Delegate Assembly

Ninth Annual Convention

August 25-29 1987

Chicago Marriott Chicago, Illinois

Book of Reports

The National Council's Communication and Convention Planning Committees are responsible for planning the Convention.

Communications Committee

Jean C. Caron, Maine, Chairperson
Sandra Brown, Arkansas
H. Jean Bruhn, Pennsylvania
Leota Rolls, Nebraska

Convention Program Planning Committee

Carol Monteuffel, Wyoming, Chairperson
Patricia Calico, Kentucky
Mary McSherry, Rhode Island
Garnette Thorne, West Virgina-RN

NATIONAL COUNCIL

National Council of State Boards of Nursing, Inc.

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7. A time keeper will signal when allotted time has expired.

ELECTIONS

1. Election for officers and members of the Committee on Nominations shall be held Friday, August 28, 1987 at 7:00 AM.

2. If nominations are made from the floor, there shall be no seconding speeches.

Jean Caron, Chair, Maine, Area IV

Sandra Brown, Arkansas, Area III

REPORT OF THE NOMINATING COMMITTEE

COMMITTEE MEMBERSHIP

The Nominating Committee membership remained as elected at the August 1986 Delegate Assembly. The Committee met once, in Chicago on February 20, 1987 and by conference call on May 28th. The names of the members and their areas of representation are:

Area I	Ann Petersen
Area II	Florence McGuire
Area III	Lula Finley
Area IV	Sylvia Edge, Chairperson

COMMITTEE MEETINGS

At the February 20 meeting in Chicago, the Committee reviewed the sections of the By-laws and Standing Rules of the National Council concerning the Nominating Committee and the process of nomination. In compliance with Standing Rule IV the Committee developed Campaign Guidelines to be circulated to each nominee placed on the slate. The Committee decided that individuals nominated at the Delegate Assembly must submit a completed Candidate Information, Consent to Serve, and a signed Campaign Guidelines forms. Forms can be obtained prior to the Delegate Assembly from the Nominating Committee Chairperson. A copy of the Campaign Guidelines is enclosed with this report.

The Committee Chairperson had requested all Member Boards to submit names of qualified individuals to serve as officers of the National Council of State Boards of Nursing by February 19, 1987. The Committee received nominations or endorsements of 24 candidates from 28 jurisdictions. The nominees represented each area of the National Council as follows:

Area I	3
Area II	10
Area III	8
Area IV	3

Nominations or endorsements received by the time of the February 20 meeting were considered by the Committee. In the process of assembling a slate of nominees for two-year terms to the offices of Secretary, Treasurer, Area I Director, and Area III Director. The Committee further assembled a slate of nominees for the Committee on Nominations for a one-year term.

BALLOT

The following ballot was developed and unanimously adopted by the Nominating Committee on February 20, 1987. The information about each candidate is organized as follows under the position the candidate is seeking.

1. Name, Jurisdiction, Area
2. Present Board Position
3. Present Employment
4. National Council Offices or Committees
5. Educational Preparation
6. Statement of Interest

SECRETARY

1. **Loquist, Renatta,** South Carolina, Area III
2. Executive Director
3. South Carolina Board of Nursing
4. Director-at-Large, 1984 to 1986
   Exam Committee, 1983 to 1984
   Item Writer Consultant, 1982 to 1983
   Exam Committee, 1979 to 1981
5. University of South Carolina, Nursing Administration, M.N., 1982
   University of South Carolina, Nursing, B.S.N., 1967
6. It is indeed an honor to have my name placed in nomination for the office of Secretary of NCSBN. I have been a staff member of a Board of Nursing for 9 years and have previously served the Council in various appointed and elected positions for the past 8 years. I sense the unique and critical role the Council plays in the regulation of the nursing profession. I have an understanding of the Council's goals and objectives because of my participation on the Examination Committee and the Long Range Planning process as a previous NCSBN Board member. I believe the Council's top priorities should be to remain an organization dedicated to meeting the needs of its member boards in areas of test development, consultation on legal/disciplinary/competency issues and nursing education. I would assist the Council in achieving these goals by loyal participation in meetings and representation of the views of the member boards.

1. **Manahan, Kathleen F.**, RN, Minnesota, Area II
2. Board Member
3. Delegate, NCSBN, August, 1985
   Board representative to Area II meeting, Spring, 1985
   Board representative to Area II, Spring, 1987
4. University of Minnesota, Minneapolis, MN, Publ. Hlth. Nsg., MS, 1972 College of St. Teresa, Winona, MN, Nsg., B.S.N., 1965
5. As a member of the Minnesota Board of Nursing and as its President in 1985 and 1986, I have had the opportunity to participate in all matters related to NCSBN that came to the attention of the Board. Some examples are serving on the committees which gave priority ranking to the NCSBN goals and objectives recommending nominations for item writers and content experts for NCLEX, and proposing resolutions for consideration by the Delegate Assembly.

   In the early stage of development, the priority of NCSBN has naturally been the licensing examination. The Council is now entering a phase where it is crucial to develop relationships with Boards of Nursing which balance states rights with functions at a national level which can enhance the functioning of the Boards. Some activities that would be helpful include educational programs for Boards on regulatory issues, particularly in the area of discipline; research in areas such as licensure; and continuation of the disciplinary data bank. It is crucial at this time to convert our dreams for the future into realistic, manageable steps which foster the stability of the organization as it grows.

TREASURER

1. **Dorsey, Donna,** Maryland, Area
2. Board Staff, Executive Director
3. Treasurer, 1986 to 1987
   By laws Committee, 1984 to 1986
4. University of Maryland, Community Health Nursing & Nursing, M.S., August, 1975
   East Carolina University, Nursing, B.S.N., June, 1967
5. The issues facing the National Council of State Boards of Nursing require creative leadership approaches to meet member needs. New revenue sources must be identified that will meet goals without placing an undue burden on members boards. There continues to be a need for further development of a fiscal plan which reflects the rapid development of the organization. The Treasurer must assume the leadership in fiscal planning and monitoring to assure fiscal stability. I have functioned as Treasurer in other organizations and bring that experience to the Council. I want to continue the activity started by serving a full term as Treasurer.

1. **Malasanos, Lois J.,** Florida, Area III
2. Board Member
3. None
4. University of Texas, B.S.N.
   University of Iowa, B.A. in General Science, 1945-48
   University of Chicago, Nursing Education, 1949-52
   M.A.N. Ed., 1957-59; Clinical Specialist, Med-Surg
   University of Illinois Medical Center, Physiology - Ph.D., 1969-73

5. The opportunity to learn finance and accounting, negotiation of contracts and proposal preparation has been provided this candidate both in the classroom and through practical experience. The candidate has been in administrative positions since 1973. The budget administered since 1980 has exceeded $2 1/2 million. In addition the candidate is principal investigator of several federally funded grants. Issues of high priority to the organization include implementation of a valid and reliable national testing program for professional and technical nurses. The test must evolve as the nursing profession changes. The NCSBN could readily develop a data base for licensed nurses. The potential for research regarding offenses against nurse practice acts is great. Data yielded from such studies might serve in the development of preventive programs. Constant evaluation of procedures could lead to cost effective procedures for the National Council.

AREA I DIRECTOR

1. **Twigg, Nancy,** New Mexico, Area I
2. Executive Director
3. NCSBN Bylaws Committee, 1984 through 1988
4. University of Arizona, Nursing, M.S.N., 1979
   University of Arizona, Nursing, B.S.N., 1972
   Clark County and Community Hospital School of Nursing (formerly Springfield City Hospital School of Nursing), Nursing, diploma, 1964
5. It is a pleasure and honor to be considered for the Area I Director of the National Council of State Boards of Nursing. The opportunities in which I have had to serve various nursing organizations as an elected officer and committee chairman have given me the knowledge and skills necessary to provide leadership in Area I and to represent member boards nationally.

If elected, I will facilitate the achievement of the Council's goals and objectives through communication and education of the Council's mission to member boards, the nursing community and the public.

1. **Burress, Lonna,** Nevada, Area I
2. Executive Director
3. None
4. Orvis School of Nursing, Nursing, B.S.N., 1976
   University of Nevada-Reno, M.S.N. in progress
5. National Council of State Boards of Nursing has gained recognition for its unique role and contributions as a national organization in the last nine years. This is due to the capability resourcefulness of the organization, and the leadership and imagination of the members. With the focus on the future, I believe the primary priorities for the Council should be:
   - Continued provision of legally and psycometrically sound licensing examinations.
   - Implementation of the proactive long range plan which ensures financial stability and clear direction in organizational planning.
   - Continued emphasis on member board needs.

   I would welcome the opportunity to serve the Council and its constituents.

AREA III DIRECTOR

1. **Hutcherson, Carolyn,** R.N., M.S., Georgia, Area III
2. Executive Director
3. Executive Directors Conference Group Facilitator, August, 1984 - August, 1986
   Committee for Special Projects (CAT), January, 1987 - Present
4. University of Southern Mississippi, Nursing, MS, 1978
   Mississippi College, Nursing, B.S.N., 1977
   Gilfoy School of Nursing, Nursing, Diploma, 1965

5. In a time of unprecedented focus on health related issues, the National Council of State Boards of Nursing and Member Boards play a vital role in the regulation of nursing. Decisions about licensure requirements, educational standards, disciplinary activities and continuing competency have direct impact on the consumer of nursing care. Area member boards often share similar challenges and dilemmas and contact each other for assistance in problem solving. I believe that my background, interests and experience would enable me to facilitate the information exchange between Area III Member Boards and the National Council State Boards of Nursing.

1. **Ritter, Judie K.,** Florida, Area III
2. Executive Director
3. No officers or committees, however, co-sponsored a national workshop on Continuing Competence with the NCSBN, hosted by the Florida Board of Nursing in Orlando, Florida (March 26 & 27, 1984); served as Alternate Delegate to 1985 convention in Chicago; Delegate to 1986 NCSBN Convention in Williamsburg.
4. University of Florida, Nursing, Ph.D., 1986 to Present Boston University School of Nursing, Doctoral Work, Completed half of Course Work, D.N. Sc., 1979 Ohio State University, Nursing Education, Masters, 1969, Duke University, Nursing, B.S.N., 1968
5. The NCSBN has the vital mission of influencing health care policies affecting public health and safety. My background includes thirteen years experience as professional staff in a regulatory agency. This gives me a unique perspective in dealing with NCSBN concerns.

Priority issues include:

(a) Ensuring that our licensing examination is as current, valid, and reliable as possible.

(b) Responding to individual states' needs as they relate to the mission of the Council and ensuring response to their expressed concerns.

(c) Expanding our communication network to increase the speed and accuracy of information sharing.

It would be a privilege for me to serve the NCSBN.

COMMITTEE ON NOMINATIONS

AREA I

1. **Petersen, Ann,** Utah, Area I
2. Executive Secretary and Nurse Consultant
3. Director Area I, 1979 to 1981
   Director At Large 1982, Vice President, 1982 to 1984
   Test Service Eval. Committee, 1985-1986
   Nominating Committee, 1986-1987
4. University of Utah, Nursing, M.S., C.N.M., 1967
   University of Utah, Nursing, B.S., C.N.M., 1962
   Holy Cross Hospital School of Nursing, Nursing, Diploma, 1960
5. I am interested in serving on the Committee on Nominations for a second term. My previous experiences on both the Board of Directors and on Committees provides perspective on the need for well qualified candidates. It is critical to encourage the submission of a broad representation of individuals that can bring a variety of expertise and experiences to their position on the Board of Directors. I have been involved in Council activities for almost ten years and feel my experiences will provide me with the information and judgement needed to select excellent candidates for Board positions.

1. **Hinchey, Gwen,** California, Area I
2. President, California Board of Vocational Nurse and Psychiatric Technician Examiners
3. Board Representative, Area I Meeting, March 1987
4. University of San Francisco, M.A. 1983
   California State University at Sacremento, BS, 1977
   Fresno County General Hospital, School of Nursing, Diploma, 1950
5. I would like to actively participate on the Committee on Nominations.

I possess the vision, objectivity, motivation, leadership and assessment abilities to critically review and analyze the qualifications of individuals who wish to provide leadership for the National Council of State Boards of Nursing.

The impact of high technology, diagnostic related groups, and the Graying of America is having and will continue to have far reaching effects on health care delivery systems and all health professionals.

My experience and knowledge of current and future nursing trends and practices will enhance my ability to identify qualified individuals who can address the issues and meet the challenges necessary for the continued success and credibility of the National Council of State Boards of Nursing.

1. **Trimbo, Laura L.,** L.P.N., Minnesota, Area II
2. Board Member
3. Delegate, NCSBN, 1985
4. Rochester School of Practical Nursing, Practical Nursing, 1966
5. The ballot of the National Council should reflect the diversity as well as the similarities within and among the Member Boards. I will seek to prepare as balanced a ballot as possible.

1. **Loversidge, Jacqueline M.,** R.N., M.S., Ohio, Area II
2. Assistant Executive Secretary
3. Committee for Special Projects, 1/87 - Present
4. Wright State University, Nursing, M.S., 12/85
   Ohio University, Nursing, B.S.N., 6/82
   Muhlenberg Hospital School of Nursing, Nursing, Diploma, 6/73
5. I have 14 years worth of experience in practice, management and education, and have been a board staff member since January, 1986. Although I am a relative newcomer to the Council, I have become acquainted quickly with both the organization and its members, and serve as a member of the Committee on Special Projects.

   In nursing management, one must learn to objectively evaluate job applicants. I hope that I would be able to use those skills by participating in preparing a slate of the most qualified, committed candidates who have clear priorities in mind.

AREA III

1. **Calico, Patricia A.,** Kentucky, Area III
2. Board Member, D.N.S., R.N.
3. Member, Convention Planning Committee, 1986-1988
   Delegate Representative, 1987
   Alternate Delegate, 1985 and 1986
   Delegate Representative, 1983
4. Indiana University, Nurs. Admin., D.N.S., 6/86
   Wright State University, Counseling, M.A., 1979
   Boston University, Rehabilitation Nursing, C.A.G.C., 1970
   University of Maryland, Med/Surg Nurs., M.S., 1968
   University of Kentucky, Nursing, B.S.N., 1965
5. The Nominating Committee provides an essential role in enhancing the well-being of the NCSBN. An excellent candidate slate assures that the Council's work will be professionally conducted. Whatever election decisions are made by the Delegate Assembly. My involvement with the NCSBN since 1981 as a Board Member, Delegate, and Committee Member provides a perspective of the NCSBN and it's membership necessary for the candidate selection role. I have served as a Kentucky League for Nursing and a Kentucky Nurses Association Nominating Committee member, and I would be pleased to further serve the NCSBN as a Nominating Committee member.

1. **Jackson, Mary Elizabeth,** Texas, Area III
2. Board Member President
3. None at this time.
4. The University of Texas, Austin, Textile Sc., B.S., Jan. 1974, Bastrop High School
   I am presently working on a masters degree from the University of Texas, Tyler, and I have taken graduate work from the following institutions of higher education: University of Texas, Austin; Southwestern Oklahoma State University; and University of Oklahoma.

5. As a member of the RN Board of Nurse Examiners for the State of Texas for 4 years, I have during this time gained a strong working knowledge of the problems and concerns of both the professional nurse working in the field and the regulatory boards of this profession. I believe that a consumer member on the nominating committee could bring a different perspective to the selection process that this committee accomplishes. Through my committee work on other boards, I feel that I have the necessary skills to facilitate the selection of leaders for the NCSBN in a very positive manner.

AREA IV

1. **Brodeur, Constance,** M.Ed., RN, New Hampshire, Area IV
2. Member
3. None
4. Rivier College, Education, M.Ed., 1978
   Boston College, Nursing, BSN, 1955
5. As a member of the National Council of State Boards of Nursing, Inc., I will actively seek the individuals who are professionally current, and knowledgeable creative leaders in both nursing practice and education to implement the mission of the Council which is to promote the public welfare through effective and safe nursing practice. Over a period of 25 years I have been an active participant in the New Hampshire Nurses Association and the National League for Nursing. I have willingly accepted leadership positions in both organizations. My current involvement as a member of the New Hampshire Board of Nursing has broadened my vision and further impacted upon me the importance of the value of committed leadership within the National Council.

   It is my belief that the mission of the Council will be achieved through the efforts of individuals who have the foresight and commitment to implement collaborative strategies between nursing practice and nursing education in pursuit of the public welfare.

1. **Seymour, Rosalee J.**, Delaware, Area IV
2. Executive Director
3. Chairperson-Election Committee, August, 1986 Convention
4. University of Delaware/Newark, Delaware, Doctoral student - Educational Administration and Leadership
   University of Delaware/Newark, Delaware, Master of Science Degree - (earned), 1980
   West Chester University/West Chester, Pennsylvania, Bachelor of Science Degree - Education (earned), 1971
   Hahnemann Hospital School of Nursing/Philadelphia, Pennsylvania, Diploma (earned), 1964
5. I am a leader and a seeker and finder of both career and personal growth experiences.

   I can offer a Nominating Committee my patience, evaluative skills, time and energy. I can also offer my sense of humor. Each of these qualities and skills will facilitate achievement of the goals and objectives of the Council particularly if they are coupled with an enthusiastic willingness to learn more about those goals and objectives through the vehicle of committee participation.

   Top priority issues for the Council for the next five years should be computerized testing, close monitoring of industrial take over of health services and the impact of that on the organization and nursing and economic solvency.

CAMPAIGN PROCEDURES

Introduction: The Committee on Nominations was directed by the 1986 Delegate Assembly to prepare electioneering guidelines for distribution to candidates for Officer or Committee on Nominations positions. Attached are the Campaign Procedures that have been developed for use by candidates seeking these positions.

The Campaign Procedures are based on the belief that candidates will design and conduct a campaign in an honest and ethical manner with due consideration for the rights and privileges of fellow candidates. The Campaign Procedures are not designed to encourage campaign activities, but to outline reasonable and equal limits to the usual activities that are a part of an electioneering process.

Purpose: The Campaign Procedures were developed to accomplish the following:

- assist candidates running for Officer or Committee on Nominations positions in designing a campaign effort that speaks to their personal qualifications, goals and objectives, and stands on issues for the office sought; and

- provide delegates with the information needed to use in selecting candidates to serve as Officers and Committee on Nominations members for the National Council.

The implementation of a campaign for candidates is expected to be conducted in a cost-efficient manner with consideration for the rights and privileges of fellow candidates.

CAMPAIGN PROCEDURES

Candidates for Officer or Committee on Nominations Positions of the National Council shall comply with the following procedures when campaigning for election:

A. Once the Slate has been officially announced, the candidates for Office or the Committee on Nominations may:

1. Organize a campaign strategy and appoint a campaign chairperson

2. Notify National Council of campaign chairperson

3. Prepare and circulate campaign material to Member Boards prior to Convention

4. Solicit Member Board support

The candidates for Office or the Committee on Nominations may:

1. Distribute campaign badges or materials at Convention after the first business session.

2. Prepare for display at Convention no more than two campaign posters/banners. The posters/banners will be displayed in a designated area according to the rules of the Convention center. (This information will be provided candidates no later than 45 days prior to Convention on a year by year basis.)

3. Schedule and host any campaign function not in time conflict with the schedule of the Convention center. Cost of any such function will be the responsibility of the candidate(s) and will be dependent on availability of the Convention Hotel to comply with the function request. Campaign functions must be pre-arranged with the National Council's Convention Manager.

4. Distribute campaign materials and solicit votes EXCEPT DURING BUSINESS SESSIONS OF THE CONVENTION.

NO BADGES, CAMPAIGN MATERIAL OR CAMPAIGN POSTERS CAN BE DISPLAYED WITHIN 50 FEET OF THE VOTING AREA. FURTHER, NO SOLICITING OF VOTES CAN OCCUR WITHIN 50 FEET OF THE VOTING AREA.

As a candidate for an Officer or Committee on Nominations Position, I have read the above Campaign Procedure and agree to comply with the rules as presented.

_____
Signature of Candidate

_____
Date

(This form must be returned with the consent to serve form.)

REPORT OF THE PRESIDENT

It is my privilege to welcome all members and guests to the Ninth Annual Convention of the National Council of State Boards of Nursing with its central theme "Mastering the Changes". The Board of Directors extends greetings and best wishes to all in attendance. A special word of appreciation is extended to those individuals who have generously given of their time and creative talents to the National Council. As the Book of Reports clearly illustrates, our organization continues to adhere to its mission which is to promote "public policy related to the safe and effective practice of nursing." It is an honor to report on major accomplishments that have taken place over the past year.

In the Fall of 1986 the Board of Directors completed the rank ordering of objectives in the Long Range Plan based upon responses from Member Boards. As in the past, testing continues to be our first priority. To this end, the Examination Committee reviewed the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses (Study)* and its implications for licensure examinations. The Examination Committee subsequently revised the RN Test Plan to coincide with the findings of the *Study*. A second team of the Examination Committee was appointed in the Spring of 1987 to relieve the workload of the Examination Committee. This team reviewed the issue of pass/fail score reporting and is exploring the use of computer simulation testing as a mechanism for testing continuing competence.

The Special Projects Task Force began work in the Fall of 1986 on the computer adaptive testing project and continued pursuit of external funding for this project. A grant was submitted to the W.K. Kellogg Foundation for a project in computer simulation testing. As of this publication date, the Foundation's decision is still pending.

The Task Force on Examinations for the Future reviewed issues related to future examination development and analyzed models that might be used by Member Boards that have changes in their entry into practice requirements.

In keeping with our need to safeguard the examination, the Administration of Examination Committee completed a study of the relationship between security procedures and organizational structure of Member Boards that has both immediate and long term implications.

Research continues to be another important National Council activity. The *Study of Nursing Practice and Role Delineation and Job Analysis for Entry Level Performance of Registered Nurses (Study)* was presented at each of the four regional Area meetings in the Spring of 1987. These sessions were well attended and provided a beneficial forum for the discussion of research findings and implications for public policy. The job analysis for practical/vocational nurses is in progress with a final report expected in 1988.

Nursing practice has been another focal area for the organization during the year. The Nursing Practice and Standards Committee reviewed the findings of the *Study* for implications in legal standards of nursing practice. In addition, the National Council continues to act as an information clearinghouse for the entry into practice and continued competence issues. Monographs on the chemically dependent nurse and the disciplinary data bank have been completed.

From an operational perspective, the National Council has taken several important steps. Specifically, the Finance Committee has developed policies for the management and investment of funds. The Committee also recommended the Budget for Fiscal Year 1988 based on our organization's assumptions and consistent with its long term plan. Planning during the year continued as a function of the Board of Directors consistent with the operational plan. The Board of Directors continues to evaluate the feasibility of the National Council becoming its own test service given its goals and objectives. This activity will continue to be evaluated in terms of assumptions about the organization and its testing programs.

Another study of importance is the proposed bylaws revision. The proposed revisions were presented at the regional Area meetings in the Spring of 1987 with the major issues identified as membership and voting.

The National Council recognizes the importance of information technology and effective communication. Because of this recognition, the National Nursing Licensee Data Base Committee continues to explore the feasibility of developing and maintaining a national data bank of nursing licensees. Plans are also underway to implement an electronic mailing system that will enhance communications among Member Boards and the National Council. The system will be introduced at convention where training sessions will be held for interested Member Boards. Other efforts to improve communications include the Board of Directors' recent initiation of an open forum whereby Member Boards can raise issues and concerns for Board consideration. Communication between the Board and Member Boards is further enhanced through the liaison role of the Area Directors who coordinate and relay vital information to the Board of Directors at its regularly scheduled meetings.

The National Council continues to strengthen relationships with those individuals and organizations that shape public policy and promote safe and effective nursing practice. Attendance and presentations at national nursing and health care meetings help to foster these relationships. The Council also continues to enhance relationships by means of liaison meetings between the Presidents and Executive Directors of the American Nurses' Association and National League for Nursing and liaison meetings with the National Association for Practical Nurse Education and Service and the National Federation of Licensed Practical Nurses.

Another major activity during recent months has been the preparation of a response to the Internal Revenue Service with respect to the 501(c)(3) tax status of the Council. This report would be remiss were it not to recognize the outstanding efforts of Member Boards, Board members and staff for their swift and dedicated efforts in responding to this request.

It is an honor to recognize everyone who made this year's accomplishments possible. Member Boards, the members of the Board of Directors, committees, task forces, staff, Testing Service, Data Center and the many individuals that have so generously contributed to organizational accomplishments during the year deserve our thanks and appreciation. It is with enthusiasm and excitement that I look forward to meeting with you at our Ninth

Annual Convention in Chicago. Together we will work to shape the future of the National Council of State Boards of Nursing and to master any and all change in our effort to promote public health, safety and welfare.

Ruth L. Elliott, Oklahoma, Area III
President

REPORT OF THE VICE PRESIDENT

Since assuming the office of Vice President in August of 1986, I have attended one orientation meeting for new Board members and four regular meetings of the Board of Directors.

Other activities I have participated in are:

Two meetings and a telephone conference call of the Board of Directors' Coordinating Committee

One meeting of the Board of Directors' Legal Affairs Committee

At the request of the President, assumed Chairmanship of the Task Force on Examinations for the Future and presided at four meetings of this Task Force

My first year on the Board of Directors has provided me with a great respect and understanding of the multitude of complex issues facing the National Council of State Boards of Nursing, Inc. There is much to know and care about regarding this organization. As a Board, we have had to make many difficult decisions this past year, and we have another important year ahead of us.

The input the Board has received this year from individual Member Boards regarding their opinions and concerns about specific issues has been extremely helpful to the Board in facilitating decision making which best represents the perspective of all members of the Council. We encourage you to continue to assist us in going forward in our work regarding the Council's programs and services by keeping the channels of communication open between the Board of Directors and Member Boards.

Joan Bouchard, Wyoming, Area I
Vice President

REPORT OF THE SECRETARY

As I have over the past three years I continued to review the minutes of the scheduled meetings prior to distribution to the members of the Board of Directors. A summary of major actions for each meeting was reviewed prior to distribution to the Member Boards.

My other National Council activities of the past year have included participation in the Board Retreat and membership on the Legal Affairs Committee.

The members of the Board of Directors this year have again had an extremely productive relationship, and I thank my fellow members and the National Council staff for their continued assistance and support.

It has been a privilege and pleasure to serve as the National Council's Secretary for the past three years. The ability to plan and participate in the decision making process, provided an excellent opportunity to observe the National Council's continued achievements. Finally, I am especially grateful to the Washington State Board of Nursing and the Department of Licensing for their support.

Constance E. Roth, Washington, Area I
Secretary

REPORT OF THE TREASURER

The major priority for this past year has been the implementation of the program budget. Converting the budget format from the National Council's original budget format to a program budget has not been a simple task. It has required countless hours of work by the staff to rework the approved budget into the program format. Throughout the year the budget required careful monitoring to determine whether variations were due to incorrect allocations or actual change in the budget. New formats were designed and revised for all financial reports to meet the needs of the Finance Committee and the Board of Directors.

The new budget format has permitted an indepth analysis of National Council expenditures and revenue by program category. This has proven very beneficial in planning fiscal needs and activities. Monitoring of the budget can now be done by program which permits better evaluation of the fiscal impact of each National Council activity.

Quarterly financial reports and statements on investment activity have been presented to the Board of Directors along with the report and recommendations of the Finance Committee. Expenditures have been maintained within the budgetary allowances. Revenue has been higher than anticipated due to an increase in the projected number of examination candidates, slightly higher return on investments and higher revenues from publications. Therefore, the excess revenue over expenditures was higher than projected in the FY 87 budget.

The proposed budget for FY 88 was prepared by the Finance Committee and presented to the Board of Directors. The budget reflects revenue adequate to support expenditures.

Current fiscal policies were reviewed. New policies were developed by the Finance Committee and presented to the Board of Directors. Additional policies have been identified for development during FY 88.

Although additional revenue sources are currently being evaluated, the National Council Licensure Examination continues to be a major source of income. After careful review of the revenue projections and fiscal needs of the National Council, the Finance Committee recommended an increase in the National Council portion of the examination fee. That recommendation was presented to the Board of Directors.

I was surprised at the fiscal impact of the resolutions approved by the Delegate Assembly last year. The cost of the resolutions are additions to the already approved budget and could adversely affect the budget. To provide the cost of resolutions to the delegates, the fiscal impact statement was developed and approved by the Finance Committee. All resolutions presented at the Delegate Assembly will have the fiscal impact stated. This will permit the delegates to consider all aspects of the impact of a resolution and make an informed decision. The Board of Directors has also added a member of the Finance Committee to the Resolutions Committee for the purpose of reviewing the fiscal impact of resolutions presented at the Delegate Assembly not previously published in the Book of Reports.

As Treasurer I have chaired all meetings of the Finance Committee and attended all meetings of the Board of Directors and Coordinating Committee. I also represented the

National Council at a reception marking the establishment of the Center for Nursing Research at the National Institute of Health and at the Division of Nursing workshop for reviewing and updating the criteria for future requirements for nursing personnel.

I want to thank a very hardworking Finance Committee for their support and assistance. Working with the Council staff and the Board of Directors has been a pleasure. I especially want to thank Kathleen Hayden, Accountant and William Lauf, Deputy Director, Administrative Services for their work in implementing the program budget. I have enjoyed the challenges of this year and appreciate the opportunity afforded me by the Delegate Assembly to serve as Treasurer of the National Council. The support from Member Boards has made my role as Treasurer a rewarding experience.

Recommendation: The auditor's report for fiscal year 1986 be approved as presented.

Donna M. Dorsey, Maryland, Area IV
Treasurer

Financial Statements and Auditors' Report

National Council of State Boards of Nursing, Inc.

June 30, 1986 and 1985

AUDITOR'S REPORT

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

We have examined the balance sheets of the National Council of State Boards of Nursing, Inc. (a not-for-profit Pennsylvania corporation) as of June 30, 1986 and 1985, and the related statements of revenues and expenses, changes in fund balance and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of the National Council of State Boards of Nursing, Inc. at June 30, 1986 and 1985 and the results of its operations, changes in fund balance and changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Grant Thornton Accountants and Management Consultants
Chicago, Illinois
July 31, 1986

BALANCE SHEET
June 30, 1986

Assets	1986	1985 (Restated Note B)
Cash and cash equivalents		
Bank checking accounts	$ 49,161	$ 42,864
First Chicago Money Market	2,213,497	1,276,383
Continental Money Market	98,649	110.841
Crocker National Bank Money Market	2,546	110,816
	2,362,853	1,540,904
Accounts receivable		
Royalties	51,574	21,393
Interest and other	61,909	107,607
	113,483	129,000
Publication inventories (note A3)	21,579	10,966
Other assets and prepaid expenses	47,175	11,885
Prepaid disaster plan costs (note A4)	191,008	174,650
Investments - at cost (market value $1,512,000 in 1986 and $1,510,000 in 1985)		
U.S. government instruments	1,166,260	1,204,080
Commercial paper		195,768
Certificates of deposit	300,000	
	1,466,260	1,399,848
Property and equipment - at cost (note A2)		
Furniture and fixtures	89,548	71,179
Equipment	266,343	208,531
	355,891	279,710
Less accumulated depreciation	187,597	100,209
	168,294	179,501
	$4,371,652	$3,446,754

Liabilities and Fund Balance	1986	1985 (Restated Note B)
Accounts payable	$ 225,534	$ 73,551
Accrued expenses and withheld taxes	41,165	29,225
Deferred revenue		
Examination fees collected in advance (net of prepaid processing fees of $72,376 in 1986 and $62,429 in 1985)	1,787 043	1,302,099
Contract and convention fees	121,430	41,385
	1,908,473	1,343,484
Commitments (note D)		
Fund balance		
Unrestricted	2,196,480	1,389,894
Board designated Nursing study costs		610,600
	2,196,480	2,000,494
	$4,371,652	$3,446,754

The accompanying notes are an integral part of these statements.

STATEMENT OF REVENUES AND EXPENSES
Year ended June 30, 1986

	1986	1985 (Restated Note B)
Revenue		
Examination fees	$3,512,236	$3,260,450
Less cost of development, application and processing	2,416,412	2,256,370
Net examination fees	1,095,824	1,004,080
Contract fees (dues)	180,000	180,000
Publication royalties	99,254	52,931
Investment income	232,965	294,322
Convention fees	35,904	29,621
Honorariums and other	3,371	2,868
Total revenue	1,647,318	1,563,822
Program expenses		
Test security and administration	51,478	22,714
Nursing standards and practice	13,711	13,341
Convention costs	42,122	44,463
Research	15,844	64,378
Publications	41,489	25,761
Nursing Study - ACT project	324,413	389,400
Other	45,100	41,254
Total program expenses	534,157	601,311
Organizational expenses		
Salaries and benefits - staff	492,969	387,094
Travel and expenses (exclusive of Board)	31,764	23,642
Travel and expenses - Board	71,563	37,928
Insurance	5,266	2,930
Printing and supplies	22,135	18,750
Professional services	82,820	76,856
Library subscriptions and memberships	3,091	2,799
Sundry	2,122	700
Total organizational expenses	711,730	550,699

Occupancy expenses		
Rent and utilities	$116,491	$88,725
Telephone	15,435	10,793
Postage	13,759	11,053
Equipment costs		
Lease and maintenance	24,670	23,574
Depreciation	35,090	15,134
Moving		6,740
Total occupancy expenses	205,445	156,019
Total expenses	1,451,332	1,308,029
Excess of revenue over expenses	$195,986	$255,793

The accompanying notes are an integral part of these statements.

STATEMENT OF CHANGES IN FUND BALANCE
Years ended June 30, 1986 and 1985

		Board Designated For:		
	Unrestricted	Test Security Fund	Nursing Study Costs	Total
Fund balance at July 1, 1984	$ 729,027	$ 15,674	$1,000,000	$1,744,701
Excess of revenue over expenses for the year - restated (note B)	645,193		(389,400)	255,793
Transfer from test security fund	15,674	(15,674)		
Fund balance at June 30, 1985 - as restated	1,389,894		610,600	2,000,494
Excess of revenue over expenses for the year	520,399		(324,413)	195,986
Transfer from nursing study costs (note D)	286,187		(286,187)	
Fund balance at June 30, 1986	$2,196,480			$2,196,480

The accompanying notes are an integral part of this statement.

STATEMENT OF CHANGES IN FINANCIAL POSITION
Year ended June 30, 1986

	1986	1985 (Restated Note B)
Sources of cash		
Excess of revenues over expenses	$ 195,986	$ 255,793
Add (deduct) items not using (providing) cash		
Depreciation of property and equipment	87,388	43,037
Amortization of prepaid disaster plan costs	33,241	
(Increase) decrease in receivables	15,517	(54,265)
(Increase) in inventories and other assets	(99,503)	(181,099)
Increase in deferred revenues	564,989	148,622
Increase (decrease) in accounts payable and accrued expenses	163,923	(217,815)
Cash provided (used) by operations	965,541	(5,727)
Decrease in investments		928,463
	965,541	922,736
Applications of cash		
Increase in investments	66,411	
Additions to property and equipment	76,181	103,190
	142,592	103,190
Increase in cash and equivalents	822,949	819,546
Cash and cash equivalents at beginning of year	1,540,904	721,358
Cash and cash equivalents at end of year	$2,363,853	$1,540,904

The accompanying notes are an integral part of these statements.

NOTE A: SUMMARY OF ACCOUNTING POLICIES

A summary of the Council's significant accounting policies consistently applied in the preparation of the accompanying financial statements follows.

1. Accounting Method

The Council prepares its financial statements on the accrual basis of accounting. Examination fees are collected and processing costs incurred in advance are deferred and recognized at the date of the examination.

2. Depreciation

Depreciation is provided for in amounts sufficient to relate the cost of depreciable equipment and leasehold improvements to operations over their estimated service lives on the straight-line method. During 1986 the Council adjusted certain equipment lives to reflect updated estimates of service periods. This change had the effect of increasing depreciation by $36,413.

3. Inventories

Inventories, primarily publications, are stated at the lower of the actual cost or market. Cost is determined principally by specific identification.

4. Prepaid Disaster Plan Costs

The Council incurred supplemental reprinting costs for examinations in 1985 and 1986. The costs are being amorized over a six-year period on a straight-line basis.

5. Services of Volunteers

Officers, committee members, the Board of Directors and various other non-staff associates assist the Council in various program and administrative functions without renumeration. No value has been ascribed for such volunteer services because of the impracticality of their measurement.

NOTE B: ADJUSTMENT OF PRIOR PERIOD EXAMINATION FEES

The financial statements for 1985 have been restated to correct an error noted in deferred examination fees at June 30, 1985. The effect of the restatement was to increase examination fees and the excess of revenues over expenses by $141,586 for the year ended June 30, 1985.

NOTE C: PURPOSE AND TAX STATUS

The Council is a nonprofit corporation organized under the Statutes of the Commonwealth of Pennsylvania. Its purpose is to serve as a charitable and educational organization through which State Boards of Nursing act on matters of common interest and concern affecting the public health, safety and welfare including the development of licensing examinations and standards in nursing. It is exempt from Federal income tax under Section 501(C)(3) of the Internal Revenue Code as indicated in a letter dated July 24, 1980. Therefore, the accompanying financial statements reflect no provision for income taxes.

NOTE D: COMMITMENTS

Operating Lease

The Council's lease agreement for official facilities extends through August 31, 1989 and calls for monthly payments of $8,621, which are adjusted annually based on the changes in the Consumer Price Index. In addition to basic rental, the Council is required to pay for electricity.

The Council's future minimum rental payments required under this long-term lease are as follows:

Period ending	
June 30, 1987	$103,452
June 30, 1988	103,452
June 30, 1989	103,452
July and August, 1989	17,424
Total minimum lease payments	$327,780

Data Center Contract

The Council has entered into an agreement for the design of a computerized system for processing test applications. In connection with this system, the agreement provides for the test service company to process the test applications with a minimum annual fee of $343,000 through July, 1988.

Nursing Study

The Council entered into a contract with an outside research organization to conduct a study of nursing practice and role delineation and job analysis of entry level performance of registered nurses. The contract called for aggregate payments of $713,000 over the period from August, 1984 to April, 1986.

The Council designated $1,000,000 to fund this contract and associated administrative costs through 1986. In the year ended June 30, 1985, $389,400 of this fund was expended. In the year ended June 30, 1986, $324,413 of this fund was expended and the balance of the fund was transferred to unrestricted funds.

REPORT OF AREA I DIRECTOR

As Area I Director, I have attended all scheduled Board of Directors' meetings and conference calls. I chaired the Legal Affairs Committee for the Board of Directors and was Chair of the Rules Committee at the August 1986 Convention.

During the winter of 1987, Area I was responsible for providing articles for the National Council of State Boards of Nursing, Inc. publication *Issues*. Many informative and outstanding articles were provided by Member Boards in Area I.

The Area I meeting was held March 23-24, 1987 in Kahului, Maui, Hawaii with forty board and staff members in attendance. Fourteen of the eighteen Boards of Nursing were represented. We had several guests who participated at the meeting. They were Dr. Ruth L. Elliott, President, NCSBN; Dr. Eileen McQuaid Dvorak, Executive Director, NCSBN; Dr. Carolyn Yocom, Assistant Director of Testing Services, NCSBN; Mr. Peter Bailey, Chairman of National Nursing Licensee Data Base Committee and Chief of Demographic, Cartographic and Health Statistics Division of Research & Statistical Studies, State of South Carolina; Mr. Bruce Kramer and Meredith Mullins of CTB/McGraw-Hill. Other guests included Mr. Duane Alexenko, Chairperson, Umpequa Community College, Roseburg, Oregon; Marilyn Newcomer Culp, Assistant Professor in Nursing, Southern Oregon State College, Ashland, Oregon; Ms. June Delong and Ms. Betty Lister, faculty members from the State of Michigan.

The Hawaii Board gave us a very gracious and warm welcome with leis, macadamia nuts, pineapple and many other mementos to take home. They were most gracious host & hostesses.

Dr. Carolyn Yocom gave a thorough presentation of A *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses* which was followed by group discussion.

During the meeting, the following topics were presented, discussed, and updated.

Internal Revenue Service, Nursing Practice and Standards, and Department of Defense request were reported by Dr. Eileen McQuaid Dvorak.

National Nursing Licensee Data Base
Status of Computer Adaptive Testing (CAT)
Status of Computer Simulated Testing (CST)
Report of Futures Committee
Bylaws Review
Report from Committee on Nominations
Electronic Mail
Health Club Membership

In addition each Member Board submitted a one page written report regarding their activities which was distributed to all who attended.

Area I's spring meeting was very informative. Input from the members on the issues presented was valuable.

Our next Area I Meeting will be held during the August 1987 Convention in Chicago, Illinois.

I want to thank the members from Area I for electing me your Director. It has been a most rewarding experience working with all of you these last three years and representing you on the Board of Directors.

Dorothy J. Davy, Oregon
Area I Director

REPORT OF THE AREA II DIRECTOR

As Area II Director of the National Council of State Boards of Nursing, I have participated in all regular meetings of the Board of Directors and all conference calls of the Board of Directors.

In addition, I served as a member of the Public Relations (Communications) Committee of the Board of Directors and participated in all meetings and conference calls of that committee.

Correspondence was sent to all Area II Member Boards in October requesting input for Board actions and again in December requesting input for the Area II Meeting held in Columbus, Ohio April 9-11, 1987. I wish to express my appreciation to Rosa Lee Weinert, Executive Secretary, Ohio Board of Nursing, who planned and organized the arrangements for the meeting.

All Boards with the exception of one, were represented at the Area II Meeting. Rosa Lee Weinert, the staff, and the Board of Ohio were most gracious and extended every effort to make our meeting both enjoyable and productive.

The major areas presented for information and discussion were:

1. Licensee Data Base
2. Proposed Bylaws revisions
3. Revised RN Test Plan
4. Scoring mechanism for the NCLEX examinations including pass/fail scoring
5. Computer Adaptive Testing (CAT) and Computer Simulated Testing (CST)
6. The North Dakota activities relative to Entry into Practice
7. States' specific concerns

Approximately one hundred registrants attended the April 10, 1987 presentation of the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses.*

The Area II representatives agreed to support in concept a resolution to study how to facilitate interstate endorsement.

Numerous National Council officers, staff and committee chairs and members were represented and shared a variety of information with the Boards and received feedback to share with their respective groups.

Thank you for the privilege of serving you this past year.

Leota Rolls, Nebraska
Area II Director

REPORT OF THE AREA III DIRECTOR

As Area III Director of the National Council of State Boards of Nursing, I have participated in the scheduled meetings of the Board of Directors. I have served on the Communications (Public Relations) Committee of the Board of Directors. In addition, I represented the National Council at the 75th Diamond Jubilee of the Nursing Practice Act roasting of Merlyn Maillian, Executive Director, Louisiana State Board of Nursing.

Area III Member Boards met April 2-3, 1987, in Little Rock, Arkansas. There were thirteen Member Boards in attendance. Also in attendance, were Ruth Elliott, President; Eileen McQuaid Dvorak, Executive Director; and Carolyn Yocom, Assistant Director of Testing Services. The major agenda items included the following topics:

1. The *Study of Nursing Practice and Job Analysis and Role Delineation of Entry Level Performance of Registered Nurses*
2. National Nursing Licensee Data Base
3. Test Plan and Scoring Mechanism
4. NCSBN Update
5. Bylaws Revision Plan
6. Status of Computer Adaptive Testing and Computer Simulated Testing Projects
7. Arrangement of Delegate Assembly Agenda Items to Allow Adequate Discussion of Issues Which Affect Member Boards
8. Internal/External Programs for Nursing Students in Clinical Facilities
9. Unlicensed Personnel
10. Reporting of Examination Scores (Pass/Fail)
11. Future Directions for Licensing Examinations
12. In Relation to Disciplinary Activities:

    a) Mandatory Reporting by Facilities, Peer Review Committees, Insurance Companies, etc.

    b) Subpoena Power - Access to Records

    c) District Review Committees

    d) Use of Clinical Investigators to Investigate Incompetent Practice and Malpractice Complaints
13. The New Disciplinary Reporting Form
14. Employment With a Lapsed License

The Area III Meeting was successful, and the Arkansas Board of Nursing was very hospitable. The 1988 spring meeting of Area III will be held in Alabama, and in 1989, the meeting will be held in Louisiana.

Serving as Area III Director has been a rewarding experience. I appreciate the support I've received from Area III Member Boards. I extend a warm "Thanks" for giving me the privilege of serving you this past year.

Sandra Brown, Arkansas
Area III Director

REPORT OF THE AREA IV DIRECTOR

The thirteen (13) Area IV Member Boards met April 28-29, 1987, in Boston, Massachusetts. Also in attendance representing the Council were: Dr. Ruth L. Elliott, President; Dr. Eileen McQuaid Dvorak, Executive Director; Walter P. Bailey, Chairman, National Nursing Licensee Data Base Committee; and Dr. Carolyn J. Yocom, Assistant Director of Testing Services.

We were priviledged to have Dr. R. Louise McManus as our honored guest at the Area Meeting.

The 1988 spring meeting of Area IV will be held in Hartford, Connecticut.

As a member of the Board of Directors, I have served as Chairman of the Communications Committee.

Thank you for the opportunity to serve you as Area IV Director.

Jean C. Caron, Maine
Area IV Director

REPORT OF THE DIRECTOR AT LARGE

As Director at Large, I have attended all meetings of the Board of Directors and the Area IV Meeting in Boston. In addition to those duties, I serve as a member of the Communications Committee and the Bylaws Committee.

Thank you for the privilege and honor of serving the Council. A special thank you to staff for those exceptional skills and talents that maintain this organization's viability.

See you in Chicago.

H. Jean Bruhn, Pennsylvania
Director at Large

Recommendations

The following recommendations are submitted to the 1987 Delegate Assembly for its consideration:

The Board of Directors recommends that the portion of the examination fee for National Council services be established at $16.49 per candidate effective for the period of October 1988 through July 1990. (See page 53 for further details.)

The Board recommends that the RN job analysis scheduled for Fall 1987 be completed as scheduled, and using the same questionnaire as used in the original study, to determine the impact of Diagnostic Related Groups (DRG) implementation and the "nursing shortage" on the nursing care activities engaged in by newly-licensed registered nurses and subsequently on the validity of the NCLEX-RN Test Plan.

The Board of Directors recommends that data collection instruments developed for use in future job analysis studies be redesigned to facilitate identification of qualitative differences in the performance of nursing care activities by different levels or categories of nursing personnel.

Request for Guidance

In accordance with the long range plan, the Board of Directors has reviewed the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses* for implications for continuing licensure of nurses. The Board requests direction from the Delegate Assembly on whether or not the National Council should explore mechanisms for identifying minimum levels of ongoing (continued) competence of licensed nurses and methods for testing the maintenance of minimum competence.

Meetings

The Board of Directors of the National Council of State Boards of Nursing, Inc. met on the following dates:

August 9, 1986
November 6-7, 1986
February 10-12, 1987
May 5-7, 1987

The preconvention meeting of the Board is scheduled for August 23-25, 1987 in Chicago, Illinois.

1986-1987 Adopted Activities

In January 1987, following responses from Member Boards, the Board of Directors approved the new rank ordering of National Council Goals and Objectives (see Attachment A). Specific Board activities to support the Goals were detailed in the National Council two year Operational Plan distributed at the 1986 Delegate Assembly.

Committees

The following Board committees assisted with the work of the Board of Directors on behalf of the National Council:

Coordinating Committee
Communications Committee
  Convention Program Planning Committee
Legal Affairs Committee

The following standing and ad hoc committees and task forces assisted with the work of the Board and of the National Council:

Administration of Examination Committee
Bylaws/Special Committee
Special Projects Task Force
Examination Committee
Executive Director Conference Group Facilitators
Finance Committee
Licensee Data Base Committee
Nursing Practice and Standards Committee
Task Force on Examinations for the Future

Appointments

To the Board of Trustees of the Commission on Graduates of Foreign Nursing Schools - Lois R. Scibetta, Kansas, Area II.

Board Activities

Reviewed reports at each meeting from officers, staff, test service, data center, the Board and standing committees, ad hoc committees, and task forces; and took action as appropriate.

Recompiled the two-year Operational Plan to integrate directives from the Delegate Assembly.

Authorized collaboration with the American Society of Clinical Pathologists on Computer Adaptive Testing (CAT) proposal. After determining external funding efforts for Phase I of the CAT project were not successful, approved internal funding for the first phase of the project. Approved two CAT software programming options, external and internal, to ensure software availability and warranty at reasonable price. Monitored the progress of CAT.

Adopted a motion to make time available for Member Boards at each regularly scheduled Board of Directors' Meeting to allow Member Boards to meet with Directors and present issues and concerns for consideration.

Adopted amended guidelines for Member Board participation at the "Open Forum" at regularly scheduled Board of Directors' Meetings.

Approved the use of guides for facilitating discussion of policy implications of the results of the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses* with Member Board and the nursing community during the 1987 Area Meetings.

Adopted a motion that increased the fee paid to CTB/McGraw-Hill for handscoring of the RN examination to $110.00. The total fee charged to candidates was increased to $125.00 effective with the February 1987 examinations.

Authorized proceeding with the two scheduled RN item writing sessions, the two scheduled RN panel of content experts session for 1987, and required the Board reevaluate the adequacy of the item pools again in Fall 1987.

Authorized the National Council to disseminate a request to Member Boards to enable use of NCLEX-RN and NCLEX-PN candidate data for research studies conducted by the Council. The request would remain in effect until such time when a Member Board submits written notice revoking such permission. All results will be reported in aggregate form with no identification of individual candidates or programs.

Adopted a motion to authorize the use of assumptions as set forth in revised staff documentation as the basis for continuing to investigate the feasibility of the National Council becoming its own test service. A possible plan of incremental steps for producing and implementing the licensing examinations in-house was developed in accord with Goal I, Objective A, Strategy 9 of the National Council's Long Range Plan. The plan is based on seven assumptions about the examinations, the mode of administration, and participation in administration responsibilities by Member Boards and National Council staff (see Appendix A for list of assumptions). Monitored the continued viability of assumptions.

Rejected a request from Dr. Peggy Primm to fund a project office for assessing differentiated levels of nursing practice.

Directed the Administration of Examination Committee to continue to schedule examinations 10 years in advance.

Approved revised procedures for appointment to Committee members to enhance input from Area Directors.

Adopted revised statements of functions from the Coordinating, Communications, and Legal Affairs Committees.

Authorized the Coordinating Committee to appoint a second three-person team to the Examination Committee to relieve its work load.

Approved an "Investment Policy" which sets philosophy and provides direction for investments.

Approved a policy on "Funds of the Organization" on how funds are to be managed.

Approved guidelines for scoring candidates on the basis of partial NCLEX information and recommendations for advising Member Boards of the results.

Approved a recommendation for the National Council to take a more active role in the dissemination of information regarding legal issues facing Member Boards and to devote a forum at the 1988 Delegate Assembly to the topic.

Approved written procedure for the Legal Affairs Committee to review the status of Member Board contracts.

Approved written procedures for referring problems on Member Board contracts and/or non-administrative contracts to the Legal Affairs Committee.

Approved a program to recognize the efforts of the volunteers on National Council committees, task forces, item writers and subject matter experts.

Approved the 1987 Convention Plan and business agenda.

Approved a change in policy requiring that honorarium be paid to convention speakers upon submission of a copy of their presentation.

Approved restructuring of the convention refund policy.

Approved a policy change to provide all jurisdictions an opportunity to host the annual convention.

Approved a recommendation that the National Council co-sponsor with the Irish Nursing Board, a two-day workshop in Dublin as part of the 1988 International Symposium on Nursing Use of Computers and Information Science.

Adopted amended guidelines for sharing research data, other than that relating to candidate performance, collected by the National Council.

Approved for FY 88 two new staff positions to include the exempt position Director of Research Services and a non-exempt position of an Assistant for Testing Services.

Made a formal proposal to the American Nurses' Association for the National Council to assume publication of the *State Nursing Legislative Quarterly* journal.

Approved the FY 88 budget.

Approved institution of the electronic mail system between the National Council and interested Member Boards.

Approved a reference hearing process to review any proposed resolutions and assigned responsibilities to the Resolutions Committee.

Selected recipients for the initial Meritorious Service Award and Member Board Award and directed that the announcement remain confidential until the second session of the 1987 Delegate Assembly.

Approved a concept of field consultation visits to better inform Member Boards of major projects and goals of the National Council, beginning in FY 88.

Approved a plan enabling voluntary participation by Member Boards to provide names of registered nurses to the Defense Department in the event of a presidentially-declared national crisis.

Supported a recommendation of the Examination Committee to remind those Member Boards reviewing item drafts of the development process currently used to insure that examination items are appropriate for each NCLEX examination and to advise Member Boards that in the future, items in review drafts identified as not representing legal scope of practice must be accompanied by documentation that the item is not consistent with Nursing Practice Act or otherwise the Examination Committee will not consider the objection.

National Council Examination Fee for Management/Supervision, Research, Contingency, Item Development, Disaster Plan/Liability Costs

The Board of Directors reviewed the cost factors for ongoing support of the National Council programs. The National Council portion of the examination fee is the major source of revenue for National Council programs. This source provides for management/supervision, item development, job analysis studies for validation of current and future examinations, research including funding the second phase of the computer adaptive testing feasibility study, contingency fees, disaster plan maintenance, liability costs, and reimbursement for disaster examination printing and the prior job analysis study.

The Delegate Assembly in August 1986 approved an increase in the fee for CTB/McGraw-Hill as test service and for CTB/McGraw-Hill as data center for test applications.

The Board of Directors recommends that the portion of the examination fee for the National Council be $16.49 per candidate for the period of October 1988 through July 1990. The two year timeframe is used because decisions by the Delegate Assembly about the National Council becoming its own test service and about computer adaptive testing implementation will not be made until August 1989. The Board believes the effect of those decisions on the National Council operations will necessitate evaluation of the fee after 1990.

Cost factors used in the computation of the $16.49 National Council fee are detailed in the attached analysis of projected revenue and expenses. The total fee incorporating test service and data center for test application fees is explained.

Analysis of Projected Revenue and Expenses for Examination Fee

It is recommended that the National Council portion of the fee per candidate for the National Council Licensure Examinations (NCLEX) effective with the October 1988 examination administration and extending through the July 1990 examination administration be $16.49. This amount covers basic services which are explained under the section, "National Council Examination Fee Categories".

National Council Examination Fee Categories

Management/Supervision: The personnel, travel, publications and printing costs and all expenses associated with the examination and other program services, not including research, provided to Member Boards in FY 87 are calculated. An additional ten percent was added to actual expenses to provide for new programs within the purpose of the National Council but not yet defined by the Delegate Assembly.

Carryover Validation/Disaster Plan Printing: The validation price was calculated previously to compensate for the cost of the *Study of Nursing Practice and Job Analysis and Role Delineation of Entry Level Performance of Registered Nurses*. The disaster printing price was calculated previously to compensate for preparation of materials and shipping to storage.

Item Development: New items will need to be developed to enable production of the number of items necessary for the National Council to become its own test service and to implement computer adaptive testing if these decisions are made by the Delegate Assembly. The timeframe will not allow waiting for the decisions before producing items.

