Annual Meeting
August 4-7, 1993
The Hilton at Walt Disney World® Village
Orlando, Florida

1993 Book of Reports

Copyright 1993

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

Table of Contents

Tab 1: 1993 Annual Meeting Schedule

1993 Annual Meeting Schedule 1
Hotel Floor Plan 2

Tab 2: Business Agenda/Rules/1993 Recommendations

Business Agenda of the 1993 Delegate Assembly 1
Standing Rules of the Delegate Assembly 3
Summary of Recommendations to the 1993 Delegate Assembly 5

Tab 3: Committee on Nominations

Report of the Committee on Nominations 1

Tab 4: Officer Reports

Report of the President 1
Report of the Vice President 3
Report of the Secretary 4
Report of the Treasurer 5
Report of the Independent Auditors 6
- Balance Sheets 7
- Statements of Revenue and Expense 8
- Statements of Changes in Fund Balance 9
- Statements of Cash Flows 10
- Notes to Financial Statements 11

Report of the Area I Director 13
Report of the Area II Director 14
Report of the Area III Director 15
Report of the Area IV Director 16
Report of the Director-at-Large 17

Tab 5: Report of the Executive Director

Report of the Executive Director 1
1992-93 National Council Staff 4

Tab 6: Report of Board of Directors

Report of the Board of Directors 1
- Attachment A: Draft Readiness ("Go/No Go") Criteria 7
- Attachment B: Report on Nurse Aide Disciplinary Data Bank Feasibility Study 13

Tab 7: Role Delineation Study Report

Report of the Role Delineation Study 1

Tab 8: Long Range Planning Committee

Report of the Long Range Planning Committee 1
- Attachment A: Methodology and Description of Data 3
- Attachment B: Survey Data 5
- Attachment C: Rank Ordering of Importance of Objectives 9
- Attachment D: Percentage of Points Allotted to Objectives Within Each Goal 13

Tab 9: CST Steering Committee

Report of the Steering Committee, Computerized Clinical Simulation Testing Project 1
Attachment A: CST Project Budget (FY94-FY98) 5

Tab 10: Foreign Educated Nurse Credentialing Committee

Report of the Foreign Educated Nurse Credentialing Committee 1

Tab 11: Nurse Information System Committee

Report of the Nurse Information System (NIS) Committee 1
Attachment A: Questions and Answers on the Nurse Information System 5

Tab 12: NACEP Committee

Report of the Nurse Aide Competency Evaluation Program (NACEP) Committee 1
Attachment A: 1993 User Survey—Cumulative Results 3
Attachment B: Comparison of Cumulative Results 5

Tab 13: NACEP Test Service

Annual Report of the NACEP Test Service 1
Attachment A: NACEP Written/Oral Evaluation 3
Attachment B: NACEP Manual Skills 5

Tab 14: NCLEX Test Services

Annual Report of the NCLEX Test Service (CTB) 1992-1993 1
Annual Report of the NCLEX Data Center 13
Annual Report of Educational Testing Service (ETS) and Sylvan/KEE Systems (SKS) 15

Tab 15: Administration of Examination Committee

Report of the Administration of Examination Committee 1
Attachment A: Policy for Member Board Review of Newly Developed NCLEX Items or Computer Simulated Examinations 5
Attachment B: Summary of Effect of Increase in Testing Time 9
Attachment C: Security Measures for NCLEX-CAT 11
Glossary of Terms 15

Tab 16: Examination Committee/CAT-PN Field Test Team

Report of the Examination Committee—Team 1 1
Report of the Examination Committee—Team 2 (CAT) 5
Report of the CAT-PN Field Test Team 9
Attachment A: A Psychometric Comparison of Computerized Adaptive and Paper-and-Pencil Versions of the National Practical Nurse Licensure Examination 23

Tab 17: Bylaws Committee

Report of the Bylaws Committee 1

Tab 18: Communications Committee

Report of the Communications Committee 1
Attachment A: Certification Program Survey Instrument & Statistical Data 5
Attachment B: Fiscal Impact Summary Sheet for Recommendation #1 9
Attachment C: Fiscal Impact Summary Sheet for Recommendation #2 11
Attachment D: National Council's Crisis Communication Plan 13

Tab 19: Finance Committee
Report of the Finance Committee 1

Tab 20: Nursing Practice and Education Committee and Subcommittees
Report of the Nursing Practice and Education Committee and Subcommittees 1
Attachment A: Revised *Model Nursing Practice Act* 5
Attachment B: Draft Concept Paper—Competence Paradigm Shift 7
Report of the Subcommittee to study the Regulation of Advanced Nursing Practice 9
Attachment A: A Position Paper on the Regulation of Advanced Nursing Practice 11
Attachment B: Model Legislative Changes for Advanced Nursing Practice 19
Attachment C: Model Nursing Administrative Rules for Advanced Nursing Practice 21
Report of the Subcommittee to Study Regulatory Models for Chemically Dependent Nurses 23

Tab 21: Resolutions Committee/New Business
Report of the Resolutions Committee/New Business 1

Tab 22: Summary of 1992 Delegate Assembly Actions
Summary of 1992 Delegate Assembly Action and Subsequent Implementation 1

Tab 23: FY93 Organization Plan and Budget
National Council Organization Plan 1
FY93 Budget by Program 13

Tab 24: Orientation Manual
Orientation Manual 1

Tab 25: Glossary
Glossary 1

1

1993 ANNUAL MEETING
SCHEDULE

2

BUSINESS AGENDA
RULES
1993 RECOMMENDATIONS

Business Agenda of the 1993 Delegate Assembly

Thursday, August 5
10:45 am-11:45 am

	Resource Materials and Forums
■ Opening Ceremonies	Orientation, Thursday, 8:00 – 9:00 am
• Introductions	
• Announcements	
■ Opening Reports	
• Registration Committee	
• Rules Committee	Tab 2
• Adoption of Agenda	Tab 2
■ Report of the Committee on Nominations	
• Slate of Candidates	Tab 3
• Nominations from Floor	
■ President's Address	

Friday, August 6
7:30 am–8:30 am

■ Election of Officers & Committee on Nominations	Tab 3 Candidates' Forum, Thursday, 7:30 – 8:30 pm

Friday, August 6
2:00 pm–5:30 pm

■ Officers' Reports	Tab 4
• Treasurer's Report—Audit	Tab 4, page 6
■ Executive Director's Report	Tab 5
■ Board of Directors' Report	Tab 6 Board of Directors' Forum, Thursday, 1:00 – 2:30 pm
■ Long Range Planning Committee Report	Tab 8
■ CST Steering Committee Report	Tab 9 CST Forum, Thursday, 2:30 – 3:30 pm
■ Foreign Educated Nurse Credentialing Committee Report	Tab 10
■ Nurse Information System Committee Report	Tab 11
■ Nurse Aide Competency Evaluation Program Committee Report	Tab 12

Friday, August 6 *(continued)*
2:00 pm–5:30 pm

Resource Materials and Forums

- NACEP Test Service Report .... Tab 13

- NCLEX Test Services
  - CTB .... Tab 14
  - ETS/SKS .... Tab 14

Saturday, August 7
9:00 am–11:30 am

- Administration of Examination Committee Report .... Tab 15

- Examination Committee Report
  - Team 1 .... Tab 16, page 1
    Examination Committee Forum,
    Saturday, 8:00 – 8:30 am

  - Team 2 .... Tab 16, page 5
    CAT Forum,
    Friday, 8:30 – 10:15 am

- Bylaws Committee Report .... Tab 17
  Bylaws Committee Forum,
  Thursday, 3:45 – 4:30 pm

- Communications Committee Report .... Tab 18

- Finance Committee Report .... Tab 19
  Finance Committee Forum,
  Thursday, 4:30 – 5:00 pm

Saturday, August 7
2:30 pm–5:00 pm

- Nursing Practice and Education Committee Report & Subcommittees
  - Nursing Practice & Education Committee .... Tab 20, page 1
    NP&E Committee Forum,
    Thursday, 5:00 – 5:30 pm

  - Subcommittee to Study the Regulation of Advanced Nursing Practice .... Tab 20, page 9
    Advanced Nursing Practice Forum,
    Friday, 10:30 – 11:30 am

  - Subcommittee to Study Regulatory Models for Chemically Dependent Nurses .... Tab 20, page 23

- New Business
  - Resolutions Committee Report .... Tab 21
    Resolutions Forum,
    Friday, 11:30 am – 12:30 pm

- Adjournment

Standing Rules of the Delegate Assembly

1. Procedures

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

B. Upon registration:
   1. Each delegate and alternate shall receive a badge which must be worn at all meetings.
   2. Each delegate shall receive a voting card: a white voting card designates one vote, a pink voting card designates two votes. Any change in voting cards must be made through the Registration Committee.

C. A member registered as an alternate may, upon proper clearance of the Registration Committee, be transferred from alternate to delegate.

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

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

2. Motions

A. All new business, except motions proposed by the Board of Directors or as recommendations made in reports of officers or committees, shall be referred without debate to the Resolutions Committee; motions proposed by the Board of Directors or by officers or committees shall be presented by the Board or proposing officer or committee directly to the Delegate Assembly. The Delegate Assembly by a majority vote may suspend this rule and immediately consider a question.

B. Motions and recommendations shall be presented to the Resolutions Committee by 12:00 noon on Thursday, August 5, 1993.

C. The Resolutions Committee shall prepare suitable motions to carry into effect recommendations referred to it, and shall submit to the Delegate Assembly, with the committee's own recommendation as to appropriate action accompanied by a fiscal impact statement, these and all other motions referred to the committee.

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

3. Debate

A. Any representative of a Member Board wishing to speak shall go to the appropriate microphone. For this purpose, specific microphones shall be designated to be used when speaking in the affirmative on the motion on the floor and the others for speaking in the negative.

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

C. Debate shall be alternated between the affirmative and negative microphones.

D. No delegate or board member shall speak in debate more than twice on the same question on the same day, or longer than two minutes per speech, without permission of the assembly granted by a majority vote without debate. Other representatives of Member Boards may speak only after all delegates and board members who wish to speak on the motion have spoken. Guests may speak upon recognition by the chair. The two minute time allowance applies to all speakers.

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

F. A timekeeper will signal when allotted time has expired.

4. Nominations and Elections

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

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

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

D. Election for officers and members of the Committee on Nominations shall be held Friday, August 6, 1993, from 7:30 a.m.-8:30 a.m.

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

Summary of Recommendations to the 1993 Delegate Assembly

To provide an overview, the recommendations to be presented to the 1993 Delegate Assembly for consideration are listed below. These recommendations were received by May 7, 1993, the deadline for publication in the 1993 *Book of Reports*. Additional recommendations may be considered during the 1993 Annual Meeting.

Committee on Nominations

1. Adoption of the 1993 Slate of Candidates.

Treasurer

1. The auditor's report for October 1, 1991, through September 30, 1992, be approved as presented.

Board of Directors

1. The Readiness Criteria for computerized adaptive testing (CAT) implementation be adopted.

2. The National Council not establish a disciplinary data bank for nurse aides at this time.

Administration of Examination Committee

1. That the Delegate Assembly approve the following policy for Member board Review of Newly Developed NCLEX Items or Simulated Computerized Adaptive Examinations: *It is the policy of the National Council to cooperate with Member Boards in providing appropriate opportunities for their review of newly developed NCLEX items or simulated computerized adaptive examinations. The National Council will do so by developing procedures which ensure that the review of the material will be under conditions which do not adversely affect the security of the test items.*

Communications Committee

1. That the Board of Directors determine the methodology to implement educational programs for nursing education program surveyors that best meets the needs of the membership within National Council's Organization Plan.

2. That the Board of Directors determine the methodology to implement educational programs for discipline investigators that best meets the needs of the membership within National Council's Organization Plan.

Nursing Practice and Education Committee

1. That the Delegate Assembly adopt the revised *Model Nursing Practice Act.*

Subcommittee to Study the Regulation of Advanced Nursing Practice

1. That the Delegate Assembly adopt the Position Paper on the Regulation of Advanced Nursing Practice.

2. That the Delegate Assembly adopt the Model Legislative Language and Model Administrative Rules for Advanced Nursing Practice, to be incorporated into the existing *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

3

COMMITTEE ON NOMINATIONS

Report of the Committee on Nominations

Committee Members
Doris Nuttelman, NH, Area IV, *Chair*
Judy Colligan, OR, Area I
Linda Murphey, AR, Area III
Nancy Smart, IL, Area II

Relationship to Organization Plan
Goal V .... Implement an organizational structure that uses human and fiscal resources efficiently.

Objective C .... Maintain a system of governance that facilitates leadership and decision making.

Recommendation(s)
No recommendations.

Highlights of Activities

- **Dissemination of Call for Nominations**

  An activity under Tactic 4 of Objective C states, *"Analyze the process of recruiting qualified candidates for election and make recommendation(s) as deemed appropriate."* To respond to this, and in acknowledgment of the 1992 Delegate Assembly's expressed wish that the Committee on Nominations seek increased board member participation in National Council activities, the committee requested that executive directors of the Member Boards furnish the mailing addresses of their board members. The committee then sent a Call for Nominations directly to each board member for which an address had been provided. The Call for Nominations was also distributed via five National Council *Newsletters,* and a sufficient supply was provided to Member Boards for distribution. In order to perpetuate this effective endeavor in future years, executive directors of the Member Boards were requested to provide updated mailing list information as it became available.

  Recognizing, from the number of board member nominations received, the positive impact of this direct-distribution of the Call for Nominations, the committee expresses its gratitude to the Member Boards for their efficient and enthusiastic response to this request.

- **Bylaws**

  As requested by the Bylaws Committee, the Committee on Nominations reviewed and discussed its duties as stated in the current bylaws in order to prepare recommendations for revisions. The Committee on Nominations submitted recommendations for bylaw revisions to the Bylaws Committee.

Meeting Dates
- October 10-11, 1992
- December 15, 1992, *telephone conference*
- January 12, 1993, *telephone conference*
- March 4, 1993, *telephone conference*
- March 19, 1993, *telephone conference*

Recommendation(s)
No recommendations.

Staff
Christopher T. Handzlik, *Editor*
Susan Woodward, *Director of Communications*

Slate of Candidates

An overview of the slate developed and adopted by the Committee on Nominations follows. More-detailed information on each nominee is provided in the subsequent pages of this report. This detailed information is taken directly from the nomination forms. Each nominee on the slate will have an opportunity to expand on this information during the Candidates' Forum, scheduled to be held Thursday, August 5, 1993, from 7:30 - 8:30 p.m.

Secretary

Timothy McBrady .... Maine .... Area IV
Jo Elizabeth Ridenour .... Arizona .... Area I
Cindy VanWingerden .... Virgin Islands.................. Area IV

Treasurer

Kathleen Bellinger............. Kentucky .... Area III
Nancy Breen .... Florida .... Area III
Charlene Kelly................ Nebraska .... Area II

Area I Director

Patricia Krumm .... Oregon .... Area I
Fran Roberts.................. Arizona .... Area I

Area III Director

Nancy Durrett .... Virginia .... Area III
Sulinda Moffett .... Oklahoma.................... Area III

Committee on Nominations

<u>Area I</u>

Teresa Bello-Jones............. California-VN .... Area I
Judy Colligan................. Oregon .... Area I

<u>Area II</u>

Barbara McClaskey .... Kansas .... Area II
Barbara Staab................. Illinois .... Area II

<u>Area III</u>

Amy Cox .... Georgia-PN .... Area III
Gregory Howard .... Alabama..................... Area III

<u>Area IV</u>

Iva Boardman................. Delaware .... Area IV
Marilyn Horan .... Rhode Island .... Area IV

Detailed Information, as taken directly from nomination forms and organized as follows:

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Present employer
4. Educational preparation
5. Offices held or committee membership, including National Council activity
6. Professional organizations
7. Personal statement

Secretary

1. **Timothy McBrady, Maine, Area IV**

2. Member, Maine State Board of Nursing

3. Serenity House, Portland, ME

4. University of Maine at Augusta, Chemical Dependency Counseling, Current
   University of Southern Maine, Liberal Arts, 1980-1981
   Southern Maine Vocational Technical College, Diploma, Practical Nursing, 1978

5. National Council
   - Bylaws Committee, 1988-Present

   Maine State Board of Nursing
   - Secretary, 1986-Present

   Maine Licensed Practical Nurses' Association
   - President, 1982-1985

   National Federation of Licensed Practical Nurses, Inc.
   - Various committees, 1978-Present

   Maine State Nurses' Association
   - Task Force on Entry into Practice, Subcommittee Chair, Educational Mobility & Waiver Provisions, 1984 - 1985

6. National Federation of Licensed Practical Nurses
   Maine Licensed Practical Nurse Association

7. It is an honor and a privilege to serve the Council as a member of the Bylaws Committee. During the 1991 Delegate Assembly, I had the unexpected opportunity to conduct the Bylaws Forum in the absence of the Chair. That particular experience, as well as my attendance at several annual and area meetings, has provided me with direct knowledge of the Council's role and functions. In addition, I gained invaluable organizational experience during my tenure as president of the Maine State Licensed Practical Nurse Association.

   The many complex issues facing the Council today such as the regulation of unlicensed assistive personnel, as well as current trends impacting on practical nursing, can best be addressed in an atmosphere of openness and trust. If elected, I promise to keep an open mind and to never lose my sense of humor.

Secretary

1. **Jo Elizabeth Ridenour, Arizona, Area I**

2. Member, Arizona State Board of Nursing

3. Maricopa Medical Center, Phoenix, AZ

4. University of Phoenix, MSN, 1993
   Arizona State University, BSN, 1969

5. Arizona State Board of Nursing
   - Legislative Committee, Chairperson, 1992-Present
   - President, 1986-1989
   - Scope of Practice, 1987-1988

   Arizona Department of Health Services
   - Statewide Trauma, Chairperson, 1992-Present

Quality Management Network
Harvard Community Medicine Project, Task Force, 1990-Present
Wharton/Johnson & Johnson Nurse Executive Project, Fellow, 1989

6. Arizona Organization of Nurse Executives
American Organization of Nurse Executives
Sigma Theta Tau

7. Qualities and Skills: 24 years of demonstrated competence in various leadership roles as a nurse executive and past President of the Arizona State Board of Nursing. Effective group member and builds cooperative efforts between groups.

Contributions to National Council's goals and objectives: Goal II - Promote changes in public policy through results in restructuring of the health care system for more effective utilization of advanced practice nurses thus fulfilling the mandate to protect the public.

Priorities of the Council: Provide guidance to reduce restrictions that constrain advanced practice nurses. Eliminating restrictions would increase the public's access to health care while preserving quality and reducing costs.

Secretary

1. **Cindy VanWingerden, Virgin Islands, Area IV**

2. Chair, Education Committee, Virgin Islands Board of Nursing

3. Virgin Islands Government, Department of Ed./Voc. Ed.

4. University of Miami, MS, 1989
Boston University, BSN, 1973

5. National Council
Foreign Educated Nurse Credentialing Committee, Chair, 1991-Present
Foreign Nurse Issues Committee, Member, 1990-1991
Virgin Islands Board of Nursing
Education Committee, Chair, 1989-Present
Virgin Islands Nurse Action Council
Board of Directors, Secretary, 1991-Present
Nurse Practice Act Review Committee, Member, 1991-Present
American Cancer Society
Professional Education Committee, Chair, 1988-90
Board of Directors, Secretary, 1986-Present

6. Virgin Islands Nurse Action Council
National Association for Practical Nurse Education and Service
Beta Sigma Nu, Virgin Islands nurses honor society
National Association of Parish Nurses

7. Committee work with the National Council has been rewarding, and I feel that serving as Secretary on the Board of Directors would utilize the variety of skills I have developed over the last 20 years of professional nursing. In addition to being a PN educator and administrator, I have served as committee member, committee chair, and officer of the Board of Directors for a variety of organizations. I enjoy the group process, working through ideas and discussing options toward achieving specified goals. Over the next two years, I visualize the National Council exploring the ramifications of CAT on jurisdictions, the impact of economics in general on boards of nursing, the expanding issues of advanced practice, the continuing need for the disciplinary data bank, and the challenges presented by foreign-educated nurse credentialing.

Treasurer

1. **Kathleen Bellinger, Kentucky, Area III**

2. Member, Kentucky Board of Nursing

3. SpectraCare, Louisville, KY

4. State University New York-Albany, Ed.D., 1980
Russell Sage College, MS, 1971
Russell Sage College, BSN, 1969

5. National Council
    Committee to Approve Minutes, Member, 1992
    Diagnostic Assessment Committee, Chair, 1985-1986
    Diagnostic Assessment Committee, Member, 1983-1985
    Delegate, 1983 and 1984; Alternate Delegate, 1992
American Academy of Pain Management
    Board of Advisors, Member, 1989-Present
    Board of Advisors, First Co-Chair, 1989-1990
Kentucky Board of Nursing
    President, 1983-1985
    Finance Committee, Chair, 1982-1985

6. American Academy of Nursing
American Academy of Pain Management
American Society of Pain Management Nurses
Kentucky Nurses' Association (District #1)
National League for Nursing
Kentucky League for Nursing
Sigma Theta Tau

7. To some, Total Quality Management (TQM) and Continuous Quality Improvement (CQI) are only buzz words for the 1990s, but to the National Council, they reflect a commitment to quality outcomes through assessment, accountability and planned change. As a member of a Member Board, I share that commitment. The Treasurer plays a pivotal position in the quality structure, processes and outcomes. With a doctorate in Program Evaluation and a successful history in financial as well as Total Quality Management, I have the requisite skills and experience to serve the National Council for the two-year remainder of my current term on the Kentucky Board of Nursing. Empower me to serve by selecting (nominating and electing) me Treasurer of the National Council.

Treasurer

1. **Nancy Breen, Florida, Area III**

2. Vice Chairman, Florida Board of Nursing

3. Lakeland Regional Medical Center, Lakeland, FL

4. University of South Florida, Nursing, 1978-1980
Crawford W. Long Hospital of Emory University, Diploma, 1964
University of Tennessee, Business Administration, 1959-1961

5. Florida Nurses' Association
    Nominating Committee, Chair, 1986-1989
    President, 1983-1985
    President-Elect, 1981-1983

American Nurses' Association
Nominating Committee, Chair, 1985-1986
Florida Practitioners in Infection Control
Bylaws Committee, Member, 1984-1985

6. American Nurses' Association
Florida Nurses' Association
Florida Student Nurses' Association

7. The issues facing the National Council require creative leadership approaches to meet Member Board needs. The Treasurer must assume a leadership role in fiscal planning and monitoring to assure the resources are available to achieve the Council's goals. Being practical and innovative, yet futuristic in my approach to situations would contribute to a more cost-effective organization. I believe my experience in leadership roles, administering budgets exceeding one million dollars and presently serving as the budget liaison between the Florida Board of Nursing and the Department of Professional Regulation provides me with the knowledge and skills to assist the National Council in meeting its objectives.

I believe the issues and/or priorities for the National Council to address within the next two years should include the implementation of computerized adaptive testing, expanding the communication network to increase the speed and accuracy of information sharing, as well as responding to the Member Boards' needs.

Treasurer

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

2. Executive Secretary, Nebraska Board of Nursing
Associate Director, Nebraska Bureau of Examining Boards

3. State of Nebraska, Department of Health

4. University of Nebraska, PhD, 1986
University of Nebraska, MSN, 1976
University of Nebraska, BSN, 1971

5. National Council
Finance Committee, 1990-Present
Committee to Review Minutes of Delegate Assembly, 1992
Resolutions Committee, 1991 and 1992
Elections Committee, 1990
Communications Committee, 1989-1990

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

7. As a Finance Committee member for three years, I have come to realize that the Treasurer of National Council must have the ability to think conceptually without losing sight of details. I believe I have those skills. As Associate Director for the Bureau of Examining Boards in Nebraska, I am responsible for the licensure and regulation of six professions - nursing, dentistry, chiropractic, optometry, podiatry, and veterinary medicine. Keeping six professions in perspective certainly requires conceptualization. In a small state with a small staff, I also attend to details on a daily basis.

Increase in staffing, technological advances and the development of financial policies to guide decision-making have moved the Finance Committee into a position to begin looking conceptually at the National Council's resources. The Finance Committee needs to examine requests in light of the mission and long range plan of the Council and develop financial strategies that reflect that mission.

Area I Director

1. **Patricia Krumm, Oregon, Area I**

2. Board Secretary, Oregon State Board of Nursing

3. Clackamas Community College, Oregon City, OR

4. Oregon Health Sciences University, MN, 1982
   University of Oregon Medical School, BSN, 1964

5. National Council
      Delegate, 1992
   Oregon State Board of Nursing
      LPN/RN IV Therapy, Chair, Present
      Licensure Task Forces, Present
      Advanced Practice Committee, Present
      CMA Task Forces, Present
   Oregon Health Sciences University, School of Nursing
      Statewide RN/BSN Articulation Task Force, Member, Present
   Oregon Council of Associate Degree Nursing Programs
      Executive Committee/Immediate Past President, Present
   Oregon Nurses' Association
      President of Foundation, 1990-Present
      Cabinet on Health Policy, 1989-1992
      Board of Directors, 1984-1988
      President, District 26, 1983-1984
      Convention Delegate, 10 Years, Various
   American Nurses' Association
      Delegate, Various Years, 1978-1988

6. American Nurses' Association
   Oregon Nurses' Association
   Oregon Council of Associate Degree Nursing Program
   Sigma Theta Tau, Beta Psi Chapter
   Oregon Education Association/National Education Association

7. I will bring the perspective of a current Member Board member to the National Council, as well as the perspective of nursing education and advanced practice. My participation on the Oregon Board has given me a tremendous appreciation for the value of involvement at the National Council level. I am interested in pursuing increased participation by Member Board members, and have a strong interest in issues surrounding licensure examination/CAT, advanced practice, the nursing information system, and unlicensed personnel. In Oregon, as elsewhere, the issues of advanced practice and unlicensed personnel are under continual scrutiny. It is my desire to address these and other issues at the National Council representing Area I as Director. My background in education and in direct practice, my organizational involvement, and my role as Secretary of the Oregon Board have provided me with the background necessary to become an effective Area I Director.

Area I Director

1. **Fran Roberts, Arizona, Area I**

2. Executive Director, Arizona State Board of Nursing

3. Arizona State Board of Nursing

4. University of Colorado, PhD, 1992
   Arizona State University, MS, 1981
   Elmhurst College, BSN, 1976

5. National Council
   - Area I Director, 1992-Present
   - NACEP Committee, 1989-1992

   Arizona State Board of Nursing
   - Vice-President, 1985-1987

   Arizona State University
   - Adjunct Faculty, Colleges of Nursing and Social Work

   Arizona Nurses' Association
   - Council on Gerontological Nursing, Chair

6. Valley Leadership Association
   Alzheimer's Disease Association, Professional Advisory Board
   Hospice of the Valley, Board of Directors
   Sigma Theta Tau

7. Having just completed my first year as Area I Director, I would like to have the opportunity to continue in a leadership role for both the Area I boards of nursing and for the National Council's Board of Directors, by being elected to a full two-year term of office. Feeling somewhat "over the curve" on learning the inner workings of the National Council, I believe I will only improve in representing Area I concerns and being an effective change catalyst for the National Council. My priorities, if re-elected as Area I Director, will continue to be set by Area I constituent Member Boards and by my own commitment to licensure and regulation of the nursing profession, which includes advanced nursing practice, registered nursing, licensed practical nursing, and the delivery of care by nursing assistants.

Area III Director

1. **Nancy Durrett, Virginia, Area III**

2. Assistant Executive Director, Virginia Board of Nursing

3. Virginia Board of Nursing

4. Virginia Commonwealth University, MSN, 1972
   Medical College of Virginia, BSN, 1958

5. National Council
   - Long Range Planning Committee, 1989-Present

   Virginia Nurses' Association
   - Consumer Advisory Committee, Chair, 1985-1988

   Ginter Park Junior Women's Club
   - Board of Directors, President, Vice-President

6. American Nurses' Association
   Virginia Nurses' Association
   Sigma Theta Tau

7. Serving as a member of the Long Range Planning Committee since 1989 has given me the opportunity to learn about the structure, purpose, and operation of the National Council, thus building a foundation for continued involvement as the Area III Director. My participation in the collection of data on the trends and issues which the membership feels will

impact the organization has helped me to understand where the organization should put its emphasis in the coming years. Member Boards gave high priority to the need for the National Council to serve as a clearinghouse for information, and I believe the organization must be responsive to this.

As a member of the Board of Directors, I would work to meet the many challenges of the decade ahead and would be honored to serve as the Area III Director.

Area III Director

1. **Sulinda Moffett, Oklahoma, Area III**

2. Executive Director, Oklahoma Board of Nursing
3. Oklahoma Board of Nursing

4. West Texas State University, MSN, 1983
   Oklahoma City University, M.Ed., 1972
   Texas Christian University, BSN, 1962

5. National Council
   Resolutions Committee, Chair, 1991
   Resolutions Committee, 1989-1991

6. Oklahoma Nurses' Association
   American Nurses' Association
   Sigma Theta Tau

7. My ten years of Board of Nursing staff experience have provided an understanding of nursing regulation and the mission of the National Council, as well as the issues currently confronting state boards of nursing.

   I believe the major priorities are a smooth transition to CAT and continued effective protection of the public's health and welfare in this era of budget constraints, decreasing or unevenly distributed resources and innovative methods of health care delivery.

   I will bring to this position commitment, enthusiasm, experience and proven leadership competencies. It would be an honor and privilege to serve as Area III Director.

Committee on Nominations

Area I

1. **Teresa Bello-Jones, California-VN, Area I**

2. Supervising Nursing Education Consultant, California Board of Vocational Nurse and Psychiatric Technician Examiners

3. California Board of Vocational Nurse and Psychiatric Technician Examiners

4. Golden Gate University, JD, 1980
   University of California-San Francisco, MSN, 1971
   California State University at San Jose, BSN, 1968

5.

6. Sigma Theta Tau - Alpha Eta Chapter

7. My academic and professional experiences provide me with numerous opportunities to utilize my analytical, organizational, interpersonal and problem-solving skills. Now, I would like an opportunity to put these skills to work for the National Council. Three years of attending the Delegate Assembly (as a delegate) increased my awareness of the enormity of the issues the National Council faces (successful implementation of CAT, decreased and limited resources of Member Boards, changing demographics, etc.) and the need for energetic participation of members. The Committee on Nominations seeks out individuals who have a commitment to and the capability for carrying out the goals of the National Council. I would like to add my energetic and enthusiastic efforts to this process.

Area I

1. **Judy Colligan, Oregon, Area I**

2. Board President, Oregon State Board of Nursing

3. Good Samaritan Hospital & Medical Center, Portland, OR

4. University of Washington, Health Care Ethics Certificate Program, 1992-Present
   Family Studies Institute, Advanced Family Therapy Certificate Program, 1989-Present
   Portland State University, MPA, 1990
   Oregon Health Sciences University, MN, 1984
   University of Oregon, BSN, 1975

5. National Council
   Committee on Nominations, 1992-1993
   Subcommittee to Study the Regulation of Advanced Nursing Practice, 1990-Present
   Oregon State Board of Nursing
   Board President, Present
   Nurse Practitioner Prescriptive Authority Council, Chair, Present
   Nurse Monitoring Committee, Chair, Present
   Advanced Practice Committee, Chair, Present
   Good Samaritan Hospital and Medical Center, Institutional Ethics Committee
   Subcommittee on Education, Chair, Present
   Washington Consulting Group, United States Government Task Force on Advanced Practice, Present

6. American Nurses' Association
   Council of Psychiatric-Mental Health Nursing (ANA)
   Oregon Nurses' Association
   Nurse Practitioners of Oregon (ONA)
   Oregon Council of Clinical Nurse Specialists
   OHSU Nursing Alumni Association
   Psychiatric Clinical Liaison Nurses
   Sigma Theta Tau - Beta Phi

7. I have been an active member of my profession for over twenty years in multiple clinical areas which have included both the private and public sectors of health care. Recent experience in legislation, regulatory and advanced practice issues has broadened my background in nursing.

   I have participated in National Council activities as a delegate to the 1991 and 1992 Delegate Assemblies as President of the Oregon State Board of Nursing, and as a member of the National Council Subcommittee to Study the Regulation of Advanced Nursing Practice and the Committee on Nominations. Three issues which should be priorities for National Council are: the transition to computerized nursing exams; issues related to advanced nursing practice regulations; and the ongoing efforts of the National Council to support participation by appointed board members.

   I feel my background and eclectic practice would allow me to continue to be an active participant on the Committee on Nominations.

<u>Area II</u>

1. **Barbara McClaskey, Kansas, Area II**

2. Secretary, Kansas State Board of Nursing

3. Pittsburg State University, Pittsburg, KS

4. University of Kansas, MSN, 1981
   Pittsburg State University, MS, 1972
   Pittsburg State University, BS, 1951
   Mt. Carmel Hospital, School of Nursing, Diploma, 1947

5. Kansas State Nurses' Association
      Finance Committee, 1988-1989
      Board of Directors, 1981-1987
      Editorial Board, 1985-1987
      Council on Education, 1984-1986
      Economic and General Welfare Committee, 1986-1988
   Sigma Theta Tau, Gamma Upsilon Chapter
      President, 1992-1994
      Advisor, 1989-1991; 1985-1987
   Kansas State Nurses' Association, District 20
      Nominating Committee, 1986-1987
      President, 1982-1984; 1978-1980
      Parent-Child Conference Group, President, 1979-1981
   St. John's Medical Center
      Board of Directors, 1992-1995

6. Kansas State Nurses' Association
   Sigma Theta Tau
   Delta Kappa Gamma
   Perinatal Association of Kansas

7. It is essential that Committee on Nominations members recognize the responsibilities of the offices of the National Council and the criteria to be utilized in selecting nominees. I believe my professional background, activities in numerous organizations and committee participation have provided me with the necessary skills to contribute to the attainment of the committee goals. A positive reputation for working effectively on committees has been developed as I can express myself while listening to and considering the beliefs of others.

   I would contribute to the goals and objectives of the National Council by selecting candidates who best meet the criteria for each office and have the ability to facilitate the purposes of the organization.

   An obvious priority of the Council is the implementation of CAT while maintaining standards and fiscal responsibility. Specificity on other priorities is difficult as the Council must maintain flexibility as health care issues change.

<u>Area II</u>

1. **Barbara Staab, Illinois, Area II**

2. Member, Committee on Nursing, Illinois Department of Professional Regulation

3. Southern Illinois University School of Medicine, Belleville, IL

4. University of Illinois, MS, 1988
   Washburn University, BSN, 1979

5. Illinois Nurses' Association
   Public Relations Committee, District 10, Chair, 1992-Present
   Illinois Interdivisional Council of Nurse Practitioners
   Secretary, South Region, 1991-1993
   University of Illinois Family Nurse Practitioner Program
   Advisory Committee, Member, 1992-Present

6. American Nurses' Association
   Illinois Nurses' Association
   Illinois Nurses' Association's Interdivisional Council of Nurse Practitioners
   Sigma Theta Tau
   Society of Teachers of Family Medicine

7. I have served in both leadership and supporting capacities on many organizational committees throughout my 14-year nursing career. I am experienced in committee work, reliable, and self-motivating. My experience, which is varied, will enable me to contribute to National Council's goals attainment. One of the priority issues I see before the National Council currently is advanced practice issues, including the question of second licensure.

<u>Area III</u>

1. **Amy Cox, Georgia-PN, Area III**

2. Member, Georgia State Board of Licensed Practical Nurses

3. Community Home Nursing Care, Cartersville, GA

4. West Georgia College, 1991
   Morris County School of Practical Nursing, Diploma, Practical Nursing, 1977
   Dover High School, 1975

5. Georgia Board of Examiners
   Board Member, 1992-1995
   American Heart Association
   Education Chair, 1993
   North Georgia Association for Continuity of Care
   Program Chair, 1993

6. North Georgia Association for Continuity of Care
   Toastmasters - CTM
   American Heart BCLS Instructor

7. Adequately preparing nursing programs and students across the country for computerized adaptive testing (CAT) is a priority for National Council in the immediate future. Approximately 170,000 graduates a year will sit for RN and LPN/VN exams at over 200 CAT test sites. Photographs and fingerprinting of candidates to provide security will be a major challenge. I believe National Council should address the issue that, while this organization represents all nursing boards, the LPN/VN does not appear to have a voice. No opposition was heard when Maine and Alaska, in effect, banished the LPN. America's health care crisis will not be resolved by losing the very nurses at the core of bedside nursing. An innovative point of view from a practical nurse perspective, and my enthusiasm and commitment will make me an asset to the Committee on Nominations.

<u>Area III</u>

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

2. Member, Alabama Board of Nursing

3. Tuscaloosa VA Medical Center, Tuscaloosa, AL

4. Shelton State Technical College, Diploma, Practical Nursing, 1982

5. Alabama Federation of Licensed Practical Nurses (State)
   Program Chair, 1986-1990
   Executive Board, 1987-1989
   Alabama Federation of Licensed Practical Nurses (Local)
   Treasurer, 1985-Present
   Nomination Committee, 1990-1991

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

7. As a nurse and board member, I am interested in the survival and advancement of our profession. I would like to be an influencing factor in making this happen. By selecting nominees with the collaboration from other nurses who share in the advancement of the National Council and its mission to the public, we can choose a strong slate. Our organization can only be as strong as its leaders. This is why the selection of the leaders is so important and why I would like to be a part of this process. My experience on the Board in the screening process of NCLEX item writers, scholarship candidates, Alabama Board of Nursing advisory panels, as well as the experience gained from my nursing organization (Alabama Federation of Licensed Practical Nurses), will assist me to serve you on the National Council's Committee on Nominations.

<u>Area IV</u>

1. **Iva Boardman, Delaware, Area IV**

2. Executive Director, Delaware Board of Nursing

3. Delaware Board of Nursing

4. Widener University, MSN, 1989
   Rutgers University, BSN, 1964
   Rutgers University, AS, 1962

5. National Council
   Subcommittee to Study the Regulation of Advanced Practice, 1991-Present
   Claymont Community Center
   Personnel, Chair, 1990-Present
   Nominating Committee, 1990
   Secretary, 1987 - 1988

6. American Nurses' Association
   Delaware Nurses' Association
   Delaware Organization of Nurse Executives

7. I have enjoyed multiple opportunities within the nursing profession through staff and administrative positions in acute care, home health care, and long term care, as well as experiences in education, quality assurance, and utilization review. This broad exposure has helped me develop a genuine appreciation for differences and the need to be flexible, open-minded, and above all, maintain a sense of humor. I have always enjoyed being a part of the action, and believe that I have the energy and commitment to contribute toward the achievement of the National Council's goals and objectives. National Council must continue to take the lead in the regulatory arena, while communicating openly within and outside of the organization.

<u>Area IV</u>

1. **Marilyn Horan, Rhode Island, Area IV**

2. Vice-President, Rhode Island Board of Nurse Registration and Nursing Education

3. St. Joseph Hospital, North Providence, RI

4. Providence College, M.Ed., 1981
   Rhode Island College, BS, 1976
   St. Joseph Hospital, School of Nursing, Diploma, 1964

5. Rhode Island Board of Nursing
   - Vice-President, 1992-Present
   - Proctor, Investigator, 1989-Present

   Rhode Island State Nurses' Association
   - Nominating Committee, 1986-1988
   - Board of Directors, 1968-1971

   Association of Women's Health Obstetric and Neonatal Nurses (AWHONN), formerly Nurses' Association of the American College of Obstetricians and Gynecologists (NAACOG)
   - Program Chair, 1980, 1982

   St. Joseph Hospital School of Nursing Alumni
   - President, 1983-1987
   - Vice-President, 1988-1991 and 1966-1968

   Dorcas Place, Child and Parent Literacy Program
   - Board of Directors, 1986-1988

6. American Nurses' Association
   National League for Nursing
   American Association for Legal Nurse Consultants
   AWHONN (Charter Member of NAACOG)
   Diocesan Council of Catholic Nurses
   St. Joseph Hospital, School of Nursing, Alumni Association

7. Throughout my 29 years of nursing, I have had experience in practice, education, administration, and legal consulting. All of these together with my four and one-half years of service on the Rhode Island Board of Nursing have given me the skills necessary to serve as an integral part of National Council. My interest was sparked soon after my board appointment, but now having served in a variety of roles as a member and officer, I feel I have much to contribute to the goals of the national organization in searching for the most qualified candidates for officers. I see two issues of top priority for the National Council in the next two years: perfecting NCLEX-CAT while researching CST for the near future, and continuing to work for funding for the NIS, so necessary for use by Member Boards in order to control the licensing of problem nurses.

4

OFFICER REPORTS

Report of the President

Rosa Lee Weinert, RN, MS, *President*
Executive Director, Ohio Board of Nursing

Welcome to the Fifteenth Annual Meeting of the National Council of State Boards of Nursing, Inc. On behalf of the Board of Directors, I extend to each of you an invitation to seek every opportunity to discuss with us individually or collectively any issue with which the National Council is currently involved or if you have any questions about decisions made by the Board during this past year. One of my goals in seeking the office of President was to carefully examine if the National Council was indeed fulfilling its mission in the most effective and efficient manner possible and if the organization is truly meeting the needs of its Member Boards. One way to evaluate the accomplishment of this goal is to solicit feedback from the Member Boards. Therefore, I ask you to accept my invitation to interact with the members of the Board and let us know, in your opinion, how you think we are doing. Constructive criticism is always welcome!

It has been both a privilege and an awesome responsibility serving as President of the National Council this past year. While I had been intimately involved in the National Council since 1982, I had not fully realized the scope and complexity of the multitude of concerns, issues, and functions of the National Council until this past year. Reading through the following pages of this *Book of Reports* will give you the outcome of a certain activity, but only a brief overview of the intense and thoughtful hours of deliberation that went into framing the outcome. Many hours were consumed and much energy was expended by numerous committee members and staff to carry out the actions taken by the 1992 Delegate Assembly, the ongoing decisions of the Board of Directors, and the multiple functions of the National Council as required in the bylaws. To all those who are involved in some way in the functioning of the National Council, I extend my sincere appreciation for your continued support and your dedicated commitment.

After assuming the office of President, one of my first responsibilities was to facilitate the coordination of five new members of the Board and four continuing members into a cohesive functioning group. I truly believe this has been accomplished. During the December 1992 Board meeting and again during the March 1993 meeting, the Board spent approximately eight hours in two very productive brainstorming sessions. The purpose of these sessions was to dissect the organization and closely examine each piece to determine if that particular piece was in fact structured in the most effective way to enhance a solid two-way communication system between all the pieces and if it was structured to facilitate goal accomplishment. Also during these sessions, the Board carefully looked at making a clear distinction between *governance* and *administration*, and agreed on a firm commitment to render to the Executive Director the responsibility for those functions that involve administration/management of the National Council's resources and to the Board the responsibility for the governance/policy-making decisions. In making this determination, the Board believes that while it has the legal power to set policy and take action, the volunteers and staff share in this power. All members of the Board participated freely in these sessions and the most rewarding outcome for me was to witness the emergence of a cohesive group.

Another outcome of the brainstorming sessions was the design of a vision statement for the National Council which is, *"The National Council will be the international authority and leader on the regulation of nursing."* I am sure you will agree with me that those 15 words truly comprise a very powerful statement and an ambitious goal to work toward. In developing this statement, the Board considered a variety of documents related to vision that had been suggested by the previous Board, committees, staff and attendees at the 1991 Fall Retreat. We believe that the National Council, made up of 62 boards of nursing, is making progress toward being recognized as the "national" authority on the regulation of nursing, hence the goal to intensify this leadership role in the years to come and to share our expertise worldwide. Most of the suggested vision statements that the Board examined included this international/global focus; thus, the Board capitalized on that futuristic expanded thinking.

In looking to the future, the National Council can enhance its effectiveness as a resource to those who regulate nursing by: providing leadership in developing public policy for nursing regulation; integrating access to information about nursing regulation using state-of-the-art communication technology; leading innovation for the evaluation of competence in nursing practice; marketing products and services internationally; and diversifying organizationally to provide a stable financial basis.

As to our short term goals, at each meeting the Board monitors the National Council's Organization Plan, which includes the five goals and 24 objectives approved by the 1992 Delegate Assembly and 82 tactics, developed by staff, committees and the Board, to accomplish the objectives. All activities performed to carry out the tactics are presented to the Board in a grid format, according to the four quarters of the year, and are carefully reviewed by the Board. The plan readily serves as a road map to keep the Board on target; it very effectively serves as a continuous evaluation tool and it will also serve as a valuable historical document of functions and activities of the National Council for years to come.

Without exception, the Board's top priority for this past year has been to do everything possible to provide for a smooth transition to Computerized Adaptive Testing (CAT) for NCLEX. Various deadlines and timelines for lists of items to be addressed/accomplished by the Educational Testing Service (ETS) and Sylvan/KEE Systems (SKS) were established and were critically monitored before the decision to proceed with the Beta Test could be made. Also, the Board has assisted with the readiness of the Member Boards participating in the Beta Test through continuous communications with Member Boards. The Board wishes to firmly assure the Member Boards that the National Council is indeed on top of every phase of the transition to CAT. The decision to switch to CAT on April 1, 1994, will not be made unless the Board is confident that the transition will be successful in all aspects. Yes, there probably will be a few minor glitches, but we can handle those. Hopefully, the major components of the transition will be well grounded so that the transition will not be traumatic for either the Member Boards or the candidates. It occurs to me that prayers would certainly be in order for the success of this major change.

While many members and staff of Member Boards have been actively involved in a variety of activities of the National Council, there continues to be a need for volunteers for the various NCLEX development panels and for licensed practical nurses to serve on National Council committees and the Board of Directors. The Communications Department has produced a very attractive brochure to help Member Boards recruit nurses who demonstrate an interest in serving on one of the NCLEX panels. The process of securing a completed application has now been assumed by the National Council which definitely simplifies the process for the Member Boards. In preparation for the transition to CAT, a very large number of item writers and reviewers is needed to increase the item pool to its maximum. I encourage Member Boards to engage in the recruitment of panel members by whatever means is available and effective. Another group that also needs to be recruited is the licensed practical nurses (LPNs) to become involved in board of nursing activities at the jurisdiction level and subsequently to become involved in National Council activities on the national level. In our liaison meetings with the National Federation of Licensed Practical Nurses (NFLPN) and the National Association for Practical Nurse Education and Service (NAPNES), the idea of an aggressive recruitment program for LPNs was greatly stressed. At the suggestion of one of the executive directors, there will be published in their journal an article from me stressing the importance for qualified licensed practical nurses to become involved on their respective boards and to further consider serving the National Council in some capacity.

It has been extremely enlightening and enjoyable attending the four Area Meetings this past year, learning of the specific concerns of the various Areas. It appears that the overriding issues across the country continue to include dealing with the practice of nursing by unlicensed persons and the advanced practice of nursing. In one way, it is heartening to know that one is not alone with these problems, but in another way, it is most frustrating trying to find a reasonable, rational and cost-effective resolution that is acceptable to all persons involved. Hopefully, during the time available at this Annual Meeting, attendees will be able to network to gain ideas and suggestions that will be assistive in dealing with these issues.

Again, I invite you to dialogue with me or any member of the Board regarding what the organization has been doing or what you think it should be doing. To learn about what has been going on, please read the various reports contained in this *Book of Reports* and attend the forums that have been planned to provide the opportunity for an informal discussion of the specific issues.

Thank you for this exciting pleasure of serving the National Council as its President for the past year. This truly has been the capstone of my professional life. My sincere hope is that I have performed according to your expectations and that I will continue to provide the leadership that progresses the National Council to goal achievement.

I also want to publicly express my personal thanks to all the staff of the National Council and especially to Jennifer Bosma for their dedication and commitment to making the National Council the dynamic organization it is.

Report of the Vice-President

Gail McGuill, RN, BSN, ***Vice-President***
Executive Director, Alaska Board of Nursing

As the Vice-President of the National Council of State Boards of Nursing, Inc., during the past year, I have participated in the following activities since the 1992 Delegate Assembly:

- Attended all Board of Directors' meetings and participated in Board telephone conference calls;
- Participated in the National Council's Fall Retreat;
- Represented the Board of Directors at the Advanced Practice Roundtable meeting in Chicago, held April 2, 1993;
- Represented the National Council at the Annual Meeting of the National Student Nurses' Association in Kansas City, Missouri, held April 14-17, 1993;
- Enjoyed the opportunity to attend portions of the Area II Meeting held in Overland Park, Kansas, April 16-17, 1993.

I am pleased to have had the opportunity to serve as your Vice-President this year and to liaison with other organizations on your behalf. I look forward to continuing to work with the Board of Directors, volunteers and staff during the next exciting year as we transition our testing program into the future.

Report of the Secretary

Helen Kelley, LPN, *Secretary*
Board Member, Massachusetts Board of Registration in Nursing

As the Secretary of the National Council of State Boards of Nursing, Inc., I have participated in the following activities since the 1992 Delegate Assembly:

- Attended all but one Board of Directors' meeting;
- Participated in Board telephone conference calls;
- Attended the National Council Fall Retreat in Chicago, Illinois, in October 1992;
- Reviewed all minutes of the Board of Directors' meetings and the summary of major Board actions [all of which are reviewed before any public distribution or publication in the National Council's *Newsletter*];
- Continued to serve as a member of the CAT-PN Field Test Team. Attended all but one meeting and participated in telephone conference calls;
- Observed a training session for the CAT-PN Field Test in Edison, New Jersey, in September 1992;
- Represented the National Council at the National Federation of Licensed Practical Nurses' Annual Convention in Norfolk, Virginia, in October 1992, and presented with others on a panel, regarding LPNs' involvement in state and national activities with boards of nursing;
- Attended the Area IV Meeting in Burlington, Vermont, in April 1993, and gave the CAT-PN Field Test presentation.

This past year has been extremely busy for the Board, in dealing with issues around preparing for the implementation of computerized adaptive testing (CAT), while keeping a focus on the issues which are of concern and interest to Member Boards. Even with all these activities, the Board continued to look forward to the future of the National Council. The Board works along with committee members and staff on the organizational needs and structure, assessing from a close look at the bylaws. Everyone has been asking themselves and each other some hard questions about where does the National Council go from here and how to get there. This is what the National Council is all about, progress and the regulation of the nursing practice. This is because of the commitment shown by the people who serve the National Council.

Thank you for the honor of serving the National Council as Secretary this past year. It has been a privilege to have represented you in this manner, and I thank you for this opportunity.

Report of the Treasurer

Carol Osman, RN, EdD, *Treasurer*
Executive Director, North Carolina Board of Nursing

Recommendation(s)

1. The auditor's report for October 1, 1991, through September 30, 1992, be approved as presented.

Rationale

The audit was completed in December 1992, and reviewed by the Finance Committee in January 1993. The auditors found no irregularities in the financial statements and expressed an unqualified opinion.

I am very pleased to report that the National Council of State Boards of Nursing, Inc., continues to maintain a strong financial position. Revenue continues to exceed expenditures due to an increased number of examination candidates, royalties from the Nurse Aide Competency Evaluation Program (NACEP™), favorable interest rates on long-term investments, and successful marketing of National Council publications. Our success has been due to careful management and monitoring by staff, the Finance Committee, and the Board of Directors. This has been extremely important as we have proceeded with the implementation of Computerized Adaptive Testing (CAT) and is reflected in the continuing assurance of quality in CAT while continually monitoring the fiscal impact.

We continue to maintain a conservative approach throughout the budget process. All requests for adjustments are reviewed in terms of their impact on the approved budget as well as other financial resources. The requests, accompanied by a recommendation and pertinent specific information, were presented to the Board of Directors for consideration and action. Quarterly financial reports were reviewed by the Finance Committee and the Board of Directors. Following the review by the Board of Directors, the reports were sent to Member Boards.

During the past year, I attended all meetings of the Board of Directors and participated in all of the telephone conference calls. I also chaired the Finance Committee. Throughout the year, I communicated regularly with Kathleen Hayden, Financial Manager, on all financial matters. Her commitment, expertise, and support has been invaluable to me and to the Finance Committee, and has had a significant impact on the fiscal soundness and stability of the National Council.

I would like to thank each member of the Finance Committee for the support they have provided me. They are a very committed group and take their responsibilities very seriously.

I would also like to thank the Member Boards for giving me the opportunity to serve as Treasurer for the National Council for the past two years. It has been a very exciting period of time, and I have enjoyed it.

Report of Independent Auditors

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

We have audited the accompanying balance sheets of National Council of State Boards of Nursing, Inc. as of September 30, 1992 and 1991, and the related statements of revenue and expenses, changes in fund balances, and cash flows for the years then ended. These financial statements are the responsibility of management of National Council of State Boards of Nursing, Inc. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. at September 30, 1992 and 1991, the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young
December 4, 1992

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

	September 30	
	1992	1991
Assets		
Current assets:		
Cash and cash equivalents	$ 1,451,068	$ 521,291
Accounts receivable	116,111	90,453
Examination fees due from member boards	482,598	92,897
Inventories (less reserve for obsolenscence of $22,000 in 1991)	8,825	62,018
Accrued interest, prepaid expenses, and other	514,426	369,808
Total current assets	2,573,028	1,136,467
Investments, at cost (market: 1992—$7,259,966; 1991—$6,493,162)	7,148,879	6,453,534
Property and equipment:		
Furniture, fixtures, and leasehold improvements	196,788	179,485
Equipment and computer software	708,447	429,954
	905,235	609,439
Less: Accumulated depreciation	563,803	475,411
	341,432	134,028
	$10,063,339	$7,724,029

	September 30	
	1992	1991
Liabilities and fund balances		
Accounts payable	$ 1,896,455	$ 253,135
Accrued salaries and payroll taxes	204,083	187,384
Total current liabilities	2,100,538	440,519
Deferred revenue:		
Examination fees collected in advance (net of prepaid processing fees of $137,914 in 1992 and $134,862 in 1991)	1,186,326	1,232,658
Fund balances:		
Unrestricted:		
Undesignated	2,110,775	3,045,836
Designated	4,643,970	2,911,381
	6,754,745	5,957,217
Restricted	21,730	93,635
Total fund balance	6,776,475	6,050,852
	$10,063,339	$7,724,029

See notes to financial statements.

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

	Year ended September 30	
	1992	**1991**
Revenue—Unrestricted funds		
Examination fees	$7,871,943	$7,256,956
Less: Cost of development, application, and processing	4,620,943	4,165,464
Net examination fees	3,251,000	3,091,492
Member board contracts	186,500	186,000
Publications	223,852	194,774
Delegate assembly	62,515	55,873
Honoraria and other	4,969	47,158
Nurse aide program	442,889	409,734
Investment income	485,254	520,749
Total revenue—Unrestricted funds	4,656,979	4,505,780
Program and organizational expenses—Unrestricted funds		
Member board contracts	15,890	5,662
Publications	162,209	79,956
Delegate asembly and convention planning	59,327	76,318
Nurse aide program	25,260	40,304
Job analysis studies	61,929	40,466
Computerized adaptive testing (CAT)	843,549	359,369
Role delineation study	66,061	—
Computerized clinical simulation testing (CST)	106,914	—
Board meetings and travel	120,782	184,866
Public relations and communications	38,851	79,092
Other committee expenses	168,741	123,878
Total program and organizational expenses—Unrestricted funds	1,669,513	989,911
Administrative expenses—Unrestricted funds		
Staff salaries and benefits	1,506,027	1,262,483
Professional fees	89,171	77,559
Office supplies	152,307	89,302
Insurance	31,164	28,433
Rent and utilities	271,235	250,160
Equipment maintenance and rental	42,856	30,133
Depreciation	88,391	72,247
Miscellaneous	8,787	6,000
Total administrative expenses—Unrestricted funds	2,189,938	1,816,317
Total expenses—Unrestricted funds	3,859,451	2,806,228
Revenue in excess of expenses—Unrestricted funds	797,528	1,699,552
Restricted grant revenue		
Computerized clinical simulation testing	81,233	—
Nurse information system	—	107,606
Expenses related to restricted grants		
Computerized clinical simulation testing	153,138	375,640
Nurse information system	—	107,606
Revenue less than expenses—Restricted funds	(71,905)	(375,640)
Revenue in excess of expenses	$725,623	$1,323,912

See notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements Of Changes In Fund Balance

	Unrestricted												
	Undesignated	Designated for Computerized Adaptive Testing (CAT)	Designated For Crisis Mgmt.	Designated for NACEP	Designated for Working Capital Reserve	Designated for Role Delineation	Designated for Computerized Clinical Simulation Testing (CST)	Designated for Self-Insurance	Designated for CAT Member Boards Computers	Designated for Computer Acquisition	Total Unrestricted Fund	Restricted - Computerized Clinical Simulation Testing (CST)	Total
Fund balance at October 1, 1990	$3,210,401	$273,819	$121,836	$651,609	$-	$-	$-	$-	$-	$ -	$4,257,665	$469,275	$4,726,940
Transfer to Board-designated funds	(2,875,095)	1,448,733	-	-	956,387	248,100				221,875	-	-	-
Transfer to undesignated funds	651,609	-	-	(651,609)	-	-	-			-	-	-	-
Revenue in excess of (less than) expenses	2,058,921	(359,369)	-	-	-	-				-	1,699,552	(375,640)	1,323,912
Fund balances at September 30, 1991	3,045,836	1,363,183	121,836	-	956,387	248,100				221,875	5,957,217	93,635	6,050,852
Transfer to Board-designated funds	(2,970,988)	2,441,542	-	-	-	-	144,646	50,000	334,800	-	-	-	-
Transfer to undesignated funds	221,875	-	-	-	-	-	-			(221,875)	-	81,233	81,233
Revenue in excess of (less than) expenses	1,814,052	(843,549)	-	-	-	(66,061)	(106,914)			-	797,528	(153,138)	644,390
Fund balances at September 30, 1992	$2,110,775	$2,961,176	$121,836	$-	$956,387	$182,039	$37,732	$50,000	$334,800	$-	$6,754,745	$21,730	$6,776,475

See notes to financial statements.

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

	Year ended September 30	
	1992	**1991**
Operating activities		
Revenue in excess of expenses	$ 725,623	$1,323,912
Adjustments to reconcile revenue in excess of expenses to net cash provided by operating activities:		
Depreciation	88,391	72,247
Provision for obsolete inventories	—	6,000
(Increase) decrease in accounts receivable and examination fees due from member boards	(415,359)	372,806
Increase in accrued interest, prepaid expenses, and other	(144,618)	(155,968)
Decrease (increase) in inventories	53,193	(15,573)
Increase (decrease) in accounts payable	1,643,320	(1,441,045)
Increase in accrued salaries and payroll taxes	16,699	63,537
(Decrease) increase in deferred revenue	(46,332)	267,555
Net cash provided by operating activities	1,920,917	493,471
Investing activities		
Net additions to property and equipment	(295,795)	(25,587)
Increase in investments, net	(695,345)	(1,084,487)
Net cash used in investing activities	(991,140)	(1,110,074)
Increase (decrease) in cash and cash equivalents	929,777	(616,603)
Cash and cash equivalents at beginning of year	521,291	1,137,894
Cash and cash equivalents at end of year	$1,451,068	$ 521,291

See notes to financial statements.

National Council of State Boards of Nursing, Inc.

Notes to Financial Statements
September 30, 1992 and 1991

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

2. Summary of Significant Accounting Policies
Examination fees—Examination fees collected in advance net of processing costs incurred are deferred and recognized as revenue at the date of the examination.

Cash Equivalents—Cash equivalents consist of money market funds.

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

Pension Plan—The Council maintains a defined-contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The Council's policy is to fund pension costs accrued. Pension expense was $105,714 and $86,639 for the years ended September 30, 1992 and 1991, respectively.

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

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

	1992		1991	
	Cost	Market Value	Cost	Market Value
U.S. government obligations	$5,648,879	$5,759,966	$4,953,534	$4,993,162
Certificate of deposit	1,500,000	1,500,000	1,500,000	1,500,000
	$7,148,879	$7,259,966	$6,453,534	$6,493,162

Board-Designated Funds—The Board of Directors has designated certain funds to be used for specific projects. These projects include the development of computerized adaptive testing (CAT) for licensure examinations, the purchase of paper and printing materials to be used in the event of a security break occurring directly prior to a scheduled examination (crisis management), working capital reserve, role delineation research study, computerized clinical simulation testing (CST), self-insurance, and CAT Member Board Computers. These funds are reflected as designated unrestricted funds in the accompanying financial statements.

Restricted Funds—In 1988, the Council was awarded a restricted grant from the Kellogg Foundation to develop a software system to ensure clinical competence of nurses and to ensure interprofessional collaboration between nursing and medicine, through computer-based clinical simulation. The grant, amounting to $1,868,954, was received in full in four installments through December 1991. During 1992, the Kellogg Foundation approved an extension through December 31, 1992, to utilize the remainder of the grant funds.

In 1991, the Council received a restricted grant from The Robert Wood Johnson Foundation to support the study of the feasibility of establishing a national nurse data base. The grant, amounting to $107,606, was expended during fiscal 1991.

In addition, the Division of Nursing of the Public Health Service awarded a grant of $15,000 to the Council for this project, and the American Nurses' Association contributed in-kind services.

3. Commitments

On September 1, 1989, the Council entered into a lease agreement for office space. Under this agreement, the Council has the option to terminate the lease after five years or continue under the lease agreement through August 31, 1999.

On May 19, 1992, the Council entered into a lease agreement for additional office space, subject to the same terms as the original lease.

Future noncancelable rental commitments as of September 30, 1992, are as follows:

1992 .... $321,100
1993 327,529
1994 334,093

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

4. Subsequent Events

In October 1992, the Council received a $530,110 grant from the Robert Wood Johnson Foundation for the implementation of a national nurse information system. They received $292,609 of the $530,110 from the Robert Wood Johnson Foundation on November 17, 1992.

In December 1992, the Board of Directors approved an additional $287,000 as designated funds for the Computerized Clinical Simulation Testing (CST) project.

The Board of Directors also approved $236,000 as designated funds for the Nurse Information System (NIS) project and an additional $150,150 as designated funds for the Computerized Adaptive Testing (CAT) project.

Report of the Area I Director

Fran Roberts, RN, MS, ***Area I Director***
Executive Director, Arizona State Board of Nursing

As Area I Director of the National Council of State Boards of Nursing, Inc., I have attended and have been active in all Board of Directors' meetings and conference calls. I have worked in a collaborative manner with other Area Directors in evaluating the Regulatory Day of Dialogue concept as a precedent to Area Meetings and in the planning of Area Meetings. I have brought both my own and Area I Member Boards' interest in National Council's committee process and structure to the National Council board table for attention and evaluation.

The Area I Meeting was held, through the graciousness of the Nevada State Board of Nursing, in Las Vegas on March 25-26, 1993. Thirteen of the 18 jurisdictions in Area I were represented, for a total of 50 participants. The meeting was structured to provide for an initial day of presentation and discussion regarding matters affecting all jurisdictions, including:

- Computerized Adaptive Testing (CAT) and beta testing
- Computerized Clinical Simulation Testing (CST)
- Nurse Information System (NIS)
- Advanced Practice
- Bylaws

The second day of the meeting provided an opportunity for Area I Member Boards to discuss issues more specific to the region or to individual boards. Topics both scheduled and those spontaneously raised included:

- National Council committee process and structure
- Disciplinary issues, expert witnesses, use of case studies and exemplars as investigative material, and the potential role of National Council in researching and documenting such information
- Arizona's CANDO program
- A panel discussion on autonomous, umbrella and privatized board structures
- Advanced practice and concerns regarding the certification process, including the soundness of various examinations and credentials
- Pharmacy issues, including the writing of orders by pharmacists and the role of the nurse in this process
- Unlicensed personnel

The 1994 Area I Meeting will be hosted by the Washington State Board of Nursing and the Washington State Board of Practical Nursing.

The commitment, creative thinking and spirit of Area I Member Boards and individuals continues to motivate and inspire me as your Area I Director. Your support has made all the difference in my year in this honored position, and I thank you.

Report of the Area II Director

Thomas Neumann, RN, MSN, ***Area II Director***
Administrative Officer and Consultant, Wisconsin Department of Regulation and Licensing

As Area II Director of the National Council of State Boards of Nursing, Inc., I participated in all Board of Directors' meetings and conference calls during this past year. I represented the National Council at the American Association of Colleges of Nursing Spring Meeting in Washington, DC.

The Area II Meeting was held in Overland Park (Kansas City), Kansas, on April 16-17, 1993. There were 69 participants, and all Area II jurisdictions were represented. Members and staff of the Kansas Board of Nursing served as very gracious hosts, and provided Kansas hospitality as we followed the yellow-brick road through the following agenda items:

- Computerized Adaptive Testing (CAT): Beta Test, Readiness Criteria, Security Measures, PN Field Tests
- Advanced Nursing Practice
- Computerized Clinical Simulation Testing (CST) Progress Report
- Bylaws Committee Progress Report
- Area II Specific Concerns

Presenters at the meeting included Dorothy Fiorino (Steering Committee for CST), Libby Lund (Bylaws Committee), Susan Boone (Examination Committee Team 2), Barbara Halsey, Anna Bersky, and Vickie Sheets (National Council staff), Lisbeth Penn (CTB), and Linda Waters (ETS). Rosa Lee Weinert, President, and Jennifer Bosma, Executive Director, were also in attendance to present their reports and provide additional information about National Council issues. A written update report was available regarding the activities of the Nursing Practice & Education Committee.

The 1994 Area II Spring meeting will be hosted by the Iowa Board of Nursing.

I wish to thank all of the Area II board members, staff, and others who have participated in National Council activities this year, whether on committees, panels, or in meetings addressing National Council issues. Your commitment and enthusiasm contribute to the vitality and achievements of the organization.

Thank you for the opportunity to serve you during this past year. I have appreciated your openness and interest in discussing Area II and National Council issues.

Report of Area III Director

Marcella McKay, RN, MSN, *Area III Director*
Executive Director, Mississippi Board of Nursing

As Area III Director of the National Council of State Boards of Nursing, Inc., I participated in Board of Directors' meetings and conference calls. I had the pleasure of representing the National Council at the 1992 Annual Meeting of the National Association for Practical Nurse Education and Service (NAPNES) in Birmingham, Alabama, and the 1993 Annual Meeting of the American Organization of Nurse Executives (AONE) in Orlando, Florida.

The Area III Meeting was held April 5-6, 1993, in Richmond, Virginia. There were 75 individuals in attendance, representing 13 of the 16 Member Boards in Area III. The President, Executive Director, Director of Testing Services, and Director of Research Services represented the National Council at the meeting, and representatives for CTB MacMillan/ McGraw-Hill and Educational Testing Service attended as well. Reports were presented regarding National Council projects and activities, and specific Area III concerns regarding regulation and testing were discussed among jurisdiction representatives. Prior to the meeting, jurisdictions submitted written reports of specific activities for the past year. Reports were compiled and distributed to attendees.

Appreciation is extended to the members and staff of the Virginia Board of Nursing for their warmth and hospitality during the Area III meeting. Our stay in Virginia was both pleasant and productive due to their planning and hard work.

Throughout the past year, Area III representatives continued to actively participate in a wide variety of National Council committees and activities. It was a pleasure to be associated with these talented individuals.

I greatly appreciate the opportunity to have represented Area III on the Board of Directors. The support of Area representatives, National Council staff, the Mississippi Board of Nursing members and staff, and my colleagues on the Board of Directors has made the past two years an exciting and rewarding experience.

Report of the Area IV Director

Sister Teresa Harris, RN, MSN, *Area IV Director*
Executive Director, New Jersey Board of Nursing

As Area IV Director of the National Council of State Boards of Nursing, Inc., during the past year, I attended the Board of Directors' meetings and participated in conference calls.

The Area IV Member Boards met on April 29–30, 1993, in Burlington, Vermont. Agenda items included the following:

- The report of the President and Executive Director
- Proposed bylaws revisions were presented by Libby Lund, Chair of the Bylaws Committee
- Computerized Adaptive Testing (CAT) and beta testing were presented
- A demonstration of Computerized Clinical Simulation Testing (CST) was presented

Area issues included:

- Advanced Nursing Practice *Model Nursing Practice Act*
- Unlicensed Practice
- Diversion Programs
- Location of Area and Annual Meetings

Vermont Board members and staff were most hospitable, providing an atmosphere that led to a successful meeting.

The 1994 Area IV spring meeting will be hosted by the Maryland Board of Nursing.

Report of the Director-at-Large

Judi Crume, RN, MSN, *Director-at-Large*
Executive Officer, Alabama Board of Nursing

Since the 1992 Annual Meeting, as Director-at-Large, I have had the opportunity to participate in the following activities:

- Attended all meetings of the Board of Directors and participated in all Board conference calls.
- Participated in the Fall Retreat in Chicago, Illinois, in October 1992.
- Served on the Board of Directors of the Federation of Associations of Regulatory Boards (FARB) and represented National Council through attendance and program presentation at the 1993 FARB Forum.

The Federation of Associations of Regulatory Boards was the Board representative activity that I participated in for National Council this year. The annual FARB Forum was held in Tucson, Arizona, in February. Attending were over 150 board members, board staff persons, attorneys, and other interested parties. The program was varied with high evaluative marks given to the many volunteer presenters. Boards of nursing throughout the United States were there and expressed that not only was their involvement valuable, but also National Council's involvement is valuable. The National Council's Board of Directors supports our continued representation and leadership in that organization.

Led by Randolph P. Reaves, JD, as the Executive Director and the FARB Board (currently seven associations of regulatory boards have designated board positions) and due to the success and growth over the past few years of the organization, there is an Attorney's Certification Course scheduled for October 29-30, 1993, in New Orleans, Louisiana, as well as the 18th Annual FARB Forum to be held in Seattle, Washington, on February 25-27, 1994. Regulatory boards do indeed share similar concerns, hopes and dreams, and collaboration is not only beneficial, but exciting and challenging.

While NCLEX-CAT has seemed to predominate Board discussion and decision-making this year, as a new Board member, there are several points that I have learned through Board involvement that are worth sharing: 1) the complexity and diversity of the many issues facing the National Council membership as individual boards and together as an organization are tremendous; 2) there is a broad spectrum of support and assistance that the National Council provides to all of us; and, 3) the number and depth of committed individuals invested in furthering our objectives and mission is what makes this such a vital and timely organization.

My thanks goes to each of you who have expressed your ideas and concerns to me so that I can better represent those perspectives to the National Council Board of Directors. Additionally, you have my continued respect and appreciation for your support and involvement.

5

REPORT OF
EXECUTIVE DIRECTOR

Report of the Executive Director

Jennifer Bosma, PhD, CAE, Executive Director

Introduction

This report highlights major areas of staff activity from May 1992 through April 1993. Activities are linked to the key purposes of each department. An alphabetical list of staff names, including positions, accompanies this report. A description of staff responsibilities is found behind Tab 24, Orientation Manual, in this *Book of Reports*.

Testing Department

Purpose 1: To maintain the highest quality and integrity of the National Council licensure examinations.
Supporting activities:

- Assembled background information for a re-evaluation of the NCLEX-PN passing standard, including the survey of nursing professionals, trend data for PN achievement tests, and the recommendation of a standard setting panel.
- Coordinated procedures to implement and analyzed the effects of an additional 10 minutes per booklet for the licensure examinations.
- Coordinated investigative efforts, statistical analyses, and information dissemination related to the July 1992 NCLEX-RN security break in New Jersey.

Purpose 2: To facilitate a successful, smooth transition to Computerized Adaptive Testing (CAT).
Supporting activities:

- Worked closely with Educational Testing Service (ETS) staff to implement the master plan for CAT, including:
  - conducted CAT-PN field testing in seven jurisdictions
  - disseminated information (with Communications Department)
  - secured 235 item development panel members to attend ETS-sponsored sessions
  - coordinated provision of Member Board uniform computing capability (with Operations Department)
  - planned Beta Test
  - made individualized Member Board contacts for transition support
  - responded to Member Board contract questions and needs (with legal counsel and other staff)
- Provided legislative/rule assistance as requested (with Public Policy Department).

Purpose 3: To produce and promote a high-quality Nurse Aide Competency Evaluation Program (NACEP), in compliance with all federal standards.
Supporting activities:

- Assisted with performance evaluation of The Psychological Corporation (TPC) as test service for the Nurse Aide Competency Evaluation Program, leading to contract extension.
- Supported continued quality development of the NACEP™ through collaboration with TPC psychometricians, marketing specialists, and project managers.
- Instituted publication of *Insight: NACEP News and Notes* (with Communications Department).
- Sponsored a fourth National Nurse Aide Conference.

Public Policy, Nursing Practice and Education Department

Purpose: To promote public policy related to the safe and effective practice of nursing in the interest of public welfare.
Supporting activities:

- Coordinated efforts to obtain and collate input regarding advanced practice regulation from Member Boards and other organizations.
- Worked closely with subcommittee in developing a package of position paper, model legislative language and model rules for advanced practice.
- Provided staff support to committee considering issues related to competence, including ramifications of disabilities, discipline, individual scope and maintenance of competence.

- Supported committee work pertaining to revisions of the *Model Nurse Practice Act* and *Model Nurse Administrative Rules*.
- Authored a general brochure on nursing regulation, targeted at nursing students.
- Worked closely with legal counsel to produce the amicus curiae brief submitted to the Montana Supreme Court.
- Analyzed statistics for reporting to National Council's Disciplinary Data Bank (DDB), and took measures to increase reporting to one hundred percent.
- Implemented new reporting forms and electronic access to the DDB.
- Represented the National Council on the National Practitioner Data Bank Executive Committee.
- Performed a feasibility study of establishing a Nurse Aide Disciplinary Data Bank, at the direction of the 1992 Delegate Assembly.
- Coordinated sharing of information regarding challenges to licensure and education policies under the Americans with Disabilities Act.
- Filled a new professional position, to serve as resource to Member Boards with regard to nursing education-related needs.

Research Department

Purpose 1: To provide research and development for National Council programs.
Supporting activities:
- Completed a Registered Nurse job analysis/validation study for the NCLEX-RN, and reported the findings to the Examination Committee.
- Continued research and development regarding Computerized Clinical Simulation Testing (CST), including seeking funds for Phase II and working closely with the National Board of Medical Examiners (NBME) to evaluate past collaboration and to plan for the future.

Purpose 2: To provide information valuable to Member Boards.
Supporting activities:
- Performed and reported results of a major role delineation study, including nurse aides, LPN/VNs, RNs, and advanced practice nurses.
- Performed a logical job analysis of the role of the baccalaureate-educated nurse, under contract to the Maine State Board of Nursing.
- Supported committee in collecting information from agencies capable of evaluating foreign-educated nurse credentials and in drafting guidelines for credentials review.
- Continued to seek external funding for study of the effectiveness of various approaches to the regulatory management of chemically dependent nurses, and worked with subcommittee to redesign study when funding was not forthcoming.
- Collected licensure and examination statistics for 1992.
- Maintained a database of surveys conducted by Member Boards and the National Council, and published its index periodically.

Purpose 3: To provide and promote use of information about nursing regulation.
Supporting activities:
- Worked with committee to develop policies for the Nurse Information System (NIS).
- Planned NIS procedures, and worked with Operations Department to begin programming.
- Responded to Member Boards' questions and needs with regard to data collection agreements for the NIS.

Communications Department

Purpose: To promote recognition of the National Council as the prime source of information and expertise regarding nursing regulation.
Supporting activities:
- Supported Communications Committee in gathering information and analyzing options for certification programs for nursing education program surveyors and discipline investigators.
- Published *Issues*, *State Nursing Legislation Quarterly*, the *Newsletter* and the Annual Report on a regular basis.
- Produced *Emerging Issues*, newsreleases, fact sheets, brochures, and other special-purpose publications as warranted.
- Created a general National Council brochure and a portfolio of brochures on more than a dozen program areas for use in orientation to the National Council.

- For CAT education and informational purposes, produced two videos, a second brochure, slides, audio tapes, and *Communiques*, as well as coordinated four regional workshops and more than half-a-dozen exhibiting opportunities.
- Planned and implemented logistics of membership meetings, including the Annual Meeting with educational sessions, the Fall Retreat, and Area Meetings.

Administration Department

Purpose: To assure National Council programs and services are well-planned and implemented, consistent with Delegate Assembly and Board direction.

Supporting activities:

- Worked with Long Range Planning Committee to survey, interpret, and use Member Boards' ratings of importance and satisfaction with National Council programs.
- Implemented a Board-approved organizational assessment structure and conducted an internal evaluation of processes used in all departments.
- Promoted responsiveness by the most appropriate department to Member Board requests, including use of the Resource Network.
- Maintained telephone and personal contact when possible with Member Boards to remain abreast of needs.
- Represented the National Council at meetings of multiple nursing and other related organizations.
- Coordinated interorganizational leadership meetings and promoted the inclusion of National Council viewpoints in relevant issues.

Operations Department

Purpose: To provide cost efficient and effective operational services and work environment.

Supporting activities:

- Supplied and monitored financial reports and projections which provide information on the National Council's current and projected financial status.
- Arranged for the annual audit by certified public accountants.
- Provided and maintained a computing environment to maximize the efficiency of other departments as well as enhance communication with Member Boards.
- Planned for office space in cost-effective manner.

The staff has found the opportunity to work in an organization with high standards and commitment to excellence to be professionally stimulating. Especially rewarding is the partnership with committees and the Board of Directors in working on multiple programs that we hope have contributed to make the job of Boards of Nursing easier.

1992-93 National Council Staff

Administrative Staff

Ruth Bernstein, M.B.A. .... CAT Project Associate
Anna Bersky, M.S., R.N. .... CST Project Director
Jodi Borger .... NCLEX Administrative Assistant
Jennifer Bosma, Ph.D., C.A.E. .... Executive Director
Nancy Chornick, Ph.D., R.N. .... Research Associate
Susan Davids, C.M.P. .... Meetings Manager
Ellen Gleason, M.S.I.R. .... NACEP Program Manager
Christopher T. Handzlik .... Editor
Barbara Halsey, M.B.A. .... CAT Project Manager
Carol Hartigan, M.A. .... CAT Testing Manager
Kathleen J. Hayden, B.B.A. .... Financial Manager
Linda Heffernan, J.D., M.S.N., R.N. .... Nursing Practice and Education Associate
Ellyn Hirsch .... CAT Administrative Assistant
Ellen Julian, Ph.D. .... Psychometrician
Nancy Miller, M.S., R.N. .... NCLEX Program Manager
Craig Moore .... Computer Coordinator
Doris E. Nay, M.A., R.N. .... Associate Executive Director
Melanie Neal, M.A. .... NIS Project Manager
Bryan M. Newson .... Computer Programmer
Kerry Nowicki .... Publications Manager
Larry Sankey .... Information Resource Manager
Vickie Sheets, J.D., R.N. .... Director for Public Policy, Nursing Practice and Education
Tom Vicek, M.B.A., CPA .... Director of Operations
Ann Watkins .... Executive Secretary
Anne Wendt, Ph.D., R.N. .... NCLEX Program Manager
Susan Woodward .... Director of Communications
Carolyn J. Yocom, Ph.D., R.N. .... Director of Research Services
Anthony R. Zara, Ph.D. .... Director of Testing Services

Support Staff

Renee Albers .... Research
Wanda Anderson .... Operations *(through January 1993)*
Cynthia Bentel .... Research
Richard Bentel .... Public Policy, Nursing Practice and Education
Tamara Bowles .... Testing
Yvonne Brown .... Communications
Tom Glover .... Operations
Maria Hambesis .... Administration
Haiba Hamilton .... Communications
Beverly Howard .... Testing *(through July 1992)*
Jerrold Jacobson .... Research
Donna Masiulewicz .... NACEP *(through January 1993)*
W. Louise Peter .... Testing *(through November 1992)*
Sandra Rhodes .... Administration
Kathleen Siggeman .... Testing
Mary Trucksa .... Operations
Fleurette Workman .... Reception

REPORT OF
BOARD OF DIRECTORS

Report of the Board of Directors

Board Members

Rosa Lee Weinert, OH, Area II, *President*
Gail McGuill, AK, Area I, *Vice-President*
Helen Kelley, MA, Area IV, *Secretary*
Carol Osman, NC, Area III, *Treasurer*
Fran Roberts, AZ, *Area I Director*
Tom Neumann, WI, *Area II Director*
Marcella McKay, MS, *Area III Director*
Sr. Teresa Harris, NJ, *Area IV Director*
Judi Crume, AL, Area III, *Director-at-Large*

Relationship to Organization Plan

The Board of Directors is responsible to the Delegate Assembly for the accomplishment of all goals and objectives through coordination and monitoring of the efforts of all entities within the organization.

Recommendation(s)

1. The Readiness Criteria for computerized adaptive testing (CAT) implementation be adopted (see Attachment A).

Rationale

The Board of Directors appointed an Expert Panel, comprised of Joyce Schowalter, MN, Chair; Billie Haynes, CA-VN; Marie Hilliard, CT; Louise Waddill, TX-RN; and Sharon Weisenbeck, KY. This panel worked to draft the "go/no go" criteria to be used in determination of actual CAT implementation timing. (The panel also requested the renaming of the criteria as "readiness" criteria.) Input to the criteria was obtained from the Examination Committee-Team 2, Area Meeting participants, National Council staff, ETS, and legal counsel. After several rounds of input and revision, the Board believes that the criteria express the essential conditions which must be in place in order for CAT implementation to be successful.

If these criteria are adopted by the Delegate Assembly, it will be the responsibility of the Board of Directors to evaluate status with respect to each criterion, and authorize proceeding with implementation of CAT only when all criteria are fulfilled. This evaluation will begin as of October 1993, with notification to Member Boards as soon thereafter as possible (but no later than December 31, 1993) regarding whether or not implementation of CAT will proceed on the target date of April 1, 1994. If there must be a delay, the Board of Directors will inform Member Boards of the expected timeline for resolving the situation and set a new target date by which it is expected all criteria will be fulfilled.

2. The National Council not establish a disciplinary data bank for nurse aides at this time (see report of study in Attachment B).

Rationale

A survey of need for a nurse aide disciplinary data bank (NADDB) was distributed to 52 Nurse Aide Registries by National Council public policy staff. The returns (31 responses, 59.6%) indicated a high level of interest. Willingness to participate, for nearly a third of the respondents, was based on 100 percent participation by nurse aide registries, an unrealistic expectation for a newly developed, voluntary data bank. Also, although a need was clearly perceived, the available resources for paying for the service ranged from limited to none.

Another important consideration is the relatively small number of Member Boards which would be directly benefitted by a NADDB. Only 13 registries are affiliated with boards of nursing. Twenty-three states currently contract for use of the NACEP™ (ten of these states are board of nursing-affiliated registries).

Another consideration is the potential duplication of efforts by the National Practitioner Data Bank (NPDB). When the NPDB implements section five of P.L. 100-93, "other health care practitioners" will include any health care provider that is licensed, certified or registered. This would include individuals listed on the Nurse Aide Registries.

The fiscal impact of establishing a NADDB is estimated to be $20,000-$36,000 (start up). Ongoing maintenance would require an additional support staff person to handle data entry, prepare monthly reports, manage inquiries and other NADDB secretarial functions.

The Finance Committee evaluation of the fiscal impact, short-term and long-term, indicated that not establishing a data bank for nurse aides at this time would be the most fiscally responsible choice. Several other possible approaches to paying for the bank were evaluated as unrealistic or not fiscally responsible. The committee suggested re-evaluation of this decision in the future if the situation changes with respect to Member Board needs, federal government activities, etc.

Highlights of Activities

The Board of Directors' major activities from May 1992 through April 1993 (the year since the 1992 report to the Delegate Assembly) were focused on the accomplishment of the goals and objectives in the Organization Plan. At the Fall Retreat in October, the Board presented a complete set of 82 tactics, wherein each objective was addressed. The tactics have been used throughout the year to coordinate and monitor the work of committees, staff and the Board. This report will highlight major Board activities related to each goal.

GOAL I. Provide Member Boards with examinations and standards for licensure and credentialing.

The highest priority of the Board was given to overseeing a smooth transition to CAT for NCLEX. At each meeting, the Board has received reports from CAT-related committees, testing staff, ETS and CTB. Progress has been checked against the CAT Master Plan, and "task bundles" have been accomplished in a timely manner. As policy-related issues have arisen, the Board has requested analysis of options and, after consideration, has selected the course of action in the best interests of the organization and its members. For example, ETS' "open systems architecture" (OSA) software was deemed a more viable, long-term software program for the NCLEX/CAT; CTB was authorized to proceed with assembly of an April 1994 NCLEX-PN as a contingency in the event of CAT implementation delay; a decision was made to hold all July 1993 NCLEX-RN results until beta test validity is confirmed. The Board established Beta Test readiness criteria with ETS, which it required be met prior to May 15 when Beta Test candidate assignment to groups was to begin. A viable method for application/payment for current tape and batch states was approved. Responsibilities for decisions related to modifications under the Americans with Disabilities Act were delineated. CAT education/information efforts and reports of their effectiveness were reviewed by the Board.

As of the first of May, the Board believes that the tremendous amount of work done by ETS, the committees, and staff has moved the National Council well along the way to a successful transition to CAT. To each group and individual involved, the Board expresses its appreciation.

■ RN Job Analysis

Throughout the course of the year, the Board received regular reports from research staff on the performance of the triennial job analysis which serves as the validation study for the NCLEX-RN. The report has been published separately, and implications for the RN test plan are included in the report of the Examination Committee-Team 1.

■ NCLEX-PN Standard Setting

At its June 1993 meeting, the Board will complete the triennial re-evaluation of the NCLEX-PN passing standard. The Board considers data from a nine-member panel of judges, a nationwide survey of nursing service and education representatives, and tests of PN/VN-student achievement. The expected effects of the standard, if changed, will be reported to Member Boards as soon as possible. The standard will be effective with the October 1993 NCLEX-PN.

■ Computerized Clinical Simulation Testing (CST) Funding

Upon receiving notification that the W.K. Kellogg Foundation's funding priorities had changed, and therefore funding for continued research and development of CST would not be forthcoming, the Board, with the assistance of the CST Steering Committee and staff, analyzed options. At the 1991 Delegate Assembly, discussion regarding research and development of CST indicated that this would be the task of the Board if additional Kellogg funds were not obtained.

Based on consideration of all factors and the original direction of the 1991 Delegate Assembly, the Board has designated $2,965,817 of the National Council's fund balance for the purpose of continued research and development of CST for the period FY94 through FY98, with review of budget and project progress annually. The Board believes that this major commitment is consistent with the National Council's purpose in its bylaws, with its mission, and with Goal I—identified as most important by the Member Boards.

■ Nurse Aide Competency Evaluation Program (NACEP)

The 1992 Delegate Assembly assigned responsibility for selection of a contractor for the NACEP™ to the Board of Directors. The Board received detailed reports and analyses from the NACEP Committee, testing staff, and NACEP user surveys as background for this important decision. Based on data indicating a high level of satisfaction among all groups with services of The Psychological Corporation (TPC), the Board granted a four-year contract extension. An amendment to the terms gives TPC financial incentive to market the full-service program aggressively in states issuing new requests for proposals.

GOAL II. Provide information, analyses and standards regarding the regulation of nursing practice.

■ Advanced Practice

As the Subcommittee to Study the Regulation of Advanced Nursing Practice worked to fulfill the mandate of the Delegate Assembly to complete a "package" of position paper, model statute and rules, the Board provided guidance and support to the subcommittee while also interacting with external organizations interested in this controversial issue. Board members addressed the topic from the regulatory perspective during liaison and committee meetings of such groups. Comments were given by the Board both on the subcommittee's work products and the work products of other groups, upon request. The Board's aim was to work within the current environment to arrive at a strong and viable National Council proposal for the regulation of advanced nursing practice that would be useful to the largest possible number of jurisdictions as a generic model to which local adaptations may be made.

■ Amicus Curiae Brief

From time to time, an issue of broad significance to the system of state regulation of nursing practice arises in an individual state. During the past year, such an issue arose when a Montana District Court attempted to interpose its judgment for the judgment of the Montana Board of Nursing in a disciplinary case involving hospice nurses' use of medications. The Board authorized the preparation and submission of an amicus curiae brief to the Montana Supreme Court. The position articulated by the National Council in the amicus curiae brief was that the issues presented in the case will have a significant impact not only on the regulation of nursing in Montana, but also in other states with similar practice acts, administrative procedure acts and constitutions. Specifically, the National Council argued that the violations committed by the nurses evidenced poor nursing practice, that the District Court erred in substituting its judgment for that of the Board in awarding discipline and that the Board did not act arbitrarily or capriciously in imposing probation with corrective conditions. The case is pending in the Montana Supreme Court as of the first of May 1993.

■ Obtaining a Uniform Interpretation regarding Discipline Reporting from the Department of Health and Human Services

Information received from a number of states in the latter half of 1992 indicated that boards of nursing were being subjected to non-uniform requirements for reporting discipline cases (and consequent prohibition of the nurse from working in facilities receiving federal funds). The source seemed to be differing interpretations of the law by the various HHS regional offices. The Board requested staff and legal counsel to work toward obtaining a uniform interpretation of the law, which can be shared with Member Boards. The outcome of these efforts is still pending.

■ Role Delineation Study

The Role Delineation Study authorized by the Delegate Assembly in 1990 has been completed. The report is presented under Tab 7. The Board plans to direct further analyses and the study of implications by appropriate National Council groups during the coming year.

GOAL III. Provide information, analyses and standards regarding the regulation of nursing education.

■ Foreign Educated Nurse Credentialing

In 1991, the Board appointed a committee on Foreign Educated Nurse Credentialing and charged the committee to survey Member Boards' needs in this area. If common needs were identified, the committee was to investigate existing services and report its findings to the Board so that an informed decision could be made regarding how best to meet the identified Member Board needs. The committee completed its study and analysis and has reported its findings (see the report of the committee under its tab in this *Book of Reports*). Based on the committee's analysis and recommendations, the Board has identified the Commission on Graduates of Foreign Nursing Schools (CGFNS) and the Foundation for

International Services (FIS) as agencies capable of providing quality services to Member Boards in the areas of (1) repository of credentials of individual foreign-educated nurses, (2) evaluation of such credentials, and (3) a library of information regarding foreign nursing education programs. These services will be available for applicants and programs for practical nurse licensure as well as registered nurse licensure.

Based on the recommendation of the Foreign Educated Nurse Credentialing Committee, the Board has determined that the National Council will play an ongoing role in providing liaison between Member Boards and these agencies, as well as monitor and report periodically to Member Boards on quality of services. Two agencies were identified for National Council endorsement in order to provide choice to Member Boards, particularly those Member Boards which must themselves provide choices to their applicants for endorsement. The offering of credentials-type services separate from a screening examination, such as the examination currently sponsored by CGFNS, was designed to create maximum flexibility for Member Boards to obtain services most useful to them. The Board anticipates making an announcement of specific services available, jointly with the identified agencies, within the next several months.

■ Certification Programs for Nursing Education Program Surveyors

(Please see the report on certification programs below, under Goal IV.)

■ Education Services

The groundwork for future education services to Member Boards has been laid through the Board's provision of resources for the hiring of an additional professional staff person in this area.

GOAL IV. Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

■ Certification Programs

Following the 1992 Delegate Assembly's directive to study the feasibility of certification programs for nursing education program surveyors and discipline investigators, the Board of Directors requested that the Communications Committee survey Member Boards' needs and likelihood of using National Council-established services in this area. The committee's findings and recommendations are reported to the Delegate Assembly under its tab in this *Book of Reports.*

The Board and committee have begun exploration of the most effective and least costly methods of structuring the programs. From reviewing other programs for certification, it appears that costs per program registrant may range from under $100 (for a local or "correspondence" program) to over $500 (for a multiple-day, national seminar). If the Delegate Assembly approves proceeding with the establishment of the programs, the Board will continue this exploration and develop the programs during FY94. It is anticipated that at least some portion of each program would be offered by the Fall of 1994.

■ Nurse Information System (NIS) Funding

Following notification that the Robert Wood Johnson Foundation (RWJF) had awarded the National Council a two-year, $530,110 grant for the establishment of the Nurse Information System, the Board acted to create a designated fund of $254,744, set aside for the National Council's responsibilities in the program. The Board also approved and appointed a Technical Advisory Panel, as required by the RWJF as a condition of the grant. The NIS Committee's report, under its tab in this *Book of Reports,* provides further information about progress of the program.

■ Information Master Plan

The Board adopted a long-range plan for the coordination of current and future "information clearinghouse" functions of the National Council. The plan will facilitate access to information related to nursing regulation (e.g., the Disciplinary Data Bank, licensure requirements, surveys done by Member Boards, pending legislation, the Nurse Information System, nurse practice acts, etc.) through the electronic linkage of Member Boards to the National Council and each other.

GOAL V. Implement an organizational structure that uses human and fiscal resources efficiently.

- **Master Plan for Organizational Assessment**

In the last several years, the Board's focus has been primarily on planning. While significant planning activity has and will continue, the Board has moved this year to incorporate a systematic evaluation component as well. In December 1992, the Board adopted a Master Plan for Organizational Assessment. The plan for assessment calls for periodic evaluation of: (1) outcomes and (2) processes in various areas of National Council endeavors. In addition, organizational structures and documents will undergo periodic re-evaluation, and future needs of Member Boards will be assessed. Multiple National Council groups have been and will provide data to the assessment. The Board maintains a cumulative record of the of the overall status of the organization. These documents are available to any Member Board upon request.

