Leader to Leader

Nursing Regulation & Education Together

Spring 2010

What Happened to the Nursing Shortage?

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A few days ago, I received the following e-mail from a new graduate nurse:

> *"I am a new RN graduate who has applied to over 90-100 jobs with no luck. Every reply I receive from employers is that no one is hiring new grads at the time. Even new grad entry level positions like Rehab, Skilled Nursing Facility, Home Health Care, Hospice and night positions are off limits to new grads. All the places I have applied to tell me that they would hire me, but the only problem is that I have **no RN** experience. If no one is hiring new grad RNs, how will I ever gain RN experience? Some hospitals are creating new grad waiting lists. It is so bad for us that some facilities are currently hiring new grad RNs as CNAs! For my whole life I have looked forward to being a Registered Nurse. Now that I am a Registered Nurse, I am denied the opportunity to live my dream of having a career as a licensed RN to trade it for a CNA job."*

The National Student Nurses Association (NSNA) conducted a survey of employment among new graduates in 2009 and found that 44 percent did not have jobs within a month of graduation. Of those, 50 percent who did not have a job had associate degrees; 38 percent had baccalaureate degrees. The most common reason for not having a job was that there were no jobs for new graduates in the area. New graduates from Arizona were among the highest in the nation who cited no jobs for new graduates in the area as the reason for nonemployment (Mancino, 2009).

In my previous capacity as the education consultant for the Arizona State Board of Nursing, I oversaw and shepherded in a near tripling of graduates in Arizona nursing programs from 2001 to 2009 (2001 data reveals 1,116 graduates; 2009 data reveals 3,054 graduates). Based on assumptions from economists and futurists, we were told a crisis was headed our way and a prime strategy was to prepare more new nurses. I recall one recruiter testifying before a legislative committee considering a bill to provide funds to expand nursing programs. When asked if we were in any danger of producing too many nurses, the recruiter responded that there was no possibility of that. We recruited persons into the profession with promises of plentiful employment opportunities, job mobility and high salaries. Then the economy took an unprecedented nosedive and all bets were off.

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So what happened to the shortage? It is in remission. Baby boomer nurses are working when they would rather retire, part-time nurses are working full time and nurses who left the profession to enter real estate are flocking back. Refresher courses are full, but nurses struggle to obtain clinical placements; there are long waiting lists for nursing programs and existing programs struggle to place students in acute care facilities for clinical experiences. Births are down, elective surgeries are down and some hospitals are closing units. As unemployment increases, health care insurance is lost with a resultant decrease in demand for preventive and elective health services. The emergency department is increasingly used as a primary care clinic for the uninsured causing further stress on hospital financial resources.

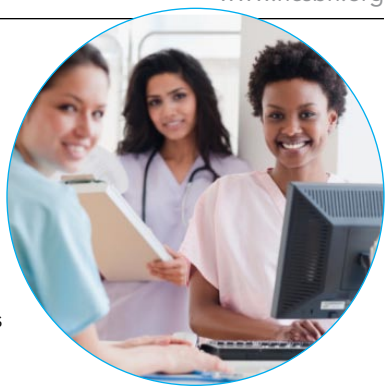
We are at a historic moment when previously held assumptions on both the nature of the economy and health care delivery will change. Nursing will also adapt and change. The bright side for now is that the Bachelor of Science in Nursing (BSN) degree is being increasingly valued by employers. For the first time in recent memory, employers are able to pick the best and brightest to join their staff. New graduates are approaching jobs with more eagerness and willingness to work hard.

We are at a historic moment when previously held assumptions on both the nature of the economy and health care delivery will change. Nursing will also adapt and change.

New graduates are increasing their education, which should increase their employability. Recently released Health Resources and Services Administration (HRSA) data (HRSA, 2010) reveals that nationally, 50 percent of registered nurses (RNs) have achieved a baccalaureate degree or higher in 2008 as compared to 27.5 percent in 1980.