Disaster Storage/Liability: Continuing cost of shipping disaster plan examinations and for storage as provided. Liability insurance costs include projected annual cost of premiums divided by projected number of candidates.

Contingency if less than 135,000 Candidates: The contingency fee previously used was recalculated because of negotiation of the new contract with CTB/McGraw-Hill in 1986; it provides for payment of CTB/McGraw-Hill should the number of candidates fall below 135,000 annually.

Research: Personnel and travel costs are calculated. In addition costs for future ongoing job analysis studies and other research studies appropriate to National Council purposes are projected. The second phase of the Computer Adaptive Testing feasibility study is included.

Inflation Factor Applied

The 1988-1990 costs are calculated using FY 87 program revenues and expenses and inflation factors. Inflation forecasts made by Data Resources, Inc. have been used with labor modified to reflect a smaller increase in 1987 and therefore subsequent years.

Factor	1987	1988	1989	1990
Labor	1.06	1.14	1.22	1.30
Paper/Printing	1.035	1.095	1.132	1.169
Travel/Lodging	1.047	1.098	1.146	1.196
All Other	1.03	1.07	1.113	1.158

Derivation of Price for Management/Supervision

Actual 9-month expenses plus projected fourth-quarter expenses for FY 87 were grouped according to the inflation factors listed. The inflation factors for 1989 and 1990 were applied to current budget expenses by program area. The total was calculated for 1989 and 1990.

Anticipated revenue minus examination revenue was calculated using the appropriate inflation factor for 1989 and 1990. The total cost of programs minus research and minus revenue other than examination revenue was combined for 1989 and 1990. This cost was divided by the expected number of candidates for those two years to yield the price per candidate for existing programs with inflation. Ten percent of that figure was added for new programs not currently offered.

National Council Portion of Fee

National Council - Management/Supervision	$ 7.52
National Council - Carryover Validation/Disaster Print	$ 1.42
National Council - Item Development Cost	$ .78
National Council - Disaster Storage/Liability	$ .86
National Council - Contingency if Less Than 135,000	$ .91
National Council - Research	$ 4.48
National Council Subtotal	**$15.97**

Previously approved by Delegate Assembly (1986) for CTB/McGraw-Hill portion of fee:

CTB/McGraw-Hill Portion of Fee

CTB - Test Development	$19.38
CTB - Test Application Data Center	$ 4.13
CTB Subtotal	**$23.51**

Total NCLEX Fee

CTB Subtotal	$23.51
National Council - Management/Supervision etc. Subtotal	$15.97
NCLEX Calculated Fee	$39.48
NCLEX Total Fee (Rounded)	**$40.00**

Based upon previous experience in collecting odd dollar-and-cents fees from candidates, the Board of Directors determined the recommended price should be rounded to $40.00 per candidate. The additional monies would be used for test development and research activities.

Tape States' differential deducted from Test Application price is $ .96. The price for Tape State candidates would be $39.04 per candidate.

Board Processed States' differential added to Test Application price is $2.50 which is divided equally between CTB/McGraw-Hill and National Council. The price for Board Processed States' candidates would be $42.50 per candidate.

Assumptions for Plan of Incremental Steps for Producing and Implementing Licensing Examinations

Assumptions

The outline of incremental steps was developed based upon the following assumptions:

1) The administration of examinations will be via computer. The components of the process that are affected the most by this assumption are the distribution and collection of examination forms for use by boards with candidates, and the scoring and reporting of individual results.

2) The study of the feasibility of Computer Adaptive Testing (CAT) will proceed as outlined at the November 1986 meeting of the Board of Directors, and positive decisions will be made to continue with each successive phase. Several key assumptions are subsumed within this general assumption about the CAT project. They are the following:

a) that it will prove to be legally feasible to administer computer adaptive licensure examinations,
b) that jurisdictions will have the computer capabilities to administer computerized licensure examinations, and
c) that computer adaptive licensure examinations will prove to be "cost effective" in the sense that candidates can realistically be expected to pay the cost.

Positive decisions at the end of the two phases of the CAT project will result in beginning "for real" implementation in some jurisdictions in 1990 and would allow for reasonable projection of full implementation about four to five years thereafter. To a lesser extent, the steps also depend on satisfactory progress with the Computerized Clinical Simulation Testing project, with total simultaneous implementation sometime after full implementation of CAT.

The cost per square foot of space would be no greater than that for current rented space, adjusted for inflation.

4) Parts of the production and implementation operation will continue to be subcontracted. During the period of phase-in computer administered testing, paper-and-pencil examinations must continue to be offered; the most efficient way of providing this service would be to contract with CTB to perform it. A function which would logically be brought in-house if a research and development department were established is test validation (job analyses ; otherwise this function would continue to be subcontracted. Other functions that could potentially be subcontracted, but are included in the steps for bringing testing services in-house are (in approximate order of desirability of contracting out):

5) Member Boards will continue to be responsible for determining eligibility prior to examination and giving notice of results to individuals and programs after examination.

6) The additional staff necessary to perform the in-house functions will be part of the testing services department. However, other departments of the National Council staff will also have increased workloads due to the expansion of the testing services department. There will be more financial work due not only to increased staff, but also to more volunteer participants, more inflow of application money, and more direct relationships with suppliers and subcontractors. Computer/statistical services will have a greater volume of work due to the need to handle downloading and uploading of files of all examinees who take the examination at all sites. Programming to meet new reporting and information management needs will be required from time to time. Additional data processing will be necessary to handle preparation and dissemination of reports and candidate information. Handscore and review requests would also be likely to affect the workload of data processing personnel.

7) Use of unpaid volunteers will continue to be a viable means for National Council to obtain needed expertise for item writing and content review. The cost of producing examination items, whether carried on internally or externally, would increase tremendously if it were to become necessary to pay item writers and reviewers.

Rank Ordering of Goals and Objectives

The five top priority objectives, as determined by the work of the Long Range Planning Committee, National Council Board of Directors, standing committees and staff, and the rankings of Member Boards as revised January 1987 follow:

1. Goal I. Develop, promote, and provide relevant and innovative services.

Objective A. Develop licensure examinations that are based upon current accepted psychometric principles and legal considerations.

2. Goal I. Develop, promote, and provide relevant and innovative services.

Objective B. Establish policies and procedures for the licensing examinations in nursing.

3. Goal II. Utilize human and fiscal resources efficiently to allow for growth and creativity.

Objective A. Implement a planning model to be used as a guide for the development of NCSBN.

4. Goal IV. Develop a comprehensive information system for use by members, organizations and the public.

Objective A. Implement a five year plan for an information system.

5. Goal I. Develop, promote, and provide relevant and innovative services.

Objective D. Maintain and enhance communication about NCSBN, its members, and issues concerning safe and effective nursing practice.

The remaining goals and objectives were ranked as follows:

6. Goal IV. Develop a comprehensive information system for use by members, organizations, and the public.

Objective B. Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions.

7. Goal V: Advance research that contributes to the public health, safety, and welfare.

Objective A. Conduct and disseminate research pertinent to the mission of NCSBN.

8. Goal I. Develop, promote, and provide relevant and innovative services.

Objective E. Promote consistency in the licensing process among the respective jurisdictions.

9. Goal I. Develop, promote, and provide relevant and innovative services.

Objective C. Provide consultative services for Council members, groups, agencies, and individuals regarding the safe and effective practice of nursing.

10. Goal III. Expand collaborative relationships with relevant organizations to facilitate the development and promotion of health related policy.

Objective A. Provide specific opportunity for direct dialogue, interaction and mutual decision making among national health groups.

11. Goal III. Expand collaborative relationships with relevant organizations to facilitate the development and promotion of health related policy.

Objective C. Increase consumer involvement with NCSBN.

12. Goal III. Expand collaborative relationships with relevant organizations to facilitate the development and promotion of health related policy.

Objective B. Promote and facilitate effective communications with related organizations, groups, and individuals.

13. Goal II. Utilize human and fiscal resources efficiently to allow for growth and creativity.

Objective B. Strengthen the organizational structure in the complex environment of high technology, transforming health care delivery systems, global communication and international interaction.

14. Goal V. Advance research that contributes to the public health, safety, and welfare.

Objective B. Promote research proposals annually which merit funding.

15. Goal V. Advance research that contributes to the public health, safety, and welfare.

Objective C. Involve Member Boards in research at the jurisdictional level for use and distribution.

FY 1988 BUDGET:
BY PROGRAM

NCLEX		
NCLEX Exam Revenue	($3,765,915)	
NCLEX Processing Costs	2,496,545	
Handscoring Fees	(62,500)	
Handscoring Costs	55,000	
Other NCLEX Related Expense	41,524	
Exam Committee	20,150	
Administration of Examination Committee	30,050	
AdHoc - Testing	20,900	
Task Force - Future Examinations	1,700	
NCLEX Support Costs	48,710	
NCLEX Income Subtotal		**($1,113,836)**
INVESTMENTS		
Investment Income		**(179,940)**
MEMBER BOARDS		
Member Board Contract Income	(183,000)	
Associated Expense (Legal and Other)	20,000	
Member Board Income Subtotal		**(163,000)**
PUBLICATIONS		
Publications Revenue	(211,100)	
Publications Expense	68,592	
Publications Income Subtotal		**(142,508)**
DELEGATE ASSEMBLY		
Delegate Assembly Income	(45,820)	
Delegate Assembly Expense	44,259	
Delegate Assembly Income Subtotal		**(1,561)**

Note: Revenue is indicate by ( ) Program Totals are in Bold

AREA MEETINGS

Area Meetings Board Travel	8,000	
Area Meetings Staff Travel	4,000	
Area Meetings Expense Subtotal		12,000

PUBLIC RELATIONS

Honoraria	(5,000)	
Public Relations Expense	24,500	
Communications Committee Expense	7,200	
Public Relations Expense Subtotal		26,700

RESEARCH

Research - ACT	129,646	
Research - CAT	55,900	
Research Expense Subtotal		185,546

STANDARDS AND PRACTICE

Standards and Practice Committee	19,550	
Disciplinary System	3,100	
Standards and Practice Expense Subtotal		22,650

ORGANIZATION:

Board of Directors Expense	45,687	
Licensee Data Base Expense	12,500	
Coordinating Committee Expense	4,300	
Legal Affairs Committee Expense	3,315	
Nominating Committee Expense	3,850	
Finance Committee Expense	17,750	
Bylaws Committee Expense	4,950	
Organizational Expense Subtotal		92,352

ADMINISTRATION:		
Personnel Costs		
Salary and Benefits	813,417	
Staff Travel	1,000	
Professional Fees		
Legal	10,000	
Accounting	9,000	
Other	19,250	
Library Membership	3,700	
Printing/Supplies	35,000	
Insurance	39,000	
Miscellaneous Expense	1,600	
Administration Expense Subtotal		931,967
OCCUPANCY:		
Rent/Utilities	165,000	
Electronic Mail	12,405	
Telephone	16,100	
Postage	19,635	
Equipment Maintenance/Rental	6,300	
Computer Maintenance/Rental	6,230	
Depreciation	80,050	
Occupancy Expense Subtotal		305,720

SUMMARY

Total Revenue	**($4,453,275)**
Total Expense	**4,429,365**
Revenue Over Expense	**($23,910)**

REPORT OF THE TEST SERVICE

INTRODUCTION

This report provides a summary of CTB/McGraw-Hill's activities with the National Council Licensure Examinations during the past year. The NCLEX project staff members have focused on:

EXAMINATION DEVELOPMENT

- developing test items that are a valid and reliable measure of entry-level proficiency in the professions of registered and practical (vocational) nursing

- continuing to provide test development and measurement expertise in support of the National Council's Testing Services staff and Examination Committee

EXAMINATION ADMINISTRATION, SCORING, AND REPORTING

- continuing to provide service to the Member Boards and the Administration of Examination Committee to maintain the security of the examination test pool, to monitor the production and shipment of all examination materials, and to provide scoring and reporting services to meet the information needs of the Member Boards

RESEARCH AND TECHNICAL SUPPORT

- providing technical support in all areas of research, including the monitoring of examination statistics, the establishment of passing standards, preliminary research for computer adaptive testing, and the review of the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses.*

In addition to supporting these major phases of the NCLEX program, the CTB project staff has also provided additional services and information in response to requests from the National Council and its Member Boards.

EXAMINATION DEVELOPMENT

ITEM WRITING

One of the major services that the CTB/McGraw-Hill test development staff provides is the coordination, training, and support of writers in the development of test items. A primary focus during this past year has been to increase the number of items produced for the Registered Nursing item pool. The additional item development was planned to strengthen the Registered Nursing item pool in anticipation of content shifts that may occur as a result of revisions in the Registered Nursing test plan.

The existing item development and review procedures for both the NCLEX-PN and the NCLEX-RN item pools continue to ensure the quality of all test items and continue to ensure that each test item measures a knowledge, skill, or ability associated with current entry-level nursing practice. Several procedural modifications made during the past year should be noted:

- a focus on writing individual (discrete) test items and compact case structures (4-7 test items). Small cases and individual test items enhance the potential of the pool as a computer-adaptive database and allow greater flexibility in examination construction.

- a revision of the pre-conference item-writing exercise so that writers gain experience in the writing process before the conference.

- modifications in the content validation procedures to ensure that writers provide complete documentation to support the accuracy and validity of each correct response.

- an increase in the number of returning writers invited to participate in the writing conferences.

ITEM WRITING CONFERENCES

Two Registered Nursing item-writing conferences and one Practical Nursing item writing conference were held during the past year at CTB headquarters in Monterey, California. The first Registered Nursing conference was held from July 28 - August 1, 1986, and included 16 writers (4 returning writers) selected by the National Council Examination Committee from nominations submitted by State Boards of Nursing. Representatives from California, Indiana, Kentucky, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, and Vermont participated. Over 600 test items were created during the conference.

A special Registered Nursing item-writing conference was held from January 12-16, 1987 to address the need for additional Registered Nursing items. The 11 writers selected by the National Council to participate in this conference represented the following states: Arizona, Idaho, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, New York, and Oregon. Over 340 test items were created during this writing session.

The Practical Nursing item-writing conference was held from July 7-11, 1986, and included 12 writers selected by the National Council Examination Committee from nominations submitted by State Boards of Nursing. The following states were represented: Connecticut, Iowa, Kansas, Michigan, Mississippi, New Hampshire, New York, Oregon, Rhode Island, South Carolina, Tennessee, and Utah. Over 400 items were created by the writers from this session.

As is standard in current CTB item-development procedures, test development staff members not only work with the item writers during the writing conferences but also review each test item prior to the Panel of Content Experts review. This initial review is intended to ensure that all items are developed according to test plan specifications and are free of bias or extraneous clues that may benefit a test-wise candidate.

ADDITIONAL ITEM WRITING ACTIVITIES

Limited mail solicitation for test items was implemented in 1986 to address specific needs

of the item pool. Writers from past writing conferences were contracted to write new test items according to security procedures approved by the Administration of Examination Committee. Forty-seven items were written and were submitted for review to the Registered Nursing Panel of Content Experts in March 1987.

PANEL OF CONTENT EXPERTS

Three Panels of Content Experts were convened during the past year to review test items. This review ensures that all items to be field tested reflect current, national, entry-level practice; have only one correct response; and have documentation confirming the correct response in two standard nursing textbooks.

The Practical Nursing Panel of Content Experts met from August 18-22, 1986 and included 14 panel members, a representative from the Examination Committee, and a representative from National Council Testing Services staff. Panel members were selected by the National Council Board of Directors from nominations submitted by Member Boards. Panelists included representatives from Alaska, Arizona, Arkansas, Florida, Maine, Nebraska, New Jersey, and New York. The panel reviewed 403 test items and approved 383 items for use as experimental items.

The first Registered Nursing Panel of Content Experts met from September 8-12, 1986 and included 15 panel members, a representative from the Examination Committee, and a representative from National Council Testing Services staff. Panel members were selected by the National Council Board of Directors from nominations submitted by Member Boards. Representatives from Alabama, California, Colorado, Delaware, Missouri, New York, Texas, Virginia, and Wisconsin participated in the review. The panel reviewed 545 test items and approved 523 items for use as experimental items.

The second Registered Nursing Panel of Content Experts met from March 16-20, 1987, and included 14 panel members selected by the National Council Board of Directors from nominations submitted by participating Member Boards. Two representatives from the Examination Committee were also present. Representatives from the following states participated: Alabama, Colorado, Delaware, Kansas, Missouri, Ohio, Pennsylvania, Virginia, Washington, and Wisconsin. The panel reviewed 449 items and approved 430 items for use as experimental items.

MEMBER BOARD REVIEW OF EXPERIMENTAL ITEMS

Experimental items approved by the Panels of Content Experts were sent to all Member Boards who requested a review. The review panel of each Member Board indicated whether each item was consistent with the state's Nursing Practice Act and whether the item was an appropriate measure of entry-level practice. Responses from the 1986 Member Board review of experimental items were summarized and presented to the 1986 Panels of Content Experts and the Examination Committee for review. Fifteen items were deleted from the item pool based on the results of this review.

Experimental items were sent in January 1987 to the 37 Practical Nursing Boards request-

ing review. Experimental items were sent in April 1987 to the 35 Registered Nursing Boards requesting review. At the request of the Council, review timeframes were extended in 1987 to eight weeks to allow all Member Boards the opportunity to participate. Prior to the 1987 review of experimental items, CTB staff worked cooperatively with the Examination Committee to clarify the review procedures in the *Manual for Reviewing Try-out Items.*

The responses from the 1987 Member Board review will be summarized, and designated test items will be presented to the Panel of Content Experts in July and September 1987.

EXAMINATION CONSTRUCTION

The two Registered Nursing examinations (NCLEX-RN 786 and NCLEX-RN 287) and the two Practical Nursing examinations (NCLEX-PN 086 and NCLEX-PN 487) constructed for use this past year were developed according to the Registered Nursing and Practical Nursing test plans approved by the Delegate Assembly and the test construction guidelines established by the Examination Committee. The content blueprints (confidential directions) for each examination were presented to the Examination Committee for review and, upon approval, the examinations were developed for final review by the Examination Committee. The examinations were constructed to be equivalent to previous forms of Registered Nursing and Practical Nursing examinations from both a content and a statistical perspective and were reviewed by both the Test Service's staff and the Examination Committee to ensure that all items met the established criteria.

EXAMINATION ADMINISTRATION, SCORING, AND REPORTING

EXAMINATION MATERIALS

All testing materials were shipped to the Member Boards within the established timeframe, allowing Boards sufficient time for the required inventories and familiarization with testing procedures. CTB staff worked in cooperation with the Administration of Examination Committee to revise, redesign, and index the *Manual for Administration of NCLEX* to ensure efficient use by examination administrators. The format of the test booklets was also modified so that ethnicity and gender information could be collected for each candidate and so that no test items would appear on the back page. The new manual and the booklet modifications were introduced during the NCLEX-RN 287 examination cycle.

ADMINISTRATION

Two Registered Nursing and two Practical Nursing examinations were administered during the period covered by this report. The NCLEX-RN 786 (July) examination was administered to 77,157 candidates, and the NCLEX-RN 287 (February) examination was administered to 31,824 candidates. The NCLEX-PN 086 (October) examination was administered to 26,948 candidates, and the NCLEX-PN 487 (April) was administered to approximately 17,136 candidates. (The exact number of candidates was not available when this report was prepared. NCLEX-PN 486 was administered to 17,173 candidates. That figure was not available at the writing of the 1986 annual report.)

EXAMINATION MATERIALS RETRIEVAL/SCORING

All examination materials were collected under secure conditions and accounted for; candidate information, test materials, and late applications were checked by the CTB scoring staff for completeness and accuracy; and test materials were scanned. The passing scores were set in cooperation with the National Council according to the established standard of entry-level proficiency, and all score reports were shipped on or before the scheduled date. Report modifications provided during the past year include the addition of a leading zero on individual candidate reports for all three-digit Registered Nursing scale scores and all two-digit Practical Nursing scale scores.

HANDSCORING

The test service responded to handscoring requests from 128 NCLEX-RN 286 candidates (18 early requests), 16 NCLEX-PN 486 candidates, 341 NCLEX-RN 786 candidates, 16 NCLEX-PN 086 candidates, and 44 NCLEX-RN 287 candidates (as of the writing of this report). It should be noted that "early" handscoring was discontinued after the NCLEX-RN 286 examination at the request of the Board of Directors.

DISASTER PLAN EXAMINATIONS

CTB continued to assimilate test booklet overages after specified examination administrations for use by the National Council in case of a disaster.

RESEARCH AND TECHNICAL SUPPORT

The research staff of the test service has provided the National Council with the research support necessary to analyze the soundness of each examination; to analyze the performance of each test item; to analyze the content of the item pools; to undertake additional studies such as the Compromised Item Study and the Study of Pass Decisions Based on Partial Information; and to support, as requested, the activities of all National Council committees. CTB test development and research staff has also begun submitting a technical report to the National Council detailing the development and analysis of each examination. The first of these reports summarized the NCLEX-RN 786 examination.

A summary of additional studies follows:

- A study designed to indicate whether NCLEX-RN 785 test questions had been compromised was completed in September 1986. The analyses provided no evidence that candidates had prior access to the questions suspected of being compromised.

- A study designed to assess how accurately pass decisions could be made on NCLEX if one or more booklets were not able to be score was completed in September 1986. A full report was submitted to the Examination Committee at their September 1986 meeting.

- A person-fit analysis has been designed and piloted on the NCLEX-RN 287 examination. The purpose of this analysis is to identify candidates who may have had access to test items before the examination administration.

- The initial phase of an ethnicity/gender analysis has been designed and piloted on the NCLEX-RN 287 examination. Results from this pilot will be provided to the National Council so that decisions about the specific design of the analyses can be made.

CTB has worked in cooperation with the National Council to identify important areas for additional research. Members of CTB's research staff met with representatives of the National Council at the annual American Educational Research Association meeting in April 1987 to discuss the research issues of importance to the NCLEX program.

ADDITIONAL SERVICES

NCLEX INVITATIONAL CONFERENCE

CTB sponsored its second NCLEX Invitational Conference in Monterey, California on February 26 and 27, 1987. More than 65 participants from 30 Member Boards attended. The many months of planning and the surveys and questionnaires sent to the participants before the conference enabled CTB to design the conference to meet the specific needs of those attending. CTB staff members presented information about all phases of the NCLEX program, including test development, administration, scoring, reporting, statistical analyses, and research. Members of the National Council staff as well as National Council committee chairpeople were present to provide information about the National Council's role in developing the national licensure examination and to answer questions about National Council policies and procedures.

TEST PLAN RETREAT

Members of CTB's test development staff were present at the November 10-14, 1986 Test Plan Retreat in Chicago to provide information about the current test plan and item pool as needed, to provide support as requested in analyzing and interpreting the results of a *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses*, and to assist in drafting new language for the test plan.

ADMINISTRATION OF EXAMINATION COMMITTEE TOUR

CTB hosted the February 1987 meeting of the Administration of Examination Committee and conducted a tour of CTB's scoring facilities to provide all committee members with an overview of the NCLEX scoring process.

DELEGATE ASSEMBLY CONVENTION

CTB project staff attended the Delegate Assembly Convention in Williamsburg, Virginia from August 5-9, 1986, to respond to questions from the Member Boards as requested. CTB project staff will also be present at the 1987 Delegate Assembly Convention.

CONTRACT EVALUATION MEETING

CTB/McGraw-Hill's NCLEX project managers met with the National Council staff and

committee chairpeople in Monterey, California, on February 27, 1987, to discuss issues related to CTB/McGraw-Hill's compliance with the test service and data center contracts and to evaluate the services provided. Issues related to every aspect of the contract were discussed and several specific ideas for procedure modifications were presented.

ELECTRONIC CONFERENCING SYSTEM

As a service to the National Council until its adoption of a computer communication system, CTB has made a computer conferencing system available for dialogue between the test service and the National Council and for immediate written transmissions between the two organizations.

SPECIAL REQUESTS

CTB responded to requests for special examination reviews from Member Boards and provided costs for special examination administration services for Member Boards as requested. CTB also responded to requests for specifications and costs from the National Council for research, implementation of a disaster plan examination, report modifications, and data aggregation for special interest groups. CTB provided several sets of summary data in support of the National Council's research relating to the ACT studies and computer adaptive testing.

NCLEX SUMMARY PROFILES

The NCLEX Summary Profiles service continues to provide important information to subscribing nursing programs. The summary reports have been sent to approximately 530 subscribing Registered Nursing programs after each of the Registered Nursing examination administrations during the past year and to over 125 subscribing Practical Nursing programs after each of the Practical Nursing examination administrations.

Two representatives from the NCLEX Summary Profiles project were present at the National League for Nursing Convention in June 1987 to present an overview of the service and respond to any questions nursing educators might have about the information provided in the profiles.

Information about the service was sent in June 1987 to all nursing programs that were not current subscribers.

REPORT OF THE DATA CENTER

This report provides an overview of CTB/McGraw-Hill's activities in the NCSBN Data Center during the past year and covers the NCLEX-RN 786, the NCLEX-PN 086, the NCLEX-RN 287, and the NCLEX-PN 487. Major areas of focus include applications processing, application packets, the NCSBN program code system, and program code corrections.

APPLICATIONS PROCESSING

The NCSBN Data Center processed 78,972 candidate applications for the NCLEX-RN 786 examination, including tape and late candidates; 28,355 candidate applications for the NCLEX-PN 086 examination, including tape and late candidates; 33,044 candidate applications for the NCLEX-RN 287 examination, including tape and late candidates; and 18,003 candidate applications for the NCLEX-PN 487 examination, including tape and late candidates. These figures represent a total of 158,374 candidates over the four NCLEX examinations.

APPLICATION PACKETS AND NCSBN PROGRAM CODE SYSTEM

A total of 235,000 applications were shipped to Member Boards during the fall and spring application reprinting and delivery periods. The Data Center staff made 398 changes, additions, or deletions to the program codes inserts for both the fall and spring sendouts. The NCSBN Data Center staff continues to monitor codes in the NCSBN code system.

PROGRAM CODE CORRECTIONS

NCSBN Data Center staff processed program code corrections for 3597 candidates for the four NCLEX examinations: 39 Member Boards sent in 1069 changes for NCLEX-RN 786; 37 Member Boards sent in 1306 changes for NCLEX-PN 086; 37 Member Boards sent in 385 changes for NCLEX-RN 287; and 36 Member Boards sent in 837 changes for NCLEX-PN 487. The total represents an increase of 30.9% in the number of corrections over the same period in 1986 and is 2.27% of the applications processed through the NCSBN Data Center for the four examinations.

These corrections include changes in program codes, educational background, and repeat status.

THE PRACTICE PATTERNS OF NEWLY LICENSED PRACTICAL/VOCATIONAL NURSES: PRELIMINARY REPORT

This report provides a description of the job analysis/role delineation of licensed practical/vocational nurses who passed the NCLEX-PN in October of 1986. The analyses summarized here provide a general description of practice patterns of newly licensed practical/vocational nurses. Additional analyses (including a comparison of the 1986 sample of newly licensed practical/vocational nurses to the sample of newly licensed practical/vocational nurses who pass the NCLEX-PN in October of 1987) will be reported at a later date.

SAMPLING

The population of interest for this study of the practice patterns of newly licensed practical/vocational nurses consists of recently licensed practical nurses currently practicing in the U.S. In order to develop a sampling frame for this population, we obtained a tape with the names and addresses of all individuals who took the NCLEX-PN (the licensure examination for licensed practical/vocational nurses) in October of 1986. This tape was provided by CTB/McGraw-Hill, the testing service that develops and scores the NCLEX-PN, under contract with the National Council of State Boards of Nursing. Based on this list of those who took the NCLEX-PN in October of 1986, we developed a sampling frame (i.e., the list from which we would draw our sample) by dropping from the list those who had failed the test, had foreign mailing addresses, or incomplete records (e.g., invalid jurisdiction codes). Those who failed the NCLEX-PN would not be eligible to practice as licensed practical/vocational nurses in the United States, and those with foreign addresses would generally not be practicing in the United States; both of these groups could not provide data on current practice patterns of licensed practical/vocational nurses in the United States. Individuals for whom records were incomplete (e.g., a valid jurisdiction code was not available) were dropped from the sampling frame in order to eliminate possible sources of error in the data.

In addition, candidates tested in Hawaii, Kansas, and New Hampshire were not included in the sampling frame because of legal restrictions on the use of data from these states. Confidentiality requirements precluded the use of the names and addresses of individuals tested in these states for the job analysis and role delineation study. However, with the exception of those candidates who took the NCLEX-PN in Hawaii, Kansas, and New Hampshire, the sampling frame included essentially all individuals who passed the NCLEX-PN in October of 1986, were licensed, and had current mailing addresses in the United States.

The resulting sampling frame included 20,456 individuals. A stratified random sample (with stratification on jurisdiction of testing) of 3,415 was drawn for the study. Therefore, the sample included about 16.7% of the newly licensed practical/vocational nurses in the sampling frame. Since the sampling frame provided an essentially complete enumeration of the target population (with the exception of three jurisdictions), the stratified random sample drawn from this population provided a highly representative sample from the target population.

DEVELOPMENT OF THE SURVEY OF NURSING ACTIVITIES

The procedures used to develop the *Survey of Nursing Activities* are described in some detail in Chapter 2 of *A Study of Nursing Practice and Role Delineation and Job Analysis of Entry-level Performance of Registered Nurses* (Kane, Kingsbury, Colton, and Estes, 1986) published by the National Council of State Boards of Nursing, Inc., and referred to here as the *"Study of Nursing Practice"*. These procedures are briefly summarized below.

The Survey of Nursing Activities was one of five questionnaires developed during the *Study of Nursing Practice*. It contained a list of 222 activities and was designed for registered nurses and practical nurses as well as several other categories of nursing personnel. Many of the activities in this questionnaire were targeted, in terms of their wording and level, on registered nurse practice. However, most of the activity statements were general enough to apply to the practice patterns of both registered nurses and licensed practical/vocational nurses, and the list of activities used in this questionnaire also contained a large number of activity statements specifically targeted on licensed practical/vocational nurses (as well as some items specifically aimed at advanced practitioners). This wide range of activities was included in the *Survey of Nursing Activities* in order to facilitate the effective use of the questionnaire with different groups.

The initial draft of the list of activities was based on a review of previous research. For the activity statements that were designed to reflect the practice patterns of licensed practical/vocational nurses a major source was an earlier role delineation study of practical nursing, *Practical Nurse Role Delineation and Validation Study for the National Council Licensure Examination for Practical Nurses* (Ference, 1983; CTB/McGraw-Hill, Monterey, CA).

The activity statements were worded in terms of what the nurse does rather than in terms of how the nurse performs the activity, how well the nurse performs the activity, or why the nurse performs the activity. Since one of the questions to be asked about each activity was how frequently it is performed, the activities were described in terms of discrete events; for example, rather than ask the respondents whether they "are aware of" or "meet" the needs of immobilized patients, item 45 is stated as "check a client for complications due to immobility."

After the first draft of the list had been developed, it was reviewed by the project staff for comprehensiveness and was compared to a number of existing lists to check that no major area of activity had been left out. It was then reviewed by a panel of nursing consultants several times and revised based on their comments and suggestions at each of these sessions. The list of nursing activities was also pilot-tested with groups of registered nurses, advanced practitioners, licensed practical/vocational nurses and nurses' aides. Finally, it was reviewed by the Advisory Committee for the Study of Nursing Practice at several of its meetings and revised after each meeting.

In refining the list of activities, an effort was made to ensure that a wide range of client-nurse goals, various nursing roles and subroles, and the steps of the nursing process were covered. Although it was not feasible to include equal numbers of activities under each client-nurse goal, under each nursing role, and under each step of the nursing process, the activities were distributed so that they covered practice across different categories of nurses and across different practice settings.

At several points in the development of the list of activities, the project consultants and Advisory Committee of the *Study of Nursing Practice* reviewed and revised drafts of the list of activities and subsequently of the *Survey of Nursing Activities*. In addition, educators and practitioners from different clinical areas, practice settings, and levels of education were asked to critique the lists. Essentially, the reviewers were asked to judge whether or not the activities were representative of what nursing personnel do in the clinical settings with which the reviewers were familiar. Based on their judgments, activities were added, deleted, or reworded until the activity list was in its final form for use in the questionnaires.

The questions asked about each activity were designed to address two basic issues, the frequency with which the activities are performed in practice and the criticality of the activities for client outcomes. A great deal of time and effort was given to the development of the questions because the exact wording of the questions can be a major determiner of the interpretability (or validity) of the data in survey research.

The final form of the *Survey of Nursing Activities* included four questions for each activity. Question A asked whether the activity applied to the nurse's work setting. Since the activities were designed to cover practice in a variety of settings, it was anticipated that some activities would simply not be appropriate for nurses in some settings. Respondents who indicated that an activity did not apply to their settings were instructed not to respond to the other three questions for that activity.

Question B asked how often the activity is delegated to other nursing staff. This question was designed to collect information on the extent of responsibility that the nurses had for the activity even if they didn't actually perform it themselves very frequently.

Question C asked how often the nurse **personally** performed the activity per week. Question C was intended to provide basic data on frequency for the activities for different categories of nursing personnel in various settings. Question C included four response categories:

1. Less than 1 Per Week
2. 1-5 Per Week
3. 6-10 Per Week
4. Over 10 Per Week

In most of our analyses, data from question C were combined with data from question A to provide a 5-point scale; for respondents who indicated, in their response to question A, that an activity did not apply, the frequency variable was set equal to 0. For respondents who indicated that the activity did apply by leaving the oval for question A blank, the frequency was set equal to 1, 2, 3, or 4 corresponding to the category they chose for questions C.

Question D asked about criticality. This question posed some of the most difficult problems of wording. First, experience with questionnaires of the type suggests that if respondents were asked to rate the "criticality" or "importance" of each activity, many of them would rate everything as being critical or important. Such responses would not necessarily be inappropriate since all of the activities were designed to benefit clients, and all can be important parts of nursing care in some situations. However, this type of response set would not provide data that would be helpful in distinguishing relatively more critical activities from relatively less critical activities. Furthermore, in the absence of some criterion for judging criticality, it would be very difficult for respondents to rate criticality in a consistent way.

Therefore, we tried to make the criticality question as simple as possible and at the same time to provide an operationally defined criterion for rating criticality. The criterion that we used was based on whether the activity could sometimes be omitted without a "substantial risk of unnecessary complications, impairment of function, or serious distress." This criterion had the desirable properties of: (1) focusing on the needs of clients (2) providing a behavioral criterion (i.e., omitting or not omitting the activity) for criticality, and (3) being relatively simple and clear. Even with this wording, question D is more judgmental than the other questions, but is far less subjective that it would be if we simply asked for a rating of criticality or importance.

Given the purposes of the study–job analysis and role delineation–it was decided that the focus of the activity statements should be on what activity is being performed rather than on how the activity is performed, how well the activity is performed, or why it is performed. The wording of the instructions and the activity statements was edited to make each activity statement as short and simple as possible. Technical terminology was used where it was thought that the use of such terminology would enhance clarity; however, unnecessary technical vocabulary was avoided. The results of subsequent pilot testing and analyses indicated that respondents in all categories of nursing personnel were able to read the questionnaire without problems (the most frequent complaint about the questionnaire was that it was too long).

Several aspects of the questionnaire were designed to avoid response sets. A response set is a tendency of respondents to answer in a particular way regardless of the specific content of the question. For example, some individuals might have a tendency to respond in terms of what they thought they should be doing, or what they would be expected to do, rather than in terms of what they actually do.

First, items were worded to be descriptive rather than evaluative. The items asked about what the respondent did rather than asking how well the activity was performed. Evaluative adverbs, like "carefully", and "safely" were avoided.

Second, the questions were designed to be as explicit as possible. Question B (delegation) and C (frequency) asked the respondent how often they delegate and perform the activity. Responses to these questions involve estimation of how often something is done; this type of question was expected to be less prone to response sets than more qualitative questions would be. As noted earlier, Question D (dealing with criticality) is more judgmental than the others and, in this case, explicit criteria for responding were provided.

Third, the questionnaires explicitly acknowledged that the activities described nursing practice "in a variety of settings", and that the respondent should not be "surprised if some activities do not apply to your setting". Furthermore, the order of the activities was scrambled to avoid having clusters of activities such that a person working in a setting where most of the activities in the cluster were performed might assume that they should be performing all of the activities. In summary, the *Survey of Nursing Activities* was designed to elicit the information about practice as accurately as possible.

RESPONSE RATES

Each of the newly licensed practical/vocational nurses in the sample was sent a copy of the *Survey of Nursing Activities*, a postage-paid envelope, and a pencil. The packet sent to each individual in the sample also contained a cover letter from the president of the National Council of State Boards of Nursing, Inc. describing the purposes and importance of the study, and asking the recipient to participate.

After approximately two weeks, a postcard reminder was sent to individuals who had not responded. After approximately two more weeks, a second copy of the questionnaire, return envelope, etc., was sent to individuals who had still not responded.

The addresses that we had for some of the individuals in the sample were not complete or not current, and as a result, 175 questionnaires were returned as being undeliverable. Subtracting the number of undeliverables from the initial sample size of 3,415, we have an effective sample size of 3,240.

A total of 2,074 questionnaires were returned. Dividing the number of questionnaires returned (2,074) by the effective sample size (3,240), we have a response rate of 64.0%. Note, however, that of the 2,074 questionnaires returned, 636 (or 30.7% of the 2,074 returned questionnaires) were from individuals who were not working as licensed practical/vocational nurses. Since the individuals who were not working as licensed practical/vocational nurses were instructed not to fill out most of the questionnaire (i.e., they did not respond to the questions about the 222 activities), these individuals could not be included in most of our analyses.

Of the 636 respondents who indicated that they were not working as licensed practical/vocational nurses, most (493 of the 636) gave no reason for why they were not working as licensed practical/vocational nurses. The instructions in the cover letter accompanying the questionnaire said,

> "If you are not currently working in nursing, simply write 'not working in nursing' on the front of the questionnaire and return it in the postage-paid envelope. If you are not working in nursing, there is no need to fill out the questionnaire, but we would appreciate it if you would return the questionnaire even if you are not currently practicing."

That is, we had not asked respondents who were not working in nursing to indicate why they were not working in nursing.

However, a total of 143 respondents who were not working in nursing did provide comments on the questionnaire indicating why they were not working in nursing. The largest group, 47 respondents (or 32.9%), reported that they were in school, without indicating what kind of school. The second largest group 45 (or 31.5%) indicated that they were in a registered nurse program. Although these percentages are based on a small subset of the data (those respondents who were not working in nursing and indicated why they were not working in nursing), the fact that 92 (or 64.3%) of the respondents who indicated why they were not working in nursing said they were not working in nursing because they were pursuing further education suggests that a substantial proportion of the newly licensed practical/vocational nurses who were not working as practical/vocational nurses were, instead, pursuing further education.

The next largest group of respondents who were not working in nursing, consisting of 26 (or 18.2%) nurses, indicated maternity leave, illness, vacation, move to new state, etc. as the reason. 9 (or 6.3%) indicated that they had a different job, 8 (or 5.6%) said they were working as licensed practical/vocational nurses but were too inexperienced to respond, and 2 (or 1.4%) indicated that they were working as aides. Only 6 (or 4.2%) of the newly licensed practical/vocational nurses who were not working in nursing indicated that they had not yet found a job.

In addition, 533 questionnaires were not included in the analyses because the data they contained were considered problematic for some reason. In most cases, these questionnaires were eliminated from the analyses because they were not filled out completely or were not filled out correctly. The criteria used to identify questionnaires that would not be included in the analyses because they were filled out incompletely or incorrectly were the same as the criteria used for newly licensed registered nurses in the Study of Nursing Practice.

In particular, the participants' responses to various sets of questions were examined to detect inconsistencies that indicated a failure to follow instructions for one or more questions. For example, nine types of errors that could be made in responding to the four questions, A, B, C, and D for each of the 222 activity statements were identified:

E1	marking the oval for question A (thereby indicating that the activity does not apply), and answering question B
E2	marking the oval for question A (thereby indicating that the activity does not apply), and answering question C
E3	marking the oval for question A (thereby indicating that the activity does not apply), and answering question D
E4	leaving the oval for question A blank (thereby indicating that the activity does apply), and not answering question B
E5	leaving the oval for question A blank (thereby indicating that the activity does apply), and not answering question C
E6	leaving the oval for question A blank (thereby indicating that the activity does apply), and not answering question D
E7	filling in more than one oval for question B
E8	filling in more than one oval for question C
E9	filling in more than one oval for question D

For each individual, the number of errors of each type, E1-E9, was computed. Note that respondents who failed to respond to an activity would, as a result, have errors of types E4, E5, and E6 for that activity.

In order to ensure accuracy in the conclusions drawn from subsequent analyses, questionnaires with significant numbers of response errors were eliminated from the data base. In particular, a fairly stringent rule was adopted; any individual with ten or more errors of any type, E1-E9, was excluded from the data base. The exclusion of some questionnaires from the analyses decreases the sample sizes for these analyses but also decreases the opportunities for biases in the analyses.

Of the 553 respondents who were not included in the analyses because of questionable data, there were also 23 who indicated that their current position was as an "RN-staff nurse" and 19 who indicated that their most recently completed education was a registered nurse program. We called about half a dozen of these individuals to determine the reason for these responses; the explanation for these responses was either that the individual had failed the NCLEX-RN and therefore sought licensure as a licensed practical/vocational nurse or the individual had taken the NCLEX-PN as a backup in case they failed the NCLEX-RN. Since the practice patterns of those who were working as registered nurses would not reflect licensed practical/vocational nurse practice, and the practice patterns of those who had graduated from RN programs might not be typical of licensed practical/vocational nurses in their work settings, the questionnaires for these groups were not used in the analyses; these respondents are part of the group of 553 respondents who were excluded from the analyses.

As noted earlier, a total of 2,074 questionnaires were returned. Of these, 636 of the respondents reported that they were not working as licensed practical nurses and did not fill out the questionnaire. In addition, 553 questionnaires were excluded from the analyses because they included some questionable data. This left 885 questionnaires that were used in the analyses:

885 - number of questionnaires used in analyses
636 - number of respondents not working as LPN/VNs
553 - number of questionnaires with questionable data

2,074 Total number of responses

Therefore, in spite of the fact that almost a third of the respondents did not fill out the questionnaire and 553 questionnaires were eliminated because of questionable data, the number of questionnaires available for analyses was quite large. This occurred because we started out with a large initial sample and got a good response rate.

In summary, of the 3,240 questionnaires that were delivered to licensed practical/vocational nurses in the sample, 2,074 (or 64.0%) were returned. Of the returned questionnaires, a substantial number (636 or 30.7% of the returned questionnaires) indicated that the respondent was not working in nursing. As indicated above, the most commonly given reason for not working in nursing was further education. In addition, 533 questionnaires were not included in the analyses because they included questionable data. The criteria for deciding which questionnaires should be eliminated were quite stringent and were the same as those used with the data from newly licensed registered nurses in the Study of Nursing Practice. The elimination of these data reduced the sample sizes for analyses, but avoided the use of questionable data in describing the practice patterns of newly licensed practical/vocational nurses.

REPRESENTATIVENESS OF THE SAMPLE

Table 1 provides data on the distribution of the sampling frame, the sample, and the analysis sample (the 885 questionnaires included in the analyses) over four geographic regions: North Atlantic, Midwest, Southern, and Western. The jurisdictions included in each of the regions are listed in the bottom half of Table 1.

As one might expect, the percentages of licensed practical/vocational nurses in the sampling frame and the sample are very similar. The stratified random sampling procedure (with stratification on jurisdictions) was designed to ensure that the sample would be as representative as possible in terms of geographic distribution, and it is clear from Table 4 that the sampling procedures did produce a sample that was geographically representative. The sample used in the analyses is also quite similar to the sampling frame in terms of geographic distribution, with the largest percentage in the Southern Region and the smallest percentage in the Western Region. However, as compared to the sampling frame, the Southern Region is somewhat overrepresented in the analysis sample and the North Atlantic and Western Regions are somewhat underrepresented in the analysis sample.

As an additional check on the representativeness of the sample and the group used in the analyses (i.e., the analysis sample), distributions of scores on the NCLEX-PN were examined for the sampling frame, the sample, and the analysis sample. For the sampling frame the mean score on the NCLEX-PN was 524.9 and the standard deviation was 108.7. For the sample, the mean NCLEX-PN score was 524.3 and the standard deviation was 109.2. Therefore, both the mean and standard deviation of NCLEX-PN scores were essentially identical for the sample and sampling frame. For the 885 respondents used in the analyses, the mean NCLEX-PN score was 551.7 and the standard deviation was 110.5. Therefore, the analysis sample got a somewhat higher average score on the NCLEX-PN than the population represented in the sampling frame.

The analysis sample also had a somewhat lower percentage of graduates of foreign nursing programs than the sampling frame. While 2.6% (528 individuals) of the sampling frame, and 2.8% (95 individuals) of the sample had graduated from a foreign nursing program, only 1.0% (9 individuals) in the analysis sample had graduated from a foreign nursing program.

VALIDITY OF THE DATA

This section reports analyses that were designed to investigate the accuracy of the responses provided by newly licensed practical nurses to the *Survey of Nursing Activities*. There are a number of reasons why the responses to particular questions might be inaccurate, including a misinterpretation of a particular question by some respondents, or "slips of the pencil" by a respondent. Questionnaire data can also be misleading because of response sets; i.e., a tendency for a participant to respond in a particular way (e.g., to give "expected" responses). In order to examine the impact of various types of erroneous responses, we performed several analyses that provided checks on the accuracy of the data.

Initially, the returned questionnaires were examined directly to identify any obvious problems in the way that the individual questionnaires were filled out. These reviews of the questionnaires did not identify any major problems. Some newly licensed practical nurses omitted some items and/or did not respond to some of the questions about the activities appropriately (e.g., they filled in the oval indicating that the activity did not apply and yet, contrary to the instructions, responded to one or more of questions B, C, and D). However, most of the newly licensed practical/vocational nurses responded to the questions correctly.

Most of the data from the questionnaires were transferred to a computer file by optical scanning of the booklets. The scanning programs used to read the optically scannable parts of the questionnaire were checked by having the program read sets of questionnaires specifically designed to identify any problems in the scanning procedures (e.g., did the machine detect light marks and multiple responses as intended?).

Some of the data from the questionnaire could not be read by machine and were keypunched. All keypunched data were verified. After all of the data had been entered into computer files and these files had been combined (by matching on ID number), samples of questionnaires were selected and the data on each questionnaire were compared, item by item, to the data on the computer record for that questionnaire to ensure that the data in the computer file were accurate reflections of the responses on the questionnaires.

Next, the frequency of errors in following instructions was examined. In particular, the participants' responses to various sets of questions were examined to detect inconsistencies (i.e., the nine types of errors described earlier) that indicated a failure to follow instructions for one or more questions. The patterns of responses (e.g., frequency distributions) to some of the other questions in the *Survey of Nursing Activities* were also examined. In cases where responses on the data files appeared anomalous, these responses were compared to the responses on the questionnaire to check that the data had been entered correctly.

CONSTRUCT VALIDITY

Next, the consistency among the responses to different questions was examined. This step of data checking required that patterns of responses that might indicate errors in responding to specific questions be identified. The relationships among a number of variables were examined to determine if the general patterns in these relationships confirmed what would be expected on the basis of what is known about nursing practice. Following the general approach of construct validity, we identified a number of hypotheses that should be confirmed by the data if the survey questionnaires were interpreted correctly and filled out accurately, and then checked to see if these hypotheses were confirmed by the data.

Table 2 provides a description of the relationship between the settings in which the newly licensed practical nurses said they worked (in response to question 1, section 1) and how they characterized "most" of their clients (in response to question 5 of section 1). In indicating the setting(s) in which they worked, respondents were allowed to choose more than one option if they worked in more than one setting. However, they were encouraged to choose only one setting if they worked "mainly" in one setting; in particular, the instructions indicated that they should choose more than one setting only if they spent at least a third of their time in more than one setting. The data in Table 2 are for respondents who marked only one setting (but even these respondents could regularly work in another setting for a substantial fraction of their time).

In indicating the types of clients that they worked with, the respondents could also choose more than one option, and many respondents did choose more than one option. Therefore, the type-of-client dimension in Table 2 includes 21 categories. The first six categories correspond to respondents who chose one category of clients,, and the remaining 16 categories correspond to respondents who chose two categories of clients. The results in Table 2 suggest that the great majority of newly licensed registered nurses were consistent in how they filled out these two questions.

Table 3 presents the relationship between the settings in which the respondents worked (again for those indicating that they worked mainly in one setting in responding to question 1, section 1) and the ages of "most" of their clients (as indicated by the responses to question 6, section 1). Table 3 does not indicate any anomalies that might cast doubt on the accuracy of the responses. Category "99" indicates missing data or multiple settings.

Table 4 presents the average frequency for seventeen categories of activities within selected settings. It was expected that licensed practical/vocational nurses in certain settings would have higher frequencies of performing activities in certain categories than would nurses in other settings. Although nurses who said that they work mostly in one setting could spend time in others, the relationship between settings and categories is quite strong. For example, in category 8, Monitor Clients at Risk, nurses in Medical/Surgical units had the highest average frequency, nurses in nursing homes and client homes had the second and third highest frequencies, and nurses in offices and in group practices with other nurses and physicians had the lowest frequencies. These data tend to support the validity of the frequency data. Although the 17 categories of nursing activities were developed by a factor analysis of RN responses in the Study of Nursing Practice, they appear to work rather well for the LPN/VN data reported here.

For several reasons, it was not possible to perform as many tests of construct validity for the delegation and criticality scales as it was for the frequency scale. In particular, persons who responded "does not apply" to question A for an activity were instructed not to respond to the remaining three questions. Therefore, most respondents did not reply to the questions on criticality and delegation for many items. So, for example, comparisons across settings would not be very reliable since respondents in settings where an activity did not apply would not respond to these two questions.

In addition, specific predictions about criticality and delegation ratings for activities as a function of other variables seemed less clear than they were for frequency. For example, it seems reasonable to assume that nurses working in a psychiatric unit would perform activities related to the prevention of suicide more frequently than nurses working in other settings, but it is certainly not clear that nurses in other settings would view the criticality of delegation of activities aimed at the prevention of suicide differently.

However, some checks on the validity of responses to the criticality of delegation scales were possible. As part of the Study of Nursing Practice, some activities were identified that were expected to have relatively high criticality in the sense that they could never be omitted without a, "substantial risk of unnecessary complication, impairment of function, or serious distress", to clients. Similarly, activities were identified that could often be omitted without substantial risk to the client. These two sets of activities are listed in Table 5 along with the average criticality rating for each activity for those newly licensed practical/vocational nurses who responded to each activity. In computing values of the criticality variable, a response indicating that the activity could sometimes be omitted was coded as a zero, and a response indicating that the activity could never be omitted was coded as a 1.0.

If the participants responded to the criticality question as intended, the activities in the top half of Table 5 would be expected to have higher criticality ratings than the activities in the bottom half of the table. This prediction was clearly confirmed since the activities predicted to have relatively high criticality ratings had an average criticality rating of .92, and the activities predicted to have relatively low criticality ratings had an average value of .50. In fact, there was no overlap in the two distributions of average criticality ratings; the lowest criticality rating in the top half of Table 5 (0.88 for activity 14) was higher than the highest criticality rating (0.73 for activity 109) in the bottom half of Table 5. Therefore, the data suggest that the participants generally interpreted the criticality question as intended and responded appropriately.

In the pilot testing of the questionnaire, some ambiguity was encountered in the question on delegation. The primary intent of the delegation question was to examine patterns of delegation among RNs, LPN/VNs and aides. However, some of the nurses who participated in the pilot testing sessions interpreted delegation in terms of any referral of an activity to another person (e.g., other practical nurses, physical therapists, social workers, physicians, and the families of clients). Revisions in the delegation question during pilot testing reduced this ambiguity but did not completely eliminate it. Therefore, a note was included with each booklet that said, "In question B on page 3, 'delegation' means the assignment of the activity to someone who works **under your supervision**".

As part of the Study of Nursing Practice, a set of activities that could be expected to be delegated relatively frequently and a set of activities that could be expected to be delegated relatively infrequently were identified. These two sets of activities are listed in Table 6 with the average value of the delegation variable for each activity. In computing the average delegation, "never delegate" was coded as 0, "sometimes delegate" was coded as 1, and "usually delegate" was coded as 2.

If participants responded to the delegation question as intended, the activities in the top half of Table 6 would be expected to have a higher value of delegation than the activities in the bottom half of the table. This prediction was confirmed. Almost all of the values of the delegation variable in the top half of the table are substantially higher than the values in the bottom half. The average value of delegation in the top half of Table 6 was 0.96, while the average value of delegation in the bottom half was 0.39. Therefore, the data in Table 6 suggest that most of the newly licensed registered nurses responded to the question on delegation as intended.

However, Table 6 also suggests that the kind of ambiguity encountered during pilot testing still exists to some extent. For example, the average delegation value was 0.75 for activity 188, "administer anesthesia", whereas the average frequency of personally performing the activity was 0.03. Although these are two different scales, it is clear that there must have been some misinterpretation of the delegation question.

Therefore, it would seem to be the case that, although the average value of delegation can be interpreted as providing and indication of how often activities are delegated, the accuracy of this interpretation is limited, to some extent, by the fact that some respondents interpreted delegation to include referral.

On the last page of the questionnaire, the nurses were asked two questions about their education. First, what type of nursing education they had most recently completed, and second, what type of nursing program they were currently enrolled in, if any. Almost all of the responses to these two questions were not contradictory. However, eight of the nurses said both that the education they most recently completed was a Licensed Practical/Vocational Program, and that their current study was in a Licensed Practical/Vocational Program.

With the possible exception of the delegation scale, no evidence was found that would suggest serious misinterpretations of instructions, carelessness, or response sets that would invalidate the interpretation of the results. Some errors in recording responses, some variability in the interpretation of instructions, and some degree of response set are inevitable in any set of survey data. However, if sample sizes are large, as they are in this study, the occurrence of some response errors will have a negligible impact on the final results.

WORK SETTINGS AND EDUCATIONAL EXPERIENCES OF THE NEWLY LICENSED PRACTICAL/VOCATIONAL NURSES

This section provides a description of the educational preparation of the newly licensed practical/vocational nurses and of the environments in which they work. The analyses reported in this section are based on responses by the 885 nurses in the analysis sample to questions in Section 1 and 4 and some questions on the first page of the *Survey of Nursing Activities*.

Question 1 in Section 4 of the *Survey of Nursing Activities* asked respondents to indicate "The type of nursing education most recently **completed**". Of the 883 nurses who responded to this question, 868 (or 98.3%) chose "Licensed Practical/Vocational Program" as their response. Four nurses (or 0.5%) chose "any nursing program not in the U.S." and eight (or 0.9%) chose "Other". Three nurses (or 0.3%) gave multiple responses. As expected, the overwhelming majority of newly licensed practical/vocational nurses had most recently graduated from a program preparing practical/vocational nurses.

