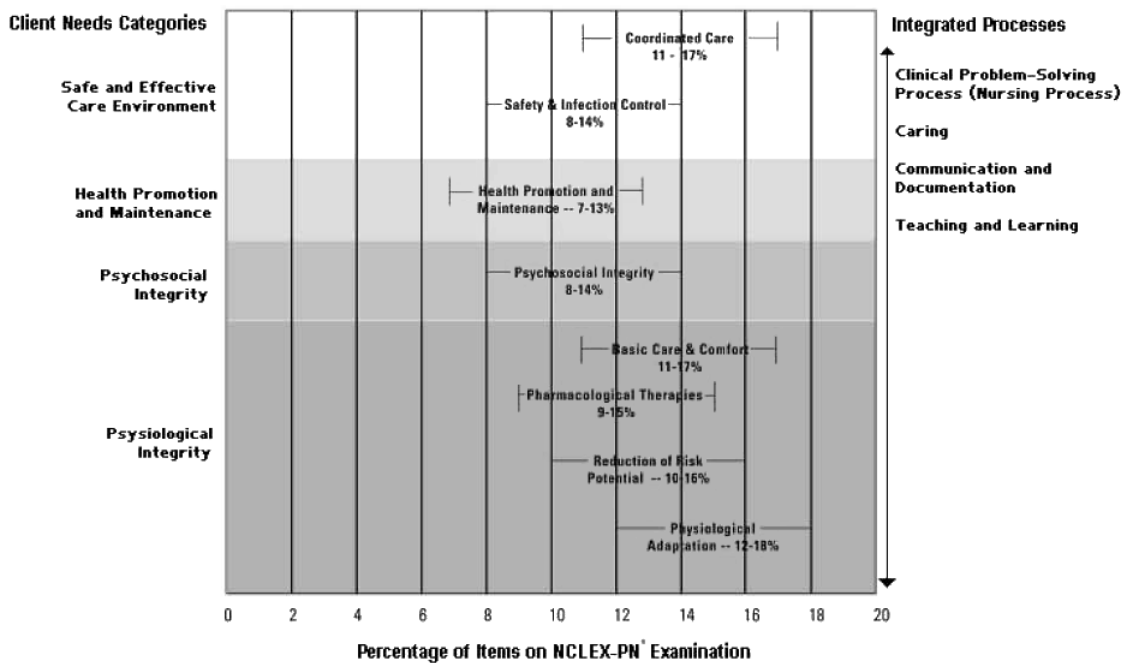
- **Communication and Documentation** – verbal and nonverbal interactions between the practical/vocational nurse and clients, families, significant others and members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- **Teaching and Learning** – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting positive changes in behavior.

Distribution of Content

The percentage of test items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Report of Findings from the 2003 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (Smith & Crawford, 2003), and expert judgment provided by members of the NCSBN Examination Committee.

Client Needs	Percentage of Items from each Category/Subcategory
Safe and Effective Care Environment	
■ Coordinated Care	11-17%
■ Safety and Infection Control	8-14%
Health Promotion and Maintenance	7-13%
Psychosocial Integrity	8-14%
Physiological Integrity	
■ Basic Care and Comfort	11-17%
■ Pharmacological Therapies	9-15%
■ Reduction of Risk Potential	10-16%
■ Physiological Adaptation	12-18%

Distribution of Content for the NCLEX-PN® Test Plan





* Clients are defined as individuals, families and significant others.

Overview of Content

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

Safe and Effective Care Environment

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

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

Related content includes but is **not limited** to:

- Advance Directives
 - Advocacy
 - Client Care Assignments
 - Client Rights
 - Concepts of Management and Supervision
 - Confidentiality
 - Consultation with Members of the Health Care Team
 - Continuity of Care
 - Establishing Priorities
 - Ethical Practice
 - Informed Consent
 - Legal Responsibilities
 - Performance Improvement (Quality Assurance)
 - Referral Process
 - Resource Management
- **Safety and Infection Control** – The practical/vocational nurse contributes to the protection of clients and health care personnel from health and environmental hazards.

Related content includes but is **not limited** to:

- Accident/Error Prevention
- Handling Hazardous and Infectious Materials
- Home Safety
- Injury Prevention
- Internal and External Disaster Plans
- Medical and Surgical Asepsis
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plans
- Standard/Transmission-Based/Other Precautions
- Use of Restraints/Safety Devices

Health Promotion and Maintenance

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

Related content includes but is **not limited** to:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Data Collection Techniques
- Developmental Stages and Transitions
- Disease Prevention
- Expected Body Image Changes
- Family Interaction Patterns
- Family Planning
- Health Promotion/Screening Programs
- High Risk Behaviors
- Human Sexuality
- Immunizations
- Lifestyle Choices
- Self-Care



Psychosocial Integrity

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

Related content includes but is **not limited to**:

- Abuse or Neglect
- Behavioral Interventions
- Behavioral Management
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness
- End of Life Concepts
- Grief and Loss
- Mental Health Concepts
- Mental Illness Concepts
- Religious or Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Substance-Related Disorders
- Suicide/Violence Precautions
- Support Systems
- Therapeutic Communication
- Therapeutic Environment
- Unexpected Body Image Changes

Physiological Integrity

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

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

Related content includes but is **not limited to**:

- Assistive Devices
- Elimination
- Mobility/Immobility
- Nonpharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Palliative/Comfort Care
- Personal Hygiene
- Rest and Sleep

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

Related content includes but is **not limited to**:

- Adverse Effects
- Expected Effects
- Medication Administration
- Pharmacological Actions
- Pharmacological Agents
- Side-Effects

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

Related content includes but is **not limited to**:

- Diagnostic Tests
- Laboratory Values
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests/Treatments/Procedures/Surgery or Health Alterations
- Therapeutic Procedures
- Vital Signs



- *Physiological Adaptation* – The practical/vocational nurse participates in providing care for clients with acute, chronic or life-threatening physical health conditions.

Related content includes but is **not limited** to:

- Alterations in Body Systems
- Basic Pathophysiology
- Fluid and Electrolyte Imbalances
- Medical Emergencies
- Radiation Therapy
- Unexpected Response to Therapies

Administration of the NCLEX-PN® Examination

The NCLEX-PN® Examination is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. An extensive multi-step process is followed in the development of items. Examination items are primarily four-option and multiple-choice. Other types of item formats may include, but are not limited to, multiple response, ordered response, fill-in-the-blank (e.g. calculation) and hotspot. All item formats, including standard multiple-choice, may have charts, tables or graphic images.

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

All practical/vocational nurse candidates must answer a minimum of 85 items. The maximum number of items that a practical/vocational nurse candidate may answer is 205 during a five-hour maximum testing period. The maximum five-hour time limit to complete the examination includes the tutorial, sample items and all breaks. More information about the NCLEX® examination, including CAT methodology, is listed on the NCSBN Web site: <http://www.ncsbn.org>.

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Attachment C

Setting a Performance Standard on the Test of English as a Foreign Language: Defining the Minimum English Language Competencies Necessary for the Job of an Entry-Level Nurse

Final Report Submitted to the National Council of State Boards of Nursing

Chauncey Group International
January 9, 2004

ABSTRACT

The purpose of this study was to arrive at a recommended passing score on the computer-based TOEFL that represented the level of English language proficiency believed necessary to perform important entry-level nursing tasks safely and effectively. Twenty-five experts were selected by NCSBN to participate in the two-day standard-setting (passing-score) study. The *Wainer Method* was implemented for the multiple-choice questions, and the *Examinee Paper Selection Method* was implemented for the essay portion of the TOEFL. The recommended passing score based on the mean judgments of the full group of panelists was 221. The recommended passing score for the cluster of panelists who reported having taken the TOEFL was 218; it was 223 for the cluster of panelists who reported having not taken the TOEFL. Test score information is provided for more than 750,000 examinees that took the computer-based TOEFL in 2001-2002. NCSBN may want to interpret the results of this standard-setting study in light of this information.

INTRODUCTION

The National Council of State Boards of Nursing (NCSBN) has contracted with the Chauncey Group International¹ (CGI) to design and conduct a standard-setting study to establish an NCSBN recommended minimum passing score on the Test of English as a Foreign Language (TOEFL). Defining a legally defensible passing standard and documenting the procedures used to identify that standard have been a hallmark of NCSBN's NCLEX[®] examinations for many years. Given the number of foreign nurses that seek licensure in the United States and that NCSBN has both the resources and the experience to manage the standard-setting process, it would be a benefit to the Member Board jurisdictions to make available a legally defensible passing standard for commonly used English proficiency examinations. An additional benefit to using the NCSBN recommended English proficiency standard is that it would make the examination results portable across all jurisdictions that use the standard.

This passing-score standard reflects the level of English language proficiency, as measured by TOEFL, believed necessary for entry-level nurses to possess in order to be able to perform important nursing responsibilities safely and effectively. It would be recommended that foreign nurse candidates should meet or exceed this standard before

¹The Chauncey Group International is now known as Capstar[™]. However, for this report, the title Chauncey Group International (CGI) will be used.



they would be issued a license. It is important to note that the standard is intended to reflect the minimum level of English proficiency necessary for safe and effective entry-level practice, not the level of proficiency necessary for nurse candidates to take the NCLEX examination. This report documents the methods and results of the standard-setting (passing score) study conducted in Chicago on December 7 and 8, 2003.

PERFORMANCE STANDARDS AND PASSING SCORES

In general, a performance standard reflects a set of values, beliefs, or expectations about the level of competence, proficiency, or readiness necessary to support a desired claim. In terms of occupational testing, a performance standard reflects what an examinee is presumed to need to know and/or be able to do in order to perform important occupational tasks safely and effectively. A passing score is the numerical equivalent of the performance standard; that is, it operationally defines the performance standard in terms of a test score – the minimum score necessary to demonstrate that an examinee has acquired a level of knowledge and/or skill necessary to be a safe and effective practitioner.

A passing score is a function of informed professional judgment. There is no absolute, unequivocal passing score. There is no single “correct” or “true” passing score. A passing score reflects the values of those professionals who participate in its definition and adoption, and different professionals may hold different sets of values. Its determination may be informed by empirical information or data, but ultimately, the passing score is a judgment-based decision.

STANDARD SETTING

A passing score is recommended through a standard-setting process. As noted by the *Standards for Educational and Psychological Testing* (1999), the rationale and procedures for a standard-setting study should be clearly documented. This includes the method implemented, the selection and qualifications of the panelists, and the training provided. With respect to training, panelists should understand the purpose and goal of the standard-setting process (e.g., what classification is being made on the basis of the test score), be familiar with the test, have a clear understanding of the judgments they are being asked to make and have an opportunity to practice making those judgments. The standard-setting process followed in this study is consistent with these guidelines; the context, methods and results of the study are described below.

Context

OBJECTIVE

The objective of the study is to determine the minimum total TOEFL score believed necessary to demonstrate a level of English language proficiency sufficient to perform important nursing responsibilities safely and effectively.

FOCAL GROUP OF EXAMINEES

The focal group of examinees consists of nurse candidates who have been educated outside of the United States and in a language other than English. English is not, therefore, the first or primary language of these candidates. This population likely includes both inexperienced practitioners (those with little or no nursing experience in their native countries) and experienced practitioners; regardless, all will be seeking entrance into the nursing profession in the United States. As a consequence, the minimum level of English language proficiency necessary is being set in the context of entry-level [United States based] practice.



TOEFL EXAMINATION

The TOEFL is an examination designed to assess English language ability in examinees for whom English is not their native language. Although there is also a paper format², the computer-based format is the most widely used (approximately 80%). Because most examinees take the computer-based TOEFL, the test form used in this study is aligned with the computerized specifications³. With the exception of the writing section, all items are dichotomously scored and use a Selected Response (SR) type item format (essentially multiple-choice-question format, although the mechanism for selection can vary a bit and multiple responses are required in some instances). The writing sample is a single prompt that is scored 0-6. Three section-level subscores (0 to 30 points each) and a total TOEFL score (0 to 300 points) are reported. The total TOEFL score is equal to the sum of each section score multiplied by ten-thirds. The three sections are listed below.

1. Listening Comprehension (30 scored SR items administered adaptively)
2. Structure and Written Expression
 - a. 20 scored SR items administered adaptively
 - b. One nonadaptive writing sample (scored 0-6, then weighted to be approximately half of the Structure and Written Expression section)
3. Reading Comprehension (44 scored SR items administered nonadaptively)

Method

Because some sections of the TOEFL are adaptive and the test uses item response theory (IRT) to equate all examinee's performances to a common scale, it was desirable to use a standard-setting procedure that was congruent with adaptive testing and IRT. Such a method was described by Sireci & Clauser (2001), which will be referred to as the *Wainer Method*. The *Wainer Method* (described in the Procedure subsection) essentially asks each standard-setting panelist to respond to a sample of items the way they imagine a minimally competent examinee would. Based upon those responses, a score that reflects each panelist's notion of minimal competence is computed. If the items are already calibrated using IRT, the tests can even be given adaptively because the resulting thetas will all be on the same scale. Therefore, this method permits each panelist to receive either identical or different sets of items. In this way, items can be administered to panelists in a manner similar to how an examinee receives them on an actual test.

ADAPTIVE TESTING

The adaptive sections of the TOEFL (Listening Comprehension and Structure and Written Expression) are targeted to the examinee's current ability estimate. That is, the difficulty level of an item presented to an examinee is dependent on the examinee's response to the immediate previous item and to the other previous items. A correct response to an item, for example, is followed by an item of greater difficulty; an incorrect response is followed by an item of lesser difficulty. In this way, an examinee receives a set of items maximally tailored to his or her overall ability in each of the two adaptive sections.

For this standard-setting study, the items were administered to panelists just as they would be administered to examinees on the TOEFL. More specifically, this means:

- Listening comprehension items were administered adaptively.
- Structure and written expression items (except the writing sample) were administered adaptively.
- The writing sample of the structure and written expression section was not administered. Instead, each panelist selected an example from a set of writing samples that

²The paper format does not have a writing sample component that is incorporated into the total score; however, the results report does have a box for the Test of Written English (TWE) results.

³For the purposes of this study, all subsequent references to TOEFL will refer to the computer-based test.



she believed represented sufficient English language competence.

- Reading comprehension items were administered in a fixed format (nonadaptively).

POWERPREP®

Each panelist had a laptop computer that was preloaded with TOEFL PowerPrep® software. PowerPrep contains two full-length, computer-adaptive editions of the TOEFL, drawing upon a pool of more than 1,200 questions. The software automatically scores all multiple-choice responses to produce a score for each section of the test. The software does not provide a score for the essay portion of the Structure and Written Expression section. The lower bound of the Structure score it does provide assumes no points (zero points) were earned on the essay. Panelists combine this lower-bound Structure score with the essay score they will pick (described below) through the use of a conversion table to produce one score for the Structure and Written Expression section of the TOEFL.

PowerPrep considers difficulty and discrimination parameters of the items presented and the individual panelist's responses to the items (with an adjustment for "guessing") to compute the estimate of the panelist's ability for each of the three sections. For each section, this ability estimate is translated to a raw score on a reference form. For listening comprehension and reading comprehension, these reference form raw scores are then transformed into scaled scores (0 to 30) on the listening comprehension and reading comprehension scales. For structure and written expression, a composite is obtained by combining the reference form raw scores on the structure section and the rating on the essay, with each effectively contributing 50 percent to the composite. This composite score is then transformed into a scaled score on the 0 to 30 structure and writing scale. Finally, a total score (0 to 300) for the panelist is obtained by summing the three sections' scaled scores and multiplying this sum by ten-thirds, effectively allowing each section scaled score to contribute equally to the total scaled score.

PANEL OF JUDGES

Twenty-five experts served on the standard-setting panel (see Table 1 and Appendix A). These experts, all female, were recruited by NCSBN to represent a range of professional perspectives and experiences. Nine of the panelists self-reported being nurses who were educated internationally and had also taken the TOEFL. Seven panelists reported being nurses who work with clients who speak languages other than English. Five panelists reported being clinical supervisors of nurses who speak a primary language other than English. Four reported being a nursing regulator, nursing educator, or public member (two of the four reported having had taken the TOEFL). Seven panelists reported having five or fewer years of experience, three reported having between 6 and 10 years of experience, six reported having between 11 and 20 years, and five reported having more than 20 years. Collectively, 18 jurisdictions were represented on the panel: Arkansas; California; Washington, D.C.; Florida; Georgia; Hawaii; Iowa; Illinois; Kansas; Louisiana; Massachusetts; Minnesota; New Jersey; North Carolina; Ohio; Oregon; Texas and Virginia.

Procedure

PANELIST ORIENTATION AND TRAINING

The purpose of the panelist orientation and training was to familiarize the panelists with the overall goal of the study and standard-setting process that would be followed. Through a series of steps, described below, the panelists were calibrated to a shared understanding of the focal group of examinees who would be taking the TOEFL; the core tasks that all entry-level nurses, regardless of practice setting, need to be able to perform; the concept and definition of a nurse candidate with sufficient English language skills to perform these tasks safely and effectively; and the judgment process used to arrive at the recommended passing-score standard for the TOEFL.



Panelists were first provided with an overview of the purpose of the study and a definition of a passing score, as applied to the current purpose. A passing score was stated to reflect the level of English language proficiency believed necessary for entry-level nurses to possess in order to be able to perform important nursing tasks safely and effectively. It was clarified that the passing score was not the level of English language proficiency necessary to take the NCLEX[®] examination – the focus of the study was on the job. The panelists were then led through an overview of the TOEFL computer-based test and the general process that was to be followed in arriving at the recommended passing score. (The initial agenda for the study is included in Appendix A. Training for the multiple-choice questions occurred on Day 1 and for the essay portion of the Structure and Written Expression section on Day 2. For ease of presentation, they are described jointly below.)

The first major event of the training process required the panel to define, through consensus, core tasks that all entry-level nurses needed to perform, regardless of their practice setting. As the focus of the study was on benchmarking the level of English language proficiency necessary to perform the job, it was important to come to a consensus on an agreed upon definition of job tasks. The panel was assembled into two groups and worked independently for approximately 30 minutes to define approximately 10 important tasks for entry-level nurses; each group recorded their task list on flipchart paper. The two groups then reassembled and a whole group discussion followed whereby the final task list was defined. Table 2 lists the agreed upon nursing tasks⁴. This list was posted for all to see and served as a frame-of-reference for the subsequent standard-setting judgments.

The panelists were then led through a discussion of the focal group of examinees who would be taking the TOEFL, and through a discussion of the one examinee from among that focal group who would be the specific target of their standard-setting judgments. The larger focal group was defined as nurse candidates who were educated outside the United States and in a language other than English; as such, their primary or first language is not English. The members of the focal group were also defined as first seeking entrance into the nursing profession in the United States, regardless of their nursing experience internationally, and so an entry-level expectation was appropriate. Consistent with the Wainer Method, it was necessary for the panelists to concentrate on one member of the focal group whose level of English language proficiency defined the boundary, in their expert judgment, between just sufficient to perform the job (the tasks the panel defined) safely and effectively, and not sufficient enough to perform the job safely and effectively. In other words, the panelists were to think of a single examinee who had just enough English language skills to perform entry-level nursing tasks safely and effectively. It was also discussed that while this examinee may be stronger in certain English language skills than in others, overall, this examinee is proficient enough in English to perform the job. Panelists were reminded that the focus was not on the examinee's nursing knowledge or skill, only on their English language skills.

Panelists were then provided with an overview of the basic standard-setting-judgment process. They were informed that they would each be taking the computer-based TOEFL-responding to each of the questions. However, they were to respond as if they were the one examinee, from among the focal group, who had just enough English language skills to perform the job of an entry-level nurse safely and effectively. In other words, they were asked to respond to each question, as they believe this examinee would.

For the multiple-choice questions (all questions except for the writing sample portion of the Structure and Written Expression section), this meant that if they believed that the level of English tapped by a question was consistent with the level of English language skill possessed by this examinee, they were to select what they considered to be the correct answer. If, on the other hand, they believed that the level of English tapped by a question was beyond the English skill possessed by this examinee, they were to select any one of the incorrect answers. For the writing sample, a slightly different judgment process

⁴The wording of the tasks was slightly modified for this report without altering task meaning.



was to be followed. The essay is scored using a rubric that ranges in value from 0 to 6 points; there is no one correct answer. For this type of question, panelists were asked to read the rubric descriptions (the elements of what constituted each point on the rubric) and to read sample essay responses that corresponded to each point on the rubric. They were then asked to pick the response that, in their expert judgment, reflected the response of the single examinee with just enough English language skills to perform the job of an entry-level nurse safely and effectively. Hambleton, Jaeger, Plake, and Mills (2000) refer to this basic process as the *Examinee Paper Selection Method*. Operationally, an examinee's essay response is scored by two assessors and an average of the two scores equals the score earned by an examinee; panelists were able to pick half points. If a panelist believed, for example, that a score of between 3 and 4 points best reflected the performance of this examinee, the panelist could pick 3.5 as the essay score.

PANELIST JUDGMENTS

Panelists rendered their item-level judgments for each section of the TOEFL before proceeding onto the next section. On day one, panelists completed their first round of judgments for the listening section and then for the structure portion of the structure and written expression section. On day two, panelists completed their first-round judgments for the reading section and for the essay portion of the structure and written expression section. The essay score and the lower bound score associated with the Structure portion were combined to form one structure and written expression score using a conversion table (see Table 3).

Also on day two, panelists were given the opportunity to change their first-round judgments for each section. Once all the first-round judgments were complete, and each panelist's section score was available, a whole group discussion occurred, whereby panelists shared their thoughts and rationales for their independent judgments. Based on this discussion, each panelist was given the opportunity to change her section scores. These second-round judgments were accepted as the final section scores, and each panelist's recommended total TOEFL passing score was computed from these second-round section scores.

Before making their first-round standard-setting judgments for each multiple-choice section of the TOEFL, panelists were given an opportunity to practice making judgments on five sample questions from that section from a previously administered paper version of the TOEFL. The edition chosen had been administered to more than 750,000 examinees in 1997-1998. For each sample question, each panelist was asked to note what she thought the correct answer was, whether or not the one examinee with just enough English language skills to perform the job of an entry-level nurse would know the correct answer, and whether she thought the English language skills tapped by the item was easy, of medium difficulty, or hard. Once each panelist noted their responses, a whole group discussion occurred whereby panelists were asked to share their item-level decision rationales. After the discussion of each item, the correct answer was revealed, as was the proportion of 1997-1998 examinees who chose the correct answer, and whether the item would be classified as being easy, of medium difficulty, or hard, based on the proportion of 1997-1998 examinees who had answered it correctly. (The rule of thumb used in this latter classification was if 70% or more answered it correctly, the item was easy, if 30% or less answered it correctly, it was hard, and if between 40% and 60% answered it correctly, it was of medium difficulty.) The practice session helped to calibrate the panelists and make explicit the diversity of relevant professional perspectives reflected by the panel. The panelists, as expected, varied somewhat in their judgments regarding whether the one examinee with just enough English language skills to perform the job of an entry-level nurse would know the correct answer; but all successfully identified the correct answer, and agreed for the most part in their item difficulty classifications.



The first practice opportunity was for the Listening section of the TOEFL, as that was the first section presented by the PowerPrep® software. Following the listening section practice, the panelists completed a one-time PowerPrep® tutorial. The tutorial enabled the panelists to become familiar with the laptop and how to navigate the software including setting the volume for the listening section, responding to items, scrolling, and quitting the test and getting back into the test. Following the tutorial, panelists were asked to complete a training evaluation form. The form requested each panelist to indicate if she had received adequate training to begin making her consequential standard-setting judgments or if additional training was necessary. All panelists signed-off on the adequacy of the training received.

Panelists then proceeded to render their first-round standard-setting judgments for the listening section. Each panelist was asked to respond to two items, as if she was the one examinee with just enough English language proficiency to perform the job of an entry-level nurse (as exemplified by the list of tasks previously defined) safely and effectively. Once two items were completed, they were asked to quit the test. A whole group discussion then occurred to get a sense of how difficult the panelists believed the questions were for this examinee. Although panelists likely encountered different items, as the listening section is adaptive, the discussion was helpful to bring to light the relevant perspectives of the panelists. After the discussion, panelists completed all their remaining first-round items for the listening section of the TOEFL⁵. This process of practice (first on paper-based sample items and then on actual section items) followed by completion of first-round judgments was next implemented for the structure portion of the structure and written expression section on day one, and then implemented for the reading section on day two. Before each section, panelists were reminded to respond as if they were the examinee with just enough English language skills to perform the job of an entry-level nurse safely and effectively.

As noted previously, for the essay portion of the structure and written expression section, panelists read the scoring rubric and a sample essay corresponding to each rubric score point and then selected the point on the rubric (either a whole number between 0 and 6 or a half-point interval, for example, 1.5, 2.5, 3.5, etc.) that best represented the response of the examinee with just enough English language skills to perform the job of an entry-level nurse safely and effectively. Panelists, consistent with the multiple-choice-based judgments made first-round, and, following whole group discussion, second-round essay judgments.

Each panelist recorded her second-round judgments and then computed her recommended TOEFL passing score by summing the three section scores (listening, structure and written expression, and reading) and multiplying the sum by ten-thirds. (Each panelist was provided with a calculator to facilitate the computation.)

Results

The first-round judgments and second-round judgments are presented in a series of tables (Tables 4 through 9). For each set of judgments (first and second round) section-level judgments are presented and total TOEFL scores are presented. (First-round total TOEFL scores were computed by CGI for this report.) Basic summary statistics, across panelists, for the total TOEFL recommended passing score – mean (truncated), median (truncated), standard deviation, and minimum and maximum values – are also presented. Tables 4 and 5 display the first- and second-round judgments, respectively, for all 25 panelists. Table 6 displays the judgments for the 11 panelist who reported having had taken the TOEFL. Table 7 displays the judgments for the 14 panelists who reported not having taken the TOEFL. Finally, Tables 8 and 9 provide first- and second-round comparisons for these three

⁵During the discussion of the first two questions in the Listening section, it became apparent that not all panelists assumed the role of the target examinee. All panelists were consequently reminded to "role play" accordingly and asked to redo their Listening judgments.



clusters of panelists.

SUMMARY OF RESULTS TABLES

Tables 8 and 9 will be discussed, as they present the most concise data synopsis of results. The results are reproduced below in Table 10 in a slightly different form for ease of discussion. The maximum total computer-based TOEFL score obtainable is 300 points, and the minimum is 0 points. As illustrated in Table 10, the first-round judgments, expressed as truncated means and truncated medians, are consistent across the three clusters of panelists, with the values ranging from 212 to 216. The values for the second-round (final) judgments, which occurred after whole group discussion, increased in all instances – the recommended passing score, whether based on the mean or median increased. This was expected, as the discussion of the first-round section-level judgments served to highlight the critical role of the nurse in patient care, and the panel's low tolerance for mistakes or errors on the job due to less than adequate English language skills. While the mean and median values increased, the variability (standard deviation) of the panelists' judgments decreased post-discussion, indicating a greater degree of panelist consensus. This too, was expected, as previous research (Hurtz & Auerbach, 2003) indicates that group discussion of standard-setting judgment results in reduced variability in panelist judgments and higher mean values.

Considering the all-panelist cluster as the primary decision-making group, the recommended passing score for the TOEFL, based on the truncated mean is 221. (The truncated median value of 223 is only marginally higher.) The results change somewhat when the judgments are disaggregated by whether panelists took the TOEFL or not. The mean-based passing score recommended by the cluster of panelists who reported having had taken the TOEFL decreases to 218, but increases to 223 for the cluster who reported having not had taken the TOEFL. (Although displaying a greater range, the median values follow the same pattern—lower median-based passing score for the cluster that reported having had taken the TOEFL, and higher score for the cluster that reported having not had taken the TOEFL.)

Table 10

First- and Second-Round Judgments by Panelist Cluster

Panelist Cluster	Round 1			Round 2		
	Mean	Median	SD	Mean	Median	SD
All panelists (n=25)	212	216	22.77	221	223	15.74
Took TOEFL (n=11)	213	213	21.01	218	220	13.73
Did not take TOEFL (n=14)	212	216	24.07	223	228	16.88

Note. Mean and median values are truncated.

Conclusion

The purpose of this study was to arrive at a recommended passing score on the TOEFL that represented the level of level of English language proficiency believed necessary to perform important entry-level nursing tasks safely and effectively. Twenty-five experts were selected by NCSBN to participate in the two-day standard-setting (passing score) study. The *Wainer Method* was implemented for the multiple-choice questions, and the *Examinee Paper Selection Method* was implemented for the essay portion of the TOEFL.

The recommended passing score based on the mean judgments of the full group of panelists was 221. The recommended passing score for the cluster of panelists who reported having had taken the TOEFL was 218; and it was 223 for the cluster of panelists who reported having not had taken the TOEFL. NCSBN may want to interpret these results in light of recent (2001-2002) test score information for the computer-based TOEFL.

Table 11 summarizes the test score information for all 2001-2002 examinees, as well as for those examinees who reported that they were taking the test to become licensed to



practice their chosen profession; therefore, this group is more similar to focal group of internationally educated nurses in this study than would likely be the total 2001-2002 examinee pool. This subset of examinees seeking a professional license was then disaggregated by sex to further align the test score information with the focal group of nursing candidates, who are likely to consist more of females than males.

Table 11: Computer-based TOEFL Score Information: 2001-2002 Administration

Examinee Cluster	Mean	SD
All examinees (n=572,394)	214	47
Examinees for professional license (n=34,721)	229	42
Examinees for professional license: Female (n=21,187)	225	40
Examinees for professional license: Male (n=13,283)	235	44

Note. Numbers of examinees are based on those who responded to a question about their group membership.

The all-panel, mean-based recommended passing score for this study (221) is higher than the mean examinee score achieved in 2001-2002 (214). The recommended passing score, however, is lower than the mean scores achieved by all examinees in 2001-2002 who reported seeking a professional license (229) and by the subset of female examinees seeking a professional license (225).

These data are presented for comparison purposes, which NCSBN may chose to take into consideration as it decides on its final recommended passing score. As these data merely describe the test performance of the examinees who took the TOEFL during the 2001-2002 administration, they do not, necessarily, offer a more accurate source of information than that provided by the judgments of the expert panel. It is unknown, for example, which particular professions the examinees were seeking a license to practice or which examinees eventually achieved their professional license. The data are useful, nonetheless, to help NCSBN frame discussions regarding the results of the standard-setting (passing score) study.

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**Table 1: Panel Demographics****25 PANELISTS**

	Number	Percent
Gender		
Female	25	100%
Panelist Selection Criteria		
Eligibility Criteria 1: Nurses who have taken the TOEFL	9	36%
Eligibility Criteria 2: Nurses who work with clients who speak a primary language other than English	7	28%
Eligibility Criteria 3: Clinical supervisors of nurses who speak a primary language other than English	5	20%
Eligibility Criteria 4: Nursing regulators, Nursing Educators, or Public Members	4	16%
Years of Nursing Experience		
1 to 5 Years	7	28%
6 to 10 Years	3	12%
11 to 15 Years	3	12%
16 to 20 Years	3	12%
More than 20 Years	5	20%
No Response	4	16%
Panelists Who Took TOEFL Test		
Yes	11	44%
No	14	56%
States Represented (see text for the list of states)	18	

Table 2: List of Nursing Tasks

Taking Patient History	Implementing Safety Practices
Conducting Patient Assessment	Delegating
Completing Documentation	Communicating
Educating/Training Patients	Providing Client Service
Taking Orders	Prioritizing Responsibilities
Reporting	

**Table 3: Conversion Table for Structure and Writing Scores**

		WRITING SCORE												
		0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6
MINIMUM STRUCTURE SCORE	0	0	2	3	5	7	8	10	11	13	15	17	18	20
	1	1	3	4	6	8	9	11	13	14	16	18	19	21
	2	2	4	5	7	9	10	12	14	15	17	19	20	22
	3	3	5	6	8	10	11	13	15	16	18	20	21	23
	4	4	6	7	9	10	12	14	16	17	19	21	22	24
	5	5	7	8	10	11	13	15	17	18	20	22	23	24
	6	6	8	9	11	13	14	16	18	19	21	22	24	25
	7	7	9	10	12	14	15	17	19	20	22	23	25	26
	8	8	10	11	13	15	16	18	20	21	23	24	25	26
	9	9	11	12	14	16	17	19	21	22	24	25	26	27
	10	10	12	13	15	17	18	20	22	23	24	26	27	28
	11	11	13	14	16	18	19	21	23	24	25	26	28	28
	12	12	14	15	17	19	20	22	23	25	26	27	28	29
	13	13	14	16	18	20	21	23	24	25	26	28	28	30

**Table 4: Round 1 Judgments for All Panelists**

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
P1	22	12	3.5	19	23	213.33
P2	22	10	4	26	23	236.67
P3	18	6	5	24	22	213.33
P4	24	9	5	23	25	240.00
P5	25	11	4	24	24	243.33
P6	24	6	3.5	23	18	216.67
P7	16	6	4	22	19	190.00
P8	15	2	4	19	15	163.33
P9	17	11	5	24	26	223.33
P10	13	7	3.5	22	19	180.00
P11	25	12	3	20	22	223.33
P12	10	6	4	24	19	176.67
P13	24	13	4.5	25	26	250.00
P14	23	9	4	19	22	213.33
P15	23	10	4	19	23	216.67
P16	20	10	3.5	24	22	220.00
P17	22	8	4	24	21	223.33
P18	21	3	4	18	16	183.33
P19	22	8	3.5	19	20	203.33
P20	22	9	4	21	22	216.67
P21	22	5	4	16	18	186.67
P22	26	13	3.5	21	24	236.67
P23	24	5	4.5	18	20	206.67
P24	20	11	3	19	21	200.00
P25	24	12	4	25	25	246.67
Mean (truncated)	20	8	3	21	21	212
Median (truncated)	22	9	4	22	22	216
Standard Deviation	3.94	3.02	0.53	2.70	2.87	22.77
Minimum	10	2	3	16	15	163.33
Maximum	26	13	5	26	26	250.00

**Table 5: Round 2 Judgements for All Panelists**

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
P1	20	8	4	20	21	203.33
P2	22	10	4	23	23	226.67
P3	26	9	5	26	25	256.67
P4	24	9	4	22	22	226.67
P5	22	10	4.5	21	24	223.33
P6	24	10	3.5	23	22	230.00
P7	20	6	4	22	19	203.33
P8	24	8	4	20	21	216.67
P9	20	11	4.5	24	25	230.00
P10	18	8	3.5	22	20	200.00
P11	20	9	3.5	20	21	203.33
P12	15	7	4	24	20	196.67
P13	23	11	4	23	24	233.33
P14	23	9	4.5	22	24	230.00
P15	21	10	4.5	20	24	216.67
P16	20	10	4.5	24	24	226.67
P17	22	10	4.5	24	24	233.33
P18	25	9	4	25	22	240.00
P19	21	8	3.5	19	20	200.00
P20	22	8	4	21	21	213.33
P21	22	9	4	22	22	220.00
P22	26	11	3.5	25	23	246.67
P23	22	10	3.5	20	22	213.33
P24	20	8	3.5	20	20	200.00
P25	22	11	4	25	24	236.67
Mean (truncated)	21	9	4	22	22	221
Median (truncated)	22	9	4	22	22	223
Standard Deviation	2.40	1.29	0.41	1.95	1.73	15.74
Minimum	15	6	3.5	19	19	196.673
Maximum	26	11	5	26	25	256.67



Table 6: Round 1 and Round 2 Judgements for Panelists Who Have Taken the TOEFL – 11 Panelists

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
Round 1 Judgement						
P1	22	12	3.5	19	23	213.33
P2	24	9	5	23	25	240.00
P3	25	11	4	24	24	243.33
P4	16	6	4	22	19	190.00
P5	10	6	4	24	19	176.67
P6	23	9	4	19	22	213.33
P7	20	10	3.5	24	22	220.00
P8	22	9	4	21	22	216.67
P9	22	5	4	16	18	186.67
P10	26	13	3.5	21	24	236.67
P11	24	5	4.5	18	20	206.67
Mean (truncated)	21	8	4	21	21	213
Median (truncated)	22	9	4	21	22	213
Standard Deviation	4.39	2.67	0.43	2.59	2.23	21.01
Minimum	10	5	3.5	16	18	176.67
Maximum	26	13	5	24	25	243.33
Round 2 Judgment						
P1	20	8	4	20	21	203.33
P2	24	9	4	22	22	226.67
P3	22	10	4.5	21	24	223.33
P4	20	6	4	22	19	203.33
P5	15	7	4	24	20	196.67
P6	23	9	4.5	22	24	230.00
P7	20	10	4.5	24	24	226.67
P8	22	8	4	21	21	213.33
P9	22	9	4	22	22	220.00
P10	26	11	3.5	25	23	246.67
P11	22	10	3.5	20	22	213.33
Mean (truncated)	21	8	4	22	22	218
Median (truncated)	22	9	4	22	22	220
Standard Deviation	2.68	1.40	0.33	1.56	1.60	13.73
Minimum	15	6	3.5	20	19	196.67
Maximum	26	11	4.5	25	24	246.67

**Table 7: Round 1 and Round 2 Judgements for Panelists Who Have Not Taken the TOEFL – 14 Panelists**

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
Round 1 Judgement						
P1	22	10	4	26	23	236.67
P2	18	6	5	24	22	213.33
P3	24	6	3.5	23	18	216.67
P4	15	2	4	19	15	163.33
P5	17	11	5	24	26	223.33
P6	13	7	3.5	22	19	180.00
P7	25	12	3	20	22	223.33
P8	24	13	4.5	25	26	250.00
P9	23	10	4	19	23	216.67
P10	22	8	4	24	21	223.33
P11	21	3	4	18	16	183.33
P12	22	8	3.5	19	20	203.33
P13	20	11	3	19	21	200.00
P14	24	12	4	25	25	246.67
Mean (truncated)	20	8	3	21	21	212
Median (truncated)	22	9	4	22	21	216
Standard Deviation	3.53	3.27	0.59	2.71	3.28	24.07
Minimum	13	2	3	18	15	163.33
Maximum	25	13	5	26	26	250
Round 2 Judgment						
P1	22	10	4	23	23	226.67
P2	26	9	5	26	25	256.67
P3	24	10	3.5	23	22	230.00
P4	24	8	4	20	21	216.67
P5	20	11	4.5	24	25	230.00
P6	18	8	3.5	22	20	200.00
P7	20	9	3.5	20	21	203.33
P8	23	11	4	23	24	233.33
P9	21	10	4.5	20	24	216.67
P10	22	10	4.5	24	24	233.33
P11	25	9	4	25	22	240.00
P12	21	8	3.5	19	20	200.00
P13	20	8	3.5	20	20	200.00
P14	22	11	4	25	24	236.67
Mean (truncated)	22	9	4	22	22	223
Median (truncated)	22	9	4	23	22	228
Standard Deviation	2.14	1.12	0.46	2.19	1.80	16.88
Minimum	18	8	3.5	19	20	200
Maximum	26	11	5	26	25	256.67



**Table 8: Round 1 Judgements
Summary of Panelist Clusters**

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
All Panelists (25 Panelists)						
Mean (truncated)	20	8	3	21	21	212
Median (truncated)	22	9	4	22	22	216
Standard Deviation	3.94	3.02	0.53	2.70	2.87	22.77
Minimum	10	2	3	16	15	163.33
Maximum	26	13	5	26	26	250.00
Panelists Who Took the TOEFL (11 Panelists)						
Mean (truncated)	21	8	4	21	21	213
Median (truncated)	22	9	4	21	22	213
Standard Deviation	4.39	2.67	0.43	2.59	2.23	21.01
Minimum	10	5	3.5	16	18	176.67
Maximum	26	13	5	24	25	243.33
Panelists Who Did Not Take the TOEFL (14 Panelists)						
Mean (truncated)	20	8	3	21	21	212
Median (truncated)	22	9	4	22	21	216
Standard Deviation	3.53	3.27	0.59	2.71	3.28	24.07
Minimum	13	2	3	18	15	163.33
Maximum	25	13	5	26	26	250



**Table 9: Round 2 Judgements
Summary of Panelist Clusters**

	Listening (0-30)	Structure (0-13)	Writing (0-6)	Reading (0-30)	Structure/ Writing	Total (0-300)
All Panelists (25 Panelists)						
Mean (truncated)	21	9	4	22	22	221
Median (truncated)	22	9	4	22	22	223
Standard Deviation	2.40	1.29	0.41	1.95	1.73	15.74
Minimum	15	6	3.5	19	19	196.67
Maximum	26	11	5	26	25	256.67
Panelists Who Took the TOEFL (11 Panelists)						
Mean (truncated)	21	8	4	22	22	218
Median (truncated)	22	9	4	22	22	220
Standard Deviation	2.68	1.40	0.33	1.56	1.60	13.73
Minimum	15	6	3.5	20	19	196.67
Maximum	26	11	4.5	25	24	246.67
Panelists Who Did Not Take the TOEFL (14 Panelists)						
Mean (truncated)	22	9	4	22	22	223
Median (truncated)	22	9	4	23	22	228
Standard Deviation	2.14	1.12	0.46	2.19	1.80	16.88
Minimum	18	8	3.5	19	20	200
Maximum	26	11	5	26	25	256.67



APPENDIX A

STANDARD-SETTING PANEL PARTICIPANTS

Kathleen Carlyle	Sibley Hospital
Shu-Chen Jennie Cheng	The Permanente Medical Group
Shelba Durston	San Joaquin Delta College and San Joaquin General Hospital
Chinyere Connie Ekenna	Duke University Hospital
Jacqueline Fernandez	Oregon Health and Sciences University
Laarni C. Florencio	St. Lucie Medical Center
Alia Fouz	Ohio Health; Riverside Methodist Hospital
Alba C. Gier	Salina Regional Health Center
Lorna Hermogino-Garcia	Providence Alaska Medical Center
Mercelita L. Ibarra	Bethel Lutheran Homes
Lorinda Inman	Iowa Board of Nursing
Diana Ruegilin Machado	Hilo Medical Center
Irisan F. Manalo	Marion County School System
Louellyn Monera	University of California, San Diego
Anh Kim Nguyen-Woods	Craig Home Care
Justina Ozioma Obi	Westbay Rehab and Healthcare
Villarosa Buctuan Pareja	Lake Cook Health Care Center
Navid Sabati	United Hospital
Lorinda J. Sealey	Southeastern Louisiana School of Nursing
Louise Shores	Oregon State Board of Nursing
Elena Sierra	Brigham and Women's Hospital
Linda A. Tjiong	Maryview Medical Center, Bon Secours Health System, Inc.
Maricella L. Vara	Texas Children's Hospital
Sarah Vázquez	Houghton Mifflin Company
Maria Elena Zapata	Maria Elena Zapata Family Practice Center



STANDARD-SETTING AGENDA¹

Day 1

8:00 - 8:30 am	Breakfast
8:30 - 9:00 am	Introductions
9:00 - 9:45 am	Overview of study and TOEFL
9:45 - 10:30 am	Define focal group of candidates and important core nursing tasks
10:30 - 10:45 am	Break
10:45 - 11:15 am	Standard-setting training: Overview
11:15 am - 12:15 pm	Standard-setting training: Practice judgments (Listening items)
12:15 - 1:15 pm	Lunch
1:15 - 1:45 pm	Familiarization with TOEFL PowerPrep software
1:45 - 2:45 pm	Standard-setting judgments on Listening items
2:45 - 3:00 pm	Break
3:00 - 3:45 pm	Standard-setting training: Practice judgments (Structure items)
3:45 - 4:30 pm	Standard-setting judgments on Structure items
4:45 pm	Wrap up for the day and adjourn

Day 2

8:00 - 8:30 am	Breakfast
8:30 - 8:45 am	Recap of previous day
8:45 - 9:30 am	Standard-setting training: practice judgments (reading items)
9:30 - 11:00 am	Standard-Setting judgments on reading items
11:00 - 11:15 am	Break
11:15 am - 12:15	Training and standard-setting judgments on writing component
12:15 - 1:15 pm	Lunch
1:15 - 1:45 pm	Panelists compute individual recommended TOEFL score
1:45 - 2:00 pm	Break
2:00 - 3:30 pm	Discussion and final standard-setting judgments
3:30 - 4:00 pm	Wrap up
4:15 pm	Adjourn

¹This reflects the initial agenda. The tasks outlined in this agenda did not differ from the tasks of the operational study agenda, but the times or timing of the tasks may have varied for the operational agenda. For example, the study was completed at approximately 2:00 pm on Day 2.

**ATTACHMENT D**

Criteria for the Evaluation of International Administration Locations

The following criteria have been accepted and approved by the NCSBN Board of Directors in fulfillment of the 2002 Delegate Assembly resolution regarding the selection of international administration locations for the NCLEX examinations. The Examination Committee will use the following approved criteria to evaluate locations, including NAFTA countries, for initial international administration of the NCLEX examinations:

- **National Security.** The Examination Committee will only consider locations that have favorable reports regarding security and economic climate from the U.S. Department of State (www.state.gov).
- **Examination Security (Replication of Current Pearson Professional Centers).** Because of the high security and administration standards required for the NCLEX Examination, only locations where Pearson VUE can build, staff and replicate current Pearson Professional Centers (the same as in current member board jurisdictions) will be considered.
- **Similarity with U.S. Intellectual Property and Copyright Laws.** The Examination Committee will select countries for initial consideration that are generally regarded by the U.S. government and industry as areas that minimize risk for new business ventures.
- **Pearson Locations with High Stakes Testing.** The Examination Committee will consider the experiences of other high stakes testing programs and test service in international markets. Reliability of service and security were the primary measures under consideration. Currently Pearson VUE delivers high-stakes examinations in 123 countries through 3500+ VUE authorized centers. Approximately 50% of all Pearson's electronic testing volume comes from outside the U.S.
- **Numbers and Locations of Internationally Educated Nurses (2003 NCLEX Candidate Volume).** The Examination Committee will consider favorably individual countries and regions with traditionally high NCLEX candidate volume.
- **Regional Accessibility.** The Examination Committee will chose initial center locations that will serve broad, regional candidate volume needs. Not all countries with high candidate volume can be considered for initial launch due to the inability to rate highly on all criteria, hence the need for convenient alternative regional locations.
- **Number of U.S. Military Personnel and Dependents.** The committee will consider potential demand for NCLEX examination administration by U.S. Military personnel and dependents as part of the administration locations decisions.
- **Similarity to U.S. Nursing Educational Systems.** The Committee will consider locations with candidates who have similarities in preparation with candidates from U.S. educational systems.



ATTACHMENT E

Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®)

This report represents Pearson VUE's first complete year (calendar 2003) of providing test delivery service for the NCLEX® examination program to the National Council of State Boards of Nursing (NCSBN). This report summarizes the activities of the past year (last year's report covered the period from January through December 2002).

Pearson Professional Testing Organizational Change

As we saw last year in the dynamic environment of the testing business, there were a few organizational changes at Pearson VUE again this year. Marilyn Martin, who has been the NCLEX Program Manager since the contract was signed, will be changing roles to help launch another large professional client for Pearson VUE. Kim Clausen, who many of you have worked with in her previous role of Assistant Program Manager, has been promoted to Program Manager for the NCLEX. Additionally, Heidie Santiago, who also worked on the program as NCLEX Associate Program Manager, has been brought back to the program and has also been promoted to Program Manager for the NCLEX. Their hands-on experience with the NCLEX and extensive knowledge of Pearson VUE's processes and technology makes the pairing of these two a very strong, well-balanced Program Management team for the NCLEX.

Test Development

The NCLEX Test Development group at Pearson VUE remains fully committed to support the NCLEX examination program's psychometric and test development needs. The item development process continues on pace to produce the items expected in our contract. In addition to continuing the development of multiple-choice items, we are well into the creation, revision and review of items in alternate formats; we began pretesting the alternate items in mid-2003 and anticipate first live delivery during the October 2004 examination release cycle. Psychometric and statistical analyses of the NCLEX examination data continue to be conducted and documented as expected.

NCLEX® Examination Operations

NCLEX candidates have been able to schedule appointments within 30 days (or 45 days for repeaters) as specified in the NCLEX Test Services contract; any deviations have been reported to NCSBN in a timely way. Pearson VUE added an additional Pearson Professional Center (PPC) in Manhattan, New York with 45 seats, increasing the number of PPC to 202 total. Pearson VUE also added an additional 15 seats in the Saipan PPC, for a total of 19 seats.

PEARSON VUE STAFF VISITS TO NCSBN

- November 5-7, 2003(Examination Committee Business Meeting)
- January 28-30, 2004 (Examination Committee Business Meeting)
- March 10-12, 2004 (Joint Research Committee)
- March 17-19, 2004(Item Review Subcommittee Meeting)
- April 26-28, 2004 (Examination Committee Business Meeting)



Summary of NCLEX Examination Results for the 2003 Testing Year

Summary statistics for the NCLEX examination program are provided in Tables 1-8 below. Tables 1-4 present NCLEX-RN® examination data; Tables 5-8 present NCLEX-PN® examination data. We have included data from the 2002 testing year also to provide a basis of comparison to identify trends in candidate performance and item characteristics over time (Tables 2, 4, 6, 8). Test level data are presented in Tables 1 and 2 for the NCLEX-RN examination and Tables 5 and 6 for the NCLEX-PN examination. Item level data are presented in Tables 3 and 4 for the NCLEX-RN and Tables 7 and 8 for the NCLEX-PN.

The following present candidate highlights of the 2003 testing year for the NCLEX-RN examination:

- Overall, 124,737 NCLEX-RN examination candidates tested during 2003, as compared to 113,420 during the 2002 testing year. This represents an increase of about 10%.
- The candidate population reflected 76,719 first-time, U.S.-educated candidates who tested, as compared to 70,970 for the 2002-testing year, representing an increase of 8.1%.
- The 2003 average passing rate for the total group and reference group were slightly higher than in 2002. The overall passing rate was 71.1% in 2003 compared to 70.9% in 2002. The passing rate for the reference group was 87.0% in 2003 as compared to 86.6% in 2002.
- Of the total group 47.5% and 51.2% of the reference group ended their tests after a minimum of 75 items were administered. This is lower than for the 2002-testing year in which 49.4% of the total group and 53.4% of the reference group took minimum length exams.
- The percentage of maximum length test takers was 13.8% for the total group and 12.7% for the reference group. This is somewhat higher than last year's percentages (12.7% for the total group and 11.4% for the reference group).
- The average time needed to take the NCLEX-RN examination during the 2003 testing period was 2.3 hours (two hours, 18 minutes) for the overall group, and 2.0 hours for the reference group.
- A total of 49.2% of the candidates chose to take a break during their exam.
- Overall, 3.8% of the total group, and 1.8% of the reference group ran out of time before completing the test. These percentages of candidates timing out were slightly lower than the overall cumulative percentages for candidates during the 2002 testing year.
- In general, the NCLEX-RN examination summary statistics for the 2003 testing period indicated patterns that were similar to those observed for the 2002 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following present candidate highlights of the 2003-testing year for the NCLEX-PN examination:

- Overall 56,579 PN candidates tested in 2003, as compared to 49,518 PN candidates tested during 2002. This represents an increase of 14.3%.
- The candidate population reflected 44,078 first-time, U.S.-educated candidates who tested in 2003, as compared to 37,340 for the 2002-testing year representing an increase of 18%.
- As for the NCLEX-RN, the 2003 average passing rate for the total group and reference group were slightly higher than in 2002. The overall passing rate was 78.5% in 2003 compared to 76.2% in 2002, and the reference group-passing rate was 88.2% in 2003 compared to 86.3% in 2002.



- There were 55.3% of the total group and 60.1% of the reference group who ended their tests after a minimum of 85 items were administered. This is somewhat higher than the 2002-testing year in which 52.8% of the total group and 57.5 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 17.0% for the total group and 14.0% for the reference group. This is slightly lower than last year's percentages (18.1% for the total group and 15.3% for the reference group).
- The average time needed to take the NCLEX-PN examination during the 2003 testing period was 2.1 hours (or two hours, 6 minutes) for the overall group, and 1.9 hours (or one hour and 54 minutes) for the reference group.
- Overall, 1.5% of the total group and 0.7% of the reference group ran out of time before completing the test. This is slightly lower than the 2.6% and 1.5% of candidates who ran out of time in 2002 (total group and reference groups, respectively).
- In general, the NCLEX-PN examination summary statistics for the 2003 testing period indicated patterns that were similar to those observed for the 2002 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.



**Table 1: Longitudinal Technical Summary for the NCLEX-RN Examination:
Group Statistics for 2003 Testing Year**

	Jan 03 - Mar 03		Apr 03 - Jun 03		Jul 03 - Sep 03		Oct 03 - Dec 03		Cumulative 2003	
	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	26,085	14,905	31,440	20,201	47,882	36,287	19,330	5,326	124,737	76,719
Percent Passing	69.1	87.1	74.3	90.1	76.6	86.5	54.9	78.2	71.1	87.0
Ave. # Items Taken	124.8	118.5	119.0	113.2	122.0	120.1	135.6	127.1	123.9	118.5
% Taking Min # Items	47.7	52.3	50.5	54.6	48.2	49.6	40.8	46.6	47.5	51.2
% Taking Max # Items	13.7	12.5	12.1	10.9	13.4	13.3	17.6	15.8	13.8	12.7
Ave. Test Time	2.30	2.02	2.10	1.84	2.21	2.06	2.65	2.26	2.3	2.0
% Taking Break	49.9	39.2	43.7	33.1	46.9	40.9	62.6	48.5	49.2	39.0
% Timing Out	4.3	1.9	3.0	1.2	3.0	1.9	6.4	3.4	3.8	1.8

**Table 2: Longitudinal Technical Summary for the NCLEX-RN Examination:
Group Statistics for 2002 Testing Year**

	Jan 02 - Mar 02		Apr 02 - Jun 02		Jul 02 - Sep 02		Oct 02 - Dec 02		Cumulative 2002	
	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	22,646	13,161	23,331	12,995	52,549	40,167	14,894	4,647	113,420	70,970
Percent Passing	68.3	86.7	69.0	88.7	76.4	86.9	58.1	77.8	70.9	86.6
Ave. # Items Taken	121.6	115.4	120.2	112.4	118.1	115.9	138.4	132.3	121.9	116.2
% Taking Min # Items	49.5	54.1	50.5	56.7	51.9	53.4	38.7	42.5	49.4	53.4
% Taking Max # Items	12.3	10.9	11.6	10.0	11.6	11.4	18.9	17.4	12.7	11.4
Ave. Test Time	2.46	2.21	2.43	2.11	2.34	2.18	2.64	2.34	2.4	2.2
% Taking Break	-	-	-	-	37.5	32.6	59.0	48.3	42.2	34.2
% Taking Mand. Break	41.6	32.9	41.2	29.9	-	-	-	-	-	-
% Taking Opt. Break	3.4	1.9	3.7	2.1	-	-	-	-	-	-
% Timing Out	5.4	3.4	5.9	2.8	4.1	2.9	5.6	3.1	4.9	3.0

**Table 3. Longitudinal Technical Summary for the NCLEX-RN Examination:
Item Statistics for the 2003 Testing Year**

Operational Item Statistics										
RN	Jan 03 - Mar 03		Apr 03 - Jun 03		Jul 03 - Sep 03		Oct 03 - Dec 03		Cumulative 2003	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point Biserial	0.20	0.08	0.21	0.09	0.20	0.09	0.20	0.08	NA	NA
Z-Statistic	0.24	2.53	0.22	2.50	0.31	2.69	0.09	2.24	NA	NA
Ave Item Time (Secs)	66.1	15.4	64.4	16.9	63.8	16.7	69.5	16.6	NA	NA
Tryout Item Statistics										
# of Items	320		329		1,012		129		1790 ¹	
Ave. Sample Size	602		666		490		554		547	
Mean Point-Biserial	0.09		0.09		0.08		0.11		0.09	
Mean P+	0.70		0.69		0.65		0.61		0.66	
Mean B-Value	-1.05		-1.03		-0.84		-0.66		-0.90	
Total Number Flagged	126		148		449		39		762	
Pct. Items Flagged	39.4%		45.0%		44.4%		30.2%		42.6%	

¹The total (unique) number of items pretested during 2003 was 1,775.