According to the Nursing Executive Center, only 10 percent of hospital and health system nurse executives think new graduates are prepared to provide safe, effective care. The challenge for regulation is to maintain and enhance the competency of unemployed new graduate nurses. We are challenged to propose solutions to help new graduates attain and maintain the skills necessary to provide quality care. Eventually, the baby boomers will leave the workforce and new graduates will be sorely needed when the shortage created by those retirements occurs. In the meantime, the following suggestions should be considered:

- Employers are encouraged to change nursing delivery systems to incorporate new graduates at a lower salary into a primary nursing role, while decreasing reliance on unlicensed personnel. Rationale: As a society we have already invested heavily in preparing an RN through various funding mechanisms, including Pell grants, student loans and subsidized public education. The nurse has devoted three to five years of his/her time in reaching this goal. All this will be lost if we fail to reap the benefits of this investment with RN employment soon after graduation. When the shortage returns we will be in need of a skilled workforce. At that time we can also increase the shorter, less costly training of unlicensed persons and adapt service models.



- Craft a plan, state-by-state, to ensure nursing programs and nursing program expansion will meet the health care needs of the future. Rationale: Evidence suggests that the higher proportion of RNs with BSN degrees is associated with lower mortality and lower failure-to-rescue incidents (Kane et al., 2007; Aiken et al., 2003). Nurses in the future will be caring for patients who are older, more culturally diverse and have more complex health problems.
- Encourage new graduates to continue their education. Associate degree graduates are encouraged to complete their BSN. BSN graduates should start advanced education toward a master's degree. Certification in life support or in a specialty should be considered. Rationale: Employers are preferentially hiring more educated nurses. Advanced education will be necessary if nurses are to meet the health care needs of the future.
- Faculty should inform current students that each clinical rotation is a job interview; they cannot afford to make a bad impression. Faculty must provide students with the skills necessary to be helpful to nurses and patients on the units. Rationale: Some recruiters are reporting that even graduates six to12 months beyond graduation without employment are approaching them with demands for daytime hours, no weekends and incredibly, "I don't want to work with old people." This sense of entitlement is the surest way to kill a job offer. Clinical placement coordinators report that students frequently stand around on the unit or nurse the chart and hinder the work of the staff.
- Develop program/facility partnerships to offer unpaid internships and residencies or transition programs to new graduate nurses with a promise to hire a certain number of those who successfully complete the program. Rationale: This will increase new graduate skills with minimal investment on the part of the facility.

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Meet Philip Dickison

NCSBN's New Director of NCLEX® Examinations

Philip Dickison, PhD

On Feb. 1, 2010, NCSBN welcomed its newest staff member, Philip Dickison, PhD, director, NCLEX® Examinations, to the organization. With more than 20 years of experience working in testing and certification, Dickison will work towards advancing the organizational mission and vision of NCSBN by managing the programs and services related to the NCLEX® Examinations department.

Dickison previously served as director of Health Professions Testing with Elsevier, Inc., and as associate director and department coordinator of the National Registry of Emergency Medical Technicians (NREMT). While working at NREMT, Dickison provided psychometric services for more than 10 years and worked with EMS officials from all 50 states in the implementation of national testing, conflict resolution, ADA issues, regulatory topics and customer service needs.

In this interview, Dickison discusses his vision for the NCLEX examinations, the department and the importance of teamwork.

? Throughout your career, you have worked in the field of testing and certification with such companies as Elsevier and NREMT. How will your experience in these industries influence your work here at NCSBN?

DICKISON: The more than 18 years I spent at NREMT, as well as the three years of service to Elsevier, working with health care professionals in examination development, psychometric oversight and state/national regulatory bodies were invaluable experiences. I came to realize through these experiences, that whether an individual was a member of a state regulatory agency, an official of the federal department, a board member, a staff member or a member of the profession, they formed a community based on the common commitment to excellence in the profession and the assurance of public protection. This has allowed me to participate more effectively in discussions about testing and competence.

During my tenure at NREMT, I had the opportunity to help transition the testing program from a paper-and-pencil examination based in classical test theory to a computer-adaptive test (CAT) based in item-response theory. While many of the processes of item development, item review and item content are unique to NCLEX, the underlying principles and processes of using CAT as a measurement of ability are consistent, regardless of the testing program; this fact should prove to be an asset as I orient myself to the NCLEX examination development process.

? NCLEX® is the premier examination for nursing licensure. What are your goals for the NCLEX® Examinations department?

DICKISON: My goal for the NCLEX examination is to advance this premier status by: (1) actively investigating innovative item types that may more accurately measure a candidate's knowledge and abilities to perform the functions of an entry-level nurse; (2) improving the flow of communication across the various functional components of the NCLEX examination team to ensure that NCLEX examination decisions are made with the greatest degree of input from NCLEX staff and NCLEX committee members; (3) investigating emerging scoring models to ensure that NCLEX is using scoring models that reflect the best measurement available, not only in nursing, but across all domains of high-stakes testing; and (4) evaluating each touch point of the NCLEX® Examinations department with internal and external individuals and groups to identify areas of improvement that will make the interaction of the NCLEX® Examinations department not only a pleasant, but a beneficial experience at each touch point.