Question 3 of Section 4 asked, "If you are now enrolled in a nursing program, what kind is it?" A total of 274 nurses in the analysis sample did not respond to this question and were presumably not enrolled in a nursing program. Of the 611 nurses who did respond to this question, 414 (or 67.8%) explicitly stated that they were, "Not enrolled in a nursing program". Ten (or 1.6%) indicated that they were enrolled in a "Licensed Practical/Vocational Program". Fourteen (or 2.3%) chose "Other" and two (or 0.3%) gave multiple responses.

Fifteen (or 2.5%) indicated that they were enrolled in a Diploma Program, 132 (or 21.6%) indicated that they were enrolled in an Associate Degree Program, and 24 (or 3.9%) indicated that they were enrolled in a Baccalaureate Program. As indicated earlier, almost a third of the respondents did not fill out the questionnaire because they were not working as licensed practical/vocational nurses, and of those who indicated why they were not working in nursing, a substantial number said they were pursuing further education on a full-time basis. The responses to question 3 of Section 4 for the nurses in the analysis sample (who were working as licensed practical/vocational nurses) indicate that there is also a large group of newly licensed practical/vocational nurses who are enrolled in registered nurse programs while working.

Question 1 of Section 1, asked respondents to indicate the type of setting in which they worked. Table 7 lists the 25 settings listed in the questionnaire as possible choices, as well as the number of nurses and the percentage of nurses in the analysis sample who chose each setting. Of the 885 nurses in the analysis sample, 320 indicated multiple settings.

Of the 567 newly licensed practical/vocational nurses who chose a single setting, the highest number, 169 (or 29.9%) chose "Skilled care facility". The two other specific types of setting listed under the general heading of "Nursing Homes" were also frequently chosen; "Intermediate care facility", was chosen by 91 (16.1%) of the newly licensed practical/vocational nurses and "Residential care facility", was chosen by 29 (or 5.1%) of the nurses. Therefore, of the newly licensed practical/vocational nurses who chose one work setting, 51.1% chose one of the three types of nursing homes listed, with skilled care facilities being the most commonly chosen type of setting.

"Medical/surgical unit" was chosen by 167 (or 29.6%) of the nurses who chose one setting. The "Client's home" was chosen by 26 (or 4.6%) of the nurses. "Physician's or dentists office" was chosen by 20 (or 3.5%), and "Group practice including nurses and physicians" was chosen by 17 (or 3.0%). The remaining settings all had 8 or fewer of the newly licensed nurses.

Table 8 provides data on the shift worked by the newly licensed practical/vocational nurses. Of the 881 nurses who responded to this question, the highest percentage (31.8%) worked evenings. The percentages for days (27.6%) and nights (20.3%) were also quite large. The percentage reporting that they worked rotating shifts (17.3%) was smaller, but still quite large. The percentages choosing "Other" (2.0%) or giving multiple responses (1.0%) were quite small.

Question 4 of Section 1 asked, "Are you a charge nurse or assistant head nurse? Of the 880 newly licensed practical/vocational nurses who responded to this question, 332 (or 37.7%) indicated that they were a charge nurse or assistant head nurse, and 548 (or 62.3%) indicated that they were not a charge nurse or assistant head nurse. Therefore, over a third of the newly licensed practical/vocational nurses served as charge nurses or assistant head nurses.

Question 5 on the first page of the *Survey of Nursing Activities* asked, "How long have you been working in your current position"? Table 9 summarizes the responses to this question. A total of 846 of the 885 nurses (or 95.6%) in the analysis sample recorded lengths of experience in their current position of between 1 and 12 months when they filled out the questionnaire, and most of these indicated that they had 3-6 months of experience in their current position.

PRACTICE PATTERNS OF NEWLY LICENSED PRACTICAL/VOCATIONAL NURSES

Table 10 provides a summary of the responses of the 885 newly licensed practical/vocational nurses in the analysis sample to each of the 222 activities that were listed in the *Survey of Nursing Activities*. Table 10 also includes similar data on newly licensed registered nurses collected in 1985 as part of the Study of Nursing Practice. The data on newly licensed registered nurses are presented as a basis for examining the relationship between the practice patterns of newly licensed practical/vocational nurses and newly licensed registered nurses.

On the left side of Table 10, shortened versions of the 222 activity statements are listed. The activity statements are grouped into the seventeen categories derived from a factor analysis that was done as part of the Study of Nursing Practice; this factor analysis was based on data for newly licensed registered nurses (a similar factor analysis of the data for the 885 licensed practical/vocational nurses in the analysis sample will be completed later this year). As indicated earlier, this category system also worked fairly well for the data on licensed practical/vocational nursing practice collected in this study.

The first three columns of Table 10 provide the mean (or average) frequency (on the 5-point scale, 0-4), mean delegation, and mean criticality for each of the activity statements in each of the seventeen categories for the total sample of newly licensed, domestically educated registered nurses from the Study of Nursing Practice.

The second set of three columns provide the mean (or average) values of frequency, criticality, and delegation for the newly licensed practical/vocational nurses on each of the 222 activities in the seventeen categories. The average values of frequency, delegation, and criticality for the category are given at the end of the list of activities in each category.

In computing the average frequency for each activity, the frequency variable was set equal to zero for respondents who indicated that the activity did not apply to their setting. For those who indicated that the activity applied to their setting and responded to question C, the frequency was set equal to:

1 if the activity was performed less than once a week
2 if the activity was performed 1 to 5 times per week
3 if the activity was performed 6 to 10 times per week
4 if the activity was performed more than 10 times per week

For those who responded to question B, the delegation variable was set equal to:

0 if the activity was never assigned to other nursing staff
1 if the activity was sometimes assigned to other nursing staff
2 if the activity was usually assigned to other nursing staff

For those who responded to question D, the criticality variable was set equal to:

0 if the activity could sometimes be omitted
1 if the activity could never be omitted

Those who did not respond to questions B and D were not included in computing the averages for these variables. At the end of the list of activities in each category, the average values of frequency, delegation, and criticality for the category is given.

As noted earlier, the seventeen categories in Table 10 were derived from a factor analysis of the frequency data for the newly licensed registered nurses in the Study of Nursing Practice. However, this category system captures much of the variability in the frequency, delegation, and criticality variables for the newly licensed practical/vocational nurses among the 222 activities, and the category system is employed as a framework for the discussion below.

For the newly licensed practical/vocational nurses, Category 12 - "Performing Routine Nursing Activities" had the highest average frequency (2.29). Other categories with relatively high average frequencies were Category 4 - "Protecting Client", with an average frequency of 1.74, Category 8 - "Monitoring Clients at Risk", with an average frequency of 1.66, and Category 10 - "Controlling Pain", with an average frequency of 1.50. The category with the lowest average frequency was Category 11 - "Meeting Client Needs Relating to Parenting", with an average frequency of 0.18. Note that, although the categories capture part of the variability in average frequencies over activities, there is also considerable variability within categories.

For the delegation variable, Category 12 - "Performing Routine Nursing Measures", has the highest average value, 0.70. For the remaining categories, the average value of delegation does not vary much, ranging from a low of 0.22 for Category 5 - "Meeting Acute Physical Needs" up to 0.39 for Category 14 - "Assisting Clients with Self-care". The fact that the highest average value for delegation occurred for Category 12, involving "routine" measures suggests that most of the newly licensed practical/vocational nurses interpreted the delegation questions as intended (i.e., delegation to a health worker who reports to the licensed practical/vocational nurse). However, there are also indications that at least a few of the newly licensed practical/vocational nurses interpreted delegation more broadly to include referral to other health workers who do not report to the licensed practical/vocational nurse; for example, activity 103 in Category 5, involving the interpretation of an EKG, has a mean delegation of 0.48.

The question on criticality (or impact), asked whether or not the activity "could sometimes be omitted" for some clients without a substantial risk of unnecessary complications, impairment of function, or serious distress. The criticality scale showed a substantial amount of variation among categories, with the category averages ranging from a high of 0.90 for Category 5 - "Meeting Acute Physical Needs" to a low of 0.66 for Category 15 - "Helping Clients to Cope with Stress" and Category 16 - "Supporting Client's Family". Again, however, it is important to note that the variability in mean criticality within categories is also quite large.

Some additional insights into the responses of the newly licensed practical/vocational nurses can be achieved by comparing their data to that of the newly licensed registered nurses (collected in 1985 as part of the Study of Nursing Practice).

For most activities, the mean frequency for the new RNs was higher than the mean frequency for the new LPN/VNs. The mean frequency for the RNs was greater than or equal to the mean frequency for LPN/VNs on 191 of the 222 activities, and the mean frequency for LPN/VNs was larger than that of the RNs on only 31 activities.

Of the 31 activities for which LPN/VN mean frequency was higher than the RN mean frequency, the three activities on which the largest difference between the LPN/VN mean and the RN mean were: Activity 17 - "Help a client to eat" (2.07 for LPN/VN and 1.77 for RN), Activity 89 - "Do passive range-of-motion exercises for a client" (1.72 for LPN/VN and 1.47 for RN), and Activity 157 - "Sterilize equipment" (.49 for LPN/VN and .28 for RN). More generally, of the 31 activities on which the mean frequency for new LPN/VNs was higher than the mean frequency for new RNs, eight were in Category 12 - "Performing Routine Nursing Measures", four were in Category 13 - "Meeting Acute Emotional/Behavioral Needs" and three were in Category 14 - "Assisting Clients with Self-care".

There were six activities on which the mean frequency for newly licensed registered nurses was greater than that for newly licensed practical/vocational nurses by a full point or more: Activity 39 - "Write a nursing care plan" (0.99 for LPN/VN and 2.13 for RN); Activity 119 - "Give a report to the nurses on the next shift" (1.78 for LPN/VN and 2.85 for RN); Activity 53 - "Administer blood" (0.13 for LPN/VN and 1.31 for RN); Activity 115 - "Alter an intravenous infusion rate based on a client's condition" (0.45 for LPN/VN and 1.61 for RN); Activity 132 - "Administer medications intravenously" (0.51 for LPN/VN and 2.76 for RN); and Activity 143 - "Start an intravenous infusion" (0.30 for LPN/VN and 1.68 for RN). The first two of these activities are from Category 3 - "Planning/Managing Client Care" and the last four are from Category 5 - "Meeting Acute Physical Needs".

On the delegation variable, the newly licensed practical/vocational nurses generally had lower mean values on activities than the newly licensed registered nurses. Of the 222 activities, there were only 20 on which the mean delegation for newly licensed practical/vocational nurses was higher than the mean delegation for registered nurses. For the remaining 202 activities, the mean delegation was higher for RNs than it was for LPN/VNs.

The newly licensed practical/vocational nurses and the newly licensed registered nurses were in good agreement on their ratings of the criticalities of activities. Figure 1 presents a plot of the average criticality for new LPN/VNs on each activity as a function of the average criticality for new RNs. Each point in Figure 1 presents an activity, and the location of each point is determined by the mean (or average) criticality for new RNs (x-axis) and the mean criticality for new LPN/VNs (y-axis). It is clear from Figure 1 that there is a strong positive relationship between the mean criticality ratings for licensed practical/vocational nurses and licensed registered nurses.

There are two points in Figure 1 that deviate substantially from the strong linear relationship between the mean criticality for LPN/VNs and the mean criticality for RNs. In both cases, the mean criticality rating for RNs is substantially higher than the mean criticality rating for LPN/VNs. Activity 118 - "Administer anesthesia" had a mean criticality rating of 0.50 for LPN/VNs and a mean criticality rating of 0.81 for RNs. Activity 24 - "Plan sex education classes for a group of clients" had a mean criticality of 0.13 for LPN/VNs and a mean criticality of 0.38 for RNs. These two activities had very low mean frequencies for both the newly licensed practical/vocational nurses and the newly licensed registered nurses, and are essentially not performed by either of these two groups. Therefore, the mean criticality ratings for these two activities would be based on very small samples and would, therefore, have large errors of measurement.

IMPORTANCE

In order to get an estimate of the overall importance of each activity for the practice patterns of newly licensed practical/vocational nurses, the mean ratings on frequency and criticality for each activity were combined into an index of importance. In combining frequency and criticality, this study employed the type of multiplicative model that was used for the sample of newly licensed registered nurses in the *Study of Nursing Practice* (See Appendix B, of *A Study of Nursing Practice and Role Delineation and Job Analysis of Entry-level Performance of Registered Nurses*).

In this multiplicative model, the importance assigned to each activity is assumed to involve the product of a frequency variable and a criticality variable. The criticality of an activity can be viewed as a measure of the importance of the activity (in terms of impact on client well being) per occurrence of the activity. Therefore, the product of frequency and criticality would provide an overall measure of importance.

This simple view of importance as the product of frequency and criticality is complicated somewhat by three considerations. First, the mean frequencies included in this report are not actual frequencies, but are based on a 5-point scale corresponding to frequency categories.

Second, in order to ensure that the emphasis, or weight, given to criticality is at least as great as that given to frequency in determining overall importance, the mean criticalities were raised to a power, yielding the relationship.

$$I' = FC^a.$$

The value of the exponent, "^{a}," necessary to ensure that equal weight was assigned to frequency and criticality was 4.51 for the data in this study. Third, it is the relative values of the importance variable, I', that are important rather than the absolute values. Therefore, the values of I' for the 222 activities were scaled so that their sum was 100; the rescaled importance variable is represented by w'_i.

The last two columns of Table 10 provide the values of w'_i for the 222 activities for the newly licensed registered nurses (from the Study of Nursing Practice) and the newly licensed practical/vocational nurses.

There are three particularly salient features of the importance analyses reported in the last two columns of Table 10. First, the average value of w'_i in Category 11 - "Meeting Client Needs Related to Parenting" for the newly licensed practical/vocational nurses is particularly low. This result is similar to that for the newly licensed registered nurses.

Second, the average value of w'_i for the newly licensed practical/vocational nurses on Category 12 - "Performing Routine Nursing Activities" is substantially higher than the average w'_i for the newly licensed registered nurses on this category (0.76 for the LPN/VNs and 0.54 for the RNs).

Third, the average value of w'_i for the newly licensed practical/vocational nurses on Category 5 - "Meeting Acute Physical Needs" is substantially lower than the average value of w'_i for the newly licensed registered nurses on this category (0.45 for the LPN/VNs and 0.66 for the RNs).

CONCLUDING REMARKS

The results reported here provide a general description of the results of the job analyses/role delineation of practice patterns of the 1987 sample of newly licensed practical/vocational nurses. A second sample of newly licensed practical/vocational nurses will be collected in 1988 and the final report of this study will contain analyses of both of these samples. The final report will also include an update of the job analyses/role delineation of newly licensed registered nurses, based on a sample of newly licensed registered nurses to be surveyed in the fall of 1987.

Table 1

Percentages of Sampling Frame, Sample, and Analysis Sample as a Function of Geographic Region

	Sampling Frame		Sample		Analysis Sample	
Region	#	%	#	%	#	%
1. North Atlantic	5171	25.3	860	25.2	178	20.1
2. Midwest	4661	22.8	778	22.8	228	25.8
3. Southern	7273	35.6	1213	35.5	367	41.5
4. Western	3351	16.4	564	16.5	112	12.7

JURISDICTIONS INCLUDED IN THE GEOGRAPHIC REGIONS BY CODE NUMBERS

1. **North Atlantic:** Connecticut, Delaware, District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

2. **Midwest:** Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin

3. **Southern:** Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia

4. **Western:** Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Table 2
Types of Clients as a Function of Work Setting (October 1986 Sample of New LPNs)

Setting	W	M	C	A	T	P	WM	WC	WA	WT	WP	MC	MA	CA	CT	CP	AT	AP	TP
1. MEDSURG	1	0	10	38	3	0	0	4	3	0	0	1	0	15	4	0	21	1	0
2. PEDS	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3. ICU	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
4. OR	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5. RR	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6. PSYCH	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	3	0	2	0
7. ANESTHES	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8. CNTRLSRV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9. ER	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
10. LABORDLV	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
11. POSTPART	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12. NURSERY	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13. PATNTED	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14. SKILLED	1	0	34	5	6	4	0	1	0	0	1	0	0	4	15	6	2	1	4
15. INTERMED	4	0	25	1	0	2	0	3	0	0	1	0	0	0	3	9	1	1	1
16. RESIDNTL	3	0	6	0	1	4	0	1	0	0	0	0	0	1	0	2	0	0	0
17. OFFICE	4	1	0	2	0	0	2	0	1	0	0	0	0	1	0	0	0	0	0
18. SCHOOL	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19. INDUSTRY	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
20. CLINIC	1	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
21. OUTSURG	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
22. HOME	0	1	10	2	1	1	0	0	0	0	0	0	0	0	2	0	1	0	0
23. INDIVID	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
24. GROUPNUR	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
25. GROUPPHY	2	0	0	1	1	0	3	2	4	0	0	0	0	0	0	0	0	0	0

W - Well clients, possibly with common minor illnesses
M - Maternity clients
C - Clients with stabilized chronic conditions
A - Clients with acute conditions
T - Terminally ill clients
P - Clients with behavioral/emotional disorders

Table 3
Ages of Clients as a Function of Work Setting
October 1986 Sample of Newly Licensed Practical Nurses

		N	C	A	E	NC	NA	NE	CA	CE	AE	O
1	MEDSURG	0	0	43	17	0	0	-	1	1	97	8
2	PEDS	0	2	0	0	0	0	-	1	0	0	0
3	ICU	0	0	1	1	0	0	-	0	0	2	0
4	OR	0	0	2	0	0	0	-	0	0	0	0
5	RR	-	-	-	-	-	-	-	-	-	-	-
6	PSYCH	0	0	7	0	0	0	-	0	0	1	0
7	ANESTHES	-	-	-	-	-	-	-	-	-	-	-
8	CNTRLSRV	0	0	1	0	0	0	-	0	0	0	0
9	ER	0	0	3	0	0	0	-	2	0	0	3
10	LABORDLV	-	-	-	-	-	-	-	-	-	-	-
11	POSTPART	0	0	1	0	0	0	-	0	0	0	0
12	NURSERY	2	0	0	0	0	0	-	0	0	0	0
13	PATNTED	0	0	0	1	0	0	-	0	0	0	0
14	SKILLED	0	0	1	137	0	0	-	1	0	29	1
15	INTERMED	0	0	2	74	0	0	-	0	0	14	1
16	RESIDNTL	0	1	3	21	0	0	-	0	0	4	0
17	OFFICE	0	0	7	0	1	0	-	2	0	7	3
18	SCHOOL	0	0	0	0	0	0	-	1	0	0	0
19	INDUSTRY	0	0	3	0	0	0	-	0	0	0	0
20	CLINIC	0	0	2	0	0	0	-	3	0	1	1
21	OUTSURG	-	-	-	-	-	-	-	-	-	-	-
22	HOME	0	1	3	12	1	1	-	0	0	8	0
23	INDIVID	0	0	1	0	0	0	-	0	0	3	1
24	GROUPNUR	-	-	-	-	-	-	-	-	-	-	-
25	GROUPPHY	0	1	7	0	1	0	-	2	1	3	2
99	Multiple	0	5	53	99	2	15	-	7	4	94	41

N - Newborns
C - Infants/children
A - Adults (ages 15-65)
E - Elderly clients (over 65)

Table 4
Category Average Frequencies for Selected Settings

Categories	Med/ Surg	Skilled Care	Inter. Care	Resid. Care	Office	Home	Group NurPhy
1. Staff Development, Collaboration	0.43	1.06	1.07	0.96	0.34	0.21	0.18
2. Quality Assurance and Safety	0.57	0.88	0.99	0.90	0.37	0.44	0.34
3. Planning/Managing Client Care	1.23	1.36	1.52	1.35	0.72	0.66	0.74
4. Protecting Client	1.97	1.92	1.90	1.75	0.91	0.81	1.14
5. Meeting Acute Physical Needs	0.73	0.63	0.55	0.59	0.32	0.27	0.28
6. Preparing Clients for Procedures	1.82	0.85	0.84	0.70	1.38	0.39	1.45
7. Ensuring Safety During Procedures	1.01	0.85	0.76	0.69	1.25	0.62	1.17
8. Monitoring Clients at Risk	2.02	1.74	1.72	1.66	0.50	1.26	0.46
9. Assisting Clients with Mobility Needs	1.34	1.14	1.13	0.94	0.17	0.96	0.26
10. Controlling Pain	1.76	1.54	1.51	1.43	0.79	1.03	0.78
11. Meeting Client Needs Related to Parenting	0.11	0.07	0.08	0.07	0.36	0.13	0.35
12. Performing Routine Nursing Activities	2.71	2.46	2.40	2.25	1.02	1.65	1.11
13. Meeting Acute Emotional/Behavioral Needs	0.41	0.49	0.55	0.66	0.11	0.24	0.23
14. Assisting Clients with Self-Care	0.90	0.80	0.93	0.94	0.55	0.65	0.62
15. Helping Clients to Cope with Stress	1.33	1.22	1.26	1.33	0.56	1.07	0.54
16. Supporting Client's Family	0.75	0.66	0.68	0.67	0.40	1.09	0.31
17. Immunizing/Screening	0.33	0.34	0.36	0.32	1.05	0.03	1.49

Table 5
Average Criticality Ratings for Activities Predicted to Have Relatively High Criticality and Relatively Low Criticality

	Activity	Criticality
	High Criticality Predicted	
10.	Check with a physician about contraindicated medications or treatments	0.91
14.	Evaluate the impact of therapeutic interventions on a client's potential for suicide	0.88
53.	Administer blood	0.89
83.	Notify a physician about significant changes in a client's condition	0.94
130.	Provide emergency care for a wound	0.95
145.	Carry out radiation protection measures	0.93
161.	Label and prepare specimens for transmission to the laboratory	0.95
184.	Administer oxygen	0.89
213.	Check that a hemodialysis machine is working properly	0.92
220.	Intervene in situations involving unsafe or inadequate care	0.92
221.	Manage a medical emergency until a physician arrives	0.97
Average		0.92
	Low Criticality Predicted	
1.	Measure vital signs	0.56
4.	Assist a client with personal hygiene	0.55
12.	Weigh a client	0.43
29.	Give a back rub	0.22
57.	Use resources to learn more about the culture of a client	0.36
91.	Teach clients about normal nutrition	0.52
109.	Give perineal care	0.73
125.	Plan anticipatory guidance for developmental transitions (e.g., puberty, retirement)	0.64
126.	Adjust visiting hours to meet a family's need	0.49
219.	Help clients choose recreational activities that fit their age and condition	0.51
Average		0.50

Table 6
Average Value of Delegation Scale for Activities Predicted to be Delegated More Frequently and Less Frequently

High Delegation Prediction

	Activity	Delegation
1.	Measure vital signs	0.76
4.	Assist a client with personal hygiene	1.07
6.	Position or turn a client	1.08
12.	Weigh a client	1.08
17.	Help a client to eat	1.13
29.	Give a back rub	1.00
50.	Give an enema	0.66
69.	Record intake and output	0.79
135.	Help a client in and out of bed	1.04
180.	Help a client to do activities of daily living	1.02
Average		0.96

Low Delegation Prediction

14.	Evaluate the impact of therapeutic interventions on a client's potential for suicide	0.25
30.	Verify that a client or family has information needed needed for informed consent	0.28
53.	Administer blood	0.36
54.	Perform complete physical examinations	0.28
63.	Plan measures to deal with cardiac arrhythmias	0.28
90.	Direct a support group for staff	0.67
94.	Perform a vaginal-pelvic examination	0.38
103.	Interpret an electrocardiogram monitor strip	0.48
118.	Administer anesthesia	0.75
179.	Insert a nasogastric tube	0.16
197.	Interpret central venous pressure readings	0.39
203.	Engage a client in individual psychotherapy	0.38
Average		0.39

Table 7
Distribution of New LPN/VNs as a Function of Setting

	Activity	Number	Percentage
1.	MEDSURG	167	29.6
2.	PEDS	3	0.5
3.	ICU	4	0.7
4.	OR	2	0.4
5.	RR	0	0.0
6.	PSYCH	8	1.4
7.	ANESTHES	0	0.0
8.	CNTRLSRV	1	0.2
9.	ER	8	1.4
10.	LABORDLV	0	0.0
11.	POSTPART	1	0.2
12.	NURSERY	2	0.4
13.	PATNTED	1	0.2
14.	SKILLED	169	29.9
15.	INTERMED	91	16.1
16.	RESIDNTL	29	5.1
17.	OFFICE	20	3.5
18.	SCHOOL	1	0.2
19.	INDUSTRY	3	0.5
20.	CLINIC	7	1.2
21.	OUTSURG	0	0.0
22.	HOME	26	4.6
23.	INDIVID	5	0.9
24.	GROUPNUR	0	0.0
25.	GROUPPHY	17	3.0
Total		565	100.0

Table 8
Distribution of Newly Licensed Practical/Vocational Nurses as a function of Shift Worked

Shift	Number	Percentage
Days	243	27.6
Evenings	280	31.8
Nights	179	20.3
Rotating Shifts	152	17.3
Other	18	2.0
Multiple Responses	9	1.0

Table 9
Distribution of Newly Licensed Practical/Vocational Nurses as a Function of Experience in Current Position (in months)

Experience in Current Position (months)	Number	Percentage
1	50	5.6
2	73	8.2
3	120	13.6
4	121	13.7
5	131	14.8
6	162	18.3
7	81	9.2
8	60	6.8
9	23	2.6
10	11	1.2
11	1	0.1
12	13	1.5
over 12	39	4.3

Table 10
Mean Frequency, Delegation, Criticality, and Importance Weights, w_i ($I' = FC^a$) on the 222 Activities for Newly Licensed Practical/Vocational Nurses and Newly Licensed Registered Nurses

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w′	LPN/VN w′
1. Staff Development, Collaboration								
44. Assist staff to respond to complaints	1.56	0.46	0.55	1.55	0.38	0.64	0.15	0.23
56. Teach staff about confidentiality	0.70	0.30	0.77	0.77	0.26	0.82	0.22	0.35
57. Learn about client's culture	0.64	0.46	0.30	0.65	0.31	0.36	0.01	0.01
90. Direct support group for staff	0.07	0.65	0.38	0.04	0.67	0.59	0.00	0.00
92. Plan assignments for staff	1.38	0.37	0.81	1.02	0.26	0.78	0.51	0.38
133. Teach staff precautions for equip.	0.46	0.46	0.82	0.42	0.28	0.88	0.18	0.26
174. Plan care in team conference	0.69	0.23	0.58	0.33	0.18	0.67	0.08	0.06
Average	**0.79**	**0.42**	**0.60**	**0.68**	**0.33**	**0.68**	**0.17**	**0.18**
2. Quality Assurance and Safety								
10. Check on contraindicated orders	1.65	0.18	0.96	1.32	0.25	0.91	1.10	0.93
19. Eval. staff on infection control	0.81	0.34	0.72	0.72	0.27	0.80	0.20	0.29
25. Withhold med. for adverse reaction	1.31	0.16	0.97	1.15	0.16	0.95	0.91	1.03
32. Recommend change in drug therapy	1.33	0.19	0.85	0.97	0.27	0.86	0.59	0.54
35. Eval. nursing documentation system	0.84	0.38	0.48	0.57	0.31	0.61	0.05	0.07
55. Look for source of infection	0.91	0.41	0.85	0.79	0.31	0.89	0.40	0.51
71. Help run community safety program	0.04	0.61	0.44	0.06	0.50	0.63	0.00	0.01
72. Audit nursing records	0.26	0.34	0.53	0.18	0.38	0.77	0.02	0.06
106. Analyze hazards in community	0.36	0.62	0.72	0.34	0.55	0.86	0.09	0.20
123. Document errors or accidents	1.05	0.13	0.93	1.01	0.10	0.96	0.63	0.93
181. Identify clients needing isolation	1.12	0.31	0.92	0.62	0.21	0.90	0.65	0.41
202. Help plan a disaster program	0.08	0.54	0.74	0.11	0.53	0.76	0.02	0.03
217. Develop standards of care	1.24	0.38	0.72	0.90	0.28	0.76	0.30	0.29
220. Intervene in inadequate care	1.20	0.21	0.93	1.18	0.19	0.92	0.73	0.89
Average	**0.87**	**0.34**	**0.77**	**0.71**	**0.31**	**0.83**	**0.41**	**0.44**

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w´	LPN/VN w´
3. Planning/Managing Client Care								
7. Plan for discharge	1.76	0.50	0.79	0.92	0.36	0.79	0.61	0.35
9. Alter plans based on client values	1.82	0.36	0.49	1.21	0.38	0.57	0.13	0.10
18. Record nursing history	2.03	0.31	0.83	1.18	0.23	0.83	0.85	0.55
31. Plan communication methods	1.35	0.60	0.81	1.17	0.43	0.81	0.50	0.51
39. Write care plan	2.13	0.33	0.64	0.99	0.29	0.72	0.36	0.25
61. Prescribe medications	0.09	0.47	0.63	0.09	0.32	0.81	0.01	0.04
77. Schedule med. administration	2.30	0.38	0.90	1.49	0.18	0.91	1.25	1.05
119. Give shift report	2.88	0.16	0.96	2.42	0.14	0.97	1.98	2.28
144. Transcribe MDs orders	2.85	0.16	0.96	1.78	0.18	0.95	1.96	1.57
Average	**1.91**	**0.40**	**0.78**	**1.25**	**0.28**	**0.82**	**0.85**	**0.74**
4. Protecting Client								
87. Arrange room for safety	2.04	0.84	0.81	1.85	0.77	0.83	0.77	0.88
155. Check accuracy of orders	2.79	0.21	0.91	2.05	0.14	0.91	1.56	1.45
158. Act when client dignity is violated	1.38	0.27	0.81	1.27	0.20	0.85	0.52	0.67
163. Plan for client safety needs	0.92	0.48	0.87	0.73	0.34	0.89	0.44	0.48
194. Identify clients who need restraints	1.76	0.39	0.86	1.81	0.32	0.85	0.83	0.95
198. Verify client's identity	3.01	0.27	0.94	2.73	0.18	0.93	1.86	2.19
Average	**1.98**	**0.41**	**0.87**	**1.74**	**0.32**	**0.88**	**1.00**	**1.10**
5. Meeting Acute Physical Needs								
53. Administer blood	1.31	0.13	0.95	0.13	0.36	0.89	0.84	0.08
54. Perform complete physical exams	0.93	0.20	0.73	0.26	0.28	0.69	0.25	0.06
60. Insert endotracheal tube	0.19	0.48	0.91	0.10	0.27	0.87	0.10	0.06
63. Plan to deal with arrhythmias	0.94	0.25	0.95	0.34	0.28	0.93	0.61	0.27
76. Perform CPR	0.91	0.28	0.94	0.66	0.13	0.88	0.57	0.41
79. Report changes in consciousness	1.92	0.21	0.95	1.81	0.18	0.95	1.23	1.56
83. Notify MD about changes in condition	2.54	0.18	0.97	1.81	0.18	0.94	1.78	1.54
103. Interpret EKG	0.94	0.47	0.87	0.19	0.48	0.85	0.46	0.10
104. Eval. response to TPN	1.02	0.29	0.86	0.48	0.23	0.85	0.47	0.26
108. Monitor mechanical ventilator	0.62	0.36	0.98	0.24	0.23	0.97	0.44	0.23
115. Alter I.V. Rate	1.61	0.17	0.87	0.45	0.21	0.84	0.78	0.23

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w'	LPN/VN w'
117. Attach monitoring equip.	1.36	0.53	0.86	0.61	0.26	0.82	0.63	0.28
127. Provide tracheostomy care	1.02	0.35	0.91	0.83	0.12	0.94	0.57	0.69
130. Give emergency care to wound	0.67	0.24	0.95	0.87	0.12	0.95	0.43	0.74
132. Give I.V. meds	2.76	0.16	0.93	0.51	0.21	0.91	1.68	0.37
138. Assess severity of chest trauma	0.31	0.17	0.98	0.22	0.10	0.96	0.21	0.20
143. Start an intravenous infusion	1.68	0.43	0.87	0.30	0.37	0.88	0.80	0.18
161. Counteract adverse effects of meds.	1.15	0.20	0.94	0.81	0.16	0.95	0.72	0.72
165. Report change - intracranial pressure	0.63	0.11	0.98	0.38	0.07	0.96	0.45	0.35
166. Order tests in emergencies	0.55	0.26	0.97	0.15	0.19	0.96	0.38	0.14
179. Insert nasogastric tube	1.02	0.30	0.84	0.45	0.16	0.85	0.43	0.24
184. Administer oxygen	2.17	0.54	0.86	1.56	0.22	0.89	0.99	1.04
197. Interpret C.V.P. readings	0.50	0.21	0.90	0.11	0.39	0.91	0.26	0.08
208. Suction respiratory tract	1.73	0.41	0.90	1.30	0.12	0.90	0.90	0.91
212. Order routine tests	1.23	0.58	0.77	0.76	0.23	0.82	0.39	0.34
221. Manage emergency until MD arrives	1.06	0.16	0.98	0.72	0.15	0.97	0.75	0.67
Average	**1.18**	**0.29**	**0.91**	**0.62**	**0.22**	**0.90**	**0.66**	**0.45**
6. Preparing Clients for Procedures								
15. Prepare client for test	2.17	0.70	0.84	1.61	0.46	0.86	0.94	0.92
30. Verify client has info. for consent	1.83	0.30	0.92	1.05	0.28	0.91	1.05	0.75
171. Insert indwelling urinary catheter	1.47	0.52	0.81	1.46	0.14	0.84	0.54	0.73
175. Explain outcomes of therapy	1.98	0.34	0.72	1.20	0.24	0.72	0.49	0.31
196. Ask about allergies	2.58	0.42	0.97	1.91	0.20	0.93	1.82	1.55
200. Check emotional readiness for proc.	1.66	0.35	0.77	0.72	0.21	0.87	0.52	0.43
213. Check physical readiness for proc.	1.54	0.34	0.93	0.63	0.20	0.92	0.93	0.47
Average	**1.89**	**0.42**	**0.85**	**1.23**	**0.25**	**0.87**	**0.90**	**0.74**
7. Ensuring Safety During Procedures								
43. Set up a sterile field	1.86	0.35	0.92	1.66	0.11	0.92	1.06	1.26
96. Maintain asepsis	2.29	0.35	0.96	2.08	0.25	0.95	1.51	1.86
105. Check functioning of suction equip.	1.94	0.50	0.87	1.40	0.20	0.89	0.92	0.90
114. Pass instruments during procedure	0.35	0.39	0.80	0.22	0.24	0.83	0.12	0.11
145. Carry out radiation protect. measures	0.36	0.38	0.93	0.17	0.30	0.93	0.21	0.13

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w´	LPN/VN w´
152. Check electronic equip.	1.78	0.63	0.82	1.30	0.38	0.84	0.70	0.66
157. Sterilize equip.	0.28	1.10	0.89	0.49	0.54	0.91	0.14	0.35
176. Stay with client to promote safety	1.85	0.76	0.75	1.61	0.56	0.77	0.53	0.54
186. Monitor client status during procedure	0.70	0.24	0.96	0.24	0.24	0.92	0.47	0.18
210. Check hemodialysis machine	0.06	0.47	0.94	0.04	0.31	0.88	0.04	0.02
Average	**1.14**	**0.52**	**0.88**	**0.92**	**0.31**	**0.88**	**0.57**	**0.60**
8. Monitoring Clients at Risk								
13. Assess respiratory status	3.31	0.30	0.85	2.67	0.23	0.85	1.44	1.45
27. Assess cardiovascular status	3.09	0.26	0.88	2.11	0.22	0.91	1.52	1.55
37. Plan to prevent circulatory compl.	2.28	0.40	0.89	1.78	0.35	0.91	1.20	1.30
46. Assess orientation	2.86	0.51	0.73	2.74	0.40	0.71	0.74	0.66
47. Observe for side effects of therapy	0.75	0.29	0.90	0.42	0.26	0.89	0.41	0.28
58. Assess tolerance for activity	2.20	0.58	0.72	1.82	0.39	0.74	0.56	0.50
67. Check for drug interactions	1.84	0.31	0.83	1.50	0.23	0.86	0.77	0.82
74. Plan measures to promote sleep	2.04	0.59	0.51	1.71	0.43	0.56	0.16	0.14
82. Prevent respiratory complications	2.57	0.43	0.93	2.06	0.32	0.95	1.55	1.80
100. Modify care based on test results	1.72	0.36	0.82	0.94	0.30	0.84	0.67	0.48
112. Check bowel sounds	2.60	0.34	0.59	1.95	0.15	0.64	0.34	0.29
131. Record characteristics - tube drainage	2.00	0.34	0.59	1.51	0.15	0.90	0.85	1.03
134. Plan to reduce discomfort	1.96	0.61	0.61	1.59	0.51	0.71	0.28	0.37
139. Assess nutrition and hydration status	2.59	0.38	0.82	2.00	0.28	0.86	1.00	1.14
159. Assess need for sensory stimulation	1.61	0.42	0.61	1.00	0.32	0.68	0.24	0.19
169. Assess patency of tubes	1.80	0.36	0.94	1.28	0.21	0.96	1.10	1.17
177. Check for bleeding	2.39	0.35	0.94	1.78	0.25	0.94	1.48	1.48
189. Determine expected effects of therapy	1.32	0.20	0.60	0.87	0.17	0.64	0.18	0.12
209. Assess wound healing	2.40	0.37	0.85	2.27	0.17	0.89	1.05	1.47
211. Suggest changes in med. orders	1.87	0.22	0.74	1.30	0.14	0.79	0.51	0.48
215. Plan to maintain skin integrity	2.58	0.50	0.82	2.33	0.39	0.86	1.03	1.30
218. Refer to literature in planning care	1.25	0.24	0.46	0.91	0.17	0.57	0.07	0.08
Average	**2.14**	**0.38**	**0.77**	**1.66**	**0.28**	**0.80**	**0.78**	**0.82**

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w'	LPN/VN w'
9. Assisting Clients with Mobility Needs								
33. Position client with spinal injury	0.64	0.49	0.94	0.54	0.42	0.95	0.40	0.47
45. Check for complic. from immobility	2.35	0.51	0.87	2.17	0.37	0.90	1.14	1.51
80. Check traction devices	0.74	0.51	0.89	0.48	0.24	0.91	0.39	0.34
89. Do passive R-O-M exercises	1.47	0.95	0.53	1.72	0.84	0.66	0.13	0.28
98. Plan to prevent neuro. complications	1.30	0.30	0.91	0.60	0.25	0.90	0.72	0.41
149. Assess neurosensory function	1.94	0.33	0.80	1.23	0.18	0.83	0.70	0.59
167. Check for cast complications	0.97	0.39	0.94	0.81	0.21	0.93	0.60	0.65
188. Evaluate crutch walking	0.88	0.78	0.70	0.94	0.42	0.73	0.20	0.25
Average	**1.29**	**0.53**	**0.82**	**1.06**	**0.37**	**0.85**	**0.54**	**0.56**
10. Controlling Pain								
20. Plan to minimize pain	2.33	0.38	0.74	1.88	0.29	0.78	0.65	0.67
118. Administer anesthesia	0.04	0.44	0.81	0.02	0.75	0.50	0.01	0.00
146. Teach pain management techniques	1.37	0.49	0.63	0.82	0.29	0.69	0.22	0.17
187. Plan to deal with anxiety from pain	1.76	0.41	0.75	1.10	0.29	0.80	0.51	0.44
199. Eval. response to pain control meas.	2.76	0.43	0.78	2.32	0.25	0.83	0.91	1.11
205. Assess need for prn meds	3.16	0.32	0.84	2.85	0.14	0.87	1.36	1.67
Average	**1.90**	**0.41**	**0.76**	**1.50**	**0.33**	**0.74**	**0.61**	**0.68**
11. Meeting Client Needs Related to Parenting								
11. Teach a childbirth class	0.03	0.64	0.41	0.04	0.74	0.43	0.00	0.00
24. Plan sex education classes	0.06	0.69	0.38	0.03	0.59	0.13	0.00	0.00
38. Deliver a newborn	0.11	0.37	0.94	0.06	0.30	0.94	0.06	0.05
51. Compare physical develop. to norms	1.12	0.49	0.67	0.87	0.28	0.55	0.10	0.07
94. Perform a vaginal-pelvic exam	0.49	0.43	0.52	0.09	0.38	0.79	0.04	0.03
95. Assess parents-growth and develop.	0.40	0.54	0.78	0.25	0.29	0.53	0.04	0.02
99. Check parent skill at infant feeding	0.40	0.55	0.65	0.25	0.22	0.79	0.14	0.09
102. Teach parenting skills	0.21	0.46	0.38	0.19	0.29	0.70	0.07	0.04
116. Assess attitudes to contraception	0.30	0.40	0.93	0.12	0.35	0.44	0.01	0.00
122. Assess new mothers for complications	0.19	0.34	0.82	0.21	0.12	0.94	0.18	0.18
129. Eval. understanding of fetal risks	0.19	0.34	0.82	0.11	0.23	0.80	0.08	0.05
140. Conduct a prenatal care session	0.03	0.56	0.59	0.04	0.47	0.74	0.00	0.01

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w	LPN/VN w
142. Assess mother and fetus during labor	0.18	0.37	0.95	0.12	0.27	0.92	0.12	0.09
178. Assess a newborn	0.36	0.33	0.96	0.20	0.26	0.89	0.25	0.13
201. Identify sexuality problems	0.35	0.47	0.54	0.12	0.39	0.54	0.03	0.01
216. Analyze adaptation - newborn's family	0.30	0.42	0.66	0.12	0.41	0.70	0.06	0.03
Average	**0.29**	**0.47**	**0.67**	**0.18**	**0.35**	**0.68**	**0.07**	**0.05**
12. Performing Routine Nursing Activities								
1. Measure vital signs	3.37	0.97	0.56	3.10	0.76	0.56	0.35	0.25
2. Modify food and fluid intake	2.38	0.66	0.61	2.02	0.64	0.66	0.34	0.34
4. Assist with hygiene	2.74	1.05	0.39	2.58	1.07	0.55	0.09	0.19
6. Position or turn a client	3.08	1.01	0.66	2.91	1.08	0.78	0.57	1.07
12. Weigh a client	1.96	1.26	0.34	1.85	1.08	0.43	0.04	0.04
17. Help a client to eat	1.77	1.25	0.75	2.07	1.13	0.81	0.54	0.88
22. Schedule client rest	2.02	0.68	0.49	1.50	0.65	0.59	0.14	0.15
29. Give a back rub	2.00	1.09	0.10	2.13	1.00	0.22	0.00	0.00
34. Give a tube feeding	1.67	0.49	0.85	1.78	0.15	0.91	0.73	1.27
41. Test a urine specimen	2.05	1.02	0.58	1.67	0.69	0.73	0.24	0.44
50. Give an enema	1.37	1.02	0.58	1.50	0.66	0.63	0.17	0.21
69. Record intake and output	3.17	0.99	0.64	2.78	0.79	0.77	0.53	0.94
70. Administer oral medications	3.51	0.44	0.87	3.44	0.15	0.88	1.66	2.12
86. Give I.M. or Sub Q. injections	2.97	0.40	0.87	2.64	0.10	0.90	1.43	1.78
109. Give perineal care	2.06	1.01	0.58	2.13	1.00	1.73	0.25	0.58
113. Apply dressing to a wound	2.44	0.50	0.76	2.52	0.18	0.82	0.75	1.11
135. Help client in and out of bed	2.78	0.07	0.63	2.76	1.04	0.74	0.46	0.76
160. Label specimens for lab	2.66	0.81	0.90	2.14	0.33	0.91	1.41	1.56
172. Obtain specimens for tests	2.47	0.88	0.80	2.03	0.50	0.84	0.89	1.01
180. Help with activities of daily living	2.25	1.10	0.57	2.29	1.02	0.71	0.26	0.55
Average	**2.44**	**0.88**	**0.63**	**2.29**	**0.70**	**0.71**	**0.54**	**0.76**
13. Meeting Acute Emotional/Behavioral Needs								
14. Eval. therapy - potential for suicide	0.60	0.27	0.88	0.41	0.25	0.88	0.30	0.25
23. Check for alcohol/drug withdrawal	1.10	0.34	0.80	0.66	0.26	0.78	0.39	0.24
36. Record behaviors indicating delusions	1.11	0.28	0.86	1.39	0.12	0.88	0.51	0.85

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w′	LPN/VN w′
40. Help clients understand behavior	1.38	0.47	0.50	0.84	0.39	0.56	0.10	0.07
48. Refer to a self-help group	0.55	0.65	0.47	0.23	0.39	0.40	0.03	0.00
49. Teach signs of depression	0.35	0.48	0.57	0.24	0.36	0.59	0.04	0.02
52. Develop substance abuse program	0.07	0.71	0.57	0.03	0.16	0.61	0.01	0.00
62. Plan to increase client self-esteem	0.68	0.47	0.51	0.53	0.46	0.59	0.05	0.05
68. Teach behavior management techniques	0.29	0.54	0.69	0.26	0.34	0.67	0.06	0.05
75. Assess potential for violence	1.08	0.38	0.86	1.19	0.32	0.90	0.49	0.80
97. Assess environment of suicidal client	0.61	0.34	0.96	0.49	0.22	0.95	0.41	0.44
124. Counsel victims of abuse	0.17	0.53	0.85	0.06	0.31	0.90	0.08	0.04
147. Evaluate recreational therapy	0.39	0.87	0.37	0.53	0.69	0.52	0.01	0.03
153. Counsel substance abuser	0.31	0.68	0.70	0.11	0.29	0.75	0.07	0.03
168. Evaluate desensitizing techniques	0.24	0.50	0.63	0.23	0.37	0.74	0.04	0.06
182. Record data for behavior modif. prog.	0.31	0.47	0.68	0.34	0.27	0.74	0.07	0.10
190. Plan to control disruptive behavior	0.76	0.52	0.73	0.79	0.34	0.77	0.20	0.27
191. Teach communication skills	0.52	0.65	0.58	0.50	0.54	0.62	0.06	0.06
195. Conduct group therapy session	0.09	0.59	0.71	0.04	0.48	0.67	0.02	0.01
203. Provide indiv. psychotherapy	0.15	0.48	0.67	0.07	0.38	0.68	0.03	0.01
Average	**0.54**	**0.51**	**0.68**	**0.45**	**0.35**	**0.71**	**0.15**	**0.17**
14. Assisting Clients with Self-Care								
64. Analyze self-care abilities	2.20	0.63	0.63	1.76	0.45	0.66	0.35	0.30
85. Plan to improve appetite	1.43	0.78	0.51	1.40	0.56	0.66	0.11	0.24
91. Teach about normal nutrition	0.99	0.79	0.40	0.74	0.51	0.52	0.03	0.04
107. Assess need to teach client hygiene	1.35	0.73	0.42	1.39	0.53	0.59	0.05	0.14
110. Teach about self-admin. of meds	1.50	0.33	0.86	0.84	0.16	0.83	0.69	0.40
120. Teach how to avoid infections	1.71	0.51	0.72	1.53	0.36	0.78	0.43	0.54
121. Eval. performance of breathing exer.	1.50	0.55	0.64	0.88	0.29	0.76	0.25	0.27
128. Plan bowel/bladder training prog.	0.70	0.56	0.69	0.89	0.39	0.72	0.15	0.23
137. Help clients adopt healthy roles	1.17	0.39	0.62	0.60	0.32	0.74	0.18	0.18
141. Counsel an incontinent client	0.84	0.54	0.55	0.89	0.40	0.67	0.09	0.16
148. Compare clients and MD view of status	1.36	0.38	0.55	0.80	0.30	0.56	0.14	0.06
150. Evaluate understanding of ostomy care	0.75	0.58	0.71	0.70	0.25	0.73	0.17	0.19
151. Plan counseling for weight control	0.38	0.84	0.47	0.23	0.48	0.52	0.02	0.01

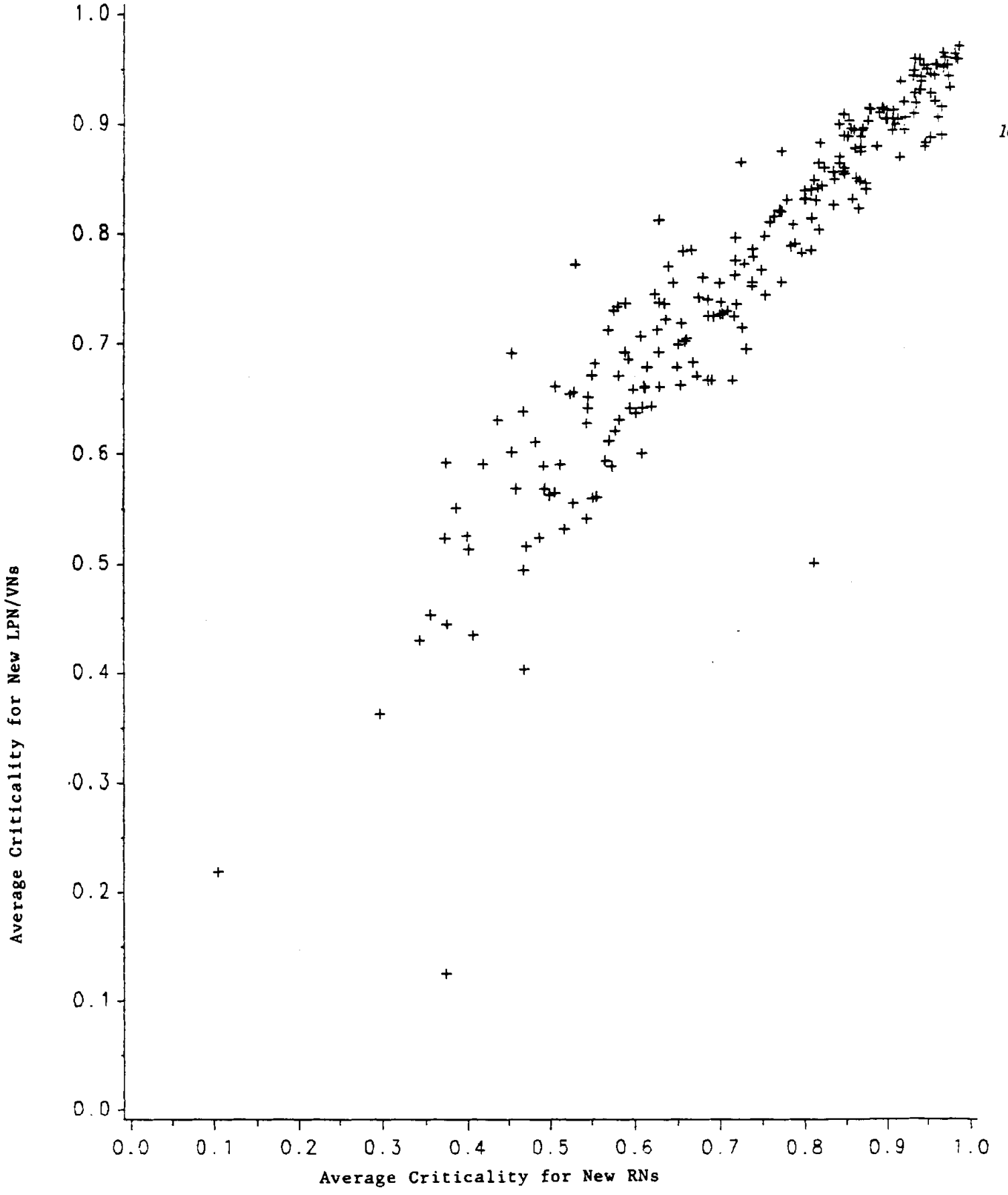
Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w′	LPN/VN w′
154. Teach how to exercise	0.84	0.83	0.45	0.66	0.57	0.60	0.04	0.07
164. Prepare teaching materials	0.93	0.58	0.62	0.41	0.38	0.64	0.14	0.06
170. Teach about assistive devices	0.41	0.68	0.70	0.33	0.45	0.74	0.09	0.09
173. Decide to refer for sensory deficit	0.74	0.50	0.67	0.57	0.36	0.74	0.15	0.16
185. Adapt diet to client's special needs	1.22	0.77	0.68	0.71	0.40	0.76	0.25	0.23
192. Assess adequacy of nutrition	0.42	0.86	0.65	0.13	0.33	0.66	0.08	0.02
193. Teach self-care to impaired client	0.90	0.73	0.74	0.83	0.55	0.75	0.25	0.26
206. Eval. use of remedies and OTC drugs	1.17	0.36	0.65	0.67	0.19	0.72	0.21	0.17
214. Suggest modification of medical ther.	1.58	0.24	0.70	0.96	0.20	0.73	0.37	0.25
219. Help choose recreational activities	0.63	0.83	0.40	0.66	0.65	0.51	0.02	0.04
222. Eval. compliance with therapy	1.77	0.36	0.79	1.31	0.22	0.81	0.60	0.55
Average	**1.10**	**0.60**	**0.62**	**0.83**	**0.39**	**0.68**	**0.20**	**0.19**
15. Helping Clients to Cope with Stress								
5. Assess adequacy of emotional support	2.51	0.42	0.57	2.11	0.45	0.59	0.30	0.21
16. Plan to improve coping behaviors	1.47	0.45	0.54	0.99	0.44	0.63	0.14	0.13
21. Arrange spiritual support in crises	1.09	0.69	0.59	0.76	0.48	0.69	0.14	0.16
26. Help clients talk about fears	2.16	0.40	0.61	1.86	0.32	0.66	0.32	0.32
59. Record behaviors indicative of mood	2.24	0.42	0.52	2.26	0.23	0.65	0.19	0.37
65. Eval. learning of relaxation tech.	0.84	0.59	0.36	0.59	0.48	0.45	0.02	0.02
73. Help client deal with neg. attitudes	1.62	0.48	0.63	1.47	0.37	0.71	0.26	0.35
78. Encourage persistance with therapy	1.63	0.56	0.61	1.31	0.42	0.64	0.24	0.20
84. Assess adjust. to body-image changes	1.27	0.44	0.60	0.86	0.34	0.66	0.17	0.14
101. Help client with anxiety about dyspnea	1.58	0.34	0.88	1.32	0.25	0.91	0.77	0.97
111. Assess emot. adjust. in handicapped	1.38	0.42	0.69	1.04	0.31	0.72	0.30	0.27
125. Plan guidance for develop. changes	0.24	0.63	0.47	0.07	0.33	0.64	0.01	0.01
156. Compare behavioral develop. to norms	1.21	0.46	0.55	1.03	0.34	0.65	0.12	0.16
Average	**1.48**	**0.49**	**0.59**	**1.21**	**0.37**	**0.66**	**0.23**	**0.25**
16. Supporting Client's Family								
3. Assess safety of home	0.88	0.75	0.45	1.02	0.62	0.69	0.05	0.21
8. Assess knowledge - cause of illness	2.10	0.34	0.61	1.31	0.31	0.60	0.30	0.14
81. Support terminal clients and fam.	1.39	0.41	0.84	1.33	0.26	0.86	0.61	0.73

Table 10 *continued*

Activities	Domestic RN Freq	Del	Crit	LPN/LVN Freq	Del	Crit	RN w'	LPN/VN w'
88. Teach home-care givers	0.78	0.53	0.75	0.35	0.37	0.74	0.23	0.10
93. Counsel family of handicapped	0.48	0.57	0.65	0.25	0.39	0.68	0.09	0.05
126. Adjust visiting hours for family	1.20	0.42	0.47	0.47	0.34	0.49	0.07	0.02
136. Assess emot. resp. to chronic disorder	1.32	0.39	0.59	0.86	0.31	0.69	0.17	0.17
162. Evaluate quality of home care	0.43	0.70	0.67	0.23	0.32	0.67	0.08	0.04
183. Assess patterns of family interaction	1.07	0.49	0.49	0.56	0.39	0.52	0.07	0.03
204. Help client adjust to role changes	1.15	0.53	0.68	0.67	0.35	0.67	0.25	0.12
207. Look for burnout in home-care givers	0.48	0.53	0.66	0.26	0.26	0.70	0.09	0.06
Average	**1.03**	**0.52**	**0.62**	**0.66**	**0.36**	**0.66**	**0.18**	**0.15**
17. Immunizing/Screening								
28. Administer an immunizing agent	0.58	0.41	0.77	0.61	0.17	0.76	0.18	0.19
42. Conduct screening sessions	0.12	0.52	0.55	0.11	0.57	0.68	0.01	0.02
66. Interpret skin tests	0.54	0.38	0.89	0.43	0.18	0.91	0.28	0.32
Average	**0.41**	**0.44**	**0.74**	**0.38**	**0.31**	**0.78**	**0.16**	**0.18**

Figure 1
Average Criticality Ratings
of the 222 Activities for LPN/VNs vs. RNs



REPORT OF THE NATIONAL LICENSEE DATA BASE COMMITTEE

CHARGE

Study the need and use of a national and comprehensive information system and prepare a recommendation to NCSBN.