**Table 4. Longitudinal Technical Summary for the NCLEX-RN Examination:
Item Statistics for the 2002 Testing Year**

Operational Item Statistics										
RN	Jan 02 - Mar 02		Apr 02 - Jun 02		Jul 02 - Sep 02		Oct 02- Dec 02		Cumulative 2002	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point Biserial	0.21	0.09	0.21	0.09	0.21	0.09	0.19	0.08	NA	NA
Z-Statistic	0.28	2.12	0.26	2.13	0.44	2.39	0.09	2.35	NA	NA
Ave Item Time (Secs)	67.4	17.9	67.4	17.6	65.4	17.0	66.8	15.6	NA	NA
Tryout Item Statistics										
# of Items	299		340		446		121		1,206	
Ave. Sample Size	613		594		1,171		584		811	
Mean Point-Biserial	0.09		0.10		0.09		0.09		0.09	
Mean P+	0.55		0.55		0.55		0.62		0.56	
Mean B-Value	-0.23		-0.16		-0.20		-0.71		-0.25	
Total Number Flagged	111		110		143		40		404	
Pct. Items Flagged	37.1%		32.4%		32.1%		33.1%		33.5%	



**Table 5: Longitudinal Technical Summary for the NCLEX-PN Examination:
Group Statistics for 2003 Testing Year**

	Jan 03 - Mar 03		Apr 03 - Jun 03		Jul 03 - Sep 03		Oct 03 - Dec 03		Cumulative 2003	
	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	12,119	8,903	10,646	7,496	20,796	17,759	13,018	9,920	56,579	44,078
Percent Passing	76.1	86.9	73.8	86.2	83.8	90.7	76.3	86.5	78.5	88.2
Ave. # Items Taken	119.1	113.3	118.2	112.2	111.9	108.4	117.8	113.1	116.0	111.1
% Taking Min # Items	52.2	57.8	53.1	58.9	59.4	63.0	53.4	58.1	55.3	60.1
% Taking Max # Items	19.2	15.6	18.1	14.3	14.4	12.3	18.4	15.6	17.0	14.0
Ave. Test Time	2.16	1.94	2.13	1.90	1.98	1.83	2.22	2.02	2.1	1.9
% Taking Break	50.5	40.9	51.2	40.8	42.6	36.6	53.2	45.1	48.3	40.1
% Timing Out	1.7	1.0	1.9	1.0	1.1	0.5	1.6	0.7	1.5	0.7

**Table 6: Longitudinal Technical Summary for the NCLEX-PN Examination:
Group Statistics for 2002 Testing Year**

	Jan 02 - Mar 02		Apr 02 - Jun 02		Jul 02 - Sep 02		Oct 02 - Dec 02		Cumulative 2002	
	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	9,869	6,669	9,293	6,100	18,796	15,537	11,560	9,034	49,518	37,340
Percent Passing	72.4	84.0	71.6	84.7	79.8	87.9	77.3	86.5	76.2	86.3
Ave. # Items Taken	119.6	114.5	121.8	115.6	115.5	111.6	118.8	114.6	118.3	113.5
% Taking Min # Items	50.6	55.6	49.2	55.2	55.7	59.7	52.7	56.8	52.8	57.5
% Taking Max # Items	18.1	15.1	20.1	16.3	16.3	14.2	19.3	16.7	18.1	15.3
Ave. Test Time	2.46	2.24	2.50	2.25	2.34	2.16	2.20	2.01	2.4	2.2
% Taking Break	-	-	-	-	40.9	34.4	49.3	41.9	44.1	37.2
% Taking Mand. Break	46.3	37.7	47.5	38.1	-	-	-	-	-	-
% Taking Opt. Break	2.6	1.5	2.9	1.8	-	-	-	-	-	-
% Timing Out	3.2	2.0	3.4	2.1	2.6	1.6	1.4	0.7	2.6	1.5



**Table 7. Longitudinal Technical Summary for the NCLEX-RN Examination:
Item Statistics for the 2003 Testing Year**

Operational Item Statistics										
RN	Jan 03 - Mar 03		Apr 03 - Jun 03		Jul 03 - Sep 03		Oct 03 - Dec 03		Cumulative 2003	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point Biserial	0.21	0.08	0.21	0.08	0.22	0.08	0.21	0.09	NA	NA
Z-Statistic	0.09	2.48	0.07	2.42	0.16	2.54	0.12	2.41	NA	NA
Ave Item Time (Secs)	64.8	18.8	65.6	18.2	61.8	17.1	65.2	18.2	NA	NA
Pretest Item Statistics										
# of Items	296		259		534		375		1464 ²	
Ave. Sample Size	672		609		745		592		667	
Mean Point-Biserial	0.11		0.13		0.12		0.13		0.12	
Mean P+	0.64		0.67		0.65		0.66		0.65	
Mean B-Value	-0.80		-0.86		-0.71		-0.86		-0.79	
Total Number Flagged	82		68		142		111		403	
Pct. Items Flagged	27.7%		26.3%		26.6%		29.6%		27.5%	

²The total (unique) number of items pretested during 2003 was 1,422.

**Table 8. Longitudinal Technical Summary for the NCLEX-PN Examination:
Item Statistics for the 2002 Testing Year**

Operational Item Statistics										
PN	Jan 02 - Mar 02		Apr 02 - Jun 02		Jul 02 - Sep 02		Oct 02- Dec 02		Cumulative 2002	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point Biserial	0.21	0.09	0.21	0.08	0.22	0.09	0.21	0.08	NA	NA
Z-Statistic	0.05	2.17	0.02	2.14	0.10	2.28	0.11	2.45	NA	NA
Ave Item Time (Secs)	66.2	16.5	67.4	17.8	64.8	17.2	63.5	18.4	NA	NA
Pretest Item Statistics										
# of Items	193		145		514		342		1194	
Ave. Sample Size	833		776		741		601		720	
Mean Point-Biserial	0.11		0.12		0.10		0.11		0.11	
Mean P+	0.58		0.56		0.59		0.65		0.60	
Mean B-Value	-0.44		-0.27		-0.37		-0.91		-0.52	
Total Number Flagged	56		41		158		98		353	
Pct. Items Flagged	29.0%		28.3%		30.7%		28.7%		29.6%	

Report of Practice, Regulation and Education Committee

Recommendation to the Delegate Assembly

Adopt the Model Nursing Practice Act and Model Nursing Administrative Rules.

Rationale: The Practice, Regulation and Education (PR&E) Model Revision Subcommittee, working under the oversight of the PR&E Committee, has spent three years reviewing, researching, drafting and refining the revised models for presentation to the 2004 Delegate Assembly. In completing this project, the subcommittee consulted with other NCSBN committees, NCSBN staff, Member Boards and interested external groups. The PR&E Committee agrees with the subcommittee that the models are ready to go forward and supports their adoption.

Background of the PR&E Committee

Ever since the creation of NCSBN, there have been committees appointed to counsel together regarding topics of interest to nursing regulation. Currently, the PR&E committee, one of four standing committees prescribed by NCSBN Bylaws, is charged with providing general oversight of nursing practice, regulation and education. This year, the PR&E Committee worked with three subcommittees, the PR&E Model Revision Subcommittee, the PR&E Delegation Subcommittee and the PR&E Subcommittee on International Nurse Issues (see separate board reports from these subcommittees).

Highlights of FY04 PR&E Committee Activities

- Planned a second Patient Safety Summit, held November 15, 2004, in conjunction with the Citizen Advocacy Center's Annual Meeting.
- Received report on plans for the 2004 UAP Summit.
- Developed, in collaboration with the NCSBN Research Services Department, a survey to identify research-based elements of nursing education leading to safe entry-level practitioners. This will be conducted in the fall of 2004.
- Following a comprehensive literature review, began developing a systematic review of nursing education research.
- Developed a formal collaboration with the Vermont Nurse Internship Program (VNIP), which transitions nurses from education to practice, with the intent of studying the outcomes of these programs in the future.
- Developed approval models for boards of nursing in a white paper, entitled, "State of the Art of Approval/Accreditation Processes in Boards of Nursing."
- Received report on CCNE proposed standards for accreditation.
- Reviewed results of a Member Board survey regarding disabled nurses.
- Met with PR&E Delegation Subcommittee chair to provide direction as that group began their work.
- Reviewed and provided feedback on the PR&E Delegation Subcommittee two-year work plan.
- Reviewed report from the International Nurse Subcommittee and provided feedback.
- Reviewed and provided comment on draft documents from the PR&E Models Revision Subcommittee.

PR&E Committee Members

Cookie Bible, BSN, RNC, APN, Chair,
Nevada, Area I

Mary Calkins, PhD, RN
Wyoming, Area I

Gino Chisari, MSN, RN
Massachusetts, Area IV

Marcy Echternacht, MS, RN, CS
Nebraska, Area II

Rose Kearney-Nunnery, RN, PhD
South Carolina, Area III

Barbara Knopp, RN, MSN
North Carolina, Area III

Therese B. Shipp, RN, DNSc
Maine, Area IV

Robin Vogt, PhD, RN, FNP-C
Missouri, Area II

Board Liaison

Mary Blubaugh, MSN, RN
Kansas, Area II

Staff

Vickie Sheets, JD, RN, CAE
Director of Practice and Regulation

Nancy Spector, PhD, RN
Director of Practice and Education

David Henley, MM
Administrative Assistant

International Nurse Subcommittee Members

Julia E. Gould, MS, RN, Chair
Georgia, Area III

John Brion, MS, RN
Ohio, Area II

Joyce A. Bonick, JD, BA, RN
Kentucky, Area III

Donald S. Rennie, MSN, RN
Nevada, Area I

Usrah Claar-Rice, MSN, RN
California-RN, Area I

G. Joan Sheverbush, RNC, MSN, MN
Kansas, Area II

Staff

Nancy Chornick, PhD, RN, CAE
Director of Credentialing

Carin Zuger, Credentialing
Administrative Assistant



Members of the PR&E

Delegation Subcommittee

Cheryl Koski, MN, RN, CS, Chair
Wyoming, Area I

Sue Deroen, BSN, RN
Kentucky, Area III

Julia George, MSN, RN
North Carolina, Area III

Judith Hiner, RN, CNA, BC
Kansas, Area II

George Herbert, MA, RN, APN, C
New Jersey, Area IV

Janette E. Wackerly, MBA, RN
California-RN, Area I

Board Liaison

Mark Majek, MA, PHR
Texas, Area III

Staff

Vickie Sheets, JD, RN, CAE; Director of
Practice and Regulation

David Henley, MM
Administrative Assistant

Members of the PR&E Models

Revision Subcommittee

Barbara Newman, MS, RN, Chair
Maryland, Area IV

Maura Egan, PhD, MHP, BSN, RN
Washington, Area I

Nathan Goldman, JD, BA
Kentucky, Area III

Barbara Morvant, MN, RN
Louisiana, Area III

Debra Scott, MS, RN, APN
Nevada, Area I

Carol Swink, PhD, RN
North Carolina, Area III

Cynthia VanWingerden, MS, RN
Virgin Islands, Area IV

Sandra Webb-Booker, PhD, MS, BSN
Illinois, Area II

Future PR&E Committee Activities

- Review the actions and decisions at the Annual Meeting to determine if there are content implications for the models, and make recommendations to the Board of Directors.
- Oversee the work of PR&E subcommittees.
- Update white paper on continued competence (work in conjunction with Testing and Research Departments' development of continued competence job analysis)
- Evaluate outcomes of programs or models that transition new nurses from education to practice.
- Review the results of the Fall 2004 study, *Elements of Nursing Education*, for indicators of quality education programs.

Background of the International Nurse Subcommittee

In FYO2, the PR&E Committee recommended the formation of a special subcommittee to study the effect of nurses educated outside of the United States in relation to U.S. nursing regulation. The Foreign Nurse Issues Subcommittee was formed in February 2002 and in FYO3 developed a resource manual to meet the needs of Member Boards. In FYO4, the International Nurse Issues Subcommittee (formerly known as the Foreign Nurse Issues Subcommittee) was charged with reviewing the manual for currency. At their December 2003 meeting, the NCSBN Board of Directors expanded the charge of the International Nurse Subcommittee to include:

[The International Nurse Subcommittee] will make recommendations regarding the level of credential evaluation needed for regulatory purposes. The subcommittee will also review the services of available credentialing evaluation agencies and make this available to boards of nursing.

Highlights of FYO4 International Nurse Subcommittee Activities

- Updated the Resource Manual for Licensure of International Nurses (to be completed at the last meeting of FYO4).
- Developed guidelines regarding the level of credential evaluations needed for regulatory purposes (to be completed at the last meeting of FYO4).
- Reviewed services of available credentialing agencies (to be completed at the last meeting of FYO4).

Future International Nurse Subcommittee Activities

Subcommittee has completed its charge.

Background of the PR&E Delegation Subcommittee

Providers of health care must maximize the use of every health care worker to meet the public's increasing need for accessible, affordable and quality health care. Nurses coordinate and supervise the delivery of nursing care in many settings. Nurses typically have the broadest interface with patients in acute care provide nursing care, long term care and many community settings, and work with a variety of assistive personnel who may delegate nursing tasks. In addition, the United States is facing an ominous nursing shortage at a time when demographic trends and available treatment modalities collide to create an escalating need for nursing care. Issues related to delegation have become increasingly complex in today's evolving health care environment.

The critical nature of the regulatory issues raised by the use of unlicensed assistive personnel (UAP) has been long recognized by NCSBN. A number of committees and projects have focused on UAP topics. In 1997, the Unlicensed Assistive Personnel Task Force developed strategies to support Member Boards in addressing UAP issues including a

position paper and several resource documents related to delegation and unlicensed assistive personnel.

NCSBN research findings show that a variety of methodologies are being used to prepare assistive personnel, that 10-20% of assistive personnel are performing activities considered outside the range of assistive personnel practice and that adequacy of preparation for supervision of care was the lowest rated of all activities by both newly licensed nurses and employers. The PR&E Models Revision Subcommittee also identified the need to revisit the issues of delegation and assistive personnel and recommended to the Board of Directors that a NCSBN group explore the broader topic of how nurses work with and through others. At the 2003 NCSBN Annual Meeting, the delegates adopted a resolution proposed by the Kentucky Board of Nursing, which states “that NCSBN develop a position paper on the regulation of nursing assistive personnel which includes model act and rule/regulations with a report to the 2004 Delegate Assembly.”

In September 2003, the NCSBN Board of Directors charged a new PR&E Delegation Subcommittee to:

- Collect information about how nurses work with assistive personnel.
- Study how delegation is currently being implemented.
- Analyze the congruence between education, practice and regulation in the use of delegation.
- Develop content related to delegation for the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules.
- Suggest ways to reconnect education to practice in terms of delegation.

In addition, the subcommittee was directed to identify data elements that can be tracked regarding assistive personnel and to use registry states to provide a beta test for these data elements.

At its first meeting, the PR&E Delegation Subcommittee developed a plan to meet this charge (See Attachment A). Given the breadth of the project, the subcommittee recommended a two-year process, with an updated report to the 2004 Delegate Assembly (see Attachment C), final position paper and resources for consideration by the 2005 Delegate Assembly.

FY04 Activity PR&E Delegation Subcommittee Highlights

- Reviewed and analyzed state nurse practice acts, and nursing administrative rules and regulations for language addressing delegation, assignment, supervision and assistive personnel.
- Reviewed Model Nurse Practice Act and Model Nursing Administrative Rules for language pertaining to delegation, assignment, supervision and assistive personnel, and made recommendations to PR&E Models Revision Subcommittee.
- Surveyed Member Boards regarding needs and concerns pertaining to delegation and assistive personnel.
- Developed a Nurse Aide Registry Checklist and piloted it with subcommittee member states.
- Provided feedback regarding planned nurse aide research.
- Reviewed and analyzed various organization position statements regarding delegation and assistive personnel.
- Planned for obtaining stakeholder input regarding delegation and assistive personnel.
- Developed questions in preparation of external outreach.
- Conducted literature review.

Board Liaison

Donna Dorsey, MS, RN, FAAN
Maryland, Area IV

Staff

Vickie Sheets, JD, RN, CAE, Director of
Practice and Regulation

David Henley, Administrative
Assistant

Relationship to Strategic Plan

Strategic Initiative II Regulatory Effectiveness

NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome A

Effective strategies are identified to assist Member Boards to respond effectively to critical issues and trends impacting nursing education, practice and regulation.

Outcome C

Approaches and resources are developed to address issues related to assistive personnel.

Meetings

PR&E Committee

October 2-3, 2003

January 8-9, 2004

April 22-23, 2004

June 18, 2004 (conference call)

International Nurse Subcommittee

February 9-10, 2004

April 6-7, 2004

May 24-25, 2004

June 15-16, 2004



PR&E Delegation Subcommittee

November 20-21, 2003

January 9, 2004 (Teleconference)

February 18-19, 2004

April 29-30, 2004

PR&E Models Revision Subcommittee

October 15-17, 2003

December 8-10, 2003

January 21-22, 2004

March 12, 2004 (conference call)

March 15, 2004 (conference call)

March 30, 2004 (conference call)

April 28, 2004 (conference call)

Attachments

- A State of the Art of Approval/ Accreditation Processes in Boards of Nursing, May 12, 2004
- B Delegation Subcommittee Progress Report to the 2004 NCSBN Delegate Assembly
- C NCSBN and Continued Competence - The Current Model and Recommendations for Future Initiatives
- D Proposed Revisions to NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules

- Began development of annotated bibliography on delegation and assistive personnel.
- Requested legal case review regarding delegation and assistive personnel.

Future PR&E Delegation Subcommittee Activities

- Conduct external outreach to obtain stakeholder input.
- Develop position paper to include following recommendations:
 - Whether to regulate assistive personnel
 - If so, how and why
 - Is so, who and why
 - Minimum educational preparation for assistive personnel (including receiving delegation and working with nurses as part of health care team)
 - Educational preparation for nurses regarding delegation, supervision and working with and through others
 - How to teach assistive personnel
 - Conceptual framework for how nurse interfaces with assistive personnel in various roles and settings
 - Suggested research
 - Other
- Develop Model Act/Rule language, to include:
 - Definitions
 - Regulation UAP
 - Delegation/Assignment
 - Education
 - Discipline
 - Other
- Additional Recommendations

Background of the PR&E Models Revision Subcommittee

Model laws and rules provide resources for boards of nursing that are used in a variety of ways. Some boards look to the models for new ideas and different approaches for regulation. Other boards may use them in evaluating their existing regulatory language. Some boards use the framework and/or language in developing amendments and revisions to state laws and rules. The models may assist in the development of rationales for rules as part of the rule promulgation process.

The first NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules were developed in 1981-1983, and were funded by the Kellogg Foundation. The models have been revised twice, once in 1987 and again in 1993. The work of the PR&E Models Revision Subcommittee has been to conduct a comprehensive review of the Models and propose revisions to the models. In FY02, the subcommittee presented revisions to the Model Nursing Practice Act as well as Model Rules for Nursing Education. The 2002 NCSBN Delegate Assembly adopted both.

In FY03, the subcommittee began to work on Model Rules, and drafted them in a format that presented the Model Act in one column and the Model Rules in the second column. This formatting was intended to show the interrelationship and congruency of the model law and the model rules. The Model Act was used as the framework, and the rules reorganized to follow an outline reflecting the organization of the Model Act. While

drafting this new approach, the subcommittee discovered areas of the Model Act where there needed to be changes and additions to the law to be congruent with the rules under development. The NCSBN Board of Directors was informed of this need, and instructed the subcommittee to move forward.

A draft document was disseminated for Member Board and external review in the spring of 2003. In response, the subcommittee received many comments. The Board encouraged the subcommittee to take the time needed for careful and thoughtful review of this feedback. In addition, there were two last content areas to be addressed – relating to nursing delegation and continued competence. The NCSBN Board of Directors directed the subcommittee to work on the additional content areas, working with the newly formed Delegation Subcommittee, and plan to bring the completed, comprehensive Models document to the 2004 Delegate Assembly for consideration.

The subcommittee has been asked if this model is an inspirational document that presents a higher standard to strive for or whether it reflects the current state of regulation. The answer is it is both. Much of law and rule language in the document is very pragmatic and does reflect current practice. But there are also new ideas, and new approaches and suggestions for future goals. Often the latter appear in comments, but they are part of the document.

Finally, the subcommittee's goal is an electronic models document, with multiple appendices to provide a variety of resources and links. The electronic model will be broadly accessible and easy to update as needed. The models will be a living document used for multiple purposes by boards and others.

Highlights of PR&E Models Revision Subcommittee FY04 Activities

- Reviewed all comments and feedback received.
- Incorporated many suggestions from that review into the current draft models.
- Requested feedback on the current draft revisions regarding specific content areas from NCSBN committees.
- Incorporated many suggested changes from other NCSBN committees into the current draft document.
- Reviewed literature regarding continued competence.
- Reviewed continued competence approaches used by other professions.
- Reviewed IOM reports in relation to continued competence.
- Prepared supporting paper for continued competence approach incorporated into the revised models (see Attachment A).
- Developed current revised models draft that includes:
 - Introduction of a different approach for continued competence based on latest research.
 - Inclusion of the Nurse Licensure Compact and the APRN Compact and rules for both.
 - Clearer delineation of standards of practice.
 - Specification of board authority and powers.
 - Updated education rules, including language for a board role in approval of APRN programs.
 - Revised reporting requirements.
 - Additions to discipline grounds and process.
- Distributed 2004 draft models for additional comment.
- Incorporated Member Board feedback into final draft for business book.



Future Activities of PR&E Models Revision Subcommittee

Subcommittee has completed its charge.



Attachment A

State of the Art of Approval/Accreditation Processes in Boards of Nursing

Introduction

This white paper analyzes some of the issues and trends of approval processes, not only in the U.S., but also worldwide. The impetus for the white paper, a recommendation from the Practice, Education, and Regulation Congruence (PERC) Task Force, is described. The history of approval/accreditation of nursing programs is discussed, both in the U.S. and globally. The comprehensive work on approval/accreditation processes that was done at NCSBN in the 1990s is reviewed and put in context with research currently being done. Globalization issues of approval processes are discussed, considering the approval guidelines issued by the International Council of Nurses. Current models of approval/accreditation by boards of nursing in the U.S. are presented, and future trends are identified.

Background

The Practice, Regulation and Education (PR&E) Committee considered the following tactic: Utilize the approval criteria to develop models of collaboration between boards of nursing and accrediting agencies.

This particular tactic was devised from NCSBN's strategic initiative and the work of the PERC Task Force (NCSBN, 2002a; NCSBN, 2002b). This group, looking at the future of regulation, recommended that NCSBN identify the models that boards of nursing use to approve/accredit schools of nursing. Some of their conclusions related to this tactic were:

- 1) It became apparent that there are times when regulation should operate in isolation, and others where regulation, education and practice should act together (NCSBN, 2002a).
- 2) It became evident that a greater degree of congruence will be needed in the health care arena of the future. The PERC Task Force created a three-dimensional model to describe the impact of incongruence on the nursing profession. This model (See Appendix A) demonstrates practice, education and regulation as circular bands. Pictured as a ball, the circles are close together and the centers aligned. When this level of congruence is present, they form a perfect ball, thus being round and functional (i.e., the ball can bounce.) Yet, when the circles are misaligned and the centers far apart, the ball is asymmetrical and dysfunctional. (NCSBN, 2002a).
In order to look at congruencies and incongruencies the Task Force invited comments from 200 nursing, governmental and regulatory organizations. This open invitation was distributed by mail and posted on the NCSBN Web site. Fourteen stakeholders were then selected to meet with the Task Force to hear their perspectives directly and to clarify written comment.
- 3) Some of the congruencies/incongruencies related to this topic of approval were (NCSBN, 2002b):
 - Regulation and education both value high quality nursing education. (Congruent)
 - Most boards collaborate with educators. (Congruent)
 - Although the business of accreditation may pose a potential conflict of interest, some boards grant approval to nursing programs that meet national accrediting agency standards. (Incongruent)



- For nursing programs that are reviewed by both their board of nursing and nursing accrediting body, review processes are often not coordinated and review requirements may be duplicated. Documentation requirements sometimes differ. The duplication of resources and effort are a burden to nursing programs. (Incongruent)
- The majority of nursing graduates pass NCLEX and nursing programs teach content related to licensure requirements. (Congruent)
- Public health nursing and population-focused nursing concepts receive inadequate attention in nursing curricula. (Incongruent)
- Educational programs do not consistently provide theory content and clinical experience essential for practice. Curricula of today compare with those of 20 years ago, with additional content added. The acuity of patients and technology advancements are not consistently reflected in program syllabi/curricula. (Incongruent)
- While an assumption is made that graduates from an approved nursing program who have passed a licensure exam are able to practice safely at an entry level, there is no agreement among practice, education and regulation on criteria to measure safe post-entry practice. (Incongruent)
- A healthy separation exists when regulation provides a process for input from all affected parties and considers the input received, but in the end focuses on what is in the best interest of the public. Yet, an unhealthy separation exists when boundaries are in place that exclude education and practice from providing input and when boards do not take into account information from a variety of sources. (Congruent/Incongruent)
- When practice, education, or regulation works to influence regulation from any agenda other than public protection, congruence is disrupted. (Incongruent)
- Variation and lack of standardization in regulations across jurisdictions. (Incongruent)

The PERC Task Force discussed the philosophical and operational differences between nursing program approval by boards of nursing and voluntary accreditation by national accrediting bodies. While the mission of boards of nursing is to protect the health, safety and welfare of the public by establishing minimum standards for prelicensure programs, the mission of the accrediting agencies is to ensure the quality and integrity of nursing programs by assessing and identifying programs that engage in effective educational practices (NCSBN, 2002b). Boards of nursing are state agencies, while the national nursing accrediting bodies are not-for-profit, financially dependent on the voluntary accreditation of nursing programs. The PERC Task Force also concluded that since there are two national nursing accrediting bodies, there could be competition for business.

History of Approval/Accreditation

With that background identifying the development of this tactic, some historical discussion of the development of approvals/accreditation in boards of nursing will be helpful in understanding how approval/accreditation in boards of nursing has evolved. The 1994 NCSBN Model Administrative Education Rules (p. 2) defined board of nursing approval/accreditation as: “official recognition of nursing education programs which meet standards established by the board of nursing.” That is the definition that will be used in this white paper. Some boards of nursing use “accreditation” instead of “approval,” so the terminology in this paper is “board of nursing approval/accreditation.” Board of nursing accreditation should be differentiated from accreditation by national nursing accreditors, such as the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLN-AC). Generally, accreditation by the national



nursing accreditors is defined as: “a voluntary process by private agencies which is an external quality review by peers to assure that an educational program meets established standards for structure, function, and performance” (Sheets, 2002). Board of nursing approval/accreditation is done for the purpose of protecting the health, safety, and welfare of the public, while national nursing accreditation is a voluntary, nongovernmental peer-review process to assure that schools of nursing are meeting standards. There is a more in-depth discussion of the differences between board of nursing approval/accreditation and national nursing accreditation elsewhere (Spector, 2004), and more discussion of regulation in general can be found elsewhere (Clark & Waring, 2001; Crawford, 2001; International Council of Nurses, 1985; Safriet, 2002; Sheets, 2002; Weisenbeck & Calico, 1991)

During the late 1800s and early 1900s, England first struggled with nursing regulation, the debate being self-regulation versus legal regulation. Florence Nightingale, and other nurse opponents to regulation, believed the focus should be on the societal/moral standards of the professional nurse, rather than on their nursing abilities. Nurses who favored regulation thought this was the opportunity to establish qualifications, thus safeguarding the public and nursing. Physicians and administrators feared losing control over nursing and therefore were opponents to regulation. While this debate was raging, New Zealand was the first country to enact an independent licensing law on August 12, 1901, and Ellen Dougherty of New Zealand was the first nurse, worldwide, to be registered (ICN, 1985; Spector, 2004; Weisenbeck & Calico, 1991). Likewise, Canada began to regulate nurses in the early 1900s (Clarke & Wearing, 2001). In 1919, England finally enacted The Nurses Registration Act of 1919, and this provided for a main registry for general nurses who met certain qualifications. It further established supplemental registries for male nurses and specialists in mental disease, care of children and infectious disease (ICN, 1985.)

In the U.S., North Carolina enacted the first registration law in 1903, followed by New York, New Jersey and Virginia. However, the early registration laws did not define the scope of practice. New York, in 1938, was the first state to define a scope of practice and to adopt a mandatory licensure law (Flanagan, 1976; Weisenbeck, 1991). After the registration laws were enacted in the U.S., state boards of nursing began to emerge for the purpose of regulating nurses and protecting the public. By 1906 inspectors of schools or hospitals with nursing training programs began making program visits for approval. One of the first nurse inspectors was Annie Damer in New York (American Nurses Association ANA, 2001; N. Birnbach, personal communication, July 29, 2002; Spector, 2004).

When national nursing organizations began to accredit nursing education programs, boards of nursing continued with their approval processes, utilizing the standards of education found in the nursing practice acts and the rules and regulations. As a result, nursing’s dual process for evaluating nursing education programs evolved. Complicating this was the development, in the 1990s, of two national nursing accrediting agencies, CCNE and NLN-AC. No other professional group in the U.S. has two accrediting agencies.

International Work on the Approval/Accreditation by Regulatory Bodies

In 1995 the International Council of Nurses (ICN, 1997) was asked to prepare a guide for an approval system for schools of nursing, based on the previous work of ICN in this field. This recommendation arose out of the understanding that high practice standards and quality education are influenced by the approval system serving it. Yet, at that time, many countries lacked approval systems or were being served by poor approval systems. By calling on this international group to establish approval standards for schools of nursing, the ICN member associations made a statement that excellent approval systems,



measured and monitored by a regulatory authority, benefit society and add to the credibility of nursing.

In preparing their guide for approval systems in schools of nursing, the ICN considered potential benefits and problems of approval systems. According to ICN, potential benefits of good approval systems include:

- While ICN did not provide data to validate this, they state that there is a direct relationship between poor nursing care and the quality of nursing programs.
- An approval system communicates to the nursing profession, policy makers, employers, and citizens that the profession has established standards, with continuous review, monitoring, and enforcement, guaranteeing that the graduates of these programs have met certain criteria.
- A well-developed approval system is current and abreast of progress in the nursing field, as well as health sciences and education.
- Approval systems can be a source of development for the nursing faculty and the institution.
- A good approval system in a country can assist with promoting greater uniformity in educational outcomes across the country.
- An effective approval system in a country can help with cross border agreements about equivalence of standards.

Regulators and educators in the U.S. would agree with these benefits.

The ICN members state that potential problems of approval systems are:

- There are expenses for the educational system and the authority charged with the approval.
- They may create a heavy burden on the schools of nursing.
- New or changing approval systems may leave faculty feeling threatened and vulnerable, particularly those faculty members who have insufficient knowledge of the approval system.
- External or multidisciplinary review bodies may have insufficient appreciation of the discipline and practice of nursing.
- Inconsistent application of standards may undermine the existing system.

In the U.S., except for a few jurisdictions, there are usually not external or multidisciplinary review bodies doing approvals, so that is not a potential problem for most of our boards of nursing. However, the others can be potential problems for the approval system in the U.S.

The ICN document (ICN, 1997) identifies seven essential elements of approval systems, regardless of the jurisdiction, and places these within a conceptual framework. The essential elements are:

- *A statement of purpose* – The purpose of the approval system should be stated clearly as it will provide direction. A purpose might include protecting the public from unsafe practices, as well as fostering the profession of nursing.
- *The focus of approval* – The ideal focus of regulatory control in the approval system would include the educational programs preparing the nurse for practice, the educational institutions in which the programs are offered and the clinical facilities used for learning.
- *Regulatory mechanisms* – When an external authority, such as the government, applies standards and grants credentials (i.e., approval), this is often called the credentialing process. The credentialing mechanisms can be referred to by a variety of terms including approval, accreditation, certification, licensure, recognition, registration and



validation. In this instance the credentialing activity is termed approval, and this is usually given to the school of nursing for three to five years. Continuing approval must be sought, and approvals may be withdrawn when the standards aren't met.

- *Regulatory authority* – The regulatory authority may vary according to the purpose of approval and the particular jurisdiction. The authority may be the government, but other authorities also could exist. Ideally, however, the approval/accreditation body should be independent of the institution being reviewed to avoid conflicts of interest; an example of a conflict of interest would be a governmental agency that is the credentialing authority, but also the owner of the school of nursing.
- *Agents of approval* – The associations, or people carrying out the approval/accreditation processes, are referred to as the “agents of approval.” Often legislation designates are responsible for approval/accreditation of nursing programs. A variety of key stakeholders may participate in some way in the activities of approval/accreditation of nursing programs.
- *Standards to be achieved* – The ICN defines the standards to be achieved as “the desirable and achievable levels of performance against which actual practice is compared.” Processes for establishing standards should include regular review and revision, without compromising the authority of the standards. The following are likely standards to be addressed in nursing program approvals:
 - Organization and administration
 - Structure, organizational policies and relationships
 - Director
 - Faculty
 - Personnel policies
 - Budget
 - Documentation
 - Curriculum
 - Content
 - Implementation
 - Evaluation
 - Students
 - Selection
 - Policies
 - Rights and responsibilities
 - Resources and facilities
 - Faculty
 - Classrooms/laboratories
 - Clinical and community learning sites
 - Library
 - Other school activities
 - Support services
- *Methods and Instruments of Approval* – Suggested methods and instruments used to validate that programs are meeting the required standards may include:
 - Performance on examinations
 - Self-evaluations
 - Review of university documents, including policies, curriculum documents, samples of tests, evaluation tools, minutes of meetings, faculty appraisals, etc.



- Review of faculty qualifications
 - Letters of recommendation
 - Interviews with students, clinical staff, faculty and administrators
 - On-site visits to classrooms and clinical learning settings

Surely these guidelines are very similar to the structures in place in the U.S. boards of nursing. If all nursing programs throughout the world were approved by authorities as described by the ICN, equivalency of standards would be in place.



Appendix A

Previous Work by NCSBN on Approval Models

In the mid-90s, NCSBN was involved in a major initiative to study approval models in boards of nursing (NCSBN, 1998b). This initiative involved the following (results can be found in the 1998 NCSBN Business Book):

- Member board needs assessment, related to approval/accreditation.
- Completion of quantitative research study related to approval of nursing programs.
- Completion of a qualitative research study related to the relationship between the approval and accreditation processes for basic nursing programs.
- Completion of a survey to the 10 boards of nursing that deem accreditation as meeting state approval requirements.
- Hosting of an approval/accreditation round table.
- Development of a position paper (NCSBN, 1998a).

The Member Boards of NCSBN completed an assessment related to approval/accreditation of nursing education programs, addressing various approaches to approval/accreditation of nursing programs and the desirability of having uniform requirements. They identified models for approval (134), and they found that the predominant model being used was Model A (79.5% of the boards). The responses indicated that most boards were satisfied with their model, and 89% of the boards indicated that their present model would continue to safeguard the public in the changing healthcare environment. Furthermore, 72.2% of the boards reported that future needs would be met by boards of nursing granting initial and continuing approvals of education programs (NCSBN, 1998c).

Nurse educators (stratified random sample of 560 nursing education programs) indicated that both Models A and B were effective in demonstrating accountability and protecting the public. However, they felt Model B. was advantageous because it was less costly, more of a time-saver, and was more user friendly. While over 87% of the educators believed that it was essential or very essential that boards be involved in the approval of basic nursing education programs, 78% believed that boards of nursing should follow uniform procedures. Respondents were in agreement that boards of nursing should have a role in setting standards for advanced practice, but they were not in agreement as to whether boards of nursing should approve these programs (NCSBN, 1998c).

In-depth qualitative telephone interviews from 16 major stakeholders were conducted, representing consumers, interest organizations, professional organizations, accrediting bodies and employers. A strong majority of the respondents believed that boards of nursing should deem CCNE or NLN-AC accreditation as meeting state approval requirements. However, a subset of the interviewees didn't agree with the boards of nursing deeming CCNE or NLN-AC accreditation as meeting state approval requirements. The consumers and employers were concerned that this wouldn't protect the public. Their concerns about the accrediting agencies were:

- Tend to be too academically oriented
- Are sometimes out-of-touch with market realities
- Are slow to respond to changes in the marketplace

However, these same employers and consumers did agree that national nursing accreditation standards would be acceptable if the process ensured that the approval/accreditation criteria from the boards of nursing were incorporated.



These stakeholders generally agreed that a single set of national standards that encompass minimum criteria should be created. While this group recognized the historical role of boards in establishing approval criteria, with advances in professional standards, conduct and roles, they perceived less regulatory need by the boards of nursing in the future. Therefore, they believed that boards of nursing no longer need to be as involved with approval/accreditation of nursing programs as they have been (NCSBN, 1998c).

On April 21, 1998, NCSBN hosted a Nursing Approval/Accreditation round table meeting, with the following in attendance: ANCC, CCNE, NLNAC and the NCSBN Subcommittee on Nursing Program Approval/Accreditation. At this time significant issues in approval were discussed, including outcomes, effectiveness of approval and accreditation processes, consistency, federal funding issues, redundancy, and economy of resources (NCSBN, 1998c).

A Position Paper, entitled “Position Paper Related to Approval of Nursing Education Programs by Boards of Nursing” was then developed, outlining these unique roles of boards of nursing (NCSBN, 1998a):

- Granting initial approval of basic nursing education programs
- Monitoring and sanctioning programs at risk by statutory authority
- Demonstrating greater awareness of statewide nursing education program needs.
- Participating in standard setting of nursing education programs.

NCSBN Models of Approval in the 1990s

- **Model A** Separate and Distinct Mechanism – The board of nursing grants initial and continuing approval of nursing programs based on the board’s separate and distinct view of the nursing education program.
- **Model B** Accreditation Recognition Mechanism – The board of nursing grants initial approval based on the board’s separate and distinct view, and grants continuing approval based on the board’s recognition of national nursing accreditation as a criterion for continuing approval for those programs that choose to be nationally accredited. Boards of nursing retain their authority for program approval. For those programs not accredited, the separate and distinct mechanism would apply.
- **Model C** Non-involvement Mechanism – The board of nursing is not involved in the approval process; another agency approves nursing education programs.
- **Model D** Other – Other approaches used for approval of nursing education programs.

Current Work at NCSBN on Approval/Accreditation Processes

Currently, the 2002 Profiles of Member Boards (Crawford & White, 2002) reports that 54 boards of nursing approve/accredit basic RN educational programs, while two boards of nursing do not; there is no information from four boards of nursing. In the two boards that don’t approve nursing programs, the approval is done by the Department of Education. The 2002 Profiles reports that 44 boards of nursing approve PN programs, while three do not; of the three who do not, one is only an RN board of nursing, and approvals in the other two states approvals are done by the Department of Education. Fourteen boards of nursing did not report data about the PN programs in their states. Five boards of nursing are recognized as an accrediting agency by the U.S. Department of Education. Eight boards of nursing grant approval to those nursing programs that meet national accreditation standards (Crawford & White, 2002). This number is down from the 2000 Profiles (Crawford & White, 2000), at which time that number was 10. However, the number of boards that will accept programs that meet accreditation standards, along with other qualifications (such as maintenance of NCLEX results), has increased from 8 to 10. Similarly, the number of boards that collaborate/coordinate with national accreditation bodies has risen (from 2000 to 2002) in all of the following areas:



- On-site collaborative visits have risen from 28 to 30.
- Use of reports prepared by educational programs has risen from 29 to 35.
- Use of reports prepared by visitors regarding findings has risen from 21 to 25.

Therefore, the trend is for the boards of nursing to collaborate with the national accrediting agencies on approval/accreditation of nursing programs. Another trend has developed that bears watching. In a survey sent out by the NCSBN PR&E Committee (Does your state require national accreditation by CCNE or NLNAC, 2003), the findings indicate that there is a trend for boards of nursing to mandate national nursing accreditation, though so far, many of the boards that do require accreditation, or will in the future, are in small jurisdictions. To date, five boards of nursing require national accreditation by NLNAC or CCNE; two boards will require it in the future (one board will require it by 2008, and in the other board it will be required for RNs and PNs in their new regulations); and one board is considering requiring national accreditation.

Other data regarding approval/accreditation by boards of nursing (Crawford & White, 2002) include the following:

- 48 of the 50 boards responding have authority for new programs.
- 57 of the 59 boards responding have authority for existing programs.
- 48 of 50 boards responding have authority for program modifications.
- 48 of the 50 boards responding have authority for program closures.
- 41 of the 50 boards responding have the authority to intervene when a problem is identified during the accreditation process; two of the nine boards that responded no can intervene during the approval process only.

In 2003 the PR&E Committee developed essential criteria (NCSBN, 2003a) for those boards that deem approval to nursing programs that are nationally accredited by NLN-AC or CCNE. These criteria were based on the results of surveys sent to all the boards of nursing (49 responded), as well as CCNE and NLN-AC (NCSBN, 2003c). These criteria are:

1. Initial approval of nursing education programs, including:
 - a. Review proposed curriculum
 - b. Review educational facilities and resources
 - c. Review clinical teaching facilities and methodologies
 - Clinical ratios should consider acuity of patients, objectives of the learning experience, geographic placement of the students, requirements established by the clinical agency and agency resources
 - d. Assessment of organization of nursing education programs
 - e. Review qualifications of program administrators
 - f. Review responsibilities of program administrators
 - g. Review qualifications of program faculty
 - h. Review responsibilities of program faculty
2. Continuing approval of nursing education programs, including:
 - a. Review/evaluate curriculum
 - b. Review/evaluate educational facilities & resources
 - Clinical ratios should consider acuity of patients, objectives of the learning experience, geographic placement of the students, requirements established by the clinical agency and agency resources



- c. Review qualifications of program administrators
 - d. Review qualifications of program faculty
3. Monitor and sanction nursing education programs that put the public at risk.
- Make emergency visits for complaints.
 - Suggested areas of concern may include decreasing NCLEX results, sudden high student attrition rates, national accreditation changes and significant faculty attrition.

Lastly, research by the Commitment to Ongoing Regulatory Excellence (CORE) Committee provided NCSBN with some very illuminating data. They had educators rate the essentiality of the involvement of boards of nursing in program approval. The answers were generally quite positive, validating the need for program approvals. They were asked to rate how essential board of nursing involvement is in the approval/accreditation of nursing programs, on a scale of 1 (very essential) to 3 (not essential). Educators reported from basic nursing programs (534) the essentiality as 1.23; RN completion programs (394) as 1.90, MSN programs (363) as 2.18 and doctoral programs (347) as 2.42. While the educators see approvals as essential for basic programs, this belief was less strong with RN completion and graduate programs. The nursing programs generally reported adequate board approval processes, with all their ratings being lower than 1.5 (1= always adequate; 3= inadequate). The elements of the approval processes that they rated included:

■ Interval between visits	1.40
■ Preparation time for board visits	1.38
■ Communication with board staff	1.43
■ Time spent on site during visit	1.31
■ Feedback/evaluation provided by board	1.37
■ Timeliness of providing feedback	1.40
■ Comprehensiveness of feedback	1.38
■ Fairness/objectivity of board findings	1.42
■ Time given to correct deficiencies	1.37
■ Fairness in monitoring compliance	1.32
■ Overall benefit of approval process	1.39
■ Due process of disagreements regarding findings and plan of corrections	1.42

Furthermore, the educators found the boards of nursing consistently helpful (1.11 on a scale of 1= consistently helpful; 3= not helpful at all) (NCSBN, 2004).

Models of Approval/Accreditation by Boards of Nursing

Considering the work to date on approval/accreditation of nursing programs by boards of nursing, the Practice, Regulation and Education (PR&E) Committee identified the following as the models of approval/accreditation that currently exist. While they differ slightly from the Models that were developed in 1998, they are still very similar.

- I. Boards of nursing are independent of the national nursing accreditors. These boards of nursing approve/accredit nursing programs separately and distinctly from the national nursing accrediting bodies. Initial approval processes are conducted before accreditation takes place.
- II. Collaboration of boards of nursing and national nursing accreditors. Boards of nursing share reports with the national nursing accrediting bodies, and/or make visits with them, sharing information. However, the final decision about approval is made by the board of nursing, independent of decisions by the national nursing



accreditors. Initial approval processes are conducted before accreditation takes place.

- III. Deem national nursing accreditation as meeting state approvals. Boards of nursing deem CCNE or NLN-AC accreditation as meeting state approvals, though they continue to approve/accredit those schools that don't voluntarily get accredited. The board of nursing is available for assistance with statewide issues (e.g., the nursing shortage in that state); boards retain the ability to make emergency visits to schools of nursing, if requested to do so by a party reporting serious problems; and the board of nursing has the authority to close a school of nursing, either on the advice of the national nursing accreditors or after making an emergency visit with evidence that the school of nursing is causing harm to the public. Initial approval processes are conducted before accreditation takes place.
- III a. Deem accreditation as meeting approvals with further documentation
Similar to III, these boards deem CCNE or NLN-AC accreditation as meeting state approvals, but they may require more documentation, such as complaints, NCLEX results, excessive student attrition, excessive faculty turnover and lack of clinical sites.
- IV. Boards of nursing require national nursing accreditation
Boards require their nursing programs to become accredited by CCNE or NLN-AC, and then they will use Model III or III a to approve them. Initial approval processes are conducted before accreditation takes place.
- V. Boards of nursing are not involved with the approval system at all. In this model the board of nursing is not given the authority to approve nursing programs. This is usually done by another state authority.

As boards of nursing move more toward sharing the data with the national nursing accreditors, or deeming CCNE or NLN-AC accreditation as meeting state approval requirements, they need to be able to identify the advantages and disadvantages of these systems.

An advantage of systems that are independent of the national nursing accreditors is that the boards of nursing have more control in their processes of approval/accreditation. They can dictate what data should be collected and what reports should be written, without having to abide by, or work with, the national accreditors' format. Likewise, the scheduling of visits is easier, as they don't have to consider the schedules of the peer reviewers. Besides having more control in the approval/accreditation process, the independence provides for checks and balances in the approval/accreditation of nursing programs.

A disadvantage of the boards' approval/accreditation processes that are conducted independently is that it may take more work and time for the boards to complete the surveys of the schools since they won't be collaborating with the accrediting body. This, of course, may mean that these surveys are more expensive, both for the boards and for the nursing programs. Similarly, some nursing programs have complained that independent surveys are burdensome, and may be redundant. The boards of nursing that independently survey nursing programs do not have the benefit of collaborating with the panel of experts from the national nursing accreditors. This collaboration can assist in clarification and validation of findings.

An Advantage of the boards of nursing sharing data with the national nursing accreditors, or deeming CCNE or NLN-AC accreditation as meeting state approval requirements, is that it saves them time and money, since there is cooperation between the two agencies to collect the data. Similarly, it saves the nursing programs time and money in preparation, and may avoid redundancies for them. Further, when the boards of nursing collaborate with the accrediting agencies, they have the benefit of input by a panel of nursing experts in making their decisions.



A disadvantage for boards of nursing that share data with the national nursing accreditors or who deem CCNE or NLN-AC accreditation as meeting state approval is that, depending on the boards' processes, there may be limited checks and balances on the national nursing accreditors' decisions. Yet, since most boards retain a right to make emergency visits when there are complaints and the authority to close nursing programs based on those complaints, this should not be a disadvantage that adversely affects public safety. Another disadvantage is that planning the visits can sometimes be complicated because of the schedules of people in the school of nursing, board of nursing and national accrediting nursing agency. The boards of nursing may lose control over what data is collected, especially when they deem national accreditation as meeting state approval.

Future of Approval/Accreditation by Boards of Nursing

Nursing is continually changing. There are new roles being promoted, such as the Clinical Nurse Leader (access at: <http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader.htm>) and the Practice Doctorate (accessed at: <http://www.aacn.nche.edu/Education/ExecutiveSummary.pdf>), and researchers are studying the best ways to teach nursing students. These will have to be considered in future approval systems. It is recommended that approval processes include the five competencies that were developed by the Institute of Medicine in their April 8, 2003, report, entitled, "Health Professions Education: A Bridge to Quality." These competencies are:

- Delivering patient-centered care
- Working as part of interdisciplinary teams
- Practicing evidence-based health care
- Focusing on quality improvement
- Using information technology

Because nursing programs are more creatively using their faculty, the approval/ accreditation systems in boards of nursing may need to have specific qualifications for adjunct faculty, part-time faculty, or preceptors. The boards, however, might encourage a greater use of interdisciplinary people to teach nursing students in order to enhance interdisciplinary practice. Informatics and the management of knowledge are increasingly impacting nursing so that boards of nursing will have to be informed of these changes and innovations in order to adequately evaluate nursing programs. There is a movement in regulation to approve APRN programs, and boards of nursing will need to carefully consider this in the future. Initial approval of APRN programs at least may be considered, with the APRN programs then meeting acceptable national standards. Boards of nursing are moving toward more collaboration with the national nursing accreditors for approving/accrediting programs, and some boards of nursing are beginning to require accreditation. This may continue to be a movement in the future. Likewise, in the future we may see international collaboration with approval processes, and this will enable us to have cross border agreements and more equivalence of standards worldwide.

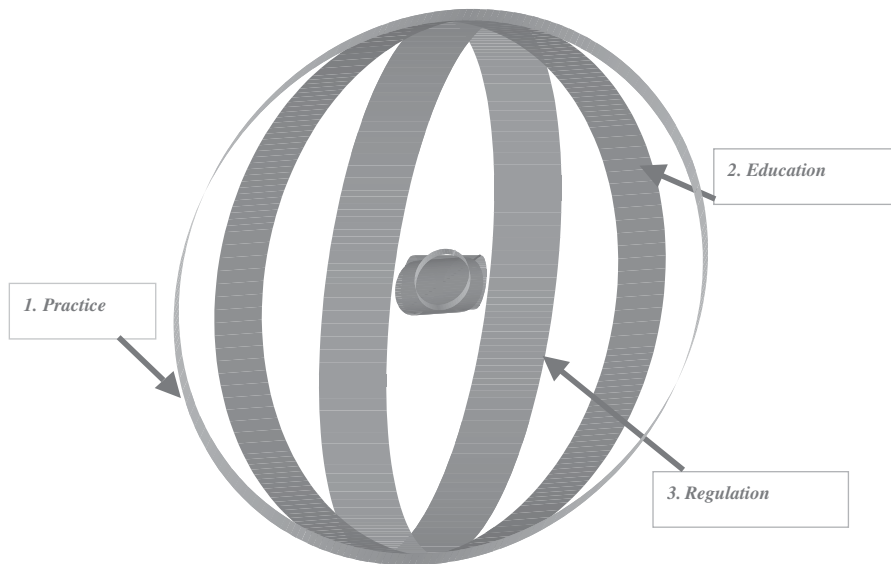
Conclusion

Approval systems have been present in the U.S., and worldwide, for over 100 years. It is becoming important for nurses to be more international in scope, and a review of the international philosophy of program approval/accreditation showed that it is very similar to that in the U.S. Stakeholders in the U.S. still see the approval process as necessary. For example, even nurse educators continue to report that program approval is essential for public protection (1.23, with 1 = very essential, and 3 = not essential). Boards of nursing are moving towards collaboration with the national nursing accreditors for approval/ accreditation. While in the mid-90s, a clear majority of the boards of nursing had separate or distinct models (Model A in Box 1) for approving nursing schools, current data show



that a majority of the boards of nursing share data and visits with the national nursing accreditors. Another trend may be for the boards of nursing in the future to require national nursing accreditation. There may be international collaboration with approval systems in future as well. Approval/accreditation processes in the future may address the IOM competencies.

Appendix A



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Attachment B

Delegation Subcommittee Progress Report to 2004 Delegate Assembly

Introduction

The NCSBN Board of Directors charged the Practice, Regulation & Education (PR&E) Delegation Subcommittee to develop a position paper and model legislative and rule language pertaining to delegation and assistive personnel. As part of a two-year plan to develop these resources, this paper is an update to the 2003 Delegate Assembly to report the progress of the subcommittee this past year. The first year of the project has been devoted to data collection. The second year will be used to obtain stakeholder input and to develop a position paper and model language pertaining to delegation, assistive personnel, and working with and through others. The critical and complex concepts related to assistive personnel are extremely important in today's health care environment and warrant careful study and consideration when preparing a position for NCSBN and resources to support Member Boards in the regulation of nursing practice.

Background

Providers of health care must maximize the use of every health care worker to meet the public's increasing need for accessible, affordable and quality health care. Nurses coordinate and supervise the delivery of nursing care in many settings. Nurses typically have the broadest interface with patients in acute care, long-term care and many community settings, working with a variety assistive personnel who may be delegated nursing tasks. In addition, the United States is facing an ominous nursing shortage at a time when demographic trends and available treatment modalities collide to create an escalating need for nursing care. Issues related to delegation have become increasingly complex in today's evolving health care environment.

The critical nature of the regulatory issues raised by the use of unlicensed assistive personnel (UAP) has long been recognized by NCSBN. A number of committees and projects have focused on UAP topics. In 1997, the Unlicensed Assistive Personnel Task Force developed strategies to support Member Boards in addressing UAP issues, including a position paper and several resource documents related to delegation and unlicensed assistive personnel.

The PR&E Committee became greatly concerned regarding this topic when NCSBN research findings were presented at a meeting last year. This research showed that a variety of methodologies are being used to prepare assistive personnel, 10-20% of assistive personnel are performing activities considered outside the range of assistive personnel practice and adequacy of preparation for supervision of care was the lowest rated of all activities by both newly licensed nurses and employers. The PR&E Models Revision Subcommittee also identified the need to revisit the issues of delegation and assistive personnel, and recommended to the Board of Directors that an NCSBN group explore the broader topic of how nurses work with and through others. At the 2003 NCSBN Annual Meeting, the delegates adopted a resolution proposed by the Kentucky Board of Nursing, "that NCSBN develop a position paper on the regulation of nursing assistive personnel which includes model act and rule/regulations with a report to the 2004 Delegate Assembly."



In September 2003, the NCSBN Board of Directors charged a new PR&E Delegation Subcommittee to:

- Collect information about how nurses work with assistive personnel.
- Study how delegation is currently being implemented.
- Analyze the congruence between education, practice and regulation in the use of delegation.
- Develop content related to delegation for the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules.
- Suggest ways to reconnect education to practice in terms of delegation.

In addition, the subcommittee was directed to identify data elements that can be tracked regarding assistive personnel and to use registry states to provide a beta test for these data elements.

At its first meeting, the PR&E Delegation Subcommittee developed a plan to meet this charge (see Attachment A1). Given the breadth of the project, the subcommittee recommended a two-year process with an updated report to the 2004 Delegate Assembly (this report), and final position paper and resources for consideration by the 2005 Delegate Assembly.

Assumptions

The following assumptions, developed from the previous Delegation Concepts and Decision Making Process (NCSBN, 1997), guided the subcommittee deliberations:

1. Consumers have a right to health care that meets legal standards of care.
2. 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.
3. Nursing is an outcome-driven, knowledge-based process that is context dependent and requires critical thinking. Nursing 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.
4. A licensed nurse must be actively involved in and accountable for all managerial decisions, policymaking and practices related to the delegation of nursing care.
5. A licensed nurse must have ultimate responsibility and accountability for the management and provision of nursing care.
6. There is a need and place for competent, appropriately supervised unlicensed assistive personnel in the delivery of affordable, quality health care.
7. Boards of nursing are responsible for the regulation of nursing. Provision of any care that constitutes nursing or any activity represented as nursing is a regulatory responsibility of boards of nursing.

Definitions

The subcommittee reviewed the Model Nurse Practice Act and Model Nursing Administrative Rules for language pertaining to delegation, assignment, supervision and assistive personnel, and made recommendations to PR&E Models Revision Subcommittee to continue to use the following definitions:

- *Unlicensed assistive personnel* – any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.
- *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.
- *Assignment* – designating nursing activities to be performed by another nurse or assistive personnel that are consistent with his/her scope of practice (licensed person)



or role description (unlicensed person).

- *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.