? How do you envision working with member boards, Pearson VUE, NCLEX® Examination Committee and NCLEX® Item Review Subcommittee?

DICKISON: I envision providing leadership through continually placing the mission of excellence and public protection at the forefront of all we do. In addition, I envision building teams that strive to use creative thought and imagination to collectively find solutions and processes that advance the profession of nursing and continue to ensure that the NCLEX remains the premier examination for the profession.

? What does the future of the NCLEX® examinations look like to you?

DICKISON: I envision an NCLEX examination that continues to set the standards of high-stakes certification examinations and is the benchmark by which all licensure/certification bodies judge their own success. As testing delivery engines improve, and new scoring models and item types emerge, the NCLEX examination should be positioned to capitalize on any innovations that provide three things: (1) the candidate with an improved testing experience; (2) NCSBN with improved return on investment relative to test security and item measurement accuracy; and (3) member boards with improved confidence in making licensing decisions based on examination outcomes. ●

The Agony and the Ecstasy: Philosophical Considerations for Developing a Master's Entry Program

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The face of health care and nursing education is changing rapidly. The demand for nurses, especially nurses with advanced degrees, grows daily. In response to the increased knowledge and competence nurses need to flourish in a dynamic and complex health care arena, nursing education has begun to explore innovative programs that effectively respond to the profession's needs. One such innovation is providing entry-level education at the master's degree level. There appears to be much confusion about this type of degree because there are several entry and exit points to which students can refer.

Currently, there are three ways in which an individual can enter into professional nursing via a master's degree: (1) as a registered nurse (RN) with a diploma or associate degree; (2) as a nonnurse with a bachelor's degree in an area other than nursing; or (3) through a prelicensure program that provides a Bachelor of Science in Nursing (BSN) on the way to a Master of Science in Nursing (MSN). Similarly, programs generally offer two distinct exit points: preparation as a generalist or preparation as a specialist (e.g., nurse practitioner [NP] or certified nurse specialist [CNS]). The decision to offer this type of program is a monumental one for faculty, as there are many considerations that need to be taken into account. The purpose of this article is to explore some of the philosophical, conceptual, and operational issues that faculty will need to address when deciding to develop and implement a master's entry program.

A significant philosophical issue the faculty must resolve is whether the master's entry program will produce a specialist or a generalist.

A significant philosophical issue faculty must resolve is whether the master's entry program will produce a specialist or a generalist. Generally, nursing practice is viewed as an accumulation of knowledge that builds over time and experience, and results in specialized practice (e.g., advanced practice). Though the notion of a specialist is well understood, that of the generalist is quite new.

Typically, a generalist, or advanced generalist, as it is known at the master's level, is an individual who possesses advanced knowledge of a microsystem and its management. This individual is prepared to provide leadership at point-of-care with the goal of improving health care outcomes. This individual has advanced knowledge of systems organization and analysis, informatics, evidence-based practice, and team-building concepts; they also have the ability to synthesize this knowledge and bring it to bear on patient care issues related to a group of clients.

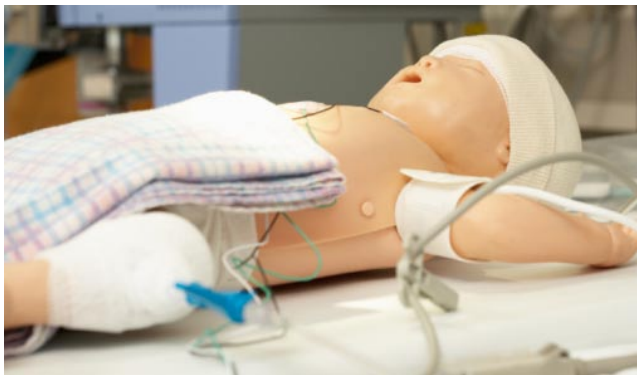
The education of an advanced generalist can occur in two ways. An RN with a BSN, diploma or associate degree may be admitted to a program that will provide them with core master's knowledge in nursing theory, advanced pathophysiology, pharmacology, health assessment, informatics, biostatistics, research, evidence-based practice and health promotion. This program also provides advanced knowledge focused on leading a microsystem of care. Courses include those that define the role expectations for the advanced generalist, system organization and analysis, human and fiscal resource management, and outcomes evaluation. Their course of study culminates in a concentrated clinical residency where they are expected to operationalize the role of the advanced generalist and develop a synthesizing project (e.g., capstone), which is generally focused on evidence-based protocol development or a safety initiative for the microsystem in which they practice.