This concept was first recommended by Touche, Ross & Co. in an analysis of membership needs performed for NCSBN in 1985. This report led NCSBN to establish a goal and objective, revised January 1987, to wit:

> "Develop a comprehensive information system for use by members, organizations, and the public."

WORK OF THE COMMITTEE

The full committee met in May 1986, and in January and May, 1987 to study the concept of a National Data Base of Nursing Information.

The committee studied the Touche, Ross & Co. report; reviewed what data elements are available and in what format; reviewed the benefits of such a system; and explored the cost and potential revenue sources. The committee and Council staff prepared, distributed, and collated a questionnaire regarding state data base needs and uses.

After reviewing the survey responses, the committee requested its chairman to attend all Area meetings to present the work of the committee and the value of a comprehensive information system to the Member Boards; and discuss problems, issues and future direction of the system.

Additional site visits by Council staff were made to South Carolina to study that state's statistical collection and analysis systems; and to Florida to study their data and data handling systems.

CONCLUSIONS

It is the conclusion of the committee that an information system would be beneficial to Member Boards and/or national agencies. Some benefits are delineated below:

General Statistics

General information relating to age, race, sex, setting and educational level in aggregate form.

Central Clearinghouse and Linkage

Could establish a central on-line data base at the National Council head- quarters to allow Member Boards direct access to disciplinary and licensure data provided by other Member Boards. Linkage would permit a quick and efficient method of verifying the information on an endorsement application.

For the future planning of the profession and educational institutions, e.g., supply projections.

Provides a data base for studying trends data, activity levels, gains and losses, attrition, etc.

RECOMMENDATION

The Committee recommends the implementation of activities to establish a National Nursing Information System (NNIS).

As an initial step, the Committee recommends the development of a small, sample data base for testing purposes. The Committee further recommends (1) that this sample data be gathered on magnetic tape from 2 to 5 Member Boards on a voluntary basis, (2) that a data base be built on the NCSBN computer using currently in-house software and (3) that this sample data be processed through a to-be-acquired statistical software package with the goal of developing sample statistical reports for the proposed long-range system.

Computer consulting services relating to building the data base file and producing the sample reports would involve an expenditure of approximately $2,500. With the exception of the statistical software, all required hardware and software is currently on-hand. The statistical software has been requested as part of the research and testing services budget requests for fiscal 1988. The Committee's entire budget for fiscal 1988 consists of this $2,500 plus travel expenses for Committee meetings. No other expenses are anticipated.

LONG RANGE OUTLOOK

The long range goal for the NNIS is to have full participation of all member boards through the provision of a specified data set (See Attachment A) gathered through a common renewal period data of all licensees. This data set would be merged with existing NCLEX and disciplinary data sets. The NCSBN would at a minimum produce general statistical information and trend analysis in aggregate and by general jurisdiction. Potential additional uses of the NNIS have been delineated in the body of the report.

Until such time as full participation is achieved, Member Boards may participate in the NNIS at a variety of levels which may be self selected. The information which the NCSBN would produce for each Member Board, and thus the potential usefulness of the system to the Member Board, will be enhanced as the level of involvement is increased. A minimum requirement for involvement is the provision of basic identifying information including the social security number of licensees.

Options for participation would be as follows:

LEVEL I PARTICIPATION would be full participation in the NNIS. It would require provision of the specified data set collected during a common renewal period of all licensees. General statistics, the central clearinghouse and linkage function and detailed statistical analysis for planning (See discussion, page 1 and 2) would be available for states participating at this level. The specified data set may be derived from the existing renewal form or a scannable insert form provided by the NCSBN or a combination thereof.

LEVEL II PARTICIPATION would require provision of the specified data set collected during the Member Boards' existing renewal period. General statistics, the central clearinghouse and linkage function, would be available to boards participating at this level. Detailed statistical analysis for planning would not be available or, depending on the Boards' collection process, be available only to a limited extent. The specified data set may be derived as in Level I.

LEVEL III PARTICIPATION would require provision of current data collected at the time of renewal of the license. At a minimum, this must include identifying information and social security number. The central clearinghouse and linkage function would be available to boards participating at this level. General statistics and detailed statistical analysis for planning would not be available.

Note: It should be further emphasized that as far as national analysis is concerned until all states are participating at level one status, general statistical analysis and the central clearinghouse and linkage function will be limited. Detailed statistical analysis for planning will probably be impossible.

All Boards are urged to strive for Level I participation to enhance a comprehensive National Nursing Information System.

TENTATIVE DATA SET

Type (RN, LPN)
Name
Address
Date of Birth
Social Security Number
Race
Employment Setting
Highest Nursing Degree
Activity Status
Sex

REPORT OF COMMITTEE FOR SPECIAL PROJECTS

BACKGROUND

Phase I of the Computer Adaptive Testing Project began in December 1986. The Board of Directors authorized the implementation of this phase, believing that it was critical to obtain answers to a wide range of questions so that the Delegate Assembly can have access to the necessary information prior to deciding whether or not NCLEX should be administered using computer adaptive testing (CAT). The results obtained in the course of the research planned in Phases I and II will provide data which will show whether the potential benefits of CAT will be realized in actual administration of nursing licensure examinations.

COMMITTEE PURPOSE

The Committee for Special Projects is addressing the complex issue of determining the feasibility of administering the National Council licensure examinations using computer adaptive testing (CAT). The primary responsibility of the Committee is to oversee the progress of the CAT project.

The thrust of Phase I (calendar 1987) of the project is twofold: 1) to develop and try out CAT software, and 2) to plan for psychometric, legal, operational, and security studies to be carried out in Phase II. The thrust of Phase II (calendar 1988 and 1989) will be threefold:

1) to perform studies addressing the following areas:
   - **Psychometric.** Does CAT accurately measure competence to practice beginning nursing?
   - **Legal.** Is CAT defensible?
   - **Operational.** Is CAT practical and cost effective?
   - **Security.** Does CAT allow secure (and therefore fair) test administration?

2) to enhance the item pools as needed to optimize CAT measurement benefits

3) to field test CAT administration concurrent with four scheduled paper-and-pencil examinations, in jurisdictions (to be determined) which encompass the broadest possible range of Member Board characteristics

RATIONALE FOR COMPUTER ADAPTIVE TESTING

The "adaptive" aspect of CAT has the following major benefits. First, the accuracy of each candidate's score can be enhanced because testing will continue for each individual until a desired level of precision has been reached. Previously, the accuracy of scores has been evaluated on a group basis. Secondly, efficiency in the measurement process will result from use of CAT. Since only the most appropriate questions are given to each candidate, the amount of "measurement information" contained in each response is maximized. Preliminary research indicates that decisions at least as reliable as those the current examina-

tions yield, can be made for about two-thirds of examinees with considerably fewer items. This will result in significant savings of testing time for both Member Boards and candidates. A third benefit is that the security of the item pool will be better maintained, since each candidate will be administered a different set of items. This prevents the possibility of a "test form" being compromised, since there is no single test form.

The "computerized" aspect of CAT also has several benefits. Immediate scoring will reduce or eliminate the waiting time from examination administration to receipt of results. This will reduce the amount of time that graduate nurses practice on temporary permits, and speed up the identification of incompetent individuals. Member Boards will thus be better able to assure protection of the public. A second benefit is that examinations can be offered more than twice per year while continuing to maintain the security and integrity of the examination questions. This may enable most candidates to sit for the examination closer to the time of their graduation. Member Boards will be able to spread out the load of processing applications, evaluating credentials, and providing staffing for examination days. The third benefit is better control over access to examination questions and answers. Since test booklets will no longer be printed, the availability of questions in hard copy form will be drastically reduced. In addition, opportunities for copying answers during the examination will be virtually eliminated.

Based on the rationale stated above, the Committee has concluded that the potential benefits of CAT to Member Boards, candidates, and the public are great. It encourages Member Board interest in and support of the CAT project, which will produce concrete evidence regarding whether these benefits will be realized in actual practice.

COMMITTEE ACTIVITIES

The Board of Directors approved commencement of Phase I of the CAT project at its November 1986 meeting. The Committee for Special Projects was charged with responsibility for oversight of the CAT project, and subsequently met twice at National Council headquarters: January 29-30 and April 13-14, 1987. Members also attended their respective Area Meetings and presented progress reports on the CAT project.

At its meetings, the Committee dealt with four areas: education and information for Committee members, identifying major project questions, the process of project implementation, and fundraising. Activities within each area will be briefly described.

1. Education and information. Committee members informed themselves about concepts underlying CAT (such as computerized testing, adaptive testing, and Item Response Theory) through reading of an extensive set of journal articles, receiving presentations by National Council staff with specialties in psychometrics, and attending conferences such as the annual meeting of the American Educational Research Association.

2. Identifying major questions. Representing the perspective of Member Boards, Committee members have discussed extensively the questions which must be answered within the CAT project in order to allow an informed decision regarding the feasibility of using CAT for NCLEX. Some sample questions are:

- How will the test plan be covered in CAT examinations?
- What kind of reporting to candidates and Member Boards will be done, and at what times?
- How can CAT software be tried out without compromising the item bank?
- What kinds of test centers and equipment will be required for CAT?
- How much will candidate fees have to be with CAT?

The Committee has identified specific individuals or groups and specific times at which these and other questions will be investigated and answers proposed during the course of the project. Answers to these questions and others must be provided before the Member Boards will have sufficient information to evaluate the desirability of using CAT to administer NCLEX. The Committee believes that providing these answers is the single most important purpose of the CAT project.

3. Process. The Committee has received and reviewed staff updates on acquisition of project staff (director and secretary), and on the retention of consultants in areas of psychometrics, software development, and fundraising. Anthony R. Zara assumed duties as project director in February 1987, and has also served as staff to the Committee.

4. Fundraising. Staff have worked to revise the CAT funding proposal to foundations, to contact approximately 60 new potential funding sources, and to plan for re-contact of some foundations previously giving negative responses.

FUTURE ACTIVITIES

The Committee plans one more meeting during Phase I, near the end of October. In addition to evaluating progress to date, the Committee hopes to finalize plans for Phase II studies and funding. Possible facilities for CAT administration will be investigated at this meeting. At the end of 1987, the Committee will submit a final report for Phase I and its recommendation regarding implementation of Phase II to the Board of Directors.

SUMMARY

The Committee for Special Projects has met twice to oversee the progress of the CAT project. The Committee has monitored implementation of project tasks in Phase I. The Committee and staff have identified the following possible benefits to the National Council from the implementation of CAT: increased accuracy of each candidate's score; efficiency in the measurement process; the security of the item pool will be better maintained; immediate scoring will help Member Boards to assure protection of the public; examinations can be offered more than twice per year allowing Member Boards to spread out the load of processing applications, evaluating credentials, and providing staffing for examination days; and better control over access to examination questions and answers.

The Committee has also identified major questions from the Member Board perspective which require answers during Phase II. Because it is critical to obtain answers to these questions prior to the time of Delegate Assembly deciding whether or not NCLEX should be administered using CAT, the Committee is dedicated to continual careful monitoring of CAT project progress and outcomes throughout Phases I and II.

REPORT OF THE EXECUTIVE DIRECTOR

Sharing ideas and achievements with the membership of an organization is not only an ongoing responsibility of staff but also an opportunity to communicate perspectives of both past and future.

This report to Member Boards summarizes the major efforts and activities of staff as they work on achieving the objectives as defined by the Delegate Assembly. It also communicates the vision that staff share with members, in that the achievements of this time are the bases for the future programs of the National Council.

In *The Next American Frontier*, Robert Reich states, "conquering the first American frontier demanded little but vision, daring, and initiative....The industries that will sustain the next stage of America's economic evolution will necessarily be based on a skilled, adaptable, and innovative labor force and on a flexible organization of work." Using this framework, one can state that the establishment of the National Council demanded vision, daring and initiative. The reader will note that the phrase "little but" is omitted because risk taking is not perceived as an ordinary quality. The future developments that will sustain the National Council will be realized by persons who are skilled, adaptable, innovative, and have a flexible organization structure that can manage change.

Major efforts and activities of staff on program objectives are divided into the categories of testing, education and practice, research, and communications.

TESTING:

As in the past, the National Council devoted much of its resources to the issues that surround examinations and their administration, bringing skill and innovation to this major focus of the National Council. Staff continues to monitor the data center and testing service contract with CTB/McGraw-Hill, particularly with respect to item production and candidate/ program coding problems. Changes in the current services have been monitored and their implementation coordinated.

National Council test service staff contributed to the planning of, and participated in, the February 1987 National Council Licensure Examination (NCLEX) Invitational Conference. Steps needed to produce and implement in-house licensure examinations were prepared. Research needs related to test development and item pools have been determined.

Staff continue to provide support to the Examination Committee teams during regularly scheduled meetings and assisted in the special meeting for the revision of the NCLEX-RN test plan. An additional item-writing session was coordinated in order to augment the registered nurse item pool. In-depth investigation of the score reporting options was also accomplished along with an analysis of their advantages, disadvantages, and implications for candidates and Member Boards. Staff provided support to the Committee in its analysis of the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses (Study)*.

Staff also continue to provide support to the Administration of Examination Committee in its effort to update security measures and specifically reviewed all relevant security docu-

ments submitted by 55 Member Boards. Staff also monitored updating of the Manual for the Use of Examination Application Material. A major revision of the candidate brochure was undertaken, as was the development of a database of administration-related problems. These data were then correlated with various board characteristics in order to identify potential problem areas. Staff have facilitated implementation of the review and challenge policy and continue to monitor the accuracy of automatic and manual scoring methods.

Adaptability and innovation are synonymous with the Computer Adaptive Testing Project (CAT). Phase I activities of CAT have begun and a project director has been hired. Working in conjunction with the Special Projects Committee, staff have met with consultants to develop Phase II fundraising strategies. A cooperative relationship with the American Society of Clinical Pathologists (ASCP) has been initiated and the National Council and ASCP staff have developed a Request for Proposal for CAT software development. In addition to providing support to the Committee for Special Projects in its two meetings, staff have established liaisons with other testing organizations interested in CAT methods.

Laying the groundwork for future developments, is demonstrated by computerized clinical simulation testing (CST). Staff have developed a funding proposal to adapt software technology and databases developed by the National Board of Medical Examiners for a CST examination in nursing. The proposed software and database modifications would facilitate the development of nursing simulations for inclusion in NCLEX. The proposal has been submitted to the W.K. Kellogg Foundation.

Another example of groundwork for future developments is the work of the Task Force for Examinations for the Future. Staff have facilitated the Task Force's work at its four meetings. They also coordinated input from legal and psychometric experts regarding the development of new examinations that would meet the future needs of Member Boards which change their requirements for entry into nursing practice and/or the definition of practice.

EDUCATION AND PRACTICE:

Information gathered from Member Boards by surveys has been the basis for developing positions and guidelines by the Nursing Practice and Standards Committee. These data are obvious links between the past and future. Several different practice issues have been addressed by Nursing Practice and Standards Committee during the past year. Staff assisted in conducting surveys regarding use of the Model Nursing Practice Act and Model Administrative Rules and Regulations. An updated survey of Member Boards' continued competence mechanisms has been completed as has a monograph on the regulatory management of chemically dependent nurses. A statement on the activities of unlicensed personnel has also been developed. Staff assisted in the research and preparation of these documents.

Other activities related to nursing practice included publication of a longitudinal study of the National Council's disciplinary data bank, modification of the disciplinary data report-

ing forms to reflect mutually exclusive categorical data, and sharing of that data with the Public Health Service and Veterans Administration hospital system. The National Council and the major branches of the military continue to share their disciplinary data. A voluntary system whereby Member Board licensee data might be transferred to the Department of Defense in the event of a presidentially-declared emergency has been designed and is in process of being implemented.

The National Council provided legal consultation and support following a request from the North Dakota Board of Nursing. As reported in the *Newsletter* to Member Boards and *Issues*, two North Dakota general hospitals challenged the Board's authority to establish rules to raise entry-level educational requirements. The National Council filed an amicus curiae brief supporting the Board of Nursing's authority to promulgate rules which was subsequently affirmed by the North Dakota Supreme Court. In its unanimous decision, the Court cited legal arguments presented in the amicus curiae brief filed by National Council.

A survey was circulated to Member Boards to assess their positions and responses to the entry into practice issue. The results of this survey will be presented at the Delegate Assembly.

RESEARCH:

Member Board surveys are an important National Council activity in meeting the National Council objective of sharing data with Member Boards. Research findings continue to be communicated to Member Boards, to the Interagency Conference on Nursing Statistics and to groups such as the American Nurses' Association, National League for Nursing, American Association of Colleges of Nurses, U.S. Health and Human Services and others.

As one of several research activities, Member Board surveys on licensure data, licensure requirements and other Board data are in their third year of development. They will be transferred from staff in the data processing area to the research area. These surveys continue to be refined with emphasis on clarifying categories of information. Transfer of research responsibilities from an outside research consultant to National Council staff should increase the utility of data and minimize research expenses. These new efforts will use existing data processing and statistical analytic capabilities.

Job analysis studies are a major research activity. This year, National Council staff monitored the extension of the job analysis *Study* which includes a licensed practical/vocational nurse job analysis scheduled for completion in 1988. Staff members secured Member Board permission for data use, reviewed survey materials, and monitored response rates. Staff have also coordinated data collection for the differentiated practice demonstration project involving the Rush-Presbyterian- St. Luke's Medical Center for use by the Task Force for Examinations for the Future.

COMMUNICATIONS:

Due to personnel changes, the American Nurses' Association (ANA) is no longer publish-

ing its *State Nursing Legislative Quarterly*, a journal that addresses legislative and regulatory trends in nursing. Subsequent to this decision, the National Council has issued a formal proposal to take over the publication which was accepted by ANA. Staff estimate that the first issue to be published will be in December 1987.

In December 1986, National Council began typesetting its publications using its newly acquired desktop publishing capabilities. Substantial savings have already been realized.

The first Annual Report has been published as directed by the 1986 Delegate Assembly. The initial report included the National Council's history and accomplishments since its inception.

Other communications activities included the publication, coordination, and marketing of the final report of the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses, (Study)*. Staff provided information to Member Boards for their use in responding to proposed legislation especially about testing, sunset review, and restructuring. Staff members continue to serve as liaisons among the various committees that are concerned with examinations, future examinations and their administration. Liaison with staff at similar organizations has been established for the purpose of sharing information about common problems and issues.

Introducing flexibility into the communication system this year, the Board of Directors gave approval to the establishment of an electronic mailing system for the purpose of improving communication among Member Boards and the National Council office. This system will be demonstrated at convention to allow Member Boards to see its capabilities and to be trained on the system if representatives wish.

Once in place, electronic mail will allow Member Boards to communicate among themselves about applications, examination proctering, endorsements, and disciplinary actions. The National Council will be able to communicate with Member Boards on survey information and to respond on general matters, and with CTB/McGraw-Hill regarding jurisdictional control files, candidate information, test orders, and summary profiles.

The National Council will also be able to use electronic mail to communicate more efficiently with committee members and with members of the Board of Directors. Eventually, the system could also be used by Member Boards to communicate with schools of nursing in their jurisdiction.

In October 1986, Noel Daly, Executive Director of the Irish Nursing Board invited the National Council to co-sponsor a workshop that will precede the Irish Nursing Board symposium on computers in nursing scheduled for June 1988. The workshop will focus on activities of the National Council, its structure, disciplinary data base, and the test development process current and future. Participation will give the National Council an opportunity to communicate with international boards of nursing and will help identify common concerns and interests. Such a joint venture demonstrates the innovation of persons and the flexibility of organization that will sustain the National Council in the future.

Building upon the National Council past became particularly significant during this year. The Executive Director participated with the President in an interview with Dr. R. Louise McManus which was filmed in April 1987 in preparation for the National Council's 10th anniversary. The film, which was produced at Cape Cod Community College, emphasizes Dr. McManus' accomplishments as well as her views for nursing's future. Plans are to integrate segments of this interview into the National Council's videotape on its ten year history and accomplishments.

Again quoting Reich in *The Next American Frontier*, he states that "the way people are organized is becoming a critical determinant of productivity. We understand when a factory is not producing at full capacity, but it is far more difficult to perceive the unused potential in people." Member Boards and other agencies have used the potential of several staff in communicating ideas or data during the past year.

Presentations have been made at various certifying agencies, academic institutions, and research associations over the past year. The National Council also planned and participated in several forums and workshops. A presentation by the Director of Program Services was made to assist the Georgia Board of Nursing in its planning for a continued competence mechanism. The Director of Program Services included regulatory issues surrounding entry into practice in a presentation made to the Wisconsin Bureau of Nursing.

The National Council staff also planned and participated in the Federation of Associations of Regulatory Boards Forum held in February 1987. This forum was well attended by Member Boards.

The Executive Director presented two research studies at the annual meeting of the Council of Baccalaureate and Higher Degree Programs of the National League for Nursing. The Assistant Director of Testing Services and/or the Executive Director presented the *Study of Nursing Practice and Role Delineation and Job Analysis of Entry Level Performance of Registered Nurses* to participants at the National Council Area meetings Spring 1987, and to the following organizations:

- American Organization of Nurse Executives

- Massachusetts Chapter of the Organization for the Advancement of Associate Degree Nursing

- Educational and Administrative Research Interest Group of the University of Illinois College of Nursing

- "Nurses in Agreement" Conference sponsored by Consensus in Nursing Project Midwest Alliance in Nursing

- Middle Atlantic Regional Nursing Association

- Sigma Theta Tau International Research Conference

In addition, the Executive Director made three different presentations on regulatory issues during the American Association of Nurse Anesthetists annual meeting.

The Director of Testing Services participated in a symposium, "Microcomputers in Measurement in the Health Professions", at the National Council on Measurement in Education annual meeting and, with the Executive Director, presented a paper entitled "Simulating Adaptive Administration of a Nursing Licensure Examination", at the American Educational Research Association 1987 annual meeting. In addition, the Director of Testing Services prepared and presented a paper, "Computer Based Evaluation of Nursing Competence", at the National League for Nursing 1987 biennial convention.

The Assistant Director of Testing Services presented "Student Socialization into the Professional Nursing Role: Psychometric Assessment of the Professional Nursing Questionnaire" at the Fifth Annual Research in Nursing Education Conference held this year.

Two articles written by the Assistant Director of Testing Services have been accepted for publication; one by editors of *Current Concepts in Nursing* and one by *The Journal of Professional Nursing.*

OPERATIONS:

Operational matters reenforced the need for adaptability, skill, and flexibility this year. Following its incorporation in Pennsylvania, the National Council re-applied for exemption from federal income tax under section 501 (c) (3). Subsequently, the district office of the Internal Revenue Service (IRS) argued that a 501 (c) (6) tax status was more appropriate. The National Council issued a strong disclaimer and the matter was forwarded to IRS headquarters. In an effort to comply with IRS documentation requests, the National Council solicited Member Boards for their statements as to how the National Council lessens the burden of government. These statements, and a letter from the President, were forwarded on 24 April 1987 to IRS headquarters for review. Substantial resources have been devoted to these unforeseen and unprogrammed documentation efforts. A positive result of this challenge has been the letters of support received from Member Boards. The attesting to services rendered to its members by the National Council has been a source of satisfaction for all.

An internal review system has been established to track the current status of Member Boards' contracts and security measures. This arrangement will make notification of changes efficient.

Accounting functions have been computerized and the program budget system implemented. Data are being supplied for ongoing analysis. A full evaluation of the system will occur after the audit scheduled for 1987.

In August 1985, the Board of Directors authorized the upgrading of computing services throughout the National Council office. The office is now fully automated through use of microvax II minicomputer system. Major data banks, including the disciplinary database and mailing lists, are on system and operational. Full implementation of office automation

will be completed by October 1987. Microcomputers are being used for specialized tasks such as detailed test plan development, accounting, database applications, and telecommunications. This microcomputer/miniframe environment enables the National Council to assume efficient and effective functioning to meet Member Board needs in an adaptable way.

Other operational activities included assisting organizational committees in the thorough review of the bylaws, in development of campaign guidelines for use by candidates seeking office, in preparation of the National Council slate of candidates, in preparation of the budget for FY 88, and in preparation of fiscal policies.

CONCLUSION:

This report began with the concept that the National Council will be sustained if the qualities of skill, adaptability, flexibility and innovation can be fostered. It ends with another quote that implies the need for the qualities listed. It is attributed to Daniel Burnham, an architect who designed Chicago's lake front parks. "Make no little plans; they have no magic to stir men's blood."

Staff join National Council membership in making "no little plans" but ones that lead to sustaining the National Council in its next frontier.

REPORT OF THE FINANCE COMMITTEE

Over the past year the Finance Committee met October 20-21, 1986, January 5-7, 1987, and March 1-3, 1987 in Chicago. Telephone conference calls were held April 8, 1987, May 1, 1987 and May 4, 1987.

In accordance with the bylaws, the Committee has provided general supervision of the finances of the National Council and prepared a proposed fiscal year 1988 budget for approval of the Board of Directors.

The Finance Committee has accomplished a substantial amount of work toward achievement of the goals set forth in the long range plan. This is particularly noteworthy in view of the fact that all committee members were new to the Finance Committee. In addition, this was the first year of implementation of the program budget.

Activities for fiscal year 1987 were focused on Goal II, Objective I of the Long Range Plan. The Committee work was centered specifically on the strategies identified as responsibilities of the Finance Committee.

Goal II: Utilize human and fiscal resources efficiently to allow for growth and creativity.

Objective I: Implement a planning model to be used as a guide for development of NCSBN.

Strategy 3: Implement a program budgeting system for the National Council.

Activity: The program budgeting system has been fully implemented. The Finance Committee reviewed and evaluated all fiscal reports for presentation to the Board of Directors. A great deal of time was spent revising the fiscal reports to reflect clearly the program budget system and provide the information needed for monitoring the finances of the National Council.

The fiscal year 1988 budget was developed for presentation in the program format. Budget assumptions were revised to reflect the new system.

The Finance Committee also recommended a price for the National Council portion of the NCLEX fee. Inflation factors, projections of program costs and future needs were considered in developing the price recommendation.

Strategy 4: Investigate the feasibility of new revenue sources for the organization.

Activity: Data collected and maintained by the National Council have been identified as a potential new source of revenue. Work has begun on the development of a policy regarding release of the data and costs of the data.

The Finance Committee reviewed a proposal regarding publication of the *State Nursing Legislative Quarterly* by the National Council. The Committee viewed this activity as a potential source of revenue. It was recommended to the Board of Directors that the National Council consider publication of the *State Nursing Legislative Quarterly* in fiscal year 1988.

Work will continue to identify revenue sources. The Committee is currently studying the Touche-Ross Report for implications regarding revenue sources.

Strategy 6: Maintain financial policies which provide guidelines for organizational development.

Activity: All financial policies were reviewed and evaluated. Two new policies were developed by the Finance Committee and approved by the Board of Directors: the Investment Policy (attachment A) and the policy on Funds of the Organization (attachment B). The Committee identified additional policies for development in the coming year.

A fiscal impact statement was approved for the purpose of detailing the fiscal impact of proposals and resolutions brought before the Delegate Assembly. The Committee felt the fiscal information would allow the delegates to consider proposals in light of the costs as well as the program needs.

The investment activity has been carefully managed. The Finance Committee has reviewed all investments on a quarterly basis.

Strategy 7: Review and revise forecast assumptions to maintain a current forecasting model.

Activity: The Committee reviewed the assumptions developed in fiscal year 1986. No changes were made for fiscal year 1987.

In order to assist in forecasting, 18 month projections of revenue and expenditures will be reviewed by the Committee on a quarterly basis.

The goals, objectives, and strategies identified in the Long Range Plan for fiscal year 1988 will direct the activities of the Finance Committee for the coming year.

INVESTMENT POLICY

All funds of the NCSBN shall be kept productively employed at all times. It shall be a practice of the Council to keep all non-operating monies invested at the highest interest rate consistent with the maintenance of financial integrity and security. It shall be permissible for funds to be invested in any of the following ways:

1. Money-market account or overnight investment Repurchase Agreements in a commercial bank;

2. Certificates of Deposit;

3. Savings Accounts;

4. U.S. Government Treasury obligations (notes, bills or securities);

5. Prime Commercial Paper;

6. Investment program through a bank trust department or investment brokerage house.

These investments give the Council safety and liquidity. Determination of the type of investment should be based on cash flow needs. Investments in money market accounts, certificate of deposit and/or savings accounts shall be maintained in federally insured banking and savings institutions. Overnight/Repo agreements are backed by obligations of the United States Treasury.

GUIDELINES FOR INVESTMENTS

In order to maintain liquidity to meet the obligations of the Council, the following guidelines will be used to determine the investment vehicle to be utilized:

1. funds equal to six months' operating requirements of the Council shall be maintained in interest- bearing accounts, which are subject to withdrawal daily without penalty;

2. funds equal to a second six month period of operating requirements may be invested in the above permissible investments numbered 1, 2, 3 or 4 and have a maturity not to exceed 120 days;

3. funds equal to a third six month period of operating requirements may be invested in the above permissible investments numbered 1, 2, 3 or 4 and have a maturity not to exceed one year;

4. funds which exceed 1-1/2 times the annual operating budget may be invested in a self-directed stock and bond portfolio through a trust department of a commercial bank, bond or investment brokerage firm.

CUSTODIAN FOR SECURITIES

All investments in United States Treasury obligations shall be maintained in a custodial account by the trust department of a commercial bank. Stocks and bonds purchased for a self-directed investment portfolio shall be maintained by the trust department or broker, whichever is selected. Authorized to purchase and sell securities shall be any one of the following:

1. President,
2. Treasurer,
3. Executive Director, or
4. One of two staff members as designated

by the Executive Director.

SELF-DIRECTED INVESTMENT PROGRAM

An investment broker or trust department shall be selected to purchase and hold investments and give periodic advice on investment mix (i.e., bonds, high-tech stocks or high-grade stocks). Selection of a custodial agent shall be approved by the Board of Directors, from recommendations of the Finance Committee.

COMMITTED FUNDS

Funds which are committed for special programs may be invested in accordance with guidelines as their needs relate to the operating budget.

CASH FLOW PROJECTIONS

Staff will prepare cash flow statements for the present quarter and the following six quarters (18 months).

REVIEW

The Finance Committee shall review the entire investment portfolio on a quarterly basis. Should the self-directed investment program be utilized, a representative of the agent will meet to evaluate performance and recommend changes if necessary at each of its meetings.

A report of investment transactions shall be reviewed by the Finance Committee and a report submitted to the Board of Directors quarterly.

FUNDS OF THE ORGANIZATION

The NCSBN shall maintain such accounts in financial institutions that are federally insured. All funds received by the Council shall be deposited at a minimum of twice weekly. All nonproductive funds shall be invested in accordance with the investment policy established by the Board of Directors.

AUTHORITY TO SIGN

Orders of withdrawal shall bear the signature of one of the following officers or staff member:

(1) President;
(2) Treasurer;
(3) Executive Director;
(4) two staff members, as designated by the Executive Director;
(5) any checks issued over $15,000 shall require two signatures.

COMPENSATING BALANCE

It is understood that certain expenses are incurred by banking institutions that process exam fees received from candidates. Sufficient funds will be maintained in a non-interest bearing account to compensate this bank for services rendered. The balance required shall be monitored by the Council's in-house accountant, and reviewed semiannually by the Finance Committee.

BONDING

Each officer or designated signatory with authority to withdraw funds shall be bonded. The cost associated with securing the aforementioned coverage shall be that of NCSBN. The amount of insurance coverage will be reviewed annually.

QUARTERLY REVIEW

The Finance Committee shall, on a quarterly basis, review all disbursements in the amount of $10,000 or more.

REPORT OF THE BYLAWS SPECIAL COMMITTEE

RECOMMENDATIONS

1. The Committee recommends the 1987 Delegate Assembly adopt the Bylaws Revision presented in this report.

2. The Committee further recommends that the Special Committee on Bylaws commissioned by the 1986 Delegate Assembly continue its work in FY '88 to specifically study the following:

- Review and revision of the National Council Standing Rules; and,

- Further review of the Bylaws relative to the Article X. of the revised Bylaws dealing with Committees - their structure and function.

This recommendation has a fiscal impact and a Fiscal Impact Statement is attached.

MEETING DATES

The Bylaws Special Committee met 11-12 December 1986, 23-24 February 1987, and 11-13 May 1987.

ACTIVITIES

The specific activities of the Special Bylaws Committee focused on the following:

(1.) a review of the Bylaws for revision;

(2.) preparation of an Interim Report on the Proposed Bylaws Revision which was circulated to Member Boards, the Board of Directors and Council Committees as a vehicle for receiving feedback on the proposed revisions;

(3.) a review of the Council Standing Rules; and

(4.) preparation of the Proposed Bylaws Revision for presentation to the 1987 Delegate Assembly.

The Bylaws were sent to Member Boards, the Board of Directors, committees and the National Council staff for review relative to areas of concern to be addressed in a Bylaws revision. The comments and suggestions were considered in preparing an Interim Report on the Bylaws revision which was circulated for discussion at Area Meetings. The comments and suggestions, along with legal and parliamentary review, were incorporated in the final revision as attached.

OBJECTIVES

The Committee's objectives for 1987-1988 are as follows:

- To complete a review of the Council Standing Rules for revision; and

- To further review the Bylaws specific to Committees of the Council (Article X.) - their structure and function.

PRESENTATION OF THE BYLAWS REVISION TO THE DELEGATE ASSEMBLY

When a Bylaws revision, which is presented in a series of articles in paragraph form, is presented, it is usually considered paragraph by paragraph. This method of procedure is called Seriatim consideration and is followed in order to avoid confusion in amending.

Following the Seriatim consideration method, the first paragraph is read and the presiding officer asks if there are any amendments to it. Primary and secondary amendments may be made to the words in the paragraph just as if it stood alone. After the entire Bylaws has been presented, a vote is taken on the document as a whole.

This procedure will be used in the presentation to the 1987 Delegate Assembly of the National Council's Bylaws revision. The revision as attached is presented as if it were a new document and does not include the language of the present Bylaws.

PROPOSED BYLAW REVISION	RATIONALE
I. NAME The name of this organization shall be National Council of State Boards of Nursing, Inc., hereafter referred to as the Council.	
II. PURPOSES AND FUNCTIONS	Changed the title of this section to reflect the new heading of "purpose" and new heading of "functions".
A. PURPOSE The purpose of the National Council of State Boards of Nursing, Inc. 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.	Moved Preamble statement and retitled it "Purpose" because the preamble statement gives the National Council's purpose.
B. FUNCTIONS The Council's functions shall include, but not be limited to the following:	Changed the title of this section to reflect what the statements really refer to – which is the functions of the association.
1. Develop, establish policy and procedure for and regulate the use of the licensing examinations for nursing.	

PROPOSED BYLAW REVISION	RATIONALE
2. Identify and promote desirable and reasonable uniformity in standards and expected outcomes in nursing education and practice as they relate to the protection of the public health, safety, and welfare;	A change was made to this section by deleting an unnecessary phrase.
3. Assess trends and issues affecting nursing education and nursing practice as they affect the licensure of nurses;	
4. Identify mechanisms for measuring the continuing competence of licensed nurses and assist in efforts to promote the same;	This statement reflects a change to assist with the clarity of the statement.
5. Collect, analyze and disseminate data and statistics relating to the licensure of nurses;	This statement reflects a change to assist with the clarity of the statement.
6. Conduct studies and research pertinent to the purposes of the Council;	
7. Provide consultative services for Council members, groups, agencies, and individuals concerned with the protection of the health and welfare of the public;	This statement reflects a change to more clearly identify to whom consultative services are provided.
8. Plan and promote educational programs for its members;	This statement changed because members include the other two categories mentioned so they are not necessary to include here.
9. Promote and facilitate effective communications with related organizations, groups, and individuals.	

PROPOSED BYLAW REVISION	RATIONALE
III. MEMBERSHIP AND FEES	
A. Definition and Qualifications 1. Definition 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.	The Bylaws Committee recommends no change to extend membership to beyond the United States based on feedback received from Member Boards and area meetings.
2. Qualifications Any State Board of Nursing that pays the required fees may be a member of the Council.	This change would allow for the inclusion of all the regulatory agencies of nursing to belong whether they used the examination or not. This would allow continued participation in the National Council by Member Boards who, in the future might not be able to use the National Council Licensure Examination.
B. Admission A State Board of Nursing shall become a member of the Council and be known as a Member Board upon approval of the Delegate Assembly, payment of the required fees and execution of a contract when using a Council examination.	This change is proposed to be consistent with the intent of the change suggested in qualifications for membership as presented above.
C. Fees Fee Schedule for Member Boards 1. The annual fee payable by each Member Board shall be $3000.00 2. In addition to membership fees, delinquent fees shall be assessed as follows: a. Ninety days after the beginning of the Council's fiscal year, a delinquent fee of $500.00 shall be added to the annual fee. b. A member whose annual fee is not paid within the designated 90 day period shall be subject to review and possible termination by the Board of Directors at its next regular meeting.	The changes in this new section are proposed to clearly identify all fees and the penalties for nonpayment of fees, within the structure of the Bylaws.

PROPOSED BYLAW REVISION	RATIONALE
D. Good Standing A Member Board in good standing is one which has paid the current fee and which complies with the provisions of bylaws, standing rules and contracts.	A change in the reorder of bylaws, standing rules, and contracts was made to reflect the order of authority under which Member Boards operate. The change will be reflected anywhere in these Bylaws that the list appears.
E. 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 licensing examinations in nursing when using a Council examination.	To clarify the privileges of membership related to the examination.
F. Termination and Reinstatement 1. Any Member Board whose fees remain unpaid 90 days after the beginning of the Council's fiscal year, or who does not comply with the provisions of the bylaws, standing rules or contracts shall be subject to termination after review by the Board of Directors. Such Board action is subject to appeal to the voting body of the Council, hereinafter referred to as the Delegate Assembly.	This reflects a change and clearly delineates the process of termination without spelling out a procedure.
2. Any Member Board which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fees and the delinquent fees.	This change made for clarity with no change in substance.
Member Boards in good standing that terminate membership shall not be required to pay the delinquent fees as a condition of reinstatement.	This change made for clarity with no change in substance.

PROPOSED BYLAW REVISION	RATIONALE

IV. AREAS

A. The Delegate Assembly shall divide the membership of the Council into a number of geographical areas. At no time shall the number of areas be less than three nor more than six.

The distribution of Member Boards into areas was seen as a structural change that should be the responsibility of those that it will affect, the members of the Council; and this change reflects that concept.

B. The purpose of this division is to facilitate communication, encourage regional dialogue on Council issues, and provide diversity of representation on the Board of Directors and on committees.

C. Each Area shall elect a Director

V. OFFICERS

A. Enumeration
The officers of the Council shall be a president, a vice-president, a secretary, a treasurer, and a director representing each area and one director-at-large.

B. Qualifications

1. Members and employees of Member Boards shall be eligible to serve as officers.

Restrictions on officer qualifications are removed to allow full participation from Member Boards and their respective members and staff.

2. No person may hold more than one elected office at the same time.

3. No officer shall hold elected or appointed office in a state, regional or national association or body if such an office might result in potential, actual or appearance of conflict of interest to the Council as determined by the Board of Directors of the Council in accordance with standing rules.

A change in this section reflects the Committee's belief that the Delegate Assembly should determine what qualifications are needed to carry out a position and that restrictions on qualifications for any office limits full participation by all members and employees of Member Boards.

PROPOSED BYLAW REVISION	RATIONALE
C. Term of Office	
1. The president, vice-president, secretary, and treasurer shall be elected for a term of two years or until their successors are elected. The president and vice-president shall be elected in even-numbered years and the secretary and treasurer shall be elected in odd-numbered years.	The two changes that were made in this section included deleting the requirement on limiting the time of service of an officer and the dated language regarding initial terms of officers under the new Pennsylvania Bylaws.
2. The directors shall be elected for a term of two years or until their successors are elected. Directors from odd-numbered areas shall be elected in odd-numbered calendar years. Directors from even-numbered areas and the director-at-large shall be elected in even-numbered calendar years.	
3. If a current officer agrees to be presented on the ballot for another office, the term of the current office shall terminate at the close of the session at which the election is held.	
D. Vacancies and Removal from Office	Title change to reflect new structure of this Article.
1. Vacancies a. 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.	See new D.2.a. of this Article for rationale for changes in this section.
b. The person filling the vacancy shall serve the remainder of the term.	This change would allow for continuity of service from the person appointed to fill an unexpired term.

PROPOSED BYLAW REVISION	RATIONALE
2. Removal from office.	
a. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly.	Legal counsel suggested that a provision for removal from an office be provided for in the bylaws.
b. A member of the Board of Directors may be removed for a conviction of a felony, failure to perform duties of the office or other cause as may be specified in the standing rules by a two-thirds vote of the Delegate Assembly.	The changes provide for due process rights of the individual Board Member and are consistent with Pennsylvania Corporate Law.
c. The officer shall be given written notice 30 days prior to consideration of removal.	
d. Removal from office is subject to appeal by the Delegate Assembly.	
E. Duties of Officers	
All officers shall perform duties as usually pertain to their offices and prescribed in the bylaws and standing rules.	
1. President	
The president shall:	The only two changes in this section are found in the new "c" and the deletion of the phrase "if a delegate" from "f" (to be consistent with the proposed change that the Board of Directors have a vote as presented in Article VIII a.1)
a. preside at all meetings of the Delegate Assembly and Board of Directors;	
b. appoint, subject to ratification by the Board of Directors, all committees not otherwise provided for in the bylaws;	
c. appoint committees and other personnel to serve the Delegate Assembly.	

PROPOSED BYLAW REVISION	RATIONALE
d. fill all vacancies not otherwise provided for;	
e. sign all contracts as authorized by the Board of Directors except those contracts between the Member Boards and the Council and except those contracts for a routine type authorized by the Board of Directors, which shall be signed by the Executive Director;	
f. retain the right to vote on all matters before the Delegate Assembly, or on all matters before the Board of Directors, casting that vote at the same time all voters cast their votes;	
g. serve or delegate a qualified representative of a Member Board or staff of the Council to serve as the official representative of the Council in its contacts with governmental, civic, business and other organizations.	
h. Have the authority to authorize payment in the absence or inability of the treasurer to do so.	This change was made consistent with the belief that such authority should rest with the chief elected officer of the association.
2. Vice-President	
The vice-president shall:	
a. preside in the absence of the president;	
b. succeed to the office of president for the unexpired term in the event of a vacancy in the office of president;	
c. assume all such functions or responsibilities as may be delegated by the president or the Board.	

PROPOSED BYLAW REVISION	RATIONALE
3. Secretary The secretary shall: a. record the minutes of all meetings of the Delegate Assembly and the Board of Directors; b. maintain the master copy of the articles of incorporation, bylaws and standing rules and the minutes of any meeting of the Delegate Assembly and the Board of Directors;	The change in this section moved the authority for authorizing payment in the absence of the treasurer from the secretary to the president as presented in Article V. Section E.1.h.
4. Treasurer The treasurer shall: a. be custodian of all funds; b. serve as chairperson of the finance committee; c. present quarterly reports to Board of Directors and an annual report to the Delegate Assembly.	
5. Directors a. The directors shall assume such responsibilities as may be delegated by the Board of Directors. b. The area directors shall preside at meetings of the Member Boards in their respective areas. c. The area directors shall serve as a liaison and resource person to employees and members of Member Boards in their respective areas. d. The director at large shall preside at an area meeting in the absence of the area director.	The changes in this section are proposed to more clearly delineate the specific responsibilities of the directors.

PROPOSED BYLAW REVISION	RATIONALE
VI. NOMINATIONS AND ELECTIONS	
A. Committee on Nominations	
1. Composition and Term	
a. The committee on nominations shall be comprised of one person from each area. Committee members shall be either members of Member Boards or employees of Member Boards.	This change is proposed to be consistent with proposed language in Article V.B.1.
b. The term of office shall be one year. Members shall assume duties at the close of the session at which they are elected.	This is consistent with lifting restrictions for service requirements of members in Council activities throughout these proposed bylaws.
2. Election of Committee on Nominations.	
The committee shall be elected by ballot at the annual session of the Delegate Assembly. A plurality vote shall elect. The member receiving the highest number of votes shall serve as chairperson.	
3. A Member Who Consents to Be Nominated.	
A member of the committee who consents to be nominated to a position on the Board of Directors, shall be required to resign from the committee or withdraw his or her consent to nomination.	
4. Vacancy	
a. A vacancy occurring in the committee shall be filled from the remaining nominees from the area in which the vacancy occurs in the order of votes received.	The change made in this section reflects dealing with a singular phenomenon which is appropriate.

PROPOSED BYLAW REVISION	RATIONALE
b. The Board of Directors shall fill a vacancy from the area in which the vacancy occurs if none of the remaining nominees can serve.	
5. Duties	
a. The committee on nominations shall consider qualifications of all candidates for officers and the committee on nominations as proposed by Member Boards or by members of the committee on nominations.	
b. Candidates for area director or a position on the committee on nominations representing an area may be proposed only from the area involved.	The changes to this section reflect deletion of a section that was procedural and some clarifying language.
6. Report	
The committee on nominations shall submit at least two names for each position to be filled. The report shall be read on the first day of the meeting 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.	

PROPOSED BYLAW REVISION

B. Election of Officers

1. Election of officers shall be by ballot during the annual session of the Delegate Assembly. The area directors shall be elected by delegates and officers from their respective areas. Write-in votes shall be prohibited.

2. A majority vote shall elect. If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest number of votes. In case of a tie on the re-balloting the choice shall be determined by lot.

3. Officers shall assume duties at the close of the session at which they are elected.

VII. MEETINGS

Open Meetings

All meetings called under the auspices of the Council shall be open to the public with the following exceptions:

1. meetings of the examination committee whenever activities pertaining to test items are undertaken; and

2. executive meetings of the Delegate Assembly, Board of Directors and committees whenever the body has voted to hold such a meeting provided that the minutes of such meeting reflect the purpose of the executive session and the action taken.

RATIONALE

The changes to this section reflect deletion of the statement that is in conflict with the requirement of the bylaws that there be two candidates for each office and the addition of a statement about the election of area director as moved from Article IV.B.2. The prohibition of write-in votes is added because of ample opportunity for prior nomination and the requirement for written consent to serve from all nominees.
This change is proposed based on the belief that if a tie on re-balloting occurs, the Delegate Assembly has equally endorsed each candidate as being qualified to serve and a decision by lot is as reasonable as re-balloting several times.

PROPOSED BYLAW REVISION	RATIONALE
B. Participation at Meetings	
1. Members and employees of Member Boards shall be given the right to voice at all meetings called under the auspices of the Council. Only delegates to the Delegate Assembly, members of the Board of Directors and members of committees shall be entitled to make motions and vote in their respective meetings.	
2. Business may be transacted by telephone conference call or by mail in which case a report of such action shall be made part of the minutes of the next meeting.	
C. Convention Time, Call and Cancellation	
1. An annual session of the Council, hereinafter referred to as a convention, shall be held at a time and a place as determined by the Board of Directors.	
2. The official call to the convention, giving the time and place of the session, shall be sent to each Member Board at least 90 days prior to the convention.	
3. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the annual convention and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the Council.	The change in this section allows for a convening of a Delegate Assembly meeting in case of a national emergency or disaster.

PROPOSED BYLAW REVISION	RATIONALE
VIII. DELEGATE ASSEMBLY	
A. Composition, Term and Voting	
1. Composition	
a. The Delegate Assembly, the voting body of the Council, shall be comprised of two delegates designated by each Member Board and the officers of the Council.	Because an officer of an association has a fiduciary obligation to the organization as a whole without partisan obligated views, it is reasonable for officers to have a vote on matters that come before the Delegate Assembly.
b. An alternate duly appointed by a Member Board may replace a delegate and assume all privileges of a delegate.	
c. An officer may not represent a Member Board as a delegate.	A conflict of interest exists, according to legal counsel, with an officer of an organization being obligated to represent a particular view from a Member Board rather than that of the organization. This change, prevents this conflict from arising.
2. Term	
Delegates and alternates serve from the first day of the Delegate Assembly to which they have been designated until replaced by the Member Board.	
3. Voting	
a. Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates.	
b. There shall be no other proxy or absentee voting at a session of the Delegate Assembly.	
c. Only delegates from Member Boards using a Council examination may vote on matters related to the development and the administration of an examination.	This change assures that issues related to testing will be reserved to members of the Council using an examination.

PROPOSED BYLAW REVISION	RATIONALE
d. Each officer shall be entitled to one vote and may vote on all matters before the Delegate Assembly.	To be consistent concerning the composition of the Delegate Assembly.
B. Duties of the Delegate Assembly	
The Delegate Assembly shall be the legislative and policy making body of the Council and shall:	
1. Approve new Council memberships:	This change gives the Delegate Assembly a new duty in allowing for approval of all new membership in the Council.
2. elect officers and members of the committee on nominations;	
3. receive reports of officers and committees and take action as appropriate.	
4. approve any examination fee to be charged by the Council;	
5. approve the auditor's report;	
6. approve policy and position statements and strategies that give direction to the Council;	This change assures that the Delegate Assembly is the policy setting body of the Council.
7. approve the substance of all contracts between the Council and Member Boards and the Council and the test service:	
8. establish the criteria for and select the test service to be utilized by the Council unless the Council provides such services itself;	
9. adopt test plans to be used for the development of licensing examinations in nursing;	The establishment of dates for licensing examinations and the adoption of criteria for maintaining security have been moved to Article X, Section 8 under the Duties of the Administration of Examination Committee.
10. transact any other business as may properly come before it.	

PROPOSED BYLAW REVISION	RATIONALE
C. Sessions of the Delegate Assembly 1. The Delegate Assembly shall meet annually during the convention of the Council. 2. Special sessions of the Delegate Assembly may be called by the Board of Directors and shall be called by petition of ten Member Boards made to the Board of Directors. Notice containing the agenda, stated reasons, supporting information and the date and place of said session shall be mailed to each Member Board at least 30 days prior to the date for which such a session is called.	
D. Quorum The quorum for conducting business at any session of the Delegate Assembly shall be a majority of the Member Boards and two officers.	The minor language change made in this section was for clarity.
IX. BOARD OF DIRECTORS	
A. Composition The Board of Directors shall consist of elected officers.	

PROPOSED BYLAW REVISION	RATIONALE
B. Duties of the Board of Directors	
The Board of Directors shall be the administrative body of the Council and shall:	
1. conduct the business of the Council between sessions of the Delegate Assembly;	
2. authorize the signing of contracts between the Council and Member Boards and the Council and the test service and other major contracts:	
3. review and act on the membership status of Member Boards who are not in compliance with the bylaws, standing rules or contracts.	
4. set the time and place for each convention and session of the Delegate Assembly;	
5. engage the services of legal counsel;	
6. present an evaluation of the test service to Member Boards prior to consideration of contract extension or termination;	
7. authorize dissemination of written information about the licensing examinations;	
8. set fees unless otherwise specified in these bylaws;	This phrase added for clarity.
9. approve and adopt an annual budget;	
10. provide for all accounts of the Council to be audited annually by a certified public accountant;	

PROPOSED BYLAW REVISION	RATIONALE
11. cause to be bonded any officer or employee of the Council who is entrusted with Council funds or property;	
12. appoint the Council's representatives to serve on council committees or task forces of other organizations;	
13. approve studies and research pertinent to the purposes of the Council and consistent with actions of the Delegate Assembly;	This places responsibility and gives direction to the Board in considering studies and research
14. appoint committee members, subcommittee members, and chairpersons unless otherwise specified in these bylaws;	
15. monitor the progress of committee activities;	
16. appoint and define the responsibilities of an executive director and delegate the authority necessary for the administration of the Council's policies and activities;	
17. provide for the establishment, supervision and maintenance of the administrative office.	
18. publish an annual report of the Council.	
19. adopt such rules and organizational structure to carry on the functions of the Board as specified in the bylaws.	This change is proposed to allow the Board authority to organize itself in a way conducive to accomplish its duties.
20. establish and administer an awards program for the Council.	This change establishes the authority to administer the Council's award program.
C. Sessions of the Board of Directors	

PROPOSED BYLAW REVISION	RATIONALE

1. The Board of Directors shall meet in the convention city prior to and immediately following the annual convention of the Council and at other times as necessary to accomplish the work of the Board.

2. Special sessions of the Board of Directors may be called by the president and shall be called upon written request of three members of the Board of Directors.

3. Ten days notice shall be given to each member of the Board of Directors for the calling of a special session. The notice shall include the business to be transacted.

D. Quorum

A quorum for the conduct of business at any session of the Board of Directors shall be a majority of the members.

X. COMMITTEES

A. Enumeration

1. Standing Committees

There shall be the following standing committees: finance, bylaws, examination, administration of examination, and nursing practice and standards.

2. Special Committees

Special committees may be appointed by the Board of Directors at any time for the purpose of performing any duties not otherwise assigned by these bylaws.