Future Considerations for the National Council

As health care reform proposals unfold on national and state levels, the National Council will be vigilant in gathering all relevant information, analyzing it, and providing guidance to the extent needed by Member Boards. International issues, such as trade agreement and the similarities and differences between the regulatory systems of Canada and Mexico with the Member Boards, will continue to be a target of information gathering and dissemination during the coming year.

The issue of use of regimens ordered by various health-care providers other than physicians was brought to the Board's attention through discussion at national-level liaison meetings with other nursing organizations. Noting that this could be a significant emerging issue, particularly in light of health care reform, the Board has requested that the Nursing Practice and Education Committee analyze and report on its implications for the regulation of nursing practice.

In response to Area Meetings' discussions, the Board is currently evaluating, with the input of appropriate committees, the need for standing committees or specially appointed groups to focus on various issues; for example, unlicensed practice, alternative-to-discipline programs for chemically dependent nurses, licensure policies, and regulation of nursing education (such as faculty shortage, faculty "retraining," and ADA implications).

Meeting Dates (since the last report to the Delegate Assembly)

- June 24, 1992, *telephone conference*
- July 13-15, 1992
- July 24, 1992, *telephone conference*
- August 7, 1992, *telephone conference*
- August 13, 1992, *telephone conference*
- August 17-21, 1992
- August 23, 1992
- October 7-8, 1992
- December 2-4, 1992
- December 21, 1992, *telephone conference*
- March 8-10, 1993
- April 26, 1993, *telephone conference*
- May 10, 1993, *telephone conference*

Attachments

A .... Readiness Criteria for CAT Implementation, *page 7*
B .... Report on Nurse Aide Disciplinary Data Bank Feasibility Study, *page 13*

Attachment A

Draft Readiness ("Go/No Go") Criteria

These Readiness Criteria are intended to be used as the criteria which must all be met in order for the Computerized Adaptive Testing (CAT) transition to continue along the current timeline for implementation in April 1994. The "Go/No Go" Expert Panel developed these criteria with significant input from the Board of Directors, Examination Committee-Team 2, National Council staff, and ETS.

The criteria were written to set forth the major categories and essential conditions for readiness. If adopted by the Delegate Assembly, the criteria will be applied by the Board of Directors to determine when all criteria have been met. The actual application of these criteria to the project's progress will be made by the Board during the Fall of 1993 to determine the final implementation timeline. The specified National Council committees will have major input and involvement in assisting the Board to make its determination.

The Board of Directors will make a decision regarding a potential delay by applying these criteria within 30 days of National Council's receipt of the final Beta Test report from ETS (as specified in the National Council-ETS contract). It is anticipated that unless the final Beta Test report is significantly delayed, this decision will be made in November. Should the final report be delayed for any reason, the National Council will make the readiness decision and notify Member Boards no later than December 15, 1993. (National Council's contract with Member Boards specifies that December 31, 1993, is the latest date for notification of a delay in CAT implementation.)

The major categories of Readiness are defined in terms of:
1. Psychometric Issues
2. Security Issues
3. Administrative Procedures
4. Test Site Readiness
5. Member Board Readiness
6. Communication/Information Issues

The following pages list the actual Readiness Criteria which the Board will apply to the project's progress.

Panel Members

Joyce Schowalter, MN, Area II, *Chair*
Billie Haynes, CA-VN, Area I
Marie Hilliard, CT, Area IV
Louise Waddill, TX-RN, Area III
Sharon Weisenbeck, KY, Area III

Staff

Anthony R. Zara, *Director of Testing Services*

READINESS CRITERIA

Standard	Criterion	Review Group
I. Psychometrics		
A. CAT NCLEX examinations are fair, psychometrically-sound and legally-defensible.	Beta test data shows no practical disadvantage to any studied subgroup on CAT NCLEX passing rates, e.g., greater than 10% as compared to paper-and-pencil NCLEX. Observed practical differences are capable of being statistically equated. Statistically significant differences in pass rates which have no practical effect and are due to the large sample sizes may occur.	Examination Committee, National Council testing staff, and legal counsel
	The NCLEX passing standard is transferable to the CAT scale through statistical equating procedures.	Examination Committee and National Council testing staff
B. A thorough item analysis can be conducted on CAT NCLEX.	All appropriate item calibration and performance indices, e.g., item difficulties, are developed and demonstrated. Approaches for investigating and correcting potential item bias in NCLEX are developed.	National Council testing staff
C. Two complete RN and two complete PN CAT NCLEX item pools are available.	Two RN item pools of at least 1,450 items each and two PN item pools of at least 1,250 items each are ready for CAT NCLEX use, to ensure NCLEX items are not overexposed.	Examination Committee

Standard		Criterion	Review Group
II.	**Security**		
A.	CAT NCLEX examinations can be delivered in a secure manner at all test centers.	A comprehensive CAT NCLEX procedure manual was used in all Beta Test centers. All security procedures were tested during the Beta Test. No intractable breach of security occurred during the Beta Test. For any known breach of security ETS provided a satisfactory plan for correction.	Administration of Examination Committee
B.	All test site staff are trained and evaluated regularly.	ETS/Sylvan/KEE has provided a written verification of training for all Beta Test sites and a plan for conducting training by March 1, 1994, for all non-Beta Test sites. The plan includes: a) training for all test center staff in the use of NCLEX security measures prior to implementation, and b) regular evaluations of staff in the mastery of techniques and procedures, and regular reports to the National Council.	Administration of Examination and Examination Committees
C.	Suspected breaches of security can be dealt with efficiently and effectively.	A comprehensive procedure for reporting and handling suspected breaches of security at test sites, test service, and other appropriate locations is written. Any security or reporting problems discovered during the Beta Test are identified and a plan with timelines for rectifying the situation prior to implementation has been approved.	Administration of Examination Committee

Standard	Criterion	Review Group
III. Administrative Procedures		
A. CAT NCLEX administrative procedures are complete and operational.	All administrative procedures, including registration, eligibility determination, results reporting and candidate tracking have been developed, approved and successfully tested in Beta Test states. A written plan of correction, including timelines, must be prepared to address any identified problems.	Administration of Examination and Examination Committees
B. All relevant policies are complete.	Policies on administration training, handling security breaks, evaluation of the programs, etc., are written and approved. A "disaster plan" is approved.	Administration of Examination and Examination Committees
IV. Test Site Readiness		
A. CAT NCLEX test sites are operational in Beta Test states.	Sylvan/KEE has signed contracts with all certified NCLEX test center operators in place. All Beta Test sites are properly configured (software, hardware, NCLEX procedures, hiring) and staff trained. Problems occurring during the Beta Test were corrected.	Examination Committee
B. CAT NCLEX test sites for non-Beta Test states will be ready for operation by March 1, 1994.	ETS provided a detailed plan for developing all non-Beta Test state sites, including executed contracts with operators or formal letters of intent to open such centers. Plans must include locations, dates for software and hardware installation, staff hiring and training in CAT NCLEX administrative and security procedures.	Administration of Examination and Examination Committees

Standard		Criterion	Review Group
V.	**Member Board Readiness**		
A.	The Member Boards are prepared to implement CAT NCLEX.	The Member Boards have completed necessary legislative changes, demonstrated computing capability, demonstrated successful use of software, including data transfer, and executed a contract with the National Council.	Legal counsel and National Council staff
B.	The Member Boards have a sufficient combined candidate volume.	Combined candidate volume of the Member Boards which are ready exceeds 142,000 between November 1, 1992, and October 31, 1993.	Legal counsel and National Council staff
VI.	**Communication/Information Issues**		
A.	Information about CAT NCLEX is available to candidates, nursing programs and other interested parties.	Drafts of informational brochures for candidates are approved. A written plan for review, production and dissemination of brochures and information/application packets to candidates and nursing programs is approved.	Examination and Administration of Examination Committees

Attachment B

Report on Nurse Aide Disciplinary Data Bank Feasibility Study

By: Vickie Sheets, JD, RN, *Director for Public Policy, Nursing Practice and Education*

April 21, 1993

Background

The 1992 Delegate Assembly adopted a resolution that the National Council conduct a Feasibility Study for the development of a Nurse Aide Disciplinary Data Bank (NADDB). This resolution was in response to concerns regarding the number and nature of complaints in several jurisdictions, and the possibility of individuals moving from state to state with Nurse Aide Registries unaware of previous actions.

An important consideration is that in section five of Public Law 100-93, the National Practitioner Data Bank (NPDB) was mandated to add information regarding "other health care practitioners" to the NPDB. Section five implementation continues to be on hold, but is being included in the contract requirements considered in NPDB contract renewal negotiations. According to Public Health Service officials, "other health care practitioners" includes any health care provider that is licensed, certified or registered. This would include individuals registered on Nurse Aide Registries.

Assumptions

1. This project is technically feasible. The National Council Disciplinary Data Bank (DDB) tracks actions taken against licenses of Registered Nurses and Licensed Practical/Vocational Nurses and has been in operation since 1981. Technical documentation of that program development could be used to develop a Nurse Aide Disciplinary Data Bank.

2. Although adding a nurse aide category to the current Disciplinary Data Bank might appear to be an easy approach operationally, the number and type of fields that would be used for nurse aides differ from the current RN and LPN/VN fields. Access to a Nurse Aide Disciplinary Data Bank would be broader than the Member Boards, armed services and Certification Council of the American Association of Nurse Anesthetists which currently receive information regarding nurses in the Disciplinary Data Bank. Many of the Nurse Aide Registries which could use the information would not be affiliated with Member Boards but rather other state agencies. The potential volume of nurse aide reports could slow down the inquiry process or direct electronic access for searching for RN or LPN actions.

Therefore, the better approach would be to develop a separate database for nurse aides. The program could parallel operationally the existing Disciplinary Data Bank and be based on the technical documentation of that system. However, its fields, functions and access would need to be tailored to the particular needs of the nurse aide population.

The Feasibility Study

Since we knew from the outset that the project is technically feasible, staff concentrated efforts on determining the extent of the perceived need for a Nurse Aide Disciplinary Data Bank and the potential costs. The study evolved into three stages.

■ Stage One - A Survey of Nurse Aide Registries

A survey instrument was designed and distributed to 52 Nurse Aide Registries. Thirty-one registries responded, or 59.6 percent of registries. Eleven of the respondents were registries affiliated with boards of nursing (85 percent of the registries placed with Boards). Twenty respondents were affiliated with other agencies (51 percent of the nurse aide registries placed with other agencies). The level of response permitted an identification of the need perceived by nurse aide registries.

A need is perceived. Twenty-six registries (84%) responded that a national data bank of nurse aide discipline would be useful. Clearly, there is a perceived need for a Nurse Aide Disciplinary Data Bank.

Level of participation needed for usefulness.

The perceived level of participation needed for usefulness varies greatly. Many expectations for the level of participation needed for a Nurse Aide Disciplinary Data Bank were extremely high. Almost one third of the respondents (ten or 32.8%) indicated that 100 percent participation would be needed and an additional respondent indicated 95 percent participation was needed. In addition, three registries listed 85-90 percent participation needed; two registries indicated 75 percent participation would be useful; and one registry indicated 50 percent would be useful. At the other end of the continuum, eleven registries (35.5%) responded that any additional information would be of assistance to them.

Information would be available.

A majority of jurisdictions (26 respondents, or 84%) indicated that they would be willing to report nurse aide disciplinary information to a national data bank. One jurisdiction was willing but not sure that current manpower would permit reporting if volumes were high. One state indicated that they would have to have approval of their attorney general. Another state would be willing to share information upon request. Only one state responded that they were not willing to share information (this was a state that reported no nurse aide complaints).

Anticipated volumes of nurse aide reports are high.

The range of estimated volumes for the 29 nurse aide registries (55.8% of all registries) which responded to this question on the survey is 250-700 reports per month (this number reflects the estimated total number of reports for all 29 registries). If participation in a nurse aide disciplinary data bank were 75 percent, that estimate could increase to 350-900 per month. (Currently, we enter 200-250 RN/LPN reports per month in the Disciplinary Data Bank, total for all reporting jurisdictions.)

Paying for a Nurse Aide Disciplinary Data Bank.

Eleven registries (35% respondents, 21% of all registries) indicated that they would be unable to participate if fees were charged. One state advised they would pay a minimum annual fee if there were 100 percent participation. Nine registries indicated that they could pay $50 or less per month. One state would be willing to pay in the range of $50-$99 per month. Seven registries responded that the fees they would be willing to pay would be dependent upon the services actually offered or that they would need more information to respond.

- **Stage Two - Projected Nurse Aide Disciplinary Data Bank Specifications**

The second stage of the study was the development of suggested specifications for a Nurse Aide Disciplinary Data Bank. These suggested specifications included elements for data entry (biographical fields, disciplinary actions and causes of action), inquiry and search, reports generated and electronic access.

The specifications were shared with a sample of Executive Directors of Member Boards (at least one Director from each National Council Area). Their suggestions and comments were incorporated into the draft specifications used to obtain cost estimates.

- **Stage Three - Estimated Costs for Nurse Aide Disciplinary Data Bank Specifications**

The Director of Operations was requested to obtain an outside consultant's cost estimates for a Nurse Aide Disciplinary Data Bank development, as well as estimates for the cost of developing the programming in-house. The possible time lines for implementation are also a factor to be considered.

A. Outside Consultant Program Development

SEI Information Technology, the computer consulting firm which programmed the Disciplinary Data Bank conversion, was asked to provide time and cost estimates for development of a NADDB. See summary of estimated expenses in chart on page 15.

The timeframe for the initiation and completion of such a project would depend upon the RFP (request for proposal) process should an outside programming be recommended. Work time to complete the project is estimated to be 48 work days. (For your information, the costs of the DDB program conversion completed by SEI was $40,000. SEI began the DDB project immediately upon receiving the contract, and completed the project within the allotted timelines.)

B. In-House Program Development

A NADDB, based on the existing DDB programming, could also be completed in-house by the National Council's

Computer Programmer and the Information Resource Manager. Other than staff time, there would be no additional costs for this programming. See summary of estimated expenses in chart below.

After reviewing the Nurse Information System (NIS) timelines, the Information Resource Manager indicated that work could begin on a NADDB by November 1, 1993, and that a pilot project could be ready for implementation by January 1, 1994.

C. Other Costs

The volume of reports projected for a NADDB would require an additional full time support staff member to complete data entry, prepare monthly reports, manage inquiries and other NADDB secretarial functions. If the proposed secretarial position for the Public Policy, Nursing Practice and Education Department is approved, that staff person would be able to perform the entry and support activities for initial implementation of a NADDB. However, depending on volume of reports, inquiries and other support activities, it is likely that additional support staff would need to be added for the ongoing project. Salary, benefits and associated expenses would total approximately $40,000 annually for each secretary required.

Supervisory activities would include working with the programmer (either in-house or outside) regarding the content, format and policy issues in NADDB development; development of reporting forms, monthly report formats, orientation materials for NADDB users and oversight of the project implementation. Promotional articles and other educational materials would need to be developed.

Work space, computer support, mailing, phone, supplies are other expenses which would be incurred on a regular basis. Additional network disk space has already been budgeted for FY94.

D. Summary of Cost Estimates

START-UP COSTS EXTERNAL PROGRAMMING	START-UP COSTS INTERNAL PROGRAMMING	ONGOING ANNUAL COSTS
Consulting Firm Costs - based on current DDB program (includes printing, mailings, etc.) $21,000 - 28,000	No additional cost, except for current computer staff time; 25 full days estimated to do programming. Additional supervisor time to work with programmer, develop forms, report format, educational and orientation materials, etc. Total Indirect Cost $20,000	Includes one additional full-time support staff (salary, benefits), printing, mailings, computer support, supplies, etc. $50,000

Analysis and Discussion

Three important questions regarding the feasibility of a Nurse Aide Disciplinary Data Bank are easily answered: a need is perceived, the project is technically feasible, and the cost of the project can be estimated.

Other issues are more gray. Clearly, the usefulness of any data bank of this type increases as the number of participating agencies increases. About one-third of the respondents indicated that full 100% participation was needed for a Nurse Aide Disciplinary Data Bank to be useful. Yet, a slightly larger number of respondents thought that any information would be of assistance. While costs can be estimated, the more difficult question is who pays? And policy issues arise - only 13 registries are affiliated with boards of nursing. Twenty-three states contract for NACEP (ten of those states have board of nursing-affiliated registries). Should the National Council expend significant resources on an ongoing project that will directly affect a minority of its Member Boards?

Some of the considerations identified by staff are summarized below.

ON THE POSITIVE SIDE...

1. There is clearly a perceived need for a national data bank of nurse aide disciplinary actions.

2. A NADDB would expand Member Boards' services and assist participating Member Boards in meeting their charge to protect the public.

3. A NADDB could be developed relatively easily. From experience with the DDB, we know the project is technically feasible.

4. The development of a parallel system based on existing Disciplinary Data Bank programming would not require a tremendous dollar investment.

5. The National Council could investigate other possible long-term marketing initiatives, e.g., explore the possibility of contracting with the NPDB or the Public Health Services (PHS) to provide the NPDB services for nurse aides.

ON THE NEGATIVE SIDE...

1. Although there is a perceived need, about one-third of the registries responding to the survey advised they would participate only if there were 100% participation. Is this a realistic expectation for a newly developed, voluntary data bank?

2. All registries are required to include information regarding findings of abuse, neglect or misappropriation of property by a nurse aide. States may also choose to include additional information. According to the comments to CFR 483.156(c), findings are determinations made after considering the evidence and after a hearing. The due process requirements are to be defined in the survey and certification regulations which have not yet been developed. There is significant variation in the process from jurisdiction to jurisdiction; thus there would also be great variation in the information made available for a data bank.

3. Although the estimated cost of development ($20,000 - $36,000 for outside consultant programming; approximately $14,700 based on 350 hours of staff time if done in house) is not a tremendous sum, consideration must be given to who pays for the service. In many jurisdictions, state resources are sorely limited.

4. Consideration should be given to the best use of National Council resources, weighing the costs and benefits of a NADDB versus other uses of those funds or staff time, e.g., further upgrading the services of the DDB for RNs and LPNs.

5. There is potential duplication of effort with the NPDB. The likelihood of contracting to provide NADDB services is remote. If contracting to provide some portion of NPDB services is a desirable goal, efforts might be better spent in promoting the use of the RN/LPN DDB for NPDB. The promotion of an established bank with over 10 years of reported cases might be more effective than that of a newly developed data bank.

6. Is contracting with NPDB, for either nurse aides or licensed nurses, a goal the National Council should pursue? Until rules implementing section five are developed which clarify when inquiry regarding other health care practitioners will be required and who is required to inquiry, the extent of the use of the NPDB for this level practitioner not known. The volume of reports and inquiries is likely to be substantial, requiring a very large operation.

7

ROLE DELINEATION
STUDY REPORT

Report of the Role Delineation Study

Relationship to Organization Plan

Goal V .... Implement an organizational structure that uses human and fiscal resources efficiently.
Objective D .... Conduct and disseminate research pertinent to the mission of the National Council.

Recommendation(s)

No recommendations.

Highlights of Activities

In response to a 1990 directive from the Board of Directors, Research Services staff conducted a role delineation study of nurse aides, licensed practical/vocational nurses (LPN/VNs), registered nurses (RNs), and advanced registered nurse practitioners (ARNPs). It was anticipated that the results of the study would facilitate evaluation of the legal scopes of practice of licensed personnel and the delegation of nursing activities to unlicensed personnel.

Planning for implementation of the study was initiated in 1991 and completed in Spring 1992. This work included designing the methodology, developing and pre-testing the data collection instrument, and working with Member Boards to coordinate sample selection activities.

This non-experimental, descriptive study was implemented in September 1992 using a modification of the data collection instrument used in the 1992 job analysis study of newly licensed registered nurses. A random sample of 15,411 individuals was drawn from the LPN/VN, RN, and ARNP licensure lists, state-level registries of nurse aides certified for employment in Medicare-supported nursing homes and home health care agencies, and from lists of nurse aides (provided by members of the American Organization of Nurse Executives) employed in acute care settings. An overall response rate of 49.3 percent was achieved.

Usable data were provided by 6,930 respondents. This included 1,046 nurse aides, 2,155 LPN/VNs, 2,620 RNs, and 1,109 ARNPs. The methodology used to perform this study and results of initial data analysis procedures are provided in the attached preliminary report (Attachment A). The results provide an overview of the similarities and differences of the four participant groups relative to their demographic and educational characteristics, work settings, functional roles and, for those engaged in client care provision, client characteristics and practice activities.

Future Considerations for the National Council

Due to the amount of available data, analyses designed to compare and contrast practice activities of the four levels of personnel will continue into FY94. It is anticipated that further analysis of this rich data set, including information relative to the delegation of tasks by one personnel category to another, will yield specific descriptions of the practice characteristics of each type of licensee/registrant within and across a variety of client care settings. Future data analysis plans also include, but are not limited to, examining the practice characteristics of participants within each personnel category across the various practice settings (e.g., all LPNs/VNs) and examining the practice of ARNPs following their separation into more homogeneous groups (e.g., nurse midwives, nurse anesthetists, etc.). It is anticipated that this work will be completed during FY94. The results will be communicated to the membership and to appropriate committees.

Recommendation(s)

No recommendations.

Staff

Carolyn J. Yocom, PhD, RN, *Director of Research Services*
Nancy L. Chornick, PhD, RN, *Research Associate*
Jerold Jacobson, BS, *Research Assistant*

Attachments

A .... Preliminary Report: Role Delineation Study of Nurse Aides, Licensed Practical/Vocational Nurses, Registered Nurses, and Advanced Registered Nurse Practitioners

Attachment A

Preliminary Report: Role Delineation Study of Nurse Aides, Licensed Practical/Vocational Nurses, Registered Nurses and Advanced Registered Nurse Practitioners

In 1990, the Board of Directors of The National Council of State Boards of Nursing directed that a role delineation study be performed for the purpose of describing the practice characteristics of four levels of nursing personnel: nurse aides, licensed practical/vocational nurses (LPN/VNs), registered nurses (RNs) and advanced registered nurse practitioners (ARNPs). It was anticipated that the results of the study would facilitate evaluation of the legal scopes of practice of licensed personnel and the delegation of nursing activities to unlicensed personnel.

METHODOLOGY

This section provides a description of the methodology used to conduct the role delineation study. Descriptions of the design, sample selection procedure, instrument development, data collection procedure and information about response rates are included. In addition, procedures used to screen data and to establish the analysis files are also described.

Design and Sample Selection

A non-experimental, descriptive study of the practice of nurse aides, LPN/VNs, RNs and ARNPs was undertaken. The populations of interest were all (1) LPN/VNs, RNs and ARNPs included on licensure lists, (2) certified nurse aides included on federally mandated state-level registries and (3) nurses aides employed in acute care settings. The geographic target area encompassed the United States, the District of Columbia (DC) and five U.S. territories (American Samoa, Puerto Rico, Commonwealth of the Northern Marianas, Guam and the Virgin Islands). The actual size of the sampling frame for the study is unknown due to the current lack of unduplicated lists of licensed/regulated nursing personnel.

Sample selection process. The regulatory agencies responsible for maintaining the licensure/registration lists in each of 56 political jurisdictions (i.e, state, territory, district) were requested to draw random samples of nursing personnel and provide the names and mailing information to the National Council. In the event that an agency was unable to select a random sample, the entire list of licensees/registrants was submitted to the National Council where the selection process was completed. The sample selection procedure for licensed personnel (i.e., LPN/VNs, RNs and ARNPs) differed from that for nurse aides. These two different procedures are described below.

LPN/VNs, RNs, ARNPs: Each board of nursing was asked to select a simple random sample of 110 individuals from each of their LPN/VN and RN licensure lists and an additional 100 ARNPs if they regulated this level of practice. The composition of the ARNP list was to be divided as follows: 20% nurse midwives, 20% nurse anesthetists, 60% all other ARNPs. If nurse midwives and/or nurse anesthetists could not be identified as a distinct subgroup(s), the percentage of all other types of ARNPs included in the sample was to be increased accordingly (i.e., from 60% to 80% or 100%).

Nurse aides: Two sources of nurse aide information were used. By federal law, each political jurisdiction is mandated to maintain registries of nurses aides employed in Medicare/Medicaid certified nursing homes and home health care agencies. With the exception of six jurisdictions, there is no comparable registry requirement for nurse aides employed in acute care settings. Therefore, two different approaches were used to select the nurse aide sample. One approach consisted of asking the governmental agency responsible for maintaining the nurse aide registries within each jurisdiction to select a simple random sample of 35 individuals from each of their two or three existing registries.

The second approach, developed to take advantage of a source of nurse aides employed in acute care settings, involved the cooperation of members of the American Organization of Nurse Executives (AONE). In response to a request from National Council, each AONE member was asked to submit the name(s) and mailing address(es) of one to ten individuals. Project staff subsequently selected, at random, at least one name from each submitted list. This resulted in the additional inclusion of up to 37 individuals employed in acute care settings from within each of 43 jurisdictions.

Following completion of the selection process, the total sample size for this study was 15,411. This included 2,617 nurse aides from 48 jurisdictions, 5,178 LPN/VNs from 48 jurisdictions, 5,324 RNs from 49 jurisdictions and 2,292 ARNPs from 29 jurisdictions. Table 1 contains frequency distributions for the various categories of nursing personnel, within the 54 jurisdictions from which data were available.

Instrument Development

The data collection instrument used in this study is a modification of an instrument developed by the National Council in 1992 for use in the performance of job analysis studies. (For a full description of the instrument development procedure, see Chornick, Yocom, & Jacobson, 1993.) A general description of the instrument is provided below.

Instrument Description

The Survey of Nursing Practice (Instrument) contained five sections plus a cover page. The cover page provided general information (e.g., assurance of confidentiality), instructions about how to respond to the questions that followed and how to request a letter of recognition.

Section 1 of the instrument included several questions addressing basic and current levels of educational preparation, certification and current level of practice (e.g., LPN/VN, RN, etc.). This information is useful in examining differences in practice across types of nursing personnel and by level of education.

Section 2 of the instrument included several questions about participants' work experience, job titles, work settings and client characteristics. An additional question asked what percentage of time was spent on certain role functions (e.g., administration/management, direct client care, etc.). Participants not employed in nursing were directed to skip to the fifth section. The information obtained in response to this series of questions is useful in examining differences in practice across work settings. The data collected about work settings also provides information about the characteristics of the participants as a whole.

Section 3 contained a series of questions requesting information about participants' teaching and research activities. This information will further assist in describing activities of nursing personnel.

Section 4 asked participants to provide information about their performance of 238 nursing activities. If participants were not involved in the provision of nursing care directly to clients at least 20 hours per week, they were directed to skip to the fifth section.

The activity statements were listed according to their expected universality of performance. Those activities which all personnel levels were expected to perform with a relatively high frequency were listed first. It was anticipated that those at the end of the list were primarily within the domain of advanced RN practice. Between these two extremes, the remainder of the activity statements were distributed according to their expected level of complexity.

In developing the list of nursing activities, a conceptual framework was identified to provide structure and a framework for evaluating its comprehensiveness and representativeness. The framework used was one previously identified by the National Council's Examination Committee following review of the 1985 RN job analysis study results (Kane, Kingsbury, Colton, & Estes, 1986) and their subsequent development of a new NCLEX-RN Test Plan (National Council, 1987).

The framework consists of two components: (1) the *Nursing Process* and (2) *Client Needs*. The *Nursing Process* component consists of five steps - *Assessment, Analysis, Planning, Implementation* and *Evaluation*. *Client Needs*, the second component, is comprised of four major categories: (1) *Safe, effective care environment*, (2) *Physiological integrity*, (3) *Psychosocial integrity* and (4) *Health promotion and maintenance*. Each of the four major categories of *Client Needs* is further divided into a total of 16 subcategories. The *Nursing Process* and *Client Needs* components interact to produce a holistic picture of nursing practice. Additionally, integrated throughout the framework are the role elements of nursing practice which include communication skills, principles of teaching and learning, community resources and family systems.

Five questions were asked regarding each activity statement. The questions were designed to address three basic issues: the frequency with which the activities are performed in practice, how often the activities are delegated and the criticality of the activities relative to their impact on client outcomes.

Question A asked whether the activity applied to the nurse's work setting. Since the instrument was designed to apply to practice in a variety of work settings, it was anticipated that some activities would not always be relevant. Participants who indicated that an activity did not apply to their work setting were instructed not to respond to the subsequent questions for that activity. Question B asked the participants if they had ever performed this activity in their current position.

Question C asked how often the participant personally performed the activity on the last day worked. This question was intended to provide basic data on how frequently each activity was performed. The eleven response categories ranged from "0 times" to "10 times or more."

Question D referred to the delegation of activities for which the care provider was responsible. Participants were asked how often they assigned the performance of the activity to nursing staff who were equally or less skilled than themselves. The three response categories were: (1) never assign, (2) sometimes assign and (3) always assign.

Question E asked about the criticality of the activity as it related to the provision of safe care to clients. The operational definition of criticality was based on whether the activity could sometimes be delayed or omitted without a "substantial risk of unnecessary complications, impairment of function, or serious distress." This criterion has the desirable properties of focusing on the needs of clients and providing a behavioral indicator (i.e., delaying/omitting or not delaying/omitting the activity) of criticality.

Section 5 of the instrument requested demographic data and responses to four open-ended questions. Participants were asked to provide background information that was summarized to describe the group that participated in the study. Questions addressed gender, race and whether English was the first language they learned. The open-ended questions were included to obtain information about (1) maintaining client safety, (2) use of time, (3) frustrations and (4) rewards provided by the job.

Data Collection

A four-phase mailing process, using first-class mail, was used to collect data from prospective study participants. Initially, the 15,411 individuals included in the sample were sent a letter (pre-letter) from the president of the National Council informing them of their selection for inclusion in the study, the study's purpose and the importance of their participation. In addition, the letter informed them that they would be receiving a questionnaire in approximately one week.

One week after the pre-letter was mailed, a copy of the instrument was sent. Included in this mailing was a second letter from the president reiterating the purpose of the study, the importance of participation and how the confidentiality of their responses would be maintained. A postage-paid return envelope was also included.

Approximately two weeks later, a postcard was sent to all non-respondents. It emphasized the importance of the study and asked again for their cooperation.

A final mailing was sent to all non-respondents approximately two weeks after the postcard was sent. This mailing contained another cover letter, a copy of the instrument and a postage-paid return envelope.

All instruments were pre-printed with a code number to facilitate tracking returns and mailing follow-up correspondence. In addition, when corrected addresses were provided by the post office following the first two mailings (pre-letter and instrument package), repeat mailings were made in an attempt to increase the potential pool of participants.

The data collection process was initiated in September 1992 and the final mailing was sent in mid-October 1992. Responses received through the end of the third week in November 1992 were accepted for inclusion in the study.

Confidentiality

All potential participants were promised confidentiality with regard to their participation and their responses. Pre-assigned code numbers were used to facilitate cost-effective follow-up mailings and for merging data files generated from machine scannable and non-scannable data. However, the files containing mailing information were kept separate from the data files.

Response Rates

As described above, materials were sent to the 15,411 nurse aides, LPN/VNs, RNs and ARNPs included in the sample. Of these, 702 were undeliverable due to invalid addresses. Therefore, the adjusted total sample size was 14,709. The adjusted sample sizes for the different categories of nursing personnel[1] were: nurses aides - 2,375; LPN/VNs - 4,938; RNs - 5,084; and ARNPs - 2,222. The instrument was returned by 7,250 individuals, representing an overall response rate of 49.3% (7,250/14,709). Response rates for the different levels of nursing personnel were: nurses aides - 48.3%, LPN/VNs - 47.5% , RNs - 50.6% and ARNPs - 53.2%. Frequency distributions of study participants, by category of personnel and jurisdiction of origin, are reported in Table 1.

Data Screening Procedures

Participant responses to most questions contained in the data collection instrument were transferred to a computer file by optical scanning of the booklets. During scanning, "flags" were employed to identify where an item did not fit established response criteria. Subsequently, all records containing flagged data were compared with the respondents' marks on the instruments and either the true responses, if they could be determined, or invalid data codes were entered. After scanning and editing, the resulting data file was sent to the National Council where additional data screening was performed to identify any out of range values or questionable responses.

Each participant's responses to the four open-ended questions and the pre-printed instrument code number were entered into a data base file. This information will be merged with participants' demographic data and those regarding practice characteristics, thus allowing further analysis.

Establishment of Analysis Files

In preparation for data analysis, the personnel category of each study participant was determined based on the responses to selected items in the data collection instrument. This approach, as opposed to relying on the licensure/registry lists, was used because inclusion on a licensure/registry list does not preclude licensure at another level (e.g., an individual licensed as an LPN/VN can also be licensed as an RN). Participants reporting ambiguous data regarding their personnel category or not reporting this data were eliminated prior to the establishment of all analysis files.

---

[1] The terms *category(ies) of nursing personnel* or *personnel category(ies)* are used to refer to two or more of the following groups: nurse aides, LPN/VNs, RNs, and ARNPs.

The primary source of information was the participant's response to an item requesting identification of their current level of practice (i.e., nurse aide, LPN/VN, or RN). Additional verifying information was obtained following examination of responses to questions about the current level of educational preparation and position title.

Participants were considered part of the ARNP group if they:

1. were included on the list of names of ARNPs (certified nurse midwife, certified nurse anesthetist, advanced practitioner, or clinical specialist) submitted by a jurisdiction regulating advanced practice;
2. identified themselves as a nurse practitioner who had completed a nurse practitioner program awarding either a certificate of completion or a masters degree;
3. identified themselves as a certified nurse midwife or certified nurse anesthetist;
4. identified themselves as a nurse clinician or clinical nurse specialist who had completed an educational program awarding a minimum of a masters degree.

Three types of analysis files were established for data contributed by participants within each personnel category. The number of participants included in each analysis file, by personnel category, is reported in Table 2.

The first analysis file (*all respondents*) contains demographic data reported by all study participants who returned a completed questionnaire. This file includes data from those licensees/registrants who reported they were working in nursing in addition to those reporting they were not currently employed. It consists of demographic data and information regarding level of educational preparation.

The second analysis file (*working in nursing*) contains data contributed by only those participants who indicated they were employed in nursing. In addition to containing demographic and educational information, this file also contains data describing participants' current position, employment setting, teaching and research activities and, if employed in a clinical setting, client characteristics.

The third analysis file (*care providers*) contains all data contained in the previous file but for only those participants who reported they were currently employed in nursing and (a) worked a minimum of 20 hours per week providing care directly to clients and (b) met specific criteria with regard to completion of Section 4 of the data collection instrument. This file also contains data describing the practice activities of the participants.

The following criteria for inclusion of participants' data in the care provider file were instituted to insure that data with questionable validity would not be used. Participants who met <u>both</u> of the following criteria were included in the file.

1. Provides direct care to clients at least 20 hours per week; and

2. Made response errors in 50 or fewer of the first 100 activity statements in Section 4 of the instrument.

The errors that could occur are as follows:

Error 1 - Marking the oval for Question A (indicating that the activity does not apply to the setting), and answering Question C (frequency of activity performance);

Error 2 - Leaving the oval for Question A blank (indicating that the activity does apply to the setting) and not answering Question C; and

Error 3 - Filling in more than one oval for Question C.

Several factors were considered in establishing criterion number 2, above. Primary consideration was given to the heterogeneity of the participants, the complexity of the questionnaire section requesting information about nursing activity performance and the paucity of studies documenting the practice patterns of nurse aides. Therefore, we attempted to include as many nurse aides as possible without compromising the quality of the data analyzed. Secondly, the majority

of nurse aides were not expected to perform frequently those activities with an item number greater than 100 because of the ordering of the items (See Instrument Development above). Therefore, only the first 100 items were checked for errors. Additionally, no category of personnel was considered more important than another to the purpose of this study. Therefore, the inclusion criteria were implemented uniformly across all four personnel categories.

The percentage of participants in the working in nursing file, by type of personnel category and number of errors is summarized in Figure 1. While 74% of the nurse aides committed 10 or less errors, the percentages for the other personnel categories were: LPN/VNs - 82%, RNs - 87%, ARNPs - 84%. At the other extreme, an error rate of 41 - 50% was identified by 5% of the nurse aides, 4% of the LPN/VNs, 3% of the RNs and 2% of the ARNPs. These rates were considered acceptable based on the expectation that some errors in recording responses, some variability in the interpretation of instructions and some degree of response patterning 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.

Response Validity

The validity of responses provided by participants included in the care provider file was evaluated by examining the consistency among responses to selected questions. A number of hypotheses were formulated and tested to determine if questions were interpreted and filled out correctly. The hypotheses examined were concerned with the:

1. Relationship between the mean criticality values of activities provided by each category of personnel;

2. Reported criticality values of activities expected to have either very high or very low criticality values; and,

3. Reported frequency of performance values provided by each category of personnel.

Relationship between criticality values for different personnel categories. It was hypothesized that a comparison of the mean criticality values generated by any one of the four different personnel categories with those generated by any other category would have a relatively high positive relationship. In computing values for 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".

The correlation coefficients calculated between all possible pairs of personnel categories' mean criticality values are reported in Table 3; plots of the various relationships are contained in Figures 2 - 7. The coefficients range between +0.75 and +0.97. The weakest relationships were demonstrated between the nurse aides' mean criticality values and those of the other categories of personnel. The strongest relationship (r=0.97) was demonstrated between RNs and LPN/VNs. Therefore, the data suggest that participants within the different personnel categories interpreted the criticality question similarly. For the most part, activities deemed critical by participants included in one personnel category were also thought to be critical by those in the other three.

Expected high and low criticality values. Specific activities were identified which were anticipated to have relatively high criticality values in the sense that, in the investigators' judgment, they could never be delayed or omitted without a "substantial risk of unnecessary complications, impairment of function, or serious distress," to clients. Similarly, activities were identified that could often be delayed or omitted without substantial risk to the client. The two sets of activities and the mean criticality values for each activity, by category of personnel, are reported in Table 4.

The prediction made about activities in Table 4 was that, if the participants responded to the criticality question as intended, the activities in the top half of the table would have higher mean criticality values than those in the bottom half. This prediction was confirmed by the data. The mean criticality value for those activities predicted to have a high value ranged between 0.86 and 1.00. The average value for those activities predicted to have a low value ranged between 0.72 and 0.06. There were no overlapping values in the two halves of the table; the lowest criticality value in the top half of Table 4 was 0.86 (activity #214). This was higher than the highest criticality value in the lower half of Table

4 (0.72 for activity #5). Therefore, the data support a conclusion that participants generally interpreted the criticality question as intended and responded appropriately.

Expected high and low mean frequency values. Specific activities were identified which were anticipated to have relatively high or low frequency of performance values depending upon the category(ies) of personnel engaged in the activity. Based on knowledge of nursing practice, specific performance patterns were predicted. The hypothesized outcomes were:

1. The mean frequency of performance of the following activities would be 5.0 or greater for all categories of personnel:

   2. Verify identity of client
   14. Use universal precautions

2. Rank ordering of the mean frequency of performance of the following activities by all categories of personnel would result in the following pattern: nurse aide > LPN/VN > RN > ARNP.

   1. Assist client to ambulate
   5. Change client's position
   66. Assist client with use of a walker, crutches prosthesis, etc.

3. Rank ordering of the mean frequency of performance of the following activities by all categories of personnel would result in the following pattern: ARNP > RN > LPN/VN > nurse aide.

   133. Collect physical assessment data
   164. Evaluate client's compliance with prescribed therapy
   201. Identify client's perception of health status

The mean frequency of performance values are reported in Table 5. With one exception (nurse aides - item # 2), the predicted values or relationships were observed. This finding supports a conclusion that study participants generally interpreted the frequency question as intended and responded appropriately.

Study Limitations

Interpretation and/or generalization of the results of this study may be limited due to the following factors:

1. There is a paucity of descriptive information about the actual numbers and characteristics of nurses and nurse aides comprising the sampling frame. Therefore, this prohibited our determining whether participants' characteristics and practice activities are representative of the population of nurse aides, LPN/VNs, RNs and ARNPs.

2. The inclusion of nurse aides from all three care settings was considered important to the conduct of this study. Since registries of nurse aides employed in acute care settings are only maintained in six jurisdictions, the sampling procedure used to select nurse aides employed in this setting was not equivalent to those used to select all other potential study participants. In addition, the use of an employer nomination procedure may have introduced a selection bias.

3. The nursing activity statements and the response options were constructed to provide information regarding the frequency and criticality of activity performance. Therefore, information about the specific characteristics (i.e., depth, breadth, extent, etc.) of performance was not obtained.

RESULTS

This section provides a general description of the demographic characteristics, educational preparation, employment status, work environments, and practice activities of the nurse aides, LPN/VNs, RNs and ARNPs who participated in this study. All statistical analyses were performed using SAS.

Of the 7,250 respondents, 6,930 individuals whose level of practice could be determined unequivocally, contributed data for use in the study. Three sets of analyses were performed using data contributed by participants included in a specific personnel category: (1) all respondents, (2) all respondents working in nursing and (3) all respondents working in nursing who (a) worked a minimum of 20 hours per week in providing care directly to clients and (b) met the error limitations criteria established for Section 4 of the data collection instrument.

Demographic Characteristics

Gender. Compared to the general population, women, as expected, were over represented in each personnel category. However, it is interesting to note that while the representation of men was very low within each of the three nurse aide files (5%), LPN/VN files (3%) and RN files (3 - 4%), there was a greater representation of men in the three ARNP files (13 - 16%). In all instances, the percentage of men within a specific personnel category was highest in the care provider files.

Ethnicity/Racial composition. The distribution of each category of personnel, by ethnic/racial composition is reported in Table 6. Examination of the data revealed very little change in the ethnic/racial diversity across the different analysis files within a personnel category. Comparisons across the four personnel categories revealed that the minority composition of a group changed as the level of practice increased. Approximately 27% of the nurse aide population was composed of representatives of minority groups. This is in contrast to 18% of the LPN/VN group, 12% of the RN group and 6% of the ARNP group.

English as a second language. In response to a question about the first language they learned to speak, only a small percentage of participants indicated that a language other than English was their first spoken language. The highest incidence of English as the non-primary language was reported by participants in the nurse aide (8%) and RN (6%) respondent groups. Smaller percentages were observed for the LPN/VN (4%) and ARNP (3%) respondent groups. It was also observed that there was very little variation across the three sets of analysis files within each personnel category.

Educational preparation. The highest level of educational preparation completed by participants within each personnel category is reported in Table 7. Within the nurse aide group, 71% of all participants in the respondent file reported completion of a nurse aide training program. The second most frequent response was "none" (16%). The LPN/VN participants indicated that the types of programs most frequently completed were either a diploma or certificate program (76%) or "none" (11%). Examination of the RN participants' responses revealed a fairly even distribution across three types of educational programs: diploma - 26%, associate degree - 27% and baccalaureate degree - 24%. This finding is similar to findings in the 1992 Registered Nurse Sample Survey (E. Moses, personal communication, June 6, 1993). For ARNPs, the most frequently identified responses were nurse practitioner programs resulting in the award of a certificate of completion (36%) or a masters' degree (23%).

Examination of participant data across the three analysis files for a specific category of personnel revealed no statistically significant differences for those levels of education with the highest percentages of representation. It is interesting, but not surprising, to note that very low percentages of RNs and ARNPs had doctoral degrees and that the magnitude of their representation in the care provider group was always lower than that for the working in nursing group.

Work history. Participants were requested to indicate the total number of years they have worked in nursing and in their current positions. These data are reported in Figures 8 and 9, respectively. The average length of time employed in nursing varied across all respondents within the four personnel categories: nurse aides - 11 years, 7 months; LPN/VNs - 15 years, 8 months; RNs - 18 years, 5 months; and ARNPs - 20 years, 10 months.

In contrast, for those participants currently employed in nursing, the average lengths of time they were employed in their current position were as follows: nurse aides - 7 years, 2 months; LPN/VNs - 7 years; RNs - 6 years, 2 months; and ARNPs - 7 years, 5 months. Within a personnel category there was little variation in the length of employment in nursing across the different sets of analysis files. This phenomenon was also observed with the data describing length of employment in the current position.

Additional course work / Certification. Participants who were LPN/VNs, RNs or ARNPs were requested to indicate what additional course work and/or certification programs they had completed. In addition, RNs and ARNPS were requested to indicate if they were currently certified by a national accrediting body (e.g., AACN, ANCC, etc.). Information for the LPN/VN working in nursing and care provider files is reported in Table 8; the RN and ARNP data are reported in Table 9.

The LPN/VN participants indicated that course work or certification most frequently completed addressed intravenous (IV) therapy, advanced cardiac life support (ACLS) and pharmacology. For RNs, the most frequently completed course work or certification addressed IV therapy, ACLS and critical care or coronary care. A similar finding was also identified with respect to the ARNP participants.

As expected, major differences were observed in the percentages of RN and ARNP participants currently certified by a national accrediting body. Over 85% of the ARNPs had achieved this level, compared to less than 30% of the RNs.

Job title. The job titles of study participants who were care providers and/or working in nursing are reported in Table 10. Since participants were permitted to indicate all titles that best described their position, the percentages add to more than 100%.

Work Environment

Work setting and shift assignment. The work settings of those study participants who were employed in nursing are listed in Table 11. Also included is the percentage of participants within each personnel category who indicated they worked in a specific setting. While participants were encouraged to indicate the setting in which they mainly worked, they could indicate all those in which they spent at least a third of their time. Because participants could indicate more than one work setting, it is difficult to make comparisons across the four categories of personnel. However, general trends can be identified for each personnel category within the two analysis files (i.e., working in nursing and care providers).

Nurse aides' responses indicate that the majority work in hospital-based medical surgical units. Caution needs to be exercised in interpreting this data due to the measures used to identify nurse aides employed in acute care settings. It is possible that their employers may have provided them with a more positive level of encouragement to participate in the study than was provided to nurse aides employed in other settings. Relatively large percentages of nurse aides reported they work in various types of long-term care facilities and in clients' homes. It should also be noted that very few differences were noted when the data for the two analysis files were compared.

The largest percentages of LPN/VNs indicated they worked in a skilled care unit, hospital-based medical surgical unit, or a long term care nursing facility. Other settings where significant numbers of LPN/VNs worked were residential care facilities and a physician's or dentist's office. The data in the two files are very similar.

Within both RN analysis files, the work settings with the highest percentages were hospital-based medical surgical and intensive care units. Compared with the nurse aide and LPN/VN groups, smaller percentages of RNs indicated they worked in long term care facilities.

The employment settings of ARNP participants included in the two analysis files differ from those of the other three categories of personnel. The largest percentage of ARNPs indicated they worked in outpatient clinics. Other areas of concentration were in anesthesia (the certified nurse anesthetists), labor and delivery (certified nurse midwives) and in independent practice.

Participants who were care providers were asked to describe the size and geographic location of their employment setting. This data is reported in Tables 12 and 13 respectively. Examination of data reported in Table 12 revealed that the majority of nurse aide, LPN/VN, and RN care providers were employed in facilities of 499 or fewer beds. The ARNP data is remarkably different in that more than 50% did not report the size of their employing institution. This is understandable in light of the number of ARNPs reporting they worked in community settings.

The largest percentages of participants (ranging between 19% and 28%), regardless of personnel category, reported they were employed in rural settings with a population of less than 20,000 (see Table 13). A similar percentage (19%) of ARNPs also reported employment in urban areas of 100,000 to 499,999. Another predominant employment location for nurse aides and LPN/VNs was in population areas of 20,000 to 99,000 (13-17%). In addition, similar percentages (13% - 14%) of RNs and/or ARNPs also reported employment in population areas of 20,000 to 99,000 (both RNs and ARNPs), in urban areas of 100,000 to 499,999 (RNs only) and urban areas of more than 500,000 (both RNs and ARNPs). Therefore, it appears that the geographic distribution of nurse aides and LPN/VNs is different than that of RNs and ARNPs.

Table 14 reports data relative to the work hours of the four categories of personnel who were care providers. The greatest proportion of participants, regardless of personnel category, reported they worked the day shift.

Client characteristics. The characteristics of clients cared for by the four categories of personnel are reported in terms of a client's condition (Table 15) and age (Table 16). Participants could mark more than one condition and many did so. Therefore, the percentages add up to more than 100%.

Examination of the data reported in Table 15 reveals that nurse aides, LPN/VNs and RNs interacted with similar types of clients. They primarily cared for clients with acute conditions, stable and unstable chronic conditions, and the terminally ill. In contrast, the ARNP data indicated the largest percentage provided care to well clients.

Participants were asked to report the age group(s) that best described their clients. The percentages of participants indicating they cared for a specific age group of clients are reported in Table 16. Since participants could select more than one age category, percentages add up to more than 100%. Nurse aide and LPN/VN participants most frequently reported that they cared for adult clients and for the elderly, aged 65 to over 85 years. Different age groups were cared for by RNs and ARNPs. The RN participants most frequently reported that they cared for young adults and adults, and for the elderly, aged 65 to 85 years. In contrast, the ARNPs most frequently reported they cared for adolescents, young adults and adults.

Functional Roles

Percentage of time spent on various nursing functions. Participants were asked what percentage of their time was spent in each of five general nursing functions, plus an additional "Other" category. The mean percentage of time that participants performed these various functions is reported in Table 17. For all four categories of personnel included in the working in nursing and care provider files, the majority of time was spent providing direct client care. The percentage of time spent in administration, the provision of indirect care (e.g., planning care, consulting, etc.) and student education varied by category of personnel (e.g., nurse aides reported they spent less time performing these activities) and whether the participant was a care provider.

Administrative responsibilities. Care provider participants were asked if they had administrative responsibilities. Those indicating an affirmative response were then requested to indicate if this was their primary position (e.g., unit manager, team leader). The data, summarized in Table 18, revealed that no less than 40% of LPN/VNs, RNs and ARNPs had administrative responsibilities. In addition, 19% of LPN/VN and 21% of RN participants indicated that this was their primary position. In contrast, only 8% of the ARNPs responded similarly.

Teaching and research activities. Participants were requested to provide information about their involvement in selected teaching and research activities. Data for all participants working in nursing and those in care provider positions, by category of personnel, are reported in Table 19. Examination of the data revealed nurse aides and LPN/VNs had little

involvement in either teaching or research activities. The activities for which they reported the most involvement were either the supervision of student learning experiences or serving as a preceptor for recent graduates or students.

The RNs and ARNPs also reported that supervising student learning experiences or precepting students or new graduates represented their highest areas of involvement in teaching-related activities. Involvement in teaching non-credit, inservice and/or continuing education programs was also apparent to a certain degree. The predominant involvement of RNs and ARNPs in research consisted of data collection activities.

Practice Activities

This section provides information on the frequency of performance and criticality of each of the 238 activities listed in Section 4 of the data collection instrument. Participants were asked if the performance of each activity applied to their work setting. If activity performance did apply to their work setting, participants were instructed to answer the subsequent questions about how frequently they performed the activity during the last day they worked, and how critical the performance of the activity was to the well-being of the client. If an activity did not apply to their work setting, participants were instructed to go on to the next activity statement. (Although participants were also requested to indicate how frequently they delegated performance of an activity to other nursing personnel, analysis of this data has not been completed.)

Participants reporting that an activity applied to their work setting, were asked to respond to the following question, "How often did you personally perform the activity the last time you worked?" The eleven response options ranged from "0 times" to "10 times or more." A default frequency value of "0" was assigned to an activity if a participant indicated it "did not apply" to their setting. Since the mean frequency of performance of each activity was calculated using all available data, it represents the frequency that an activity is performed by all care provider participants within each of the four personnel categories. The mean frequency values for each of the 238 activities are reported, by personnel category, in Table 20. The activities are grouped according to the four categories and 16 subcategories of *Client Needs* (n=212 activities) and by the five steps of the *Nursing Process* (n=26 activities).

The criticality of each nursing activity to the maintenance of client well-being was determined by participants' responses to the following question: "Could the activity be delayed or omitted on some occasions without having a major impact on client well-being?" "Major impact" was further defined as a substantial risk of unnecessary complications, impairment of function, or serious distress. Values of "0" (can sometimes omit) and "1" (can never omit) were used to code the data. The mean criticality values for each of the 238 activities are also reported in Table 20.

Client Needs. Examination of the data in Table 20 revealed several trends. For each personnel category, there is considerable variation in the mean frequency of performance values for activities within each *Client Need* subcategory. These findings may be related to several factors, among which are the influences of employment setting and client characteristics on the activities performed by a specific category of personnel. When compared across the four personnel categories, considerable variations in the mean frequency of performance values for many activities also exist, thus reflecting differences in practice. Since study participants were only requested to indicate the frequency with which they performed an activity, information describing specific characteristics of activity performance (e.g., depth, breadth, extent, etc) that could further delineate practice differences, is not available.

The activity with the highest overall mean frequency of performance, calculated using data contributed by all four personnel categories, was *#14 Use universal precautions* (7.53). The activity with the lowest, overall mean frequency of performance was *#208 Teach childbirth classes* (0.08). The lowest mean frequency of performance value calculated for a specific activity was 0.00 (*#227 Prescribe medications (nurse aides)).*

The mean criticality values for the 238 nursing activities ranged from an overall mean of 0.29 (*#10 Weigh client*) to a high of 0.97 (*#14 Use universal precautions*). With the exception of those activities which were performed by only a few nurse aides or LPN/VNs, the criticality values calculated for a specific activity were fairly stable across all four personnel categories (See Figures 2-7).

Nursing Process. The mean frequency of performance and criticality values for 26 activities representative of the five steps of the *Nursing Process* are also included in Table 20. The activities with the highest mean frequency values were *#150 Communicate client's needs to others* (5.28 - nurse aides), *#100 Document provision of client care* (4.92 - LPN/VNs; 5.51 - RNs) and *#133 Collect physical assessment data* (6.73 - ARNPs). For all four personnel categories, the activity with the highest mean criticality value was *#18 Report significant changes in client's condition* (0.89 - 0.98).

In examining the frequency of performance data for *Nursing Process* activities, a specific pattern emerged. As the level of practice of participants increased (i.e., nurse aide → LPN/VN → RN → ARNP), so did the mean frequency of activity performance. This pattern was also evident when the mean frequency values within a specific step of the *Nursing Process* were averaged. This data is reported in Figure 10. Rank ordering the means for each *Nursing Process* step within a personnel category provides additional information regarding differences in the practice characteristics of the four personnel categories. For nurse aides and LPN/VNs, the order, from highest to lowest mean value, is *Implementation, Assessment, Analysis, Planning, Evaluation*. The order for RNs is *Assessment, Implementation, Analysis, Evaluation and Planning*. The order for ARNPs is *Assessment, Implementation, Analysis, Planning, Evaluation*.

Additional Analyses

Two factors currently obscuring interpretation of the frequency and criticality data for the *Client Need* activities are: (1) the work settings and client characteristics of participants within each of the four personnel categories and (2) the wide variety of specialty practice areas represented within the ARNP group. Future data analysis plans include, but are not limited to the following: (1) Examining the practice characteristics of all study participants employed in a specific work setting (i.e., all those working in acute care), by personnel category; (2) Examining the practice characteristics of participants within each specific personnel category (e.g., all LPN/VNs) across the various practice settings; (3) evaluating participant responses to the frequency of delegation question and the value of this data to differentiating practice activities; and (4) examining the practice of ARNPs following their separation into more homogeneous groups (e.g., nurse midwives, nurse anesthetists).

Summary

A descriptive study of the nursing practice of nurse aides, LPN/VNs, RNs and ARNPs in the United States, the District of Columbia and the U.S. territories was undertaken using a newly developed data collection instrument. A major component of the instrument consisted of a list of 238 nursing activities. For each activity, respondents were asked to provide information regarding frequency of performance and delegation and activity criticality. Data were collected using a four-phase mailing process over approximately three months. Screening procedures were implemented to eliminate respondents' data when there was evidence of carelessness or misinterpretation. Based on the outcomes of a series of selected data analysis procedures, there was no evidence of response bias or other problem that would invalidate interpretation of the results.

An initial analysis of data provided by 6,930 nurse aides, LPN/VNs, RNs and ARNPs provided general information about the similarities and differences relative to their respective demographic characteristics, educational preparation, work setting, functional roles and, for those providing direct care to clients, client characteristics and practice activities. It is anticipated that further analysis of this rich data set, including information relative to the delegation of tasks by one personnel category to another, will yield more specific descriptions of the practice characteristics of each personnel category within and across a variety of client care settings.

Staff

Carolyn J. Yocom, *Director of Research Services*
Nancy Chornick, *Research Associate*
Jerrold Jacobson, *Research Assistant*

REFERENCES

Chornick, N., Yocom, C., and Jacobson, J. (1993). *Job analysis study of newly licensed, entry-leel registered nurses, 1992-1993.* Chicago, IL: National Council of State Boards of Nursing, Inc.

Kane, M., Kingsbury, C., Colton, D., and Estes, C. (1986). *A Study of nursing practice and role delineation and job analysis of entry-level performance of registered nurses.* Chicago, IL: national Coucnil of State Boards of Nursing, Inc.

National Council of State Boards of Nursing, Inc. (1987). *NCLEX-RN test plan.* Chicago, IL: Author.

Table 1. Frequency distribution of sample and respondents, by jurisdiction of origin and personnel category.

	Nurse Aides				LPNs				RNs				ARNP			
	Sample		Respondents		Sample		Respondents		Sample		Respondents		Sample		Respondents	
State	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
AK	73	2.8	34	3.0	120	2.3	44	1.9	100	1.9	52	2.0	99	4.3	49	4.1
AL	30	1.1	7	0.6	110	2.1	52	2.2	110	2.1	52	2.0	101	4.4	50	4.2
AR	46	1.8	16	1.4	110	2.1	40	1.7	110	2.1	47	1.8	0	0.0	0	0.0
AS	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
AZ	86	3.3	57	5.0	110	2.1	48	2.0	110	2.1	47	1.8	160	7.0	47	4.0
CA	108	4.1	32	2.8	110	2.1	35	1.5	110	2.1	51	2.0	100	4.4	49	4.1
CM	0	0.0	0	0.0	0	0.0	0	0.0	110	2.1	48	1.9	0	0.0	0	0.0
CO	123	4.7	63	5.5	110	2.1	49	2.1	110	2.1	61	2.4	0	0.0	0	0.0
CT	67	2.6	32	2.8	110	2.1	30	1.3	110	2.1	51	2.0	100	4.4	42	3.6
DC	35	1.3	10	0.9	49	0.9	13	0.6	110	2.1	29	1.1	0	0.0	0	0.0
DE	0	0.0	0	0.0	110	2.1	52	2.2	110	2.1	60	2.3	20	0.9	10	0.8
FL	72	2.8	24	2.1	110	2.1	39	1.7	110	2.1	50	1.9	100	4.4	46	3.9
GA	36	1.4	12	1.0	110	2.1	44	1.9	110	2.1	46	1.8	0	0.0	0	0.0
HI	25	1.0	8	0.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
IA	36	1.4	16	1.4	110	2.1	66	2.8	110	2.1	60	2.3	49	2.1	23	1.9
ID	0	0.0	0	0.0	110	2.1	66	2.8	110	2.1	62	2.4	100	4.4	51	4.3
IL	36	1.4	16	1.4	110	2.1	45	1.9	110	2.1	50	1.9	0	0.0	0	0.0
IN	73	2.8	37	3.2	110	2.1	50	2.1	110	2.1	42	1.6	0	0.0	0	0.0
KS	76	2.9	36	3.1	110	2.1	49	2.1	110	2.1	54	2.1	83	3.6	49	4.1
KY	72	2.8	33	2.9	110	2.1	50	2.1	110	2.1	45	1.7	20	0.9	5	0.4
LA	37	1.4	11	1.0	110	2.1	47	2.0	110	2.1	44	1.7	0	0.0	0	0.0
MA	15	0.6	4	0.3	110	2.1	42	1.8	110	2.1	61	2.4	100	4.4	43	3.6
MD	53	2.0	30	2.6	110	2.1	47	2.0	110	2.1	42	1.6	100	4.4	60	5.1
ME	36	1.4	26	2.3	110	2.1	63	2.7	110	2.1	65	2.5	100	4.4	59	5.0
MI	36	1.4	20	1.7	110	2.1	57	2.4	110	2.1	53	2.1	0	0.0	0	0.0
MN	36	1.4	16	1.4	106	2.0	48	2.0	110	2.1	61	2.4	0	0.0	0	0.0
MO	30	1.1	19	1.7	110	2.1	52	2.2	110	2.1	50	1.9	0	0.0	0	0.0
MS	72	2.8	30	2.6	110	2.1	54	2.3	110	2.1	50	1.9	102	4.5	57	4.8
MT	0	0.0	0	0.0	110	2.1	64	2.7	110	2.1	55	2.1	91	4.0	53	4.5
NC	36	1.4	17	1.5	110	2.1	48	2.0	110	2.1	60	2.3	105	4.6	50	4.2
ND	36	1.4	15	1.3	98	1.9	55	2.3	101	1.9	58	2.3	69	3.0	52	4.4
NE	16	0.6	10	0.9	110	2.1	67	2.9	110	2.1	60	2.3	68	3.0	38	3.2
NH	10	0.4	4	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NJ	63	2.4	22	1.9	110	2.1	45	1.9	110	2.1	55	2.1	0	0.0	0	0.0
NM	50	1.9	22	1.9	110	2.1	48	2.0	110	2.1	55	2.1	100	4.4	52	4.4
NV	118	4.5	58	5.1	96	1.9	33	1.4	95	1.8	35	1.4	104	4.5	56	4.7
NY	36	1.4	14	1.2	110	2.1	43	1.8	110	2.1	54	2.1	0	0.0	0	0.0
OH	72	2.8	25	2.2	110	2.1	55	2.3	110	2.1	69	2.7	20	0.9	11	0.9
OK	46	1.8	16	1.4	110	2.1	54	2.3	110	2.1	54	2.1	0	0.0	0	0.0
OR	138	5.3	49	4.3	110	2.1	50	2.1	110	2.1	47	1.8	18	0.8	9	0.8
PA	72	2.8	27	2.4	95	1.8	44	1.9	78	1.5	38	1.5	0	0.0	0	0.0
RI	120	4.6	58	5.1	110	2.1	42	1.8	110	2.1	26	1.0	0	0.0	0	0.0
SC	20	0.8	4	0.3	110	2.1	55	2.3	110	2.1	56	2.2	99	4.3	63	5.3
SD	36	1.4	16	1.4	110	2.1	61	2.6	110	2.1	67	2.6	84	3.7	46	3.9
TN	12	0.5	3	0.3	110	2.1	48	2.0	110	2.1	52	2.0	0	0.0	0	0.0
TX	72	2.8	19	1.7	110	2.1	49	2.1	110	2.1	50	1.9	0	0.0	0	0.0
UT	0	0.0	0	0.0	106	2.0	48	2.0	110	2.1	54	2.1	48	2.1	27	2.3
VA	37	1.4	22	1.9	110	2.1	47	2.0	110	2.1	65	2.5	39	1.7	27	2.3
VI	24	0.9	16	1.4	110	2.1	33	1.4	110	2.1	48	1.9	23	1.0	9	0.8
VT	5	0.2	4	0.3	110	2.1	58	2.5	110	2.1	57	2.2	0	0.0	0	0.0
WA	36	1.4	16	1.4	108	2.1	61	2.6	110	2.1	72	2.8	90	3.9	49	4.1
WI	141	5.4	63	5.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
WV	96	3.7	49	4.3	110	2.1	57	2.4	110	2.1	55	2.1	0	0.0	0	0.0
WY	16	0.6	8	0.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	2617	100.0	1146	100.0	5178	100.0	2347	100.0	5324	100.0	2575	100.0	2292	100.0	1182	100.0

Figure 1. Number of errors committed in the first 100 activity statements by participants working in nursing, by personnel category.

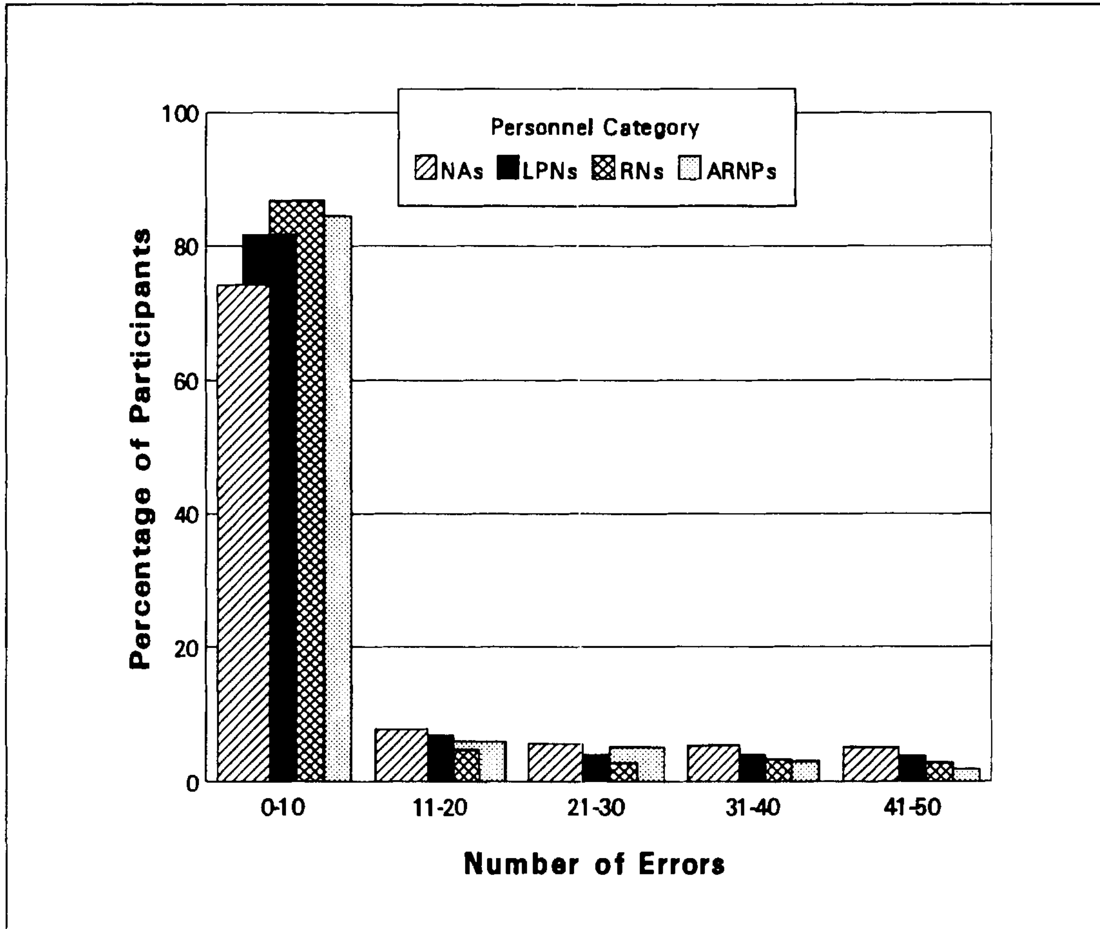
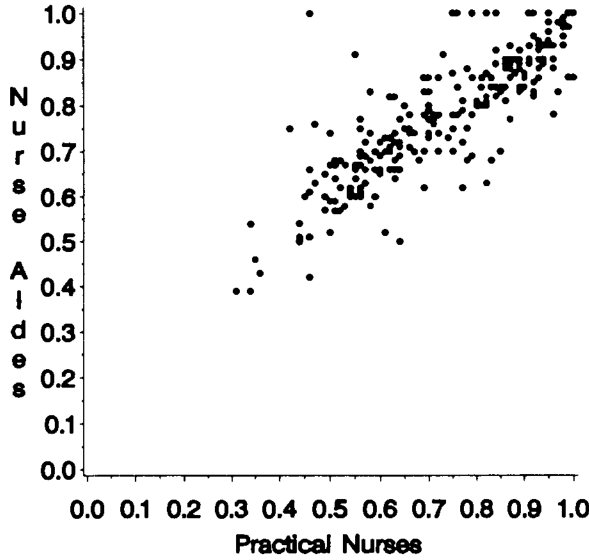


Table 2. Number of study participants within each of three analysis files, by personnel category.

	All Respondents	Working in Nursing	Care Provider
Nurse Aids	1,046	929	766
LPN/VNs	2,155	1,799	1,225
RNs	2,620	2,279	1,265
ARNPs	1,109	1,046	664
Totals	6,930	6,053	3,920

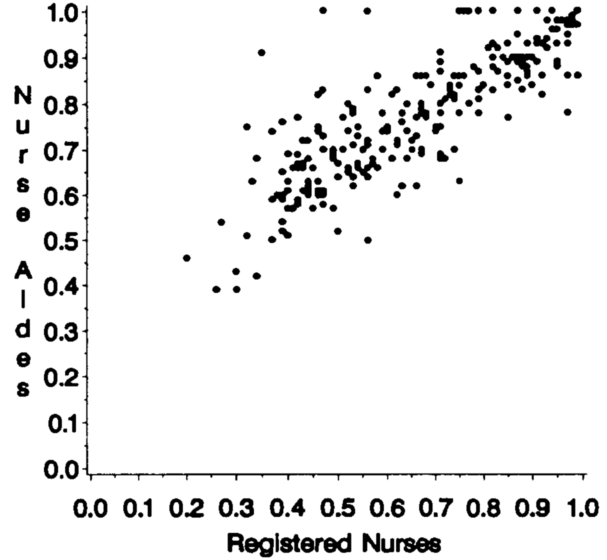
Figures 2 - 7. Relationships between mean criticality values of four categories of nursing personnel on 238 activity statements.

Figure 2. NAs and LPNs



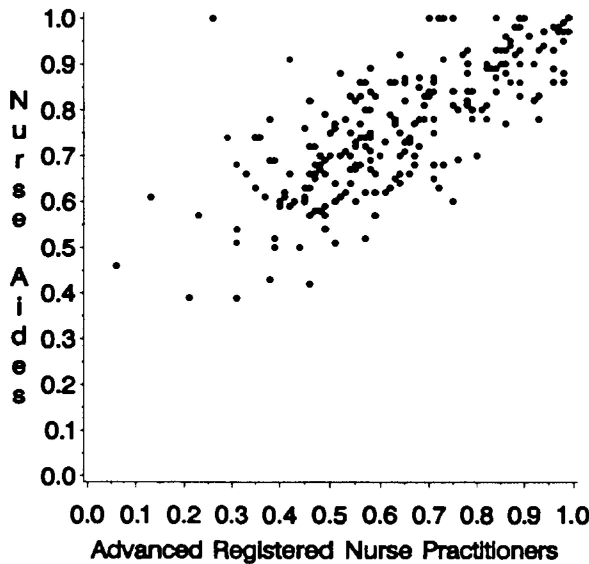
r(237) = 0.84, p = 0.0001

Figure 3. NAs and RNs



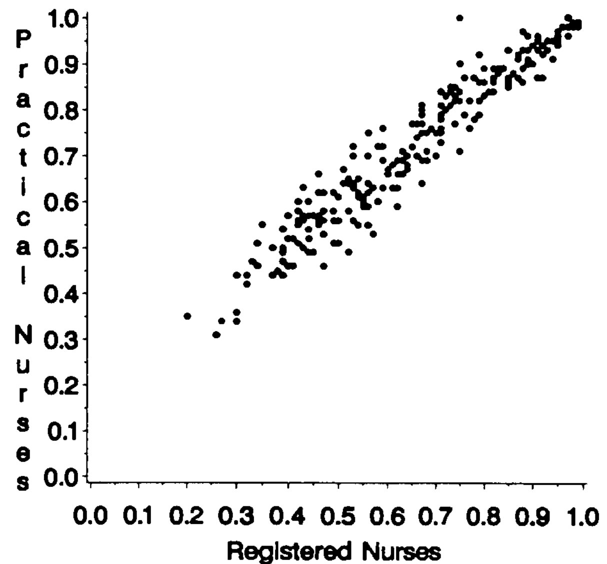
r(237) = 0.82, p = 0.0001

Figure 4. NAs and ARNPs



r(237) = 0.75, p = 0.0001

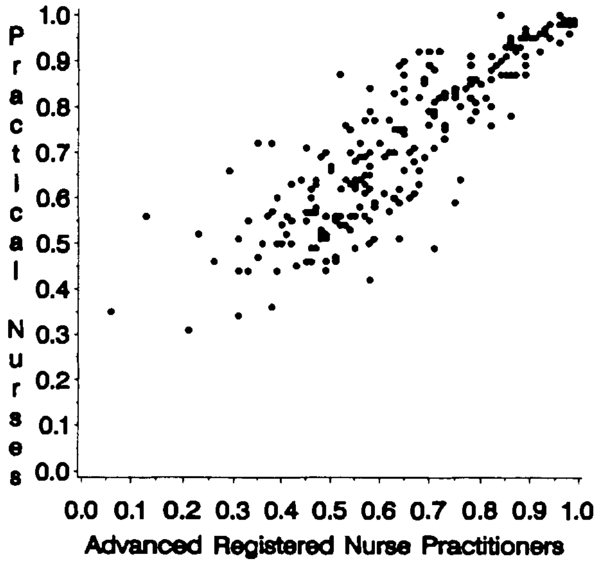
Figure 5. LPNs and RNs



r(238) = 0.97, p = 0.0001

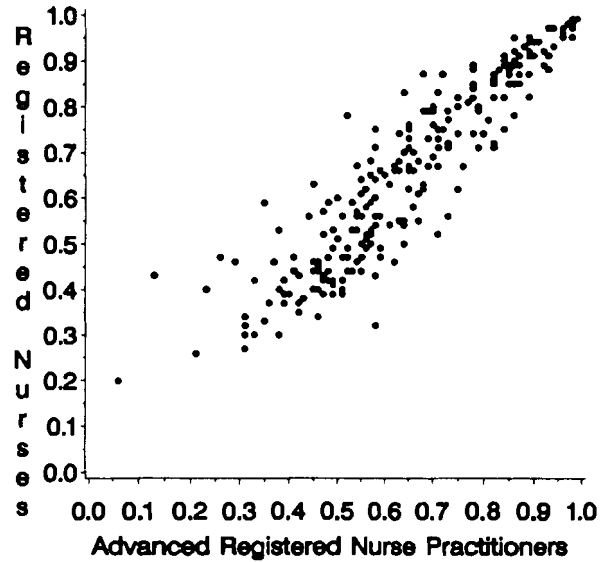
Figures 2 - 7. Relationships between mean criticality values of four categories of nursing personnel on 238 activity statements. (continued)

Figure 6. LPNs and ARNPs



r(238) = 0.87, p = 0.0001

Figure 7. RNs and ARNPs



r(238) = 0.92, p = 0.0001

Table 3. Relationships between mean criticality values for 238 nursing activities provided by different personnel categories.

	LPN/VNs	RNs	ARNPs
Nurse Aides	0.84 [1] 0.0001 [2]	0.82 0.0001	0.75 0.001
LPN/VNs		0.97 0.0001	0.87 0.0001
RNs			0.92 0.0001

[1] correlation coefficient

[2] p-value

Table 4. Mean criticality values for nursing activities predicted to have relatively high criticality and relatively low mean criticality values.

Item #	Activity	Criticality Ratings NA	LPN/VN	RN	ARNP
	High Criticality Predicted				
14.	Use universal precautions	0.98	0.98	0.97	0.96
18.	Report significant changes in client's condition	0.98	0.97	0.95	0.89
36.	Perform cardiopulmonary resuscitation	0.97	0.98	0.99	0.98
43.	Perform Heimlich maneuver/abdominal thrust	0.97	0.98	0.99	0.99
69.	Provide emergency care for a wound disruption (e.g., evisceration, dehiscence, etc.)	0.97	0.99	0.98	0.97
107.	Recognize occurrence of a hemorrhage	0.99	0.98	0.98	0.98
120.	Manage a medical emergency until a physician arrives	1.00	0.99	0.99	0.99
177.	Implement measures to prevent circulatory complications (e.g., hemorrhage, embolus, shock, etc.)	0.93	0.96	0.91	0.93
214.	Respond to symptoms of fetal distress	0.86	0.99	0.99	0.98
	Average Rating	0.96	0.98	0.94	0.96
	Low Criticality Predicted				
1.	Assist client to ambulate	0.39	0.34	0.30	0.31
5.	Change client's position	0.72	0.60	0.44	0.46
9.	Assist client with personal hygiene	0.68	0.51	0.44	0.46
10.	Weigh client	0.39	0.31	0.34	0.31
11.	Transport client using wheelchair, cart, etc.	0.57	0.49	0.26	0.21
12.	Do range-of-motion exercises for a client	0.51	0.44	0.45	0.46
15.	Apply ted hose/elastic stockings	0.57	0.56	0.32	0.31
16.	Give a sitz bath	0.46	0.52	0.40	0.23
24.	Apply heat or ice to extremity as needed	0.66	0.63	0.43	0.42
46.	Provide opportunities for client to vent	0.62	0.52	0.44	0.41
	Average Rating	0.56	0.49	0.38	0.36

Table 5. Mean frequency values for nursing activities with expected high and low values.

Activity		NA	LPN	RN	ARNP
Hypothesis:	Mean frequency of performance will be 5.0 or greater for all levels of personnel.				
2.	Verify identity of a client	4.90	6.03	5.92	5.19
14.	Use universal precautions	7.91	7.68	7.69	6.85
Hypothesis:	Rank ordering of mean freqency of performance will be as follows; Nurse Aides > LPN/VN > RN > ARNP.				
1.	Assist client to ambulate	5.95	3.85	2.70	0.69
5.	Change client's position	6.63	4.42	4.09	1.78
66.	Assist client with use of a walker, crutches, prosthesis, etc.	4.89	2.40	1.28	0.23
Hypothesis:	Rank ordering of mean frequency of performance will be as follows: ARNP > RN > LPN/VN > Nurse Aide.				
133.	Collect physical assessment data	0.91	3.35	4.74	6.73
164.	Evaluate client's compliance with prescribed therapy	0.66	2.38	2.61	3.85
201.	Identify client's perception of health status	0.87	1.89	2.39	3.97

Table 6. Ethnic/racial composition of study participants, by personnel category and type analysis file.

	All Respondents				Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(1000)	(2100)	(2585)	(1109)	(891)	(1769)	(2279)	(1046)	(736)	(1206)	(1265)	(664)
Race	%	%	%	%	%	%	%	%	%	%	%	%
American Indian/ Eskimo	1.8	1.8	0.8	0.5	1.5	1.6	0.8	0.5	1.5	1.5	1.0	0.3
Asian Indian	0.1	0.1	0.2	0.3	0.1	0.1	0.2	0.3	0.1	0.2	0.2	0.3
Pacific Islander	0.5	0.1	1.0	0.2	0.6	0.2	1.1	0.2	0.4	0.2	1.0	0.2
Other Asian	1.5	0.4	2.2	0.6	1.5	0.4	2.4	0.6	1.8	0.5	3.0	0.5
Hispanic	3.8	2.9	1.7	1.3	3.8	2.9	1.8	1.3	4.2	3.2	2.1	1.4
Black/African American	19.5	11.9	4.9	3.4	19.6	12.7	5.3	3.5	17.7	12.4	5.2	3.0
White, not of hispanic origin	72.8	82.8	89.3	93.8	73.0	82.1	88.4	93.7	74.3	82.0	87.5	94.4

Table 7. Educational preparation of study participants, by personnel category and type analysis file.

	All Respondents				Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(965)	(2077)	(2539)	(1052)	(861)	(1739)	(2219)	(997)	(718)	(1186)	(1237)	(633)
Type of Program	%	%	%	%	%	%	%	%	%	%	%	%
None	16.4	10.8	7.3	0.6	16.5	10.4	7.0	0.4	16.6	9.5	6.6	0.5
Nurse aide program	71.1	0.2	0.0	0.0	70.6	0.2	0.0	0.0	70.6	0.2	0.0	0.0
LPN/LVN - certificate/ diploma	1.0	76.3	0.1	0.0	1.1	77.3	0.0	0.0	1.0	79.5	0.0	0.0
LPN/LVN - associate degree	0.0	6.0	0.1	0.0	0.0	5.8	0.1	0.0	0.0	5.1	0.0	0.0
RN - diploma	0.4	0.2	26.0	1.8	0.3	0.2	24.6	1.7	0.5	0.3	25.4	1.7
RN - associate degree	0.0	0.7	26.9	0.3	0.0	0.7	28.6	0.2	0.0	0.6	34.9	0.3
RN - baccalaureate degree	0.3	0.1	23.9	3.2	0.2	0.1	24.4	3.3	0.3	0.2	22.8	3.0
RN - generic masters or doctorate	0.0	0.0	2.7	8.1	0.0	0.0	2.9	8.4	0.0	0.0	1.0	4.1
Nurse practitioner program - certificate	0.0	0.0	1.3	35.8	0.0	0.0	1.2	36.0	0.0	0.0	1.4	40.8
Nurse practitioner program - masters degree	0.0	0.0	0.3	22.5	0.0	0.0	0.3	22.9	0.0	0.0	0.1	22.6
Other masters degree	0.1	0.2	4.6	9.9	0.1	0.0	4.2	9.6	0.0	0.0	2.3	8.7
Doctorate	0.0	0.0	0.9	3.8	0.0	0.1	0.9	3.8	0.0	0.0	0.0	1.9
Other	10.7	5.4	5.9	14.4	11.0	5.3	5.8	13.6	10.9	4.6	5.4	16.4

Table 8. Additional course work or certification programs completed by LPN/VNs, by type analysis file.

Types of Course Work	Working in Nursing (n = 1,799) %	Care Providers (n=1,225) %
Intravenous therapy	38.4	39.5
Advanced Cardiac Life Support	17.3	17.0
Electrocardiogram	13.4	13.7
Pharmacology	18.3	18.0
Gerontology	6.8	6.7
Leadership/management	15.6	13.3
Rehabilitation	5.3	4.9
Other	16.8	16.9

Table 9. Additional course work or certification programs completed by RNs and ARNPs, by type analysis file.

	Working in Nursing		Care Provider	
Types of Course Work	RN (n = 2279) %	ARNP (n = 1046) %	RN (n = 1265) %	ARNP (n = 664) %
Intravenous Therapy	29.2	14.1	32.5	16.0
Advanced Cardiac Life Support	28.8	29.8	33.0	31.0
Critical Care	17.2	10.1	19.5	10.1
Coronary Care	12.6	6.6	13.9	8.3
Chemotherapy	7.2	3.0	8.8	3.0
Rehabilitation	3.5	1.7	3.2	1.8
Other	24.8	47.5	25.5	50.3

Figure 8. Length of employment in nursing, by personnel category and type analysis file.

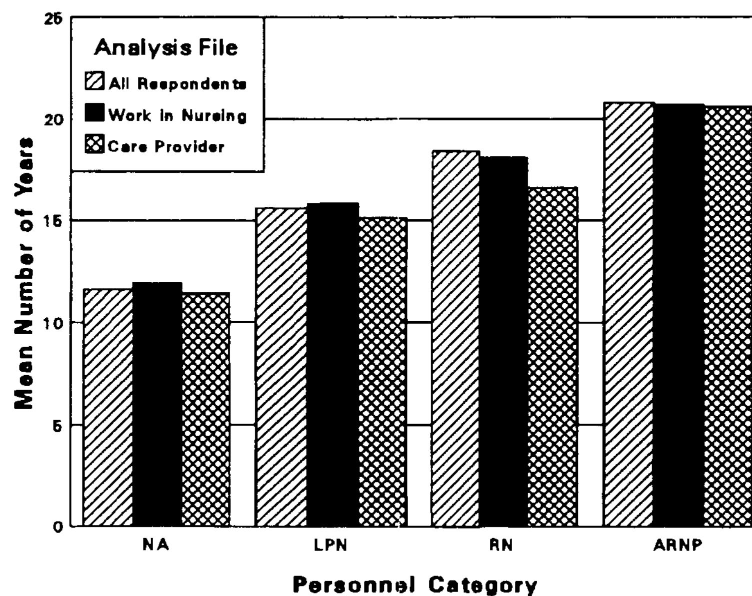


Figure 9. Length of employment in current position, by personnel category and type analysis file.

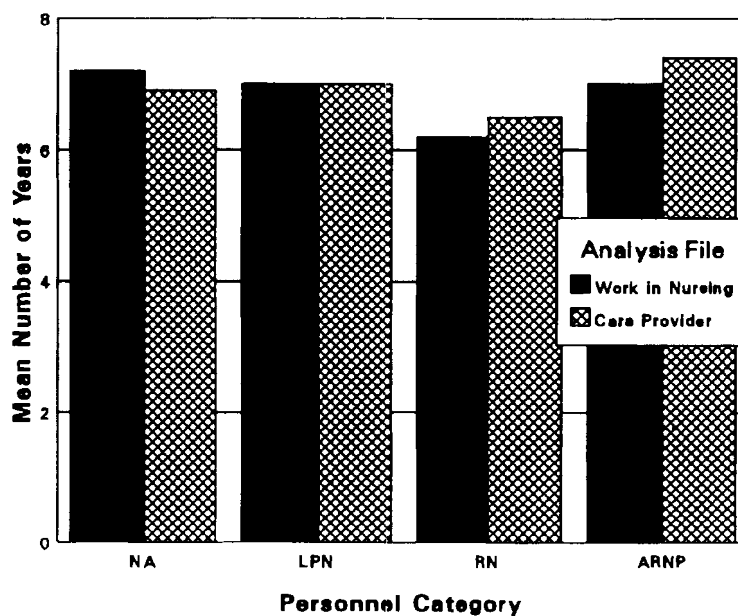


Table 10. Position titles of study participants, by personnel category and type analysis file.

	Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(929)	(1799)	(2279)	(1046)	(766)	(1225)	(1265)	(664)
Title	%	%	%	%	%	%	%	%
Administrator or assistant administrator	0.3	1.2	3.2	4.9	0.4	0.5	0.9	2.9
Case associate/associate nurse	0.1	0.3	0.8	0.0	0.1	0.5	1.3	0.0
Case manager	0.2	0.7	4.3	2.6	0.3	0.6	4.0	2.1
Certified nurse aide	76.4	0.4	0.0	0.0	79.0	0.7	0.0	0.0
Certified registered nurse anesthetist (CRNA)	0.0	0.0	0.0	16.6	0.0	0.0	0.0	20.9
Charge nurse	0.1	27.7	23.7	1.0	0.1	27.8	33.6	1.4
Clinical nurse specialist	0.0	0.0	2.1	11.7	0.0	0.0	2.1	7.8
Consultant	0.4	1.2	2.5	4.1	0.5	0.8	1.1	2.6
Dean, director, or assistant/associate director of nursing education	0.0	0.1	0.7	0.5	0.0	0.0	0.0	0.2
Director or assistant/associate director of nursing service	0.0	0.8	4.1	2.0	0.0	0.6	0.7	1.2
Discharge coordinator/planner	0.0	1.2	2.1	0.5	0.0	1.0	1.7	0.5
Enterostomal therapist	0.0	0.2	0.4	0.2	0.0	0.2	0.6	0.2
General duty nurse	0.0	31.4	12.3	1.1	0.0	34.0	17.4	0.6
Head nurse or assistant head nurse	0.1	3.7	6.6	1.1	0.0	3.4	6.6	0.8
Home health/community health nurse	4.3	5.5	7.3	1.9	4.2	5.1	5.8	2.0
Infection control nurse	0.0	3.4	2.1	0.4	0.0	3.3	1.5	0.5
In-service education director or instructor	0.2	2.2	3.9	1.8	0.1	2.0	2.8	1.1
Instructor/nurse educator	0.1	2.2	5.5	8.3	0.1	2.0	2.7	4.5
Insurance reviewer/ utilization review nurse	0.0	1.3	2.0	0.1	0.0	0.5	0.4	0.0
Intravenous therapy nurse	0.0	6.4	6.0	0.5	0.0	7.8	8.8	0.3
Medication aide/technician	4.6	0.8	0.0	0.0	4.3	0.8	0.1	0.0
Medication nurse	0.9	43.7	12.5	0.6	0.9	47.8	18.1	0.5
Nurse aide/nursing assistant	50.7	0.6	0.0	0.0	50.4	0.5	0.0	0.0
Nurse clinician	0.0	0.0	1.4	1.8	0.0	0.0	1.7	1.5
Nurse coordinator	0.0	0.9	3.1	1.6	0.0	0.7	2.0	1.5
Nurse midwife	0.0	0.1	0.0	12.3	0.0	0.1	0.0	15.1
Nurse practitioner	0.0	0.0	1.0	50.0	0.0	0.0	1.1	54.8
Nurse recruiter	0.0	0.1	0.2	0.3	0.0	0.0	0.1	0.3
Orderly	4.4	0.2	0.1	0.0	4.4	0.2	0.2	0.0
Parish Nurse	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Patient care coordinator	1.1	3.2	3.8	0.9	1.3	3.0	3.6	0.9
Primary nurse	0.1	12.0	13.5	1.1	0.4	14.8	20.5	1.4
Private duty nurse	3.4	6.2	1.7	0.1	4.0	6.8	1.9	0.0
Professor or assistant/associate professor	0.0	0.0	0.9	3.7	0.0	0.0	0.1	1.5
Public health nurse	0.0	0.9	3.8	3.2	0.0	0.9	3.5	3.6
Quality assurance/improvement nurse	0.1	2.4	4.8	1.1	0.1	1.7	2.8	0.8
Researcher	0.0	0.3	1.2	2.5	0.0	0.2	0.5	1.2
School nurse	0.0	1.6	3.6	1.8	0.0	1.5	3.6	1.5

Table 10. Position titles of study participants, by personnel category and type analysis file. (continued)

	Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(929)	(1799)	(2279)	(1046)	(766)	(1225)	(1265)	(664)
Title	%	%	%	%	%	%	%	%
Staff nurse	0.3	40.6	39.4	2.3	0.3	45.8	56.1	1.8
Supervisor or assistant supervisor	0.3	4.1	7.9	2.9	0.1	4.2	4.3	3.5
Team leader	2.3	9.1	7.7	0.7	2.3	10.4	11.3	0.8
Technician	5.3	1.6	0.1	0.1	4.8	1.7	0.1	0.0
No position title	0.4	2.4	0.7	0.2	0.1	2.1	0.6	0.2
Other	8.4	12.3	12.5	7.6	8.1	10.3	10.8	5.7

Table 11. Work settings of study participants, by personnel category and type analysis file.

	Working in Nursing				Care Provider			
	NA	LPN/VN	RN	ARNP	NA	LPN/VN	RN	ARNP
(n)	(929)	(1799)	(2279)	(1046)	(766)	(1225)	(1265)	(664)
Type Setting	%	%	%	%	%	%	%	%
Hospitals:								
Medical-Surgical	36.8	21.3	19.2	4.9	37.9	24.0	23.5	2.3
Pediatrics	7.1	4.4	3.9	2.0	7.8	5.6	4.3	0.8
Intensive Care	6.7	4.2	12.4	5.2	7.0	4.8	16.4	3.9
Stepdown/ Intermediate Care	9.1	4.8	5.4	1.4	9.9	5.5	7.2	1.1
Anesthesia	0.1	0.1	0.4	14.7	0.1	0.0	0.2	18.8
Operating Room	1.0	3.1	6.9	6.4	0.8	2.4	8.1	7.8
Recovery Room	1.6	1.7	4.2	1.9	1.6	1.7	5.4	2.7
Emergency Room	4.4	4.1	7.2	3.1	4.4	4.2	9.1	2.6
Psychiatric	3.1	4.1	4.9	3.6	3.7	4.2	4.9	2.4
Rehabilitation	6.9	4.9	2.5	0.6	7.6	5.5	2.5	0.5
Chemical Dependency	1.3	1.8	1.2	0.7	1.4	1.2	1.2	0.8
Labor & Delivery	4.7	2.9	5.1	11.0	5.0	3.5	6.6	13.4
Postpartum	7.0	5.1	5.9	5.5	7.4	5.7	7.8	5.6
Nursery	8.6	4.8	5.3	3.5	9.7	5.6	7.0	3.0
Patient Education	0.6	0.4	1.6	0.8	0.7	0.4	1.4	0.5
Inservice Education	0.5	0.5	1.6	0.9	0.5	0.4	0.5	0.3
Other	15.2	20.7	22.9	25.1	15.4	20.8	19.3	23.5
Long-Term Care:								
Skilled Care	27.9	30.8	9.4	2.6	29.2	30.8	7.7	2.0
Nursing Care facility	20.6	17.8	5.4	1.3	22.3	18.2	3.9	0.9
Residential	14.6	10.3	2.9	1.1	15.7	9.5	2.2	0.6
Community/Home Care Settings:								
Physician's/ Dentist's Office	0.5	10.8	5.0	11.5	0.5	9.3	5.5	13.0
School	0.1	1.3	3.5	4.4	0.0	1.1	3.4	4.5
Occupational	0.8	0.4	1.4	1.1	0.9	0.4	1.0	1.2
Outpatient Clinic	0.8	4.9	4.0	22.0	0.7	4.6	4.1	24.5
Outpatient Surgery	0.6	1.1	1.1	1.0	0.5	1.1	1.3	1.1
Client's Home	11.8	7.1	7.6	2.4	12.1	7.6	5.6	1.8
Hospice	3.2	1.3	1.3	0.3	3.7	1.1	0.9	0.2
Public Health Agency	2.2	1.2	4.2	8.1	2.3	1.1	3.2	8.9

Table 11. Work settings of study participants, by personnel category and type analysis file. (cont.)

	Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(929)	(1799)	(2279)	(1046)	(766)	(1225)	(1265)	(664)
Type Setting	%	%	%	%	%	%	%	%
Private Practice Settings:								
Independent practice (individual or group)	4.1	5.0	1.7	11.3	3.8	5.0	1.6	13.1
Other:								
Temporary employment agency	3.6	3.9	1.4	0.1	3.3	4.4	1.5	0.0
Nursing education program	1.0	0.4	2.9	6.6	0.7	0.5	0.2	2.0
Self-employed	1.4	1.5	1.1	3.7	1.7	1.5	0.7	3.9
Nursing/Health care organization	4.1	0.8	0.5	0.4	4.3	1.0	0.2	0.2
Government agency	1.4	0.7	1.3	1.3	1.2	0.7	0.6	0.5
Department of corrections	0.0	0.8	0.4	0.5	0.0	0.9	0.6	0.8
Medical Supplier	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.0
Insurance company	0.0	0.7	0.6	0.5	0.0	0.2	0.0	0.3
Other	1.6	4.5	3.7	5.5	1.7	4.1	2.9	5.1

Table 12. Distribution of care providers by personnel category and size of employing hospital or nursing home.

(n) Size	NAs (766) %	LPN/VNs (1225) %	RNs (1265) %	ARNPs (664) %
under 100 beds	30.0	24.5	16.2	10.7
100 - 299 beds	36.4	32.6	29.6	15.5
300 - 499 beds	16.1	9.6	17.1	10.2
500 or more beds	7.3	7.8	14.1	9.0
unknown	1.7	0.7	0.9	0.5
missing[1]	8.5	25.0	22.1	54.1

[1] Information requested only from participants employed in hospitals or nursing homes.

Table 13. Distribution of care providers, by personnel category and location of employment setting.

(n) Location	NAs (766) %	LPN/VNs (1225) %	RNs (1265) %	ARNPs (664) %
urban, > 500,000	6.0	7.7	13.1	12.0
suburban, > 500,000	4.4	4.6	7.9	6.2
urban, 100,000 to 499,999	10.6	9.3	13.6	19.3
suburban, 100,000 to 499,999	5.1	8.2	9.8	8.1
city, 50,000 to 99,999	13.8	14.0	13.2	14.8
city, 20,000 to 49,999	15.0	16.4	14.5	14.9
rural, < 20,000	27.2	26.8	18.5	20.3
unknown	14.0	7.7	4.9	1.2
missing	3.9	5.5	4.4	3.2

Table 14. Shift assignment of care providers, by personnel category.

	NAs	LPN/VNs	RNs	ARNPs
(n)	(766)	(1225)	(1265)	(664)
Shift	%	%	%	%
Days (8, 10 or 12 hour shift)	48.6	51.4	57.7	77.2
Evenings (8, 10 or 12 hour shift)	21.1	18.0	11.0	1.8
Nights (8, 10 or 12 hour shift)	17.1	18.3	17.8	0.8
Rotating Shifts	9.7	9.2	9.8	5.4
Other	3.5	3.1	3.6	14.8
Total	100.0	100.0	99.9[1]	100.0

[1] Adds to less than 100% due to rounding

Table 15. Percentage of care providers caring for specific types of clients, by personnel category.[1]

	NAs	LPN/VNs	RNs	ARNPs
(n)	(766)	(1225)	(1265)	(664)
Type of Client	%	%	%	%
Well	29.5	29.5	27.9	57.4
Maternity	10.7	12.0	15.3	36.6
Stabilized Chronic	53.5	55.4	34.7	34.6
Unstabilized Chronic	44.4	45.0	43.4	29.7
Acute Conditions	46.9	47.8	57.8	45.0
Terminally ill	51.4	41.7	28.1	14.5
Behavioral/Emotional Disorders	38.1	39.9	21.5	21.7
Other	7.8	8.1	9.2	7.8

[1] Adds to more than 100% because participants could mark more than one response option.

Table 16. Percentage of care providers caring for different age groups of clients, by personnel category.[1]

	NAs	LPN/VNs	RNs	ARNPs
(n)	(766)	(1225)	(1265)	(664)
Client Age Group	%	%	%	%
Newborns (1 - 30 days)	9.5	11.6	15.1	18.4
Infants/Children (1 month to 12 years)	10.7	17.3	21.6	29.4
Adolescents (13 - 18 years)	12.5	18.6	20.9	47.0
Young adults (19 - 30 years)	28.3	30.2	40.3	64.9
Adults (31 - 64 years)	56.9	56.6	65.4	66.3
Elderly (65 - 85 years)	84.7	71.1	64.3	36.1
Elderly (over 85 years)	59.1	42.5	27.7	15.4
Other	2.1	4.6	4.3	3.8

[1] Adds to more than 100% because participants could mark more than one response option.

Table 17. Mean percent of time spent performing different functional roles, by personnel category and type analysis file.

Functional Roles	Working in Nursing				Care Provider			
	NA	LPN/VN	RN	ARNP	NA	LPN/VN	RN	ARNP
	%	%	%	%	%	%	%	%
Administration/Management	1.2	7.3	17.3	11.8	0.8	5.2	7.8	8.6
Direct Client Care	88.3	70.6	54.3	61.2	90.0	76.3	71.8	73.1
Indirect Client Care	3.8	13.5	17.2	13.7	3.6	11.9	14.2	11.7
Education of Students	1.3	2.1	4.8	8.2	1.2	1.8	2.4	3.9
Research	1.2	2.5	2.8	2.4	1.3	2.6	2.3	1.4
Other	4.2	4.0	3.7	2.7	3.0	2.2	1.6	1.3
Total	100.0	100.0	100.1[1]	100.0	99.9[1]	100.0	100.1[1]	100.0

[1] Adds to more or less than 100% due to rounding

Table 18. Administrative responsibilities of care providers, by personnel category.

	Have administrative responsibilities		Have primary administrative position	
	#	%	#	%
Nurse aides (n = 766)	64	8.4	20	2.6
LPN/VNs (n = 1225)	490	40.0	233	19.0
RNs (n = 1265)	695	54.9	270	21.3
ARNPs (n = 664)	288	43.4	54	8.1

Table 19. Teaching and research activities engaged in, by personnel category and type analysis file.

	Working in Nursing				Care Provider			
	NA	LPN/ VN	RN	ARNP	NA	LPN/ VN	RN	ARNP
(n)	(929)	(1799)	(2279)	(1046)	(766)	(1225)	(1265)	(664)
Activity	%	%	%	%	%	%	%	%
Research								
Independently design a research study	0.2	0.5	3.6	7.9	0.3	0.3	1.7	6.8
Participate in developing a research proposal	0.9	1.3	5.3	13.0	0.7	1.4	3.3	8.3
Collect data for a research study	2.5	5.5	15.0	27.1	2.6	5.7	12.6	24.7
Analyze data resulting from a research study	1.1	2.0	6.2	10.8	1.4	2.2	3.7	7.1
Present research results at a conference or in a publication	0.5	0.8	3.5	8.4	0.4	0.7	2.1	6.0
Serve as an advisor or supervisor for student research	0.0	0.7	2.3	7.6	0.0	0.8	1.0	5.7
Teaching								
Teach a noncredit, in-service course in nursing	0.9	5.0	14.9	23.1	0.8	5.1	13.3	20.6
Teach a continuing education course/program in nursing	0.4	1.4	7.0	19.6	0.5	1.5	4.8	16.6
Teach an academic credit course in a basic nurisng education program	0.1	0.2	3.1	8.8	0.1	0.1	0.2	4.7
Teach a graduate-level course in nursing	0.1	0.0	0.7	6.2	0.1	0.0	0.0	4.7
Develop or revise a course or class in nursing	1.1	0.7	5.0	11.3	0.9	0.7	2.0	6.2
Supervise students' clinical learning experiences	3.4	7.6	17.1	35.9	4.0	8.2	16.8	33.0
Serve as a preceptor for recent graduates or students	5.4	9.4	24.4	30.9	6.1	11.2	31.0	32.5

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
	Safe, Effective Care Environment								
	Subcategory: Coordinated Care								
156	Collaborate with other health team members to achieve desired outcomes of client care	3.82	0.71	3.69	0.62	3.84	0.56	4.47	0.58
218	Act as a resource person to other staff	2.18	0.64	2.79	0.55	3.64	0.56	4.15	0.51
20	Participate in client care conference (formal & informal)	1.97	0.52	1.97	0.50	2.03	0.39	2.59	0.39
105	Initiate a consultation/referral (e.g., social service, physical therapy, etc.)	0.54	0.59	1.48	0.50	1.61	0.39	2.48	0.40
143	Supervise delivery of client care by assistive personnel	0.44	0.74	2.55	0.67	2.99	0.64	2.42	0.58
141	Plan client-care assignments for staff	0.25	0.86	1.44	0.69	1.85	0.68	0.69	0.57
	Subcategory: Quality Assurance								
14	Use universal precautions	7.91	0.98	7.68	0.98	7.69	0.97	6.85	0.96
6	Intervene when a client's dignity or privacy is being violated	2.29	0.89	1.96	0.89	1.69	0.88	1.46	0.83
158	Intervene in situations involving unsafe or inadequate client care	2.16	0.92	1.97	0.93	1.45	0.93	1.30	0.88
38	Document/report treatment errors or accidents	1.91	0.95	2.04	0.92	0.99	0.87	0.82	0.87
220	Participate in a quality assurance program and/or peer review	0.84	0.59	1.08	0.50	1.40	0.37	1.78	0.42
144	Intervene to provide more effective treatment in order to improve client outcomes	0.72	0.77	1.86	0.70	2.06	0.66	2.62	0.63
	Subcategory: Environmental Safety								
26	Follow infection control guidelines/protocols	7.38	0.98	6.90	0.98	6.38	0.96	6.33	0.96
23	Protect client from injury	6.64	0.97	5.63	0.98	5.29	0.97	3.84	0.94
2	Verify identity of a client	4.90	0.82	6.03	0.92	5.92	0.92	5.19	0.92
40	Monitor activities of confused client	3.84	0.87	3.39	0.90	1.99	0.89	0.51	0.84
4	Report malfunctioning equipment	2.55	0.75	1.86	0.66	1.31	0.60	1.01	0.50
29	Follow procedures for handling bio-hazardous materials (e.g., chemotherapeutic agents, radiation therapy, etc.)	2.37	0.95	2.61	0.98	2.11	0.97	2.73	0.98
44	Explain agency routines to client/family	1.58	0.58	2.33	0.53	2.61	0.47	3.19	0.48

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
	Subcategory: Preparation for Treatments and Procedures								
62	Physically prepare client for a procedure/surgery	1.25	0.84	1.64	0.85	1.90	0.85	1.39	0.78
34	Explain procedures to client and family	1.18	0.78	3.19	0.79	3.72	0.79	4.95	0.79
95	Explain reasons for care client will receive following a procedure/surgery	1.12	0.75	1.97	0.75	2.31	0.70	2.16	0.64
130	Describe expected outcomes of treatment or therapy to client/family	0.76	0.70	1.98	0.61	2.77	0.55	4.23	0.67
45	Determine if client has relevant information prior to surgery	0.50	0.90	1.17	0.86	1.62	0.82	1.73	0.82
33	Determine if client is emotionally ready for a procedure/surgery	0.35	0.92	1.07	0.84	1.73	0.81	2.14	0.77
	Subcategory: Safe and Effective Treatments and Procedures								
21	Obtain specimen from client for laboratory tests	3.63	0.76	3.40	0.71	3.09	0.63	3.30	0.45
68	Use aseptic technique when handling equipment/supplies during a procedure	2.28	0.94	4.00	0.95	3.91	0.93	4.08	0.94
27	Set up a sterile field	1.35	0.86	2.50	0.93	2.18	0.89	1.91	0.87
115	Monitor status of client during a procedure/surgery	0.36	0.88	0.86	0.96	1.64	0.95	2.20	0.98
	Physiological Integrity								
	Subcategory: Physiological Adaptation								
47	Encourage client to use prescribed breathing techniques/exercises	3.06	0.66	2.40	0.64	2.29	0.52	1.54	0.47
24	Apply heat or ice to extremity as needed	3.03	0.66	2.04	0.63	1.68	0.43	0.57	0.42
127	Use alternative methods of communication for a client with hearing, speech or vision problem	2.87	0.78	2.14	0.69	1.31	0.67	0.87	0.69
91	Administer oxygen	2.15	0.88	2.56	0.93	2.62	0.89	1.94	0.86
122	Maintain desired temperature of client using external devices (e.g., hypothermia unit, blankets, ice, etc.)	1.84	0.84	1.18	0.86	1.34	0.80	1.17	0.79
59	Report characteristics of a client's seizure	1.77	0.96	1.36	0.95	0.75	0.94	0.39	0.91
167	Monitor status of a postoperative client	1.27	0.98	1.51	0.95	1.88	0.93	1.31	0.88
35	Test blood glucose levels	1.05	0.88	2.90	0.87	2.17	0.78	1.57	0.52
107	Recognize occurrence of a hemorrhage	0.91	0.99	1.12	0.98	1.10	0.98	1.21	0.98
110	Physically stimulate client to breathe	0.81	0.93	0.72	0.98	0.88	0.97	1.01	0.96

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides		LPN/VNs		RNs		ARNPs	
		Freq.	Crit.	Freq.	Crit.	Freq.	Crit.	Freq.	Crit.
43	Perform Heimlich maneuver/abdominal thrust	0.78	0.97	0.37	0.98	0.17	0.99	0.13	0.99
132	Determine changes in client's neurological status	0.78	0.84	1.88	0.90	2.13	0.90	1.78	0.84
36	Perform cardiopulmonary resuscitation	0.73	0.97	0.59	0.98	0.54	0.99	0.46	0.98
32	Irrigate colostomy	0.70	0.74	0.77	0.66	0.35	0.46	0.02	0.29
149	Monitor client's response to total parenteral nutrition	0.59	0.68	1.12	0.83	0.85	0.72	0.22	0.73
81	Obtain Doppler readings	0.56	0.87	0.70	0.75	0.94	0.71	1.34	0.65
134	Suction client's respiratory tract (e.g., oral, nasal, tracheostomy, endotrachial tube, etc.)	0.56	0.90	1.75	0.94	1.66	0.90	1.34	0.86
109	Use Ambu bag to ventilate client	0.51	0.98	0.68	0.98	0.81	0.98	0.84	0.97
102	Provide care for client with vascular access for hemodialysis (e.g., AV shunt, fistula, etc.)	0.49	0.83	0.62	0.92	0.69	0.79	0.14	0.70
120	Manage a medical emergency until a physician arrives	0.49	1.00	0.90	0.99	0.98	0.99	1.05	0.99
69	Provide emergency care for a wound disruption (e.g., evisceration, dehiscence, etc.)	0.48	0.97	0.90	0.99	0.53	0.98	0.32	0.97
79	Apply sequential compression device (e.g., Mast trousers, anti-shock trousers, etc.)	0.37	0.88	0.21	0.78	0.32	0.78	0.05	0.86
67	Obtain hemodynamic measurements	0.36	0.84	0.48	0.81	1.47	0.73	1.73	0.71
214	Respond to symptoms of fetal distress	0.34	0.86	0.22	0.99	0.27	0.99	0.75	0.98
119	Provide tracheostomy care	0.31	0.82	1.06	0.84	0.74	0.73	0.21	0.65
104	Monitor client's gas exchange status using arterial blood gases, pulse oximetry reading, etc.	0.30	0.77	0.98	0.87	2.20	0.85	1.58	0.86
98	Manage long-term central or implanted vascular devices (e.g., Hickman catheter, etc.)	0.26	0.84	0.47	0.89	0.89	0.80	0.23	0.70
75	Insert feeding/nasogastric tube	0.13	0.62	0.85	0.77	0.84	0.66	0.62	0.59
199	Implement measures to manage cardiac arrhythmias	0.13	0.89	0.68	0.94	1.01	0.95	0.74	0.96
184	Wean client from ventilator	0.09	1.00	0.16	0.76	0.36	0.77	0.40	0.73
145	Perform peritoneal dialysis for client	0.08	0.83	0.17	0.97	0.11	0.88	0.00	0.93
175	Administer blood or blood products	0.03	1.00	0.27	0.92	0.99	0.87	0.69	0.72
225	Insert an endotracheal tube	0.03	1.00	0.13	0.95	0.15	0.94	1.26	0.90
228	Administer anesthesia	0.02	1.00	0.03	1.00	0.03	0.75	1.54	0.84
	Subcategory: Reduction of Risk Potential								
37	Use measures to maintain skin integrity (e.g., skin care, turn client, alternating pressure mattress, etc.)	6.32	0.86	4.55	0.79	3.29	0.67	0.97	0.71

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
56	Determine if client has a decreased urinary output	3.30	0.88	2.70	0.89	2.41	0.82	1.55	0.78
49	Identify change in client's mental status	2.94	0.88	2.96	0.86	2.39	0.88	1.78	0.78
124	Identify signs of an infection	2.26	0.90	2.63	0.91	2.07	0.87	2.90	0.89
147	Determine changes in client's respiratory status	1.85	0.93	2.49	0.96	2.75	0.95	2.78	0.89
58	Inspect intravenous site for infiltration	1.61	0.90	2.62	0.93	3.96	0.88	1.62	0.85
151	Check for interactions among client's drugs, foods, and fluids	1.49	0.81	3.07	0.82	2.56	0.74	2.67	0.75
93	Identify factors interfering with wound healing	1.06	0.80	1.93	0.80	1.49	0.67	1.09	0.76
50	Insert suppository	1.00	0.66	2.07	0.55	1.02	0.42	0.16	0.33
161	Relate client's symptoms to side effects/adverse reactions of medication	0.96	0.93	2.35	0.93	1.81	0.85	2.65	0.85
139	Determine cause of symptoms of nausea, vomiting, and/or diarrhea	0.95	0.82	2.42	0.82	2.21	0.74	2.76	0.78
88	Check for complications due to a cast	0.90	0.90	1.10	0.89	0.74	0.84	0.32	0.78
215	Recommend change in treatment based upon client's response	0.86	0.68	1.70	0.68	1.79	0.61	2.90	0.67
48	Determine need for administration of PRN medications	0.77	0.70	4.69	0.75	3.99	0.67	2.57	0.54
177	Implement measures to prevent circulatory complications (e.g., hemorrhage, embolus, shock, etc.)	0.72	0.93	1.32	0.96	1.55	0.91	1.21	0.93
111	Determine if water-seal drainage system is functioning properly	0.63	0.94	0.58	0.93	0.67	0.91	0.20	0.87
41	Administer oral medications	0.55	0.84	6.69	0.84	4.97	0.75	1.24	0.58
77	Determine if characteristics of drainage from nasogastric tube are within normal limits	0.51	0.83	1.21	0.85	1.12	0.73	0.51	0.69
82	Determine characteristics of bowel sounds	0.51	0.70	2.67	0.67	3.02	0.51	2.33	0.50
153	Intervene to control symptoms of hyperglycemia or hypoglycemia	0.48	0.96	1.77	0.95	1.55	0.95	1.38	0.86
142	Determine changes in client's cardiovascular status	0.46	0.93	1.55	0.94	2.46	0.92	2.44	0.86
154	Identify evidence of sensory deprivation	0.42	0.86	1.05	0.72	1.08	0.58	0.69	0.56
166	Observe client for side effects of radiation therapy	0.38	0.86	0.41	0.90	0.32	0.75	0.09	0.65
216	Order routine laboratory tests	0.33	0.83	1.92	0.69	2.48	0.62	5.23	0.56
146	Interpret cardiac monitor strip	0.32	0.86	0.63	0.87	1.97	0.85	1.58	0.87
99	Identify symptoms of deep vein thrombosis	0.29	0.90	0.96	0.96	0.87	0.89	0.64	0.92
148	Change rate/amount of tube feeding based on client's response	0.21	0.69	1.01	0.79	0.74	0.71	0.21	0.58

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides		LPN/VNs		RNs		ARNPs	
		Freq.	Crit.	Freq.	Crit.	Freq.	Crit.	Freq.	Crit.
155	Determine if client's pacemaker is functioning properly	0.19	0.89	0.62	0.87	0.49	0.91	0.36	0.84
178	Identify signs of potential prenatal complications	0.18	0.83	0.34	0.89	0.45	0.82	1.76	0.89
180	Implement procedures to counteract adverse effects of medication	0.15	1.00	0.97	0.95	1.10	0.91	1.36	0.90
121	Monitor blood levels of medications	0.10	1.00	1.06	0.82	1.23	0.79	1.20	0.73
222	Identify the occurrence of extravasation of a chemotherapeutic agent	0.08	1.00	0.18	0.91	0.19	0.94	0.16	0.89
171	Start intravenous therapy	0.05	1.00	0.81	0.79	2.27	0.76	1.62	0.70
72	Administer intramuscular or subcutaneous injections	0.04	0.89	3.95	0.84	3.16	0.71	2.29	0.58
179	Administer intravenous medication	0.02	1.00	1.17	0.84	3.44	0.82	1.89	0.75
227	Prescribe medications	0.00	1.00	0.14	0.75	0.21	0.56	5.70	0.73
	Subcategory: Mobility								
1	Assist client to ambulate	5.95	0.39	3.85	0.34	2.70	0.30	0.69	0.31
66	Assist client with use of a walker, crutches, prosthesis, etc.	4.89	0.70	2.40	0.56	1.28	0.47	0.23	0.52
12	Do range-of-motion exercises for a client	3.58	0.51	1.95	0.44	1.14	0.32	0.21	0.31
25	Use assistive device to move a client (e.g., Hoyer lift, transfer board, etc.)	3.58	0.68	1.54	0.58	1.33	0.49	0.99	0.56
19	Apply immobilizing equipment such as a splint or brace	2.30	0.70	1.70	0.69	1.04	0.59	0.45	0.48
126	Check client for complications due to immobility	2.13	0.84	2.48	0.76	1.91	0.69	0.74	0.70
71	Maintain traction devices	1.11	0.81	0.65	0.86	0.49	0.79	0.05	0.69
	Subcategory: Comfort								
57	Question client about effectiveness of pain medication	2.05	0.62	4.10	0.69	3.37	0.63	2.39	0.61
196	Determine client's response to nursing measures for controlling pain or discomfort	0.88	0.73	2.48	0.74	2.77	0.66	1.79	0.65
173	Try measures other than medication to relieve pain (e.g., transcutaneous nerve stimulation, imagery, distraction, etc.)	0.57	0.68	0.98	0.63	1.12	0.57	1.23	0.47
212	Teach client pain management techniques	0.40	0.64	1.04	0.63	1.36	0.53	1.39	0.54
73	Determine if patient controlled analgesia (PCA) pump is providing adequate medication	0.15	0.92	0.72	0.89	0.85	0.83	0.36	0.64

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
116	Monitor placement of epidural analgesia catheter	0.11	0.86	0.18	0.87	0.37	0.92	0.61	0.89
	Subcategory: Provision of Basic Care								
9	Assist client with personal hygiene	6.93	0.68	3.37	0.51	2.67	0.34	0.71	0.31
42	Measure vital signs	6.80	0.74	6.44	0.67	6.33	0.60	4.60	0.58
5	Change client's position	6.63	0.72	4.42	0.60	4.09	0.44	1.78	0.46
17	Record intake and output	6.44	0.79	4.25	0.77	3.82	0.67	1.42	0.62
46	Provide opportunities for client to rest	5.74	0.62	4.46	0.52	3.80	0.44	0.88	0.41
11	Transport client using wheelchair, cart, etc.	5.71	0.57	3.73	0.49	2.52	0.45	1.15	0.46
3	Help client to eat	4.22	0.79	2.50	0.70	1.50	0.53	0.22	0.49
10	Weigh client	3.71	0.39	3.11	0.31	2.50	0.26	2.16	0.21
22	Use measures to improve client's nutritional intake (e.g., small feedings, preferred foods, etc.)	3.57	0.69	2.46	0.60	1.70	0.42	1.23	0.39
15	Apply ted hose/elastic stockings	3.53	0.57	1.60	0.52	0.95	0.40	0.14	0.23
123	Initiate a toileting schedule	2.77	0.63	1.46	0.47	0.64	0.33	0.21	0.35
83	Use alternative methods to promote voiding (e.g., run water over perineum, etc.)	2.70	0.61	1.68	0.56	0.98	0.46	0.39	0.37
55	Reposition tube to promote drainage	2.36	0.86	1.98	0.83	1.40	0.74	0.38	0.63
51	Give decubitus care	2.19	0.86	2.32	0.81	1.12	0.67	0.10	0.65
13	Give an enema	1.99	0.61	1.22	0.56	0.64	0.43	0.10	0.13
16	Give a sitz bath	1.82	0.46	0.64	0.35	0.40	0.20	0.05	0.06
28	Use abdominal binder or other device to support client's incision	1.67	0.78	0.95	0.72	0.77	0.53	0.17	0.38
54	Apply wound dressing (e.g., 4 x 4, opsite, duoderm, etc.)	1.61	0.70	3.42	0.72	2.49	0.65	0.92	0.60
52	Determine patency of drainage and decompression tubes	1.05	0.87	1.86	0.88	1.56	0.83	0.37	0.71
31	Remove fecal impaction	1.04	0.78	1.25	0.76	0.53	0.59	0.03	0.53
70	Maintain client's continuous bladder irrigation	0.96	0.85	0.94	0.92	0.61	0.87	0.07	0.68
152	Adjust food and fluid intake to improve fluid and electrolyte balance	0.77	0.91	1.53	0.73	1.59	0.71	1.53	0.73
64	Apply ostomy appliance	0.68	0.74	1.09	0.72	0.56	0.59	0.06	0.35
128	Insert indwelling urinary catheter	0.45	0.72	1.87	0.77	1.24	0.65	0.36	0.57
	Psychosocial Integrity								
	Subcategory: Psychosocial Adaptation								
61	Orient client to reality	3.73	0.66	3.25	0.59	2.29	0.56	1.12	0.59
165	Determine client's potential for violence to self or others	1.62	0.90	1.81	0.91	1.37	0.89	1.01	0.85
209	Use behavior modification techniques with client	1.29	0.69	1.55	0.57	1.08	0.40	1.38	0.38

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
170	Plan measures to control or help a client to control aggressive behavior	1.12	0.87	1.46	0.82	0.90	0.79	0.56	0.68
80	Determine if client is experiencing signs and symptoms of alcohol/drug withdrawal	0.88	0.90	0.99	0.88	0.97	0.86	0.86	0.82
237	Assist client to deal with a disfunctional family	0.30	0.62	0.33	0.54	0.39	0.44	0.98	0.53
226	Counsel suspected victims of abuse	0.25	0.70	0.22	0.85	0.37	0.74	0.95	0.80
232	Engage client and family in family therapy	0.25	0.91	0.36	0.55	0.41	0.35	0.55	0.42
238	Engage client in individual psychotherapy	0.15	0.75	0.13	0.65	0.26	0.54	0.58	0.58
236	Conduct a group therapy session for clients with psychiatric disorders	0.11	0.83	0.12	0.70	0.16	0.56	0.17	0.54
	Subcategory: Coping/Adaptation								
8	Allow client to talk about his/her feelings	5.49	0.73	5.07	0.70	4.82	0.66	6.80	0.66
85	Implement measure to reduce sources of discomfort in client's environment (e.g., noise, temperature, etc.)	4.69	0.69	3.29	0.56	2.89	0.49	1.65	0.49
53	Provide support to client who is upset or distraught	4.23	0.90	3.13	0.87	2.50	0.87	2.66	0.85
39	Stay with a client to promote safety and reduce fear	3.97	0.89	2.77	0.86	2.51	0.85	2.09	0.82
76	Assist client to communicate effectively	3.44	0.74	2.79	0.63	2.33	0.59	2.49	0.57
84	Provide support to terminally ill client and family	3.05	0.84	1.94	0.83	1.38	0.80	0.56	0.75
210	Help client to cope with negative attitudes related to his/her illness	2.59	0.77	1.97	0.64	1.63	0.51	1.77	0.56
190	Provide time and opportunity for client to practice his/her religion	2.15	0.63	1.55	0.57	0.94	0.40	0.41	0.46
224	Encourage client to use problem solving skills	1.79	0.61	1.50	0.46	1.74	0.40	2.66	0.45
205	Assist client to set goals	1.65	0.60	1.52	0.45	1.78	0.38	2.54	0.43
206	Maintain a therapeutic milieu/environment	1.29	0.71	2.53	0.66	3.66	0.62	3.44	0.65
163	Plan measures to deal with client's anxiety	1.22	0.77	2.21	0.71	2.54	0.68	3.30	0.67
191	Promote client's adjustment to changes in body image	1.07	0.61	1.15	0.56	1.14	0.47	1.61	0.41
113	Identify effects of environmental stressors on client	1.01	0.57	1.81	0.52	2.36	0.41	3.27	0.49
117	Explore why client is refusing treatment	0.99	0.74	1.50	0.70	1.07	0.70	1.11	0.66
211	Teach stress reduction techniques	0.56	0.60	0.86	0.54	0.99	0.39	1.45	0.40

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
	Health Promotion and Maintenance								
	Subcategory: Continued Growth and Development								
203	Compare client's behavioral characteristics to norms	1.24	0.67	2.08	0.51	2.39	0.42	3.26	0.48
200	Modify approaches to care in accordance with client's development stage	0.85	0.67	1.13	0.55	1.49	0.54	2.40	0.58
101	Compare the physical development of client to norms	0.79	0.63	1.95	0.57	2.24	0.46	3.74	0.62
60	Provide physical care for a newborn	0.66	0.93	0.68	0.87	0.71	0.82	0.75	0.84
90	Perform postpartum assessments	0.47	0.86	0.54	0.87	0.59	0.76	1.13	0.65
168	Instruct client about infant feeding procedures/techniques (e.g., breast feeding, formula, etc.)	0.46	0.82	0.68	0.63	0.76	0.61	1.60	0.55
169	Instruct client on antepartal and/or postpartal care	0.39	0.86	0.50	0.70	0.57	0.66	1.98	0.62
103	Provide care for newborn receiving phototherapy (bililight)	0.38	0.93	0.23	0.91	0.22	0.89	0.11	0.78
197	Facilitate parental attachment with newborn	0.28	0.68	0.41	0.78	0.55	0.71	1.34	0.71
183	Assess new mother for postpartum complications	0.25	0.89	0.39	0.91	0.50	0.87	0.99	0.82
97	Auscultate fetal heart tones	0.21	0.80	0.47	0.81	0.61	0.71	2.17	0.79
189	Determine parents' understanding of normal growth and development	0.17	0.65	0.60	0.49	0.80	0.39	1.66	0.47
221	Determine if client has problems related to sexuality or fertility	0.17	0.42	0.30	0.46	0.41	0.34	1.91	0.46
204	Teach parenting skills	0.15	0.60	0.52	0.56	0.71	0.47	1.69	0.51
114	Monitor client in labor	0.13	0.93	0.27	0.95	0.38	0.91	0.78	0.89
86	Determine Apgar score of newborn	0.07	0.78	0.15	0.96	0.27	0.97	0.62	0.93
172	Perform vaginal-pelvic examination	0.07	0.67	0.22	0.53	0.51	0.57	3.83	0.54
202	Manage delivery of a newborn	0.07	0.86	0.10	1.00	0.25	0.97	0.55	0.96
195	Determine client's attitudes toward and use of birth control methods	0.06	0.75	0.44	0.42	0.55	0.32	2.95	0.58
234	Plan anticipatory guidance for developmental transitions (e.g., puberty, retirement, etc.)	0.04	0.43	0.18	0.36	0.31	0.30	1.40	0.38
235	Teach sex education classes	0.03	0.00	0.09	0.44	0.12	0.30	0.32	0.33
208	Teach childbirth classes	0.01	1.00	0.03	0.46	0.05	0.47	0.23	0.26
	Subcategory: Self-care								
129	Determine client's ability to perform self-care	3.58	0.60	2.82	0.49	2.47	0.44	1.42	0.55

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
192	Teach client with physical impairment to perform self-care	1.95	0.66	1.35	0.57	0.93	0.45	0.33	0.46
194	Initiate bowel or bladder retraining program	1.65	0.72	1.38	0.57	0.68	0.43	0.18	0.47
233	Advise client with urinary or bowel incontinence	1.43	0.61	1.22	0.54	0.77	0.44	0.58	0.52
176	Adapt diet to special needs of a client	0.96	0.82	1.52	0.62	1.31	0.46	1.30	0.46
201	Identify client's perception of health status	0.87	0.59	1.89	0.51	2.39	0.42	3.97	0.49
157	Determine when client is ready to learn	0.81	0.54	1.10	0.44	1.91	0.39	2.29	0.49
164	Evaluate client's compliance with prescribed therapy	0.66	0.66	2.38	0.62	2.61	0.54	3.85	0.64
137	Consider client's background when preparing teaching materials	0.57	0.57	1.63	0.51	2.22	0.49	3.49	0.59
159	Instruct client about self-administration of prescribed medications	0.39	0.81	2.06	0.80	2.15	0.72	3.83	0.82
174	Identify community/home services which would facilitate a client's independent living	0.36	0.50	0.71	0.44	0.80	0.37	0.80	0.39
231	Advise client regarding acceptable methods of weight control	0.33	0.54	0.63	0.34	0.69	0.27	1.84	0.31
193	Evaluate client's use of home remedies and over-the-counter drugs	0.28	0.73	1.03	0.62	1.27	0.47	2.74	0.55
185	Educate client/family regarding options related to directives to be given to physicians (e.g., code status, heroic measures, etc.)	0.17	0.68	0.67	0.68	0.86	0.64	0.38	0.55
	Subcategory: Integrity of Support Systems								
94	Provide emotional support to family	3.54	0.78	2.99	0.75	3.19	0.68	2.94	0.63
217	Identify problems within a family which could impact on client well-being	1.18	0.80	1.26	0.65	1.42	0.52	2.09	0.57
182	Help family adjust to role changes due to illness, accident, or developmental changes	1.02	0.63	1.21	0.57	1.22	0.44	1.45	0.45
160	Assist family to manage care of a client with chronic needs	0.93	0.71	1.32	0.64	1.21	0.53	0.91	0.53
162	Determine family's understanding of the causes/consequences of client's illness	0.75	0.70	1.63	0.62	1.82	0.49	1.91	0.52
188	Determine family's emotional reaction to a client's chronic disorder	0.55	0.58	1.13	0.58	1.23	0.42	0.71	0.47

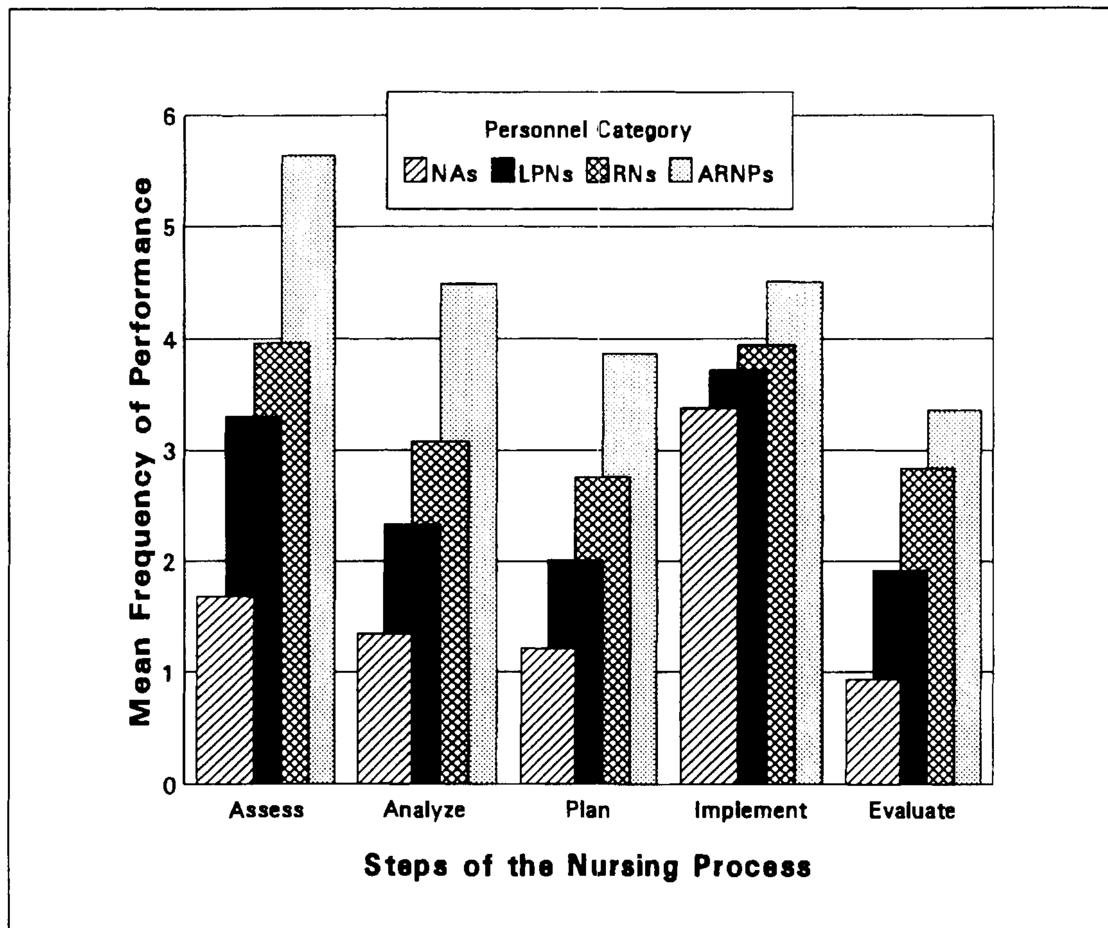
Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides Freq.	Nurse Aides Crit.	LPN/VNs Freq.	LPN/VNs Crit.	RNs Freq.	RNs Crit.	ARNPs Freq.	ARNPs Crit.
186	Determine needs of family regarding ability to provide home care after discharge	0.39	0.52	0.76	0.61	1.31	0.50	0.76	0.57
	Subcategory: Prevention and Early Treatment of Disease								
131	Conduct screening sessions (e.g., blood pressure, cholesterol, etc.)	0.95	0.74	1.61	0.50	1.30	0.37	1.91	0.36
229	Teach health promotion information (e.g., exercise, diet, smoking cessation, cardiac risk factors, etc.)	0.48	0.68	1.38	0.52	1.93	0.44	4.36	0.48
181	Teach client how to perform self-examinations (e.g., breast, testicular, etc.)	0.19	0.76	0.64	0.47	0.57	0.39	3.13	0.51
140	Teach early warning signs of cancer	0.13	0.77	0.71	0.56	0.66	0.42	2.54	0.51
230	Teach basic first aid, CPR, or ACLS	0.13	0.60	0.20	0.55	0.27	0.46	0.35	0.45
78	Interpret skin tests for allergy, tuberculosis, etc.	0.12	0.63	1.35	0.82	0.86	0.75	0.85	0.72
87	Administer an immunizing agent	0.01	0.50	1.35	0.64	1.01	0.56	1.09	0.44
	Nursing Process								
	Assessment								
92	Ask client to describe his/her symptoms	3.45	0.81	4.59	0.77	4.71	0.74	6.53	0.78
30	Obtain client data from family/significant others	1.60	0.62	2.86	0.56	3.28	0.53	4.28	0.57
133	Collect physical assessment data	0.91	0.69	3.35	0.64	4.74	0.67	6.73	0.76
65	Record a nursing history/client data base	0.74	0.72	2.38	0.63	3.09	0.62	5.01	0.68
	Analysis								
74	Identify client's unmet needs	3.23	0.72	2.92	0.64	2.78	0.56	3.47	0.55
108	Determine client's strengths and weaknesses	2.58	0.66	2.70	0.46	2.80	0.41	3.76	0.49
96	Identify client's potential problems	1.30	0.78	2.72	0.66	3.76	0.63	5.41	0.68
89	Determine cause of client's symptoms	0.60	0.80	2.40	0.82	3.09	0.77	5.81	0.81
112	Formulate nursing diagnoses	0.23	0.83	1.49	0.58	3.05	0.47	3.85	0.59
63	Determine impact of results of diagnostic tests (e.g., laboratory value, x-rays, etc.) on client	0.12	0.75	1.73	0.78	2.99	0.71	4.65	0.71
	Planning								
118	Set priorities for client care	2.52	0.78	3.68	0.71	4.60	0.75	4.70	0.71

Table 20. Mean frequency of performance and mean criticality values for 238 nursing activities, by personnel catagory.

Item #	Activity Statement	Nurse Aides		LPN/VNs		RNs		ARNPs	
		Freq.	Crit.	Freq.	Crit.	Freq.	Crit.	Freq.	Crit.
219	Revise approach to care in order to meet client's specific needs	1.74	0.73	1.92	0.61	2.27	0.54	3.03	0.61
125	Develop individualized plan of care	1.02	0.65	1.69	0.49	2.99	0.52	5.56	0.71
106	Revise goals/plan of care to accommodate client's values, customs or habits	0.76	0.51	1.47	0.46	1.84	0.40	2.40	0.51
136	Plan measures to minimize anticipated symptoms	0.62	0.65	1.80	0.60	2.65	0.55	3.73	0.63
138	Consult with client/family in developing a plan of care	0.61	0.67	1.52	0.50	2.22	0.43	3.81	0.58
Implementation									
150	Communicate client's needs to others	5.28	0.80	4.09	0.70	3.83	0.64	3.16	0.58
18	Report significant changes in client's condition	4.80	0.98	4.39	0.97	3.58	0.95	3.66	0.89
223	Utilize client's strengths to achieve goals of care	2.59	0.75	2.30	0.56	2.30	0.46	3.05	0.54
100	Document provision of client care	2.22	0.78	4.92	0.76	5.71	0.71	6.49	0.82
7	Implement a plan of care	2.00	0.60	2.88	0.59	4.26	0.62	6.21	0.75
Evaluation									
213	Identify need for change in approach to client care	1.59	0.74	1.78	0.58	1.62	0.52	2.25	0.56
207	Determine if goals of care are being achieved	1.58	0.70	3.09	0.59	3.96	0.55	4.24	0.64
135	Compare client's response to expected outcomes	0.89	0.64	1.93	0.51	3.08	0.50	4.16	0.64
198	Determine impact of therapeutic interventions on client	0.30	0.66	1.44	0.60	2.81	0.58	3.56	0.66
187	Gather data to indicate effectiveness of each intervention	0.27	0.67	1.33	0.56	2.73	0.50	2.57	0.55

Figure 10. Average mean frequency of performance values for Nursing Process activity statements, by personnel category.



8

LONG RANGE PLANNING COMMITTEE

Report of the Long Range Planning Committee

Committee Members
Marcia Rachel, MS, Area III, *Chair*
Jean Caron, ME, Area IV
Leola Daniels, ID, Area I
Nancy Durrett, VA, Area III
Lorinda Inman, IA, Area II
Nancy Smart, IL, Area II

Relationship to Organization Plan
Goal V ....Implement an organizational structure that uses human and fiscal resources efficiently.
Objective A ....Implement a planning system to guide the National Council.

Recommendation(s)
No recommendations.

Highlights of Activities

- **Evaluate National Council goals and objectives**

The tactic assigned to the Long Range Planning Committee by the Board of Directors states, "*Develop and evaluate the Organization Plan for National Council.*" Activities under this tactic include "*Obtain and evaluate rank ordering of goals and objectives by Member Boards,*" and "*Obtain and review Member Boards' rating of effectiveness of the organization in meeting the goals and objectives.*"

An evaluation tool was developed and distributed to Member Boards for the purpose of determining the effectiveness of the National Council in implementing the Organization Plan. Information received from Member Boards (board members and executive directors) resulted in a rank ordering of goals and objectives and an evaluation of the effectiveness of the National Council in meeting the objectives. The methodology used in conducting the survey and a description of the data received are found with this report as Attachment A.

Survey results showed a congruence between the responses from board members and the executive directors. Participants rated all 24 objectives as being met effectively. The following objectives were ranked highest both in importance and in degree of effectiveness by board members and/or executive directors.

Goal I: Provide Member Boards with examinations and standards for licensure and credentialing.
Objective A: Conduct job analysis studies to serve as the basis for examinations.
Objective B: Provide examinations that are based on current accepted psychometric principles and legal considerations.
Objective C: Implement computerized adaptive testing for the licensure examinations.
Objective F: Promote consistency in the licensure and credentialing process.

In addition, participants were asked to list any additional areas of their responsibility which they would like addressed by National Council. Responses included issues related to a non-disciplinary program for substance abuse rehabilitation, educational opportunities for board of nursing staff members specifically related to regulation, public policy, investigative activities, an orientation program for new members of Member Boards, research on impaired nurses, and the development of a self assessment instrument for boards of nursing.

Meeting Dates
- October 10-11, 1992
- February 24-26, 1993
- May 13-14, 1993

Future Considerations for the National Council

After careful evaluation of the data, the Long Range Planning Committee advises that the results of this survey be used to assist with organizational decision-making in areas related to the allocation of resources (human, material, fiscal) and in decisions affecting the future direction of the National Council.

Future Activities

A Trend Analysis Survey Tool will be distributed to all member jurisdictions of the National Council. The trend analysis is a procedure whereby current trends will be identified, future trends projected, and potential National Council responses formulated. A report of the preliminary analysis of the Trend Analysis data will be presented to the 1994 Delegate Assembly.

Staff

Doris E. Nay, RN, MA, *Associate Executive Director*

Attachments

A ....Methodology and Description of Data, *page 3*
B ....Survey Data, *page 5*
C ....Rank ordering of Importance of Objectives, *page 9*
D ....Percentage of Points Allotted to Objectives within Each Goal, *page 13*

Attachment A

Methodology and Description of Data

In order determine the effectiveness of the structure, the committee evaluated the relative importance and attainment of the goals and objectives of the organization. An Objective Importance and Effectiveness Questionnaire was distributed to board members and executive directors of Member Boards. Participants were asked to determine the importance of each of the objectives in terms of how they assist the Member Board in performing its functions and to determine the effectiveness of the National Council in meeting the objectives. Completed questionnaires were received from 33 executive directors and board members from 35 Member Boards, with equal representation from all four National Council Areas.

The committee evaluated the data and prepared a compilation, identified in Attachments B, C and D.

- Attachment B contains the responses to the completed questionnaire.
- Attachment C identifies the rank ordering of importance of objectives specifically targeting the upper third and lower third of the 24 objectives.
- Attachment D represents the percentage of points allotted to objectives within each goal.

In its determination that the data provided were a valid and reliable representation of the Member Boards' perspective, the Long Range Planning Committee took the following factors into consideration:

1. Data were provided by a majority of the Member Boards' board members (56%) and executive directors (53%).
2. An evaluation of supporting statistical data, (e.g., ranges, standard error of measurement, etc.) showed they were within acceptable limits.

The overall importance of each goal was determined as follows: (1) the sum of all mean importance points for each objective listed under a goal was calculated; (2) the sum for each goal was divided by the total number of points assigned and then multiplied by 100 percent. Based on the values obtained, Goal I, "*Provide Member Boards with examinations and standards for licensure and credentialing*" was rated the highest (see Attachment D). In addition, it should be noted that board members and executive directors were in general agreement regarding the overall importance of each Goal.

The following three objectives of Goal I were within the top four rankings based on data provided by board members and executive directors: Objective A: Conduct job analysis studies to serve as the basis for examinations; Objective B: Provide examinations that are based on current accepted psychometric principles and legal considerations; Objective C: Implement computerized adaptive testing for the licensure examinations. A strong, positive correlation (0.76) was demonstrated when the rank ordered executive directors' importance ratings were compared with those provided by board members (see Attachment B).

Related to the rank ordering of importance of objectives (Attachment C), in addition to the previously noted objectives, the following objectives were also ranked in the upper third by board members and executive directors:

Goal I: Provide Member Boards with examinations and standards for licensure and credentialing.

Objective D: Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Objective F: Promote consistency in the licensure and credentialing process.

Goal II: Provide information, analyses and standards regarding the regulation of nursing practice.

Objective A: Develop documents which provide guidance regarding the regulation of nursing practice.

Objective D: Provide information about disciplinary actions taken by Member Boards.

The following objectives were ranked in the upper third but by only one group:

Goal IV: Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective B: Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.
(Board Members)

Objective D: Facilitate communication between National Council, Member Boards and related entities.
(Executive Directors)

LONG RANGE PLANNING COMMITTEE

OBJECTIVE IMPORTANCE AND EFFECTIVENESS QUESTIONNAIRE

SURVEY DATA

	Importance				Effectiveness	
	Mean Rating (1000 Points Total)		Rank		*Mean Rating Rounded to Whole Number	
	Executive Director	Board Member	Executive Director	Board Member	Executive Director	Board Member
Goal I: Licensure and Credentialing **Provide Member Boards with examinations and standards for licensure and credentialing.**						
Objective A: Conduct job analysis studies to serve as the basis for examinations.	75.73	64.09	2	4	3	3
Objective B: Provide examinations that are based on current accepted psychometric principles and legal considerations.	117.18	92.69	1	1	3	3
Objective C: Implement computerized adaptive testing for the licensure examinations.	73.39	77.73	3	2	3	3
Objective D: Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.	40.27	48.00	7	5	2	2
Objective E: Provide a competency evaluation program for nurse aides.	28.61	25.57	20	22	3	2
Objective F: Promote consistency in the licensure and credentialing process.	41.88	65.81	6	3	2	3
Objective G: Investigate mechanisms for evaluating continued competence.	29.61	39.95	17	10	2	2

* 1 = Not at all
2 = Somewhat
3 = Completely

	Importance				Effectiveness	
	Mean Rating (1000 Points Total)		Rank		*Mean Rating Rounded to Whole Number	
	Executive Director	**Board Member**	**Executive Director**	**Board Member**	**Executive Director**	**Board Member**
Goal II: Nursing Practice **Provide information, analyses and standards regarding the regulation of nursing practice.**						
Objective A: Develop documents which provide guidance regarding the regulation of nursing practice.	43.52	44.06	5	6	2	2
Objective B: Develop documents regarding health care issues which affect safe and effective nursing practice.	34.76	38.65	15	12	2	2
Objective C: Conduct research on regulatory issues related to disciplinary activities.	34.97	39.78	14	11	2	2
Objective D: Provide information about disciplinary actions taken by Member Boards.	52.25	43.62	4	7	2	2
Objective E: Review and analyze actions of government and other entities that affect the regulation of nursing practice.	35.22	41.44	13	9	2	2
Goal III: Nursing Education **Provide information, analyses and standards regarding the regulation of nursing education.**						
Objective A: Develop documents which provide guidance regarding the regulation of nursing education.	32.03	37.29	16	13	2	2
Objective B: Develop documents regarding issues that affect the regulation of nursing education.	29.30	32.79	19	17	2	2
Objective C: Provide for Member Board needs related to the approval process of nursing education programs.	28.24	32.19	22	19	2	2
Objective D: Review and analyze actions of government and other entities that affect the regulation of nursing education.	27.15	34.97	24	14	2	2

* 1 = Not at all
2 = Somewhat
3 = Completely

	Importance				Effectiveness	
	Mean Rating (1000 Points Total)		Rank		*Mean Rating Rounded to Whole Number	
	Executive Director	**Board Member**	**Executive Director**	**Board Member**	**Executive Director**	**Board Member**
Goal IV: **Information** **Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.**						
Objective A: Implement a comprehensive repository of information.	36.73	34.73	12	15	2	2
Objective B: Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.	38.28	42.88	9	8	2	2
Objective C: Provide consultative services for Member Boards.	29.45	32.64	18	18	2	2
Objective D: Facilitate communication between National Council, Member Boards and related entities.	39.88	33.36	8	16	2	2
Goal V: **Organization** **Implement an organizational structure that uses human and fiscal resources efficiently.**						
Objective A: Implement a planning system to guide the National Council.	37.79	22.72	10	24	2	2
Objective B: Implement a fiscal resource management system.	36.88	26.32	11	21	3	2
Objective C: Maintain a system of governance that facilitates leadership and decision making.	28.58	25.33	21	23	2	2
Objective D: Conduct and disseminate research pertinent to the mission of the National Council.	27.33	26.99	23	20	2	2

* 1 = Not at all
2 = Somewhat
3 = Completely

2/25/93

Attachment C

LONG RANGE PLANNING COMMITTEE
OBJECTIVE IMPORTANCE AND EFFECTIVENESS QUESTIONNAIRE

RANK ORDERING OF IMPORTANCE OF OBJECTIVES

RANK	EXECUTIVE DIRECTOR		MEMBER BOARD	
	GOAL OBJ		GOAL OBJ	
Upper third				
1	I-B	Provide examinations that are based on current accepted psychometric principles and legal considerations.	I-B	Provide examinations that are based on current accepted psychometric principles and legal considerations.
2	I-A	Conduct job analysis studies to serve as the basis for examinations.	I-C	Implement computerized adaptive testing for the licensure examinations.
3	I-C	Implement computerized adaptive testing for the licensure examinations.	I-F	Promote consistency in the licensure and credentialing process.
4	II-D	Provide information about disciplinary actions taken by Member Boards.	I-A	Conduct job analysis studies to serve as the basis for examinations.
5	II-A	Develop documents which provide guidance regarding the regulation of nursing practice.	I-D	Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.
6	I-F	Promote consistency in the licensure and credentialing process.	II-A	Develop documents which provide guidance regarding the regulation of nursing practice.
7	I-D	Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.	II-D	Provide information about disciplinary actions taken by Member Boards.

8	*IV-D	Facilitate communication between National Council, Member Boards and related entities.	*IV-B	Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.

Middle third not included

Lower third

17	**I-G	Investigate mechanisms for evaluating continued competence.	III-B	Develop documents regarding issues that affect the regulation of nursing education.
18	IV-C	Provide consultative services for Member Boards.	IV-C	Provide consultative services for Member Boards.
19	III-B	Develop documents regarding issues that affect the regulation of nursing education.	III-C	Provide for Member Board needs related to the approval process of nursing education programs.
20	I-E	Provide a competency evaluation program for nurse aides.	V-D	Conduct and disseminate research pertinent to the mission of the National Council.
21	V-C	Maintain a system of governance that facilitates leadership and decision making.	**V-B	Implement a fiscal resource management system.
22	III-C	Provide for Member Board needs related to the approval process of nursing education programs.	I-E	Provide a competency evaluation program for nurse aides.
23	V-D	Conduct and disseminate research pertinent to the mission of the National Council.	V-C	Maintain a system of governance that facilitates leadership and decision making.

24	**III-D	Review and analyze actions of government and other entities that affect the regulation of nursing education.	**V-A	Implement a planning system to guide the National Council.

* = Not ranked in upper third by both groups
** = Not ranked in lower third by both groups

Attachment D

LONG RANGE PLANNING COMMITTEE
OBJECTIVE IMPORTANCE AND EFFECTIVENESS QUESTIONNAIRE
PERCENTAGE OF POINTS ALLOTTED TO OBJECTIVES WITHIN EACH GOAL

Goal I **Licensure and Credentialing**
Provide Member Boards with examinations and standards for licensure and credentialing.

Executive Director = 41% Board Member = 41%

Goal II **Nursing Practice**
Provide information, analyses and standards regarding the regulation of nursing practice.

Executive Director = 20% Board Member = 21%

Goal III **Nursing Education**
Provide information, analyses and standards regarding the regulation of nursing education.

Executive Director = 12% Board Member = 14%

Goal IV **Information**
Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Executive Director = 14% Board Member = 14%

Goal V **Organization**
Implement an organizational structure that uses human and fiscal resources efficiently.

Executive Director = 13% Board Member = 10%

9

CST STEERING COMMITTEE

Report of the Steering Committee, Computerized Clinical Simulation Testing (CST) Project

Committee Members
Debra Brady, NM, Area I, *Chair*
Patricia Beck, NY, Area IV
Dorothy Fiorino, OH, Area II
Jeffrey Hill, GA-RN, Area III
Sheryl Jackson, SD, Area II
Sally Phillips, CO, Area I

Relationship to Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective D .... Conduct research and development regarding Computerized Clinical Simulation Testing (CST) for initial and continued licensure.

Recommendation(s)
No recommendations.

Highlights of Activities

■ CST Project Activity Planning
At its October 1992 meeting, the CST Steering Committee began its planning for Phase II of the CST Project by reviewing the 1991 Delegate Assembly action regarding CST. In August 1991, the Delegate Assembly directed that CST research and development continue and that requests for external funding of the project be pursued. At the 1991 CST Forum, there was a question raised about what would happen if outside funding from the W. K. Kellogg Foundation was denied. It was determined that, under such circumstances, the Board of Directors would decide how to proceed in terms of funding the project.

In planning Phase II of CST research and development, the committee determined that these activities should focus on the use of CST as a component of the licensure exam. Although several potential uses for CST have been identified,

- *A future component of a CST and Computerized Adaptive Testing (CAT) NCLEX-RN*
- *A competence evaluation tool for RNs in current practice or those returning to practice after a period of absence*
- *An evaluation of RNs who have been disciplined as a result of substance abuse or practice deficiencies*
- *An education and evaluation tool within educational programs*

the committee felt that focusing research efforts in the area of initial licensure would more efficiently provide the evidence necessary to determine whether or not CST can be used for evaluating competence in nursing problem-solving and decision-making. The evidence obtained from this investigation can then be used as a foundation for investigating other potential evaluation and educational applications of CST. Some of these applications may be potential sources for revenue generation from CST software. The committee believed that a marketable CST product could be ready near the conclusion of Phase II of CST. At its December 1992 meeting, the Board of Directors approved a request for $75,000 to conduct a market analysis survey. Consultation with a market analyst has been initiated.

■ Public Relations and Education on CST
At its October 1992 meeting, the CST Steering Committee determined that public relations and education about CST should be enhanced by:

- displaying, demonstrating, and discussing CST at National Council meetings and at other national meetings;
- producing public relations and educational materials; and
- publishing information and articles about CST.

At its December 1992 meeting, the Board of Directors approved the committee's request for $16,600 for CST public relations and education for the balance of FY93.

Finalize Computer Model and Databases

An activity under Objective D states, "*Finalize and try out computer model and databases.*" A number of tasks related to this activity have been completed. CST model modifications have been made by the National Board of Medical Examiners (NBME). In the original version of CST, requests for interview and physical examination data were made by selection from a list of options. Requests for other nursing actions were made through free-text entry. In the new model, all requests for nursing actions are specified through free-text entry. The database, which is actually a thesaurus of nursing terms, was enhanced (and expanded to include more than 13,000 terms) so that the system could recognize actions requested in a variety of ways. Seven of the existing cases were revised to fit the new model and database. The programming of cases, model revisions and database was completed by NBME, and a field test of the new model and database was conducted in May 1993. The findings will be reported at the CST Forum during the 1993 Delegate Assembly.

Funding Proposals and Contract Negotiations

Two activities under Objective D state, "*Identify alternative sources of funds (internal and/or external) and submit funding proposals,*" and "*If proceeding with CST, negotiate contract with National Board of Medical Examiners.*" In the Fall of 1991, a CST funding proposal requesting $1.6 million was submitted to the W. K. Kellogg Foundation. In the Fall of 1992, this request was denied by the W. K. Kellogg Foundation due to a change in their funding priorities.

At its meeting in December 1992, the Board of Directors:

- expressed its commitment to carrying out research and development of CST to establish psychometric soundness and legal defensibility, and directed the CST Steering Committee and staff to explore the composite of funding options, including National Council self funding, and to report back in March 1993;
- directed that the staff and legal counsel review the structure of the contractual relationship between the National Board of Medical Examiners and the National Council and to negotiate appropriate changes;
- approved the committee's request for $212,875 for FY93 CST project activities; and
- established a designated fund of $75,000 for performance of a market analysis survey.

In January 1993, a request for $100,000 was submitted to the W. K. Kellogg Foundation in response to their expression of the possibility of granting a small sum of money for transition purposes. In February 1993, the National Council was awarded $100,000 from the W.K. Kellogg Foundation for the period February 1993, through December 1993. Additionally, a request for $638,000 to assist in CST research and development was submitted to the Helene Fuld Health Trust. It is anticipated that word regarding this request will be received prior to August 1993.

In February 1993, staff and legal counsel of the National Council and NBME met at the NBME in Philadelphia, to review the structure of the contractual relationship between NBME and the National Council. During that meeting, NBME staff explained their plans for simulation software modifications which are intended to provide for more efficient state-of-the-art programming and scoring, and the following agreements were reached:

- The National Council will be permitted to submit NBME's long-term plans for technologic (hardware and software) enhancement to external review for evaluation in terms of its representativeness of "state-of-the-art" technology.
- Staff from both organizations will meet on a regular basis to collaborate in planning and decision-making regarding NBME software revisions which impact CST, and CST Phase II Project activities and timelines.
- Legal counsel from both organizations will identify key questions to be addressed and options for modifying the current software licensing and maintenance agreement.
- During its April 1993 conference call, the Board of Directors approved the establishment of a National Council designated fund for a five-year CST Project in the amount of $2,965,817. The progress and budget of the CST Project are to be reviewed annually by the Board of Directors.

Meeting Dates

- October 10-11, 1992
- November 6, 1992, *telephone conference*
- June 21-22, 1993

Future Activities

- **CST Phase II Project Activities FY94 through FY98**

  Phase II of the CST Project includes the following activities:

  - Regular meetings of National Council and NBME staff for collaborative planning and decision-making regarding adaptation of NBME's revised software for use with CST, and Phase II CST Project activities and timelines.

  - Building of relationships between all supporting databases of CST (i.e., nursing activity database, cases, scoring keys, NCLEX Test Plan, etc.) which will be used in the new software system to facilitate the efficiency of case development, scoring, and programming.

  - Development of 20 new CST cases as well as the revision of previously developed cases to fit the new model and nursing activity database.

  - Introduction of CST software into 30 to 40 schools of nursing for use and practice during the academic year preceding the large-scale CST Pilot Study.

  In order to participate, schools must agree to provide feedback regarding their use of the CST software, serve as a pilot test site, and solicit their graduates' participation in the Spring 1997 CST Pilot Study. Feedback from the schools will assist in evaluating the use of CST for educational purposes, as well as in the evaluation of the psychometric characteristics and legal defensibility of CST.

Recommendation(s)

No recommendations.

Staff

Anna Bersky, MS, RN, *CST Project Director*
Carolyn Yocom, PhD, RN, *Director of Research Services*

Attachments

A .... Computerized Clinical Simulation Testing Project Budget, *page 5*

Computerized Clinical Simulation Testing Project
Budget FY94 - FY98

	10/93 - 9/94 FY 94	10/94 - 9/95 FY 95	10/95 - 9/96 FY 96	10/96 - 9/97 FY 97	10/97 - 9/98 FY 98
1. Personnel	163,389	171,558	180,136	189,143	198,600
2.a. Legal Consultants	5,000	5,000	40,000		
2.b. Psychometric Consultant		1,000	2,000	1,000	10,000
3. Steering Committee	23,850	25,042	26,294	27,608	28,988
4. Exam Committee					4,368
5. Case Development Committee	40,100	42,104	22,092		
6. Scoring Key Development Committee		45,570	36,162	37,926	
7. Data Base Consultants		3,000	3,000		
8. RN consultants	35,000	3,300	5,500		
9. Content experts		5,000	2,500		
10. Honorarium: Testing Subjects		18,750	16,875	34,750	
11. Data Collection & Analysis				5,000	
12. Recruit Educ. Programs		23,100			
13. Orient Site Coordinators			24,360		
14. Install Pilot Test Software				30,870	
15. Video disk production		44,000			
16.a. Travel (P.R./D.A./Area Meetings)	8,650	9,082	9,536	10,012	23,478
16.b. Travel - field tests		6,036	5,166		
17. Office Equipment	9,062				
18. Printing costs				5,250	
19. Software Lic (NBME)	59,850	62,645	66,000	69,300	72,765
20. NBME services	265,000	425,000	125,000	75,000	
21. Staff travel to NBME	24,420	16,700	17,530	18,400	
Totals	634,321	906,887	582,151	504,259	338,119

GRAND TOTAL $2,965,817.00

10

FOREIGN EDUCATED
NURSE CREDENTIALING
COMMITTEE

Report of the Foreign Educated Nurse Credentialing Committee

Committee Members

Cynthia VanWingerden, VI, Area IV, *Chair*
Carmen Enz, OH, Area II
Frazine Jasper, NV, Area I
Jean Penny, FL, Area III
Patricia Swann, GA-PN, Area III
Mary Jane Ewart, *Consultant*

Relationship to Organization Plan

Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective A .... Implement a comprehensive repository of information.

Recommendation(s)

No recommendations.

Highlights of Activities

■ Credentialing Services

A preliminary investigation by the Foreign Educated Nurse Credentialing Committee of evaluation agencies revealed that no one agency currently provided all of the services which Member Boards indicated they needed. A comprehensive investigation of existing evaluation agencies was conducted to determine their willingness and capability of providing the full range of foreign educated nurse credentialing services needed by Member Boards.

The investigation was conducted in three stages: (1) Stage 1 - A survey to agencies to determine willingness and current capabilities; (2) Stage 2 - A survey to agencies to determine quality of services; and (3) Stage 3 - An interview with agencies to answer questions and clarify issues. The first survey investigated the current capabilities of existing agencies and willingness of agencies to expand current services. Results indicated that eight agencies were interested and claimed to be capable of providing all or part of the services proposed by the committee. Because the committee was not able to anticipate if all services would ultimately be obtained from a single agency or if it would be necessary to parcel out specific services to specific agencies, all eight of the agencies were then surveyed to ascertain quality of services. In the second survey, the agencies were asked to evaluate three transcripts. Based on analysis of the results of these two surveys, four agencies were selected to meet with the committee during its January 22-24, 1993, meeting. Utilizing a structured interview guide, the committee met for two hours with each of the four agencies.

The committee made decisions regarding the number of agencies as well as which agencies to endorse. After reviewing the positive and negative aspects of possible outcomes, the committee determined that the outcome most beneficial to Member Boards would be a recommendation to endorse two agencies. Each agency would provide all three services. The three services include: (1) an evaluation service, (2) a central repository for documents, and (3) a center for information regarding foreign education programs. The evaluation service will evaluate foreign nurse credentials using criteria of specific jurisdictions. The central repository will consist of a document center where foreign educated nurses will be able to have institutions send original verification of their education and licensure. With authorization of applicants, these documents will then be made available to academic institutions, licensing authorities, etc. The information center will provide Member Boards information about foreign education programs upon request.

By selecting two agencies, Member Boards would have all of the positive elements of multiple agencies, but by limiting the selection to two, the negative aspects of multiple agencies would be minimized. Member Boards will be able to select which agency they wish to work with, or they can provide both names to an applicant. In addition, by limiting the number of recommended agencies to two, the additional cost to the National Council will be minimal. The element of competition could lead to a better quality of services and lower cost for applicants and Member Boards. Lastly, the confusion over which agency the applicant should or did use is minimal.

The Foreign Educated Nurse Credentialing Committee reviewed all of the qualifications of the agencies which were interviewed. They concluded that each of the four agencies was capable of providing all three of the services which Member Boards have indicated are needed (as noted on page 1). However, based on all of the data collected, the committee recommended two agencies they felt would best serve Member Boards. Implementation is currently in progress.

- **Develop Guidelines**

The committee developed *The Guidelines for Evaluation of Foreign Educated Nurse Qualification* to assist Member Boards to evaluate foreign educated nurse credentials. The guidelines were reviewed by selected experts in the field and also by Member Boards who have experience in evaluating credentials of foreign educated nurses. Revisions were made based on the feedback received. They were then pilot tested to determine their potential benefit to Member Boards. The guidelines consist of sections such as "Helpful Hints," "Using Evaluation Agencies," "Definitions," and "Resources." They will be distributed to Member Boards in conjunction with information on the two evaluation agencies endorsed by the National Council.

Meeting Dates

- October 10-11, 1992
- January 22-24, 1993

Future Considerations for the National Council

The credentialing services explored by the Foreign Educated Nurse Credentialing Committee will be communicated as part of the current negotiations with selected agencies.

Recommendation(s)

No recommendations.

Staff

Nancy Chornick, PhD, RN, *Research Associate*

11

NURSE INFORMATION
SYSTEM COMMITTEE

Report of the Nurse Information System (NIS) Committee

Committee Members

Marie Hilliard, CT, Area IV, *Chair*
Patricia Brown, WA-RN, Area I
Vicky Burbach, NE, Area II
Anna Ferguson, OK, Area III
Barbara Powers, IN, Area II *(through February 1993)*
Brenda Smith, IN, Area II *(beginning March 1993)*

Relationship to Organization Plan

Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective A .... Implement a comprehensive repository of information.

Objective B .... Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.

Recommendation(s)

No recommendations.

Highlights of Activities

■ New Committee Charge

In order to carry out the goals of NIS implementation, the NIS Committee found it necessary to develop a new charge. Previously, the committee was charged to study the need for and use of a comprehensive, national nurse information system and, if needed, determine the steps necessary to create the database. Because the committee completed this charge, a new charge based on the NIS Committee's tasks outlined in the funding proposal to the Robert Wood Johnson Foundation (RWJF) was developed by the committee and approved by the Board of Directors. The NIS Committee is now charged to recommend policies regarding uses of, access to, and security measures for the Nurse Information System, and provide input on other aspects of the project as necessary through the second project year or until policies are in place. See the updated *NIS Question and Answer Sheet* (Attachment A) for details on the background of the NIS.

■ Funding for NIS Implementation

In 1992, the Delegate Assembly adopted the Board of Directors' recommendation that "*National Council implement a Nurse Information System, contingent upon the receipt of substantial external funding for development and initiation of the system.*" In accordance with Goal IV, Objective B, and receipt of the Robert Wood Johnson Foundation's funding, NIS implementation began January 1, 1993.

In October 1992, the Robert Wood Johnson Foundation awarded the National Council a grant of $530,110 over a two-year period in support of NIS implementation. The National Council is eligible to apply for a continuation grant for project years 1995-96. The National Council's total cost for the two-year period is $254,744. Included in this total is $77,425 approved by the Board of Directors to cover the cost of computer equipment. The Board of Directors approved the purchase of computer equipment because the Dr. Scholl Foundation denied a request for funding submitted by the National Council. In addition to the cost of computer equipment, the National Council's actual out-of-pocket costs are $48,741. The remainder covers indirect expenses such as routine office supplies, computer time, office support services, and space rental.

■ Progress on NIS Implementation

In order to fulfill the specific activities related to Goal IV, Objective A, the NIS Committee refined the NIS data collection form, and is working with a vendor to develop the scannable format. In addition, the National Council developed a schedule for NIS data collection, the database structure, and data processing procedures required for the NIS.

The National Council plans to acquire an optical mark reader. The updated *NIS Question and Answer Sheet* (Attachment A) contains more detailed information on NIS implementation. The NIS Committee has developed policies addressing the following areas:

- Guidelines for data transfer from Member Boards.
- Schedule for and frequency of data collection.
- Data maintained in accordance with NIS data collection agreements.
- Unduplicated count.
- Retention of inactive records.
- File back up.
- Maintenance of historical records.
- Release of data.
- Data security.

Liaison Activities

Goal IV, Objective A, also includes a tactic that calls for the NIS Committee to establish a liaison with the Nursing Practice and Education Committee (NPEC) and staff. The committee maintained the liaison relationship by sharing summaries of meeting minutes and by directing staff to provide an NIS update at NPEC meetings. Public Policy staff has interacted with the NIS Committee to discuss issues related to the NIS.

NIS Data Collection Agreement Negotiations

Continuing NIS contract negotiations relate to tactics under Goal IV, Objective B. The National Council sent the NIS data collection agreement to Member Boards in early 1992. As of May 7, 1993, 25 Member Boards have signed letters or contracts agreeing to provide NIS data. An additional nine negotiated contracts have been sent to Member Boards for signatures. The National Council is currently negotiating with 18 Member Boards as to the details of NIS participation. Seven Member Boards have not responded to the National Council regarding the NIS, and three have indicated that they will not be participating. It is likely, however, that data can be purchased from non-participants and included in the national, unduplicated count.

The committee reviewed reports on the status of contract negotiations over the past year, and made suggestions regarding strategies for continued negotiations. Member Boards have been contacted regularly regarding the status of their contracts and to address questions about the NIS.

NIS Technical Advisory Panel

The NIS Technical Advisory Panel (TAP) was formed at the request of the RWJF, and in accordance with Goal IV, Objective B. The NIS TAP held its first meeting on February 4, 1993, at the National Council. The purpose of the NIS TAP is to provide advice on technical matters related to the NIS project.

The NIS TAP reviewed results of the NIS feasibility study and plans for NIS implementation, and offered suggestions in the areas of data collection procedures, database structure and management, and data security and access. The panel will meet approximately three times per year to review progress on NIS implementation and provide suggestions on technical matters.

Meeting Dates

- October 10-11, 1992
- February 12-13, 1993
- June 28, 1993

Future Activities

NIS Implementation

NIS implementation will continue with collection of licensee data. Data will be unduplicated as they are incorporated into the database.

NIS Marketing Plan

A consultant will be hired to develop a marketing plan that is in accordance with Member Board policies on release and sale of licensee data.

■ NIS Data Fee Structure

A fee structure for the sale of NIS data will be developed, based on the costs of obtaining, processing, and distributing licensee data.

■ NIS Policies

The committee plans to develop policies on fees and marketing of NIS data over the next year.

Recommendation(s)

No recommendations.

Staff

Melanie Neal, MS, *NIS Program Manager*
Carolyn Yocom, PhD, RN, *Director of Research Services*

Attachments

A .... The NIS Question and Answer Sheet, *page 5*

Attachment A

Questions and Answers on the Nurse Information System (NIS)

Q: What is the NIS?
A: The NIS will be a national database containing demographic information on all licensed nurses. It will provide an unduplicated count of licensees and be a resource on the characteristics of licensed nurses (e.g., employment status, educational preparation, clinical specialty, etc.).

Q: Who is responsible for its development?
A: The NIS Committee is charged with recommending policies regarding uses of, access to, and security measures for the NIS, and providing input on other aspects of the project as necessary through the second project year, or until policies are in place. The National Council staff is responsible for developing the technical aspects of the NIS, based on results of the feasibility study and committee input.

Q: How has the Delegate Assembly been involved?
A: In 1992, the Delegate Assembly adopted the NIS Committee's recommendation that "*the National Council implement a Nurse Information System, contingent upon the receipt of substantial external funding for development and initiation of the system.*" In 1988, the Delegate Assembly adopted the recommendation that "the National Council pursue obtaining a grant or other outside funding to assist Member Boards in setting up a system to collect information from licensees."

Q: What is the current status of the NIS?
A: The National Council has received funding for NIS implementation, and has begun to develop and refine the information management systems required for the database. When these systems are in place, the National Council will begin to request licensee data from Member Boards. The National Council continues to negotiate contracts and letters of agreement with Member Boards as to NIS participation.

Q: Explain the NIS contract.
A: The National Council established contracts for three reasons: 1) the contract delineates the data that a Member Board is able to provide to the NIS; 2) the contract offers a Member Board the opportunity to maintain control over data released to the NIS; and 3) responses to the contract permitted the National Council to determine if adequate data are available for the NIS.

Q: How is NIS implementation being funded?
A: In October 1992, the Robert Wood Johnson Foundation (RWJF) awarded the National Council a grant of $530,110 over a two-year period in support of NIS implementation. The National Council will be eligible to apply for a continuation grant for project years 1995-96. The National Council has contributed funding for indirect costs and computer equipment. The Robert Wood Johnson Foundation, Public Health Service's Division of Nursing, and the American Nurses' Association granted funding for the 1990 Feasibility Study.

Q: What costs will be involved in the NIS participation?
A: The NIS Committee has worked hard to identify ways to reduce the cost and workload for Member Boards as they participate in the NIS. External funding will be used to assist Member Boards with the cost of collecting and transferring data.

Q: Has the original purpose of the NIS project changed?
A: No. The original purpose of the NIS was to produce a national, unduplicated count of nurse licensees, and this still holds true. In 1990, when funding was received to conduct the feasibility study, the Robert Wood Johnson Foundation suggested that external funds would be available for implementation of the NIS but not for ongoing maintenance of the system. As a result, the NIS was expanded to include demographic data describing the nurse population in order to enhance its marketability, and make it a potential source of revenue to support ongoing maintenance.

Q: Is the NIS project related to national licensure?
A: Just as the implementation of a national nursing exam did not lead to national licensure, the NIS project is in no way related to national licensure. Some individuals have raised the concern that the NIS will lead to a system for national licensure, but this is not the intention of the National Council or Member Boards that have agreed to participate in the database. With the National Council developing and managing the NIS, Member Boards will maintain control over their licensee data and help to ensure that the information is used in ways that will benefit Member Boards and the nursing profession.

Q: How will Member Boards benefit from the NIS?
A: The NIS will be a resource on licensee characteristics that will help Member Boards in their mission to protect the public health. The NIS, with its link to the Disciplinary Data Bank, will assist Member Boards in detecting applicants for endorsement who do not report previous licenses or disciplinary actions. Member Boards could expand data collection by using the NIS form provided by the National Council. The National Council could fill requests for data and labels from state data sets, with royalties from these sales going directly to Member Boards. Some Member Boards may see increased revenue from this arrangement, particularly if they have limited data on their own systems. Member Boards could use the NIS to track the movement of licensees across borders, and would be able to obtain comparative data from other states and regions.

Q: How can Member Boards use the data collection form developed by the National Council?
A: The National Council is developing a form that Member Boards can use to collect NIS data from new and renewing licensees. The form can be distributed through renewal mailings and to prospective licensees when they apply for licensure. The National Council will supply the form to Member Boards for two consecutive renewal cycles, and will scan the data free of charge. Following the first two renewal cycles, Member Boards may adopt a modified scannable form, or supply their regular data to the NIS.

Q: How will the NIS accommodate various Member Board data restrictions?
A: Some Member Boards place restrictions on the uses of their licensee data, and these limitations can be explicitly stated in the NIS contract. For example, a Member Board could limit release of data to educational and research purposes.

Q: Won't Member Boards lose revenue by allowing the National Council to release licensee data if they currently charge a fee when releasing their own data?
A: No. Member Boards can opt to respond to all requests for data that they currently fill. The National Council would be available to supply data that the Member Board is unable to provide (e.g., an unduplicated national or regional data set). In any case, Member Boards can receive royalty payments whenever their data is released through the NIS and should not experience a drop in revenues. In fact, it may be possible to recognize increased revenue once the NIS becomes a viable program.

Q: How will the National Council ensure the confidentiality of data that Member Boards do not want to release to third parties?
A: One of the major goals of NIS implementation is to develop a security system to ensure the confidentiality of NIS data. The system will limit access to data within the National Council, so that only staff with the responsibility of processing information will have access. Because some Member Boards restrict the release of data to third parties, systems will be set up to ensure that Member Boards can approve the requests for data.

Q: What are some uses for NIS data?
A: The NIS will be the only national, unduplicated source of information on nurse licensees. It will be an excellent and unique sampling frame for the National Council and others conducting research in areas of importance to Member Boards. State as well as federal government agencies could have access to the data they need for research and decision-making on the funding for existing education programs and the need for additional programs. The NIS will give health care planners access to information on the geographical distribution of licensees that might lead to solutions to the nursing shortage in certain areas.

Q: What is the likelihood of the NIS being implemented by a group other than the National Council?
A: In 1989, the Health Resources and Services Administration (HRSA) sponsored a conference on nursing data in response to a recommendation by the Secretary of Health and Human Services' Commission on Nursing. The commission, charged with investigating the extent of the nursing shortage, recommended establishment of a data source to assess nursing resources in relation to health planning and manpower. Because of the great need for and interest in a database like the NIS, it is likely that another group will undertake its development if the National Council does not do so. As the developer of the NIS, the National Council will ensure that Member Boards maintain control over licensee data compiled in the database, and that Member Boards can benefit from the system.

revised March 1993

12

NACEP COMMITTEE

Report of the Nurse Aide Competency Evaluation Program (NACEP) Committee

Committee Members

Sharon Weisenbeck, KY, Area III, *Chair*
Caroline Ace, PA, Area IV
Linda Fleming, CO, Area I
Etta Johnson-Foster, MD, Area IV
Dorothy Fulton, AK, Area I
Cindy Lyons, OK, Area III
Janette Pucci, KS, Area II
Nelwyn Broussard, LA, *Consultant*
Ted Day, WA, *Consultant*
Sarah Greene Burger, DC, *Consultant*

Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Provide a competency evaluation for nurse aides.

Recommendation(s)

No recommendations.

Highlights of Activities

■ Manual Skills Review

An activity under Objective E, Tactic 1 of Goal I states, *"Review manual skills situations for content, criticality and independence."* The committee began the process of reviewing the manual skills situations for content, criticality and independence at its January meeting. With the assistance of psychometricians at The Psychological Corporation (TPC), preliminary statistics regarding the performance of candidates on the manual skills situations and individual tasks within situations were presented and reviewed. The committee reviewed rater training and its possible effects on candidate performance at its April meeting.

■ Statistics

An activity under Objective E, Tactic 1 of Goal I states, *"Review statistics from manual skills and written evaluation on a semi-annual basis."* The results of the administration of the written/oral and manual skills evaluation components were carefully studied during the October and April committee meetings. Statistics regarding the number of candidates who passed the written and oral evaluation were reviewed. Passing rates for the written/oral and manual skills components decreased slightly from those of the preceding year as a result of the revised passing standard. The new passing standard for the written evaluation was revised and became effective in May 1992. In April, seven new manual skills were introduced to assure compliance with final federal regulations. The revised passing standard for the manual skills component became effective in April 1992.

■ Intimate Care Skills

An activity under Objective E, Tactic 1 states, *"Determine the need to reintroduce intimate care skills (peri-care, catheter care) into manual skills evaluation."* Requests from several NACEP™ users to re-introduce intimate care skills (perineal care, catheter care) were reviewed by the committee. At the committee's request, TPC developed two new manual skills forms which incorporate intimate care skills. Per communication from the Health Care Financing Administration (HCFA), intimate care skills may be tested using a mannequin. Requests from other NACEP users for other modifications of the manual skills evaluation were reviewed. These requests included use of transfer belts and proper technique for wheelchair transfer.

Communications

The NACEP Committee continued to promote the cooperation of constituent members and other organizations in order to safeguard public health and welfare. Information regarding federal legislation was distributed to Member Boards and other interested organizations. National Council staff has maintained regular communication with representatives from HCFA to assure compliance with final federal regulations and has monitored the Federal Register for any proposed legislation which would affect the NACEP.

A fourth Conference on Nurse Aides/Assistants was held in Baltimore, Maryland, on February 11-12, 1993. Representatives of HCFA spoke to interested parties from state agencies and Member Boards regarding interpretation of the final rules relating to nurse aide training, competency and the nurse aide registry. Facilitated group discussion centered on nurse aide education, the nurse aide registry, the disciplinary process, nurse aide training and the survey process. Evaluations from the conference were positive and indicated that participants felt that the conference provided useful information and an opportunity to network with colleagues from around the country.

Insight : NACEP News & Issues was distributed to over 500 individuals. *Insight*, a tri-annual publication, provides information to readers regarding nurse aide regulation and other timely information regarding nurse aide roles and responsibilities.

Publication of Manual Skills

The committee recommended and the Board of Directors approved that the NACEP manual skills be publishable material. Manual skills steps sans critical steps will be available for publication in the future. The rationale for publishing the manual skills steps is that the steps are not unique and are common to all nurse aide training programs.

Test Service

A tactic under Objective E states, *"Select vendor for NACEP."* The Board of Directors, using recommendations from the committee and staff, selected TPC to be the test service through October 31, 1997.

Disciplinary Data Bank

The committee reviewed a proposal resulting from the 1992 Delegate Assembly action which charged the National Council to investigate the feasibility of including nurse aides in a disciplinary data bank. The committee provided National Council staff with input for a survey which was then distributed to appropriate state agencies. Results of the survey will be presented to the Delegate Assembly at the Annual Meeting in August 1993.

Study Guide

The committee discussed plans to produce a study guide for the written/oral and manual skills situations. A proposed format was developed and approved by the committee. Development of study guide content will be deferred pending review and analysis of content, criticality and independence of manual skills situations.

Meeting Dates

- October 10-11, 1992
- January 21-22, 1993
- April 27-28, 1993

Future Considerations for the National Council

Manual Skills Evaluation

The NACEP Committee plans to continue to focus efforts on analyzing the manual skills evaluation for content, criticality and independence.

Recommendation(s)

No recommendations.

Staff

Ellen Gleason, MSIR, *NACEP Program Manager*

Attachments

A .... 1993 User Survey, Cumulative Results, *page 3*
B .... Comparison of Cumulative Results, *page 5*

Attachment A

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
NURSE AIDE COMPETENCY EVALUATION PROGRAM
APRIL 1993 USER STATE AGENCY SURVEY - CUMULATIVE RESULTS
N = 22

		SA	A	D	SD	Other*
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	12	8			2
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	9	12			1
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	5	15			2
4.	NACEP meets all the legal requirements in this jurisdiction:					
	a. for aides employed in long term care.	11	11			
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	4	11			6
	c. for aides employed in acute care settings (hospitals).	5	9	2		6
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	5	16			1
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	7	13			2
7.	The test service provides accurate and necessary information regarding the NACEP.	4	17		1	
8.	The test service answers inquiries from this agency in a reasonable amount of time.	4	12	5	1	
9.	Evaluation materials from the test service arrive on time at test sites.	3	15	1	1	2
10.	Candidates receive score reports within the time period specified by your contract.	2	12	5	1	2
11.	The state agency score reports have been received in a timely manner.	1	12	8	1	

		SA	A	D	SD	Other*
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	4	15	3		
13.	NACEP security measures are effective.	6	15		1	
14.	Feedback on the NACEP from nurse aides has been positive.	5	15	1		1
15.	Feedback on the NACEP from facilities has been positive.	7	11	4		
16.	The application process is easy for candidates and sponsors to compete.	4	12	4	1	1
17.	NACEP is an effective evaluation for <u>home health aides</u> (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as <u>long term care aides</u>.	3	12			7
18.	The Nurse Aide Practice Test has been useful.	8	9			5

			Yes	No	Other*
22.	In your jurisdiction, are you currently using NACEP to evaluate:				
	a.	aides employed in long term care settings	19	0	3
	b.	aides employed in home health settings	10	8	4
	c.	aides employed in acute care (hospital) settings	9	9	4

		Very Low	Low	Med	High	Very High
26.	Overall, how satisfied is this agency with the Nurse Aide Competency Evaluation Program (NACEP) offered by the National Council of State Boards of Nursing and The Psychological Corporation . Please respond on a scale of 1 to 5, with 1 indicating a very low level of satisfaction.			8	10	3 NR=1

Responses to open-ended questions (19-21 and 23-25) are available upon request.
**Other includes responses such as no answer given, not applicable, perhaps, etc.*

Attachment B

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
NURSE AIDE COMPETENCY EVALUATION PROGRAM
USER STATE AGENCY QUESTIONNAIRE
COMPARISON OF CUMULATIVE RESULTS

		1993	1992	1991
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	3.60	3.42	3.38
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.43	3.16	3.16
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.25	2.94	3.11
4.	NACEP meets all the legal requirements in this jurisdiction:			
	a. for aides employed in long term care.	3.50	3.42	3.29
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	3.06	3.38	3.08
	c. for aides employed in acute care settings (hospitals).	3.19	3.19	2.91
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	3.24	3.00	3.17
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	3.35	3.26	2.88
7.	The test service provides accurate and necessary information regarding the NACEP.	3.09	3.21	2.77
8.	The test service answers inquiries from this agency in a reasonable amount of time.	2.86	3.17	2.83
9.	Evaluation materials from the test service arrive on time at test sites.	3.00	3.10	2.86

Averages calculated - highest possible score = 4.00, lowest possible score = 1.00

		1993	1992	1991
10.	Candidates receive score reports within the time period specified by your contract.	2.75	3.05	2.33
11.	The state agency score reports have been received in a timely manner.	2.59	2.84	2.58
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	3.04	3.10	2.70
13.	NACEP security measures are effective.	3.18	3.26	3.00
14.	Feedback on the NACEP from nurse aides has been positive.	3.19	2.95	2.55
15.	Feedback on the NACEP from facilities has been positive.	3.14	2.68	2.52
16.	The application process is easy for candidates and sponsors to complete.	2.90	2.94	2.52
17.	NACEP is an effective evaluation for home health aides (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as long term care aides.	3.20	3.06	2.91
18.	The Nurse Aide Practice Test has been useful.	3.47	3.14	3.38

**Other includes responses such as no answer given, not applicable, perhaps, etc. This type of response was not used in calculating the results for questions 1 through 18.*

13 NACEP TEST SERVICE

Annual Report of the NACEP Test Service

Submitted by The Psychological Corporation
Ann Breen, *Project Planning Coordinator*
Edward Clifton, *Senior Program Director*
Lucille Dungan, *Business Area Director*
Janie Menchaca-Wilson, *Nurse Consultant*
Sue Traweek, *Operations Supervisor*

Highlights of Activities

■ Psychometric

Beginning in May 1992, the first of five new forms of the written evaluation was introduced. The 1992 *Nurse Aide Competency Evaluation Program (NACEP™) Blueprint* (based on the National Council job analysis conducted in 1990) was used to construct the five forms, all of which are now in use. The mean passing rate for the written evaluation for the period March 1, 1992, through February 28, 1993, was 89.9 percent, a drop from 97.2 percent from the last twelve-month period (see Table 1). This drop was expected due to the higher passing score approved by the National Council Board of Directors in May 1992. Higher standards were justified due to the minimum training hours now required of all nurse aides. Reliability indices (KR20's) for new forms are good for a 65 item test, ranging from .83 to .86.

Seven new manual skills situations were introduced in April 1992 to meet final federal requirements. An analysis of the task level statistical data of the seven new manual skills situations indicated that three of the seven situations contained tasks that were not performing as expected, given field test results. Issues regarding the scoring of those situations were resolved by the National Council, The Psychological Corporation, and the NACEP Committee, and all new situations have been in use since July 1992. Table 2 presents the passing rate by state for the manual skills evaluation for the period March 1, 1992, through February 28, 1993. In states administering the evaluation to at least 100 candidates, the percent passing ranged from 86.4 to 97.7 percent. Reliability indicators (item and task reliabilities, task intercorrelations, and inter-rater reliabilities) are very good for performance assessments.

Additional manual skills situations which include perineal and catheter care tasks were approved for use in jurisdictions requesting these tasks in the evaluation.

A comprehensive review of the manual skills evaluation (both content and process) was initiated by the NACEP Committee. Item, task and form psychometric information will be published in a technical report in October 1993. Analysis of both rater consistency and methods for determining passing scores will continue through the summer of 1993. Additionally, a task force will be convened in July to develop more specific rater directions for the skills evaluation with a goal of publishing a new rater manual after approval by the NACEP Committee in October 1993.

■ Operations

Because of growth during the past year, both in numbers and in services being requested by NACEP clients, a second shift was added in March 1993 which operates from 1:30 pm to 11:30 pm, CST, Monday through Thursday. First shift (regular hours) employees have been relieved of many of the document processing and staging activities, which reduce the quality of customer service and "on-time" reporting (e.g., mailing of candidate handbooks, evaluation center admission tickets and score report).

■ Marketing

The NACEP continues to experience high success in retaining states. All of the NACEP states which had contract expiration dates between May of 1992 and April of 1993 have renewed or extended their agreements. Arizona, California, Colorado, Delaware, the District of Columbia, Louisiana, Nevada, Oregon, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia, and Wyoming, 14 states in all, expressed their continued confidence in The Psychological Corporation by going forward with the NACEP. Most satisfying is that of those 14 states, only four, Colorado, Delaware, Nevada, and South Carolina, issued formal requests for proposals.

In addition to retaining clients, The Psychological Corporation has worked hard to win new contracts. We received invitations to bid from Arkansas, Connecticut, Michigan, New Mexico, Ohio, and Pennsylvania. Prior to the bid opening in Arkansas, the RFP was canceled with an explanation that a new one requiring additional services would be released

in the near future. In the case of Michigan which required, as a prerequisite for responding, a Procare IVD or Procare facsimile examination, we chose not to respond. Both Connecticut and New Mexico decided to remain with their current vendors. We anticipate awards being made in Ohio and Pennsylvania in May 1993 and are optimistic about our prospects for winning both.

Meeting Dates

- Annual License Agreement Meeting, July 10, 1992
- National Council Annual Meeting, August 18-22, 1992
- National Council Fall Retreat, October 10-11, 1992
- NACEP Committee Meeting, January 21-22, 1993
- NACEP Committee Meeting, April 27-28, 1993

Future Considerations for the National Council

We expect states will continue to request enhanced services, (e.g., in-state consultants, custom applications, on-site scoring). This will have both cost and staffing implications for the program. The review of the manual skills evaluation will continue with a focus on fine-tuning the training and scoring procedures to increase our level of confidence in the skills component.