Survey of Member Boards

NCSBN Member Boards were surveyed regarding needs and concerns pertaining to delegation and assistive personnel. An electronic survey was distributed by e-mail in November 2003 asking for input regarding delegation and assistive personnel. The critical challenges identified by respondents included:

- Evolving work settings, with expanded use of assistive personnel, fragmentation in regulation, use of untrained personnel in some settings (e.g., schools, jails, community homes) and assistive personnel in physician offices.
- Variation in terminology and titles.
- Lack of standardized training and competency assessment issues.
- Accountability and responsibility issues.
- Lack of understanding by employers regarding the scope of issues and problems.
- RN discomfort with the delegation process and lack of both authority and time to appropriately delegate and provide adequate supervision.

The survey respondents suggested a variety of resources that would be helpful to address these challenges, ranging from an updated position paper to standardized curriculums to standards for use and training across all settings. Data about how other states regulate, as well as models for monitoring and precepting assistive personnel, and quality improvement tools would also be useful. Outcomes research was suggested to look at medication aide errors (e.g., frequency, type and cause).

Review of Current State NPAs and Rules/Regulations

Member Board Nurse Practice Acts and Nursing Administrative Rules/Regulations were accessed via Web sites (seven boards were not included in the review because these documents were either not available on the Web or, for two states, the Web sites were not accessible). The documents were reviewed for the following search terms: delegation, direction, assignment, supervision, management and assistive personnel (nursing assistants, nurse aides and unlicensed assistive personnel).

Forty-eight boards have some reference to delegation in either the Nurse Practice Act or rules; of these, 35 boards' references appear in the nurse practice act and 43 boards' references appear in the rules. Thirty-three boards included a definition of delegation in either the practice act or rules. Twenty-seven boards addressed delegation in the RN scope of practice; 18 boards addressed delegation in the LPN/VN scope of practice. Fifteen boards addressed delegation in standards of nursing practice. Twenty-nine boards addressed delegation or supervision in the grounds for discipline. Five boards addressed delegation in the curriculum portion of education rules. Six boards inferred delegation when no specific language exists. One state advised that nurses do not delegate in that jurisdiction.

Twenty boards have separate portions of the act or rules that address delegation, often providing criteria for delegation, and lists of nursing functions that may be delegated or lists of nursing tasks that should not be delegated. Some states are silent regarding in their Nurse Practice Act regarding delegation, but have lengthy rules about the topic. Currently, 14 nursing boards manage the nurse aide registry in their respective states. Sixteen address nurse aide/nursing assistant training, 15 boards address medication aides and 12 boards have sections of the law or rules regulating some aspect of nurse



aides/nursing assistants activities.

There is much variation in the titles of assistive personnel (e.g., certified nursing assistants, certified nurse aides, medication aides, trained medication aides, medication assistants, nursing assistants and advanced certified nurse aides). At least two states license assistive personnel and three states have a second level of assistive personnel. Ten boards have one or more advisory opinions addressing delegation, supervision or nurse aides/nursing assistants. Other resources include guidelines (eight boards), decision trees (eight boards) and task lists (three boards).

There is no clear consensus as to the best regulatory approach at this time.

Review of Position Statement of Various Nursing Organizations

A number of nursing organizations and a teaching organization have developed position statements and guidelines regarding delegation and assistive personnel. The subcommittee reviewed and analyzed various organizations' position statements regarding delegation and assistive personnel. See Attachment B1, Analysis of Position Statements Regarding Assistive Personnel and Delegation.

Review of Other Professions

Other health professions were contacted regarding delegation and how they work with assistive personnel. The subcommittee is in the process of contacting pharmacy groups for input. Medical students receive little to no instruction on working with supportive personnel, and Dr. David Leach, executive director of the American Accreditation Council for Graduate Medical Education (ACGME), suggested further discussions with NCSBN regarding preparing medical and nursing students to work together. There was little information in the medical literature. However, a two-part series was found on the Indiana State Medical Association Web site discussing the risks associated with the use of assistive personnel in a medical practice.

Dietitians did some significant work on delegation in the early 1990s, and these resources have been requested from the Commission on Dietetic Registration. In addition, some state boards have developed guidelines on assistive personnel. For example, the Ohio Board of Dietetics states, "tasks which require the skill, knowledge and judgment of a licensed or exempted person should not be delegated to others." The guidelines also list activities that are considered the practice of dietetics and cannot be delegated.

The American Physical Therapy Association (APTA) has addressed the issue of working with assistive personnel by developing a number of policies that represent the profession's view of appropriate use of personnel. They do not use the term "delegation" but rather discuss three levels of supervision. General supervision is when the physical therapist is not required to be onsite for direction and supervision, but must be available at least by telecommunication. Direct supervision is when the physical therapist is physically present and immediately available for direction and supervision. The physical therapist will have direct contact with the patient/client during each visit and telecommunication does not meet the requirement of direct supervision. Direct personal supervision is when the physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed.

As the requirements vary from state to state, physical therapists are advised to review the laws and regulations for the state looking carefully at definitions for the different physical therapy personnel covered and how supervision is defined and applied. APTA's position is that physical therapists are the only professionals who provide physical



therapy interventions. Physical therapist assistants are the only individuals who provide selected physical therapy interventions under the direction and at least general supervision of the physical therapist. Physical therapy aides are any support personnel who perform designated tasks related to the operation of the physical therapy service. The APTA goes on to define tasks as those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant.

Literature Review

When “delegation” is entered as a keyword in search engines such as CINAL, MEDLINE, ABI-INFORM, LEXIS-NEXIS, EBSCO host, ERIC and Psych INFOR, many articles are found until the search years are limited to 1998-2004. Recently, there has not been much published on the subject. The main concepts addressed in the available recent articles include:

Implementation

- Delegation dos and don'ts – protect your practice (MNA Online Publications).
- Moen, 2001, references both ANA and NCSBN work in writing about how to make delegation work.
- Buppert, 2004, writes from the APRN perspective of whether it is safe to delegate to UAP and the business implications.
- Clarke, 2003, discusses several high-profile research studies linking nurse staffing and patient safety.
- Parsons, 1998, describes increased confidence in RN delegation after training using a Nursing Assessment Decision Grid, as well as increasing job satisfaction experienced by RNs relative to autonomy and promotional opportunity.

Staff Mix

- Changes in staff mix (with increased numbers of assistive personnel) causes role confusion for both RNs and assistants (Zimmerman, 2000; Potter & Grant, 2004; Hall, 1998); especially when job descriptions/level of training and expectations are unknown (Thomas & Hume, 1998; Barter, McLaughlin & Thomas, 1997).
- Thomas, et al, 2000, states that RNs do not feel confident with UAP skills.
- Unruh, 2003, notes that the number of LPNs has decreased and may contribute to increased workload for RNs.
- Bernrueter & Cardona, 1997, observes a dramatic rise in the number of UAP with mixed feelings from RNs about UAP value.
- Potter & Grant, 2004, notes that UAP working with multiple RNs can cause UAP confusion (because UAP are not taught to prioritize, they are task oriented).
- Kido, 2001, suggests making staff mix public knowledge.
- Clarke, 2003, observes more RNs equal fewer adverse outcomes.

Communication

- Good communication helps nurture RN-UAP relationship (Thomas & Hume, 1998; Potter & Grant, 2004).
- Parsons, 1998, notes that lack of communication makes relationships poor (UAP not relaying information because they are not trained to recognize things that nurses are and RNs are not trained on how to deal with less skilled workers).
- Emphasis on group function may help improve RN-UAP interactions (Anthony, Casey, Chau & Brennan, 2000).



Education/Training

- There is a lack of UAP education, or a lack of consistency of UAP education (Thomas, et al, 1998; Kido, 2001).
- Education of UAP recommended (Barter, McLaughlin and Thomas, 1997).
- Another barrier is the lack of RN educational preparation regarding delegation skills (Thomas & Hume, 1998; Hopkins, 2002; Anthony, Standing & Hertz, 2001).
- Recommend teaching delegation skills (Thomas & Hume, 1998; Parsons, 1998; Anthony, Standing & Hertz, 2001).
- Barter, McLaughlin & Thomas, 1997, suggests that UAP have formal training with a defined scope.
- Hopkins, 2002, develops a continuing education tool.
- Conger, 1999, adjusts the Nursing Assessment Decision Grid (NADG 1993/1994), to teach nursing students delegation tools.
- The U.S. Department of Labor's Occupation Outlook Handbook advises that minimum education and training is generally required for entry-level nursing, psychiatric and home health aides, that job prospects will be very good because of fast growth and high replacement needs, but that earnings are low.
- Kopishke, 2002, provides a historical perspective on the use of assistive personnel and how nurses must prepare themselves to head the team of caregivers found in today's acute care facilities.
- Numerous continuing education offerings address delegation and supervision.

Regulation

- There is a need to work with boards of nursing to assure regulatory language is clear to support delegation to UAP in OR setting (Habgood, 2000).
- Recommendations that states mandate minimal educational requirements and competency evaluation for UAP in acute care settings, with a movement to establish national regulation of educational requirements to ensure the competency of UAP in acute-care hospitals (Thomas, Barter & McLaughlin, 2000).
- The best foundation for teaching what can and cannot be delegated is the state's Nursing Practice Act (Hall, 1996).

The subcommittee has begun developing an annotated bibliography that will be made available on the NCSBN Web site.

Review of Case Law

The subcommittee also requested that Tom Abram provide a legal case review regarding delegation and assistive personnel. A case law search was conducted. No cases were found holding a nurse accountable for actions performed by a UAP whether or not the activity was delegable according to the state statutes. Two Illinois cases, *People v. Stults*, 683 N.E.2d 521 (Ill. App. Ct. 1997) and *People v. Cryns*, 763 N.E. 2d 904 (Ill. Ct. 2002) discussed actions brought against unlicensed personnel for practicing nursing without a license (neither involved delegation).

Some cases were identified where courts have addressed the use of UAP in other professions.

- The appellate court affirmed the trial court decision that unauthorized dentistry took place when a dentist authorized the unlicensed assistant's acts, and inadequately supervised, was held to be unprofessional conduct by a dentist. *Fotovotjah v. State of Washington*, 1998 Wash. App. LEXIS 1689 (Wash. App. 1998).
- The appellate court affirmed the trial court's decision to revoke the physician's license



after he ordered an unlicensed person to administer injections to patients, holding that “when a doctor directs an unlicensed person to perform a medical act, the question is not whether the unlicensed person may be disciplined for the act, but whether the doctor’s conduct is unprofessional.” *Kolnick v. Board of Medical Quality Assurance*, 161 Cal. Rptr. 289 (Cal. Ct. App. 1980).

- In the presence of conflicting evidence, a jury found that a patient’s injury was not caused by a flu shot administered by an unlicensed and untrained individual. The appellate court affirmed the decision because it could not state the jury was clearly wrong. However, in its opinion, the court stated that the standard of care that nurses are subject to is the same as the standard applied to physicians. *Novak v. Texada, et. al.*, 514 So.2d 524 (Ct. App. La. 1987).
- The Colorado Supreme Court found that an unlicensed lab technician was not a “health care professional,” within the meaning of a statute designed to protect individuals from negligent acts of health professionals but that the statute still applied under the circumstances of the case. *Scholtz v. Metropolitan Pathologists, P.C.*, 851 P.2d 901 (Colo. 1993).

Other Activities

In addition to the work described above, the subcommittee also:

- Developed a Nurse Aide Registry Checklist and piloted it with subcommittee member states.
- Provided feedback regarding planned NCSBN nurse aide research.
- Planned for obtaining stakeholder input regarding delegation and assistive personnel.
- Developed questions for various stakeholder groups in preparation for external outreach.

Discussion

Assistive personnel are used in many different health care settings. The information to date shows great variation in the titles and roles of assistive personnel. Having so many titles is confusing to the public as well as to other health care providers. Other than the OBRA training and assessment requirements, there is no consistent education and training for assistive personnel. Each state has a nurse aide registry, but they reside in only 14 boards of nursing. The other state registries are managed by a plethora of state agencies and departments and these registries only address long-term care and home health. In most states, there is little to no regulation of assistive personnel in acute care, physician offices and ambulatory care settings. Another concern for the subcommittee is residential settings, where the main focus is on living but where the vulnerable residents often have chronic health needs. Although criminal backgrounds may be required by individual states, there is no process for consistent tracking and communication regarding these unlicensed individuals, though these workers make up a highly mobile population.

The subcommittee has identified numerous stakeholders including recipients of care, families, nurses, other members of the health care team, employers, insurers, legislators and other policymakers, as well as assistive personnel themselves. The subcommittee plans to contact representatives of these various groups as part of its external outreach planned for the fall of 2004.

The regulatory schemes for assistive personnel seem at best fragmented, at worst nonexistent. In the coming year, the subcommittee plans to use the information it has collected from the many different sources to propose an NCSBN position on delegation and assistive personnel. This position will include minimum educational preparation and training of assistive personnel and a statement on the regulation of assistive personnel (including who should regulate as well as the level of regulation). The position statement



will address the educational preparation of nurses working with assistive personnel, including delegation, assignment, supervision, communication and team concepts, both in theory and clinical application. The subcommittee also plans to address nurses and delegation in various roles and settings.

It used to be that nursing units had full patient censuses and were staffed with a consistent group of nurses and assistive personnel. The patients stayed for days rather than hours, giving the nurse time to know them and their needs. Nurses had the opportunity to know the staff with whom they worked, to learn their strengths and challenges. Nurses had more time and more ready information to support their delegation decisions.

Today, many nurses are reluctant to delegate. This is reflected in NCSBN research findings and literature as well as anecdotal accounts from nursing students and practicing nurses. There are many contributing factors to this, ranging from not having educational opportunities to work with others in nursing programs to not knowing the skill level and abilities of assistive personnel to simply the work pace and turnover of patients. Yet with the nursing shortage, the demographic changes and the resultant increase in the need for nursing services, nurses cannot go it alone without assistive support. As noted above, there is no clear consensus as to the best regulatory approach at this time. The subcommittee's challenge will be to propose a realistic and workable regulatory framework that will support the delegating nurse and assistive personnel in the many health care settings. Most importantly, this regulatory framework must enhance public protection.

Future Activities

The subcommittee members believe that they have a strong plan and good start on implementation, but there is still much to do in the coming year. Those activities include:

- Conduct external outreach to obtain stakeholder input
- Develop position paper to include following recommendations:
 - Whether to regulate assistive personnel
 - If so, who and why
 - If so, how and why
 - Education and training
 - Minimum educational preparation for assistive personnel (including receiving delegation and working with nurses as part of health care team)
 - Educational preparation for nurses regarding delegation, supervision and working with and through others
 - Conceptual framework for how nurse interfaces with assistive personnel in various roles and settings
 - Suggested research
 - Other
- Develop Model Act/Rule language to include:
 - Definitions
 - Regulation UAP
 - Delegation/Assignment
 - Education
 - Discipline
 - Other
- Develop additional recommendations as needed.



Attachments

Attachment B1: PR&E Delegation Subcommittee Plan

Attachment B2: Analysis of Organizational Position Statements

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ATTACHMENT B1

Delegation and Assistive Personnel Subcommittee Work Plan FY04-FY05

Timeline	Activity
December 2003	Review of model NPA and rules Provide input to models subcommittee
February 2004	Assessment of legal environment literature review
April 2004	Identify external contacts and provide notice to “hold date” Pose questions to member boards about oversight of assistive personnel Begin to contact other professions for information and resources
May 2004	Develop Recommendations – <ul style="list-style-type: none"> ■ Continue Subcommittee ■ Ongoing Research ■ Other Business book report – progress to date <ul style="list-style-type: none"> ■ Results of literature review ■ Description of legal environment ■ Description of looking other health professions ■ Description of looking outside health care ■ Plan
October 2004	Review results of assistive personnel outcomes research Planning for inviting external groups to present testimony
January 2005	Meeting with invited external groups to provide testimony Day One – subcommittee meets to plan strategy Days Two and Three – external groups present testimony Day Four – subcommittee meets to debrief
February 2005	Determine next steps Begin to revise existing NCSBN resources Develop outline, content areas for position paper Develop outline, content areas for model rules
April 2005	Continue work on position paper Continue work on model rules
May 2005	Develop recommendations – <ul style="list-style-type: none"> ■ Research ■ Other ■ Business Book Report Position paper – <ul style="list-style-type: none"> ■ Model Rules ■ Other resources



ATTACHMENT B2

Analysis of Position Statements Regarding Assistive Personnel and Delegation

Academy of Medical-Surgical Nurses

- *Delegation/Decision making.* Globalization of market forces and evolving health care reform provide opportunity to analyze nurses' traditional roles and assume responsibility for judicious delegation of nursing tasks to UAP. The RN uses professional judgment to determine what to delegate.
- *UAP Role.* Redesign of traditional nursing roles does not replace RNs with UAP; it gives RNs the opportunity for appropriate support for the delivery of nursing care.
- *UAP Titles.* Variety of job classifications.
- *UAP Training.* Must be commensurate with the activities that will be delegated. UAPs should be provided ongoing education and competency should be evaluated annually.
- *Accountability.* RNs are accountable for patient outcomes from nursing care. RNs must participate in decisions regarding UAP job descriptions and duties within the clinical setting, and be knowledgeable about the competency of each UAP and intervene when needed.
- *Regulation.* Support the control and monitoring of UAP through the use of existing mechanisms that regulate nursing practice (state board of nursing), including the clarification of the delegation process and what may be delegated and restrictions.

American Association of Spinal Cord Injury Nurses (AASCIN), 1995

- *Delegation/Decision making.* Budgetary and resource considerations not valid reasons for wrongful delegation. RN does not have to teach a UAP who does not demonstrate the ability to learn and perform care.
- *UAP Role.* RNs asked to increase delegation and use of UAPs. UAP not a substitute for RN. UAP should be under direct supervision of RN. UAP role varies by setting.
- *UAP Titles.* Nursing aides, personal care attendants, family members, friends and appointees of the client.
- *UAP Training.* At the request of the client or the client's agent the RN may teach the client's care to UAP. The client or agent then accepts responsibility for the UAP supervision and the type and quality of UAP care, except when the UAP is from agency.
- *Accountability.* The RN has a legal scope of practice and a legal authority to perform nursing acts; UAPs do not.
- *Regulation.* Employers and RNs who participate in wrongful delegation should be sanctioned.

American Federation of Teachers (AFT), 1995

- *Delegation/Decision making.* The RN must remain the single authority over delegation of nursing tasks and responsibilities to UAP based on the nurse's evaluation of the training and competencies of the unlicensed person and the nature of the tasks to be performed.
- *UAP Role.* Performance of nonnursing duties such as environmental maintenance, clerical tasks and directly assisting patients with ADL such as hygiene, feeding and ambulation. However, licensed personnel increasingly are being pressured to inappropriately delegate.
- *UAP Titles.* Standardized job titles and description are needed.



- *UAP Training.* Minimum education and training requirements needed at state level.
- *Accountability.* The RN retains responsibility for all tasks he/she delegates.

American Nurses Association (ANA), 1997

- *Delegation/Decision making.* Direct patient care activities are delegated by the RN and involve ADL; indirect patient care activities focus on environmental maintenance, such as housekeeping, transporting clerical and stocking. In delegation the RN uses professional judgment to determine the appropriate activities to delegate.
- *UAP Role.* UAP provide support services to the RN. In virtually all health care settings, UAP are inappropriately performing functions within the legal scope of nursing.
- *UAP Training.* The nursing profession should define and supervise the education, training and utilization of UAP.
- *Accountability.* The RN is responsible and accountable for the provision of nursing practice. The RN supervises and determines the appropriate use of UAPs. Therefore, it is the responsibility of the nursing profession to establish and the individual RN to implement standards for the practice and utilization of UAPs.
- *Regulation.* Definitions of nursing in state practice acts.

American Nephrology Nurses' Association (ANNA) 1983, revised and reaffirmed 2003

- *Delegation/ Decision making.* Never delegate a nursing care activity that requires the specialized skill, judgment and decision making of an RN or the core nephrology principles needed to recognize and manage real or potential complications.
- *UAP Role.* The RN shall have either instructed the UAP in the delegated activity or verified the UAP competency. Administration of medications is beyond the scope of practice of UAP, and shall be limited to those medications considered part of the routine hemodialysis treatment (e.g., normal saline and heparin via the extracorporeal circuit and intradermal lidocaine).
- *UAP Titles.* Dialysis technicians, patient care technicians, reuse technicians, nephrology technologists are all under the supervision of RN.
- *UAP Training.* Assistive personnel in dialysis need not be licensed but must complete a standard program of education and training for UAP in dialysis preferable in a junior college or vocational school with ongoing CE requirements.
- *Accountability.* The RN is accountable and responsible for all delegated nursing care activities and interventions. RNs must be present in the patient care area for ongoing monitoring and evaluation of the patient's response to the therapy. The RN is legally accountable and clinically responsible for the complete documentation of the entire nursing process.
- *Regulation.* UAP must function under the state Nurse Practice Act. ANNA prefers specific language referring to UAP in dialysis settings.

Arizona Nurses Association (ANA) 1992, renewed 2002

- *Delegation/ Decision making.* Delegation presumes the delegator has greater knowledge and a delegated task is only a subcomponent of a larger whole.
- *UAP Role.* Written job descriptions with clear parameters that define and limit the responsibilities of the position. RNs should never delegate to any member of the health team a function for which that person is not qualified.
- *UAP Training.* Core curriculum developed and supervised by RN that includes but is not limited to communication, customer service, safety and clinical practice issues.
- *Accountability.* RN is originator of delegation and retains responsibility for outcomes. The employing organization has a responsibility to assure that the appropriate



training, orientation and documented competencies are in place for the UAP so that the RN can be reasonably assured that the UAP can function safely.

Association of periOperative Registered Nurses (AORN), 1995, reaffirmed 1999

- *Delegation/Decision making.* Restructuring of traditional roles does not replace perioperative RNs, but provides opportunity to focus leadership skills on coordinating patient care and directing activities of the nursing team. The perioperative RN may delegate appropriate patient care activities.
- *UAP Training.* Perioperative RNs define and supervise the training and utilization of UAP who provide direct and indirect care in the perioperative setting. UAP must receive appropriate training and demonstrate competency before assuming new and expanded responsibilities, and must be commensurate with the delegated activities.
- *Accountability.* Perioperative RNs are accountable for patient outcomes resulting from nursing care provided during the perioperative experience.

Association of Rehabilitation Nurses (ARN) 1995, revised 2003

- *Delegation/Decision making.* UAPs needed to “achieve the goal of assisting individuals in the restoration and maintenance of maximal physical, psychosocial and spiritual health.”
- *UAP Role.* Basic scope ADL tasks plus support of RN assessment. Secondary scope consists of those tasks that require additional training and demonstration of competence prior to being performed by the UAP including insertion of catheters, NG feedings, bowel programs, single dressing changes, glucose testing, ECGs and bladder scans.
- *UAP Titles.* Institutional, residential, outpatient and community settings under the supervision of RN.
- *UAP Training.* Qualifications include high school diploma or equivalent, nurse aide training certificate or a minimum of documented four weeks on-the-job training, CPR training additional training prior to performing tasks in secondary scope of care, demonstrated initial and ongoing competence in both categories.
- *Regulation.* Tasks delegated by RN shall not exceed any restrictions in the scope of care as set forth by the state.

Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), 1997, 2000

- *Delegation/Decision making.* Clear written parameters for direct supervision by RNs; includes lengthy list of nursing activities that should not be delegated.
- *UAP Role.* Need written job descriptions that clearly delineate the duties, responsibilities, qualifications, skills and supervision of UAPs.
- *UAP Titles.* UAP should be clearly identifiable to patients as unlicensed.
- *UAP Training.* Orientation and training of UAPs, including didactic content, knowledge base evaluation and clinical skills verification consistent with performance expectations and role responsibilities.
- *Accountability.* UAPs work under supervision of and are accountable to RN. The RN remains responsible and accountable for the overall nursing care.
- *Regulation.* Need to evaluate state practice act to ensure that UAP job descriptions and delegated activities are consistent with rules and regulations.



Massachusetts Organization of Nurse Executives (MONE), 1994, 2002

- *Delegation/Decision making.* Supervision of UAP remains with the licensed nurse.
- *UAP Role.* Delegation must occur within the job description and organizational policies and procedures. Individual health care facilities need flexibility in developing institution specific programs.
- *UAP Training.* Should be determined by nursing leadership in individual facilities.
- *Accountability.* Differing concerns and debates have focused on primary area of accountability and decision making.
- *Regulation.* MA Board of Registration in Nursing has regulations on delegation and supervision.

National Association of Neonatal Nurses (NANN), 1999

- *Delegation/Decision making.* RN may assign or delegate tasks to assistive personnel based on the assessed patient need, potential for harm, complexity of the care, knowledge and skill of the UAP.
- *UAP Role.* Tasks based on needs, potential for harm, complexity and UAP KSAs.
- *UAP Titles.* Nursing assistants, nursing aides, orderlies, assistive personnel, LPN/VNs, respiratory therapists (RTs) and emergency medical technicians (EMTs).
- *UAP Training.* UAP in this area must have appropriate education in the care of the high-risk newborn and family, even when carrying out support services for the RN.
- *Accountability.* Neonatal RN responsible for the assessment, planning delivery and evaluation of newborn care.

National Association of School Nurses (NASN)

- *Delegation/Decision making.* Key factors for effective and competent use of assistive personnel are role definition, adequacy of training and appropriate delegation and supervision.
- *UAP Role.* Assistive personnel can be used to supplement professional school nursing services but should not be used to supplant school nurses or be permitted to practice nursing without a license.
- *UAP Titles.* School staff, clerical aides, health/nursing assistants (HA). Paraprofessionals are LPN/VNs, certified nurse aides and RNs who do not meet requirements for school nurses.
- *UAP Training.* The professional school nurse should take lead in helping school districts determine whether and how to use assistive health personnel.
- *Accountability.* The school nurse is the only one who can legally delegate nursing activities to assistive personnel.
- *Regulation.* State Nursing Practice Acts determine scope of practice and what nursing activities may be delegated or given to assistive personnel.

New Jersey State Nurses Association (NJSNA), 1995, revised 1999

- *Delegation/Decision making.* The RN may transfer responsibility for carrying out specified tasks to UAP to assist health care consumer through delegation of nursing tasks. RN in charge of delegating has confidence in the UAP and has adequate time allowed. Delegation may be direct or indirect.
- *UAP Role.* RNs must develop and implement standards, policies and procedures for UAPs to assist health care consumer in meeting basic needs. UAP does not practice nursing and does not provide total nursing care.
- *UAP Titles.* Nurse aides, orderlies, assistants, technicians and home health aides in hospitals, LTC, schools, prisons or community settings et al.



- *UAP Training.* Require education developed, taught and evaluated by RNs. UAP preparation is skill oriented to assist health care consumer in meeting basic human needs. UAP competency is evaluated by an RN and does not require a written examination.
- *Accountability.* The RN retains accountability for the outcomes of care.
- *Regulation.* New Jersey Board of Nursing, the same that governs nursing, should regulate UAPs.

New York State Nurses Association (NYSNA), 1996

- *Delegation/Decision making.* Does not address delegation. Speaks of RN assignment of tasks and care to other members of nursing staff, including UAP.
- *UAP Role.* Concern regarding shift in use of UAPs to more complex tasks and patients with higher acuity. RNs must express concern when the inappropriate use of UAPs is suggested or employed.
- *UAP Training.* Identification of tasks, patients and circumstances in which care can be assigned to UAPs is responsibility of the nursing profession. RNs need to be involved in establishing the parameters of care and in the standardization of preparation.
- *Nursing Education.* Forums should be established to prepare RNs to use UAPs appropriately.
- *Accountability.* RNs accountable for the delivery of safe, competent care to those patients entrusted to them.

Oncology Nursing Society (ONS), 1997, revised 2000, 2002

- *Delegation/Decision making.* RN validates UAP competency, completes ongoing client assessment, provides ongoing supervision of UAP, performs evaluation of client response to care and interprets and makes decisions regarding care.
- *UAP Role.* Performance of repetitive, common tasks and procedures that do not require the professional judgment of an RN.
- *Accountability.* Nurse retains accountability for delegated tasks and decisions.
- *Regulation.* Use existing mechanisms for regulation of nursing practice to regulate UAPs.

Society of Gastroenterology Nurses and Associates (SGNA), 1996, 2001

- *UAP Role.* Perform duties under direct, onsite supervision of delegated patient care.
- *UAP Titles.* GI assistants.

Society of Otorhionolaryngology and Head-Neck Nurses (SOHN), 1996, 2003

- *Delegation/Decision making.* Lists criteria to be considered in decision to use UAPs.
- *UAP Role.* Supports safe and appropriate use of UAP, supervised by RN, who identifies tasks and [level of] supervision.
- *UAP Training.* Promotes UAP education and training programs consistent with the SOHN mission and vision.
- *Accountability.* RN accountable for patient safety and nursing care and maintains responsibility for patient assessment, care planning and evaluation.

The American Association of Nurse Attorneys (TAANA)

- *UAP Role.* Increase in recent years partially due to managed care and decrease in Medicare reductions. Used in more settings, doing more complex tasks. Supervising nurses have increased responsibility.



- *UAP Titles.* Certified nurses aide, home health aide, personal care assistant, personal care attendant, certified phlebotomist, clinical assistant, nursing assistant and orderly.
- *UAP Training.* Recommend standardized curriculum and testing by state similar to OBRA 1987 requirements for long-term care assistants.
- *Nursing Education.* Recommend that nursing schools add team nursing to curriculum and/or supervision and delegation to assist working with UAPs.
- *Accountability.* Nurses ultimately responsible for the provision of nursing care.
- *Regulation.* Recommend Board provide guidance and direction, including criteria for determining what can and cannot be delegated, and direction on the type of supervision needed.

Tri-Council, 1995

- *Delegation/Decision making.* Must be made by RN based on the patient, task, preparation of the UAP and other factors.
- *UAP Role.* Increase use due to economic pressures. Increase concerns about role and use of UAP.
- *Accountability.* Nurses accountable for all nursing care provided including policies, procedures and standards.
- *Regulation.* Board of nursing.



Attachment C

NCSBN and Continued Competence: The Current Model and Recommendations for Future Initiatives

Purpose

The purpose of this paper is to describe the new approach for continued competence requirements that have been developed by the Practice, Regulation and Education Subcommittee to Revise Models (Subcommittee) and incorporated into the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. This paper also articulates the subcommittee's rationale for the approach to using practice as the strongest current measure for continued competence. Recommendations for ongoing work regarding continued competence are discussed.

Introduction

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 the evolving health care environment. Public concerns about medical error and patient safety are prominent media topics and political issues. Increasingly, licensing boards are challenged to provide assurance to the public that licensees meet minimum levels of competence throughout their careers. No profession has devised a perfect solution for assuring continued competence. But in a world where the half-life of knowledge can be measured in months and technology is expanding exponentially, continued competence and the need for life-long learning has never been so important. Continued competence is a critical regulatory challenge of the 21st century.

Since 1978, NCSBN has provided psychometrically sound and legally defensible licensing examinations that provide the means for the assessment of knowledge, skills and abilities of individuals applying for entry into nursing practice. Boards can be assured that the examination, combined with review of education and other requirements for licensure, provide a sound basis for decisions to grant initial authority to practice nursing. Boards are much less sure about how to evaluate the ongoing competence of nurses.

Background

NCSBN has struggled with the concept of continued competence for many years. Starting in 1985, NCSBN has explored the regulatory role in continued competence and attempted to develop some practical approaches toward implementing that role. In 1991, NCSBN published a Conceptual Framework on Continued Competency, which stated that both assessment to identify learning needs and strategies to address those needs are critical to assuring ongoing competence of nurses. In 1996, NCSBN defined competence 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. This definition is applicable to all nurses at every level of practice, in all practice settings.

Using the nursing literature and a variety of resources, NCSBN raised questions, identified guiding principles and offered possible strategies for approaching the challenge of ongoing competence. One proposal by NCSBN was using a portfolio for the regulatory management of continued competence. This was called the Continued Competence



Accountability Profile (CCAP) and it had many similarities to the portfolio approach used by the Ontario College of Nursing. When CCAP was presented to the NCSBN membership at the 1998 Area Meetings, it was found to be interesting but not administratively feasible for boards at that time. CCAP was tabled.

A variety of Member Board actions have been described in NCSBN work. These actions continue to be reflected in various chapters of the revised model and include:

- Establishing standards for safe and effective practice.
- Communicating standards to consumers, nurses, nursing educators, employers and other regulators.
- Holding individual nurses accountable for safe and effective practice.
- Engaging in collaborative activities with nurses, educators, employers and consumers to ensure nurses practice safely and effectively.
- Identifying a variety of techniques nurses may employ to demonstrate competence.
- Disciplining nurses who fail to meet standards for safe and effective practice.
- Informing the public of disciplinary actions taken against nurses.
- Establishing nondisciplinary models to monitor and/or limit the practice of nurses who demonstrate the inability to carry out essential nursing role functions.

Many concepts identified in previous NCSBN work continue to be applicable to current nursing practice and regulation, and were considered in the work of this subcommittee. Most importantly, a recent NCSBN research project, *Exploring the Value of Continuing Education Mandates* (Smith, 2003) revealed how professionals perceive they have attained professional development. This research has been used to support the continued competence approach used in the current models.

Guiding Principles Utilized by Subcommittee

These statements were used to guide the selection of the regulatory approach incorporated into the revised models:

- The primary responsibility of boards of nursing is to protect the public.
- Licensure is a privilege, not a right. Therefore, each licensed nurse has responsibility to the licensing entity granting the authority to practice and to the public who receives nursing services.
- Boards have a role in assuring the public that licensed nurses meet minimum standards of competence throughout their professional lives.
- Regulatory approaches to continued competence, in order to be viable, must be:
 - Administratively feasible
 - Publicly credible
 - Professionally acceptable
 - Legally defensible
 - Economically affordable
- Attaining, maintaining and advancing competence is a joint responsibility between the individual nurse, employer, licensing board, educator and profession.

Subcommittee Premises, Values and Beliefs Regarding Continued Competence

The following statements delineate other considerations in developing the revised models:

- The public expects safe and competent nursing care.



- The public expects boards of nursing to regulate the practice and monitor the competence of nurses throughout their careers.
- The nurse is responsible for maintaining competence in nursing practice through the process of life-long learning. It is an essential component of professional accountability.
- Professional accountability also requires nurses to recognize limitations and place themselves in settings and roles that allow them to function safely.
- Minimum, essential competence for safe practice includes elements such as critical thinking, interpersonal relations, basic nursing principles and aspects of jurisprudence/ethics.
- Continued competence requirements apply to endorsement, renewal and reinstatement of licensure.
- Reentry into nursing practice following a significant period of absence from practice requires evidence of current knowledge, skills and abilities.
- What constitutes “minimal, essential” varies over time, just as advances in knowledge and technology vary over time.
- Excellence is desirable but is within the purview of the professional rather than the regulatory community. Collaboration between the professional and regulatory communities is both logical and reasonable since growth and excellence are on a continuum with minimal, essential.

Continued Competence Regulation: A new Approach

Article III, §5 C 4. of the Model Nursing Practice Act grants broad authority to the board of nursing to develop standards for maintaining competence of licensees and for licensees returning to practice. Currently, boards of nursing vary in continued competence requirements; approaches include mandatory continuing education and required hours of practice. Some boards are exploring the use of portfolios, similar to CCAP and the reflective practice concept developed by the Ontario College of Nursing.

Chapter Five, 5.9.3 of the Model Nursing Administrative Rules sets forth a minimum practice hour requirement for addressing continued competence. This approach requires every licensed nurse to verify <x> hours of practice satisfactory to the board in the three years immediately preceding application for license renewal (the actual number of hours required would be determined by the state implementing this approach). Nurses would be expected to attest to and document the number of hours practiced in the preceding three years on a form provided by the board (e.g., the renewal application) and be subject to audit at the discretion of the board. It would be the responsibility of the licensee to demonstrate to the board how activities constitute nursing practice.

Research has demonstrated that continuing education does not assure competence. However, continuing education is an important and useful strategy for professional development, and an activity undertaken by many nurses. In a recent NCSBN study, a majority of nurses attended continuing education courses regardless of a board mandate. The study also revealed that nurses who selected courses of convenience over more practice relevant programs were apt to be satisfying mandatory continuing education requirements.

Rationale for Practice Approach

The requirement to demonstrate minimum practice hours for license renewal is based on NCSBN research that indicated the factor that contributed most to professional development was the practice of that profession. Five other health care professions participated in this research study with the same outcomes. The three-year time frame was selected to be congruent with the reinstatement requirements (5.11.2) that a nursing refresher course is required for licensure reinstatement of an individual who has been out of practice three



years or longer. If a nurse cannot report the minimum number of practice hours in the three years preceding application for renewal, his or her license would lapse and the nurse would not be eligible for licensure renewal until completing the requirements of 5.11.2.

The subcommittee recognizes that the quality of practice experiences will vary with nurses practicing in different facilities, agencies and types of employers. Minimum practice hours do assure currency of practice. When making application for renewal, nurses will need to think about how their day-to-day activities relate to nursing practice. Examples of satisfactory practice hours may include clinical practice, nursing education (both as educator and as student), nursing research and performance of other activities requiring a nursing license. Boards are encouraged to provide guidelines for nurses regarding the practice requirement through policy development.

The subcommittee believes that requiring minimum practice hours meets the following criteria:

- Administratively feasible with quantifiable hours for the board to review and opportunity for boards to work within current available resources to determine numbers and processes for audits;
- Professionally acceptable to the nurse as having relevance to the practice setting, area of practice and role;
- Publicly acceptable as being a positive step toward looking at ongoing competence;
- Legally defensible as having a rational relationship to competence; and
- Economically affordable for both the nurse and board.

Recommendations for Further Work

The PR&E Models Revision Subcommittee was charged to complete a comprehensive review of the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. There are several areas of the models that will be subject to the evolution of new knowledge and analysis of the regulatory role. One of these topics is continued competence. There are several NCSBN research projects currently underway that will provide more information about the development of continued competence. The subcommittee views continued competence as a major regulatory challenge for the new century and recommends continued work in this area.

Recommended future NCSBN activities:

- Analyze outcomes of NCSBN research (studies such as the *Post-Entry Competence Study*, the *Practice and Professional Issues Studies*, the *Epidemiology of Nursing Error Study*, and future work of the Practice Breakdown Focus Group).
- Analyze outcomes of state nursing board continued competence initiatives.
- Analyze approaches utilized by other professions.
- Take the lead to collaborate with other nursing organizations, educators, employers, nurses and other stakeholders to identify essential nursing competencies.
- Revisit the management of continued competence.
- Explore forms of assessment of continued competence, which may include testing.

The subcommittee's recommendation regarding the identification of the essential nursing competencies acknowledges that NCSBN is well positioned for this leadership role. NCSBN research initiatives are obtaining rich data related to nursing practice. NCSBN has access, through its Member Boards, to all licensed nurses. NCSBN can use its established meetings as well as nationally convened nurse focus groups to validate findings. Work on essential nursing competencies can be used to inform nursing regulation and identify next steps for the advancement of continued competence.



Assuring continued competence is complicated in a profession with varying scopes, levels and settings of practice. Requiring practice hours, while appropriate at this point in time, does not go far enough in delineating the regulatory role regarding continued competence. The ongoing NCSBN research and other new knowledge will provide additional data to support further work in this area.



Attachment D

Model Act and Rules

Model legislation is a way to look at issues and needs in a comprehensive manner. Models can be used to identify essential elements for legislation. They can also encompass new ideas and approaches to regulation. And while there will always be some variation with state nursing statutes, models are a way to advance a degree of uniformity among the several states to promote a common nationwide understanding of what constitutes the practice of nursing. This is increasingly important in a mobile society where nurses often relocate to meet both professional and personal interests.

Model laws and rules provide resources for boards of nursing that are used in a variety of ways. Boards may look to the models for new ideas and different approaches for regulation, use them in evaluating their existing regulatory language, or use the framework and/or language in developing amendments and revisions to state laws and rules. The models may assist in the development of rationales for rules as part of the rule promulgation process.

In the early years of NCSBN, Member Boards expressed the need for a model nurse practice act. Financial support for proposing model legislation was provided through the W.K. Kellogg Foundation grant obtained by NCSBN in its initial years. The 1982 Delegate Assembly adopted the first Model Nursing Practice Act. The Model Nursing Administrative Rules followed in 1983. The model rules served to clarify and make more specific the model act. Rules must be consistent with the law, cannot go beyond the law, and once enacted have the force and effect of law. The model act and rules were revised in 1988 and 1993-1994.

This is the third major revision of the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. The Practice, Regulation & Education Model Rules Revision Subcommittee has spent three years reviewing, researching, drafting and refining the revised models for presentation to the 2004 Delegate Assembly. In completing this project, the subcommittee has consulted with other NCSBN committees, NCSBN staff, Member Boards and interested external groups.

As nursing education, practice and policy evolves, so must the laws and rules that regulate nursing. New concepts, such as the Nurse Licensure Compact, have been incorporated into this revision. The document has been developed to be an electronic resource. Once adopted, it will be available on the NCSBN Web site. The models have been prepared in a format that tracks the act in one column and the rules in the other. This formatting was intended to show the interrelationship and congruency of the model law and the model rules. The model act was used as the framework, and the rules reorganized to follow an outline reflecting the organization of the model act.

These models are intended to serve as a guide to boards in considering revision to state nurse practice acts and nursing administrative rules. Potential users of the model act and model rules are urged to study them in the context of the law in their particular jurisdiction. Seeking legal counsel in implementing elements of these models will assist in determining that there is congruence with the existing law. If there are conflicts, legal counsel can assist to adapt the model approaches to be consistent with the existing state statutory or constitutional law.

The question has been asked if this model is an inspirational document that presents a higher standard to strive for or whether it reflects the current state of regulation. The answer is that it is both. Much of law and rule language in the document is very pragmatic and does reflect current practice. There are also new ideas, new approaches



and suggestions for future goals. Once adopted, the models will become an electronic document, supplemented with multiple appendices that provide additional resources and links. The electronic model will be broadly accessible and easy to update as needed. The subcommittee's vision is a living document to be regularly reviewed and revised, responsive to changes in nursing and the health care environment, frequently consulted, and used for multiple purposes.



Model Nursing Practice Act

Introduction to Revised Models

- Article I. Title and Purpose
- Article II. Scope of Nursing Practice
- Article III. Definitions
- Article IV. The Board of Nursing
- Article V. Application of Other Statutes
- Article VI. Licensure
- Article VII. Titles and Abbreviations
- Article VIII. Approval of Nursing Education Programs
- Article IX. Violations and Penalties
- Article X. Discipline and Proceedings
- Article XI. Emergency Relief
- Article XII. Reporting
- Article XIII. Exemptions
- Article XIV. Revenue and Fees
- Article XV. Implementation
- Article XVI. Nurse Licensure Compact
- Article XVII. APRN Compact

Model Nursing Administrative Rules

- Chapter One – Title and Purpose
- Chapter Two – Standards of Nursing Practice
- Chapter Three – Definitions
- Chapter Four – The Board of Nursing
- Chapter Five – Application of Other Statutes
- Chapter Six – Licensure
- Chapter Seven – Titles and Abbreviations
- Chapter Eight – Approval of Nursing Education Programs
- Chapter Nine – Violations and Penalties
- Chapter Ten – Discipline and Proceedings
- Chapter Eleven – Emergency Relief
- Chapter Twelve – Reporting
- Chapter Thirteen – Exemption
- Chapter Fourteen – Revenue and Fees
- Chapter Fifteen – Implementation
- Chapter Sixteen – Nurse Licensure Compact



Model Nursing Practice Act

Model Nursing Administrative Rules

Article I. Title and Purpose

Section 1. Title of Act. This Act shall be known and may be cited as The <NAME OF STATE> Nursing Practice Act.

Section 2. Description of Act. An Act concerning the regulation of nursing that creates and empowers the state board of nursing to regulate nursing and to enforce the provisions of this act.

**** The language was changed to concisely describe the Act as concerning the regulation of nursing and creating the board to enforce the Act.*

Section 3. Purpose. The legislature finds that the practice of nursing is directly related to the public health, safety and welfare of the citizens of the state and is subject to regulations and control in the public interest to assure that nurses at all levels are qualified and competent. It is further declared that the practice of nursing, as defined in the Act, merits and deserves the confidence of the public and that only qualified persons be permitted to engage in the practice of nursing. The legislature recognizes that the practice of nursing is continually evolving and responding to changes within health care patterns and systems.

****This model recognizes that nursing is an evolving profession and acknowledges overlapping functions with other health care providers.*

Chapter One – Title and Purpose

1.1 Title. This section of the administrative rules shall be known and may be cited as the <NAME OF STATE> Nursing Administrative Rules.

**** If a board of nursing has developed a board philosophy and wishes to include it in the administrative rules, this would be an appropriate section to make that statement.*

Article II. Scope of Nursing Practice

Section 1. Practice of Nursing. Nursing is a scientific process founded on a professional body of knowledge; it is a learned profession based on an understanding of the human condition across the lifespan and the relationship of a client with others and within the environment; and it is an art dedicated to caring for others. The practice of nursing means assisting clients to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals within the context of a client-centered health care plan, and evaluating responses to nursing care and treatment. Nursing is a dynamic discipline that is continually evolving to include more sophisticated knowledge, technologies and client care activities.

Chapter Two – Standards of Nursing Practice

****Article II of the Model Nursing Practice Act (MNPA) and Chapter Two of the Model Nursing Administrative Rules (MNAR) address scopes of nursing practice and standards for nursing practice, respectively. The rules have been reordered to follow the framework provided by the MNPA so that the scope defined in the MNPA and the standards delineated in the MNAR can be viewed together to facilitate their use.*

2.1 PURPOSE OF STANDARDS

- A. To communicate board expectations and provide guidance for nurses regarding safe nursing practice.
- B. To articulate board criteria for evaluating the practice of nurses to determine if the practice is safe and effective.

****Standards promulgated by boards of nursing provide a broad framework for nursing practice and provide notice to nurses as to board expectations regarding practice. Nursing standards developed by professional and specialty nursing organizations complement board standards, provide detail and specificity, and are typically drafted to promote excellence in clinical practice.*

Model Nursing Practice Act

Section 2. Registered Nurse. Practice as a registered nurse means the full scope of nursing, with or without compensation or personal profit, that incorporates caring for all clients in all settings; is guided by the scope of practice authorized in this section, through nursing standards established or recognized by the board and includes, but is not limited to:

- A. Providing comprehensive nursing assessment of the health status of clients.

****Comprehensive nursing assessment is an extensive data collection (initial and ongoing) for individuals, families, groups and communities addressing anticipated changes in client conditions as well as emerging changes in a client's health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing interventions, evaluate the need for different interventions, and the need to communicate and consult with other health team members.*

- B. Collaborating with health care team to develop an integrated client-centered health care plan.
- C. Developing a strategy of nursing care to be integrated within the client-centered health care plan that establishes nursing diagnoses; setting goals to meet identified health care needs; prescribing nursing interventions; and implementing nursing care through the execution of independent nursing strategies and regimens requested, ordered or prescribed by authorized health care providers.
- D. Delegating and assigning nursing interventions to implement the plan of care.
- E. Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.
- F. Promoting a safe and therapeutic environment.
- G. Advocating for clients by attaining and maintaining what is in the best interest of clients.
- H. Evaluating responses to interventions and the effectiveness of the plan of care.
- I. Communicating and collaborating with other health care providers in the management of health care and the implementation of the total health care regimen within and across care settings.
- J. Acquiring and applying critical new knowledge and technologies to the practice domain.
- K. Managing, supervising and evaluating the practice of nursing.

Model Nursing Administrative Rules**2.2.1 Standards Related to Registered Nurse Professional Accountability**

The registered nurse:

- A. Practices within the legal boundaries for nursing through the scope of practice authorized in the Nurse Practice Act and rules governing nursing.
- B. Demonstrates honesty and integrity in nursing practice.
- C. Bases professional decisions on nursing knowledge and skills, the needs of clients, and the expectations delineated in professional standards.
- D. Accepts responsibility for judgments, individual nursing actions, competence, decisions and behavior in the course of nursing practice.
- E. Maintains continued competence through ongoing learning and application of knowledge in the client's interest.

****The first two standards reflect 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 on the client's behalf. Nursing judgments and actions include decisions made when delegating nursing tasks to others, and providing supervision for those activities. The delegating/supervising nurse is not accountable in the sense of having to stand at the delegate's elbow throughout the activity. The delegating/supervising nurse is accountable for decisions made and actions taken in the course of that delegation/supervision.*

2.2.2 Standards Related to Registered Nurse Responsibility for Nursing Practice Implementation

The registered nurse:

- A. Conducts a comprehensive nursing assessment that is an extensive data collection (initial and ongoing) regarding individuals, families, groups and communities.
- B. Detects faulty or missing patient/client information.
- C. Applies nursing knowledge effectively in the synthesis of the biological, psychological and social aspects of the client's condition.
- D. Uses this broad and complete analysis to plan strategies of nursing care and nursing interventions that are integrated within the client's overall health care plan.
- E. Provides appropriate decision-making, critical thinking and clinical judgment to make independent nursing decisions and nursing diagnoses.
- F. Seeks clarification of orders when needed.



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- L. Teaching the theory and practice of nursing.
- M. Participating in development of policies, procedures and systems to support the client.
- N. Other acts that require education and training as prescribed by the board commensurate with the registered nurse's continuing education, demonstrated competencies and experience.

- G. Implements treatments and therapy, including medication administration, delegated medical and independent nursing functions.
- H. Obtains orientation/training for competence when encountering new equipment and technology or unfamiliar care situations.
- I. Demonstrates attentiveness and provides client surveillance and monitoring.
- J. Identifies changes in client's health status and comprehends clinical implications of client signs, symptoms and changes, as part of expected and unexpected client course or emergent situations.
- K. Evaluates the impact of nursing care, the client's response to therapy, the need for alternative interventions, and the need to communicate and consult with other health team members.
- L. Documents nursing care.
- M. Intervenes on behalf of client when problems are identified and revises care plan as needed.
- N. Recognizes client characteristics that may affect the client's health status.
- O. Takes preventive measures to protect client, others and self.

2.2.3 Standards Related to Registered Nurse Responsibility to Act as an Advocate for Client

The registered nurse:

- A. Respects the client's rights, concerns, decisions and dignity.
****This standard includes respecting the client's concerns regarding end-of-life care.*
- B. Identifies client needs.
- C. Attends to client concerns or requests.
- D. Promotes safe client environment.
- E. Communicates client choices, concerns and special needs with other health team members regarding:
 1. Client status and progress.
 2. Client response or lack of response to therapies.
 3. Significant changes in client condition.
- F. Maintains appropriate professional boundaries.
- G. Maintains client confidentiality.
- H. Assumes responsibility for nurse's own decisions and actions.

**Model Nursing Practice Act****Model Nursing Administrative Rules****2.2.4 Standards Related to Registered Nurse Responsibility to Organize, Manage and Supervise the Practice of Nursing**

The registered nurse:

- A. Assigns to another only those nursing measures that fall within that nurse's scope of practice, education, experience and competence or unlicensed person's role description.
- B. Delegates to another only those nursing measures which that person has the necessary skills and competence to accomplish safely.
- C. Matches client needs with personnel qualifications, available resources and appropriate supervision.
- D. Communicates directions and expectations for completion of the delegated activity.
- E. Supervises others to whom nursing activities are delegated or assigned by monitoring performance, progress, and outcomes. Assures documentation of the activity.
- F. Provides follow-up on problems and intervenes when needed.
- G. Evaluates the effectiveness of the delegation or assignment.
- H. Intervenes when problems are identified and revises plan of care as needed.
- I. Retains professional accountability for nursing care as provided.
- J. Promotes a safe and therapeutic environment by:
 - 1. Providing appropriate monitoring and surveillance of the care environment.
 - 2. Identifying unsafe care situations.
 - 3. Correcting problems or referring problems to appropriate management level when needed.
- K. Teaches and counsels client and families regarding health care regimen, which may include but is not limited to, general information about health and medical condition, specific procedures and wellness and prevention.

2.2.5 Standards Related to Registered Nurse Responsibilities as a Member of an Interdisciplinary Health Care Team

The registered nurse:

- A. Functions as a member of the health care team, collaborating and cooperating in the implementation of an integrated client-centered health care plan.
- B. Respects client property and the property of others.
- C. Protects confidential information.



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	<p>2.2.6 Standards Related to the Registered Nurse When Functioning in a Chief Administrative Officer Role</p> <p><i>The registered nurse as a chief administrative nurse:</i></p> <ul style="list-style-type: none">A. Assures that organizational policies, procedures and standards of nursing practice are developed, kept current and implemented to promote safe and effective nursing care for clients.B. Assures that the knowledge, skills and abilities of nursing staff are assessed and that nurses and nursing assistive personnel are assigned to nursing positions appropriate to their determined competence and licensure/certification/ registration level.C. Assures that competent organizational management and management of human resources within the nursing organization are established and implemented to promote safe and effective nursing care for clients.D. Assures that thorough and accurate documentation of personnel records, staff development, quality assurance and other aspects of the nursing organization are maintained. <p><i>***Assessing the knowledge, skills and abilities of nursing staff includes initial and periodic validation of licensure status.</i></p> <p>2.2.7 Standards Related to the Registered Nurse when Functioning in a Nursing Program Educator (Faculty) Role</p> <p><i>The registered nurse as nursing faculty:</i></p> <ul style="list-style-type: none">A. Teaches current theory, principles of nursing practice and nursing management.B. Provides content and clinical experiences for students consistent with the MNPA, board promulgated administrative rules, and other relevant state statutes.C. Supervises students in the provision of nursing services.D. Evaluates student scholastic and clinical performance with expected program outcomes.
<p>Section 3. Licensed Practical/Vocational Nurse. Practice as a licensed practical/vocational nurse means a directed scope of nursing practice, with or without compensation or personal profit, under the supervision of the registered nurse, advanced practice registered nurse, licensed physician or other health care provider authorized by the state; is guided by nursing standards established or recognized by the board; and includes, but is not limited to:</p> <ul style="list-style-type: none">A. Collecting data and conducting focused nursing assessments of the health status of individuals.	<p>2.3.1 Standards Related to Licensed Practical/Vocational Nurse Professional Accountability</p> <p><i>The licensed practical/vocational nurse:</i></p> <ul style="list-style-type: none">A. Practices within the legal boundaries for practical nursing through the scope of practice authorized in the MNPA and rules governing nursing.B. Demonstrates honesty and integrity in nursing practice.C. Bases nursing decisions on nursing knowledge and skills, the needs of clients and the expectations delineated by the board.

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**** A focused assessment is an appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the registered nurse, supporting ongoing data collection, and deciding who needs to be informed of the information and when to inform.*

- B. Planning nursing care episode for individuals with stable conditions.
- C. Participating in the development and modification of the comprehensive plan of care for all types of clients.
- D. Implementing appropriate aspects of the strategy of care within client centered health care plan.
- E. Participating in nursing care management through delegating to assistive personnel and assigning to other LPN/VNs nursing interventions that may be performed by others and do not conflict with the act.
- F. Maintaining safe and effective nursing care rendered directly or indirectly.
- G. Promoting a safe and therapeutic environment.
- H. Participating in health teaching and counseling to promote, attain and maintain the optimum health level of clients.
- I. Serving as an advocate for the client by communicating and collaborating with other health service personnel.
- J. Participating in the evaluation of client responses to interventions.
- K. Communicating and collaborating with other health care professionals.
- L. Providing input into the development of policies and procedures.
- M. Other acts that require education and training as prescribed by the board, commensurate with the licensed practical nurse's experience, continuing education and demonstrated licensed practical/vocational nurse competencies.

Each nurse is accountable to clients, the nursing profession and the board for complying with the requirements of this Act; and for the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.

****Additions to the LPN/VN scope of practice are based on analysis of the various elements that make up this scope as evidenced by the most recent LPN job analysis. This remains a directed scope of practice.*

****The first step in the nursing process, assessment, is the basis for nursing decisions and interventions. The subcommittee believes that the first step is implemented in much the same way across jurisdictions, but that it is described and*

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- D. Accepts responsibility for individual nursing actions, competence, decisions and behavior in the course of practical nursing practice.
- E. Maintains continued competence through ongoing learning and application of knowledge in the client's interest.

2.3.2 Standards Related to Licensed Practical/Vocational Nurse

Responsibilities for Nursing Practice Implementation.