PROPOSED BYLAW REVISION	RATIONALE
3. Sub-committees A committee may recommend the appointment of one or more sub-committees each of which shall be responsible to the committee.	This specific change allows for committees to organize themselves in a way conducive to accomplish their duties.
B. Membership	
1. Composition	
a. Committees shall include only current members and employees of Member Boards.	The changes in this section describe the use of subcommittees.
b. In the selection of members for committees, consideration shall be given to area representation and the composition of member boards.	
c. Subcommittees may include nonmembers of a committee and individuals not affiliated with the Council who are recommended by the chairperson.	
d. The president shall be an ex-officio member without vote of all committees except the committee on nominations.	
e. The chairperson of each committee shall be an ex-officio member without vote of all subcommittees within the respective committee.	

PROPOSED BYLAW REVISION	RATIONALE
2. Term	
a. Unless specified to the contrary elsewhere in these Bylaws, the term of all standing committee members shall be two years or until their successors are appointed.	
b. The term shall begin after convention and shall be completed at the end of the second convention following appointment by the Board of Directors. The Board of Directors shall appoint as nearly as possible one-half the members of each committee to terms expiring in even and odd numbered years.	
3. Vacancy	
a. A vacancy may occur when a committee member resigns or fails to meet the responsibilities of committee as determined by the Board.	The change in this section is proposed to more clearly delineate what constitutes a vacancy.
b. The vacancy may be filled by the Board of Directors.	
C. Functions	
1. Budget	Title of this section changed from "Expenses" to "Budget."
Committees shall submit an estimated budget for committee activities prior to the beginning of the fiscal year. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board.	
2. Records and Reports	
a. Each committee shall keep a written record of its proceedings.	

PROPOSED BYLAW REVISION	RATIONALE
b. Each committee shall submit an annual report at least 60 days before the annual convention for presentation to the Delegate Assembly. The report shall include a review of the past year and all activities or programs proposed for the succeeding year. The proposed plan shall include: (1) specific goals and objectives (2) number of meeting and/or workshop days anticipated	
D. Finance Committee 1. Composition The finance committee shall be composed of at least three members, including the treasurer as chairperson. 2. Duties The committee shall: a. provide general supervision of the finances of the Council, subject to the approval of the Board of Directors; b. present a proposed annual budget for the Council to the Board of Directors prior to the beginning of each fiscal year.	
c. present a fiscal impact statement on proposed activities of the Council to the authorizing body.	This change is proposed to assure that any new activity of the Council has a fiscal impact statement attached to provide the Delegate Assembly or the Board of Directors the needed information to act on new proposals.

PROPOSED BYLAW REVISION	RATIONALE
E. Bylaws Committee	
1. Composition	
The bylaws committee shall be composed of at least three members.	
2. Duties	
The committee shall:	
a. receive, consider, edit, and/or correlate proposed amendments to the articles of incorporation, bylaws and standing rules submitted by Member Boards, the Board of Directors, and committees. The committee may originate amendments;	
b. submit all proposed amendments to the articles of incorporation, bylaws, or standing rules to the Delegate Assembly together with the committee's recommendations for action.	
F. Examination Committee	
1. Composition	
a. The examination committee shall consist of at least six members. One of the members shall represent Member Boards licensing only practical nurses.	
b. The chairperson shall have served as a member of the committee prior to being appointed as chairperson.	

PROPOSED BYLAW REVISION	RATIONALE
2. Duties The committee shall: a. review and evaluate procedures for producing licensing examinations in nursing; b. review and adopt licensing examinations in nursing; c. evaluate licensing examinations which have been administered; d. assist with evaluation of the test service in accordance with responsibilities of the Board of Directors. e. make recommendations to the Board of Directors and provide direction for investigation, study and research concerning development of the licensing examinations in nursing; f. select appropriate persons to write and review test items for the licensing examinations based on criteria established by Board of Directors; g. recommend to the Delegate Assembly test plans to be used for the development of licensing examination in nursing; h. prepare written information about the licensing examinations for dissemination to Member Boards and other interested parties; i. conduct educational conferences as authorized by the Board of Directors or Delegate Assembly.	This proposed change transfers the selection of the Panel of Content Experts and Item Writers from the Board to the Examination Committee.

PROPOSED BYLAW REVISION

RATIONALE

G. Administration of Examination Committee

1. Composition

The administration of examination committee shall be composed of at least six members.

2. Duties

The committee shall:

a. Adopt criteria and procedures to be used by Member Boards for maintaining the security of the licensing examinations;

b. evaluate proposed and actual compliance of Member Boards, Test Service, and others with established criteria and procedures for maintaining the security of licensing examinations;

c. conduct an investigation for each alleged failure to maintain the security of the licensing examinations and/or loss of a test booklet and submit a written report to the president and executive director;

d. report to the Board of Directors possible violations of the contract between a Member Board and the Council;

e. conduct educational conferences as authorized by the Board of Directors or Delegate Assembly;

f. establish dates for the administration of the examinations.

PROPOSED BYLAW REVISION	RATIONALE

H. Nursing Practice and Standards Committee

1. Composition

The nursing practice and standards committee shall be composed of at least six members.

2. Duties

The committee shall:

a. propose and periodically review model statutory definitions of professional and practical nursing practice;

b. propose and periodically review model laws pertaining to nursing practice and standards, licensure, license renewal, disciplinary action, approval of nursing education programs and any other matters which come under the legal purview of Member Boards.

c. prepare written information about standards of nursing practice and nursing educaton to the extent that these matters relate to the legal definition of nursing practice for dissemination to Member Boards and other interested parties;

d. conduct educational conferences as authorized by the Board of Directors or Delegate Assembly.

XI. FEES AND FINANCE

A. Fees

1. Each fiscal year each Member Board shall pay a fee as set by the Delegate Assembly.

PROPOSED BYLAW REVISION	RATIONALE
2. If the fee has not been received within 90 days of the beginning of the Council's fiscal year, the Member Boards shall be subject to termination in accordance with the provisions of these bylaws.	
B. Audit The financial records of the Council shall be audited by a certified public accountant annually. The audit report shall be presented to the Delegate Assembly for action.	
C. Fiscal Year The fiscal year shall be from July 1 to June 30.	
XII. INDEMNIFICATION	
A. Direct Indemnification To the full extent permitted by, and in accordance with the standards and procedures prescribed by, Sections 7741 through 7745 of the Pennsylvania Nonprofit Corporation Law of 1972 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 attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.	The changes in this section are proposed to simplify the section while being more specific relative to Pennsylvania Corporate Law.

PROPOSED BYLAW REVISION	RATIONALE
B. Insurance To the full extent permitted by Section 7747 of the Pennsylvania Nonprofit Corporation Law of 1972 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain 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 the Article XII. C. Additional Rights Pursuant to Section 7746 of the Pennsylvania Nonprofit Corporation Law of 1972 or the corresponding provision of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 and/or 2 of this Article XII shall: 1. 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	

PROPOSED BYLAW REVISION	RATIONALE
2. Shall 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.	
XIII. PARLIAMENTARY AUTHORITY *ROBERT'S RULES OF ORDER NEWLY REVISED (Current Edition)* shall govern the proceedings of the Council in all cases not provided for in the articles of incorporation, bylaws, or standing rules.	This proposed change makes sure we are using the most recent edition of our parliamentary authority.
XIV. AMENDMENT AND REVISION	
A. Amendment These bylaws may be amended at any annual or special session of the Delegate Assembly as follows: 1. by a two-thirds vote of the delegates present and voting provided copies of the proposed amendments shall have been presented in writing to the Member Boards at least 45 days prior to the session, or 2. without previous notice, by a ninety-five percent vote of the delegates present and voting.	
B. Revision These bylaws may undergo comprehensive revision only upon authorization by the Delegate Assembly as follows:	

PROPOSED BYLAW REVISION	RATIONALE
1. a special committee for revision, authorized by the Delegate Assembly, shall prepare and present the proposed revision, and 2. by two-thirds vote of the delegates present and voting, provided copies of the proposed revision shall have been submitted in writing to the Member Boards at least 45 days prior to the session at which action is to be taken.	

Will this proposal generate revenue? *NO* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *YES*

   How many members are anticipated including the chairperson? _____

   How often would the committee meet? *3 times*

2. How many mailings would this proposal require? *One*

   To whom? *Member Boards, Board of Directors, National Council Committees*

3. Printing (surveys, special reports, etc.) Please describe:
   Special report with Bylaws and Standing Rules revisions

4. Other than committee meetings, is travel required? *NO*

   Please describe: _____

   _____

   _____

5. What type of consultation is required (i.e., legal, computer, etc.)?
   Legal review and a parliamentarian

6. Staff time required (preparation time, travel time, research presentations)
   - number of hours (estimated) _____

7. Projected beginning date: *September 1987*

   Projected completion date: *May 1988*

FISCAL IMPACT - SUMMARY

EXPENSES

1. Committee Meetings

   $500 * per member per meeting (Travel) = $*12,000*

   $150 per day per member = $*7,200*

   (8 members x 3 meetings)*
   = $19,200 minus $4,000 (in approved budget) = $15,200
   (8 members x 6 days)*

2. Mailings
   $0.25 per letter = $_____, or

   $2.00 * per 9 x 12 manila envelope (First Class) = $*202*
   ($2 x 101 mailings)*

3. Surveys (Printing)

   $0.05 * per page = $*202*
   ($0.05 x 40 page special report x 101 copies)*

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $ *None*

   $150 per day per member (Expenses) = $ *None*

5. Consultation

   $125 per day = $*600 (in addition to amount approved in budget)*
   ($125 x 4 days = $600)

6. Other Printing

   $0.05 per page = $ *None*

Subtotal Expenses: $*17,204*

Subtotal Revenue: $ *None*

Net: $*17,204*

** (101 mailings and printings include 61 Member Boards 31 committee members from the five National Council standing committees, and 9 members of the Board of Directors.)*

REPORT OF THE EXAMINATION COMMITTEE - TEAM I

RECOMMENDATION:

The Examination Committee Team I, recommends that the proposed revision of the NCLEX-RN Test Plan be adopted.

MEETING DATES:

During Fiscal Year 1987, the Examination Committee met at CTB/McGraw-Hill in Monterey, California a total of four times: 29 September - 1 October 1986; 1 - 5 December 1986; 30 March - 2 April 1987; and 9 - 13 June 1987. The Committee met 10 - 14 November 1986 in Chicago, Illinois for a workshop and also had telephone conference calls on 22 October and 18 May 1987.

TEST DEVELOPMENT ACTIVITIES:

The following test development activities were completed:

1. Adopted NCLEX-PN, Form 487, and approved 180 items to be administered as tryout items with Form 487.

2. Adopted NCLEX-RN, Form 787, and approved 360 items to be administered as tryout items with Form 787.

3. Adopted NCLEX-PN, Form 088, and approved 180 items to be administered as tryout items with Form 088.

4. Adopted NCLEX-RN, Form 288, and approved 360 items to be administered as tryout items with Form 288.

5. Adopted Confidential Directions for the development of NCLEX-PN and NCLEX-RN examinations, as follows:

    a. NCLEX-RN, Form 787 (July 1987)
    b. NCLEX-PN, Form 087 (October 1987)
    c. NCLEX-RN, Form 288 (February 1988)
    d. NCLEX-PN, Form 488 (April 1988)

6. Reviewed and evaluated policies regarding Member Board review of experimental item drafts.

7. Evaluated Item Writing conferences for process and productivity

    a. NCLEX-PN Item Writers, July 1986
        1) 12 writers
        2) over 400 items produced

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b. NCLEX-RN Item Writers, July 1986
   1) 16 writers
   2) over 600 items produced

ATTACHMENT A

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PROPOSED REVISION OF THE NCLEX-RN TEST PLAN

BACKGROUND

The Delegate Assembly, in August 1986, directed the Examination Committee to revise the current NCLEX-RN Test Plan to bring it in line with the job analysis findings reported in *A Study of Nursing Practice and Role Delineation and Job Analysis of Entry-Level Performance of Registered Nurses (Study)*. The Examination Committee met 10 - 14 November 1986 in Chicago, Illinois to analyze the results of the *Study* and to draft a revised test plan. This draft was then circulated to Member Boards for their review and comment. During its 30 March - 2 April 1987 meeting, the Committee determined the weights to be assigned to the categories of the "Client Needs" dimension of the test plan. The document submitted to the Delegate Assembly for its consideration was finalized on 18 May 1987 and incorporates many of the suggestions and comments received from the membership.

The process used in the preparation of the proposed NCLEX-RN Test Plan was as follows:

(1) Identification and elimination of those nursing activity statements included in the *Study's* questionnaire which did not reflect entry-level activities engaged in by newly licensed registered nurses.

(2) Determination that the results of the *Study* supported retention of the "Nursing Process" as one component of the NCLEX-RN Test Plan and revision of the definitions included in the test plan document.

(3) Determination that the results of the *Study* supported continuation of the assignment of equal weights to all phases of the Nursing Process.

(4) Determination that the results of the *Study* supported replacement of the "Locus of Decision Making" component of the current NCLEX-RN Test Plan with "Client Needs", as described in the *Study*.

(5) Performance of a content analysis of the activities included within each of the seventeen categories of client needs, and assignment of each of the seventeen categories to one of four groups of client needs; and development of titles and definitions to be used in the test plan document (See Table 1.)

Board comments and suggestions. A copy of the proposed NCLEX-RN Test Plan is attached (See Attachment A).

RELATED ACTIVITIES:

Additionally, the Committee accomplished the following activities:

1. Established goals and objectives for Fiscal Year 1988 (See Attachment B).

2. Initiated work on the Knowledges, Skills, and Abilities Statements (KSAs) for the proposed revision of the NCLEX-RN Test Plan.

3. Revised the procedure used to screen and select potential NCLEX item writers.

4. Submitted suggestions and recommendations to the Bylaws Committee.

5. Began process for revising the Diagnostic Profiles that are disseminated to NCLEX-RN and NCLEX-PN failing candidates.

6. Submitted to the Board of Directors, recommendations on scoring guidelines based on the results of a study designed to assess how accurately pass decisions could be made on NCLEX if one or more booklets were unavailable for scoring.

MOTION:

The Examination Committee moves adoption of the recommendation stated at the beginning of the report.

Fiscal Impact Statement:

If the motion is adopted by the Delegate Assembly, the National Council will incur the following expenses:

Expenses:

Publication of new NCLEX-RN Test Plan documents - estimated cost = $7500.00 (included in FY 1988 budget)

Total Estimated Expenses = $7500.00

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(3) Determination that the results of the *Study* supported continuation of the assignment of equal weights to all phases of the Nursing Process.

(4) Determination that the results of the *Study* supported replacement of the "Locus of Decision Making" component of the current NCLEX-RN Test Plan with "Client Needs", as described in the *Study*.

(5) Performance of a content analysis of the activities included within each of the seventeen categories of client needs, and assignment of each of the seventeen categories to one of four groups of client needs; and development of titles and definitions to be used in the test plan document (See Table 1.)

(6) Determination that in the calculation of weights for the "Client Needs" dimension of the test plan, that: (a) both the frequency with which an activity is performed and the impact the nonperformance of an activity has on client safety

(criticality) should be considered; (b) criticality should contribute more than frequency; (c) the weight assigned to each of the four "Client Needs" should be calculated using an application of Rasch Model that uses a rating system to combine each respondent's frequency and criticality rating for each nursing activity.

(7) Determination that the need for additional dimensions of the test plan (e.g., clients' ages,work settings, etc.) was not supported by the *Study* data.

(8) Revision of the "Introduction" and "Beliefs" sections of the Test Plan.

Client Needs:	Grouping and titles used in proposed test plan and (titles used in the *Study*).

I. Safe, effective care environment

There is a client need for:

1. Coordinated care (Staff development, collaboration) [a]
2. Quality assurance (Quality assurance and safety)
3. Goal-oriented care (Planning/management)
4. Environmental safety (Protecting the client)
5. Preparation for treatments and procedures (Preparing the client for procedures)
6. Safe, effective treatments and procedures (Ensuring safety during procedures)

II. Physiological integrity

There is a client need for:

1. Physiological adaptation (Meeting acute physical needs)
2. Reduction of risk potential (Monitoring clients at risk)
3. Mobility (Assisting clients with needs related to mobility)
4. Comfort (Controlling pain)
5. Provision of basic care (Performing routine nursing measures)

III. Psychosocial integrity

There is a client need for:

1. Psychosocial adaptation (Meeting acute emotional/behavioral needs)
2. Coping/adaptation (Helping clients to cope with stress)

IV. Health promotion/maintenance

There is a client need for:

1. Continued growth and development (Meeting client needs related to parenting)
2. Self care (Assisting clients with self care)
3. Integrity of support systems (Supporting client's family)
4. Prevention and early detection of disease (Immunizing/screening)

[a] "Coordinated care" is the wording recommended by the Examination Committee; "Staff development, collaboration" is the original title used in the *Study*.

PROPOSED TEST PLAN FOR THE NATIONAL COUNCIL LICENSURE EXAMINATION FOR REGISTERED NURSES

Entry into the practice of nursing in the United States and its territories is regulated by the licensing authorities in the jurisdictions. Each jurisdiction requires a candidate for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed entry-level registered nurse. Developed by the National Council of State Boards of Nursing, Inc., *The National Council Licensure Examination for Registered Nurses (NCLEX-RN)* is the examination used by those jurisdictions whose boards of nursing are National Council members.

The initial step in developing the examination for registered nurse licensure is preparation of a test plan to guide selection of content and behaviors to be tested. In the plan, provision is made for an examination reflecting entry-level nursing practice as identified by Kane and others [1] in *A Study of Nursing Practice and Role Delineation and Job Analysis of Entry-Level Performance of Registered Nurses*. The activities identified in the job analysis component of this study were analyzed in relation to the frequency of their performance, their impact on maintaining client safety, and the various settings in which they were performed. This analysis resulted in the identification of a framework for entry-level performance that incorporates the nursing process and specific client needs. The test plan, which was derived from this framework, provides a concise summary of the content and scope of the examination and serves as a guide for candidates preparing to write the examination and for those who develop it. Based on the test plan, each assembled NCLEX-RN examination reflects the knowledge, skills and abilities essential for application of the phases of the nursing process to meet the needs of clients with commonly occurring health problems. The following sections describe the levels of cognitive ability which will be tested in the examination, beliefs about nursing and clients which are basic to the examination, and the specific components of the NCLEX-RN test plan.

LEVELS OF COGNITIVE ABILITY

The examination includes test items at the cognitive levels of knowledge, comprehension, application and analysis [2]. Weighting (i.e., the number of items assigned to each level) is not specified for the levels of cognitive ability; however, most items in the examination are at the application and analysis levels.

BELIEFS

Beliefs about the nature of people and nursing underlie the test plan. The profession of nursing has a unique concern toward helping clients to achieve an optimal state of health. Recipients of nursing care are viewed as finite beings with varying capacities to function in society. These recipients are unique persons defining their own systems of daily living which reflect values, motives, and life styles. Additionally, they are viewed as having the right to determine what kind of health care should be available to meet present and future needs. The consumer of nursing is an individual or group of individuals in need of assistance that involves the maintenance of life and promotion of health, coping with health problems, adapting to or recovering from the effects of disease or injury, or assisting in death with dignity.

The nature of nursing is dynamic and evolving. It is perceived as deliberate action of a personal and assisting nature. The goal of nursing is to promote health and to assist individuals to attain an optimal level of functioning. To assist individuals in attaining an optimal level of health, nurses respond to the needs, conditions, or events that result from actual or potential health problems [3] and which provide the focus for the nurse's plan of care.

Upon entry into nursing practice, the registered nurse is expected to care for the client and/or to assist the client's significant others in the provision of care. The registered nurse is expected to identify the health needs/problems of clients throughout their life cycle and in a variety of settings, to plan and to initiate appropriate action based upon nursing diagnoses derived from these assessments, and to evaluate the extent to which expected outcomes of the plan of care are achieved.

The practice of nursing requires knowledge of: 1) nursing process, 2) management and coordination of safe, effective care, 3) client's physiological needs, 4) client's psychosocial needs, and 5) maintenance and promotion of health. The following elements, embodied in the five categories of nursing knowledge, are integrated throughout the National Council Licensure Examination: accountability, mental health concepts, pharmacology, nutrition, body structure and function, pathophysiology, principles of asepsis, growth and development, documentation, communication and teaching.

COMPONENTS OF THE TEST PLAN

Within the framework of the test plan, two components are addressed: 1) Phases of the Nursing Process and 2) Client Needs. These are described in the following sections.

PHASES OF THE NURSING PROCESS

The phases of the nursing process to be measured in the licensure examination are grouped under the broad categories of Assessment, Analysis, Planning, Implementation and Evaluation. The nurse collects data about the client and health care system, identifies specific needs, plans with clients, significant others and/or health team members to meet those needs, implements a plan of action and evaluates the outcomes of the interventions [4, 5, 6, 7, 8]. Because the five phases have equal importance, each one is represented by an equal percentage of items in the examination.

The phases of the nursing process are described as follows:

I. Assessment: establishing a data base.

A. Gather objective and subjective information relative to the client:

1. Collect verbal and nonverbal information from the client, significant others, health team members records, and other pertinent resources.
2. Review standard data sources for information.
3. Recognize symptoms and significant findings.

4. Determine client's ability to assume care of daily health needs.
5. Determine health team member's ability to provide care
6. Assess environment of client.
7. Identify own or staff reactions to client, significant others, and/or health team members.

B. Verify data:

1. Confirm observation or perception by obtaining additional information.
2. Question orders and decisions by other health team members when indicated.
3. Check condition of client personally instead of relying upon equipment.

C. Communicate information gained in assessment.

II. Analysis: identifying actual or potential health care needs/problems based on assessment.

A. Interpret data:

1. Validate data.
2. Organize related data.

B. Collect additional data as indicated.

C. Identify and communicate client's nursing diagnoses.

D. Determine congruency between client's needs/problems and health team member's ability to meet client's needs.

III. Planning: setting goals for meeting client's needs and designing strategies to achieve these goals.

A. Determine goals of care:

1. Involve client, significant others, and health team members in setting goals.
2. Establish priorities among goals.
3. Anticipate needs/problems on basis of established priorities.

B. Develop and modify client's care plan:

1. Involve the client, significant others, and/or health team members in designing strategies.
2. Include all information needed for managing the client's care, such as age, sex, culture, ethnicity, and religion.
3. Plan for client's comfort and maintenance of optimal functioning.
4. Select nursing measures for delivery of client's care.

C. Collaborate with other health team members for delivery of client's care:

1. Identify health or social resources available to the client and/or significant others.
2. Coordinate care for benefit of client.
3. Delegate actions.

D. Formulate expected outcomes of nursing interventions

IV. Implementation: initiating and completing actions necessary to accomplish the defined goals.

A. Organize and manage client's care.

B. Perform or assist in performing activities of daily living:

1. Institute measures for client's comfort.
2. Assist client to maintain optimal functioning.

C. Counsel and teach client, significant others, and/or health team members:

1. Assist client, significant others, and/or health team members to recognize and manage stress.
2. Facilitate client relationships with significant others and health team members.
3. Teach correct principles, procedures and techniques for maintenance and promotion of health.
4. Provide client with health status information.
5. Refer client, significant others and/or health team members to appropriate resources.

D. Provide care to achieve established client goals:

1. Use correct techniques in administering client care.
2. Use precautionary and preventive measures in providing care to client.
3. Prepare client for surgery, delivery or other procedures.
4. Institute action to compensate for adverse responses.
5. Initiate necessary life-saving measures for emergency situations.

E. Provide care to optimize achievement of the client's health care goals:

1. Provide an environment conducive to attainment of client's health care goals.
2. Adjust care in accord with client's expressed or implied needs/problems.
3. Stimulate and motivate client to achieve self care and independence.
4. Encourage client to follow a treatment regime.
5. Adapt approaches to compensate for own and health team members' reactions to factors influencing therapeutic relationships with client.

F. Supervise, coordinate, and evaluate the delivery of client's care provided by nursing staff.

G. Record and exchange information:

1. Provide complete, accurate reports on assigned client to other health team members.
2. Record actual client responses, nursing actions, and other information relevant to implementation of care.

V. **Evaluation: determining the extent to which goals have been achieved.**

A. Compare actual outcomes with expected outcomes of therapy:

1. Evaluate responses (expected and unexpected) in order to determine the degree of success of nursing intervention.
2. Determine need for change in the goals, environment, equipment, procedures, or therapy.

B. Evaluate compliance with prescribed and/or proscribed therapy.

1. Determine impact of actions on client, significant others and/or health team members.
2. Verify that tests or measurements are performed correctly.
3. Ascertain client's significant others' and/or health team members understanding of information given.

C. Record and describe client's response to therapy and/or care.

D. Modify plan as indicated, and reorder priorities.

CLIENT NEEDS

The health needs of clients are grouped under four broad categories: 1) Safe, effective environment, 2) Physiological integrity, 3) Psychosocial integrity, and 4) Health promotion/maintenance. The weighting of these categories was based on an analysis of the results of a job analysis study completed in 1986 [1]. Thus, the weighting assigned to each category of client need is as follows:

I. Safe, effective care environment	25 to 31 percent
II. Physiological integrity	42 to 48 percent
III. Psychosocial integrity	9 to 15 percent
IV. Health promotion and maintenance	12 to 18 percent

The categories of client needs are described as follows:

I. Safe, effective care environment.

The nurse meets client needs for a safe and effective environment by providing and directing nursing care that promotes achievement of the following client needs:

1. Coordinated care
2. Quality assurance
3. Goal-oriented care
4. Environmental safety
5. Preparation for treatments and procedures
6. Safe and effective treatments and procedures

Knowledge, Skills, and Abilities

In order to meet client needs for a safe, effective environment, the nurse should possess knowledge, skills, and abilities in areas which include but are not limited to the following examples:

knowledge of bio/psycho/social principles; teaching/learning principles; basic principles of management; principles of group dynamics and interpersonal communication; expected outcomes of various treatment modalities; general and specific protective measures; environmental and personal safety; client rights; confidentiality; cultural and religious influences on health; continuity of care; and spread and control of infectious agents.

II. Physiological Integrity

The nurse meets the physiological integrity needs of clients with potentially life-threatening and/or chronically recurring physiological conditions, and of clients at risk for the development of complications or untoward effects of treatments or management modalities by providing and directing nursing care that promotes achievement of the following client needs:

1. Physiological adaptation
2. Reduction of risk potential
3. Mobility
4. Comfort
5. Provision of basic care

Knowledge, Skills and Abilities

In order to meet client needs for physiological integrity, the nurse should possess knowledge, skills, and abilities in areas which include but are not limited to the following examples:

normal body structure and function; pathophysiology; drug administration and pharmacological actions; intrusive procedures; routine nursing measures; documentation; nutritional therapies; managing emergencies; expected and unexpected response to therapies; body mechanics; effects of immobility; activities of daily living; comfort measures; and use of special equipment.

III. Psychosocial Integrity

The nurse meets client needs for psychosocial integrity in stress and crisis-related situations throughout the life cycle by providing and directing nursing care that promotes achievement of the following client needs:

1. Psychosocial adaptation
2. Coping/Adaptation

Knowledge, Skills, and Abilities

In order to meet client needs for psychosocial integrity, the nurse should possess knowledge, skills, and abilities in areas which include but are not limited to the following examples:

communication skills; mental health concepts; behavioral norms; psychodynamics of behavior; psychopathology; treatment modalities; psychopharmacology; documentation; accountability; principles of teaching and learning; and appropriate community resources.

IV. Health promotion/maintenance

The nurse meets client needs for health promotion/maintenance throughout the life cycle by providing and directing nursing care that promotes achievement, within clients and their significant others, of the following needs:

1. Continued growth and development
2. Self-care
3. Integrity of support systems
4. Prevention and early treatment of disease

Knowledge, Skills, and Abilities

In order to meet client needs for health promotion/maintenance, the nurse should possess knowledge, skills and abilities in areas which include but are not limited to the following examples:

communication skills; principles of teaching and learning; documentation; community resources; family systems; concepts of wellness; adaptation to altered health states; reproduction and human sexuality; birthing and parenting; growth and development including dying and death; pathophysiology; body structure and function; and principles of immunity.

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Examination Committee
Goals and Objectives for 1987-88

Goal I:

Monitor the licensing examinations according to established policies and procedures.

Objectives:

1. Develop confidential directions for item writing sessions to meet the needs of the pool.
2. Develop confidential directions for forms of the examinations.
3. Approve forms of the examinations which meet the test plan specifications and established criteria.
4. Approve items for tryout according to established criteria.
5. Evaluate licensing examinations after administration according to established criteria.
6. Evaluate the process used by the Panel of Content Experts utilizing established criteria.
7. Represent Examination Committee at Panel of Content Experts sessions.
8. Continue to monitor the effectiveness of the diagnostic profiles.
9. Evaluate the reliability of the NCLEX-RN relative to the reduction in the number of test items, using established criteria.

10. Continue to monitor current trends in the health care delivery system relative to content and face validity of examination items.

11. Review and revise policies and procedures.

12. Evaluate process by which item writers are nominated and selected according to established criteria.

13. Select item writers using established criteria.

Goal 2:

Monitor other committees and task forces dealing with the development of future examinations.

Objectives:

To be determined after Delegate Assembly action on Bylaws revisions.

Goal 3:

Provide direction for investigation, study, and research impacting on licensing examinations.

Objectives:

1. Review periodic progress reports on the ACT extension study.

2. Plan for additional meetings as needed in relationship to test plan revision.

3. Review periodic progress reports on the development of Computer Adaptive Testing and Computer Clinical Simulation Testing as they relate to the Examination Committee.

Goal 4:

Review, revise, and implement the revised NCLEX-RN test plan based on direction from the 1987 Delegate Assembly.

Objectives:

To be determined after Delegate Assembly action.

REPORT OF THE EXAMINATION COMMITTEE - TEAM II

RECOMMENDATION

The Examination Committee, Team II, recommends:

That the Delegate Assembly adopt a policy of reporting scores on the nursing licensure examinations as pass/fail, effective with the October 1988 examination; and that failing candidates receive an enhanced diagnostic profile.

MEETING DATES

The Committee met one time, on 30 April - 1 May 1987, and held one telephone conference meeting on 28 May 1987.

ACTIVITIES

At its meeting, the Committee dealt with three issues:

1. Pass/fail score reporting
2. The potential division of the RN test plan between computer adaptive testing and computerized clinical simulation testing (CST)
3. Potential use of computerized clinical simulation testing as a mechanism for assessing continued competence.

The Committee gave direction regarding the division of the test plan sufficient to guide writers of prototype cases for clinical simulations, so that at such time as external funding for CST is received, work on cases can begin.

The Committee discussed use of CST as a mechanism for assessing continued competence, and came to the conclusion that there is definitely potential for this use. However, the initiation of any exploration in this area is deferred until after the Delegate Assembly gives direction on whether or not methods for testing the maintenance of minimum competence should be explored by the National Council.

The remainder of this report will deal with the first issue, pass/fail score reporting.

HISTORICAL OVERVIEW

The first objective of the first goal of the National Council of State Boards of Nursing is to "develop licensure examinations that are based upon current accepted psychometric principles and legal considerations." Since its founding in 1978, the National Council has consistently striven to improve the examinations provided to the Member Boards so that they reflect the best available current knowledge in the psychometric and legal fields. Many changes in the examinations and policies for administration have occurred during this short span of nine years' time:

- adoption of a comprehensive examination format, rather than a five-subtest format
- use of Item Response Theory (the Rasch Model) for equating purposes
- change to criterion-referenced determination of the passing point
- performance of two major and one update job analysis studies
- creation of Diagnostic Profiles for failing candidates
- development of Summary Profiles for providing aggregate data about graduates' examination performances to schools of nursing
- removal of confidential jurisdiction codes and approval for general release of aggregate national and jurisdiction-level examination performance data
- adoption of procedures for modifying examination administration conditions for candidates with handicapping conditions
- implementation of a handscoring service by which candidates can have their examination scores confirmed
- adoption of first a "closed" review, and subsequently an "open" review, procedure for failing candidates to inspect their own examination booklets

The latter items listed above in particular illustrate that there has been a movement toward openness with examination information toward candidates, schools of nursing, the nursing community, and the general public. This movement has been a response to the general societal push for accountability, freedom of information, and consumers' rights.

Openness with information sometimes entails misuse of information, however, and the National Council has on several occasions considered its responsibilities for promoting valid interpretations of the information it supplies. As early as 1981, the Delegate Assembly adopted the following policy statement:

> Boards of Nursing will advise candidates, at the time of initial release of their scores to them, that the use of scores for any purpose other than licensure is not appropriate and, therefore, Boards of Nursing will not provide a copy of licensee's examination scores to a prospective employer or to a graduate nursing program.

More recently, it has come to the attention of several Member Boards and the National Council staff that, contrary to the above policy, licensee's scores are being used by employers and nursing programs as criteria for decision-making. The Executive Director's column in the Summer 1985 *Issues* addressed the problem, pointing out that "the real problem with providing numbered scores is that these scores are being used by others as a measure of various abilities beyond that of the entry-level nurse, and NCLEX cannot measure those abilities."

A specific concern about inappropriate uses of NCLEX scores arose in connection with widespread use of the scores for admission into programs for nurse anesthetists. A letter from the National Council to the American Association of Nurse Anesthetists (AANA) was written in early 1986 stating that the National Council had become aware of this practice, that this represented an invalid interpretation of NCLEX scores, and that the AANA was requested to instruct the schools to discontinue using the scores as criteria for admission. The AANA has indicated that this information has been communicated to its schools.

During FY 86 the Examination Committee studied the issue of whether the NCLEX scores should be reported as pass/fail rather than numerically. The Committee proposed to the 1986 Delegate Assembly "that a policy be instituted for scoring whereby a passing score will be reported as 'pass' and a failing score will be reported numerically along with the diagnostic profile." This recommendation was referred back to the Committee by the Delegate Assembly for further study of issues raised by the delegates.

FY 87 ACTIVITIES RELATED TO PASS/FAIL SCORE REPORTING

The problems with misuse of NCLEX scores have been discussed with Member Boards at the CTB Invitational Conference and at the Area Meetings, with members of the National League for Nursing, and with members of the Organization for the Advancement of Associate Degree Nursing. In all cases, valid interpretations and invalid interpretations were enumerated and contrasted.

In preparation for and during its 30 April - 1 May meeting, the Examination Committee, Team II, undertook further study of pass/fail scoring, as well as dissemination of additional information to Member Boards and others regarding reporting of NCLEX scores. A survey was distributed to Member Boards requesting a statement of the board's current position on pass/fail score reporting, and confirmation of whether or not any prohibition against pass/fail score reporting existed in their statutes or regulations. The results of the survey are presented in Attachment A.

The Examination Committee, Team II, also directed that three informational articles be disseminated to Member Boards, addressing the areas of concern voiced by the delegates in 1986 (legal, psychometric, and research-related). Input from experts in each of these areas was obtained, and the Committee produced a document of the advantages and disadvantages to candidates, Member Boards, and the National Council for the two score reporting options it considered most viable out of four that were originally considered (see Attachment B). The two options are as follows:

Option #1: All candidates receive a scaled score, and failing candidates receive a diagnostic profile like the one currently used; disclaimer printed on score reports and additional educational efforts undertaken.

Option #2: All candidates whose raw score equals or surpasses the passing score will be reported as "pass"; all candidates whose raw score is less than the passing score will be reported as "fail". All failing candidates will receive an enhanced diagnostic profile containing information similar to the present one, plus a graphic depiction of their distance from the passing point (based on their raw score). An additional enhancement might take the form of graphic depictions of the magnitude of strengths and weakness in each area of the test plan. No scaled scores for candidates would be generated during the scoring process.

The two options were evaluated by the Committee from the perspective of three critical questions:

1) How can the National Council satisfy the consumer's "right to know" by providing maximum information, while also fulfilling its responsibility to ensure valid interpretation of the information provided?

2) How can the National Council best maintain the uniformity of examination requirements that enables smooth functioning of the present endorsement system?

3) To what extent are the legal and psychometric problems associated with misuse of NCLEX scores real rather than potential?

The Committee decided that it did not have sufficient information in order to address the third question; thus staff were directed to survey a representative sample of licensees, nursing education programs, and nursing service institutions. The methodology and results of the survey are described in Attachment C.

The Committee met a final time via telephone conference on 28 May 1987 to consider the survey results and make a final determination of its recommendation to the Delegate Assembly.

The results of the survey support the inference that more than 600 nursing service institutions and 20 educational programs are misusing NCLEX scores, and that more than 3,800 candidates annually are affected by these misuses. Based on the results of the survey, the Committee determined that invalid interpretations and misuse of NCLEX scores were pervasive enough to represent a real rather than a potential problem. Therefore, the Committee decided to recommend that the Delegate Assembly adopt a uniform policy of pass/fail score reporting (as described in Option #2 above).

The Committee believes that this policy satisfies the critical question of the consumer's right to know. Clearly, all candidates have the right to know whether they failed or passed the licensing examination. In addition, failing candidates have a right to feedback which will help them to assess their strengths and weaknesses, and thus effectively plan their study efforts prior to retaking the examination. The enhanced diagnostic profile actually may offer more useful information to the failing candidate than the current numeric score because it will not only show how close or far the candidate was from passing, but will report for each area of the test plan the relative level of performance. In comparison with the current diagnostic profile giving an "X" in cells of the test plan where weak performance was shown, the enhanced information will enable failing candidates to consider their weak areas in order of weakness. A prototype of the approximate format of the score report/diagnostic profile under this score reporting policy is presented in Attachment D.

The Committee also reviewed the other report formats (jurisdiction, program, frequency distribution, summary) and the Summary Profiles to identify what changes would have to be made. It was determined that a frequency distribution could no longer be produced under this score-reporting policy; however, other reports could be maintained in a format very similar to the present format. Whenever mean scores are used in the report format, these would be replaced by percent passing. Ranking on the basis of mean score would be replaced by ranking on the basis of percent passing for the Summary Profiles.

As noted in the advantages to Member Boards of scoring Option #2 (Attachment B), the only statute or rule changes required by adoption of this policy would be in those jurisdictions with laws/rules specifically stating that each candidate must be given a numeric score. Those jurisdictions with laws/rules stating that the passing scores are 1600 (RN) and 350 (PN) would not need to make changes since, through the equating process, those benchmark points would still exist and have the same meaning in terms of nursing competence that they do now. Telephone contact with jurisdictions indicating on the pass/fail survey that they may have to make changes, revealed that nearly all could accomplish these changes in twelve months or less. Thus the Committee is recommending that the change to the new score reporting policy be effective for the October 1988 examination.

So long as all jurisdictions continue to set the same passing scores, the endorsement process would continue to function as it does currently. If jurisdictions did choose to set different passing scores, and not accept the recommendation of the Panel of Judges for the criterion-referenced passing score, endorsement could be handled by involving the National Council in the verification process. This would be slightly more complicated, but would be an effective mechanism. Thus, the Examination Committee feels that the recommended policy also satisfies the critical question of facilitating endorsement.

RECOMMENDATION

The Examination Committee, Team II, recommends:

That the Delegate Assembly adopt a policy of reporting scores on the nursing licensure examinations as pass/fail, effective with the October 1988 examination; and that failing candidates receive an enhanced diagnostic profile.

SURVEY OF MEMBER BOARDS
SUMMARY OF RESULTS

Question 1:

Does language in your jurisdiction's Nurse Practice Act or in regulations prohibit use of a pass/fail report to candidates (i.e., specify that each candidate's score report must include his/her numeric score)?

YES, in Practice Act		YES, in regulations		NO, there is no prohibition		NO RESPONSE	
#	%	#	%	#	%	#	%
0	0%	9	15%	46	75%	6	10%

Question 2:

Does your Board of Nursing support the institution of the pass/fail score reporting policy at this time?

	YES		NO		UNDECIDED		NO RESPONSE	
	#	%	#	%	#	%	#	%
Area I	8	44	4	22	4	22	2	11
Area II	9	64	3	21	2	14	0	0
Area III	5	31	7	44	4	25	0	0
Area IV	3	23	2	15	5	38	3	23
Total	25	41	16	26	15	25	5	8

Advantages/Disdadvantages of Score Reporting Options

SCORE REPORTING OPTION #1

Numeric Scores

ADVANTAGES

Candidates	Member Boards	National Council
1. Passing and failing candidates have indication of how well or how badly they did.	1. Continuing to provide familiar information, and same amount of information is less likely to prompt litigation, or complaints by candidates and educators.	1. No expense for re-programming and re-designing reports.
2. Satisfies consumers' right to information.	2. No statute/rule changes required.	2. Ease of continuing to provide familiar information.
3. Facilitates endorsement process if in the future Member Boards choose different passing scores.	3. Facilitates ability to choose different passing scores, if desired.	3. No transition period while Member Boards make statute/rule changes.
		4. Providing full score reports promotes the image of National Council as open and accountable.

SCORE REPORTING OPTION #1
Numeric Scores

DISADVANTAGES

Candidates

1. As distance between actual scaled score and pass point increases, standard error increases and scaled scores are less precise indicators of actual competence; therefore, ranking candidates on scaled scores can lead to unjustified interpretations of performance, especially at the extremes of the scale.

2. Examination is developed to provide information relative to one point: minimal competence to practice safely. Therefore, other interpretations regarding degrees of competence are not valid.

3. Passing candidates' scores can be misinterpreted and used unfairly in decisions about their employment or admission to academic programs.

4. Higher exam fees would need to be charged to cover costs of validity studies, item development, and litigation.

5. Under CAT, gains in efficiency would be less if numeric scores must be reported for all candidates than if some form of pass/fail reporting is used. This would result in longer tests and therefore even higher costs for candidates.

Member Boards

1. NCLEX may be deemed by courts to be an employment examination, thereby exposing it to courtroom scrutiny and potential adverse judgments regarding validity.

2. NCLEX may be deemed by courts to be an admissions test, thereby bringing it under current truth-in-testing laws requiring extensive item disclosure.

3. Court determination that NCLEX is subject to existing truth-in-testing laws in one state would lead to difficult situation regarding that state's continued use of NCLEX, and if so, bearing costs for additional item development.

4. Possible inclusion in litigation regarding discriminatory use of NCLEX as employment or admissions test.

5. Board may have to go through rule changes to change candidate fees; for some Boards this is reflected as an increased expense in their budgets.

6. Boards would need to undertake additional efforts to educate schools, employers, and candidates against score misuse.

7. Perpetuates misinterpretation of scaled scores as indicating the degree to which a nurse is competent to practice, and that small score difference represents real difference in competence.

8. CAT programming more expensive if later switch to pass/fail reporting.

National Council

1. NCLEX may be deemed by courts to be an employment examination, thereby exposing it to courtroom scrutiny and potential adverse judgments regarding validity.

2. NCLEX may be deemed by courts to be an admissions test, thereby bringing it under current truth-in-testing laws requiring extensive item disclosure.

3. Court determination that NCLEX is subject to existing truth-in-testing laws in one state would lead to difficult situation: either loss of revenue if NCLEX denied to that state, or increased item development costs and potential problems with equating if state uses and discloses exam.

4. Possible inclusion in litigation regarding discriminatory use of NCLEX as employment or admissions test, entailing cost of litigation and possible compromise of exam security during discovery.

5. Possible obligation to implement a court-imposed remedy, entailing use of National Council resources.

6. Possible need to devote additional National Council resources to validation studies.

SCORE REPORTING OPTION #2
Pass/fail with Diagnostic Profile

ADVANTAGES

Candidates

1. Passing candidates not discriminated against by future employers or by educators based on rank-order comparisons of NCLEX scores.

2. Failing candidates have an indication of how close they came to passing.

3. Passing candidates not treated differently than failing candidates with regard to type of report received (i.e., a potential problem with one group receiving a scaled score while the other group does not is eliminated).

4. Use of enhanced diagnostic profile provides candidate with improved information as to relative strengths and weaknesses.

Member Boards

1. Prevents invalid use of NCLEX scores.

2. Prevents inclusion of Member Boards in litigation regarding discrimination if candidates denied employment or admission based on their passing scores.

3. Provides failing candidate with feedback regarding performance and therefore may reduce the risk of legal action by failing candidate on basis of right to know exam performance.

4. Passing and failing candidates treated the same in that neither gets a scaled score.

5. Percent passing scores are still available for evaluation of nursing education programs.

6. Statistical techniques are still available to educators studying program effectiveness.

7. Passing scores of 1600 and 350 will continue to exist, allowing Boards to maintain existing rules and regulations regarding the passing point; only Boards with rules saying specifically that a (numeric) score must be given to each candidate will have to make changes.

8. A mechanism for endorsement exists should Member Boards set different passing scores.

National Council

1. Accurate estimate of ability at passing point will be focus; appropriate interpretations will be facilitated.

2. Prevents invalid use of NCLEX scores.

3. Provides failing candidates with relevant and appropriate feedback regarding areas of strength and weakness.

4. Scaled scores not generated for individual candidates, therefore not being "withheld" from anyone.

5. Reduces risk of legal problems associated with continued misinterpretation and invalid use of scaled scores.

6. Minimizes transition period due to Member Boards having to change rules and regulations.

SCORE REPORTING OPTION #2
Pass/fail with Diagnostic Profile

DISADVANTAGES

Candidates

1. Failing candidates receive different information than previously: may be perceived as "less information".

2. Additional item development costs will result in higher candidate fees if perception of "less information" leads to adoption of truth-in-testing legislation covering licensure examinations.

3. Endorsement process more cumbersome if Member Boards choose to have different passing standards, therefore may take longer to get license through endorsement.

Member Boards

1. May lead to candidate/legislator complaints about lack of information to failing candidates.

2. Perception that information is being withheld may arise, leading to increased efforts to include licensure exams under truth-in-testing laws.

3. May be sued by passing candidates who wish to obtain a numeric score.

4. Endorsement process more cumbersome if Member Boards choose different passing scores.

5. Change in Summary Profiles data may lead to complaints from educators due to perception of less information.

National Council

1. Perception that information is being withheld may arise, leading to increased efforts to include licensure exams under truth-in-testing laws.

2. One-time cost of $1500 for CTB to re-program score reporting system, and $9,900 for developing enhanced diagnostic profiles.

3. May be sued by passing candidates who wish to obtain a numeric score.

4. Increased workload due to processing endorsement requests if in future Member Boards choose different passing scores.

5. Change in Summary Profiles data may lead to decreased revenue due to decrease in subscription rate.

SURVEY OF NURSING SERVICE INSTITUTIONS, EDUCATIONAL PROGRAMS, AND LICENSEES

A mail survey was conducted to determine the incidence of misuse of NCLEX scores by educational programs and employers. The methodology and the results of this survey will be described.

METHODOLOGY

Several populations were targeted for representation in the study. These were: (1) individuals licensed as Registered Nurses (RN) based on their performance on the NCLEX-RN administered in July 1985 (n = 57,368); (2) individuals licensed as Practical Nurses (PN) based on their performance on the NCLEX-PN administered in October 1986 (n = 20456); (3) Acute care and psychiatric institutions (n = 6888); (4) skilled, intermediate, and long term care institutions (n = approximately 23,000); and (5) educational institutions admitting Registered Nurses or Practical Nurses to programs leading to an Associate Degree, Bachelor's Degree, or higher degree (n = 599).

With the exception of the educational programs, all samples were drawn from lists available to the National Council that were maintained at American College Testing Program (ACT) as a part of *A Study of Nursing Practice* and for the current job analysis study designed to examine the validity of the NCLEX-PN test plan. The sample of educational programs was selected from all mainland U.S. programs listed in the National League for Nursing Publication, *State Approved Schools of Nursing - RN* (1986). All lists were stratified according to jurisdiction. Systematic samples (i.e. 1 of n) were drawn from each stratified list. Sample sizes were as follows:

GROUP	SAMPLE SIZE
Registered Nurses	300
Practical Nurses	200
Acute Care and Psychiatric Institutions	150
Skilled, Intermediate, and Long Term Care Institutions	50
Educational Programs	100
TOTAL	800

Sample sizes were determined based on projected return rates, the numbers of individuals working in the various types of health care delivery agencies, and (due to the "age" of the lists of RNs and PNs) the potential number of bad addresses.

DATA COLLECTION

Three sets of questions were developed for dissemination to the nursing service institutions, the educational programs, and licensees. The specific questions asked were as follows:

1. **Nursing service institutions:**

   o Do you ask applicants for employment to submit NCLEX-RN or NCLEX-PN scores as part of the application process? ___YES ___NO; If yes, for what purpose are these used?

   o Do you ask employees being considered for promotion or assignment to specialty areas to submit NCLEX scores? ___YES ___NO; If yes, for what purpose are these used?

2. **Educational programs:**

   Do you request applicants to submit NCLEX-RN or NCLEX-PN scores as part of the application process for any of your institution's educational programs? ___YES ___NO; If yes, for what programs and for what specific purpose are the scores used?

3. **Licensees:**

   Indicate which of the following have requested copies of your actual NCLEX scores. For those requesting your scores, please indicate for what purpose they were to be used: ___potential employer; ___current employer; ___educational program you are considering; ___ none of the above.

Each potential respondent received a cover letter indicating that the National Council was interested in identifying what uses are made of NCLEX scores and requesting them to complete and return the enclosed stamped, addressed postcard on which the appropriate set of questions had been printed. All responses were anonymous since the only identifying information was a code imprinted on the postcard to indicate which of the four National Council Areas the response came from.

DATA ANALYSIS

Responses from the acute care/psychiatric institutions and from the nursing homes were grouped together to represent nursing service institutions, and responses from the RNs and LPNs were grouped together to represent licensees.

RETURN RATES

Return rates, adjusted for bad mailing addresses, were as follows: Nursing service institutions - 53%; Educational programs - 72%; and Licensees - 22%.

RESULTS AND ANALYSIS

The responses for each of the three groups surveyed were as follows:

NURSING SERVICE INSTITUTIONS

(population = 30,000; sample = 200; responses = 105)

Inappropriate Use of NCLEX Scores

	YES		NO	
	#	%	#	%
AREA I	1	4%	23	96%
AREA II	1	3%	34	97%
AREA III	1	4%	27	96%
AREA IV	1	6%	17	94%
TOTAL	4	4%[a]	101	96%

[a] The 95% confidence interval for this proportion (0.04) is 0.021 - 0.078. Therefore, an inference can be made that the actual rate of misuse in the population (30,000 x .021; 30,000 x .078) is projected to be between 630 and 2340 employers of nurses.

EDUCATIONAL PROGRAMS

(population = 599; sample = 100; responses = 72)

Inappropriate Use of NCLEX Scores

	YES		NO	
	#	%	#	%
AREA I	1	8%	11	92%
AREA II	3	13%	20	87%
AREA III	1	5%	19	95%
AREA IV	3	18%	14	82%
TOTAL	7	11%[a]	57	89%

[a] The 95% confidence interval for this proportion (0.11) is 0.036 - 0.184. Therefore, an inference can be made that the actual rate of misuse in the population (599 x .036; 599 x .184) is projected to be between 23 and 109 educational programs.

LICENSEES

(population = 77,824; sample = 500; responses = 96)

Inappropriate Use of NCLEX Scores

	YES		NO	
	#	%	#	%
AREA I	1	8%	12	92%
AREA II	5	15%	29	85%
AREA III	4	15%	23	85%
AREA IV	1	4%	22	96%
TOTAL	11[a]	11%[b]	85	89%

[a] 3 of 11 indicated requests by educational programs; 8 of 11 indicated requests by employers.

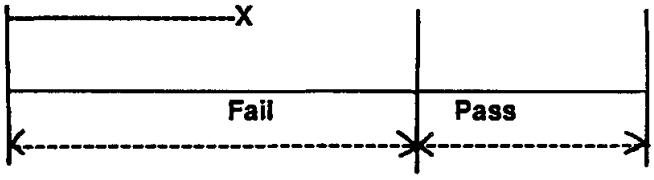
[b] The 95% confidence interval for this proportion (0.11) is 0.05 - 0.18. Therefore, an inference can be made that the actual rate of misuse (77824 x .05; 77824 x .18) is projected to affect between 3891 and 14008 licensees.

ATTACHMENT D

PROTOTYPE: NCLEX CANDIDATE DIAGNOSTIC PROFILE
NCLEX-PN OCTOBER 20, 1988

Candidate Name:	Jane S. Smith	Passing Standard: 350
Candidate No.:	00000000	Candidate DID NOT PASS
Date of Birth:	01/01/64	
Social Security No:	111-11-1111	
		96-000
		State College
		Anytown,CR

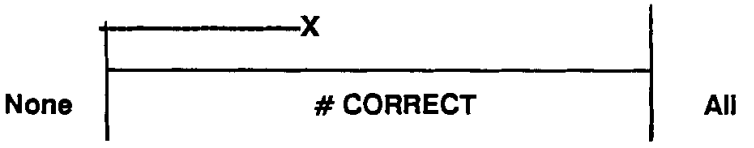
OVERALL PERFORMANCE ASSESSMENT



Interpretation: The candidate's overall performance on the examination, in relation to the passing point, is marked by the "X".

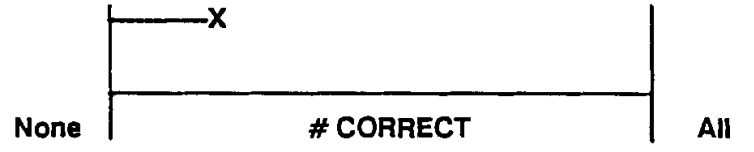
PHASES OF THE NURSING PROCESS:

Assessment



Interpretation: The candidate's performance on those items testing knowledges, skills and abilities essential for client assessment, in relation to all items testing this dimension, is marked by the "X".

Analysis



Interpretation: The candidate's performance on those items testing knowledges, skills and abilities essential for analysis, in relation to all items testing this dimension, is marked by the "X".

FISCAL IMPACT STATEMENT - DESCRIPTION

Will this proposal generate revenue? *NO* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *NO*

   How many members are anticipated including the chairperson? _____

   How often would the committee meet? _____

2. How many mailings would this proposal require? *None*

   To whom? _____

   _____

3. Printing (surveys, special reports, etc.) Please describe:
   None

4. Other than committee meetings, is travel required? *NO*

   Please describe: _____

   _____

   _____

5. What type of consultation is required (i.e., legal, computer, etc.)?
   One-time programming charge by CTB/McGraw-Hill: $1500 for score report, $9,900 for diagnostic profile accrued to FY 89 budget.

6. Staff time required (preparation time, travel time, research presentations)
   - number of hours (estimated) *Minimal*

7. Projected beginning date: *October 1988 for score report; concurrent with new RN test plan implementation for diagnostic profile*

   Projected completion date: *Not applicable*

EXPENSES

1. Committee Meetings

   $500 per member per meeting (Travel) = $_____

   $150 per day per member = $_____

2. Mailings
   $0.25 per letter = $_____, or

   $2.00 per 9 x 12 manila envelope (First Class) = $_____

3. Surveys (Printing)

   $0.05 per page = $_____

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $_____

   $150 per day per member (Expenses) = $_____

5. Consultation

   $125 per day = $_____

6. Other Printing

   $0.05 per page = $_____

Subtotal Expenses: $ *None*

Subtotal Revenue: $ *None*

Net: $ *11,400 to be accrued to FY 89 budget.*

REPORT OF THE ADMINISTRATION OF EXAMINATION COMMITTEE

RECOMMENDATIONS

1. The Committee recommends the following dates for the 1997 administration of the NCLEX examinations: RN, February 4 and 5 (T-W) and July 15 and 16 (T-W); PN, April 16 (W) and October 9 (TH).