The education of a nonnurse in a master's entry advanced generalist program offers more challenges. Though educated at the graduate level, these students also need the requisite prelicensure clinical didactic experiences to qualify them to successfully pass the licensing examination (NCLEX-RN® Examination). There are two broad approaches to this issue. First, faculty can develop a prelicensure curriculum that students must pass the NCLEX before moving into the graduate portion of the program. The alternative would be to integrate the two components and teach all courses at the graduate level. The student completes all degree requirements prior to sitting for the NCLEX. The conundrum with this approach arises out of the question of how to teach the prelicensure clinical courses at the graduate level given that students have little or no background in nursing. The answer to this conundrum lies in the role of the advanced generalist. Keeping in mind how this individual will eventually function, the integration of systems knowledge occurs from the beginning of the program. Students are taught to see the patient within a system of care and the influence one has on the other. Further, there is a greater level of analysis and synthesis expected of these students from the outset of their programs. Case studies and simulations are prime examples of how to teach synthesis and application. Leadership opportunities are made available in a variety of clinical settings, requiring the students to analyze microsystems and outcomes of care. These help to solidify role expectations throughout the curriculum. Like the licensed RN, these students must also complete a clinical immersion experience and produce a capstone as evidence of their attainment of the curriculum's terminal objectives.

It must be remembered, however, there is no substitute for clinical experience. Though all programs provide sufficient clinical experience to prepare the student to be an entry-level nurse, students entering through a generalist route will need to gain additional clinical experience upon graduation. However, they will have deeper and richer competencies upon which to draw as their clinical knowledge accumulates. ●

NCSBN Conducting National Multi-Site Simulation Study

The NCSBN departments of Research and Regulatory Innovations are collaborating to conduct a landmark, national, multi-site study of simulation use in prelicensure nursing programs to:



- Highlight best practices in simulation use;
- Evaluate the learning occurring with various amounts of simulation substituting for clinical hours;
- Establish key simulation standards and learning experiences in each core clinical course; and
- Evaluate new graduates' ability to translate simulation experiences into the workplace.

This large scale study is being led by NCSBN staff members Jennifer Hayden, MSN, RN, associate, Research; Kevin Kenward, PhD, director, Research; and Nancy Spector, PhD, RN, director, Regulatory Innovations; and two national experts in the area of simulation in nursing education: Pamela Jeffries, DNSc, RN, FAAN, Johns Hopkins University; and Suzan Kardong-Edgren, PhD, RN, Washington State University. The study will follow a cohort of beginning prelicensure students throughout their curriculum and into their first year of practice.

The study will be conducted in several phases:

- The first phase consists of a survey of simulation use in the prelicensure nursing curriculum to understand the current prevalence of simulation, how simulation is integrated in the curriculum, and how faculty are prepared to write and facilitate simulation scenarios. Surveys were mailed in January 2010 to every prelicensure nursing program in the U.S. Data collection is ongoing, with results expected this fall. The survey return due date was March 19, 2010.
- Phase two of the project will involve a randomized, controlled, multi-site, longitudinal study of three levels of simulation use in lieu of clinical hours. Students will be randomly assigned to a group where 25 percent of the time normally spent at clinical sites would be spent in simulation, a group where 50 percent of the time normally spent at clinical sites would be spent in simulation or a group where 100 percent of their time is spent at a clinical site. Substitution of simulation for experience at clinical sites will take place across the curriculum over a two- to three-year time span.
- Phase three will evaluate the translational outcomes of simulation into the workforce, heretofore the missing link that has never been studied in previous simulation studies. This longitudinal follow-up of graduates into their first year of practice will focus on retention of new nurses and clinical judgment after graduation will be evaluated in this phase of the study.

Site selection for phase two of the study is underway. Schools participating in the study will reflect bachelor of science in nursing (BSN) and associate degree in nursing (ADN) programs across the country.

Visit www.ncsbn.org/2094.htm for more information about the study.