Staff

Ellen Gleason, MSIR, *NACEP Program Manager*

Attachments

A ....Table 1 - NACEP Number Tested and Percent Passing Rate, Written/Oral, *page 3*
B ....Table 2 - NACEP Number Tested and Percent Passing Rate, Manual Skills, *page 5*

Attachment A

Table 1. NACEP Written/Oral Evaluation

Number Tested, Mean Scaled Score and Percent Passing by State
March 1, 1992 - February 28, 1993

State	Written/Oral		Written		Oral[b]	
	Number Tested	Percent Passing	Number Tested	Percent Passing	Number Tested	Percent Passing
Alabama	3,820	84.2	3,739	84.8	81	56.8
Alaska	213	100.0	213	100.0	a	a
Arizona	2,881	98.1	2,874	98.2	7	57.1
California	5,216	81.6	5,184	81.8	32	46.9
Colorado	3,794	95.6	3,718	96.0	76	73.7
Delaware	836	86.5	817	87.4	19	47.4
District of Columbia	830	74.1	829	74.1	1	100.0
Idaho	2,041	96.6	2,021	97.0	20	60.0
Louisiana	1,067	89.7	1,039	90.4	28	64.3
Maine	394	98.5	394	98.5	a	a
Maryland	2,637	83.8	2,606	84.0	31	67.7
Nevada	986	96.0	976	96.4	10	60.0
New Hampshire	494	99.4	493	99.6	1	100.0
North Dakota	1,538	95.6	1,516	96.0	22	63.6
Oregon	3,227	98.1	3,208	98.2	19	94.7
Puerto Rico	6	16.7	a	a	6	16.7
Rhode Island	625	95.7	625	95.7	a	a
South Carolina	4,105	75.9	4,023	76.5	82	47.6
South Dakota	1,096	97.8	1,085	98.2	11	54.5
Vermont	944	94.7	932	95.2	12	58.3
Virgin Islands	52	78.8	52	78.8	a	a
Virginia	7,267	88.6	7,203	88.7	64	76.6
West Virginia	2,642	95.6	2,626	95.7	16	75.0
Wyoming	863	99.7	860	99.8	3	66.7
Total	47,574	86.5	47,033	89.9	541	62.1

a No oral evaluations administered
b Includes Spanish

National Council of State Boards of Nursing, Inc./1993

Attachment B

Table 2. NACEP Manual Skills

Number Tested and Percent Passing by State
March 1, 1992 - February 28, 1993

State	Number Tested	Number Passing	Percent Passing
Alabama	3,534	3,231	91.4
Alaska	213	20	97.7
Arizona	1,752	1,675	95.6
California	5,025	4,344	86.4
Colorado	3,660	3,264	89.2
Delaware	686	629	91.7
District of Columbia	740	644	87.0
Illinois	48	46	95.8
Louisiana	1,264	1,117	88.4
Maine	418	377	90.2
Maryland	2,252	2,102	93.3
Nevada	1,242	1,171	94.3
New Hampshire	558	507	90.9
North Carolina	62	6	100.0
North Dakota	1,447	1,357	93.8
Oregon	3,179	2,891	90.9
South Carolina	3,638	3,157	86.8
South Dakota	1,460	1,393	95.4
Vermont	886	831	93.8
Virgin Islands	51	44	86.3
Virginia	6,973	6,282	90.1
West Virginia	2,126	1,925	90.5
Wyoming	876	822	93.8
Total	**42,090**	**38,079**	**90.5**

14 NCLEX TEST SERVICES

Annual Report of the NCLEX Test Service (CTB) 1992-1993

Introduction

This report provides a summary of CTB Macmillan/McGraw-Hill's activities with the National Council Licensure Examinations (NCLEX) from July 1, 1992, through June 30, 1993. During this time, the NCLEX project staff members have provided support for the following major phases of the NCLEX program:

Examination Development

- continued development of valid and reliable Registered Nursing (RN) and Practical (Vocational) Nursing (PN) tests that accurately measure entry-level proficiency in the RN and PN professions
- development of 1,121 RN test items and 681 PN test items that measure the performance of the job-related nursing skills identified in the RN and PN test plans
- creation of 10 additional tryout forms containing 360 tryout items for both NCLEX-PN 092 and NCLEX-PN 493
- creation of 18 additional tryout forms containing 648 tryout items for NCLEX-RN 293
- continued monitoring of the RN and PN item pools to determine pool deficiencies and direct item development at targeted test plan areas and difficulty levels
- coordination of a mail-in item-writing project to develop RN items for use as additional Computerized Adaptive Testing (CAT) field test items in NCLEX-RN 294
- preparation of quarterly and yearly item pool tallies according to specifications requested by the National Council
- preparation of yearly RN and PN item pool text and statistics diskettes
- preparation of a document that lists and organizes Member Board practice limitations
- coordination and facilitation of the Bias Sensitivity Review Panel (BSRP); incorporation of information provided by the BSRP into item development
- review of items for characteristics that result in appropriate difficulty levels; incorporation of difficulty level information into additional item writer and item reviewer training
- continued implementation of operational definitions for the NCLEX-RN and PN test plans (for Examination Committee and CTB staff use)
- review of the usability of items for the NCLEX-RN and NCLEX-PN reserve and pre-printed Crisis Management Plan Examinations; creation of a new reserve NCLEX-RN Crisis Management Plan Examination

Examination Administration, Scoring, and Reporting

- reporting of examination results and Jurisdiction Summary Reports ("Green Sheets") in a timely manner
- continued work with the Administration of Examination Committee and National Council staff to monitor all shipping and security procedures
- support to Member Boards in tracking the arrival of examination booklets

- distribution of the Candidate Information Brochure and the Scoring Brochure to Member Boards

- effective with the NCLEX-PN 493 examination, inclusion of a candidate confidentiality agreement and signature line on the front cover of NCLEX examinations

Research and Technical Support

- technical support in all areas of research, including the monitoring of examination statistics, passing standards, and the performance of special research studies requested by the National Council and its committees

- provision of a quarterly review of literature related to testing and measurement, published in the NCLEX Quarterly Reports

- implementation of new techniques to detect possible ethnic or gender bias in test items and refinement of existing statistical procedures for implementation with small ethnic groups

Examination Development

Item Writing

A major focus of the CTB test development staff has been the coordination, training, and support of item writers in the development of NCLEX test items. That focus has become increasingly important in anticipation of the change to computerized adaptive testing. Additional item development efforts have been completed to substantially increase the item pool. These efforts include additional item-writing sessions and a mail-in item-writing project.

Because of the complex item pool needs for CAT, item development plans became increasingly specific in regard to difficulty level, test plan coverage, and general nursing content coverage. Additional training materials were developed to assist item writers in targeting item difficulty. Additional monitoring of the content of the pool has been required in order to reduce the extent of duplication in item writing and to ensure content coverage for the CAT item pool.

- **Item-Writing Conferences**

Two RN item-writing conferences, two RN-CAT item-writing conferences, one PN item-writing conference, and one PN-CAT item-writing conference were held during the past year. Participants were sent pre-conference exercises, provided as an introduction to CTB's item development process. These exercises were rated by CTB content staff and the ratings were shared with the Examination Committee.

- **RN Item Writing**

An RN item-writing conference was held July 13-17, 1992, in Monterey, California. Fifteen writers selected by the National Council were invited to participate. These writers represented Arkansas, Colorado, Delaware, Georgia, Massachusetts, New York, North Carolina, Pennsylvania, Texas, Washington, and Wisconsin. Three hundred sixty-seven items were created by the item writers and then reviewed by CTB nursing consultants and editing staff.

A second RN item-writing conference was held January 25-29, 1993, in Monterey, California. The fifteen writers selected by the National Council represented Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, North Carolina, Pennsylvania, and Texas. A total of 398 items were written.

A third RN item-writing conference was held February 15-19, 1993, in Monterey, California, to develop items for RN-CAT. The 15 writers selected by the National Council represented Arkansas, California, Indiana, Maryland, Michigan, Minnesota, New York, Ohio, Oklahoma, Oregon, Tennessee, and Texas. The total number of items written was 399.

- **RN Mail-In Item Writing**

Mail-in test items were solicited from item writers to obtain additional RN-CAT items for use as NCLEX-RN 294 tryouts. Twenty-three writers who had previously attended item-writing sessions and were recommended for return participated as mail-in writers. These writers developed 324 items.

- **PN Item Writing**

A PN item-writing conference was held August 31-September 4, 1992, in Monterey, California. The 15 participants selected by the National Council represented Alabama, Colorado, Florida, Georgia, Idaho, Indiana, Massachusetts, Maryland, Minnesota, Tennessee, and Washington. A total of 317 items were written.

A PN-CAT item-writing conference was held October 19-23, 1992, in Monterey, California. Fifteen writers participated in developing PN-CAT items. The writers represented Illinois, Kansas, Louisiana, Maryland, Missouri, North Carolina, Ohio, Pennsylvania, Texas, and Washington. During this session, 364 items were written for possible inclusion as CAT items.

Item Review Conferences

Six item review conferences were coordinated during the past year. Two of those conferences were RN conferences, two were RN-CAT conferences, one was a PN conference, and one was a PN-CAT conference. At the conferences, items were reviewed to ensure existence of one and only one correct response (documented in two standard nursing textbooks or one textbook and one approved journal), to ensure that the content represents current entry-level practice, and to address any regional or nurse practice act issues.

- **RN Item Review Conferences**

A CAT item review conference convened in Monterey, California, September 14-18, 1992. The 20 participants selected to participate by the National Council represented Alabama, California, Colorado, Florida, Georgia, Illinois, Iowa, Michigan, Minnesota, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Texas. During this session, 539 newly created items were reviewed; 26 items were deleted during review, and 513 were accepted for future use as experimental items.

An item review conference was held September 21-25, 1992, in Monterey, California, for the review of NCLEX-RN test items. The 15 participants selected by the National Council represented Alaska, Arizona, Colorado, Connecticut, Iowa, Kansas, Maine, Oregon, South Carolina, Tennessee, Virginia, and Wisconsin. A total of 367 newly written items were reviewed as well as 125 recycled items. A total of 17 items were deleted and 475 were accepted for future use as experimental items.

A second RN item review conference convened March 15-19, 1993, in Monterey, California. The 14 participants selected to participate by the National Council represented Alaska, California, Florida, Georgia, Illinois, Indiana, Nevada, New York, North Carolina, Pennsylvania, West Virginia, and Wisconsin. During this session, 398 items from the January 1993 conference were reviewed; 10 items were deleted during review, and 388 were accepted for future use as experimental items. In addition, 72 mail-in items were reviewed; two were deleted during review and 70 were accepted.

The final RN item review conference was held April 26-30, 1993, in Monterey, California. The 16 participants selected by the National Council represented Arkansas, Connecticut, Idaho, Illinois, Kentucky, Louisiana, Minnesota, Montana, North Carolina, Nebraska, New Hampshire, Pennsylvania and Texas. A total of 399 items from the February item-writing session were reviewed. Additionally, 252 mail-in items were reviewed. Nineteen items from the writing session were deleted and 380 were accepted for future use as experimental items. Twelve mail-in items were deleted, and 240 items were accepted.

- **PN Item Review Conferences**

A PN item review conference was held November 16-20, 1992, in Monterey, California, for the review of NCLEX-PN test items. The 14 participants selected by the National Council represented Colorado, Idaho, Kentucky, Louisiana, Massachusetts, Minnesota, North Carolina, New Mexico, and West Virginia. A total of 319 items were reviewed. Eleven items were deleted and 308 items were approved for future use as experimental items.

A PN-CAT review conference was held January 11-15, 1993. The 15 participants represented Arkansas, Florida, Illinois, Kentucky, Minnesota, Montana, New Jersey, North Carolina, Pennsylvania, South Carolina, Tennessee, and Texas. The panel reviewed 364 newly created items. During review, 16 items were deleted from the RN pool, and 348 were accepted for future use as experimental items.

BSRP Sensitivity Review Panel

CTB coordinates the meetings of the Bias Sensitivity Review Panel (BSRP) at CTB headquarters in Monterey, California. The panel met three times this year. Panel members represent the four largest minority ethnic groups taking the examination. A linguist also serves on the panel.

The BSRP provides the judgmental process that complements the statistical procedures which detect potential bias in NCLEX test items. During sessions, the panel members review selected items for facial bias and culturally bound material. A summary of the items reviewed is sent to the National Council after each session. Items identified by the panel as requiring revision are reviewed at the following Examination Committee meeting.

The BSRP meetings took place August 3-5, 1992; November 2-4, 1992; and February 8-10, 1993.

Continuing Education Credits

Both item writers and item reviewers were awarded 41.4 contact hours of Continuing Education credit for their participation in these conferences.

Member Board Review of Experimental Items

CTB staff completed a review of information provided by Member Boards in their 1992-1993 review of experimental items. One-thousand and eight PN experimental items were available for Member Board review during the late summer/early fall review period. A total of nine Member Boards participated in this review. Items identified as inconsistent with entry-level practice were submitted to the PN Item Review Panel that met in November 1992. The items designated as inconsistent with a state's nurse practice act were submitted with documentation to the National Council for final review in September 1992 and were reviewed by the Examination Committee at its October 1992 meeting.

Two-thousand and sixteen RN experimental items were available for Member Board review during the winter review period. A total of eight Member Boards participated in this review. Items designated as inconsistent with entry-level practice were submitted to the RN Item Review Panel that met in March 1993. The items designated as inconsistent with a state's nurse practice act were submitted with documentation to the National Council in March 1993, and were reviewed by the Examination Committee at its March 29-April 1, 1993, meeting.

CTB continues to closely monitor the security and packaging procedures for review drafts.

Item Bank Assessment

CTB completed its annual assessment and update of the RN item pool in November 1992, and completed the PN item pool update in December 1992. A tally of items in the pool, according to difficulty and discrimination indices, was provided to the National Council. Tallies also reflected Item Response Theory (IRT) difficulty statistics.

The RN tallies were sent to the National Council in December 1992; the PN tallies were sent in January 1993. Diskettes containing the statistics of all usable items and diskettes containing the corresponding item text were also provided.

Item Pool Tallies and Diskettes

CTB provided item pool tally reports, diskettes containing statistics, and diskettes containing text on a quarterly basis, after each examination administration. With each report CTB also provided a listing of items deleted for content reasons.

Examination Construction

The two registered nursing examinations (NCLEX-RN 793 and NCLEX-RN 294) and the two practical nursing examinations (NCLEX-PN 493 and NCLEX-PN 093) were developed according to the RN and PN test plans approved by the Delegate Assembly and the test construction guidelines established by the Examination Committee. The examinations were constructed to be equivalent to previous forms of RN and PN examinations from both a content and a statistical perspective. They were reviewed by CTB's nursing consultant staff, editorial staff, research staff, and the Examination Committee to ensure that all items met the established criteria.

The Examination Committee reviewed a total of 540 tryout items for RN 493; 1,008 tryout items for RN 793; 540 tryout items for PN 093; and 1,008 tryout items for RN 294.

Examination Committee Meetings

The Examination Committee met in Monterey, California, on October 5-8, 1992; December 7-11, 1992; March 29-April 1, 1993; and June 21-25, 1993. The Examination Committee also met in Chicago, Illinois, on October 9-11, 1992. At these meetings, CTB staff worked in cooperation with committee members to review all NCLEX examination materials and to discuss related issues.

CTB Test Development staff provided information as requested and provided summary reports on all committee-related activities. CTB Technical Coordinators presented research reports analyzing results of the two RN examinations and the two PN examinations. In addition, Person-Fit reports, Ethnicity/Gender reports, and results of various research studies were presented. Additional research studies that were completed and presented in 1992-1993 are described in the Research and Technical Support section of this report. Test development activities presented to the Examination Committee are described in the test development section.

Examination Administration, Scoring, and Reporting

■ Examination Administration

Two RN and two PN examinations were administered during the past year. The NCLEX-RN 792 examination was administered to 83,867 candidates. The NCLEX-RN 293 examination was administered to 43,124 candidates. The NCLEX-PN 492 examination was administered to 25,920 candidates. The NCLEX-PN 092 examination was administered to 41,421 candidates. Information regarding the NCLEX-PN 493 examination was not available at the time this report was prepared and will be reported in the 1993-1994 Annual Report.

■ Examination Materials Retrieval/Scoring

The retrieval and scoring of all examination materials were conducted under secure conditions. Candidate information, test materials, and late applications were checked by the CTB scoring staff and the Data Center 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 competence, and all score reports were shipped on or before the scheduled date.

CTB staff continued to provide the service of automatically handscoring all examinations within a particular range of the passing score. Approximately 1,214 booklets were handscored during the verification process for NCLEX-PN 492 (this figure was not available for the 1991-1992 Annual Report); 2,031 booklets were handscored for NCLEX-RN 792, 1,415 were handscored for NCLEX-PN 092; and 1,498 were handscored for NCLEX-RN 293. At the time this report was written, information regarding the number of examination booklets verified for NCLEX-PN 493 was not available. This information will be included in the 1993-1994 Annual Report.

CTB reviewed booklets for abnormal markings and omitted responses, updated candidate information that was in error, and provided a scoring tracking record to each Member Board to summarize key dates in the scoring cycle and to summarize details of incomplete, duplicate, or inaccurate candidate data.

■ Handscoring

CTB responded to 116 handscoring requests from candidates for the NCLEX-RN 292, which represents an eight percent increase from the previous year; and responded to 50 requests for the NCLEX-PN 492, which is a 20 percent increase over the previous year. (These figures were not available for the 1991-1992 Annual Report.) One hundred and ninety-six handscoring requests were received for the NCLEX-RN 792 examination, which represents a 16 percent decrease from the previous year, and 41 handscoring requests were received for the NCLEX-PN 092 examination, which is a 22 percent increase from the previous year. At the time this report was written, 40 handscoring requests had been received for NCLEX-RN 293, and no requests had been received for NCLEX-PN 493.

No scoring errors were revealed as a result of the handscoring process. All scores remained as originally reported.

■ Candidate Information Brochures

The 1992-1993 generic Candidate Information Brochures were included with candidate applications.

Brochures for the NCLEX-PN 493 and NCLEX-RN 793 examination administrations were distributed to Member Boards in October 1992. Brochures for the NCLEX-PN 093 and NCLEX-RN 294 examination administrations were distributed to Member Boards in April 1993.

■ New Scoring Brochure

CTB also sent new scoring brochures to Member Boards. This brochure was distributed to candidates at the test sites, after they completed the NCLEX. The brochure describes what happens to the test booklets after they leave the test site and explains the steps taken to ensure accuracy during scoring.

Operational Issues

The following operational issues have been addressed during the fourth quarter:

■ Quality Assurance Program

CTB staff continued to ensure quality throughout the NCLEX program by improving procedures and reviewing project issues at regular team meetings. Quarterly reviews of the established procedures by the staff of all departments who work on NCLEX were also conducted.

Following the reviews, modifications to procedures were documented and distributed in CTB's internal document for project procedure details and comprehensive documentation.

■ Research and Technical Support

The research staff continues to provide the National Council with the information needed to monitor the technical performance of each examination. Technical reports have been submitted to the National Council for the NCLEX-PN 492, NCLEX-RN 792, NCLEX-PN 092, and NCLEX-RN 293 examination administrations. In each technical report, CTB test development and research staff have provided a detailed description of the development activities and analyses carried out for each examination. Tables of historical statistics were also included in those reports.

■ Other Research Activities

- CTB continues to publish a review of literature regarding pertinent measurement issues in CTB's Quarterly Report to the National Council.

- In January 1993, CTB provided the National Council with a report summarizing psychometric issues concerning the licensing of visually-impaired and hearing-impaired candidates.

- CTB completed two cheating analyses for the New York jurisdiction and three cheating analyses for the South Dakota jurisdiction for the NCLEX-RN 792 examination. The reports were sent to the jurisdictions in August 1992.

- For the NCLEX-RN 293 examination, CTB completed three cheating analyses for the Florida jurisdiction, two analyses for the Maryland jurisdiction, and one analysis each for the South Carolina and Texas jurisdictions. The results were reported in March 1993.

- Three NCLEX staff members from CTB attended the annual American Educational Research Association (AERA)/ National Council on Measurement and Education (NCME) conference in Atlanta on April 12-16, 1993. CTB research staff presented a paper at the conference, entitled "Item Parameter Drift in IRT-Based Licensure Examinations."

- CTB staff coordinated and participated in a PN Standard Setting Session on April 19-21, 1993. At this session, nine judges recommended a new passing standard for NCLEX-PN 093 and subsequent NCLEX-PN examinations. The appointed judges represented Louisiana, Massachusetts, Missouri, Nebraska, New Mexico, North Carolina, Pennsylvania, and South Dakota. The National Council's Psychometrician, Ellen Julian, attended the session. A report on the NCLEX-PN 093 standard setting was presented to the National Council in May 1993.

■ Annual CTB - National Council Research Meetings

CTB continues to work with the National Council to discuss the results of current research studies and to identify future research directions for the NCLEX. To this end, CTB research staff met with National Council staff in Chicago, Illinois, on October 11, 1992, to develop a plan for research studies for 1993.

Subsequent to the October meeting, CTB provided the National Council staff with final specifications for studies in the plan. The National Council staff reviewed the specifications and determined the final order of the research studies. Item difficulty and item development targeting and a replication of the item classification study were among the studies given high priority.

Research Studies

The CTB research staff has conducted the following research studies during the past year:

- **Person-Fit Analyses**

Person-fit analyses are studies conducted to assess whether there is any evidence suggesting that candidates have had prior access to items which appeared in previously administered examinations. Such analyses were conducted on NCLEX-RN 792 and NCLEX-PN 092. Reports summarizing these analyses and the obtained results were submitted to the National Council in October 1992 and January 1993.

A special person-fit analysis was performed on the NCLEX-RN 292 examination at the request of the National Council. The results were presented to the National Council in May 1993.

- **Ethnicity/Gender Bias Analysis**

Ethnicity/gender bias analyses were conducted on NCLEX-PN 492, NCLEX-RN 792, NCLEX-PN 092, and NCLEX-RN 293. Reports summarizing these analyses and the obtained results were submitted to the National Council after each examination administration.

- **NCLEX-RN 792 Security Breach Analysis**

CTB performed statistical analyses on the NCLEX-RN 792 examination in order to determine whether or not a widespread dissemination of the items had occurred due to a security breach in the New Jersey jurisdiction. A summary of the results was presented to the National Council in October 1992.

- **Replication of the NCLEX-RN Item Classification Study**

The replication of the RN Item Classification Study is going to be conducted in the second-half of 1993.

- **Analysis of Items Administered in NCLEX-RN 291 and NCLEX-RN 792**

The 67 items that were administered in NCLEX-RN 291 and subsequently in NCLEX-RN 792 are being examined for possible effects of the July 1992 security breach on their statistics. This analysis is due to be completed by June 1993.

Communications

National Council/CTB Communication Services

CTB has instituted the following programs and services in the area of communication with Member Boards, educators, and related consumer groups:

- **24-Hour Emergency Telephone Service**

CTB continues to provide an emergency telephone number so that Member Boards may reach CTB personnel 24 hours per day. When the National Council and CTB are closed, Member Boards can reach the CTB Security Department who will then contact the appropriate NCLEX personnel at home.

- **Direct Toll-Free Access to NCLEX Staff and Conference Information**

CTB continues to provide a toll-free telephone number specifically for NCLEX. The number provides recorded information about NCLEX Summary Profiles and access to key NCLEX staff members.

- **Reports**

CTB staff produced four Quarterly Reports and one Annual Report that provide documentation of the activities and accomplishments in the areas of examination development; research; examination administration, scoring, and reporting; and the NCLEX Data Center.

- **NCLEX Invitational Conferences**

CTB presented the Fourth NCLEX Regional Invitational Conference on November 12-13, 1992, in Albuquerque, New Mexico. Three staff members from CTB, as well as the National Council's NCLEX Program Manager and Project Director of Computertized Clinical Simulation Testing (CST), presented at the conference. Over 75 educators and Member Board staff attended the two-day conference. The conference included an overview of test development,

administration, scoring and reporting, research, and the NCLEX Summary Profiles. A workshop for educators was given by CTB staff on the principles of item writing. A presentation of Computerized Clinical Simulation Testing and Computerized Adaptive Testing was given by the National Council's CST Project Director. Conference participants were given an opportunity for hands-on experience with CST.

Pre-conference planning began in August when approximately 1,000 announcements were sent to all Member Boards, to various consumer groups, and to registered and practical nursing programs in the Western Region. Announcements and information on the conference were also distributed through the NCLEX Summary Profiles and at the Delegate Assembly in Colorado Springs, Colorado.

CTB produced informational material for distribution at the conference. The Invitational Binder, which was distributed to all conference attendees, describes the processes of Test Development, Research, Scoring and Reporting, and the NCLEX Data Center. The Principles of Item Writing is an instructional guidebook that was distributed to all participants in the Item-Writing Seminar at the Invitational. Additional copies of materials were made available for mail-order purchase.

Additionally, CTB provided all conference attendees with continuing education Certificates of Completion for their participation. Conference attendees received 11 continuing education units (CEU) for attending the full two-day conference, and four CEUs for attending one-day of the conference. Conference attendees were asked to complete continuing education and CTB program evaluations.

Meetings/Conferences

- **National Council Annual Meeting**

The National Council's Fourteenth Annual Meeting was held in Colorado Springs, Colorado, August 18-22, 1992. Sixteen staff members from CTB attended all Annual Meeting sessions and forums.

CTB's test development and research staff gave presentations at an educational forum on August 18, 1992. This four-hour educational session provided an overview of all NCLEX test development activities.

The NCLEX Test Development Manager presented information about the item writing, item review, BSRP, and test assembly processes. CTB's Director of Research Applications discussed NCLEX research and statistical analysis, including such topics as bias research, and the standard-setting process. Evaluations by participants indicated that attendees found the educational forum informative and interesting.

CTB hosted a dessert reception at the Antler's Doubletree on Wednesday evening, following the Candidates' Forum.

All Annual Meeting attendees were provided with packets containing a description of the CTB and Data Center staff, information about the 1992 Regional Invitational, a special NCLEX brochure produced specifically for the Annual Meeting, an issue of *NCLEX News and Notes*, and an NCLEX Summary Profiles brochure.

- **Contract Evaluation**

The National Council and CTB staff participated in quarterly conference calls to discuss contract issues on September 22, 1992; December 14, 1992; and June 30, 1993. Topics of discussion included the NCLEX item bank, security, CAT Beta Test, computer adaptive testing, research, the crisis management plan, and other issues related to the contract.

On March 30, 1993, CTB managers met with the National Council Director of Testing Services, one of the National Council NCLEX Program Managers, and the Chair of the Examination Committee for the annual evaluation of CTB's service. Issues and procedures related to various aspects of the contract were discussed.

- **1992 Fall Retreat**

On October 10-11, three CTB staff members attended the 1992 Fall Retreat in Chicago, Illinois. During the retreat, CTB staff attended the joint meeting of the Examination Committee–Teams 1 and 2, the joint meeting of the Examination Committee and the Bylaws Committee; and the Administration of the Examination Committee Meeting.

CTB met separately with National Council staff to discuss the tasks necessary for a smooth transition to CAT. CTB requested this meeting so that the National Council could develop schedules, timelines, and specific activities during the transition period. CTB initiated this discussion to facilitate CTB's efforts to provide support to the National Council during the transition to CAT as well as meet current contract commitments.

CTB provided the National Council staff with a list of issues relative to the transition to CAT and the completion of the paper-and-pencil contract for their consideration prior to the meeting. Topics included:

Beta Test
- schedule
- extent of support required
- effect on application processing
- need for incorporating beta test candidate results into standard analyses and reports
- effect of Beta Test on processing of applications

Item Pool
- need for additional item pool summaries
- schedule of use of items for paper-and-pencil examinations
- request for central National Council staff person for item bank requests

Return of NCLEX materials
- identification of type and amount of materials stored
- timeframe for shipping materials to National Council

• **Research Planning Meetings**

The Fall Research Planning Meeting was also held by CTB and the National Council's Testing Services and Research staff on October 11, 1992. In lieu of the *NCLEX Three-Year Plan* usually discussed at the fall meeting, CTB presented a draft of the *NCLEX Plan, 1992-1994*, covering the remainder of the paper-and-pencil contract. The research portion of the plan identified research studies that are to be conducted within the 1,300 research hours CTB contributes to the National Council each year. The Research Plan was reviewed and discussed in detail; discussions focused on the current status of NCLEX research for 1992 and CTB's proposed NCLEX research topics of discussion for 1993. Suggested revisions were incorporated into the final *NCLEX Plan, 1992-1994* document.

• **Administration of Examination Committee (AEC)**

The NCLEX Program Director attended the Administration of Examination Committee meeting held on October 10-11, 1992, in Chicago, Illinois. At this meeting, the Program Director presented information and answered questions about the administration of NCLEX-PN 492 and NCLEX-RN 792.

The NCLEX Associate Manager also attended the Administration of Examination Committee meeting held on March 4-5, 1993, in Chicago, Illinois. Information about the administration of NCLEX-PN 092 and NCLEX-RN 293 and issues related to security and shipping were discussed at the meeting.

• **1993 Area Meetings**

An overview of CTB's current item development activities, Bias Sensitivity Review Panel activities, NCLEX invitational conferences, and operational issues was presented by CTB staff at each Area Meeting.

The NCLEX Associate Manager, Karen Selikson, and the NCLEX National Accounts Manager, Meredith Mullins, attended the Area I Meeting in Las Vegas, Nevada; the NCLEX Editing Manager, Lisbeth Penn, attended the Area II meeting in Kansas City, Kansas, and the Area III Meeting in Richmond, Virginia; and the NCLEX Program Director, Sally Gensberg attended the Area IV Meeting in Burlington, Vermont.

Special Requests and Additional Services

In addition to supporting the major phases of the NCLEX program, the CTB project staff members have also responded in a timely and effective manner to all requests from the National Council and its Member Boards for additional services and information.

CTB provided the following services at no additional cost:

- responded to 12 requests from Member Boards for special analysis of suspected cheating
- responded to 13 requests from Member Boards for review of previously administered examinations: six Member Boards requested a review of NCLEX-PN 091 and seven Member Boards requested a review of NCLEX-RN 792
- provided answer keys for each examination administration to the National Council for Member Board reviews
- provided options related to a contract extension for NCLEX paper-and-pencil testing at the Annual Meeting in August 1992
- provided background data related to the PN-CAT field-test states to assist in the sampling design
- provided the National Council with item responses for samples of 5,000 for NCLEX-RN 792 and NCLEX-PN 092 examinations
- provided the National Council with the NCLEX-PN tryout items and statistics on diskette for use in NCLEX-PN/CAT field-testing
- entered NCLEX-PN 492 candidate code changes after the deadline and reran reports for a PN nursing Board
- distributed the final edition (1992 summer edition) of *NCLEX News and Notes*
- participated in a meeting with a jurisdiction's Assistant State Attorney General and the jurisdiction's Board staff to further clarify information regarding a cheating analysis
- developed special application procedures in an effort to meet specific state requirements for a jurisdiction's Board
- provided information regarding response patterns for five candidates at the request of a Member Board
- provided candidate performance data for PN field-test participants
- provided the National Council with diskettes containing text and statistics for the usable PN items that are less than four-years-old

The following services were provided to the National Council and its Member Boards at additional cost:

- responded to requests from Member Boards for 100 failure candidate reviews: 40 for NCLEX-RN 292, seven for NCLEX-PN 492, 41 for NCLEX-RN 792, 10 for NCLEX-PN 092, and two (to date) for NCLEX-RN 293
- prepared two large-print NCLEX examination booklets for testing visually impaired candidates for NCLEX-RN 792, NCLEX-RN 293, and NCLEX-PN 493 examination administrations, and prepared three large-print examinations for the NCLEX-PN 092 examination administration
- prepared black-and-white print test booklets for testing a visually handicapped candidate for NCLEX-RN 293
- performed 10 special initial handscoring services for handicapped candidates

- provided results for NCLEX-PN 493, NCLEX-RN 293 and NCLEX-RN 792, and NCLEX-PN 092 on diskette for two Member Boards
- prepared the NCLEX-PN 492, NCLEX-PN 092, NCLEX-RN 792 and NCLEX-RN 293 tryout item text and statistics on diskette for the National Council
- provided booklets for use as the RN pre-printed Crisis Management Plan Examination and for use in the NCLEX/CAT Beta Test
- reviewed and implemented a previously-administered examination for use as an alternate examination for Guam
- provided booklets from a previously-administered PN examination for use as the pre-printed Crisis Management Plan Examination and for use in the NCLEX/CAT Beta Test

NCLEX Summary Profiles

- The April 1992 Summary Profiles were shipped to 225 practical nursing programs on July 1, 1992. These profiles included a flyer announcing the November 12-13 Regional Invitational in Albuquerque, New Mexico.
- The July 1992 Summary Profiles were shipped beginning in early October 1992 to 683 registered nursing programs.
- The Profiles included registration materials for the Albuquerque Invitational, copies of the *NCLEX News and Notes*, and recruitment information for NCLEX item writers and reviewers.
- Summary Profiles for the October 1992 PN examination were shipped in January 1993 to 193 practical nursing programs.
- Summary Profiles for the February 1993 examination were shipped in mid-May 1993. The initial shipment was for 657 schools, and late renewals and new orders continue to be received.
- Information about the Summary Profiles was also presented at the NCLEX Invitational Conference in Albuquerque, New Mexico, on November 12.
- Promotional brochures and information on the NCLEX Summary Profiles were provided at the National League for Nursing (NLN) Convention in Boston, Massachusetts, in June 1992.

Annual Report of the NCLEX Data Center

Introduction

This report provides an overview of CTB Macmillan/McGraw-Hill's activities in the NCLEX Data Center during the past year and covers NCLEX-RN 792, NCLEX-PN 092, NCLEX-RN 293, and NCLEX-PN 493. This year, efforts in the NCLEX Data Center have concentrated on being responsive to the needs of all Member Boards and continuing to provide Member Boards with the necessary support.

Applications Processing

The Data Center shipped a total of 243,000 application packets to Member Boards during the fall 1992 and spring 1993 send-out periods. The candidate brochures were reproduced to reflect the new ADA requirements for disabled candidates. These brochures were included as part of the application packet, and an additional 80,000 brochures were sent to tape states.

The four NCLEX examinations covered in this report reflect a total of 201,953 applications processed and represent an increase of 7,637, or 3.9 percent over last year's 194,316 applications. An additional 4,926 applications were returned to candidates for errors, for receipt after the deadline, or for being too early to process.

A summary of applications processed can be found below.

Program Code Changes

For any one examination, a maximum of 41 Member Boards sent in program code corrections and/or changes in education or repeat status, for a total of 3,474 candidates. This total is 130 candidates less than the 3,604 total number of candidates for 1991-1992, or a decrease of 3.6 percent.

Candidate Code Change/Correction Process

Starting with NCLEX-RN 791, a pre-examination roster was sent to all Member Boards. These rosters list all candidates, by program/school name, in a given jurisdiction, regardless of where the candidates are testing. Member Boards, in turn, send the rosters to each school listed for verification. A pre-examination roster was included in the deliverables package sent to each Member Board, resulting in deliverables arriving seven to 10 days earlier than usual.

Application Packets

The application packet send-outs included inserts for all regions and contained separate pages for PN and RN codes. The typeface on the inserts is now larger and easier to read, making it easier for candidates to identify the correct program codes. School codes for practical nursing are printed on colored paper and school codes for registered nursing are printed on white paper. The Data Center will continue to include both PN and RN information in all packets, except where Boards make a special request for different packaging.

Applications Processed

The following is a summary of the NCLEX-RN 792, NCLEX-PN 092, NCLEX-RN 293, and NCLEX-RN 493 applications processed to date.

Table 1. Summary of Applications Processed

Applications Processed	RN 792	PN 092	RN 293	PN 493
Including Tape and Late Applications	87,266	43,245	45,648	25,794
Applications Returned	934	824	2,442	726
Candidate Code Corrections (to date):				
Number of Candidates	829	1,288	425	932
Percent of Direct Applications	2.1%	4.0%	1.4%	4.8%
Number of Boards	41	36	38	36

As Table 1 illustrates, approximately 201,953 applications were received and processed at the Data Center during 1992-1993.

Annual Report of Educational Testing Service (ETS) and Sylvan/KEE Systems (SKS)

Highlights of Activities

Educational Testing Service (ETS) has been pleased to have had the opportunity to travel throughout the National Council's four Areas to meet Member Board staff and members. The October Fall Retreat introduced us to the committee structure within the National Council and provided the chance to meet with members of the two Examination Committees (EC1 and EC2) and the Administration of Examination Committee (AEC), the major committees with whom we have interacted over the past months. Since that time, we have attended all meetings of EC2, one meeting of the AEC, plus participated in numerous conference calls and a joint meeting of the EC1 and EC2 to discuss the RN job analysis results. In addition, ETS staff participated in the four CAT Regional Workshops in November and January and attended all of the Area Meetings. It has also been our pleasure to sponsor two trips for National Council staff and committee members to the ETS offices in Princeton, New Jersey. In early September 1993, we invited National Council staff to come to Princeton so that staffs of both organizations could meet and begin planning for the move to Computerized Adaptive Testing (CAT). We used that visit to define our roles and the interactive nature of our working relationship. Later in the Fall, we invited members of the Operations Subgroup of EC2 to meet with us to provide the valuable input needed for designing the system to be used in the ETS Data Center and for communicating with Member Boards.

We have found that frequent communications with National Council staff are essential in our progress. We are in touch daily either by telephone or electronic mail. We also hold weekly conference calls to address issues that arise.

The joint efforts of the Member Boards and the National Council staff have contributed to the extraordinary progress we have made in working toward the implementation of CAT. We look forward to the challenges of the work still ahead.

The following sections outline the accomplishments to date.

■ Systems

The communications network needed to implement NCLEX/CAT involves linking the ETS Data Center with the Sylvan/KEE Corporate Data Center, the Sylvan/KEE Technology Centers, and the individual Member Boards. Our first major goal was to design the system needed to operate the ETS Data Center where the critical information about individual candidates is collected and stored. We spent considerable time defining the components needed and how these components should interact. Next we moved to the design of the software used by individual Member Boards to communicate with the ETS Data Center about candidate registration and eligibility data. At several points during the development phases, we were fortunate to have input from the EC2 Committee and the Operations Subgroup. The result of this undertaking has produced a communication software system named Member Board Office System (MBOS), which was recently installed in all Beta Test jurisdictions. Sylvan/KEE staff visited each of these Member Boards to provide a full day of training in the use of MBOS. We have received very positive comments about MBOS, particularly its ease of use and simplicity. We have received suggestions for enhancements to the system which we will incorporate as new versions of MBOS are released. Non-Beta Test states will receive their MBOS training in Fall 1993.

■ Alpha Test

We have recently completed an Alpha Test of computer systems and operational processes to be used for delivering NCLEX/CAT. The Alpha Test was a pre-requisite to Beta Testing to ensure successful communication and interchange of data among the ETS Data Center, National Council Member Boards, Sylvan/KEE Corporate Data Center, and local Sylvan Technology Centers.

The Alpha Test began in March 1993 with full-system testing of the telecommunications, hardware, and software systems. In addition to each unique component being tested individually, integrated testing also occurred to assure the systems' abilities to interact effectively. Stress testing of the system included using a simulated volume of candidates that exceeded realistic projections of daily loads expected during implementation.

The full systems test revealed no major problems. Data were successfully transmitted among the ETS Data Center, Sylvan/KEE Corporate Data Center, and Sylvan Technology Centers. Issues related to ways to improve functioning and increase efficiency were explored. When appropriate, enhancements were made to the systems.

The next part of the Alpha Test involved the transmission of simulated data to and from five participating Member Boards. Although some Member Boards needed assistance in implementing their computer systems for the first time, overall comments from these Member Boards were favorable. Data were exchanged between the ETS Data Center and the Member Boards and fictitious candidates were entered into the system with eligibility determinations made.

The third component of the Alpha Test involved simulated candidate testing. Using scripts intended to test exhaustive testing scenarios, NCLEX/CAT staff visited six Sylvan Technology Centers around the country and acted the part of test takers. These "test takers" followed exactly the detailed scripts so that predictable outcomes could be validated through the Data Center.

Completed test sessions resulted in results reporting and, in cases of failing candidates, the generation of diagnostic profiles.

The Alpha Test demonstrated empirically ETS's and Sylvan/KEE's strengths in successfully implementing computerized adaptive testing for NCLEX.

■ Research

The anticipated transition to computerized adaptive testing has already led to the identification of a number of issues that can be best addressed through a research program. ETS has proposed the establishment of a Joint Research Committee composed of representatives from the National Council, ETS, and from the wider community of scholars interested in CAT. In February, ETS presented to the National Council a formal proposal for the committee structure and functioning.

We have identified several issues that need to be addressed by the Joint Research Committee. Primary among these issues are the establishment of measures for assessing item difficulty parameters within a computerized adaptive test and the concept of face validity.

■ Test Development

The first major test development effort in 1992 was the review of the existing NCLEX-RN and NCLEX-PN item pools in preparation for CAT and the Beta Test. Approximately 6,000 items were reviewed for content accuracy and currency by five-member panels of nurse professionals selected by the National Council and representing the four geographic areas of the National Council.

At the meetings, the panel members reconfirmed the accuracy, currency, and appropriateness for entry-level of the vast majority of the items in the pools which were used in the last four years. Items in the over-four-year-old category which satisfied the review criteria are being revalidated, and case-linked items are being rewritten as individual items in accord with the National Council policy for the Beta Test and the planned implementation of CAT.

The first phase of RN and PN item writing workshops occurred in January and February 1993. Forty-eight item writers attended the five RN workshops and a total of 59 item writers attended the six PN workshops, all of which were held at ETS facilities. In preparation for the workshops, the ETS test development team reviewed the existing training materials for item writers and, with the assistance of National Council staff, developed a Manual for Item Writers. Folders of materials were prepared for distribution at the workshops, which included a security pledge to be signed by the participants and retained in the ETS Contracts and Proprietary Rights area. To assist in the item writing efforts, we have also established a library of reference textbooks and journals which includes more than 200 titles. We are currently surveying PN and RN programs to determine textbooks in use in nursing programs.

The panels of NCLEX-RN item writers who attended the workshops created a total of approximately 1,440 new items, and the panels of NCLEX-PN item writers generated a total of approximately 1,470 new items. These items were processed at ETS in preparation for meetings with the Item Review Panels. Item review meetings were scheduled for six NCLEX-RN Item Review Panels and seven NCLEX-PN Item Review Panels in March, April, May, and June 1993.

The ETS test development team has been expanded considerably since August 1992. Four staff members in the Princeton office and two in the Atlanta office direct the test development effort, including two full-time nurses who have joined the team to provide the essential content expertise. They have been supported by a cadre of ten nurse specialist collaborators with diverse clinical backgrounds and experience, which serve them well in their review and critique of items for content accuracy. They have devoted significant amounts of time to providing the second validation for the thousands of items written since August 1992, and revalidating items in the existing NCLEX item pools as needed.

■ Beta Test

A major focus of our work has been planning the Beta Test which is scheduled for June-July 1993. We have worked closely with the National Council and EC2 to construct a comprehensive plan that will address the critical issues needed for fulfilling the intended purpose of the Beta Test, the implementation of CAT. At the December meeting, EC2 approved a research design that allows for the collection of data to assess the comparability of paper-and-pencil testing to CAT for the overall group of licensure candidates and to examine the performance of critical subgroups of test takers.

We are pleased that Member Boards have decided to participate in the Beta Test. We believe a large group of National Council jurisdictions will provide the diversity needed to assess both comparability and operational functions of CAT.

Over the past few months, we have undertaken a broad and intensive recruitment effort to attract volunteers for the Beta Test. We started the process with a survey sent to all PN and RN educational programs identified by the National Council. The purpose of the survey was to determine among programs the distribution and pattern of graduation dates and, for PN programs, to determine whether a sufficient number of PN graduates would be available for testing in the summer months. We received usable responses from over half of the schools surveyed and found a wide distribution of graduation times and indications that a cadre of PN graduates would be available during Beta Testing.

Our next efforts were directed to identifying ways to publicize the Beta Test. We began with the publication of 75,000 recruitment flyers sent to each Member Board for distribution to interested candidates and to educational programs within their jurisdictions. These flyers included a postage-paid postcard to be filled out and returned to ETS by interested candidates.

Next, we sent to each PN and RN educational program a Beta Test poster that again included postcards to be completed and returned to ETS. More than 3,000 posters were distributed with 100 postcards per poster. We took advantage of every opportunity to supply posters and postcards to any Member Boards and National Council staff who attended meetings or activities where students and educators would be in attendance. To date we have received more than 23,000 postcards in response.

Each person who completed a postcard received a Candidate Information Bulletin which provided detailed information about the Beta Test. Candidates were also instructed to call a toll-free number to register. Additional recruitment strategies have been implemented to attract candidates, particularly candidates from critical subgroups. We are confident that as registration continues we will meet our recruitment objectives for the Beta Test. Planning for all other components of the Beta Test continues. We will report operational results at the 1993 Delegate Assembly. Comparability data will not be available by that time.

■ Sylvan/KEE Technology Centers

There will be 109 Sylvan Technology Centers (STC) operational for the Beta Test. In most cases, these are existing STCs that have been outfitted with the security equipment needed to deliver NCLEX/CAT. A comprehensive Administrator's Manual, prepared with the assistance of the Administration of Examination Committee and EC2, has been distributed to each test center. This manual details the operating procedures for processing candidates at the centers and delivering NCLEX/CAT. Security is emphasized throughout the manual and in the training of the center staff.

Participating Member Boards were asked to review the STC sites selected for Beta Testing. During this coming summer, all Member Boards will be contacted to plan the best locations for the testing centers needed for CAT implementation.

Summary

The past nine months at ETS have been both exciting and rewarding. We have enjoyed working closely with the National Council staff, the National Council committees, and the 62 Member Boards. As a team, we have made significant progress in accomplishing the goal of moving to computerized adaptive testing. We anticipate a successful Beta Test and look forward to the implementation of CAT.

15

ADMINISTRATION OF
EXAMINATION COMMITTEE

Report of the Administration of Examination Committee

Committee Members

Alta Haunsz, KY, Area III, *Chair*
Sheila Exstrom, NE, Area II
Deborah Feldman, MD, Area IV
Claire LeFrancois, VT, Area IV
Toma Nisbet, WY, Area I
Vella Salazar, TX-VN, Area III *(through April 1993)*

Relationship to Organization Plan

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

Recommendation(s)

1. That the Delegate Assembly approve the following policy for Member Board Review of Newly Developed NCLEX Items or Simulated Computerized Adaptive Examinations: *It is the policy of the National Council to cooperate with Member Boards in providing appropriate opportunities for their review of newly developed NCLEX items or simulated computerized adaptive examinations. The National Council will do so by developing procedures which ensure that the review of the material will be under conditions which do not adversely affect the security of the test items.* Presented in Attachment A is the policy statement with procedures for your information.

Rationale

An activity under Tactic 3 of Objective C states, "*Develop CAT-specific policies and procedures, including security measures.*"

Highlights of Activities

■ Candidates with Disabilities

An activity under Tactic 2 of Objective B states, "*Monitor requests for modifications for candidates with disabilities to evaluate the impact of the Americans with Disabilities Act (ADA) and the effectiveness of new forms and policies to assure compliance with ADA.*" The committee reviewed and ratified National Council staff authorizations for modifications issued to 273 candidates with disabilities for the NCLEX-RN 792, 293 and NCLEX-PN 092, 493. Conditions included: 226 learning/reading disabilities, 27 visual impairments, 16 physical disabilities, and four hearing disabilities. Extended time was granted to 260 candidates; readers were granted to 51 candidates; recorders were granted to eight candidates; large print exams were granted to nine candidates; black and white booklets were granted to one candidate; and approved aids were approved in conjunction with other modifications for 36 candidates.

Research on modifications for candidates with disabilities continued. Data were obtained from surveys of candidates who sat for the NCLEX-RN 792, 293 and NCLEX-PN 092, 493. Ninety-two complete sets (Member Board, candidate and candidate's nursing program) were obtained from a possible 270. Since a larger database is necessary, data will continue to be collected from candidates who request modifications on future examinations.

■ Failure Candidate Reviews

Tactic 4 of Objective B states, "*Assure examinations are administered according to approved security measures.*" Fifty requests for failure candidate reviews for NCLEX-RN 792, 293 and NCLEX-PN 092, 493 were authorized by National Council staff. These were reviewed and ratified by the committee. A failure candidate challenged one item on the NCLEX-RN 792, but after review of the documentation, the item was upheld as valid by the Board of Directors.

Security Measures

An activity under Tactic 4 of Objective B states, "*Assure that all boards of nursing have current procedures to implement security measures approved.*" The current status of security measures and procedures to implement security measures were reviewed by the committee. Fifty-one sets of procedures have been approved; 11 sets of procedures are pending. The committee recommended that the Board of Directors send a letter to one Member Board requesting procedures to implement security measures be submitted or future examinations would be withheld.

A security break occurred during the administration of the NCLEX-RN 792. The Board of Directors determined that no widespread dissemination of examination content occurred. Anomaly analysis data were provided to Member Boards making licensure decisions on candidates who were flagged during the investigation.

An activity under Tactic 2 of Objective B states, "*Monitor administration of examination in Puerto Rico and administration by the Delaware Board of Nursing in Germany.*" The committee reviewed a report on the administration of the NCLEX-PN 092 in Germany by the Delaware Board of Nursing. The examination was administered according to security measures and Delaware's procedures to implement security measures. The committee received a report on the site visit during the administration of NCLEX-RN 792 in Puerto Rico. The committee determined that observations of Puerto Rico administrations were no longer necessary.

Site Visits

Tactic 4 of Objective B states, "*Assure examinations are administered according to approved security measures.*" Representatives of the committee observed administration of the CAT-PN Field Test in October 1992, and plan to conduct additional observations during the Beta Test.

A representative of the committee made a site visit to the NCLEX-RN 293 administration in the state where the NCLEX-RN 792 security break occurred. The committee was satisfied that the state took the appropriate steps to ensure that the security of the examination materials is being maintained.

Examination Administration Issues

Tactic 4 of Objective B states, "*Assure that examinations are administered according to approved security measures.*" Reports of problems with examinations and scoring and tracking reports for NCLEX-RN 792, 293 and NCLEX-PN 092, 493 were reviewed and appropriate actions taken.

The committee recommended to the Board of Directors that a letter of reprimand be sent to Member Boards for violations of security measures which led to the NCLEX-RN 792 security break, and for problems with the candidate data tape experienced following the NCLEX-RN 293. The committee recommended to the Board of Directors that a letter of concern be sent to the test service regarding two incidents of failure to detect unreturned test booklets.

An activity under Tactic 2 of Objective B states, "*Monitor the impact of time extension on English as a Second Language (ESL) performance and exam speededness.*" The committee reviewed the report (Attachment B) of adding ten minutes to each NCLEX booklet. The committee decided that the addition of ten minutes per booklet is adequate and sees no need to continue further studies in this area.

Tactic 2 of Objective B states, "*Review and revise procedures for examination administration as necessary.*" The committee developed a candidate confidentiality agreement, corresponding SAY instructions and language for the candidate brochure. The confidentiality agreement was approved by the Board of Directors and was included on the cover of test booklets beginning with the NCLEX-PN 493.

Computerized Adaptive Testing (CAT) Issues

An activity under Tactic 3 of Objective C states, "*Develop CAT-specific policies and procedures, including security measures.*" The committee approved the Computer Based Testing Test Administrator's Manual for use at Sylvan/KEE Beta Test sites. The committee approved procedures for Member Board review, failure candidate review, and modifications to the examination for disabled candidates. The committee approved Educational Testing Service (ETS) Corporate Security Procedures for NCLEX, with revisions.

The committee made suggestions for revisions to the Sylvan/KEE Disaster Recovery Plan and the Criteria for Non-Compliance of a Test Site. These documents were referred to Examination Committee-Team 2 for further review.

The committee developed CAT Security Measures. These security measures were approved by the Board of Directors and can be found in Attachment C.

Meeting Dates

- September 10, 1992, *telephone conference*
- October 10-13, 1992
- November 4, 1992, *telephone conference*
- January 22, 1993, *telephone conference*
- March 4-6, 1993
- March 22, 1993, *telephone conference*
- April 7, 1993, *telephone conference*
- May 6, 1993, *telephone conference*

Future Considerations for the National Council

- **CAT Beta Test**

  Reports from the committee members' observations at selected sites for the CAT Beta Test will be reviewed at the October meeting.

Recommendation(s)

1. That the Delegate Assembly approve the following policy for Member Board Review of Newly Developed NCLEX Items or Simulated Computerized Adaptive Examinations: *It is the policy of the National Council to cooperate with Member Boards in providing appropriate opportunities for their review of newly developed NCLEX items or simulated computerized adaptive examinations. The National Council will do so by developing procedures which ensure that the review of the material will be under conditions which do not adversely affect the security of the test items.* Presented in Attachment A is the policy statement and procedures for your information.

Staff

Jodi Borger, *NCLEX Administrative Assistant*
Nancy Miller, *NCLEX Program Manager*

Attachments

A .... Policy for Member Board Review of Newly Developed NCLEX Items or Computer Simulated Examinations, *page 5*
B .... Summary of Effect of Increase in Testing Time, *page 9*
C .... Security Measures For NCLEX-CAT, *page 11*

Attachment A

National Council of State Boards of Nursing, Inc.

Policy for Member Board Review of Newly Developed NCLEX Items or Computer Simulated Examinations

It is the policy of the National Council to cooperate with Member Boards in providing appropriate opportunities for them to review newly developed NCLEX items or computer simulated examinations. The National Council will do so by designing procedures which ensure that the review of the material will be under conditions which do not adversely affect the security of the test items.

Procedure for Member Board Review of Newly Developed NCLEX Items or Simulated Computerized Adaptive Examinations

Background

1. Board of Nursing's review of NCLEX items may take two forms: review of items that have been recently developed and review of computer simulated examinations.

2. To provide the best possible security, it is advised that these reviews take place at a test center. If that is absolutely impossible, the material will be transported to and from the review site by test service personnel who will also project the items from a computer for the board during the review. No paper copies of test items will be produced.

3. Reviews will be available twice a year. These time frames will be March-April and November-December. At that time, the board may review RN or PN materials, or both.

4. The reviews will take place in a one-day time frame.

5. The rooms at the test centers are small, so this needs to be taken into consideration when deciding who will participate in the review. It is advised that the Member Board consult the test center that they plan to use to help the board determine the number of board representatives who may participate in the review.

6. The test center will utilize the same check-in and check-out procedures that are used for all Member Board visits. The board representatives must have a letter of introduction on board letterhead signed by the authorized person, a photo ID with signature and another ID with signature. Without these credentials, representatives will not be admitted to the testing room.

7. The only materials that will be allowed into the testing room will be one copy of the jurisdiction's Nurse Practice Act (NPA) and the associated administrative rules, and the official paper issued by the test center for notes. Item text may not be written down; however, the item number and comments about the item may be recorded for follow-up communication to the National Council.

8. Any person participating in the review may not divulge in any way the nature or content of any test items to any individual or entity.

9. During the review, Member Boards may comment on two aspects of the items: if the item violates the jurisdiction's NPA or if the item is not entry-level practice. Items designated as being against the NPA must have an interpretation of why the items violate the law and a copy of the citation from the law or rules that support the finding. Only items which have this supporting documentation will be considered by the Examination Committee. Items designated as not being entry-level must also have an explanation of why the board believes they are not entry-level. These items will be taken to the next item review session for additional discussion.

Member Board Responsibilities

1. Submit to the National Council bi-annually the Member Board NCLEX Review Request form. This form will be in the *Newsletter* in January and September. The following information will be required: the anticipated date of the review, the test center to be used, how many people will attend, the type of review desired (newly developed items, simulated examinations, or both) and if the items should be RN, PN, or both. Contact the test center prior to submitting the request for assistance in planning the visit.

2. Schedule review with the test center.

3. Conduct the review in the manner outlined above.

4. If there are items of concern, submit the item number(s) (identified as RN or PN), the explanation of the problem and the appropriate documentation to the National Council.

5. Contact the National Council and report that the review took place.

National Council Responsibilities

1. Publish each January and September in the *Newsletter* a notice that requests review of NCLEX items by Member Boards; the request would be due that month.

2. Collect the forms and send them to the test service.

3. Collect any concerns that are sent. All concerns will be forwarded to the test service and "against NPA" issues will be presented to the Examination Committee at its next meeting.

Test Service Responsibilities

1. Receive copies of request forms from the National Council.

2. Work with test centers to schedule reviews. Assure that the materials requested by the Member Board are at the test centers on the right day.

3. If a Member Board requests a review at a non-test center site, assure that the test service staff member personally carries the materials to and from the review and that the materials do not leave his/her sight at any time during the transport or during the review until they are once again secured at the test service.

4. Receive copies of comments from the National Council. All items designated as not entry-level should go to the next scheduled item review session for consideration. All items that are designated "against NPA" must be made ready for review at the next scheduled Examination Committee meeting.

5. Inform the National Council of any unusual incidents that occurred during the review.

Test Center Responsibilities

1. Assist the Member Board in determining the number of people that can easily fit in the testing room and a date that the board can have the testing room for an entire day, if they desire.

2. Use the approved check-in and check-out procedures for Member Board visitors. One copy of the Nurse Practice Act and associated rules my be taken into the testing room. Item text may not be copied down; however, notes on the items that the board has concerns about may be removed from the room for follow-up correspondence to the National Council.
3. The review session does not have to be monitored; however, there must be at least one person at the test center to assist the board.

4. Notify the test service at the completion of the review.

Member Board NCLEX Review Request

This form must be submitted by [date].

The Board wishes to review:

_______ newly developed items

_____ RN

_____ PN

_____ Both

_______ computer simulated examinations

_____ RN

_____ PN

_____ Both

The anticipated review date is ______________________________

The test center location where the review will be conducted:

____

The anticipated number of people participating in the review: ____________

Names of the participants:

____

____

If the Board is absolutely unable to review at a test center, please check here and someone from the test service will contact you to arrange the review elsewhere: __________

________________________________ Member Board Representative's Signature

________________________________ Date

________________________________ Jurisdiction

Attachment B

Summary of Effect of Increase in Testing Time

Background

This report summarizes the relationship of time spent to performance on the NCLEX-PN 092 and NCLEX-RN 292, the first NCLEX administrations allowing an additional 10 minutes per book (as per 1992 Delegate Assembly action). The question of most pressing interest is whether a larger percentage of the English-as-a-Second-Language (ESL) population was able to finish the examination before time ran out.

Under the old time limits, approximately 20 percent of the ESL candidates ran out of time on the NCLEX-PN 492, about 16 percent on the NCLEX-RN 292, and almost 20 percent on NCLEX-RN 792.

Results

When more time was allowed on the NCLEX-PN 092, fewer than nine percent of the ESLs were still working when time was called. This represents a reduction of one-half in the proportion of ESLs who used all of the time available. On the first RN examination administered with the more generous time limits, NCLEX-RN 292, 12 percent of ESLs used all of the time allowed. Almost a quarter of the English-Native-Language (ENL) candidates, and half of the ESLs, used more time than would have been allowed under the old time limits.

In April 1992, before time was extended, ESL PN candidates spent an average of seven seconds-per-item longer than the ENL candidates. In October, with five additional seconds-per-item allowed, the ENL candidates increased their average time-per-item by less than one second, but the ESL candidates used an additional three seconds-per-item. Thus, on the October 1992 NCLEX-PN, ESLs spent an average of nine seconds-per-item more than the ENL candidates.

On the RN examination, the February-to-February (1992-to-1993) comparison is stronger than the April-to-October PN comparison because the groups are more similar. Both ESLs and ENLs increased their average time-per-item by four seconds (6.5 additional seconds-per-item were allowed), so their average times still differ by six seconds-per-item. Average performance increased for both groups by about the same amount. In addition, the relationship between time and performance vanished for the ESLs, but a correlation of -.25 between seconds-per-item and performance still exists for ENLs. This suggests that the ENLs who took more time also did not know the answers, whereas the ESLs who took more time knew as many answers as those who took less.

Conclusions

Many candidates, both ESL and ENL, used the extra time allowed. Average performance was higher for both groups in February 1993, as compared to February 1992, but it is not possible to determine if that is because of the extra time or because of an increase in ability of the candidates. The difference in performance between the average ESL and ENL candidate has remained the same. The percent of ESLs still working when time was called is lower than before the additional time was allowed. It is, however, still higher than that of ENLs. There is anecdotal evidence to suggest that the percentage may never fall as low as that of the ENLs, no matter how much time is allowed. In summary, the additional time was used and a higher percentage of ESL candidates finished the examination.

Attachment C

National Council of State Boards of Nursing, Inc. Security Measures for NCLEX-CAT

I. Implementation of Security Measures *(see also section 1.9 of Contract with the Test Service)*

The test center director shall be the person designated as responsible for implementing the security measures and other associated policies. In the director's absence, there shall be a designee who shall be responsible for implementing the security measures and other associated policies. The director shall assure all staff are trained in implementing the security measures and associated policies. Each test center shall have available a current copy of the security measures and associated policies for immediate reference.

II. Security of Test Data

The test service shall assure the National Council that all test related data is being secured by methods which are the current state-of-the-art. This includes actual data transmission, data stored on the file server and software. This might include: encryption; fragmentation; unique passwords; prevention of printing any test items, candidate files or software files (see also pages 4-18, 4-19, 4-20, and 4-23 of the ETS Proposal).

File Server Security *(see also page 4-17 of the Proposal)*

At the test centers, the file server is the hub of the system controlling all activities on the network. The file server may be secured in two ways.

- **Situation One.** The file server may be located in a locked cabinet in an area which is usually locked. In the situation where the file server is in a cabinet, the cabinet must be locked at all times. If an authorized person is not in the center, the area must also be locked. The lock to the area and to the cabinet shall be unique (e.g., key lock, combination lock, fail-secure electronic locking device). There shall be no more than three authorized persons with access to the unique locks. If keys are used, the keys must be kept in a separate locked location or carried by the authorized persons only. The keys must not be identified. If a combination lock or electronic locking device is used, the combination must not be readily available and not identified. There also will be no written record of passwords at the test center.

- **Situation Two.** The file server may be housed in its own storage room that will be locked without a locked cabinet. In the situation where the file server is located in a separate room, the lock to the room shall be unique (e.g., key lock, combination lock, fail-secure electronic locking device). There shall be no more than three authorized persons with access to the unique lock. If a key is used, the key must be kept in a separate locked location or carried by the authorized persons only. The key must not be identified. If a combination lock or electronic locking device is used, the combination must not be readily available and not identified. There also will be no written record of passwords at the test center.

Limited Access

Whenever an authorized person is no longer employed at the test center, all locks, combinations and passwords must be changed.

An authorized person must supervise the access into the file server by unauthorized persons (e.g., a repair person). The file server must be unmovable (e.g., it must be bolted to the floor or be fitted with a device making it inoperable if moved).

Software Security *(see also pages 4-24 and 4-25 of the Proposal)*

Software security shall be ensured by both prevention and detection. The administration system will permit staff and candidates only to access the functions for which they are approved. Four levels of password authorization will assure secure and controlled operation. These include:

- Support staff level. This is the lowest security level. It is used to check in examinees, photograph examinees, schedule test appointments, access electronic mail, change own password, access DOS, deliver Smarts2, perform screen lock, access system status, perform system maintenance and access communication management.

- Test administrator level. The test administrator can perform all activities at the support staff level in addition to the following: administer tests, start tests, terminate a test, administer test demonstrations, prepare irregularity reports, retrieve examinee data to disk and perform system maintenance.

- Lead administrator level. This shall be held by the test center director and at least one lead administrator. The test center director and lead administrator can perform all activities at the support staff level and the test administrator level in addition to the following: enter and delete staff names and login identification on the system.

- System administrator level. This shall be held by Sylvan/KEE corporate administrative staff only. This level will be used in preparation, distribution, installation and trouble-shooting of the administration software and in high level problem-solving.

The National Council shall have a list of all the system administrator level staff with access to the software and the names of the authorized staff in each of the test centers. This list shall be current at all times.

Record of Transactions *(see also page 4-25 of the Proposal)*

A software log shall be instituted which will record the date, time and type of action performed by each staff member and candidate. All unauthorized attempts will be catalogued by date, time and type. The security logs will be viewed daily by test service staff and investigative action will be taken immediately upon discovery of any abnormalities.

III. Test Center

Configuration *(see also section 5.1.(c) of the Contract and pages 4-8 and 4-9 of the Proposal)*

The testing centers shall meet the following requirements:

- The testing room and check-in desk used by National Council candidates shall be separate from any areas being used for other education or training activities. A common waiting room and reception area is allowed.

- Each computer workstation will be separated by a sound absorbent privacy divider. Each candidate will have a table with a working surface at least 30 inches deep and 60 inches wide. Each station will hold the computer equipment, a desk lamp and any material associated with the testing process. All tables will accommodate right or left-handed candidates and will include a height adjustment mechanism. The chairs will be ergonomically designed with arms and will be height adjustable.

- A comfortable testing environment shall be provided. This includes: comfortable temperature, noise kept to a minimum and proper lighting.

- The testing centers must provide secure storage for candidate valuables during the testing process.

- A telephone with access to an outside line shall be available at all times.

- Each testing center shall have at least one administrative computer which is reserved for the exclusive use of the test center staff.

- Restroom facilities shall be in close proximity to the testing room.

Each test center will conform to all federal and state regulations that apply to candidates with disabilities (see also section 5.1.(d) of the Contract and page 4-30 of the Proposal).

Security *(see also pages 4-11 and 4-12 of the Proposal)*

Security of the test centers is of utmost importance. The testing rooms will be of sufficient size and design to assure direct monitoring of each person testing. A proctor observation station will be set up outside the testing room. Candidates will be directly observed by the proctor at all times. A sound insulated partition with a viewing window is placed between the testing room and the proctor. The proctor will be located at the station. The testing room will be configured so the proctor will have a clear view of all candidates in the testing room. A parabolic mirror will give the proctor a complete view of all the testing stations. A microphone in the testing area will broadcast all sounds to the proctor. The proctor will not enter the room unless summoned there by a candidate, to fill a specific operational need or to address an unusual incident.

In addition to live monitoring, a video camera will be in the testing room. A video monitor will also be positioned at the proctor station and a second monitor will be in the center director's office. Full sound and motion videotaping will be done of each testing session. The videotape will be held in secure storage for at least thirty days. Tapes for sessions in which any unusual incidents occurred will be kept until the problem has been resolved.

IV. Examination Team *(see also section 5.1.(b) of the Contract)*

The center testing staff shall consist of at least a full-time director and an educational director. These two individuals will be the primary management team. They will be responsible for the other staff who may be full-time or part-time employees. Regional directors shall supervise and monitor the center staff.

Test Center Director *(see also page 4-13 of the Proposal)*

The center director shall be responsible for maintaining current copies of all the materials related to the administration of NCLEX. The director is responsible for assuring all center staff are trained in these matters and shall retrain all staff annually. A detailed orientation plan will be part of the associated policies kept at the test center.

Staffing Requirements *(see also section 5.1.(b) of the Contract)*

At least two center staff shall be present at all times when NCLEX is being administered. At least one of these staff members must be observing the candidates at all times throughout the examination. If there are not two staff available at the center, the candidate may choose to stay at the center if the center can accommodate them when the staff arrives. If not, the candidate will be rescheduled at no additional cost.

Test Administrator *(see also pages 4-14 and 4-15 of the Proposal)*

Established criteria for test administrator and support staff selection will be available in the procedure manual and utilized in the creation of the examination team. Test administrator duties include:

- scheduling candidates
- admitting and identifying candidates (including photographing and fingerprinting)
- logging candidates on and off the computers
- distribution and collection of secure notepaper from candidates
- observing candidates during the testing process
- logging candidates in and out for breaks
- monitoring the exit of candidates
- dealing with unusual incidents (e.g., cheating, power outages, equipment malfunction, etc.)
- escorting personnel (e.g., janitors, repair persons, etc.), other than test center staff and candidates into and out of the test room

Support Staff

Support staff duties include:

- scheduling candidates
- admitting and identifying candidates (including photographing and fingerprinting)

V. Examination Administration

Admission *(see also section 5.2.(b) of the Contract and pages 4-33 and 4-34 of the Proposal)*

Candidates shall be issued an authorization to test by the Data Center prior to the examination. The candidate may then schedule an appointment. A mechanism shall be in place that will prevent a candidate from scheduling testing in more than one location with a single application or for having multiple applications active at a single time.

Upon arrival at the test center, the candidate must present the authorization to test and two forms of identification. One must bear the candidate's photograph and signature, the other must have at least a signature. The name on the photobearing identification must be the same as the name on the authorization to test. The candidate will not be admitted without these pieces of identification. Candidates will sign a test center log and the test center staff will compare the signature to the signature on the photo identification. The candidate will also be fingerprinted and photographed.

Late Candidates *(see also section 5.2.(d) of the Contract and page 4-29 of the Proposal)*

Candidates will be admitted to the test center up to 30 minutes late. Test center staff may allow candidates arriving after that time to test if a slot is available. Candidates arriving late who cannot be accommodated must re-register and pay another examination fee.

Seating

Candidates shall retain the same computer assignment for the entire examination except if operational or security reasons prevent it.

Breaks *(see also section 5.2.(a) of the Contract)*

Candidates shall be allowed to use the restroom facilities during the examination. Candidates will also be allowed two 10-minute breaks. After two hours of testing, a mandatory 10-minute break is given. Candidates must leave the testing room for this break. An optional 10-minute break will be offered after 3.5 hours of testing. If they choose to take this break, they must leave the testing room. They will have to sign in and out on a log sheet and present their identification to regain entrance to the testing room.

Notepaper

Secure notepaper will be provided to each examinee and must be returned to the test administrator at completion of the examination. A system shall be in place to account for the paper and to log the paper in and out. The paper shall be shredded after the examination unless needed for the investigation of an unusual incident.

Access to Testing Room *(see also pages 4-34 and 4-35 of the Proposal)*

Access to the testing room shall be limited to approved candidates and authorized testing center staff during test administrations. National Council staff, Member Board representatives and vendor representatives must be accompanied by testing center staff and may not enter the testing room during test administration.

VI. Unusual Situations *(see also section 5.4 of the Contract and page 4-42 of the Proposal)*

All unusual incidents will be reported to the National Council, the test service and to the Member Boards who are licensing the candidate(s) involved. These unusual incidents may include but are not limited to: cheating behavior, power failure, fires, disaster drills, impersonation, theft of any equipment, unauthorized access to data and computer malfunction.

There shall be written procedures outlining how to handle these unusual incidents. There also shall be a written crisis management plan which shall be approved by the National Council.

Emergencies

Procedures dealing with emergencies shall address the safety of the candidates, security of the file server, security of the data and safety of the testing center personnel. Cheating procedures shall address observing, documenting and reporting the behavior.

Restarting

If a computer cannot be restarted to allow the candidate five hours of testing time, the candidate shall be rescheduled at no charge to the candidate.

VII. Unannounced Site Visits *(see also section 5.1.(e) of the Contract and pages 4-35 and 4-43 of the Proposal)*

National Council staff and Member Board representatives may make unannounced site visits. Proper identification will be required. This identification shall include: 1) a letter of introduction on National Council or Member Board letterhead signed by an authorized person and bearing an official seal and 2) a photo identification with signature. The visitors will be asked to sign a log and signatures will be checked. Visitors will not be allowed in the testing room if testing is taking place at the time of their visit.

Glossary of Terms

- Associated policies refers to a procedure manual that will have specific instructions on how to handle any situation that should arise at the testing center.
- Authorized person refers to the person listed in the security measures as having permission to carry out a particular activity. A listing of these persons must be kept at each center.
- Combination lock is a manual or number punch (electronic or manual) lock.
- Fail-secure electronic monitoring device maintains locks in a locked position in the case of a power failure.
- Investigative action refers to reporting of an incident immediately to the National Council and Member Board, and the subsequent follow-up by the test service, National Council and Member Board.
- Member Board is the board of nursing in the jurisdiction where the candidate has applied for licensure.
- Unique lock refers to locks being off all master keying. Only staff cited in the security measures may access the lock.

16

EXAMINATION COMMITTEE
CAT-PN FIELD TEST TEAM

Report of the Examination Committee – Team 1

Committee Members
Patricia Earle, MN, Area II, *Chair (through early March 1993)*
Gwen Hinchey, CA-VN, Area I, *Chair (beginning March 1993)*
Betty Clark, ME, Area IV
Constance Connell, AZ, Area I
Lynn Norman, AL, Area III
Paulette Worcester, IN, Area II

Committee Alternates
Karen Brumley, CO, Area I
Terry DeMarcay, LA-PN, Area III
Renatta Loquist, SC, Area III
Sandra Mackenzie, MN, Area II
Cynthis Purvis, SC, Area III
Richard Sheehan, ME, Area IV

Relationship to Organization Plan
Goal I .... Licensure and Credentialing
Objective B .... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation(s)
No recommendations.

Highlights of Activities

■ **Reviewed the 1992-93 Job Analysis Results**

The Examination Committee-Team 1 (EC1) and four members from Examination Committee-Team 2 (EC2) reviewed the results of the 1992-93 RN Job Analysis study at a joint meeting on March 28, 1993, and a telephone conference call on May 4, 1993. Analysis of the results generally support retention of the overall structure of the NCLEX-RN Test Plan (i.e., "Phases of the Nursing Process and Client Needs" categories). However, due to the use of a new data collection instrument, the assignment of the new activity statements for the "Client Needs" sub-categories needs to be carefully examined before the final calculation of category weights (e.g., percent of test items assigned to a specific content area) can be determined. Assignment of activity statements to "Client Needs" sub-categories and calculation of category weights will be performed during FY94 in preparation for presenting a specific recommendation regarding the NCLEX-RN Test Plan to the 1994 Delegate Assembly.

■ **Provided Licensure Examinations**

The EC1 was responsible, in part, for providing the current paper-and-pencil NCLEX to Member Boards. In order to accomplish this task, the committee approved the NCLEX-PN 493 and 093 and NCLEX-RN 793 and 294 examination forms. The committee also approved the NCLEX Beta Test examinations: (1) the RN paper-and-pencil one-day and computer-linear Beta Test examinations, and (2) the PN paper-and-pencil and computer-linear Beta Test examinations. Furthermore, the committee determined which previously administered NCLEX-RN and NCLEX-PN examinations could not be used to construct the pool of items for the computerized adaptive portion of the Beta Test. In order to be able to provide reliable and valid licensure examinations in the event of a declared crisis, the committee approved new forms for both PN and RN pre-printed Crisis Management Plan examinations and PN and RN reserve Crisis Management Plan examinations.

■ **Monitored Licensure Examinations**

The committee evaluated the licensure examinations following each administration by reviewing reports on item performance, reliability, mean discrimination index and deleted items. These reports confirmed that the NCLEX meets

the National Council's quality standards. By reviewing reports on average percent correct, standard deviation, mean difficulty level, mean ability estimates, passing score and passing rate, it was determined that the new passing score was adjusted for the difficulty of the examination. The following examinations were evaluated this year: NCLEX-RN 792 and 293; NCLEX-PN 492, 092, and 493 (preliminary report). In addition, the committee evaluated the examination items for potential bias. To accomplish this task, the committee reviewed reports from the Bias Sensitivity Review Panel and Ethnicity-Gender Reports for NCLEX-RN 292, 792, and NCLEX-PN 492 and 092 and approved items revised due to their potential bias. The committee also reviewed the Person-Fit Reports for NCLEX-RN 792 and NCLEX-PN 092. Based on the report of Person-Fit for NCLEX-RN 792, the committee directed CTB MacMillian/McGraw-Hill (CTB) to conduct additional Person-Fit Analyses for NCLEX-RN 292. The results of this research will be discussed at the EC1 June meeting. Finally, the committee is overseeing the development of mechanisms for monitoring the content and face validity of the nursing licensure examinations.

- **Monitored Item Development**

The committee evaluated the CTB Item Writing and Item Review Sessions from July 1, 1992, to June 30, 1993, for process and productivity; 690 PN items were written, 683 were reviewed, and 656 were accepted; and 1,486 RN items were written, 2,152 were reviewed and 2,060 accepted. The committee also evaluated the ETS Currency Review, Item Writing, and Item Review Sessions for process and productivity. At the Currency Review Sessions, approximately 3,750 RN items and 2,250 PN items were reviewed. Approximately 1,440 RN items and 1,470 PN items have been written and will be reviewed at ETS Item Review Sessions. In addition, the committee made appointments to the NCLEX test development panels, including making recommendations to the Board of Directors regarding the Panel of Judges for a PN Standard Setting session conducted in April 1993. To improve the recruitment of NCLEX panel members and reduce the workload of Member Boards, a change in the sequence of processing steps for NCLEX panel applicants was instituted. Applicants are able to send their applications directly to the National Council where the materials are compared to the established qualifications. To assure that Member Boards have a chance to "sign-off" on applicants, the National Council sends the name and license number of all applicants to the Member Board and requests approval before the applicants are contacted to serve at a session. The committee monitored feedback on this change and suggested methods to communicate with Member Boards about the NCLEX item development process as well as Member Boards' responsibility for preparing NCLEX panel members. The committee also approved revised *Guidelines for RN Item Writers* and *Guidelines for PN Item Writers.*

- **Responded to Member Boards and Candidates**

As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX items and examinations. For example, the committee reviewed RN and PN items that were designated by Member Boards as inconsistent with state statutes. The committee directed CTB to compile a list of those concepts which were designated as inconsistent with state statutes. The committee responded to a candidate challenge of one item on NCLEX-RN 792. After review of the documentation from the nursing literature and the conclusion of the expert nursing panels during the test development process, the committee reported and the Board of Directors determined that the item challenged was a valid test item and that the answer keyed as correct was the only correct answer.

- **Recommended Bylaws Revisions**

As requested by the Bylaws Committee, the committee reviewed and discussed its duties as stated in the current bylaws in order to prepare its recommendations for revisions.

Meeting Dates

- October 5-8, 1992
- October 10-11, 1992
- November 6, 1992, *telephone conference*
- December 7-11, 1992
- February 12, 1993, *telephone conference*
- March 28 - April 1, 1993
- May 4, 1993, *telephone conference*
- June 21-25, 1993

Future Considerations for the National Council

- The National Council needs to continue to investigate methods for monitoring examination performance in a computerized adaptive testing environment. In addition, policies and procedures regarding size and cycling of item pools will need to be made.

Recommendation(s)

No recommendations.

Staff

Anne Wendt, PhD, RN, *NCLEX Program Manager*

Report of the Examination Committee – Team 2 (CAT)

Committee Members

Renatta Loquist, SC, Area III, *Chair*
Susan Boone, OH, Area II
Shirley Brekken, MN, Area II
Rosalyn Cousar, VA, Area III
Teofila Cruz, Guam, Area I
Charlie Dickson, AL, Area III
Donna Dorsey, MD, Area IV
Faith Fields, AR, Area III
Carolyn Hutcherson, GA-RN, Area III
Carol McGuire, KY, Area III
Milene Megel, NY, Area IV
Catherine Puri, CA-RN, Area I
Julie Campbell-Warnock, CA-RN, Area I

Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective C .... Implement computerized adaptive testing for the licensure examinations.

Recommendation(s)

No recommendations.

Highlights of Activities

■ Communications

The activities under Goal I, Objective C, Tactic 1 are concerned with the development and dissemination of CAT communications to Member Boards, educators, candidates, and the general public. The committee provided direction to the National Council Communications Department regarding the content of a CAT video targeted for NCLEX candidates. The video was produced and distributed to each Member Board, and is available for purchase by interested individuals and groups. Additionally, the committee oversaw the update of the *CAT Question and Answer Reference Guide* and the prepared speech for Member Boards; the presentation of the four CAT regional workshops; a new student-focused brochure entitled, "*NCLEX Using CAT*"; the ETS-produced *Candidate Information Bulletin* for the Beta Test; two *CAT Communiques* concerning the Beta Test for Member Board use and a specially tailored version for distribution to educators; and a special CAT edition of *Issues*.

By Fall 1993, many more decisions, policies and procedures related to CAT will be finalized on the national and individual state level. The committee recommended and the Board of Directors considered and approved NCLEX Beta Test Regional Conferences, to provide the opportunity to disseminate psychometric results of beta testing; operational results regarding registration procedures, data transfer, software, reports, exam sites; resulting implementation issues related to security measures, crisis management, Americans with Disabilities Act (ADA) accommodations; and to discuss individual jurisdictional regulatory changes which have been made as a result of planned CAT implementation. The target audience for the conferences is Member Board members and staff, and the learning format will utilize a "train the trainer" approach.

Because the administration of NCLEX using CAT is a dramatic departure from the traditionally understood and utilized method of examination administration, the committee believes that it is the responsibility of the National Council to produce a disk which clarifies the process, and that this candidate preparation disk should be distributed as widely as possible. The committee recommended and the Board of Directors considered and approved the production of a disk at a minimal cost for candidates.The focus of the disk will be tutorial, rather than diagnostic; the distribution channels have not yet been finalized. It will also be necessary to develop methods for reaching the non-traditional candidate if the disk is not a part of the candidate bulletin.

The Sylvan/KEE Security Plan and the Sylvan/KEE Disaster Recovery Plans were reviewed and modified by the committee. The Sylvan/KEE Systems Security Plan was revised and was presented to the Administration of the Examination Committee at its March meeting for further review and editing.

The desire of some Member Boards to maintain blanket authorization of designated staff to make announced and unannounced visits to testing centers was debated. The committee reaffirmed the fact that testing centers located within jurisdictional borders are not for the sole use of that jurisdiction. The committee further discussed operational issues associated with blanket authorization and referred the issue to the Administration of the Examination Committee for policy and procedure development.

The committee reviewed ETS' proposed irregularity reports. Discussion focused on those irregularities which would affect a candidate's licensure decision versus those which need to be reported due to potential candidate complaint of fairness, or unusual occurrences. Input was given to ETS; revisions were proposed by the committee, and additional revisions which arose from the committee's May meeting were incorporated into another draft document by ETS.

The committee reviewed *Guidelines for Noncompliance at Exam Centers* developed by the Administration of the Examination Committee and provided comments back to that group.

The committee considered and made recommendations for proposed national and intrajurisdictional post-examination reports, including a revised diagnostic profile for failing candidates.

Taking into consideration newly revised regulations arising from the Americans with Disabilities Act, the committee reviewed procedures for dealing with requests for NCLEX modifications for candidates with disabilities, and forwarded recommendations to the Administration of the Examination Committee. These comments were incorporated into the *NCLEX Beta Test Edition of the Computer-Based Testing Test Center Administrator's Manual.*

■ Pre-Implementation Testing

An activity in Goal I, Objective C, Tactic 3 states, "*Design, administer and evaluate Alpha and Beta tests; plan corrective actions based on results.*"

The committee reviewed and approved the Alpha Test Plan developed by ETS. Committee members were invited by ETS to provide input into scenarios for Alpha Test scripts. Jurisdictions which agreed to participate in the Alpha Test included California-RN, Kentucky, Maryland, Michigan and Virginia. The committee reviewed the *Executive Summary of Alpha Testing*, and ETS provided a detailed Alpha Test report which included problems that occurred and possible fixes.

Extensive input was provided by committee members into the development of the registration process and the Member Board Office System (MBOS) software. The committee viewed a demonstration of a current version of MBOS presented by ETS and approved the MBOS design as presented for beta testing. The committee reevaluated MBOS following the beginning of candidate Beta Test registration and alpha testing. Impetus for future software and screen changes will result from Member Board training and the outcomes of beta testing.

The committee outlined key components of a communication to Member Boards participating in beta testing, including supplies needed for the new personal computer, and the proposed installation and training schedule. The committee also outlined an additional communication to be sent to Member Boards participating in the Beta Test which included information about what to expect in training, the capabilities of the MBOS software, methods to start linkage of MBOS to individual jurisdiction computer systems, and a referral plan for who should be contacted for various computing needs of Member Boards.

Critical RN subgroups identified by the committee for analysis in the Beta Test were African-American, Hispanic, Filipino and other candidates for whom English is their second language (ESL). Critical PN/VN subgroups identified for analysis in the Beta Test were African-American, Hispanic and ESL.

The committee reviewed a preliminary report based on a survey of programs in nursing nationwide, compiled by Sylvan/KEE on the potential number of candidates for beta testing who were graduating from programs in nursing. The committee decided to continue with the research design as presented in the proposal, acknowledging the potential difficulty of recruiting enough PN candidates. The committee further decided to schedule the RN Beta Test window as June 23 - July 8, 1993, and the PN Beta Test from July 1 through July 14 to facilitate obtaining more PN candidates. In considering the logistics of administration, the committee decided it would be easier for the jurisdictions to deal with the NCLEX-RN one-day paper-and-pencil exam to be held on July 8, 1993, and the NCLEX-PN special paper-and-pencil administration on July 7, 1993.

Before final approval of the proposed Beta Test research design, the committee debated the necessity of design changes if volunteer candidate recruiting goals could not be met. The discussion included licensure and endorsement issues related to jurisdictions granting licensure based on results of one of the atypical treatment conditions of the Beta

Test research design. The committee also received input from educators and others concerning the possibility of a change in passing rate for the atypical treatment conditions.

Multiple iterations of the Beta Test plan developed by ETS were reviewed and refined by the committee. The committee determined that a non-secure version of the plan will be prepared by National Council staff in consultation with selected committee members for ETS publication and distribution to all Member Boards.

National Council Criteria for Beta Test Readiness were reviewed. The committee regularly evaluated these milestones for completion, to assure that preparations for the Beta Test proceed on a timely basis.

The committee discussed the status of forms for Beta Test NCLEX-RN one-day paper-and-pencil examination and Beta Test NCLEX-PN paper-and-pencil examination. Based on the report of the National Council psychometrician, the committee approved changes recommended for each paper-and-pencil treatment condition. The committee also decided not to use tryout items in the RN one-day form because it will be administered in one day. Discussion was also held concerning the Beta Test item pool, with reference to past examination items which must be excluded from the item pool, and proposed possible solutions to the problem of overlapping RN and PN items in the item pool. It was determined by the committee that if a previous NCLEX-RN failure candidate is assigned to the Beta Test treatment condition that would be using the same previously-administered form of NCLEX-RN that this candidate had written before, that candidate will be excluded from that condition. Jurisdictions would be asked to notify National Council which examination forms that Beta Test repeaters have previously taken.

The committee reviewed a draft of the *Readiness ("Go/No Go") Criteria* and provided input to the Expert Panel.

The committee defined the free CAT retest window for RNs and PNs from approximately September 7, 1993, or when results have been received, through November 30, 1993. Those candidates who do not choose to take the free CAT retest during this time may take it when CAT goes operational, without forfeiting their right to a free CAT retest.

■ Member Board Support

An activity under Goal I, Objective C, Tactic 5, states *"Identify/support legislative change as needed."* The committee monitored the legislative readiness of Member Boards in making the statutory and administrative rule changes necessitated by the change in testing modality. Fifty-two Member Boards have returned surveys indicating legislative readiness.

Meeting Dates

- October 10-13, 1992
- December 16-17, 1992
- February 24-26, 1993
- May 3-5, 1993

Future Considerations for the National Council

■ Post-Implementation Evaluation and Follow Up

Using the CAT Master Plan as a guide, the committee plans to comprehensively evaluate all aspects of pre-implementation testing and Member Board Readiness to assure a smooth transition to NCLEX using CAT.

Recommendation(s)

No recommendations.

Staff

Barbara Halsey, *CAT Project Manager*
Carol Hartigan, *CAT Testing Manager*
Anthony Zara, *Director of Testing Services*

Report of the Computerized Adaptive Testing - Practical Nurse Field Test Team (CAT-PN Team)

Committee Members

Barbara Kellogg, SC, Area III, *Chair*
Marjorie Bronk, TX-VN, Area III
Helen Kelley, MA, Area IV

Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective C .... Implement computerized adaptive testing for the licensure examinations.

Recommendation(s)

No recommendations.

CAT-PN Field Test - Background

The National Council Delegate Assembly voted in 1991 to implement Computerized Adaptive Testing (CAT) for nurse licensure because it offers some significant advantages. CAT provides increased measurement efficiency over paper-and-pencil testing and can significantly reduce the amount of time needed to complete the examination. When CAT is implemented, examinations will be administered throughout the year. Examination results will be available in much less time following the CAT examination, enabling candidates to enter the workforce as licensed nurses sooner. In addition, CAT may be less stressful since it provides an individualized testing setting for candidates.

CAT Feasibility Study

- **Phase I**

The feasibility of CAT for NCLEX was investigated in two phases. The major tasks accomplished in Phase I were the development of the CAT software, investigation into the capabilities of the software through pilot testing, assessment of nurses' interactions with the software, pursuit of external funding for the project, and the communication of outcomes. Phase I was completed in 1988 with a report to the Delegate Assembly.

- **Phase II**

In August 1988, the Delegate Assembly voted to continue the CAT Feasibility Study through Phase II, but due to possible PN test plan changes, to field test CAT using only RN candidates in July 1990, and February 1991. Phase II expanded the study to investigate the feasibility of the entire CAT measuring system, with the RN field testing designed to provide pivotal information about psychometric comparability and administrative logistics. Phase II was completed with a final report to the 1991 Delegate Assembly.

From Phase II, it was determined that CAT and paper-and-pencil nurse licensure testing are psychometrically comparable and that previous computer experience had virtually no effect on candidate performance. The RN field testing also showed CAT testing security could be maintained and that demographically diverse groups of candidates are not disadvantaged by taking a CAT examination. To determine if these findings also held true for the PN population, a PN/VN CAT field test was conducted during October and November 1992.

Purpose of the CAT-PN Field Testing

The purpose of the CAT field testing for PN/VN candidates was to replicate the CAT-RN field testing study and to ensure that CAT is a feasible measurement technology for administering the NCLEX-PN. Specifically, the research was being conducted to address the psychometric comparability of CAT-PN to paper-and-pencil (PP) NCLEX; to investigate the efficacy of the field-tested CAT procedures for PN candidates; and to gather reactions of PN candidates to the CAT testing process.

The primary psychometric questions addressed by this study included:

(1) Do candidates perform in a comparable way on CAT and on the paper-and-pencil (PP) examinations?

   a) To what extent is there agreement between the pass/fail decisions made on the basis of CAT or PP examinations?

b) What are the characteristics of the candidates for whom the decisions differ, and are there non-ability related explanations apparent?
c) To what extent is there a relationship between candidates' ability estimates produced by CAT and PP?

(2) Are individuals from protected demographic classes advantaged or disadvantaged by CAT?
a) Is the relationship between the ability estimates the same for investigated subgroups of candidates?
b) Are attitudes and experiences reflected in the questionnaires related to differences in performance between CAT and PP?

The CAT-PN field tests were scheduled to take place in conjunction with the October 1992 NCLEX-PN administration (within approximately two weeks before and after the NCLEX examination date).

CAT-PN Field Test Study Design and Selection of Jurisdictions

The CAT-PN Team selected jurisdictions for participation based on the jurisdiction's characteristics, candidate demographics, and previous CAT Field Test experience.

Area I	Area III
Washington-PN	Louisiana-PN
Guam	Texas-VN
(Alt) Oregon	(Alt) Florida

Area II	Area IV
Missouri	New Jersey
Ohio	(Alt) Pennsylvania
(Alt) Minnesota	(Alt) Virgin Islands

With statistical stability being a paramount goal, the CAT-PN Team recommended that the sampling design for the CAT-PN field testing include 150 candidates per jurisdiction (except for Guam), comprising a target sample of 900 candidates.

Candidate Recruitment

Jurisdiction visits were completed in all CAT-PN field test sites: Guam, Louisiana-PN, Missouri, New Jersey, Ohio, Texas-VN, and Washington-PN. The boards of nursing arranged for meetings of a CAT project staff person with the PN Program Directors. Board of nursing staff contributed time and effort to the recruitment of candidates in each jurisdiction.

In April 1992, education programs were selected, faculty coordinators identified, and initial candidate recruitment efforts started. Letters, fact sheets, brochures, and personal contact were used to recruit and motivate candidates to participate in the CAT-PN field tests.

Item Pool for CAT-PN Field Testing

In preparation for the CAT-PN field test, the NCLEX-PN item pool was reviewed. Content experts verified that the text was accurate and coherent, checked for correct spellings and matching names, and verified that every question reflected current practice. Two complete reviews of the NCLEX-PN item pool were conducted. Tryout items from the NCLEX-PN administered in 492 were added to the PN item pool prior to the October field test.

CAT-PN Field Test Sites

In contrast to the CAT-RN field testing where different types of computerized testing facilities were investigated, the CAT-PN field tests were conducted only in professional testing centers (except in Guam). This decision mirrored the 1991 Delegate Assembly direction that the National Council contract with a commercial vendor for CAT administration services. The CAT-PN Field Test Team reviewed proposals submitted by administration service vendors, and after vendor selection, test administration site assignments were made: Sylvan/KEE Systems for Louisiana-PN and New Jersey, The Roach Organization for Texas-VN and Washington-PN, and Insurance Testing Corporation for Missouri and Ohio. Due to the distance and travel expenses required to conduct the field test in Guam, a National Council staff member assisted the Guam Board of Nurse Examiners in conducting the test independently at the University of Guam Computer Center.