The licensed practical/vocational nurse practicing under the direction of a registered nurse, advanced practice registered nurse, licensed physician or other authorized licensed health care provider:

- A. Conducts a focused nursing assessment, which is an appraisal of the client's status and situation at hand that contributes to ongoing data collection.
- B. Plans for episodic nursing care.
- C. Demonstrates attentiveness and provides client surveillance and monitoring.
- D. Assists in identification of client needs.
- E. Seeks clarification of orders when needed.
- F. Demonstrates attentiveness and provides observation for signs, symptoms and changes in client condition.
- G. Assists in the evaluation of the impact of nursing care. Contributes to the evaluation of client care.
- H. Recognizes client characteristics that may affect the client's health status.
- I. Obtains orientation/training for competency when encountering new equipment and technology or unfamiliar care situations.
- J. Implements appropriate aspects of client care in a timely manner:
 1. Provides assigned and delegated aspects of client's health care plan.
 2. Implements treatments and procedures.
 3. Administers medications accurately.
- K. Documents care provided.
- L. Communicates relevant and timely client information with other health team members.
 1. Client status and progress.
 2. Client response or lack of response to therapies.
 3. Significant changes in client condition.
 4. Client needs.



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discussed very differently. The subcommittee members believe that both LPN/VNs and RNs assess but identified a significant difference in the breadth, depth and comprehensiveness of the assessments conducted by the two levels of licensed nurses. These differences are reflected in the term “focused assessment” to describe the LPN/VN role in the first step of the nursing process and the term “comprehensive assessment” to describe the role of the RN (see definitions in Section 4 below).

****An alternative for boards that have difficulty with the term assessment is to not use the term with either LPN/VN or RN practice, but rather describe what is expected of the level of licensee for the first step of the nursing process. See definitions below for focused assessment and comprehensive assessment for these descriptions.*

M. Participates in nursing management:

1. Assigns nursing activities to other licensed practical/vocational nurses.
2. Delegates nursing activities for stable clients to assistive personnel.
3. Observes nursing measures and provides feedback to nursing manager.
4. Observes and communicates outcomes of delegated and assigned activities.

N. Takes preventive measures to protect client, others and self.

O. Respects client’s rights, concerns, decisions and dignity.

****This standard includes respecting the client’s concerns regarding end-of-life care.*

P. Attends to client or family concerns or requests.

Q. Promotes safe client environment.

R. Maintains appropriate professional boundaries.

S. Assumes responsibility for nurse’s own decisions and actions.

2.3.3 Standards Related to Licensed Practical/Vocational Nurse Responsibilities as a Member of an Interdisciplinary Health Care Team

The licensed practical/vocational nurse:

- A. Functions as a member of the health care team, contributing to the implementation of an integrated health care plan.
- B. Respects client property and the property of others.
- C. Protects confidential information unless obligated by law to disclose the information.

Section 4. Advanced Practice Registered Nurse. Advanced practice registered nursing by nurse practitioners, nurse anesthetists, nurse midwives or clinical nurse specialists is based on knowledge and skills acquired in basic nursing education; licensure as a registered nurse; graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and specialty.

Practice as an advanced practice registered nurse means an expanded scope of nursing in a category approved by the board, with or without compensation or personal profit, and includes the registered nurse scope of practice. The scope of an advanced practice registered nurse includes but is not limited to performing acts of advanced assessment, diag-

2.4.1 Standards Related to the Advanced Practice Registered Nurse

- A. The advanced practice registered nurse shall comply with the standards for registered nurses as specified in 2.2.1-2.2.7 above, and to the standards of the national professional associations approved by the board. Standards for a specific role and specialty of advanced practice registered nurse supersede standards for registered nurses where conflict between the standards, if any, exists.
- B. Advanced practice registered nurses are expected to practice within standards established by the board in rule and assure client care is provided according to relevant client care standards approved by the boards, including standards of national professional associations.



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nosing, prescribing, selecting, administering and dispensing therapeutic measures, including over-the-counter drugs, legend drugs and controlled substances, within the advanced practice registered nurse's role and specialty appropriate education and certification.

Advanced practice registered nurses are expected to practice within standards established or recognized by the board. Each advanced practice registered nurse is accountable to clients, the nursing profession and the board for complying with the requirements of this Act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring clients to other health care providers as appropriate.

****Evidence-based practice guidelines developed by recognized authority may be applied to the practice domain by advanced practice registered nurses to promote optimal client outcomes.*

Article III. Definitions

Section 1. Board. Board means the <NAME OF STATE> Board of Nursing.

Section 2. Other Board. Other Board means the comparable regulatory agency in any U.S. state, territory or the District of Columbia.

Section 3. License. License means current authority to practice nursing as a registered nurse, licensed practical nurse or advanced practice registered nurse.

Chapter Three – Definitions

Section 4. Other Definitions.

- A. **Advanced assessment.** Assessment by an advanced practice registered nurse based on additional knowledge and skill developed, a graduate level nursing education program in the APRN category, and the nurse's experience working in the APRN role.
- B. **Alford plea.** Plea agreements where the defendant may plead guilty yet not admit all the facts that comprise the crime. North Carolina v. Alford, 40 US 25, 91 S Ct 160, 27 L Ed2d 162 (1970).
- C. **Assignment.** Designating nursing activities to be performed by another nurse or assistive personnel that are consistent with his/her scope of practice (licensed person) or role description (unlicensed person).
- D. **Chief administrative nurse.** The registered nurse who oversees the provision of nursing services in an organization, regardless of title.
- E. **Client.** The client, as a recipient of care, may be an individual, family, group or community.

3.4 OTHER DEFINITIONS.

- A. **Adjunct faculty.** Temporary nursing faculty, in addition to regular program faculty, used to enrich student experiences.
- B. **Clinical judgment.** The application of the nurse's knowledge and experience in making decisions about client care.
- C. **Content validity.** The degree to which an examination is representative of a defined body of knowledge.
- D. **Cultural bias.** Nonnursing elements of examination items that may influence the performance of culturally distinct groups of examinees.
- E. **Direction.** Monitoring and guiding the practice of another through written or verbal communication.
- F. **Distance education.** Teaching/learning strategies used to meet the learning needs of students, when the students and faculty are separate from each other.

****This model uses a broad definition that captures many different technological approaches. Other sources may use this term in a more restricted fashion.*



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- F. *Client-centered health care plan.* Identification of desired goals, strategies for meeting goals and processes for promoting, attaining and maintaining optimal client health outcomes. The multidiscipline health care team partners with the client to develop this plan. Team members identify, respect, and care about client differences, values, preferences and expressed needs.
- G. *Competence.* 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.
- H. *Competence Assessment.* Evaluation of the practitioner's knowledge, skills and abilities. Assessment mechanisms may include examination, peer review, professional portfolio and professional certification.
- I. *Competence Conduct.* The health and behavior expectations that 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.
- J. *Competence Development.* The method by which a practitioner gains, maintains or refines practice knowledge, skills and abilities. This development can occur through a formal education program, continuing education or clinical practice, and is expected to continue throughout the practitioner's career.
- K. *Comprehensive nursing assessment by RN.* An extensive data collection (initial and ongoing) for individuals, families, groups and communities addressing anticipated changes in client conditions as well as emerging changes in a client's health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses; planning nursing interventions, evaluating need for different interventions, and the need to communicate and consult with other health team members.
- L. *Delegation.* Transferring to a competent individual the authority to perform a selected nursing task in a selected situation.
- M. *First officer.* The presiding officer of the board who may be called "board president" in some jurisdictions and "board chairman" in others.

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- G. *Episodic care.* Nursing care that occurs at nonspecific intervals, focused on the individual and situation at hand.
- H. *Faculty directed clinical practice.* The role of nursing program faculty in overseeing student clinical learning including those programs utilizing preceptors.
- I. *Grandfathering.* Provision in a new law or regulation exempting those already in or a part of the existing system that is being regulated. An exception to a restriction that allows all those already doing something to continue doing it even if they would be stopped by the new restriction.
- J. *Informatics.* Information technology that can be used to communicate, manage knowledge, mitigate error, and support decision making.
- K. *Interdisciplinary faculty.* Faculty from other professions who, in addition to regular program faculty, add diversity and enrich student experiences.
- L. *Interdisciplinary team.* All individuals involved in providing a client's care, who cooperate, collaborate, communicate and integrate care to ensure that care is continuous and reliable.
- M. *NCLEX-PN®.* The National Council Licensure Examinations for Practical Nurses is used in the United States and its territories to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.
- N. *NCLEX-RN®.* The National Council Licensure Examinations for Registered Nurses is used in the United States and its territories to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.
- O. *Nursing program faculty.* Individuals employed full or part time by academic institution responsible for developing, implementing, evaluating and updating curricula.
- P. *Nurse refresher course.* A formal program with both didactic and clinical components, designed to prepare a nurse who has been out of practice to reenter into the profession.
- Q. *Nursing management.* The coordination and integration of resources through planning, organizing, directing and controlling the provision of nursing services while managing role differences and staffing to accomplish specific institutional goals and objectives within the context of legal considerations, regulatory issues, patient safety and continuous quality improvement.
- R. *Preceptors.* An individual at or above the level of licensure that an assigned student is seeking, who may serve as a teacher, mentor, role model and/or supervisor in a clinical setting.



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- N. *Focused nursing assessment by LPN/VN.* An appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the registered nurse, supporting ongoing data collection, and deciding who needs to be informed of the information and when to inform.
- O. *Health care provider.* An individual authorized (e.g., licensed or certified) to prescribe and/or administer various aspects of health care.
- P. *Independent nursing strategies.* Nursing activities based on nursing assessment, within the nurse's scope of practice and not subject to control by others.
- Q. *Internationally educated nurse.* A nurse educated outside the United States who applies for state licensure or seeks temporary authorization to practice as a graduate nursing student to complete program objectives.
- R. *Interpretive statement.* A statement developed by a board of nursing to provide guidance, clarification and direction regarding whether nursing practice procedures or policies comply with acceptable standards of nursing practice as defined in the Nursing Practice Act and rules.
- S. *Lapsed license.* The termination of an individual's privilege to practice nursing due to the individual's failure to renew the nursing license within a specified period of time.
- ***Some boards of nursing refer to this situation as an *inactive license*.
- T. *Licensure by endorsement.* The granting of authority to practice based on an individual's licensure in another jurisdiction.
- U. *Licensure by examination.* The granting of authority to practice based on an individual's passing of a prescribed examination.
- V. *Licensure reinstatement.* The procedure of restoring or reestablishing a nursing license that has lapsed or that has been suspended, revoked or voluntarily surrendered.
- W. *Licensure renewal.* The process for periodic reissuing of the legal authority to practice.
- X. *Modified license.* A license to practice nursing within a scope of practice with limitations or with accommodations or both, as specified by the board through a nondisciplinary process.
- Y. *Moral turpitude.* Conduct that involves one or more of the following:
- Intentional, knowing or reckless conduct that causes injury or places another in fear of imminent harm.
 - Conduct done knowingly contrary to justice or honesty.

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- S. *Prescribed devices.* An instrument or an apparatus intended for use in diagnosis or treatment and in the prevention of disease or restoration of health.
- T. *Professional boundaries.* The space between the nurse's power and the client's vulnerability – the power of the nurse comes from the professional position and access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client's needs.
- U. *Professional certification.* A credential issued by a national certifying body meeting specified requirements acceptable to the board that is used a requirement for APRN licensure.
- V. *Quality improvement processes.* To identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to client and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.



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<ul style="list-style-type: none">■ Conduct that is contrary to the accepted and customary rule of right and duty that a person owes to fellow human beings and society in general.■ Conduct that is wrong in itself even if no statute were to prohibit the conduct. <p>Z. <i>Nolo contendere</i>. A “no contest” plea in a criminal case that has a similar effect as pleading guilty.</p> <p>AA. <i>Nursing services</i>. The professional practice and auxiliary functions that support the client’s meeting of the client’s desired health goals; and processes for promoting, attaining and maintaining optimal health outcomes.</p> <p>BB. <i>Nursing student</i>. A person studying in an approved nursing education program</p> <p>CC. <i>Prescribing</i>. Determining which legend drugs and controlled substances shall be used by or administered to a client exercised in compliance with applicable state and federal laws.</p> <p>DD. <i>Prescriptive authority</i>. The authority to determine the need for drugs, immunizing agents, or devices; selecting the remedy; and writing a prescription to be filled by a licensed pharmacist.</p> <p>EE. <i>Second officer</i>. The board member next in line after the first officer to be presiding officer, often called vice president or vice chair, but could also be the secretary, treasurer or other title.</p> <p>FF. <i>Strategy of nursing care</i>. Goal-oriented nursing activities developed within the client-centered health care plan to assist clients achieve optimal health potential.</p> <p>GG. <i>Supervision</i>. Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity.</p> <p>HH. <i>Unlicensed assistive personnel (UAP)</i>. Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.</p>	
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Model Nursing Practice Act**Model Nursing Administrative Rules****Article IV. The Board of Nursing****Section 1. Membership, Nominations, Qualifications, Appointment and Term of Office.**

- A. The board of nursing shall consist of < > members to be appointed by the governor < > days prior to the expiration of the term of office of a current member. Nominations for appointment may be made to the governor by any interested individual, association, or any other entity, provided that such nominations be supported by a petition executed by no less than < > qualified voters in this state. These nominations shall not be binding upon the governor.
- B. The membership of the board shall be at least < > members of registered nurses; at least < > members of licensed practical/vocational nurses; at least < > members of advanced practice registered nurses; and at least < > members representing the public.
- C. Each registered nurse member shall be an eligible voting resident in this state, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a registered nurse and shall have no less than five years of experience as a registered nurse, at least three of which immediately preceded appointment.
- D. Each licensed practical/vocational nurse member shall be an eligible voting resident in this state, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a licensed practical/vocational nurse and shall have no less than five years of experience as a licensed practical/vocational nurse, at least three of which immediately preceded appointment.
- E. Each advanced practice registered nurse member shall be an eligible voting resident in this state, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as an advanced practice registered nurse and shall have no less than five years of experience as an advanced practice registered nurse, at least three of which immediately preceded appointment.
- F. The representatives of the public shall be eligible voting residents of this state who are knowledgeable in consumer health concerns and shall not be associated with the provision of health care or be enrolled in any health-related education program.
- G. Membership shall be restricted to no more than one person who is associated with a particular agency, corporation, other enterprise or subsidiary at one time.
- H. Members of the board shall be appointed for a term of < > years.
- I. The present members of the board holding office under the

Chapter Four – The Board of Nursing

****Article IV of the MNPA and Chapter Four of the MNAR define the authority of the board of nursing and parameters for how it functions.*



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provisions of the <NAME OF ACT BEING AMENDED OR REPEALED> shall serve as members for their respective terms.

- J. No member shall serve more than two consecutive full terms. The completion of an unexpired portion of a full term shall not constitute a full term for purposes of this section. Any board member initially appointed for less than a full term shall be eligible to serve two additional terms.
- K. An appointee to a full term on the board shall be appointed by the governor before the expiration of the term of the member being succeeded and shall become a member of the board on the first day following the appointment expiration date. Appointees to unexpired terms shall become members of the board on the day following such appointment.
- L. Each term of office shall expire at midnight on the last day of the term of the appointment or at midnight on the date on which any vacancy occurs. If a replacement appointment has not been made, the term of the member shall be extended until a replacement is made.

Section 2. Officers.

- A. The board shall elect from its members officers. Officers elected by the board shall serve a term of < > years, beginning on the day of election and ending upon the election of successors.

****Boards of Nursing have different titles for their elected officers, e.g., president and vice president; chairman and vice chairman; or some other combination of officer titles.*

- B. The first officer shall preside at board meetings and shall be responsible for the performance of all duties and functions of the board required or permitted by this act. In the absence of the first officer, the second officer shall assume these duties.
- C. Additional offices shall be established and filled by the board at its discretion.

Section 3. Meetings. The board shall conduct meetings within the following guidelines:

- A. The board of nursing shall meet at least once every < > months to transact its business. One meeting shall be designated as the annual meeting for the purpose of electing officers and board reorganization and planning. The board shall meet such additional times as it may determine. Such additional meetings may be called by the first officer of the board or shall be called at the request of two-thirds of the board members.
- B. The board shall give official and public notice of the place and time of the meeting. Board meetings and hearings shall

4.3.1 Quorum.

- A. A majority of the board members, including the first or second officer, shall constitute a quorum for the conducting of a board meeting.
- B. The act of the majority of the members present at a meeting at which a quorum is present shall be the act of the board of nursing.

4.3.2 Guidelines.

- A. The board shall develop guidelines to assist board members in the evaluation of possible conflicts of interests. Members



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be open to the public. In accordance with the law, the board may, in its discretion, conduct part of the meeting in executive session closed to the public. Notice of all board meetings shall be given in the manner and pursuant to requirements prescribed by the state's applicable statutes and rules and regulations.

Section 4. Vacancies, Removal and Immunity.

- A. Any vacancy that occurs for any reason in the membership of the board shall be filled by the governor in the manner prescribed in the provisions of this article regarding appointments. Vacancies created by reason other than the expiration of a term shall be filled within < > days after such a vacancy occurs. A person appointed to fill a vacancy shall serve for the unexpired portion of the term.
- B. The governor may remove any member from the board for neglect of any duty required by law or for incompetence or for unprofessional or dishonorable conduct. The general laws of this state controlling the removal of public officials from office shall be followed in dismissing board members.
- C. All members of the board shall have immunity from individual civil liability while acting within the scope of the duties as board members. In the event that the entire board, an individual member or staff is sued, the attorney general shall appoint an attorney to represent the involved party.

Section 5. Powers and Duties. The board shall:

- A. Be responsible for the interpretation and enforcement of the provisions of this act. The board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this act, as well as other duties, powers and authority as it may be granted by appropriate statute.
- B. Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with the law, as it deems necessary for the proper administration of this act and to protect the public health, safety and welfare.
- C. Further be authorized to do the following without limiting the foregoing:
 - 1. Related to the competence development duties of the board:
 - a) Develop standards for nursing education.
 - b) Enforce educational standards and rules set by the board.
 - c) Provide consultation and conduct conferences, forums, studies, and research on nursing education and practice.

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shall abstain from voting when a conflict arises.

- B. The board shall develop guidelines to assist board members in the disclosure of ex parte communications.
- C. The board may develop other guidelines as needed that would support governance and direction of work.



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<p>2. Related to competence assessment duties of the board:</p> <ul style="list-style-type: none"> a) Maintain membership in national organizations that develop national licensure examinations and exclusively promote the improvement of the legal standards of the practice of nursing for the protection of the public health, safety and welfare. b) Require criminal background checks on applicants and licensees as determined by the board. <p>3. Related to the licensing responsibilities of the board:</p> <ul style="list-style-type: none"> a) Grant temporary permits for qualified applicants as set forth in rule. b) License qualified applicants for RN, LPN/VN and APRN licenses. <p>4. Related to competence maintenance duties of the board:</p> <ul style="list-style-type: none"> a) Develop standards for maintaining competence of licensees. b) Develop standards for maintaining competence of licensees returning to practice. <p>5. Related to the regulation of nursing practice responsibilities of the board:</p> <ul style="list-style-type: none"> a) Regulate the practice of LPN/VN, RN and APRN practice. b) Regulate the clinical support of nursing services by unlicensed assistive personnel regardless of title. c) Develop standards for nursing practice. d) Enforce nursing practice standards and rules set forth by the board. 	
<ul style="list-style-type: none"> e) Interpret and apply MNPA and MNAR through the issuance of advisory opinions, interpretive statements and declaratory statements. f) Regulate the manner in which nurses announce their practice to the public. g) Issue a modified license to practice nursing to an individual to practice within a limited scope of practice or with accommodations or both, as specified by the board. <p>6. Related to the discipline duties of the board:</p> <ul style="list-style-type: none"> a) Implement the discipline process. <ul style="list-style-type: none"> (1) Issue subpoenas in connection with investigations, inspections and hearings. (2) Obtain access to records as reasonably requested by the board to assist the board in its investiga- 	<p><i>***States vary widely as to whether and what process is used for advisory opinions, interpretive statements and declaratory statements. Some states may not have such authority; others find such documents to be useful tools for the board and the public. The users of these models are advised to seek legal counsel regarding the authority and required process in specific states.</i></p>

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- tion; the board shall maintain any records pursuant to this paragraph as confidential data
- (3) Order licensees to submit to physical, mental health or chemical dependency evaluations for cause.
 - (4) Cause prosecution of allegations of violations of this Act.
 - (5) Conduct hearings, compel attendance of witnesses and administer oaths to persons giving testimony at hearings.
 - (6) Close discipline sessions and hearings to the public.
 - (7) Provide alternatives to discipline.
 - (a) Establish alternative programs for monitoring of nurses who agree to seek treatment of substance abuse disorders, mental health or physical health conditions that could lead to disciplinary action by the board.
 - (b) Establish programs to educate and remediate nurses with practice concerns who meet criteria established in rule.
- b) Discipline nurses for violation of any provision of this act.
7. Related to the communication and record-keeping duties of the board:
- a) Maintain a record of all persons regulated by the board.
 - b) Maintain records of proceedings as required by the laws of the state.
 - c) Inform nurses on an established basis about changes in law and rules regarding nursing practice.
 - d) Collect and analyze data regarding nursing education, nursing practice and nursing resources.
 - e) Submit an annual report to the governor summarizing the board's proceedings and activities.
8. Related to other duties of the board:
- a) Personnel.
 - (1) Appoint and employ a qualified registered nurse to serve as executive officer and approve such additional staff positions as may be necessary, in the opinion of the board, to administer and enforce the provisions of the act.
 - (2) Employ professional and support staff, investigators and legal counsel and other personnel



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<p>necessary for the board to carry out its functions.</p> <p>(3) Delegate to the Executive Officer those activities that expedite the functions of the board.</p> <p>b) Financial.</p> <p>(1) Determine and collect reasonable fees.</p> <p>(2) Require such surety bonds as are deemed necessary.</p> <p>(3) Receive and expend funds in addition to appropriations from the state, provided such funds are received and expended for the pursuit of the authorized objectives of the board of nursing; such funds are maintained in a separate account; and periodic reports of the receipt and expenditure of such funds are submitted to the governor.</p> <p>c) Other.</p> <p>(1) Develop disaster preparedness plans.</p> <p>(2) Adopt a seal that shall be in the care of the executive officer and shall be affixed only in a manner as prescribed by the board.</p> <p>d) This act shall not be construed to require the board of nursing to report violations of the provisions of the act whenever, in the board's opinion, the public interest will be served adequately by a suitable written notice of warning.</p>	
<p>Section 6. Executive Officer.</p> <p>The executive officer shall be responsible for:</p> <p>A. The performance of administrative responsibilities of the board.</p> <p>B. Employment of personnel needed to carry out the functions of the board.</p> <p>C. The performance of any other duties as the board may direct.</p>	<p>4.6 EXECUTIVE OFFICER</p> <p>A. The board of nursing shall employ an executive officer with the following qualifications:</p> <ol style="list-style-type: none"> 1. Master's degree or higher from an accredited college or university; 2. Licensed to practice as a registered nurse in the state; and 3. At least < > years' experience in nursing practice, including administration, teaching or supervision in nursing educational programs, supervision in health agencies or nursing regulation. <p>B. The board shall monitor the effectiveness of the executive officer in carrying out the:</p> <ol style="list-style-type: none"> 1. Administrative performance of the board; and 2. Employment of personnel needed to carry out the functions of the board. <p>C. The board may authorize the appointment and employment of legal counsel, accountants and such other employees, assistants and agents as may be necessary, in the opinion of the board, to administer and enforce the provisions of this act.</p>



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<p>Article V. Application of Other Statutes</p> <p>Proceedings and records of the board are subject to the state Administrative Procedures Act and other statutes that govern administrative agencies. Nurses are subject to other statutory provisions throughout state law.</p>	<p>Chapter Five – Application of Other Statutes</p> <p><i>***There are other state statutes that affect the operation of the board of nursing and the practice of nursing. Examples range from state agencies working with the board to provisions governing work sites to laws addressing the handling of pharmaceuticals and products.</i></p>
<p>Article VI. Licensure</p> <p>Section 1. Examinations.</p> <p>A. The board shall authorize the administration of the examination to applicants for licensure as registered nurses or licensed practical/vocational nurses.</p> <p>B. The board may employ, contract and cooperate with any entity in the preparation and process for determining results of a uniform licensure examination. When such an examination is utilized, the board shall restrict access to questions and answers.</p> <p>C. The board shall determine whether a licensure examination may be repeated, the frequency of reexamination and any requisite education prior to reexamination.</p>	<p>Chapter Six – Licensure</p> <p>6.1 INFORMATION.</p> <p>The board will make information available to applicants regarding the:</p> <p>A. Examination.</p> <p>B. Examination registration process.</p> <p>C. Licensure processes.</p> <p>D. Application fees.</p>
<p>Section 2. Licensure by Examination.</p> <p>An applicant for licensure by examination to practice as a registered nurse or licensed practical/vocational nurse who successfully meets the requirements of this section shall be entitled to licensure as a registered nurse or licensed practice/vocational nurse, whichever is applicable.</p> <p>Application for licensure by examination as a registered nurse or licensed practical/vocational nurse. An applicant shall:</p> <p>A. Submit a completed application and fees as established by the board.</p> <p>B. Graduate from or verify successful completion and eligibility for graduation from a board-approved nursing education program or a program that meets criteria comparable to those established by the board in its rules.</p> <p>C. Be proficient in English language as set forth in the board rules.</p> <p><i>***English proficiency is required of all applicants and may be demonstrated by successful completion of an educational program conducted in English or by passing an approved English proficiency examination.</i></p> <p>D. Pass an examination authorized by the board.</p> <p>E. Report any pending criminal charges, criminal conviction or</p>	<p>6.2 APPLICATION FOR LICENSURE BY EXAMINATION AS A REGISTERED NURSE OR LICENSED PRACTICAL/ VOCATIONAL NURSE.</p> <p>An applicant for licensure as a registered nurse or licensed practice/vocational nurse, whichever is applicable, by examination in this state shall submit to the board the required fee for licensure by examination, as specified in Chapter 14, and a completed application for licensure by examination that provides the following information:</p> <p>6.2.1 Competence Development</p> <p>Graduation from or verification of completion and eligibility for graduation from a state-approved registered or practical/vocational nursing program as evidenced by official documentation directly from a state approved nursing education program for the level of licensure being sought. This documentation shall verify the date of graduation, credential conferred and evidence of meeting the standards of nursing education in this state. A transcript is required prior to the issuance of a permanent license.</p> <p><i>***This model does not allow RN students or RN applicants who fail the NCLEX-RN to apply for LPN/VN licensure and sit for the NCLEX-PN. According to the 2000 Member Board Profiles, 20 boards consider RN educational program graduates eligible to</i></p>



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nolo contendere plea. Alford plea or other plea arrangement in lieu of conviction.

*** See Article IX for how the board is authorized to use this information. Some states require a direct link to nursing practice. Other boards can consider convictions and pleas in making determinations about character and fitness.

- F. Have committed no acts or omissions which are grounds for disciplinary action as set forth in Article X, Section 2, of this act, or, if such acts have been committed and would be grounds for disciplinary action, the board has found after investigation sufficient restitution has been made.
- G. Meet other criteria established by the board.

sit for the NCLEX-PN and 14 boards consider students in an RN educational program who complete a set number of courses eligible to sit for NCLEX-PN.

***If a board allows an RN student to sit for the PN examination, the board may expect the RN educational program to identify a PN exit point.

***If a board allows an RN graduate to sit for the PN examination, the board may require additional coursework addressing the limitations of the LPN/VN scope of practice and the role of the LPN/VN in the health care team.

***If a board chooses to permit RN graduates to sit for the NCLEX-PN, the board should advise individuals regarding their ability to endorse to other states.

6.2.2 Competence Assessment

- A. In order to be licensed in this state, all registered nurse applicants shall take and pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The results will be reported to the applicant as pass or fail.
- B. In order to be licensed in this state, all practical/vocational nurse applicants shall take and pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN). The results will be reported to the applicant as pass or fail.

6.2.3 Competence Conduct

- A. Identification of any state, territory or country in which the applicant holds a professional license or credential, if applicable. Required information includes:
 - 1. The number and status of the license or credential.
 - 2. The original state or country of licensure or credentialing.

***Please note that a professional license may be that of a nurse or other health professional. Asking about any professional license, not just nursing, allows the board to evaluate the applicant's entire professional background for previous discipline history that could have implications for the applicant's ability to practice nursing safely.

- B. Current employer if employed in health care, including address, telephone number, position and dates of employment.
- C. Previous employer in health care, if any, if current employment is less than 12 months.
- D. The date the applicant previously applied for a license in <NAME OF STATE>, if applicable.
- E. Responses to questions related to the applicant's background in the following areas:

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	<ol style="list-style-type: none"> 1. Pending disciplinary action or investigation regarding any professional license or credential. 2. Pending criminal charges. 3. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction. 4. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any. 5. Any current substance abuse. <p>F. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.</p> <p>G. Submission of state and federal criminal background checks completed within the last < __ months >.</p> <p><i>***Details of this procedure will be state specific, depending on requirements of state criminal agencies. In the near future, expect electronic processes to be perfected for accomplishing these background checks.</i></p> <p><i>***While the majority of states use criminal history of candidates on a case-by-case approach, the MNPA provides a time-limited bar to licensure if an individual has felony convictions. This approach provides protection to the public (as most recidivism occurs in the first years after a criminal conviction) but also leaves the opportunity for an individual to apply for licensure after a criminal conviction.</i></p>
<p>Section 3. Licensure by Examination of Internationally Educated Applicants.</p> <p>An internationally educated applicant for licensure by examination shall meet the requirements in Section 2 above and follow the process for application set forth in rule.</p>	<p>6.3 APPLICATION FOR LICENSURE BY INTERNATIONALLY EDUCATED APPLICANTS</p> <p>An internationally educated applicant for licensure by examination in this state shall submit to the boards required fee for licensure by examination, as specified in Chapter 14 of these rules, and a completed application for licensure by examination that provides the following information:</p> <p>6.3.1 Information Regarding Competence Development</p> <p>A. Graduation from an international nursing program comparable to an approved nursing education program in the United States, as documented in an official transcript directly from the international nursing education program and verified by a credentials evaluation by a board approved/authorized organization for the level of licensure being sought.</p> <p><i>***"Comparable" is the term used by many academic evaluation services for describing programs similar in content and process to U.S. nursing education programs.</i></p>



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- B. Acceptable documentation shall verify the date of enrollment, date of graduation and credential conferred. An official transcript and, if not in English, a certified translation is required prior to the approval to take NCLEX.
- C. Credentials shall be reviewed internally or by an external agency specializing in international academic credentials review to verify the comparability of the international nursing education program to nursing education programs in the jurisdiction.

****The Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate program for internationally educated and licensed nurses includes credentials review, qualifying examination and English proficiency evaluation, and is required by many boards of nursing. Other boards use other private agencies established for credential review or do the credential review internally.*

6.3.2 Information Regarding Competence Assessment

****Language proficiency is a critical variable in the practice of safe nursing care. Nurses must be able not only to understand, but also to speak English in order to practice safely in the United States.*

- A. Documentation of English proficiency by:
 - 1. Graduation from a school of nursing outside of the United States in which:
 - a) All classroom instruction was in English;
 - b) All nursing textbooks were in English; and
 - c) The preponderance of clinical experience was in English; or
 - 2. Passing a designated English proficiency examination with <board set standard>.

Please note that the focus of the English proficiency examinations has been on reading and listening skills. Health related terminology is not assessed because there are currently no English proficiency examinations that measure an individual's knowledge and understanding of medical terminology.

On July 25, 2003, the Department of Homeland Security (DHS) published its final rule related to Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA). Section 343 requires that certain health care workers have their credentials evaluated and certified before they will be allowed to work in their profession in the United States. A health care certification identifies and documents that an international health care worker has met minimum requirements for training and English proficiency.

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The final rule applies to temporary and permanent employment based visas as well as Trade NAFTA health care workers from Canada and Mexico. There is a transition period when DHS may admit a temporary internationally educated health care worker or extend or change the status of workers already in the United States even if the worker does not, at the time of application, possess the required certification. Grants of admission, extension or changes of status to temporary immigrants during the transition period will be valid for only one year. There is no change and no transition period in the requirement for those applying to enter the U.S. under an employment-based permanent visa.

This is an evolving situation and readers are advised to consult their legal counsel for updated information regarding immigration.

- B. Evidence of licensure or eligibility for licensure from the original country of nursing education. This documentation shall be in English or a certified translation.
- C. Assessment of nursing knowledge, skills and abilities.
 - 1. In order to be licensed in this state, all registered nurse applicants shall take and pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The results will be reported to the applicant as pass or fail.
 - 2. In order to be licensed in this state, all practical/vocational nurse applicants shall take and pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN). The results will be reported to the applicant as pass or fail.

6.3.3 Competence Conduct

- A. Identification of any state, territory or country in which the applicant holds a professional license or credential, if applicable. Required information includes:
 - 1. The license number and status of the license or credential.
 - 2. The original state or country of licensure or credentialing.

****Please note that a professional license may be that of a nurse or other health professional. Asking about any professional license, not just nursing, allows the board to evaluate the applicant's entire professional background for previous discipline history that could have implications for the applicant's ability to practice nursing safely.*
- B. Current employer if employed in health care, including address, telephone number, position and dates of employment.



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	<ul style="list-style-type: none"> C. Previous employer in health care, if any, if current employment is less than 12 months. D. The date the applicant previously applied for a license in <NAME OF STATE>, if applicable. E. Responses to questions related to the applicant’s background in the following areas: <ul style="list-style-type: none"> 1. Pending disciplinary action or investigation regarding any professional license or credential. 2. Pending criminal charges. 3. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction. 4. Any chemical, physical or mental impairment and/or disability that impacts the nurse’s ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any. 5. Any current substance abuse. F. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant’s background. G. Submission of state and federal criminal background checks completed within the last < > months. <p><i>***While the majority of states use criminal history of candidates on a case-by-case approach and use proximity in time, along with other factors, as a consideration in licensure denial on the basis of criminal conviction. However, at least one state uses a time-limited bar to licensure if an individual has felony convictions. The rationale for this approach is that it provides protection to the public (as the most recidivism occurs in the first years after a criminal conviction) but also leaves the opportunity for an individual to still apply for licensure after a criminal conviction.</i></p>
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<p>Section 4. Initial Licensure for Advanced Practice Registered Nurse.</p> <p>An applicant for initial licensure as an advanced practice registered nurse shall:</p> <ul style="list-style-type: none"> A. Submit a completed written application and appropriate fees as established by the board. B. Hold an unencumbered license as a registered nurse. C. Have completed an accredited graduate level APRN program or completed an approved ARPN certificate program prior to 2003. D. Be currently certified by a national certifying body recognized by the board in the APRN role and specialty appropriate to educational preparation. 	
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<p>6.4 APPLICATION FOR INITIAL LICENSURE AS AN ADVANCED PRACTICE REGISTERED NURSE</p> <p>An applicant for licensure as an advanced practice registered nurse in this state shall submit to the board the required fee as specified in Chapter 14, verification of licensure or eligibility for licensure as a registered nurse in this jurisdiction, and a completed application that provides the following information:</p> <p>6.4.1 Information Regarding Competence Development</p> <p>Graduation from or verification of completion and eligibility for graduation from a graduate level APRN program, as evidenced by official documentation directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and the board. This</p>	
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- E. Report any criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction.
- F. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article X, Section 2, of this act, the board has found, after investigation, that sufficient restitution has been made.
- G. Provide other evidence as required by rule.

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documentation shall verify the date of graduation, credential conferred and evidence of meeting the standards of nursing education in this state. A transcript is required prior to the issuance of a permanent license.

6.4.2 Information Regarding Competence Assessment

Current certification by a national certifying body in the APRN role and specialty appropriate to educational preparation.

****For applicants for whom there is no appropriate certifying examination available, the Uniform Core Licensure/Authority to Practice Requirements allowed states to offer alternate mechanisms to assure initial competence until January 2005.*

6.4.3 Information Regarding Competence Conduct

- A. Identification of any state, territory or country in which the applicant holds a professional license or credential, if applicable. Required information includes:
 1. The license number and status of the license or credential.
 2. The original state of licensure.

****Please note that a professional license may be that of a nurse or other health professional. Asking about any professional license, not just nursing, allows the board to evaluate the applicant's entire professional background for previous discipline history that could have implications for the applicant's ability to practice nursing safely.*
- B. Current employer if employed in health care, including address, telephone number, position and dates of employment.
- C. Previous employer in health care, if any, if current employment is less than 12 months.
- D. The date the applicant previously applied for a license in <NAME OF STATE>, if applicable;
- E. Responses to questions related to the applicant's background in the following areas:
 1. Pending disciplinary action or investigation regarding any professional license or credential.
 2. Loss of hospital privileges.
 3. Any pending criminal charges.
 4. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction.
 5. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any.



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	<p>6. Any current substance abuse.</p> <p>F. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.</p> <p>G. Federal criminal background checks completed within the last < > months.</p> <p>6.4.4 Criteria for Evaluating APRN Certification Programs</p> <p>The board shall determine whether a certification program can be used as a requirement for licensure of advanced practice registered nurses based upon the following standards:</p> <p>A. The program is national in the scope of its credentialing.</p> <p>B. Conditions for taking the certification examination are consistent with standards of the testing community.</p> <p>C. Educational requirements are consistent with the requirements of the advanced practice role and specialty.</p> <p>D. The standard methodologies used are acceptable to the testing community such as incumbent job analysis studies and logical job analysis studies.</p> <p>E. The examination represents entry-level practice in the advanced nursing practice role and specialty.</p> <p>F. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to clients.</p> <p>G. Examination items are reviewed for content validity, cultural bias and correct scoring using an established mechanism, both before use and periodically.</p> <p>H. Examinations are evaluated for psychometric performance.</p> <p>I. The passing standard is established using acceptable psychometric methods and is reevaluated periodically.</p> <p>J. Examination security is maintained through established procedures.</p> <p>K. Certification is issued based upon passing the examination and meeting all other certification requirements.</p> <p>L. A retake policy is in place.</p> <p>M. Certification maintenance program, which includes review of qualifications and continued competence, is in place.</p> <p>N. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status and changes in the certification program, including qualifications, test plan and scope of practice.</p> <p>O. An evaluation process is in place to provide quality assurance in the certification program.</p>
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	<p>6.4.5 Board Review</p> <p>Each program shall be subject to periodic review by the board to determine whether criteria for approval are being maintained.</p> <p>6.4.6 Application of an Internationally Educated Advanced Practice Registered Nurse</p> <p>An internationally educated applicant for licensure in this state as an advanced practice registered nurse shall:</p> <p>A. Graduate from a graduate level APRN program equivalent to an approved APRN education program in the United States; as documented in an official transcript directly from the international nursing education program and verified through a credentials evaluation for the level of license being sought.</p> <p>B. Meet all other initial criteria required of applicants educated in the United States.</p> <p><i>***There has not been significant numbers of nurses prepared as advanced practice registered nurses immigrating to the United States. Nurses who have practiced in an advanced role in another country may initially obtain RN licenses when coming to this country. The same issues pertaining to licensure of internationally educated LPN/VNs and RNs also pertain to APRNs, e.g., credential verification and English proficiency.</i></p>
<p>Section 5. Modified License.</p> <p>The board may issue a modified license to an individual who has met licensure requirements and who is able to practice without compromise to the public safety within a modified scope of practice or with accommodations or both as specified by the board.</p>	<p>6.5 MODIFIED LICENSE</p> <p>A modified license requires that an individual nurse practice only within a modified scope of practice or with accommodations or both, as specified by the board of nursing. A modified license may be granted for all levels of licensure.</p> <p>6.5.1 Purpose</p> <p>To provide a process to authorize licensure for individuals with current disabilities who can practice nursing safely within a modified scope, or practice safely with accommodations, or both, to be granted a license for modified practice.</p> <p>6.5.2 Identification of Need</p> <p>The board may be informed of the potential need for a modified license by:</p> <p>A. Request from an individual for a modified license;</p> <p>B. Information provided by an individual on application for licensure by examination, licensure by endorsement or licensure renewal;</p> <p>C. Information provided by an endorsing state as part of the license verification process; or</p>



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	<p>D. Information provided by a nursing educational program that a student required accommodation to accomplish clinical education objectives.</p> <p>6.5.3 Process</p> <p>An applicant for licensure may request a modified license. The issuance of a modified license is documented in a written agreement between the applicant and the board.</p> <p><i>***Consideration should be given to whether the agreement needs to address practice in other jurisdictions. The board may require that the nurse holding the modified license inform the board of an intention to move or work in another state, as well as inform that state as to the modified license status in this state. This is particularly important if the board participates in the Nurse Licensure Compact and the nurse would have a privilege to practice in other compact states.</i></p> <p>6.5.4 Reconsideration</p> <p>A nurse granted a Modified License may apply to the board for reconsideration if the licensee’s circumstances change.</p>
<p>Section 6. Licensure by Endorsement.</p> <p>An applicant for licensure by endorsement to practice as a registered nurse or licensed practical/vocational nurse shall:</p> <p>A. Submit a completed application and fees as established by the board.</p> <p>B. Graduate from or verify successful completion and eligibility for graduation from a board-approved nursing education program or a program that meets criteria comparable to those established by the board in its rules which prepares for the level of licensure being sought.</p> <p>C. Hold an unencumbered license as a registered nurse or a licensed practical/vocational nurse.</p> <p>D. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article X, Section 2, of this Act, the board has found after investigation that sufficient restitution has been made.</p> <p>E. Pass an examination authorized by the board.</p> <p>F. Be proficient in the English language as set forth in the board rules.</p> <p>G. Submit verification of licensure status directly from the U.S. jurisdiction of licensure by examination.</p>	<p>6.6 APPLICATION FOR LICENSURE BY ENDORSEMENT AS A REGISTERED NURSE OR LICENSED PRACTICAL/VOCATIONAL NURSE</p> <p><i>***Acceptance and use of the Uniform Core Licensure Requirements would promote mobility of nurses and decrease challenges arising from the variation between board licensure requirements. Verification of licensure in another jurisdiction, whether electronically or by paper copy, is the key requirement for licensure by endorsement. Boards are challenged to meet the goal of using technology and trust that other boards have reviewed transcripts and other information in making licensure decisions.</i></p> <p>6.6.1 Competence Development</p> <p>A. An applicant for licensure by endorsement in this state shall submit to the board the required fee for licensure by endorsement, as specified in Chapter 14, and a completed application for licensure by endorsement.</p> <p>B. The board shall verify licensure by examination by the state of original licensure and receive from that board information regarding graduation or successful program completion from a nursing education program for the level of license, date of original licensure and current licensure status in the jurisdiction.</p> <p>C. The board shall also verify date of the applicant’s licensure and licensure status with the state of most recent employ-</p>



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- H. Meet continued competency requirements as stated in Article VI, Section 9 B., and as set forth in board rules.
- I. Report any conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction.
- J. Meet other criteria established by the board.

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ment, if different from the state of original licensure. Nursys offers boards direct access to licensure information for those participating boards.

6.6.2 Competence Assessment

- A. Evidence of having passed the licensure examination required by this jurisdiction at the time the applicant was initially licensed in another jurisdiction.
- B. Evidence of continued competence as defined in 6.9.3 below.

****A refresher course may be required if an individual has not maintained active licensure and practice in the last three years.*

6.6.3 Competence Conduct

- A. Identification of any state, territory or country in which the applicant holds a health profession license or credential, if applicable. Required information includes:

1. The number and status of the license or credential.
2. The original state or country of licensure or credentialing.

****Please note that a professional license may be that of a nurse or other health professional. Asking about any professional license, not just nursing, allows the board to evaluate the applicant's entire professional background for previous discipline history that could have implications for the applicant's ability to practice nursing safely.*

- B. Current employer if employed in health care, including address, telephone number, position and dates of employment.
- C. Previous employer in health care, if any, if current employment is less than 12 months.
- D. The date the applicant previously applied for a license in <NAME OF STATE>, if applicable.
- E. Responses to questions related to the applicant's background in the following areas:
 1. Pending disciplinary action or investigation regarding any professional license or credential.
 2. Any pending criminal charges.
 3. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction.
 4. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any.
 5. Any current substance abuse.



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	<p>F. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.</p> <p>G. Submission of state and federal criminal background checks completed within the last < > months.</p>
<p>Section 7. Endorsement of Advanced Practice Registered Nurses.</p> <p>The board may issue a license by endorsement to an advanced practice registered nurse licensed under the laws of another state if, in the opinion of the board, the applicant meets the qualifications for licensure in this jurisdiction. An applicant for advanced practice registered nurse licensure by endorsement shall:</p> <p>A. Submit a completed written application and appropriate fees as established by the board.</p> <p>B. Be licensed as a registered nurse (unencumbered).</p> <p>C. Have completed an accredited graduate level APRN program or completed an approved APRN certificate program prior to 2003.</p> <p>D. Be currently certified by a national certifying body recognized by the board in the APRN role and specialty appropriate to educational preparation.</p> <p>E. Meet continued competency requirements as stated in Article VI, Section 10 B., and as set forth in board rules.</p> <p>F. Report any conviction, nolo contender plea, Alford plea or other plea arrangement in lieu of conviction.</p> <p>G. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article X, Section 2, of this Act, the board has found, after investigation, that sufficient restitution has been made.</p> <p>H. Provide other evidence as required by the board in its rules.</p> <p><i>***An individual new to a state can apply for an RN and an APRN license at the same time.</i></p>	<p>6.7 APPLICATION FOR LICENSURE BY ENDORSEMENT REQUIREMENTS AS AN ADVANCED PRACTICE REGISTERED NURSE</p> <p>An applicant for licensure by endorsement as an advanced practice registered nurse in this state shall submit to the board the required fee as specified in Chapter 13, verification of an unencumbered license as a registered nurse in this jurisdiction, and a completed application that provides the following information:</p> <p>6.7.1 Competence Development</p> <p>A. Graduation from or verification of completion from a graduate level APRN program, as evidenced by an official transcript or other official documentation directly from a graduate program accredited by nursing accrediting body that is recognized by the U.S. Secretary of Education and the board. This documentation shall verify the date of graduation, credential conferred and evidence of meeting the standards of nursing education in this state. A transcript is required prior to the issuance of a permanent license; or</p> <p>B. Demonstrates successful completion of approved APRN certificate program prior to 2003.</p> <p>6.7.2 Competence Assessment</p> <p>A. Current certification by a national certifying body in the APRN role and specialty appropriate to educational preparation; or</p> <p>B. Authorized to practice as an APRN in another jurisdiction through a mechanism to ensure initial competence when no appropriate certification exam is available.</p> <p><i>***For applicants for whom there is no appropriate certifying examination available, the Uniform Core Licensure/Authority to Practice Requirements allowed states to develop alternate mechanisms to assure initial competence until January 2005.</i></p> <p>6.7.3 Information Regarding Competence Conduct</p> <p>A. Identification of any state, territory or country in which the applicant holds a health profession license; the license number and status of the license, including original state of licensure, if applicable.</p> <p>B. Current employer if employed in health care, including address, telephone number, position and dates of employment.</p>

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	<ul style="list-style-type: none"> C. Previous employer in health care, if any, if current employment is less than 12 months. D. The date the applicant previously applied for a license in <NAME OF STATE>, if applicable. E. Responses to questions related to the applicant's background in the following areas: <ul style="list-style-type: none"> 1. Pending disciplinary action or investigation regarding any professional license or credential; 2. Loss of hospital privileges. 3. Any pending criminal charges. 4. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction. 5. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any. 6. Any current substance abuse. F. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background. G. Submission of state and federal criminal background checks completed within the last < > months.
<p>Section 8. Temporary Permits.</p> <p>The board of nursing may issue time-limited authorization to practice nursing through the granting of temporary permits as set forth in board rules.</p>	<p>6.8 TEMPORARY PERMITS</p> <p>A temporary permit is a time-limited authorization to practice nursing as specified by the type of permit.</p> <p>6.8.1 Types of Temporary Permits</p> <p>The board may issue, upon request of the applicant, a temporary permit to practice nursing to:</p> <ul style="list-style-type: none"> A. Applicants for licensure by examination, to practice under the direct supervision of a registered nurse. B. Applicants for endorsement, to practice nursing at the applied level of licensure to an individual who submits an application for licensure by endorsement and with verification of current licensure in another jurisdiction. C. Individuals enrolled in refresher courses, to provide direct client nursing care as part of a nursing refresher course. The individual shall have been previously licensed to practice. The refresher course may be for completing continued competence requirements, for seeking reinstatement of license or application for licensure by endorsement. D. Applicants for licensure as advanced practice registered nurses to work under supervision of another APRN or physician.



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****Rationale: In the previous version of the Model Rules, “post basic” was a separate type of permit granted to individuals in certain educational situations. However, the term “post basic” may be confusing in light of some of the new educational programs that have evolved since the last edition of the rules, so this type of permit was deleted. See exemptions in Article XIII for a provision to allow practice by graduate students.*

6.8.2 Duration

Temporary permits may be issued for a time period not to exceed < > months. Permits are nonrenewable and are valid from the submission of a proper request until the date of the board decision on the application.

6.8.3 Procedure for Issuing Temporary Permits

An applicant may request a temporary permit to practice nursing by making an application to the board and paying the required fee, as specified in Chapter 14 of these rules.

- A. Upon submission of application for licensure and to sit for the licensing examination, including submission of request for a criminal background check, an applicant for licensure by examination may receive a temporary permit to practice under the direct supervision of a registered nurse.
- B. Upon submission of application for licensure, including submission of request for criminal background check, and receipt of verification of unencumbered license from another jurisdiction, an applicant for licensure by endorsement may receive a temporary permit to practice nursing.
- C. Upon verification, made on the applicant’s behalf, that the individual has been enrolled as a nursing refresher student and agreement by the applicant to practice nursing only as part of the nursing refresher course and under the supervision of a registered nurse, an applicant may receive a temporary permit to enroll in a nursing refresher course. This permit is only in effect while the holder is enrolled in a refresher course and authorizes the holder to actively practice only in the clinical portion of the refresher course.
- D. Upon submission of application for licensure, including submission of request for a criminal background check and verification that the applicant has registered for the appropriate certification examination an applicant may receive a temporary permit for supervised nursing practice in a specified APRN role and specialty.

****The temporary APRN permit allows graduate APRNs to practice with supervision during the time between when an applicant registers for a certification examination and when results are available.*

Model Nursing Practice Act**Section 9. Renewal of RN/LPN/VN Licenses.**

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

- A. An applicant for license renewal shall submit a verified statement that indicates whether the applicant has been convicted of a felony, and, if convicted of one or more felonies, indicates the date of absolute discharge from the sentences for all felony convictions.
- B. A renewal license shall be issued to a registered nurse or licensed practical/vocational nurse who remits the required fee and satisfactorily completes any other requirements established by the board as set forth in rules.
- C. No license shall be renewed unless the RN or LPN/VN shows evidence of continued competence as specified in board rule.

Failure to renew the license shall result in forfeiture of the right to practice nursing in this jurisdiction.

Model Nursing Administrative Rules**6.9 RENEWAL OF LICENSES**

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

6.9.1 Notification to Renew

At least < > days before the expiration date of a license, the board shall notify the licensee that it is time to renew and inform the licensee of the timelines and options for completing the application.

****Many boards are using new ways to provide notice of renewal to nurses, including the use of postcards and the Internet.*

6.9.2 Application for Renewal of License as a Registered Nurse or Licensed Practical/Vocational Nurse

An applicant for license renewal shall submit to the board the required fee for license renewal, as specified in Chapter 14, and a completed application for license renewal that provides the following information:

- A. Evidence of completion of the continued competence requirements specified in 6.9.3 below;
- B. Responses to questions related to the applicant's background in the following areas:
 1. Pending disciplinary action or investigation regarding any professional license or credential.
 2. Pending criminal conviction.
 3. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction since the last renewal.
 4. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any.
 5. Any current substance abuse.
- C. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.

6.9.3 License Renewal Practice Hours Requirement for Registered Nurses and Licensed Practical/Vocational Nurses

- A. *Purpose.* The purpose of requiring practice hours for license renewal is to promote currency of practice for licensed nurses.



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- B. *Practice Hours Requirement.* Each registered nurse and licensed practical/vocational nurse shall document 960 hours of nursing practice satisfactory to the board in the three-year period immediately preceding application for license renewal.
- C. *Documentation and Audit.* Practice hours requirements shall be documented as directed by the board and are subject to audit at the discretion of the board.

****Examples of satisfactory practice hours may include clinical practice, nursing education (both as educator and as student), nursing research and performance of other activities requiring a nursing license. The board may provide additional guidelines for nurses regarding the practice requirement through policy development. It is the responsibility of the licensee to demonstrate to the board how activities constitute nursing practice.*

Requiring practice hours for license renewal is based on National Council of State Boards of Nursing research, Exploring the Value of Continuing Education Mandates (Smith, 2003) that indicated that the factor that contributed most to professional development was the practice of that profession. Five other health care professions participated in this research study with the same outcomes. Continuing education, while an important strategy that is used by many nurses regardless of board mandate, in and of itself has not been demonstrated to assure competence.

At the 2004 Midyear Meeting, the subcommittee received feedback regarding this approach to continued competency that requested that a specific number of practice hours be recommended to promote uniformity and ease of endorsement. The 960 practice hours in three years requirement was added per this recommendation. Having a set number of practice hours is intended to promote consistency among boards. This number was selected because it approximates the number of hours of service and training required annually of military reservists. Given that reserve training is intended to prepare personnel for ready deployment, it seemed a reasonable and realistic model to use to show practice currency, until specific research is available to assist in setting this figure. In addition, this number is reflective of practice hours currently required in one state that uses practice hours for renewal of licensure.

Lifelong learning and professional development have never been more important. There are several ongoing NCSBN initiatives as well as several state projects that will provide additional data to support the work in this area. Given the continuous development of new technology and the short half-life for knowledge, it is likely that some form of standardized continued competency assessment, which may include testing, will be used by boards in the future.

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	<p>6.9.4 Issuance of License</p> <p>The board shall renew the license of each renewal applicant who complies with the requirements listed in 6.9.2 and 6.9.3.</p>
<p>Section 10. Renewal of APRN License.</p> <p>Advanced practice registered nurse licenses issued under this act shall be renewed every < > years according to a schedule established by the board. An applicant for APRN license renewal shall:</p> <ol style="list-style-type: none"> A. Submit a renewal application as directed by the board and remit the required fee as set forth in rule. B. Maintain national certification in the appropriate APRN role and specialty through an ongoing certification maintenance program of a nationally recognized certifying body. C. Meet other requirements set forth in rule. 	<p>6.10 APPLICATION FOR RENEWAL OF LICENSE AS AN ADVANCED PRACTICE REGISTERED NURSE</p> <p>6.10.1 Application for Renewal</p> <p>An applicant for license renewal as an advanced practice registered nurse shall submit to the board the required fee for license renewal, as specified in Chapter 14, and a completed license renewal application that provides the following information:</p> <ol style="list-style-type: none"> A. Responses to questions related to the applicant's background in the following areas: <ol style="list-style-type: none"> 1. Pending disciplinary action or investigation regarding any professional license or credential. 2. Pending criminal charges. 3. Criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction since the last renewal. 4. Any chemical, physical or mental impairment and/or disability that impacts the nurse's ability to practice nursing safely, and a description of accommodations and/or practice limitations needed, if any. 5. Any current substance abuse. B. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background. C. Evidence of completion of continued competence requirements including: <ol style="list-style-type: none"> 1. Evidence of current certification or recertification, as applicable, by a national professional certification or recertification organization that meets the requirements of section 6.4.4; and 2. Satisfactory completion of 960 hours of practice in the advanced practice role and specialty in the three years preceding APRN renewal. <p><i>***A different approach has been used with the continued competence requirements for APRNs because the majority of boards require national certification. Most certification programs require significant amounts of continuing education or other activities that are appropriate for meeting the licensure continued competence requirements. Practice hours used to meet certification</i></p>



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	<p><i>requirements could also be used to meet license renewal requirements.</i></p> <p>6.10.2 Documentation and Audit</p> <p>A. Satisfaction of continued competence requirements shall be documented as directed by the board and must be submitted prior to license renewal.</p> <p>B. All information concerning continued competence submitted with a renewal application or licensure by endorsement application is subject to audit at the discretion of the board.</p> <p>C. The board may conduct a random audit of nurses to verify APRN recertification or verify APRN practice hours. Upon request of the board, licensees shall submit documentation of compliance with 6.10.1 C.</p> <p>6.10.3 Issuance of License</p> <p>The board shall renew the license of each APRN renewal applicant who complies with all the above requirements.</p>
<p>Section 11. Reinstatement of License.</p> <p>The board of nursing shall reinstate a nursing license as set forth in board rules.</p>	<p>6.11 REINSTATEMENT OF LICENSE</p> <p>An individual whose license has lapsed by failure to renew may apply for reinstatement by submitting an application, paying a fee as specified in Chapter 14 of these rules, meeting all practice requirements for renewal of licensure set forth in Chapter 6.9 and satisfying the conditions listed below. At any time after a license has lapsed or been inactive, the board may require evidence of the licensee’s current nursing knowledge and skill before reinstating the licensee to the status of active license.</p> <p>6.11.1 Refresher Course Required</p> <p>An individual who applies for licensure reinstatement who has been out of practice for three years or longer shall provide evidence of passing a nursing refresher course approved by the board. Completion of a refresher course would waive the current practice hours requirement of 6.9.3 for RNs and LPN/VNs and 6.10.1 C. 2. for APRNs.</p> <p>6.11.2 Reinstatement Following Disciplinary Action</p> <p>For those licensees applying for reinstatement following discipline action, compliance with all board licensure requirements as well as any specific requirements set forth in the board’s discipline order is required.</p>



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Section 12. Duties of Licensees.