Update on the Transition to Practice Pilot Study

As reported in the last *Leader to Leader*, NCSBN's Board of Directors (BOD) will review the business plan for the Transition to Practice Pilot Study at their May 2010 board meeting. That business plan will also include a template addressing the impact on boards of nursing (BONs) that choose to implement the model. Another template is being designed to analyze the impact on practice settings that develop their own program to meet the standards of the NCSBN model. After reviewing the business plans, if the BOD decides to continue with the plan, the NCSBN Interactive Services department will begin to develop six modules for the pilot program (which will also be used at a later date when a practice setting does not have a transition program that meets NCSBN's standards):

- Preceptor training;
- Patient-centered care;
- Communication and teamwork;
- Evidence-based practice;
- Quality improvement; and
- Informatics.

NCSBN's Transition to Practice Model has been designed to promote experiential learning, rather than relearning material that should have been learned in the nursing program. Therefore, the online modules will be interactive, where the new nurses will make decisions, set priorities and choose appropriate pathways using cutting edge technologies.

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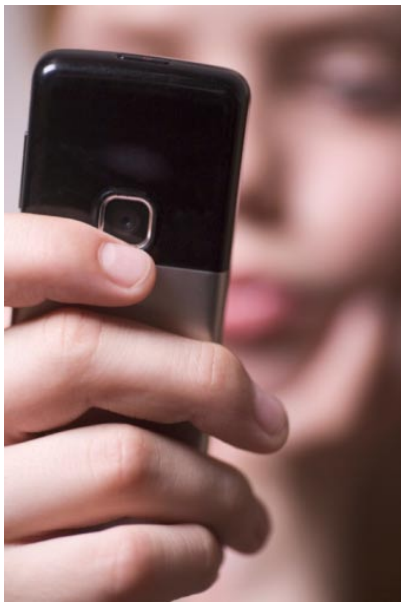
Boundary Violations Via the Internet

Boards of nursing (BONs) have asked NCSBN to develop more detailed language on boundary crossings and violations as they have received increasingly more complaints, particularly those related to cell phone cameras and use of the Internet. Therefore, NCSBN's Disciplinary Resource Committee is now working on model nurse practice act and administrative rule language related to questions of boundary violations and crossings. That language will be voted on by the NCSBN Delegate Assembly in August during the NCSBN Annual Meeting in Portland, Ore. When the model language is adopted, NCSBN's Marketing & Communications department will revise the current professional boundaries brochure to reflect the new language.



As this project has progressed, it has become apparent that educators need to be very clear with students about boundary violations on the Internet and with the use of cell phones, as well as boundary crossings and violations in general. People have become very free with disclosing personal details about themselves and others on the Internet. Likewise, intimate photos are uploaded on social networking sites on a daily basis. This has become second nature to many people today. Therefore, it is no wonder that nurses, particularly young nurses who have grown up with social media are crossing the line and posting details about patients, their work and even photos of their patients. Most educators are stunned when they first hear about these violations, but it is happening, and your help is needed to put an end to it. Students need to know that they are putting their jobs and licenses at risk when they divulge information of any sort about their patients on the Internet.

> Boundary issues should be brought up early in the students' education program, and educators should encourage dialogue and reflections about boundary crossings and violations.

Recently, there have been a couple of professional boundary issues reported by news media across the country. In Wisconsin a patient was brought into the emergency room where two nurses, independently, took cell phone photos of the patient's body part. One of the nurses allegedly posted it on her Facebook page. Needless to say, both nurses were fired from their positions and their future nursing careers look bleak (www.wisn.com/news/18796315/detail.html). The FBI is investigating this case for HIPPA (Health Insurance Portability and Accountability Act) violations.

On Dec. 14, 2009, the *Chicago Tribune* published an article entitled "Disclosure: The New Closure?" The author, Jordan Whelan, writes, "…my sister, fresh from a tenure in Australia, shared with me the distasteful behavior of her nursing colleagues who spend their breaks offering family and cyber cohorts a snapshot of a stressful shift, complete with the evening's death tolls, diagnoses and patient demographics." Even when nurses "deidentify" patients, information such as this is often enough for others to identify the patients, particularly in small communities. Beyond being a boundary violation, it is disrespectful to the patient and to the employing agency. In Washington state two certified nursing assistants and a licensed practical nurse were fired from their positions for taking cell phone photos of nude nursing home residents, most of whom had dementia (www.kitsapsun.com/news/2010/feb/12/state-gives-kitsap-health-rehab-a-deadline-after/?partner=RSS). While the employees have not been charged with a crime, they too will most likely not be hired to work in health care again. They have also put the nursing facility in jeopardy of losing their Medicare/Medicaid funding.