During initial software tests, it was discovered that the CAT-PN field test software was not compatible with the computer equipment at the Insurance Testing Corporation (ITC) test sites. As the expense of modifying the equipment

was prohibitive, ITC requested alternative arrangements be made. Sylvan/KEE agreed to administer the field tests in Missouri and Ohio, as well as in Louisiana and New Jersey.

CAT-PN Field Test Results - Executive Summary

A psychometric monograph was developed which describes the CAT field test results in detail. This monograph was reviewed by a panel of outside experts, the Psychometric Review Panel (PRP). The PRP was composed of Dr. Ben Wright (Professor, University of Chicago), Dr. Gage Kingsbury (Coordinator of Measurement Research, Portland Public Schools), Dr. Barbara Showers (Director, Office of Examinations, State of Wisconsin), and Dr. Joanne Stevenson, RN, (Professor, Ohio State University). The outside review process was incorporated beginning with the RN Field Tests to assure that the psychometric results and conclusions of the CAT Feasibility Study were supported by other experts in the field. For additional information on the CAT-PN Field Test, please refer to Attachment A, A Psychometric Comparison of Computerized Adaptive and Paper-and-Pencil Versions of the National Practical Nurse Licensure Examination.

Available Data

Of the 912 candidates who participated in the PN Field Test, 424 participated in the pre-test (took CAT before the PP examination) and 488 were in the post-test condition. Of the 912, only 854 had CAT results available. CAT data from 57 of the pre-test examinees were lost when proctors' attempts to record candidate identifying information on the data records, in compensation for a bug in the software, were not successful. An equivalent proportion of the data were lost across all demographic categories. The software bug was fixed before the post-test began. An additional candidate's CAT data were lost when files were not successfully transferred from hard disk to floppy. As a result, CAT data are available for 367 pre-test and 487 post-test candidates.

All candidates were required to participate in the regular October administration of the PP NCLEX-PN. Two of the 912 did not. NCLEX measures for three others were not available because of Social Security number mismatches. Measures for both CAT and PP were available on a total of 850 candidates (one candidate was missing both measures). The initial analyses were conducted on these 850 candidates. Six additional candidates were deleted from succeeding analyses because evidence showed that they did not take CAT seriously, or because of their extreme results (outliers). Table 1 (page 15) shows the demographic characteristics of the 844 "final-analysis" candidates. The sampling design of the study was met; the number of participating Hispanic and Asian candidates was lower than desired, but sufficient for allowing generalizable conclusions.

Time Spent and Number of Items Taken

The largest number of examinees finished CAT in about an hour (see Figure 1, page 18). These measures of time include only time spent answering items. Keyboard training-time is not included in these computer-recorded times, so more candidates were stopped by proctors after four hours than is apparent from the low number shown at 240 minutes. Proctors reported total times of four hours for seven candidates. Time to finish the examination is related to both speed of responding (seconds-per-item) and the number of items taken. Approximately one-third of the candidates were released after only 68 items, and just over one-third had to stay for all 196. The other third is distributed between these extremes (see Figure 2, page 19).

Measure Comparability

Overall, measures were slightly lower on CAT than on the PP examination, as they were in the RN Field Test, but this did not hold true for all groups of candidates. English Second Language (ESL) and Asian candidates, in particular, did not consistently score lower using CAT. Overall, CAT and PP measures correlated .90 when corrected for the unreliability of the two measures, approximately the same as was found on the RN Field Test. (See Figure 3, page 20)

Pass/Fail Decision Agreement

When the same passing standard is applied to CAT measures as it was for to PP, CAT failed 18.7 percent of the 844 candidates, in contrast to the 11.7 percent who failed PP. This is consistent with the lower average measures on CAT.

Overall, CAT and the PP examination agreed on the pass/fail decisions of 87 percent of the candidates, 89 percent of the post-test candidates, and 86 percent of the pre-test candidates. These proportions represent somewhat greater agreement than was found for the RNs (81 percent in July and 82 percent in February). The levels of agreement are shown in Table 3 (page 17).

The same decision was made on only 74 percent of the candidates for whom English was a second language (ESL), in part because the proportion passing rose from 62 percent on the PP to 66 percent on CAT, despite the overall lower average on CAT.

For the 286 candidates for whom CAT made a decision quickly, and who took fewer than 75 items, CAT and PP pass/fail decisions agreed on all but two (99 percent). A high degree of agreement is expected on these candidates, because they were classified as either passers or failers by CAT after relatively few items, indicating that they were performing well above or below the cutpoint. Candidates for whom the decision was not so clear, and who had to take 150 or more items, were classified the same way by CAT and PP 77 percent of the time. These were candidates near the cutscore, so some lack of agreement is not surprising. Candidates whose ability is truly close to the passing point may achieve different pass/fail decisions in any retest situation due to measurement error.

Precision of Measurement

Figure 4 (page 21) represents the precision of the measures, as reported by the standard error of measurement (SEM), for both CAT and PP. The relationship between measurement precision and SEM is that, as precision increases, the SEM decreases. The two examinations differ in where and how sharply they focus their measurement precision. The greatest precision (lowest SEM) for the PP examination is for low ability levels. CAT's precision is greatest for abilities in the vicinity of the passing score. A striking difference is in the extreme abilities. CAT is not measuring these candidates as precisely as the PP examination (fewer items are administered since these areas of the ability continuum are not as relevant to the licensure decision as the area near the passing score). Another difference is the lower CAT SEM (higher precision) for most candidates in the vicinity of the cutscore.

Also evident in Figure 4 (page 21) is that all candidates with the same measure have the same SEM on the PP examination, but a variety of SEMs exist for each measure in CAT. On CAT, different candidates may take different numbers of items before they arrive at the same measure, resulting in different SEMs.

The average SEM for the candidates with abilities close to the passing score on PP is 0.154 (after 204 items) and for those close to the passing score on CAT, who took at least 180 items (as anyone who is that close to the cutscore will have to do when CAT is implemented), the average SEM is 0.145. Both will be rounded to 0.15 for computations throughout this report.

The reliability of the PP examination is .88. The estimated reliability for the CAT examination is .87.

Seconds-Per-Item

Previous research has demonstrated that ESLs may feel time pressure on the PP examinations. CAT offers them the opportunity to take as long on each item as they wish, because items they do not reach will not automatically be scored wrong.

In fact, ESL candidates spent an average of 60 seconds-per-item, in contrast to the English native language (ENL) candidates, who spent an average of 45 seconds-per-item. On the PP examination, ESLs averaged 55 seconds-per-item and ENLs, 47. The average ESL spent five seconds-per-item more on CAT than on PP, and the average ENL spent two seconds _less_.

Gender, Ethnicity, Repeaters, and Foreign-Educated

Table 1 (page 15) shows the average CAT and PP measures, and the average CAT - PP difference for all candidates in each demographic group. Only Asians scored significantly higher on CAT than on the PP examination. No other ethnicity had more of a decrease in average measure than the Caucasian group. Overall, there was no significant difference between repeaters' and first-time takers' CAT-PP contrast; the measure difference was greater for foreign-educated than US-educated candidates. Table 2 (page 16) shows that within the reference group, there was no significant difference in CAT-PP contrast among the ethnicities.

Attitudes and Experience

Questionnaire items asked the candidate to either pick one of several offered responses, or to mark a point on a continuum. Those items producing continuous variables were included in a regression analysis predicting CAT-PP difference. A regression equation including seconds-per-item, and whether they felt rushed, predicted 14 percent of the variance in the CAT-PP difference.

Questionnaire Results

On average, the field test volunteers were slightly inexperienced with computers, but only four percent thought that CAT was a poor way to test. Less than one percent (four candidates) felt that the keyboard training did not prepare them to take the CAT examination. Candidates felt slightly more comfortable taking the test on computer than by paper-and-pencil, on the average. They thought items were somewhat easier to understand, and markedly easier to read.

Candidate reactions show that the keyboard training is both effective and essential. Although many candidates found the printed instruction card unnecessary due to the keyboard training exercise, even more found it useful. The responses show that candidates had no difficulty in using the computer. Previous experience with computers is not related to either performance on CAT or to the standardized difference between CAT and PP measures.

Overall, candidates believed that the inability to return to previous answers affected their performance "somewhat."

Comparison with RN Field Test Results

The RN Field Test was conducted around two PP-examination dates, July 1990 and February 1991. The results sometimes differed, probably because of the different nature of the candidate populations for those two examinations. The October PN examination more closely resembles the July, in that it is the administration date most closely following school graduation dates, and is, by far, the larger administration.

In many ways, the PN results fall between those of the two RN administrations. The correlation of CAT and PP measures, and also the average difference between CAT and PP measures, are between the values obtained in the February and July RN Field Tests.

The PN PP and CAT examinations agreed on a higher percentage of the Pass/Fail decisions than did the RN. Standard errors of measurement were smaller for all RN examinations than for the PN examination, because more items were administered.

Conclusions

1) Candidates perform in a comparable way on CAT and the PP examinations. CAT and the PP NCLEX examinations appear to be measuring the same variables, and the lower measures on CAT that were found are not consistently related to any of the extraneous variables, such as computer experience or ethnicity.

2) Within the reference group, no demographically-diverse group is at a significantly greater disadvantage than the majority group. In fact, the performance of some of the demographically-diverse groups was closer to that of the majority on NCLEX using CAT than on the paper-and-pencil NCLEX.

Highlights of Activities

- Reviewed the PN field test design, monitored the implementation of the field test study, and assisted in interpretation of findings.

- Prepared regular reports of team plans and activities for use by the Board of Directors in coordinating CAT activities. Developed recommendations for matters relating to National Council policy and budgetary adjustments.

- Given policy and budgetary constraints, maintained accountability for PN field testing by successfully conducting the CAT-PN Field Test within the approved budgetary guidelines.

- Recommended National Council proceed with the current CAT implementation timeline consistent with other readiness criteria. The CAT-PN Field Test showed no evidence of factors influencing the reliability or fairness of the NCLEX-PN administered via CAT, therefore, no procedural changes were recommended. The Board of Directors concurred.

- Based on the CAT-PN Field Test Team recommendations, the Board of Directors adopted the following policies for the implementation of the NCLEX-PN using CAT:
  - The maximum number of real items for the NCLEX-PN administered via CAT will be 180; the minimum number of real items will be 60.
  - The maximum testing time for the NCLEX-PN administered via CAT will be five hours, including the keyboard familiarity exercise and all rest breaks.
  - The acceptable range of tryout items for the NCLEX-PN administered via CAT will be no fewer than 15 tryout items and no greater than 25 tryout items. The exact number of tryout items will be determined by National Council and ETS staff, based on the requirements of the item pool and the realities of reasonable candidate expectations.

Table 1. Average Performance for Those with Complete Measure Information

Group	Count	Average Measure		Differ	Percent Failing	
		CAT	Paper		CAT	Paper
When CAT Taken						
Pre-PP	364	-.22	-.10	-.12	23.1	13.7
Post-PP	480	-.11	-.02	-.09	15.4	10.2
Gender						
Female	735	-.14	-.03	-.11	18.1	10.9
Male	109	-.27	-.21	-.06	22.9	17.4
Ethnicity						
Asian	61	-.45	-.51	.06	32.8	37.7
Black	190	-.44	-.34	-.10	36.8	26.3
White	532	.00	.12	-.12	9.4	3.0
Hispanic	55	-.38	-.26	-.12	29.1	16.4
Native American	4	.08	.12	-.04	0	0
Repeater						
No	775	-.10	.01	-.11	14.6	7.7
Yes	69	-.80	-.75	-.05	65.2	56.5
Education Country						
US	817	-.14	-.03	-.11	17.4	10.0
Foreign	25	-.81	-.90	.09	64.0	68.0
Native Language						
English	741	-.12	.00	-.12	16.5	8.1
Other	101	-.43	-.47	.04	33.7	37.6
Total Analysis Group	844	-.16	-.05	-.11	18.7	11.7

Table 2. Average Performance for Reference Group (US-Educated, First-time Takers)

Group	Count	Average Measure CAT	Average Measure Paper	Differ	Percent Failing CAT	Percent Failing Paper
When CAT Taken						
Pre-PP	328	-.15	-.03	-.12	8	18
Post-PP	438	-.06	.04	-.10	12	7
Gender						
Female	667	-.08	.04	-.12	14	7
Male	99	-.22	-.15	-.07	13	20
Ethnicity						
Asian	35	-.25	-.25	0.00	20	17
Black	166	-.38	-.28	-.10	31	22
White	513	.02	.14	-.12	8	2
Hispanic	48	-.30	-.17	-.13	21	8
Native American	4	.08	.12	-.04	0	0
Repeater—Not Applicable						
Education Country—Not Applicable						
Native Language						
English	693	-.08	.05	-.12	14	5
Other	73	-.31	-.34	.03	13	17
Total Analysis Group	766	-.10	.01	-.11	14	7

Table 3. Agreement on Pass/Fail Decisions by CAT and PP

		Paper-and-Pencil		
	Decision	**Fail**	**Pass**	**Total**
CAT	**Fail**	74 (9%)	84 (10%)	158 (19%)
	Pass	25 (3%)	661 (78%)	686 (81%)
	Total	99 (12%)	745 (88%)	844 (100%)

Figure 1. Time Spent on CAT

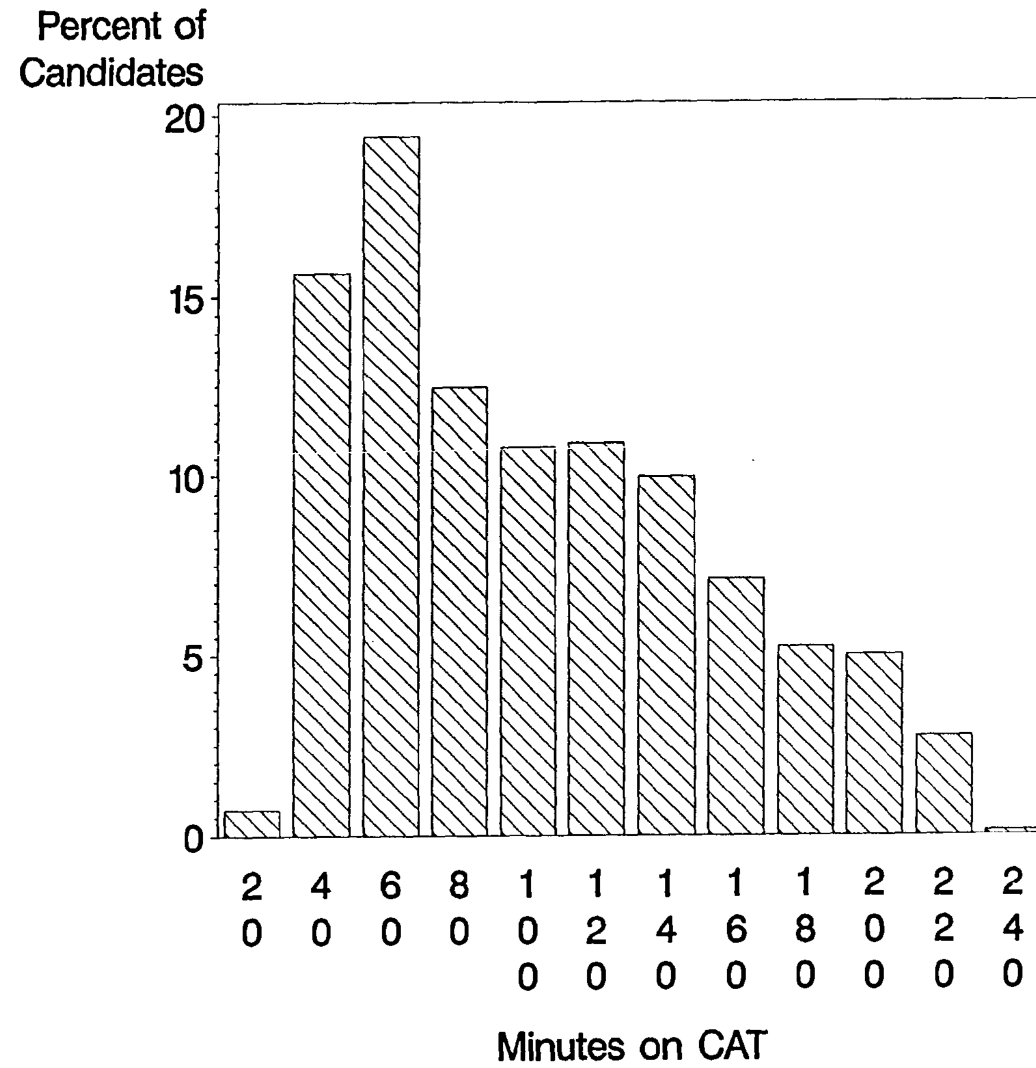


Figure 2. Number of Items Taken

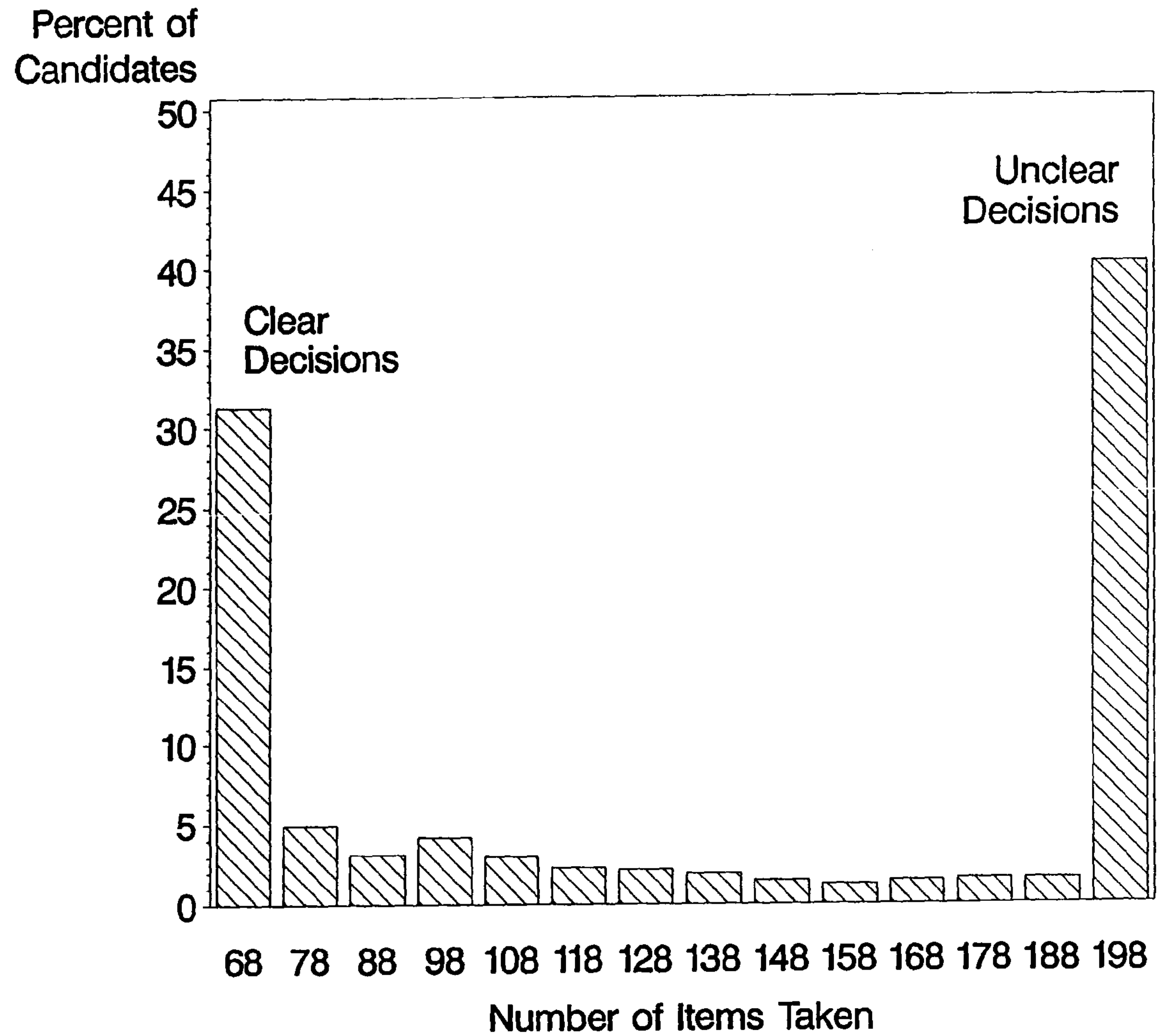


Figure 3. Comparison of CAT and Paper Measures – Excluding Outliers

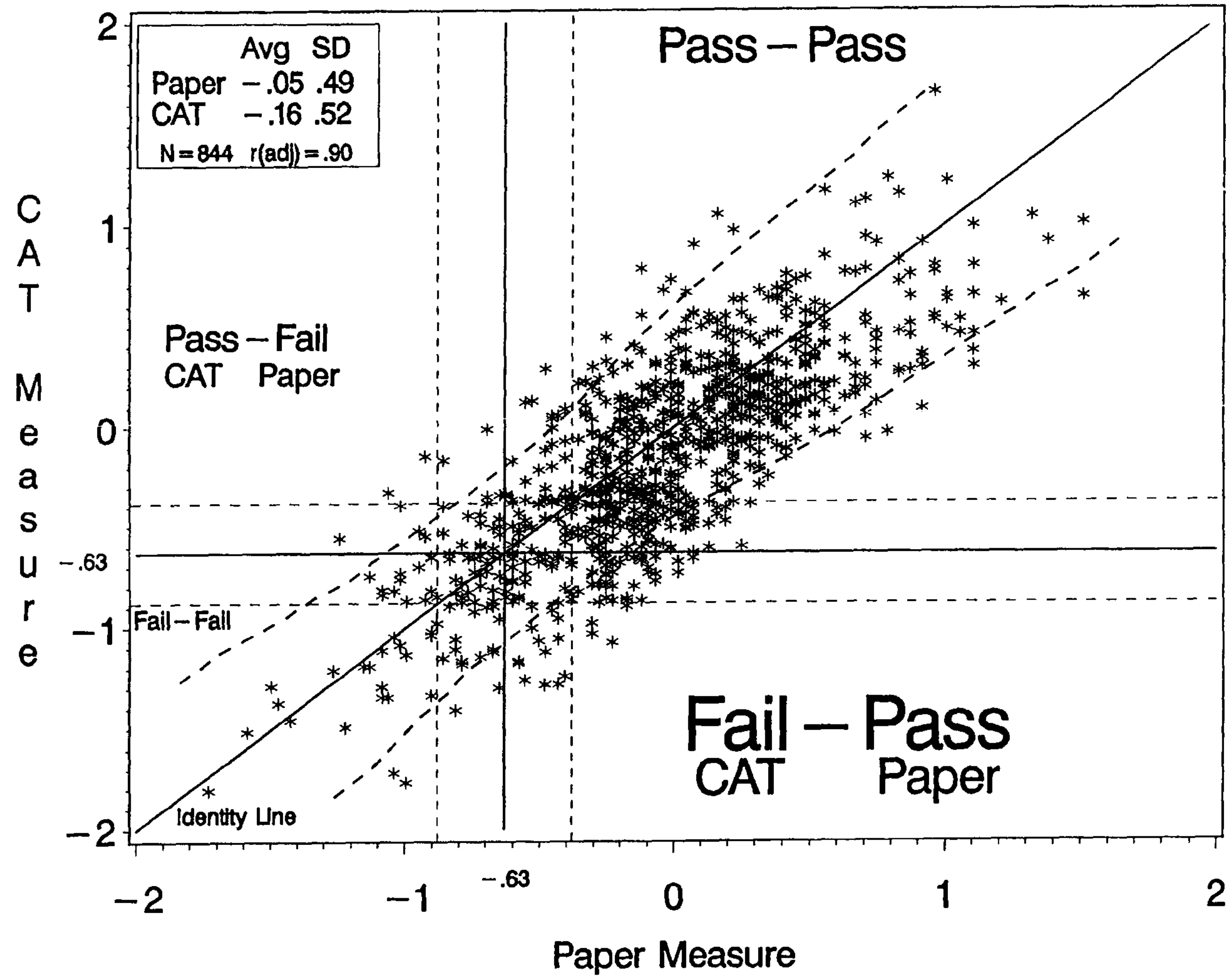
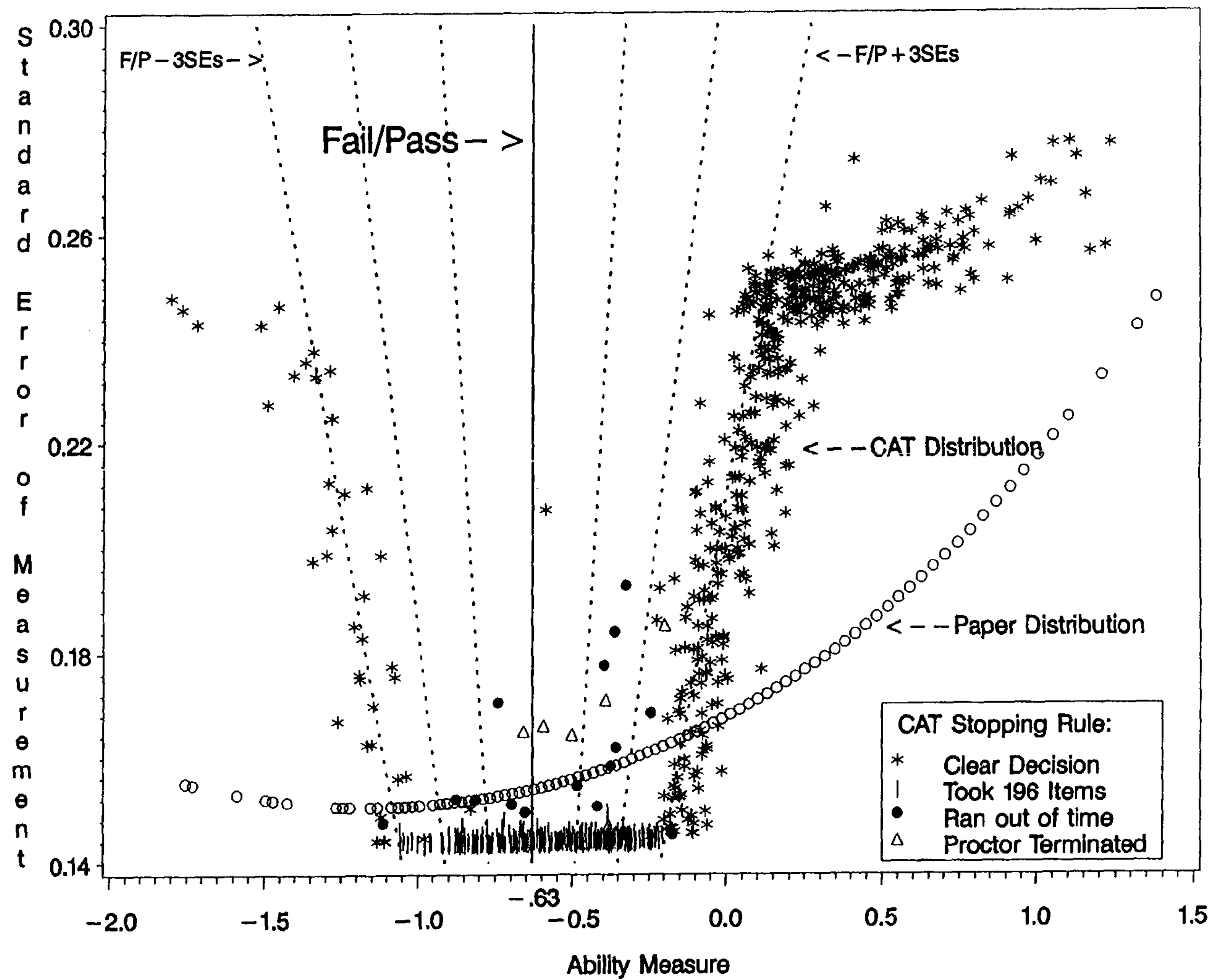


Figure 4. Comparison of Paper and CAT Standard Errors of Measurement



Attachment A

A Psychometric Comparison of Computerized Adaptive and Paper-and-Pencil Versions of the National Practical Nurse Licensure Examination

INTRODUCTION

In October 1992 a field test of the computerized adaptive version of the National Council Licensure Examination for Practical Nurses (NCLEX-PN) was conducted. The National Council of State Boards of Nursing (National Council) is an association composed of state boards of nursing in the United States and its territories. One major function of the National Council is to develop the national licensure examinations for registered and licensed-practical nurses (NCLEX-RN and NCLEX-PN). Computerized adaptive testing (CAT) has been considered by the National Council since the early 1980s. Field tests of the CAT version of the NCLEX-RN were conducted in July of 1990 and February of 1991 . Based, in part, on the positive outcomes of the analyses of that field test (see A Psychometric Comparison of Computerized Adaptive and Paper-and-Pencil Versions of the National RN Licensure Examination, National Council, July 1991), the National Council voted in 1991 to administer the NCLEX-RN and NCLEX-PN using CAT. In 1992, the National Council voted to have Educational Testing Service assist in the implementation, with a 1994 target date.

Due to the possibility of PN test plan changes, the field test of CAT in July, 1990 and February, 1991 used only RN candidates. As part of the transition to CAT, the 1991 Delegate Assembly directed that PN candidates be field tested in October, 1992. The objectives of the PN field test were to confirm the psychometric comparability found between performance on CAT and paper-and-pencil NCLEX for RN candidates, and to evaluate the effectiveness of the CAT administration procedures for PV/VN candidates. This paper summarizes psychometric results of the CAT-PN Field Test.

Computerized Adaptive Testing

A CAT examination is assembled interactively as the candidate answers the questions. When a question is answered, the computer calculates an ability estimate based on the candidate's earlier answers. The test questions, which are stored in a large item bank and classified by test plan area and Rasch-calibrated difficulty level, are then scanned and the one question determined to measure the candidate's ability most precisely in the appropriate test plan area is selected and presented on the computer screen. This process is repeated for each question, creating an examination tailored to the candidate's knowledge and ability, and fulfilling all test plan requirements. CAT continues until one of the stopping-rule conditions is met. CAT administers standard NCLEX multiple-choice questions.

Purpose/Limitations of Study

The purpose of the CAT-PN Field Testing was to gather information and conduct research to address Member Boards' concerns regarding the feasibility of replacing the current paper-and-pencil (PP) NCLEX-PN with a CAT version. Specific information was acquired on the psychometric comparability of CAT and PP, operational issues (costs, logistics, staffing and computer needs), and security for CAT. Given the nature of the field test design, it was expected a priori that candidates would obtain slightly lower scores on CAT than PP due to a number of factors. First, candidates were repeatedly informed that the PP examination counted toward licensure and that the CAT did not. Second, the timing of the CAT administration was such (as long as two weeks before PP) that the pre-NCLEX candidates could use the CAT experience as a diagnostic test to help hone their final studying for PP. Third, the post-NCLEX candidates might have felt that, having already taken the licensure examination, the CAT examination was unimportant. As a result, lower CAT scores could have been caused by any of these factors or

some intrinsically higher difficulty of items when administered adaptively by computer. This research design does not allow the separation of these effects.

When the next psychometric study (the Beta test) of CAT is conducted in collaboration with ETS, a decision will need to be made about the adequacy of the current item-pool difficulty estimates for use in CAT. That study will include recalibration of the item difficulties to determine if they rank-order the same way for both modes of administration, but this study does not attempt it.

The primary questions addressed by this study included:

(1) Do candidates perform in a comparable way on CAT and on the PP examinations?

a) To what extent is there a relationship between candidates' ability estimates produced by CAT and PP?

b) To what extent is there agreement between the pass/fail decisions made on the basis of CAT or PP examinations?

c) What are the characteristics of the candidates for whom the decisions differ, and are there non-ability related explanations apparent?

(2) Are individuals from protected demographic classes advantaged or disadvantaged by CAT?

a) Is the relationship between the ability estimates the same for investigated subgroups of candidates?

b) Are attitudes and experiences reflected in the questionnaires related to differences in performance between CAT and PP?

METHOD

Examinations

Paper-and-pencil. The CAT-PN Field Test was conducted in conjunction with the standard NCLEX-PN (PP) in October 1992. The PP contained 240 items, of which 204 contributed to the candidates' performance estimates. Candidates in Guam, however, took an alternate form of the PP examination one week later than the rest of the nation, because of a typhoon.

Approximately half of the field-test candidates took CAT before the PP examination, and the other half took CAT after the PP examination. The counterbalancing of CAT administration allowed practice effects and learning to be controlled. The CAT examinations initially were scheduled within a two-week period either before or after the normal PP examination. The post-test period for CAT examinations was extended to three weeks after PP in order to recruit more candidates to fill the sampling plan. In Guam, because of the delay in administration of the PP examination, the pre-test candidates were tested three weeks before the PP administration.

CAT. The CAT examination for each candidate was composed of items drawn from the complete NCLEX-PN item pool which consisted of 2072 Rasch-model calibrated items. The maximum testing time allowed for CAT was four hours. The keyboard familiarity exercise that each candidate received prior to the actual CAT examination was also administered as part of the four-hour time period.

The software constrained the minimum number of items administered to be 68 and the maximum to be 196. The items administered in each candidate's CAT examination conformed to the NCLEX-PN test plan. Candidates were not permitted to skip items or return to previously-answered items. The CAT examination blocked from

administration any items present on the October, 1992 NCLEX, preventing the testing results from being contaminated due to candidate memory effects. Candidates from Guam had the items from their alternate PP form blocked from the CAT pool, rather than the October 1992 PP items.

The number of items administered depended on the candidate's performance with respect to the passing standard: those close to the cutpoint were administered more items; those far from the cutpoint needed fewer items. No more items were administered after one of these three "stopping rules" was met: (1) the candidate's ability estimate was more than three standard errors of measurement (SEMs) from the cutscore and the minimum number of items had been taken, or (2) the candidate had answered 196 items, or (3) four hours had elapsed.

The test-plan coverage routine in the CAT software continues to administer items until all test-plan categories are filled, even after the "three standard errors of measurment" (3SEM) stopping rule has been met. An inconsistency in this routine resulted in the candidates' eligibility for the 3SEM stopping rule not being reevaluated after the test-plan categories were filled. Some candidates' final theta was closer to the passing-score than the earlier estimate which had triggered the 3SEM stopping rule. This inconsistency will not exist in the final CAT software.

Jurisdiction and Candidate Selection

The candidate-sampling design specified that the National Council oversample from some demographic groups (African-Americans, Hispanics, Asians, foreign-educated, and repeat candidates) to assure their adequate representation in the field tests. To fulfill these needs, the selection of participating jurisdictions was particularly important.

Jurisdictions were selected for participation based on the jurisdiction's characteristics, candidate demographics, and previous CAT experience. The jurisdictions selected were Guam, Louisiana-PN, Missouri, New Jersey, Ohio, Texas-VN, and Washington-PN.

The sampling for the field tests was conducted at the level of the nursing schools in each jurisdiction. The rationale for selecting programs, rather than individual candidates, for participation was that students who would not otherwise participate might be more inclined to take CAT if the rest of their classmates did so. The programs in each jurisdiction were selected for their expected cooperation level, as well as for having students to help fill the sampling requirement of a strong representation of minority candidates.

Letters from the deans of the selected nursing programs were sent to students with notification that their program was selected to participate in the CAT field tests. A candidate brochure giving basic information about the National Council's CAT Project and the field test was distributed. A letter was also sent from the board of nursing to the students after graduation, notifying them that they were selected as part of the sample chosen to participate in the CAT field tests.

Test Sites

In contrast to the CAT-RN field testing where different types of computerized testing facilities were investigated, the CAT-PN field tests were conducted only in professional testing centers (except in Guam). This decision mirrored the 1991 Delegate Assembly direction that the National Council contract with a commercial vendor for CAT administration services. The CAT-PN Field Test Team reviewed proposals submitted by administration service vendors, and after vendor selection, test administration site assignments were made: Sylvan-KEE Systems for Louisiana-PN and New Jersey, The Roach Organization for Texas-VN and Washington-PN, and Insurance Testing Corporation for Missouri and Ohio. Due to the distance and travel expenses required to conduct the field test in Guam, a National Council staff member assisted the Guam Board of Nurse Examiners in conducting the test independently at the University of Guam Computer Center.

Just prior to the CAT-PN Field Test, testing site difficulties were encountered. The original test administration site

in Louisiana suffered severe damage from a hurricane, which necessitated a relocation of the field test site to a satellite center nearby.

In addition, it was discovered that the CAT-PN field test software was not compatible with the computer equipment at the Insurance Testing Corporation (ITC) test sites, originally assigned to administer the examinations in Missouri and Ohio. As the expense of modifying the equipment was prohibitive for ITC, alternative arrangements were made, with Sylvan-KEE administering the field tests in Missouri and Ohio, as well as in Louisiana and New Jersey.

Candidates

The candidates were 912 fully-qualified PN/VN candidates who volunteered to participate in the study. The CAT examination was conducted at nine sites in seven jurisdictions. Candidates were informed on numerous occasions that the CAT examination did not count toward their licensure decision. Volunteers were issued stipends ranging from $75 to $125 (except for military personnel, because military regulations prohibit the receipt of monetary stipends). In Texas and Guam, the stipend was $100. Other jurisdictions offered $75 to those who took CAT before PP (pre-test candidates) and $125 to those who took CAT after PP (post-test candidates).

Candidates can be classified as belonging to the reference group, on whom all examination equating and item evaluations are routinely performed, or as non-reference group. The reference group is defined as US-educated, first-time takers of the NCLEX. This group is relatively homogeneous and consistent in its performance across time, providing the stable basis necessary for assessment of item and examination difficulty. Overall evaluations of CAT's impact on candidate performance will be performed on the reference group. The effect of CAT on foreign-educated and repeat candidates' performance will be investigated separately.

DATA ANALYSIS

Comparability

Measure Distributions. The distributions of measures from the participating candidates' PP and CAT examinations were compared. Both examinations produce measures and estimates of measurement precision on the logit scale of the calibrated item difficulties. The location, shape and dispersion of the distributions are of interest.

The distribution shapes could be identical, and individual candidates still have a large difference in their two measures. A paired-difference t-test determines if the average candidate's difference between their CAT and PP measures is significantly different from zero.

Measurement Precision. A central advantage of CAT is that it provides each candidate with an individual error of measurement. The concept of examination reliability, which is often invoked for evaluation of a PP examination, provides only a single, average estimate of precision across all candidates. For comparison, a reliability index for the CAT examination can be computed, using the ideas of marginal reliability as proposed by Green, et al. (1984).

A more reasonable and sensitive indicator of the measurement accuracy of CAT is the average SEM for points near the cutscore. The average SEM was calculated for candidates within $\pm$ 0.1 logit from the cutscore for both CAT and PP. Because the CAT SEM is dependent on the number of items administered, an additional limitation on the CAT grouping was that the candidates must have answered at least 180 items to be included. The CAT group was limited to those candidates taking at least 180 items because candidates will not take less than 180 items on an actual CAT administration of the licensure examination if their measure is within $\pm$ 1.65 SEM of the cutscore.

Measures. The most powerful CAT vs. PP information is yielded by a comparison of the within-candidate measures. The two measures were plotted against each other, with the cutscores and $\pm$ 1.65 error bands (95% one-tailed confidence interval) indicated. Of most interest are the candidates who fall above the error band on PP (clearly passing it) and below the error band on CAT (clearly failing it). These candidates, and others who had

large differences between their two measures, were analyzed on a case-by-case basis to determine if they shared common features.

A goal of the counterbalancing of pre- and post-test conditions was to eliminate alternate hypotheses for any discovered differences in candidate abilities. If all candidates have uniformly lower measures on CAT, it may be assumed that something in the testing situation (such as the higher motivation for the examination on which the licensure decision would be based) has made the items more difficult for candidates. If, however, the measures are lower on CAT in comparison to PP for some groups of candidates, or in some regions of the ability distribution, then the CAT Field Test experience would seem to be affecting groups differently.

Pass/Fail Decisions. The NCLEX-PN is a high-stakes licensure examination with a pass or fail decision as the primary outcome for the candidates. Scores are not reported. For these reasons, comparisons of the pass/fail categorizations of candidates by the two examination modalities are important. In the scatterplot of candidates' measures from the two examinations, pass/fail lines (at -.63 logits) and standard-error bands (at ±1.65 times the average SEM for candidates within 0.1 logit of the cutpoint) are marked and candidates who fall in regions of clear difference will be investigated. The numbers of these candidates are summarized in contingency tables and evaluated compared to the maximum expected decision concordance.

In this field test, overall differences in passing rates and average ability might be caused or inflated by a lack of candidate motivation on the CAT examination. For this reason, such differences will be noted, but not necessarily a cause for concern.

Covariates. Additional information was gathered from the candidates by the CAT examination software, on the cover of the PP test booklet, from the applications for participation in the field test, and from questionnaires completed by the candidates after taking CAT. Of particular interest were ethnicity, whether English was the candidate's second or native language (ESL or ENL), self-reported computer experience, feelings about the CAT examination, and time spent on the two examinations. Time spent on CAT has two components, time spent in the testing situation and average time per item, because candidates took different numbers of items, whereas time spent on the PP does not.

Candidate distributions on some of the attitudinal and experience variables are of interest because they inform decision makers about the testing process. Responses to these variables will simply be reported. Other variables, such as computer experience, ESL and ethnicity, are important potential contributors to the effect of CAT on a candidate's performance.

RESULTS

Available Data

Of the 912 candidates who participated in the PN Field Test, 424 participated in the pre-test (took CAT before the PP examination) and 488 were in the post-test condition. Of the 912, only 854 had CAT measures available. CAT data from 57 of the pre-test candidates were lost when proctors' attempts to record candidate identifying information on the data records, in compensation for a bug in the software, were not successful. An equivalent proportion of the data were lost across all demographic categories. The bug was fixed before the post-test began. An additional candidate's CAT data were lost when files were not successfully transferred from hard disk to floppy. As a result, CAT data are available for 367 pre-test and 487 post-test candidates.

All candidates were required to participate in the regular October administration of the PP NCLEX-PN. Two of the 912 did not. PP measures for three others were not available because of Social Security Number (SSN) mismatches. Measures for both CAT and PP were available on a total of 850 candidates (one candidate was missing both measures). The initial analyses were conducted on these 850 candidates. Six additional candidates were deleted from succeeding analyses because evidence showed that they did not take CAT seriously, or because of their

extreme outlier status (see later section on Individual Candidates). Table 1 shows the demographic characteristics of the 844 "final-analysis" candidates. Of the 844, 767 were reference-group (US-educated, first-time taker) candidates.

Demographic and attitudinal information about the candidates were available from the NCLEX records and from their applications for the field test, and from the questionnaires they filled out after completing CAT. Candidates were at liberty to refuse to answer any of the questions so, for most of the attitudinal and demographic variables, a few candidates have missing data. Analyses will include whomever has complete data for the variables under investigation.

As part of ongoing research into the relationship of a candidate's native language and time spent on the PP examination to a candidate's final measure, data were collected about time spent on the PP examination. Candidates were asked to record starting and stopping times for each of the test booklets, but some did not perform this task and so their time data are missing for PP. Of the 850 who have both CAT and NCLEX measures, 647 also have valid time data for both NCLEX and CAT. CAT time data were recorded automatically by the computer.

Research Question (1a): To what extent is there a relationship between candidates' ability estimates produced by CAT and PP?

Measure Distributions

For the 850 candidates with complete data, the average CAT measure is -.17 and the average PP is -.05. The spread of the two distributions were similar, .54 for CAT and .49 for PP. The difference between the average CAT and PP measures, -.12, is similar to that found in the RN Field Tests (-.06 in July and -.16 in February). The average difference for reference-group candidates was -.11.

The difference between each candidate's two measures was computed, as was the standard error of this difference (SEdiff). The SEdiff is the square root of the sum of the squared standard errors of the two measures. The SEdiff is the appropriate indicator of the difference in two measures of the same person that might be attributable to the different samples of items. The difference between each candidate's two measures is divided by the SEdiff to determine how many times further apart the two measures are than might be expected by chance alone. When no true difference exists, the observed difference will be less than 1.65 SEdiffs approximately 95% of the time. The SEdiff is used for consideration of individual candidate's differences, not for evaluation of a group's average difference. The average candidate's two measures differed by .12 logits, which is .49 SEdiffs. The significance of an average difference is determined by the paired-difference t-test, which confirms that this value is significantly different from zero ($p < .001$).

This difference suggests that something about the CAT administration made PN candidates score less well, on the average, as also happened for the RNs. Because the same people took both examinations at about the same point in time, it is not unreasonable to assume that their nursing competence is the same for both examinations. The increased challenge of the CAT situation might be from something inherently more difficult in either computer administration or in adaptive item selection or from a lower level of motivation on an examination that did not count.

Comparability

Measures. A plot of CAT and PP measures is shown in Figure 1. Candidates are represented by a star at the intersection of their CAT and PP measures. The correlation of the two measures is .76. When corrected for the unreliability of both examinations, the correlation becomes .87. For the RN July Field Test, the uncorrected correlation was .71; for February, it was .83.

Vertical and horizontal reference lines are drawn at the cutscore (-.63), and at 1.65 times .15 (the average SEM for candidates in the vicinity of the cutscore for both CAT and PP, see following section on Precision of Measurement) above and below the cutscore. These bands represent the region where pass/fail decisions were made with less than 95% certainty.

The diagonal line on Figure 1 is the identity line, along which points will fall if the two examinations produce identical measures. The curved band around the identity line reflects twice the average SEdiff for candidates in that region of the ability continuum. Candidates whose points fall outside of that band have significantly different measures on the two examinations.

Research Question (1c): What are the characteristics of the candidates for whom the decisions differ, and are there non-ability related explanations apparent?

Individual Candidates. In Figure 1, the candidates whose measures fall in the upper-right quadrant labelled Pass-Pass, outside of the cutscore-error bands, are those who clearly passed both examinations. Conversely, those in the lower-left quadrant labelled Fail-Fail clearly failed both examinations. Those in the upper left passed CAT and failed PP, and those in the lower right failed CAT and passed PP. This latter group is of most concern because they are the ones who might be impacted most negatively by a switch to CAT.

Eight candidates clearly passed the PP for licensure but have measures that would have clearly failed them on CAT. Because a key hypothesis for lower performance on the field test must be lower motivation on an examination that does not count towards licensure, these eight candidates were subjected to individual scrutiny for evidence of how seriously they took the CAT examination.

An indicator of earnestness in this endeavor is time spent on the examination. Because total time is also a function of the number of items taken, the average number of seconds spent on each item (secs-per-item, or SPI in tables) was used. All eight candidates had lower than average secs-per-item. Four of the candidates on whom different decisions were made, and one other who only marginally failed CAT, appear to have not taken the examination seriously. They are labelled A-E in Figure 1, and their data will not be used in the following analyses. An additional candidate, labelled F, is excluded because of its exteme outlier status, leaving 844 candidates. Table 2 summarizes these candidates' characteristics.

Table 2. Outlier Characteristics

Label	Std Diff	Items	Total Mins	CAT SPI	PP SPI	Eth	ESL	Rptr	Q1. Feel	Q26. Comp Exp	Q5. Good Way	Q21. Choice
A	-7	68	20	18	.	W	N	N	5	1	B	A
B	-5	68	16	14	48	W	N	N	1	4.5	A	B
C	-6	140	60	26	38	W	N	N	4	2.6	B	A
D	-4	196	75	23	35	W	N	N	1	5	A	B
E	-5	196	49	15	33	W	N	N	5	4	B	A
F	-9	68	96	85	64	H	Y	Y	4	3	B	A
Tot Grp Avg or Key	0	134	103	47				N= no Y= yes	Comfort: CAT vs PP 1=more 5=less Avg=2.4	1=inexp 5=quite exp Avg=2.8	A=Good way B=Only because other adv.	A=PPB = CAT C= either

The two most striking points, labelled A and B in Figure 1, took 18 and 14 secs-per-item. Candidate B's 14 secs-per-item average was the lowest in the entire sample. The average was 47 secs-per-item. Fourteen secs-per-item was also less than a third of the time that candidate spent on the PP items. Candidate B spent a total of 16 minutes on the entire examination. Candidate A, with a 18 secs-per-item average, was fourth quickest and spent a total of 20 minutes on the examination. Candidate C spent 26 secs-per-item, but had to take 140 items, and so spent an hour on the examination. Candidate E spent 15 secs-per-items, the second lowest in the study, and also spent less than half as much time on CAT items as on PP items.

The candidate labelled 'F' is excluded from further analyses for different reasons. Candidate F scored much lower than any other candidate on CAT. Candidate F failed PP (not for the first time--she was a repeater), but others scored lower. This candidate spent a long time on each item, 85 seconds and, from a review of her response pattern, appears to have attempted to answer each item (i.e. did not select the same option for all items). Spanish, rather than English, was this candidate's native language. To the NCLEX question, candidate F responded that she did not read English as well as her native language. Her -2.8 logit difference in measures translates to over nine SEdiffs. Candidate F is not excluded from the analyses because of an apparent attitude problem; she is excluded because her performance is so unlike that of any other candidates that it will not contribute to an understanding of how future candidates may perform on CAT.

The exclusion of these outliers leaves four candidates who clearly passed PP and clearly failed CAT. Figure 1a shows an enlarged view of the critical region. The group of four includes two black and two hispanic candidates, one of whom was male. All are native English speakers and none are repeaters. All but one are post-test candidates, who might be expected to have lower motivation than the pre-test group, because CAT could not help prepare them for their licensure examination. In fact, all four spent less than the average amount of time on each item. They had a variety of responses to the questions asking how they felt about CAT. Three of the four took all 196 items allowed, never reaching the 3SEM stopping rule.

Other candidates scored substantially higher on CAT than on PP. On Figure 1, a line of candidates who appear to float above and to the left of the majority of points, and outside of the confidence bands, is apparent. These candidates performed markedly better on CAT than on PP. This group includes a disproportionate number of ESLs. Fifteen percent of ESLs passed CAT but failed PP, in contrast to one percent of the ENLs.

Researh Question (1b): To what extent is there agreement between the pass/fail decisions made on the basis of CAT or PP examinations?

Pass/Fail Decisions. When the same passing standard of -.63 logits is applied to CAT measures as is applied to PP, CAT failed 18.7% of the 844 candidates, in contrast to the 11.7% who failed PP. This is consistent with the lower average measures on CAT.

Overall, CAT and the PP examination agreed on the pass/fail decisions of 87% of the candidates (89% of the reference group), 89% of the post-test candidates and 86% of the pre-test candidates. These proportions represent somewhat greater agreement than was found for the RNs (81% in July and 82% in February). The levels of agreement are shown in Table 3.

Table 3. Agreement on Pass/Fail Decisions by CAT and PP

		Paper-and-Pencil		
	Decision	Fail	Pass	Total
CAT	Fail	74	84	158 (19%)
	Pass	25	661	686 (81%)
	Total	99 (12%)	745 (88%)	844

The same decision was made on only 74% of the ESL candidates, in part because the proportion passing rose from 62% on the PP to 66% on CAT, despite the total group's lower average on CAT.

For the 286 candidates for whom CAT made a decision quickly, and who took fewer than 75 items, CAT and PP pass/fail decisions agreed on all but two (99%). Both of these failed CAT, but passed PP. A high degree of agreement is expected on these candidates, because they were classified as either passers or failers by CAT after relatively few items, indicating that they were performing well above or below the cutpoint. Candidates for whom the decision was not so clear, and who had to take 150 or more items, were classified the same way by CAT and PP 77% or the time. These were candidates near the cutscore, so some lack of agreement is not surprising. Candidates whose ability is truly close to the passing point may achieve different pass/fail decisions in any retest situation due to measurement error.

CAT and PP disagreed on pass/fail decisions for 2% of the candidates when both made 95% confident decisions (measure was more than 1.65 SEMs from the cutscore). When CAT was 95% confident, PP disagreed with 5% of the decisions, and when PP was confident, CAT disagreed with 8%.

Precision of Measurement

Figure 2 represents the precision (average SEM) of different measures, for both CAT and PP. The relationship between measurement precision and standard errors is that, as precision increases, the SEM decreases. The two examinations differ in where and how sharply they focus their measurement precision. The greatest precision (lowest SEM) for the PP examination is for low ability levels, -0.8 through -1.3. CAT's precision is greatest for abilities between -.2 and -1.0. A striking difference is in the extreme abilities. CAT is not measuring these candidates as precisely as the PP examination (fewer items are administered since these areas of the ability continuum are not as relevant to the licensure decision as the area near the cutscore). Another difference is the

lower CAT SEM for most candidates in the vicinity of the cutscore.

Also evident from Figure 2 is that all candidates with the same measure have the same SEM on the PP examination, but a variety of SEMs exist for each measure in CAT. On CAT, different candidates may take different numbers of items before they arrive at the same measure.

The average SEM for the 66 candidates within 0.1 logit of the passing score on PP is 0.154 (after 204 items) and for the 86 within 0.1 logit who took at least 180 items (as anyone who is that close to the cutscore will have to do when CAT is implemented) on CAT, the average SEM is 0.145. Both will be rounded to 0.15 for computations throughout this report.

One aberrant CAT candidate is apparent on Figure 2. She is the one close to the pass/fail line with a moderately high SEM, who appears to have had a clear decision made. A scattering of other candidates around the pass/fail line also have somewhat higher SEMs than the minimum. These candidates all had testing terminated by the proctor, ran out of time, or reached the 196 item maximum. However, the aberrant candidate was there for only 3 hours and 20 minutes and took only 100 items. None of the stopping rules apply to her. It is not clear why this candidate's examination ended when it did, and the proctor's journal provides no clues.

The sprinkling of candidates within the three SEM band who appear to have had confident decisions made represent the outcome of the inconsistency in the software mentioned above. The decision to terminate their examination was made before all of the content categories had been filled, and was not reevaluated after the necessary additional items were administered.

The KR-20 reliability of the PP examination is .88. The marginal-reliability estimate calculated for the CAT examination is .87.

Decisions At 1.65 SEMs from Cutscore

A comparison of the pass/fail decisions that would have been made if testing had ended when the ability estimate exceeded 1.65 SEMs from the cutscore, rather than continuing until it was more than three SEMs away, is shown in Table 4. Only 9 candidates (of the 838 available for this analysis) would have had different decisions made. An investigation of these candidates revealed that all nine had much higher ability estimates at the time of the 1.65 SEM decision, and that the decision was made after relatively few items, whereas the 3SEM decision in fact was never made -- they all took the maximum of 196 items. This led to the suspicion that the candidates had quit attempting to answer questions after a certain point in time, perhaps from fatigue or boredom.

Figures 3 and 4 show maps of the performance of the candidates with the least and most difference (respectively) between their measure at the time of the 1.65 SEM decision and at the end of the examination. Both of them, and the other seven who had different decisions made, showed a typical "zig-zag" pattern of ability estimates only for the beginning of the examination. At some point, all nine candidates showed a dramatic shift in pattern to an sharp descent in ability estimates. They evidently became less attentive to the correctness of their answers. This pattern suggests that the measure of their ability when the decision was made at 1.65 SEMs might have actually been a better reflection of their ability than the one at the end of the examination. These results suggest that the stopping rule to be implemented in the live CAT, of requiring measures to be 1.65 SEMs away from the cutscore, provides sufficient precision that continued testing would not change the decisions for many, if any, candidates, unless fatigue or boredom became an issue.

Table 4. Agreement on Pass/Fail Decisions at 1.65 SEMs and Made by Field Test

		Field Test Decision		
	Decision	Fail	Pass	Total
1.65 SEM Decision	Fail	151	0	151
	Pass	9	678	687
	Total	160	678	838

Time Spent and Number of Items Taken

The largest number of candidates finished CAT in about an hour (see Figure 5). These measures of time spent include only time spent answering items. Keyboard training-time is not included in these computer-recorded times, so more candidates were stopped by proctors after four hours than is apparent from the low number shown at 240 minutes. Proctors reported total times of four hours for seven candidates. Time to finish the examination is related to both secs-per-item and the number of items taken. Almost one-third of the candidates were released after only 68 items, and another 40% had to stay for all 196. The other third is distributed between these extremes (see Figure 6).

Research Question (2a): Is the relationship between the ability estimates the same for investigated subgroups of candidates?

Standardized Differences. Figures 7 and 8 show the relationship between PP measure and the difference between CAT and PP. Positive differences result from higher CAT measures, and negative from higher PP. The standardized differences themselves are the number of SEdiffs between the two measures. The vertical dotted line at -.63 marks the pass/fail score on the PP examination. The horizontal dotted lines at +2 and -2 define the region within which differences could be expected to fall by chance alone.

Figure 7 has each candidate identified as either ESL or ENL and Figure 8 identifies each by ethnic affiliation. Each group has a regression line plotted, allowing comparison of the relationship across groups. The regression line for the four Native American candidates is omitted. All four passed both examinations, and any trend line based on only four observations is misleading.

The regression line for ESL candidates in Figure 7 reveals what the passing percentages also demonstrated: ESL candidates, especially the lower scoring ones, consistently do better on CAT than on PP. Throughout most of the range of the ability distribution, ESL candidates profit more from CAT than the ENLs (their regression line is above that of the ENLs). Measures for ESL candidates were more similar on CAT and NCLEX, on the average, than were those of the ENL candidates. The average standardized difference for the 87 candidates who identified themselves as ESLs was .01 and for the 715 who identified themselves as native-English speakers, it was -.54 (.12 logits before standardization).

In Figure 8, the regression line for the White group is the solid line that is the lowest on the left end of the plot. The lines for Blacks and Hispanics fall so close together that they appear to be solid on the left (above the line for Whites), but separate slightly to the far right. For abilities below the passing score, all other ethnic groups have the same or greater advantage on CAT as the White group. Note that all seven of the failing PP candidates who improved more than two SEdiffs on CAT (those in the upper left quadrant) were Black or Asian. For all groups, it appears to have been the high scorers who did less well on CAT.

Seconds-per-item. Previous research has demonstrated that ESLs may feel time pressure on the PP examinations. CAT offers them the opportunity to take as long on each item as they wish, because they know that items they do not reach will not be automatically scored wrong. They may not complete enough items for a confident decision to be made about them or the maximum number of items in the time allowed, but they have been able to control their pace. A potential disadvantage for those who run out of time would be encountering a different stopping rule than those who finish in less than the allowed time. The "ran-out-of-time" stopping rule requires that an estimated ability above the passing score on each of the last sixty items in order to pass.

ESL candidates spent an average of 60 secs-per-item, in contrast to the ENLs, who spent an average of 45 secs-per-item (see Figure 9). On the PP examination ESLs averaged 55 secs-per-item and ENLs, 47. The average ESL spent 5 secs-per-item more on CAT than on PP, and the average ENL spent 2 seconds less.

Figure 10 is a plot of the relationship between secs-per-item and standardized difference with ESL and ENL candidates distinguished. Many of the candidates who scored much lower on CAT than PP (had large negative differences) spent little time on the items. Almost no candidates who spent more than 70 secs-per-item did significantly worse on CAT. Many of these candidates were ESLs.

Time spent on items was also strongly associated with whether the candidate took CAT before or after PP. Figure 11 is the same as Figure 10, but with pre- and post-test candidates distinguished. The post-test candidates tend to cluster in the low secs-per-item, and the pre-test, in the higher. Those who took CAT as a pre-test spent an average of 2 secs-per-item longer on CAT items than on PP items, but those who took CAT as a post-test spent 3 seconds less than on PP items. Figure 12 is an equivalent Figure with the ethnicities distinguished. It indicates that for all ethnic groups except Asian, with more time spent on the items, there is an increased probability that the CAT performance would be higher than the PP performance.

Gender, ethnicity, repeaters, and foreign-educated. Table 5 shows the average CAT and PP measures, and the average CAT minus PP (CAT-PP) difference for all candidates in each demographic group. Within the reference group (Table 6), there was no significant difference in CAT-PP contrast among the ethnicities, although differences do exist when repeaters and foreign-educated candidates are included. (A probability of .05 or less was used to indicate significance for all statistical tests.) Overall, there was no significant difference between repeaters' and first-time takers' CAT-PP contrast, although the measure difference was greater for foreign-educated than US-educated candidates.

Pre- and post-test. Because of the concern about motivation differences for pre- and post-test candidates, the relationship of demographic variables and measures was investigated separately for pre- and post-test candidates within the reference group. Foreign-educated candidates had a greater difference between CAT and PP measures only within the pre-test group. In regression analyses, pre-test candidates had Asian ethnicity and secs-per-item (both with positive loadings) as significant predictors of the CAT-PP difference (and explained 15% of the variance), and for post-test candidates, Hispanic ethnicity (with a negative loading) and secs-per-item were significant (and explained 11% of the variance).

Attitudes and Experience. Questionnaire items asked the candidate to either pick one of several offered responses, or to mark a point on a continuum. Those items producing continuous variables were included in a regression analysis predicting CAT-PP difference. In addition to secs-per-item, whether they felt rushed to finish the examination, predicted 14% of the variance of the CAT-PP difference.

Again, the results for pre- and post-test candidates differed. For the post-test candidates, Hispanic ethnicity, secs-per-item, Male gender, perceived impact of being able to go back to change answers and whether they felt rushed contributed to an explanation of 19% of the variance. For pre-test candidates, secs-per-item, Asian ethnicity, and feelings about CAT contributed to explaining 14% of the variance.

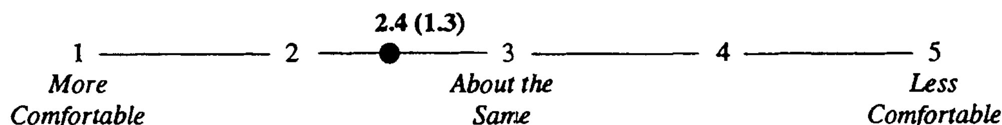
Research Queston (2b): Are attitudes and experiences reflected in the questionnaires related to differences in performance between CAT and PP?

Questionnaire Results

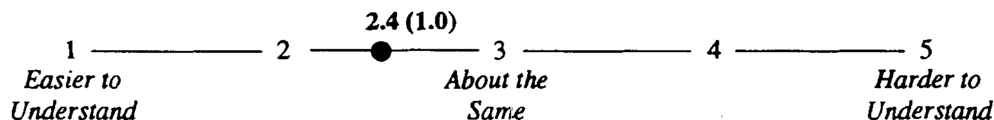
On average, the field test volunteers were slightly inexperienced with computers (average = 2.8 on a 1-5 scale), although only four percent thought that CAT was a poor way to test. Less than one percent (4 candidates) felt that the keyboard training did not prepare them to take the CAT examination.

The following questionnaire items assessed candidates' reactions to CAT in relation to the PP administration. As language used in the post-examination questionnaires differed slightly for pre-test and post-test administrations, language used in the pre-test questionnaire appears in parentheses in questions #1 and #2. Average responses are indicated on the rating scale, with the standard deviation in parentheses:

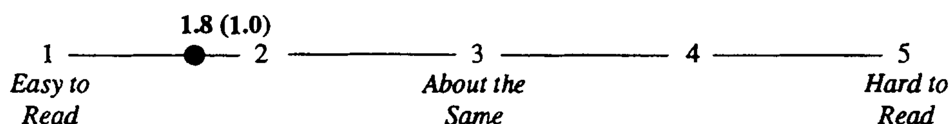
1. How did you feel about taking this test administered by computer in comparison to taking the NCLEX (similar tests) using pencil-and-paper?



2. In comparison to the format in which the questions appear in the paper-and-pencil test (paper-and-pencil tests), was the computerized format?



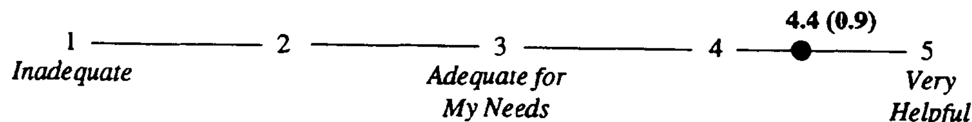
3. Were the questions in the computerized format easy or hard to read?



Candidates felt slightly more comfortable taking the test on computer than as PP, on the average. They thought items were somewhat easier to understand, and markedly easier to read.

Candidate reactions from the post-examination questionnaire (Questions #6, #7, and #8) show that the keyboard training is both effective and essential:

6. The instructions explaining how to use the computer for testing were:



7. The keyboard training exercise (about how to use the keys) at the start of the test:

	Percent
taught me all I needed to know to take the test using the computer...	93.3
taught me almost everything I needed to know to use the computer to take the test...	6.2
did not teach me nearly enough to use the computer to take the test ...	0.4

8. The printed instruction card was:

	Percent
Very useful	41.0
Somewhat useful	18.5
Not useful at all	2.1
Unnecessary, due to the training exercise	38.4

These data show that the instructions, and particularly, the hands-on training in how to use the computer and keyboard, are helpful and important. Although many candidates found the printed instruction card unnecessary due to the keyboard training exercise, even more found it useful. The responses to #7 show that candidates had no difficulty in using the computer.

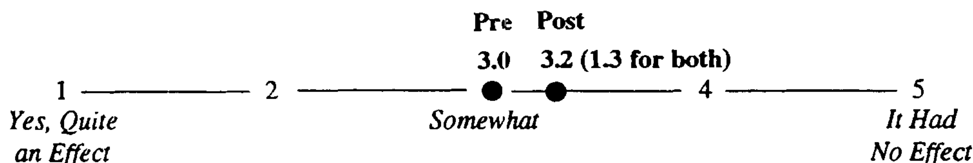
In comparing the pre-test and post-test groups, the questionnaire revealed significant differences in candidates' responses to two questions. These related to:

* proctors' availability during the test,
* the perceived effect of not being able to change answers.

The first difference, that of the availability of the proctors during testing, may by attributed to the software problems encountered during the pre-PP testing session, necessitating the proctors be in the room to monitor the keyboard familiarity exercise, startup of the tests, and any unusual incidents during testing. However, these problems were corrected in the software for the post-test, and the presence of the proctors may have been less obvious.

Candidates taking the CAT examination before the PP believed their inability to return to earlier questions affected their performance more than the group taking the CAT examination after the PP. The probability of this difference occurring by chance for this comparison is 0.006.

19. Do you feel that the inability to return to earlier questions on the computerized test affected your performance?



Overall, candidates believed that the inability to return to previous answers affected their performance "somewhat".

Appendix A details average or frequency of candidate responses to each item on the post-examination questionnaire. All averages and frequencies represent both pre-test and post-test groups combined, except where statistically significant differences occur and are noted.

DISCUSSION

Measure Differences

Overall, measures were slightly lower on CAT than on the PP examination, as they were in the RN Field Test, but this did not hold true for all groups of candidates. ESL and Asian candidates, in particular, seemed not to be at a consistent disadvantage on CAT.

Pass/Fail Agreement

The two modalities agree on pass/fail decisions for 87% of the candidates, with no adjustment for lower overall scores on CAT. The four individual candidates who decisively passed their licensure examination, but clearly would have failed CAT were investigated individually. At least two of these candidates did not take the examination seriously, spending 20 minutes or less on the entire examination. None of them spent even the average amount of time on individual items. None of them responded that, given the choice between computerized and paper examinations, they would choose CAT.

Relationship of Time to Performance

A relationship exists between time spent on each item and the difference between CAT and PP performance measures only for the candidates who took CAT after the PP, if ESL is taken into account. Several of these candidates spent very little time on each item and scored quite poorly. They had no need to use CAT as a study-guide for the NCLEX, and finished the examination in less than an hour. Among those who spent reasonable amounts of time on items, a relationship with the standardized difference still exists, but is almost entirely explained by English-language status. ESL candidates took more time on items than ENLs, and also had more positive differences between CAT and PP, although their average CAT performance was still lower than that of ENLs. A possible explanation is that the PP examination has not allowed them enough time to perform as well as they are able, and CAT, with its essentially unlimited available time for each item, enabled them to perform better.

Effect of CAT on Protected Groups

Only Asians scored significantly higher on CAT than on the PP examination. No other ethnicity had more of a decrease in average measure between PP and CAT than the Caucasian group.

Covariates

Candidates responded that the training prepared them for CAT, and that they had no trouble reading or answering the items on the computer. This suggests that requiring candidates to use a computer or keyboard to record their answers to test questions does not invalidate CAT as a testing modality, provided candidates are given adequate

instructions and training prior to testing.

Previous experience with computers is not related to either performance on CAT or to the difference between CAT and PP measures.

Comparison with RN Field Test Results

The RN Field Test was conducted around two PP examination dates, February and July. The results sometimes differed, probably because of the different nature of the candidate populations for those two examinations. The October PN examination more closely resembles the July, in that it is the administration date most closely following school graduation dates, and is by far the larger administration.

In many ways, the PN results fall between those of the two RN administrations. The correlation of CAT and PP measures (.76) is between those of February and July (.71 and .83), and the average difference in CAT and PP measures (.12) is also between those of February and July (.06 and .16).

In classification agreements, the PN examinations outperform the RN. Overall, the PN examinations agreed on 85% of the candidates, and the RN examinations agreed on only 81% and 82%. On decisions made by one or both examinations with 95% confidence, the PN examinations outperformed the February RN examinations, but performed comparably with the July. Standard errors were smaller for all RN examinations than for the PN, because more items were administered.

CONCLUSIONS

CAT and the PP NCLEX examinations appear to be measuring the same traits, and the lower measures on CAT that were found are not consistently related to any of the covariates, such as computer experience or ethnicity. In fact, the performance of some protected demographic groups was closer to that of the majority on CAT than on the paper-and-pencil NCLEX.

Table 1. Demographic Characteristics of Sample with Complete Measure Information

	Group	Final Analyses Freq	Final Analyses Percent	Took CAT Freq	Took CAT Percent
When CAT Taken					
	Pre-PP	364	43%	424	46
	Post-PP	480	57	488	54
Gender					
	Female	735	87	799	88
	Male	109	13	113	12
Ethnicity					
	Asian	61	7	64	7
	Black	190	22	197	22
	White	532	63	582	64
	Hispanic	55	7	63	7
	Native American	4	1	4	1
Repeater					
	No	775	92	836	92
	Yes	69	8	76	8
Education Country					
	US	817	97	881	97
	Foreign	25	3	27	3
Native Language					
	English	741	88	770	89
	Other	101	12	94	11
Jurisdiction					
	Guam	20	2	22	2
	Louisiana	140	17	150	16
	Missouri	153	18	154	17
	New Jersey	127	15	141	16
	Ohio	143	17	150	16
	Texas	118	14	133	15
	Washington	149	18	162	18
Total		844*		912	

* Rows may not add to 844 because some candidates did not provide demographic information.

Table 5. Average Performance for Those with Complete Measure Information

Group		Count	Average Measure		Differ	Percent Failing	
			CAT	Paper		CAT	Paper
When CAT Taken							
	Pre-PP	364	-.22	-.10	-.12	23.1	13.7
	Post-PP	480	-.11	-.02	-.09	15.4	10.2
Gender							
	Female	735	-.14	-.03	-.11	18.1	10.9
	Male	109	-.27	-.21	-.06	22.9	17.4
Ethnicity							
	Asian	61	-.45	-.51	.06	32.8	37.7
	Black	190	-.44	-.34	-.10	36.8	26.3
	White	532	.00	.12	-.12	9.4	3.0
	Hispanic	55	-.38	-.26	-.12	29.1	16.4
	Native American	4	.08	.12	-.04	0	0
Repeater							
	No	775	-.10	.01	-.11	14.6	7.7
	Yes	69	-.80	-.75	-.05	65.2	56.5
Education Country							
	US	817	-.14	-.03	-.11	17.4	10.0
	Foreign	25	-.81	-.90	.09	64.0	68.0
Native Language							
	English	741	-.12	.00	-.12	16.5	8.1
	Other	101	-.43	-.47	.04	33.7	37.6
Total Analysis Group		844*	-.16	-.05	-.11	18.7	11.7

* Rows may not add to 844 because some candidates did not provide demographic information.

Table 6. Average Performance for Reference Group (US-Educated, First-time Takers)

	Group	Count	Average Measure		Differ	Percent Failing	
			CAT	Paper		CAT	Paper
When CAT Taken							
	Pre-PP	328	-.15	-.03	-.12	8	18
	Post-PP	438	-.06	.04	-.10	12	7
Gender							
	Female	667	-.08	.04	-.12	14	7
	Male	99	-.22	-.15	-.07	13	20
Ethnicity							
	Asian	35	-.25	-.25	0.00	20	17
	Black	166	-.38	-.28	-.10	31	22
	White	513	.02	.14	-.12	8	2
	Hispanic	48	-.30	-.17	-.13	21	8
	Native American	4	.08	.12	-.04	0	0
Repeater	- Not Applicable						
Education Country	- Not Applicable						
Native Language							
	English	693	-.08	.05	-.12	14	5
	Other	73	-.31	-.34	.03	13	17
Total Analysis Group		766	-.10	.01	-.11	14	7

Appendix A

NATIONAL COUNCIL OF STATE BOARDS OF NURSING COMPUTERIZED ADAPTIVE TEST FIELD TEST QUESTIONNAIRE

** **All candidate responses are cumulative for Pre-NCLEX and Post-NCLEX administrations. Where statistically significant differences occur (Questions #16 and #19), both Pre-NCLEX and Post-NCLEX results are indicated separately.**

Please complete the following questionnaire to help the National Council evaluate CAT. You must return this questionnaire before leaving. Thank you.

Please place an X on the scale (or circle the letter) corresponding to your response.

1. How did you feel about taking this test administered by computer in comparison to taking the NCLEX (similar tests) using pencil-and-paper?

2.36

1 - - - - - - - - - - - - - 2 - - - * - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - 5

More Comfortable — About The Same — Less Comfortable

2. In comparison to the format in which the questions appear in the paper-and-pencil test (paper-and-pencil tests), was the computerized format?

2.44

1 - - - - - - - - - - - - - 2 - - - - -*- - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - 5

Easier To Understand — About The Same — Harder To Understand

3. Were the questions in the computerized format easy or hard to read?

1.77

1 - - - - - - - - - -*- - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - 5

Easy To Read — Hard To Read

4. If others finished the computerized test before you, how did that affect your performance?

A. Quite a bit **(79)**
B. Somewhat **(160)**
C. It had little effect **(377)**
D. I finished early **(285)**

5. What do you think about testing in the computerized format?

   A. It is a good way to test under any circumstances. **(463)**

   B. It is an acceptable way to test only because it provides other advantages such as more frequent administrations. **(394)**

   C. It is a poor way to test. **(37)**

6. The instructions explaining how to use the computer for testing were:

4.37
1 - - - - - - - - - - - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - -*- - - - - - - - - 5
Inadequate — Adequate For My Needs — Very Helpful

7. The computerized keyboard training exercise (about how to use the keys) at the start of the test:

   A. taught me all I needed to know to take the test using the computer. **(840)**

   B. taught me almost everything I needed to know to use the computer to take the test. **(56)**

   C. did not teach me nearly enough to use the computer to take the test. **(4)**

8. The printed instruction card was:

   A. very useful **(369)** B. somewhat useful **(166)** C. not useful at all **(19)**

   D. unnecessary, due to the keyboard training exercise **(345)**

9. How difficult was it for you to manipulate the keys to choose an answer?

1.11
1 -*- - - - - - - - - - - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - - 5
Not Difficult — Somewhat — Very Difficult

10. The wait between answering one question and having the next question appear on the screen was:

1.64
1 - - - - - - - -*- - - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - - 5
Not Noticeable — Acceptable — Much Too Long

11. Did you feel rushed while taking the test on the computer?

1.48
1 - - - - - -*- - - - - - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - - - 4 - - - - - - - - - - - - - 5
Not At All — Sometimes — Always

Please rate each of the following testing environmental features from 0 (very bad) to 5 (very good)

12.	the room layout	4.49
13.	the testing stations	4.59
14.	the noise level	4.51
15.	the physical act of taking a test by computer	4.35
16.	proctors' availability for help	Pre - 4.90 Post - 4.84
17.	parking at the testing center	4.75

18. How much reading was there on this test (as compared to the paper-and-pencil NCLEX)?

3.82

1 - - - - - - - - - - - - - - 2 - - - - - - - - - - - - - 3 - - - - - - - - - - - * - - 4 - - - - - - - - - - - - - - - 5

Much More Reading — Somewhat More Reading — Not Noticeably More Reading

19. Do you feel that the inability to return to earlier questions on the computerized test affected your performance?

Pre 2.97 **Post** 3.20

1 - - - - - - - - - - - - - - 2 - - - - - - - - - - - - -*- 3 - - * - - - - - - - - - - - - 4 - - - - - - - - - - - - - - 5

Yes, Quite An Effect — Somewhat — It Had No Effect

20. How difficult were the questions you had to answer?

2.93

1 - - - - - - - - - - - - - - 2 - - - - - - - - - - - -*- - 3 - - - - - - - - - - - - - - 4 - - - - - - - - - - - - - - 5

Very Difficult — Moderately Difficult — Very Easy

21. If you had a choice of formats in which to take the NCLEX, which would you choose?

A. Paper and pencil format **(228)**

B. Computerized format **(462)**

C. The two formats would be equally acceptable to me **(216)**

22. How long did you have to travel to take the CAT test?

A. less than 1 hour **(365)**

B. 1 - 2 hours **(396)**

C. more than 2 hours **(147)**

23. How long will (or did) you have to travel to the NCLEX?

    A. less than 1 hour **(229)**

    B. 1 - 2 hours **(298)**

    C. more than 2 hours **(378)**

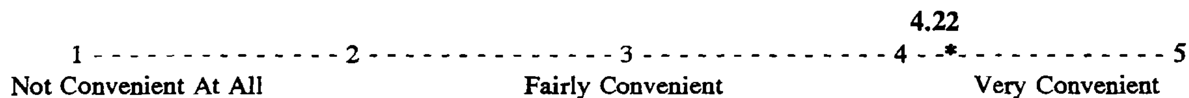
24. Did there seem to be an excessive number of questions with a particular type of content?

    A. No **(620)**

    B. Yes **(287)**

    If your answer was yes, please specify the content type: ________________________________