- A. The nurse shall comply with the provisions of this act. The burden of responsibility is on the licensee to know and practice according to the laws and regulations of the state.
- B. The nurse shall report to the board those acts or omissions which are violations of the act or grounds for disciplinary action as set forth in Articles IX and X of this act.
- C. The licensee shall, in response to board inquiries, provide relevant and truthful personal, professional or demographic information requested by the board to perform its duties in regulating and controlling nursing practice in order to protect the public health, safety and welfare.
- D. Failure to provide the requested information may result in nonrenewal of the license to practice nursing and/or licensure disciplinary action.
- E. A licensee or an applicant for licensure shall submit to a board-ordered physical or mental evaluation for cause. The board shall direct the licensee or applicant in writing of the type of evaluation and shall designate a professional to conduct the evaluation.
 1. The licensee may also designate another professional to conduct an independent medical examination.
 2. Refusal or failure of a licensee or applicant to complete such examinations shall constitute an admission of any allegations relating to such condition.
 3. All objections shall be waived as to the admissibility of the examining professional's testimony or examination reports on the grounds that they constitute privileged communication.
 4. The medical testimony or examinations reports shall not be used against a registered nurse, licensed practical nurse or advanced practice registered nurse in another proceeding and shall be confidential.
 5. At reasonable intervals, a registered nurse, licensed practical nurse or advanced practice registered nurse shall be afforded the opportunity to demonstrate competence to resume the practice of nursing with reasonable skill and safety to clients.

6.12 DUTIES OF LICENSEES

****The specificity of Article VI in the Model Nursing Practice Act precludes the need for additional rules at this time. This chapter is a placeholder until and if rules are needed in the future. This column is used for explanatory comments.*

****Board ordered evaluations of fitness to practice may include physical, mental, chemical dependency or other types of evaluation.*

Article VII. Titles and Abbreviations

Section 1. Titles and Abbreviations for Licensed Nurses.

- A. Only those persons who hold a license to practice nursing in this state shall have the right to use the following title abbreviations:

Chapter Seven – Titles and Abbreviations

7.1 TITLES AND ABBREVIATIONS FOR LICENSED NURSES

7.1.1 Individuals are licensed as advanced practice registered nurses in the categories of nurse practitioner, nurse anesthetist, nurse midwife or clinical nurse specialist.



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1. Title: "Registered Nurse" and the abbreviation "RN."
 2. Title: "Licensed Practical/Vocational Nurse" and the abbreviation "LPN/VN."
 3. Title: "Advanced Practice Registered Nurse" and the abbreviation "APRN."
 B. It shall be unlawful for any person to use the title "Nurse," "Registered Nurse," "Licensed Practical/Vocational Nurse," "Advanced Practice Registered Nurse," or their authorized abbreviations, or any other title that would lead a person to believe the individual is a licensed nurse unless permitted by this act.

Section 2. Titles and abbreviations for temporary permits.
 Any person who has been approved as an applicant for licensure and has been granted a temporary permit shall have the right to use the titles <> and abbreviations <> designated by the state.

7.1.2 Each Advanced Practice Registered Nurse shall use the category designation for purposes of identification and documentation.

Article VIII. Approval of Nursing Education Programs

Section 1. Approval Standards.
 The board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the act and board rules.

Chapter Eight – Nursing Education

8.1 PURPOSE OF NURSING EDUCATION STANDARDS
 The purpose of nursing education standards is to:

- A. Ensure that graduates of nursing education programs are prepared for safe and effective nursing practice.
- B. Provide criteria for the development, evaluation and improvement of new and established nursing education programs.
- C. Assure candidates are educationally prepared for licensure and recognition at the appropriate level.

8.1.1 Nursing Education Standards
 All nursing education programs shall meet these standards:

- A. The purpose and outcomes of the nursing program shall be consistent with the Nursing Practice Act and board-promulgated administrative rules, regulations and other relevant state statutes.
- B. The purpose and outcomes of the nursing program shall be consistent with generally accepted standards of nursing practice appropriate for graduates of the type of nursing program offered.
- C. The input of consumers shall be considered in developing and evaluating the purpose and outcomes of the program.
- D. The nursing program shall implement a comprehensive, systematic plan for ongoing evaluation that is based

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on program outcomes and incorporates continuous improvement.

- E. The curriculum shall provide diverse, didactic and clinical learning experiences consistent with program outcomes.
- F. Faculty and students shall participate in program planning, implementation, evaluation, and continuous improvement.
- G. The nursing program administrator shall be a professionally and academically qualified registered nurse with institutional authority and administrative responsibility for the program.
- H. Professionally, academically and clinically qualified nurse faculty shall be sufficient in number and expertise to accomplish program outcomes and quality improvement.
- I. The fiscal, human, physical, clinical and technical learning resources shall be adequate to support program processes, security and outcomes.
- J. Program information communicated by the nursing program shall be accurate, complete, consistent and readily available.

****This includes all methods of educational program delivery.*

8.1.2 Required Criteria for Nursing Education Programs

The organization and administration of the nursing education program shall be consistent with the law governing the practice of nursing. The nursing education program shall be an integral part of a governing academic institution that is accredited by a body that is recognized by the U.S. Secretary of Education.

The following minimal criteria serve to support implementation of the nursing education standards:

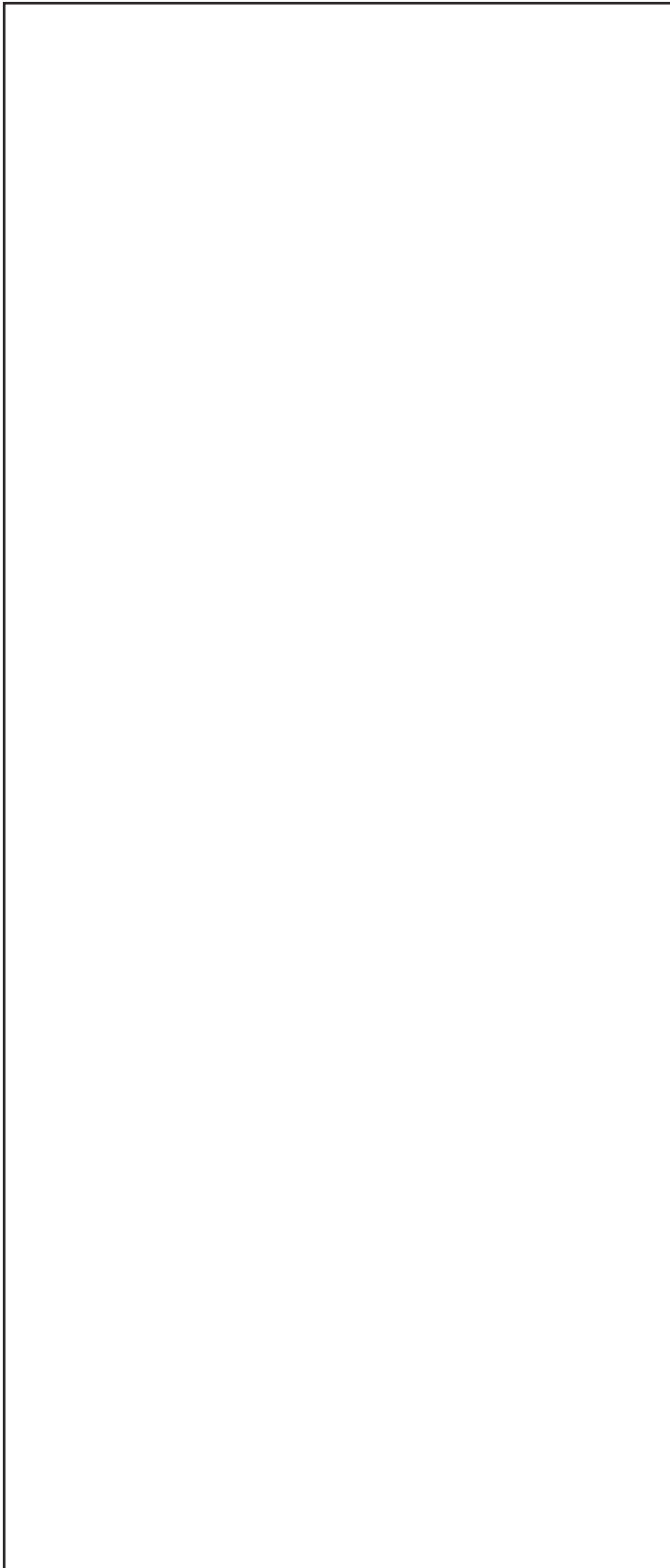
- A. *Evaluation.* A comprehensive nursing education program self-evaluation shall be performed annually for quality improvement and shall include but not be limited to:
 1. Students' achievement of program outcomes.
 2. Evidence of adequate program resources including fiscal, physical, human, clinical and technical learning resources; and the availability of clinical sites and the viability of those sites to meet the objectives of the program.
 3. Multiple measures of program outcomes for graduates.

****Examples of measures of students' success include NCLEX pass rates, student and/or employer survey, and successful completion of national certification programs.*



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- 4. Evidence that accurate program information for consumers is readily available.
****Examples of information include fees and admission criteria, which can be made available by oral, written and electronic means.*
- 5. The head of the academic institution and the administration support program outcomes.
- 6. Program administrator and program faculty meet board qualifications and are sufficient to achieve program outcomes.
- 7. Evidence that the academic institution assures security of student information.
****This is a minimal requirement. Nursing programs are encouraged to develop ongoing evaluation programs as part of continuous quality improvement.*

B. Curriculum

- 1. The curriculum of the nursing education program shall enable the student to develop the nursing knowledge, skills and competencies necessary for the level, scope and standards of nursing practice consistent with the level of licensure. The curriculum shall include:
 - a) Content regarding legal and ethical issues, history and trends in nursing and health care, and professional responsibilities;
 - b) Experiences that promote the development of clinical judgment, leadership and management skills, and professional socialization consistent with the level of licensure. This includes demonstration of the ability to supervise others and provide leadership of the profession;
 - c) Learning experiences and methods of instruction, including distance education methods, consistent with the written curriculum plan; and
 - d) Coursework including, but not limited to:
 - (1) Content in the biological, physical, social and behavioral sciences to provide a foundation for safe and effective nursing practice;
 - (2) Didactic content and supervised clinical experience in the prevention of illness and the promotion, restoration, and maintenance of health in clients across the lifespan and in a variety of clinical settings, to include:
 - (a) Using informatics to communicate, manage knowledge, mitigate error and support decision making.

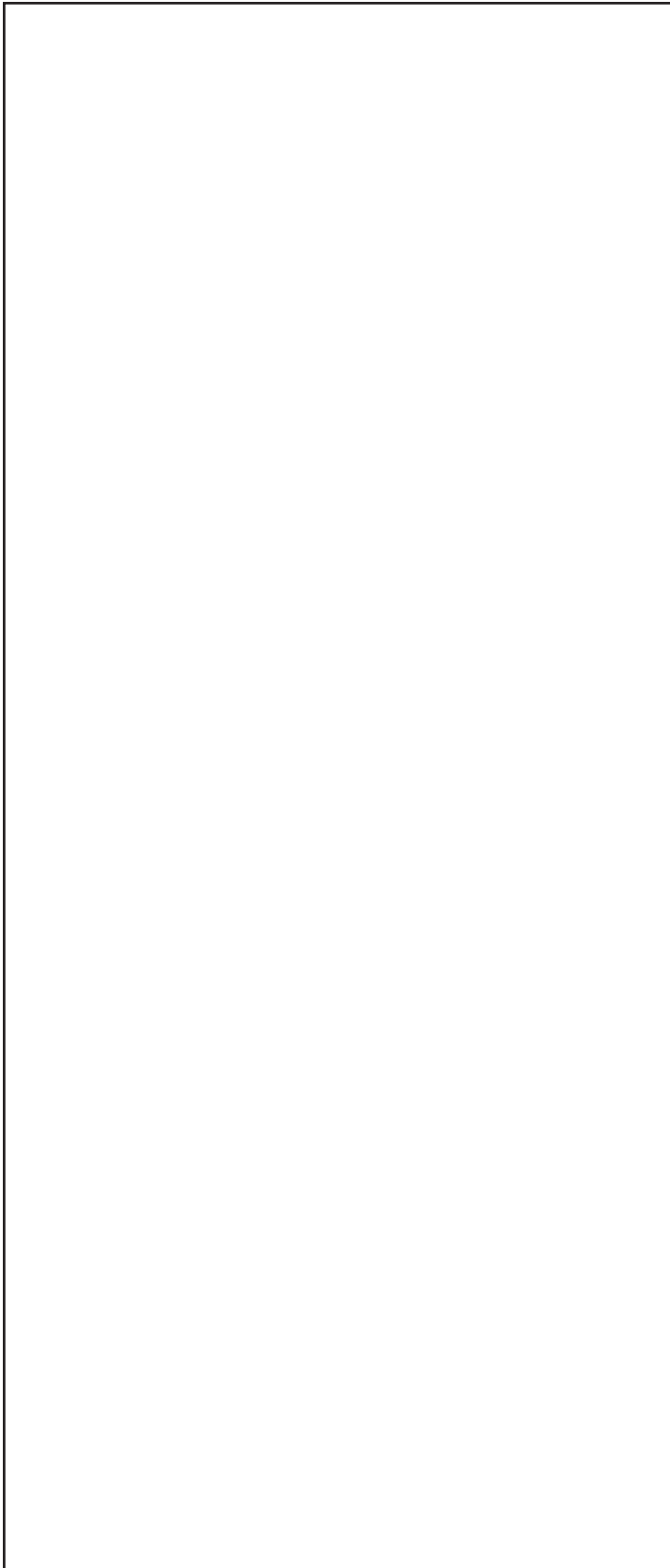
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	<p>(b) Employing evidence-based practice to integrate best research with clinical expertise and client values for optimal care, including skills to identify and apply best practices to nursing care.</p> <p>(c) Providing client-centered, culturally competent care.</p> <p>i) Respecting client differences, values, preferences and expressed needs.</p> <p>ii) Involving clients in decision-making and care management.</p> <p>iii) Coordinating and managing continuous client care.</p> <p>iv) Promoting healthy lifestyles for clients and populations.</p> <p>(d) Working in interdisciplinary teams to cooperate, collaborate, communicate and integrate client care and health promotion.</p> <p>(e) Participating in quality improvement processes to measure client outcomes, identify hazards and errors, and developing changes in processes of client care.</p> <p>*** (i) through (iv) reflect the recommendations for competencies needed by all health care professionals as recommended by the Institute of Medicine in "Who Will Keep the Public Healthy: Educating Health Care Professionals for the 21st Century." The content presented for these competencies will vary as to each level of educational preparation.</p> <p>2. Supervised clinical practice shall include development of skill in making clinical judgments, management and care of groups of clients, and delegation to and supervision of other health care providers.</p> <p>a) Clinical experience shall be comprised of sufficient hours to meet these standards, be supervised by qualified faculty and ensure students' ability to practice at an entry level.</p> <p>b) All student clinical experiences, including those with preceptors, shall be directed by nursing faculty.</p> <p>***Crossing state borders for clinical experiences raises questions regarding who approves these clinical sites, the state of the parent academic institution or the state where the clinical opportunity is located. In</p>
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addition, schools need to determine whether student practice is covered under an exemption in the state where the practice occurs. [Chapter Thirteen of these rules provides an exemption for “the practice of nursing that is an integral part of a program by nursing students enrolled in board-approved nursing education programs.”]

****Boards of the involved states need to determine who should approve these clinical sites and what the process should be. Consensus on the essential components of nursing education program approval would facilitate the reliance on program approval by another board. Interstate clinical presents an opportunity for boards of nursing to communicate and collaborate for the benefit of the student and the protection of the public.*

- 3. Delivery of instruction by distance education methods must be consistent with the program curriculum plan and enable students to meet the goals, competencies and objectives of the educational program and standards of the board.

C. Students

- 1. Students shall be provided the opportunity to acquire and demonstrate the knowledge, skills and abilities for safe and effective nursing practice, in theory and clinical experience with faculty oversight.
- 2. All policies relevant to applicants and students shall be available in writing.
- 3. Students shall be required to meet the health standards and criminal background checks as required in the state.
- 4. Students shall receive faculty instruction, advisement and oversight.
- 5. Students shall be held accountable for the integrity of their work.

****This statement reflects the expectation that students do their own work, e.g., not purchasing prewritten papers.*

D. Administrator qualifications

- 1. Administrator qualifications in a program preparing for practical/vocational nurse licensure shall include:
 - a) A current, active and unencumbered registered nurse license or privilege to practice and meet requirements in the state where the program is approved and/or accredited;
 - b) A minimum of a baccalaureate degree in nursing and Master’s degree in nursing or related field, or a nursing doctorate;

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	<p>c) Educational preparation and at least < > years experience in teaching and learning principles for adult education, including curriculum development and administration, and at least two years of clinical experience; and</p> <p>d) A current knowledge of nursing practice at the practical/vocational level.</p> <p>2. Administrator qualifications in a program preparing for registered nurse licensure shall include:</p> <p>a) A current, active and unencumbered registered nurse license or privilege to practice and meet requirements in the state where the program is approved and/or accredited;</p> <p>b) A doctoral degree in nursing; or a Master's degree in nursing and a doctoral degree in a related field;</p> <p>c) Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration, and at least two years of clinical experience; and</p> <p>d) A current knowledge of registered nursing practice.</p> <p>3. Administrator (program head) qualifications in a program preparing for advanced practice registered nurse licensure shall include:</p> <p>a) A current, active and unencumbered registered nurse license or privilege to practice and meet requirements in the state where the program is approved and/or accredited;</p> <p>b) A doctoral degree in nursing; or a Master's degree in nursing and a doctoral degree in a related field;</p> <p>c) Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration, and at least two years of clinical experience; and</p> <p>d) A current knowledge of advanced practice registered nurse practice.</p> <p><i>***Preparation in an advanced practice registered nursing role and specialty and licensure as an APRN is desirable for the APRN program administrator.</i></p> <p>E. Faculty</p> <p>1. There shall be sufficient number of qualified faculty to meet the objectives and purposes of the nursing education program.</p> <p>2. The nursing faculty shall hold a current, active and unencumbered registered nurse license or privilege to practice and meet requirements in the state where the</p>
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	<p>program is approved and/or accredited.</p> <ol style="list-style-type: none">3. Clinical faculty shall hold a license or privilege to practice and meet requirements in the state of the student's clinical site.4. Qualifications for nursing faculty who teach in a program leading to licensure as a practical/vocational nurse:<ol style="list-style-type: none">a) Have a minimum of a baccalaureate degree with a major in nursing;b) Have < > years of clinical experience;c) Have preparation in teaching and learning principles for adult education, including curriculum development and implementation; andd) Have current knowledge of LPN/VN nursing practice.<p><i>***It is preferable that the nursing faculty members have a Master's degree with major in nursing or a nursing doctorate degree.</i></p>5. Qualifications for nursing faculty who teach in a program leading to licensure as a registered nurse:<ol style="list-style-type: none">a) Have a minimum of a Master's degree with a major in nursing or a nursing doctorate degree;b) Have < > years of clinical experience;c) Have preparation in teaching and learning principles for adult education, including curriculum development and implementation; andd) Have current knowledge of RN nursing practice.<p><i>***It is preferable that the nursing faculty hold an earned doctorate related to nursing education and/or the specific content area that the individual teaches.</i></p>6. Qualifications for nursing faculty who teach in a program leading to licensure as an advanced practice registered nurse:<ol style="list-style-type: none">a) Have a minimum of a Master's degree with a major in nursing or a nursing doctorate degree;b) Licensure or privilege to practice as an advanced practice registered nurse;c) Have < > years of clinical experience;d) Have preparation in teaching and learning principles for adult education, including curriculum development and implementation; ande) Have current knowledge of APRN nursing practice.<p><i>***Doctorate education is desirable for faculty of the APRN graduate nursing education track.</i></p>
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****There is an evolving field of nursing where the nurse is educated with a practice doctorate, also termed a nurse doctorate. This education emphasizes the science of nursing practice, rather than nursing theory and research. Boards of nursing should be aware of this movement and understand how it differs from traditional doctoral education and consider this degree for faculty qualifications for all three types of program when appropriate.*

7. Adjunct clinical faculty employed solely to supervise clinical nursing experiences of students shall meet all the faculty qualifications for the program level they are teaching.
8. Interdisciplinary faculty who teach nonclinical nursing courses shall have advanced preparation appropriate to these areas of content.

****The purpose of adjunct clinical faculty and interdisciplinary faculty is to supplement and complement the nursing faculty, not to substitute for nursing faculty. A team approach, having adjunct faculty work closely with the nursing faculty will facilitate the clinical application of the specialized content in nursing practice (e.g., issues and trends, nursing law and ethics, pharmacology, nutrition, research, management and statistics).*

9. Preceptors – Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities and will serve as a role model and educator to the student. Clinical preceptors may be used to enhance faculty-directed clinical learning experiences. Clinical preceptors should be licensed as a nurse at or above the level for which the student is preparing.

8.1.3 Additional Required Components of Graduate Education Programs Preparing Advanced Practice Registered Nurses

- A. Licensure Requirement for APRN Students – Each student enrolled in an APRN program shall be currently licensed or privileged to practice as a registered nurse in this or another state prior to involvement in clinical practice as a student APRN, unless exempted from this licensure requirement under §13.1.

****This requirement for RN licensure reflects that APRN roles and specialties build upon educational preparation and experience as a registered nurse.*

- B. Education programs offered by an accredited college or university that offers a graduate degree with a concentration in the advanced nursing practice specialty; or post-Master's certificate programs offered by an accredited college or university shall include the following components:



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<ol style="list-style-type: none">1. Clinical supervision must be congruent with current national specialty organizations and nursing accrediting body standards applicable to the APRN role and specialty.2. The curriculum is congruent with national standards for graduate level and advanced practice nursing education and is consistent with nationally recognized APRN roles and specialties, and includes but is not limited to:<ol style="list-style-type: none">a) Graduate nursing program core courses.b) An advanced practice nursing core, including legal, ethical and professional responsibilities of the APRN.<p><i>***Examples of APRN core courses include advanced pathophysiology, advanced pharmacology, advanced assessment and diagnostic reasoning, and management of health care status.</i></p>3. Coursework focusing on the APRN role and specialty. <p>B. The curriculum meets the following criteria:</p> <ol style="list-style-type: none">1. Consistent with competencies of the specific areas of practice.2. Dual track APRN programs (preparing for two specialties) or combined nurse practitioner/clinical nurse specialist shall include content and clinical experience in both functional roles and specialties.3. Instructional track/major has a minimum of 500 supervised clinical hours. The supervised experience is directly related to the knowledge and role of the specialty and category. Specialty tracks that provide care to multiple age groups and care settings will require additional hours distributed in a way that represents the populations served.<p><i>***This requirement is for 500 supervised clinical hours for each specialty track.</i></p>4. There shall be provisions for the recognition or prior learning and advanced placement in the curriculum for individuals who hold a Master's in nursing who are seeking preparation in a different role and specialty. Post-Master's nursing students shall complete the requirements of the Master's APRN program through a formal graduate level certificate or Master level track in the desired role and specialty. Post-Master's students must master the same APRN outcome criteria as the Master-level students and are required to complete a minimum of 500 supervised clinical hours.<p><i>***The advanced practice nursing student prepared in any of the current direct care provider roles must receive</i></p>

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	<p><i>sufficient clinical experience to provide depth and breadth in a given specialty or with designated populations.” (AACN, p.15, 1996) This rule reflects the 500-hour supervised clinical standard of the National Organization of Nurse Practitioners Faculties, the National Task Force on Quality Nurse Practitioner Education and the National Association of Clinical Nurse Specialist, and endorsed by the American Association of Colleges of Nursing. Boards should be aware that other APRN groups are requiring set numbers of cases (nurse anesthetists) or mastery of clinical skills (nurse mid-wives) to meet the supervised clinical requirement.</i></p> <p>C. A lead faculty member who is educated and nationally certified in the same specialty area and licensed as an APRN shall coordinate the educational component for the role and specialty in the APRN program.</p> <p><i>***Most boards of nursing do not approve graduate level nursing programs at this time and some boards have raised concerns that national nursing accreditation programs address the entire graduate program without specifically focusing on APRN tracks. This concern about the oversight of APRN nursing programs, particularly with the number of new programs being developed, may reflect a future need for boards of nursing to become involved in the approval of graduate programs with APRN tracks, and these models include a regulatory basis for boards that identify the need to approve APRN educational programs in their jurisdiction.</i></p>
<p>Section 2. Process for Determining Compliance with Standards.</p> <p>The board shall, by administrative rules, identify the process for determining nursing education program compliance with standards.</p>	<p>8.2 MODELS FOR DETERMINING COMPLIANCE WITH STANDARDS</p> <p>The evaluation model for achievement of these standards is determined by each individual jurisdiction and may be met by state approval and/or through accreditation by a recognized national, regional, or state accreditation body.</p> <p><i>***Member Boards vary in the approach used to implement standards. Many boards are involved in program approval, including school surveys. Others deem CCNE or NLNAC accreditation as meeting state approval requirements. Others perform initial approval and then make joint visits with the accrediting bodies and/or use the accrediting organization reports to inform their decision making.</i></p>
<p>Section 3. Nursing Education Program Approval.</p> <p>The board shall approve nursing education programs that meet the legal standards established by the board.</p>	<p>8.3 PURPOSES OF NURSING EDUCATION PROGRAM APPROVAL</p> <p>A. To promote the safe practice of nursing by implementing standards for individuals seeking licensure as registered nurses, licensed practical/vocational nurses and advanced practice registered nurses.</p>



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A. Establishment of a New Nursing Education Program.

The board shall set requirements for the establishment of a new nursing education program.

- B. Grant legal recognition to nursing education programs that the board determines have met the standards.
- C. To assure graduates that they meet the educational and legal requirements for the level of licensure for which they are preparing and to facilitate their endorsement to other states and countries.
- D. Assure continuous evaluation and improvement of nursing education programs.
- E. To provide the public and prospective students with a list of nursing programs that meet the standards established by the board.

8.3.1 Establishment of a New Nursing Education Program

Before establishing a new nursing education program, the program shall complete the process outlined below:

- A. Phase I – Application to board. The proposed program shall provide the following information to the board:
 - 1. Results of a needs assessment, including identification of potential students and employment opportunities for program graduates.
 - 2. Identification of sufficient financial and other resources.
 - 3. Governing institution approval and support.
 - 4. Community support.
 - 5. Type of educational program proposed.
 - 6. Clinical opportunities and availability of resources.
 - 7. Availability of qualified faculty.
 - 8. A pool of available students.
 - 9. A proposed timeline for initiating and expanding the program.
- B. Phase II – Approval for admission of students. The proposed program shall provide verification to the board that the following program components and processes have been completed:
 - 1. Employ director and faculty to develop program.
 - 2. Overview of total curriculum including:
 - a) Content
 - b) Schedule (course sequence)
 - c) Course descriptions
 - d) Contracts for clinical sites
 - e) Program evaluation plan
 - f) Board consultation
 - g) Course syllabi for first year with identified timeline for submission of syllabi for next years.

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	<p>3. Student policies for admission, progression, retention and graduation.</p> <p>When the board determines that all components and processes are completed and in place, the board shall authorize the program to admit students.</p> <p>C. Phase III – Approval</p> <ol style="list-style-type: none"> 1. The board shall approve the program upon: <ol style="list-style-type: none"> a) Graduation of first class. b) Completion of board program survey visit concurrent with graduation of first class or eligibility for NCLEX, or with established eligibility for a national certification in an APRN role and specialty. c) Submission of program’s ongoing evaluation plan and data. d) Satisfactory survey report that verifies that the program is in compliance with the board’s Nursing Education Standards in 8.1.1. 2. The board may request periodic reports from the new program regarding initial program operations before granting approval.
<p>B. <i>Continuing Approval of Nursing Programs.</i> The board shall periodically review educational nursing programs and require such programs to submit evidence of compliance with standards and administrative rules. If upon review of evidence the board determines that the program(s) meets the established standards, it shall grant continuing approval. The board will publish a list of approved programs.</p>	<p>8.3.2 Continuing Approval of Nursing Education Programs</p> <p>A. Every <> years or at the board’s discretion, previously approved nursing education programs will be evaluated for continuing approval. The board shall monitor and analyze various sources of information regarding program performance, including but not limited to:</p> <ol style="list-style-type: none"> 1. Periodic survey visits and/or reports. 2. Accreditation visits and reports. 3. Results of ongoing program evaluations. 4. Other sources of information regarding achievement of program outcomes, including: <ol style="list-style-type: none"> a) Student retention and attrition. b) Faculty turnover. c) Complaints regarding program. d) Trend data regarding NCLEX performance. e) Trend data regarding success in obtaining national certification for APRN roles and specialties. <p>B. Continuing approval will be granted upon the board’s verification that the program is in compliance with the board’s Nursing Education Standards in 8.1.1.</p>



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<p>C. Denial or Withdrawal of Approval. The board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the board, provided that all such actions shall be in accordance with this state's Administrative Procedures Act and/or the administrative rules of the board.</p>	<p>8.3.3 Denial or Withdrawal of Approval</p> <p>A. The board may deny initial approval if it determines that a new nursing education program will be unable to meet the standards for nursing education.</p> <p>B. The board may withdraw approval if it determines that:</p> <ol style="list-style-type: none"> 1. A nursing education program fails substantially to meet the standards for nursing education; or 2. A nursing education program fails to correct the identified deficiencies within the time specified. <p>8.3.4 Conditional Approval of Nursing Education Programs</p> <p>A. If the board determines that an approved nursing education program is not meeting the criteria set forth in these regulations, the governing academic institution shall be given a reasonable period of time to submit an action plan and to correct the identified program deficiencies.</p> <p>B. The board may grant conditional approval when it determines that a program is not fully meeting approval standards.</p> <p>8.3.5 Appeal A program denied approval or given less than full approval may appeal that decision within a < > month period. All such actions shall be effected in accordance with due process rights and the <NAME OF STATE> Administrative Procedures Act and/or board rules.</p>
<p>D. Reinstatement of Approval. The board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the board.</p>	<p>8.3.6 Reinstatement of Approval</p> <p>The board may reinstate approval if the program submits evidence of compliance with nursing education standards within the specified time frame.</p>
<p>Section 4. Closure of Nursing Education Programs. The board shall, by administrative rules, identify the process for nursing education programs that cease operation.</p>	<p>8.4 Closure of Nursing Education Program and Storage of Records</p> <p>A nursing education program may close voluntarily or may be closed due to withdrawal of board approval. Provision shall be made for:</p> <ol style="list-style-type: none"> A. Maintenance of the standards for nursing education during the transition to closure. B. Placement for students who have not completed the program. C. Arrangements for the secure storage and access to academic records and transcripts.

Model Nursing Practice Act**Model Nursing Administrative Rules****Article IX. Violations and Penalties**

****This chapter describes the remedies available to the board when there is a violation of the Nursing Practice Act or nursing administrative rules by a person who is not a licensee or a candidate for licensure, thus not directly subject to the jurisdiction of the board.*

Section 1. Violations

- A. Failure of an employer of a licensed nurse or any person acting as an agent for the nurse in obtaining employment to verify the current status of the licensee's authorization to practice nursing in this jurisdiction. As used in this section, the term "agent" includes, but is not limited to, nurse recruiters and nurse registries.
- B. No person shall:
1. Engage in the practice of nursing as defined in the act without a valid, current license, except as otherwise permitted under this act.
 2. Practice nursing under the cover of any diploma, license or record illegally or fraudulently obtained, signed or issued unlawfully or under fraudulent representation.
 3. Practice nursing during the time a license is suspended, revoked, surrendered, inactive or lapsed.
 4. Use any words, abbreviations, figures, letters, title, sign, card or device tending to imply that he or she is a registered nurse, licensed practical nurse or advanced practice registered nurse unless such person is duly licensed to practice under the provisions of this act.
 5. Fraudulently obtain or furnish a license by or for money or any other thing of value.
 6. Knowingly employ unlicensed persons in the practice of nursing.
 7. Fail to report information relating to violations of this act.
 8. Conduct a program for the preparation for licensure under this chapter unless the board has approved the program.
 9. Conduct courses or provide consultation that conflicts with the scope and standards of practice set forth in this act and in rule.
 10. Otherwise violate, or aid or abet another person to violate any provision of this act.

Chapter Nine – Violations and Penalties

****The specificity of Article IX in the Model Nursing Practice Act precludes the need for rules at this time. The chapter title is a placeholder until and if rules are needed in the future.*



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11. Engage in irregular behavior in connection with the licensure examination, including, but not limited to, the giving or receiving of aid in the examination or the unauthorized possession, reproduction or disclosure of examination questions or answers.

Section 2. Penalties

Violation of any provision of this article shall constitute a misdemeanor.

****A state's practice act may specify that all violations of the listed provisions are misdemeanors or may choose to specify which violation would constitute a misdemeanor.*

Section 3. Criminal Prosecution

Nothing in this act shall be construed as a bar to criminal prosecution for violation of the provisions of this act.

Section 4. Civil Penalties

The board may, in addition to any other sanctions herein provided, impose on any person violating a provision of this act or administrative rules, a civil penalty not to exceed <\$> for each count or separate offense.

Article X. Discipline and Proceedings

****This chapter provides remedies for the board to address violations of the Nursing Practice Act or Nursing Administrative Rules by licensees or applicants for licensure. The Model Act includes a very detailed list of discipline grounds. The subcommittee that worked on this revision identified two approaches to discipline grounds in Nursing Practice Acts:*

APPROACH ONE – BROAD GROUNDS CATEGORIES IN NPA
Details would be promulgated in rules/regulations.

APPROACH TWO – DETAILED GROUNDS IN NPA
The detailed language is included as part of the Nursing Practice Act, precluding the need for additional rules.

****There are advantages to both approaches. Having broad ground category with detail in rules/regulations provides more flexibility for the board to add to the rules as needed. Having the detail in the act provides clear notice to nurses as to the types of conduct that the board sees as problematic.*

****This document presents the grounds in a format that will meet both needs. Boards using the broad category approach can use the heading language for each group of grounds in their act and the details in their rules. The boards using the*

Chapter Ten – Discipline and Proceedings

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<p><i>detailed grounds can use all or selected parts of the detailed language in their law.</i></p>	
<p>Section 1. Authority.</p> <p>For any one or combination of the grounds set forth below, the board of nursing shall have the power to:</p> <ol style="list-style-type: none"> A. Refuse to issue or renew a license. B. Limit/restrict a license. C. Suspend a license. D. Revoke a license. E. Place a license on probation or place conditions on a license. F. Reprimand or otherwise discipline a licensee. G. Impose a civil penalty not exceeding \$10,000 for each separate violation. H. Impose fines of up to <\$>. I. Take any other action justified by the facts in the case. J. Recover the costs of the proceedings resulting in revocation, suspension or limitation/restrictions of a nursing license. The cost of proceedings shall include, but is not limited to, the cost paid by the board to the office of administrative hearings and the office of the attorney general or other board counsel for legal and investigative services; the costs of a court reporter and witnesses; reproduction of records, board staff time, travel and expenses; and board members' per diem reimbursements, travel costs and expenses. <p><i>***States will vary as to how they obtain investigative, legal and administrative proceedings services, and the language of this section would need to be congruent with the state's administrative process and procedures.</i></p> <p><i>***The rationale for the option of large civil penalties is to deprive the nurse of any economic advantage gained by reason of the violation charged, to reimburse the board for the cost of counsel, investigation and proceeding, and to discourage repeated violations. The "other action" provision gives to the board flexibility to be creative with remedy provisions.</i></p> <p>Section 2. Grounds for discipline.</p> <p>The board may discipline a licensee or applicant for any one or a combination of the following grounds:</p>	<p><i>***There is variation in the use of the language among boards of nursing to describe the disciplinary process. For example, some boards are specifically authorized to limit (or restrict) a license as a discipline action while other boards may incorporate a limitation as an element of probation (or conditional license).</i></p>
<ol style="list-style-type: none"> A. <u>Failing to meet requirements</u> – failure to demonstrate the qualifications or satisfy the requirements for licensure contained in Article VI. 	<p><i>*** A person applying for a license has the burden of proof to demonstrate the qualifications or satisfaction of the requirements.</i></p>



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<p>B. <u>Licensing Examination Violations</u> – conduct that violates the security of the examination, including, but not limited to:</p> <ol style="list-style-type: none"> 1. Copying, disseminating or receiving any portion of an examination. 2. Having unauthorized possession of any portion of a future, current or previously administrated examination. 3. Violating the standard of test administration. 4. Permitting an impersonator to take the examination on one’s behalf or impersonating an examinee. 	<p>***Other examples of examination violations include:</p> <ol style="list-style-type: none"> 1. Communicating with another examinee during the examination. 2. Possessing unauthorized materials during the examination.
<p>C. <u>Criminal Convictions</u> – convictions by a court or entry of an Alford plea or a nolo contendere plea to a crime in any jurisdiction that relates adversely to the practice of nursing or to the ability to practice nursing.</p>	<p>***While some states require a specific relationship between the crime and nursing practice, this broader ground provides the opportunity for boards to review a variety of crimes that, while not directly related to nursing practice, could be relevant to an individual’s ability to practice nursing, including information related to judgment and character issues.</p>
<p>D. <u>Fraud and/or Deceit</u> – employing fraud or deceit in procuring or attempting to procure a license to practice nursing, in filing any reports or completing client records, in representation of self to board or public, in authenticating any report or records in the nurse’s capacity as a registered nurse, licensed practical/vocational nurse or advanced practice registered nurse or in submitting any information or record to the board.</p>	<p>***Previous models have focused on fraud in procurement of a nursing license. This broadened language reflects other situations where a nurse’s misrepresentation or use of fraud could impact nursing practice. Unfortunately, this ground reflects situations observed in other professions and modern society.</p>
<p>E. <u>Unethical conduct</u> – including but not limited to conduct likely to deceive, defraud or harm the public; or demonstrating a willful or careless disregard for the health or safety of a client. Actual injury need not be established.</p> <p>F. <u>Action in Another Jurisdiction</u> – a nurse’s license to practice nursing or a multi-state practice privilege or another professional license or other credential has been denied, revoked, suspended, restricted or otherwise disciplined in this or any other state.</p> <p>G. <u>Unsafe Practice/Unprofessional Practice</u> – actions or conduct including, but not limited to:</p> <ol style="list-style-type: none"> 1. Failure or inability to perform registered nursing, practical/vocational nursing or advanced practice nursing, as defined in Article II of this act and rule, with reasonable skill and safety. 	<p>***Unethical conduct may include behavior that demeans the nursing profession at large. Examples of unethical nursing conduct include lying to a client and/or insurer about whether a service was provided or failing to report an error to avoid difficulty for the nurse.</p>
<ol style="list-style-type: none"> 2. Unprofessional conduct, including, but not limited to: <ol style="list-style-type: none"> a) A departure from or failure to conform to nursing standards. b) Improper management of client records. 	<p>***Standards promulgated by boards of nursing provide a broad framework for nursing practice and provide notice to nurses as to Board expectations regarding practice. Violations of such standards may result in unsafe or unprofessional practice.</p>

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<p>c) Delegating or accepting the delegation of a nursing function or a prescribed health function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective client care.</p> <p>d) Failure to supervise the performance of acts by any individual working at the nurse's delegation or assignment.</p> <p>e) Failure of a clinical nursing instructor to supervise student experiences.</p>	
<p>3. Failure of a chief administrative nurse to follow appropriate and recognized standards and guidelines in providing oversight of the nursing organization and nursing services of a health care delivery system.</p> <p>4. Failure to practice within a modified scope of practice or with the required accommodations, as specified by the board in granting a modified license as defined in Article VI, Section 5, or any stipulated agreement with the board.</p> <p>5. Conduct or any nursing practice that may create unnecessary danger to a client's life, health or safety. Actual injury to a client need not be established.</p> <p>6. Inability to practice safely – demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness; use of alcohol, drugs, chemicals, or any other material; or as a result of any mental or physical conditions.</p>	<p>***<i>Appropriate oversight includes causing validation of a nurse's licensure status on initial hire and periodically throughout employment.</i></p>
<p>H. <u>Misconduct</u> – actions or conduct that include, but are not limited to:</p> <p>1. Falsifying reports, client documentation, agency records or other essential health documents.</p> <p>2. Failure to cooperate with a lawful investigation conducted by the board.</p> <p>3. Failure to maintain professional boundaries with clients and/or client family members.</p>	<p>***<i>Misconduct addresses situations when the client is harmed or placed at risk of harm by the conduct of the nurse, including deliberate acts. It may be useful for boards using broad grounds categories in the NPA to promulgate rules with the more detailed descriptions and examples.</i></p>
<p>4. Use of excessive force upon or mistreatment or abuse of any client.</p> <p>5. Engaging in sexual conduct with a client, touching a client in a sexual manner, requesting or offering sexual favors or language or behavior suggestive of the same.</p>	<p>***<i>Abuse includes all types of verbal and psychological abuse in addition to physical abuse.</i></p>
<p>6. Threatening or violent behavior in the workplace.</p> <p>I. <u>Drug Diversion</u> – diversion or attempts to divert drugs or controlled substances.</p>	<p>***<i>“Excessive force” means force clearly greater than what would normally be applied in similar clinical situations.</i></p>



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<p>J. <u>Failure to Comply with Alternative Program Requirements</u> – failure of a participant of an alternative (to discipline) program to comply with terms of his /her alternative program agreement.</p> <p>K. <u>Other Drug Related</u> – actions or conduct that include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Use of any controlled substance or any drug or device or alcoholic beverages, to an extent or in a matter dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use may impair his or her ability to conduct with safety to the public the practice authorized by his or her license. 2. Falsification of or making incorrect, inconsistent or unintelligible entries in any agency, client or other record pertaining to drugs or controlled substances. 3. A positive drug screen for which there is no lawful prescription. <p>L. <u>Unlawful Practice</u> – actions or conduct that include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Knowingly aiding, assisting, advising or allowing an unlicensed person to engage in the unlawful practice of registered or practical nursing. 	<p><i>*** This section of the act provides a specific ground for failure to comply with terms of program agreement with the Alternatives to Discipline Program. This ground addresses the challenge to investigate if a nurse who has been in a program for some time were to relapse and is referred to the board for possible disciplinary action.</i></p> <p><i>***Drug screening may be conducted as a condition of employment.</i></p>
<ol style="list-style-type: none"> 2. Violating a rule adopted by the board, an order of the board or a state or federal law relating to the practice of registered or practical nursing, or a state or federal narcotics or controlled substance law. 3. Practicing beyond the scope of practice as stated in this act. 4. Failing to report violations of this act as required in Article XI, Sections 1 and 2. 	<p><i>***This section of the act makes not completing or otherwise complying with a board order a ground for discipline in itself. Board orders are interpreted to include settlement agreements. This ground also addresses failure to comply with other laws and rules/regulations.</i></p>
<p>Section 3. Procedure.</p> <p>The board shall establish a disciplinary process based on the Administrative Procedure Act of the state of <NAME OF STATE>.</p> <p><i>***The board of nursing disciplinary process assures due process to any nurse who is the subject of a complaint and investigation. The statutory language for due process requirements is set forth in the state’s Administrative Procedures Act.</i></p>	<p>10.3 DISCIPLINARY PROCESS</p> <p>10.3.1 Complaint Investigation</p> <p>The Board shall investigate alleged acts or omissions that the Board reasonably believes violate the Nursing Practice Act or Nursing Administrative Rules.</p> <p>10.3.2 Complaint Resolution</p> <ol style="list-style-type: none"> A. Complaints may be settled through informal negotiations with the subject nurse and/or subject nurse’s attorney. B. Negotiated settlements shall be reviewed to determine that any proposed remedy is appropriate for the facts as admitted or stipulated.

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<p>Section 4. Immunity.</p> <p>Any member of the board or staff, or any person reporting to the board of nursing in good faith information relating to alleged incidents of negligence or malpractice or the qualifications, fitness or character of a person licensed or applying for a license to practice nursing shall not be subject to a civil action for damages as a result of reporting such information. The immunity provided by this section shall extend to the members of any professional review committee and witnesses appearing before the committee authorized by the board to act pursuant to this section.</p>	<p>C. If a complaint cannot be resolved through informal negotiations, the case may be referred for formal administrative hearings.</p> <p>D. The board shall review the evidence and record produced at administrative hearings, and recommendations of the administrative law judge to determine whether the burden of proof has been met showing that the licensee has violated one or more grounds for disciplinary action. The Board is responsible for making complaint resolution decisions.</p>
<p>Section 5. Notification.</p> <p>The board shall communicate disciplinary actions taken as set forth in rule and may report to other entities.</p>	<p>10.5 NOTIFICATION</p> <p>The board shall provide information as required by federal law to federal databanks, to the National Council of State Boards of Nursing centralized licensing and discipline databank (Nursys), and may develop procedures for communicating with others in board policy.</p>
<p>Section 6. Alternative to Discipline Monitoring Program.</p> <p>The board shall establish through rules an alternative program to discipline for nurses with chemical dependency.</p>	<p>10.6 ALTERNATIVE TO DISCIPLINE MONITORING PROGRAM</p> <p>10.6.1 Purpose</p> <p>Alternative to Discipline Monitoring Programs promote public health and safety by facilitating early intervention and entry into a nonpunitive and nonpublic process for monitoring participants' recovery from substance abuse as well as their ability to provide safe nursing care.</p> <p>10.6.2 Objectives</p> <p>A. To promote early identification and close monitoring of nurses who are impaired due to substance abuse.</p> <p>B. To decrease the time between the nurse's acknowledgement of a substance abuse problem and the time she/he enters a treatment and recovery program.</p> <p>C. To assure that recovering nurses are compliant with treatment, recovery and work plans.</p> <p>D. To provide monitoring when the nurse returns to nursing practice to assure the safety of the public while the nurse progresses in recovery.</p>



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- E. To provide education to nurses, nursing schools and nursing employers regarding the disease of chemical dependency, the implications for nursing practice and to promote nurse self-reporting as well as earlier identification and treatment.

10.6.3 Program Structure

- A. A qualified administrator with education and expertise regarding the identification of substance abusers, treatment options and recovery maintenance shall direct the program.
- B. The program shall meet specific reporting criteria and timelines established by the board.
- C. The program shall make aggregate data regarding operations and outcomes available to the board and interested others.

10.6.4 Criteria for Entry

- A. The program shall develop admission criteria for review and approval by the board.
- B. Admission to the alternative program may be denied for any of the following conditions, including, but not limited to:
 - 1. The nurse is not eligible for licensure in the jurisdiction.
 - 2. The nurse has a history of prior licensure disciplinary action.
 - 3. The nurse has pending criminal action or past criminal conviction.
 - 4. The nurse denies substance abuse or addiction.
 - 5. The nurse has diverted controlled substances for sale or for other than self use.
 - 6. The nurse's participation in the program is determined to pose significant risk for the health care consumer as determined by alternative program staff, a consulting board member, the treatment provider or the nurse.
 - 7. The nurse's practice has caused client harm.

****Note that the verb in the stem of this provision is may. This section provides discretion for program staff to allow individuals into the program with one or more of these conditions.*

****An example of significant client risk would be a situation where there is information available indicating that incidents have occurred where the nurse caused harm, abuse or neglect to clients. In such cases, a disciplinary outcome for the nurse is needed.*

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	<p>10.6.5 Terms and Conditions for Alternative Program Participation</p> <ul style="list-style-type: none"> A. Each nurse entering the alternative program is responsible for meeting the requirements of the alternative program. B. Each nurse entering the alternative program shall agree to inform any and all employers of participation in the program. C. Alternative Program Agreements define the monitoring requirements, expected reports and information to be provided to the program. <ul style="list-style-type: none"> 1. Standard provisions shall be developed and submitted to the board to approve use for all participants. 2. Agreements may be individualized to meet specific nurse needs. D. Agreements and supporting data shall be reviewed on a regular basis. <p>10.6.6 Successful Program Completion</p> <ul style="list-style-type: none"> A. A participant successfully completes the program when the participant complies with all terms and conditions of the program as specified in this chapter and the participant's agreement. <p>10.6.7 Causes for Termination from Program</p> <p>Participation in the alternative program may be terminated for any of the following reasons:</p> <ul style="list-style-type: none"> A. The participant fails to comply with any of the terms and conditions of the program specified in this chapter. B. The participant fails to comply with any provision of the participant's agreement. C. The participant is unable to practice according to acceptable and prevailing standards of safe care. D. The program receives information that indicates that the participant may have committed additional violations of the grounds for disciplinary action or the provisions of this chapter. E. The participant receives a felony conviction.
<p>Section 7. Practice Remediation Program.</p> <p>The board shall establish through rules a practice remediation program to offer an alternative to discipline opportunity to correct nursing practice deficiencies.</p>	<p>10.7 PRACTICE REMEDIATION PROGRAM (PRP)</p> <p><i>***The Practice Remediation Program (PRP) offers an alternative to discipline opportunity for nurses with demonstrated practice deficiencies to correct those deficiencies. The program serves nurses who work in employment settings where there are not adequate mechanisms in place to take corrective action, to monitor effectiveness of remediation, or to monitor the nurses' behavior and practice. The program is also available to</i></p>



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nurses who request assistance from the board as an alternative to working with an employer (see minor incident rule, Chapter 12, Section 12.3.1).

10.7.1 Purpose

To offer an alternative to discipline for nurses with practice deficiencies.

10.7.2 Objectives

- A. To promote early identification of practice deficiencies.
- B. To assess the practice deficiencies in relation to the nurse, the practice context and public safety.
- C. To provide remediation plans for correcting practice deficiencies.
- D. To monitor the progress of nurses toward meeting remediation goals.

10.7.3 Program Structure

- A. A qualified administrator with education and teaching expertise working with adult learners shall direct the program.
- B. The program shall develop criteria for selection, performance and evaluation of educational providers who participate in PRP.
- C. The program shall report to the board regarding the utilization of the program and shall meet specific reporting criteria established by the board.
- D. The program shall make aggregate data regarding operations and outcomes available to the board and interested parties.

10.7.4 Identification of Practice Deficiencies

- A. Reports that a nurse may have practice deficiencies may be referred to the Practice Remediation Program (PRP) for review.
- B. Criteria to determine if a licensee's identified practice deficiency can be corrected through participation in PRP rather than through formal disciplinary action include, but are not limited to:
 - 1. The licensee's eligibility to participate in PRP in accordance with 10.7.5.
 - 2. The licensee's willingness to participate in PRP.
 - 3. Whether the reported practice deficiency:
 - a) Represented an intentional or willful commission or omission by the licensee.
 - b) Represented a single incident or a pattern of behavior

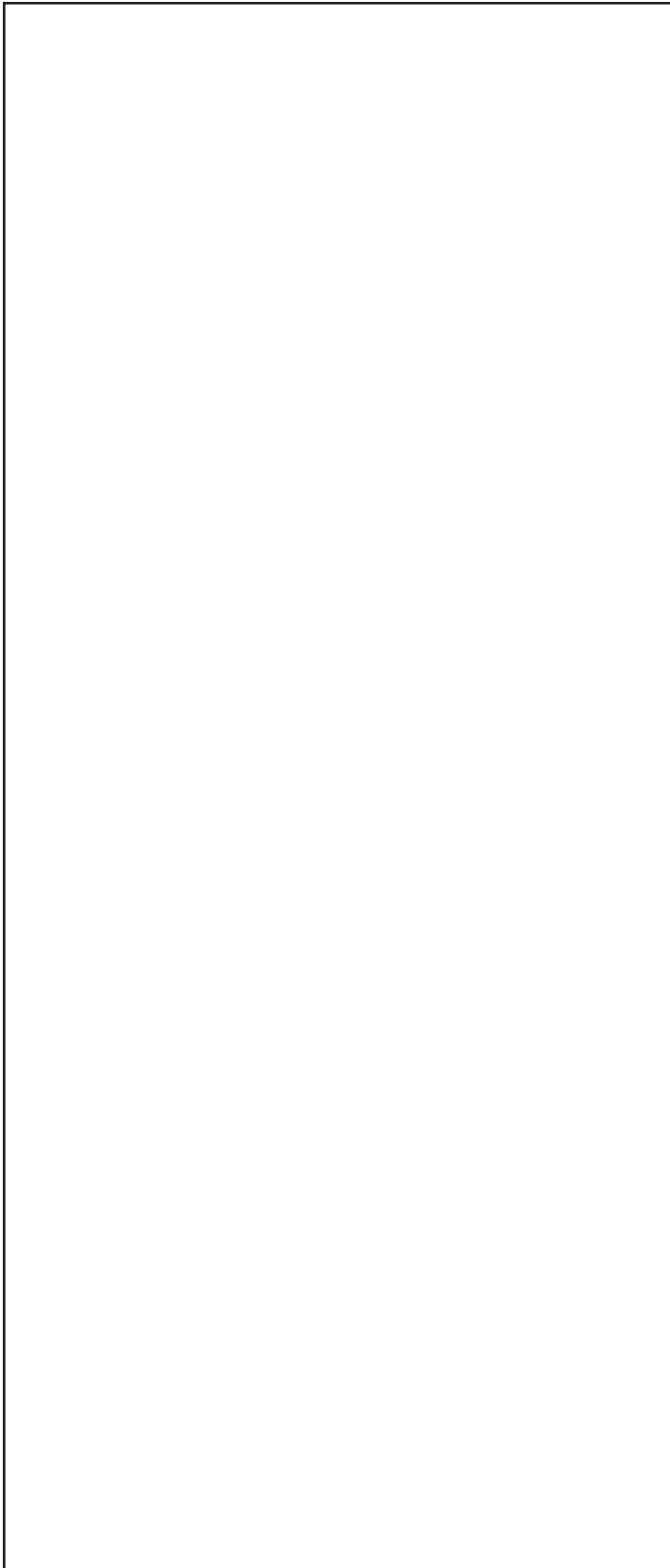
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	<p>by the licensee, and if a pattern of behavior, the frequency of the occurrence.</p> <p>c) Involved a vulnerable client.</p> <p>4. The impact of the practice deficiency on patient care and outcomes.</p> <p>5. The likelihood of correcting the practice deficiency through remediation.</p> <p>6. Whether remediation and monitoring of the nurse's practice will provide reasonable assurance that the public will be adequately protected from unsafe practice if the licensee enters PRP.</p> <p>10.7.5 Eligibility Requirements for Participation in the Practice Remediation Program (PRP)</p> <p>A licensee may participate in PRP if:</p> <p>A. The licensee is currently licensed to practice nursing in the state and is eligible to renew the license.</p> <p>B. The licensee has not been the subject of formal disciplinary action by any regulatory board or entity located in this state or in another jurisdiction unless the board determines that the previous disciplinary action was for a violation that would not preclude participation in the PRP.</p> <p>C. The nurse has no pending criminal conviction.</p> <p>D. The review of the criteria in 10.7.4 determines that the licensee's identified practice deficiency is appropriate to correct through remediation and would not pose a significant risk for the health care consumer as determined by PRP staff.</p> <p>10.7.6 Provisions of the Participatory Agreement for the Practice Remediation Program</p> <p>A. When a licensee has been determined by the board to be eligible for PRP, the licensee shall execute a participatory agreement with PRP which includes, but is not limited to:</p> <ol style="list-style-type: none"> 1. A description of the identified practice deficiency. 2. The specific remediation the participant must complete, including identification of educational providers and time frame for compliance with the terms of the participatory agreement. 3. Requires the participant to pay all expenses the participant incurs as a result of the required remediation. 4. Requires the participant to notify all employers during the course of participation in PRP. 5. Requires the participant to agree not to practice in any other jurisdiction during the term of the PRP agreement
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without prior authorization from the other jurisdiction and PRP.