2. The Committee recommends as alternate dates for the 1997 administration of the NCLEX examinations, in case of disaster, the following: RN, March 4 and 5 (T-W) and September 9 and 10 (T-W); PN, May 13 (T) and November 13 (TH).

MEETING DATES

The Committee met two times, on October 27-29, 1986, and February 28 and March 2, 1987, and had one telephone conference call on April 15, 1987.

ACTIVITIES

The Committee received no specific assignment from the 1986 Delegate Assembly or from the Board of Directors.

In carrying out the duties of the Committee as specified in the National Council Bylaws, the following activities were accomplished:

1. Reviewed the Security Measures and determined that no revisions were necessary.

2. Requested that 55 Member Boards resubmit Security Measures as those on file either no longer reflected current Member Board personnel or were outdated due to modifications approved by the Delegate Assembly in 1985 and in 1986. At the time this report was written, Security Measures had been received from 53 jurisdictions and subsequently approved.

3. Adopted and disseminated Guidelines for the Procedures to Implement the Security Measures for the purpose of assisting Member Boards to develop procedures and of assisting the Committee to review procedures. The Committee will evaluate the effectiveness of the Guidelines.

4. Requested and reviewed procedures to implement the Security Measures from 14 Member Boards. The policy to review procedures from at least one Member Board in each Area was waived in order to evaluate all procedures that had not been reviewed since 1980.

5. Investigated each alleged failure to maintain security, as well as reported irregularities that occurred during examination administration. The Committee requested and reviewed Member Boards' procedures to implement the Security Measures in all instances and recommended that the Board of Directors issue one reprimand. An investigation involving a questioned loss of test booklets was completed and the Committee determined that, based upon the evidence and conclusions, it would monitor a particular test administration agency, the shipping of examination materials and the printing operation relative to the numbering and the packaging of booklets.

6. Selected examination administration dates for 1997. At its fall meeting, the Committee determined that the selection of dates beyond 1996 was time consuming and unnecessary unless Member Boards required 10 years lead-time to reserve facilities. The Board of Directors determined that the Committee should continue to set dates 10 years in advance so long as any Board had a need for the dates. Since a survey of Member Boards revealed that several do require 10 years lead-time, the Committee has continued to set dates 10 years in advance.

7. Did not conduct or request to conduct any educational conferences. The Chairperson participated on panels for test administration during the Invitational Conference sponsored by CTB/McGraw-Hill in Monterey, California on February 26-27, 1987.

Additionally, the Committee accomplished the following activities:

200 1. Approved, with minor revisions, a draft of the *Manual for*

Administration of Examination

204 **Committee Goals and Objectives for 1987 - 1988**

Goals	Objectives	Suggested Strategies
		2. Revise the manual as necessary for clarification and to address problems identified relative to examination administration.
	C. To evaluate the compliance of Member Boards and the Test Service with established criteria and procedures for maintaining the security of the licensing examinations.	1. Randomly select at least one Member Board from each area annually for review of procedures to implement the Security Measures.
		2. Review Member Board's procedures to implement the Security Measures if there is a report of a break in security or of inadequate security.

7. Determined that the Test Booklet/Candidate Rosters submitted by the "tape states" must include the candidate name and number and the booklet numbers for all parts of the examination on one page, as this information is essential when questions arise concerning scoring.

8. Reviewed all Committee documents and procedures and revised them as necessary to reflect changes in procedures.

9. Adopted procedures for the Review and Challenge Policy that was approved by the Delegate Assembly in 1986.

10. Approved National Council staff authorizations for 5 open examination reviews in accordance with adopted policies and procedures. One candidate challenged three examination questions.

11. Reviewed and analyzed a computer summary of various problems associated with examination administration by type of Board. The Committee placed this item on its fall meeting agenda for further consideration and formulation of recommendations.

12. Reviewed examination score and summary report forms and determined that, due to increased costs to prepare the reports, in-state and out-of-state candidates would not be listed separately on the Jurisdiction Reports.

13. Determined that when a candidate loses examination administration time due to delays in replacement of a defective booklet, additional time, to equal the full examination time period, should be allowed.

14. Approved arrangements for storage of the disaster supply of examination booklets.

15. Recommended a document retention policy for various report forms including compliance reports, damage reports, etc.

16. Revised the Compliance Report forms for review drafts to address orientation to the need for confidentiality, due to Member Boards' objections to signing the Confidentiality Agreement form.

17. Proposed a budget for 1987-88 that would provide for 3 meetings, a conference call, investigation and a site visit (if necessary), and the travel expenses for the chairperson to attend the Delegate Assembly, a liaison committee meeting and a Test Service Evaluation meeting.

18. Adopted Goals and Objectives for 1987-88. (Refer to Attachment A).

MOTION

The Committee moves adoption of the recommendations stated in the beginning of the report.

Fiscal impact: Adoption of these recommendations has no impact on the National Council's FY '88 budget.

Administration of Examination

Committee Goals and Objectives for 1987 - 1988

Goals	Objectives	Suggested Strategies
I. To safeguard the security of the licensure examination.	A. To recommend to the Delegate Assembly changes or modifications in the criteria and procedures for maintaining security of the licensing examination.	1. Review the Security Measures and suggested procedures to implement the Security Measures at least annually.
		2. Develop proposed changes in the Security Measures for presentation to the Delegate Assembly as the need arises.
		3. Initiate research into the development of security measures for computer adaptive testing.
	B. To evaluate the *Manual for Administration of NCLEX* annually.	1. Consider recommendations for revisions in the *Manual* from Member Boards and Test Service.

Administration of Examination

Committee Goals and Objectives for 1987 - 1988

Goals	Objectives	Suggested Strategies
		2. Revise the manual as necessary for clarification and to address problems identified relative to examination administration.
	C. To evaluate the compliance of Member Boards and the Test Service with established criteria and procedures for maintaining the security of the licensing examinations.	1. Randomly select at least one Member Board from each area annually for review of procedures to implement the Security Measures.
		2. Review Member Board's procedures to implement the Security Measures if there is a report of a break in security or of inadequate security.
		3. Evaluate committee policies and procedures annually and revise if necessary.
		4. Continue to evaluate the committee guidelines for review of jurisdiction procedures for implementing the Security Measures.

Goals	Objectives	Suggested Strategies
	D. To recommend dates for administration of the examination.	1. Select dates for examination administration at the fall meeting.
		2. Have dates reviewed for conflicts with religious holidays and other dates that might cause conflicts for candidates.
		3. Present dates to the Delegate Assembly for adoption.
	E. To evaluate procedures for responding to the needs of handicapped candidates.	1. Evaluate criteria and approval procedures at least annually and modify or recommend modification as necessary.
		2. Review and accept National Council staff approvals.
		3. Refer requests for modification in test materials to the Test Service.
		4. Prepare a summary report for the Board of Directors and the Delegate Assembly of the number and types of approvals granted.

Administration of Examination

Committee Goals and Objectives for 1987 - 1988

Goals	Objectives	Suggested Strategies
	F. To evaluate other related examination administration materials. (Candidate Brochure, Score Reports, etc.)	1. Review the materials at least annually. 2. Recommend changes and revise as necessary. 3. Revise candidate information brochure.
	G. To respond to concerns of Member Boards.	1. Review and respond to communications from Member Boards.
	H. To evaluate procedure for review and challenge.	1. Evaluate Member Boards' procedures. 2. Authorize release of testing materials. 3. Prepare summary reports to Board of Directors and Delegate Assembly. 4. Develop proposed changes to Delegate Assembly as the need arises.

Committee Goals and Objectives for 1987 - 1988

Goals	Objectives	Suggested Strategies
II. To investigate alleged failure to maintain the security of the licensing examination.	A. To investigate all matters relating to aberrant behavior in examination administration, loss of a test booklet, failure to follow the contract and/or Security Measures, shipping/transportation problems, and storage problems.	1. Review Compliance Report Forms, Damage/Tampering Report Forms, and other reports to determine deviations that warrant further investigation. 2. Review written information and materials and evaluate compliance with the contract, Security Measures, the *Manual for Administration of the NCLEX* and other defined criteria. 3. Request approval to conduct (and make) site visits as deemed necessary. 4. Submit a written report of each investigation to the Executive Director and the Board of Directors. 5. Recommend to the Board of Directors that letters of concern or letters of reprimand be sent to Member Boards as appropriate.

Administration of Examination

Committee Goals and Objectives for 1987 - 1988

Goals	Objectives	Suggested Strategies
		6. Evaluate reporting forms annually and revise as necessary.
		7. Evaluate policies and procedures for investigation of violations of the contract and/or Security Measures annually and revise as necessary.
III. To conduct educational conferences.	**A.** To identify needs for educational conferences and to request authorization from the Board of Directors or Delegate Assembly as the need arises.	**1.** Request budget as necessary.
	B. To participate in invitational conferences upon request.	**1.** Designate committee members for participation in educational conferences.
		2. Request budget as necessary.

REPORT OF THE NURSING PRACTICE AND STANDARDS COMMITTEE

RECOMMENDATIONS

The Committee recommends that the Delegate Assembly approve the following:

- Statement on the Nursing Activities of Unlicensed Persons; and
- The Monograph entitled "The Regulatory Management of the Chemically Dependent Nurse."

MEETING DATES

The Committee met three times: 18-20 December 1986, 13-15 February 1987 and 22-24 March 1987. The Committee further met by telephone conference call on 19 May 1987, and completed other work by mail exchange. The Committee was directed by the Delegate Assembly to bring an update report on entry into practice and continued competence to the 1987 Delegate Assembly and to participate in the review of the Study of Nursing Practice.

ACTIVITIES

The Committee accomplished the following activities:

(1) An update Report on Entry Into Practice (Attachment A);

(2) An update Report on Continued Competence (Attachment B);

(3) A Statement on the Nursing Activities of Unlicensed Persons (Attachment C);

(4) A Monograph entitled "The Regulatory Management of the Chemically Dependent Nurse" (Attachment D); and

(5) A survey and tabulated data on the use of the Model Nursing Practice Act and the Model Administrative Rules and Regulations. This tabulated data will be used as the basis for the Committee's review for possible revision of these two documents in FY 88.

The data from this survey was encouraging as it documented significant use by Member Boards of the Model Act and Rules. Recorded use of the documents included: (1) orientation for new board members and staff; (2) comparison of model language to existing state statute language; (3) sunset review process; (4) model language for new state statutory or rule language and; (5) general resource for a variety of specific concerns.

Additionally, the Committee worked on the following:

(1) A thorough review of the Study of Nursing Practice to identify the implications of the findings on the regulation of nursing; to identify the need for additional (secondary) analyses of the data to be performed by the National Council; and to identify the need for additional follow up research; and

(2) A beginning resource list for nursing and regulatory issues.

Committee objectives for 1987-1988 will include the following:

1. Complete update reports on entry into nursing practice and continued competence;

2. Identify essential standards of education and competencies for practice that can be used by Member Boards;

3. Review for revision the Model Nursing Practice Act and the Model Administrative Rules and Regulations; and

4. Develop a comprehensive reference center on trends and issues in the practice of nursing and regulatory significance.

ENTRY INTO PRACTICE REPORT

The 1986 Delegate Assembly of the National Council of State Boards of Nursing, Inc., directed the Nursing Practice and Standards Committee to prepare an update report on entry into practice for presentation to the 1987 Delegate Assembly. The Committee circulated the extensive questionnaire developed by the Entry Into Practice Report Committee in 1986 to Member Boards and asked them to update the information if changes had occurred since 1986. An additional question that asked if the Member Board could implement change by the administrative rule process was added to the cover memo of the questionnaire. The questionnaire was not circulated to state nurses' associations for RN's and PN's.

RESULTS

Forty-eight Member Boards (79%) responded to the entry into practice questionnaire. Most states reported no change in data from the 1986 questionnaire.

Three areas of information are reported from the survey data as follows:

- Table I indicates that 17 Member Boards of the forty-eight Member Boards responding have taken a formal position on entry.

- Table II indicates progress toward implementation of the ANA goal of two levels of nursing education, with two new titles and distinct scopes of practice. The data is a compilation of data from the American Hospital Association in a report entitled "Building Momentum for the 90's: Nurse Titling and Licensure".

  The data from that report indicated: 1) thirteen states that plan to implement with a known target date; 2) ten states that plan to implement without a known target date; 3) seventeen states in the early exploratory stage of activity, including formation of task force; and 4) ten states with no plans or activity, related to entry, at this time.

- Table III presents the data relative to states who could implement change by the administrative rules process. Of the forty-eight reporting Member Boards, twenty-nine Boards could make the change through the administrative rules process, while nineteen could not.

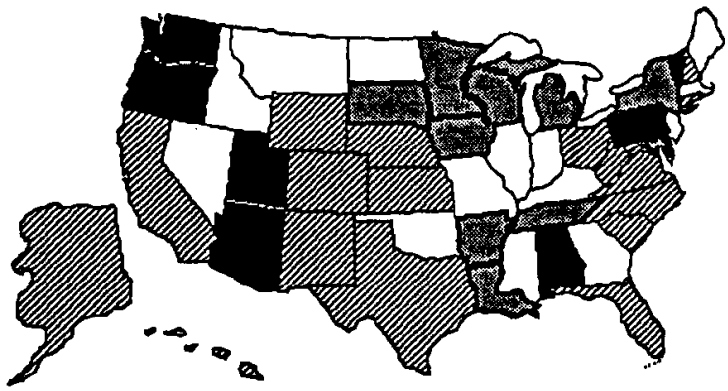
FORMAL POSITION TAKEN BY MEMBER BOARDS ON CHANGING ENTRY INTO PRACTICE REQUIREMENTS

Table I

Jurisdiction	Position
Alabama	
Alaska	
American Samoa	
Arizona	
Arkansas	
California-PN	
California-RN	
Colorado	
Connecticut	Maintain current NPA language
Delaware	
District of Columbia	
Florida	
Georgia-PN	
Georgia-RN	
Guam	
Hawaii	
Idaho	Two licensure levels titled as RN, RAN who would be required to have BSN and AD respectively
Illinois	Position of Neutrality
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana-PN	
Louisiana-RN	Philosophical Statement in support of baccalaureate degree for entry into professional nursing
Maine	Position of Neutrality
Maryland	
Massachusetts	Position of Neutrality
Michigan	
Minnesota	No authority to take position
Mississippi	Position of Neutrality
Missouri	
Montana	Position of Neutrality

Jurisdiction	Position
Nebraska	
Nevada	"Support in Concept" two levels as ANA Proposes
New Hampshire	
New Jersey	
New Mexico	
New York	Position of Neutrality
North Carolina	Position of Neutrality
North Dakota	**Adoption of revised administrative rules**
Northern Mariana Islands	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	Support State Wide Manpower Planning Com.
South Dakota	Two licensure levels titled as RN, RAN who would be required to have BSN and AD respectively
Tennessee	
Texas-LVN	
Texas-RN	
Utah	
Vermont	
Virgin Islands	
Virginia	
Washington-PN	
Washington-RN	Position of Neutrality
West Virginia-PN	
West Virginia-RN	Support ANA Position of Two Levels
Wisconsin	
Wyoming	Position of Neutrality

PROGRESS TOWARDS IMPLEMENTATION OF ANA GOALS
Table II



Plans to Implement & Target Date Known:

Georgia
Idaho
Illinois
Indiana
Maine
Massachusetts
Mississippi
Missouri
Montana
Nevada
New Jersey
North Dakota
Oklahoma

Plans to Implement & Target Date Not Known:

Arkansas
Iowa
Louisiana
Maryland
Michigan
Minnesota
New York
South Dakota
Tennessee
Wisconsin

Early Exploratory Activity

Alaska
California
Colorado
Connecticut
Florida
Hawaii
Kansas
Nebraska
New Hampshire
New Mexico
North Carolina
Ohio
South Carolina
Texas
Virginia
West Virginia
Wyoming

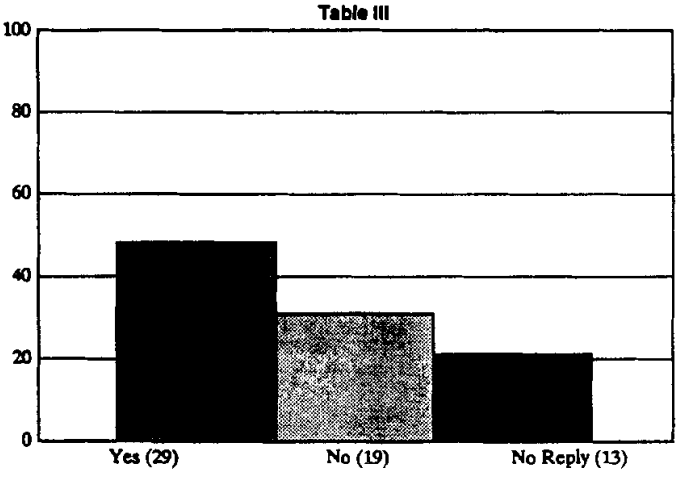
No Plans at This Time

Alabama
Arizona
Delaware
D.C.
Oregon
Pennsylvania
Rhode Island
Utah
Vermont
Washington

As reported in "Building Momentum for the 90's: Nurse Titling and Licensure" American Hospital Association Live Satellite Teleconference. March 19, 1987

ABILITY TO MAKE CHANGES IN ENTRY REQUIREMENTS BY ADMINISTRATIVE RULE

Table III



29 Boards	19 Boards
Alabama	Arkansas
Alaska	California-RN
Arizona	Connecticut
Delaware	Illinois
Florida	Indiana
Georgia-PN	Kansas
Georgia-RN	Maine
Idaho	Minnesota
*Louisiana-PN	Montana
Lousiana-RN	New York
Maryland	North Carolina
Massachusetts	Oregon
Michigan	Texas-PN
Mississippi	Texas-RN
Missouri	Utah
Nebraska	Vermont
Nevada	Virgin Islands
New Hampshire	Virginia
New Mexico	W. Virginia-PN
North Dakota	
Ohio	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Washington-PN	
W. Virginia-RN	
Wisconsin	
Wyoming	

*(Depending on type of change)

CONTINUED COMPETENCE UPDATE REPORT

The 1986 Delegate Assembly of the National Council of State Boards of Nursing, Inc., directed the Nursing Practice and Standards Committee to present an update report of continued competence to the 1987 Delegate Assembly. The Committee developed a questionnaire and circulated it to Member Boards for response, in fulfillment of this directive.

QUESTIONNAIRE DEVELOPMENT

The questionnaire was developed to solicit information relative to the following areas: a. use by the jurisdiction of six identified continued competence mechanisms: 1) peer review; 2) continuing education; 3) client review; 4) periodic refresher course; 5) competency examination; and, 6) minimal practice requirement; b. an explanation of the requirements of the mechanism; c. benefits/weaknesses of the mechanism used; d. the effectiveness of the mechanism in measuring continued competence; e. if state is considering implementation of any continued competence mechanism; f. impetus for consideration of change; and, g. any projected change in present continued competence mechanism.

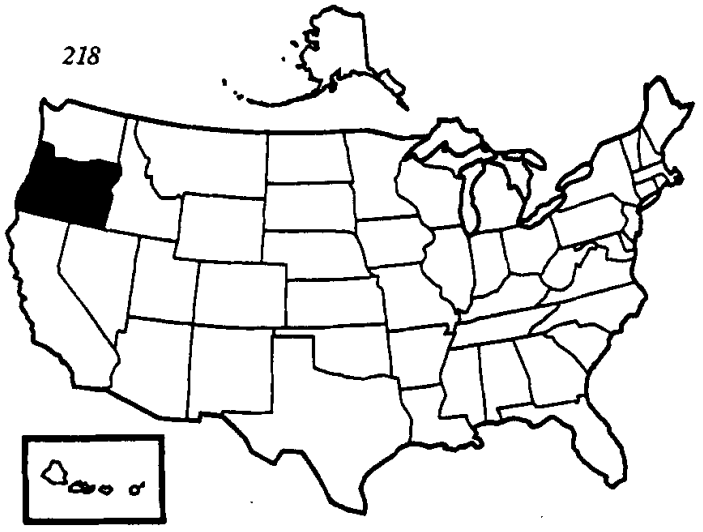
RESULTS

Fifty-two Member Boards (85%) responded to the questionnaire by the deadline date. Table I identifies the mechanisms reported by Member Boards as being implemented within their respective jurisdictions. The tabulated data from the questionnaire will be circulated prior to the Delegate Assembly. One state reported the use of peer review for nurse practitioners; one state reported the use of competency examinations for legal recognition as an advanced registered nurse practitioner (ARNP); thirteen states reported the use of continuing education; eleven states reported the use of periodic refresher courses; one state reported the use of client review; and 10 states reported using minimal practice requirements.

Those states using the continued competence mechanism of continuing education reported a requirement range of 45 hours in a three year renewal cycle to 24 hours in a two year renewal cycle. Most states using refresher courses as a criteria for relicensure required a refresher course after being out of practice for a five year period. States using a minimal practice mechanism reported a requirement range of 1600 hours in a five year period to 140 hours in any one year of the last six years.

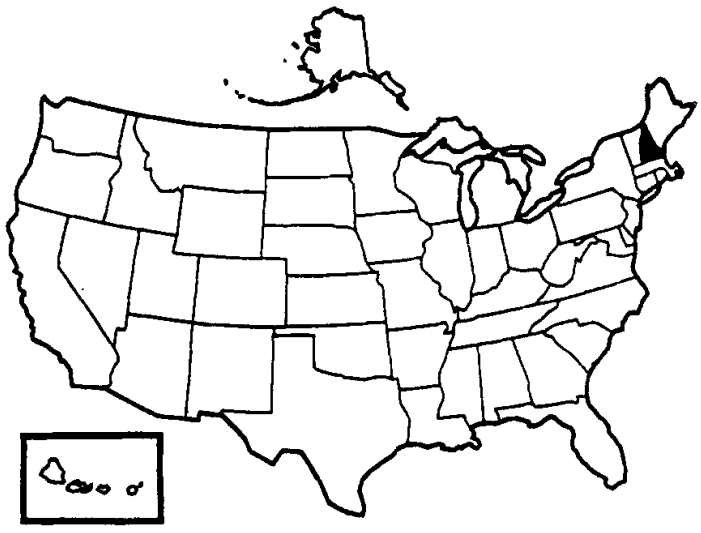
CONTINUED COMPETENCY MECHANISMS - Table I

1. For Nurse Practitioners



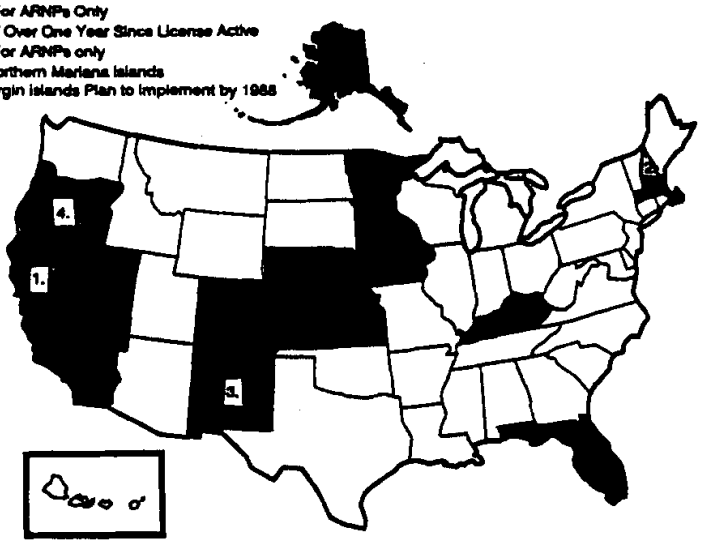
Peer Review

1. For Legal Recognition As An ARNP



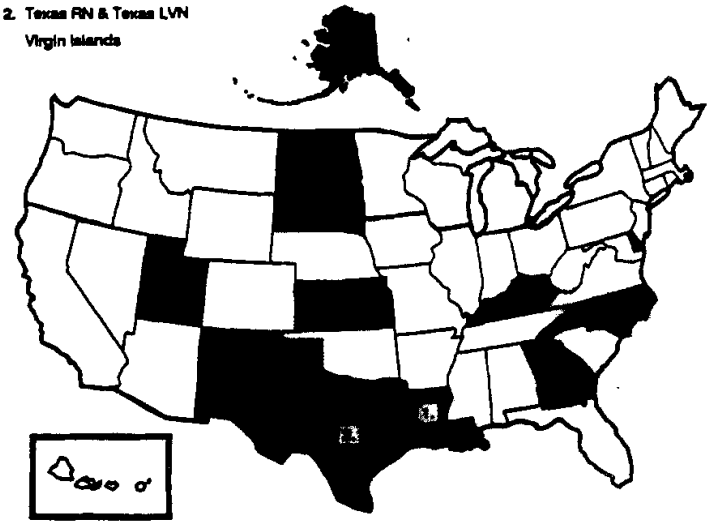
Competency Examination

1. California RN & California LVN
2. For ARNPs Only
3. If Over One Year Since License Active
4. For ARNPs only
- Northern Mariana Islands
- Virgin Islands Plan to implement by 1988



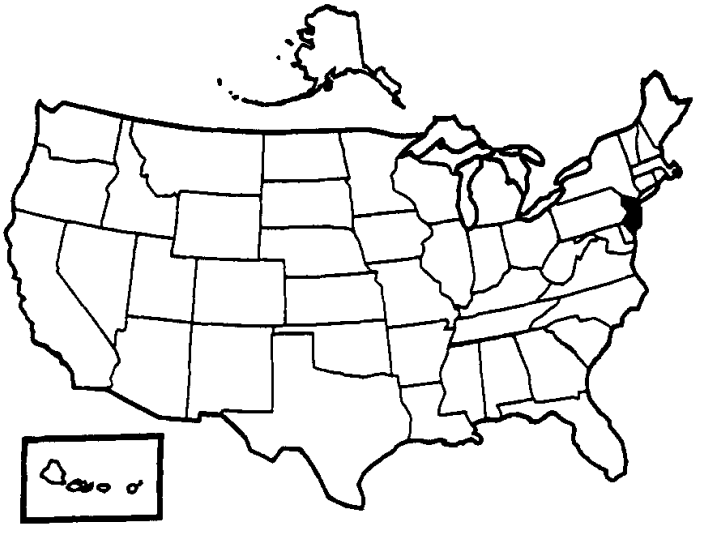
Continuing Education

1. Louisiana PN Only
2. Texas RN & Texas LVN
Virgin Islands



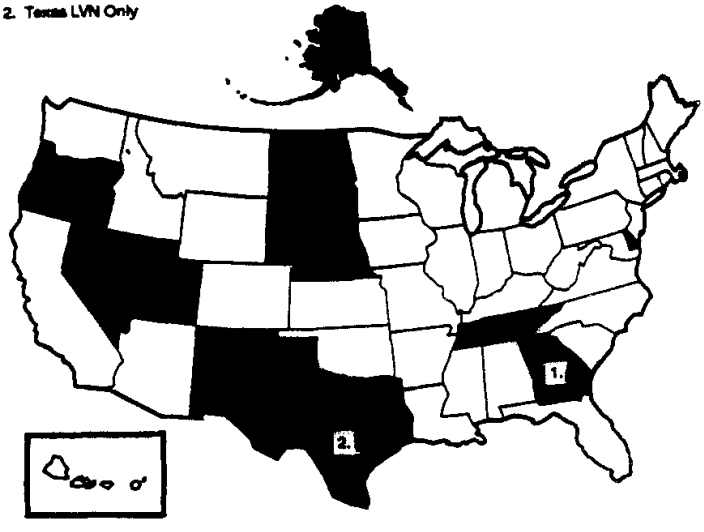
Periodic Refresher Course

1. For Reinstatement of License



Client Review

1. Georgia RN Only
2. Texas LVN Only



Minimal Practice Requirements

As both a statement of general weakness and as a statement of effectiveness, most states reported that the continued competence mechanism used in their respective states did not help in measuring continued competence. Many commented, however, that having to meet some type of requirement did say to the public that the board was attempting to assure the ongoing competency of its practicing nurses; and that the likelihood of nurses benefitting by staying competent, from having to meet the requirement, was greater than if no requirement existed. The boards generally viewed the cost to both the board and the individual nurse as a weakness.

Many states reported looking at new mechanisms for assuring continued competence, mostly due to Sunset Review recommendations. Arkansas will enact a continuing education requirement in 1988 for both RN's and LPN's. Michigan is in the rule promulgation state of requiring continuing education requirements for implementation two years after the rules are finalized. Minnesota will require a practice, refresher course or continuing education requirement by Fall of 1988 for all nurses re-negotiating after having lapsed licenses. New Hampshire's proposed new nursing practice act includes a continuing education requirement which if enacted would take effect in 1988. No states reported a change in mechanisms already in place.

REPORT OF TWO MAJOR STUDIES

Two major studies on continuing competence were published in Fall 1986. They were the *National Commission for Health Certifying Agencies Final Report* and the *Final Report on the Continuing Professional Education Project.* The findings are presented below.

National Commission for Health Certifying Agencies Final Report:

The National Commission for Health Certifying Agencies presented its final report entitled *To Assess the Status of Activities to Assure the Continuing Competence of Health Professionals.* Findings of the report included the following:

- The vast majority of programs, both public and private intended to assure continuing competence include continuing education requirements;
- Some states have eliminated continuing education and are considering alternatives;
- Mandatory reexamination by certifying agencies for recertification is infrequent;
- Both professional associations and private certifiers have undertaken approaches other than continuing education and/or re-examination to assuring continuing competence;

- Pilot studies and experimental research programs have begun to explore continuing competency assurance mechanisms;
- Employers are playing an important part in assuring continued competence;
- Computer, video, and telecommunications technology are playing an important role in developing programs; and
- There is a lack of data available on the validity of assessment mechanisms.

Continuing Professional Education Project Final Report

Though the report focus was for all health professions, the report findings appear applicable to nursing.

The second study completed in 1986 was the Kellogg funded study on Continuing Professional Education Project, sponsored by the Pennsylvania State University. The Project ran for a five year period and included representatives from public accounting, architecture, clinical dietetics, clinical psychology, medicine and nursing.

The Practice Audit Model, a systematic process for continuing professional education program development that bases the identification of learning needs on an analysis of professional performance in selected areas, provided direction for project activities. The study project concluded the Model to be effective in assessing practitioner performance and in analyzing assessment results. Implementation of the Model was concluded to be costly. Though a potentially useful Model for nursing cost will more than likely prohibit any universal implementation of the Model as a continuing competence mechanism.

The Project did accomplish its goals of 1) developing and implementing a practice oriented continuing professional education program; 2) developing models of a university/ collaborative relationship that can lead to institulization of the program; and, 3) establishing collaborative relationships between the University (Pennsylvania State University) and each of the participating professions to strengthen the development and implementation of continuing professional education programs. In the Fall of 1986, Pennsylvania State established the office of Continuing Professional Education Within Planning Studies to continue and expand upon work begun by the Project.

STATEMENT ON THE NURSING ACTIVITIES OF UNLICENSED PERSONS

PURPOSE:

The purpose of the NCSBN in formulating this statement is to provide information to jurisdictions regarding the regulation of nursing acts performed by unlicensed persons.

INTRODUCTION

Unlicensed persons performing nursing acts has been a concern since the early 1900's. In the early 1900's the establishment of standards of nursing led to the formation of boards of nursing. Early licensure laws delineated the educational preparation required to become a nurse; however, they did not define nursing practice. Anyone who had successfully completed the requisite training program and examination was identified as a registered nurse.

Because nursing practice lacked definition, anyone could perform nursing functions as long as they did not identify themselves as nurses. However, the care that was provided then was custodial in nature because nursing care consisted of assisting with the activities of daily living. Because of the simplicity of nursing tasks in that time, it is not surprising that unlicensed persons learned on the job how to give custodial care.

Today, unlicensed persons are trained on the job or in short term training programs and are employed to perform nursing acts or functions that range from custodial to complex. These ever expanding job roles for unlicensed persons are of growing concern to the nursing and consumer communities. Some of the possible reasons for the increase of nursing acts being performed by unlicensed persons and the role of boards of nursing in this issue will be addressed.

Through the years, health care, including nursing, has become far more sophisticated. Nursing is no longer a compilation of tasks and caring related to daily living. The process of caring and doing in nursing are now integrated with technology. The integration of knowledge, judgment and skill is needed to practice nursing. As a result, the field of nursing has come to recognize the need for academic preparation for its practitioners.

The image of nursing commonly held by the public and many employers is that the intellectual component is not essential to the practice of nursing. This misperception of nursing has not changed even as the complexity of client's problems and need for care has increased; thus, the job market within nursing for unlicensed persons has increased.

The 1960's and 70's focused the nation's attention on improving the availability of health care for all. With the inauguration of Medicare and Medicaid programs and widespread availability of comprehensive health insurance, approximately 90% of all health care services were being reimbursed by third party payers by 1981. The public policy that promoted third party reimbursement added little incentive to health care providers to economize. As a result, in within this timeframe, the cost of health care tripled in the United States. [1]

Other costly shifts took place in the health care system beginning in the 1970's. Public policy changes expanded or relocated services so that there evolved a demand for health care, especially nursing services, in far more settings than had ever been experienced. De-institutionalization caused many services to be shifted into the community. Also occurring in this period was an emphasis on health care as a right rather than a privilege. Changes in public policy promoting accessability of care for all increased the public's expectation for care in many arenas and not just in the traditional physician's office, hospital, or nursing home.

There are many examples of how public policy made health care more widely accessible, often in previously underserved areas. Handicapped children who had previously been institutionalized or uneducated were mainstreamed into the public school classrooms, requiring schools to provide more complex health services. The chronically mentally handicapped were de-institutionalized and often needed community-based health services. Communities made strides in improving the quality and availability of emergency services which required increased manpower. In response to societal changes, prisons began to provide health care services to inmates, requiring staff who could provide these health services.

Related changes occurred even in the traditional facilities. Chronic care once provided in hospitals was shifted to long term care facilities or to home settings because more of the chronically ill were simply living for much longer periods of time and were requiring care during their expanded lifespans. The elderly population also rose with better standards of living and better health care. More nursing homes were built to care for the elderly and for those with chronic debilitating illnesses, while the need for care in people's private homes continued to grow as well. These examples reflect how more people came to expect broader services as a result of public policies.

Formerly, many of these services were unavailable or were available from nurses and those they supervised in institutions. Now community settings were responsible for providing health care which was mainly nursing care. This care was often needed on an intermittent or part time basis and at low cost. Nurses simply were not available in sufficient numbers or were not hired because of cost. These forces resulted in unlicensed persons, who frequently lacked any instruction or supervision by nurses, carrying out ever increasing complex care.

The use of unlicensed persons was also encouraged by many health care businesses. The possibility of making large profits through the expanded third party reimbursement mechanisms gave birth to many health care businesses. These businesses often chose to use unlicensed persons in order to keep profit margins high.

In the 1980's, the public policies that stimulated runaway growth in the health care industry came under criticism. Americans expected accessible, quality health care for all segments of the population, but were unable to afford the rising health care costs. In order to control escalating costs, the health care industry was coerced into implementing cost containment measures by the government, the industrial community, and the insurance industry.

With cost containment came greater increasing demand for home care delivery and even greater efforts from health care businesses to use unlicensed persons. Because nursing services are required on such an on-going intensive basis, they are a substantial budgetary item. Thus the price of unlicensed staff members continues to be attractive.

Another justification used for employing unlicensed persons has been the current nursing shortage. This argument is weak because the impetus for unlicensed persons to be hired to perform nursing services has existed in times of abundant supply of nurses as well as in shortages. At this time there are nurses, especially LPNs, who are available in places where they are being bypassed in favor of unlicensed and unregulated persons.

Today one of the driving forces to hire unlicensed personnel is largely financial in nature. The one time concerns of the previous decades regarding accessability and quality which brought runaway costs have now been controlled and the pattern of care is determined by the money available. Unlicensed persons remain an attractive substitute to employers who often hold the common misconceptions about nursing and who have serious financial concerns.

This inappropriate use of unlicensed persons to perform nursing acts at a lesser cost than nursing care provided by nurses is placing the public health, safety, and welfare at risk. Unsafe care results in higher mortality rates, greater morbidity, unnecessary suffering, and increased utilization of both inpatient and outpatient facilities. The nursing profession has historically demonstrated its responsibility to the public to deliver high quality nursing care by supporting the licensure of nurses, the formulation of standards of nursing practice, and the passage of legislation for mandatory licensure. The threat to the public now caused by the increasing pressure to use unlicensed persons is reason again for boards to take action.

RATIONALE FOR BOARD INVOLVEMENT:

Since the role of the Board of Nursing in each jurisdiction is to protect the health, safety and welfare of the public by regulating nursing practice, Boards of Nursing have a legitimate concern and have the legal responsibility to monitor any and all nursing activities. This responsibility and its attendant powers are delegated to the Board by the state legislature to fulfill the state's constitutional obligation to protect its citizens. Statutes are enacted by the legislature to grant power to the Board and to provide general mandates pertaining to the regulation of nursing. The statutes also empower and even mandate the Board to adopt applicable administrative regulations.

When the registered nurse delegates selected nursing functions or tasks, the responsibility and accountability to the public for the overall nursing care remains with the registered nurse. Administrative rules often provide what functions or tasks may or may not be delegated and under what conditions delegation may be made. The burden of determining the competency of the person who will perform the tasks and of evaluating the situations rest with the licensed nurse.

Because unlicensed persons perform tasks and functions in one or more of the several categories which constitute the practice of nursing without a license, the Board of Nursing must be involved in their activities. These categories of type of practice by unlicensed persons are:

1. Little or no instruction or supervision by licensed persons

2. Minimal instruction with return demonstration of particular task with no follow up supervision by licensed persons

3. Limited to moderate instruction with return demonstration of particular task under supervision by licensed persons

4. Moderate to ample instruction with return demonstration of particular task under supervision of licensed person functioning adequately in assigned areas

In each instance when the unlicensed persons perform nursing functions without the benefit of instruction or supervision by nurses, this constitutes the practice of nursing without a license and, therefore, should be a concern to the Board of Nursing.

Boards are receiving many requests to allow unlicensed persons to give medications in a variety of settings serving dependent persons. The argument frequently given is that it is a simple technical skill. While this may be true in a few other unique situations, these dependent persons have a high incidence of complex nursing care needs and a high percentage of chronic illness. Hence the nurses' knowledge, judgment and skill are needed to prevent aspiration, to prevent over and under medication, to administer sliding scale insulin, to administer medications by other than the oral route, and to assess and determine when to administer the multiplicity of p.r.n. medications.

Arguments presented by those who would use unlicensed persons to do complex nursing tasks usually include, for example, "you teach the family to give insulin, to give morphine, to irrigate colostomies". The primary differences with family members are: 1) family members know the patient or client well, 2) family members are only performing the activity for one person, and 3) a nurse has assessed the client, made a nursing diagnosis and planned the care. The nurse teaches the family members what to do for that one client. The nurse evaluates the competency of the family members and instructs them accordingly. When something unexpected occurs, the family members will call the nurse who taught them and this nurse can reevaluate the entire situation. The change is gauged easily by a family member because of the familiarity with the person gained over a long period of time. This familiarity is not afforded the unlicensed person giving care.

In contrast, the unlicensed person may be doing a task for many clients who are usually not well known to the worker but with a multiplicity of needs. The unlicensed person has been taught to do a task in a general way but without the knowledge to evaluate each client's needs or problems. The unlicensed persons' lack of knowledge, skill and judgment becomes apparent in their inability to adapt care to individuals' needs based on anything other than rudimentary decision making. Adaptation of care to individual needs requires nursing decisions. Without adequate nursing involvement in the education and supervision of unlicensed persons, patients can be subject to unskilled persons doing nursing tasks without any appreciation of their psychosocial or physical needs. Further, unlicensed persons are reluctant to call for help for fear of being judged incompetent.

Hence, there is a clear difference between care delivered by a family member and that delivered by a paid unlicensed person.

DOCUMENTATION OF THE PROBLEM:

A questionnaire on "The Activities of Unlicensed Personnel" was circulated to Member Boards in 1986 with a 71% response rate. The data identified activities by unlicensed and unauthorized personnel to include such things as administration of medications (oral, intramuscular, subcutaneous, intravenous); fresh colostomy irrigations; peritoneal dialysis; and a variety of other nursing activities requiring a nurse's knowledge and judgment. Boards of Nursing responding to the survey reported considerable concern, especially over the wide reporting of administration of medication by a variety of unauthorized personnel in a multiplicity of settings.

The following table summarizes examples of inappropriate utilization of unlicensed personnel: [2]

TABLE I

POPULATION OF RECIPIENTS	SETTING	SOURCE OF PROBLEM
I Individuals of all age groups with non-acute health problems	Physicians' offices	Physician Delegation clauses in medical practice acts

II. Dependent Persons (persons unable to exercise their rights without assistance)		
A. Mentally Handicapped	Group Homes, Community Living Arrangements, Intermediate Care Facilities, Institutions	**A.** State Departments of Health Guidelines or Federal Guidelines which frequently are misinterpreted or misapplied
B. Elderly	Boarding Homes, Nursing Homes, Community Living Arrangements	**B.** Department of Aging Guidelines or Federal Guidelines which frequently are misinterpreted or misapplied
C. Children of all ages	Schools K-12, Head Start Centers, Nursery Schools	**C.** Department of Education Guidelines which are frequently misinterpreted or misapplied
D. Chronically Ill	Homes, Skilled Care Nursing Homes, Hospices	**D.** Departments of Health and Welfare Guidelines which are frequently misinterpreted or misapplied
III. Prison Population	Prisons and Detention Centers	Department of Criminal Justice or Corrections Department Regulations which are frequently misinterpreted or misapplied

IV. Populations Served by Non-Nurse Anesthetist, Lay Midwives, Dialysis Technicians, or EMT's	Hospitals, Doctors' Offices, Various Settings	Physician Delegation Clauses in medical practice acts and Department Health Guidelines which are frequently misinterpreted or misapplied

DEFINITIONS:

The following operational definitions are presented as a means to establish common understanding of the terms used in this paper:

Nursing Practice: The NCSBN *Model Nursing Practice Act* defines the practice of nursing as assisting individuals or groups to maintain or attain optimal health status, establishing a diagnosis, planning and implementing a strategy of care to accomplish defined goals, and evaluating responses to care and treatment. [3]

Delegation: Nurses entrusting the performance of selected nursing tasks to competent unlicensed persons in selected situations. The nurse retains the accountability for the total nursing care of the individual.

Supervision: Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse.

Accountability: State of being responsible, answerable, or legally liable for action.

Nurse: Generic term referring to a person licensed to practice nursing.

Knowledge: Understanding, familiarity or awareness acquired through science, art, technique, and experience where known fact, ideas, and skill has been applied.

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Judgment: A process of forming an opinion or evaluation of a situation arrived at by reasoning discerning and comparing from premises or some [illegible]

ATTACHMENT D

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THE REGULATORY MANAGEMENT OF THE CHEMICALLY DEPENDENT NURSE

National Council of State Boards of Nursing, Inc.
Nursing Practice and Standards Committee

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5. Boards of Nursing need to monitor guidelines and regulations of federal and state regulatory agencies with the understanding that the state's Nursing Practice act has the higher legal authority.

6. Boards of Nursing need to work to assure evidence of adequate nurse involvement where nursing services are being provided.

7. Boards should promulgate clear rules on the utilization of unlicensed persons in all settings where nursing care is delivered.

8. Boards need to clearly define delegation in regulation.

9. A limited supply of nurses is not to be used as an excuse for the inappropriate utilization of unlicensed persons.

10. Boards must set standards based on the health, safety, and welfare of the public regardless of cost containment arguments for lowered standards.

11. Regulations regarding the delegation of nursing functions must be linked to the disciplinary process.

12. Boards need to pursue criminal prosecution when there is clear evidence that unlicensed persons are performing nursing activities.

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PREFACE

The publication of this monograph is the result of three years of directive work by the Nursing Practice and Standards Committee of the National Council of State Boards of Nursing (NCSBN) to address the issues and alternatives involved in the regulatory management of the chemically dependent nurse. This action is a result of NCSBN's concern for providing boards of nursing with the information needed to design discipline management plans that meet the regulatory mandate of public protection while also having a rehabilitative impact on the chemically dependent nurse. The concern is based on the assumption that a well defined and implemented discipline management plan, resulting in a rehabilitated nurse, well serves the public's health, safety and welfare.

The issues and concerns involved in the regulatory management of the chemically dependent nurse have grown with an increased awareness of the existence of chemical dependence in the general population and the professions. The nursing regulatory community has seen an increase in reported cases and had attempted to respond in a way to both affect the public's common good and to protect the due process rights of the chemically dependent nurse.

Early efforts by the National Council to provide information to assist in dealing with the chemically dependent nurse have included a NCSBN Task Force on Discipline which presented in 1986, following two years of work, a *"Model Disciplinary Procedure"* for use by boards in carrying out their discipline function. The model appears in a publication entitled *The National Council of State Boards of Nursing, Inc. Disciplinary Data Bank: A Longitudinal Study* which was published in Spring, 1987. That monograph analyzed the types of disciplinary actions taken by state boards of nursing from September, 1980 through December, 1986.

The Nursing Practice and Standards Committee of NCSBN would like to acknowledge the contributions of the previous committee members of the NCSBN Nursing Practice and Standards Committee who helped begin this work; to the several states who are exploring and/or implementing alternative methods to a strict discipline model in dealing with the chemically dependent nurse, and who are mentioned in appropriate chapters of this monograph; and to the NCSBN Delegate Assembly for directing the exploration of the issues and alternatives involved in the regulatory management of the chemically dependent nurse. The Committee would like to further acknowledge the work of the American Nurses' Association on the professional issues involved in dealing with the chemically dependent nurse, especially the reference document entitled, *Addictions and Psychological Dysfunctions in Nursing: The Professions Response to the Problem.*

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CHAPTER ONE

Introduction

Boards of Nursing are agencies of State Government charged with the responsibility for licensing individuals to practice nursing in the interest of the public's health, safety, and welfare. This includes the authority to take disciplinary action against nurses who are unable, or potentially unable, to meet acceptable standards of nursing practice because of chemical dependence or abuse. Pursuant to this authority, boards of nursing are involved in taking disciplinary action based on specific complaints about particular individuals, including cases involving chemical dependence.

It is estimated that 5% of the 2.4 million nurses are chemical abusers and 75,000 are chemically dependent. [1] It is believed, however, that the problem is far greater than this number reflects because the problem of impairment or potential impairment related to chemical dependence or abuse grows in magnitude in the general population each year and therefore would be assumed to also be growing in magnitude for the members of the profession of nursing.

The chemical dependence or abuse seen in nurses is often related to more than one drug or chemical of choice. While there are commonalities of patterns of behavior related to the use of a chemical of choice, there may also be specific aspects of behavior that need to be evaluated when use involves: 1) alcohol; 2) controlled substances gained through legal means; 3) controlled substance gained through illegal means, such as fraud and deceit; and 4) street drugs.

The reported estimates regarding the numbers of chemically dependent nurses in today's work force have become increasingly alarming and are a major concern to boards of nursing. Of equal concern is the fact that the majority of actions taken by state boards of nursing against licensees are for violations of the Nurse Practice Act that involve chemical abuse. [2] Consequently, the Nursing Practice and Standards Committee of the National Council of State Boards of Nursing developed this monograph to provide an overview of the issue of the chemically dependent nurse. The monograph was also developed to provide guidance for jurisdictions to use as they fulfill their legislative responsibilities and mandates which involve the regulation of nursing practice for the protection of the health, safety and welfare of citizens.

Domains of Boards of Nursing and the Professional Nursing Organizations

Boards of nursing as agencies of state governments are charged with the responsibilities for licensing individuals to practice nursing in the state and for regulating such practice in the interest of the public's health, safety and welfare. Boards have the ultimate authority to deny licensure, to suspend, revoke or to limit the licenses of nurses who are unable to practice with reasonable skill or safety. Whereas, the professional nursing associations are non-profit corporations with a membership of nurses licensed to practice nursing in a state. By their Charter and Bylaws, by the Code of Ethics to which they adhere, and by tradition, the nursing associations are committed to the highest ideals of the nursing profession, to the preservation of the integrity and vitality of the profession, and to the maintenance and enhancement of high standards of nursing practice among its members, toward the end that the nursing profession of the state may provide safe, quality nursing service to clients.

While the responsibilities and roles of Boards of Nursing and the professional organization are different, they do, however, share a concern for the dependent or abusing nurse. This shared concern has been an impetus for the development of compatible relationships between Boards of Nursing and the professional organization and has resulted in joint efforts in many states of the Associations and Boards of Nursing in the development of programs to assist professionals whose practices has been impaired by chemical dependence. These joint efforts have centered on preventing the necessity for board imposed sanctions or restrictions by diverting the chemically dependent or abusing nurse into treatment.

The activities of both groups should be complementary in their efforts to identify, intervene, rehabilitate, discipline, and restore licensure. The board of nursing has the responsibility to assure public safety by enforcing the nurse practice act and disciplining nurses who violate that act while the professional associations' role is to assist members of the profession, provide for their welfare, and act as their advocate. [3]

However, where cooperative relationships and open lines of communication have been established between the Boards and the Professional Associations, then in such instances as formal action may become necessary, boards will impose only such restrictions or conditions as it deems necessary to protect the public health, welfare, and safety to permit the program to achieve successful rehabilitation of the impaired or potentially impaired nurse. However, Boards may condition their withholding of formal action on a nurse's compliance and cooperation with the impaired nurse program. [4]

Conclusion

With these premises established, the monograph presents an overview of: (1) theories on abuse and chemical dependence of nurses; (2) legal implications of chemical dependence and boards of nursings' responsibilities in protecting both individual and public rights; (3) regulatory approaches to resolving chemical nurse violations of the Nurse Practice Act; and (4) treatment models for the chemically dependent nurse. The final section of the monograph includes a summary, conclusions, and recommendations regarding the regulation of chemically dependent nurses.

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CHAPTER TWO

Chemical Dependence

There are a variety of theories that espouse a cause(s) of chemical dependence. Though this monograph will not explore each specific theory that exists in the literature, it will present the tenets of thought for major theories that fall into three categories: psychological, sociocultural and biological. The data presented will indicate the literature's divergent view that there is no definitive or mutually exclusive theory of chemical dependence. Chemical dependence rather is presented as a phenomenon with multiple causative factors.

THEORIES OF CHEMICAL DEPENDENCE

Psychological:

The major tenets of these theories center on the individual as the primary source of the problem. The person is perceived as being disturbed or as being unable to cope with a variety of environmental influences. Some psychological theories emphasize a cycle of behavior based on low self esteem [1] and some focus on dependency behavior stemming from an inability to rely on one's own resources for gratification. [2]

Though the psychological theories are not widely utilized as a conceptual framework in treatment programs as they once were, they still exist as a conceptual base for many health care providers in their everyday care delivery to chemically dependent clients.

Sociocultural:

Sociocultural theories focus on environmental elements or cultural values as general contributing factors in chemical dependence. Theories vary on their specific focus but three major sociocultural theories will be briefly discussed: family theory, subculture theory and role theory. [3]

Family theory regarding chemical dependence, according to Stanton, has four major features: traumatic loss, fear of separation, addict family context (close ties between chemically dependent persons and their families) and family structure (which involves an overinvolved relationship between the chemically dependent person and the parent of the opposite sex). When these four features exist the family pattern generally produces children who have difficulty individuating and who, therefore, grow up to adulthood without adult coping skills. [4]

Subculture theory attempts to describe the emergence of chemical dependence based on the adoption of values of a norming group that will allow chemical use, abuse and dependence. This subculture is usually a part of the general cultural structure of the chemically dependent person but is chosen to allow for acceptance of a life style that includes drug use. This theory is based on a general theory of culture that groups people according to social values and norms. If the general culture is not as accepting of chemical dependent behavior (and cultures do vary in their acceptance of such behavior) but the individual desires or values a certain behavior, then a norming group is sought that allows for and supports the chemical dependent life style. [5]

Role Theory espouses that a certain status or position in society can be the precipitating factor in the emergence of chemical dependence especially if role strain, which occurs when one perceives an inability to fulfill the expectations of a role, occurs. According to this theory three factors, that when present promote a high incidence of drug abuse, follow:

- Access to dependence-producing substances
- Disengagement from prescriptions against their use
- Role strain [6]

This particular theory provides a possible rationale for the phenomenon of relapse that occurs for recovering chemically dependent persons who have professional roles that give access to drugs in a high stress environment where role strain is likely.