25. If you scheduled your own CAT exam, how convenient was the procedure used for scheduling your CAT test?



26. How do you rate yourself in using computers in general?

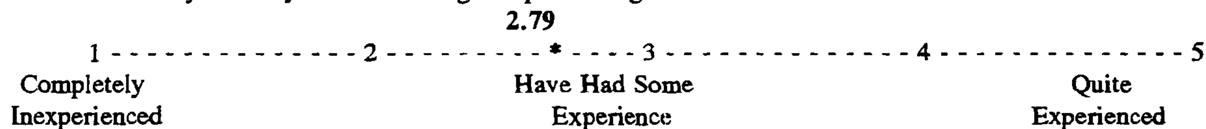


Figure 1. Comparison of CAT and Paper Measures

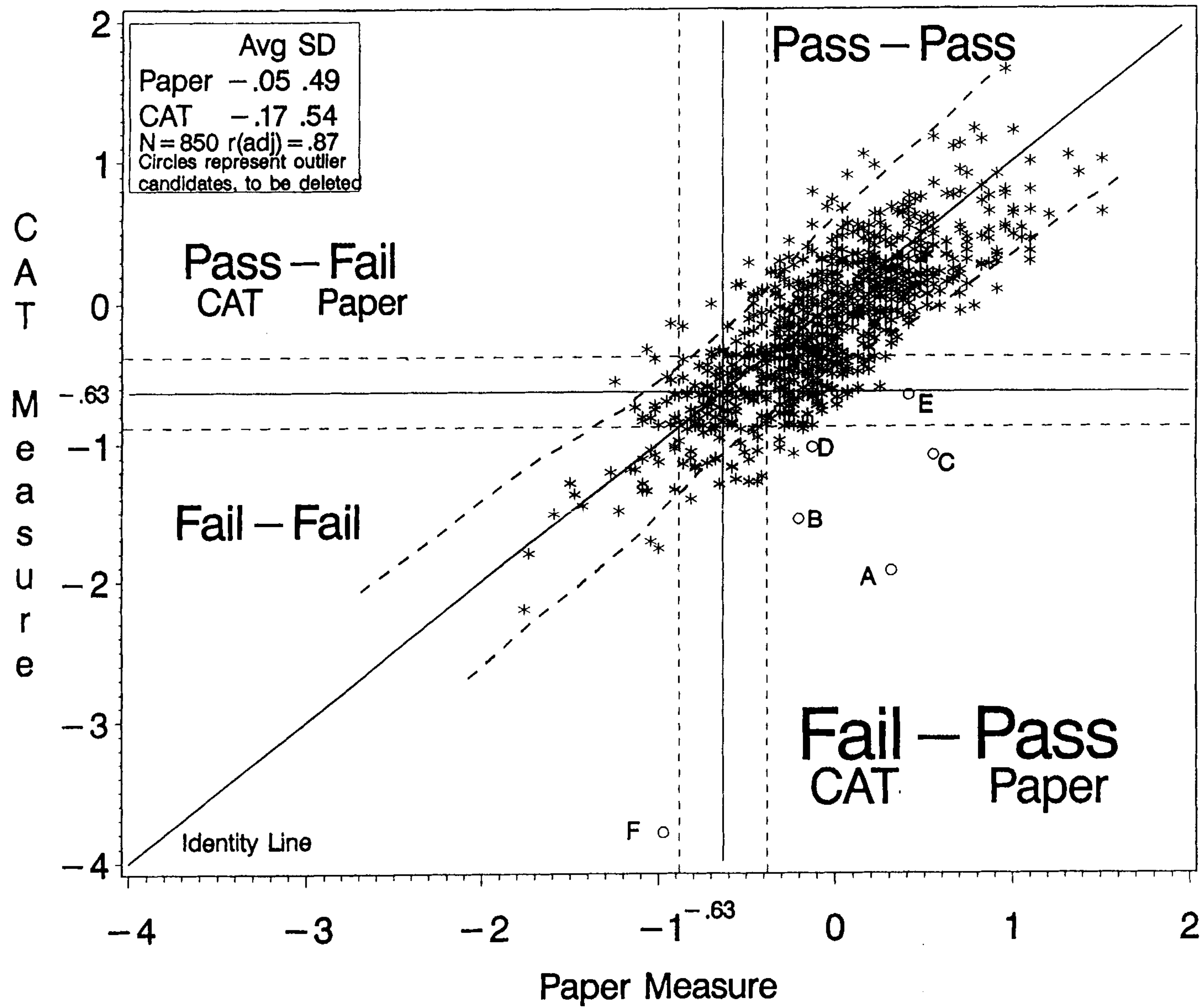


Figure 1a. Comparison of CAT and Paper Measures –
Excluding Outliers

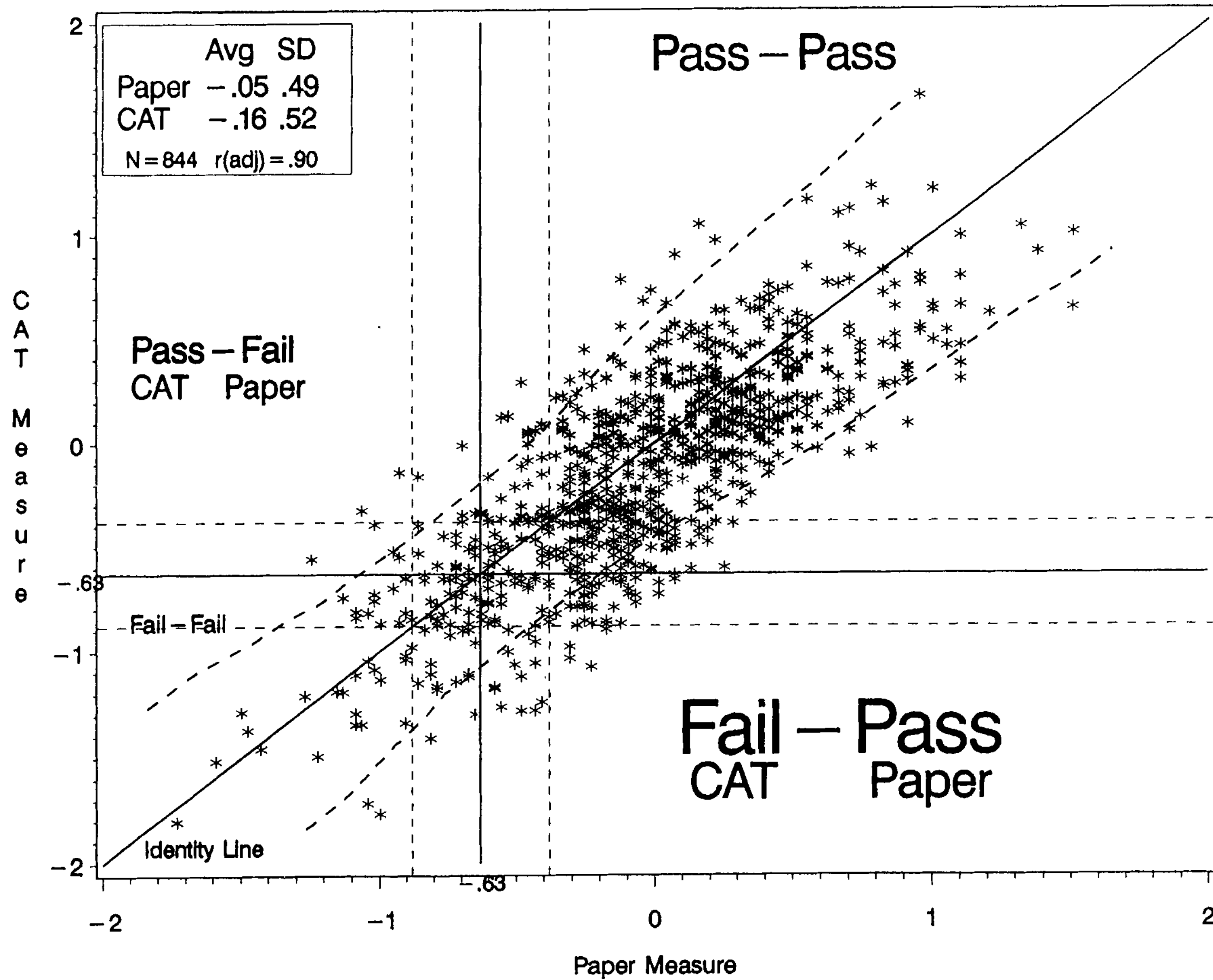


Figure 2. Comparison of Paper and CAT Standard Errors

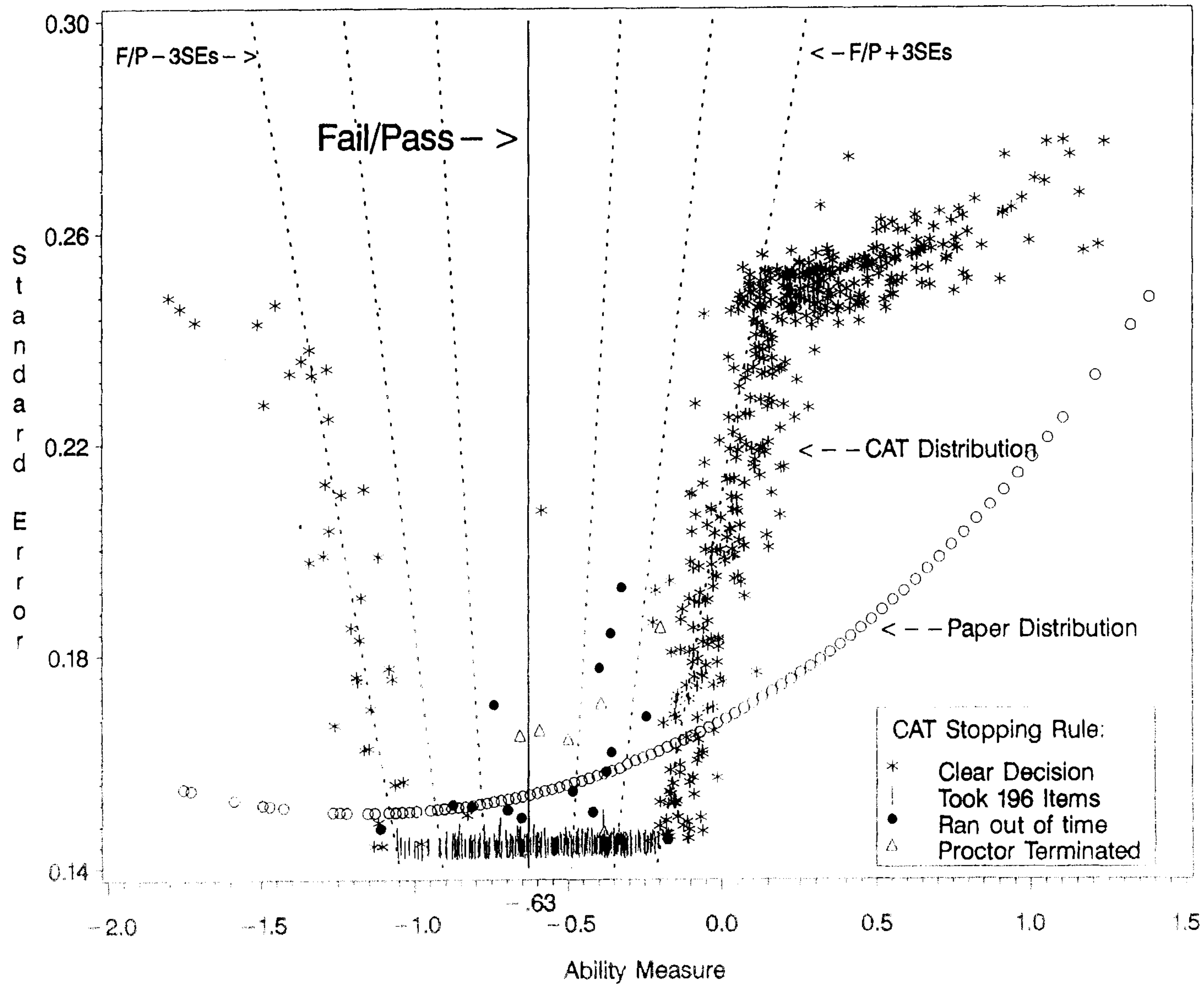


Figure 3. One Candidate's Progress Through Examination

Passed with 1.65 SE Decision Rule, Failed with Field–Test Rules

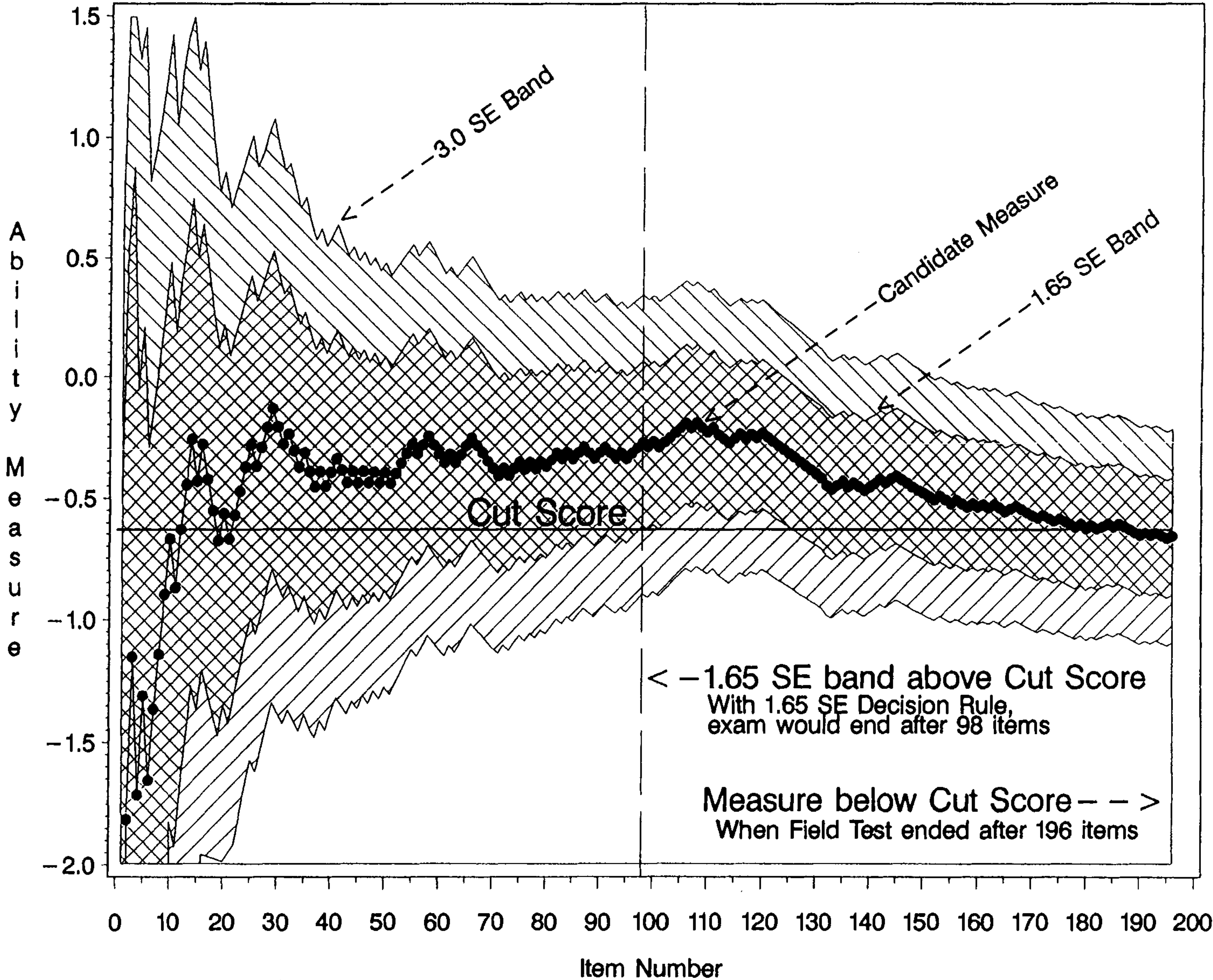


Figure 4. One Candidate's Progress Through Examination

Passed with 1.65 SE Decision Rule, Failed with Field–Test Rules

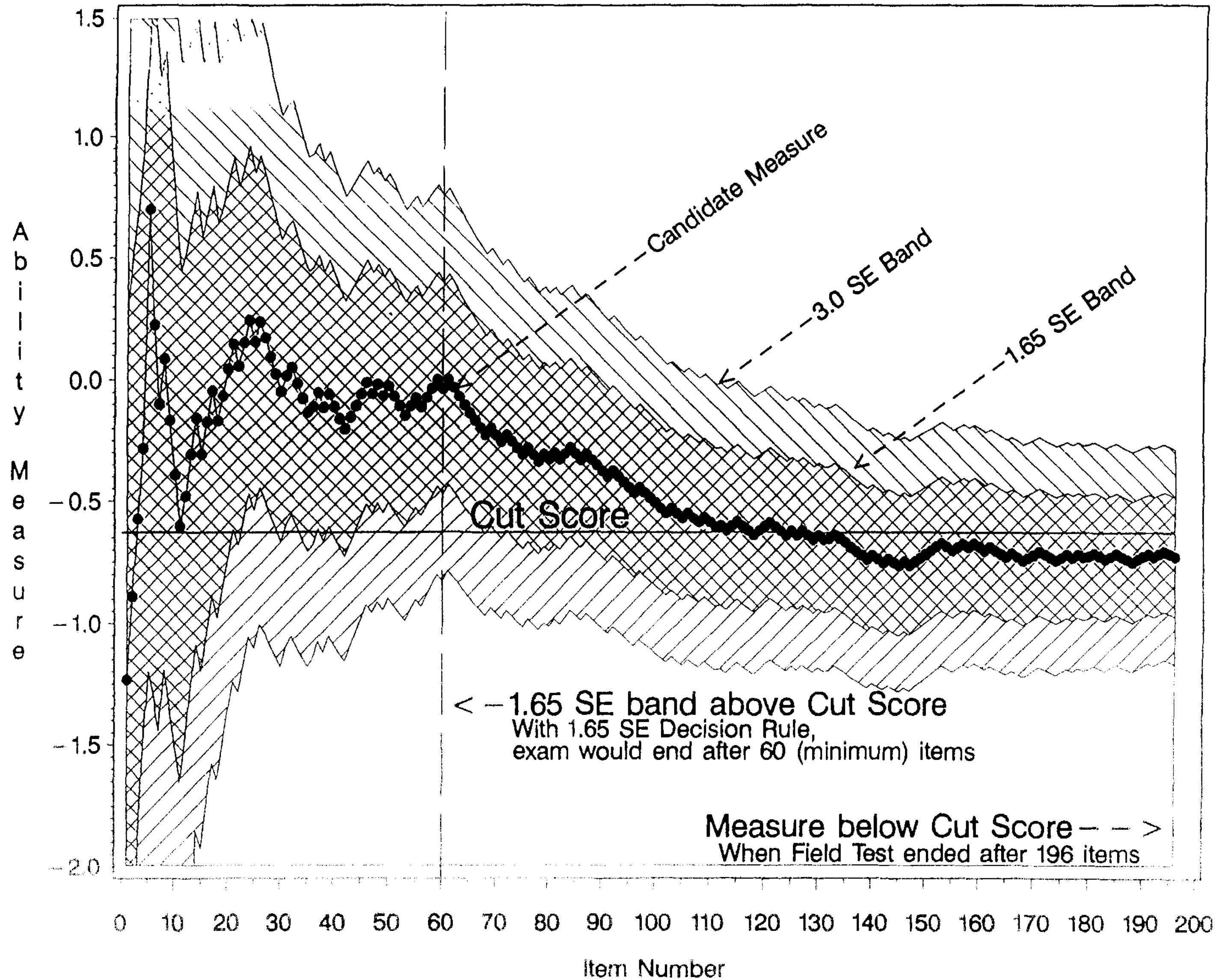


Figure 5. Time Spent on CAT

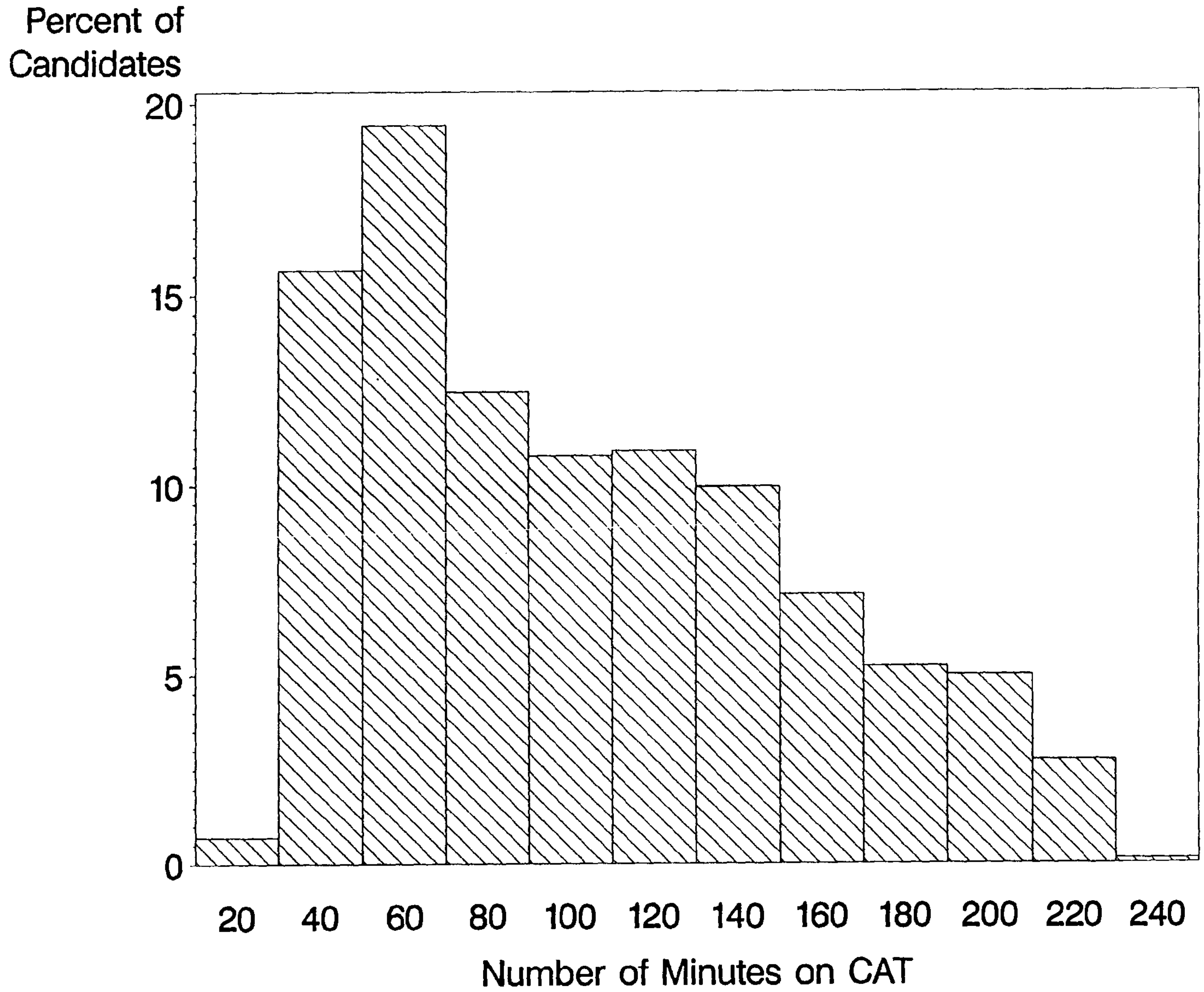


Figure 6. Number of Items Taken

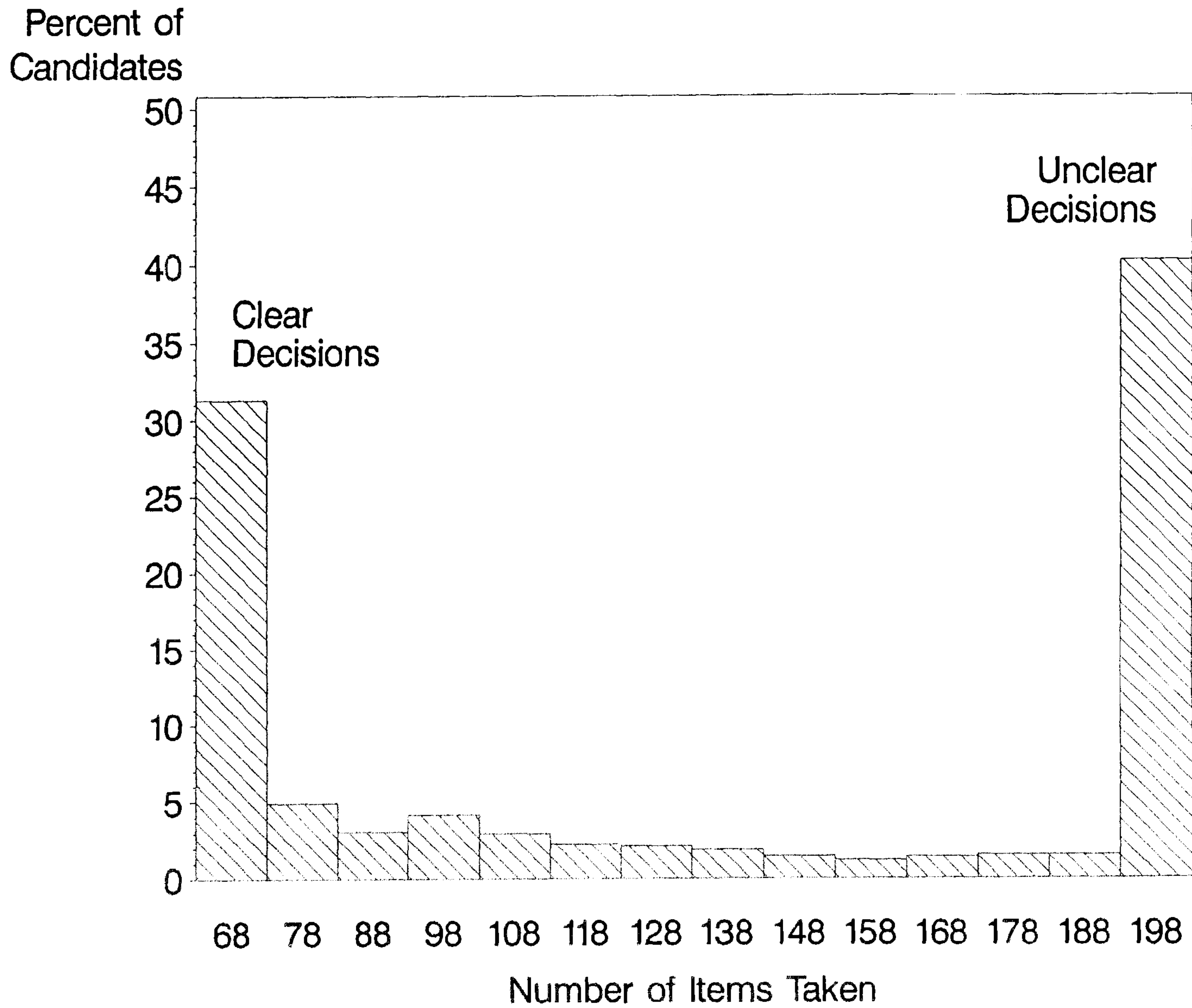


Figure 7. Comparison of Standardized Difference with Paper Measure, By ESL

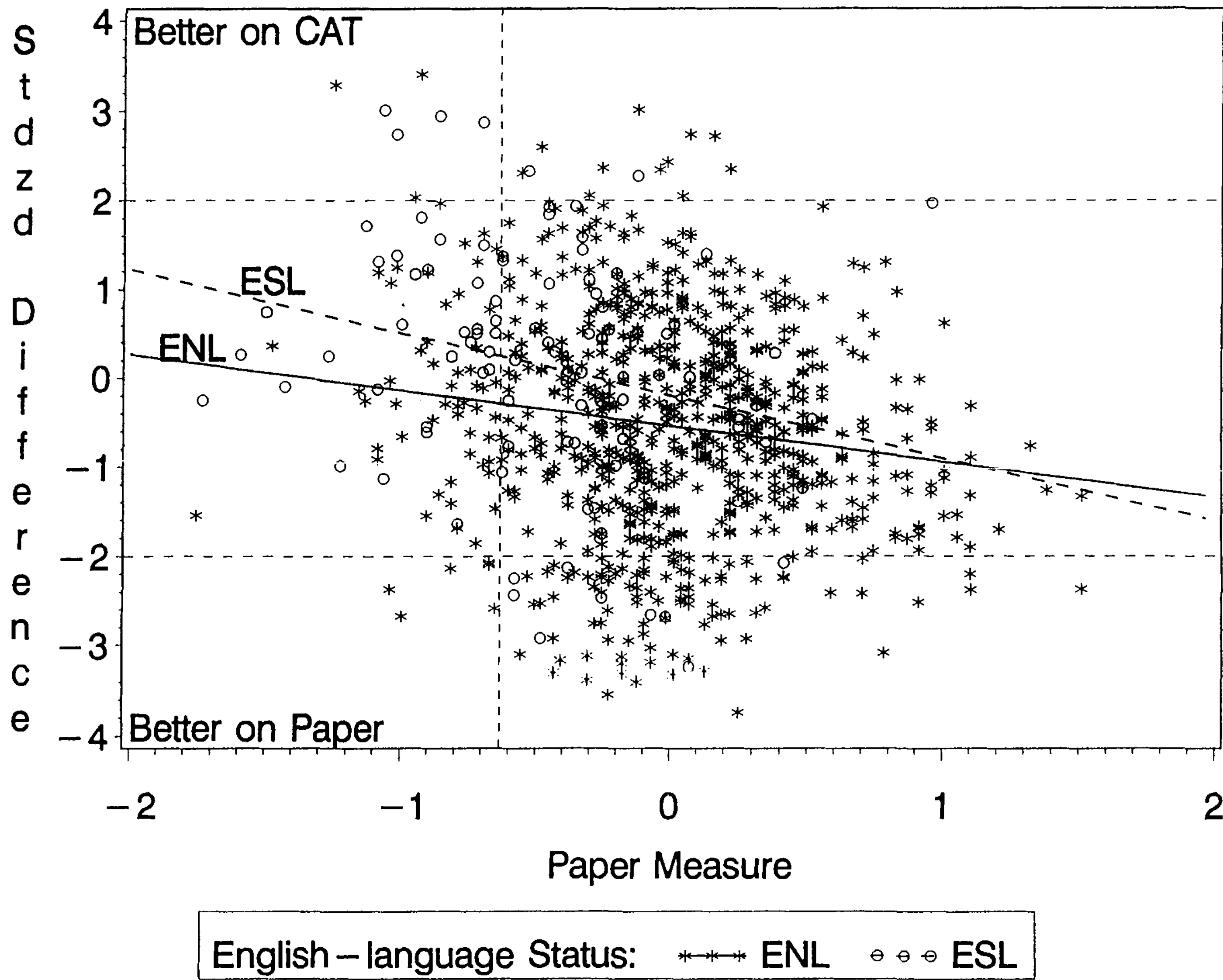
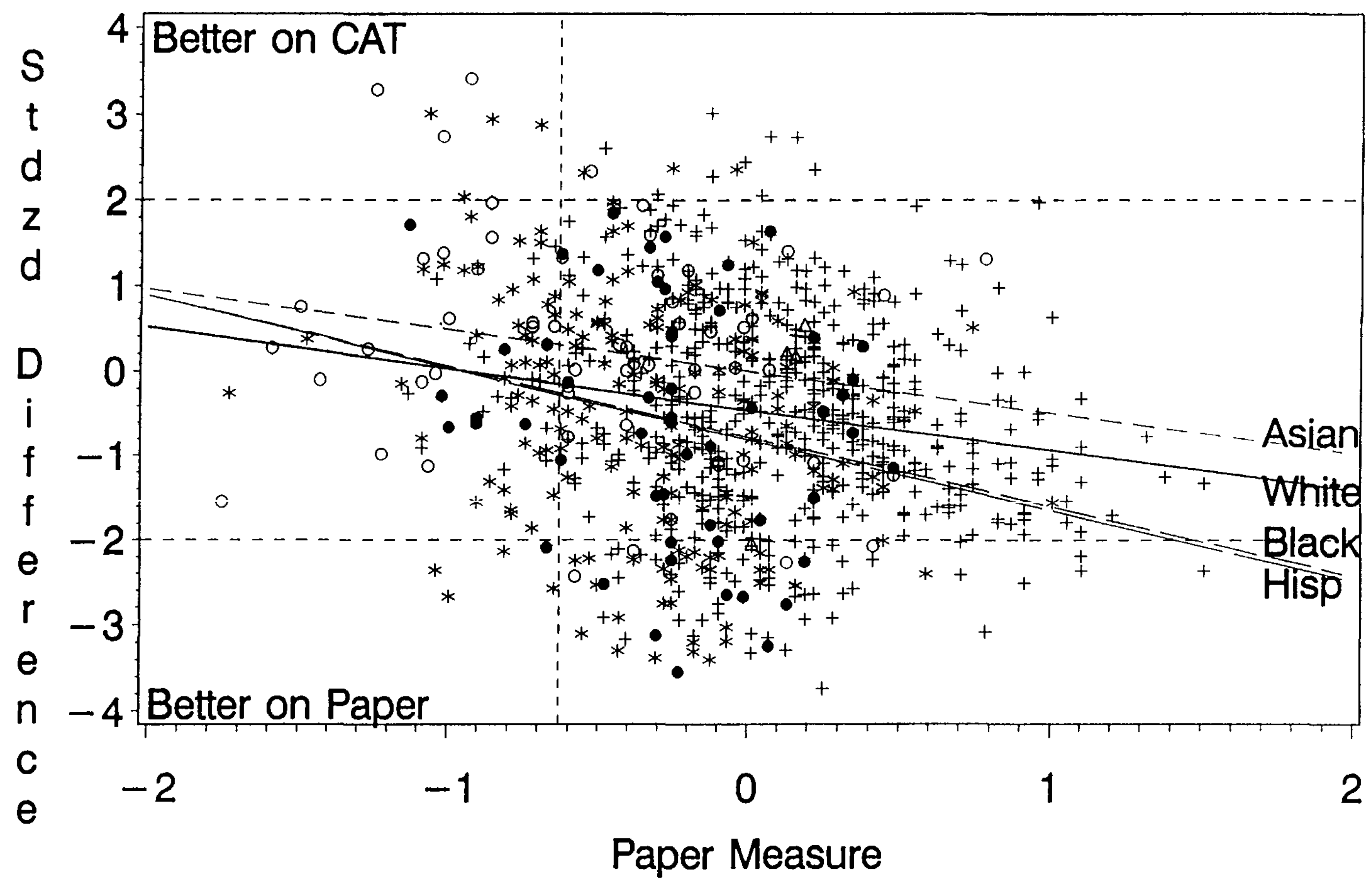


Figure 8. Comparison of Standardized Difference with Paper Measure, By Ethnicity



Ethnicity: Asian; White; Native American; Black; Hispanic

Figure 9. Average Seconds Spent on CAT Items, by ESL

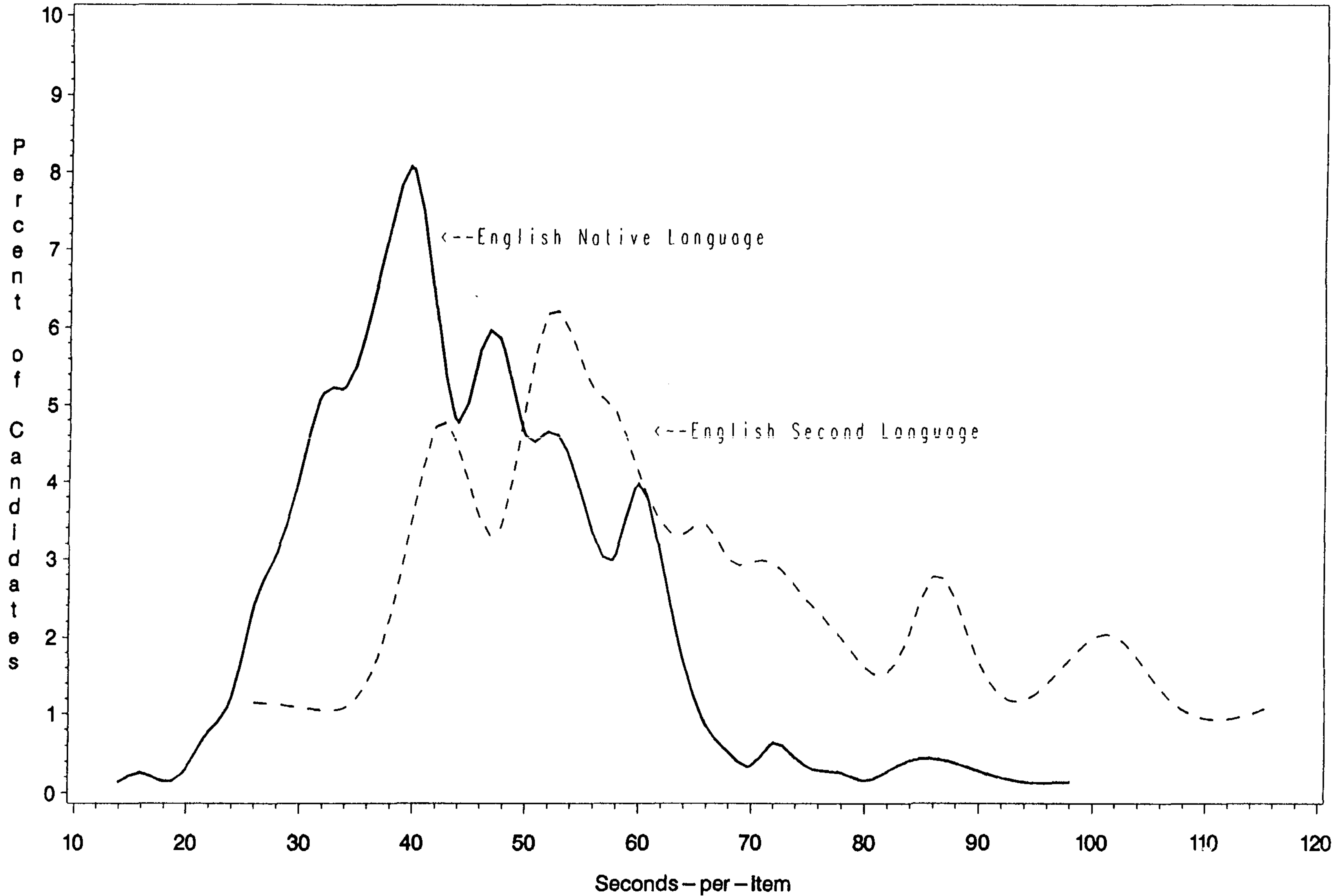


Figure 10. Comparison of Standardized Difference with Seconds – per – Item, By ESL

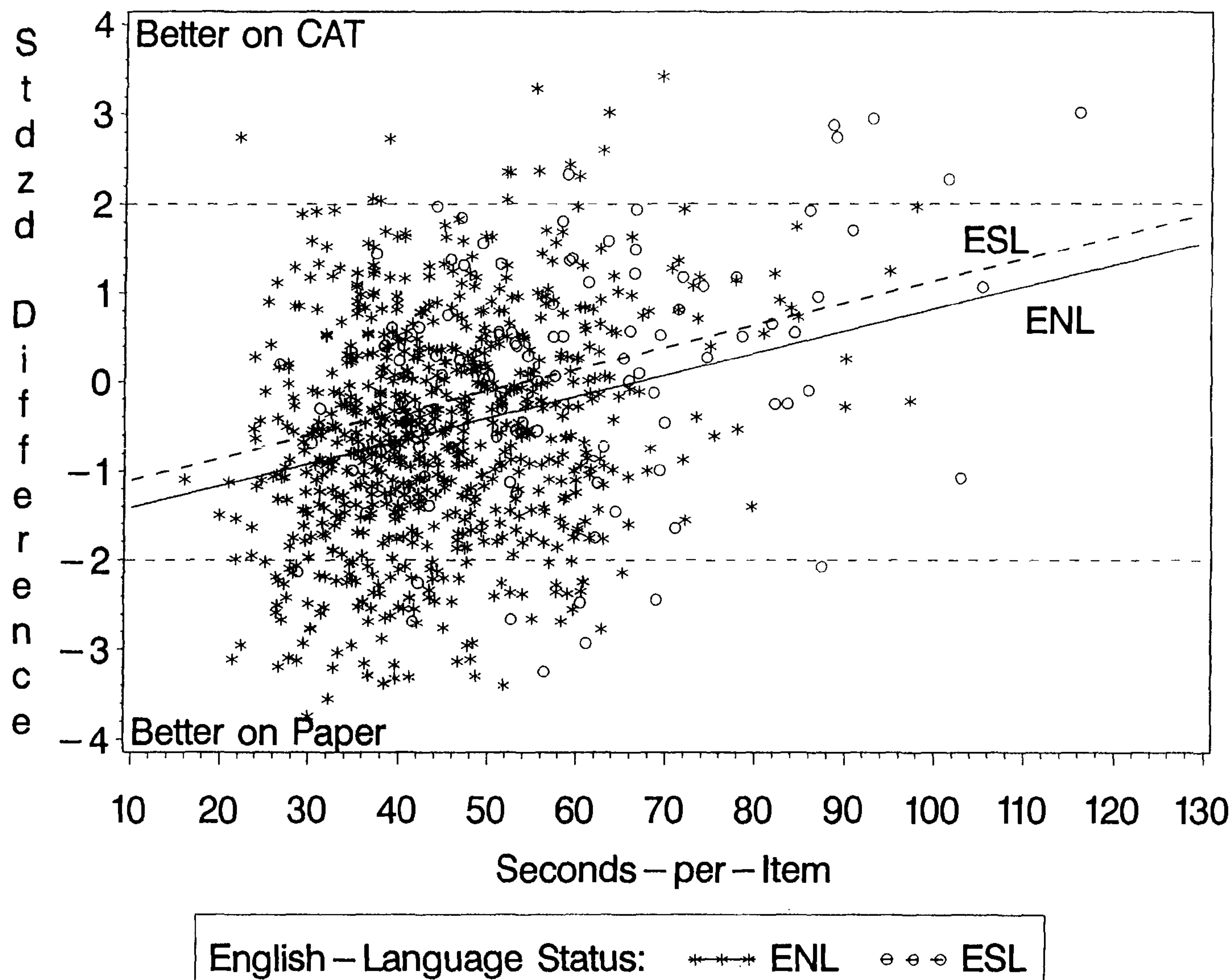
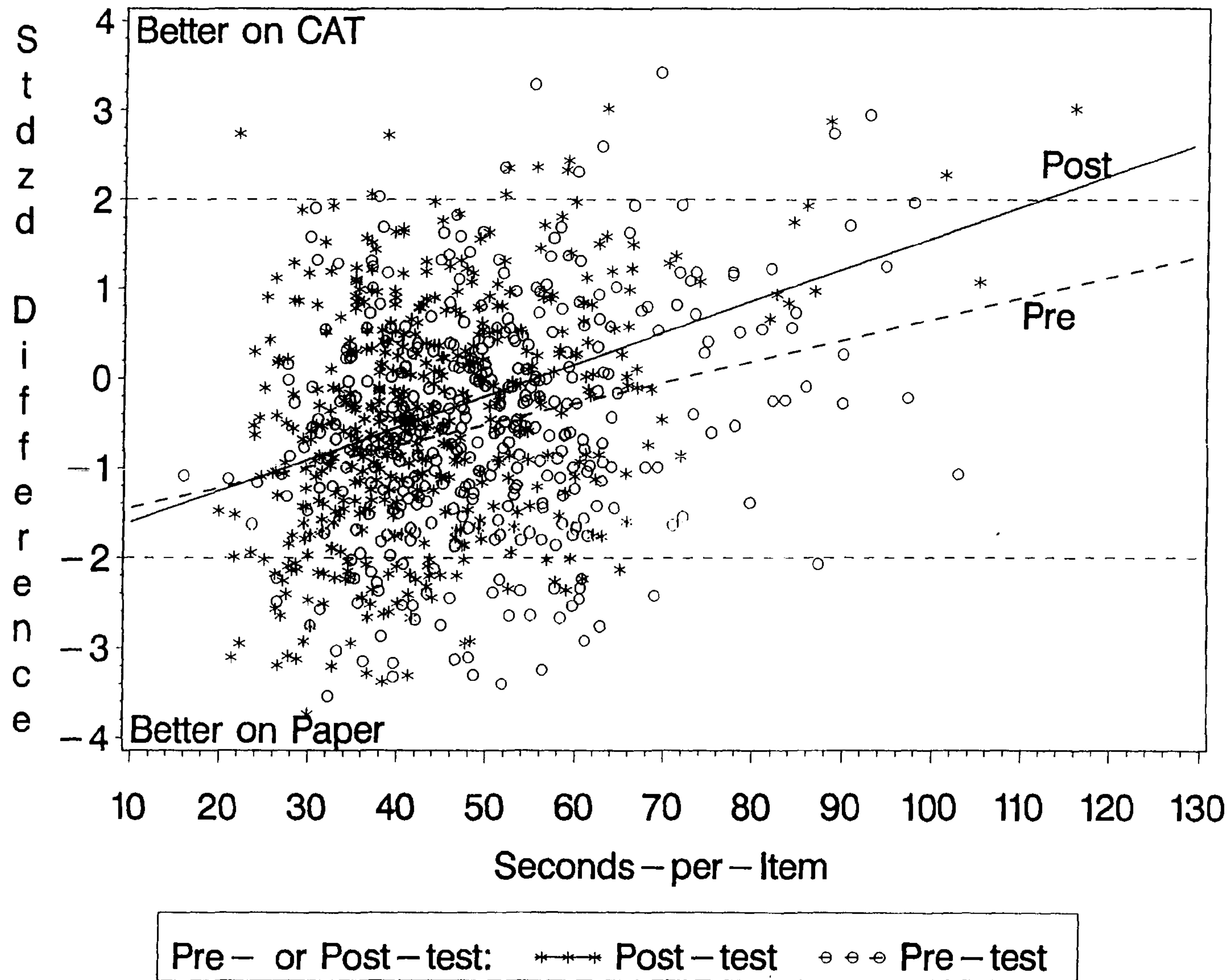
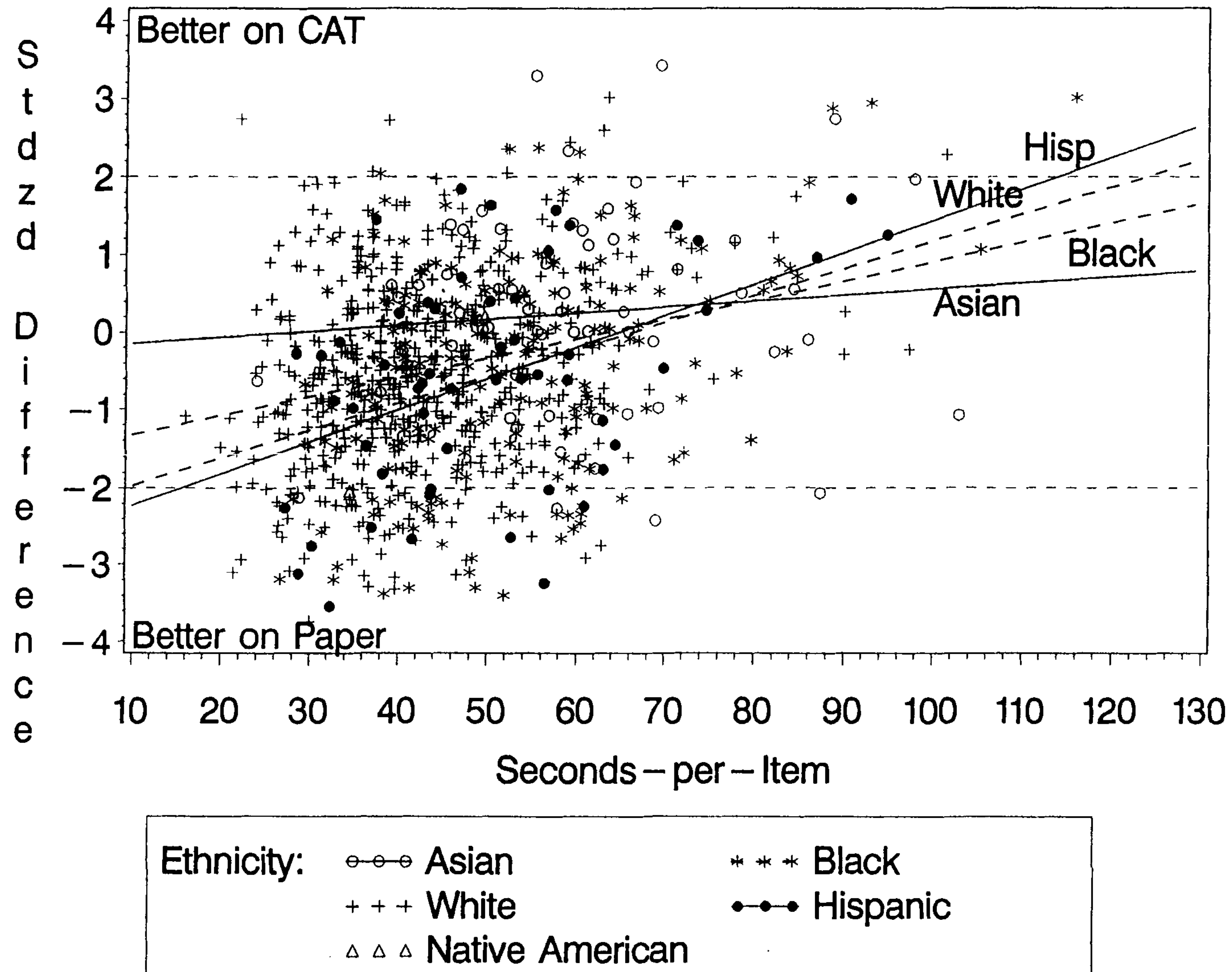


Figure 11. Comparison of Standardized Difference with Seconds-per-Item, By Pre- or Post-Test



National Council of State Boards of Nursing, Inc./1993

Figure 12. Comparison of Standardized Difference with Seconds – per – Item, By Ethnicity



17 BYLAWS COMMITTEE

Report of the Bylaws Committee

Committee Members

Libby Lund, TN, Area III, *Chair*
Joan Bouchard, OR, Area I
Harriett Clark, CA-RN, Area I
Tim McBrady, ME, Area IV
William Polaski, PA, Area IV
Marcia Rachel, MS, Area III
Larry Stump, MI, Area II

Relationship to the Organization Plan

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

Recommendation(s)

No recommendations.

Highlights of Activities

- **Fall Retreat**

The 1992 National Council Delegate Assembly authorized a revision of the National Council's Bylaws. A comprehensive review was begun in order to identify any changes needed for the implementation of CAT and to evaluate the congruency of the bylaws with the Organization Plan adopted in August 1992.

At the Fall Retreat, the Bylaws Committee began one of the activities identified under Goal V, Objective C, Tactic 3 which is to receive input for bylaws revision. The committee met with the Examination Committees (Team 1 and Team 2), the Administration of Examination Committee, the Communications Committee, and the Committee on Nominations. The committee also met with the President, Executive Director, Attorney and Parliamentarian. The purpose of these meetings was to identify the areas that the various committees felt needed revision and to discuss approaches to the bylaws revision.

The committee also received written comments from the Board of Directors; Nurse Information System (NIS) Committee; Nursing Practice and Education Committee; Communications Committee; Steering Committee, Computerized Clinical Simulation Testing (CST); Committee on Nominations; and the National Council staff.

- **Review and Analysis of Comments and Information**

The Bylaws Committee reviewed all of the information and comments received. The committee also reviewed bylaws from other organizations and discussed broad concepts related to organizational structure and functioning. A major consideration was the Organization Plan adopted by the 1992 Delegate Assembly.

- **Area Meetings**

Libby Lund, Chair of the Bylaws Committee, presented the work of the committee at each of the Area Meetings. She outlined the basic assumptions agreed upon by the committee. She also presented the sections of the Bylaws that the committee is considering changing. The committee wanted to obtain feedback from the Member Boards attending the Area Meetings. It was stressed that these were ideas under consideration; nothing has been finalized or formally proposed.

- **Proposed Bylaws Amendments**

The Bylaws Committee reviewed all proposed bylaws amendments submitted by Member Boards and committees. The committee prepared amendments to the bylaws for presentation to the 1993 Delegate Assembly (Attachment A). The Bylaws Committee, however, is not recommending any changes this year in light of the anticipated comprehensive bylaws revision next year.

Meeting Dates

- October 9-12, 1992
- January 29-30, 1993
- April 25-26, 1993

Future Activities

- **Evaluation of Input from Delegate Assembly**

  The Bylaws Committee will receive comments at the Annual Meeting's Bylaws Forum and will use the feedback in the revision process.

- **Bylaws Revision**

  The Bylaws Committee will complete the bylaws revision to present for adoption at the 1994 Delegate Assembly.

Recommendation(s)

No recommendations.

Staff

Vickie R. Sheets, *Director for Public Policy, Nursing Practice and Education*

Attachment

A .... Presentation of Proposed Bylaws Amendments

1. Bylaws amendment proposed by the Committee on Nominations

Article V. Officers
B.1. Qualifications

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
Members and employees of Member Boards shall be eligible to serve as officers until their term or their employment with the Board ends. Members of the Board who become permanent employees of the Board will continue their eligibility to serve.	Members and employees of Member Boards shall be eligible to complete terms as officers or Committee on Nominations members even if their Member Board term or Board employment ends. Board members who become permanent Board employees may continue their eligibility to serve.	Continuation of the terms will preserve continuity and will inspire interest among those board members whose terms will expire within a year, or who are not certain if their term will expire before a National Council board term would be completed.	The Bylaws Committee does not recommend this proposed change. While the committee concurs that continuity is important, the committee feels strongly that for the National Council, a body that is composed of and represents the interests of state boards, to allow persons who are no longer affiliated with a Member Board to continue to serve as officers or as members of the Committee on Nominations is fraught with potential problems. An individual's interests and priorities may change after leaving a Board. There is also the great potential for conflict of interest or the appearance of conflict of interest. Additionally, one of the working assumptions of the committee, based

1. Bylaws amendment proposed by the Committee on Nominations

Article V. Officers
B.1. Qualifications

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
			upon views expressed at the Delegate Assembly and Fall Retreat, is that increased opportunity for participation would enrich the National Council. Allowing persons no longer affiliated with Boards to serve in elected positions would actually decrease the opportunities for persons currently affiliated.

2. Bylaws amendment proposed by the Committee on Nominations

Article V. Officers
B.4 Qualifications

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
An officer shall serve no more than six consecutive years on the Board of Directors in addition to filling and unexpired term.	An officer shall serve no more than six consecutive years on the Board of Directors in addition to filling an unexpired term. <u>No member shall be eligible to serve more than two consecutive terms in the same office.</u>	This amendment is expected to diminish the problem of popular incumbents running for the same Board office for three consecutive elections, thereby possibly discouraging others from running for that office.	The Bylaws Committee does not recommend this proposed change. The committee members do not believe that it is in the best interest of the organization to require an individual doing a good job in a particular office to move on to another office. With the annual turnover in delegates, candidates have to convince new people at each election. Individuals may be popular incumbents because they are doing a good job.

3. Bylaws amendment proposed by the Committee on Nominations

Article V. Officers
D.1.a Vacancies and Removal From Office

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
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.	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 <u>from a list of candidates jointly compiled by the Committee on Nominations and the Board of Directors.</u>	To obtain similar qualifications when filling a vacancy.	The Bylaws Committee does not recommend this proposed change. The National Council's interests are best served by a full complement of officers to execute the duties directed by the Delegate Assembly and oversee the affairs of the organization between Annual Meetings. The committee members believe that the Board of Directors needs the freedom and flexibility to make timely appointments without being encumbered by additional required process. Based on its working knowledge, the Board can, as in the past, assess the strengths and weaknesses of the Board and select replacements who best meet the organization's needs. Nothing prevents the Board from asking for feedback from

3. Bylaws amendment proposed by the Committee on Nominations

Article V. Officers
D.1.a Vacancies and Removal From Office

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
			the Committee on Nominations, but the Bylaws Committee does not believe this should be a requirement.

4. Bylaws amendment proposed by the Committee on Nominations

Article VI. Nominations and Elections
A.1.b Committee on Nominations

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
The term of office shall be one year. Members shall assume duties at the close of the session at which they are elected.	The term of office shall be two years. Members from odd-numbered areas shall be elected in odd-numbered years. Members from even-numbered areas shall be elected in even-numbered years. Members shall assume duties at the close of the session at which they are elected.	One-year terms promote over-reliance upon staff to orient committee members each year, particularly when a majority of those members are new to the committee. Further, one-year terms tend to encourage concentration upon immediate, rather than long-term, nominations concerns.	The Bylaws Committee does not recommend this proposed change. The committee members note that the Committee on Nominations has one function, a very important one, to nominate a slate of officers. The Delegate Assembly elects a representative from each Area to serve for the coming year and complete this task. The Bylaws Committee notes that two-year terms on this committee would decrease the opportunity for participation on this important group.

5. Bylaws amendment proposed by the Committee on Nominations

Article VI. Nominations and Elections
A. Committee on Nominations

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
5.d Duties	Add new section 5.d. Meet during the Delegate Assembly each year to carry out candidate recruitment activities and responsibilities of the committee. The committee's attendance at the Delegate Assembly shall be funded by the National Council.	1) Equity in elected office with board officers. 2) Recruitment and visibility at the annual meeting. 3) Promote long-range planning and enhance visibility of committee.	The Bylaws Committee does not recommend this proposed change. The members of the Committee on Nominations are not Board officers, they comprise a committee. As with other committees, the chair of the Committee on Nominations is funded to attend the Delegate Assembly. This is a policy decision, not a bylaws requirement. The Bylaws Committee does not believe that it is fiscally sound, cost effective or fair to single out one committee for funding in the bylaws when other committees could also benefit from visibility and more efficient long-range planning by full attendance at the Delegate Assembly. The Bylaws Committee suggests that the Fall Retreat offers an excellent

5. Bylaws amendment proposed by the Committee on Nominations

Article VI. Nominations and Elections
A. Committee on Nominations

Current Bylaw	Proposed Bylaw Amendment	Rationale	Bylaws Committee Recommendation
			opportunity to meet other committee members, who comprise one potential pool of candidates.

18

COMMUNICATIONS
COMMITTEE

Report of the Communications Committee

Committee Members
Margaret Howard, NJ, Area IV, *Chair*
Peggy Hawkins, NE, Area II
Barbara Hayman, MS, Area III
Patricia McKillip, KS, Area II
Cassie Vander Wegen, WA-PN, Area I

Relationship to Organization Plan
Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective D ....Facilitate communication between National Council, Member Boards and related entities.

Recommendation(s)
1. That the Board of Directors determine the methodology to implement educational programs for nursing education program surveyors that best meets the needs of the membership within National Council's Organization Plan.

Rationale
For both recommendations, the committee reviewed the results of the survey which was sent to Member Boards (n=62) and all National Council committee members (n=65). Returns were received from 38 Member Boards and 17 committee members, in time for consideration by the committee. The survey instrument and statistical data are included as Attachment A.

Taking a look first at the Nursing Education Program Surveyor section of the survey, results indicated that 74 percent of Member Boards would consider using a National Council-sponsored program, with no respondents currently utilizing a formal course presented by an outside organization to prepare nursing education program surveyors. Committee members examined all data to conclude that, in regard to educational certification programming for nursing education program surveyors, the need among Member Boards is high, the staff turnover is low, and the variety of surveying methods used is wide. The committee agreed that the National Council membership might benefit from a basic training program which addressed nursing education program surveyor needs in general terms (e.g., basic principles and processes) that then could be applied by each jurisdiction according to its unique program needs.

In discussing possible direction, the committee suggests that there might be development of two learning/training tracks: 1) Basic Education for Nursing Education Program Surveyors, and 2) Certified Nursing Education Program Surveyor Consultant. The difference between the two is primarily the scope of knowledge.

The first track would be geared for any nursing education program surveyor who is learning his/her job within the regulatory arena and would benefit from national perspectives and generalities which may then be applied to the rules and regulations in their own jurisdiction. Course work would include modular self-instructional materials which cover general principles and processes, with pre-test and post-test sections. A single education program could be scheduled in conjunction with National Council's annual meeting, offering continuing education units with a didactic learning opportunity in the morning and hands-on interaction with small work groups, roundtables or panels in the afternoon. Those completing this track would receive, from the National Council, a letter of completion in the Basic Education for Nursing Education Program Surveyors. Development of this program would require the appointment of a team of nurse professionals, experts as nursing education program surveyors, who would develop the written materials and plan an annual education program. (See fiscal impact, Attachment B.)

The second track, Certified Nursing Education Program Surveyor, is perceived to be a more advanced program for those who have completed the basic course. There would be specific entrance criteria to this program with requirements such as completion of National Council's basic course, master's prepared, years of professional experience, curriculum background, and possibly other academic criteria. Those in this course would need to demonstrate ability to evaluate the curriculum, as it flows from the philosophy. There could be specialization areas according to nursing education program type (e.g., PN, BSN, ADN, Diploma). Those completing this track would receive, from the National Council, a certificate of excellence and would be recognized for expertise as a nursing education program surveyor on a national

level. The program could be developed to include a re-certification aspect to demonstrate continued competence. Development of this program would require the time investment of educational program planners who are able to develop course work and accompanying budgets.

Although the committee believes that the cost of both tracks could be covered by assessment of registration fees, the decision for implementation and accompanying budgetary impact is best left to the Board of Directors who has responsibility for the organization's total budget.

2. That the Board of Directors determine the methodology to implement educational programs for discipline investigators that best meets the needs of the membership within National Council's Organization Plan.

Rationale

The Discipline Investigator section of the survey revealed that 71 percent of Member Board respondents would consider using a National Council-sponsored program to prepare discipline investigators, and 61 percent currently utilize a formal course presented by an outside organization (most frequently, a CLEAR program). In regard to discipline investigators, survey results indicated that Member Boards did not wish to duplicate currently offered programs, but preferred to provide an enhancement to a program with which they are partially satisfied in order to better serve the health care professions.

Committee members concurred that CLEAR's program needs a health care focus dedicated to subjects such as: how to write a report, how to put a case together, standards of care, how to read charts, how to determine negligence through documentation, how health care works with law enforcement, etc. The curriculum needs to be more focused on administrative law as opposed to criminal law, with components on ethics and professional sensitivity included in the program. It was agreed that although CLEAR's basic National Certified Investigator/Inspector Training (NCIT) Program is of value to nurse investigators, CLEAR must improve its education component for health care professions.

With most respondents indicating their utilization of CLEAR programs as well as a desire not to duplicate such programs, the committee met with the Executive Director to request that she gather additional information from CLEAR's leadership regarding the possibility of joint programming. Further discussion with CLEAR confirmed an interest in developing a joint program focused on the health care professions.

At its March meeting, the committee reviewed and discussed not only an initial response from CLEAR, but further defined its thoughts regarding possible program development. Committee members concurred that three basic options were available to the National Council. All options require the development of an "add-on" program as developed by the National Council, but differ in how attendees might glean information from what the committee refers to as the "core" curriculum. The "core" curriculum, it was believed, is not only of value to nurse investigators, but is already being offered by other organizations such as CLEAR. Therefore, committee members agreed that it would not be prudent to develop and offer a program which would duplicate and therefore compete with established basic programs. Rather, nurse investigators would benefit from a National Council "add-on" program which would focus on the needs of nursing.

The three options are summarized below:

Option 1: .... Develop a National Council "add-on" program that would be offered in conjunction with CLEAR's National Certified Investigator/Inspector Training Program (NCIT).

Option 2: .... Develop a National Council "add-on" program that would be offered in conjunction with an organization other than CLEAR that provides a core curriculum that meets National Council's quality standards. (Although the committee reviewed the informational brochure of one other company currently providing this type of "core" curriculum, committee members agreed that there may be a number of others worthy of exploration.)

Option 3: .... Develop a National Council "add-on" program that would actually be offered independently of any other organization, but would have program entrance prerequisites such as attendance at a core curriculum program or on-the-job experience.

For all three options, the National Council would be in control of the curriculum and instructor selection/evaluation for the "add-on" program. This would require the involvement of National Council experts to concentrate on program design and development. In the first two options, the National Council would additionally assume a negotiated portion of responsibility for meeting logistics, marketing and fees of the "add-on" program. In the last option, the National Council assumes total responsibility for the entire program, including meeting logistics, marketing and fees, in addition to curriculum and instructors.

Joint programming with CLEAR seems to answer the replies gathered from National Council's survey. CLEAR is interested and, depending upon further negotiation between the two organizations, the program maybe a viable means

of training nurse discipline investigators. However, the committee believes that there are other options open to the National Council, all requiring sound negotiation for a business arrangement that best serves the needs of National Council's Member Boards. This negotiation, the committee believes, is best left to the Board of Directors, Executive Director and legal counsel. (See fiscal impact for an advisory group, Attachment C.)

The committee believes that these recommendations are within the mission of the National Council and are consistent with Goal IV, Objective D. The fiscal impact of actual program implementation is dependent upon the design of the program, negotiation, and the methodology determined by the Board of Directors.

Highlights of Activities

■ Crisis Communications Plan

An activity under Tactic 2 of Goal IV states, *"Effectively communicate crises information to Member Boards and appropriate audiences."* The associated task for that activity is to *"develop a communications crises plan of action."* To be sure that Member Board needs were accurately and appropriately reflected in a crisis communications plan, this task was completed by the Communications Committee. Members of the committee agreed that although each crisis is unique and therefore warrants individual handling, the National Council would benefit from general guidelines that ensured consistency as much as possible while allowing for flexibility when required. The Crisis Communications Plan (Attachment D) was developed by the committee and approved by the Board of Directors at its December meeting.

■ Awards Program

In their review of the awards brochure, newly appointed committee members questioned why awards were presented in a cyclical fashion, in that the R. Louise McManus Award is presented every third year and the remaining two awards presented in the years opposite. Following discussion, committee members concluded that the awards program may better serve the membership if the cyclical requirements were removed. This revision would open the awards for nomination every year, but yet would not mandate that the award be presented. The organization, therefore, could bestow an honor on a deserving individual or Member Board in a timely fashion, rather than waiting until the appropriate year rolled around. The committee suggests that this revision may also assist in achieving greater nominations from which to choose since, essentially, the nominations would be open all year round for all three awards. Selection continues to be the responsibility of the Board of Directors, relying on the published criteria for selection rather than having to make a selection that is restricted by a yearly cycle.

■ 1993 Educational Session at Annual Meeting

The Communications Committee reviewed and selected the presentations to be given during the educational session scheduled on the day preceding the official start of the 1993 Annual Meeting. Based on the attendee evaluations from 1992, the session was expanded from six to eight concurrent programs. The 1993 Call for Papers resulted in 17 abstracts for consideration. In the Call for Papers, and as reported to the Board in the committee's December report, there were four categories in which one could have submitted an abstract for consideration: 1) Public Policy; 2) Education; 3) Practice; and 4) Credentialing. The committee reviewed all abstracts (n=17) for the concurrent educational programs, designed the criteria for selection, and selected eight presentations and one alternate to complete the 1993 educational session.

■ Regulatory Day of Dialogue

The committee began the year by developing an agenda for the proposed 1993 Regulatory Day of Dialogue. Following the Board of Directors' meeting in December, where discussion resulted in the decision that the Regulatory Day of Dialogue should be planned in concert with Area Meetings, it was decided to postpone implementation of the program until 1994 to allow adequate joint planning time between the committee and Area Directors. A joint meeting has been scheduled for October 1993.

■ Bylaws

As requested by the Bylaws Committee, the committee reviewed and discussed its duties as stated in the current bylaws in order to prepare its recommendations for revisions. A memo with the committee's conclusions was provided to the Bylaws Committee, the Long Range Planning Committee and the Board of Directors.

Meeting Dates

- October 10-12, 1992
- January 28-29, 1993
- March 22-23, 1993

Future Considerations for the National Council

- **National Council Educational Programs**

  The National Council should continue and possibly expand its offering of planned educational programs that include Member Board participation in program development and instructor selection/evaluation.

- **Certification Programs**

  Depending on the outcome of the vote of the 1993 Delegate Assembly regarding the feasibility of educational certification programs for nursing educational program surveyors and discipline investigators, the National Council may realize new involvement in this area.

Recommendation(s)

1. That the Board of Directors determine the methodology to implement educational programs for nursing education program surveyors that best meets the needs of the membership within National Council's Organization Plan.

2. That the Board of Directors determine the methodology to implement educational programs for discipline investigators that best meets the needs of the membership within National Council's Organization Plan.

Staff

Susan Davids, CMP, *Meetings Manager*
Susan Woodward, *Director of Communications*

Attachments

A ....Certification Program Survey Instrument and Statistical Data, *page 5*
B ....Fiscal Impact Summary Sheet for Recommendation #1, *page 9*
C ....Fiscal Impact Summary Sheet for Recommendation #2, *page 11*
D ....National Council's Crisis Communications Plan, *page 13*

Attachment A

FEASIBILITY OF CERTIFICATION PROGRAMS QUESTIONNAIRE

(Member Board Response –n=38)
(Committee Member Response – n=17)

Note: Numbers in parenthesis represent total response to given question. Numbers in **BOLD** are Member Board data.

1. What type(s) of programs are you currently using to prepare nursing education program surveyors (surveyors) and nursing disciplinary investigators (investigators)? Please check all that apply.

	Member Board		Committee	
a. Nursing education program surveyors:				
___ On-the-job training	**84%**	**(32)**	59%	(10)
___ Formal course presented by in-house personnel	**03%**	**(1)**	06%	(1)
___ Formal course presented by an outside organization If yes, please identify	**0%**	**(0)**	06%	(1)
___ Informal orientation by previous/current job holder	**68%**	**(26)**	59%	(10)
___ Other, please describe:	**24%**	**(9)**	12%	(2)
b. Nursing disciplinary investigators:				
___ On-the-job training	**74%**	**(28)**	65%	(11)
___ Formal course presented by in-house personnel	**05%**	**(2)**	0%	(0)
___ Formal course presented by an outside organization If yes, please identify	**61%**	**(23)**	41%	(7)
___ Informal orientation by previous/current job holder	**42%**	**(16)**	35%	(6)
___ Other, please describe:	**29%**	**(11)**	12%	(2)

2. If a structured program is offered, what specific content areas are covered?

			Member Board		Committee	
a. Nursing Education Program Surveyor Certification Program						
Curriculum	___Yes ___No	Yes	**13%**	**(5)**	29%	(5)
Faculty	___Yes ___No	Yes	**13%**	**(5)**	29%	(5)
Administration	___Yes ___No	Yes	**13%**	**(5)**	29%	(5)
Practice Act/Rules	___Yes ___No	Yes	**13%**	**(5)**	29%	(5)
		No	**06%**	**(2)**		
Administrative Law/Rules	___Yes ___No	Yes	**13%**	**(5)**	18%	(3)
Clinical Agencies	___Yes ___No	Yes	**13%**	**(5)**	29%	(5)
Other If yes, please describe:	___Yes ___No	Yes	**08%**	**(3)**	18%	(3)
b. Nursing Disciplinary Investigators Certification Program						
Report Taking	___Yes ___No	Yes	**32%**	**(12)**	35%	(6)
		No	**03%**	**(1)**		
Report Writing	___Yes ___No	Yes	**32%**	**(12)**	29%	(5)
		No	**03%**	**(1)**		
Interview Techniques	___Yes ___No	Yes	**32%**	**(12)**	29%	(5)
		No	**03%**	**(1)**		

			Member Board		Committee	
Evidence Receipt, Care, Custody	___Yes ___No	Yes	**32%**	**(12)**	29%	(5)
		No	**03%**	**(1)**		
Maintaining Files	___Yes ___No	Yes	**26%**	**(10)**	29%	(5)
		No	**08%**	**(3)**		
Testifying	___Yes ___No	Yes	**32%**	**(12)**	35%	(6)
		No	**03%**	**(1)**		
Investigative Techniques	___Yes ___No	Yes	**32%**	**(12)**	35%	(6)
		No	**03%**	**(1)**		
Practice Act/Rules	___Yes ___No	Yes	**18%**	**(7)**	24%	(4)
		No	**08%**	**(3)**	06%	(1)
Administrative Law/Rules	___Yes ___No	Yes	**24%**	**(9)**	18%	(3)
		No	**05%**	**(2)**	06%	(1)
Other	___Yes ___No	Yes	**05%**	**(2)**	06%	(1)
If yes, please describe:						

3. What does it cost you to train and maintain surveyors and investigators?

	Member Board	Committee
a. Nursing education program surveyors:		
Initial cost (per person) $_____	No response	No response
Annual cost (per person) $_____	No response	No response
b. Nursing disciplinary investigators:		
Initial cost (per person) $_____	No response	No response
Annual cost (per person) $_____	No response	No response

4. Are you satisfied with the programs currently offered for:

		Member Board		Committee	
a. Nursing education program surveyors: ___Yes ___No	Yes	**34%**	**(13)**	18%	(3)
If no, please explain why not:	No	**32%**	**(12)**	41%	(7)
b. Nursing disciplinary investigators: ___Yes ___No	Yes	**34%**	**(13)**	18%	(4)
If no, please explain why not:	No	**39%**	**(15)**	47%	(8)

5. Are you aware of any organization that offers programs for the following:

		Member Board		Committee	
a. Nursing education program surveyors: ___Yes ___No	Yes	**13%**	**(5)**	41%	(7)
If yes, please name:	No	**79%**	**(30)**	41%	(7)
b. Nursing disciplinary investigators: ___Yes ___No	Yes	**58%**	**(22)**	53%	(9)
If yes, please name:	No	**37%**	**(14)**	35%	(6)

The National Council is investigating the feasibility of offering a nursing education program surveyors certification program and a nursing disciplinary investigators certification program.

6. Would you consider using a National Council-sponsored program for educating surveyors and investigators?

			Member Board		Committee	
a.	Nursing education program surveyors: ___Yes ___No	Yes	**74%**	**(28)**	71%	(12)
	If no, please explain:	No	**18%**	**(7)**		
b.	Nursing disciplinary investigators: ___Yes ___No	Yes	**71%**	**(27)**	59%	(10)
	If no, please explain:	No	**13%**	**(5)**	06%	(1)

7. If the National Council offered certification programs, how would you like the program to be structured? Please indicate the elements that you feel should be included:

a.	Nurse Education Program Surveyor Certification Program						
	Modular self-study process	___Yes ___No	Yes	**61%**	**(23)**	41%	(7)
			No	**08%**	**(3)**	18%	(3)
	Training component	___Yes ___No	Yes	**66%**	**(25)**	59%	(10)
			No	**03%**	**(1)**		
	Certification component	___Yes ___No	Yes	**61%**	**(23)**	71%	(12)
			No	**05%**	**(2)**		
	Other, please explain	___Yes ___No	Yes	**13%**	**(5)**	06%	(1)
			No	**03%**	**(1)**		
b.	Disciplinary Investigators Certification Program						
	Modular self-study process	___Yes ___No	Yes	**61%**	**(23)**	47%	(8)
			No	**08%**	**(3)**	18%	(3)
	Training component	___Yes ___No	Yes	**66%**	**(25)**	71%	(12
	Certification component	___Yes ___No	Yes	**63%**	**(24)**	76%	(13)
	Other, please explain	___Yes ___No	Yes	**11%**	**(4)**	06%	(1)
			No	**05%**	**(2)**		

8. For the proposed certification programs, the following training tracks have been suggested. Please indicate which of the following should be included based on your needs and/or interests:

a.	Nurse Education Program Surveyor Certification Program						
	Curriculum	___Yes ___No	Yes	**89%**	**(34)**	65%	(11)
	Faculty	___Yes ___No	Yes	**84%**	**(32)**	65%	(11)
	Administration	___Yes ___No	Yes	**82%**	**(31)**	65%	(11)
	Practice Act/Rules	___Yes ___No	Yes	**84%**	**(32)**	59%	(10)
			No	**03%**	**(1)**	06%	(1)
	Administrative Law/Rules	___Yes ___No	Yes	**74%**	**(28)**	53%	(9)
			No	**08%**	**(3)**	12%	(2)
	Clinical Agencies	___Yes ___No	Yes	**89%**	**(34)**	65%	(11)
	Other	___Yes ___No	Yes	**24%**	**(9)**	24%	(4)
	If yes, please describe:		No	**03%**	**(1)**	06%	(1)
b.	Nursing Disciplinary Investigators Certification Program						
	Report Taking	___Yes ___No	Yes	**79%**	**(30)**	65%	(11)
			No	**03%**	**(1)**		
	Report Writing	___Yes ___No	Yes	**82%**	**(31)**	76%	(13)
			No	**03%**	**(1)**		
	Interview Techniques	___Yes ___No	Yes	**82%**	**(31)**	76%	(13)
			No	**03%**	**(1)**		

			Member Board		Committee	
Evidence Receipt, Care, Custody	___Yes ___No	Yes	**79%**	**(30)**	65%	(11)
		No	**03%**	**(1)**		
Maintaining Files	___Yes ___No	Yes	**79%**	**(30)**	76%	(13)
		No	**08%**	**(3)**		
Testifying	___Yes ___No	Yes	**82%**	**(31)**	76%	(13)
		No	**03%**	**(1)**		
Investigative Techniques	___Yes ___No	Yes	**82%**	**(31)**	76%	(13)
		No	**03%**	**(1)**		
Practice Act/Rules	___Yes ___No	Yes	**68%**	**(26)**	59%	(10)
		No	**08%**	**(3)**	12%	(2)
Administrative Law/Rules	___Yes ___No	Yes	**66%**	**(25)**	59%	(10)
		No	**05%**	**(2)**	12%	(2)
Other	___Yes ___No	Yes	**24%**	**(9)**	12%	(2)
If yes, please describe:						

9. If the National Council offered a nursing education surveyor certification program and/or a nursing disciplinary investigator certification program, would you want to have a <u>continuing</u> education component included?

a. Nursing education program surveyors	___Yes ___No	Yes	**71%**	**(27)**	59%	(10)
		No	**21%**	**(8)**	12%	(2)
b. Nursing disciplinary investigators	___Yes ___No	Yes	**66%**	**(25)**	41%	(7)
		No	**13%**	**(5)**	12%	(2)

10. If the National Council offered these certification programs, how many staff and/or board members from your board of nursing would you anticipate participating in these programs annually?

a. Nursing education program surveyors	___ Staff/Board members	No response	No response
b. Nursing disciplinary investigators	___ Staff/Board members	No response	No response

11. Do you have personnel or other experts who could serve as instructors for any of the following proposed National Council certification programs:

a. Nursing education program surveyors:	___Yes ___No	Yes	**32%**	**(12)**	41%	(7)
If yes, please provide names:		No	**55%**	**(21)**	29%	(5)
b. Nursing disciplinary investigators:	___Yes ___No	Yes	**34%**	**(13)**	24%	(5)
If yes, please provide names:		No	**55%**	**(21)**	41%	(7)

12. Are there other departments/agencies/boards in your state which might be interested in this type of certification program?

___Yes ___No	Yes	**42%**	**(16)**	41%	(7)

If yes, please provide names of agency and contact person:

13. Any additional comments?

THANK YOU FOR YOUR INPUT.
THE RESULTS OF THIS SURVEY WILL BE INCLUDED
IN A REPORT TO THE 1993 DELEGATE ASSEMBLY.

Attachment B

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

FISCAL IMPACT STATEMENT - DESCRIPTION

TITLE OF PROPOSAL: NURSING EDUCATION PROGRAM SURVEYORS

Proposed by: __________ Name __________

Date AUGUST 1993 Committee __________

Will this proposal generate revenue? ______ Please describe below:

EXPENSES

1. Does this proposal require a committee? Yes

   How many members are anticipated including the chairperson? 6

   How often would the committee meet? 4 times, 3 days each time

2. How many mailings would this proposal require? 7

   To whom? Committee mailings, Board mailings

3. Printing (surveys, special reports, etc.) Please describe:

4. Other than committee meetings, is travel required? No

   Please describe:

5. What type of consultation is required (i.e., legal, computer, etc.)?

6. Other. Please describe:

7. Projected beginning date: October 1993

   Projected completion date: __________

TITLE OF PROPOSAL: NURSING EDUCATION PROGRAM SURVEYORS

FISCAL IMPACT - SUMMARY

REVENUE

______________________ $______________________

EXPENSES

A. DIRECT COST

1. Committee Meetings

$875 per member airfare x 6 (# of members) x 4 (# of meetings) = $ 21,000

$225 per day per diem x 6 (# of members) x 12 (# of days) = $ 16,200

$225 per telephone conference x 2 (# of Telephone Conferences) = $ 450.00

2. Staff Travel - Purpose - ______________________

$875 per member airfare x ______ (# of members) x ______ (# of meetings) = $______

$225 per day per diem x ______ (# of members) x ______ (# of days) = $______

3. Mailings

$0.32 per letter x 3 (# of mailings) x 18 (# mailed) = $ 5.76

$2.50 per 9 x 12 manila envelope (First Class) x 4 (# of mailings) x 18 (# mailed) = $ 180.00

$9.75 per Overnight Mail x 2 (# of mailings) x 12 (# mailed) = $ 234.00

4. Printing and Copying

A. ______ (# of reports) x ______ (# of pages) = Total pages

B. ______ (total # of pages) x $0.05 = $______

5. Other Travel (Annual Meeting)

$875 per person airfare x 1 (# of persons) x 1 (# of meetings) = $ 875.00

$225 per day per diem x 1 (# of persons) x 5 (# of days) = $ 1,125

6. Consultation

A. Legal Fees

$200 per hour x ______ (# of hours) x ______ (# of meetings) = $______

B. Other Consultation

$______ per hour x ______ (# of hours) x ______ (# of meetings) = $______

7. Other

$______ per ______ x ______ = $______

B. INDIRECT COST

1. Professional and support time required:

Total ______ hours = $______

Total Revenue: $ ______

Total Expenses: $ 40,069.76

Net: $ ______

Indirect Cost: $ ______

KJH/mct/030193

Attachment C

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

FISCAL IMPACT STATEMENT - DESCRIPTION

TITLE OF PROPOSAL: DISCIPLINE INVESTIGATORS

Proposed by: ______ Name ______

Date AUGUST 1993 Committee ______

Will this proposal generate revenue? ______ Please describe below:

EXPENSES

1. Does this proposal require a committee? Yes

   How many members are anticipated including the chairperson? 6

   How often would the committee meet? 3 times, 3 days each time

2. How many mailings would this proposal require? 6.

   To whom? Committee mailings, Board mailings, mailings to possible program partners

3. Printing (surveys, special reports, etc.) Please describe:

4. Other than committee meetings, is travel required? Possibly

   Please describe: May require travel of one/two persons to site of possible program partners for negotiation purposes.

5. What type of consultation is required (i.e., legal, computer, etc.)?

   Legal, for involvement in negotiation process.

6. Other. Please describe:

7. Projected beginning date: Septeber/October 1993

   Projected completion date: ______

TITLE OF PROPOSAL: DISCIPLINE INVESTIGATORS

FISCAL IMPACT - SUMMARY

REVENUE

______________________ $______

EXPENSES

A. DIRECT COST

1. Committee Meetings

$875 per member airfare x 6 (# of members) x 3 (# of meetings) = $ 15,750

$225 per day per diem x 6 (# of members) x 9 (# of days) = $ 12,150

$225 per telephone conference x 3 (# of Telephone Conferences) = $ 675.00

2. Staff Travel - Purpose - ______

$875 per member airfare x ______ (# of members) x ______ (# of meetings) = $______

$225 per day per diem x ______ (# of members) x ______ (# of days) = $______

3. Mailings

$0.32 per letter x 3 (# of mailings) x 18 (# mailed) = $ 17.28

$2.50 per 9 x 12 manila envelope (First Class) x 3 (# of mailings) x 18

(# mailed) = $ 135.00

$9.75 per Overnight Mail x 2 (# of mailings) x 12 (# mailed) = $ 234.00

4. Printing and Copying

A. ______ (# of reports) x ______ (# of pages) = Total pages

B. ______ (total # of pages) x $0.05 = $______

5. Other Travel

$875 per person airfare x 2 (# of persons) x 1 (# of meetings) = $ 1,750

$225 per day per diem x 2 (# of persons) x 1 (# of days) = $ 450.00

6. Consultation

A. Legal Fees

$200 per hour x 8 (# of hours) x 1 (# of meetings) = $ 1,600

B. Other Consultation

$______ per hour x ______ (# of hours) x ______ (# of meetings) = $______

7. Other

$______ per ______ x ______ = $______

B. INDIRECT COST

1. Professional and support time required:

Total ______ hours = $______

Total Revenue: $ ______

Total Expenses: $ 32,761.28

Net: $ ______

Indirect Cost: $ ______

KJH/mct/030193

Attachment D

NATIONAL COUNCIL'S
CRISIS COMMUNICATIONS PLAN

Definition: A crisis is an unexpected incident or event that warrants public notification via media.

GUIDELINES

In the event of a crisis, communication will proceed in the following manner:

1. The President and the Executive Director determine that a crisis has occurred.

2. In consultation among the President, Executive Director, and involved parties which may include Member Board(s), test service, legal counsel and/or investigative personnel, a decision is made regarding the information that may be released.

3. When a Member Board(s) is directly involved in the crisis, the Executive Director consults the involved Member Board(s) to determine the timing of communication dissemination to the membership as well as to those outside the membership.

4. Member Boards receive verbal or written advance notice of the planned communication prior to dissemination outside the membership.

5. Recommendations regarding appropriate responses and further dissemination of information shall accompany each newsrelease sent to Member Boards.

6. All communications, including informational updates and newsreleases, should follow these guidelines until the crisis is resolved, as determined by the President and Executive Director in consultation with the involved Member Board(s) and/or other appropriate personnel (e.g., legal counsel, investigative staff).

7. When the crisis is resolved, Member Boards receive a final communication that brings closure to the crisis.

PRINCIPLES

The National Council will employ the following principles when faced with a crisis communications situation:

1. Act in an ethical, humane fashion.
2. Act quickly and immediately identify a chief spokesperson.
3. Employ an efficient decision-making process.
4. Be open with as much information as possible that does not compromise confidentiality or impact legal ramifications.
5. Ensure accuracy and validity of information.
6. Be available to the media.
7. Express concern.
8. Reassure that measures have been taken to prevent future occurrences.
9. Consider needs and best interests of Member Boards first.
10. Respect Member Boards' communications processes and needs.

19 FINANCE COMMITTEE

Report of the Finance Committee

Committee Members

Carol A. Osman, NC, Area III, *Treasurer and Chair*
Lucille Baldwin, AZ, Area I
Charlene Kelly, NE, Area II
Barbara Morvant, LA-RN, Area III
Richard Sheehan, ME, Area IV

Relationship to Organization Plan

Goal V. ....Implement an organizational structure that uses human and fiscal resources efficiently.
Objective B. ....Implement a fiscal resource management system.

Recommendation(s)

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

Highlights of Activities

- Developed FY94 Budget Assumptions and Budget Calendar.
- Reviewed the FY94 budget including capital acquisitions, and presented a tentative budget to the Board at its June meeting. The final budget, with any budget adjustments resulting from Delegate Assembly action, will be approved by the Board for implementation October 1, 1993.
- Met with Ernst & Young audit firm to discuss the FY92 audit. The committee reviewed the management letter and recommended to the Board of Directors that the FY92 audit be approved.
- Reviewed quarterly financial reports.
- Reviewed all funding proposals, provided feedback, and recommended designated funds as deemed appropriate.
- Reviewed budget requests and analyzed the impact on FY93 budget and the five-year financial forecasts, and proposed revisions to FY93 budget throughout the year.
- Analyzed and recommended registration fees for various National Council activities.
- Analyzed and recommended prices for various National Council publications.
- Evaluated and recommended policies on the use of purchase orders and discounts on volume purchases of publications.
- Evaluated and recommended a designated fund for self-insurance regarding indemnification of Member Boards.

Meeting Dates

- October 11, 1992
- November 30, 1992, *telephone conference*
- January 28-29, 1993
- February 8, 1993, *telephone conference*
- February 25, 1993, *telephone conference*
- April 21, 1993, *telephone conference*
- May 17-18, 1993
- May 28, 1993, *telephone conference*
- July 12-13, 1993

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

Staff
Kathleen J. Hayden, *Financial Manager*

Point of Personal Privilege For the Finance Committee
The work of the committee was greatly facilitated by Kathleen Hayden and the committee wishes to express its appreciation for her commitment and hard work. The committee would like also to express its appreciation to National Council staff for their responsiveness to requests from the committee.

20

NURSING PRACTICE AND EDUCATION COMMITTEE & SUBCOMMITTEES

Report of the Nursing Practice and Education Committee and Subcommittees

Committee Members
Julia Gould, GA-RN, Area III, *Chair*
Barbara Hatcher, DC, Area IV
Geoff Hodge, WA-RN, Area I
Betty Hunt, NC, Area III
Karen Macdonald, ND, Area II
Jan Zubieni, CO, Area I

Relationship to the Organization Plan
Goal I ....Provide Member Boards with examination and standards for licensure and credentialing.
Objective F.........Promote consistency in the licensure and credentialing process.
Objective G ....Investigate mechanisms for continued competence.
Goal II ....Provide information, analyses and standards regarding the regulation of nursing practice.
Objective A.........Develop documents which provide guidance regarding the regulation of nursing practice.
Objective B ....Develop documents regarding health care issues which affect safe and effective nursing practice.
Objective C ....Conduct research on regulatory issues related to disciplinary activities.
Objective D ....Provide information about disciplinary actions taken by Member Boards.
Objective E ....Review and analyze actions of government and other entities that affect the regulation of nursing.
Goal III ....Provide information, analyses and standards regarding the regulation of nursing education.
Objective A ....Develop documents which provide guidance regarding the regulation of nursing education.
Objective B ....Develop documents regarding issues that affect the regulation of nursing education.
Objective C ....Provide for Member Board needs related to the approval process of nursing education programs.
Objective D ....Review and analyze actions of government and other entities that affect the regulation of nursing education.

Recommendation(s)
1. That the Delegate Assembly adopt the revised *Model Nursing Practice Act*.

Rationale
It has been five years since the *Model Nursing Practice Act* has been looked at for possible revision. The Nursing Practice and Education Committee has reviewed the model to incorporate changes needed to reflect computerized adaptive testing (CAT) implementation and to make the *Model Nursing Practice Act* consistent with the requirements of the Americans with Disabilities Act.

Highlights of Activities

■ *Model Nursing Practice Act*
The Nursing Practice and Education reviewed the *Model Nursing Practice Act* for any revisions related to licensure, nursing practice, and nursing education. Particular attention was paid to revisions needed because of CAT and the Americans with Disabilities Act. The revised *Model Nurse Practice Act* is found in Attachment A, page 5.

■ Continued Competence Paper
The Nursing Practice and Education Committee, and previously, the Nursing Practice and Standards Committee, began to deal with the regulatory issues presented by continued competence in nursing by the development of papers such as the *1991 Conceptual Frameworkfor Continued Competence*. This year, the committee broadened its perspective to look at the integrated whole of competence, which included not only continued competence but also disabled nurses and the disciplinary process. The committee began work on a paper with the working title, "*The Many Faces of Competence.*" The committee experienced a shift in thinking, a paradigm shift, which is the focus of this paper. The

concept of a new paradigm is presented in Attachment B, page 7, and will be discussed at the Nursing Practice and Education Forum.

- **Review of Subcommittee Activities**

  The Nursing Practice and Education Committee reviewed and commented on reports from the Subcommittee to Study the Regulation of Advanced Nursing Practice and has been supportive of the subcommittee's work. The committee will make a recommendation regarding the subcommittee's proposal in the supplement to the *Book of Reports,* scheduled to be mailed in early July 1993. The committee also monitored the plans of the Subcommittee to Study Regulatory Models for Chemically Dependent Nurses.

- **Nurse Practice Act Database**

  The Nursing Practice and Education Committee advised staff regarding the development of a Nurse Practice Act database. The committee had developed a "wish list" of items that it would like to see included in a database. This is envisioned as a service that all Member Boards would be able to access for information.

- **Disciplinary Data Bank**

  The Nursing Practice and Education Committee continued to review information relating to the National Council's Disciplinary Data Bank and to make recommendations to staff regarding the data bank reports and electronic access.

- ***Issues***

  The committee identified topics and articles for inclusion in the nursing practice and education edition of *Issues,* which will be published this summer.

Meeting Dates

- October 10-12, 1992
- January 16-18, 1993
- March 5-7, 1993
- April 8, 1993, *telephone conference*
- April 27, 1993, *telephone conference*

Future Considerations for the National Council

- **Competence Paper**

  The Nursing Practice and Education Committee will continue to develop the paper on competence to present at the Delegate Assembly in 1994.

- **Competence Assessment Tools**

  The Nursing Practice and Education Committee will explore the development of tools that licensees and employers could use to facilitate the self assessment of competence and the early identification of competence problems.

- **Nondisciplinary Approach for Limited License**

  The Nursing Practice and Education Committee will develop guidelines for nondisciplinary approaches for issuing limited licenses to disabled applicants and nurses.

- **Chemically Dependent Nurses Study**

  Depending upon the recommendations made by the Subcommittee to Study the Regulatory Models for Chemically Dependent Nurses, the National Council will need to determine the subcommittee's future role.

- ***Model Nursing Administrative Rules***

  The Nursing Education and Practice Committee will complete the review and revision of the *Model Nursing Administrative Rules* for the 1994 Delegate Assembly.

Recommendation(s)

1. That the Delegate Assembly adopt the revised *Model Nursing Practice Act*.

Staff

Linda F. Heffernan, *Nursing Practice and Education Associate*
Vickie R. Sheets, *Director for Public Policy, Nursing Practice and Education*

Attachments

A ....*Model Nursing Practice Act*, *page 5*
B ....Draft Concept Paper - Competence Paradigm Shift, *page 7*

Addendum to the Report of the Nursing Practice and Education Committee

Members of the Nursing Practice and Education Committee reviewed the final draft of the Subcommittee to Study the Regulation of Advanced Nursing Practice after the subcommittee held its final meeting May 7–8, 1993. The Nursing Practice and Education Committee supports the adoption of the recommendations of the Subcommittee to Study the Regulation of Advanced Nursing Practice.

Attachment A

Revised Model Nursing Practice Act

The National Council's *Model Nursing Practice Act* was last revised in 1988. The Nursing Practice and Education Committee reviewed the *Model Nursing Practice Act*, and the committee's suggested revisions are presented in this attachment. Any added language is underlined, and deleted language is crossed out of the original text.

NOTE: Page numbers for this document appear on the bottom of each page.

Article I.

Comment

Section 1. Title of Act. This Act shall be known and may be cited as "The (state) Nursing Practice Act."

Date of enactment of Nursing Practice Act should be cited on any reprint of the Act.

Section 2. Description of Act. An Act to provide for the regulation of the practice of nursing, a practice affecting the public health, safety and welfare; to provide for a State Board of Nursing; and to define the powers and duties of that Board, including licensure of practitioners of nursing, establishment of standards for nursing practice and ~~educational~~ nursing education programs, adoption of administrative rules to implement this Act, and prescription of penalties for violation of the provisions of this Act.

This section describes the general scope of the Nursing Practice Act. It summarizes and clarifies the main elements of the Act and serves as a useful reference.

Section 3. Purpose. The legislature finds that the practice of nursing by competent persons is necessary for the protection of the public health, safety and welfare; and further finds that the two levels of practice within the profession of nursing should be regulated and controlled~~,~~ in the public interest. Therefore, it is the legislative purpose of this Act to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of ~~the practice of nursing and of the educational preparation for this practice,~~ nursing education and practice, and to ensure that any person practicing or offering to practice nursing, as defined in this Act, or using the title of Registered Nurse or Licensed Practical Nurse after the effective date of this Act within this state shall, before entering upon such practice or using such title, be licensed as hereinafter provided. Boards of Nursing shall adopt regulations to identify those essential elements of practice necessary to protect the public.

This section will answer questions about what a legislature intended to accomplish through passage of the statute when the courts, an Attorney General or other legal counsel seek interpretation of the Act.

~~*Regulatory bodies are charged with establishing standards for minimum safe and effective nursing practice.*~~

~~*Within the minimum level there is a range from low minimum to high minimum points. In order to promote nursing at the highest enforceable level, Boards of Nursing should design regulations at the high minimum level of practice.*~~

In this section, nursing is established as a legal role, thereby, affording its professional members, Registered Nurses, the attendant rights and responsibilities. In addition, this section acknowledges the practice of Licensed Practical Nurses, the nature of whose practice also affects directly the public health, safety and welfare and, consequently, should be regulated and controlled. Other persons to whom certain tasks may be delegated by Registered Nurses or Licensed Practical Nurses should not be licensed because the tasks involved are limited, delegated and performed under supervision and can be controlled and

regulated by other means.

In the history of American nursing, the process of registration preceded that of licensure. Nongovernmental registries listed nurses who met certain qualifications and thus served to protect the public against incompetent practitioners. When licensure was instituted in the various states, the term "registered nurse" and the abbreviation "R.N." were protected for use by only qualified nurses. Registration, however, differs from licensure in that it is a process by which qualified individuals are listed on an official roster. Because mandatory licensure affords greater protection for the public than registration, the Nursing Practice Act should refer only to this process. Current references to registration that are embodied in the legally recognized Licensed Practical Nurse title can confuse the public and the ~~nursing practitioners~~ licensees. Alternate titles that would reflect the licensed status of ~~both~~ all levels of nurses should be considered in revisions of the Act.

Alternative titles for Registered Nurse and Licensed Practical Nurse, which better reflect the method of regulation and control ~~and regulation~~ and the relationship between the two levels of licensed practitioners, should be considered. The method of control and regulation specified in the Practice Act is licensure rather than registration. Licensure is the process by which an agency of state government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the essential degree of competency necessary to ensure that the public health, safety and welfare will be reasonably well protected. In granting an individual permission to practice through licensure, the state holds the individual responsible and accountable for that practice. The state also maintains records of past and present licenses.

Article II.

Section 1. Practice of Nursing. The "Practice of Nursing" means assisting individuals or groups to maintain or attain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to care and treatment. This practice includes, but is not limited to, initiating and maintaining comfort measures, promoting and supporting human functions and responses, establishing an environment conducive to well-being, providing health counseling and teaching, and collaborating on certain aspects of the health regimen. This practice is based on understanding the human condition across the lifespan and ~~understanding~~ the relationship of the individual within the environment.

Comment

The most important part of a practice act is the definition of the practice that it seeks to regulate. ~~The definition should distinguish nursing practice from the practice of other health by assessing health status, establishing a nursing diagnosis, planning and professions, yet should be stated~~ The practice of nursing should be distinguished from the practice of other health care providers in terms sufficiently broad to include all levels of ~~practice, including that of the~~ Registered Nurse and Licensed Practical Nurse practice. ~~and all extended and expanded nursing roles.~~

~~Nurses who practice advanced clinical nursing are practicing a specialty in accordance with advanced education in clinical nursing. However, their practice should be within the parameter of the legal scope of nursing practice.~~

A broad definition of nursing will enable the Board of Nursing to adopt implementing rules to meet changing practice. This definition is based partly on information ~~found~~ in the report, "Critical Requirements for Safe/Effective Nursing Practice," a 1978 research project conducted for the National Council of State Boards of Nursing by Angeline M. Jacobs and others.

~~In 1986, the National Council completed a "Job Analysis and Role Delineation Study of Entry Level Registered Nursing Practice" that further defined critical entry level elements of nursing practice.~~

In 1993, the National Council completed the latest in a series of job analysis studies, entitled "Job Analysis Study of Newly Licensed, Entry-Level Registered Nurses," that further defined critical entry level elements of nursing practice.

The definition does not include reference to educational preparation or responsibilities that are common to all health professions, such as knowledge of biological, physical, behavioral, psychological and sociological sciences; supervision, administration, delegation and

teaching; and ~~performing~~ practicing interdependently with other health professionals. ~~It is believed that execution of the medical regimen does not describe the essence or unique elements of nursing that distinguishes it from other health professionals and for which regulation is required in order to safeguard the public health, safety and welfare.~~

~~Others, such as pharmacists, medical social workers, and physical therapists, also execute aspects of the medical regimen, but this Act does not describe their particular practices. However,~~ The process of implementing a strategy of care may encompass collaboration with ~~the profession of medicine carrying out certain aspects of the medical regimen~~ other health care providers. ~~In many instances, the welfare of the health care recipients necessitates medical and nursing care synergism. Assisting other health professionals in providing care~~ It should be a legally recognized component of practice not only for nurses, but for all health professionals.

Section 2. Registered Nurse. The Practice of nursing as a Registered ~~Nursing~~ Nurse means the practice of the full scope of nursing which includes but is not limited to:

(a) Assessing the health status of individuals and groups;

(b) Establishing a nursing diagnosis;

(c) Establishing goals to meet identified health care needs;

(d) Planning a strategy of care;

(e) Prescribing nursing intervention to implement the strategy of care;

(f) Implementing the strategy of care;

(g) Delegating nursing interventions ~~that may be performed by~~ to qualified others ~~and that do not~~

This definition describes the responsibilities and scope of practice of registered nurses and entrusts them with overall responsibility for nursing care. It outlines certain essential responsibilities which require professional judgment, which registered nurses have the educational preparation to undertake, and for which they are held accountable. In addition, it enables the registered nurse to delegate nursing measures that may be performed by others under appropriate supervision. Such a definition clearly distinguishes the difference between a Registered Nurse's practice and the practice of others within the field of nursing, such as Licensed Practical Nurses and ~~Auxiliaries~~ Nurse Aides.

The Model Act has not incorporated the Model Nurse Aide Regulation Act into its provisions.

~~conflict with~~ as provided in this Act;

(h) ~~Maintaining~~ Providing for the maintenance of safe and effective nursing care rendered directly or indirectly;

(i) Evaluating responses to interventions;

(j) Teaching the theory and practice of nursing;

(k) Managing and supervising the practice of nursing; and

(l) Collaborating with other health care professionals in the management of health care ~~and~~.

~~(m) Practicing advanced clinical nursing in accordance with knowledge skills acquired through graduate nursing education.~~

Section 3. Licensed Practical Nurse. The practice of nursing as a Licensed Practical ~~Nursing~~ Nurse means ~~practice of~~ a directed scope of nursing practice which includes, but is not limited to:

This definition describes the responsibilities and scope of practice for which Licensed Practical Nurses will be held accountable and clearly distinguishes their responsibilities and practice from that of the Registered Nurse. The responsibility for directing nursing care ~~belongs~~ is that of a ~~to the~~ Registered Nurse. However, because many Licensed Practical Nurses work under the direction of physicians and dentists, the law should accommodate this practice.

(a) Contributing to the assessment of the health status of individuals and groups;

(b) Participating in the development and modification of the strategy of care;

(c) Implementing the appropriate aspects of the strategy of care as defined by the Board;

Some jurisdictions may use the term Licensed Vocational Nurse instead of Licensed Practical Nurse.

(d) Maintaining safe and effective nursing care rendered directly or indirectly;

(e) Participating in the evaluation of responses to interventions, and;

Participation implies collaboration with other members of the health care team

(f) Delegating nursing interventions ~~that may be performed by~~ to qualified others ~~and that do not conflict with~~ as provided in this Act.

The Model Act has not incorporated the Model Nurse Aide Regulation Act into its provisions.

The Licensed Practical Nurse ~~functions at~~ practices under the direction of the Registered Nurse,

The Licensed Practical Nurse may, according to state statute, perform functions delegated by other

licensed physician, or licensed dentist in the performance of activities delegated by that health care professional.

licensed health care providers under the applicable practice acts.

Section 4. Board. "Board" means the (state) Board of Nursing.

Authority base, structure, and name of regulatory agency will vary from state to state.

Section 5. Other Board. "Other Board" means the comparable regulatory agency in any U.S. State or Territory.

Section 6. License. "License" means a current document permitting the practice of nursing as a Registered Nurse or Licensed Practical Nurse.

A license is a current document issued to a qualified individual for the purpose of permitting that individual to practice as a Registered Nurse or Licensed Practical Nurse for a specific length of time. A license is renewable provided existing qualifications have been met. Because the only purpose of a license is to grant legal permission to a qualified person to do something, no inactive license should be provided.

Article III.

Section 1. Membership; Appointment; Nominations; Term of Office; Removal; Vacancies; Qualifications; Immunity.

(a) The Board of Nursing shall consist of ( ) members to be appointed by the Governor ( ) days prior to the expiration of the term of office of a current member. Nominations for appointment may be made to the Governor by any interested individual, association, or any other entity, provided that such nominations be supported by a petition executed by no less than ( ) qualified voters in this State. These nominations shall not be binding upon the Governor.

Comment

The ~~size~~ composition of the Board should take into consideration the ~~population~~ demography of the state, the numbers of Registered Nurses and Licensed Practical Nurses being regulated, the number of education~~al~~ programs and healthcare agencies. ~~and the number of members needed to effectively enforce the Act.~~ In most states, the number of Board Members is an odd number so that ~~determinations~~ decisions ~~by a clear majority~~ may be made by a clear majority.

The State Legislature may have confirming privilege. In those States where the Board is advisory, appointments to the Board may be initiated or confirmed by some governmental agency or body other than the Governor or Legislature.

Some mechanism should be developed to enable the Board to conduct its business with a full complement of members so that there is no fear of subsequent challenge regarding delayed appointments; senate confirmation, apathy, changes in the law and staggered terms.

The provision regarding nominations avoids challenges of conflicts of interest or discrimination, ensures genuine interest of a number of nominating persons, yet reserves gubernatorial discretion.

(b) The membership of the Board shall be at least ( ) members of Registered Nurses; at least ( ) members of Licensed Practical Nurses; and at least ( ) members representing the public.

Because the majority of nurses licensed in most jurisdictions are Registered Nurses, the majority of Board members should be Registered Nurses. A majority of nurse members on the board is required to determine if persons ~~performing~~ practicing nursing functions are qualified. In addition, the judgment of Registered Nurses constitutes the best possible criterion for determining the legality of a nursing action. Although it is recognized that representatives of the public make ~~a~~ significant contributions to the purpose of the Board, the need for nursing expertise is a sufficient state interest to justify a nursing majority membership on the Board.

Some states may desire Board membership to represent different geographic areas or the various areas of nursing practice such as education, administration and clinical practice.

Such special group representation and input also may be achieved through formation of special advisory committees.

Each Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Registered Nurse, and shall have had no less than five (5) years of experience as a Registered Nurse, at least three (3) of which immediately preceded appointment.

Registered Nurse and Licensed Practical Nurse members should have sufficient nursing background and expertise to make appropriate decisions regarding the complex and technical matters within the Board's jurisdiction. These members also should have a commitment to the protection and concerns of the public. Currently engaged in the practice of nursing means that the practice is concurrent with the term on the Board.

Each Licensed Practical Nurse member shall be an eligible voting resident of this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing, and shall have had no less than five (5) years of experience as a Licensed Practical Nurse, at least three (3) of which immediately preceded appointment.

Appearance of conflict of interest and, on occasion, actual conflict of interest implications are raised when Board members hold elected positions in professional association. To avoid any claim on bias, the Registered Nurse and the Licensed Practical Nurse members should not be required to be members of their respective association.

However, membership in the professional association tends to reinforce professional commitment and should not be discouraged.

The representatives of the public shall be eligible voting residents of this State who are knowledgeable in consumer health concerns, and shall neither be, nor ever have been, associated with the provision of health care or be enrolled in any health related education program.

Consideration should be given to having more than one (1) member representing the public. The number chosen should increase as the size of the Board increases.

In order to assure that public members are truly independent in their judgment, any person who has a possible substantial relationship with a health provider is rendered ineligible by this section.

Membership shall be restricted to no more than one (1) person who is associated with a particular agency, corporation or other enterprise or subsidiary at one time.

(c) Members of the Board shall be appointed for a term of ( ) years.

The present members of the Board holding office under the provisions of (Act being amended or repealed) shall serve as members for their respective terms.

In the event of passage of a new act which changes the size of the Board, provision should be made for carry-over of Board members.