6. Identifies a monitoring plan and expected progress reports from all employers, education providers and the licensee.
7. Requires the participant to sign all waivers necessary to secure all reports required by PRP.
8. Sets forth expectations for successful completion of the program.
9. Sets forth the grounds for termination from PRP.

B. A licensee determined to be eligible for PRP who refuses to enter into the participatory agreement set forth within this rule during the timeframe specified by PRP shall be subject to disciplinary action in accordance with Article X, Section 3.

10.7.7 Successful Completion of Program

A participant successfully completes the program when the participant complies with all terms and conditions of the program as specified in this chapter and the participant's agreement.

10.7.8 Termination from the Practice Remediation Program

A. Participation in the PRP may be terminated from the program for any of the following reasons:

1. Failure to comply with any term of the participatory agreement entered into by the participant.
2. Receipt of evidence from the educational provider indicating that the participant has failed to progress through or to successfully complete the remediation in the manner and during the timeframe prescribed in the participatory agreement.
3. Receipt of evidence from the workplace monitor indicating that the participant has continued to demonstrate the practice deficiency.
4. Failure to complete the remediation.
5. Failure to maintain eligibility for PRP.

B. When a licensee is terminated from PRP for one or more of these reasons, the board may proceed with disciplinary action in accordance with Article X, Section Three. The board may consider the licensee's termination from the PRP when determining the discipline to be imposed.

10.7.9 Disclosure of PRP Records

A. Information obtained by the practice program pursuant to an investigation shall be classified as not public information.



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	<p>B. All records regarding a licensee’s participation in PRP are not public and shall be maintained in the program office in a secure place separate and apart from the board’s record.</p> <p>C. The records shall be made public only by subpoena and court order.</p> <p>D. All educational providers and workplace monitors selected to provide remediation by a participant in PRP shall, as representatives of the board, maintain the privacy of all records regarding the participant’s remediation.</p> <p>E. PRP shall make regular reports to the board setting forth in aggregate, information regarding practice deficiencies, the types of educational interventions undertaken to correct the deficiencies and any other statistical information requested by the board.</p> <p>F. Nonpublic treatment of PRP records shall be cancelled if the nurse defaults on the PRP agreement and does not comply with the requirements of the program.</p> <p><i>***The Ohio State Board of Nursing Practice Identification and Improvement Program (PIIP) was the model for the Practice Remediation Program.</i></p>
<p>Article XI. Emergency Relief</p> <p>Section 1. Summary Suspension.</p> <p>A. Authority. The board is authorized to temporarily suspend the license of a nurse without a hearing if:</p> <ol style="list-style-type: none"> 1. The board finds that there is probable cause to believe that the nurse has violated a statute or rule that the board is empowered to enforce; and 2. Continued practice by the nurse would create imminent and serious risk of harm to others. <p>B. Duration. The suspension shall remain in effect until the board issues a stay of suspension or a final order in the matter after a hearing or upon agreement between the board and licensee.</p> <p>C. Hearing. The board shall schedule a disciplinary hearing to be held under the Administrative Procedures Act, to begin no later than < > days after the issuance of the summary suspension order. The licensee shall receive at least < > days notice of the hearing.</p>	<p>Chapter Eleven – Emergency Relief</p> <p><i>***Article XI of the MNPA and Chapter Eleven of the MNAR provide a process for the board to intervene quickly in emergency situations in order to protect the public from imminent and serious harm to the public. Although action is taken prior to hearing, the nurse is assured due process because of the provision that a hearing must be held within a specified time frame. Such emergency action is reserved for critical incidents.</i></p> <p><i>***The specificity of Article XI in the Model Nursing Practice Act precludes the need for additional rules at this time. This chapter is a placeholder until and if rules are needed in the future. This column has been used for explanatory comments.</i></p> <p><i>***States vary as to how summary suspensions are initiated.</i></p>
<p>Section 2. Automatic Suspension.</p> <p>A. Unless the board orders otherwise, a license to practice nursing is automatically suspended if:</p> <ol style="list-style-type: none"> 1. A guardian of a nurse is appointed by order of a court under sections <REFERENCE TO GOVERNING STATE LAW>. 	<p><i>***This section allows a board to act on a previous court action without additional proceedings. The rationale for this section, in addition to the individual already having been in court, is that if a nurse is so ill or incompetent as to require a guardian, he or she would not be able to participate in the discipline process in a meaningful way.</i></p>



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<p>2. The nurse is committed by order of a court under <REFERENCE TO GOVERNING STATE LAW>.</p> <p>3. The nurse is determined to be mentally incompetent, mentally ill, chemically dependent or a person dangerous to the public by a court of competent jurisdiction within or outside this state.</p> <p>B. The license remains suspended until the nurse is restored to capacity by a court. The nurse shall petition the board for reinstatement. The board may terminate the suspension after a hearing or upon agreement between the board and the nurse.</p>	<p><i>Example: a nurse who has been determined by a court of competent jurisdiction to be dangerous to the public because of serious mental disorder.</i></p> <p><i>Another option is to consider automatic suspension for specified, very serious criminal convictions.</i></p>
<p>Section 3. Injunctive relief.</p> <p>A. Authority. The board or any prosecuting officer upon a proper showing of the facts is authorized to petition a court of competent jurisdiction for an order to enjoin (injunctive relief):</p> <ol style="list-style-type: none"> 1. Any person who is practicing nursing within the meaning of this act from practicing without a valid license, unless exempted under Article XIII. 2. Any person, firm, corporation, institution or association from employing any person who is not licensed to practice nursing under this act or exempted under Article XIII. 3. Any person, firm, corporation, institution or association from operating a school of nursing without approval. 4. Any person whose license has been suspended or revoked for practicing as an RN, LPN/VN or APRN. 5. Any person to use the title “nurse,” “registered nurse,” “advanced practice registered nurse” or their authorized abbreviations unless licensed to practice nursing in this state. <p>B. The court may without notice or bond, enjoin such acts and practice. A copy of the complaint shall be served on the defendant and the proceedings thereafter shall be conducted as in other civil cases. In case of violation of an injunction issued under this section, the court, or any judge thereof, may summarily try and punish the offender for contempt of court.</p> <p>Section 4. Preservation of other remedies.</p> <p>The emergency proceedings herein described shall be in addition to, not in lieu of, all penalties and other remedies provided by law.</p>	<p><i>***The board’s prosecuting attorney may also petition for injunctive relief related to nursing practice.</i></p>



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Article XII. Reporting

Section 1. Duty to report by licensed nurses.

A licensed nurse shall report names of subject individuals to the board if the nurse has reasonable cause to suspect that a nurse or an applicant has violated any of the grounds for discipline found in Article X, Section 2, except for minor incidents as described in this rule.

Section 2. Duty to report by others.

- A. Hospitals, nursing homes, temporary staffing agencies and other employers of registered nurses, licensed practical/vocational nurses or advanced practice registered nurses shall report to the board the names of any licensee or applicant for nursing licensure whose employment has been terminated or who has resigned in order to avoid termination for any reasons stipulated in Article X, Section 2.
- B. A state agency that licenses, registers or certifies a hospital, nursing home, home health agency or other type of health care facility or agency section, or surveys one of these facilities or agencies shall report to the board when that agency has evidence that the nurse has violated Article IX, Section 2.
- C. Each insurer that provides professional liability insurance that covers claims arising from providing or failing to provide nursing care shall report any payment made on behalf of a nurse in a claim or lawsuit.
- D. The board shall develop procedures to identify criminal convictions of licensed nurse involving:
 1. Moral turpitude.
 2. Violation of a state or federal narcotics or controlled substances law.
 3. Fraud or abuse under the Medicare or Medicaid program.
 4. Court determination that a nurse is mentally ill or mentally incompetent.
- E. A person who is required to report a nurse under this section because the nurse is impaired or suspected of being impaired by chemical dependency or mental illness may report to the alternative to discipline program instead of reporting to the board.
- F. The board shall inform, in the manner the board determines appropriate, nurses, facilities, agencies and other persons of their duty to report under this section.

Chapter Twelve – Reporting

12.2.1 Insurers

Four times each year, by the first day of February, May, August and November, each insurer authorized to sell insurance in this state and providing professional liability insurance to registered nurses, licensed practical/vocational nurses or advanced practice registered nurses shall submit to the board a report concerning any nurse against whom a malpractice award has been made or who has been a party to a settlement. The report shall contain at least the following information:

- A. The total number of settlements or awards;
- B. The date the settlement or award was made;
- C. The allegations contained in the claim or complaint leading to the settlement or award;
- D. The dollar amount of each malpractice settlement or award and whether that amount was paid off as a result of a settlement or of an award; and
- E. The name and address of the nurse against whom an award was made or with whom a settlement was made.

An insurer shall also report to the board any information it possesses that tends to substantiate a charge that a nurse may have engaged in conduct violating Article X, Section 2.

****Boards that require liability insurer reporting may need to reference the state's statutes and rules governing insurance carriers and collaborate with other agencies to enforce this provision.*

12.2.2 Courts

The court administrator of any court of competent jurisdiction shall report to the board any judgment or other determination of the court that adjudges or includes a finding that a nurse is a person who is mentally ill, mentally incompetent, chemically dependent, dangerous to the public, guilty of a felony or gross misdemeanor, guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of operating a motor vehicle while under the influence of alcohol or a controlled substance, or guilty of an abuse or fraud under Medicare or Medicaid, appoints a guardian of the nurse or commits a nurse pursuant to the laws of this state.



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	<p>12.2.3 Deadlines, Forms</p> <p>Reports required by 12.2 must be submitted no later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that the reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting. The board shall review all reports, including those submitted after the deadline.</p> <p><i>***States vary as to processes for accessing court records. Criminal convictions involving licensed nurses should be reviewed to confirm the identity of the nurse and for the nature of the offense committed, the court's sentence and judgment.</i></p>
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<p>Section 3. Exceptions to duty to report.</p> <p>Minor incidents are exceptions to reporting requirements for violations of Article X, Section 2., when the continuing practice by the subject nurse does not pose a risk of harm to a client or others, and can be addressed through corrective action by the nurse's employer. The board shall adopt rules governing reporting of minor incidents. The board may evaluate a complaint and determine that it is a minor incident under this section.</p>	
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	<p>12.3.1 Minor Incidents</p> <p><i>***The reporting of every minor violation of the Nursing Practice Act does not enhance protection of the public. This is particularly true when there are mechanisms in place in the nurse's employment setting to take corrective action and monitor effectiveness of remediation and patterns of nurse behavior and practice. This rule is intended to clarify both what constitutes a minor incident and when a minor incident need not be reported to the board.</i></p> <p>A. The chief administrative nurse or designee responsible for reviewing incidents of practice breakdown may determine that an incident need not be reported to the board of nursing if all of the following factors exist:</p> <ol style="list-style-type: none"> 1. The potential risk of physical, emotional or financial harm to the client due to the incident is minimal. 2. The nurse exhibits a conscientious approach to and accountability for his or her practice. 3. The nurse has demonstrated the knowledge and skill to practice safely. <p>B. The review of the incident shall include evaluation of the significance of the event in the practice setting, the context of the event and the presence of contributing or mitigating circumstances in the nursing care delivery system.</p> <p>C. If an event is determined to be a minor incident:</p> <ol style="list-style-type: none"> 1. An incident/variance report shall be completed according to the employing facility's policy, including a complete description of the incident, client record number, names of witnesses, identification of subject nurse and action to correct or remediate the problem. 2. The chief administrative nurse or designee shall maintain a record of each minor incident involving nurses under his/her supervision.
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	<p>D. The chief administrative nurse or designee shall report to the board if < > minor incidents involving a nurse are documented within a one-year time period, or if a nurse leaves employment before completing any employer expectations for reeducation or other remediation, or if the risk of ongoing problems that do not respond to employer remediation expose patients to unsafe nursing care.</p> <p>E. Nothing in this rule is intended to prevent reporting of a potential violation directly to the board.</p> <p>F. Failure to classify an event appropriately in order to avoid reporting may result in violation of the mandatory reporting statute.</p>
<p>Section 4. Court Order.</p> <p>The board may seek an order from a court of competent jurisdiction for a report from any of the parties stipulated in Section 1 and 2 of this article if one is not forthcoming voluntarily.</p> <p>Section 5. Penalty.</p> <p>The board may seek a citation for civil contempt if a court order for a report is not obeyed by any of the parties stipulated in Section 1 and 2 of this article.</p> <p>Section 6. Immunity.</p> <p>A. Any organization or person reporting, in good faith, information to the board under this article shall be immune from civil action as provided in Article X, Section 4.</p> <p>B. A physician or other licensed health care professional who, at the request of the board, examines a nurse, shall be immune from suit for damages by the nurse examined if the examining physician or examining health care professional conducted the examination and made findings or diagnoses in good faith.</p>	<p><i>***This provision authorizes the board to seek court assistance in obtaining information required in Article XII of the MNPA.</i></p>
<p>Article XIII. Exemptions</p> <p>Section 1. No provisions of this act shall be construed to prohibit:</p> <p>A. The practice of nursing that is an integral part of a program by nursing students enrolled in board approved nursing education programs.</p>	<p>Chapter Thirteen – Exemptions</p> <p><i>***Article XIII of the MNPA identifies exceptional situations when an individual may practice nursing without first being granted a license by the jurisdiction. Jurisdictions may use different terminology or mechanisms to authorize practice in these temporary situations.</i></p> <p><i>***Article XIII, Section 1 A. of the MNPA provides an exemption for nursing students enrolled in board-approved nursing education programs and is intended to address practice by students in basic nursing education programs (preparation for initial licensure).</i></p> <p><i>***Clinical practice by a nurse completing a refresher course requires a temporary permit as stipulated in Chapter Six.</i></p>



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- B. The clinical practice needed to fulfill program requirements by a graduate nursing student currently licensed in another jurisdiction who meets criteria set forth in rule.
- C. The rendering of assistance by any nurse in the case of an emergency or disaster.
- D. The practice of any nurse, currently licensed in another state, in the provision of nursing care in the case of emergency or disaster.
- E. The incidental and gratuitous care of the sick by members of the family, friends or companions; or household aides at the direction of a person needing such care who resides independently outside any hospital, nursing or health care facility, or other similar institutional setting.
- F. Caring for the sick in accordance with tenets or practices of any church or religious denomination that teaches reliance upon spiritual means for healing.
- G. The practice of any nurse, currently licensed in another state who is employed by any bureau, division or agency of the United States government while in the discharge of official governmental duties.
- H. The practice of any nurse currently licensed in another state who is in this state on a nonroutine basis for a period not to exceed < > days to:
 - 1. Provide care to a client being transported into, out of or through this state.
 - 2. Provide professional nursing consulting services.
 - 3. Attend or present a continuing nursing education program.
 - 4. Provide other short-term nonclinical nursing services.
- I. The practice of any other occupation or profession licensed under the laws of this state, provided that such care does not constitute the practice of nursing within the meaning of this act.

13.1.1 Graduate Nursing Students from Another Jurisdiction

Graduate students who are licensed as registered nurses in another jurisdiction and practicing nursing in this state in fulfillment of graduate nursing program requirements are exempted from licensure if they meet the following criteria:

- A. The graduate program verifies that the student holds an active, unencumbered RN license in another jurisdiction (either in the United States or in another country).
- B. The board approves the graduate study experience.
- C. The graduate program advises the student of expectations regarding student practice and required supervision.
- D. The graduate program provides direct supervision of the clinical experience and informs faculty, preceptors and clinical facilities that the student is practicing under this limited exemption.
- E. The student limits practice to what is required for completion of the graduate program requirements.

****This exemption addresses the nursing practice by a graduate nursing student. Students who complete a graduate nursing program preparing for practice as an APRN would then apply for a temporary permit to practice during the time between program completion and licensure as an APRN.*

****Most graduate nursing education programs in the United States require students to be licensed as RNs in the state the school is located. There are some exceptions, e.g., some programs waive this requirement for international students who come to the United States solely for education, planning to return to their native country and never intending to practice in this country. If a graduate student intends to work as a nurse while enrolled in a graduate nursing education program, the student is expected to apply for licensure.*

****In the previous version of the rules, practice by graduate students in schools where RN licensure was not required was covered by a category of permit for “post basic” students that was included in MNPA, Article V, to provide for those situations when a graduate nurse wishes to practice to meet the clinical requirements of a graduate program but does not intend to otherwise practice in a jurisdiction. There was concern that the term “post basic” was confusing, so this type of permit was deleted. Instead, Article XIII, Section 1 B. provides an exemption for graduate students meeting criteria set forth in rule.*

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	<p>13.1.2 Practice Expectations</p> <p>The practice of any nurse currently licensed in another state who is in this jurisdiction on a time-limited, nonroutine basis for the activities identified in Article XIII, Section I, shall comply with the scope of practice and standards of this jurisdiction.</p>																																																						
<p>Article XIV. Revenue, Fees</p> <p>Section 1. Revenue.</p> <p>The board is authorized to establish appropriate fees for licensure by examination, reexamination, endorsement and such other fees and fines as the board determines necessary.</p>	<p>Chapter Fourteen – Revenue and Fees</p> <p>14.1 COLLECTION OF FEES</p> <p>A. The board shall collect the following fees:</p> <table border="0"> <thead> <tr> <th style="text-align: left;"><u>Fee Category</u></th> <th style="text-align: right;"><u>Fee</u></th> </tr> </thead> <tbody> <tr> <td>1. Application for licensure by examination</td> <td></td> </tr> <tr> <td> a) Registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> b) Licensed practical/vocational nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> c) Advanced practice registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>2. Temporary permit for initial licensure applicant</td> <td></td> </tr> <tr> <td> a) Registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> b) Licensed practical/vocational nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> c) Advanced practice registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>3. Application for licensure by endorsement</td> <td></td> </tr> <tr> <td> a) Registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> b) Licensed practical/vocational nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> c) Advanced practice registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>4. Temporary permit for endorsement applicant</td> <td></td> </tr> <tr> <td> a) Registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> b) Licensed practical/vocational nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> c) Advanced practice registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>5. Renewal of licensure</td> <td></td> </tr> <tr> <td> a) Registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> b) Licensed practical/vocational nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td> c) Advanced practice registered nurse</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>6. Temporary permit to practice for the clinical portion of a nursing refresher course</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>7. Late renewal fee</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>8. Reinstatement fee</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>9. Certified statement that nurse is licensed in state</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>10. Duplicate or reissued license</td> <td style="text-align: right;">< ></td> </tr> <tr> <td>11. Returned check</td> <td style="text-align: right;">< ></td> </tr> </tbody> </table>	<u>Fee Category</u>	<u>Fee</u>	1. Application for licensure by examination		a) Registered nurse	< >	b) Licensed practical/vocational nurse	< >	c) Advanced practice registered nurse	< >	2. Temporary permit for initial licensure applicant		a) Registered nurse	< >	b) Licensed practical/vocational nurse	< >	c) Advanced practice registered nurse	< >	3. Application for licensure by endorsement		a) Registered nurse	< >	b) Licensed practical/vocational nurse	< >	c) Advanced practice registered nurse	< >	4. Temporary permit for endorsement applicant		a) Registered nurse	< >	b) Licensed practical/vocational nurse	< >	c) Advanced practice registered nurse	< >	5. Renewal of licensure		a) Registered nurse	< >	b) Licensed practical/vocational nurse	< >	c) Advanced practice registered nurse	< >	6. Temporary permit to practice for the clinical portion of a nursing refresher course	< >	7. Late renewal fee	< >	8. Reinstatement fee	< >	9. Certified statement that nurse is licensed in state	< >	10. Duplicate or reissued license	< >	11. Returned check	< >
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Section 2. Disposition of fees.

All fees collected by the board shall be administered according to the established fiscal policies of this state in such manner as to implement adequately the provisions of this act.

Section 3. Grants and contributions.

The board may accept grants, contributions, devices, bequests and gifts that shall be kept in a separate fund and shall be used by the board to enhance the practice of nursing.

12. Fee for each level of nursing education program survey and evaluation < >

13. Discipline monitoring fee < >

***Applicable only to licensees with encumbered licenses.

14. Copying costs < >

15. Other miscellaneous costs < >

B. Cost of service. Fees collected by the board shall reflect the cost of service provided.

C. Refund of fees. All fees collected by the board are nonrefundable.

Article XV. Implementation

Section 1. Effective date. This act shall take effect <DATE>.

Section 2. Persons licensed under a previous law.

A. Any person holding a license to practice nursing as a registered nurse in this state that is valid on <effective date> shall be deemed to be licensed as a registered nurse under the provisions of this act and shall be eligible for renewal of such license under the conditions and standards prescribed in this act.

B. Any person holding a license to practice nursing as a licensed practical/vocational nurse in this state that is valid on <effective date> shall be deemed to be licensed as a licensed practical/vocational nurse under the provisions of this act and shall be eligible for renewal of such license under the conditions and standards prescribed in this act.

C. Any person holding a license to practice nursing as an advanced practice registered nurse in this state that is valid on <effective date> shall be deemed to be licensed as an advanced practice registered nurse under the provisions of this act and shall be eligible for renewal of such license under the conditions and standards prescribed in this act.

D. Any person eligible for reinstatement of a license as a registered nurse, licensed practical nurse or advanced

Chapter Fifteen – Implementation

15.1 APRN IMPLEMENTATION

A nurse practicing at an advanced level during a < > period preceding the effective date, may apply for licensure as an advanced practice registered nurse.

A. The graduate degree requirement is waived before January 1, 2003. The waiver of the graduate education requirement continues to apply at the time of license renewal or reinstatement of a lapsed license.

B. The applicant shall have completed an educational program designed to prepare the person to function in the advanced nursing practice role and specialty.

***Boards of nursing that implement changes in the requirements for advanced practice registered nurses should provide adequate grandfathering language to assure continued practice by individuals already safely practicing in that category.



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practice nurse respectively, under provisions, conditions and standards prescribed in this act by applying for reinstatement according to rules established by the board of nursing. Application for such reinstatement must be made within < > months of the effective date of this act.

- E. Any person holding a lapsed license to practice nursing as a registered nurse, licensed practical/vocational nurse or an advanced practice registered nurse on <EFFECTIVE DATE> because of failure to renew may become licensed as a registered nurse, licensed practical/vocational nurse or advanced practice registered nurse respectively, under the provisions of this act by applying for reinstatement according to rules established by the board of nursing. Application for such reinstatement must be made within < > months of the effective date of this act.
- F. Those so licensed under the provisions of Article XV, Section 2, A. through E. above, shall be eligible for renewal of such license under the conditions and standards prescribed by this act.

Section 3. Severability.

The provisions of this act are severable. If any provision of this act is declared unconstitutional, illegal or invalid, the constitutionality, legality and validity of the remaining portions of this act shall be unaffected and shall remain in full force and effect.

Section 4. Repeal.

The laws specified below are repealed except with rights and duties that have matured, penalties that were incurred and proceedings that were begun before the effective date of this act. <LIST STATUTES TO BE REPEALED, FOR EXAMPLE THE CURRENT NURSING PRACTICE ACT OR APPROPRIATE SECTIONS.>

Article XVI. Nurse Licensure Compact

****Set out below are a series of enabling act provisions which may be appropriate for states introducing the compact, depending on specific state requirements.*

Section 1. Enabling Provisions.

- A. The Nurse Licensure Compact is hereby enacted and entered into with all other jurisdictions that legally join in the compact, which is, in form, substantially as follows in Section 2.
- B. “The head of the nurse licensing board” is used to define the compact administrator in Article VIII(a) shall mean <DESIGNATED POSITION>.

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***Each board of nursing designates a compact administrator to oversee the implementation of the compact. This may be the executive officer of the board, the head of an umbrella organization or other designee selected by the state.

- C. Upon the effective date of this compact, the licensing board will participate in a Compact Evaluation Initiative, designed to evaluate the effectiveness and operability of the compact. Such a Compact Evaluation Initiative will be conducted by an outside researcher. A component of the evaluation shall include a remote state identification system through which nurses will designate those remote states in which the nurse is practicing. A nurse's practice information in such an identification system will be updated upon issuance and renewal of the nurse license. The evaluation shall continue until the year 2005, after which time a report shall be produced for comment by the participating licensing boards and will be submitted to the legislature in the form of a Nurse Licensure Compact Evaluation Report.
- D. To facilitate cross-state enforcement efforts, the legislature finds that it is necessary for <THIS STATE> to have the power to recover from the affected nurse the costs of investigations and disposition of cases resulting from adverse actions taken by <THIS STATE> against that nurse. Coordinating language shall be inserted in the appropriate location in the Nurse Practice Act.
- E. This Compact is designed to facilitate the regulation of nurses, and does not relieve employers from complying with statutorily imposed obligations.
- F. This Compact does not supercede existing state labor laws.

Section 2. Nurse Licensure Compact.

A. NLC – ARTICLE I. *Findings and Declaration of Purpose.*

- 1. The party states find that:
 - a) The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
 - b) Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
 - c) The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
 - d) New practice modalities and technology make

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<p>compliance with individual state nurse licensure laws difficult and complex;</p> <p>e) The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant to both nurses and states.</p> <p>2. The general purposes of this compact are to:</p> <p>a) Facilitate the states' responsibility to protect the public's health and safety;</p> <p>b) Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;</p> <p>c) Facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;</p> <p>d) Promote compliance with the laws governing the practice of nursing in each jurisdiction;</p> <p>e) Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.</p>	
<p>B. NLC – ARTICLE II. <i>Definitions.</i></p> <p>As used in this compact:</p> <ol style="list-style-type: none"> 1. "Adverse Action" means a home or remote state action. 2. "Alternative program" means a voluntary, nondisciplinary monitoring program approved by a nurse licensing board. 3. "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards. 4. "Current significant investigative information" means investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond. 5. "Home state" means the party state, which is the nurse's primary state of residence. 	<p>16.1 DEFINITION OF TERMS IN THE COMPACT.</p> <p>For the purpose of the compact:</p> <ol style="list-style-type: none"> A. "Board" means party state's regulatory body responsible for issuing nurse licenses. B. "Information system" means the coordinated licensure information system. C. "Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile. D. "Public" means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc. <p>Other terms used in these rules are to be defined as in the Interstate Compact.</p>



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6. “Home state action” means any administrative, civil, equitable or criminal action permitted by the home state’s laws which are imposed on a nurse by the home state’s licensing board or other authority including actions against an individual’s license such as revocation, suspension, probation or any other action which affects a nurse’s authorization to practice.
7. “Licensing board” means a party state’s regulatory body responsible for issuing nurse licenses.
8. “Multistate licensure privilege” means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse’s privilege such as revocation, suspension, probation or any other action which affects a nurse’s authorization to practice.
9. “Nurse” means a registered nurse or licensed practical/vocational nurse, as those terms are defined by each party’s state practice laws.
10. “Party state” means any state that has adopted this compact.
11. “Remote state” means a party state, other than the home state, where the patient is located at the time nursing care is provided, or, in the case of the practice of nursing not involving a patient, in such party state where the recipient of nursing practice is located.
12. “Remote state action” means any administrative, civil, equitable or criminal action permitted by a remote state’s laws which are imposed on a nurse by the remote state’s licensing board or other authority including actions against an individual’s multistate licensure privilege to practice in the remote state, and cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.
13. “State” means a state, territory, or possession of the United States, the District of Columbia or the Commonwealth of Puerto Rico.
14. “State practice laws” means those individual party’s state laws and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. “State practice laws” does not include the initial qualifications for licensure or requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

Model Nursing Practice Act**Model Nursing Administrative Rules**C. NLC – ARTICLE III. *General Provisions and Jurisdiction.*

1. A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical/vocational nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.
2. Party states may, in accordance with state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.
3. Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.
4. This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.
5. Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.



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D. NLC – ARTICLE IV. Applications for Licensure in a Party State.

1. Upon application for a license, the licensing board in a party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any restrictions on the multistate licensure privilege, and whether any other adverse action by any state has been taken against the license.
2. A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.
3. A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of such change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.
4. When a nurse changes primary state of residence by:
 - a) Moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;
 - b) Moving from a nonparty state to a party state, and obtains a license from the new home state, the individual state license issued by the nonparty state is not affected and will remain in full force if so provided by the laws of the nonparty state; and
 - c) Moving from a party state to a nonparty state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

16.2 ISSUANCE OF A LICENSE BY A COMPACT PARTY STATE

For the purpose of this compact:

- A. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include but is not limited to:
 1. Driver's license with a home address;
 2. Voter registration card displaying a home address; or
 3. Federal income tax return declaring the primary state of residence.

***Statutory basis for these provisions are found in Article II § 5) and Article IV §§ 3) and 4) of the Nurse Licensure Compact.
- B. A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multi-state licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days.

***Statutory basis: Article IV §§ 2), 3) and 4).
- C. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the thirty (30) day period in Section 2 B. shall be stayed until resolution of the pending investigation.

***Statutory basis: Article V § 2).
- D. The former home state license shall no longer be valid upon the issuance of a new home state license.

***Statutory basis: Article IV§ 4) (a).
- E. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days and the former home state may take action in accordance with that state's laws and rules.

16.3 LIMITATIONS ON MULTISTATE LICENSURE PRIVILEGE

Home state boards shall include in all licensure disciplinary orders and/or agreements that limit practice and/or require monitoring the requirement that the licensee subject to said order and/or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order and/or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state boards.



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E. NLC – ARTICLE V. *Adverse actions.*

In addition to the general provisions described in NLC Article III, the following provisions apply:

1. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.
2. The licensing board of a party state shall have the authority to complete any pending investigations for a nurse who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.
3. A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.
4. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.
5. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.
6. Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain nonpublic if required by the party state's laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.

***Statutory basis: State statute.



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F. NLC – ARTICLE VI. *Additional authorities invested in party state nurse licensing boards.*

Notwithstanding any other powers, party state nurse licensing boards shall have the authority to:

1. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse;
2. Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located;
3. Issue cease and desist orders to limit or revoke a nurse’s authority to practice in their state;
4. Promulgate uniform rules and regulations as provided for in H. NLC – Article VIII 3.

G. NLC – ARTICLE VII. *Coordinated licensure information system.*

1. All party states shall participate in a cooperative effort to create a coordinated database of all licensed registered nurses and licensed practical/vocational nurses. This system will include information on the licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.
2. Notwithstanding any other provision of law, all party states’ licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.
3. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.
4. Notwithstanding any other provision of law, all party states’ licensing boards contributing information to the

16.4 INFORMATION SYSTEM

A. Levels of access

1. The public shall have access to nurse licensure information limited to:
 - a) The nurse’s name
 - b) Jurisdiction(s) of licensure
 - c) License expiration date(s)
 - d) Licensure classification(s) and status(es)
 - e) Public emergency and final disciplinary actions, as defined by contributing state authority
 - f) The status of multistate licensure privileges
2. Nonparty state boards shall have access to all information system data except current significant investigative information and other information as limited by contributing party state authority.
3. Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state

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coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.

5. Any personally identifiable information obtained by a party states' licensing board from the coordinated licensure information system may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
6. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.
7. The compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

E. NLC – ARTICLE VIII. *Compact administration and interchange of information.*

1. The head of the nurse licensing board, or his/her designee, of each party state shall be the administrator of this compact for his/her state.
2. The compact administrator of each party state shall furnish to the compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this compact.
3. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this compact. These uniform rules shall be adopted by party states, under the authority invested under Section F Article VI 4.

F. NLC – ARTICLE IX. *Immunity.*

No party state or the officers or employees or agents of a party state's nurse licensing board who acts in accordance with the provisions of this compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this compact. Good faith in this article shall not include willful misconduct, gross negligence or recklessness.

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authority.

***Statutory basis: Article VII § 7).

- B. The licensee may request in writing to the home state board to review the data relating to the licensee in the Information System. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and within ten (10) business days correct inaccurate data to the Information System.

***Statutory basis: Article VII § 7).

- C. The board shall report to the Information System within ten (10) business days
1. Disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority),
 2. Dismissal of complaint, and
 3. Changes in status of disciplinary action, or licensure encumbrance.

***Statutory basis: Article VII, § 2).

- D. Current significant investigative information shall be deleted from the Information System within ten (10) business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.

***Statutory basis: Article VII §§ 2) and 6).

- G. Changes to licensure information in the Information System shall be completed within ten (10) business days upon notification by a board.

***Statutory basis: Article VII §§ 2) and 8).



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G. NLC – ARTICLE X. *Entry into force, withdrawal and amendment.*

1. This compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.
2. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the compact of any report of adverse action occurring prior to the withdrawal.
3. Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with the other provisions of this compact.
4. This compact may be amended by the party states. No amendment to this compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

H. NLC – ARTICLE XI. *Construction and severability.*

1. This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.
2. In the event party states find a need for settling disputes arising under this compact:
 - a) The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the compact administrator in the home state; an individual appointed by the compact administrator in the remote state(s) involved; and an individual mutually agreed upon by

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the compact administrators of all the party states involved in the dispute.

- b) The decision of a majority of the arbitrators shall be final and binding.

Article XVII. APRN Compact

****Set out below are a series of enabling act provisions which may be appropriate for states introducing the compact, depending on specific state requirements.*

Section 1. APRN compact enabling language.

The APRN Compact is hereby enacted and entered into with all other jurisdictions that legally join in the compact, which is, in form, substantially as follows:

- A. "The head of the licensing board" as used to define the compact administrator in Section H. APRN – Article VIII 1. shall mean <TITLE OF ROLE DESIGNATED AS COMPACT ADMINISTRATOR>.
- B. For purposes of the APRN Compact, the term APRN includes individuals who are licensed/authorized to practice under <TITLE> as advanced practice registered nurses, in one of the following categories:
1. Nurse practitioner
 2. Clinical nurse specialists
 3. Nurse anesthetists
 4. Nurse midwives
- C. An APRN practicing in this State under a multistate licensure privilege may only be granted prescriptive authority if he can document completion of graduate level course work in the following areas:
1. Advanced health assessment
 2. Pharmacotherapeutics
 3. Diagnosis and treatment
- D. An APRN practicing in this state under a multistate licensure privilege who desires to obtain prescriptive authority must meet all the requirements of Subsection (2) and this Subsection and be placed on a registry with the <NAME OF AGENCY>. To be placed on the registry, an APRN must:
1. Submit a form prescribed by the <NAME OF BOARD>
 2. Pay a fee
 3. If prescribing controlled substances:
 - a) Obtain a controlled substance license as required under Section < >

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b) If prescribing Schedule II or III Controlled Substances, have a Consultation and Referral Plan with a physician licensed in <NAME OF STATE> as required in Subsection < >.

E. To facilitate cross-state enforcement efforts, the legislature finds that it is necessary for <NAME OF STATE> to have the power to recover from the affected APRN the costs of investigations and disposition of cases resulting from adverse actions taken by this state against that APRN. Coordinating language shall be inserted in the appropriate location in the Nurse Practice Act.

Section 2. APRN Compact.

A. APRN – ARTICLE I. *Findings and declaration of purpose.*

1. The party states find that:

- a) The health and safety of the public are affected by the degree of compliance with APRN licensure/authority to practice requirements and the effectiveness of enforcement activities related to state APRN licensure/authority to practice laws;
- b) Violations of APRN licensure/authority to practice and other laws regulating the practice of nursing may result in injury or harm to the public;
- c) The expanded mobility of APRNs and the use of advanced communication technologies as part of our nation’s health care delivery system require greater coordination and cooperation among states in the areas of APRN licensure/authority to practice and regulation;
- d) New practice modalities and technology make compliance with individual state APRN licensure/authority to practice laws difficult and complex;
- e) The current system of duplicative APRN licensure/authority to practice for APRNs practicing in multiple states is cumbersome and redundant to both APRNs and states;
- f) Uniformity of APRN requirements throughout the states promotes public safety and public health benefits; and
- g) Access to APRN services increases the public’s access to health care, particularly in rural and underserved areas.

2. The general purposes of this compact are to:

- a) Facilitate the states’ responsibilities to protect the public’s health and safety;

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<ul style="list-style-type: none"> b) Ensure and encourage the cooperation of party states in the areas of APRN licensure/authority to practice and regulation including promotion of uniform licensure requirements; c) Facilitate the exchange of information between party states in the areas of APRN regulation, investigation and adverse actions; d) Promote compliance with the laws governing APRN practice in each jurisdiction; e) Invest all party states with the authority to hold an APRN accountable; and f) Meet all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses. 	
<p>B. APRN – ARTICLE II. <i>Definitions.</i></p> <p>As used in this compact:</p> <ol style="list-style-type: none"> 1. “Advanced Practice Registered Nurse” or “APRN” means a nurse anesthetist; nurse practitioner; nurse midwife; or clinical nurse specialist to the extent a party state licenses or grants authority to practice in that APRN role and title. 2. “Adverse action” means a home or remote state disciplinary action. 3. “Alternative program” means a voluntary, nondisciplinary monitoring program approved by a licensing board. 4. “APRN licensure/authority to practice” means the regulatory mechanism used by a party state to grant legal authority to practice as an APRN. 5. “APRN uniform licensure/authority to practice Requirements” means those minimum uniform licensure, education and examination requirements as agreed to by the Compact Administrators and adopted by licensing boards for the recognized APRN role and title.” 6. “Coordinated licensure information system” means an integrated process for collecting, storing and sharing information on APRN licensure/authority to practice and enforcement activities related to APRN licensure/authority to practice laws, which is administered by a nonprofit organization composed of and controlled by state licensing boards. 7. “Current significant investigative information” means: <ol style="list-style-type: none"> a) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the APRN to respond if required by 	<p>17.1 DEFINITION OF TERMS IN THE APRN COMPACT</p> <p>For the purpose of the compact:</p> <ol style="list-style-type: none"> A. “APRN practice” means the scope of practice associated with an APRN role and title. B. “Board” means the party state’s regulatory body is responsible for issuing nurse licenses. C. “Encumbrance” means that an APRN’s license or authority to practice has been disciplined and that the current status of the licensure/authority to practice is subject to conditions and/or limitations or removal from practice. D. “Grandfathering” means the process that allows an APRN who previously qualified for licensure/authority to practice under different requirements to continue to be authorized to practice even though the APRN does not meet all current requirements for licensure/authority to practice. E. “Information system” means the coordinated licensure information system. F. “Prescriptive authority” means that an APRN is qualified and authorized to determine a client’s need for medications, drugs and/or prescribed devices and to order such therapy to be dispensed by a licensed pharmacist or other authorized provider. G. “Primary state of residence” means the state of a person’s declared fixed permanent and principal home for legal purposes; domicile. H. “Public” means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc. I. “Single state licensure/authority to practice” means that a compact state has limited an APRN’s licensure/authority to practice to the home state only, without the multistate privilege to practice in other party states.



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<p>state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or</p> <p>b) Investigative information that indicates that the APRN represents an immediate threat to public health and safety regardless of whether the APRN has been notified and had an opportunity to respond.</p> <p>8. “Home state” means the party state that is the APRN’s primary state of residence.</p> <p>9. “Home state action” means any administrative, civil, equitable or criminal action permitted by the home state’s laws which are imposed on an APRN by the home state’s licensing board or other authority including actions against an individual’s license/authority to practice such as revocation, suspension, probation or any other action which affects an APRN’s authorization to practice.</p> <p>10. “Licensing board” means a party state’s regulatory body responsible for issuing APRN licensure/authority to practice.</p> <p>11. Multistate advanced practice privilege” means current authority from a remote state permitting an APRN to practice in that state in the same role and title as the APRN is licensed/authorized to practice in the home state to the extent that the remote state laws recognize such APRN role and title. A remote state has the authority, in accordance with existing state due process laws, to take actions against the APRN’s privilege, including revocation, suspension, probation or any other action that affects an APRN’s multistate privilege to practice.</p> <p>12. “Party state” means any state that has adopted this compact.</p> <p>13. “Prescriptive authority” means the legal authority to prescribe medications and devices as defined by party state laws.</p> <p>14. “Remote state” means a party state, other than the home state,</p> <p>a) Where the patient is located at the time APRN care is provided; or,</p> <p>b) In the case of APRN, practice not involving a patient, in such party state where the recipient of APRN practice is located.</p> <p>15. “Remote state action” means:</p> <p>a) Any administrative, civil, equitable or criminal action</p>	
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<p>permitted by a remote state's laws which are imposed on an APRN by the remote state's licensing board or other authority including actions against an individual's multistate advanced practice privilege in the remote state, and</p> <p>b) Cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.</p> <p>16. "State" means a state, territory or possession of the United States.</p> <p>17. "State practice laws" means a party state's laws and regulations that govern APRN practice, define the scope of advanced nursing practice including prescriptive authority, and create the methods and grounds for imposing discipline. State practice laws do not include the requirements necessary to obtain and retain APRN licensure/authority to practice as an APRN, except for qualifications or requirements of the home state.</p> <p>18. "Unencumbered" means that a state has no current disciplinary action against an APRN's license/authority to practice.</p>	
<p>C. APRN – ARTICLE III. <i>General provisions and jurisdiction.</i></p> <ol style="list-style-type: none"> 1. All party states shall participate in the Nurse Licensure Compact for registered nurses and licensed practical/vocational nurses in order to enter into the APRN Compact. 2. No state shall enter the APRN Compact until the state adopts, at a minimum, the APRN Uniform Licensure/ Authority to Practice Requirements for each APRN role and title recognized by the state seeking to enter the APRN Compact. 3. APRN licensure/authority to practice issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate advanced practice privilege to the extent that the role and title are recognized by each party state. To obtain or retain APRN licensure/authority to practice as an APRN, an applicant must meet the home state's qualifications for authority or renewal of authority as well as all other applicable state laws. 4. The APRN multistate advanced practice privilege does not include prescriptive authority, and does not affect any requirements imposed by states to grant to an APRN initial and continuing prescriptive authority according to state practice laws. However, a party state may grant prescriptive authority to an individual on the basis of a 	<p>17.2 APRN UNIFORM REQUIREMENTS</p> <p>As required in Article III, 2., the "APRN Uniform Licensure/Authority to Practice Requirements" are:</p> <p>A. For initial licensure/authority to practice in a recognized APRN role and title:</p> <ol style="list-style-type: none"> 1. Unencumbered RN license; 2. Education congruent with APRN role and title; <ol style="list-style-type: none"> a) Graduation from or completion of a graduate level APRN program accredited by a national accrediting body congruent with the APRN role and title; b) Graduation from or completion of an educational program outside the United States that meets the same criteria for accreditation equivalent to a U.S. accrediting body; c) Current certification by the national certifying body in the APRN specialty appropriate to educational preparation; and d) Until January 1, 2005, states may develop alternate mechanisms to assure initial competence for those applicants for whom there is no appropriate certifying examination. After January 1, 2005, individuals will be required to have passed approved APRN examinations.



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multistate advanced practice privilege to the extent permitted by state practice laws.

5. A party state may, in accordance with state due process laws, limit or revoke the multistate advanced practice privilege in the party state and may take any other necessary actions under the party state's applicable laws to protect the health and safety of the party state's citizens. If a party state takes action, the party state shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.
 6. An APRN practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is provided. The APRN practice includes patient care and all advanced nursing practice defined by the party state's practice laws. The APRN practice will subject an APRN to the jurisdiction of the licensing board, the courts and the laws of the party state.
 7. Individuals not residing in a party state may apply for APRN licensure/authority to practice as an APRN under the laws of a party state. However, the authority to practice granted to these individuals will not be recognized as granting the privilege to practice as an APRN in any other party state unless explicitly agreed to by that party state.
- D. APRN – ARTICLE IV. *Applications for APRN licensure/authority to practice in a party state.*
1. Once an application for APRN licensure/authority to practice is submitted, a party state shall ascertain, through the Coordinated Licensure Information System, whether:
 - a) The applicant has held or is the holder of a nursing license/authority to practice issued by another state;
 - b) The applicant has had a history of previous disciplinary action by any state;
 - c) An encumbrance exists on any license/authority to practice; and
 - d) Any other adverse action by any other state has been taken against a license/authority to practice. This information may be used in approving or denying an application for APRN licensure/authority to practice.
 2. An APRN in a party state shall hold APRN licensure/authority to practice in only one party state at a time, issued by the home state.

B. For licensure/authority to practice in a multistate privilege in a recognized APRN role and title through endorsement from another jurisdiction and applicant shall provide evidence of:

1. Meets education requirements for initial licensure/authority to practice; or
2. Demonstrates successful completion of approved APRN certificate program prior to December 31, 2004;
 - a) Unencumbered RN license;
 - b) Unencumbered APRN licensure/authority to practice in another jurisdiction;
 - c) Education congruent with the APRN role and title;
 - d) Current certification by a national certifying body in the APRN specialty appropriate to the educational preparation; and
 - e) Authorized to practice as an APRN in another jurisdiction through a mechanism to ensure initial competence when no appropriate certification examination exists.

3. The Grandfathering Clause

Option One:

The minimum educational requirement in Subsection (2) for a multistate licensure privilege is completion of a graduate level APRN program. Those states that adopt these rules on a date later than December 31, 2003, for implementing a mandatory graduate degree for licensure/authority to practice as an APRN in their respective states, shall issue to an individual who does not meet the requirements set forth in Subsection (2) an APRN single state licensure/authority to practice. However, any licensure/authority to practice as an APRN issued prior to December 31, 2003 shall include a multistate licensure privilege.

Option Two:

The minimum educational requirement in Subsection (2) for a multistate licensure privilege is completion of a graduate level APRN program. However, any licensure/authority to practice as an APRN issued prior to the effective date of these rules shall include a multistate licensure privilege.

4. APRN prescriptive authority and registry

- a) An APRN working in party states in the same role and title as in the home state, who wishes to prescribe in a remote state, shall comply with the remote state's requirements to obtain prescriptive authority.

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3. An APRN who intends to change primary state of residence may apply for APRN licensure/authority to practice in the new home state in advance of such change. However, new licensure/authority to practice will not be issued by a party state until after an APRN provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.
4. When an APRN changes primary state of residence by:
 - a) Moving between two party states, and obtains APRN licensure/authority to practice from the new home state, the APRN licensure/authority to practice from the former home state is no longer valid;
 - b) Moving from a nonparty state to a party state, and obtains APRN licensure/authority to practice from the new home state, the individual state license issued by the nonparty state is not affected and will remain in full force if so provided by the laws of the nonparty state;
 - c) Moving from a party state to a nonparty state, the APRN licensure/authority to practice issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

E. APRN – ARTICLE V. Adverse actions.

In addition to the General Provisions described in Article III, the following provisions apply:

1. The licensing board of a remote state shall promptly report to the administrator of the Coordinated Licensure Information System any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.
2. The licensing board of a party state shall have the authority to complete any pending investigations for an APRN who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the Coordinated Licensure Information System. The administrator of the Coordinated Licensure Information system shall promptly notify the new home

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- b) This rule does not preclude a state that automatically grants prescriptive authority as part of the APRN scope of practice from similarly granting prescriptive authority as part of the APRN privilege.
5. APRN practicing as an RN – The APRN multistate privilege includes the authority to practice as a registered nurse in party states.
6. Issuance of a licensure/authority to practice by a compact party state.
 - a) An APRN applying for licensure/authority to practice in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include but is not limited to:
 - (1) Driver's license with a home address;
 - (2) Voter registration card displaying a home address; or
 - (3) Federal income tax return declaring the primary state of residence.

****The statutory basis for this rule is Article II § 5) and Article IV §§ 4) and 5).*

- b) An APRN changing primary state of residence, from one party state to another party state, may continue to practice under the former home state licensure/authority to practice and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days.

****The statutory basis for this rule is Article IV, §§ 2), 3) and 4).*

- c) The licensure application in the new home state of an APRN under pending investigation by the former home state shall be held in abeyance and the thirty (30) day period in section be stayed until resolution of the pending investigation.

****The statutory basis for this rule is Article V, § 2).*

- d) The former home state licensure/authority to practice shall no longer be valid upon the issuance of a new home state license.

****The statutory basis for this rule is Article IV, § 4).*

- e) If a decision is made by the new home state denying licensure/authority to practice, the new home state shall notify the former home state within 10 business days and the former home state may take action in



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state of any such actions.

accordance with that state's laws and rules.

3. A remote state may take adverse action affecting the multistate advanced practice privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the APRN licensure/authority to practice issued by the home state.
4. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.
5. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.
6. Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the party state's laws. Party states must require APRNs who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.
7. All home state licensing board disciplinary orders, agreed or otherwise, which limit the scope of the APRN's practice or require monitoring of the APRN as a condition of the order shall include the requirements that the APRN will limit her or his practice to the home state during the pendency of the order. This requirement may allow the APRN to practice in other party states with prior written authorization from both the home state and party state licensing boards.

F. APRN – ARTICLE VI. *Additional authorities invested in party state licensing boards.*

Notwithstanding any other powers, party state licensing boards shall have the authority to:

1. If otherwise permitted by state law, recover from the affected APRN the costs of investigations and disposition of cases resulting from any adverse action taken against that APRN;
2. Issue subpoenas for both hearings and investigations, which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance

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<p>and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and</p> <ol style="list-style-type: none"> 3. Issue cease and desist orders to limit or revoke an APRN's privilege or licensure/authority to practice in their state; and 4. Promulgate uniform rules and regulations as provided for in Section H. APRN – Article VIII, 3. 	
<p>G. APRN – ARTICLE VII. <i>Coordinated Licensure Information System.</i></p> <ol style="list-style-type: none"> 1. All party states shall participate in a cooperative effort to create a coordinated database of all APRNs. This system will include information on the APRN licensure/authority to practice and disciplinary history of each APRN, as contributed by party states, to assist in the coordination of APRN licensure/authority to practice and enforcement efforts. 2. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate advanced practice privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system. 3. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards. 	<p>17.3 INFORMATION SYSTEM</p> <p>A. Levels of access:</p> <ol style="list-style-type: none"> 1. The public shall have access to nurse licensure information limited to: <ol style="list-style-type: none"> a) The nurse's name; b) Jurisdiction(s) of licensure/authority to practice; c) License expiration date; d) Licensure classification(s) and status(es); e) Public emergency and final disciplinary actions, defined by contributing state authority; and f) The status of multistate licensure/authority to practice privilege. 2. Nonparty state boards shall have access to all information system data contributed by the party states and other information as limited by contributing party state authority. 3. Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state authority. <p><i>***The statutory basis for this rule is Article VII, § 7).</i></p> <p>B. The licensee may request in writing to the home state board to review the data relating to the licensee in the information system. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and within ten (10) business days correct inaccurate data to the information system.</p> <p><i>***The statutory basis for this rule is Article VII, § 7).</i></p>



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4. Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.
5. Any personally identifiable information obtained by a party states' licensing board from the coordinated licensure information system may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
6. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.
7. The compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

- C. The board shall report to the Information System within ten (10) business days:
 - 1) Disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs relating to participation in alternative programs required to remain nonpublic by contributing state authority;
 - 2) Dismissal of complaint; and
 - 3) Changes in status of disciplinary action, or licensure encumbrance.

****The statutory basis for this rule is Article VII, § 2).*

- D. Current significant investigative information shall be deleted from the information system within ten (10) business days upon report of the disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.

****The statutory basis for this rule is Article VII, §§ 2) and 6).*

- E. Changes to licensure information in the Information System shall be completed within ten (10) business days upon notification by a board.

****The statutory basis for this rule is Article VII, §§ 2) and 6).*


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H. APRN – ARTICLE VIII. Compact administration and interchange of information.

1. The head of the licensing board, or his/her designee, of each party state shall be the administrator of this compact for his/her state.
2. The compact administrator of each party state shall furnish to the compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this compact.
3. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this compact. These uniform rules shall be adopted by party states, under the authority invested under Section F APRN – Article VI 4.

I. APRN – ARTICLE IX. Immunity.

No party state or the officers or employees or agents of a party state's licensing board who acts in accordance with the provisions of this compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this compact. Good faith in this article shall not include willful misconduct, gross negligence or recklessness.

J. APRN – ARTICLE X. Entry into force, withdrawal and amendment.

1. This compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.
2. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the compact of any report of adverse action occurring prior to the withdrawal.
3. Nothing contained in this compact shall be construed to invalidate or prevent any APRN licensure/authority to practice agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with the other provisions of this compact.
4. This compact may be amended by the party states. No amendment to this compact shall become effective



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and binding upon the party states unless and until it is enacted into the laws of all party states.

K. ARTICLE XI. Construction and severability.

1. This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.
2. In the event party states find a need for settling disputes arising under this compact:
 - a) The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the compact administrator in the home state; an individual appointed by the compact administrator in the remote state(s) involved; and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute.
 - b) The decision of a majority of the arbitrators shall be final and binding.



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Report of Advanced Practice Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background of the Advanced Practice Advisory Panel

In January 2002, the Board of Directors approved the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to ensure the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues.

Highlights of FY04 Activities

- Updated the APRN comment paper and placed it on the NCSBN Members Only Web site.
- Reviewed the APRN certification programs of the following organizations: Critical Care CNMS Certification Program, American Nurses Credentialing Center, American Association of Nurse Practitioners, Pediatric Nursing Certification Board and the National Certification Corporation. All of these programs were determined to meet NCSBN criteria. However, it was noted that not all of the examinations from these organizations were determined to be suitable for APRN licensure purposes.
- Held the APRN Roundtable in Chicago on May 5, 2004.
- Reviewed the NACNS Statement on Clinical Nurse Specialist Practice and Education and provided feedback as requested.
- Reviewed the National Organizations Psychiatric–Mental Health Nurse Practitioner Competencies and recommended to the Board of Directors to endorse the document.
- Met with the CCNE, NLNAC and NONPF to discuss regulatory issues regarding NP doctoral programs.
- Met with the Pediatric Nursing Certification Board to discuss their new certification examination, Acute Care Pediatric NP.
- Reviewed documents from the Oncology Nursing Certification Corporation and provided feedback regarding the adequacy of the examination for APRN licensure, per their request.
- Provided feedback to the Model Rules Subcommittee regarding the draft APRN Model Administrative Rules.
- Developed and initiated implementation of the board approved Educational Plan for Member Boards regarding APRN regulatory issues.
- Met with APRN certification agencies (Critical Care CNMS Certification Program, American Nurses Credentialing Center, American Association of Nurse Practitioners, Pediatric Nursing Certification Board and the National Certification Corporation) to discuss common issues and concerns.
- Developed a draft APRN Vision Paper on the future of APRN regulation.

Members

Katherine Thomas, MN, RN, Chair
Texas, Area III

Patty Brown, MS, BSN, RN
Kansas, Area II

Ann Forbes, MSN, RN
North Carolina, Area III

Jane Garvin, MS, RN, CS-P
Maryland, Area IV

Georgia Manning-Lewis, MN, RN
Arkansas, Area III

Laura Poe, MS, RN
Utah, Area I

Kim Powell, RN, APRN
Montana, Area I

Janet Younger, PhD, RN, CPCNP
Virginia, Area III

Charlene Hanson, EdD, RN, CS, FNP,
FAAN, Consultant, Georgia

Polly Johnson, MSN, RN, Board Liaison
North Carolina, Area III

Staff

Nancy Chornick, PhD, RN,
Director of Credentialing

Carin Zuger, Credentialing and
Educational Administrative Assistant

Relationship to Strategic Plan

Strategic Initiative II: Regulatory Effectiveness

NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome D

Approaches and resources assist Member Boards in the regulation of advanced practice registered nurses.