Biological:

The biological theories of chemical dependence are concerned with the human body and its physiological functioning. Two major theories that are based on the biological concept are the genetic theory and the opiate receptor theory. The genetic theory is based on the postulate that individuals are born biologically predisposed to drug abuse. Though the research supporting this postulate has been done mostly with alcoholics, it is believed that genetic factors are the basis for any drug abuse. [7] The disease of addiction theory, which is based on this genetic theory, is the primary model of treatment of chemical dependence today. If one adheres to this model, requirement of abstinence as a condition of treatment is essential. [8]

The opiate receptor theory is based on the belief that within the central nervous system there are specific areas or receptors where opiates tend to gravitate and bind to create a euphoric effect. With that discovery came evidence that potentially links opiate-like substances, known as endorphines, to the development of tolerance to or dependence on opiates in humans. This linkage offers exciting prospects for future understanding of the phenomena of dependence/tolerance and abstinence in dependence to opioids. It also gives further credence to a biological basis for chemical dependence. [9]

REVIEW OF LITERATURE RELATED TO DEMOGRAPHIC DATA ON THE CHEMICALLY DEPENDENT NURSE

Four major studies were reviewed that present a demographic picture of the chemically dependent nurse. In an effort to identify a demographic profile for the chemically dependent nurse, Hutchinson studied and reported on a sample of 20 nurses(18 were female, 2 were male, 15 were white and 5 were black) and found that their drug of choice to be Demerol, which was usually taken for relief of stress or pain. This sample of nurses used their health problems to get narcotics. The age range of this sample were nurses from 21 to 55 years who worked all areas of practice and were educated at a diploma to masters level. [10]

Levine looked at a sample of 12 chemically dependent nurses (12 black females) who reported their drug of choice, as Demerol, taken for medical problems with frequent hospital stays. The subjects had held an average of 11 different nursing positions with job changes usually resulting from drug related problems. The average age of this population was 40. [11] Bissell studied a sample of 100 chemically dependent nurses and found the nurses usually were in the top 1/3 of their class academically; held demanding responsible jobs and were highly respected for their work; and were achievement oriented and very ambitious. [12]

Poplar reported on 90 nurses who ranged in age from 23-63 with an average age of 41.7. Of the 90 nurses, 35 were married, 25 were divorced, 16 were single, 3 were widowed and 3 were separated. 62 of the nurses were Protestant, 26 were Catholic, one was Jewish and one reported no religious affiliation. Of the 84 white and 6 black nurses, 88 were female and 2 were male. The subjects described themselves as coming from stable homes with close family relationships and as greatly admiring their fathers. Their drug of choice was Demerol and it was reported to be used to handle problems of physical illness, work pressure or emotional disturbances. Fourteen of the subjects reported no reason for the use of drugs. [13]

As Poplar presented in the article on this study, these nurse subjects reported procuring the drugs by legitimate physician prescription, theft at the workplace or by forged prescriptions. The nurse subjects reported high measurement on impulse control, low self esteem, narrow interest and an ultra conventional value system. [14]

In following this population over a period of time Poplar reported that 20 of the nurses are doing well, 2 have died from an overdose, one had died of natural causes and the remainder were in various states of recovery and dependence. [15]

These studies related to data on age, correlated with data presented by Elliott et al in a study on the National Council of State Boards of Nursing's disciplinary data bank which reported that in 1980, registered nurses between the ages of 23 and 28, had the highest percentage of disciplinary actions against them while the 29 to 34 year old age group was the group with the highest percentage of disciplinary actions against them in 1986. [16]

The Elliott study also indicated that drug related incidents of discipline for registered nurses was an average of 57% of all related cases between 1980 and 1986. For practical nurses, the average of drug related cases was 46% for the same time period. [17]

ACTIVITIES INVOLVING USE OF MIND ALTERING CHEMICALS

In the data presented earlier on theories of chemical dependence there were two distinct approaches introduced to classifying activities involving the use of mind altering chemical regardless of the theory of preference. The two approaches to classifying activities follow:

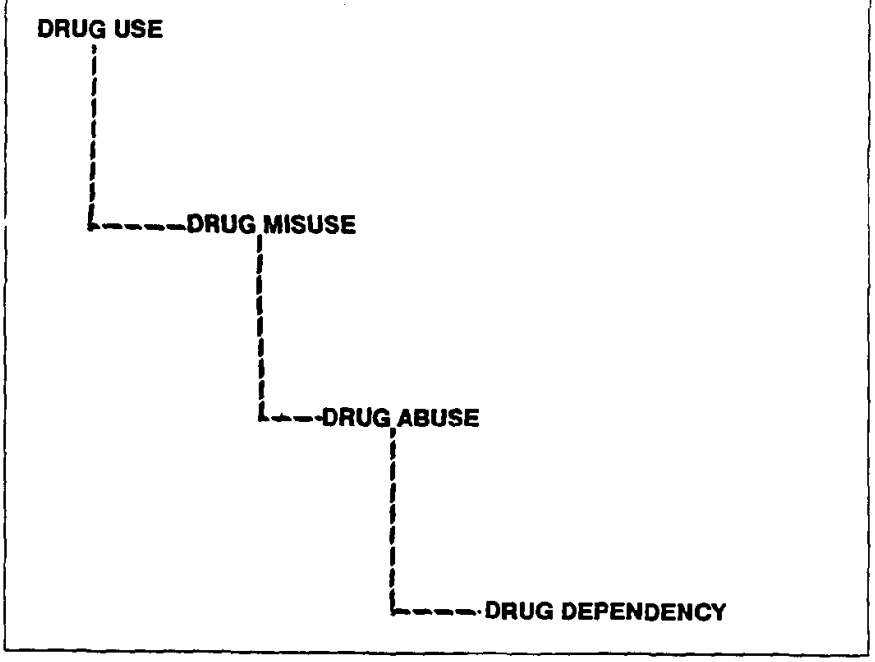
- Drug activities plotted at some point on a continuum as depicted in Figure 2.1

- Drug activities categorized according to discreet types which usually correspond to the points in the continuum depicted in Figure 2.1

Each of these activities indicate an active stage of dependence, starting with the activity of drug use. Drug use for legitimate reasons can lead to the activities of misuse to dependence, but does not always result in dependence. The Board should be careful in determining if a nurse's drug activity is for legitimate reasons, and not interfering with work, or if it is at the abusing, misusing or dependent stage with clear interference with work. The Board should be equally careful to direct the nurse toward treatment in determining action against the nurse's license, since the recovery phase for the chemically dependent person is often prone to relapse and a nurse in relapse is a risk to the public's health, safety and welfare.

ACTIVITY IN USE OF MIND-ALTERING CHEMICALS

-Figure 2.1-



Case Examples

Boards of Nursing frequently hear cases that illustrate this continuum at the stages of misuse through dependence. Boards have no jurisdiction over stage 1 activity of drug use as long as it is for legitimate use and does not affect the ability to carry out professional duties. Some case examples that illustrate both the continuum and the kind of case scenario that come before boards, follows:

Drug Misuse:

-Case A working 3-11 in a large medical center ICU, was at supper with two other nurses when she suddenly fell asleep at the table. Her colleagues woke her and because she seemed too drowsy to go back to work in ICU, she was required to report off sick for the rest of the night. The narcotic count for ICU that night revealed two tubexes of Demerol missing. The two colleagues went to Case A's house the next day to ask her whether her behavior the night before had any relationship to the missing Demerol and Case A admitted to taking the two tubexes. The incident was reported to the Director of Nursing and Case A was put on unpaid leave. A nursing chemical abuse support group was contacted and assisted Case A in locating a treatment program. About five months later at a hearing before the board of nursing, the following history was elicited by the board:

> 2 brothers had committed suicide; Father had deserted family; Mother had had treatment for depression; and Case A had had counseling for depression during her nursing education program.
>
> A counselor from the state impaired nurse support group recommended probation, with the adherence to the established chemical dependence guidelines, including continued treatment for chemical misuse. The counselor stated the Demerol incident was believed to be a one-time occurrence, but the nurse had classic signs of an "addictive personality".

Board Action

The nurse board member who heard the case, based on the family history of Case A, recommended psychiatric therapy and follow up. The recommendation from the impaired nurse support group was followed and Case A has been put on probation with practice prohibited in intensive care settings, and with required written reports from the treatment program and from the employer.

Drug Abuse:

-Case B works on an oncology unit. One day on duty, he took and self-administered 180 mg. of Demerol. Another nurse sees him and reports the incident to the Director of Nursing. A check of the unit records revealed questionable wasteage (of Demerol) involving Case B, 4 times over the last 3 weeks.

The case was reported to the board of nursing. The investigator's report yielded the following:

Case B has chronic back pain. He stated that oral analgesics could not control his pain. His doctor would only prescribe a periodic shot of Demerol which was not enough to control the pain. He admitted to stealing and forging a prescription pad but had not used it to obtain medication.

Board Action:

The board put him on probation for 3 years, pending completion of the program; referred him to an inpatient treatment program; and required future written reviews from the employer when Case B returns to work.

Chemical Dependence:

-Case C was observed by colleagues to be behaving erratically on the 3-11 shift in the emergency room. The director of nursing was contacted and had security escort Case C to her office for evaluation. Case C was found to have 36 tubexes of Demerol in her possession and retrospective investigation revealed a loss of 4-8 tubexes of Demerol per shift over the last five weeks, when Case C was on duty, the losses had been covered up by falsification of records.

The investigator's report and testimony at the hearing yielded a 4-year history of Demerol use, including use on duty; substituting saline for Demerol in tubexes and diversion of the Demerol for self use; and gross falsification of records.

Board Action:

The Board suspended her license for a minimum of 3 years with documented successful inpatient treatment required before any consideration for reinstatement. The board further suggested Narcotics Anonymous, a nurse support group and continuing care to assist with treatment.

These three cases illustrate typical hearings on chemically dependent or abusing nurses that come before a board of nursing for consideration. The scenarios also illustrate the progression of behavioral manifestations of the addictive process from a stage of misuse to dependence. The case scenarios were presented as examples and are not definitive in their presentation. Boards of Nursing might deal quite differently with chemical dependence cases than those described in these scenarios, based on the individual case history and the philosophical beliefs of the Board regarding chemical dependence.

SIGNS AND SYMPTOMS OF IMPAIRMENT

Work Performances

In considering the chemical misuse, abuse or dependence of a nurse, boards of nursing need to be aware of signs and symptoms of impairment related to work performance in three categories: personality and behavior changes, job performance changes and time and attendance changes. [17]

Personality and behavior changes may be different from those nurses who chose alcohol as the drug of choice versus another chemical substance, as demonstrated in Figure 2.1. The alcoholic nurse may demonstrate mood swings, unkempt appearance, isolation and general inappropriate response patterns in interaction with clients and co-workers. As presented in Table 2.1, the drug addicted nurse can also demonstrate mood swings but the mood swings are extreme and change more rapidly. A suspicious behavior pattern is a trade mark of the nurse addicted to narcotics.

Alcoholic and other drug addicted nurses demonstrate changes in job permanence (Table 2.2) and time and attendance (Table 2.3). Both behavioral patterns indicate a decrease in the ability of the nurse to be at work or to perform.

WORK PERFORMANCE

SIGNS AND SYMPTOMS OF IMPAIRMENT

PERSONALITY AND BEHAVIOR CHANGES

Table 2.1

Alcoholic Nurse	Drug Addicted Nurse
o More irritable with patients and co-workers	o Extreme and rapid mood swings
o Withdrawn	o Always wears long sleeves
o Mood Swings	o Suspicious behavior concerning controlled substances
o Lunch alone	
o Isolated, wants to work nights	o Signs out more controlled drugs than anyone else
o Inappropriate responses	o Frequent spills or breakage
o Elaborate excuses for behavior	o Waits until alone to open narcotics cabinet
o Unkempt appearance	o Constantly volunteers as medicine nurse
o Blackouts - phone calls euphoric recall	

These symptoms are often too vague to document but too apparent to ignore. Documentation will be anecdotal.

JOB PERFORMANCE CHANGES

SIGNS AND SYMPTOMS OF IMPAIRMENT

Table 2.2

Alcoholic Nurse	Drug Addicted Nurse
o Job shrinkage	o Too many medication errors
o Difficulty meeting deadlines	o Too many controlled drug spilled or broken
o Illogical or sloppy charting	o Illogical or sloppy charting
o Frequent errors	

These symptoms need documentation.

TIME AND ATTENDANCE CHANGES

SIGNS AND SYMPTOMS

Table 2.3

Alcoholic Nurse	Drug Addicted Nurse
o Increased absenteeism	o Frequent absence from unit
o Long lunch hours	o Comes to work early and stays late
o Absent from floor without explanation	o Hangs around
o Call in to request compensatory time at the beginning of shift	o Uses sick leave lavishly

These symptoms need documentation.

PSYCHOLOGICAL SYMPTOMS
Figure 2.3
PSYCHOLOGICAL DEPENDENCE

MENTAL OBSESSION	LOW SELF IMAGE
○ Symptoms of Delusion	○ Rigid Defense System
○ Rigid Negative Attitudes	○ Symptoms of Powerlessness
○ Emotional Compulsion	

The psychological symptoms as identified by McAuliffe, in Figure 2.3, include psychological dependence, mental obsession, low self image and the resultant symptoms under each as follows: [19]

I. Psychological Dependency

A. Prominence of drugs in lifestyle
B. Seeking an individualistic "high"
C. Arranging occasions to use
D. Making choices based on availability of drugs
E. Using alone
F. Self-administration of prescription drugs
G. Medicinal use of social drugs (for relief or problem solving)
H. Changes in personality
I. Manipulation of personal life to accommodate drug use
J. Manipulation of other people to accommodate drug use

II. Mental Obsession

A. Concern about drugs themselves

1. Looking forward to using
2. Uneasiness, worry or anxiety when supply threatened
3. Laying away or storing up
4. Hiding drug supply
5. Talking about drug rewards
6. Deep fascination or absorbing interest in drug subcultures

B. Concern about the drug relationship

1. Attempts to conceal use
2. Attempts to sneak drugs
3. Protective maneuvers or strategies

C. Decreased mental activity

1. Loss of other interests
2.- Diminished effectiveness in tasks
3.- Inconsistent, illogical, disconnected reasoning
4. Indecision, ambivalence, procrastination
5. Faulty or poor memory

D. Symptoms of Delusion

1. Unawareness of Manifested Sincere Denial

a) Denial of the existence of a personal drug problem
b) Minimizing the extent or seriousness of the personal drug problem
c) Denial of particular items of information about antisocial, destructive effects of drug use
d) Sincere conviction that these denials are valid

2. Unawareness Manifested by Sincere Affirmation

a) Says "everything is fine"
b) Explains that something else is causing the problem
c) Attributes to others the responsibility for any problems
d) Says the drug use is "completely under control" or is "now under control"
e) Says that others are mistaken about the drug involvement
f) Has grandiose fantasies and illusions
g) Has fantasies and suspicions of persecution
h) Telephonitis
i) Expresses indignation, hurt, self-pity and resentment in the face of data about drug involvement
j) Is sincerely convinced that these affirmations are valid

E. Rigid Negative Attitudes

1. Verbal/behavioral expressions of pessimistic, gloomy, judgmental thoughts
2. A suspicious attitude
3. Intolerance of others' opinions
4. Stubbornness, hard-headedness, rigidity of mind

F. Rigid Negative Emotional State

1. The hatred posture - becomes a "hateful person" and expresses hate toward anyone who threatens drug relationship
2. The aversion or rejection posture - is withdrawn, aloof, distant or evasive
3. The loneliness posture - becomes alone, isolated, lonely, desolate
4. The discouragement posture - becomes weary as sees life and problems as overwhelming
5. The desperation or despair posture - feels futile, hopeless, cynical, depressed, despondent
6. The sadness posture - becomes self-pitying person with a "poor me" attitude
7. The anger posture - becomes a resentful person

G. Rigid Negative Behavior

1. The "big ego" posture - is egocentric/self-centered and attacks others
2. The "inadequacy" posture - says "I can't" or "it's too hard"
3. The "frustration" posture - become "born losers" as set selves up for disappointments
4. The "belligerent" posture - is "always looking for trouble"
5. The "defiant" posture - "has a chip on his shoulder and dares you to knock it off"; intimidates

H. Emotional Compulsion

1. Urgency to use

a) Restlessness, uneasiness and anxiety at delays
b) Anger, hostility, resentment at real or imagined interference
c) Rapid or hurried use
d) Taking fortified dosages
e) Taking "extras"

2. Unplanned, unpremeditated, impulsive use

a) Impulsively beginning to use
b) Impulsive continuation beyond what intended
c) Abrupt changes of plans or interruption of plans in order to use or continue using

3. Continued drug use in a self-displeasing manner

a) Repeated episodes of drug use in unwanted manner
b) Regular pattern of self-disapproved use
c) Unkempt or broken promises to change manner of using
d) Unkept or broken promises to quit or totally abstain

III. Low Self-Image

A. Lowered Moral Standards and Actual Immoral Conduct

1. Dishonesty: lies, alibis, excuses, stealing
2. Destructive, antisocial behavior: disregarding feelings of others, creating disturbances
3. Serious injustices: DWI, neglecting family and responsibilities, using on the job, violating property and personal rights.

B. Defense of Irresponsible Behavior

1. Denying it
2. Repressing it
3. Minimizing it
4. Rationalizing it
5. Blaming it on others
6. Excusing it

C. Guilt and Moral Anxiety

1. Expressions of remorse
2. Expressions of shame
3. Apologies and sincere promises to change
4. Manipulation for forgiveness by reminding "no one is perfect"
5. Overcompensation to relieve guilt feelings
6. Free-floating, wispy fears growing to massive moral anxiety
7. Depression and expressions of failure
8. Suicidal tendencies

D. Low Self-esteem or Self-Respect

1. Rejection of sincere compliments
2. Servility or subservience - a "doormat complex"
3. Putting self down
4. Feelings and convictions of inadequacy
5. Grandiosity - "big ego" front

E. Rigid Defense System

1. Defensiveness about Personal Drug Involvement

a) Denial - defensively denies anything and everything that has to do with the drug involvement and its consequences
b) Minimizing - reduces in importance what is said about drug use - "You exaggerate, it's not that bad ..." "I only had two."
c) Rationalizing - gives self-satisfying "reasons" for the attitudes and behaviors - "I did it because ... I got drunk because ..." Explaining, making excuses, giving alibis are variations
d) Intellectualizing - focuses attention on analysis. Analyzing, theorizing, speculating are all forms.
e) Projection - externalizes and attributes feeling, attitudes, desires and behaviors to others. Blaming and accusing are forms.
f) Justifying - attempts to make "things right"
g) Complying - "going along with" Defiance is part of compliance - "OK, I'll do it if you insist, but just you wait..." Agreeing is another form.
h) Repression - is a sincere unawareness of painful or uncomfortable material.

2. Negative Attitudes Employed As Defenses

a) Hatred and aversion - putting others down, ridiculing, glaring, ignoring, attacking.
b) Despair or desperation - express discouragement and see themselves in an ambivalent position from which there is no escape.
c) Expressions of fear, avoidance, withdrawal.

d) Expressions of anger, resentment, belligerence, hostility.
e) Manipulation for pity
f) Expressions of insecurity or inadequacy
g) Expressions of defiance

F. Symptoms of Powerlessness

1. Inability to Control Drug Ingestion

a) Repeated drug abuse
b) Repeated unplanned, unpremeditated incidents or episodes of drug abuse
c) Repeated patterns of unplanned use
d) Repeated episodes or patterns of abuse in spite of expressed intentions, desires, efforts and/or promises to control
e) Denial of lack of control in spite of data to the contrary

2. Inability to Change Manner of Ingestion

a) Expressions of regret, embarrassment, shame or remorse about drug use, along with promises to change
b) Similar expressions about unwanted and unplanned drug-induced or related behaviors
c) Persistence in the manner of drug abuse in spite of self-disapproval of it

3. Inability to Terminate Drug Ingestion Continues or resumes ingestion

a) After expressed intention, desire or promise to quit
b) In spite of efforts to quit
c) In spite of serious or disastrous results to self and others

4. Inability to Recognize the Drug-Involved Condition

a) Sincere unawareness of the sick drug relationship, extent and manner of drug abuse, pathology, symptoms or complications
b) The symptoms of delusion, which also show mental powerlessness

5. Dysfunction or Unmanageability of Life

a) Spiritual deterioration
b) Social deterioration
c) Mental deterioration
d) Volitional deterioration

e) Emotional deterioration
f) Physical deterioration
g) Growing self-suspicion of insanity
h) Growing desperation, frantic efforts to get life under control
i) Despair, feeling that all is lost
j) Suicide attempts

CONCLUSION

Boards of nursing have many factors to consider when hearing cases related to chemical misuse, abuse and dependence by nurses. Though the literature presents divergent views on the cause of chemical dependence this chapter addressed the common espoused theories including the most widely accepted theory of the disease model of addiction. The chapter also addressed the concept of the phenomena of the progression of chemical use to chemical dependence and the work performance as well as specific behavioral manifestations of the progression.

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CHAPTER THREE

Legal Implications Related to the Chemically Dependent Nurse

Dealing with a chemically dependent nurse, whether by the purely disciplinary approach or by some other alternative, automatically triggers a complex network of legal considerations. Among the legal implications are: 1) the Board of Nursing's authority and responsibility to regulate nursing practice; 2) the constitutional rights of the consumers of nursing services; and 3) the constitutional rights of the chemically dependent nurse. It is possible to protect the rights and authority of everyone concerned by incorporating appropriate checks and balances into the process utilized for the disposition of each case.

Because it is closely related to legal issues, the economic impact of chemical addiction among nurses will also be discussed in this chapter.

Authority of the Board

In most states, the Board of Nursing is authorized and mandated, in some cases, to discipline nurses who are found guilty of certain causes which are specified in the nursing statute. Proceedings leading to disciplinary action are governed by provisions in the Nursing Practice Act and in the Administrative Procedure Act (APA) in each state. States whose APA is based on the Uniform APA must provide the following:

1. Proper notice to all parties involved;

2. Opportunities for all parties to respond, present evidence and arguments, and cross-examine on all issues involved;

3. A proper record of the proceedings;

4. Recorded or written final order or decision, including findings of fact and conclusions of law; and

5. Review and appeal of board decisions and orders. [1]

Elliot presents a model for disciplinary procedures in her monograph entitled *"National Council of State Boards of Nursing Disciplinary Data Bank: A Longitudinal Study"*. Using a model such as this one helps to insure that all requirements of due process are met in each disciplinary case. [2]

When the language of the nursing statute is broad, it is imperative that the terms relative to causes for disciplinary action be defined in the regulations. Otherwise, Boards could be found guilty of issuing administrative complaints which are too vague to provide adequate opportunity for defense. Courts could label this situation a breach of due process of law.

In Harper v. Louisiana State Board of Nursing, 484 So2d 857 (La. App. 1 Cir. 1986), Harper claimed that the district court erred by "failing to find that the 'standards for disciplinary action', as stated in La.R.S. 37:921, are unconstitutionally overbroad and vague". She asserted that the statute "denies the individual charged with notice of what standards her acts were in violation of" and that the constitutionally required "specificity of the charge" is not provided for by the statute. Harper was charged with failing to follow proper procedure for the disposal of unused portions of controlled substances. The appellate court took notice of the Board's rule which defined terms in the statute and of the Board's cooperation during the discovery process, and affirmed the judgment of the district court, which had affirmed the decision of the Board of Nursing. [3]

Charges of addiction to alcohol and drugs, or misuse of same, must be related to the practice of nursing, unless the statute provides specifically that addiction or misuse are violations of the statute in and of themselves. Reaves cites several cases involving chemically dependent professionals wherein the courts have made pronouncements which provide guidelines to boards for future actions. [4]

In Composite State Board of Medical Examiners v. Hertell, Ga.App., 295 S.E.2d 223, the appellate court affirmed the trial court's ruling that driving under the influence of alcohol and drugs was "unrelated to the practice of medicine, and is therefore insufficient as a matter of law to warrant disciplinary action". On the other hand, in the same case, the appellate court found "that the superior court erred in holding that the evidence did not authorize the conclusion that the appellee made a medical judgment while under the influence of alcohol and drugs". The case was remanded to the Board for disposition of this single remaining ground for disciplinary action. [5]

In Wegmann v. Department of Registration and Education, 377 N.E.2d 1297, the reviewing court differentiated between illegal actions and violations of the Dental Practice Act. The court held that, although inhaling nitrous oxide during office hours was not illegal, it was a violation of the Dental Practice Act. It further stated that a violation of the Dental Practice Act need not be accompanied by criminality, venality, or moral turpitude. [6]

In Petition of Johnson, 322 N.W.2d 616, certain criteria were suggested for consideration when a defense is raised: 1) that the accused is affected by alcoholism; 2) that the alcoholism caused the misconduct; 3) that the accused is recovering from alcoholism and any other disorders that may have caused or contributed to the misconduct; and 4) that the recovery has arrested the misconduct and the misconduct is not apt to reoccur. These criteria could be useful to boards in making decisions regarding chemically dependent nurses. [7]

In Sneig v. Department of Professional Regulation, Board of Medical Examiners, Florida App. 1984, 454 So.2d 795, the court found that the evidence did not support the finding of professional misconduct involving inappropriate prescription practices. The evidence simply showed that the physician failed to keep appropriate medical records regarding heavy dosages of Pilaudid prescribed for certain patients. [8]

Many other court rulings call attention to the legal balance which a regulatory board must maintain: the public must be protected from incompetent practitioners while the constitutional rights of the licensee must be preserved by careful application of due process of law.

Rights of the Consumer of Nursing Service

In each instance of chemical dependence in a nurse, the rights of the nurse must be carefully weighed against the rights of the consumers of that nurse's service. Two consumer rights come into play: the constitutional right of the public to expect protection from harm by the police power of the state, and the right to information necessary to make informed decisions about health care modalities and providers.

The right to this police protection of the state has long been accepted by the general public and the professions. The profession of nursing has been instrumental in bringing about legislation for licensure and regulation of nursing practice, a form of police protection, through establishment of regulatory boards to accomplish this protection of the health, safety, and welfare of the public.

The right of the consumer to information necessary to make informed choices is not as well defined and is not totally accepted by all professionals. The question at hand is whether or not consumers of nursing services have a right to know the disciplinary actions taken against nurses who violate the Nursing Practice Act and the identity of the nurses who are disciplined for such violations. Eason and Quick present arguments for and against making available to the public information regarding disciplinary actions. [9] The positive argument is that the consumer has a right to information about resources, equipment, technology, treatments, various disease entities and other information to facilitate actively participating in selecting a health care modality. Revealing even the identity of the nurse who is disciplined provides a mechanism for protecting the public against persons who do not provide safe nursing care. Since these nurses are accountable for their practice, the public has a right to know when nurses are found guilty of violating the Nursing Practice Act. Additionally, the publication of disciplinary information may serve as a deterrent to violations of the Nursing Practice Act and may be a real motivating factor to cause chemically dependent nurses to seek treatment before their practice deteriorates to unsafe levels. [10]

The negative argument is that publicizing disciplinary information would only increase anxiety, fear and stress in consumers of nursing services who are not prepared to utilize this information appropriately. Additionally, the opponents of publishing the information believe that this represents a breach of privacy to the nurse because protection of the public against unsafe nursing practice is not dependent on this information being published. If there is assurance that the chemically dependent nurse is in a bonafide rehabilitation program, that nurse is capable of delivering an acceptable level of nursing care. If at any time the nurse begins using drugs or alcohol, or if the nursing performance deteriorates, that information must be reported to the Board of Nursing for reconsideration of disciplinary action. [11] Consumers who are aggrieved by receiving unsafe nursing care can also obtain relief through litigation. This can be in addition to any action taken by the Board of Nursing since there may be cause for civil action in addition to cause for disciplinary action.

Personal Rights of the Nurse

Three constitutionally guaranteed personal rights must be considered: the property right of continued licensure, the right to freedom from invasion of privacy, and the right to seek employment in another state, none of which are absolute. As previously stated, personal rights are negated when the actions of the licensee places the public welfare at risk.

An additional consideration is the right not to slander. Because professional and personal reputation are often involved in cases of misconduct, one must guard against actual or even the semblance of slander.

Property Right

The Fourteenth Amendment to the United States Constitution, which reads, in part, "...nor shall any state deprive any person of life, liberty, or property without due process of law...," guarantees that property cannot be taken from an individual without just cause and without due process of law to establish just cause. The property right concept is relevant to continued licensure in a state, and, therefore, relevant to any situation which threatens the continuation of licensure. "The right to practice cannot be denied or abridged without complying with due process requirements." [12]

Although the due process clause protects a licensee from arbitrary state action, it does not prevent the Board from taking action to protect the public from the unsafe practice of a chemically dependent nurse. Care must be taken that proper procedures are followed.

Investigators and other persons who are responsible for drafting administrative complaints should be very familiar with the statutory causes for disciplinary action and with the provisions of the Administrative Procedure Act. Two cases involving nurses demonstrate the court's vigilance regarding due process.

In Hogan v. Mississippi Board of Nursing, 457 So.2d 931 (Miss.1984), involving a proceeding against a Mississippi nurse alleged to have misappropriated narcotics, the court held that since revocation of the nurse's license was a possible result of the proceedings, the allegations must be proven by clear and convincing evidence. [13]

In Ahsaf v. Nyquist, 332 N.E.2d 880, while certain allegations of misuse of controlled substances were made, it appeared to the reviewing court that the Board premised its decision to revoke on the nurse's "lack of candor", a charge which was not made. The case was consequently reversed. [14]

Right of Privacy

The Fourth Amendment of the U.S. Constitution protects individuals from unwarranted intrusion into their private lives. When investigating allegations of misuse or diversion of controlled substances and other addictive chemicals, the nurse's right to privacy must be considered. "Nevertheless, the right of privacy, sacred as it is, has limits set by the rights of other persons..." [15]

Creighton reports judicial rulings that the right of privacy is not absolute and that, in some cases, it is subordinate to the state's fundamental right to enact laws promoting the health, safety, and welfare of the public, even if such laws invade an offender's right of privacy. [16] In cases where persons challenge the legality of investigations into actions which place the public welfare at risk, the courts generally find that "government interests is one of conditional privilege, and unless there is a showing of malice, or that parties without legitimate interest had access to the individual's data, the courts deny relief". [17]

Reaves cites several cases which support statutorily authorized search and seizure when the primary purpose of the searches was not to obtain criminal evidence and when the searches were within the time and scope limits of the statute. Searches for criminal evidence require search warrants. [18]

A concept which is closely related to the privacy right is that of mandatory reporting of violations of the Nursing Practice Act. Many states have statutory reporting requirements. Although these statutes may not contain an express immunity from suit for unauthorized disclosure, as a general rule, the person making the report under statutory command will be protected by the doctrine of privilege. [19] This doctrine generally exempts the person who reports under a legal mandate from any form of legal action if the report was accurate and made in good faith.

In Judge v. Rockford Memorial Hospital, 150 N.E. 2d 202 (Illinois Appelate 1958) the court indicated that when reports include only direct observations and are made through proper channels, and when the person reporting does not knowingly make false statements to harm the chemically dependent nurse, a defamation lawsuit based on the report will be unsuccessful. [20]

Mobility of Chemically Dependent Nurses

Although the constitutionally guaranteed property right does not apply to initial licensure in any state, the U.S. Supreme Court has found that there is a liberty interest in the right "to contract, to engage in any of the common occupations of life". This liberty interest may include the right to seek licensure but not necessarily to be licensed in another state.

The concept of freedom to seek licensure is important because chemically dependent nurses are known to move from state to state, seeking "geographical cures", especially when their addiction is in the active stage. In order to facilitate the protection of the public in the receiving state, the Board of Nursing in that state should be given as much information as is legally permissible about the nurse's chemical dependency. The Board in the receiving state can then make an informed decision about licensure of the chemically dependent nurse.

Economic Impact of Chemical Dependence

The economic impact of the chemically dependent nurse is felt by many. The economic losses may include, but are not limited to: social and personal expense of chemical dependence, work-related accidents, accidents and traffic violations, homicides, suicides, property crime, damage and fires. Related expenses are the actual cost to society involving the criminal justice system, social service programs, fire protection, highway safety protection, and the general loss or interruption of productivity.

Personal economic losses include the loss of income, medical expenses, legal fees, cost of unused or unfinished education, unemployment, cost of treatment and counseling and inestimable cost of lost opportunities. For the chemically dependent nurse, there may be the loss of license to practice one's profession. The incalculable cost is the personal anguish, shame and grief experienced by the nurse and those with whom she comes in contact in daily living.

The chemically dependent nurse in the work place causes an economic loss to industry: lower productivity, reduced quality of work, increased incidents and accidents, excessive absenteeism and tardiness, increased employee turnover, causing declining morale among other employees and possible harm to the patient/client's health, safety and welfare. [21]

Boards of Nursing also experienced an economic loss of funds after a complaint against a chemically dependent nurse is filed. These costs may involve investigators, attorneys, staff, hearing officers, court reporters, and expenses incurred by board members to attend disciplinary hearings.

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CHAPTER FOUR

Regulatory Approaches

Philosophical Difference Between the Disciplinary Approach and the Preventive Approach

There are three major philosophical stances regarding the regulation of the practice of nurses who are chemically dependent: the pure disciplinary approach, the pure peer assistance approach, and a combination of discipline and peer assistance. Which avenue one favors depends on whether or not one believes that chemical addiction is a primary, preventable and treatable disease, how committed one is to protecting the public health, safety and welfare and one's interpretation of the laws governing the handling of controlled substances.

Disciplinary Avenue

The disciplinary approach to the problem of chemical addiction among nurses is based on the legal aspects of the problem. Two main legal considerations provide the rationale for this approach.

The first legal consideration related to the role of the Board of Nursing is determining the licensee's fitness to practice nursing. During the period of active chemical addiction, the chemically dependent nurse is usually found unfit and incompetent to practice nursing because: 1) patients are deprived of needed medication to control their pain when the nurse diverts controlled substances for self-use; 2) the effect of drugs is a state of altered consciousness with a consequent progressive reduction of the nurse's ability to practice safely; and 3) other behaviors which fall into a grey area of interpretation but which Boards of Nursing need to consider. These behaviors could include such things as preoccupation with obtaining a supply of drugs, absenteeism which causes decrease in staffing to unsafe levels, and irritability with patients and colleagues resulting in abuse.

Secondly, Boards of Nursing, along with other state licensing and regulatory boards, exercise a major role in the enforcement of State and Federal laws and regulations relating to the Controlled Substances Act. Most nurses who are dependent on controlled substances violate these laws and regulations at some time during their period of active addiction. Although Boards of Nursing are not empowered for criminal prosecution, they can exert some control over the illegal activities of the chemically dependent nurse through the disciplinary process and by providing information to criminal authorities.

Preventive Avenue

The preventive approach to chemical addiction among nurses is based on the rationale that chemical addiction is a process which can be prevented as well as treated. Education and identification of persons at risk are the major preventive tools. It is assumed that prevention can be attained by understanding the process of chemical addiction and developing non-chemical coping skills to equip oneself to deal with normal life stresses without relying on alcohol and other drugs.

Professional nurturing, demonstrated by assisting peers in their role as nurses, is also considered an important preventive factor. In order to promote professional nurturing, nurses strive to raise one another's consciousness regarding the needs of peers.

The preventive approach further supports secondary prevention of the disease by providing specially designed rehabilitation programs. Professional support is an essential component of the recovery process and this support must be maintained for an indefinite period of time. Prevention of relapse requires a constant consciousness that relapse can occur and an ongoing support system to help the nurse maintain alternative coping mechanisms.

Combination Avenue

During the most recent decade, a number of revolutionary models have been developed for alternatives to pure disciplinary proceedings for cases of chemically dependent nurses. These models utilize aspects of the disciplinary approach and the preventive (peer assistance) approach in varying proportions. Consequently, some models provide a better balance of peer assistance and public protection than other models. Eight examples of models of alternatives to the purely disciplinary approach for handling chemically dependent nurses are outlined below.

Models of Disciplinary Alternatives for Chemically Dependent Nurses

Model I (Statutory Arm of the Board of Nursing) depicts a process which is totally under the aegis of the Board of Nursing. Because it is created by the legislature, it is less subject to conflict of interest challenge for its professional advocacy aspects. This model provides for the protection of the public health, safety, and welfare by triggering the disciplinary process of the Board at any time a nurse becomes noncompliant with the requirements of the program. It is assumed that those nurses who are compliant can practice nursing safely. This model also protects the rights of the nurses as long as the public is not at risk. When the actions of the nurse place the public at risk, the nurses's rights fall, and this is in accord with case law. If educational services are not provided, an important preventive aspect is missing.

I. **Statutory Arm of the Board of Nursing**

a. Statutory authorization

b. Separate office and staff for chemical addiction program

c. Voluntary admissions or Board referral

d. Confidential records as long as compliant

e. Requirements for assessment, treatment, and after-care monitoring (therapy, employment, sobriety)

f. Assessment, treatment, and after-care services provided by outside agency which meets predetermined criteria

g. Routine disciplinary proceedings if nurse becomes noncompliant

h. Educational services may or may not be provided

Model II (Statutory Disciplinary Alternative under Board of Nursing with services contracted to an outside agency) has approximately the same characteristics as Model I except that, in contracting with an outside agency for all services, the Board has only indirect control over treatment specifications. Also, as in Model I, if educational services are not provided, an important preventive aspect is missing. An advantage of this Model is that the staff of the Board is not burdened with the administration of the program.

II. Statutory Disciplinary Alternative Under Board of Nursing with Services Contracted to an Outside Agency

a. Statutory or regulatory authorization, specific or implied

b. Special committee of the Board with expertise in chemical dependency decides on admissions

c. Admission pursuant to voluntary request made to the Board or pursuant to Board referral

d. Agreement for assessment, treatment, and follow-up monitoring

e. Services (consultation, referral for treatment, and monitoring) provided by contract agency

f. Records confidential on self-referrals. Reports to Board on all nurses referred by Board

g. Non-compliant nurses are referred to the Board for disciplinary action

h. Educational services may or may not be provided

Model III (Special Committee of the Board) is designed only to provide a means of protecting the public from the unsafe practice of chemically dependent nurses without exposing the identity of the nurse in the public records of the Board of Nursing. It triggers the routine disciplinary process at any time the public is at risk. Because there are not consultative and educational services, this Model does not provide for primary prevention of chemical dependence.

III. Special Committee of Board

a. Statutory or regulatory authorization

b. Reports regarding chemical addiction investigated and presented to Committee

c. Committee enters into an agreement with nurse for assessment, treatment, and after-care monitoring

- Continued therapy
- Employment conditions
- Sobriety

d. Reports from treatment program, employer, and evidence of sobriety sent to special committee

e. Routine disciplinary proceeding if nurse becomes noncompliant with requirements

f. Records confidential as long as compliant

Model IV (Consent Order for Suspension /Stayed and Probation) represents an official action of the Board of Nursing which is usually provided for in the Administrative Procedure Act, although not specifically for handling chemically dependent nurses. It is designed to protect the public from unsafe practitioners of nursing and offers no primary preventive services. There is no provision for protecting the privacy of the nurse. The records are subject to the public records law.

IV. Consent order for Suspension/Stayed and Probation

a. Statutory/regulatory authorization

b. Voluntary admission of chemical dependency followed by administrative complaint *or*
Investigation of report followed by administrative complaint

c. Nurse enters nolo contendere plea

d. Nurse agrees to certain terms (suspension/stayed, treatment, monitoring, limited practice, reports, etc.)

e. Administrative complaint and proposed Consent Order presented to Board

f. Board accepts or revises or rejects terms

g. If Board accepts terms, they become effective

h. If Board revises terms, licensee has option of accepting revised terms or having a full hearing before the Board

i. If Board rejects terms, licensee is notified of full hearing

j. License may or may not be coded "Probation", "Limited", or some similar indication of probation

k. Records subject to public records law

Model V (Special Disciplinary Provision for Voluntary Surrender of License to Board of Nursing) protects the public from actual or potential unsafe nursing practice by chemically dependent nurses because the nurse forfeits the right to practice until it can be determined that the dependency is under control. This model requires a minimum of time and effort on the part of staffs of Boards of Nursing. It is not designed to provide consultative and educational services. Although the property right of the nurse is not protected, neither is it violated because the surrender of the license is voluntary.

V. Special Disciplinary Provision for Voluntary Surrender of License to Board of Nursing

a. Statutory authorization either explicit or implicitly implied

b. Staffed by Board of Nursing

c. Voluntary admission of chemical dependency by nurse before or after Board receives report from others

d. License voluntarily surrendered to staff in informal hearing

e. Nurse enters treatment

f. License returned after informal hearing wherein nurse presents evidence of ability to practice nursing safely

g. Stipulations may or may not be placed on license

Assuming that the program is carefully planned and implemented in accord with a formal agreement between the Board of Nursing and the Professional Association, Model VI (Peer Assistance Program of Professional Association in collaboration with Board of Nursing) offers the best balance between the protection of the public and of the rights of the nurse. It also provides for consultation and educational services.

VI. Peer Assistance Program of Professional Association in Collaboration with Board of Nursing *268*

a. Statutory authorization either explicit or implicitly implied

b. Formal agreement between Board and Association, including:

1. Insurance of public health safety and welfare

2. Protection of the privacy and welfare of the nurse

3. Preservation of the regulatory power of the Board

c. Association staffs program

d. Nurse enters into an agreement with the Program regarding assessment, treatment, and after-care monitoring (continued therapy, employment, sobriety)

e. Agreement includes a statement that noncompliance will be reported to the Board for disciplinary action

f. Board provides a liaison staff person

g. Program director sends written reports to Board's liaison regarding each nurse in the program. Reports are reviewed by liaison person and, as long as they reflect compliance with the Program, they are placed in a confidential file.

h. Reports reflecting noncompliance are referred to the disciplinary staff of the Board

i. Routine disciplinary proceedings are initiated

j. Association provides consultation and education

Model VII (Peer Assistance Program of Professional Association with no relationship to the Board of Nursing) represents good protection for the nurse's rights; however, there is no provision for protecting the public against unsafe practitioners of nursing. Because this program is sponsored by a Professional Association, one may assume that nurse whose practice is very impaired will be counseled into voluntarily staying out of practice for a period of time. This assumption is based on the fact that the nurse is at risk for malpractice litigation and for disciplinary action by the Board of Nursing if that nurse practices below acceptable standards.

VII. Peer Assistance Program of Professional Association with No Relationship to Board

a. No statutory/regulatory authorization

b. Program staffed and operated by association

c. Records confidential

d. Services to chemically dependent nurse may include intervention, referral for treatment, support during and after treatment and upon re-entry into practice

e. Usually no communication with Board

f. Usually provides consultation and education

Model VIII (Peer Assistance or Employee Assistance Program with no relationship to Board) offers the least public protection and the narrowest scope of services. Although the majority of these programs may be operated similarly to programs of Professional Associations, private agencies may have ulterior motives for providing assistance to the chemically dependent nurse. Such motives include, for example, salvaging an employee to avoid the cost of hiring and orienting a replacement for the position, providing a "shelter" for nurse to escape disciplinary action by the Board of Nursing or even sheltering nurses from criminal prosecution.

VIII. Peer Assistance or Employee Assistance Program with No Relationship to Board

a. No statutory/regulatory authorization

b. Staffed and operated by private agency

c. Services usually include intervention, referral for treatment and support

d. Records confidential

e. Usually no communication with Board of Nursing

f. May or may not provide education services

To facilitate comparisons among the eight Models, the general characteristics of each model are depicted in Table 4.1. Presented in Table 4.2 are the legal and professional provisions of each model. The information charted in these tables will be clearer if one keeps in mind that the personal rights of the nurse are not absolute. They cease when the actions of the nurse place the public welfare at risk; therefore, an indication of protection of privacy and property rights of the nurse must be interpreted in that light.

Regardless of where the mandate originates, certain conditions should be present in any impaired nurse program: treatment programs should be state-of-the-art, sobriety ("no drink/use" clause) should be monitored, and nursing performance should be evaluated at frequent intervals. Documentation of these mandatory conditions should be maintained by the program staff. The Board of Nursing should be immediately notified of any situation where the nurse cannot practice nursing safely. Each of the models that protects the nurse from direct action by the Board while a treatment plan is being adhered to can be effective unless a nurse plans for and attempts a "geographical cure" by moving out of state.

MODELS OF ALTERNATIVES TO DISCIPLINARY PROCEEDINGS FOR CHEMICALLY DEPENDENT NURSES

Table 4.1

GENERAL CHARACTERISTICS OF PROGRAM	MODELS I	II	III	IV	V	VI	VII	VIII
Specific Statutory Authority	X	X		X				
Implied Statutory Authority			X		X	X		
No Statutory/Regulatory Authority							X	X
Staffed and Operated by BON	X		X	X	X			
Staffed by Sponsoring Agency						X	X	X
BON Staff with Contract for Services		X						
Formal Agreement with BON					X	X		
Voluntary Admissions	X	X	X	X	X	X	X	X
Intervention to Cause Admission						X	X	X
Board Referred Admissions	X	X	X			X		
Program Services								
-Consultations	X	X				X	X	
-Referral for Assessment and Treatment	X	X	X	X	X	X	X	X
-Monitor Re-entry into Practice	X	X	X	X	X	X	X	
-Education Services	X?	X?				X	X	X?
Communications with BON								
-Admission	X	X	X	X		X		
-Program Reports	X	X	X	X		X		
-Non-Compliance	X	X	X	X		X		
Records								
-Public				X				
-Confidential in All Instances							X	X
-Confidential When Compliant	X	X	X		X	X		
Disciplinary Proceedings								
-None in Any Instances							X	X
-None if Compliant	X	X	X		X	X		
-Action Taken and Stayed				X				

LEGAL AND PROFESSIONAL PROVISIONS OF MODELS OF DISCIPLINARY ALTERNATIVES FOR CHEMICALLY DEPENDENT NURSES

Table 4.2

	MODELS							
PROVISIONS	I	II	III	IV	V	VI	VII	VIII
Protection of Rights								
-Public H,S, & W	Yes	Yes	Yes	Yes	Yes	Yes	No	No
-Privacy of Nurse	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
-Property of Nurse	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Peer Assistance								
-Before Treatment	No	No	No	No	No	Yes	Yes	Yes
-During Treatment	No	No	No	No	No	Yes	Yes	Yes
-Re-entry into Practice	No	No	No	No	No	Yes	Yes	Yes
Mobility of Nurse								
-Public Protection	No	No	No	Yes	Yes	No	No	No
-Assistance to Nurse	No	No	No	No	No	Yes	Yes	Yes

Regulatory Role of the Board of Nursing With and Without Peer Assistance

The role of Boards of Nursing is to safeguard the health, safety, and welfare of the public by insuring that persons who practice nursing are qualified to do so. The activities involved in fulfilling this role may vary according to the structural environment in which the Board functions.

In states where there is no chemically dependent nurse assistance program all cases of chemical addiction should be reported to the Board of Nursing for disciplinary action. The action of the Board varies from revocation of licensure to dismissal of charges, depending upon the sufficiency of evidence in relationship to the administrative charges against the licensee. When the nurse is allowed to remain in practice, most Boards attach certain stipulations to the license. Chemically dependent nurses who are not reported to the Board may jeopardize the public health, safety, and welfare by continuing to practice while their judgement and skills are impaired.

Where there is a chemically dependent nurse peer assistance program, the ultimate responsibility of the Board is still to safeguard life and health. However, the disciplinary process may differ. Collaboration with the professional peer assistance program can result in a balance between total immunity for the chemically dependent nurse who cooperates fully with the program and just action of the Board when public safety is jeopardized. A very close liaison between the Board of Nursing and the peer assistance program is necessary to fulfill the role of the Board. There should be statutory provisions or a formal legal agreement between the two parties to assure the authority of the Board to regulate nursing while assuring the protection of the rights of the nurse.

Implications for Endorsement

Interstate mobility of nurses presents special problems when chemically dependent nurses are involved. The main problem is the unavailability of relevant information to the Board of Nursing in the receiving state. In some cases, when records are confidential under all circumstances, the Board of Nursing in the state from which the nurse is moving does not have information regarding the nurse's problem. In other cases the information cannot be released to the receiving Board because it is not public record.

In some models, there are provisions for triggering the disciplinary process when the nurse does not comply with the terms of the program. Once the disciplinary process reaches the public record point, the Board is then free to communicate the information to the receiving state. The public health and welfare is fully protected only in the models where the Board of Nursing is fully informed about each case and is free to communicate the information to other Boards of Nursing if the nurse moves out of state.

There is no evidence that any alternative to disciplinary proceedings for handling chemically dependent nurses provides adequate protection of the public when these nurses attempt "geographical cures" by moving from state to state. For that reason, some Boards of Nursing are hesitant to participate in any collaborative alternative to disciplinary proceedings.

Nurses whose chemical addiction has been in the active stage for long periods of time cannot be assumed to be competent when they enter recovery. The same is true for nurses whose licenses have been revoked/suspended for long periods of time. In the first case, the nurse's obsession with the addiction may preclude that nurse from even being interested in maintaining current nursing knowledge and skills. In the latter case, because the nurse cannot practice nursing while the license is not valid, that nurse's competence should be verified before re-entry into unsupervised nursing practice.

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CHAPTER FIVE

Methods of Treatment for the Chemically Dependent Nurse

Boards of Nursing are obligated by statute to assure the public that nursing care received is at least minimally safe. Within that obligation lies the responsibility to monitor for ongoing safe practice of individual nurses. Any impairment in the ability to practice, as documented by a board, must be acted upon with appropriate disciplinary action, in accordance with the Board's regulatory function of protecting the public's health, safety and welfare. Impairment caused by chemical dependence is an example of a scenario about which boards must be informed in order to administer discipline appropriately. Some common considerations and methods of treatment for chemical dependence, as described below, need to be discussed by boards in meeting this legal obligation.

Common Views

There are some common considerations boards usually employ in hearing discipline cases dealing with chemical dependence. It is generally accepted by boards that nurses who misappropriate medications, falsify records, or abuse drugs or alcohol in the work place are not safe. Specifically, those nurses who, on the job, are under the influence of drugs or alcohol or who, during care delivery, deprive patients of appropriate medications are clearly viewed by the board as a hazard to the public.

What is less clearly delineated for boards is how to deal with the nurse who abuses substances outside the work setting, but does not take drugs or alcohol immediately before or during work. Boards would need to assess each nurse for: preoccupation with attaining drugs for personal use, which can affect care delivery to clients, and any other signs and symptoms of dependence as presented in Chapter Two of this Monograph. Also needing consideration would be the suggested linkage of brain dysfunction and long term mental impairment with substance abuse. [1]

How a Board handles the discovery and elimination of the existence of the chemical dependence problem hinges largely upon the individual state's laws and regulations and the nurse's individual circumstances. A more subtle but important determinant in how these matters are handled is the Board's philosophy (written or unwritten) regarding chemical dependence - its causes, peril to the public, and appropriate disposition.

Most states have the authority to discipline nurses ranging from reprimands, probation, suspension to revocation. Discipline alone without treatment, has generally been found to be unsuccessful. Many Boards of Nursing have discovered through experience that nurses who are disciplined and kept out of nursing for some period of time and who are later allowed to return to practice without any treatment are a source of ongoing recidivism which puts the public at risk.

Boards have generally come to recognize that some combination of licensee discipline, or potential discipline and treatment, are most effective in rehabilitating the nurse and safeguarding the public. This chapter will focus on what the literature says about the methods of treating nurses who are chemically dependent and the implications for Boards of Nursing.

Treatment Methods - A Review of the Literature

Extensive research and writing have been done in search of the most efficacious method(s) of treatment for chemical dependence. The research and writings have focussed on the importance of examining the treatment process factors that contribute to a successful outcome. Although the body of research is growing, no clear-cut answers exist. There do, however, seem to be some commonly repeated themes that are worthy of discussion and consideration by boards of nursing.

I. General Review of the Literature

Although no single model for treatment has been found to be ideal, there are a number of considerations in selecting or recommending formalized treatment programs. One consideration revolves around the efficacy of treatment.

Walker and Shain cite a number of sources that suggest that spontaneous remission and recovery may occur among alcoholics more than once believed, which supports that remission rates after treatment may not be connected to the type, duration or depth of treatment, and that seldom are remission rates after treatment higher than those of spontaneous recovery. If such is true, it leaves questions as to the efficiency of treatment and also the predictability and documentation of spontaneous remission. Walker and Shain also refer to attention drawn to "minimal interventions for problem drinkers" supported in a study carried out by Edwards, et al., and reported in 1977, wherein it was discovered that a one time "advice giving" session was as effective with alcoholics as a typical inpatient alcoholism treatment program. Miller and Hester's 1981 writing is reviewed by Walker and Shain and it presents evidence from a number of other studies which indicate that "...minimal interventions can be as effective as more intensive treatments, particularly for the earlier stage problem drinker, for whom minimal outpatient intervention appears more effective than inpatient treatment." [2]

A number of other writers and researchers are examining influential treatment approaches, other than from the perspective of spontaneous remission or of minimal intervention, because these approaches from an anecdotal and experimental perspective leave many continuing to struggle with a chemical dependence problem. Aspects of these authors' writings as presented below, are important to examine prior to a Board prescribing treatment for nurses.

DeLeon and Jainchill find that the length of time spent in residential therapeutic communities is "the most consistent predictor of successful outcomes..." Their study examines the factors that affect one's staying in a residential therapeutic community. It identified a tool, CMRS, which successfully predicted one's circumstances, motivation, readiness, and suitability for treatment in a therapeutic community. They also found that the longer one stays in treatment, the longer one would continue to seek treatment and thus the more likely treatment would be successful. [3]

A literature review by Ojehagen and Berglund, related to alcoholism, identified important characteristics of successful treatment to be based on "a good social adjustment, less severe drinking problem, the absence of severe psychiatric symptoms at admission, and a good motivation for treatment..." [4] They also completed a study which looked at improvement that occurred following treatment in a two year outpatient alcoholic treatment program. An important note is that their study did not use abstinence as an objective but looked for limited drinking behavior and improved psychological adjustment. Results of their study indicated that long term treatment could be effective even when early improvement did not occur.

McLellan et al. reconfirmed the traditionally held view that no one treatment modality is effective for all substance abusers. In their study examining the possibility of "matching" clients with certain characteristics to certain treatment programs, they found that those with alcohol or drug dependence who had "LOW psychiatric severity" on admission usually made substantial gains and had the best outcomes no matter which treatment program they entered. Those with "HIGH psychiatric severity" at admission did poorly no matter in which treatment program they were enrolled. The study supported the evaluation of psychiatric severity on admission to a treatment program as an important predictor in the outcome of treatment. Findings of the study supported the hypothethis that those who were rated as "LOW severity" have the greatest chance for success and could usually be treated in an outpatient setting and that those "HIGH severity" clients needed psychiatric interventions as a part of their treatment. As a group the "HIGH severity" clients usually had had more difficulty with employment or family and generally needed inpatient treatment. The study findings led McLellan et al. to conclude that the advantage of extended inpatient treatment was that it removed the substance abuser from a damaging environment, allowing concentration upon the rehabilitation process, and permitted the families to reevaluate objectively their contribution to the patient's condition. [5]

Vaillant et al. studied one hundred patients admitted for alcohol withdrawal over an eight year period and published the findings in 1983. This study found that a number of premorbid factors were predictors of successful remission: "marital status, employment, lack of prior detoxification, and absence of previous drunkeness arrests." [6] They discovered that predictors found in previous studies were inaccurate probably because the previous studies had not covered as many years. The data analysis further suggested that abstinence of six months was not an accurate determinant of long term outcome. [7]

In a review of the ten longest studies of alcoholics which were adequately documented, Vaillant et al. found that the remission rate was not affected by intensity of inpatient treatment and that Alcoholics Anonymous affected continued abstinence. [8] Their further review of the literature found that inpatient treatment for alcoholics lasting two to four weeks demonstrated "results identical to those obtained by competent clinical advice or brief detoxification." [9] Two other studies referred by Vaillant et al. found that alcoholics showed improvement after treatment as opposed to before treatment. A number of other studies reviewed supported outpatient programs because the cost of such programs are paid back by decreases in health care required, sick days from work, and illness and accident benefits. [10]

In summary, a review of the literature indicated that researchers varied greatly in support of a standardized formalized treatment for chemical dependence. Some of the early researchers reviewed in this chapter gravitated to the idea of spontaneous remission while others found brief counseling as effective as longer term inpatient care. Although several were skeptical regarding the effects of treatment and the predictability of success over a long period of time, no one found treatment programs to be detrimental. The final group included researchers who found that inpatient treatment programs have much to offer those who are chemically dependent, including a break from their problem laden environments to focus on recovery and the opportunity for families to assess their role in the chemical dependence. Though most of the reviewed articles involved those dependent upon alcohol, and not exclusively a professional population, the data is believed applicable to the treatment of addiction to any chemical substance.