No member shall serve more than two (2) consecutive full terms. The completion of an unexpired portion of a full term shall not constitute a full term for purposes of this section. Any Board member initially appointed for less than a full term shall be eligible to serve two (2) additional consecutive full terms.

This section is intended to continue the staggered appointment process in effect in most jurisdictions. However, if a jurisdiction does not have provision for staggered appointments in the present Act, it is recommended that this section be revised to provide for staggered appointment.

An appointee to a full term on the Board shall be appointed by the Governor before the expiration of the term of the member being succeeded and shall become a member of the Board on the first day following the appointment expiration date. Appointees to unexpired portions of full terms shall become members of the board on the day following such appointment.

Each term of office shall expire at midnight on the last day of the term of the appointment or at midnight on the date on which any vacancy occurs.

If a replacement appointment has not been made, the term of the Member shall be extended until a replacement is made.

This enables the continuity of Board activity.

(d) Any vacancy that occurs for any reason in the membership of the Board shall be filled by the Governor in the manner prescribed in the provisions of this article regarding appointments. Vacancies created by reason other than the expiration of a term shall be filled within ( ) days after such vacancy occurs.

A person appointed to fill a vacancy shall serve for the unexpired portion of the term.

(e) The Governor may remove any member from the Board for neglect of any duty required by law or for incompetency ~~or~~, unprofessional or

Any concerned person may file a complaint against a Board member with the appropriate state agency or official.

dishonorable conduct.

The general laws of this State controlling the removal of public officials from office shall be followed in dismissing Board members.

If general laws do not address attendance of Board Members at meetings, it is suggested that attendance at meetings be addressed in the rules.

(f) All members of the Board shall have immunity from individual civil liability while acting within the scope of their duties as Board members.

Because of the quasi-judicial functions of regulatory boards it may be wise to cite within the law a clause granting immunity.

Each state's law should be researched to determine the power of the legislature to grant immunity as expressed in this section.

(g) In the event that the entire Board, an individual member or staff is sued, the Attorney General shall appoint an attorney to represent the involved party.

(h) Board meetings and hearings shall be open to the public. In accordance with the law, the Board may in its discretion conduct part of the meeting in executive session closed to the public.

Most states have adopted public meeting laws which provide for open meetings. The Board should investigate the content of the public meeting law in relation to executive sessions.

The provision of executive session for review of future test items by Board members and staff is necessary. Confidentiality of test items will still need to be assured when CAT is implemented.

Section 2. Powers and Duties. The Board shall:

(a) ~~Have responsibility~~ Be responsible for enforcement of the provisions of this Act. The Board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act, including subpoena power, as well as such other duties, powers and authority as it may be granted by appropriate status;

(b) Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for the proper administration and enforcement of this Act and to protect the public health, safety and welfare.

An effort should be made to allow for some freedom within the statute to accommodate for changes in the nature of practice which will occur from time to time.

State Administrative Procedure Acts specify appropriate constitutionally required procedures for rulemaking, conducting hearings and other Board functions that afford the public and affected

individual's due process of law in such matters. Some states enact procedural provisions directly as a part of each nursing act.

Rulemaking authority can only be delegated by specific statute. Rules (except for interpretive statements which are not subject to formal rulemaking process) have the force and effect of law once they have been properly adopted.

Rulemaking authority should be used only as is necessary to carry out the provision of this Act or to comply with a legislative mandate.

(c) Further be authorized to do the following without limiting the foregoing:

(i) Develop and enforce qualifications for licensure;

The Board of Nursing has a legal responsibility to develop essential standards as a basis for evaluating safe and effective nursing practice that protects the health, safety and welfare of the public. Other nursing groups or organizations may wish to develop optimal standards for nursing practice.

(ii) Develop and enforce standards for nursing practice and nursing education;

The board shall set standards that are legally defensible as "reasonable and uniform."

The board with its professional majority makes these decisions for ~~nurse~~ nursing.

(iii) ~~Examine, license and renew the licensed of duly qualified individuals;~~License qualified applicants by examination or endorsement, and renew and reinstate licenses;

~~The licensing examination and the frequency and timing should depend on a nationally established examination and calendar.~~The Board shall establish in rules the frequency and number of times a candidate may take the licensing examinations. A minimum time period may be specified by the National Council to maintain psychometric soundness of the examination.

(iv) Develop standards for ~~continued competency~~ maintaining the competence of licensees continuing in or returning to practice;

Consideration of ~~continued competency~~ competence and interstate endorsement is included here. Each state Board of Nursing should determine when and under what conditions reexamination may be required.

(v) Collect and analyze data regarding nursing~~;~~ education, nursing practice, and nursing resources;

This section allows for responsible monitoring and control of current licensure and assures the public information on the availability of nursing resources within the state.

(vi) ~~Implement a disciplinary process~~Discipline licenses as needed;

(vii) Regulate the manner in which nurses announce their practice to the public;

This section is not intended as a restriction on a nurse's right to advertise in a truthful manner or in any other way that is consistent with constitutional interpretation.

(viii) Issue a limited license to practice nursing subject to such terms and conditions as the Board may impose;

~~*To qualify for an initial limited license, a handicapped person should meet the essential standards of an educational program and other requirements specified in the statute and administrative rules.*~~

~~*A licensed nurse who becomes handicapped may also be issued a limited license.*~~

~~*A nurse whose license is under discipline by the Board may be issued a limited license if, for some reason, it is determined that the licensee is incapable at the time of safely practicing the full scope of nursing appropriate to the practice of a Registered Nurse or a Licensed Practical Nurse.*~~

~~*Questions that would establish a candidate's need for limited licensure should be included on the initial application for licensure, renewal application and verification form.*~~

Questions that would assist Boards to identify individuals who may require limited licensure in order to protect the public should be included on licensure, renewal and reinstatement applications. Applications may include questions about any physical or mental conditions which may limit the applicant's ability to perform essential nursing functions, the accommodations that were provided by the education program to assist an applicant to meet education program objectives and accommodations which would be needed to perform

essential nursing functions.

Boards may develop non-disciplinary tracks to evaluate accommodations, make licensure decisions, and issue limited licenses to individuals with disabilities. Periods of monitored practice may be used to determine whether a nurse is able to perform essential nursing functions safely, with or without accommodations.

Boards may issue a limited license through the disciplinary process if the nurse is found to be incapable of practicing the full scope of nursing safely. Typically, such disciplinary actions include both corrective action and a listing of the requirements the licensee would need to meet before an unencumbered license could be issued.

Limited licensure provisions should be noted on the license issued to the individual.

(ix) ~~Notify all~~ Inform licensees ~~annually~~ on an established basis about changes in law and rules regarding nursing practice;

(x) Maintain records of proceedings as required by the laws of this State;

(xi) Provide consultation, conduct conferences, forums, studies and research on nursing ~~practice and~~ education and practice;

This authorization provides for consideration of public policy and representation of public concerns. It may also initiate educational ~~schemes~~ strategies to improve professional and occupational performance.

(xii) Appoint and employ a qualified Registered Nurse to serve as Executive Director and approve such additional staff positions as may be necessary, in the opinion of the Board, to administer and enforce the provisions of this Act;

The Board can only operate within the limits of available resources and should be staffed to carry out functions in a meaningful manner.

(xiii) ~~Join~~ Maintain membership in national organizations that develop and regulate the national nursing licensure examinations and exclusively promote the improvement of the legal standards of the practice of

This section provides an opportunity for the Board to participate in the development of nationally standardized licensure examinations and to join with other Member Boards to act on matters of common concern, such as interstate endorsement.

nursing for the protection of the public health, safety and welfare;

The organization currently recognized as facilitating the accomplishment of these goals is the National Council of State Boards of Nursing.

(xiv) Require such surety bonds as are deemed necessary;

(xv) Determine and collect reasonable fees;

(xiv) Receive and expend funds in addition to appropriations from this State, provided such funds are received and expended for the pursuit of the authorized objectives of the Board of Nursing; such funds are maintained in a separate account; and periodic reports of the receipt and expenditures of such funds are submitted to the Governor; and

(xvii) Adopt a seal which shall be in the care of the Executive Director and which shall be affixed only in such a manner as prescribed by the Board.

(d) This Act shall not be construed to require the Board of Nursing to report violations of the provisions of the Act whenever, in the Board's opinion, the public interest will be served adequately ~~be~~ by a suitable written notice of warning.

Section 3. Executive Director. The Executive Director shall be responsible for:

The title for the Board's Executive Director may vary in the Act.

(a) The performance of administrative responsibilities of the Board;

Each Board shall appoint a permanent administrative officer or director to perform and supervise the administrative duties and responsibilities of the Board on a daily basis.

(b) Employment of personnel needed to carry out the functions of the Board; and

Conflict of interest implications must be considered when the Executive Director serves in an elected office of a professional organization.

(c) The performance of any other duties as the oard may direct.

Section 4. Compensation. Each member of the Board shall receive, as compensation, a reasonable

Board members should be reimbursed commensurate with the duties and responsibilities of

sum for each day the member is engaged in performance of official duties of the Board and reimbursement for all expenses incurred in connection with the discharge of such official duties.

the appointment. It is recommended that an amount not be specified in the statute in order to allow for adjustments in keeping with economic conditions, unless such specification is required within the jurisdiction.

Such compensation should be equivalent to that received by other Boards in the State.

Article IV. Administrative Procedure Act - Application.

The (state) Administrative Procedure Act is hereby expressly adopted and incorporated herein as if all the provisions of such Act were included in this Act.

Comment

The Administrative Procedure Act addresses the functions of rulemaking, adjudication, and judicial review. These three functions comprise basic duties of the Board and are relevant to its regulation of nurses.

Article IV. Administrative Procedure Act - Application.

The (state) Administrative Procedure Act is hereby expressly adopted and incorporated herein as if all the provisions of such Act were included in this Act.

Comment

The Administrative Procedure Act addresses the functions of rulemaking, adjudication, and judicial review. These three functions comprise basic duties of the Board and are relevant to its regulation of nurses.

Article V. Licensure | **Comment**

Section 1. Requirements. Each applicant who successfully meets the requirements of this section shall be entitled to licensure as a Registered Nurse or Licensed Practical Nurse, whichever is applicable as follows:

(a) Licensure by Examination. An applicant for licensure by examination to practice as a Registered Nurse or Licensed Practical Nurse shall:

(i) Submit a completed written application and ~~appropriate~~ fees as established by the Board;

The licensure application should include questions related to the requirements for licensure. Designating high school graduation or equivalency is not necessary if all nursing education programs in a state require it.

(ii) Be a graduate of an approved nursing education program which meets criteria similar to and not less stringent than those established by this Board and which prepares for the level of licensure being sought;

The information provided by the education program should include a description of accommodations provided by the education program to assist the applicant to meet program educational objectives related to essential nursing functions.

(iii) Be proficient in English language if a graduate of a foreign nursing educational program;

(iv) Pass an examination authorized by the Board;

~~*Not all Boards give the exams; however, they should have the authority to select the exams and provide the exam administration.*~~

(v) Have committed no acts or omissions which are grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, or if the Board has found after investigation that sufficient restitution has been made; and

Reference to grounds for disciplinary action is used instead of the phrase "good moral character" frequently seen in such acts. Defining "good moral character" has caused difficulty in the past, and its requirements for licensure may not be sustained by the courts in the future. Reference to specific grounds included in the Act should be more easily defined.

(vi) Meet other criteria established by the Board.

(b) Licensure by Endorsement. An applicant for licensure by endorsement to practice as a Registered Nurse or Licensed Practical Nurse shall:

These requirements apply the same standards to applicants for licensure by endorsement as for those applicants applying for licensure by examination. Nurses educated in foreign countries are considered under the same conditions as are nurses educated in the United States. This section does not permit licensure by waiver because requirements as listed are considered to be the minimal qualifications for safe and effective practice as a Registered Nurse or Licensed Practical Nurse.

(i) Submit a completed written application and ~~appropriate~~ fees as established by the Board;

The endorsement application should also include questions related to the requirements for licensure.

(ii) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or if such acts have been committed and would be grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, but the Board has found after investigation that sufficient restitution has been made;

(iii) ~~Submit proof of graduation from a Board approved nursing program;~~ Be a graduate of an approved nursing education program which meets criteria similar to and not less stringent than those established by this board and which prepares for the level of licensure being sought;

(iv) ~~Submit proof of initial licensure by an examination, with the examination having followed completion of the nursing education program. The applicant shall meet this State's examination requirement in effect when the applicant secured initial licensure.~~ Submit verification of licensure status directly from the jursidiction of licensure by examination;

(v) Submit verification of licensure status directly from the jurisdiction of most recent employment;

If different from the original state of licensure.

(vi) Meet continued competency requirements as stated in Article V, Section 3~~, Section 2~~b; and

(vii) Meet other criteria established by the Board.

Section 2. Examinations.

(a) The Board shall authorize the administration of the examination to applicants for licensure as Registered Nurses or Licensed Practical Nurses. ~~The Board shall give due notice in advance of the examinations.~~

(b) The Board may employ, contract and cooperate with any organization in the preparation and grading of an appropriate nationally uniform examination, but shall retain sole discretion and responsibility for determining the standard of successful completion of such an examination. When such a national examination is utilized, access to questions and answers shall be restricted by the Board.

The Board shall determine whether an examination may be repeated, the frequency of re-examination and any requisite further education.

The National Council holds a position that an integrated, criterion referenced exam, i.e., NCLEX, can assure competency when passed, no matter how often it is taken, within the constraints of maintaining the psychometric soundness of the item pools through pool rotations and new item additions. On the other hand, there is indication that the number of writings of norm referenced tests allowing partial examination, i.e., State Board Test Pool Examination, should be limited in order to assure the public health, safety and welfare. The law should be broadly stated so that the Board can set specifics in rules and ~~request~~ reflect the state-of-the-art at different points in time.

Section 3. Renewal of Licenses.

(a) Licenses issued under this Act shall be renewed every ( ) years according to a schedule established by the Board.

Licensees should be asked to attest to their ability to perform essential nursing functions on the renewal application.

Annual renewal provides the best process for tracking Registered Nurses and Licensed Practical Nurses than less frequent renewal and is, therefore, the best process relating to the protection of the public's health, safety, and welfare. However, for logistical reasons Boards may choose other renewal cycles that allow the Board time needed to carry out its other ~~Board~~ responsibilities.

Annual renewal also provides ~~good~~ accurate statistical data to be used in projecting manpower needs, mobility and other trend data for analysis. However, the cost of annual renewal may be prohibitive and biennial renewal may be preferred by some jurisdictions.

(b) A renewal license shall be issued to a Registered Nurse or Licensed Practical Nurse who ~~demonstrates satisfactory completion of such requirements established by the Board to ensure continued competence and who~~ remits the required fee and satisfactorily completes any other requirements established by the Board;

It is recognized that continued competency requirements for relicensure are complicated by frequent renewals. Each state should determine priorities and establish renewal frequency accordingly. Because practices in the health care delivery system, in general, and in the delivery of nursing service, in particular, continuously change, it is essential that nurses maintain a degree of nursing competency which assures the public safe and effective care. States may choose continuing education requirements, reexamination, peer review, self-assessment techniques or other such methods of determining competency.

(c) Failure to renew the license shall result in forfeiture of the right to practice nursing in this State.

Section 4. Reinstatement of Lapsed Licenses.

A licensee ~~who has allowed one's~~ whose license ~~to lapse~~ has lapsed by failure to renew may apply for reinstatement according to the rules established by the Board. Upon satisfaction of the requirements for reinstatement, the Board shall issue a renewal of license.

After extended absences from practice, completion of an educational program or other means of determining ~~continued competency~~ competence may be indicated. If Boards have established continuing competency requirements for renewal, such requirements ~~are~~ may also be appropriate for reinstatement.

Section 5. Temporary Licenses.

(a) The Board may issue a temporary license to practice nursing for a period not to exceed ( ) days to a Registered Nurse or Licensed Practical Nurse currently licensed in another jurisdiction of the United States, ~~and~~ who is an applicant for licensure by endorsement, provided the applicant ~~submits a written application for a temporary license in accord with the rules of the Board.~~ remits the required fee and completes the written application in accordance with the rules of the Board.

The issuing of temporary licenses lessens the mandatory effect of the Act but recognizes the mobility of the nursing work force, the need for nursing manpower, and the economic needs of beginning practitioners and those moving from state to state. States may wish to consider issuing a temporary license to Registered Nurse graduates of foreign schools of nursing who have ~~successfully~~ passed the examination administered by the Commission on Graduates of Foreign Nursing Schools (CGFNS) and whose education ~~and training are~~ is substantially similar to or higher than the educational standards for the individual state. The correlation between scores on the licensure examination and the CGFNS examination should be carefully studied before such provisions are added.

(b) The Board may issue a temporary license to practice nursing to a graduate of an approved nursing education program, ~~pending the results of the first licensing examination after graduation.~~ pending the results of an examination within ( ) days of graduation.

The procedure would be determined by individual Boards. States may wish to re-evaluate whether or not to issue temporary licenses because graduates will obtain examination results more quickly with CAT.

(c) Temporary licenses shall not be renewable.

Section 6. Limited Licenses.

(a) ~~The Board may issue a limited license to practice nursing in a restricted manner as designated by the Board.~~ The Board may issue a limited license to a licensee who is unable to practice the full scope of nursing practice. ~~This licensure is to be used because of a nurse's inability to practice safely the full range of nursing.~~

The intent of limited licensure here is to allow for practice with restrictions such as limited settings, supervision requirements, or limited ~~narcotic~~ controlled substance administration for those with physical or mental impairment, chemical dependence or deficits in practice capabilities. Due process must be offered to the nurse before a license is limited. A nurse may waive due process rights and voluntarily accept or request a limited license.

(b) The Board may issue a limited license ~~only~~ to practice nursing only as part of a nursing education program. This is allowed when the person graduated from a nursing program in another country and is licensed in that country but has not

Colleges and universities have foreign students who are nurses and who want further nursing education but do not want American licensure because they want to return to their own countries. These students are in the BSN completion and graduate

passed the examination in licensure required in that state.

programs. Limiting their practice to that controlled by the educational setting may provide for some protection to the public while allowing their advanced education.

Section 7. Duties of Licensees. Each licensee shall:

(a) In response to Board inquiries, provide personal, professional or demographic information requested by the Board to perform its duties in regulating and controlling nursing practice in order to protect the public health, safety and welfare. Failure to provide the requested information may result in nonrenewal of the license to practice nursing.

~~License holders~~ Licensees have a responsibility to cooperate with Boards in data collection for statistical purposes as well as a responsibility to provide information concerning the individual's own status which may affect his or her ability to practice nursing safely and effectively.

(b) Submit to a physical or mental examination by a designated ( ) when directed in writing by the Board for cause. If requested by the licensee, the licensee may also designate a ( ) for an independent medical examination. Refusal or failure of a licensee to complete such examinations shall constitute an admission of any allegations relating to such condition. All objections shall be waived as to admissibility of the examining ( ) testimony or examination reports on the grounds that they constitute privileged communication. The medical testimony or examination reports shall not be used against a registered nurse or licensed practical nurse in another proceeding and shall be confidential. At reasonable intervals, a registered nurse or licensed practical nurse shall be afforded an opportunity to demonstrate ~~that the nurse can~~ competence to resume the ~~competent~~ practice of nursing with reasonable skill and safety to patients.

An examination is helpful in establishing whether cause exists for disciplinary action. There are, however, safeguards that should exist for the licensee, e.g., option of second opinion and confidentiality of the records. The Board shall designate the appropriate legally authorized health care practitioners to perform the required services described in this section of the Act. The requirement by a Board for a licensee to submit to physical or mental examinations for cause is not prohibited by the Americans with Disabilities Act.

(c) Report to the Board those acts or omissions which are violations of the Act or grounds for disciplinary action as set forth in Articles VIII and IX of this Act.

This establishes mandatory reporting by nurses of unlicensed persons or nurses who violate the Nursing Practice Act.

~~(d) Report to the Board every adverse judgment in a professional or occupational malpractice action to which the licensee is party, and every settlement of a claim against the licensee alleging malpractice.~~

~~Expands mandatory reporting to the individual nurse.~~Malpractice Reports are now available to Boards of Nursing through copies of reports submitted to the National Practicioner Data Bank.

Article VI. Titles and Abbreviations.

Section 1. Only those persons who hold a license to practice nursing in this state shall have the right to use the following title abbreviations.

A. Title: "Registered Nurse" and the abbreviation "RN"

B. Title: "Licensed Practical Nurse" and the abbreviation "LPN"

Comment

Titles and abbreviations for examination or endorsement for licensure vary from state to state. Some of the titles and abbreviations are:

A. Temporary Registered Nurse - TRN/Temporary Licensed Practical Nurse - TLPN
B. Graduate Nurse - GN/Graduate Practical Nurse-GPN
C. Professional Nurse-PN/Practical Nurse-PN
D. Trained Nurse-TN/Trained Practical Nurse-TPN

Section 2. Any person who has been approved as an applicant for the licensure examination and has been granted a temporary license for examinations shall have the right to use the following abbreviations.

A. Title: "Graduate Nurse" and the abbreviation "GN"

B. Title: "Graduate Practical Nurse" and the abbreviation "GPN"

Section 3. Any person who has been approved as an applicant for licensure by endorsement and has been granted a temporary license shall have the right to use the title ( ) and abbreviations ( ) designated by the state.

Because the Practice Act incorporates the concept of mandatory licensure for the practice of nursing and assures the public that those using the titles Registered Nurse and Licensed Practical Nurse are licensed and qualified to practice nursing as defined in the Act, any provision in the Act which permits temporary licensure should be reflected in titles and accompanying abbreviations. These titles and abbreviations should clearly stipulate the temporary practice status of these authorized individuals. Other titles which seek to convey a temporary licensure status but do not include the word temporary in them can be confusing to the public and endanger its welfare.

Article VII. Approval of Nursing Education Programs.

Section 1. Approval Standards. The Board shall, by administrative rules, ~~approve the~~ set standards for the establishment and conduct of ~~and standards for~~ nursing education programs, including all clinical facilities used for learning experiences, and shall survey and approve such programs ~~as~~ which meet the requirements of the Act and the Board administrative rules.

Comment

The Board of Nursing in order to safeguard public health, safety and welfare, should approve the establishment and conduct of nursing education programs. The Board should establish standards for and approve educational programs preparing persons for the practice of nursing at the undergraduate and graduate levels. ~~The question of~~ What constitutes sufficient preparation for the practice of nursing should be decided by ~~a~~ the Board of Nursing.

Section 2. Approval Required. An educational institution within this State desiring to conduct a nursing education program shall apply to the Board and submit evidence that its nursing program is able to meet the standards established by the Board. If, upon investigation, the Board finds that the program meets the established standards for nursing education programs, it shall approve the applicant program.

Section 3. Periodic Evaluation of Nursing Programs. The Board shall periodically ~~resurvey and~~ reevaluate approved nursing education programs and shall publish a list of approved programs.

Section 4. Denial or Withdrawal of Approval. The Board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the Board, provided that all such actions shall be ~~affected~~ in accordance with this State's Administrative Procedures Act and/or the Administrative Rules of the Board. A process of appeal and reinstatement shall be delineated in Board rules.

Boards of Nursing may wish to utilize an intermediate approval status, such as conditional approval, for educational programs that do not fully meet approval standards. This status denotes that certain conditions must be met within a designated time period in order for the program to be fully approved. Failure to do so ~~would~~ could result in withdrawal of approval. The Board must provide the program due process prior to withdrawal of approval.

Conditional approval generally allows educational programs to continue operation while they correct deficiencies and work towards meeting the conditions for full approval. The graduates of conditionally approved programs should be eligible to take the licensing examinations and, upon

~~successfully~~ passing the examination, become licensed.

Section 5. Reinstatement of Approval. The Board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the Board.

Section 6. Provisional Approval. Provisional approval of new programs may be granted pending the licensure results of the first graduating class.

Article VIII. Violations and Penalties.

Section 1. Violations. No person shall:

(a) Engage in the practice of nursing as defined in the Act without a valid, current license, except as otherwise permitted under this Act;

Comment: *The regulation of the practice of nursing, including the control of unlicensed practice in the profession, has a reasonable and rational relationship to public health, safety and welfare.*

(b) Practice nursing under cover of any diploma, license or record illegally or fraudulently obtained, signed or issued unlawfully or under fraudulent representation;

In addition to potential danger to the public health, safety and welfare, the described acts would also be considered criminal acts such as fraud, false representation and others; and the provision of this section should be consistent with the general criminal statues of the state.

(c) Practice nursing during the time license is suspended, revoked, surrendered, inactive or lapsed;

The writ of injunction without bond should be available to the Board for enforcement of this section. The practice of nursing by any person who has not been issued a license under the provisions of this Act, or whose license has expired or has been suspended or revoked, would be a danger to the public health, safety and welfare.

(d) Use any words, abbreviations, figures, letters, title, sign, card or device tending to imply that he or she is a Registered Nurse or Licensed Practical Nurse unless such person is duly licensed so to practice under the provisions of this Act;

In addition to any other civil, criminal or disciplinary remedy, the Attorney General, the Board of Nursing, the Prosecuting Attorney of any county where a person is practicing or purporting to practice nursing without a valid license, or any citizen may, in accordance with the laws of the state governing injunctions, maintain an action to enjoin that person from practicing nursing until a valid license is secured.

The Board may adopt by rule a schedule for establishing the amount of civil penalty that may be imposed for any violation of the statute or any rule of the Board.

(e) Fraudulently obtain or furnish a license by or for money or any other thing of value;

(f) Knowingly employ unlicensed persons in the practice of nursing;

(g) Fail to report information relating to violations of this Act;

When the nurse is aware of inappropriate or questionable conduct including violations of the

state's Nursing Practice Act by another person, the practice should be reported to the appropriate authority. The nurse's primary commitment is to the patient's care and safety. Hence, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practices that are not in the patients's best interests.

(h) Conduct a nursing education program for the preparation ~~of Registered Nurses or Licensed Practical Nurses~~ for licensure under this chapter unless the program has been approved by the Board; or

(i) Otherwise violate or aid or abet another person to violate any provision of this Act.

Violations of any provision of this statute or administrative rules adopted thereunder are cause for disciplinary action against a licensed nurse and, when indicated, civil penalty may be imposed.

Section 2. Penalties. Initial violation of any provision of this article shall constitute a misdemeanor and each subsequent violation shall constitute a felony.

This section is intended to serve as a significant deterrent to violations of this Act and to recognize that sanctions imposed must be commensurate with the wrongful act. In most states, the misdemeanor sanction is appropriate to achieve both ends; but in those states where these actions, typically treated as misdemeanors in most states, are classified as felonies, felony sanctions would certainly be appropriate. The suggested sanction is the strongest sanction imposed by that state for violations of its professional licensing statutes, and implementation is to be consistent with the Administrative Procedure Act and Administrative Rules.

Section 3. Criminal Prosecution. Nothing in this Act shall be construed as a bar to criminal prosecution for violation of the provisions of this Act.

Implementation is to be consistent with the Administrative Procedure Act and Administrative Rules.

Section 4. Civil Penalties. The Board may, in addition to any other sanctions herein provided, impose on any person violating a provision of this Act or Administrative Rules of the Board, a civil penalty not to exceed ($) for each count or separate offense.

Implementation is to be consistent with the Administrative Procedure Act and Administrative Rules.

Article IX. Discipline and Proceedings.

Comment

Section 1. Authority. The Board of Nursing shall have the power to refuse to issue or renew; to suspend or revoke a license; or place on probation or reprimand a licensee for any one or combination of ~~the causes on~~ the grounds set forth below. Fines of up to ($) may be imposed.

This section is intended to establish a means of disciplining or barring from practice persons who properly should not be permitted to practice nursing. Fines should be limited to cases in which the licensee has made financial gain as a result of the violation. They should not be the exclusive penalty for violations resulting in patient death or injury or used for grounds involving physical or mental illness. Rules should delineate the specific conditions for which fines can be imposed.

Section 2. Grounds. The Board may ~~take disciplinary action against a license that~~ discipline a licensee or applicant for any or a combination of the following grounds:

(a) Has failed to demonstrate the qualifications or satisfy the requirements for licensure contained in Article V. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements;

This ground makes it clear that the burden to demonstrate that all licensure requirements is met is upon the applicant.

(~~a~~b) Has been convicted by a court or ~~sanctioned by another board of nursing or~~ has entered a plea of nolo contendere to a crime in any jurisdiction that relates adversely to the practice of nursing or to the ability to practice nursing;~~-or~~

~~*Section 2. (a), (b) and (c) may not be mutually exclusive in that practice which is inconsistent with the standards of nursing practice may also be a situation taken to court.*~~

Some examples of crimes which would be the basis for consideration of disciplinary action are:

1. *A felony, as defined by the laws of this state;*
2. *A finding that the licensee is guilty of any act of moral turpitude or gross immorality that relates to the individual's nursing practice;*
3. *A crime that directly relates to the practitioner's ability to practice nursing competently and safely; or*
4. *A violation of the nursing laws, or rules and regulations pertaining thereto, of any*

state or of the federal government.

This section may need to be more definitive or restrictive in some states than in others. Its content must be developed in light of other state legislation since some states, for example, restrict the circumstances under which a license may be denied to an individual because of the commission of a crime. In addition, an individual who has been convicted of a crime or an act involving gross immorality and who has paid his debt to society is entitled to constitutional protection that may prevent a strict application of Section 2. (a).

~~(b) Has been disciplined by a Board of Nursing in another jurisdiction; or~~

~~(c) Has engaged in any act inconsistent with the standards of nursing practice as defined by board rules; or~~

~~*The need for specificity in defining the grounds upon which a license may be revoked or suspended should be emphasized. The term "unprofessional conduct" is particularly susceptible to challenge as being unconstitutionally vague. Thus, Section 2 (c) is being proposed as a substitute for unprofessional conduct, and the administrative rules adopted to implement this provision, or the act itself, must define this and all terms in a manner that will permit reasonable interpretation by persons authorized to enforce this Act.*~~

~~*These potential problems make it essential that Boards issue appropriate Administrative Rules defining the grounds for disciplinary action in specific,understandable and reasonable terms. In addition, the Board must ensure that such Administrative Rules are published for the benefit of all licensees within their jurisdiction. Only by doing so can Board assure their authority to take successful and meaningful disciplinary actions that will not later be overturned by the courts.*~~

(~~d~~c) Has ~~practiced~~ employed fraud or deceit in procuring or attempting to procure a license to practice nursing~~;~~ in filing any reports or completing patient records, signing any report or records in the nurse's capacity as a Registered Nurse or as a Licensed Practical Nurse~~;~~ or in submitting any

This ground would include conduct that subverts or attempts to subvert the examination process, such as violation of examination security.

information or record to the Board; ~~or~~

~~(e) Is unfit or incompetent to practice nursing by reason of negligence, habits or other causes; or~~

~~*Incompetence should be based on a pattern of practice or behavior, not a single incident. This would include incompetence based on physical or mental illness.*~~

(d) Has had a license to practice nursing or to practice in another health care discipline denied, revoked, suspended or otherwise restricted in this or any other state;

(e) Has failed or is unable to perform professional or practical nursing, as defined in Article II, with reasonable skill and safety, including failure of the professional nurse to supervise or the licensed practical nurse to monitor the performance of acts by any individual working at the nurse's direction;

This ground replaces the unfit and incompetent language, and makes it clear that failure to supervise may be grounds for disciplinary action.

(f) Has engaged in unprofessional conduct including, but not limited to, a departure from or failure to conform to Board standards of professional or practical nursing, or any nursing practice that may create unnecessary danger to a patient's life, health or safety. Actual injury to a patient need not be established;

The previous model avoided the use of "unprofessional conduct" as it was thought to be vague. However, the term is frequently used in professional licensing acts and here is related to Board standards. The language can be further interpreted in administrative rules. It is a broad phrase that describes many ~~difficult to anticipate~~ unpredictable disciplinary situations.

(g) Has demonstrated actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition;

This language focuses on the behavior that is the result of chemical dependency, or other condition, not the status of the condition. Such language is consistent with the Board's responsibility to protect the public and is consistent with provisions of the Americans with Disability Act.

(h) Has engaged in unethical conduct, including but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established;

(i) Has engaged in sexual conduct with a patient, or conduct that may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(~~f~~j) Has diverted or attempted to divert drugs or

controlled substances; ~~for unauthorized use; or~~

~~(g) Has had a license to practice nursing or to practice in another health care discipline in another state denied, revoked, suspended or otherwise restricted, other than by reason of failure to renew or to meet continuing education requirements; or~~

~~(h) Has practiced nursing within this state without a valid current license or as otherwise permitted under this Act; or~~

~~*Since federal employees are often not licensed by the state in which they practice, they would be subject to disciplinary action in the state in which they hold a license.*~~

~~(i) Has failed to report to the Board any violation of this Act or of Board Administrative Rules; or~~

~~(j) Has been found by the Board to have violated any of the provisions of this Act or of Board Administrative Rules; or~~

~~(k) Has engaged knowingly in any act which before it was committed had been determined to be beyond the scope of the individual's nursing practice; or~~

~~(l) Has failed to meet the duties of the licensee as provided in this Act and Board Administrative Rules.~~

(k) Has knowingly aided, assisted, advised, or allowed an unlicensed person to engage in the unlawful practice of professional or practical nursing; or

(l) Has violated a rule adopted by the Board, an order of the Board, or a state or federal law relating to the practice of professional or practical nursing, or a state or federal narcotics or controlled substance law.

Section 3. Procedure. The Board shall establish a ~~discipline~~ disciplinary process based on the Administrative Procedure Act of the State of ( ).

The procedure that must be followed before disciplinary action can be taken is determined in most states by an Administrative Procedure Act. Each Board shall determine to what extent the disciplinary procedure needs to be included in the laws governing nursing. The requirements of the

state must be investigated carefully when amending the disciplinary section of the Act in order to ensure statutory requirements.

In some states, Administrative Rules governing practice and procedure are the appropriate mechanisms to define these procedures. The National Council has developed a model which can also be used as a basis for developing rules.

In states in which the Board of Nursing does not have authority to discipline, a provision may be made for a review panel of Board members to review the evidence in disciplinary cases and to make a recommendation as to the disposition of the charge prior to the final disciplinary proceeding. The Board (or its agent) shall issue an order on its findings, and its decision and the order shall be delivered to all concerned parties.

In addition to any available administrative remedies, decisions of the Board (or the disciplinary authority) may be appealed within 30 days from notification of the decision to any court of competent jurisdiction as determined by the rules of civil procedure. The court action may be de novo; but the record of the Board hearing should be admissible evidence, and the action should be on the issues presented before the Board of nursing. The court may allow amendments, however, as permitted by usual rules of the court.

Section 4. Immunity. Any member of the Board or staff and any person reporting to the Board of Nursing under oath and in good faith information relating to alleged incidents of negligence or malpractice or the qualifications, fitness or character of a person licensed or applying for a license to practice nursing shall not be subject to a civil action for damages as a result of reporting such information.

In some states, immunity is already provided under the state's Administrative Procedure Act and this possibility should be considered.

The immunity provided by this section shall extend to the members of any professional review

committee and witnesses appearing before the committee authorized by the Board to act pursuant to this section.

Article X. Injunctive Relief.

Comment

Section 1. Grounds. The Board is empowered to petition in its own name to a proper court of competent jurisdiction for an injunction to enjoin:

(a) Any person who is practicing nursing within the meaning of this Act from practicing without a valid license, unless so exempted under Article XII;

(b) Any licensee who appears to the Board to be in violation of this Act from practicing; ~~or~~

(c) Any person, firm, corporation, institution or association from employing any person who is not licensed to practice nursing under this Act or exempted under Article XII; or

(d) Any person, firm, corporation, institution or association from operating a school of nursing without approval.

Section 2. Procedure. Upon the filing of a verified petition in such court, the court, or any judge thereof, if satisfied that a violation as described in Section 1 has occurred, may issue an injunction, without notice or bond, enjoining the defendant from further violating this provision. A copy of the complaint shall be served on the defendant, and the proceedings thereafter shall be conducted as in other civil cases. In case of violation of an injunction issued under this Article, the court, or any judge thereof, may summarily try and punish the offender for contempt of court.

Section 3. Preservation of Other Remedies. The injunction proceedings herein described shall be in addition to, not in lieu of, all penalties and other remedies provided in this Act.

Article XI. Reporting Required.

Comment

Section 1. Affected Parties.

(a) Hospitals, nursing homes and other employers of Registered Nurses and Licensed Practical Nurses shall report to the Board the names of those licensees whose employment has been terminated voluntarily or involuntarily for any reasons stipulated in Article IX, Section 1.

(b) Nursing associations shall report to the Board the names of Registered Nurses and Licensed Practical Nurses who have been investigated and found to be a threat to the public health, safety and welfare for any of the reasons stipulated in Article IX, Section 2.

~~(c) Insurance companies shall report to the Board any malpractice settlements or verdicts, court awards or payment of claims based on accusations of incompetence, negligence, misconduct or other causes as stipulated in Article IX, Section 2.~~

This language is no longer needed now that copies of malpractice reports to the National Practitioner Data Bank are received by Boards.

Section 2. Court Order. The Board may seek an order from a proper court of competent jurisdiction for a report from any of the parties stipulated in Section 1 of this Article if one is not forthcoming voluntarily.

Section 3. Penalty. The board may seek a citation for civil contempt if a court order for a report is not obeyed by any of the parties stipulated in Section 1 of this Article.

Section 4. Immunity. Any organization or person reporting, in good faith, information to the Board under this Article shall be immune from civil action as provided in Article IX, Section 4.

Article XII. Exemptions.

Comment

No provision in this Act shall be construed to prohibit:

(a) The practice of nursing that is an integral part of a program by students enrolled in Board approved nursing education programs leading to initial licensure in the practice of nursing~~.~~;

Only students in programs leading to initial licensure should be exempted.

All other students, namely those in graduate, refresher courses or certification programs, should be expected to seek licensure in the jurisdiction where enrolled in the program; licensure is required to ensure that their practice meets safe minimal standards and can be a basis for continuing study.

(b) The rendering of assistance by anyone in the case of an emergency or disaster;

It should be noted that no exemption is made for care without compensation. Standards for safe and effective care are expected to apply to all care providers regardless of whether or not it is provided free of charge.

(c) The practice of any currently licensed Registered Nurse or Licensed Practical Nurse of another state in the provision of nursing care in the case of emergency or disaster~~.~~;

(d) The incidental care of the sick by members of the family, friends, domestic servants or persons primarily employed as housekeepers, provided that such care does not constitute the practice of nursing within the meaning of this Act;

(e) Caring for the sick in accordance with tenets or practices of any church or religious denomination which teaches reliance upon spiritual means ~~through prayer~~ for healing;

(f) The practice of any currently licensed Registered Nurse or Licensed Practical Nurse of another State who is employed by the United States government, or any bureau, division or agency thereof, while in the discharge of official duties;

Federal law requires this exemption. This has been problematic for Boards of Nursing because of the difficulty of monitoring these nurses. States should establish a method for identifying nurses who work in federal facilities as to the currency of the individual licenses.

(g) The practice of any currently licensed Registered Nurse or Licensed Practical Nurse of another State who is employed by an individual, agency or corporation located in another State and whose employment responsibilities include

This exemption allows for short-term nursing care by nurses in the state on a transient basis. Time limitations should be reasonable but restrictive enough to uphold the mandatory nature of the Act.

transporting patients into, out of, or through this State. Such exemptions shall be limited to a period not to exceed ( ) hours for each transport;

(h) The practice of any currently licensed Registered Nurse or Licensed Practical Nurse of another state who provides or attends educational programs or provides consultative services within this state for a period not to exceed ( ) days. Neither the education nor consultation may include the provision of patient care, the direction of patient care, or the affecting of patient care policies;

Providing or affecting patient care is the practice of nursing and should require in state licensure for the protection of the health, safety and welfare of the state's residents.

(i) The establishment of an independent practice by one or more licensed nurses for the purpose of rendering to patients nursing services within the scope of their educational preparation and the scope of the license to practice nursing;

(j) The practice of any other occupation or profession licensed under the laws of this state, provided that such care does not constitute the practice of nursing within the meaning of this act.; or

Provides for restriction on nursing practice by those who are not nurses.

(k) The practice of nursing as a registered nurse by a person currently licensed in another state who is visiting this state as a non-resident, in order to provide specific, non-clinical, short-term, time limited services including, but not limited to, consultation, accreditation site visits, and participation in continuing education programs.

Article XIII. Revenue, Fees.

Section 1. Revenue. The Board is authorized to establish appropriate fees for licensure by examination, reexamination, endorsement and such other fees and fines as the Board determines necessary.

Section 2. Disposition of Fees. All fees collected by the Board shall be administered according to the established fiscal policies of this State in such manner as to implement adequately the provisions of this Act.

Comment

Some states require that maximum or minimum fee limitations be stipulated ~~n~~in the statute. However, it is more desirable not to do so in order to enable the Board to more readily respond to changing economic and financial conditions through its administrative rules. Because the Board is subject to the state's Administrative Procedure Act when adopting and/or revising its administrative rules, those subject to the fees and fines would be adequately protected from the establishment of inappropriate fees.

A board of nursing may be authorized to establish appropriate fees and fines, or, if it functions within a state agency concerned with licensure, this state agency may establish appropriate fees for all licensing boards. In either case, there should be some reference to establishment of fees and fines within this act. Funds generated by Boards of Nursing are generally dealt with in one of three ways:

(1) The Board of Nursing maintains its own account in a bank or banks of its own choosing and provides periodic reports to certain state officials.

(2) The Board of Nursing has its own dedicated fund within the state treasury. Though funds are credited to the Board of Nursing and must be dispersed in accordance with state law, the funds are in fact a type of revolving fund and usually do not terminate at the conclusion of a specific period, such as the end of a fiscal year.

(3) The Board of Nursing deposits all funds received into the general treasury and receives an appropriation from the state legislature in the same manner as other state agencies are funded. In these instances, the appropriations usually lapse at the end of a certain period, and new appropriations are required.

The general view is that if regulatory activities in fact serve a public protective function, they should be financed by appropriations from general revenues, as are other consumer protection activities, rather than from fees. In addition, budgetary and appropriation processes provide a legislative and executive check on government agencies and, thus, increase their accountability. Although budgetary decisions involve politics, the appropriations process gives elected and appointed officials the power to compel performance and results. In most states, every agency of state government is subject to the appropriations process.

Section 3. Disposition of Fines. All fines collected shall be used by and at the discretion of the Board for designated projects as established in the fiscal policy of this state.

Allows the Board at their discretion to use ~~find~~ fine funds for the Board projects rather than going into the state's general fund that is used by others.

Article XIV. Implementation.

Section 1. Effective Date: This Act shall take effect (date).

Section 2. Persons Licensed Under a Previous Law.

(a) Any person holding a license to practice nursing as a Registered Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Registered Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.

(b) Any person holding a license to practice nursing as a Licensed Practical Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Licensed Practical Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.

(c) Any person eligible for reinstatement of a license to practice nursing as a Registered Nurse or as a Licensed Practical Nurse in this State on (effective date) shall be deemed to be eligible to be licensed as a Registered Nurse or as a Licensed Practical Nurse, respectively, under provisions under the conditions and standards prescribed in this Act.

(d) Any person holding a lapsed license to practice nursing as a Registered Nurse or Licensed Practical Nurse in this State on (effective date), because of failure to renew, may become licensed as a Registered Nurse or as a Licensed Practical Nurse, respectively, under the provisions of this Act by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.

Comment

When a nursing practice statute is repealed or substantially amended, the creation of provisions enabling persons licensed under the previous law to be licensed under the new statute should be considered. Such a provision is often referred to as a waiver, or "grandfather" provision.

If requirements for licensure and titles are changed, new requirements can be "waived" and persons licensed under the previous law are "grandfathered" into new titles.

If the requirements for licensure are not changed, the provision is usually simply referred to as a "grandfather clause." Nurses can be "grandfathered" into new scopes of practice. However, a scope of practice cannot be "waived."

(e) Those so licensed under the provisions of Article XIV, Section 2, (a) through (d) above, shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.

Section 3. Severability. The provisions of this Act are severable. If any provision of this Act is declared unconstitutional, illegal or invalid, the constitutionality, legality and validity of the remaining portions of this Act shall be unaffected and shall remain in full force and effect.

Section 4. Repeal. The laws specified below are repealed except with respect to rights and duties that have matured, penalties that were incurred and proceedings that were begun before the effective date of this Act. (List statute(s) to be repealed; for example, the current nursing practice act or appropriate section(s)).

Additional Sources

Abrams, Thomas G. Presentation on the American with Disabilities Act for St. Anselm College, Continuing Education. November 20, 1992.

Chornick, N., Yocom, C., and Jacobson, J. **Job Analysis Study of Newly Licensed, Entry-Level Registered Nurses**. Chicago: National Council of State Boards of Nursing, 1993.

Laws Relating to the Minnesota Board of Nursing Nurse Practice Act, Minnesota Statutes Section 148.261.

Model Nursing Administrative Rules - Suggested Revisions under CAT (developed by National Council staff for distribution to Member Boards). June 30, 1992.

Model Nursing Practice Act - Suggested Revisions under CAT (developed by National Council staff for distribution to Member Boards). June 30, 1992.

National Council of State Boards of Nursing, "Implication of the ADA for Boards of Nursing." Emerging **Issues**. August, 1992.

O'Brien, Thomas L. Presentation on the Americans with Disabilities Act to the Nursing Practice and Education Committee, March 5, 1993.

Washington State Regulation of Health Professions - Uniform Disciplinary Act, Chapter 18.120 RCW. 1992 ed.

Attachment B

The Nursing Practice and Education Committee's Paradigm Shift Regarding Competence...

A Draft Concept...for Discussion at the Nursing Practice and Education Forum at the 1993 Annual Meeting

The Nursing Practice and Education Committee began its study of professional competence by focusing on each of the factors that contribute to or affect competence. The committee did a critical review of the existing information and gathered new information. As the process and the paper evolved, the committee began to broaden its perspective and look at the integrated whole of competence rather than focusing specifically on each of the many factors that contribute to competence. The committee envisioned a paradigm shift with the focus on the individual licensee and on a proactive process of assessing and evaluating competence. The assessment and maintenance of competence was viewed as a process where the responsibility and accountability began at the bottom with the licensee rather than at the top with the Board of Nursing determining the ways and means of maintaining competence.

The basic assumption in the new paradigm is the acknowledgement that licensees, not the regulatory body, are primarily responsible for their own competence. The Board's role as the primary entity responsible for the assurance of professional competence and public safety should be changed to a more collaborative role with licensees and employers. The paradigm would include three aspects: promotion of individual accountability for competence; compliance with statutory requirements; and development of a positive plan for competence.

Accountability for professional competence begins at the educational level. Students are expected to assess and critique their own progress in their clinical courses. It is only natural that they should continue to assess and critique their skills as practitioners. The majority of licensees make sound and appropriate decisions on a daily basis which impact the lives of consumers, clients or students, yet many Boards continue to believe that they cannot make decisions about their own competence and learning needs. Licensees must take the responsibility and the accountability for making these decisions.

Statutory requirements provide the boundaries for the new paradigm. They serve as guidelines for the licensee, the educator, the employer, the consumer and the Board. The evaluation of safe, competent practice is based upon the essential standards of nursing practice. Standards of practice may appear in many forms in statutes and rules. Professional organizations, certifying bodies, accrediting bodies and health care agencies have standards which may assist in determining what is competent practice.

Boards should use their resources to identify the "outliers" (i.e., those nurses who are incompetent or unsafe) rather than trying to deal with all licensees. The traditional disciplinary process should be strengthened and used for licensees who have evidenced noncompliance with the statutes and/or rules. The Board is charged with the responsibility of implementing the disciplinary process to protect the public when licensees are unable to maintain competence and/or when violations occur. The evaluation of unsafe or incompetent practice must be based on the review of documented, substantiated incidents relative to the essential standards. Employers should be regarded not only as sources of information but also as potential partners in providing self-evaluation, ongoing education and other strategies to promote professional accountability.

The committee's broadened perspective led to the proposal that a positive plan for competence be developed to facilitate the collaboration between Boards, licensees and employers. A positive plan would build on the model for competence found in the 1992 Conceptual Framework of Continued Competence, with the focal point being the individual licensee's responsibility and accountability for self assessment and self limitation.

An important aspect of a positive plan for competence is the early identification of signals that a licensee is showing signs of questionable competence or that the licensees' practice may be deteriorating. Guidelines for early identification of problems may trigger a licensee's self assessment or encourage employers to intervene in a timely fashion so that the public protection can be maintained. Remediation should be a proactive response on the part of the licensee and the employer to correct a deficit early rather than only a reactive response to a problem that is serious and potentially dangerous. Licensees and employers should attempt to develop a plan to correct deficits revealed by the assessment process.

A positive plan would include the licensee who either has or acquires a disability. The licensee should be offered an opportunity to determine what accommodations, if any, would be necessary for the licensee to continue to practice in a safe manner. The Board may need to limit the license of a disabled nurse to allow the licensee to practice while still providing for public protection. A nondisciplinary process should be developed to enable the disabled licensee to practice through accommodation rather than sanction.

The Nursing Practice and Education Committee considered the integrated whole of the complex concept of competence. Their considerations turned competence on its head which led to this paradigm shift. Boards must continue to enforce compliance with statutory requirements. Effective utilization of the disciplinary process is an essential Board function. The licensee must assume the primary responsibility and accountability for assessing, attaining and maintaining competence. The new paradigm promotes a more collaborative relationship between the licensee, employers and the Board. The promotion of self assessment, early identification of problems, proactive remedies and a nondisciplinary approach for disabled nurses will assist licensees, employers and Boards of Nursing in meeting their obligation to protect both the practice of nursing and the health, welfare and safety of the public.

Report of the Subcommittee to Study the Regulation of Advanced Nursing Practice

Committee Members
Corinne Dorsey, VA, Area III, *Chair*
Iva Boardman, DE, Area IV
Judy Colligan, OR, Area I
Perlilure Jackson, MI, Area II
Gail Stewart, AK, Area I

Relationship to the Organization Plan
Goal II ....Provide information, analyses and standards regarding the regulation of nursing practice.
Objective A ....Develop documents which provide guidance regarding the regulation of nursing practice.

Recommendation(s)
1. That the Delegate Assembly adopt the Position Paper on the Regulation of Advanced Nursing Practice.
2. That the Delegate Assembly adopt the Model Legislative Language and Model Administrative Rules for Advanced Nursing Practice, to be incorporated into the existing *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Rationale
The 1986 Delegate Assembly adopted a position paper on Advanced Clinical Nursing Practice. Since then, economic, legislative and policy changes affecting health care in the United States have increased interest in alternative approaches to health care. The Subcommittee to Study the Regulation of Advanced Nursing Practice was appointed to assess the current status of advanced nursing practice, to analyze data, to make recommendations and to develop models for the regulation of advanced nursing practice.

The subcommittee presented a position paper and Model Legislative Language for Advanced Nursing Practice to the 1992 Delegate Assembly. The delegates voted to return the proposal to the subcommittee, so that an additional year could be spent reviewing the comments and discussion at the 1992 Forum, comments received from other organizations and individuals. The Delegate Assembly directed the subcommittee to develop Model Administrative Rules for Advanced Practice.

The subcommittee considered the discussion and many comments received regarding the position paper, and continued dialogue with nursing organizations regarding the subcommittee's work.

The proposal presented by the subcommittee includes a position paper, model statutes and rules. The proposal includes educational preparation based on a graduate degree with a major in nursing or in the designated practice area; criteria for reviewing certification programs if a Board chooses to require certification; prescriptive and dispensing authority; independent practice (no supervision, protocols, formulary or practice agreements); and grandfathering for those nurses practicing at an advanced level at the time of legislative implementation. The proposal includes clear authority for advanced nursing practice, a definition of a scope of practice, pre-determined requirements, title protection and the opportunity for discipline. Since these are characteristics of licensure, the three documents being presented provide for licensure as the method of regulation of advanced nursing practice.

Highlights of Activities

■ Liaison Activities
The Subcommittee for the Study of Advanced Nursing Practice held informal afternoon forums on the Friday afternoons of the December and February meetings to provide an opportunity for ongoing dialogue with other nursing organizations regarding the subcommittee's work and other issues in advanced practice.

The Third Advanced Nursing Practice Leadership Roundtable was held on April 2, 1993. This meeting of representatives from certifying bodies and nursing organizations also provided an opportunity for interaction with

representatives from the groups which certify or represent nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists.

Throughout the year, many phone calls and letters were received regarding the subcommittee's work. The subcommittee also had the opportunity to review and comment on a draft paper prepared by the American Nurses' Association Ad Hoc Committee on Credentialing of Advanced Practice.

- **Model Legislative Language and Position Paper on the Regulation of Advanced Nursing Practice**

  The subcommittee refined the Position Paper on the Regulation of Advanced Nursing Practice (Attachment A) and revised portions of the Model Legislative Language for Advanced Nursing Practice (Attachment B). These documents had been developed in 1992.

- **Model Administrative Rules for Advanced Nursing Practice**

  A major focus for the Subcommittee to Study the Regulation of Advanced Nursing Practice this year was to develop the draft Model Administrative Rules for Advanced Nursing Practice. The comments and suggestions offered were considered very seriously during the development of the rules. The Model Rules are found in Attachment C.

Meeting Dates

- October 8, 1992, *telephone conference*
- December 17-19, 1992
- February 25-27, 1993
- April 1-3, 1993
- May 7-8, 1993

Future Considerations for the National Council

Although the work of this subcommittee is comple[illegible] subcommittee suggests the following future National Council activities related to advanced nursing practice:

- Review and update the Advanced Practice Nursin[illegible]on Paper and Models (at least every five years).
- Assist Member Boards in evaluating professional certification requirements and examinations, to determine if the examinations are developed psychometrically to serve as a sound basis for regulation and are legally defensible for use in the regulation of advanced nursing practice.
- If existing examinations do not meet all criteria for legal defensibility:
  - a. work with certifying organizations to promote the meeting of these criteria; and, if needed,
  - b. give consideration to other means for providing Member Boards with examinations which would provide a sound basis for licensure of advanced nursing practice categories.
- Continue the liaison relationship with the advanced nursing practice professional certifyi[illegible] and other nursing organizations in order to provide current information regarding credentialing processes and adv[illegible] nursing practice issues.

Recommendations

1. That the Delegate Assembly adopt the Position Paper on the Regulation of Advanced Nursing Practice.
2. That the Delegate Assembly adopt the Model Legislative Language and Model Administrative Rules for Advanced Nursing Practice, to be incorporated into the existing *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

Staff

Vickie R. Sheets, *Director for Public Policy, Nursing Practice and Education*

Attachments

A ....Position Paper on the Regulation of Advanced Nursing Practice, *page 11*

B ....Model Legislative Language for Advanced Nursing Practice, *page 19*

C ....Model Rules for Advanced Nursing Practice, *page 21*

Attachment A

National Council of State Boards of Nursing, Inc. Position Paper on the Regulation of Advanced Nursing Practice

Purpose

The National Council of State Boards of Nursing proposes this position paper to provide guidance to Member Boards in the regulation of advanced nursing practice. This paper explores the previous position taken by the National Council and the changes in health care, nursing and society which stimulated review of that position. A definition of the advanced practice of nursing is presented, followed by an examination of methods of regulation and a description of considerations basic to the selection of a method of regulation. Nurses considered to be practicing in advanced nursing roles are nurse practitioners, nurse anesthetists, nurse- midwives and clinical nurse specialists.

Background

In 1986, the National Council adopted a Position Paper on Advanced Clinical Nursing Practice. The paper addressed advanced nursing practice as a concept varying in interpretation and regulation, defined the educational preparation to be at least a master's degree in nursing and concluded that the preferable method of regulating advanced nursing was designation/recognition.

Many premises of the 1986 paper continue to be valid. However, the economic, legislative and policy changes affecting health care in the United States, including concerns regarding cost and access to care, have increased the interest in alternative approaches to health care. Medical diagnosis and the prescription of medication and other therapeutic measures have traditionally been considered the practice of medicine, subject to regulation solely by Boards of Medicine. There has been an increasing recognition of the overlap between medical practice and that of other providers such as nurse practitioners, nurse-midwives, nurse anesthetists, clinical nurse specialists, and others. Regulation and regulatory authority must work to protect the public safety and welfare, yet adapt to and foster these overlapping practices in the interest of cost-effective, accessible, and competent client care.

The demand for nurses practicing in advanced roles with greater autonomy has increased. Federal regulations requiring statutory recognition of advanced nursing for third party reimbursement have been a catalyst in many jurisdictions for the regulation of advanced nursing practice. Member Boards have identified that the regulation of advanced nursing practice presents some of the most critical challenges faced by Boards of Nursing as they weigh their public protection responsibilities in relation to other developments affecting regulation.

The evolution of nursing practice has produced an increasing body of knowledge as well as multiple levels of nursing practice. Regulatory systems to authorize advanced practice and professional certification to acknowledge achievement and excellence in practice have been developed. Professional certification and regulatory systems have resulted largely from the efforts of organized groups of nurses seeking professional and economic recognition, and clarification of the authority to practice. There is variety and a lack of consistency in regulatory systems and professional certifications. Consequently, there is confusion for the public, legislators, regulators, nurses and other health care providers regarding titling, credentialing, scope of practice and reimbursement related to advanced nursing practice.

Professional nursing organizations have supported the recognition of advanced nursing practice through the mechanism of voluntary certification. At this writing, nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists are certified by the American Nurses Credentialing Center (ANCC); the Council on Certification of Nurse Anesthetists (CCNA); the National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNP/N); the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC); and the ACNM Certification Council, Inc. These and other organizations also offer specialty certification in areas not considered advanced nursing practice as defined in this paper.

While different requirements for various areas of nursing may be acceptable for professional certification, inconsistency becomes problematic when attempts are made to apply professional certification requirements to regulatory systems. Inconsistency in the requirements for certification, including the level of education and practice, titling, and logistics, makes

it difficult for Boards to determine criteria broad enough to accommodate the variations yet specific enough to be effective. Certification examinations are constructed for the purpose of professional recognition and are not necessarily appropriate for use in legal regulation. This raises several issues with respect to certification examinations. First, they may not be designed to measure ability for the purpose of regulation; that is, they may be calibrated to a higher or lower level of difficulty and a broader or narrower scope of subject matter than would otherwise be appropriate for regulation. Secondly, from a measurement perspective, they may not be constructed psychometrically in a manner appropriate for legal regulation. Finally, the subject matter may not be congruent with the scope of practice being licensed.

Legal regulation is the responsibility of legislators and Boards of Nursing. The legislature in each jurisdiction enacts nursing practice legislation and Boards of Nursing are authorized to promulgate regulations to implement the nursing statutes in order to protect the public health, safety and welfare. Current nursing practice statutes and administrative rules range from no provision addressing advanced nursing practice to entire chapters of statutes and detailed regulations. In a 1991 survey, 47 jurisdictions addressed advanced nursing in either nursing practice statutes, administrative rules, or both.

Premises

1. The purpose for any governmental regulation of nursing practice is the protection of the public health, safety and welfare. The criteria for regulation should reflect minimum requirements for safe and competent practice and should be the least burdensome criteria consistent with public protection.

2. Professional nursing standards as embodied in voluntary certification programs encompass more than essential criteria.

3. A clear and specific legislative mandate strengthens the Board's authority to promulgate rules relating to advanced nursing practice.

4. The public has a right to the access to health care, and to make informed choices regarding selection of health care options through knowledge of the area of expertise, qualifications and credentials of individuals who provide health care.

5. The public has a right to rely on the credentials of health care providers in making choices and decisions regarding health care.

Definition of the Advanced Practice of Nursing

The advanced practice of nursing by nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists, is based on the following:

a) knowledge and skills acquired in basic nursing education;

b) demonstration of minimal competency in basic nursing as evidenced by licensure as a Registered Nurse;

c) graduate degree with a major in nursing or a graduate degree with a concentration in an advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care.

Skills and abilities essential for an advanced practice registered nurse within the designated area of practice include:

- assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level;

- providing expert guidance and teaching;

- working effectively with clients, families and other members of the health care team;

- managing clients' physical and psycho-social health-illness status;

- utilizing research skills;

- analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment;
- making independent decisions in solving complex client care problems;
- performing acts of diagnosis and prescribing therapeutic measures consistent with the area of practice; and
- recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.

Each individual who practices nursing at an advanced level does so with substantial autonomy and independence requiring a high level of accountability. The scope of practice in each of the advanced roles of a nurse practitioner, nurse anesthetist, nurse-midwife, or clinical nurse specialist is distinguishable from the others. While there is an overlapping of activities within these roles, there are activities which are unique to each role. The legal scope of practice should reflect the uniqueness of each. For example, the grant of prescriptive authority should be specific to the practice area, e.g., a pediatric nurse practitioner is not responsible for prescribing medications for geriatric clients.

A nurse desiring to practice in an advanced nursing role must seek information about the regulatory requirements in the jurisdiction where the nurse intends to practice. Each jurisdiction establishes the process for regulation. The applicant provides documentation of eligibility to meet the requirements, and the Board of Nursing evaluates the applicant against established criteria and grants authority to those who demonstrate preparation to practice safely and effectively. The Board acts consistently with its mandate for public protection.

Regulation

The power to govern includes all of the legitimate powers of government, including enactment of reasonable laws necessary to protect the public health, safety and welfare. States may exercise all powers inherent to government except those explicitly reserved to the federal government in the United States Constitution or pre-empted by federal law. Laws governing individual health care providers are enacted through state legislative action. Regulatory authority is derived from legislative action. State legislatures delegate many enforcement activities to state administrative agencies. Legislatures enact laws which grant specific authority to regulatory agencies, e.g., a state legislature enacts a nursing practice act to regulate nursing, and delegates authority to the state boards of nursing to enforce the nursing practice act.

The delegation of regulatory authority allows the legislature to use the expertise of the agencies in the implementation of statutes. Administrative agencies are authorized to promulgate regulations according to a specific process defined in the state administrative procedures act. Most Boards of Nursing, for example, are authorized to promulgate regulations pertaining to the practice of nursing in the jurisdiction. Administrative agency actions and decisions are subject to review of the judiciary.

Criteria to consider when selecting an appropriate level of regulation for professional practice include the risk of harm to the consumer; the specialized education, skills and abilities required for the professional practice; the level of autonomy; the scope of practice; economic impact; alternatives to regulation; and a determination of the least restrictive regulation consistent with the public safety.

The first level of regulation, and least restrictive approach, typically corresponds to designation/recognition. This alternative does not limit the right of any nurse to practice. It does provide the public with information about nurses with special credentials. This recognition of credentials by a Board would not involve state inquiry into competence.

The second level of regulation typically corresponds to registration, and requires nurses to apply to have their names added to an official roster, maintained by the Board, of individuals who provide advanced nursing practice. Registration does not involve state inquiry into competence and the scope of practice is not generally defined.

The third level of regulation corresponds to certification and may be thought of as title protection. Applicants for certification meet specified requirements, and those persons who have met the predetermined qualifications may use the title. Certification does not include a defined scope of practice. The federal government has used the term certification to define the credentialing process by which a non-governmental agency or association recognizes the professional competence of an individual who has met the predetermined qualifications specified by that agency or association. Boards of Nursing have also used the term certification to authorize advanced nursing practice, often using the professional association certification as a requirement for the governmental credentialing. Potential for confusion exists when this term is used by both professional organizations and regulatory boards.

The fourth level of regulation corresponds to licensure. This regulatory method is used when regulated activities are complex, require specialized knowledge and skill, and independent decision-making. The licensure process includes the predetermination of qualifications necessary to perform a unique scope of practice safely and an evaluation of licensure applications to determine that the qualifications are met. Licensure provides that a specified scope of practice may only be performed legally by licensed individuals. It also provides authority to take disciplinary action should the licensee violate provisions of the law or rules. Licensure is applied to a profession when the practice of that profession could cause greater risk of harm to the public unless there is a high level of accountability.

Considerations in Selecting a Method of Regulation

Legal Implications: Since regulation may limit entry into advanced nursing practice, consideration must be given to possible legal challenges. Two possible areas of challenge would be infringement of constitutional rights and constitutional delegation.

Individuals have the right to pursue employment of their choosing. However, the individual right to seek employment must be balanced with the state responsibility to protect the health, safety and welfare of the public. Boards of Nursing are advised to justify the relationship between the restrictions imposed by regulations and the public health, safety and welfare. Boards must give attention to assuring guarantees of procedural due process, such as notice and an opportunity to be heard, to protect against charges of proceeding with arbitrary, discriminatory or unreasonable regulations.

The tenth amendment to the United States Constitution confers upon individual states the authority to adopt such laws and regulation as needed to protect the public health, safety and welfare. As administrative agencies charged with implementing legislation, Boards should be aware that their regulations will be less open to challenge if the regulation of advanced nursing practice is clearly mandated by statute rather than subject to discretionary Board regulation.

Boards could be challenged for delegating inappropriately to private entities. For example, a Board might be challenged for surrendering its regulatory authority if it passively accepted results of certification examinations without evaluation or review of the examination content, procedures and scoring process. This does not mean a Board cannot use professional certification as a regulatory requirement; rather that the Board would exercise active and final control over the determination of whether the certification examination is psychometrically sound and legally defensible for use in regulation. Recognizing established certification requirements and examinations that can be validated as providing a psychometrically sound basis for regulation would avoid duplication of effort and could be less expensive for states; however, it is essential that Boards of Nursing establish criteria for accepting the certification and maintain control of the licensure process. Boards cannot cede this authority to private entities.

In addition, a Board which designates a single private professional certification as the only acceptable credential could be challenged for excluding professional certifications granted by other certifying bodies. A process of establishing criteria and specifications for acceptable credentials, including the opportunity for interested private agencies to demonstrate that they can meet the established criteria, would avoid the automatic exclusion of other credentials, either current or future, which may comply with the Board's requirements.

Effects of Variability: Variability of systems used by states to regulate the advanced practice of nursing has resulted in problems for licensees in credentialing, practice and geographic mobility, and for Boards in implementing an endorsement process. The variability of titles, education and scopes of advanced practice among jurisdictions creates confusion for consumers of care, legislators, regulators, nurses and other health care providers.

Costs and Benefits: The cost-benefit analysis of the method of regulation must consider the value of the service and the value of the protection, as well as potential risks in not regulating this level of complex professional activity. Individual licensees bear the cost of compliance with advanced nursing practice regulation but costs are ultimately passed on to the consumer.

Effects of Statutes and Regulations by Other Administrative Agencies: Boards of Nursing should be alert to statutes and regulations promulgated by other administrative agencies for implications on their own regulations, both during initial drafting and through ongoing review. Statutes supersede rules. Rules, consistent with statutes and legislative intent (where documented) have the force and effect of law.

Impact on Nursing Practice: The regulation of advanced nursing practice has potential for unduly limiting the practice of nurses who do not meet the specified requirements. Care should be taken in the drafting of regulations so that the practice of registered nurses is not limited and the evolution of nursing practice at all levels is assured.

Discussion

The nursing profession has historically favored a credentialing model similar to physician specialization. Physicians are licensed to practice medicine without regard to specialty. Many physicians choose to seek professional recognition by obtaining certification from specialty boards which have been established by private professional organizations. These voluntary credentials are not required for medical practice, but evidence additional expertise. A similar model was promoted for nurses who are licensed to practice nursing without regard to specialty. Nursing organizations have made certification programs available and many registered nurses have sought this professional recognition. This model was reflected in the recommendation of the 1986 Position Paper in which the preferred method of regulation for advanced nursing practice was recognition/designation.

The significant change in this paper is the move from recommending recognition/designation as the method of regulation for advanced nursing practice to recommending licensure as the preferred method of regulation for advanced nursing practice. This is a major position shift in six years. The evolution of advanced nursing has produced an expanded scope of practice and a high level of autonomy based upon advanced knowledge, skills and abilities. Safe and competent advanced nursing practice requires licensure as the method of regulation necessary to protect the public.

An identifiable and unique scope of practice is a key element of licensure. The scope of practice, as defined in state nursing practice acts, is usually written in broad language and identifies boundaries of practice. Nurses in advanced roles, with additional education and experience, practice beyond traditional nursing. Medical diagnosis and prescription of medications are good examples of acts that have been viewed as traditional medical acts or as overlapping areas of practice. Regardless of how these aspects of care are characterized, additional professional education is necessary for a registered nurse to perform these functions. The core of skills and abilities described in this paper's definition of advanced nursing practice, plus the specific practice characteristics of each advanced nursing category, create distinguishable scopes of practice for the advanced nursing practice roles.

The knowledge, skills and abilities identified in this paper as essential for safe and competent advanced nursing practice are beyond those attained by an individual prepared in a basic nursing education program preparing an individual for licensure as a registered nurse. Through graduate level education, a nurse can further develop abstract and critical thinking, the ability to assess at an advanced level, as well as advanced nursing and other essential therapeutic skills. Educational preparation should encompass both knowledge and the clinical component unique to the specific advanced nursing role. Boards of Nursing should acknowledge and consider the current education, practice and health care environment by providing for "phasing in" educational requirements when developing regulations for the jurisdiction.

The costs of professional licensure must be weighed against the value of the service and the potential risks in not regulating the profession. The expenses for advanced nursing practice licensure borne by individual nurses include education, costs incurred meeting other licensure requirements and licensure fees. Boards of Nursing administrative expenses for the implementation and maintenance of advanced nursing practice licensure include rule development and promulgation, program development, personnel, equipment, and other resources. Advanced practice licensing fees could be used toward meeting those costs.

The public will benefit from licensure of advanced nursing practice. Advanced nursing practice provides an important health care alternative. However, performance of advanced nursing practice by unqualified individuals creates a high risk of harm to the public. The protection of the public health and welfare will be promoted through the identification of essential qualifications for the advanced practice role, the inquiry as to whether an individual meets those qualifications and an objective forum for review of concerns regarding an individual's practice. Consumers should be informed regarding the qualifications of the various types of health care providers and what services they can legally provide. This type of consumer education facilitates a knowledgeable choice of health care services. Increased mobility of qualified practitioners will increase public access to an important health care alternative with the public protection of licensure.

Nurses in advanced roles will benefit from having clear authority for their practice. Without clear authority for the advanced level at which they function, nurses in advanced roles may be practicing beyond the jurisdictional scope of nursing practice, or could be held accountable for practicing medicine without a license. Federal regulations defer to state authority regarding licensing. Federal regulations do, however, require the state to authorize or license individuals for the level of services provided in order to allow direct reimbursement. Although Boards of Nursing do not have direct responsibility for reimbursement issues, Boards frequently are indirectly involved when requested to identify those nurses who have met the state requirements for advanced practice and to assist insurers and others in the interpretation of practice acts to determine if specific acts fall within the authorized scope of practice. Nurses in advanced roles would also benefit from the title protection provided by licensure.

Failure to regulate advanced nursing practice creates potential risks for the public who are receiving these health care services. Without licensure, complex activities requiring a high level of specialized knowledge, skill, proficiency and

independent decision-making may be performed by unqualified providers. Without licensure, professionals are not held legally accountable for their practice. Without licensure, the public does not have the benefit of an unbiased forum to resolve complaints regarding issues of safety and competence.

Licensing requirements define what is necessary for the majority of individuals to be able to practice the profession safely and validate that the applicant has met those requirements. In any professional licensing system there are individuals who are "outliers" to the system parameters. Setting minimal educational requirements for any type of professional licensure creates the possibility that some capable individuals, who have learned through non-traditional means and experience, would be excluded from practice. It is important that a sufficient time frame or a "phasing in" for meeting the requirements be provided to allow such individuals to continue in practice if they choose. There are also situations when someone who has met the set requirements proves to be unsafe or fails to maintain competence. Licensing Boards have the authority to initiate appropriate disciplinary action against the licenses of unsafe individuals. Educational, practice and other ongoing requirements are set by many Boards to assist in maintenance of competency.

Whenever a new concept is introduced, there may be initial confusion until the concept is established. However, the benefits of moving toward a generally accepted use of terminology will, in the long run, reduce the current confusion caused by the existing "crazy quilt" of titles, abbreviations and language across jurisdictions. Movement toward uniformity of requirements and scopes of practice will facilitate mobility of qualified individuals in advanced nursing roles.

Although licensure is intended to provide public protection, some have viewed licensure as a barrier, a limitation on professional development. It has been argued that nurses prepared at the master's level and above should be "unencumbered" by additional licensure requirements. However, another view is that, in addition to protecting the public, the authorization for practice provided by licensure affords promotion and protection for the nurse.

Conclusions

1. The advanced practice of nursing is based on basic nursing education and a graduate degree with a major in nursing or a graduate degree with a concentration in an advanced nursing practice category.

2. Combined with graduate nursing education, professional certification may be used as a qualification for licensure as long as the Board of Nursing has established criteria for accepting the certification and maintains control of the licensure process.

3. Movement toward consistent titling and uniform use of terminology for those nurses who practice in advanced roles will improve public understanding. Increased knowledge leads to informed consumer health care decisions.

4. Nurses already practicing at an advanced level when new regulation is proposed should be permitted to continue practicing in the advanced nursing category through "grandfathering" provisions.

5. Boards of Nursing should regulate advanced nursing practice by licensure of advanced nursing roles due to the nature of the practice which requires advanced knowledge, clinical proficiency, independent decision-making and autonomy. The risk of harm from unsafe and incompetent providers at this level of complex care is high.

Sources

Advanced Nursing Practice Discipline Survey of National Council Members (conducted by the Subcommittee to Study the Regulation of Advanced Nursing Practice). 1992.

American Board of Nursing Specialties (ABNS), *Review Guidelines for Assessing Applications for ABNS Approval*. 1992.

American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. "Professional and Occupational Licensure and Certification," Standards for Educational and Psychological Testing, Washington, D.C.: American Psychological Association, Inc. 1985.

Fink, III, Joseph L. "Prescribing Authority for Nurses: A Pharmacy Perspective," *Specialty Nursing Forum*, Vol.2, No.1. 1990.

Hadley, Elizabeth Harrison. "Nurses and Prescriptive Authority: A Legal and Economic Analysis," *American Journal of Law and Medicine*, Vol.XV, Nos.2-3. 1989.

Massaro, Toni M. Legal Opinion on Advanced Practice (Personal Correspondence). March 27, 1983.

National Council of State Boards of Nursing. "Advanced Nursing Practice Survey Results," *Issues*, Vol.12, No.2. 1991.

National Council of State Boards of Nursing. "Advanced Nursing Practice Update," *Issues*, Vol.13, No. 2. 1992.

National Council of State Boards of Nursing. *Conceptual Framework for Continued Competence*, 1991.

National Council of State Boards of Nursing. *Position Paper on Advanced Clinical Nursing*. 1987.

O'Brien, Thomas L. and Carol Kreuger-Brophy. Memorandum: Position Paper on Advanced Nursing Practice. March 5, 1992.

Review of Advanced Nursing Practice Provisions in Nurse Practice Acts and Administrative Rules of National Council Members (conducted by the Subcommittee to Study the Regulation of Advanced Nursing Practice). 1991.

Safriet, Barbara J. "Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing," 9 *Yale J. on Reg.* 417. 1992.

U.S. Congress, Office of Technology Assessment Health Technology Case Study 37, *Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis, (Health Technology Case Study 37)*, OTA-HCS-37 (Washington, D.C.: U.S. Government Printing Office, December 1986).

Virginia Board of Health Professions. *Criteria for the Evaluation of Proposals for Regulation*. 1991.

Virginia Board of Health Professions (study conducted by the Alpha Center, Bethesda, Maryland). *The Regulation of the Health Professions: A Policy Review for the Commonwealth of Virginia.* October, 1983.

The Subcommittee to Study the Regulation of Advanced Nursing Practice acknowledges the many organizations and individuals who have written and called with comments regarding the subcommittee's work.

Attachment B

Model Legislative Changes for Advanced Nursing Practice

Positions of the National Council's *Model Nursing Practice Act* are presented here with proposed changes to incorporate the licensure of the Advanced Practice Registered Nurse. Any added language is underlined and deleted language is crossed out of the original text.

NOTE: *Page numbers for this document appear at the bottom of each page.*

Article | **Comment**

Article I.

Section 3. Purpose. The legislature finds that the practice of nursing by competent persons is necessary for the protection of the public health, safety and welfare and further finds that ~~the two~~ three levels of practice within the profession of nursing should be regulated and controlled, in the public interest. Therefore, it is the legislative purpose of this Act to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of the practice of nursing and of the educational preparation for this practice, and to ensure that any person practicing or offering to practice nursing, as defined in this Act, or using the title of Registered Nurse ~~or~~, Licensed Practical Nurse, or Advanced Practice Registered Nurse in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Nurse Practitioner or Clinical Nurse Specialist after the effective date of this Act within this state shall, before entering upon such practice or using such title, be licensed as hereinafter provided.

This section will answer questions about what a legislature intended to accomplish through passage of the statute when the courts, an Attorney General or other legal counsel seek interpretation of the ACT.

~~*Regulatory bodies are charged with establishing standards for minimum safe and effective nursing practice.*~~

~~*Within the minimum level there is a range from low minimum to high minimum points. In order to promote nursing at the highest enforceable level, Boards of Nursing should design regulations at the high minimum level of practice.*~~

This model legislation recommends licensure for advanced nursing practice. The license will be issued as an Advanced Practice Registered Nurse, in the category of Nurse Practitioner, Certified Registered Nurse Anesthetist, Certified Nurse-Midwife or Clinical Nurse Specialist.

Boards of Nursing are charged with the protection of the public health, safety and welfare through the regulation of nursing practice in their jurisdictions.

As with any service, there is a range of quality of nursing practice. Regulatory agencies are charged with identifying the minimal, essential level of competence needed for safe nursing care. Behavior which falls below this level is subject to potential disciplinary action. The professional associations promote standards of excellence for the profession, identifying a level of competence that exceeds the essential, a level to which individuals are encouraged to strive.

Boards of Nursing should design regulations to identify those essential elements of practice necessary to protect the public.

In this section, nursing is established as a legal role, thereby, affording its professional members, Registered Nurses, and Advanced Practice Registered Nurses the attendant rights and responsibilities. In addition, this section

Article	Comment

acknowledges the practice of Licensed Practical Nurses, the nature of whose practice also affects directly the public health, safety and welfare and, consequently, should be regulated and controlled. Other persons to whom certain tasks may be delegated by Registered Nurses ~~or~~, Licensed Practical Nurses or Advanced Practice Registered Nurses should not be licensed because the tasks involved are limited and performed under supervision and can be controlled and regulated by other means.

~~In the history of American nursing, the process of registration preceded that of licensure. Nongovernmental registries listed nurses who met certain qualifications and thus served to protect the public against incompetent practitioners. When licensure was instituted in the various states, the term "registered nurse" and the abbreviation "R.N." were protected for use by only qualified nurses. Registration, however, differs from licensure in that it is a process by which qualified individuals are listed on an official roster. Because mandatory licensure affords greater protection for the public than registration, the Nursing Practice Act should refer only to this process. Current references to registration that are embodied in the legally recognized Licensed Practical Nurse title can confuse the public and the nursing practitioners. Alternate titles that would reflect the licensed status of both levels of nurses should be considered in revisions of the Act.~~

~~Alternative titles for Registered Nurse and Licensed Practical Nurse, which better reflect the method of control and regulation and the relationship between the two levels of licensed practitioners, should be considered. The method of control and regulation specified in the Practice Act is licensure rather than registration.~~ Licensure is the process by which an agency of state government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the essential degree of competency necessary to ensure that the public health, safety and welfare will be reasonably well protected. In granting an individual permission to practice through licensure, the state holds the individual responsible and accountable for that practice. The state also maintains records of

Article	Comment

past and present licenses.

Article II

Section 1. Practice of Nursing. The "Practice of Nursing" means assisting individuals or groups to maintain or attain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to care and treatment. This practice includes, but is not limited to, initiating and maintaining comfort measures, promoting and supporting human functions and responses, establishing an environment conducive to well-being, providing health counseling and teaching, and collaborating on certain aspects of the health regimen. This practice is based on understanding the human condition across the lifespan and understanding the relationship of the individual within the environment.

The most important part of a practice act is the definition of the practice that it seeks to regulate. The definition should distinguish nursing practice from the practice of other health care practitioners by assessing health status, establishing a nursing diagnosis and planning, yet should be stated in terms sufficiently broad to include all levels of practice, including that of the Registered Nurse, Licensed Practical Nurse and ~~all extended and expanded nursing roles~~ Advanced Practice Registered Nurse.

~~Nurses who practice advanced clinical nursing are practicing a specialty in accordance with advanced education in clinical nursing. However, their practice should be within the parameter of the legal scope of nursing practice.~~

Section 2. Registered Nursing . . .

~~(m) Practicing advanced clinical nursing in accordance with knowledge skills acquired through graduate nursing education.~~

This language is removed from this section on the Registered Nurse to a new section defining the Advanced Practice Registered Nurse.

Advanced Practice Registered Nurse refers to nurses authorized to practice in an advanced role.

Section 3. Licensed Practical Nursing . . .

The Licensed Practical Nurse functions at the direction of the Registered Nurse, Advanced Practice Registered Nurse, licensed physician, or licensed dentist in the performance of activities delegated by that health care professional.

Advanced Practice Registered Nurse is added to those health care practitioners authorized to direct the practice of Licensed Practical Nurses.

Section 4. Advanced Practice Registered Nursing by Nurse Practitioners, Certified Nurse Anesthetists, Certifed Nurse-Midwives and Clinical Nurse Specialists, is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; and a graduate degree with a major in nursing or a graduate degree with a

This definition is written broadly, to address a core of essential skills and abilities for all categories of Advanced Practice Registered Nurses rather than listing behaviors or technical skills required for specific practice areas.

Article	Comment
concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care. Advanced Practice Registered Nursing includes but is not limited to:	*The scope of practice in each of the advanced roles of nurse practitioner, nurse anesthetist, nurse-midwife or clinical nurse specialist is distinguishable from the others. While there is an overlapping of knowledge and skills within these roles, there are activities which are unique to each role.*
(a) Assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level;	
(b) Providing expert guidance and teaching;	
(c) Working effectively with clients, families and other members of the health care team;	
(d) Managing clients' physical and psycho-social health-illness status;	
(e) Utilizing research skills;	
(f) Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment;	
(g) Making independent decisions in solving complex client care problems;	
(h) Performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures, including legend drugs and controlled substances, within the scope of practice; and	*The APRN shall identify abnormal conditions, diagnose nursing and medical problems, develop and implement treatment plans and evaluate patient outcomes.*
(i) Recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.	
This act shall supersede all prior inconsistent statutes, rules or regulation regarding this subject.	
Section 5. An Advanced Practice Registered Nurse is authorized to prescribe and dispense drugs for administration to and use by other persons within the scope of practice defined by rules adopted by	*The language provides clear statutory prescriptive and dispensing authority for the Advanced Practice Registered Nurse. Boards of Nursing should review scopes of practice to assure that Registered Nurses*

Article	Comment
the Board. This act shall supersede all prior inconsistent statutes, rules or regulations regarding nurse prescriptive authority.	*and License Practical Nurses may implement orders written by Advanced Practice Registered Nurses.* *Boards must be certain that the prescriptive and dispensing authority expressly supersedes all conflicting provision of other statutes, rules and regulations in this area.*
~~Section 4.~~ **Section 6. Board.** "Board" means the (state) Board of Nursing.	*Authority base, structure, and name of regulatory agency will vary from state to state.*
~~Section 5.~~ **Section 7. Other Board.** "Other Board" means the comparable regulatory agency in any U.S. State or Territory. ~~Section 6.~~ **Section 8. License.** "License" means a current document permitting the practice of nursing as a Registered Nurse ~~or~~, Licensed Practical Nurse, or Advanced Practice Registered Nurse.	*A license is a current document issued to a qualified individual for the purpose of permitting that individual to practice as a Registered Nurse ~~or~~, Licensed Practical Nurse, or Advanced Practice Registered Nurse for a specific length of time. A license is renewable provided existing qualifications have been met. Because the only purpose of a license is to grant legal permission to a qualified person to do something, no inactive license should be provided.* *There are numerous sections throughout the Model where Advanced Practice Registered Nurses will need to be added so that all levels of licensure are addressed.*

Article	Comment

Article III.

Section 1. Membership . . .

(b) The membership of the Board shall be at least ( ) members of Registered Nurses; at least ( ) members of Licensed Practical Nurses; at least ( ) members of Advanced Practice Registered Nurses; and at least ( ) members representing the public.

The Board of Nursing consists of representatives of all levels of nursing licensure and consumers.

Because the majority of nurses licensed in most jurisdictions are Registered Nurses, the majority of Board members should be Registered Nurses. A majority of nurse members on the board is required to determine if persons performing nursing functions are qualified. In addition, the judgment of Registered Nurses constitutes the best possible criterion for determining the legality of a nursing action. Although it is recognized that representatives of the public make a significant contribution to the purpose of the Board, the need for nursing expertise is a sufficient state interest to justify a nursing majority membership on the Board.

Some states may desire Board membership to represent different geographic areas or the various areas of nursing practice such as education, administration and clinical practice.

Such special group representation and input also may be achieved through formation of special advisory committees.

Each Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Registered Nurse, and shall have had no less than five (5) years of experience as a Registered Nurse, at least three (3) of which immediately preceded appointment.

Registered Nurse ~~and~~, Licensed Practical Nurse and Advanced Practice Registered Nurse members should have sufficient nursing background and expertise to make appropriate decisions regarding the complex and technical matters within the Board's jurisdiction. These members also should have a commitment to the protection and concerns of the public.

Each Licensed Practical Nurse member shall be an eligible voting resident of this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing, and shall have had no less than five (5) years of experience as a Licensed Practical Nurse, at least

Appearance of conflict of interest and, on occasion, actual conflict of interest implications are raised when Board members hold elected positions in professional associations. To avoid any claim of bias, the Registered Nurse ~~and~~, the Licensed Practical Nurse and Advanced Practice Registered

Article	Comment
three (3) of which immediately preceded appointment.	*Nurse members should not be required to be members of their respective associations.* *However, membership in the professional association tends to reinforce professional commitment and should not be discouraged.*
Each Advanced Practice Registered Nurse member shall be an eligible voting resident of this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing, and shall have had no less than five (5) years of experience as an Advanced Practice Registered Nurse, at least three (3) of which immediately preceded appointment.	*When Advanced Practice Registered Nurse licensure is first implemented, experience in the advanced nursing categories that was gained before the license was issued should be considered in determining the five years experience required for an Advanced Practice Registered Nurse Board member.*
Section 2. Powers and Duties.	
(c) Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for regulation of advanced nursing practice.	*A specific and clear legislative mandate to promulgate rules related to advanced nursing practice strengthens the Board's authority.*
Article V. Licensure	
Section 1. (c) Initial Licensure for the Advanced Practice Registered Nurse. An applicant for initial licensure as an Advanced Practice Registered Nurse shall:	*A variety of methods of preparation have been recognized for Advanced Practice Registered Nurses. Requirements are outlined in statute and further defined through Board rules.*
(i) Be currently licensed as a Registered Nurse in (this jurisdiction);	
(ii) Submit a completed written application and appropriate fees as established by the Board;	
(iii) Provide evidence of successful completion of a graduate degree, with a	*Specific requirements for licensure in each advanced practice category both for initial licensure*

Article	Comment
major in nursing or a graduate degree with a concentration in the advanced nursing practice category;	*and endorsement will be outlined in the Model Nursing Administrative Rules.*
(iv) Completion of other requirements set forth in rules; and	*A Board may use professional certification as a qualification for licensure as long as the Board has established criteria for accepting the certification and maintains control of the licensure process. Boards cannot cede regulatory authority to private entities.*
(v) Have committed no acts or omissions which are grounds for disciplinary action as set forth in Article IX, Section 2 of this Act, unless the Board has found after investigation that sufficient restitution has been made.	
(d) The Board may issue a license by endorsement to practice as an Advanced Practice Registered Nurse if the applicant has practiced as an Advanced Practice Registered Nurse under the laws of another state and, in the opinion of the Board, the applicant meets the qualifications for licensure in this jurisdiction.	
Section 5. Temporary Licenses.	
(c) The Board may issue a temporary license to practice advanced nursing practice to an applicant who submits a written application in accord with the rules of the Board.	*Specific requirements for temporary licensure should be set forth in administrative rules.*
Article VI. Titles and Abbreviations.	
Section 1.	
C. Title: "Advanced Practice Registered Nurse" and the abbreviation "APRN"	*This section adds Advanced Practice Registered Nurse as a protected title under the act.*

Article	Comment
Article IX. Discipline and Proceedings.	
Section 1. Authority. The Board of Nursing shall have the power to refuse to issue or renew, to suspend, revoke, place on probation or reprimand a licensee for any one or combination of the causes on the grounds set forth below. Fines of up to ($) may be imposed.	***This section is intended to establish a means of disciplining or ~~baring~~ barring from practice persons who properly should not be permitted to practice nursing. Fines should be limited to cases in which the licensee has made financial gain as a result of the violation. They should not be the exclusive penalty for violations resulting in patient death or injury or used for grounds involving physical or mental illness. Rules should delineate the specific conditions for which fines can be imposed.*** ***A disciplinary investigation regarding the Advanced Practice Registered Nurse license should also include review of other nursing licenses if applicable. These other licenses may or may not also be disciplined depending on the nature of the complaint. (E.g., false documentation might result in concerns regarding all levels of licensure, whereas inappropriate prescription might only involve the Advanced Practice Registered Nurse license.)***
Section 3. Additional Grounds. The Board may take disciplinary action against an Advanced Practice Registered Nurse who has practiced beyond the scope of the advanced practice registered nurse category.	***These additional grounds for disciplinary action reflect the scope of practice for the Advanced Practice Registered Nurse.***

Article	Comment

Article XIV. Implementation

Section 2. Persons Licensed Under a Previous Law.

(f) New applicants for Advanced Practice Registered Nurse as of (effective date of statute) shall meet requirements set forth in administrative rules. Any individual authorized to practice in an advanced role prior to (effective date) may apply for licensure on the basis of the individual's prior education and practice as set forth in administrative rule.

Some states may have no existing licensure requirement for advanced nursing practice or have used another approach toward recognition of practice.

The "grandfathering" language recommended permits individuals practicing at an advanced level on or during a specified period of time before the effective date of the legislation to apply for licensure on the basis of their education and prior practice.

Each jurisdiction needs to assess the current educational and health care environment and select the most realistic approach for their situation.

Attachment C

Model Nursing Administrative Rules for Advanced Nursing Practice

Model Nursing Administrative Rules which complement the *Model Legislative Language for Advanced Nursing Practice*, are also proposed. Other than the suggested deletion to Chapter 4 of the current National Council *Model Nursing Administrative Rules*, all the proposed language would be new language.

NOTE: Page numbers for this document appear on the bottom of each page.

Additions and Changes to the Model Nursing Administrative Rules to Incoporate Licensure of the Advanced Practice Registered Nurse

Chapter 2

Additional Definitions (all new language)

1. **Advanced Practice Registered Nurse** - An individual who has met the requirements for licensure as an Advanced Practice Registered Nurse as set forth in Rule II, and practices in the category of either a Nurse Practitioner, a Certified Registered Nurse Anesthetist, a Certified Nurse-Midwife or a Clinical Nurse Specialist in accordance with the statements found in Rule X of these rules.

2. **Advanced Practice Registered Nurse Diagnosis** - When used by the Advanced Practice Registered Nurse, diagnosis means an independent determination about the nature of health problems in an individual, family or community which is derived through a systematic process of data collection and the analysis of data to distinguish from other diagnoses, and which leads to prescribing therapeutic measures and devices.

3. **Advanced Practice Registered Nurse Educational Program** - An Educational Program which meets the requirements in Rule VI.

4. **Approved Graduate Education Program** - An Educational Program which meets the criteria set forth in Rule VI.

5. **Collaboration** - A process which involves two or more health care professionals working together, though not necessarily in each other's presence, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer.

6. **Consultation** - The process by which one obtains expert advice.

7. **National Accrediting Body** - An entity whose standards meet the requirements found in Rule VI, Section B.

8. **National Certifying Body** - An entity which meets the standards found in Rule VII.

9. **Pharmacokinetics** - The action of drugs in the body over a period of time.

   This definition is taken from Dorland's Illustrated Medical Dictionary.

10. **Pharmocotherapeutics** - The study of the uses of drugs in the treatment of disease.

    This definition is taken from Dorland's Illustrated Medical Dictionary.

11. **Prescribing and Dispensing Authority** - Legal permission to determine which legend drugs and controlled substances shall be used by or administered to a client, and to prepare and deliver substances to the user so long as the authority is exercised in compliance with applicable federal and state laws.

    The relevant statutes and rules of the jursidiction should be reviewed so that use of the terms prescribing and dispensing are consistent with existing terminology.

12. **Professional Certification** - A credential issued by a national certifying body.

13. **Supervision** - The process by which a licensed practitioner is available to direct and oversee the practice of an Advanced Practice Registered Nurse applicant pending licensure.

14. **Therapeutic Device** - An instrument or an apparatus intended for use in diagnosis or treatment, and in the prevention of disease or maintenance or restoration of health.

Chapter 4.