Boundary issues should be brought up early in students' education program, and educators should encourage dialogue and reflections about boundary crossings and violations. Particularly in this Internet age, students need to be aware that divulging any information about their patients is not appropriate.

NCSBN offers a free professional boundaries brochure, *Professional Boundaries – A Nurse's Guide to the Importance of Appropriate Professional Boundaries*, that is designed to help nursing students, educators, health care organizations, and the public understand and apply the concepts of professional boundaries between a nurse and a client. To download a free electronic copy, visit www.ncsbn.org/Professional_Boundaries_2007_Web.pdf. To order hard copies of this brochure, which are also free of charge, e-mail your contact information, as well as the quantity you would like to order, to communications@ncsbn.org.

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

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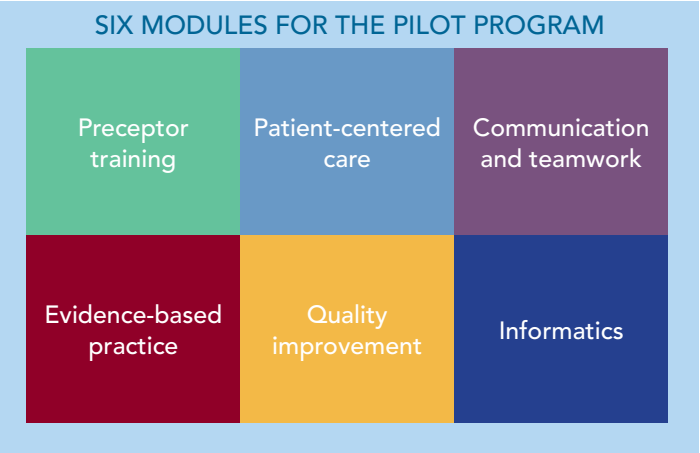
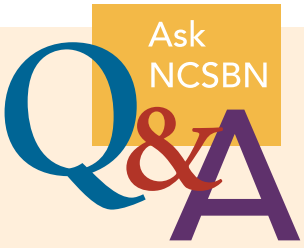


Concurrently, NCSBN's external Transition Research Advisory Panel will assist NCSBN with planning the pilot study (if approved by the BOD in May) and particularly in devising measureable outcomes of quality and safety. The Advisory Panel will also provide ongoing oversight of the study. While inclusion data for the pilots haven't been set yet, general inclusion criteria encompasses:

- Support of the BON (since this is a regulatory model, this is crucial);
- Statewide interest in becoming a pilot;
- Willingness of diverse practice settings in the state or jurisdiction to participate;
- Diversity of settings available, including acute care, long-term care, rural and urban settings, as well as few less common settings that hire new graduates, such as prisons, schools and visiting nursing; and
- Geographic representation.

The Transition to Practice Committee has developed objectives, content, exercises and sources for each of the modules. Additionally, they have provided information on what should be considered with ongoing institutional support, which will begin after the new nurse's six-month preceptorship and will continue for six more months. Strategies were also identified for providing feedback and opportunities for reflection. Since specialty content is best delivered by the employer, some general ideas addressing that concept were developed. All of this material will become part of the manual that will be used by the pilot sites. Committee members have also reviewed pocket-sized texts that new graduates might be able to use during this program, and while no decisions have been made, *Clinical Coach for Nursing Excellence*, by Campbell, Gilbert & Lausten (FA Davis, 2010) seems to be general enough that it could be used across settings and education. It was designed for new graduates and has considerable emphasis on patient safety, organization and prioritization, communication and collaboration, delegation, responding to changing patient situations, and ethical decision making, all of which are highlighted in our model.

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



Q: Has NCSBN been monitoring the Initiative on the Future of Nursing?

A: Yes. NCSBN lauds the Robert Wood Johnson Foundation Initiative on the Future of Nursing, in collaboration with the Institute of Medicine, and has been closely monitoring their progress and assisting them as needed. The goal of this national initiative is to produce a transformational report on the future of nursing. This program has asked NCSBN for data from the boards of nursing (BONs) related to a reported "proliferation" of proprietary nursing programs (for-profit programs) in some states and jurisdictions. We sent out a survey to our member boards asking about the number of proprietary programs operating in their jurisdictions, whether there has been an increase in proprietary programs, and what kinds of concerns, if any, BONs had about these programs. We then held a series of conference calls with states/jurisdictions to further delve into some of the issues and to develop recommendations for the Initiative on the Future of Nursing.