Meeting Dates

October 30-31, 2004

January 7-8, 2004

May 5 & 7, 2004

June 3, 2004 at 2pm CT –
conference call

Attachments

None

Future Activities

- Continue working with APRN certification programs and other APRN stakeholders regarding APRN regulatory issues.
- Continue working on the APRN Vision Paper.
- Implement the APRN Education Plan.
- Continue the APRN Roundtable.
- Continue to facilitate communication between outside APRN organizations and boards of nursing.



Report of the Awards Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

In FY01 the Board of Directors established the Awards Panel to review and evaluate the NCSBN Awards Program. The panel was charged with developing a new awards program that ensured consistency, fairness and celebrated the contributions and accomplishments of the membership. The panel developed a new NCSBN Awards Program with new award categories, objectives and eligibility criteria.

In FY02, the Awards Panel was renamed the Awards Recognition Panel. The development of a recognition program for outgoing and incoming Board of Director officers at the Annual Meeting was added to the Panel's charge. The awards program was also reviewed and refined with revisions to several award categories and eligibility criteria.

The Board of Directors determined the Awards Panel would select the final award recipients beginning in FY03. There were no changes to the awards program in FY03 and FY04.

Highlights of FY04 Activities

- Launched and promoted the 2004 Awards Program at the Midyear meeting in Chicago, Illinois, to encourage membership participation.
- Collaborated with the Communications Department to design the NCSBN Awards brochure.
- Facilitated Awards Panel conference calls.
- Revised award recipient letter to allow the recipient to inform their executive director and if necessary Board Members to ensure their attendance at the annual awards luncheon.
- Prepared award nominations for blind review by panel members.
- Selected the 2004 Award recipients.

Future Activities

- To review and evaluate the 2004 Awards Program and submit recommendations to the Board of Directors

Members

Louise Bailey, MEd, RN
California-RN, Area I

June D. Bell, BSN, RN, BC
Kentucky, Area III

Iva Boardman, MSN, RN
Delaware, Area IV

Lori Scheidt, BS
Missouri, Area II

Katherine Thomas, MN, RN
Texas-RN, Area III

Staff

Alicia Byrd, BSN, RN
Member Relations Manager

Relationship to Strategic Plan

Strategic Initiative V:

NCSBN will support the education and development of Member Board staff, Board Members and the Board of Directors to lead in nursing regulation.

Outcome B

Sound organizational governance advances the NCSBN mission and vision.

Meeting Dates

October 20, 2003 (conference call)

November 24, 2003 (conference call)

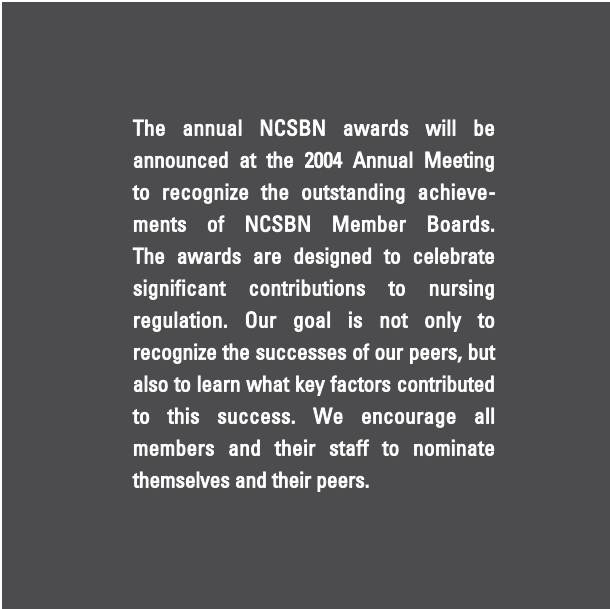
June 14-15, 2004

Attachments

A. Awards Brochure



2004 NCSBN AWARDS PROGRAM



The annual NCSBN awards will be announced at the 2004 Annual Meeting to recognize the outstanding achievements of NCSBN Member Boards. The awards are designed to celebrate significant contributions to nursing regulation. Our goal is not only to recognize the successes of our peers, but also to learn what key factors contributed to this success. We encourage all members and their staff to nominate themselves and their peers.

NOMINATION PROCEDURE AND ENTRY FORMAT

Please carefully read and consider the eligibility requirements and award criteria listed for each award. Only entries that meet all the requirements and criteria will be considered. **Electronic submission of all nomination materials is preferred.** Nomination forms can be found on the NCSBN Web site in the events section.

- Individuals may nominate themselves or others. For the Regulatory Achievement Award, Member Boards may nominate themselves or another board.
- Entries must include one letter of support from the executive officer or designee. For the Regulatory Achievement Award, entries must include one letter of support from another Member Board or a representative of a regulatory agency.
- Entries must include a one-page list of most significant leadership activities focusing on the award criteria.
- Entries must include a two-page narrative addressing the award criteria.
- Up to two additional letters of support may be submitted (optional).
- Entries must be typed and presented in a professional manner.
- Entries must be accompanied by an official entry form (or photocopy of the form).
- Entries must be typed and single-spaced on 8.5" x 11" letter-size paper. Entries must be typed no smaller than 10-point font size and 1.5" margins.
- Electronic submission of all materials is preferred, following formatting instructions above in Microsoft Word documents. Any documents that have been scanned must be in Adobe PDF format. If you use any other program, please call to be sure it is readable at NCSBN.

AWARDS REVIEW AND SELECTION

- To ensure a fair and equitable review and selection process, each individual nomination is subjected to a blind review by each Awards Panel member. The panel then makes the final decision about all award recipients.
- Awards Panel members are not allowed to write letters of support.
- Awards Panel members recuse themselves from both the blind review and the final decisions for award recipient(s) in categories where their particular board of nursing is nominated.
- Entries are evaluated using uniform guidelines for each award category.
- Awards will not necessarily be given in each category.
- Award recipients will be notified prior to the NCSBN Annual Meeting and will be honored at the Annual Meeting.



AWARDS REVIEW AND SELECTION

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2004 NCSBN AWARDS PROGRAM

GENERAL INFORMATION

Only applications that meet all requirements and criteria will be considered. Entries must be submitted in one, complete package; partial entries or entries that arrive in separate packages will not be considered. All entries must be postmarked no later than May 16, 2004, and should be sent to Alicia Byrd, Member Relations Manager, at the address below.

**NCSBN 2003 Awards
Attn: Member Relations
111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277**

**Electronic submissions should be e-mailed to:
abyrd@ncsbn.org.**

If you have questions about the Awards Program, contact Alicia at 312.525.3666 or by e-mail at abyrd@ncsbn.org.



EXCEPTIONAL CONTRIBUTION AWARD

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

Criteria for Selection

- Significant contributions to NCSBN activities
- Demonstrated support of NCSBN's mission

Eligibility – Board member on a board of nursing (not board president) or staff member of a board of nursing (not executive officer)

Award Cycle – Annually as applicable

Number of Recipients – Unlimited

REGULATORY ACHIEVEMENT AWARD

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

Criteria for Selection

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

Eligibility – A board of nursing

Award Cycle – Annually as applicable

Number of Recipients – One

R. LOUISE McMANUS AWARD

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

Criteria for Selection

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

Eligibility – Board member or staff member of a board of nursing

Award Cycle – As applicable

Number of Recipients – One

MERITORIOUS ACHIEVEMENT AWARD

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

Criteria for Selection

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

Eligibility – Board member or staff member of a board of nursing

Award Cycle – Annually as applicable

Number of Recipients – One



EXCEPTIONAL LEADERSHIP AWARD

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

Criteria for Selection

- Demonstrated leadership as the Member Board president
- Active participation in NCSBN activities
- Overall contributions to the regulation of nursing

Eligibility – Service as a state board of nursing president

Award Cycle – Annually as applicable

Number of Recipients – One

SERVICE RECOGNITION AWARDS

The Service Recognition Award was established to recognize executive officers who have made contributions to nursing regulation over a 10- to 30-year cumulative period. This will include the length of time spent as a board member or as board staff.

Criteria for Selection

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

Eligibility – Minimum five years in the role of an executive officer

Award Cycle – As applicable

Number of Recipients – As applicable

R. Louise McManus Award

- 2003 – Sharon M. Weisenbeck
- 2002 – Katherine Thomas
- 2001 – Charlie Dickson
- 1999 – Donna Dorsey
- 1998 – Jennifer Bosma
Elaine Ellibee
Marcia M. Rachel
- 1997 – Jean Caron
- 1996 – Joan Bouchard
- 1995 – Corinne F. Dorsey
- 1992 – Renatta S. Loquist
- 1989 – Marianna Bacigalupo
- 1986 – Joyce Schowalter
- 1983 – Mildred Schmidt

Meritorious Service Award

- 2001 – Shirley A. Brekken
- 2000 – Margaret Howard
- 1999 – Katherine Thomas
- 1998 – Helen P. Keefe
Gertrude Malone
- 1997 – Sister Teresa Harris
Helen Kelley
- 1996 – Tom O'Brien
- 1995 – Gail M. McGill
- 1994 – Billie Haynes
- 1993 – Charlie Dickson
- 1991 – Sharon M. Weisenbeck
- 1990 – Sister Lucie Leonard
- 1988 – Merlyn Mary Maillian
- 1987 – Eileen Dvorak

Regulatory Achievement Award

- 2003 – North Carolina Board of Nursing
- 2002 – West Virginia State Board of Examiners for Licensed Practical Nurses
- 2001 – Alabama Board of Nursing

Member Board Award

- 2000 – Arkansas Board of Nursing
- 1998 – Utah State Board of Nursing
- 1997 – Nebraska Board of Nursing
- 1994 – Alaska Board of Nursing
- 1993 – Virginia Board of Nursing
- 1991 – Wisconsin Board of Nursing
- 1990 – Texas Board of Nurse Examiners
- 1988 – Minnesota Board of Nursing
- 1987 – Kentucky Board of Nursing

Exceptional Leadership Award

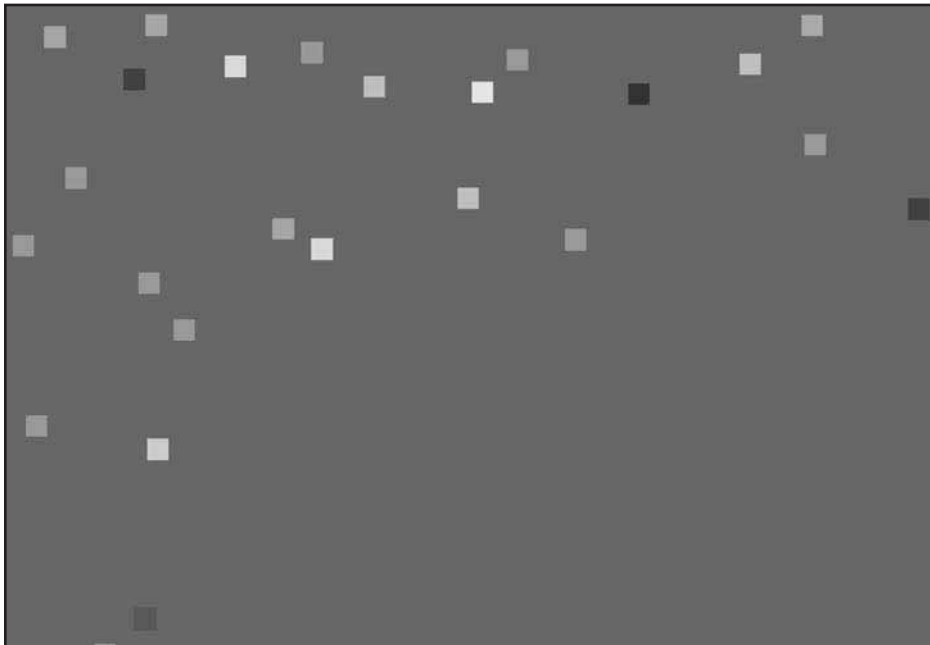
- 2003 – Cookie Bible
- 2002 – Richard Sheehan
- 2001 – June Bell

Exceptional Contribution Award

- 2003 – Sandra MacKenzie
- 2002 – Cora Clay
- 2001 – Julie Gould
Lori Scheidt
Ruth Lindgren

Silver Achievement Award

- 2000 – Nancy Wilson
- 1998 – Joyce Schowalter



NCSBN
Leading in Nursing Regulation

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277
312.525.3600
312.279.1032 fax
www.ncsbn.org

FEB04





Report of the Bylaws Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Bylaws Committee has been a standing committee since 2001 and is charged with reviewing and making recommendations on proposed bylaws amendments as directed by the Board of Directors or Delegate Assembly. The charge from the Board of Directors for FY04 was to:

1. Research the pros and cons of becoming an NCSBN Standing Committee, conduct research on other organizations' standing and ad hoc committee structures, and address the requests from the Disciplinary Resources and Advanced Practice Advisory Panels.
2. Delete the requirement that the Committee on Nominations observe an NCSBN Board meeting.
3. Allow the Committee on Nominations to select its chair and vice chair.

Research on governance models for committees consistently recommends that organizations keep committee structures simple and flexible and limit the number of standing committees to a bare minimum. It is recommended that standing committees be supplemented with other types of workgroups based on direction from the Board of Directors. Robert's Rules of Order states that standing committees are considered a permanent part of an organization where the purpose, function and duties do not change. Standing committees have certain functions to perform that are essential to the harmonious operation of the organization.

It did not appear to the committee that the charge of each of the advisory panels had changed in their direction by the Board of Directors to fulfill the defined purpose of a standing committee. The committee recognized the important and valuable contributions of the advisory panels and felt that the need to address emerging issues by these committees would be limited by a charge outlined in the bylaws. The committee believes that the utmost value of these advisory panels is best served by remaining as advisory panels.

The requirement that the Committee on Nominations observe an NCSBN Board meeting was deleted by the membership from the bylaws during the 2003 Delegate Assembly. Therefore, the request by the Committee on Nominations is in place.

At the 2001 Delegate Assembly, the membership adopted bylaw language that selects the chair and vice chair of the Committee on Nominations based on the number of votes received. The chair is a member in the second year of his/her term and the vice chair is in the first year of his/her term. The Bylaws Committee felt that there was not sufficient evidence to suggest that this language, that was placed in the bylaws three years ago, be changed at this time. The current language provides for a more objective determination directly from the membership as to selection of the chair and vice chair. The committee did note that candidates for the Committee on Nominations should understand that they might be called upon, based upon the vote of the Delegates, to be the vice chair and subsequently the chair.

Highlights of FY04 Activities

- Reviewed the NCSBN mission, vision and values.
- Reviewed the current Standing Rules.

Members

Laura Rhodes, MSN, RN, Chair
West Virginia-RN, Area II

Theresa Bonanno, MSN, RN
Massachusetts, Area IV

Charlene Kelly, PhD, RN
Nebraska, Area II

Patricia LeCroy, MSN, RN
Alabama, Area III

Board Liaison

Marjesta Jones, LPN
Alabama, Area III

Staff

Kathy Apple, MS, RN
Executive Director

Chrissy Ward, Executive Office
Relations/Meetings Manager

Beth DeMars, Executive Office
Meetings Coordinator

Relationship to Strategic Plan

Strategic Initiative V: Governance and Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome B

Sound organizational governance advances the NCSBN mission and vision.

Meeting Dates

February 19, 2004



- Reviewed the pros and cons of standing committees and addressed requests by the Disciplinary Resources and Advanced Practices Advisory Panels to become standing committees.
- Held conference calls with the chairs of the Disciplinary Resources and Advanced Practice Advisory Panel and the current chair of the Committee on Nominations.
- Reviewed whether the Committee on Nominations should observe an NCSBN Board of Directors meeting.
- Reviewed the idea of allowing the Committee on Nominations to select its own chair.

Future Activities

- None scheduled at this time.

Report of Commitment to Ongoing Regulatory Excellence (CORE)

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

In 1998, the NCSBN Board of Directors decided to embark on a ground-breaking project, the establishment of a performance measurement system that incorporates data collection from internal and external sources, and the use of benchmarking strategies and identification of best practices. The Commitment to Public Protection through Excellence in Nursing Regulation project was conducted from 1998 through 2002, producing the first data collection instruments and collecting FY00 data from 46 participating boards. A Board-appointed project advisory group provided oversight and guided the development of an innovative, sustainable system based on outcomes and focused on the identification of best practices.

The Commitment to Ongoing Regulatory Excellence (CORE) system was approved by the FY02 Board of Directors to provide an ongoing and sustainable performance measurement system. CORE was initiated August 2002. Since then, a second data collection effort has been conducted and reports disseminated to boards of nursing. The Advisory Panel conducted a workshop on “best practices” at the 2004 Midyear Meeting, presenting best practices that had been identified and standards established using 2000 and 2002 data.

Highlights of FY02 Activities

- Collected FY03 data from boards of nursing and stakeholders, and disseminated findings to participating boards of nursing.
- Provided oversight for an evaluation/impact study for compact states.
- Identified 17 best practices for boards of nursing.
- Set standards of excellence.

Future Activities

- Continue to identify, refine and better understand the processes and structures considered to be best practices that lead to desirable outcomes. Continue to link outcomes to public protection.
- Orient new executive officers to the CORE process.
- Modify and refine data collection tools.
- Collect stakeholder data for FY2005.

Members

Joan Bouchard, MSN, RN, Chair
Oregon, Area I

Lanette Anderson, JD, BSN, RN
West Virginia-PN, Area III

Kay Buchanon, MN, RN
Minnesota, Area IV

Katie Dougherty, MN, RN
California-RN, Area I

Constance Kalanek, PhD, RN
North Dakota, Area II

Cynthia Morris, MSN, RN
Louisiana-RN Area III

Board Liaison

Myra Broadway, JD, MS, RN
Maine, Area IV

Staff

Lynda Crawford, PhD, RN, CAE
Director of Research Services

Esther White, Research Project
Coordinator

Richard Smiley, Research Statistician

Relationship to Strategic Plan

Strategic Initiative II: Regulatory Effectiveness

NCSBN will assist Member to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome A

Advanced regulatory strategies promote public protection and effective nursing practice.

Meeting Dates

- October 6-7, 2003
- December 15-16, 2003
- February 2-3, 2004
- May 6-7, 2004





Report of Discipline Resources Advisory Group

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Board of Directors first appointed a Disciplinary Curriculum Advisory Panel in 2001, charged to plan an Investigators Summit. A second summit adding the attorney component was held in 2002. The advisory panel developed a Disciplinary Resources Plan in 2002, outlining a variety of discipline resources. In 2003, the Disciplinary Resources Task Force continued implementation of the Disciplinary Resources Plan, including planning the 2003 Investigator/Attorney Summit. In 2004, the Discipline Resources Advisory Group was charged to continue implementation of the Disciplinary Resources Plan, plan the 2004 Investigator/Attorney Summit, and develop additional resources and tools that support the disciplinary process for both pre- and post-board action.

Highlights of FY04 Activities

The Advisory Panel continued implementation of the Disciplinary Resources Plan developed in 2002. Activities for each plan category are listed below.

Disciplinary Resources Plan Category One – Discipline Resources

Completed resources

- Investigative Report Writing Guidelines.
- HIPAA Handbook.
- Expert Witnesses Handbook.
- Preinvestigation Hearings Guidelines.
- Unprofessional Conduct Guidelines.
- Triage of Cases Guidelines.

Reviewed and analyzed for discipline implications

- NCSBN Research White Paper on Best Practices.
- Draft Model Nursing Practice Act and Model Nursing Administrative Rules.
- IOM Report: Keeping Patients Safe.

Discipline Resource Plan Category Two – Communications/Networking

- Promoted participation in Discipline and Investigator Networking Directory.
- Identified topics and speakers for Discipline Quarterly Calls FY04.
- Participated in Discipline Quarterly Calls held December 4, 2003, and March 10, 2004 (next call scheduled for June 3, 2004). The Discipline Quarterly Calls have been met with a high level/volume of participation from Member Boards.
- Identified topics and potential speakers for Quarterly Discipline Calls in FY05.

Members

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

Renee D. Cronquist, JD, RN
Minnesota, Area II

Vicky Goettsche, MBA, BSN, RN
Idaho, Area I

Donald Hayden, BS
South Carolina, Area III

Elliot Hochberg, BS
California-RN, Area I

Emmaline T. Woodson, MSN, RN
Maryland, Area III

Board Liaison

Gregory Harris, JD
Arizona, Area I

Staff

Vickie Sheets, JD, RN, CAE
Director of Practice and Education

Relationship to Strategic Plan

Strategic Initiative II: Regulatory Effectiveness

NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome

Discipline resources are developed to support Member Boards in implementation of the discipline process.

Strategic Initiative V: Governance & Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome

Multiple levels of educational programs are accessible to assist in development of core competencies in regulation.



Meeting Dates

November 17-18, 2003

February 1-2, 2004

April 6-7, 2004

June 14-16, 2004

Discipline Resource Plan Category Three – Consultations/Collaborations

- Made recommendations regarding discipline content for next year’s Member Board Institute for Regulatory Excellence.
- Suggested possible speakers for the Institute.
- Provided feedback on the monitoring of multistate discipline cases developed for the Nurse Licensure Compact Administrators.
- Provided input to the Director of Practice and Credentialing regarding the discipline content for the Institute for Regulatory Excellence.
- Provided input and recommendations to the Director of Information Technology regarding the development of a process to track nurse impostors. This project remains ongoing at this time.

Discipline Resource Plan Category Four – Education/Training Resources

- Evaluated the 2003 Investigator/Attorney Summit.
- Planned the 2004 Investigator/Attorney Summit (renamed Investigator-Attorney Education Workshop – see Attachment C).
- Developed plans for future and ongoing Investigator/Attorney Education Workshops.
- In April 2004, the advisory panel reviewed and updated the Disciplinary Resources Plan (see attachment A).

Comments Regarding Discipline Resource Plan:

The Disciplinary Resources Plan was developed as an ongoing framework to guide NCSBN activities in support of Member Board discipline. The advisory panel members view it as a tool that will evolve as discipline evolves, adding to the repertoire of resources, communications and training opportunities each year as an ongoing resource.

The funding for the implementation of the disciplinary process, from the screening of complaints through investigations, case prosecution, board decision making and compliance monitoring, is the largest budgetary item for the majority of boards of nursing. Discipline matters also occupy the majority of board meeting time. Discipline decision making requires the best of board members to wisely balance the board’s responsibility to protect the public with an individual nurse’s right to practice a chosen profession. The board relies heavily on board staff, investigators and attorneys to inform this process. In addition, discipline is the area of board responsibility most apt to be scrutinized by the media, legislators and policymakers.

The levels of participation on the Discipline Quarterly Calls, the number of visits to the discipline page on the NCSBN Web site (albeit several levels down on the Members Only Web site) and the comments that appear in the evaluations for the summits all reflect the need for attending to this important aspect of regulation in a consistent manner, looking forward, not just for each year at a time, but to the longer view of planning for the future (see Attachment A).

Future Activities

- Continue implementation of Updated Resources Plan.
- Plan 2005 Investigator/Attorney Workshop.

Attachments

- A. Updated Disciplinary Resources Plan, 2004-2006



NCSBN Discipline Resources Plan 2004-2006 (Updated 2004)

Tactic	Priority	Year
Category One – Discipline Resources		
1. Pain Management Statement.	Medium	2004
2. Identify resources and guidelines for remediation of specific violations.	Medium	2005
3. Develop and compile discipline resources and tools.	Medium	2005
Category Two – Communication/Networking		
1. Monitor implementation of Nursys based imposter alerts.	High	2005-2006
2. Maintain state contact list for networking.	Medium	ongoing
3. Develop interactive web tool to address discipline questions.	Medium	2005
4. Continue quarterly disciplinary staff conference calls.	High	ongoing
5. Publish regular discipline-related articles in <i>Council Connector</i> and on the discipline page on the NCSBN Web site.	Medium	2004-2006
6. Continue to explore the use of the Internet and other electronic-based media to expand access to education and training opportunities for boards that are unable to attend meetings due to budgetary restraints and travel limitations.	Medium	ongoing
7. Track discipline cases specific to Nurse Licensure Compact cases.	High	2005-2006
Category Three – Consultations/Collaborations		
1. Explore implementation of a mentoring program for new discipline staff.	Low	2004
2. Maintain a directory of content experts on various topics.	Medium	ongoing
3. Consider need for NCSBN Interstate Discipline Coordinator.	Low	2005
4. Consider a member resource program to provide member discipline consultants to boards needing assistance.	Low	2005
5. Explore opportunity for member involvement and collaboration with CLEAR and FARB.	Medium	ongoing
6. Explore opportunities to recruit sponsors or vendors to defray workshop costs for NCSBN and Member Boards for educational offerings.	High	2005
7. Consult with other NCSBN committees and staff.	Medium	ongoing as needed
Category Four – Education/Training Resources		
1. Conduct workshops/seminars/training.	High	ongoing
2. Expand opportunity for participation in 2004 and future educational programs to other health care professions that impact patient safety.	High	2004-2006
3. Explore the feasibility of developing formal certification programs for nursing investigators and attorneys.	Low	2006
4. Provide speaking opportunities support for experienced members.	Medium	as available
5. Continue to explore potential for enhanced distance education (video conference and other electronic interactive approaches to increase member participation).	High	2005





Report of the Finance Committee

Recommendations to the Delegate Assembly

None. The purpose of this report is for information only.

Background of the Finance Committee

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

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

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

Highlights of FY04 Activities

- Reviewed and discussed with the independent auditors the financial statements for the fiscal year ending September 30, 2003. Based on the review and discussions, the Finance Committee recommended to the Board of Directors that the financial statements and the Report of the Auditors be accepted and provided to the Membership (Attachment B).
- Reviewed and discussed the long range forecast and proposed NCSBN budget for FY04. Recommended approval of the FY04 Budget to the Board.
- Reviewed and discussed the financial statements and supporting schedules quarterly, and made recommendations to the Board to accept the reports and post them to the Members Only section of the NCSBN Web site.
- Reviewed and discussed the performance of NCSBN investments with representatives from Becker Burke (consultant) and Richmond Capital Management (investment manager). The committee approved the performance of the Investment Manager.
- Recommended to the Board to limit maturity dates for bond holdings to no more than 10 years, and to move 20% of the value of bond investments to Treasury Inflation Protection Securities (TIPS). The Committee reaffirmed the current investment policy.
- Reviewed and discussed the liability insurance coverage for NCSBN with the account manager from USI Midwest Insurance Brokers. Based on the review and discussions, the committee confirmed the adequacy of insurance coverage for NCSBN.
- Advised the Board and made recommendations related to the finances of program activities:
 - 1) Online license renewal services
 - a. Recommended to the Board that the development of an online licensing renewal system by NCSBN for Member Boards was not feasible, and not to go forward with the project.
 - 2) Executive Officer Network Planning Group
 - a. Recommended to the Board to authorize expenses for the Executive Officer Network Planning Group meeting held in April 2004.

Members

Sandra Evans, MAEd, RN, Treasurer and Chair, Idaho, Area I

Nancy Bafundo, MS, BSN, RN
Connecticut, Area IV

Mary Dowd Struck, MSN, RN, CNM
Rhode Island, Area IV

N. Genell Lee, JD, MSN, RN
Alabama, Area III

Charles Meyer, CRNA, MPA
Nebraska, Area II

Rolf Olson, JD
Oregon, Area I

Ruth Ann Terry, MPH, RN
California-RN, Area I

Staff

Robert Clayborne, CPA, MBA
Director of Finance

Relationship to Strategic Plan

Strategic Initiative V: Governance & Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board members and Board of Directors to lead in nursing regulation.

Outcome B

A sound organizational governance and management infrastructure advances NCSBN's mission and vision.

Future Activities

Review the budget proposal for the fiscal year beginning October 1, 2004.



Meeting Dates

November 24-25, 2003

January 27, 2004 (conference call)

April 26, 2004

July 8-9, 2004

July 28, 2004 (conference call)

Attachments

A. Financial Report FY04

B. Report of the Independent
Auditors FY03

3) Resource Fund

- a. Recommended a total of \$20,000 in increases to raise the total amount available to Members from \$20,000 to \$40,000 for fiscal year 2004.

4) Nursys Database Fees

- a. Recommended to the Board to approve charging fees to nurses for payment cancellations, NSF checks and report requests from Nursys.
- b. Recommended to the Board to approve charging fees to external organizations for data downloads from Nursys.

5) Support Membership participation in NCSBN meetings

- a. Recommended to the Board to approve payment for travel expenses and waive registration fees for two delegates from each jurisdiction to attend the Annual Meeting held in 2005.



Attachment A

NCSBN Financial Report Summary for the period ending March 31, 2004

Financial Summary

At March 31, 2004, invested reserves (\$31.2 million) were equal to 10 months operating expense. For the first half of fiscal year 2004 (FY04), revenues totaled \$19.2 million. Net income for the period equaled \$3.9 million.

Revenue

NCLEX®

For the first half of FY04, NCLEX® registrations increased by 17% compared with the same period prior year, from 70,027 to 80,025. Historically, between 37% and 38% of the total registrations for the year are processed during the first six months. If applications equal the budgeted numbers for the remaining three quarters, the count would go over 190,000 registrations. The FY04 budget assumption is 175,000.

Nursys® VERIFICATIONS

Twenty-seven boards are currently using Nursys® for verifications. Based on the number of license verifications (21,590) from October 1, 2003, to March 31, 2004, the number is projected to equal budget (40,000) for the year.

EDUCATIONAL PRODUCTS

While total online course sales remain on budget, video sales have declined sharply during the second quarter. The 3,873 RN Review Course enrollments during the first half of FY04 exceeded the prior year for the same period by 922 enrollments. This is a 31% increase over the first six months of FY03. For the period October 1, 2003 to March 31, 2004, sales for the Advanced Assessment Strategies Course have been disappointing. Only 22 course enrollments were made compared to a goal of 170 for the period. Sales for the Basic Course picked up during the second quarter, and year to date numbers are near budget. Activity for the other continuing education courses also improved during the quarter, but enrollments continue to lag sales goals. Revenue for video sales was unfavorable to budget for the first half of FY04. Delegation video sales declined sharply. 98 units were sold during the first half of FY04. The sales goal for the six-month period was 140 units.

INVESTMENTS

Total returns on investments equaled 4.2% for the first half of FY04. The equity mutual fund returned 13.8%, while Inflation Protection Securities returned 3.6%, and other bonds ended up by 2.2% for the six-month period.

EXPENDITURES

During the first quarter of FY04, the Board approved \$193,000 in new expenditures. Funds were approved to reappoint the Practice Breakdown Committee, expand the charge and number of committee members for the PR&E International Nurse Subcommittee, establish a focus group to review the PN Practice Analysis, hold a two-day seminar for executive officers, and to increase the amount of money available to members from the Resource Fund. Savings in other expenses will offset the additional spending.



PROJECTION

Net assets are expected to increase by \$7.2 million during FY04. By the end of the fiscal year, 12 months operating expenses are projected to be in reserve. The forecast assumes that there will be no drop off in candidate registrations during the critical third quarter between when 37% and 40% of total exam fees for the year are expected to be received during this period.



NCSBN Financial Report

	Year to Date Actual at 03-31-04	Projected Actual for 9-30-04	Annual Budget	Variance Favorable/ (Unfavorable)	%	Yr to Dt Actual as a % of annual budget
Revenue						
NCLEX Revenue	\$16,402,471	\$38,000,000	\$35,000,000	\$3,000,000	9%	47%
NCLEX Program Reports Royalty	58,461	80,000	80,000	0	0%	73%
NCLEX Quick Results	121,558	200,000	100,000	100,000	100%	122%
NNAAP Royalty Income	113,522	243,000	185,000	58,000	31%	61%
Educational Products Revenue	371,689	914,000	947,000	(33,000)	-3%	39%
License Production Fees	3,813	3,813	0	3,813		
Nursys License Verification Fees	647,718	1,200,000	1,200,000	0	0%	54%
Nursys Data Query Fees	5,290	25,000	25,000	0	0%	21%
Meeting Revenue	40,066	167,000	170,000	(3,000)	-2%	24%
Other Publication Sales	14,527	25,000	25,000	0	0%	58%
Membership Fees	183,000	183,000	183,000	0	0%	100%
Investment Income	1,221,497	1,300,000	1,300,000	0	0%	94%
NCLA Fees	48,000	31,000	31,000	0	0%	155%
Other Revenue	500	500	0	(500)		
	19,232,112	42,372,313	39,246,000	3,125,313	8%	49%
Expenses						
Salaries	1,888,081	4,132,400	4,159,000	26,600	1%	45%
Fringe Benefits	496,829	1,022,350	1,029,000	6,650	1%	48%
NCLEX Processing Costs	8,417,925	20,292,000	18,690,000	(1,602,000)	-9%	45%
Other Professional Service Fees	1,789,603	3,061,000	3,244,000	183,000	6%	55%
Supplies & Materials	37,492	93,000	93,000	0	0%	40%
Meetings & Travel	720,423	2,267,000	2,220,000	(47,000)	-2%	32%
Telephone & Communications	104,648	292,000	292,000	0	0%	36%
Postage & Shipping	102,163	289,000	289,000	0	0%	35%
Occupancy	321,467	734,000	695,000	(39,000)	-6%	46%
Printing, copying & Publications	159,035	411,000	411,000	0	0%	39%
Library/Memberships	18,396	54,000	54,000	0	0%	34%
Insurance	56,577	60,000	60,000	0	0%	94%
Equipment Rental & Maintenance	435,286	778,000	778,000	0	0%	56%
Depreciation & Amortization	689,091	1,566,000	1,566,000	0	0%	44%
Other Expenses	13,443	103,000	103,000	0	0%	13%
Total Expenses	15,250,459	35,154,750	33,683,000	(1,471,750)	-4%	45%
Surplus/(Deficit)	3,981,653	7,217,563	5,563,000	1,654,563		
Capital	520,684	1,760,300	1,756,900	(3,400)	0%	

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



Attachment B

Report of Independent Auditors



REPORT OF INDEPENDENT AUDITORS

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

We have audited the accompanying statement of financial position of National Council of State Boards of Nursing, Inc. (National Council) as of September 30, 2003 and the related statements of activities and of cash flows for the year then ended. These financial statements are the responsibility of the National Council's management. Our responsibility is to express an opinion on these financial statements based on our audit. The financial statements of National Council of State Boards of Nursing, Inc. as of September 30, 2002 were audited by other auditors, whose reported dated November 1, 2002 expressed an unqualified opinion on those statements.

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

In our opinion, the 2003 financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. as of September 30, 2003 and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Legacy Professionals LLP

November 5, 2003

- 1 -

30 North LaSalle Street | Suite 4200 | Chicago, IL 60602 | 312.368.0500 | 312.368.0746 Fax | www.legacycpas.com



NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
STATEMENTS OF FINANCIAL POSITION
SEPTEMBER 30, 2003 AND 2002

	<u>2003</u>	<u>2002</u>
ASSETS		
CURRENT ASSETS		
Cash	\$6,655,974	\$3,119,667
Accounts receivable	342,776	424,480
Due from test vendor	138,298	1,557,206
Accrued investment income	268,777	195,051
Prepaid expenses	533,370	327,826
Inventories	4,018	1,270
Total current assets	<u>7,943,213</u>	<u>5,625,500</u>
INVESTMENTS	<u>27,785,117</u>	<u>18,808,991</u>
PROPERTY AND EQUIPMENT		
Furniture and equipment	907,119	521,743
Course development costs	186,769	127,516
Computer hardware and software	5,461,805	5,171,840
Leasehold improvements	315,785	455,970
	<u>6,871,478</u>	<u>6,277,069</u>
Less accumulated depreciation and amortization	<u>(3,770,952)</u>	<u>(3,436,106)</u>
Net property and equipment	<u>3,100,526</u>	<u>2,840,963</u>
CASH HELD FOR OTHERS	<u>368,901</u>	<u>463,439</u>
Total assets	<u>\$39,197,757</u>	<u>\$27,738,893</u>
LIABILITIES AND NET ASSETS		
Current liabilities		
Accounts payable	\$559,536	\$772,446
Accrued payroll, payroll taxes and compensated absences	357,757	415,282
Due to test vendors	5,000,252	2,281,215
Deferred rent credits	606,807	-
Deferred revenue	231,161	454,000
Total current liabilities	<u>6,755,513</u>	<u>3,922,943</u>
CASH HELD FOR OTHERS	<u>368,901</u>	<u>463,439</u>
Total liabilities	<u>7,124,414</u>	<u>4,386,382</u>
UNRESTRICTED NET ASSETS	<u>32,073,343</u>	<u>23,352,511</u>
Total liabilities and net assets	<u>\$39,197,757</u>	<u>\$27,738,893</u>

See accompanying notes to financial statements.



NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF ACTIVITIES

YEARS ENDED SEPTEMBER 30, 2003 AND 2002

	<u>2003</u>	<u>2002</u>
REVENUE		
Examination fees	\$37,346,808	\$32,135,273
Other program services income	3,145,839	3,338,156
Net realized and unrealized gain on investments	348,996	60,054
Net realized gain (loss) on disposal of property and equipment	(91,679)	1,760
Interest and dividend income	1,121,622	670,705
Membership fees	-	183,000
Total revenue	<u>41,871,586</u>	<u>36,388,948</u>
EXPENSES		
Program services		
Nurse competence	23,838,930	16,014,243
Nurse practice and regulatory outcome Information	3,037,096	3,021,569
	<u>4,627,426</u>	<u>4,212,330</u>
Total program services	31,503,452	23,248,142
Supporting services		
Management and general	<u>1,647,302</u>	<u>1,447,188</u>
Total expenses	<u>33,150,754</u>	<u>24,695,330</u>
NET INCREASE	8,720,832	11,693,618
UNRESTRICTED NET ASSETS		
Beginning of year	<u>23,352,511</u>	<u>11,658,893</u>
End of year	<u>\$32,073,343</u>	<u>\$23,352,511</u>

See accompanying notes to financial statements.



NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF CASH FLOWS

YEARS ENDED SEPTEMBER 30, 2003 AND 2002

	<u>2003</u>	<u>2002</u>
CASH FLOWS FROM OPERATING ACTIVITIES		
Net increase	\$8,720,832	\$11,693,618
Adjustments to reconcile net increase to net cash provided by (used in) operating activities		
Depreciation and amortization	1,377,524	1,186,079
Net realized and unrealized (gain) on investments	(348,996)	(60,054)
Net realized (gain) loss on disposal property and equipment	91,679	(1,760)
Changes in assets and liabilities affecting operations		
(Increase) decrease in accounts receivable	81,704	(102,430)
(Increase) decrease in due from test vendors	1,418,908	(1,005,900)
(Increase) in accrued investment income	(73,726)	(99,496)
(Increase) in prepaid expenses	(205,544)	(133,577)
(Increase) in inventories	(2,748)	(1,270)
Increase (decrease) in accounts payable	(212,910)	446,168
Increase (decrease) in accrued payroll, payroll taxes and compensated absences	(57,525)	63,886
Increase in due to test vendors	2,719,037	1,242,129
Increase in deferred rent credits	606,807	-
Increase (decrease) in deferred revenue	(222,839)	454,000
Net cash provided by operating activities	<u>13,892,203</u>	<u>13,681,393</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property and equipment	(1,669,513)	(945,524)
Investment in course development costs	(59,253)	(89,718)
Purchase of investments	(38,515,144)	(25,816,629)
Proceeds on sale of investments	<u>29,888,014</u>	<u>15,481,587</u>
Net cash (used in) investing activities	<u>(10,355,896)</u>	<u>(11,370,284)</u>
NET INCREASE	3,536,307	2,311,109
CASH		
Beginning of year	<u>3,119,667</u>	<u>808,558</u>
End of year	<u>\$6,655,974</u>	<u>\$3,119,667</u>

See accompanying notes to financial statements.



National Council of State Boards of Nursing, Inc.

NOTES TO FINANCIAL STATEMENTS

September 30, 2003 and 2002

Note 1. Description of the Organization

The 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 to promote safe and effective nursing practice in the interest of protecting public health and welfare including the development of licensing examinations in nursing.

The program services of the National Council are defined as follows:

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

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

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

Note 2. Summary of Significant Accounting Policies

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

Basis of Presentation – Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, the National Council is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. The National Council does not have any temporarily or permanently restricted net assets.

Investments – Investments are carried at fair value which generally represents quoted market price as of the last business day of the year.

Property and Equipment – Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed over the estimated useful lives of the related assets by the straight-line method. Furniture and leasehold improvements have estimated useful lives ranging from three and one half to 10 years, equipment and computer hardware and software have estimated useful lives ranging from three to five years and course development costs have estimated useful lives of three years.

Inventory – Inventories are valued at lower of first-in, first-out cost or market. Inventory is comprised of merchandise held for resale.

Due from Test Vendors – Due from test vendors represents amounts owed by NCS Pearson and the Chauncey Group for candidate applications received. The amount owed by NCS Pearson for the years ended September 30, 2003 and 2002 were \$138,298 and \$74,580 respectively. The amount owed by the Chauncey Group for the year ended September 30,



2002 was \$1,482,626.

Due to Test Vendors – Due to test vendors represents unpaid amounts to NCS Pearson and the Chauncey Group for candidate testing. The amounts owed to NCS Pearson for the years ended September 30, 2003 and 2002 was \$5,000,252 and \$1,456,215, respectively. The amount owed to the Chauncey Group for the year ended September 30, 2002, was \$825,000.

Deferred Revenue – Deferred revenue in 2002 consisted primarily of an agreed upon amount of \$400,000 due from the Chauncey Group to compensate National Council for all registered candidates who had not tested as of August 15, 2002. National Council was obligated to test those candidates and paid NCS Pearson to administer the exams as required. Also included in deferred revenue are secretariat fees assessed to National Licensure Compact Administrators (NLCA) members.

Deferred Rent Credits – Deferred credit was established in conjunction with taking possession of new leased office space in 2003. The landlord abated the first three months of rent and made cash disbursements to the National Council in connection with the lease. These amounts will be amortized to reduce rent expense over the term of the lease.

Statement of Cash Flows – For purposes of the statement of cash flows, the National Council considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions and petty cash.

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

Reclassifications – Certain reclassifications have been made to the prior year amounts to conform to the presentation for the current year.

Note 3. Tax Status

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

Note 4. Cash Concentrations

The cash balance as of September 30, 2003 and 2002 consisted of the following:

	<u>2003</u>	<u>2002</u>
Bank One:		
Checking account	\$240,832	\$800,000
Money market account	6,042,253	1,378,166
SunTrust Bank:		
Checking account	28,188	35,219
Wells Fargo Bank:		
Commercial account	341,951	906,032
Credit card merchant accounts	2,500	-
Petty cash	250	250
Total	<u>\$6,655,974</u>	<u>\$3,119,667</u>

The National Council places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.



Note 5. Operating Lease

Effective May 29, 1997, the National Council entered into a lease agreement for office space expiring April 30, 2004. During April 2003, the National Council bought out the remaining term of the lease for \$250,000. In July 2002, the National Council entered into a lease agreement for new office space which commenced February 1, 2003. The following is a summary by year of future minimum lease payments required under the new office lease as of September 30, 2003:

Year ending September 30,	
2004	\$354,391
2005	378,554
2006	394,340
2007	406,099
2008	418,262
Thereafter	<u>1,961,230</u>
Total	<u>\$3,912,876</u>

Rent expense for the years ended September 30, 2003 and 2002 was \$814,854 and \$314,942 respectively.

Note 6. Investments

The composition of investments at September 30, 2003 and 2002 is as follows:

	<u>2003</u>	<u>2002</u>
U.S. Government and Government		
Agency obligations	\$12,569,350	\$7,936,007
Corporate bonds	11,320,420	8,357,067
Foreign obligations	254,480	-
Mutual fund	3,576,515	1,452,949
Money market fund	64,352	1,062,968
Total	<u>\$27,785,117</u>	<u>\$18,808,991</u>

Note 7. Retirement 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 accrued pension contributions. Pension expense was \$296,906 and \$296,781 for the years ended September 30, 2003 and 2002, respectively.



Report of the Member Board Leadership Development Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Member Board Leadership Development Advisory Panel is charged with developing continuing education programs for Member Boards and providing orientation for newly appointed Member Board presidents and executive officers. It assures the functioning of a coach program and reviews recommendations of the Member Board presidents participating in the network session.

Highlights of FY04 Activities

- Conducted the first annual Institute of Regulatory Excellence, Public Policy and Role Development of Nursing Regulation in Fort Worth, Texas, January 12-14, 2004.
- Planned for the second annual Institute of Regulatory Excellence: Practice Violations and Discipline to be held on January 10-12, 2005.
- Discussed the feasibility of a certification program for those successfully completing the Institutes of Regulatory Excellence (June meeting).
- Discussed results of the executive officers and presidents logical job analysis studies (June meeting).
- Completed the development of a Member Board's Orientation Manual.
- Promoted and supported the Member Board president's bulletin board, evaluated its use by the presidents and determined that, due to minimal use, it was no longer needed.
- Planned program for the Member Board President's Midyear Meeting session. Selected Deborah Johnson and Mary Kay Sturbois as leaders for the Midyear Meeting President's Session.
- Finalized revisions to the executive officers coach program. Assigned seasoned executive directors as coaches to new executive directors.
- Finalized revisions to the executive officers coach evaluation that will be distributed to the coaches and new executive directors in June.
- Developed the Member Board Presidents Coach Program to provide support and serve as a resource to Member Board Presidents. This program was introduced to the Presidents who decided that it was not feasible at this time.
- Refined the Executive Officers Orientation based on the executive officers and president job analysis (June meeting).
- Completed a comprehensive review of the Web-based orientation program NCSBN 101 and recommendations for redeveloping the program.
- Determined leadership themes for the FY05-FY07 Midyear leadership programs.

Future Activities

- Implement second Annual Institute of Regulatory Excellence: Practice Violations and Discipline on January 10-12, 2005.
- Complete content/budget planning for the third Annual Institute of Regulatory Excellence: Nursing Competency, Evaluation and Remediation, January 9-11, 2006.

Members

Joey Ridenour, MN, RN, Chairperson
Arizona, Area I

Shirley Brekken, MS, RN
Minnesota, Area II

Dan Coble, PhD, RN
Florida, Area III

Deborah Johnson, PhD, RN, CNS
North Dakota, Area II

Barbara Zittel, PhD, RN
New York, Area IV

Board Liaison

Gregory Y. Harris, JD
Arizona, Area 1

Staff

Alicia Byrd, BSN, RN,
Member Relations Manager

Nancy Chornick, PhD, RN, CAE
Director of Credentialing

Relationship to Strategic Plan Strategic Initiative V:

Governance & Leadership Development and Organizational Capacity

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome A

Multiple levels of educational programs are accessible to assist in development of core competencies in regulation.

Meeting Dates

October 6-8, 2003

December 14-15, 2003

April 24-25, 2004

June 21-22, 2004

Attachments

None.



- Continue to evaluate the Institute of Regulatory Excellence Fellowship Program and impact in expanding the body of knowledge related to regulation and research through scholarly work.
- Identify future program topics based on the results of the job analysis for executive officers and board presidents for future program topics.
- Develop Executive Officers and Member Board President Partnership Seminar.
- Complete redesign of NCSBN 101.
- Plan core content for FY05 Midyear Leadership Day program.
- Develop a list of resources related to leadership development of Member Boards.

Report of the National Nurse Aide Assessment Program (NNAAP™)

Recommendations to the Delegate Assembly

None. This report is for information purposes only.

Background

Jointly owned and operated by NCSBN and Promissor, the National Nurse Aide Assessment Program (NNAAP™) is a nationally administered certifying examination program based on the activities performed by nurse aides in long-term, acute and home health care settings. The NNAAP examination test plan is based on a practice analysis conducted triennially by NCSBN.

Highlights of FY04 Activities

- The NNAAP is offered in two parts: a written portion and skills (performance) portion. The written examination is available in English, English with audiotape and Spanish with audiotape. The skills portion is conducted only in English. In 2003, 24 states used the written portion and 21 states used the skills portion of the NNAAP examination to certify the competency of nurse aides. For testing year 2003, 103,656 candidates took the written portion of the NNAAP examination with a pass rate of 92% and 84,821 candidates took the skills portion of the NNAAP examination with a pass rate of 81%.
- During FY04 NCSBN Testing Services staff provided psychometric and content oversight for NNAAP Examination item and form construction. From a review of the examination development process, major work product outcomes included a review of the master item pool, review of examination forms, review of the NNAAP Technical Report, development of the 2005 NNAAP item production schedule and a long-term (beyond 2005) NNAAP examination production schedule.
- Additional information detailing NNAAP operations is presented in the Annual Report of Promissor for the National Nurse Aide Assessment Program (NNAAP™).

Future Activities

- Continue to monitor all test development and psychometric aspects of the NNAAP Examination Program.

Staff

Casey Marks, PhD,
Director of Testing Services

Lenore Harris MSN, RN, AOCN, CNS
NCLEX Content Associate

Thomas O'Neill, PhD
Associate Director of Testing
Services – Psychometrics

Relationship to Strategic Plan

Strategic Initiative I: Nursing Competence

NCSBN will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome D

Nurse aide competence is assessed.

Attachments

- A. Annual Report of Promissor for the National Nurse Aide Assessment Program (NNAAP™)



Attachment A

Annual Report of Promissor for the National Nurse Aide Assessment Program (NNAAP™)

Company Overview

Promissor, Inc., a Houghton Mifflin Company, is a company with more than 20 years experience in providing knowledge measurement services to regulatory agencies, health services organizations, professional associations, major employers, and IT corporations. Serving an international base of clients, the company designs assessment solutions, provides quality test development services and a content management tool, delivers tests or other content with its state-of-the-art Promissor Testing System via multiple test center options, and ensures client success with industry-leading comprehensive support services.

Since 1996, the National Council of State Boards of Nursing and Promissor, Inc., have jointly developed and maintained the National Nurse Aide Assessment Program (NNAAP™). This partnership leverages the extensive assessment experience of two nationally recognized organizations, resulting in a standardized, legally defensible national nurse aide examination. Over the years, NNAAP has been administered to more than 800,000 candidates and is the leading nurse aide assessment instrument in the United States.

Promissor's Nurse Aide Testing and Registry Services

Promissor has been the leading provider of nurse aide testing and registry services since 1986. In 2003, Promissor administered the NNAAP to over 120,000 candidates in 24 states and jurisdictions, and provided nurse aide registry services in eight states. Promissor's nurse aide testing services include: eligibility screening and registration, test site scheduling, test administration (test site and Registered Nurse Evaluator management), scoring, and reporting. The registry services Promissor offers include initial certification, recertification and reciprocity management, as well as public access registry verifications through the Internet.

Program Highlights

TEST DEVELOPMENT

In January 2004, Promissor appointed Anna Bersky, PhD, RN, to the position of lead test developer, Nurse Aide Program. Dr. Bersky assumed the leadership role at Promissor in developing examinations for the NNAAP, and in this position will work closely with the NNAAP National Committee of Subject Matter Experts and NCSBN to ensure the NNAAP continues to reflect current practice.

The NNAAP National Committee of Subject Matter Experts is scheduled to meet in June 2004. Each Promissor client state was asked to recommend a registered nurse with current experience in training or supervising nurse aides. During the June meeting, SME participants will review previously written items (test questions) from the NNAAP, write new test items and review the status of recently modified skills for the NNAAP. As a result of this test development meeting, Promissor will begin administering in 2005, revised NNAAP examinations which will be consistent with the findings of the NCBSN's *Nurse Aide Job Analysis*, published in 2003.

**PAPER/PENCIL INITIATIVE**

During 2003, Promissor made significant progress in converting its nurse aide client base to a new fax-scoring technology. This technology enables candidates to receive same-day, official score results and for score results to be available to client states within 24-to-48 hours after testing. In states where Promissor provides registry services, newly qualified nurse aides are placed on the nurse aide registry within the same 24-to 48-hour time frame, allowing registry employer verifications to occur more rapidly. By the close of 2003, nine states were converted to the fax-scoring process, with three states converted at the end of March 2004. Promissor plans to fully complete the fax-scoring conversion in 2004.



National Nurse Aide Assessment Program (NNAAP™) Written/Oral Examination Content Outline

The NNAAP Written Examination is comprised of 70 multiple-choice questions. Ten of these questions are pretest (nonscored) questions on which statistical information will be collected.

The NNAAP Oral Examination is comprised of 60 multiple-choice questions and 10 word recognition (or reading comprehension) questions. This Content Outline became effective on November 1, 2001, and was the basis for NNAAP examinations administered during 2003.

I. Physical Care Skills

- A. Activities of Daily Living 7% of exam (4 questions)
 - 1. Hygiene
 - 2. Dressing and Grooming
 - 3. Nutrition and Hydration
 - 4. Elimination
 - 5. Rest/Sleep/Comfort
- B. Basic Nursing Skills 37% of exam (22 questions)
 - 1. Infection Control
 - 2. Safety/Emergency
 - 3. Therapeutic/Technical Procedures
 - 4. Data Collection and Reporting
- C. Restorative Skills 5% of exam (3 questions)
 - 1. Prevention
 - 2. Self Care/Independence

II. Psychosocial Care Skills

- A. Emotional and Mental Health Needs 10% of exam (6 questions)
- B. Spiritual and Cultural Needs 3% of exam (2 questions)

III. Role of the Nurse Aide

- A. Communication 10% of exam (6 questions)
- B. Client Rights 15% of exam (9 questions)
- C. Legal and Ethical Behavior 5% of exam (3 questions)
- D. Member of the Health Care Team 8% of exam (5 questions)



**Summary of NNAAP™ Examination Results for
2003 Pass Rates by State**

State	Skills		Written	
	% Pass	Number	% Pass	Number
1. Alabama	79%	1,912	98%	1,654
2. Alaska	89%	608	100%	563
3. California	93%	9,269	94%	9,321
4. Colorado	64%	5,544	98%	4,027
5. Connecticut	94%	3,693	93%	3,720
6. District of Columbia	48%	756	94%	565
7. Louisiana	76%	882	96%	783
8. Maryland	55%	4,587	95%	3,584
9. Minnesota	85%	7,152	87%	6,957
10. Mississippi	70%	3,405	97%	2,800
11. Nevada	79%	1,191	83%	1,141
12. New Hampshire	88%	48	100%	45
13. New Jersey	89%	5,896	63%	6,887
14. New Mexico	N/A	N/A	98%	2,051
15. North Dakota	95%	1,053	99%	1,024
16. Pennsylvania	83%	12,264	88%	11,532
17. Rhode Island	N/A	N/A	98%	1,613
18. South Carolina	83%	3,503	98%	3,154
19. Texas	N/A	N/A	97%	21,745
20. Virginia	69%	6,107	93%	5,148
21. Virgin Islands	81%	88	82%	91
22. Washington	85%	5,885	95%	5,421
23. Wisconsin	83%	9,711	99%	8,719
24. Wyoming	85%	1,267	100%	1,111
Totals	81%	84,821	92%	103,656





Report of the Practice Breakdown Focus Group

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

Boards of nursing possess a rich source of data that can be used to identify sources of nursing error and thus are well positioned to add to the body of knowledge surrounding this aspect of medical errors. Recognizing this, in 2001, the NCSBN Board of Directors appointed a task force to develop new knowledge about the causes of nursing practice breakdown.

Working with consultant Dr. Patricia Benner, 20 pilot discipline cases submitted by boards of nursing were analyzed by delving deep into the factual content of cases, using information obtained from a variety of redacted materials (ranging from the initial complaint to nurse narrative, other witness statements, investigation reports, hearing transcripts and staff interviews). When available, the analysis included the nurse's story in his or her own handwriting and/or transcripts of the nurse's interactions with the regulatory agency. Characteristics of various nursing errors were described and classified. The study of cases also involved analysis for root cause, system contributions and practice responsibility.

An audit instrument was developed from the pilot cases called TERCAP – A Taxonomy of Error, Root Cause Analysis and Practice Responsibility. This instrument was used to track case elements and recurring themes. The goal of the project was to learn from the experience of nurses who have had episodes of practice breakdown and to discover characteristics of nurses at risk. The overall aim is to promote patient safety by better understanding nursing practice breakdown and by improving the effectiveness of nursing regulation.