Board Considerations of General Literature Review

Although the research waivers in its support of formalized treatment programs, those who work closely with impaired nurses, physicians, pharmacists or other health professionals, avidly support the use of treatment programs and most encourage inpatient care of three to four weeks in length. Affirmation of treatment for health professionals can be found in the writings of Bissell, Haberman, Sullivan, Bunting and Talbot. Treatment and participation in peer support groups are advocated in the impaired nurse programs or positions established by many state nurses associations, e.g. Louisiana State Nurses Association, Nurses' Network for the Impaired Professional, [11] Missouri Peer Assistance Committee, [12] Wisconsin Board of Nursing's Proposed Recovering Nurse Program, Tennessee Nurses' Association Peer Assistance Program for Impaired Nurses [13] Kansas State Nurses' Association's Peer Assistance Program [14], and the Pennsylvania Nurses' Association Peer Assistance Program. [15]

When boards choose whether chemically dependent nurses must participate in treatment, several points should be reviewed: 1) people are not amenable to being successful with treatment until they are ready; 2) there is no correct treatment program for all chemically dependent nurses and therefore treatment must fit the situation; 3) good choices should be made available; 4) boards should be discouraged from accepting therapy on an individual basis in lieu of the nurse's involvement in the treatment process [16]; 5) boards have an obligation to safeguard the public and move the nurse toward recovery. Waiting for or believing in spontaneous remission does nothing to assist the nurse nor to assure the public that what is currently available to treat chemical dependence has not been applied through a discipline process.

Making the determination of inpatient versus outpatient for this treatment would be based on the capabilities of the program and condition of the nurse. Factors to be considered should be progression of the disease, underlying psychiatric severity, family dynamics and a host of other psychosocial characteristics. Hadley and Hadley suggest that a "program's conceptual model (medical, psychological, social, behavior modification, or self help) and its staff qualifications" are characteristics to be reviewed in light of a client's need when selecting a treatment program. [17] A final determinant is cost. Although cost of the programs can affect the nurse's ability to participate in treatment, boards should consider the likelihood for successful recovery as the primary determinant in program selection.

II. Abstinence As a Treatment Method

Controversy remains in the field over whether abstinence from all mood altering substances is necessary if one is dependant on drugs or alcohol. A. Thomas McLellan, Ph.D., in a September, 1983, *Journal of the American Medical Association* article stated that: "the majority of treatment centers are still offering 30-day abstinence, Alcoholics Anonymous-based, inpatient treatment." [18] The article further indicated that success in treatment programs continues to be measured by abstinence.

Whether abstinence is necessary to recovery from chemical dependence to drugs or alcohol is debatable according to a variety of international researchers.

The Swedish researchers, A. Ojehagen and M. Berglund, argue that there is no generally accepted definition of success in the treatment of alcoholism. They state that, "Abstinence, for example, is not always related to improvement in the other areas and psycho-social improvement is not always related to improvement of the drinking pattern. [20]

Americans in the field, Alan Marlatt, Ph.D. and Reid Hester, Ph.D., add to the skepticism surrounding abstinence in a September 1986 *Journal of the American Medical Association* article. They discussed disagreeing with the disease concept of alcoholism and not being convinced that total abstinence is necessary for recovery. [21]

There are, however, many others who disagree strongly with that position. Smith, Milkman, and Sunderwirth state that, "Abstinence and recovery (living a comfortable and responsible life without the use of psychoactive drugs) is presently the most effective long-term treatment for addictive disease." [22] Bissell and Haberman believe firmly in abstinence from alcohol and other mood-altering drugs to which people are addicted as the goal in treatment for alcoholics. [23] This position for abstinence is based on the belief that chemical dependence, whether it be to drugs or alcohol, is widely seen as a progressive and potentially fatal disorder based on a pattern of compulsive use that cannot be modified except by total abstinence from mind-altering substances.

Zweben and Smith describe how the therapeutic community has moved away from permissiveness of alcohol use, once allowed of those addicted to drugs, because of the documented outcome of that philosophy. They state that, "...the increasing integration of the TC (therapeutic community) movement into the alcohol and drug treatment system as a whole has obliged it to come to terms with the disease model, which states that abstinence from alcohol and other drugs is a prerequisite to recovery". "Use of Alcohol or other drugs while in recovery can," according to Zweben and Smith, "easily upset the precarious balance of positive thinking and emotional strength achieved while in recovery and needed to continue with recovery." [24] Those formerly dependent on drugs or alcohol, they concluded, have a life-long vulnerability to further dependence and thus must remain abstinent.

Board Considerations Regarding Abstinence

Although the debate continues regarding whether the goal should be abstinence from all mood-altering substances for those recovering from chemical dependence, boards of nursing must come to some conclusion on the topic. This conclusion is an essential part of directing a uniform discipline and recovery plan for the chemically dependent nurse brought before the board for a hearing.

In recalling Goldman's work, presented earlier in this chapter, on neurological dysfunction found in alcoholics, and in considering that the habitual use of drugs other than alcohol may cause brain damage, boards may reasonably find it difficult to allow the use of any mood-altering substances in recovering chemically dependent nurses. The risk of brain damage and potential impairment to a nurse's capability in providing competent nursing care should be a legitimate concern to boards.

Another consideration for a board in its decision making on the issue of abstinence revolves around the methods by which mood-altering substances are obtained. Although the purchase of alcohol is legal, the acquisition of most mood-altering substances is not. Boards should categorically not allow nurses to participate in such illegal acts as illegally purchasing "street drugs," fraudulently obtaining prescriptions, and/or misappropriating medications from the work place. When a nurse is in recovery, however, boards should remember that controlled substances can be obtained legally from physicians and dentists and therefore should take precautions that any such drug is being prescribed for valid health problems. In such instances boards should minimally require the nurse to provide a copy of the prescription and documentation from the practitioner who prescribed the medication. In addition, boards could consider requiring the nurse to allow the board to communicate with the prescriber.

Continued Care After Treatment as Method of Treatment

Authors in the area of chemical dependence tend to agree that continued care is important after initial treatment. Assistance should be given to recovering individuals in the period following initial treatment to assist in generalizing their treatment plans to their own environments. [25] Hoffman et al. cite studies that support aftercare for its assistance with mourning and convalescence. [26] Goldman's study with recovering alcoholics showed improved learning capacity in the first six months of recovery which may allow people to benefit from learning new behaviors through extended treatment. [27]

The continued learning and recovery process seems most natural and most readily accomplished by participation in aftercare sponsored by the original treatment facility. Little research was found in the literature to recommend aftercare by any particular description. However, Hoffman et al. cited a number of studies that show a high correlation between weekly aftercare attendance and abstinence. [28]

Many agree that self help and support groups, like Alcoholics Anonymous (A.A.) or Narcotics Anonymous (N.A.) play an important role in recovery. They are often seen as a place those who are recovering can go for a new and supportive peer group. The widespread availability of A.A. even in rural communities, its applicability to drug dependencies other than alcohol, and lack of cost make A.A. ideal for continued care for any person recovering from chemical dependence.

The research of Hoffmann et al. which examined followup data on 900 who had received inpatient care from chemical dependency treatment programs found weekly attendance at A.A. to be beneficial. Their study found that six months after discharge, 73% of those who attended A.A. one or more times per week were still abstinent. Only 33% of those who did not attend A.A. regularly remained chemically free. [29] They also found that a "significant difference in sobriety appears when attendance drops off to once a month or less." [30] In their discussion they indicated that it is still impossible to predict who will be helped by A.A. However, they remain quite supportive of its use in aftercare.

Some believe that mere attendance at A.A. or N.A. is insufficient in gaining long term sobriety. These individuals feel that participants must become fully involved in working the twelve step program. One element involved in "working the program" is seeking a sponsor who is easily available for guidance to the recovering individual.

In recent years a third group has evolved based on a concept of the importance of receiving support from a group of peer professionals, in this case nurses. The American Nurses' Association strongly advocates the formation of peer support groups for chemically dependent nurses and as previously described, many state associations have responded by developing such groups.

Board Considerations Regarding Continued Care

Those previously mentioned who worked with impaired health professionals are supportive of continued care after formal treatment. There seems to be some dispute in the field as whether nurses' support groups or A.A./N.A. should be used as an aftercare modality. Some feel that these groups should augment aftercare associated with a formal treatment program. The boards of nursing will have to determine which type of programs it will require when selecting appropriate care following treatment. Because A.A.'s success is better documented than formalized aftercare programs or nurses support groups, boards considering aftercare recommendations should be hesitant to exclude A.A. attendance as a requirement.

If boards decide impaired nurses should participate in aftercare or other programs for continued care, the boards will need to determine what program(s), the frequency of meetings, the methods for verifying attendance and progress, and the length of time required to participate in the after care or continuing care program. Requiring a sponsor for those who attend A.A. or N.A. may be helpful in assuring the nurse's progression in the twelve step program.

IV. Alcohol and Drug Screening as a Method of Treatment

As previously discussed, there is no way to be sure nurses are recovering other than to know they are free from drugs or alcohol. Drug and alcohol screening is currently under careful scrutiny as recently discussed in the popular press because of increased use by employers in screening of employees.

Boards are in a somewhat different position than employers in requiring drug and alcohol screening, since they can require this kind of testing of nurses who face or who already have disciplinary action against their licenses. Screening can be effective and with negative results often allows nurses to remain in the work force because their abstinence can be verified.

Board Considerations Regarding Drug Screens

If boards decide impaired nurses should participate in any type of drug screening tests, the boards need to consider the following:

1. The type of test to be required;

2. The method and frequency of the test administration (random or scheduled? monitored or unmonitored? if monitored, by whom - lab, board staff?, how to store - refrigeration?);

3. The sensitivity and specificity of the test to trace elements of commonly used over the counter drugs;

4. The manipulation possibilities of test results and or administration techniques by the licensee;

5. Time frame and plan for dealing with positive results of tests (e.g. emergency procedure to suspend licensee from practice);

6. The method of payment (does the licensee pay or does the board? - if board pays, need to establish an ongoing billing method for payment);

7. The appropriate choosing of a reputable lab for efficient and effective feedback and cost effectiveness;

8. The provision of a procedure for assuring storage of lab tests securely, without a tampering possibility if the board is responsible for doing the test and then taking it to the lab. If the lab is the monitoring body, the lab should provide an assured method of lab test security; and,

9. A plan or procedure for dealing with any legal problems related to a challenge to use or the results of screening tests (e.g. false positives or false negatives of test).

Because drug screening tests are subject to change as that technology expands, the board will need to develop a strong working relationship with experts in laboratory test for specific and general drug screening. This might be done by developing a colleagial relationship with a specific lab assigned to do screening tests for the board or by developing in-house expertise with the staff investigator for disciplinary cases. It would be unsound for boards to require drug screening tests unfamiliar to them and therefore boards should be cautious until set procedures and knowledge bases are established.

Sullivan suggests that the pressure on nurses from themselves to retain their licenses may be a motivation for abstinence and recovery, as documented in a study done on physicians by Morese at Mayo Clinic.30 Continued licensure with stipulations, therefore, has the potential for serving as an impetus for recovery to the impaired nurse while also offering protection to the public. However, the control of a nurse's license is strictly within the purview of the Board. Although professional associations or treatment programs can make recommendations to a Board about licensure, a Board is not compelled to follow the recommendations if in the best judgement of the board, the public health, safety and welfare would not be well served. The board is compelled only to assure due process during the discipline of any licensee.

According to a review of nurse practice acts, thirty-six states may issue temporary or limited license to those nurses who have had disciplinary action taken against their license. Since many states' nurse practice acts do not contain such statements of facilitation, most Boards of Nursing can, after the disciplinary hearing or during the decision making process, decree conditions or stipulations limiting the practice of these nurses.

For those returning to the work force with restrictions, the Board should determine whether the license should be marked as restricted or probationary. Thoughts should be given to whether employers should be knowledgeable of the nurse's dependence at the time of employment. A marked license gives the dependent nurse the impetus to discuss with the potential employer, a problem that both should be involved in addressing during the nurse's employment. If the license is not marked, Boards should consider by what other means an employer is going to be made aware of the nurse's dependence.

Once a final decision has been made by a Board in regard to licensure, thought should be given to the license itself. A dependent nurse who has a license suspended or revoked should be required to return the previously unencumbered license. Allowing a dependent nurse to continue to hold a license that has been suspended or revoked serves as temptation to the nurse to use the license. Since this is often the group that is not amenable to treatment, the public will be better protected if the board has the license rather than the individual.

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CHAPTER SIX

Summary and Conclusions

Boards of Nursing are charged with monitoring the nurse population for assurance of the safe and effective practice of nursing. This monograph explored the many responsibilities, issues, theories of causation, theories of treatment, and alternative methods for treatment of boards of nursing to use in carrying out their discipline function when safe and effective practice related to the nurse who is chemically dependent, is in question. Based on the responsibility inherent in protecting the public's health, safety and welfare in the disciplinary process function of boards of nursing, the following general conclusions and recommendations are offered:

Conclusions

1. Chemical dependence is a phenomenon with multiple causative factors.

2. The primary theory for chemical dependence currently is the disease of addiction theory, which is based on the general genetic theory.

3. Chemical dependence is a progressively declining process beginning with drug use, evolving into misuse and abuse and finally dependence.

4. Charges of addiction to alcohol and drugs, or misuse or abuse of the same, must be related to the practice of nursing unless the statute provides specifically that addiction or misuse are violations of hte statute in and of themselves.

5. The public has a right to expect protection from harm by the police power of the state from nurses who are impaired due to chemical misuse or dependence.

6. The nurse has a property right of continued licensure, the right to freedom from invasion of privacy, the right to seek employment in another state and the right to due process when allegations are brought against the nurse.

7. Personal rights of the nurse are negated when the actions of the nurse place the public welfare at risk.

8. The preventive approach to chemical dependence among nurses is based on the rationale that chemical dependence is a process which can be prevented as well as treated.

9. A combination of the preventive and disciplinary models for action by boards of nursing in dealing with the chemically dependent nurse can provide for public protection while having a rehabilitative impact on the chemically dependent nurse.

10. The effects of the different treatment modalities for chemical dependence vary greatly with their predictability of success.

11. Treatment programs (both inpatient and outpatient), though not totally predictable in success, have a more positive than negative effect.

12. Abstinence as a treatment modality is based on the belief that chemical dependence is a progressive and potentially fatal disorder that cannot be modified except by total abstinence from mind-altering substances.

13. Recovery for the dependent person can include periods of relapse.

14. Continued treatment, after initial treatment, for chemical dependence assists in long term success.

15. Alcoholics Anonymous (A.A.), because of its widespread availability, its applicability to drug dependencies other than alcohol, and lack of cost, is ideal for continued care for any person recovering from chemical dependence.

16. The nurse recovering from the process of chemical dependence should not be allowed to take on a therapeutic role with other chemically dependent nurses for a significant period of time following the beginning of the recovery process.

17. The selection of a treatment program to be required of nurses facing discipline should be determined by the likelihood for successful recovery rather than cost.

18. Continued employment in nursing by the chemically dependent nurse can have a therapeutic effect on the recovery stage of the nurse.

19. Recidivism endangers the public health safety and welfare, and increases the cost to the chemically dependent nurse, to the board of nursing, and ultimately to the public.

Recommendations

1. Pursuant to the responsibility of the board in implementing the discipline function, boards of nursing should thoroughly educate themselves in theories of treatment, the characteristic behavior patterns of the chemically dependent nurse, and the expected outcomes of any required screening test or treatment modality as required of the chemically dependent nurse in disciplinary actions.

2. Boards of nursing should develop a written philosophy, based on a conceptual framework of chemical dependence, to use in implementing discipline management plans for chemically dependent nurses.

3. Boards need to consider the following criteria to decide when discipline should be initiated:

   a. The nurse is a risk to the public or to herself; and

   b. The nurse poses a threat to the public's health, safety, and welfare.

4. Boards of nursing should use limited licensure and probation with stipulations only with nurses who are in the recovery stage of dependence.

5. Boards of nursing should allow nurses to continue active employment if the public's health, safety, and welfare is not at risk.

6. Boards should explore alternative models to the strict discipline model when dealing with the chemically dependent nurse.

Operational Definitions

Drug Use: Use of a prescription from a licensed physician or dentist according to the physician's/dentist's directions or using alcohol in normal social drinking.

Drug Misuse: Use of a prescription from a licensed physician or dentist not according to the physician's/dentist's directions or occasionally drinking alcohol to excess.

Drug Abuse: Use of a prescription from a licensed physician or dentist for purposes other than that prescribed by the licensed physician/dentist or the use of alcohol regularly to attain a euphoric state.

Chemical Dependence: Continuous use of mind-altering chemicals. This stage of activity includes: 1) persons who have medically diagnosed physical or psychological problems which requires continuous pharmacologic therapy to maintain comfort, physical, or psychological functioning or life; 2) persons who are psychophysiologically dependent on alcohol and or controlled or mind altering drugs and who do not have a medically diagnosed psychopsychologic problems requiring therapy with controlled or mind-altering drugs. The first example is a legal use of mind-altering chemicals while the latter is an example of illegal use. Either can result in the inability of a person to function in activities of daily living, including work.

Over the Counter Drugs: Drugs which are available to the public for self-medication of minor problems and/or the physician or nurse practitioner may advise the client to use an over the counter drug for a variety of good reasons.

Peer Assistance Program: A network of peers who initiate intervention, monitor progress and offer continual support to a chemically dependent peer. Formal programs usually include contracts for compliance with a prescribed treatment program and ongoing group support sessions.

Recovery: The process of regaining a state or normalcy from the addiction to drugs.

Relapse: A recurrence of symptoms of addiction after a period of recovery.

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REPORT OF TASK FORCE ON EXAMINATIONS FOR THE FUTURE

RECOMMENDATION

The following recommendation is submitted to the 1987 Delegate Assembly for its consideration:

> That the Delegate Assembly authorize a task force to implement step one of the Plan of Action in FY 88, and to recommend choice of a testing model for adoption by the Delegate Assembly in 1988.

CHARGE

In August, 1986, the Delegate Assembly of the National Council of State Boards of Nursing, Inc. adopted a Resolution to establish a task force to explore and plan the development of new licensure examinations based upon minimum competencies of evolving levels of nursing practice, and to submit a report to the Delegate Assembly in 1988.

In keeping with the National Council's position of neutrality on Entry Into Practice, which was also adopted at the 1986 Delegate Assembly, the purpose of this task force was not to debate the entry issue; rather it was to explore how the National Council can best meet the needs of individual Member Boards for licensure examinations should they enact statutory or regulatory changes which redefine legal scopes of practice and minimum competencies.

MEETINGS

The Task Force held four meetings. Major activities of the Task Force have included:

- Review of the literature and other relevant background information
- Development of working assumptions and identification of problems and issues related to each assumption
- Identification, development and refinement of potential testing models and the implications of each model
- Research into test validation options for job analysis on evolving scopes of practice
- Development of a Plan of Action including a sequence of events that would need to occur should future examinations be developed by the National Council.

REVIEW OF LITERATURE AND OTHER BACKGROUND INFORMATION

In order to determine the direction that future examinations may take, the Task Force reviewed numerous competencies developed by state boards of nursing, national nursing organizations, and nurse researchers; the National Council's past documents including the Entry Into Practice Report (1986), Trend Analysis Study and *A Study of Nursing Practice and Role Delineation and Job Analysis of Entry-Level Performance of Registered Nurses*; current research involving nurses working in differentiated job descriptions; and job analysis methodologies used by other testing organizations and professional groups. In addition, the Task Force invited staff resource people representing legal, theoretical, psychometric and fiscal perspectives to assist them in identifying issues and implications that must be addressed relative to the development of future examinations.

ASSUMPTIONS

The Task Force considered all the above information and then began the process of identifying the assumptions upon which it would work. Each assumption evolved from lengthy discussions regarding questions that were raised or issues that would need to be addressed in the development of new examinations. The ten working assumptions generated by the Task Force are as follows:

1. Efforts are in progress to develop national consensus on the definitions of essential competencies of evolving levels of beginning nursing practice.

2. National trends in nursing practice will affect licensure examinations.

3. Examinations for the future can only be developed in response to changes in nursing practice over time.

4. The National Council of State Boards of Nursing's position of neutrality regarding the entry-into-practice issue impacts upon planning for the development of future examinations.

5. Participation in activities relevant to developing licensure examinations that reflect changes in the scope of nursing practice is appropriate for the National Council of State Boards of Nursing.

6. In the development of future licensure examinations, the sole purpose of licensure examinations is to protect the public by testing minimum competencies for safe, effective beginning practice.

7. Changes in regulatory language affecting legal scopes of practice may affect the use of current licensure examinations and may create a need for new examinations.

8. Jurisdictions desire to maintain interstate mobility during evolving changes in regulation of nursing licensure.

9. New examinations that reflect the evolving levels of nursing practice must be validated according to acceptable legal and psychometric standards.

10. The fiscal impact of new examinations will depend upon such factors as: required test development activities, number of candidates tested, mode of administration, and sources of funding.

DEVELOPMENT OF TESTING MODELS

The next step of the Task Force was to conceptualize models of testing which could be used as possible frameworks for the development of new examination(s) in response to regulatory changes and changes in practice. Four major models were adopted as distinct and viable and the implications of each model were identified in terms of (1) the transition process for implementation of the model, (2) the number of examinations a candidate would have to take under this model, (3) impact on interstate mobility, and (4) fiscal implications. The Task Force also acknowledged the theoretical, philosophical and political issues surrounding each model; however, it was determined that these issues were not appropriate for the Task Force to further explore at this point in time. The models are presented below within the framework of an "if... then" statement which is intended to emphasize the fact that a specific model can only be selected as consensus is achieved regarding the competencies of the evolving levels of practice.

The descriptions of the four major models and their implications are as follows:

EVOLUTIONARY MODEL

Assumptions:

IF jurisdictions decide the scope of nursing practice is based upon:

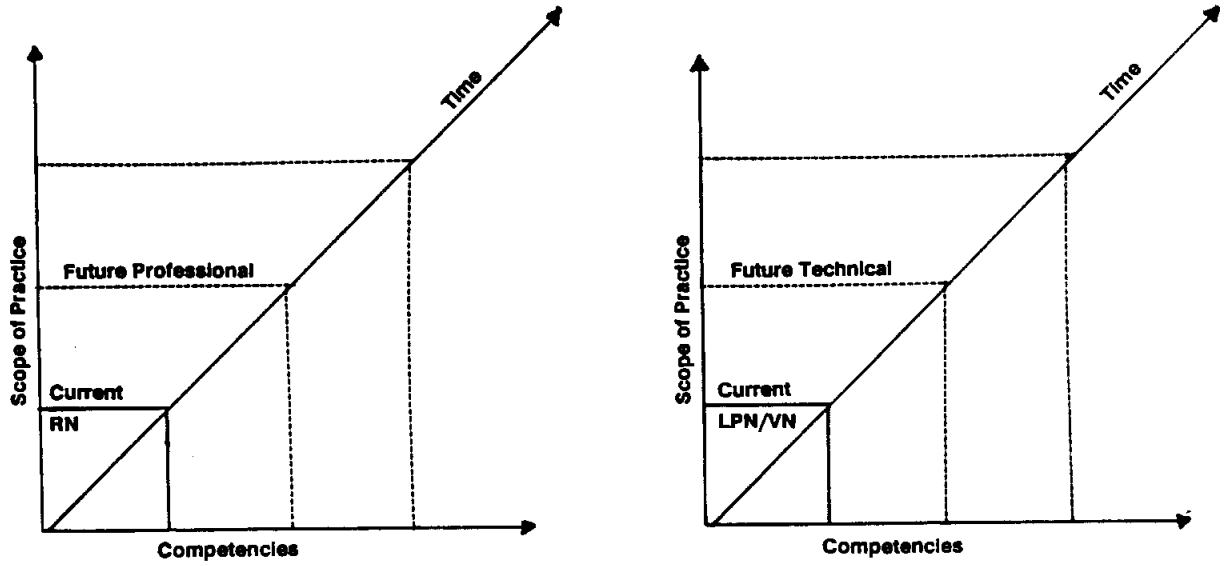
- the current two levels of practice increasing in scope and competencies to evolve into future technical and professional levels;

THEN the EVOLUTIONARY testing model would be appropriate.

Description:

The Evolutionary Model of testing reflects the current methodology used by the National Council for examination development and validation. Based on the results of ongoing job analyses, the test plans and content of the current NCLEX-RN and NCLEX-PN examinations would change over time to reflect evolving practice. Therefore there would be no need for new or replacement examinations.

EVOLUTIONARY MODEL



NOTE: Dotted lines indicate potential position of future levels.

Implications of Model:

1. **What is the transition process for implementation of this model?**

   Since there would be no new examinations, there would be no transition period for test development. For Member Boards, the transition would be dependent upon the extent of diversity among requirements for eligibility to write the examinations.

2. **How many examinations will candidates have to take?**

   One examination for each level of practice.

3. **What would be the impact on interstate mobility?**

   Interstate mobility would be minimally disrupted under this model. However, if individual states determine different eligibility requirements for writing the examinations, or implement changes at different points in time, interstate mobility would be adversely affected.

4. **What are the fiscal implications of this model?**

   The need for more frequent job analysis studies might imply some increase in cost. With respect to item development, the current level of item production might have to be increased to reflect changes needed as a result of the future job analysis studies. The number of candidates taking each examination would remain essentially the same as for current examinations. Therefore any increase in candidate fees would be due only to job analysis and item development factors.

ADD-ON MODEL

Assumptions:

300

IF jurisdictions decide that the scope of nursing practice is based upon:

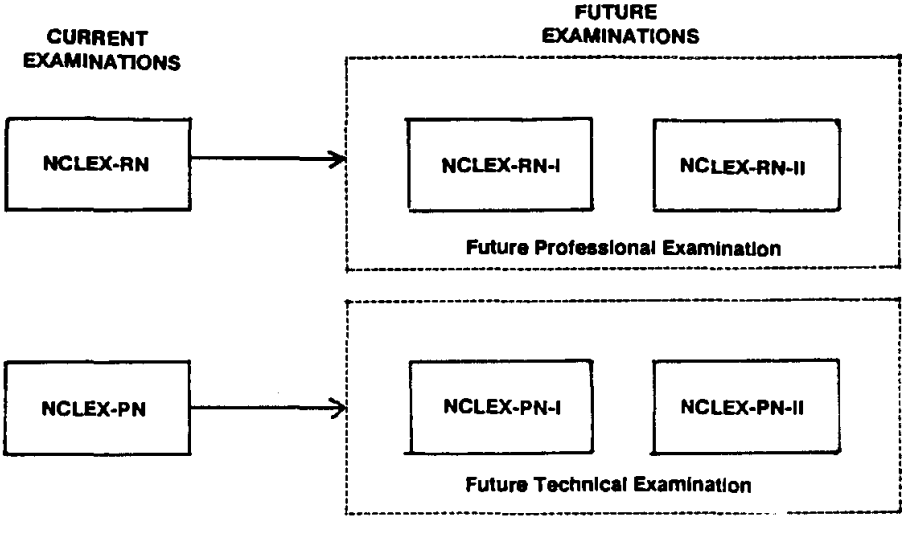
- a body of nursing knowledge common to current registered nurse practice and evolving professional practice; and a future professional level of practice which "adds on" to current registered nurse practice a component that broadens the scope of practice; and
- a body of nursing knowledge common to current practical nurse practice and evolving technical practice; and a future technical level of practice which "adds on" to practical nurse practice a component of that broadens the scope of practice;

THEN the ADD-ON testing model would be appropriate.

Description:

In the Add-On Model, there is a common core of knowledge, skills, and abilities linking the current and evolving levels of practice. The evolving professional and technical levels would each require an additional examination part to measure the depth and scope of knowledge unique to evolving professional and technical nursing, respectively.

ADD-ON MODEL



NOTE: Dotted rectangles indicate potential future merging of two parts into one examination.

Implications of Model:

1. **What is the transition process for implementation of this model?**

   The current examinations would continue to be used as part I for each level. A second part (part II) would be developed for each level, based on the results of job analyses. After a transition period, the two parts may be merged into one examination.

2. **How many examinations will a candidate have to take?**

   Candidates would have to take the part I examination in order to enter a current level. Candidates in jurisdictions with the expanded scope of practice would have to take the part I and part II examinations. The part II examination could be taken at the same time as, or after, the part I examination.

3. **What would be the impact on interstate mobility?**

   Candidates from future professional and technical programs who have taken both parts of the appropriate examination could be endorsed as RNs and PNs, respectively, in states maintaining current requirements without taking any additional examinations. Licensees from jurisdictions maintaining current entry requirements could obtain licensure as future professional and technical nurses, respectively, by writing the appropriate part II examination if they met all other requirements for licensure in the jurisdiction in which they seek endorsement. An adverse effect might arise due to individual states determining different eligibility requirements, resulting in an individual licensed in the future technical role being eligible for endorsement as a current RN in another state.

4. **What are the fiscal implications of this model?**

   Development costs for part II of each examination would be required, including job analysis studies and item

development. Two new test plans for the part II examinations would need to be developed and updated during the transition phase. After the transition period, the costs should stabilize since only one test plan would be required for each of the future levels. Because of anticipated lower numbers of candidates taking the new part II examinations, candidate fees might have to be higher.

SEPARATE MODEL

Assumptions:

IF jurisdictions decide that the scope of nursing practice is based upon:

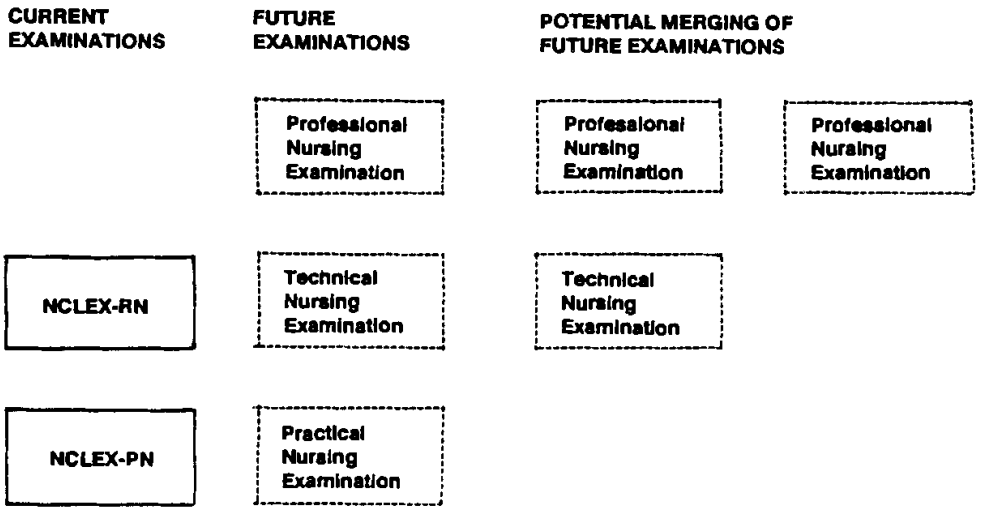
- future levels of practice representing significant change from currently defined levels; and
- each level of practice encompassing unique competencies;

THEN the SEPARATE testing model would be appropriate.

Description:

In the Separate Model, each level is a separate and distinct entity. Within each level there exists a common base of knowledge and skills. Although nurses at the different levels share this common base, nurses at each level apply it uniquely within their respective levels of practice.

SEPARATE MODEL



NOTE: Dotted rectangles indicate potential future examinations.

Implications of Model:

1. **What is the transition process for implementation of this model?**

   Each level would require a separate examination. If job analysis data support a match between any of the future levels and a current examination, then the current examination could continue to be used for that level. Where there is no match, a new examination would need to be developed. In the future, the levels may continue as they are, merge into new levels, or cease to exist; thus creating the need for new examination(s) or modification of existing examinations.

2. **How many examinations will candidates have to take?**

   One examination for each level of practice.

3. **What would be the impact on interstate mobility?**

   If neither of the current examinations can be used to test the future levels, interstate mobility would be adversely affected. If either of the current examinations could be used for any of the future levels, interstate mobility would be minimally disrupted. However, if individual states determine different eligibility requirements for writing the examinations, or implement changes at different points in time, interstate mobility could still be adversely affected.

4. **What are the fiscal implications of this model?**

   Development costs will depend upon the number of new examinations needed. New job analyses would be needed to validate the future levels of practice and to determine the need for new examinations. The number of candidates would not change; however, they would be distributed over the number of examinations that exist at that point in time. Therefore, the candidate fees could be affected.

EXPANSION MODEL

Assumptions:

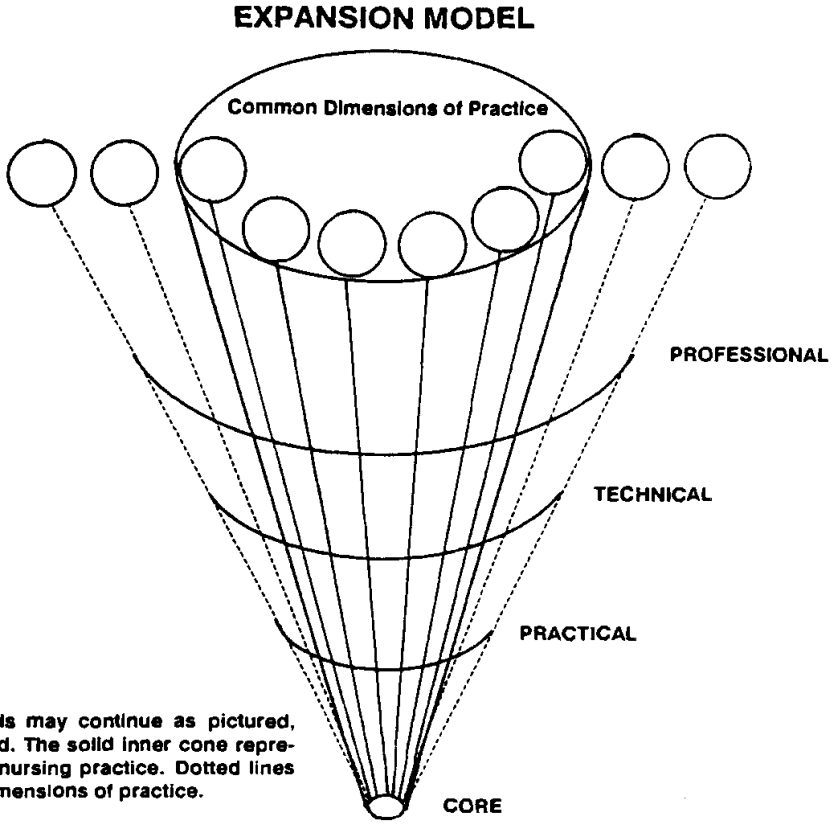
IF jurisdictions decide that the scope of nursing practice is based upon:

- one definition of nursing within which nurses can achieve different levels;
- a common "core" of nursing knowledge representing a minimal level of competency for all levels of nursing practice; and
- an expanding body, depth and complexity of knowledge, skills, and abilities at each succeeding level of nursing practice;

THEN the EXPANSION testing model would be appropriate.

Description:

At the center of the Expansion Model, there is a common core of knowledge, skills, and abilities. The core expands outwardly to reflect the depth and complexity of knowledge, skills, and abilities obtained at each succeeding level. Each level builds upon the common core and each succeeding level. This model provides for different examinations to be given at different levels using one test plan based on common dimensions of nursing practice. Dimensions may be added or deleted from the model based on results of future job analyses.



NOTE: In the future, levels may continue as pictured, cease to exist, or be added. The solid inner cone represents the single scope of nursing practice. Dotted lines indicate potential future dimensions of practice.

Implications of Model:

1. **What is the transition process for implementation of this model?**

   If a job analysis demonstrates major similarities between the existing test pool dimensions and the scope of nursing practice, then the items of the current examinations could be combined or slightly modified for use in creating new examinations. If a job analysis demonstrates little or no similarity between the existing dimensions and the new scope of practice, then new items and examinations would have to be developed. The most likely outcome would be that some of the current test items could be used in the new examinations.

2. **How many examinations will candidates have to take?**

   Persons with educational preparation appropriate for the first level (practical) examination would take that examination. If they obtain educational preparation for the second level (technical) examination, they could then take that examination, which is cumulative in the sense that it covers the first and second levels. Persons with initial educational preparation for licensure at the technical level would be eligible to take the technical examination without first writing the practical examination. Similarly, persons with initial preparation at the professional level could take the professional examination without first taking the practical and technical examinations.

3. **What would be the impact on interstate mobility?**

   If the present examinations were equivalent to any of the levels in this model, interstate mobility would be less disrupted. If there is no equivalence between present examinations and the new examinations, interstate mobility would be more adversely affected during the transition period.

4. **What are the fiscal implications of this model?**

Each time a job analysis study is done, all levels would be included. The cost of such a study might be relatively high; however, savings would result from use of a common instrument for all levels and not conducting separate job analysis studies for each level. With respect to item development costs, a common pool of items banked together would increase efficient use of items, item writers, and content experts. The number of candidates per examination would remain essentially the same as with current examinations.

MODULAR MODEL

The Task Force also considered a modular approach for the development of future examination(s). This model could provide for multiple professional and technical examinations. Initially it appeared that this model had the greatest potential for meeting the needs of individual states, should states proceed in divergent directions in regard to various legal scopes of practice for nursing personnel at different times. However, due to the problem of non-uniformity of examinations and the subsequent implications for interstate mobility, and for the cost of development for various modules, this model was not explored in depth at this time. The Task Force recognized the potential of this model for continued competency testing.

PLAN OF ACTION

The final function of the Task Force was to develop a Plan of Action including a sequence of events which would need to occur in the development of new examinations(s). A tentative timeline was also established for the Member Boards' consideration, realizing, of course, that many factors could, and would, impact this timeline. The purpose of the timeline is to provide a strategy for long term planning for the development of new examination(s).

The Plan of Action is as follows:

1. Initiate process leading to recommendation on testing model
   a. collect competency statements and job descriptions regarding professional and technical nursing at entry level and synthesize

   b. obtain input from Member Boards regarding models

   c. consider results of PN job analysis study to be completed in Spring 1988

d. reach consensus on future competencies, based on synthesis of data collected

e. identify samples of evolving levels of practice

f. recommend a testing model to Delegate Assembly

2. Determine whether/which new examinations are needed (depending on testing model selected), and identify possible sources of funding

3. Determine job analysis methodology to measure qualitative components of practice

4. Develop and field test a job analysis instrument

a. develop draft instrument to validate the identified competencies of new practice

b. evaluate instrument for appropriateness and effectiveness in validating competencies

c. refine instrument

d. field test instrument

5. Conduct a limited-scope job analysis using a representative stratified sample

6. Report to Delegate Assembly on results of limited-scope job analysis; make recommendation for authorization to develop test plan(s)

7. Develop test plan(s) based on job analysis; recommend approval to Delegate Assembly

8. Develop items and compile examination(s)

9. Administer first examination

10. Conduct full job analysis

11. Schedule re-evaluation and revision of test plan as necessary to maintain ongoing quality of the testing

program according to legal and psychometric principles

TIMELINE FOR IMPLEMENTATION OF PLAN OF ACTION

	Events	Responsibility for Implementing	Possible End Dates
1.	Competencies; samples; testing model	Task Force	Aug. 1988
2.	Need for new exams; funding sources	Examination/ Testing Committee	Oct. 1988
3.	Methodology planned	staff/consultant	Dec. 1988
4.	Instrument development	staff/consultant	Aug. 1989
5.	Limited-scope job analysis	staff/consultant	May 1990
6.	Authorization to develop test plan	Delegate Assembly	Aug. 1990
7.	Test plan approval	Delegate Assembly	Aug. 1991
8.	Item/exam development	Item Writers, PCE Examination/ Testing Committee	Feb. 1992- Feb. 1993 *
9.	First exam administration	Member Boards	July 1992 or July 1993
10.	Full job analysis	staff/consultant	Feb. 1993 or Feb. 1994
11.	Re-evaluation of test plan	Examination/ Testing Committee	ongoing

* A range is given because time needed for new item development will vary depending on the model selected and the usability of items in the current item pools.

SUMMARY

The charge of the Delegate Assembly to this Task Force was challenging and exciting.

Perhaps one of the most significant activities of the Task Force was to raise the issues that need to be addressed prior to development of any examination(s). These issues include, but are not limited to:

1. Lack of national consensus regarding the essential, safe competencies for the evolving levels of nursing practice.

2. Lack of number of nurses working in truly differentiated job descriptions at the new levels of nursing practice.

3. Lack of appropriate methodology to use for job analysis studies to validate evolving levels of nursing practice.

4. Lack of uniformity in the rate and direction in which individual states may change their entry requirements necessitating new examinations, and the effect this disparity may have on interstate mobility and cost of examinations.

These issues raised many concerns among the Task Force members. Perhaps the greatest question raised was:

> Should the National Council's direction be to prepare to meet the various needs of individual jurisdictions as they enact various statutory and regulatory changes which impact licensure examinations, *OR*
>
> Should the National Council work toward achieving consensus on a specific direction for future licensure examinations in order to maintain and facilitate interstate endorsement for licensees?

In the belief that working towards a consensus is in the best interests, not only of the National Council, but also of Member Boards, licensees, and the public, the Task Force offers the recommendation below.

RATIONALE

The Task Force presumed that it was established for a one-year period, after which time it would report its findings to the Delegate Assembly in 1987. The Task Force believes that it accomplished its goals of exploring and planning for the development of new licensure examinations by presenting potential models for future examinations and developing a plan of action and a corresponding timeline.

The purpose of the recommendation below is to offer direction as to how the National Council might proceed from this point in time to further activities regarding the development of future examinations. The Task Force believes that the first step in adopting direction for the development of new examinations must be to initiate a process of data gather-

ing and consensus building which will lead to a recommendation on a testing model for future examinations.

With this rationale in mind, the following recommendation is offered to the Delegate Assembly for its consideration:

RECOMMENDATION

That the Delegate Assembly authorize a Task Force to implement step one of the Plan of Action in FY 88, and to recommend choice of a testing model for adoption by the Delegate Assembly in 1988.

FISCAL IMPACT STATEMENT - DESCRIPTION

Will this proposal generate revenue? *NO* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *YES*

   How many members are anticipated including the chairperson? 7

   How often would the committee meet? *3 times, 4 days each*

2. How many mailings would this proposal require? *One*

   To whom? *Member Boards (in addition to usual agenda/minutes mailings)*

3. Printing (surveys, special reports, etc.) Please describe:
   Survey of Member Boards for input on testing models - could accompany Newsletter

4. Other than committee meetings, is travel required? *NO*

   Please describe: _____

   _____

   _____

5. What type of consultation is required (i.e., legal, computer, etc.)?
   Possibly job analysis specialist - one day

6. Staff time required (preparation time, travel time, research presentations) - number of hours (estimated) *30 days*

7. Projected beginning date: *September 1987*

   Projected completion date: *August 1988*

FISCAL IMPACT - SUMMARY

EXPENSES

1. Committee Meetings

   $500 per member per meeting (Travel) = $*10,500*

   $150 per day per member = $*12,600*

2. Mailings
   $0.25 per letter = $_____, or

   $2.00 per 9 x 12 manila envelope (First Class) = $_____

3. Surveys (Printing)

   $0.05 per page = $_____

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $*500 (Consultant)*

   $150 per day per member (Expenses) = $*150 (Consultant)*

5. Consultation

   $125 per day = $*125*

6. Other Printing

   $0.05 per page = $_____

Subtotal Expenses: $*23,785*

Subtotal Revenue: $ *None*

Net: $*23,875*

NOTE: The approved FY budget includes $20,900 for an ad hoc testing committee, thus this proposal entails an addition to the budget of $2975

NEW BUSINESS

The following four resolutions have been evaluated by the Resolutions Committee prior to presentation to the Delegate Assembly.

RESOLUTION

313

WHEREAS the Delaware Board of Nursing approves programs for the United States Army Reserves which prepare 91C's practical nurses, we believe active component 91C's assigned overseas before they could take NCLEX-PN should be given the opportunity to do so in Germany, and

WHEREAS 91C's were not required by the Department of Defense to be licensed prior to 1987, we believe there is intent on their part now to require licensure for this category of personnel, and

WHEREAS licensure examinations are available in the United States this request is only to accomodate those soldiers who were not required to be licensed for the 91C Military Occupational Specialty (MOS) slot and is an interim measure, and

WHEREAS the Delaware Board of Nursing (the Board) is committed to programs which prepare the U.S. Army 91C's, and

WHEREAS the Board is committed to mandatory licensure for all practical nurses, and

WHEREAS examinations are given successfully in at least two locations outside of the continental United States, and

WHEREAS the U.S. Army Practical Nurses are an important component of our military forces, and

WHEREAS administration of the examination in Germany by two Board members minimizes transportation expenses and maximizes the continuation of health care services by these soldiers,

RESOLVED that the Delaware Board of Nursing administer NCLEX-PN to a maximum of 105 eligible USAR 91C's in Germany in October, 1987, and be it further

RESOLVED that the Delaware Board of Nursing, after evaluation of the first administration, administer NCLEX-PN five more times over the next 36 months, in Germany, to a maximum of 105 91C's for each sitting of the NCLEX-PN, for a maximum total of 630 candidates.

Submitted by the Delaware Board of Nursing

FISCAL IMPACT STATEMENT - DESCRIPTION

Will this proposal generate revenue? *YES* Please describe below:

105 candidates per each of six administrations will pay examination fees to the National Council and licensing fees to the Delaware Board of Nursing

EXPENSES

1. Does this proposal require a committee? *NO*

   How many members are anticipated including the chairperson? _____

   How often would the committee meet? _____

2. How many mailings would this proposal require? *None*

   To whom? _____

3. Printing (surveys, special reports, etc.) Please describe:
   None

4. Other than committee meetings, is travel required? *YES* *

   Please describe: *Two representatives of the Delaware Board have gone to Germany for a site visit, and will go for each examination administration; the Executive Director of the Delaware Board has traveled to the Area IV Meeting, to the May Board of Directors' Meeting, and will travel to the Delegate Assembly*

5. What type of consultation is required (i.e., legal, computer, etc.)?
   None

6. Staff time required (preparation time, travel time, research presentations) - number of hours (estimated) *Minimal*

7. Projected beginning date: *October 1987*

   Projected completion date: *April 1990*

* *All paid by the US Army*

FISCAL IMPACT - SUMMARY

EXPENSES

1. Committee Meetings

   $500 per member per meeting (Travel) = $_____

   $150 per day per member = $_____

2. Mailings
   $0.25 per letter = $_____, or

   $2.00 per 9 x 12 manila envelope (First Class) = $_____

3. Surveys (Printing)

   $0.05 per page = $_____

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $_____

   $150 per day per member (Expenses) = $_____

   None to National Council or Delaware Board of Nursing

5. Consultation

   $125 per day = $_____

6. Other Printing

   $0.05 per page = $_____

Subtotal Expenses: $ *None*

Subtotal Revenue: $*5000+ to National Council*

Net: $*18,900 to Delaware Board of Nursing*

RESOLUTION

WHEREAS the legal definitions of professional and practical nursing vary among jurisdictions, yet all Member Boards require the same examination as a condition of licensure by interstate endorsement, and

WHEREAS according to the National Council *1986 Nursing Licensure Requirements*, all Member Boards accept "graduation from a state approved or accredited educational program" as a way of meeting interstate endorsement requirements, yet graduates of some approved practical nursing schools are unable to meet educational requirements in some jurisdictions, and

WHEREAS NCSBN Bylaw Article II, Objective 2. states "Identify and promote desirable and reasonable uniformity in standards and expected outcomes in nursing education and practice as they relate to the protection of the public health, safety and welfare,"

THEREFORE BE IT RESOLVED, that by August 1, 1988 the National Council's Nursing Practice and Standards Committee document and distribute the requirements of each Member Board for licensure by endorsement of Registered Nurses and Licensed Practical Nurses, and

Be it further resolved that the Nursing Practice and Standards Committee study the differences in endorsement requirements and by August 1, 1989 recommend for action by the Delegate Assembly desirable and reasonable standards, which, if implemented, would facilitate licensure by endorsement yet assure public protection, and

Be it further resolved that the Nursing Practice and Standards Committee monitor problems related to licensure by endorsement and improvements in the process and report their findings routinely in the annual report to the Delegate Assembly.

Submitted by the Minnesota Board of Nursing

Will this proposal generate revenue? *NO* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *YES*
   Nursing Practice and Standards Committee

   How many members are anticipated including the chairperson? _____

   How often would the committee meet? _____

2. How many mailings would this proposal require? *One per year*

   To whom? *Member Boards*

3. Printing (surveys, special reports, etc.) Please describe:
   Survey and report

4. Other than committee meetings, is travel required? *NO*

   Please describe: _____

   _____

   _____

5. What type of consultation is required (i.e., legal, computer, etc.)?
   None first year; legal second year

6. Staff time required (preparation time, travel time, research presentations)
   - number of hours (estimated) _____

7. Projected beginning date: *August 1987*

   Projected completion date: *August 1992 (indefinite)*

FISCAL IMPACT - SUMMARY

EXPENSES

1. Committee Meetings

   $500 per member per meeting (Travel) = $ *Part of usual meeting expenses*

   $150 per day per member = $_____

2. Mailings *x 60*
   $0.25 per letter = $*15*, or

   $2.00 per 9 x 12 manila envelope (First Class) = $*120*

3. Surveys (Printing) *x 2 x 60*

   $0.05 per page = $*6*

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $_____

   $150 per day per member (Expenses) = $_____

5. Consultation *x 3 days*

   $125 per day = $*375 second year only*

6. Other Printing *(Report first year only, x 6 pages x 200 copies)*

   $0.05 per page = $*60 (Delegate Assembly report not included)*

Subtotal Expenses: $*81 or $186 first year/ $456 or $501 second year/ $21 or $126 subsequent years*

Subtotal Revenue: $ *None*

Net: $*81 or $186 first year/ $456 or $501 second year/ $21 or $126 subsequent years*

RESOLUTION

WHEREAS, a Model Nursing Practice Act was developed by the Nursing Practice and Standards Committee of the National Council of State Boards of Nursing, Inc. and adopted by the 1982 Delegate Assembly, and

WHEREAS, the Model Practice Act is intended to serve as a guide to states in considering revisions to their nursing practice acts, and

WHEREAS, substantial changes in the Texas Nurse Practice Act are being considered by the Texas legislature to incorporate quality assurance measures through nursing peer review mechanisms and mandatory reporting by nurses, employers, nursing organizations, peer review committees, insurance companies and the courts, and

WHEREAS, the functions of the Nursing Practice and Standards Committee include periodic review of model laws pertaining to nursing practice, and

WHEREAS, a model act developed by the National Council reflects the combined experiences of persons closely associated with the regulation of nursing practice, therefore, be it

RESOLVED, that a survey of State Boards of Nursing be conducted to determine the extent to which quality assurance measures are being incorporated into the statutes, and be it further

RESOLVED, that the National Council of State Boards of Nursing, Inc. authorize the Nursing Practice and Standards Committee to review the Model Practice Act and develop recommended revisions to incorporate quality assurance measures, and be it further

RESOLVED, that the Nursing Practice and Standards Committee continue to monitor quality assurance mechanisms and submit a report at the next Delegate Assembly.

Submitted by the Texas State Board of Nursing

FISCAL IMPACT STATEMENT - DESCRIPTION

Will this proposal generate revenue? *NO* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *YES - Existing Committee - Nursing Practice & Standards*

   How many members are anticipated including the chairperson? *6*

   How often would the committee meet? *One time for this project*

2. How many mailings would this proposal require? *One*

   To whom? *Boards of Nursing*

3. Printing (surveys, special reports, etc.) Please describe:

   Surveys if done - it is possible that only a memo could be sent to Member Boards asking whether quality assurance measures were being planned

4. Other than committee meetings, is travel required? *NO*

   Please describe: _____

_____

_____

5. What type of consultation is required (i.e., legal, computer, etc.)?

   Legal - if changes are made in the Model Practice Act

6. Staff time required (preparation time, travel time, research presentations) - number of hours (estimated) *10-20 hours*

7. Projected beginning date: *Fall 1987*

   Projected completion date: *Spring 1988*

EXPENSES

1. Committee Meetings

   $500 per member per meeting (Travel) = $*3,000*

   $150 per day per member = $*900*

2. Mailings
   $0.25 per letter = $*15*, or

   $2.00 per 9 x 12 manila envelope (First Class) = $_____

3. Surveys (Printing)

   $0.05 per page = $3

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $_____

   $150 per day per member (Expenses) = $_____

5. Consultation

   $125 per day = $*125*

6. Other Printing

   $0.05 per page = $_____

Subtotal Expenses: $*4,043*

Subtotal Revenue: $ None

Net: $*4,043*

RESOLUTION

WHEREAS the NCLEX-RN examination has been reduced from 480 questions administered in four 120 minute parts to 360 questions administered in four 90 minute parts resulting in a total of 6 hours of actual testing time and

WHEREAS the costs of administering a licensing examination (costs of renting a facility, paying proctors and examiners, etc.) have increased significantly and

WHEREAS many other professional licensing examinations require 6 to 8 hours of actual testing per day and may continue for 2 to 4 days and

WHEREAS the NCLEX-RN is not unique in difficulty or format from many other professional licensing examinations and

WHEREAS costs of administering the NCLEX-RN could be reduced to both the candidate and individual Boards and

WHEREAS there is no research evidence to indicate candidates for the NCLEX-RN are less able to perform adequately on a licensing examination than candidates for other professional licensing examinations

THEREFORE BE IT RESOLVED that the Examination Committee and the Administration of Examination Committee study the issues involved in changing the examination schedule from 2 days to 1 day, considering effects on the National Council, CTB/McGraw-Hill, Member Boards and candidates, and

BE IT FURTHER RESOLVED, that the Examination Committee and Administration of Examination Committee develop an implementation plan for presentation to the next Annual Delegate Assembly Meeting in 1988.

Submitted by the Utah Board of Nursing

Will this proposal generate revenue? *NO.* Please describe below:

_____

_____

_____

EXPENSES

1. Does this proposal require a committee? *YES - referral to both the Examination Committee and the Administration of Examination Committee.*

   How many members are anticipated including the chairperson? _____

   How often would the committee meet? *Only for regularly scheduled meetings - no additional required.*

2. How many mailings would this proposal require? *None.*

   To whom? _____

_____

3. Printing (surveys, special reports, etc.) Please describe:

None.

4. Other than committee meetings, is travel required? *NO.*

   Please describe: _____

_____

_____

5. What type of consultation is required (i.e., legal, computer, etc.)?

None.

6. Staff time required (preparation time, travel time, research presentations) - number of hours (estimated) *Minimal.*

7. Projected beginning date: *FY 88*

   Projected completion date: *June 1988*

FISCAL IMPACT - SUMMARY

EXPENSES

1. Committee Meetings *No additional meetings required.*

   $500 per member per meeting (Travel) = $_____

   $150 per day per member = $_____

2. Mailings
   $0.25 per letter = $_____, or

   $2.00 per 9 x 12 manila envelope (First Class) = $_____

3. Surveys (Printing)

   $0.05 per page = $_____

4. Other Travel (including staff)

   $500 per person per meeting (Travel) = $_____

   $150 per day per member (Expenses) = $_____

5. Consultation

   $125 per day = $_____

6. Other Printing

   $0.05 per page = $_____

Subtotal Expenses: $ *None.*

Subtotal Revenue: $ *None.*

Net: $_____