This report is still being completed and will be presented as a research brief. With 42 BONs responding so far, the vast majority reported that the number of proprietary programs has increased recently and that, in some cases, there has been a cause for concern. Some of the concerns raised by BONs during these conference calls include the following, though it must be stressed that some proprietary programs have been successful in meeting BONs' standards and in educating students:

- There were several instances of programs not meeting BON standards and either being denied approval or given conditional approval.
- In some cases there was pushback from legislators when BONs denied approval.
- Problems in quality included lack of sites for clinical placements, poorly planned clinical experiences and curricula, and a lack of qualified administrators and faculty.
- Some programs had significant attrition after students had paid high tuition fees.
- Sometimes students were not able to transfer to other programs to further their education because of lack of regional accreditation.
- In some states/jurisdictions new proprietary programs have adversely impacted current programs by competing for clinical sites and faculty.
- In some states/jurisdictions proprietary programs have adversely impacted BON resources because they have required considerable assistance in meeting standards.

Once completed, the research brief will be made available to all BONs and the public.

An Update From the NCSBN NNAAP™ & MACE™ Examinations Department

The NCSBN NNAAP™ & MACE™ Examinations department is working diligently toward becoming the premier provider of high quality exams for nurse aide/nursing assistant (NA) and medication aide/assistant (MA) candidates within the U.S. and its jurisdictions. NAs and MAs are direct care providers who assist in the care provided by licensed professionals in a variety of health care settings.

Since 1996, NCSBN has cooperatively developed and maintained the National Nurse Aide Assessment Program (NNAAP™) examination, the largest NA certification program in the U.S., with more than 200,000 paper and pencil examinations administered annually. Previously jointly owned and operated by NCSBN and Pearson VUE, NCSBN acquired the exclusive ownership of the intellectual property for NNAAP and the Medication Aide Certification Examination (MACE™) in 2008. MACE is a new national MA certification examination used to ensure that individuals who administer medication to clients/residents in long-term care settings have the basic knowledge and skills needed to perform their duties safely and effectively. The NCSBN NNAAP™ & MACE™ Examinations department is responsible for the test development activities of the NNAAP and MACE programs. Pearson VUE will continue to administer both examinations.

There is an online application that licensed nurses in the fields of nurse aide and medication aide instruction can use to get involved with the development of the NNAAP and MACE programs. Visit www.ncsbn.org/1930.htm.

In 2009, NCSBN developed its first national MA exam, complete with a passing standard set by a group of subject matter experts (SMEs) who utilized the Medication Assistant Certified Model Curriculum that was adopted by the NCSBN Delegate Assembly in 2007. Jurisdictions that employ MAs in nursing homes and other long-term care settings can use this examination to assess the knowledge of those seeking to be MAs.

January 2010 saw the introduction and administration of NNAAP examination forms produced by NCSBN SME meetings and workshops. It also marked the completion of data collection efforts for the first NA job analysis survey conducted by the NNAAP™ & MACE™ Examinations department.

As the second year of test development activities for the NNAAP and MACE exams begins, the NNAAP™ & MACE™ Examinations department is looking for qualified SMEs willing to participate in test development activities and to facilitate the development of high quality competency assessments for the NNAAP and MACE programs. There is an online application that licensed nurses in the fields of NA and MA instruction can use to get involved with the development of the NNAAP and MACE programs. Visit www.ncsbn.org/1930.htm for more information.

NCSBN will host the 2010 Unlicensed Nursing Assistive Personnel Workshop June 29–30, 2010, at the Intercontinental Hotel in Chicago. The workshop will open a dialogue with stakeholders who regulate NAs and MAs and will provide the NNAAP™ & MACE™ Examinations department with greater insight into the regulation, education and delegation of NAs and MAs employed in long-term care settings. For more information visit www.ncsbn.org/events.htm.

For questions or more information regarding the NNAAP and MACE programs, contact the NNAAP™ and MACE™ Examinations department at nnaap_maceinfo@ncsbn.org or join the NNAAP & MACE electronic mailing list by visiting www.ncsbn.org/epushprofilecreate.html. ●

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