During FY03, 14 states submitted TERCAP instruments completed for over 100 cases. The Practice Breakdown Focus Group reviewed the results of the data analysis in September 2003. Some serious problems were identified with the instrument, so the TERCAP was revised and states were asked to resubmit the previous cases. The results were used to finalize the TERCAP instrument.

Highlights of FY04 Activities

The specific work of the Practice Breakdown Focus Group (PBF) for 2004 as identified by the NCSBN Board of Directors included the following goals:

- Develop plans for and promote use of the TERCAP as a data collection strategy for boards of nursing.
- Continue working with Dr. Patricia Benner as consultant to the project.
- Work with a subgroup of the focus group to complete the qualitative analysis of the 106 nursing narratives.
- Publish the TERCAP tool and coding protocol.
- Complete a document (monograph) publication of board case examination and strategies to reverse practice breakdown.
- Explore the use of TERCAP by health care facilities.

Members

Kathy Malloch, PhD, MBA, Chair
Arizona, Area I

Karla Bitz, MGMT, RN
North Dakota, Area II

Lisa Emrich, MSN, RN
Ohio, Area II

Vicky Goettsche, MBA, RN
Idaho, Area I

Dwayne Jamison, BS
Mississippi, Area III

Linda Patterson, BS, RN
Washington, Area I

Kathryn Schwed, JD
New Jersey, Area IV

Patricia E. Benner, PhD, RN, FAAN
Consultant

Kathy A. Scott, PhD(c), RN, Consultant

Staff

Vickie Sheets, JD, RN, CAE,
Director of Practice and Regulation

David Henley, MM
Administrative Assistant

Relationship to Strategic Plan

Strategic Initiative II: Regulatory Effectiveness

NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome A

Effective strategies are identified to assist Member Boards to respond effectively to critical issues and trends impacting nursing education, practice and regulation.

Meeting Dates

February 11-12, 2004

March 10-11, 2004

April 10-11, 2004

June 1-2, 2004



- Address the IOM report recommendations to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their application by state boards of nursing and other state regulatory bodies having authority over nursing.

At its meeting in February, the PBFG finalized TERCAP and drafted the document describing the instrument development and initial data analysis. In addition to finalizing the instrument, the PBFG will develop guidelines for using the tool, develop education programs for Member Boards, develop a database for comparison of collected data and develop guidelines for generating research and statistical reports from the tool.

The PBFG identified the advantages of using the TERCAP instrument as an “Intake Form” for cases of nursing error reported to the state boards, creating a database that would allow state boards to generate prospective studies of statistics on types of errors reported, the impact of changes in remediation programs, and changes in practice and education patterns on errors reported to the state boards.

Data extracted from the analysis of 79 cases indicated difficulty in identifying a primary error cause. TERCAP was revised to address this problem. For most cases, there were several causes or sources of error that included:

- Lack of agency/fiduciary concern (renamed to be lack of practice responsibility and patient advocacy)
- Inappropriate judgment
- Lack of or faulty intervention
- Lack of attentiveness/surveillance
- Documentation errors
- Medication errors
- Missed or mistaken order
- Lack of prevention

Response to IOM

The Institute of Medicine (IOM) published a report entitled “Keeping Patients Safe: Transforming the Work Environment of Nurses” in 2004. There are several aspects of the report with implications for the practice breakdown research. Of particular interest is:

Recommendation 7-2. The National Council of State Boards of Nursing, in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their application by state boards of nursing and other state regulatory bodies having authority over nursing.¹

The Practice Breakdown Focus Group plans to finalize a response to the IOM recommendation for the NCSBN Board at its June 2004 meeting. An overview of the report summary includes the following information.

NCSBN has been working with representatives from its 60 Member Boards and consultant Patricia Benner since 2002 in the identification of a standard template that will not only distinguish human errors and system errors from willful negligence and intentional misconduct, but will also serve as a guide to increase the skills and competence of regulatory professionals in addressing practice breakdowns.

The result of this work is the Taxonomy of Error, Root Cause Analysis and Practice (TERCAP), which identifies eight major categories of analysis, a coding protocol tool and several publications to further share and explain this work.

¹ Keeping Patients Safe: Transforming the Work Environment of Nurses (2004). Institute of Medicine.



NCSBN also plans to:

- Incorporate the instrument in the NCSBN Institute of Regulatory Excellence program.
- Explore the feasibility of developing Investigator Certification Training.
- Develop a TERCAP Web page or chat room for users.
- Identify patient safety and health care experts to work with the tool.
- Develop a TERCAP exhibit for display at national meetings in patient safety.

NCSBN will continue to be a leader in the development of practice breakdown science as an essential role in assisting members of the community in “Transforming the Work of Nurses.”

FYO4 Activities Currently Underway

The Practice Breakdown Focus Group has numerous activities underway:

- Developing a journal article regarding progress on instrument development, as a follow-up to the previous JONA TERCAP article².
- Publishing the TERCAP tool and coding protocol.
- Completing qualitative analysis of the 106 narratives collected for the *Epidemiology of Nursing Error Study*.
- Authoring a book about learning from practice breakdown (See attachment A for outline).
- Developing a “TERCAP Toolbox” to support Member Boards’ use of TERCAP.
- Submitting practice breakdown data to NCSBN Clearinghouse.
- Developing tools for use of TERCAP in discipline process.
- Screening.
- Investigating.
- Tracking.
- Decision making.
- Introducing TERCAP at an information session at the 2004 Annual Meeting.

Future Activities

In the coming months, the PBFG will continue to work to develop an approach to reporting errors that will increase knowledge and incentives for error detection, reporting and prevention while fulfilling the duty to protect the public from unsafe practice. Activities will include:

- Ongoing promotion of TERCAP use.
- Making recommendations regarding development of infrastructure for nursing error clearinghouse.
- Planning for promotion of use of TERCAP by Member Boards.
- Exploring broader applications, including the use of TERCAP by health care facilities to collect additional data regarding practice breakdown.
- Planning for data collection and analysis.
- Planning for ongoing communication with Member Boards, nursing educators, nursing service and nursing organizations.

Attachments

None.

² Benner, P., Sheets, V., Uris, P., Malloch, K., Schwed, K. and Jamison, D. (2002) Individual, Practice and System Causes of Errors in Nursing (2002). JONA Vol. 32, No. 10, October 2002, 509-523.





Report of the Resolutions Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Resolutions Committee is a standing committee and is responsible to review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by the delegates of Member Boards. The committee is also charged to review the resolutions process and make recommendations for process improvement.

Highlights of FY04 Activities

- Reviewed the Delegate Assembly Resolutions and open meeting process and determined the meeting required more structure. Nameplates will be used to identify persons authorized to be seated at the table during the open meeting. The following individuals shall be considered “authorized” attendees at this meeting:
 - Resolutions committee members
 - NCSBN Board president
 - NCSBN legal counsel
 - Director of finance
 - Parliamentarian
 - NCSBN executive director and staff

The Resolutions Committee reviewed the following documents in FY04:

- **Motions/Resolutions Submission Form** – In FY03, the parliamentarian recommended combining the motions and resolutions forms into one form. The Resolutions Committee did not recommend changes to the form in FY04.
- **Fiscal form** – The director of finance reviewed the form in FY03 and did not recommend any changes. The Resolutions Committee did not recommend changes in FY04.
- **Resolutions Committee Policies and Procedure** – The Resolutions Committee polices and procedures were revised in FY03, based on recommendations from the parliamentarian and NCSBN legal counsel. The Resolutions Committee did not recommend changes in FY04.
- The Resolutions Committee conducted a teleconference call for the membership on April 15, to address questions/concerns related to filing motions.

The following documents were sent on March 10, 2004, to Member Board executive officers, Member Board presidents and the Board of Directors:

- Resolutions solicitation letter
- Resolutions committee operating policies and procedures
- Motions/Resolutions submission form
- Resolutions fiscal form

Future Activities

The following meetings are scheduled at Annual Meeting:

- August 3, 2004 (Informal)
- August 4, 2004 (Formal)

Members

Charles Alexandre, MSN, RN, Chair
Rhode Island, Area IV

Sandra Evans, MAEd, RN
Idaho, Area I

Louise D. Hartz, Citizen Member
Virginia, Area III

Constance B. Kalanek, PhD, RN
North Dakota, Area II

Roberta L. Schott, LPN
Washington, Area I

Staff

Alicia Byrd, BSN, RN,
Member Relations Manager

Relationship to Strategic Plan

Strategic Initiative V:

NCSBN will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome B

Sound organizational governance advances the NCSBN mission and vision.

Meeting Dates

- October 9, 2003 (Conference Call)
- February 10, 2004 (Conference Call)
- April 15, 2004 (Conference Call)

Attachments

- A. Resolutions Solicitation Letter
- B. Resolutions Committee Operating Policies and Procedures
- C. Resolutions Motions/Resolutions Submission Form
- D. Resolutions Fiscal Form



National Council of State Boards of Nursing, Inc.
111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277
312.525.3600
312.279.1032 fax
www.ncsbn.org

March 10, 2004

TO: Executive Officers
Member Board Presidents

FROM: The FY04 Resolutions Committee

Chairperson

Charles Alexandre MSN, RN, Director, Rhode Island Board of Nurse Registration & Nursing Education, Area IV

Committee Members

Sandy Evans MA, Ed, RN, Executive Director, Idaho Board of Nursing, Finance Committee, Area II

Louise D. Hartz, Board Member, Virginia Board of Nursing, Area III

Connie B. Kalanek, PhD, RN, Executive Officer, North Dakota Board of Nursing, Area II

Roberta Schott, LPN, Board Member, Washington State Nursing Care Quality Assurance Commission, Area I

RE: Call for Motions/Resolutions to the 2004 Delegate Assembly

The Resolutions Committee is seeking motions/resolutions for consideration by the Delegate Assembly at the 2004 National Council Annual Meeting, August 3-6, in Kansas City, Missouri.

Use this link https://ncnet.ncsbn.org/about/governance_pgov_delegate_assembly.asp to access these key documents that will enable the maker to develop motions/resolutions that conform to the National Council Bylaws, 2004 Standing Rules (pending delegate approval), and the Resolutions Committee *Operating Policies and Procedures*.

- Resolutions Committee Operating Policies and Procedures (*Attachment A*)
- Motions/Resolutions Submission Form (*Attachment B*)
- Fiscal Impact Statement (*Attachment C*)
- National Council Bylaws (*Direct link to NCSBN website*)
- National Council Mission (*Direct link to NCSBN website*)

The Resolutions Committee encourages you to submit motions/resolutions early. Please use the Motions/Resolutions form and Fiscal Impact Statement when submitting a motion. These forms will also be available in a printable version on the NCSBN website.

Resolutions Committee Open Membership Call:

The Resolutions Committee will be hosting a call on **Thursday, April 15, 2004 @ 2:00 PM (CST)** to give the membership a chance to interact with the Committee members and ask questions or raise issues regarding the submission process or their particular motions/resolutions. The dial-in information will be sent on April 1, two weeks prior to the call.

Motions/resolutions may be submitted at any time up to and through Delegate Assembly.

As a reminder, only delegates, the National Council Board of Directors, and the Examination Committee (for approval of test plans) may make motions/resolutions at the Delegate Assembly.

Please contact Alicia E. Byrd if you have any questions at (312) 525-3666 or abyrd@ncsbn.org. **All submission forms can be completed electronically, then print the form, sign and send via fax to (312) 279-1032 to the attention of Alicia Byrd at the NCSBN office.**

cc: NCSBN Board of Directors
Kathy Apple, Executive Director



Resolutions Committee Operating Policies and Procedures

Purpose

The Resolutions Committee is a standing committee of the Delegate Assembly established under Article X (1)(e) of the NCSBN Bylaws to review, evaluate and report on all motions and resolutions submitted to the Committee by a delegate. The operating policies and procedures serve to guide the work of the Committee and the formulation of motions and resolutions by makers.

Policy

1. All resolutions and nonprocedural main motions unrelated to the election of officers and directors must first be submitted to the chair of the Resolutions Committee before being presented to Delegate Assembly.
2. The Resolutions Committee will receive and analyze all motions and resolutions submitted to it by authorized motion makers. The analysis shall consist of:
 - a) Determination of consistency with NCSBN articles of incorporation, bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies;
 - b) Determination of relationship to ongoing programs;
 - c) Assessment for duplication with other proposed motions;
 - d) Legal implications;
 - e) Financial impact.
3. The Resolutions Committee Chairperson will present to the Delegate Assembly oral and/or written reports of all motions and resolutions submitted to it. The report for each motion and resolution shall include the following analyses performed by the Resolutions Committee:
 - a) Determination of consistency with NCSBN articles of incorporation, bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies
 - Consistent
 - Not Consistent (with rationale)
 - b) Determination of relationship to ongoing programs
 - Not in current Strategic Plan
 - In current Strategic Plan (site identified)
 - c) Assessment for potential duplication with other proposed motion or ongoing programs
 - No duplication
 - Duplication (area of duplication specified)
 - d) Legal implications
 - None
 - Implications identified
 - e) Financial impact
 - None
 - Impact identified

In the event a motion or resolution is submitted too late for the Resolutions Committee to perform its analysis, the committee will report to Delegate Assembly the absence of any review.



Procedures

1. Motions and resolutions must be submitted by a delegate in accordance with the bylaws and the standing rules. The person seconding the motion must also sign all motions. A fiscal impact statement must accompany the motion or resolution.
2. It is desirable to have the motion or resolution submitted in time to include in the mailing to Member Boards 45 days before the Annual Meeting. However, motions and resolutions not submitted in time to meet the 45-day mailing prior to the Annual Meeting should be submitted to the Resolutions Committee by the time and date proscribed in the standing rules.
3. The Resolutions Committee may schedule a conference call and/or an informal meeting with members wanting to make a motion at Delegate Assembly to enable makers an opportunity to receive assistance in the formulation of the motion/resolution.
4. Makers may submit motions to the Resolutions Committee until the Delegate Assembly concludes its business at the Annual Meeting to allow for all matters to be addressed. However, motions and resolutions not submitted to the committee by the established deadline may not be reviewed and analyzed by the Resolutions Committee.
5. The deadline for submitting motions and resolutions to the Resolutions Committee shall appear in the Standing Rules for the Delegate Assembly.
6. The Resolutions Committee will meet with each maker in accordance with the schedule and guidelines established. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the committee's business. Once discussion is concluded, the committee will meet in executive session to prepare the motion or resolution for submission to the Delegate Assembly.
7. Courtesy resolutions are proposed directly by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted to the Resolutions Committee by the deadlines published in the NCSBN newsletter, *Council Connector*, member mailing, NCSBN Web site or other form of notice in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. Motions and resolutions submitted in advance of the Annual Meeting will be presented at the Resolutions Forum.
3. The person(s) submitting a motion or resolution must be prepared to attend and discuss the motion or resolution with the Resolution Committee at its scheduled meeting and speak to the motion or resolution to the Delegate Assembly.

Motions and Resolutions Received after the Resolutions Committee Meeting

1. A motion or resolution not submitted to the Resolutions Committee by the established deadline at the Delegate Assembly may be presented directly to the Delegate Assembly as new business, provided that the maker first submits the resolution to the Chair of the Resolutions Committee. The Resolutions Committee may make a reasonable attempt to meet with the motion maker to discuss any such motions and resolutions, time permitting, but the committee may report to the Delegate Assembly that it was unable to perform its analysis and review of the motion.
2. The maker is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be accompanied by a written analysis of consistency with NCSBN mission, purpose and functions, strategic initiatives, outcomes, assessment of fiscal impact, and potential legal implications.



The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.

Definitions

MOTIONS/RESOLUTIONS

Business items proposed by delegates, the Board of Directors, or the Examination Committee for consideration at the Delegate Assembly. Such proposals are submitted to the Resolutions Committee where they are processed for clarification and consistency.

Revisions Dates:

May 1990

January 1996

February 2002

February 2003



**National Council of State Boards of Nursing
Motions/Resolutions Submission Form**

PLEASE TYPE OR PRINT CLEARLY

Name of Motion/Resolution:

Maker:

Date:

Phone #:

E-mail Address:

I move that:

Rationale for Motion:

Signature of Maker: _____

Member Board: _____

Signature of Second: _____

Member Board: _____

I. Describe the relationship of the motion/resolution to National Council's:

a) Bylaws, mission, strategic initiatives and outcomes (see NCSBN Web site and/or current Delegate Assembly business book)

b) Ongoing programs and policies

II. Identify potential legal implications.

III. Attach a completed Fiscal Impact Statement.



National Council of State Boards of Nursing Fiscal Impact Statement

PLEASE TYPE OR PRINT CLEARLY

Title of Motion/Resolution: _____

Proposed by:

I. PROJECTED DATES

A) Beginning: _____

B) Completion: _____

II. RESOURCES ANTICIPATED

Check those resources needed to accomplish motion/resolution

A) Does this proposal require a committee? Yes No Unsure

1. Number of members anticipated including the chair? Unsure

2. How many meetings anticipated?

3. Time span of resources: 1 year 2 years 3 or more years Unsure

B) Does this proposal require printings, mailings, or electronic access (e.g., Web)?

Yes No

1. Please describe any expected surveys.

2. Please describe other expected printings (special reports, mailings).

3. Please describe any expected electronic resources (e.g., Web site).

C) Will this proposal require outside consultation? Yes No

If yes, please select all that apply:

Legal Counsel

Nursing

Testing/Psychometric

Policy/Regulation

Technical (including computer)

Other (please describe) _____

D) Will this proposal require other resources? Yes No

If yes, please complete the following:

1. Please describe expected travel (other than committee meetings).

2. Other (please describe).

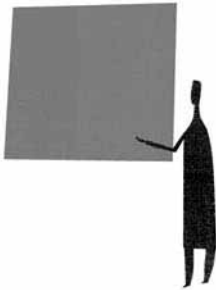
III. OTHER COMMENTS REGARDING FISCAL IMPACT.

307



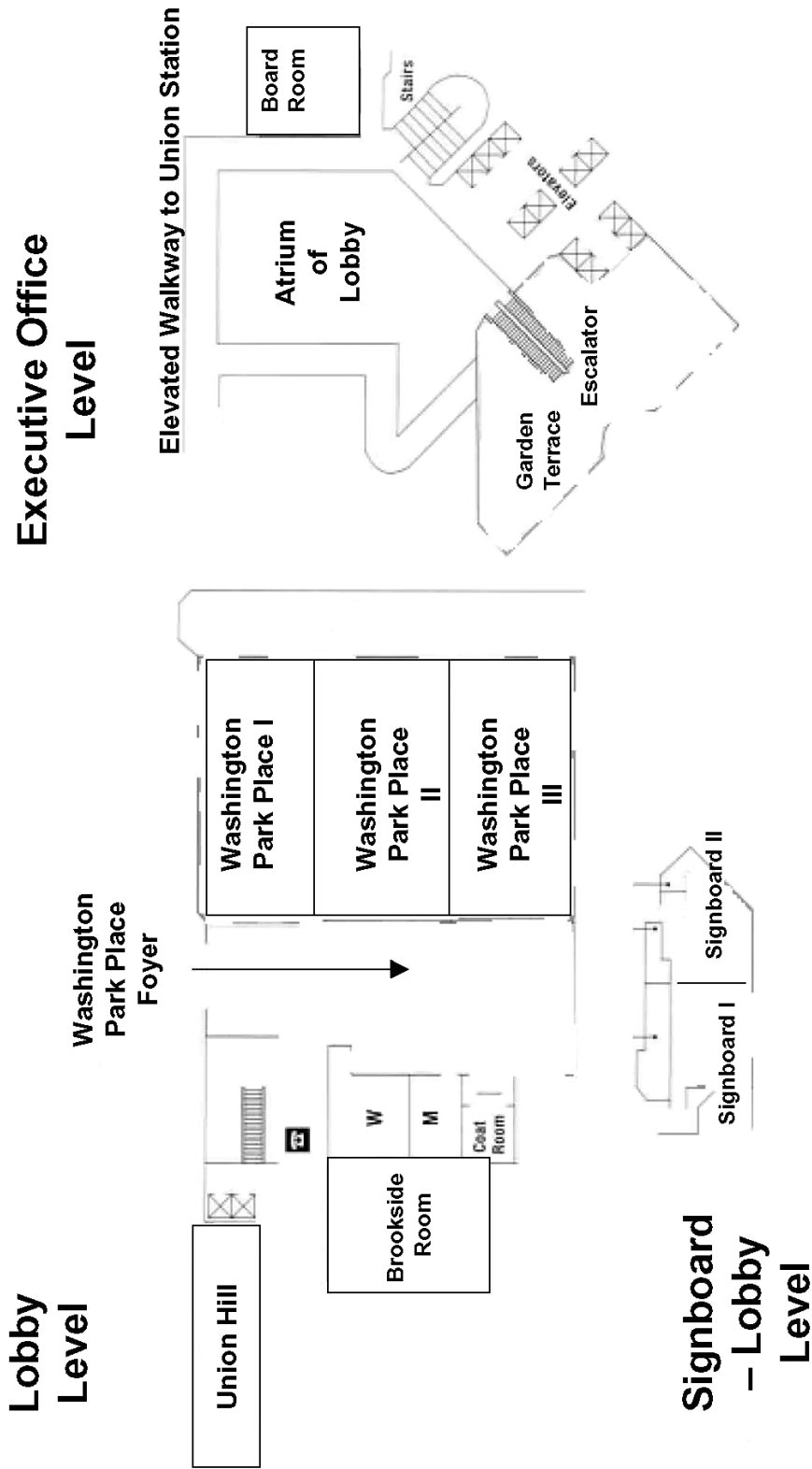
SECTION III

Resources & General Information

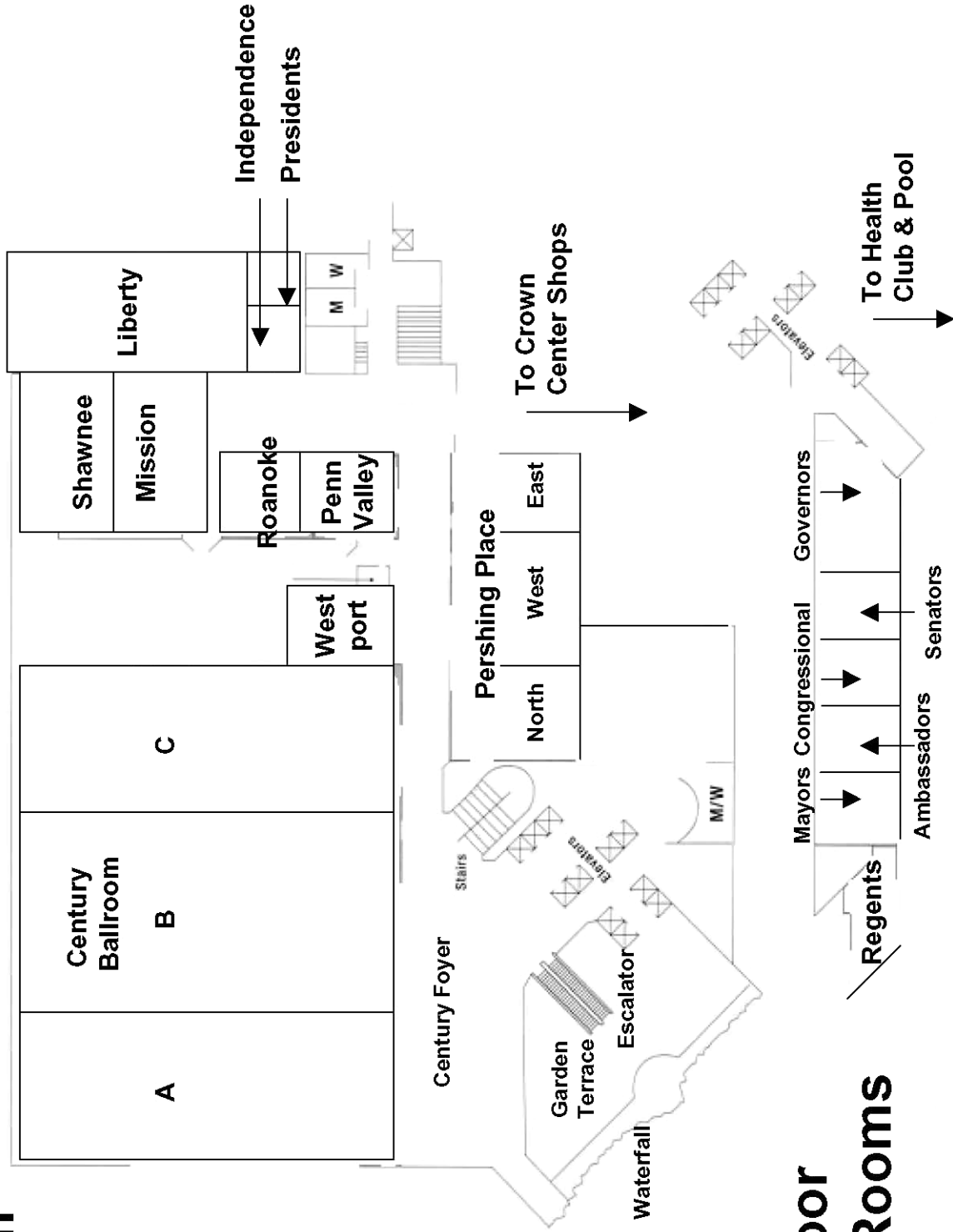


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For Resolutions policy & procedures and forms, see the Resolutions Committee Report and attachments, page 301.



Ballroom Level



5th Floor Meeting Rooms





Orientation Manual for Delegate Assembly Participants

The purpose of the Orientation Manual is to provide information about the mission, governance and operations of NCSBN. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as the Board of Directors and committee members.

Following a brief discussion of NCSBN's history, this manual will describe the organization's structure, functions, policies and procedures.

History

The concept of an organization such as NCSBN 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 people 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 ANA, 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, 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, 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 a council replace it. Although council status was achieved, many people 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 ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from ANA to form the National Council of State Boards of Nursing.

Organizational Mission, Strategic Initiatives and Outcomes

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

NCSBN currently has five strategic initiatives, one of which is to assist Member Boards in their role in the evaluation of initial and ongoing nurse and nurse aide competence. Another is to assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. NCSBN also seeks to analyze the changing health care environment to develop state and national strategies to impact public policy and regulation effecting public protection. NCSBN will develop information technology solutions valued and utilized by Member Boards to enhance regulatory sufficiency. Lastly, NCSBN seeks to support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which tactics for achieving these outcomes 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 evaluates the accomplishment of strategic initiatives and outcomes and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN 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 NCSBN. At the present time, there are 60 Member Boards, including those from the District of Columbia, the U.S. 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® examination and/or the NCLEX-PN® examination.

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 NCSBN's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards that 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

NCSBN'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. Delegates elect area directors 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 membership body of NCSBN and comprises delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in late July/early August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among Areas.

At the Annual Meeting, delegates elect officers and directors 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 to receive a copy of 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 adopts the mission statement, strategic initiatives of NCSBN, and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, adopts test plans to be used for the development of the NCLEX examination, the NCLEX examination test service, and establishes the fee for the NCLEX examination.

OFFICERS AND DIRECTORS

NCSBN officers include the president, vice president, and treasurer. Directors consist of 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, 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 terms 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 terms 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 and directors are elected by ballot during the annual session of the Delegate Assembly. Delegates elect area directors from their respective areas.

Election is by a majority vote. Write-in votes are prohibited. In the event a majority is not established, the bylaws dictate the reballoting process.

Officers and directors assume their duties at the close of the session at which they were elected. The vice president fills a vacancy in the office of president. Board appointees fill other officer vacancies until the term expires.



BOARD OF DIRECTORS

The Board of Directors, the administrative body of NCSBN, consists of the nine elected officers. The Board is responsible for the general supervision of the affairs of NCSBN between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between NCSBN 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 NCSBN's purpose, and provision for the establishment and maintenance of the administrative offices.

MEETINGS OF THE BOARD OF DIRECTORS

All Board meetings are typically held in Chicago, with the exception of the pre- and post-Annual Meeting Board meetings that are held at the location of the Annual Meeting. Board officers and directors 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 and directors two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the NCSBN Web site (www.ncsbn.org).

A memo or report that describes the item's background and indicates the Board action needed accompanies items for Board discussion and action. 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 provided for dissemination prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board officer and director for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the NCSBN office and include copies of the articles of incorporation and bylaws, strategic plan, policies and procedures, contracts, 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. In most instances, the executive director is the person responsible for communicating with NCSBN 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 members in advance of the call. These materials include committee or 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 members use NCSBN letterhead when communicating as representatives of NCSBN.

Committee on Nominations

NCSBN delegates elect representatives to the Committee on Nominations. The committee consists of four people, one from each area, who may be either board members or staff of Member Boards. Committee members are elected to two-year terms. One half of the committee members are elected in even-numbered years and one half in odd-number



years. They are elected by ballot with a plurality vote. The member receiving the highest number of votes shall serve as vice chair in the first year of the member's term and as chair in the second year of the term. The first meeting of the committee is held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.

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

Many of NCSBN's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Board of Directors. At the present time, NCSBN has five standing committees: Examination; Finance; Practice, Regulation, and Education; Bylaws; and Resolutions. Subcommittees, such as the Item Review Subcommittee (Exam), may assist standing committees.

In addition to standing committees, special committees are appointed by the Board of Directors for a defined term to address special issues and concerns. NCSBN conducts an annual call for committee member nominations prior to the beginning of each fiscal year. Committees are governed by their specific charge and NCSBN policies and procedures. The appointment of committee chairs and committee members is a responsibility of the Board of Directors. Committee membership is extended to all current members and staff of Member Boards.

In the appointment process, every effort is made to match the expertise of each individual with the needs of NCSBN. Also considered is balanced representation whenever possible, among areas, board members and staff, registered and licensed practical/vocational nurses, and consumers. Nonmembers may be appointed to special committees as consultants to provide specialized expertise to committees. A Board of Director liaison and an NCSBN staff member are assigned to assist each committee. The respective roles of Board liaison, committee chairperson and committee staff are provided in NCSBN policy. Each work collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the Board liaison nor the NCSBN staff are entitled to a vote, but respectively can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

EXAMINATION COMMITTEE

The Examination Committee comprises at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board of nursing. The committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce and deliver the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests enhancements, based on research that is important to the development of licensure examinations.

The Examination Committee provides general oversight of NCSBN Licensure Examination (NCLEX®) process, including psychometrics, item development, test security and administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions 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 NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of 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 passing standard 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 to recommend a series of passing standards for this process. Judges 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 series of recommended passing standards. Taking these recommendations along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard that 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 and utilizing item construction and test delivery processes based on sound psychometric principles constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate 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 comprises at least four members and the treasurer, who serves as the chair. The committee's primary purpose is to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis and provides the Board of Directors with a proposed annual budget prior to each new fiscal year.



PRACTICE, REGULATION AND EDUCATION COMMITTEE (PR&E)

The Practice, Regulation and Education Committee comprises at least six members. The committee's purpose is to provide general oversight of nursing practice, regulation and education issues. It periodically reviews and revises the Model Nursing Practice Act and Model Nursing Administrative Rules, and recommends white papers, guidelines or other resources to the Board of Director for Member Board use. It also reviews NCSBN research data, conducts membership surveys and disseminates information to Member Boards and other interested parties. In the recent past, the committee has utilized subcommittees to study various issues, e.g., continued competence, foreign nurse issues, and accreditation/approval in nursing education.

RESOLUTIONS COMMITTEE

The Resolutions Committee comprises at least four members generally representing each of the four NCSBN geographic areas and also includes one member of the Finance Committee. The committee's purpose is to review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the bylaws.

BYLAWS COMMITTEE

The Bylaws Committee comprises at least four members. The committee reviews and makes recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly. The bylaws may be amended at any annual meeting or special session of the Delegate Assembly upon written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting or written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present, and in no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

NCSBN STAFF

NCSBN staff members are hired by the executive director. Their primary role is to implement the Delegate Assembly's and Board of Directors' policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

Agendas for each session of the Delegate Assembly 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 prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and outcomes.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials and elections committees, as well as the Committee to Approve Minutes. The president must also appoint a timekeeper, a parliamentarian and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes to which the delegate 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

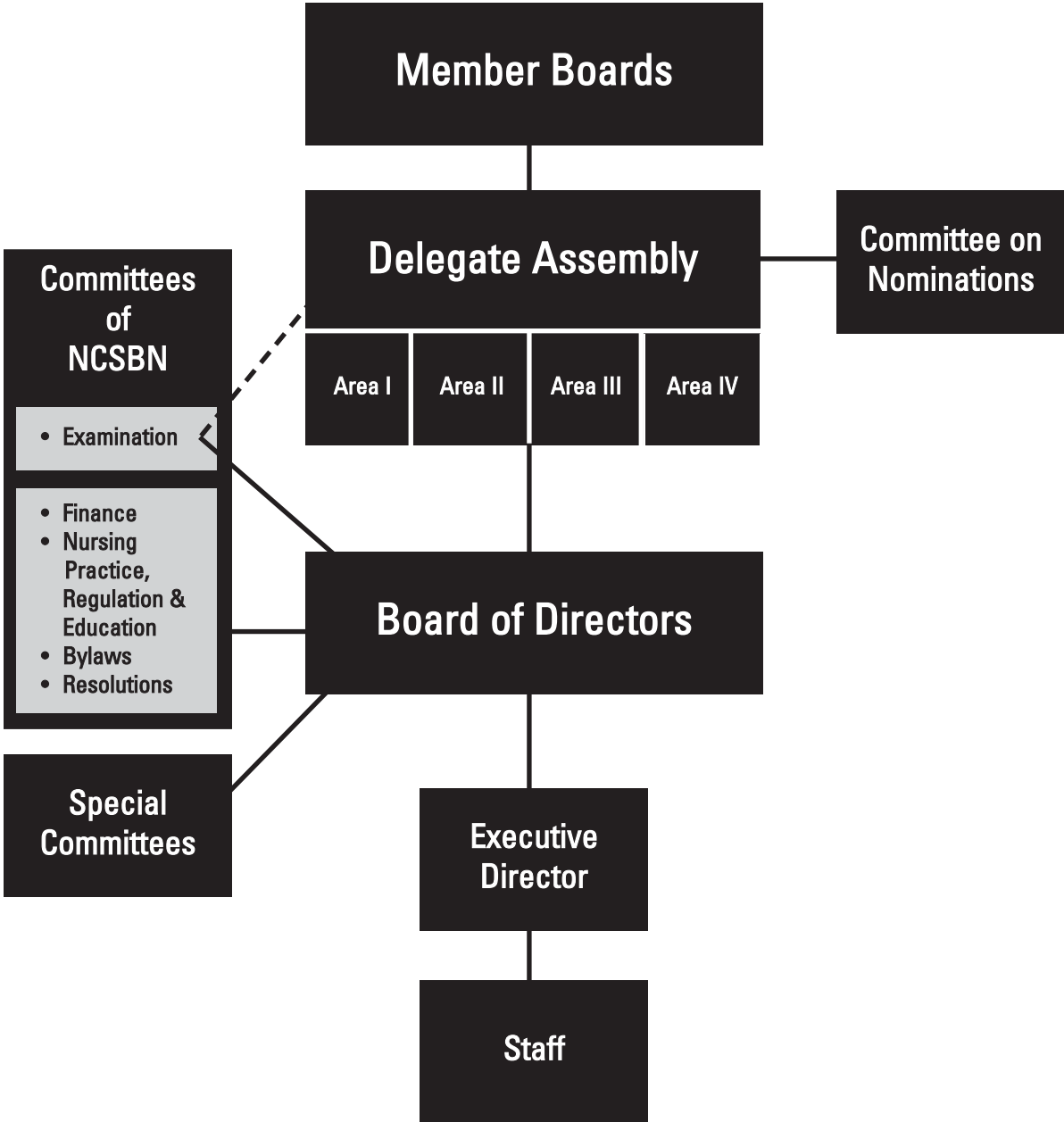


and receives, edits and evaluates all others in terms of their relationship to NCSBN's mission and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

The parliamentarian keeps minutes of the Delegate Assembly. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the executive director who serves as corporate secretary.



NCSBN Organization Chart







Bylaws of the National Council of State Boards of Nursing

Revisions adopted - 8/29/87

Amended - 8/19/88

Amended - 8/30/90

Amended - 8/01/91

Revisions adopted - 8/05/94

Amended - 8/20/97

Amended - 8/8/98

Revisions adopted - 8/11/01

Article I

NAME

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (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 (the “NCLEX® examination”) under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council (“Member Board”).

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 IV, payment of the required fees and execution of a contract for using the NCLEX® examination.



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 member fees, as set by the Delegate Assembly, shall be payable each October 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® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any Member Board whose fees remain unpaid after January 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

DELEGATE ASSEMBLY

Section 1. Composition.

- a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly (“Standing Rules”). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.
- b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A National Council officer or director may not represent a Member Board as a delegate.
- c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

- a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.
- b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the National Council, shall provide direction for the National Council through resolutions and



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

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 before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the National Council.

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

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

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

Article V

OFFICERS AND DIRECTORS

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

Section 2. Directors. The directors of the National Council shall consist of two directors at large and a director from each Area.

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

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

Section 5. Election of Officers and Directors.

- a) *Time and Place.* Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.
- b) *Officers and Directors at Large.* Officers and directors at-large shall be elected by majority vote of the Delegate Assembly.
- c) *Area Directors.* Each Area shall elect its Area director by majority vote of the delegates from each such Area.
- d) *Voting.* Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write in votes shall be prohibited.

Section 6. Terms of Office. The president, vice president, treasurer 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 and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. *Limitations.* No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the 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 incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. *Vacancies.* A vacancy in the office of president shall be filled by the vice president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting.

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

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

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

Article VI

BOARD OF DIRECTORS

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

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

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

Section 4. *Removal from Office.* A member of the Board of Directors may be removed with or without cause by a two thirds vote of the Delegate Assembly. The Board of Directors may remove any member of the Board of Directors from office upon conviction of a felony, gross misconduct, failure to perform, dereliction of duties or conflict of interest by a two-



thirds vote of the Board of Directors. The individual shall be given 30 days' written notice of the proposed removal.

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

Article VII

NOMINATIONS AND ELECTIONS

Section 1. Committee on Nominations

- 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 two years. One half of the Committee members shall be elected in even numbered years and one half in odd number years. Members shall assume duties at the close of the Annual Meeting at which they are elected.
- c) *Election.* The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The member receiving the highest number of votes shall serve as vice chair in the first year of the member's term and as chair in the second year of the term. The first meeting of the committee shall be held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.
- d) *Limitation.* A member elected or appointed to the Committee on Nominations may not be nominated for an officer or director position during the term for which that member was elected or appointed.
- e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in which 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 directors 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.

Article VIII

MEETINGS

Section 1. Participation.

- a) *Delegate Assembly Session.*
 - (i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).
 - (ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive



sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

- b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.
- c) *Meetings.* National Council, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.
- d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the National Council Office.
- e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

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

Section 3. *Evaluation.* The Board of Directors shall conduct an annual written performance appraisal of the Executive Director, and shall set the Executive Director's annual salary.

Article X

COMMITTEES

Section 1. *Standing Committees.* National Council shall maintain the following standing committees.

- a) *Examination Committee.* The Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.
- b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the National Council's investments and the audit. The



Committee shall recommend a budget to the Board of Directors and advise the Board on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

- c) *Practice, Regulation, and Education Committee.* The Practice, Regulation, and Education Committee shall be comprised of at least six members. The Committee shall provide general oversight of nursing practice, regulation, and education issues.
- d) *Bylaws Committee.* The Bylaws Committee shall be comprised of at least four members. The Committee shall review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly.
- e) *Resolutions Committee.* The Resolutions Committee shall be comprised of at least four members, including one member from the Finance Committee. The Committee shall, in accordance with the Standing Rules, review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards.

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

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

Section 4. Committee Membership.

- a) *Composition.* Members of Standing and Special committees shall be appointed by the Board of Directors. Standing committees shall include only current members and employees of Member Boards. Special committees may also include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president's 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 reappointment 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 Duties.*
 - 1. *Budget.* Standing committees shall operate within the assigned budget for 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

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 annual audit report shall be provided to the Delegate Assembly.

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

Article XII

INDEMNIFICATION

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

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

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

- a) Not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and
- b) Continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.



Article XIII

PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the 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 XIV

AMENDMENT OF BYLAWS

These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

- a) Written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or
- b) Written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

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

Article XV

DISSOLUTION

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

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

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

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

Section 2. Acceptance of Plan. Such plan shall be acted upon by Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. Seventy five percent (75%) of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

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





NCSBN Glossary

A

AACN

American Association of Colleges of Nursing or American Association of Critical Care Nurses.

AANA

American Association of Nurse Anesthetists.

AANP

American Academy of Nurse Practitioners.

ACC

ACNM Certification Council Inc.

Accrediting Agency

An organization which establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

AccuFacts

A searchable electronic database of NCSBN documents that may be distributed to the public. Accessible to Member Boards via NCNET and the public via NCSBN's Web site.

ACNM

American College of Nurse Midwives.

ADA

Americans with Disabilities Act; American Dental Association; American Dietetic Association.

ADR

Alternative dispute resolution.

Agent Role

All health care practitioner licensing boards, including boards of nursing, are required to report final adverse licensure actions to the HIPDB (see Health Care Integrity and Protection Data Bank).

NCSBN has been tracking disciplinary actions since 1981, and served in an agent role to assist most boards with reporting historical discipline data.

NCSBN maintains ongoing agent services to continue support boards of nursing in meeting this federal reporting mandate.

AMA

American Medical Association.

ANA

American Nurses Association.

ANCC

American Nurses Credentialing Center.

ANSR

Americans for Nursing Shortage Relief, a consensus document.

AONE

American Organization of Nurse Executives.

APRN

Advanced Practice Registered Nurse. This includes certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs) and nurse practitioners (NPs).

Area

One of four designated geographic regions of NCSBN's Member Boards. See list at right.

Assessment Strategies

Test service for Canadian Nurses Association.

Assessment Strategies for Nursing Educators: Test Development and Item Writing

Online course offered through NCSBN Learning Extension for nursing educators. Users earn 14.4 contact hours for completing the course.

NCSBN Area I

Alaska
American Samoa
Arizona
California
Colorado
Guam
Hawaii
Idaho
Montana
Nevada
New Mexico
N. Mariana Islands
Oregon
Utah
Washington
Wyoming

NCSBN Area II

Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
N. Dakota
Ohio
S. Dakota
W. Virginia
Wisconsin

NCSBN Area III

Alabama
Arkansas
Florida
Georgia
Kentucky
Louisiana
Mississippi
N. Carolina
Oklahoma
S. Carolina
Tennessee
Texas
Virginia

NCSBN Area IV

Connecticut
Delaware
District of Columbia
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Puerto Rico
Rhode Island
Vermont
U.S. Virgin Islands



B

Blueprint

The organizing framework for an examination which includes the percentage of items allocated to various categories.

Board of Directors (BOD)

Board of Directors of the NCSBN of State Boards of Nursing, whose authority is to transact the business and bylaws of the affairs of NCSBN.

Breaking the Habit: When Your Colleague is Chemically Dependent

Video and facilitation package within NCSBN's Professional Challenges of Nurses series, released in 2001.

Bylaws

The rules which govern the internal affairs of an organization.

C

CAC

Citizen Advocacy Center.

CAT

Computerized Adaptive Testing.

CCAP

Continued Competence Accountability Profile. This is no longer an active project of NCSBN. It provided a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation as to whether or not goals/objectives have been achieved. It is an expected activity of all licensed nurses to reflect lifelong learning activities and application to daily practice. The profile is, in essence, the application of the nursing process to one's own competence and professional development and accountability.

CCNA

Council on Certification of Nurse Anesthetists.

CCNE

Commission on Collegiate Nursing Education.

CEPN-LTC

Certification Examination for Practical Nurses in Long-Term Care.

Certification Program

An examination designed by a certifying body to evaluate candidates.

Certifying Body

A non-governmental agency that validates by examination, based on predetermined standards, an individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing (NC).

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 the NCLEX-RN® examination.

CLEAR

Council on Licensure, Enforcement and Regulation. An organization of regulatory boards and agencies, headquartered in Lexington, Kentucky.

CMS

Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health & Human Services; formerly called the Health Care Financing Administration (HCFA).

CNM

Certified Nurse Midwife.

CNS

Clinical Nurse Specialist.

**CON**

Committee on Nominations. The elected committee of NCSBN responsible for preparing a slate of qualified candidates for each year's elections. The Committee on Nominations' members serve one-year terms.

CORE

Commitment to Ongoing Regulatory Excellence. A system of performance measurement to determine best practices for nursing regulation that was established to implement NCSBN's Commitment to Excellence in Nursing Regulation project.

CPR

Candidate Performance Report, an individualized, two-page document sent to candidates who fail the NCLEX® examination, available from Testing Services.

CRNA

Certified Registered Nurse Anesthetist.

CRNE

Canadian Registered Nurse Examination. Canadian Nurse's Association Nurse Licensure Examinations.

Crossing the Line: When Professional Boundaries Are Violated

Video and facilitation package within NCSBN's Professional Challenges of Nurses series, released in 1998.

CSCC

Candidate Services Call Center. Prometric's national facility for candidate scheduling and inquiry for all their examinations (formerly National Registration Center or NRC).

CSG

Council of State Governments. NCSBN is a member at the Associate level.

CTIA

Cellular Telecommunications and Internet Association.

D**DDB**

Disciplinary data bank. An NCSBN data management system, used between 1981 and 2000 to provide a database of disciplinary actions reported by Member Boards. The DDB data was incorporated into Nursys® which continues to provide tracking of disciplinary data reported by Boards of Nursing.

DEA

U.S. Drug Enforcement Association.

Delegate Assembly (DA)

The voting body of NCSBN that comprises 61 Member Boards. Each Member Board is entitled to two votes. Provides direction through adoption of the mission, strategic initiatives and outcomes; adoption of position statements and actions.

Delegating Effectively: Working Through and With Assistive Personnel

Video and facilitation package within NCSBN's Professional Challenges of Nurses series, released in 2002.

Department of Education (DOE)

U.S. Department of Education.

Diagnostic Profile

The former name for what is now called the Candidate Performance Report (CPR).

DIF

Differential Item Functioning or a statistical measure of potential item bias.

Direct Registration

A method of submitting candidate registrations for the NCLEX® examination. Registrations are submitted by candidates, with the \$200 fee directly to Pearson Professional Testing.) An option for telephone registration is available for \$212.



Disciplinary Actions: What Every Nurse Should Know

Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 4.8 CEUs for completing the course.

E

Examination Committee (EC)

A standing committee of NCSBN. The Item Review Subcommittee is a sub-committee of the EC.

EIRs

Electronic Irregularity Reports. Reports written by the test center staff on the day of testing regarding any irregularities occurring during NCLEX® examination testing. These reports are forwarded by Sylvan overnight to The Chauncey Group (new vendor Pearson Professional testing will receive these in 2002 with the transition of test services vendors) and NCSBN. NCSBN forwards the EIRs to the Member Board where the candidate is seeking licensure.

Electronic Access

Member Boards' direct inquiry of the NCSBN Disciplinary Tracking System via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

EO Network

Executive Officer Network.

EPR

Examinee Performance Record.

ESL

English as a Second Language.

Ethics of Nursing Practice

Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 4.8 CEUs for completing the course.

F

FARB

Federation of Associations of Regulatory Boards. FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law. NCSBN holds a seat on the FARB Board of Directors.

Fiscal Year (FY)

October 1 to September 30 at NCSBN.

H

HHS

U.S. Department of Health & Human Services.

HIPDB

Healthcare Integrity and Protection Data Bank. A national data collection program mandated and operated by HRSA for the reporting of final adverse actions against health care providers, suppliers or practitioners as required by the Health Insurance Portability and Accountability Act of 1996.

HRSA

Health Resources and Services Administration. An agency of the federal government under the Department of Health and Human Services.

I

ICN

International Council of Nurses.

ICONS

The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing, American Association of Critical Care Nurses, American Organization of Nurse Executives, American Nurses Association,



Bureau of Labor Statistics, Division of Nursing (HRSA), National Center for Health Statistics, NCSBN, National League for Nursing and American Association of Nurse Anesthetists.

INS

Immigration and Naturalization Services. An agency of the U.S. Department of Justice.

Interstate Compact

An agreement (contract) between two or more states (usually adopted by legislation) which have the force and effect of statutory law.

IOM

Institute of Medicine.

Item

A test question on one of the NCLEX® examinations.

Item Response Theory (IRT)

A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. 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® examinations.

Item Writers

Individuals who write test questions for the NCLEX-RN® and NCLEX-PN® examinations.

IWHPR

Interprofessional Workgroup on Health Professions Regulation.

J**JCAHO**

Joint Commission on Accreditation of Healthcare Organizations.

JRC

Joint Research Committee. This committee consists of three NCSBN and three NCS Pearson staff members, and three external researchers. The committee is the vehicle through which research is funded for the NCLEX® examination program. Funding is provided jointly by NCSBN and NCS Pearson.

K**KSA**

Knowledge, skill and ability statements.

L**Logit**

A unit of measurement used in IRT models. The logarithmic transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

M**Member Board**

A jurisdiction that is a member of NCSBN.

MNAR

Model Nursing Administrative Rules. A publication of NCSBN.

MNPA

Model Nursing Practice Act. A publication of NCSBN.

Mutual Recognition

A mutual recognition model for nursing regulation was adopted by the August 1997 Delegate Assembly, and language for an interstate compact that would facilitate mutual recognition was adopted by a special session of the Delegate Assembly in December 1997. See also Nurse Licensure Compact.



N

NAFTA

North American Free Trade Agreement (Canada, Mexico and the United States). Addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

NAP

Nursing Assistive Personnel. Also, Nursys[®] Advisory Panel, an NCSBN committee.

NAPNES

The National Association for Practical Nurse Education and Service.

NCSBN Learning Extension

Branded name for the online campus located at www.nclex.com where NCSBN promotes educational products and provides online course access to users.

NCSBN's Review for the NCLEX-RN[®] Examination

Online course offered through NCSBN Learning Extension for NCLEX-RN[®] candidates.

NCBPNP/N

National Certification Board of Pediatric Nurse Practitioners and Nurses.

NCC

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties.

NCLEX[®] Administration Web Site

This site allows Member Boards to process and manage records for candidates who register for and take the NCLEX-RN[®] and NCLEX-PN[®] examinations.

NCLEX[®] Program Reports

Published twice per year for subscribing schools of nursing, the NCLEX[®] Program Reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX examination.

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 also are 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.)

NCLEX-PN[®] Examination

NCSBN Licensure Examination-Practical Nurse.

NCLEX-RN[®] Examination

NCSBN Licensure Examination-Registered Nurse.

NCNET

NCSBN Network. NCSBN's electronic network for Member Boards, on which a variety of software services are delivered (e.g., EDWARD, DDB, EIRs, SAVHI).

NCS Pearson

NCSBN's test service provider for the NCLEX[®] examinations as of October 1, 2002. NCSBN works specifically with the group known as Pearson Professional Testing.

NCSBN

Abbreviation for National Council of State Boards of Nursing, Inc.

NCSBN Strategic Plan

Strategic initiatives, and outcomes of NCSBN spanning a three-year period.

NFLPN

National Federation of Licensed Practical Nurses.

Niche Communications

Fulfillment vendor for NCSBN's Professional



Challenges of Nurses series of video and facilitation packages.

NLC

Nurse Licensure Compact. An agreement establishing reciprocal licensing arrangements between party states for licensed practical/vocational nurses and registered nurses. In August 2002, NCSBN delegates voted to expand the compact to include advanced practice registered nurses.

NLCA

Nurse Licensure Compact Administrators. Organized body of the heads of nurse licensing boards for states that have adopted and implemented the Nurse Licensure Compact.

NLN

National League for Nursing.

NLNAC

National League for Nursing Accrediting Commission, Inc.

NNAAP™

National Nurse Aide Assessment Program. The nurse aide certification examination developed by the NCSBN and CAT*ASI.

NP

Nurse Practitioner.

NP&E

Nursing Practice and Education Committee. The former name of a standing committee of NCSBN, now called PR&E Committee.

NPDB

National Practitioner Data Bank. A federally mandated program for collecting data regarding health care practitioners. The NPDB has been in operation for 10 years and requires medical malpractice payment reports for all health care practitioners, and 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 section 1921 of the Social Security Act (originally enacted in

P.L.100-93, section five).

N-PEC

Nursing Practice and Education Consortium.

NPI

National Provider Identifier. On May 7, 1998, rules were posted in the Federal Register proposing a standard for a national health care provider identifier and requirements for its use by health plans, health care clearinghouses and health care providers. This is planned to be a new, unique eight-character alphanumeric identifier.

Nurse Practice Acts Continuing Education Courses

Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 2.0 CEUs for completing the course.

Nursys®

A database developed by NCSBN containing demographic information on all licensed nurses and an unduplicated count of licensees and serving as a foundation for a variety of services, including the disciplinary tracking system, licensure verification, interstate compact functions and research on nurses.

O

OBRA 1987

Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

P

Pearson Professional Centers (PPC)

Pearson Professional Centers are testing locations where candidates will take the NCLEX® examinations beginning with the testing vendor transition in 2002. See also Pearson Professional Testing.

**Pearson Professional Testing**

The group of NCS Pearson that NCSBN uses on the NCLEX examinations, beginning in October 2002 and for the next seven years.

PERC

Practice, Education, and Regulation Congruence Task Force. This task force no longer exists, but its recommended action plan was approved at the 2002 Delegate Assembly and will be implemented through 2010 by staff and existing committees.

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 propose new approaches to health care workforce regulation to better serve the public's interest. The task force was composed of eight individuals with legal, policy and public health expertise. Its recommendations were issued in late 1995.

PPI

Practice and Professional Issues Survey. A survey conducted twice each year to collect information from entry-level nurses on practice activities.

PR&E

Practice, Regulation and Education Committee. A standing committee of NCSBN.

Practice (Job) Analysis

A research study that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

PREP

Practitioner Remediation and Enhancement Partnership, sponsored by CAC. NCSBN is a member of the national advisory board.

Pre-Test Items

Newly written test questions placed into

examinations for the purpose of gathering statistics. Pretest items are not used in determining the pass/fail result.

Professional Accountability & Legal Liability for Nurses

Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 5.4 CEUs for completing the course.

Professional Challenges of Nurses Series

NCSBN's branded name for the group of video and facilitation packages offered for sale.

Promissor™

The test service for the National Nurse Aide Assessment Program (NNAAP™). Formerly known as CAT*ASI.

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. These include all decisions, rules, actions and procedures established in the public interest.

R

Rasch Measurement Model

The item response theory model used to create the NCLEX® examination 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. For adaptively administered examinations, such as the NCLEX® examination, the decision consistency statistic is the preferred statistic for assessing reliability. NCSBN uses the



Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the NNAAP™.

RFP

Request for Proposal.

S

Sharpening Critical Thinking Skills for Competent Nursing Practice

Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 3.6 CEUs for completing the course.

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. NCSBN 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® examination and whenever the test plan or NNAAP™ Blueprint changes.

T

TCA

Test Center Administrator.

TERCAP

Taxonomy of Error, Root Cause Analysis and Practice Responsibility. An instrument developed for NCSBN's practice breakdown research.

Test Plan

The organizing framework for the NCLEX-RN® and NCLEX-PN® examinations that includes the percentage of items allocated to various categories.

Test Service

The organization that provides test services to NCSBN, including test scoring and reporting. NCS Pearson is the test service for the NCLEX® examinations, and CAT*ASI is the test service for NNAAP™.

The Chauncey Group International, Ltd., or The Chauncey Group (CGI)

NCSBN's former test service for the NCLEX® examinations.

U

UAP

Unlicensed Assistive Personnel.

V

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. NCSBN assures the content validity of its examinations by basing each test strictly on the appropriate test plan (NCLEX-RN® or NCLEX-PN® examination) or blueprint (NNAAP™). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.

VCampus Corporation

E-learning courseware provider for online courses offered through NCSBN Learning Extension.