~~**Rule XII - Announcement of Advance Practice. MNPA, Article II, Section 2(m).**~~

~~These requirements are reflected in the National Council's Position Paper on Advanced Clinical Nursing Practice adopted by the 1986 Delegate Assembly.~~

~~A. A licensee may announce advance practice upon meeting the following requirements:~~

~~1. Current licensure as a Registered Nurse in this state.~~

~~2. A masters degree in nursing.~~

~~3. Current national certification in the advanced practice area approved by the Board.~~

~~Boards may wish to specify the qualifications for a certifying body "approved by the Board". These qualifications may include: authority for approval of the course of study, a continued competence mechanism, examination, membership, qualifications, scope of organization, development of standards, and a scope of practice statement.~~

~~B. The title to be used shall be the title which is granted by the national certifying body.~~

Advanced nursing practice will be covered in new Chapter 5, so this rule is no longer needed.

Chapter 5

Advanced Nursing Practice Rules (all new langauge)

Rule I. TITLES
MNPA, Article VI, Section 1.C.

Individuals are licensed as Advanced Practice Registered Nurses in the categories of Nurse Practitioner, Certified Registered Nurse Anesthetist, Certified Nurse-Midwife or Clinical Nurse Specialist. Each Advanced Practice Registered Nurse shall use the category designation for purposes of identification and documentation.

Advanced Practice Registered Nurse represents an advanced level of nursing practice and is an "umbrella" classification for the purpose of regulation. Rather than add to the current plethora of names, the use of advanced practice categories for the purposes of titling and documentation will identify the nurse's area of practice as well as promoting consumer recognition of established titles. For example, Jane Doe, CRNA; John Doe, NP.

Rule II. LICENSURE AS ADVANCED PRACTICE REGISTERED NURSE
MNPA, Article V. (c).

A. INITIAL LICENSURE

1. In addition to licensure as a Registered Nurse and compliance with the disciplinary requirements as stated in the MNPA, Article V.(c) (iv), the information submitted to the Board of Nursing shall include:

The requirements for licensure should reflect minimum requirements for safe and competent care. In addition to graduate education in the advanced nursing practice category, Boards may require all or a combination of the other listed requirements.

a. A completed Board application form;

Typically, board forms are notarized and include an applicant affidavit that the information provided is accurate and complete.

Boards may include questions on the application regarding recent history of chemical dependency, criminal convictions or disciplinary actions related to drug violations. The information obtained may be used to trigger further inquiry. The Americans with Disabilities Act does not prohibit Boards from discriminating against current illegal drug users, nor does it prevent a Board from making licensure decisions based upon an individual's ability to perform the essential functions of the advanced nursing practice category.

b. The required fee(s);

c. A current Registered Nurse license in this jurisdiction or demonstration that the applicant has applied for licensure as a Registered Nurse and meets the requirements of this jurisdiction;

Encumbered RN licenses should be evaluated individually by the Board for potential applicability to the APRN practice category.

d. An official transcript from a graduate education program that meets the requirements of Rule VI for the category of advanced nursing practice for which the applicant is seeking licensure. The transcript shall verify the date of graduation and the degree conferred. If a transcript is not available, the Board may verify program completion through other means; and

Boards may allow official transcripts from other sources, excluding the applicant, such as a certifying body.

Boards may need to request additional information regarding the educational program, such as course description or program philosophy, if there are questions regarding the content of the transcript.

Boards should consider the availability of graduate programs in the advanced practice registered nurse category when planning effective dates for educational requirements. Provisions need to be

considered for the transition periods appropriate until graduate programs are available.

e. A statement directly from a national certifying body, which meets the criteria set forth in Rule VII of this chapter, evidencing that the applicant holds current certification in good standing from said national certifying body.

Boards may choose to use professional certification as a qualification for licensure as long as the Board of Nursing has established criteria for accepting the certification and retains control of the licensure process.

2. If more than [ ] years have elapsed since completion of the advanced nursing practice educational program and the applicant has never practiced in the advanced practice registered nurse category, in addition to meeting the requirements in Rule II.A.1., the applicant shall:

Throughout this model, brackets are used to indicate quantities that need to be determined by implementing Boards, e.g., relating to time periods or number of hours of a particular educational or practice requirement.

a. Apply for a temporary permit; and

b. Practicing under the temporary permit, successfully complete [ ] hours of clinical practice supervised by an APRN or health care provider in the same practice area. This provider shall submit a final evaluation to the Board and verify that the applicant has successfully completed the requisite number of hours of clinical practice.

Health care providers suitable as supervisors include Advanced Practice Registered Nurses, physicians, psychologists and other health care practitioners appropriate to the health care area. Practice hours obtained to meet professional certification requirements may be used toward meeting this practice requirement.

3. The Advance Practice Registered Nurse license will be issued with an expiration date that coincides with the applicant's Registered Nurse license.

B. ENDORSEMENT

The Board may issue a license by endorsement if the applicant has practiced under the laws of another state and if, in the opinion of the Board, the applicant meets the qualifications for licensure in this jurisdiction.

1. If the applicant is applying from another jurisdiction that licenses the category of Advanced Practice Registered Nurse that the applicant is seeking, the applicant shall submit:

a. A completed Board application form;

Typically, board forms are notarized and include an applicant's affidavit that the information provided is accurate and complete.

b. The required fee(s);

c. A current Registered Nurse license in this jurisdiction or demonstration that the applicant has applied for licensure as a Registered Nurse and meets the requirements of this jurisdiction;

Encumbered RN licenses should be evaluated individually by the Board for potential applicability to the APRN practice category.

d. Verification of licensure status directly from the jurisdiction of original licensure in the advanced practice nursing category;

e. Verification of licensure status in the advanced nursing practice category directly from the jurisdiction of most recent employment; and

If different from the original state of licensure in the advanced nursing practice category.

f. Demonstration of continued competence as required in Rule XII.

2. If the applicant is applying from a jurisdiction that does not license the Advanced Practice Registered Nurse category the applicant is seeking, the applicant shall submit:

a. A completed Board application form;

Typically, board forms are notarized and include an applicant's affidavit that the information provided is accurate and complete.

b. The requires fee(s);

c. A current Registered Nurse license in this jurisdiction or demonstration that the applicant has applied for licensure as a Registered Nurse and meets the requirements of this jurisdiction;

Encumbered RN licenses should be evaluated individually by the Board for potential applicability to the APRN practice category.

d. Information regarding the applicant's qualifications for advanced practice directly from the state where the applicant first practiced in the Advanced Practice Registered Nurse category;

e. Information regarding the applicant's qualifications for advanced practice directly from the state where the applicant was last employed in the Advanced Practice Registered Nurse category; and

f. Demonstration of continued competence as required in Rule XII.

Rule III. TEMPORARY PERMIT
MNPA, Section 5(c)

A. An Advanced Practice Registered Nurse applicant who possesses a current Registered Nurse license, and has submitted a complete application, the required fee, and evidence of meeting all educational requirements may be granted a temporary permit for supervised practice in an advanced nursing practice category if the applicant:

Encumbered Registered Nurse licenses should be evaluated by the Board for potential applicability to the Advanced Practice Registered Nurse category. The Board should have discretion regarding issuance of temporary permits in these situations.

1. Is applying for licensure under Rule II, section A.2;

2. Is complying with continued competence requirements of Rule XII;

3. Is completing practice requirements for national professional certification for the advanced nursing practice category;

Temporary permits in section 3, 4 or 5 would be needed only if a Board chooses to use professional certification as a requirement for licensure.

4. Has been accepted as a first time candidate to the next national professional certification examination for the advanced nursing practice category; or

5. Is awaiting certification results based upon initial application.

B. Temporary permits shall not include independent prescriptive authority.

Supervised practice includes supervised prescribing.

C. An individual practicing under the temporary permit shall use the title Advanced Practice Registered Nurse applicant, or APRN applicant.

D. The temporary permit shall not extend beyond receipt of certification examination results for numbers 3, 4, and 5 above and [specified time limit] for numbers 1 and 2 above. A temporary permit is not renewable.

Rule IV. RENEWAL OF LICENSURE
MNPA, Article V, Section 3.

The date for renewal of licensure to practice as an Advanced Practice Registered Nurse will coincide with renewal of the applicant's Registered Nurse license. An applicant for renewal of an Advanced Practice Registered Nurse license shall submit to the Board:

The requirements for renewal should reflect the requirements for licensure in the jurisdiction.

1. A completed Board renewal application form;

Typically, board forms are notarized and include an applicant affidavit that the information provided is accurate and complete.

2. The licensure renewal fee(s); and

3. Evidence of continued competence as required in Rule XII.

Rule V. REINSTATEMENT OF LICENSURE
MNPA, Article V. Section 4

A. REINSTATEMENT OF LAPSED LICENSE

An Advanced Practice Registered Nurse who has failed to renew licensure may apply for reinstatement by submitting to the Board:

This section is applicable to individuals who have not practiced in an advanced nursing practice category during the time of lapsed license. Practicing in an advanced nursing practice category without current licensure is grounds for disciplinary action.

1. A completed Board reinstatement application form;

Typically, Board forms are notarized and include an applicant's affidavit that the information provided is accurate and complete.

2. The required fees; and

3. Evidence of competence to return to practice as required in Rule XII.

B. REINSTATEMENT AFTER DISCIPLINARY ACTION

1. An Advanced Practice Registered Nurse who has been disciplined by the Board may be reinstated upon petition to the Board and evidence of compliance with terms of disciplinary order.

2. If the Advanced Practice Registered Nurse has been out of practice for [ ] years or more, in addition to any requirements set forth in the disciplinary order, the petitioner shall also submit to the Board:

a. A completed reinstatement application form;

Typically, board forms are notarized and include an applicant's affidavit that the information provided is accurate and complete.

b. The required fees; and

c. Evidence of competence to return to practice as required in Rule XII.

Rule VI. ADVANCED PRACTICE REGISTERED NURSE EDUCATIONAL PROGRAMS MNPA, Article VII

A. Programs Accredited by National Accrediting Bodies

1. Programs accredited by any national accrediting agency whose standards meet the requirements in section B below may be deemed approved by the Board.

2. This deemed approval may be subject to review if there are changes in the program's philosophy, curriculum or objectives, or at any time the Board determines it necessary for good cause. A program shall be notified and advised of the planned review.

3. If the Board determines that a program is not meeting the criteria set forth in these regulations, the controlling institution shall be given a reasonable period of time to correct the identified deficiencies.

4. If the controlling institution fails to correct the identified program deficiencies within a time specified, the Board may withdraw the approval following a hearing held pursuant the provisions of the Administrative Procedures Act.

B. Programs Approved by the Board of Nursing

1. The Board has authority to delegate to Board staff the approval of Advanced Practice Registered Nurse education programs which meet the following criteria:

a. The educational program for the category of Advanced Practice Registered Nurse shall be offered by a accredited college or university which offers a graduate degree with a major in nursing or a graduate degree with a concentration in the Advance Practice Registered Nurse category;

b. There shall be clearly written statements of philosophy and objectives for the program that shall include a description of the category of Advanced Practice Registered Nurse being prepared;

c. Faculty shall include Advanced Practice Registered Nurses currently licensed in the category being taught and may include other credentialed providers who provide content relevant to the category of Advanced Practice Registered Nurse being prepared;

To protect the public, consideration should be given to designating appropriate faculty-student ratios for the clinical setting and the student role.

d. The curriculum shall include but is not limited to:

(1) Biological, behavioral, medical and nursing sciences relevant to practice as an Advanced Practice Registered Nurse in the specified category;

(2) Legal, ethical and professional responsibilities of Advanced Practice Registered Nurses;

(3) Supervised clinical practice relevant to the category of Advanced Practice Registered Nurse; and

e. Course descriptions and objectives shall be available in writing.

2. Approval may be denied if the program does not meet the criteria set forth in section B.1 of this rule. The controlling institution may request a hearing before the Board and the provisions of the Administrative Procedures Act shall apply.

3. Each program shall be subject to periodic review by the Board to determine whether criteria for approval are being maintained.

4. If the Board determines that an approved program is not meeting the criteria set forth in these regulations, the controlling institution shall be given a reasonable period of time to correct the identified deficiencies. If the controlling institution fails to correct the identified program deficiencies within a time specified, the Board may withdraw the approval following a hearing held pursuant the provisions of the Administrative Procedures Act.

Rule VII. ADVANCED PRACTICE REGISTERED NURSE PROFESSIONAL CERTIFICATION PROGRAMS

A. A national certifying body which meets the following criteria shall be recognized by the Board to satisfy Rule II, section A.1(e) of these regulations.

A Board may choose to use professional certification as a qualification for licensure as long as the board of nursing has established criteria for accepting the certification and retains control of the licensure.

Currently, certification bodies may not meet all requirements. These criteria will assist Member Boards in making decisions whether to accept the certification.

The National Council of State Boards of Nursing can be a clearinghouse, obtaining, analyzing and updating information from certifying bodies and making the information available to Member Boards. The decision-making authority rests with individual Boards of Nursing.

B. The national certifying body:

1. Is national in the scope of its credentialing.

Boards may make provision for regional or state certifying bodies which meet all other criteria.

2. Has no requirement for an applicant to be a member of any organization.

3. Has educational requirements which are consistent with the requirements of these rules.

This rule specifies graduate education. Although many certification programs are moving toward masters requirements, time is needed for transition and to allow for licensure of individuals who have already obtained professional certification on the basis of certificate programs. Boards need to provide for the transition period.

4. Has an application process and credential review which includes documentation that the applicant's education is in the advanced nursing practice category being certified, and that the applicant's clinical practice is in the certification category.

5. Uses an examination as a basis for certification in the advanced nursing practice category which meets the following criteria:

Recognizing that some certification bodies may need time to conform to these criteria, Boards which choose to use professional certifications may develop time frames and temporary approval procedures for transition periods until all criteria are met.

a. The examination is based upon job analysis studies conducted using standard methodologies acceptable to the testing community;

b. The examination represents entry level practice in the advanced nursing practice category;

c. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to the clients;

d. The examination content and its distribution are specified in a test plan (blueprint), based on the job analysis study, that is available to examinees;

e. Examination items are reviewed for content validity, cultural sensitivity and correct scoring using an established mechanism, both before use and periodically;

f. Examinations are evaluated for psychometric performance;

g. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically; and

h. Examination security is maintained through established procedures.

6. Issues certification based upon passing the examination and meeting all other certification requirements.

7. Provides for periodic re-certification which includes review of qualifications and continued competence.

8. Has mechanisms in place for communication to Boards of Nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.

National Council's role as an information clearinghouse would lessen the burden on Member Boards and certification bodies.

9. Has an evaluation process to provide quality assurance in its certification program.

Rule VIII. SCOPE OF PRACTICE
MNPA, Article II, section 4

The Advanced Practice Registered Nurse shall practice in a manner consistent with the definition of advanced nursing practice set forth in MNPA, Article II, section 4 and the standards set forth in these Rules. The Advanced Practice Registered Nurse may provide client services for which the APRN is educationally prepared and for which competence has been attained and maintained.

Rule IX. PRESCRIPTIVE AND DISPENSING AUTHORITY
MNPA, Article V., Section 5.

A. An application for the authority to prescribe and dispense legend drugs, controlled substances and therapeutic devices may be made as part of initial licensure application with no additional fee or by separate application at a later date with an application processing fee.

B. An Advanced Practice Registered Nurse who applies for authorization to prescribe legend drugs and controlled substances classes II-V within the scope of practice for the advanced practice category, shall:

1. Be an applicant for Advanced Practice Registered Nurse licensure or be currently licensed as an Advanced Practice Registered Nurse in the jurisdiction; and

2. Provide evidence of completion of [ ] contact hours of education in pharmacotherapeutics obtained as part of study within the formal advanced educational program and/or continuing education programs, which:

(a) are related to the applicant's advanced practice category's scope of practice;

(b) include pharmacokinetic principles and their clinical application;

(c) include the use of pharmacological agents in the prevention of illness, restoration and maintenance of health; and

(d) are obtained within a [time period] immediately prior to the date of application for prescriptive authority.

3. Exceptions to the pharmacotherapeutic education may be approved by the Board of Nursing.

4. Prescriptions written by authorized Advanced Practice Registered Nurses shall comply with all applicable state and federal laws and be signed by the prescriber with the abbreviation for the applicable category of advanced nursing practice and the identification number assigned by the Board.

5. Advanced Practice Registered Nurse prescriptive authority shall be renewed as part of the Advanced Practice Registered Nurse license.

6. Advanced Practice Registered Nurses authorized to prescribe may dispense medications consistent with their scope of practice and in accordance with other state and federal statutes and regulations.

Boards may distribute educational materials to each APRN authorized to prescribe and dispense which include information regarding state and federal laws regarding prescribing and dispensing and the names of references which may be used for drug information and for advice to clients.

C. Board of Nursing Listing

The Board of Nursing shall be responsible for keeping an up-to-date list, available to the public, of the advanced practice registered nurses authorized to prescribe in the jurisdiction.

Creation and maintenance of a current, accurate listing of APRNs authorized to prescribe in the jurisdiction is facilitated having APRNs apply for the privilege. Some boards may share this list with the Board of Pharmacy, periodically updating the listing.

Rule X. STANDARDS OF NURSING PRACTICE FOR THE ADVANCED PRACTICE REGISTERED NURSE
MNPA, Article III, section 2(c) and section 2(d)(ii).

A. Purpose

1. To establish standards essential for safe practice by the Advanced Practice Registered Nurse.

2. To serve as a guide for evaluation of advanced nursing practice to determine if it is safe and effective.

B. Core Standards for all categories of Advanced Practice Registered Nurse

1. The standards for practice for Registered Nurses, found in MNAR, Chapter 4, Rule I, are incorporated by reference.

2. The Advanced Practice Registered Nurse shall assess clients at an advanced level, identify abnormal conditions, establish a diagnosis, develop and implement treatment plans and evaluate patient outcomes.

Implementation of treatment plan includes prescribing and dispensing medications within the scope of practice for the advanced practice category.

3. The Advanced Practice Registered Nurse shall use advanced knowledge and skills in teaching and guiding clients and other health team members.

4. The Advanced Practice Registered Nurse shall use critical thinking and independent decision making at an advanced level, commensurate with the autonomy, authority and responsibility of their practice category.

5. The Advanced Practice Registered Nurse shall have knowledge of the statutes and rules governing advanced nursing practice, and function within the legal boundaries of the appropriate advanced nursing practice category.

Boards may wish to include a generic list of legal areas which affect the APRN, e.g., insurance/reimbursement, privacy, drug, etc.

6. The Advanced Practice Registered Nurse may consult and collaborate with other members of the health team. The Advanced Practice Registered Nurse shall review, evaluate and determine which opinion(s) to use in providing optimal client care.

This Model provides for independent and autonomous practice by Advanced Practice Registered Nurses. Boards of Nursing have utilized a variety of approaches toward consultation and collaboration. Examples include practice agreements, protocols, scope of practice statements and written plans which may be submitted to the Board or made available on request. Boards moving away from supervised practice to a more independent model may find these approaches to be useful during the transition period.

7. The Advanced Practice Registered Nurse shall recognize the APRN's limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.

This is a critical aspect of independent and autonomous practice.

8. The Advanced Practice Registered Nurse shall retain professional accountability for advanced practice nursing care when delegating interventions.

9. The Advanced Practice Registered Nurse shall maintain current knowledge and skills in the advanced nursing practice category.

10. The Advanced Practice Registered Nurse shall evaluate and apply current research findings relevant to the advanced nursing practice category.

C. ADDITIONAL STANDARDS FOR EACH ADVANCED PRACTICE REGISTERED NURSE CATEGORY

1. Nurse Practitioners

In addition to the Core Standards described in section B above, Advanced Practice Registered Nurses in the category of Nurse Practitioner shall practice in accord with standards established by a national professional nursing association which have been reviewed and accepted by the Board of Nursing.

The Board of Nursing may list by name those organizations for each category of Advanced Practice Registered Nurse whose standards have been reviewed and accepted. Some jurisdictions may be able to name specific organizations in rule. Other Boards may reference generally accepted standards.

2. Certified Registered Nurse Anesthetists

In addition to the Core Standards described in section B above, Advanced Practice Registered Nurses in the category of Certified Registered Nurse Anesthetist shall practice in accord with standards established by a national professional nursing association which have been reviewed and accepted by the Board of Nursing.

3. Certified Nurse-Midwives

In addition to the Core Standards described in section B above, Advanced Practice Registered Nurses in the category of Certified Nurse-Midwives shall practice in accord with standards established by a national professional nursing association which have been reviewed and accepted by the Board of Nursing.

4. Clinical Nurse Specialists

In addition to the Core Standards described in section B above, Advanced Practice Registered Nurses in the category of Clinical Nurse Specialists shall practice in accord with standards established by a national professional nursing association which have been reviewed and accepted by the Board of Nursing.

Rule XI. DISCIPLINE
MNPA, Article IX

Any Advanced Practice Registered Nurse who violates a rule in this chapter is subject to board disciplinary action under MNPA, Article IX.

In discipline cases, the Board shall specify in the Board Order whether an action is against the Advanced Practice Registered Nurse license alone or also applies to other nursing licenses. Licensees should be given notice that all licenses may be subject to Board action.

Rule XII. CONTINUED COMPETENCE
MNPA, Article V

A. Continued competence requirements shall apply to:

Continued competence alternatives are listed. Member Boards should select those approaches which they deem appropriate. Consideration should be given to using a combination of requirements: some options providing assessment of continued competence and some options providing strategies for maintaining or regaining continued competence.

A resource for individuals, employers and Boards is the model presented in the 1992 **Conceptual Framework for Continued Competency,** which includes assessment, planning to meet identified learning needs, implementation of educational strategies to meet those needs and evaluation of the effectiveness of the educational strategies as important steps in attaining/maintaining competence.

For license renewal, Boards may direct Advanced Practice Registered Nurses to maintain documentation of continued competence activities and keep them on file. APRNs would identify the completed continued competence activities on the renewal application. The Board could select every [ ] application for an audit of complete documentation.

1. A licensee seeking to renew an APRN license, as required in Rule IV;

2. A licensee seeking to reinstate an APRN license, as required in Rule V;

3. An applicant for APRN licensure by endorsement, as required in Rule II, section B; and

4. An applicant for APRN licensure after [ ] years out of practice, as required in Rule II, section A.2.

B. The applicant or licensee shall submit evidence of competence in the advanced nursing practice category and evidence of continued study in nursing. Competence shall be demonstrated in one or more of the following ways:

This section recognizes that it is the individual APRN's responsibility to maintain competence in the APRN category of practice. Several alternatives are listed for use by Member Boards. Additional mechanisms to be considered include self assessment and performance appraisal.

1. Satisfactory peer review rating.

Peer review consists of the review and evaluation of practice of an APRN by a peer or group of peers in relation to established or accepted standards of practice. This mechanism has the advantage of being focused in the practice setting in which continued competence must be assured. If a Board uses this alternative, the rating should be submitted with the renewal or endorsement application.

2. Satisfactory client review ratings.

Client review is the retrospective evaluation of care provided by an APRN as it is documented in client records. The review is conducted by a peer or expert. As in peer review, the evaluation is based on established standards for the advanced nursing practice category. The client review ratings should be submitted with the renewal, reinstatement or endorsement application.

3. Successful completion of a refresher program in the advanced nursing practice category.

Planned and formal refresher courses for advanced nursing practice categories could be used to upgrade the knowledge and skills of an APRN whose practice has been interrupted by providing both theoretical and practice components. The Board should define the length of the program as well as the minimum theory and clinical instruction.

4. Successful completion of a preceptorship with an Advanced Practice Registered Nurse or other credentialed health care provider.

A preceptorship consists of an APRN applicant or licensee completing clinical practice under the supervision of a preceptor APRN, physician or other credentialed health care provider in the same practice area. Following the completion of the supervised practice, the supervisor shall submit an evaluation to the Board and verify that the applicant or licensee's knowledge and skill are at an acceptable level. Five hundred hours of supervised practice is suggested, Board may require more or fewer hours.

5. Continued study in the advanced practice category:

a. Completion of coursework in a formal advanced nursing practice educational program, related to the advanced nursing practice category; or

The Board should define a minimum number of credit hours to be completed within the calendar year or renewal period. The APRN should submit an official transcript verifying completion of the courses with the renewal, reinstatement or application forms.

b. Completion of [ ] hours of continuing education related to the advanced nursing practice category.

Continuing education may be structured formally or individually designed as independent studies. Boards should define the minimum number of continuing education units and the documentation required to verify participation which should be submitted with the renewal, reinstatement or application forms.

6. Satisfactory completion of [ ] hours of practice in the advanced practice category.

Boards should define what is meant by "practice in the advanced nursing practice category," giving examples of what types of clinical, administrative and teaching experience would be considered to fulfill this requirement. A notarized statement of practice, signed by the APRN's supervisor, or (if the APRN is the supervisor) by a co-worker verifying the practice hours completed should be submitted with the renewal, reinstatement or application forms.

7. Successful completion of a national competence examination approved by the Board.

The examination should be completed within a specific period of time as defined by the Board. The examination should evaluate the APRN's competence in the advanced practice category.

8. Evidence of re-certification by a national professional certification organization which meets the requirements of VII.

Re-certification requirements should include educational and practice components.

Rule XIII. IMPLEMENTATION
MNPA, Article XIV.(2)(f)

A. A nurse practicing at an advanced level during a [ ] period preceding the effective date of this jurisdiction's licensure legislation may, within [ ] of effective date, apply for licensure as an Advanced Practice Registered Nurse.

This section provides grandfathering for nurses already practicing in advanced nursing practice rules.

1. The graduate degree requirement is waived. The waiver of the graduate education requirement continues to apply at the time of license renewal or reinstatement of a lapsed license.

2. The applicant shall have completed an educational program designed to prepare the person to function in the advanced nursing practice category.

3. The applicant shall comply with all other requirements of Rule IIA.

B. Students enrolled in educational programs within [ ] year of the effective date of this jurisdiction's licensure legislation may apply for licensure as a APRN by complying with the requirements set forth in section A of this rule.

This provision allows students enrolled before the licensure legislation effective date and/or enrolled during educational program transition to be grandfathered during a specified time period.

Rule XIV. FEES
MNPA, Article XIII

A. The following Advanced Practice Registered Nurse fees shall be charged by the Board:

1. APRN application;

2. APRN renewal;

3. APRN reinstatement;

4. APRN prescribing and dispensing authority application; and

This fee would only be required if an APRN chose to apply separately for prescriptive authority.

5. Late fees.

Rule XV. APPLICABILITY

Nothing in this chapter limits the usual and customary practice of a Registered Nurse or Licensed Practical Nurse in this jurisdiction.

Sources

American Board of Nursing Specialties (ABNS), Review Guidelines for Assessing Applications for ABNS Approval. 1992.

American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. "Professional and Occupational Licensure and Certification," Standards for Educational and Psychological Testing, Washington, D.C.: American Psychological Association, Inc. 1985.

Dorland's Illustrated Medical Dictionary (27th ed.). Philadelphia: W.B. Saunders Co. 1988.

Fink, III, Joseph L. "Prescribing Authority for Nurses: A Pharmacy Perspective," Specialty Nursing Forum, Vol.2, No.1. 1990.

Hadley, Elizabeth Harrison. "Nurses and Prescriptive Authority: A Legal and Economic Analysis," American Journal of Law and Medicine, Vol.XV, Nos.2-3. 1989.

National Council of State Boards of Nursing. Conceptual Framework for Continued Competence, 1991.

National Council of State Boards of Nursing. Model Nursing Administrative Rules. Revised, 1988.

National Council of State Boards of Nursing. Model Nursing Practice Act. Revised, 1988.

Review of Advanced Nursing Practice Provisions in Nurse Practice Acts and Administrative Rules of National Council Members (conducted by the Subcommittee to Study the Regulation of Advanced Nursing Practice). 1991.

Virginia Board of Health Professions. Criteria for the Evaluation of Proposals for Regulation. 1991.

Virginia Board of Health Professions (study conducted by the Alpha Center, Bethesda, Maryland). The Regulation of the Health Professions: A Policy Review for the Commonwealth of Virginia. October, 1983.

The Subcommittee to Study the Regulation of Advanced Nursing Practice acknowledges the many organizations and individuals who have written and called with comments regarding the subcommittee's work.

Report of the Subcommittee to Study Regulatory Models for Chemically Dependent Nurses

Committee Members

Jean Sullivan, WA-RN, Area I, *Chair*
Patsy Duphorne, NM, Area I
Maggie Johnson, SC, Area III
Marcia Straus, OH, Area II
Mary Haack, *Consultant*

Relationship to Organization Plan

Goal II ....Provide information, analyses and standards regarding the regulation of nursing practice.
Objective C ....Conduct research on regulatory issues related to disciplinary activities.

Recommendation(s)

No recommendations.

Highlights of Activities

- **Development and Submission of a Research Proposal**

In 1988, the Delegate Assembly directed that "*...the Nursing Practice and Standards Committee develop a research proposal for submission to an outside agency for funding to study the effectiveness and cost implications of the various regulatory models of intervention presented in the monograph, The Regulatory Management of the Chemically Dependent Nurse.*" Since that time, the subcommittee, staff, and a consultant developed a study methodology and, in response to suggestions by numerous potential funding agencies, have re-written it several times to reflect the various specific interests of these agencies. One version of the proposal was formally submitted to and, in Spring 1992, rejected by the National Institute of Drug Abuse. During FY93, two additional sources of funding were explored. Each of these explorations resulted in responses indicating that the agency's research funding objectives did not coincide with the National Council's proposed study.

The search for a viable external funding source, and the preparation of multiple versions of the proposal to make it "fit" a potential funding source's research/funding objectives, has consumed five years of time and resources. Even though five years has passed since Delegate Assembly action, the subcommittee believes that the need for an effectiveness study continues to exist. This conclusion is based on comments made at the 1993 Area Meetings and ongoing personal contact between the subcommittee's members and representatives of various Member Boards. Furthermore, the subcommittee believes that it is possible to design and implement a methodologically sound and fiscally prudent study that can address Member Boards' information needs within the next three years.

The subcommittee has also identified several additional activities which could help meet Member Boards' information needs relative to the regulatory management of chemically dependent nurses. These include: the development of model guidelines for a non-punitive regulatory approach (i.e., a "disciplinary diversion program"); comparative information about the cost to Member Boards of various regulatory approaches; and the provision of assistance to Member Boards relative to the collection, storage, retrieval, and analysis of data about chemically dependent nurses under their jurisdiction for the purpose of promoting longitudinal program evaluation within and across Member Boards.

Information regarding this proposal has been shared with the Nursing Practice and Education Committee.

- **Proposed Action Plan**

To address perceived Member Board information needs, the subcommittee developed the following action plan:

1. Remainder of FY93
   - Prepare and disseminate a questionnaire to each Member Board requesting updated information about its approach to and the cost of regulating chemically dependent nurses.

2. FY94
   - Review collected Member Board data and conduct follow-up telephone interviews as necessary.
   - Prepare report on cost, to Member Boards, of regulating chemically dependent nurses.
   - Prepare model guidelines for a non-punitive approach to the regulation of chemically dependent nurses.
   - Develop and submit, to the Board of Directors, research methodology and budget for an internally funded study to compare and evaluate the effectiveness of regulatory approaches to the management of chemically dependent nurses.

3. FY95 and FY96
   - Perform "effectiveness study."
   - Facilitate Member Board data collection to promote ongoing internal (i.e., intra-board) program evaluation and cross-program (i.e., inter-board) comparisons and research.

The subcommittee has submitted a series of recommendations pertaining to the above action plan for the Board of Directors' consideration during its June 1993 meeting.

Meeting Dates

- April 29-30, 1993

Future Considerations for the National Council

- It is anticipated that the subcommittee will be able to provide the membership with the following products within FY94: Model Guidelines for a non-punitive approach (i.e., a "disciplinary diversion program"); a report identifying each Member Board's approach to the management of chemically dependent nurses; and a cost comparison of these different approaches.

- It is also anticipated that the outcomes of the effectiveness study, expected in FY96, will also provide Member Boards with information that can be used for informing decisions regarding the selection and use of regulatory approaches for managing chemically dependent nurses.

Recommendation(s)

No recommendations.

Staff

Carolyn J. Yocom, PhD, RN, *Director of Research Services*
Nancy L. Chornick, PhD, RN, *Research Associate*

21

RESOLUTIONS COMMITTEE
& NEW BUSINESS

Report of the Resolutions Committee/New Business

Committee Members

Debra Brady, NM, Area I, *Chair*
Susan Boone, OH, Area II
Joy Fleming, TX-VN, Area III
Patricia Beck, NY, Area IV
Charlene Kelly, NE, Area II, *Finance Committee Liaison*

Relationship to Organization Plan

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

Recommendation(s)

No recommendations at this time.

Highlights of Activities

- **Review of Motions**

  The committee will meet on Thursday, August 5, 1993, to review all motions submitted to it by 12:00 noon on that day. The committee will present the motions, with or without recommendation, to the Delegate Assembly.

- **Resolutions Forum**

  All motions received will be presented by the committee at the Resolutions Forum which will be held at 11:45 a.m. on Friday, August 6, 1993.

Meeting Date

- August 5, 1993

Staff

Thomas Vicek, *Director of Operations*

Supplemental Report of the Resolutions Committee/ New Business

Committee Members

Debra Brady, NM, Area I, *Chair*
Patricia Beck, NY, Area IV
Susan Boone, OH, Area II
Joy Fleming, TX-VN, Area III
Charlene Kelly, NE, Area II, *Finance Committee Liaison*

Relationship to Organization Plan

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

Recommendation

1. That the Maine Resolution for support of the development of a supplemental licensure examination for baccalaureate prepared nurses be adopted as amended below:

RESOLVED, *That the Delegate Assembly authorize the National Council to contract with the Maine State Board of Nursing to develop a psychometrically sound and legally defensible supplemental licensure examination for use by the Maine State Board of Nursing in licensing baccalaureate level graduates to measure the unique, minimal competencies required of these graduates.*

Rationale

The Maine Board is requesting a service which falls within the mission of the National Council.

The development of the supplemental licensure examination does not affect the National Council's formal position of neutrality on changes in nursing educational requirements for entry into practice.

Further, the 1986 Delegate Assembly adopted the following statements as part of a resolution on future direction for development of new licensure examinations: *That the National Council maintain licensure examinations based upon the minimum competencies of current levels of nursing practice; That the National Council explore the development of new licensure examinations based upon the minimum competencies of evolving levels of nursing practice; That the National Council explore mechanisms through which it can collaborate with researchers for the collection of job analysis data for the development of new licensure examinations.*

The Maine State Board of Nursing will be responsible for all costs of the supplemental examination.

Legal review of the proposal has determined that there is no obstacle to the provision of this service.

Highlights of Activities

■ Review of Motions

The committee will meet on Thursday, August 5, 1993, to review any additional motions submitted to it by 12:00 noon on that day. The committee will present the motions, with or without recommendation, to the Delegate Assembly.

■ Resolutions Forum

All motions received will be presented by the committee at the Resolutions Forum which will be held at 11:30 a.m. on Friday, August 6, 1993.

Meeting Dates

- June 23, 1993, *conference call*
- June 15, 1993, *conference call*

Recommendation

1. That the Maine Resolution for support of the development of a supplemental licensure examination for baccalaureate prepared nurses be adopted as amended below:

   RESOLVED, *That the Delegate Assembly authorize the National Council to contract with the Maine State Board of Nursing to develop a psychometrically sound and legally defensible supplemental licensure examination for use by the Maine State Board of Nursing in licensing baccalaureate level graduates to measure the unique, minimal competencies required of these graduates.*

Staff

Thomas Vicek, *Director of Operations*

Attachments

A ....Maine Resolution for Support of the Development of a Supplemental Licensure Examination for Baccalaureate Prepared Nurses.

Attachment A

Resolution for Support of the Development of a Supplemental Licensure Examination for Baccalaureate Prepared Nurses

WHEREAS, The results of the SURVEY OF FUTURE EXAMINATION NEEDS conducted by the Maine and Alaska Boards of Nursing in June of 1992 indicated that Maine, Alaska and several other states anticipate a need for a baccalaureate level licensure examination in the near future and that Puerto Rico currently uses examinations which test nurses prepared at associate and baccalaureate levels of education; and

WHEREAS, No national licensure examination exists to measure the unique, minimal competencies required of baccalaureate level graduates for safe practice; and

WHEREAS, The Maine State Board of Nursing contracted with the National Council of State Boards of Nursing to conduct a National Logical Job Analysis in order to determine if there are identifiable knowledge skills and abilities that differentiate the practice competencies of entry-level registered nurses with a generic baccalaureate degree from those with other types of generic nursing education; and

WHEREAS, A National Logical Job Analysis Study was performed by a panel of experts under the auspices of the National Council of State Boards of Nursing; and

WHEREAS, This expert panel identified activity statements representative of a level of practice specific to the baccalaureate prepared licensure and that these activities reflected minimum competencies to be demonstrated by this level of licensure in order to provide safe and effective nursing care to clients; and

WHEREAS, The National Logical Job Analysis Panel recommended that the Maine State Board of Nursing consider the development and use of a supplemental licensure examination for administration to future candidates for licensure who have completed a baccalaureate nursing education program; and

WHEREAS, On April 8, 1993, the Maine State Board of Nursing voted to accept the recommendation of the National Logical Job Analysis Panel that a supplemental licensure examination be developed for administration to baccalaureate prepared nurses, dependent on the outcome of implementing legislation and providing there is a adequate funding available from either internal or external sources.

RESOLVED, That the Delegate Assembly authorize the National Council to contract with the Maine State Board of Nursing to develop a psychometrically sound and legally defensible supplemental licensure examination to measure the unique, minimal competencies required of baccalaureate level graduates.

Submitted by
Maine State Board of Nursing

22

SUMMARY OF 1992
D.A. ACTIONS

Summary of 1992 Delegate Assembly Action and Subsequent Implementation

The 1992 Delegate Assembly passed motions directing:

1. **That Educational Testing Service be the vendor for provision of testing services and administration of NCLEX via CAT, and that fingerprinting be utilized for candidate identification.**

   A contract with Educational Testing Service was executed on August 22, 1992. To date, all provisions in the contract have been met; the Board of Directors has monitored progress of the vendor transition and beta testing at each Board meeting. The Board has submitted "readiness criteria," describing essential conditions to be fulfilled prior to implementation of computerized adaptive testing (CAT), to the 1993 Delegate Assembly for adoption.

2. **That the total candidate fee for NCLEX via CAT be $88.00.**

   This fee has been reflected in the Member Board contracts for CAT services, and in appropriate informational documents.

3. **That the substance of the contract between the National Council and Member Boards, to take effect at the time of CAT implementation, be approved.**

   Contracts were distributed to all Member Boards in September 1992. The Board and staff have continued to work with Member Boards since that time to negotiate non-substantive provisions of each contract to meet jurisdictional needs.

4. **That the revised National Council goals and objectives be approved.**

   The goals and objectives have been published in appropriate organizational documents. The Board of Directors, supported by committees and staff, established FY93 tactics for the accomplishment of the goals and objectives, and allocated the necessary organizational resources. The Long Range Planning Committee surveyed Member Boards' perceptions of the relative importance of the objectives and satisfaction with services provided in each objective area (refer to the committee's report for results).

5. **That the Delegate Assembly authorize the implementation of a Nurse Information System (NIS), contingent upon the receipt of substantial external funding for development and initiation of the system.**

   In October 1992, the Robert Wood Johnson Foundation awarded the National Council a grant of $530,110, over a two-year period, in support of NIS implementation. The National Council will be eligible to apply for a continuation grant for project years 1995-96. The National Council has contributed funding for indirect costs and computer equipment.

6. **That the time be increased by ten minutes per booklet for both the NCLEX-RN and the NCLEX-PN, starting with the NCLEX-PN 092.**

   The increased time allotment was implemented, as scheduled. Analyses of results for the NCLEX-PN 092 showed that the percentage of English-as-a-Second-Language (ESL) candidates still working at the end of the examination period had dropped to nine percent from 20 percent. Analysis of results for the NCLEX-RN 293 showed that the percentage of ESLs still working at the end of the examination period dropped to 12 percent from 20 percent.

7. **That it be the National Council's policy to cooperate with Member Boards in providing appropriate examination modifications for disabled NCLEX candidates whom Member Boards deem eligible for licensure; and that the National Council will do so by designing and approving procedures which ensure that such modifications are psychometrically sound, and safeguard the fairness and security of the testing process for all candidates.**

   This policy has been distributed, along with appropriate procedures, to Member Boards. Requests for 273 modifications have been granted for the examinations 792, 092, 293, and 493.

8. **That the National Council support philosophically the basic concepts inherent within the "Nursing's Agenda for Health Care Reform."**

   This decision has been communicated in writing to the American Nurses' Association and the National League for Nursing, sponsors of the "Agenda." Progress toward incorporating concepts from the "Agenda" into federal health care reform planning has been monitored through regular liaison meetings with the leadership of those organizations.

9. **That the National Council allow the Maine and/or Alaska Boards of Nursing to contract with the National Council for consultative services relating to a logical job analysis.**

   The Maine State Board of Nursing contracted with the National Council to perform a logical job analysis. A nationally-representative panel was appointed by the Maine Board to perform the analysis. A final report was presented to the Maine Board in April 1993 and has been distributed to all Member Boards. All costs of the services related to the logical job analysis were borne by the Maine Board.

10. **That the Board of Directors explore the feasibility and desirability of establishing certification programs for Member Boards in the areas of nursing education program surveys and nursing disciplinary investigation, and that a report of the findings and a recommendation for action be presented for consideration by the 1993 Delegate Assembly.**

    The Board requested that the Communications Committee survey Member Boards regarding needs and preferences for certification programs for nursing education program surveyors and nursing disciplinary investigators. The committee completed its survey and has presented in its report recommendations for Delegate Assembly consideration.

11. **That a feasibility study be conducted by the National Council regarding the inclusion of nurse aide disciplinary information in a disciplinary data bank such as the National Council's Disciplinary Data Bank, and that findings and recommendations be presented to the 1993 Delegate Assembly for consideration.**

    National Council staff conducted the study by surveying state agencies that might be participants and/or users of the data bank. Estimates of the effort required for establishment of the service were calculated, as well as estimates of potential revenues. A recommendation is presented in the Board of Directors' report.

12. **That the Delegate Assembly authorize a revision of the National Council Bylaws, to be acted on by the 1993 Delegate Assembly.**

    Additional members were appointed to the Bylaws Committee for the purpose of working on the revision. The committee report on its work progress is included in this *Book of Reports*, and forum time has been allocated at the 1993 Annual Meeting for Member Board feedback on the assumptions and ideas drafted by the committee. It is anticipated that a complete revision will be presented to the 1994 Delegate Assembly.

13. **That the Joint Statement on Nursing Shortage prepared in collaboration with the American Nurses' Association and the National Federation of Licensed Practical Nurses be adopted.**

    The statement has been disseminated to Member Boards and appropriate organizations.

14. **That the position paper on the Licensure of Advanced Nursing Practice and the additions of Model Language for Advanced Nursing Practice in the *Model Nursing Practice Act* be referred back to the Subcommittee to Study the Regulation of Advanced Nursing Practice for the purpose of reviewing the comments received from the delegates and interested nursing organizations (parties) and for developing the model rules; the position paper and model are to be brought to the 1993 Delegate Assembly for consideration.**

    The subcommittee has obtained comments as requested, completed its work, and presented the position paper and models in its report to the Delegate Assembly.

23

FY93 ORGANIZATION PLAN
AND BUDGET

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

Organization Plan

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

Goal I. <u>Licensure and Credentialing</u>

Provide Member Boards with examinations and standards for licensure and credentialing.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

Tactic 1. Conduct an RN job analysis study in FY93, PN in FY94. (Staff)

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

Tactic 1. Maintain and enhance licensure examinations based on current job analysis studies. (EC1)

Tactic 2. Review and revise policies and procedures for examination administration as necessary. (AEC)

Tactic 3. Provide information regarding the NCLEX process. (Staff)

Tactic 4. Assure examinations are administered according to approved security measures. (AEC)

Tactic 5. Develop and implement mechanisms for examination content development and performance. (EC)

Tactic 6. Recommend modifications to examination scoring and analysis procedures, as needed. (EC)

Objective C. Implement computerized adaptive testing for the licensure examinations.

Tactic 1. Plan and conduct communication activities for CAT, in accordance with the three year CAT Education/Information Plan. (EC2)

Tactic 2. Verify the efficacy of the CAT procedures for the PN/VN population. (CAT-PN)

Tactic 3. Implement the vendor transition. (EC2)

Tactic 4. Implement restructure of committees to support transition process to CAT. (EC1&2, AEC)

Tactic 5. Evaluate Member Board needs for support and begin implementation. (EC2, Panels)

Tactic 6. Plan for the implementation, evaluation and follow-up. (EC1&2)

Objective D. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Tactic 1. Continue research and development on CST including possible additional uses for CST. (CST)

Objective E. Provide a competency evaluation program for nurse aides.

Tactic 1. Maintain and enhance the Nurse Aide Competency Evaluation Program. (NACEP)

Tactic 2. Assure compliance of NACEP with all federal and state regulations. (Staff)

Tactic 3. Provide NACEP related services. (Staff)

Tactic 4. Select vendor for NACEP. (BOD)

Objective F. Promote consistency in the licensure and credentialing process.

Tactic 1. Evaluate and revise as needed the sections of the Model Nursing Practice Act and Model Nursing Administrative Rules relating to licensure. (NP&E)

Tactic 2. Evaluate and revise the Model Nurse Aide Regulation Act and Model Nurse Aide Administrative Rules in FY94. (Staff)

Tactic 3. Evaluate regulatory developments regarding entry into practice and analyze implications for National Council services. (NP&E)

Tactic 4. Provide information, analysis, and positions on issues related to licensure and credentialing. (Staff)

Objective G. Investigate mechanisms for evaluating continued competence.

Tactic 1. Analyze regulatory issues related to continued competence and implications for National Council services. (NP&E)

Tactic 2. Analyze regulatory issues related to continued competence and implications for Member Board services. (NP&E)

Tactic 3. Develop a plan to assist Member Boards in assessing continued competence. (NP&E)

Goal II. **Nursing Practice**

Provide information, analyses and standards regarding the regulation of nursing practice.

Objective A. Develop documents which provide guidance regarding the regulation of nursing practice.

Tactic 1. Evaluate and revise as needed sections of the Model Nursing Practice Act and Model Nursing Administrative Rules related to nursing practice and revise. (NP&E)

Tactic 2. Develop and disseminate National Council statements on trends and issues affecting the regulation of nursing practice. (NP&E)

Tactic 3. Evaluate and revise, in response to Member Board and other organization's comments, the position paper and model legislative language pertaining to regulation of advanced nursing practice; develop model rules; present to 1993 Delegate Assembly. (NP&E/Sub)

Objective B. Develop documents regarding health care issues which affect safe and effective nursing practice.

Tactic 1. Collaborate with other organizations as appropriate in formalizing statements on trends and issues affecting nursing practice. (Staff)

Tactic 2. Develop and disseminate National Council statements on trends and issues affecting nursing practice. (Staff)

Objective C. Conduct research on regulatory issues related to disciplinary activities.

Tactic 1. Submit funding proposal for study of approaches to the regulation of chemically dependent nurses and implement if funded. (NP&E/Sub)

Objective D. Provide information about disciplinary actions taken by Member Boards.

Tactic 1. Enhance and maintain Disciplinary Data Bank of nursing licensure actions. (Staff)

Tactic 2. Disseminate information regarding recent actions as reported to the Disciplinary Data Bank. (Staff)

Tactic 3. Collect, analyze and distribute data regarding types of disciplinary violations and disciplinary actions. (Staff)

Tactic 4. Provide electronic access to the Disciplinary Data Bank. (Staff)

Tactic 5. Monitor status of National Practitioners Data Bank. (Staff)

Tactic 6. Conduct feasibility study regarding inclusion of nurse aide disciplinary information in a disciplinary data bank. (Staff)

Objective E. Review and analyze actions of government and other entities that affect the regulation of nursing practice.

Tactic 1. Provide Member Boards with information, analysis and/or position papers regarding state and federal legislation that affects the regulation of nursing practice. (Staff)

Tactic 2. Provide Member Boards with information, analysis and/or position papers regarding the health care delivery system and the implications for safe and effective nursing care. (Staff)

Tactic 3. On behalf of National Council, review and comment on issues regarding regulatory implications of proposals affecting the health care system. (Staff)

Tactic 4. Monitor major nursing research projects which affect the regulation of nursing practice, and update Member Boards regarding these studies. (Staff)

Tactic 5. Investigate and provide analysis regarding the regulatory implications of Federal Laws including, but not limited to, the Americans with Disabilities Act for the practice of nurses with disabilities. (Staff)

Goal III. **Nursing Education**

Provide information, analyses and standards regarding the regulation of nursing education.

Objective A. Develop documents which provide guidance regarding the regulation of nursing education.

Tactic 1. Evaluate and revise as needed the sections of the Model Nursing Practice Act and Model Nursing Administrative Rules related to nursing education and revise. (NP&E)

Tactic 2. Develop and disseminate National Council statements on trends and issues affecting the regulation of nursing education. (NP&E)

Objective B. Develop documents regarding issues that affect the regulation of nursing education.

Tactic 1. Collaborate with other organizations as appropriate in formalizing statements on trends and issues affecting nursing education. (Staff)

Tactic 2. Develop and disseminate National Council statements on trends and issues affecting nursing education. (Staff)

Objective C. Provide for Member Board needs related to the approval process of nursing education programs.

Tactic 1. Respond to Member Boards' needs regarding the approval process of nursing education programs. (NP&E)

Tactic 2. Disseminate information among Member Boards regarding approaches to the regulation of nursing education programs. (NP&E)

Objective D. Review and analyze actions of government and other entities that affect the regulation of nursing education.

Tactic 1. Provide Member Boards with information, analysis and/or position papers regarding state and federal legislation that affects the regulation of nursing education. (Staff)

Tactic 2. Provide Member Boards with information, analysis and/or position papers regarding the health care delivery system and the implications for nursing education. (Staff)

Tactic 3. Monitor major nursing research projects which may affect the regulation of nursing education and update Member Boards regarding these studies. (Staff)

Tactic 4. Investigate the regulatory implications of Federal Laws including but not limited to the Rehabilitation Act of 1973 and the Americans with Disabilities Act for the education of students with disabilities. (Staff)

Goal IV. **Information**

Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective A. Implement a comprehensive repository of information.

Tactic 1. Establish policies for the management and use of data and other functions related to an information clearinghouse system. (Staff)

Tactic 2. Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions. (Staff)

Tactic 3. Compile abstracts of completed, ongoing and projected studies by Member Boards and the National Council. (Staff)

Tactic 4. Collect information regarding foreign educated nurses as well as potential services which could provide assistance to Member Boards with evaluating foreign educated nurse credentials. (FENCC)

Tactic 5. Design and implement a master plan for organization of and access to National Council information. (Staff)

Objective B. Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.

Tactic 1. Develop a licensee database. (NIS)

Tactic 2. Establish the policies for the management and use of the data. (NIS)

Tactic 3. Assess the market for data distribution and develop marketing plan as indicated. (NIS)

Objective C. Provide consultative services for Member Boards.

Tactic 1. Provide orientation and education programs. (Staff)

Tactic 2. Provide or identify resources to meet individual information needs of Member Boards. (Staff)

Objective D. Facilitate communication between National Council, Member Boards and related entities.

Tactic 1. Enhance existing formal communications network between the National Council and Member Boards. (Staff)

Tactic 2. Create and maintain effective working relationships with nursing, health care, consumer and regulatory organizations providing a focus on nursing regulation. (Staff)

Tactic 3. Enhance the National Council image and credibility through utilization of a variety of professional communication vehicles. (Staff)

Tactic 4. Create and seek communications opportunities that promote, inform and educate on issues regarding nursing regulation. (CC)

Tactic 5. Explore feasibility and desirability of establishing certification programs for Member Boards for nursing education program surveyors and nursing disciplinary investigators. (CC)

Goal V. **Organization**

Implement an organizational structure that uses human and fiscal resources efficiently.

Objective A. Implement a planning system to guide the National Council.

Tactic 1. Develop and communicate a clear and progressive vision for the organization. (BOD)

Tactic 2. Develop and evaluate the Organization Plan for National Council. (LRP)

Tactic 3. Develop and implement an evaluation plan for the overall effectiveness of the organization. (BOD)

Tactic 4. Facilitate intraorganizational coordination and effectiveness. (Staff)

Objective B. Implement a fiscal resource management system.

Tactic 1. Maintain and refine the program budgeting system for the National Council. (FC)

Tactic 2. Investigate the feasibility of new revenue sources for the organization. (Staff)

Tactic 3. Maintain financial policies which provide guidelines for fiscal management. (FC)

Tactic 4. Review and revise financial forecast assumptions to maintain a current forecasting model. (FC)

Objective C. Maintain a system of governance that facilitates leadership and decision making.

Tactic 1. Maintain an effective intraorganizational structure. (BOD)

Tactic 2. Manage National Council resources to effect the goals of the organization. (Staff)

Tactic 3. Revise National Council bylaws for action at the 1993 Delegate Assembly. (BC)

Tactic 4. Assure a slate of qualified candidates. (CON)

Objective D. Conduct and disseminate research pertinent to the mission of the National Council.

Tactic 1. Identify research proposals which merit funding. (Staff)

Tactic 2. Facilitate Member Boards' research activities. (Staff)

Tactic 3. Conduct role delineation studies as deemed necessary. (Staff)

FY93 Budget - 10/1/92 - 9/30/93
By Program

NCLEX		
NCLEX Exam Revenue	(7,877,796)	
NCLEX Processing Costs	4,375,935	
Handscoring Review Fees	(99,500)	
Handscoring Review Costs	86,900	
Other NCLEX Related Expense	28,000	
Exam Committee	16,125	
Admin. of Exam Committee	34,725	
Ethnic-Gender Bias Review	163,998	
NCLEX Support Costs	45,450	
NCLEX Income Subtotal		(3,226,163)
NACEP		
Royalty Income	(168,000)	
Committee Travel	19,650	
Marketing/Staff Travel	21,200	
Other NACEP Expense	13,475	
NACEP Income Subtotal		(113,675)
Investments		
Investment Income	(300,000)	(300,000)
Member Boards		
Member Board Contract Income	(186,000)	
Associated Exp. (Legal and Other)	90,000	
Member Board Income Subtotal		(96,000)
Publications		
Publications Revenue	(125,200)	
Publications Expense	94,800	
Publications Income Subtotal		(30,400)
Delegate Assembly		
Delegate Assembly Income	(57,750)	
Delegate Assembly Expense	125,503	
Convention Planning	2,000	
Delegate Assembly Subtotal		69,753

Area Meetings

Area Meetings Board Travel	10,600	
Area Meetings Staff Travel	10,600	
Area Meetings Expense Subtotal		21,200

Public Relations

Honoraria	(3,500)	
Public Relations Expense	64,500	
Communications Committee	37,485	
Public Relations Expense Subtotal		98,485

Research

Research Fees	19,890	
Job Analysis Monitoring Panel	10,525	
Other	15,725	
ADA-Related	43,156	
Supplemental Fund	92,200	
Research Expense Subtotal		181,496

Practice and Education

Public Policy Expense	4,150	
Practice and Education Committee	43,750	
Chemical Dep. Nurse Subcommittee	21,125	
Advanced Nurse Practice Subcommittee	29,375	
Disciplinary System	14,170	
Practice and Education Expense Subtotal		112,570

Organizational

Board of Directors	127,462	
Nurse Info. System Committee	57,700	
Committee on Nominations	11,725	
Finance Committee	27,900	
Bylaws Committee	39,750	
Long Range Planning Committee	34,175	
Fall Planning Retreat	26,185	
Resolutions Committee	7,475	
Foreign Educated Nurse Credentialing Committee	33,375	
Organizational Expense Subtotal		365,747

Administration

Personnel Costs		
Salary and Benefits	1,900,627	
Staff Travel	5,250	

Professional Fees		
Legal	24,000	
Accounting	21,000	
Other	14,700	
Library/Membership	7,000	
Printing/Supplies	75,600	
Insurance	35,500	
Miscellaneous Expense	2,520	
Administration Expense Subtotal		2,086,197

Occupancy

Rent/Utilities	350,000	
Electronic Mail	10,500	
Telephone	25,000	
Postage	48,090	
Equipment Maintenance/Rental	29,400	
Computer Maintenance/Rental	17,560	
Depreciation	120,620	
Occupancy Expense Subtotal		601,170

SUMMARY

TOTAL REVENUE	(8,817,746)
TOTAL EXPENSE	8,588,126
(REVENUE) OVER EXPENSE	(229,620)

24

ORIENTATION MANUAL

National Council of State Boards of Nursing, Inc.

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the functions and operations of the National Council. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as Board and committee members.

Following a brief discussion of the National Council's history, this manual will describe the organizational structure, functions, policies, and procedures. More descriptive information on the National Council is available in a published orientation portfolio, available through the communications department.

History

The concept of an organization such as the National Council had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses' Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for persons involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE) which, in 1932, became the ANA's Department of Education. In 1933, by agreement with the ANA, the NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, the NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published *A Curriculum Guide for Schools of Nursing*. Two years later, the NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine scorable form. In 1943, the NLNE Board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the "State Board Test Pool Examination" or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA Board appointed the Committee for the Bureau of State Boards of Nurse Examiners which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that it be replaced by a council. Although council status was achieved, many persons continued to be concerned about potential conflicts of interest and recognized the often heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body.

At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of the ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from the ANA to form the National Council of State Boards of Nursing.

Today, the National Council consists of 62 Member Boards including those from the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands. An organizational chart depicting the relationship between the National Council and the Member Boards is attached (Appendix A).

Organizational Mission, Goals and Objectives

The 1990 Delegate Assembly reaffirmed National Council's mission statement:

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

A Long Range Planning Committee was established in 1988, with the charge to establish and implement a periodic review of the National Council structure, mission statement, goals, objectives and strategies, and to propose revisions as indicated. Over the years, the Long Range Planning Committee, in concert with National Council's elected leadership, has employed frequent and intense communication activities among boards of nursing to garner valuable input regarding the organization's future directions. 1992 served as a year to carefully reexamine organizational goals and objectives, resulting in a new Organization Plan which was adopted by the 1992 Delegate Assembly.

The Organization Plan consists of National Council's mission statement, goals and objectives that direct all activity, as determined by the Delegate Assembly. The Long Range Planning Committee is responsible for the review and development of any recommendations that modify the plan. The Board of Directors annually develops the tactics which support the accomplishment of objectives and then, based on the entire plan, determines the human and fiscal resources required for implementation, thereby achieving the directives of the Delegate Assembly. Between annual meetings, oversight and monitoring of the Organization Plan is the responsibility of the Board of Directors.

The Organization Plan is published annually in the *Book of Reports* and is part of the orientation materials provided to Member Boards and committee members. National Council's goals and objectives are listed below:

Goal I: Licensure and Credentialing

Provide Member Boards with examinations and standards for licensure and credentialing.

Objective A .... Conduct job analysis studies to serve as the basis for examinations.
Objective B ..... Provide examinations that are based on current accepted psychometric principles and legal considerations.
Objective C ..... Implement computerized adaptive testing for the licensure examinations.
Objective D .... Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.
Objective E ..... Provide a competency evaluation program for nurse aides.
Objective F ..... Promote consistency in the licensure and credentialing process.
Objective G .... Investigate mechanisms for evaluating continued competence.

Goal II: Nursing Practice

Provide information, analyses and standards regarding the regulation of nursing practice.

Objective A .... Develop documents which provide guidance regarding the regulation of nursing practice.
Objective B ..... Develop documents regarding health care issues which affect safe and effective nursing practice.
Objective C ..... Conduct research on regulatory issues related to disciplinary activities.
Objective D .... Provide information about disciplinary actions taken by Member Boards.
Objective E ..... Review and analyze actions of government and other entities that affect the regulation of nursing practice.

Goal III: Nursing Education
Provide information, analyses and standards regarding the regulation of nursing education.
Objective A ....Develop documents which provide guidance regarding the regulation of nursing education.
Objective B .....Develop documents regarding issues that affect the regulation of nursing education.
Objective C .....Provide for Member Board needs related to the approval process of nursing education programs.
Objective D ....Review and analyze actions of government and other entities that affect the regulation of nursing education.

Goal IV: Information
Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective A ....Implement a comprehensive repository of information.
Objective B .....Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.
Objective C .....Provide consultative services for Member Boards.
Objective D ....Facilitate communication between National Council, Member Boards and related entities.

Goal V: Organization
Implement an organizational structure that uses human and fiscal resources efficiently.
Objective A ....Implement a planning system to guide the National Council.
Objective B .....Implement a fiscal resource management system.
Objective C .....Maintain a system of governance that facilitates leadership and decision-making.
Objective D ....Conduct and disseminate research pertinent to the mission of the National Council.

Organizational Structure and Function

Membership
Membership in the National Council is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by the National Council. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees, and execution of a contract for using the NCLEX-RN and/or NCLEX-PN.

Member Boards maintain their good standing through compliance with bylaws and all contract provisions and remittance of fees. In return, they receive the privilege of participating in the development and use of the National Council's licensure examinations. Member Boards also receive information services, public policy analyses, and research services. Member Boards who fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

Areas
The National Council's membership is presently divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues, and provide diversity of board and committee representation. Area Directors are elected by delegates from their respective areas through a majority vote of the Delegate Assembly. In addition, there is a Director-at-Large who is elected by all delegates voting at the annual meeting. (See Glossary for list of jurisdictions by area.)

Delegate Assembly
The Delegate Assembly is the major policy-making body of the National Council that comprises delegates designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates.

The Delegate Assembly meets at the National Council's annual meeting, traditionally in August. Special sessions can be called under certain circumstances. Regularly scheduled sessions take place in Chicago every third year. In the years between, sessions are held in other cities on a rotation basis among areas.

At the annual meeting, delegates elect officers and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and approve the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly approves most test-related decisions, including changes in examination fees and test plans.

Officers

Officers of the National Council include the president, vice-president, secretary, treasurer, area directors, and director-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate or a committee member or an officer prior to being elected to office. An officer shall serve no more than six consecutive years on the Board of Directors in addition to filling an unexpired term.

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 are elected in even-numbered years. The secretary and treasurer are elected in odd-numbered years.

The directors are elected for a term of two years or until their successors are elected. Directors from odd-numbered areas are elected in odd-numbered years. Directors from even-numbered areas and the director-at-large are elected in even-numbered years.

Officers are elected by ballot during the annual session of the Delegate Assembly. Area directors are elected by delegates from their respective areas.

Election is by a majority vote. When a majority is not established by an initial ballot, re-balloting takes place between the two nominees with the highest number of votes. In case of a tie on the re-balloting, the choice is determined by lot.

Officers assume their duties at the close of the session at which they were elected. A vacancy in the office of president is filled by the vice-president. Other officer vacancies are filled by Board appointees until the term expires.

Board of Directors

The Board of Directors, the administrative body of the National Council, consists of the nine elected officers. Its primary function is to conduct the business of the National Council between sessions of the Delegate Assembly. The Board authorizes the signing of all contracts including those between the National Council and its Member Boards. It also engages the services of legal counsel, appoints an executive director, adopts an annual budget, reviews membership status of noncompliant Member Boards, and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to the National Council's purpose, and provision for the establishment and maintenance of the administrative offices.

Meetings of the Board of Directors

All Board meetings are held in Chicago with the exception of the pre- and post-annual meeting Board meetings in those years when the annual meeting is conducted outside of Chicago. The agenda and related materials are mailed to Board members two weeks before the meeting. The agenda is prepared by the President and Executive Director.

The agenda is generally organized around committee and staff reports in the various program areas. Items for Board discussion and action are accompanied by a memo or report which describes the item's background and indicates the Board action needed. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting and later drafts a complete set in conjunction with the secretary. A summary of the Board's major decisions is also prepared, reviewed by the Secretary, and mailed to Member Boards for their information prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board member for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the National Council office and include copies of the articles of incorporation and bylaws, policy manual, contracts, organization plan, budget, test plans, committee rosters and minutes.

Communications with the Board of Directors

Communication between Board meetings takes place in several different ways. The Executive Director communicates weekly with the President, regarding major activities and confers as needed with the Treasurer about financial matters. In most instances, the Executive Director is the person responsible for communicating with National Council consultants about legal, financial, and accounting concerns. This practice was adopted primarily as a way to monitor and control the costs of consultant services.

Conference calls can be scheduled, if so desired by the President. Written materials are generally forwarded to Board members in advance of the call. These materials include staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call to assist the Secretary who submits them at the next regularly scheduled Board meeting.

Board members use the National Council letterhead when communicating as officers of the National Council.

Committee on Nominations

National Council delegates elect representatives to the Committee on Nominations. The committee consists of four persons, one from each Area, who may be either Member Board staff or Board members. Committee members are elected to one-year terms and may not serve more than two consecutive terms. They are elected by ballot with a plurality vote. The chair is that person who receives the highest number of votes.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director office and for the committee itself. The committee then prepares a slate for each position to be filled. During the first session of the Delegate Assembly, additional nominations can be received from the floor.

Committees

Most of the National Council's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Delegate Assembly. At the present time, the National Council has seven standing committees: Administration of Examination, Bylaws, Communications, Examination, Finance, Long Range Planning, and Nursing Practice and Education.

Ad hoc committees or task forces are appointed by either the Delegate Assembly or the Board of Directors and to address special issues and concerns. Examples include the Nurse Aide Competency Evaluation Program Committee, the Nurse Information System Committee, the CST Steering Committee, and the Foreign Educated Nurse Credentialing Committee.

Committees are governed by specific policies and procedures as approved by the Board of Directors. Committee membership is extended to all current members and staff of Member Boards. An effort is made to achieve balanced representation whenever possible, including Area, staff and Board members, registered and practical nurses, and consumers. Consultants provide outside expertise to committees as needed, on a one-time or ongoing basis.

No individual may serve more than six consecutive years on the same committee. Vacancies, including those resulting from a failure to attend two consecutive meetings, may be filled by the Board of Directors upon recommendation by the committee chair.

A National Council staff member is assigned to serve each committee. Staff works closely with the committee chairs to facilitate committee work and provide support and expertise to committee members, but they have no formal decision-making role. Agendas for the committee meetings are established by the chair. With staff assistance, the chair prepares the agenda and any other documents that must be reviewed prior to committee meetings. Staff supervises the mailing of these materials, which are sent to committee members no less than two weeks before the committee meeting.

At the request of committee members, staff will analyze issues and make recommendations in accordance with committee objectives and assumptions.

Administration of Examination Committee

The Administration of Examination Committee consists of at least six persons. Its purpose is to recommend criteria and procedures needed to maintain examination security and evaluate Member Board and Test Service compliance with the established criteria and procedures. It is the committee's duty to report security-related violations of contracts between the National Council and its Member Boards to the Board of Directors. The committee chair is contacted in regard to crisis management plan implementation and investigation of security breaks. The committee also reviews National Council staff authorizations for NCLEX candidates with disabilities and examination reviews.

Bylaws Committee

The Bylaws Committee consists of at least three members. Its primary duties are to receive, edit, and correlate proposed amendments to the articles of incorporation and bylaws. Such amendments may be originated in the Bylaws Committee or submitted by Member Boards, the Board of Directors, or committees. Following the Bylaws Committee's review, the proposed amendments are submitted by the committee to the Delegate Assembly together with the committee's recommendations for action. The 1992 Delegate Assembly approved a major revision of the bylaws to take place over two years.

Communications Committee

The Communications Committee consists of at least five members. Its purpose is to provide recommendations regarding National Council publications and communications; monitor the effectiveness of publications and information systems; plan the annual meeting and administer an awards program; and coordinate conferences as authorized by the Delegate Assembly or the Board of Directors.

Examination Committee

The Examination Committee consists of at least six persons. One of these persons must represent a separate board for practical/vocational nursing. The committee chair must have served on the committee prior to being appointed chair. Alternates to the Examination Committee are generally individuals with prior experience on a testing related committee. The alternates are called upon to substitute for a regular committee member who is unable to attend a meeting, as well as to assist the committee in other capacities, including representation on item development panels.

The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests research important to the development of licensure examinations.

The Examination Committee is responsible for directing all aspects of examination development. Other duties include the selection of appropriate item writers, test service evaluation, and preparation of written information about the examinations for Member Boards and other interested parties. The committee also evaluates the licensure examinations following their administration through means of item analysis, person-fit analysis, and test and candidate statistics.

One of the National Council's major objectives is to provide **psychometrically sound and legally defensible** nursing licensure examinations to Member Boards. Establishing examination validity is key to this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation. There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills, and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a cut score to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected for this process. They are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in recommendation of a cut score. Taking this outcome along with other data relevant to identification of the level of minimum competence, the Board of Directors sets a passing standard which distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes is the best legal defense available for licensing examinations. For most of the possible challenges that candidates might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

Finance Committee
The Finance Committee consists of at least three persons. One of the three is the Treasurer who serves as the committee chair. The committee's primary purpose is to supervise National Council finances, subject to the Board of Directors' approval. It also reviews financial status on a quarterly basis and provides the Board with a proposed annual budget prior to each new fiscal year.

Long Range Planning Committee
The Long Range Planning Committee consists of at least five members. Its purpose is to review the structure of the National Council and its effectiveness in meeting the National Council's purpose; review the mission statement, goals, and objectives and propose revisions, if necessary; and prepare information about the National Council goals, objectives, and tactics for dissemination.

Nursing Practice and Education Committee
The Nursing Practice and Education Committee consists of at least six persons. The committee's purpose is to provide data regarding aspects of nursing regulation to Member Boards. It periodically reviews and revises the *Model Nursing*

Practice Act and the *Model Nursing Administrative Rules*, and prepares other position statements and guidelines occasionally for presentation to the Delegate Assembly. It also prepares written information about the legal definitions and standards of nursing practice and education which it disseminates to Member Boards and other interested parties. In the recent past, the committee has had a number of subcommittees to study various issues, e.g., chemically dependent nurses and advanced practice.

National Council Staff

National Council staff members are hired by the Executive Director, to whom they report. Their primary role is to implement the Delegate Assembly's policy directives and provide assistance to the Board of Directors and committees.

The National Council staff is organized into departments for the purpose of meeting the organizational objectives. These departments are: Testing Services; Research Services; Communications; Public Policy, Nursing Practice and Education; Operations; and Administration. A list of staff and their respective responsibilities is attached (Appendix B).

General Delegate Assembly Information

Agendas for each session are prepared by the President in consultation with the Board of Directors and Executive Director and approved by the Board of Directors. At least 45 days before the annual meeting, Member Boards are sent copies of the *Book of Reports*. This document contains annual reports and recommendations from the standing and ad hoc committees, Board of Directors, officers, and Executive Director as well as new business submitted by any member or the Board. It also contains the agenda and operating budget, as well as proposed rules for the conduct of Delegate Assembly business.

Prior to the annual session of the Delegate Assembly, the President appoints the Rules, Registration, Election, and Resolutions Committees as well as the Committee to Approve Minutes. Prior to any special session, the President appoints at least the Rules and Registration Committees. In either case, the President must also appoint a timekeeper, a parliamentarian, and pages.

The purpose of the Rules Committee is to draft, in consultation with the parliamentarian, rules for the conduct of the specific Delegate Assembly. The Registration Committee's function is to provide delegates and alternates with identification bearing the number of votes to which the individual is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to council goals and fiscal impact. At a time designated by the President, it reports its recommendations to the Delegate Assembly.

Minutes of the Delegate Assembly are kept by the Secretary, with the support of National Council staff. These minutes are then reviewed, corrected and approved by the Committee to Approve Minutes.

The duties of the Delegate Assembly, as specified in the bylaws, are to:

- approve new National Council memberships;
- elect officers and members of the Committee on Nominations;
- receive reports of officers and committees and take action as appropriate;
- approve any examination fee to be charged by the National Council;
- approve the auditor's report;

- approve policy and position statements and strategies that give direction to the National Council;

- approve the substance of all contracts between the National Council and Member Boards and the National Council and test services;

- establish the criteria for and select the test service(s) to be utilized by the National Council unless the National Council provides such services itself;

- adopt test plans to be used for the development of licensing examinations in nursing;

- transact any other business as may come before it.

General Committee Information

Committee Appointments

The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and to ensure a wide representation of Member Boards, board staff and board members, the following procedure is used.

Each spring, individuals who wish to be considered for appointment or reappointment to a National Council committee submit a Committee Volunteer Information Form. All information from this form, along with information about the number of positions available on each committee, is forwarded to the respective Area Director for recommendations for appointment or reappointment. Concurrently, committee chairs are asked to provide input as to whether individuals currently serving on committees should be reappointed. In June, the Area Directors recommend the appointment/ reappointment of individuals to vacant committee positions. The Area Directors' recommendations are based on input received from committee chairs, as well as information obtained from the individuals' volunteer information form.

During its June meeting, the Board of Directors evaluates the qualifications of existing and potential committee chairs, makes the appropriate appointments for committee chairs, and reviews and approves the committee appointments which were recommended by Area Directors. All persons applying for positions on committees are notified regarding appointments after the Board's June meeting and prior to the Annual Meeting.

Committee Minutes

Minutes are taken at every committee meeting including telephone conferences. Minute-taking is an extremely important responsibility because minutes serve as records of what took place at the meeting. Although minutes can be opposed by oral testimony, they are, in the vast majority of cases, legally binding once they have been adopted and certified. Thus, it is critical that they accurately reflect the committee's process and outcomes.

Committee minutes are taken by committee members or staff. If no one volunteers to take the minutes, the committee chair may appoint someone to serve as secretary. Whomever takes the minutes records:

- the date, place, and time of the meeting;
- a statement that the meeting was duly called;
- the presiding officer, chair, or committee member;
- who served as secretary;
- names of persons present and quorum statistics;
- the correction, and adoption of minutes from the previous meeting; and
- the adjournment time.

Proprerly recorded minutes follow the specified format, are clear and concise, do not include every routine document, and are amended only with the committee's approval.

On the advice of legal counsel, the minutes of the discussion should not be laden with unnecessary detail or use a "he said/she said" approach. In other words, it is not desirable for the secretary to transcribe verbatim statements. Only in special circumstances is it necessary to identify individual speakers since the minutes should reflect **committee** discussion as well as **committee** action.

Committee Reports

Committee reports are due no later than three weeks prior to each Board of Directors' meeting. The reports are written by the committee chair and/or assigned staff person at the discretion of the chair. Staff processes the reports and supervises their mailing.

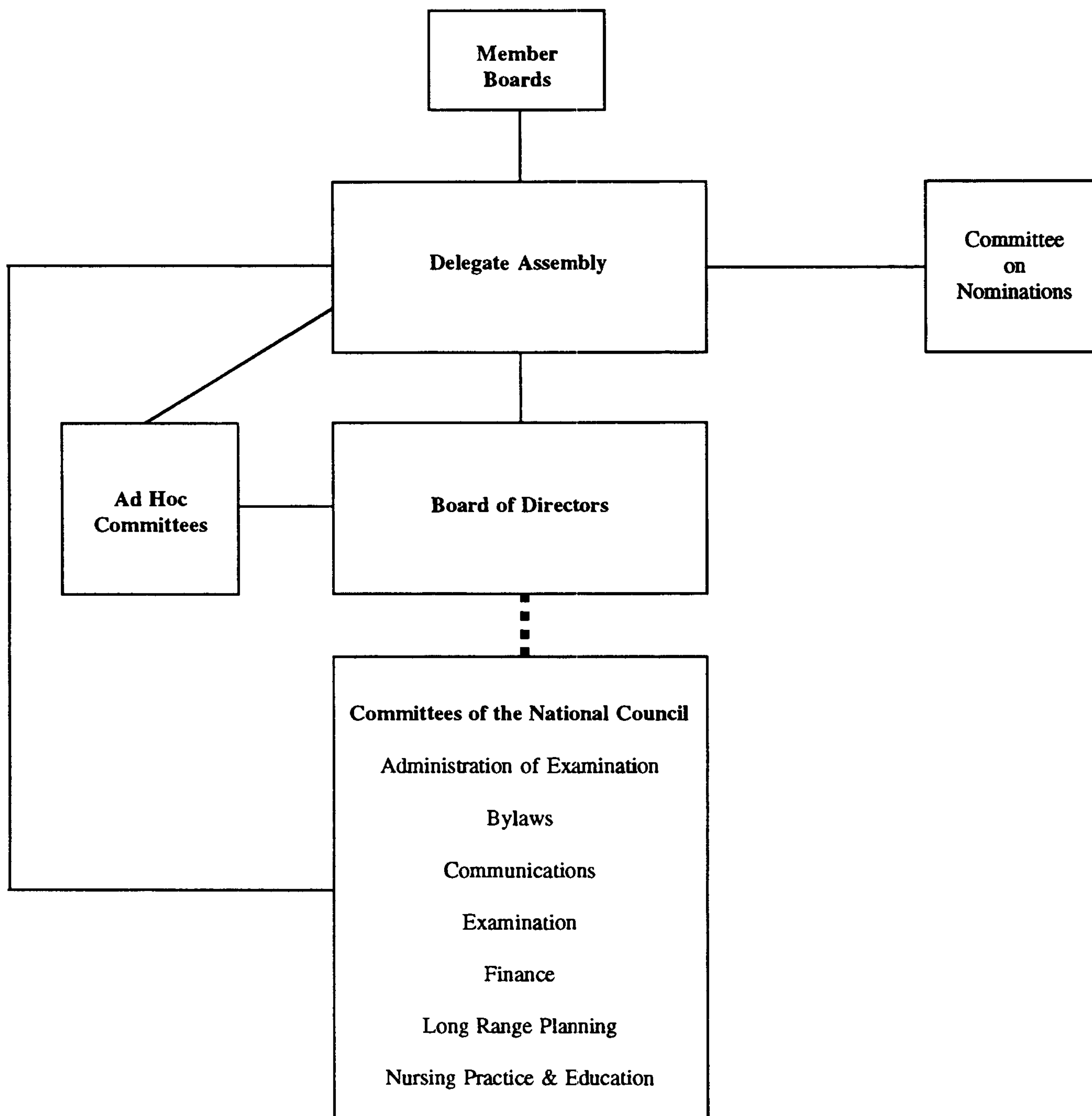
The report contains any committee recommendation(s) with rationale, followed by highlights of the committee's activities in outline format. The report concludes with an alert to anticipated future considerations.

A summary of every committee meeting is reported to the membership via the *Newsletter* that follows the close of the individual meeting.

National Council of State Boards of Nursing, Inc.

Organization

As of May 17, 1993



Appendix B

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

676 North Saint Clair Street, Suite 550, Chicago, IL 60611
Phone: (312) 787-6555 Fax: (312) 787-6898

1993 STAFF RESOURCE REFERENCE LIST

Voice mail extension numbers are listed in parentheses after the staff person's name.

ADMINISTRATION

JENNIFER BOSMA (42), *Executive Director*
- Board of Directors meetings/agenda
- Delegate Assembly meetings/agenda
- Media and interorganizational relations
- Staff speaker requests

DORIS NAY (66), *Associate Executive Director*
- Member Board liaison
- Committee membership
- Liaison with nursing, healthcare & regulatory groups

ANN WATKINS (43), *Executive Secretary*

FLEURETTE WORKMAN (10), *Receptionist*

MARIA HAMBESIS (43), *General Office Assistant*

SANDRA RHODES (61), *Administration Program Assistant*
- Committee membership inquiries

COMMUNICATIONS

SUSAN WOODWARD (65), *Director of Communications*
- National Council communications services & policies
- Reprint permission
- Media contacts
- Resource Network (tailored services for Member Boards)

KERRY NOWICKI (67), *Publications Manager*
- *Issues*
- CAT communications

SUE DAVIDS (69), *Meetings Manager*
- Annual meeting and conferences
- Area meetings
- Meeting planning assistance
- Hotel reservations while on National Council business

CHRISTOPHER HANDZLIK (68), *Editor*
- *State Nursing Legislation Quarterly (SNLQ)*
- *Insight: NACEP News and Issues*

YVONNE BROWN (63), *Communications Program Assistant*
- *Newsletter* to Member Boards
- All National Council publications: orders, payments and invoices

HAIBA HAMILTON (64), *Secretary*

OPERATIONS

THOMAS VICEK (54), *Director of Operations*
- Member Board contracts

KATHY HAYDEN (51), *Financial Manager*
- Expense reports
- Financial statements
- Travel policy

LARRY SANKEY (50), *Information Resource Manager*
- NCNET/Upfront
- Electronic access to Disciplinary Data Bank
- MBOS (CAT Software for Member Boards)
- Electronic data transfer with ETS

CRAIG MOORE (23), *Computer Coordinator*

BRYAN NEWSON (62), *Programmer/Analyst*

KATHY SIGGEMAN(49), *Secretary*

MARY TRUCKSA (52), *Accounting Assistant*

VACANT (53), *Financial Assistant*

PUBLIC POLICY, NURSING PRACTICE AND EDUCATION

VICKIE SHEETS (31), *Director for Public Policy, Nursing Practice and Education*
- Advanced nursing practice
- Nursing trends and issues affecting regulation
- Disciplinary Data Bank
- National Practitioner Data Bank (NPDB)

LINDA HEFFERNAN (30), *Nursing Practice and Education Associate*
- Nursing practice and education

RICH BENTEL (32), *Secretary*

RESEARCH

CAROLYN YOCOM (41), *Director of Research Services*
- Role delineation study
- Licensure statistics
- Member Board characteristics (as included in "Profile" survey forms)
- Research study about regulatory management of chemically dependent nurses
- Research design, statistical analysis and survey preparation (consultation)

NANCY CHORNICK (46), *Research Associate*
- Job analysis studies
- Foreign-educated nurse credentialing

JERRY JACOBSON (35), *Research Assistant*

CYNDI BENTEL (44), *Research Program Assistant*
- Surveys to Member Boards
- Member Board profile data
- License statistics

RENEE ALBERS (39), *Secretary*

ANNA BERSKY (34), *CST Project Director*
Computerized Clinical Simulation Testing (CST)

MELANIE NEAL (47), *NIS Project Manager*
Nurse Information System

LORI ROBBINS (40) - *NIS Program Assistant*

TESTING

ANTHONY ZARA (20), *Director of Testing Services*
Psychometrics and testing-related policies
Test service contract issues
Research and evaluation projects involving test services
General CAT questions

ELLEN JULIAN (17), *Psychometrician*
Psychometric studies
Test validity, reliability
Test methodology research

NANCY MILLER (16), *NCLEX Program Manager*
ANNE WENDT (16), *NCLEX Program Manager*
NCLEX panels
NCLEX security and crisis management plan
NCLEX operational issues
General NCLEX issues

JODI BORGER (13), *NCLEX Administrative Assistant*
Security measures and procedures to implement
NCLEX failure candidate review
NCLEX handicapped modification requests
General NCLEX questions
NCLEX panels
NCLEX handscoring
Program code changes

BARBARA HALSEY (27), *CAT Project Manager*
General questions about computerized adaptive testing (CAT) implementation
CAT beta testing
CAT-PN field testing
CAT education and information

TAMARA BOWLES (28), *Secretary*

CAROL HARTIGAN (21), *CAT Testing Manager*
General questions about computerized adaptive testing (CAT) implementation
CAT beta testing
CAT transition
CAT operations (?)

RUTH BERNSTEIN (25), *CAT Project Associate*
General CAT questions
CAT-PN field testing
CAT education and information

ELLYN HIRSCH (26), *CAT Administrative Assistant*
CAT education and information

ELLEN GLEASON (12), *NACEP Program Manager*
NACEP committee activities
General NACEP program questions
NACEP implementation and administration issues

MILI YOPST (57), *NACEP Program Assistant*
Nurse aide registry information
NACEP item writers, task developers, content experts

25

GLOSSARY

Glossary

AACN
American Association of Colleges of Nursing.

ADA
Americans with Disabilities Act.

AEC
Administration of Examination Committee.

AERA
American Educational Research Association.

ANA
American Nurses' Association.

AONE
American Organization of Nurse Executives.

Area
Designated regions of National Council Member Boards.

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Delaware
Arizona	Iowa	Florida	District of Columbia
California	Kansas	Georgia	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska	North Carolina	New Jersey
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Puerto Rico
N. Mariana Islands	West Virginia	Texas	Rhode Island
Oregon	Wisconsin	Virginia	Vermont
Utah			Virgin Islands
Washington			
Wyoming			

Batch Processing
A method of submitting candidate applications for NCLEX. Applications are submitted directly to the board of nursing, then forwarded to the Data Center on a regular basis with the appropriate funds.

Beta Test
The final operational and psychometric tryout of CAT prior to full implementation.

Blueprint
The organizing framework for the NACEP which includes the percentage of items allocated to various categories.

Board Member
An individual who serves on a board of directors (national level) or a board of nursing (state level).

Board Processing
A method of submitting candidate applications for NCLEX. Applications are submitted directly to the board of nursing, then forwarded to the Data Center on a regular basis without money. The board is billed for the total number of processed applications at a later date.

BOD
Board of Directors of the National Council of State Boards of Nursing.

Bylaws
The laws which govern the internal affairs of an organization.

Case Development Committee
A committee of twelve clinical experts which has the responsibility of developing cases for the Computerized Clinical Simulation Testing (CST) project.

CAT
Computerized Adaptive Testing.

CAT-PN Team
CAT-PN Field Test Team. (A team of the National Council)

CGFNS
The Commission on Graduates of Foreign Nursing Schools.

CLEAR
Council on Licensure, Enforcement and Regulation. (An organization of regulatory boards and agencies)

CMP
See Crisis Management Plan.

CNATS
Canadian Nurses Association Testing Service.

Crisis Management Plan (formerly Disaster Plan)
A plan developed for NCLEX administration to be implemented in the event of emergency or natural disaster.

CST
Computerized Clinical Simulation Testing.

CTB Macmillan/McGraw-Hill
National Council's current test service for the NCLEX paper-and-pencil development and administration.

Data Center
The unit at CTB which receives and processes direct paper-and-pencil NCLEX applications for the current paper-and-pencil examination. ETS has also established a Data Center for processing candidate registrations.

Delegate Assembly
The policy-making body of the National Council which comprises 62 Member Boards. Each Member Board is entitled to two votes.

Diagnostic Profile
The document sent to failing candidates reflecting their performance on various aspects of the NCLEX test plan.

DIF
Differential item functioning or a measure of potential bias.

Direct Application
A method of submitting candidate applications for NCLEX. Applications are submitted by candidates, with appropriate fee, directly to the Data Center.

Disciplinary Data Bank (DDB)
A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards.

EC
Examination Committee (Teams 1 and 2).

ENL
English-as-a-Native-Language.

ESL
English-as-a-Second-Language.

ETS
Educational Testing Service. National Council's test service for NCLEX using computerized adaptive testing, located in Princeton, New Jersey, and engaged in educational and certification testing services.

Experimental Items
Newly written test questions placed into examinations for the purpose of gathering statistics. Experimental items or "tryouts" are not used in determining the pass/fail result.

FARB
Federation of Associations of Regulatory Boards.

FIS
Foundation for International Services, Inc.

Fiscal Year
October 1 to September 30 at the National Council.

FY
See Fiscal Year.

HCFA
Health Care Financing Administration.

ICN
International Council of Nurses.

ICONS
The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing, the American Association of Critical Care Nurses, the American Organization of Nurse Executives, the American Nurses' Association, the Bureau of Labor Statistics, the Division of Nursing (BHPR, HRSA), the National Center for Health Statistics, the National Council of State Boards of Nursing, and the National League for Nursing American Association for Nurse Anesthetists.

Issues
A quarterly newsletter published and nationally distributed by the National Council.

Item
A test question.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses. Their use enables many measurement benefits (see Rasch Model).

Item Reviewers
Individuals who review newly written items developed for the NCLEX-RN and NCLEX-PN.

Item Writers
Individuals who write test questions for the NCLEX-RN, NCLEX-PN and NACEP.

KSA
Knowledge, Skill and Ability Statements.

Logit
The natural logrithem of an odds ratio, such as p/q or q/p where p is an odds (probability) value between 0 and 1, and q equals 1-p. For items, the ratio is q/p and p represents the item p-value. For persons, the ratio is p/q and p represents proportion of items an examinee gets correct on an examination. The log transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

LRP
Long Range Planning. (A committee of the National Council)

MAR
Model Administrative Rules.

Mantel-Haenszel
A well-accepted statistical procedure used to estimate the differential item functioning or potential bias of test items.

MBOS
Member Board Office System. The software used in many Member Board offices to communicate electronically with ETS regarding NCLEX candidates.

Member Board
A jurisdiction having a contract with the National Council to administer NCLEX-RN and/or NCLEX-PN.

MNPA
Model Nurse Practice Act. (Also a publication of the National Council)

NACEP
Nurse Aide Competency Evaluation Program. (Also a committee of the National Council)

NANDA
North American Nursing Diagnosis Association.

NAPNES
The National Association for Practical Nurse Education and Service.

National Council Organization Plan
Mission, goals and objectives of the National Council as adopted by the Delegate Assembly.

National Licensure Verification Form
A compilation of data taken from all licensure verification forms used in every state to develop a single national licensure verification form available for common use.

NBME
National Board of Medical Examiners. NBME is currently modifying its computerized clinical simulation testing (CST) software for application to nursing.

NC or NCSBN
Abbreviated form of National Council of State Boards of Nursing, Inc.

NCLEX-RN/PN
National Council Licensure Examination-Registered Nurse/Practical Nurse.

NCME
National Council on Measurement in Education.

NCNET
National Council's electronic mail network.

Newsletter
A biweekly publication produced by the National Council staff and distributed to each Member Board. Items included on a regular basis: committee reports; Board of Directors' agendas, major actions and minutes; analyses of federal legislation; examination statistics; notice of upcoming events; updates to the National Council Manual; solicitations for persons to serve in various capacities and information related to CAT implementation (CAT Corner).

NFLPN
National Federation of Licensed Practical Nurses.

NIDA
National Institute of Drug Abuse.

NIMH
National Institute of Mental Health.

NIS
Nurse Information System. A national database, developed by the National Council, containing demographic information on all licensed nurses, an unduplicated count of licensees and serving as a resource on the characteristics of licensed nurses (e.g., employment status, educational preparation, clinical specialty, etc.). (Also a committee of the National Council)

NLN
National League for Nursing.

NP&E
Nursing Practice and Education. (Also a committee of the National Council)

NPDB
National Practitioner Data Bank. A federally-mandated program for collecting disciplinary data regarding health-care practitioners. The NPDB began operation in September 1990, receiving required medical malpractice payment reports for all health care practitioners, and required reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by P.L. 100-93, section five. Implementation of section five is on hold until the NPDB has gained sufficient experience under Title IV to extend services.

OBRA 1987
Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

OSA
ETS-developed "Open Systems Architecture" software for delivering computer-based tests. National Council will use OSA to deliver NCLEX administered CAT.

Panel of Content Experts (PCE)
Terminology for Item Reviewers prior to 1993.

Person-fit Analysis
A statistical procedure conducted to determine whether or not items from a previously-administered examination may have been exposed to any group(s) of candidates.

PL 99-660
A public law which institutes the Health Care Quality Assurance Act and establishes a national practitioners databank (See NPDB).

Psych Corp
The Psychological Corporation. The Psychological Corporation is the test service contracted by the National Council and guided by the Nurse Aide Competency Evaluation Program (NACEP) Committee to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA).

Psychometrics
The scientific field concerned with all aspects of psychological measurement (or testing), specifically achievement, aptitude, and mastery as measured by testing instruments.

Rasch Measurement Model
A psychometric item response theory model used to create the NCLEX measurement scale. Its use allows person-free item calibration and item-free person measurement.

Reliability
A test statistic that indicates the expected consistency of a person's test scores across different administrations or test forms. Reliability indicates the extent to which a test score is repeatable over time. That is, it reflects the degree to which a test score reflects the examinee's true standing on the trait being measured. The National Council uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of NCLEX and NACEP.

RFP
Request for Proposals.

SNLQ
State Nursing Legislation Quarterly. A quarterly journal publication reviewing nursing legislation throughout the country. The journal is published by the National Council and mailed by subscription.

Standard Setting
The process used by the Board of Directors to determine the passing standard for an examination, above which examinees pass the examination and below which they fail. This standard denotes the minimum acceptable quantity of entry-level nursing knowledge, skills and abilities. The National Council uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is conducted every three years for NCLEX and whenever the *NACEP Blueprint* changes.

Summary Profiles
Published by CTB for paper-and-pencil NCLEX, the NCLEX Summary Profiles are a concise report of the performance of a nursing program's graduates on the National Council Licensure Examination. A subscription to this service provides a nursing program with percent of candidates passing, test plan profiles, diagnostic profiles, and content dimension reports that may help program administrators and educators to monitor the effectiveness of the curriculum and identify areas of strength and weakness. Summary Profiles will continue to be published under CAT, but may have a revised format.

Summary Reports
After all phases of a scoring cycle have been completed for an administration, CTB prepares a set of summary reports for each state or jurisdiction. The reports include a variety of data summarizing the test performance of all candidates. The reports also include summaries of test performance for candidates who were educated in that state.

Sylvan/KEE Systems
A subcontractor of ETS for delivering computerized tests. Beginning no sooner than April 1994, the NCLEX using CAT will be administered at Sylvan Technology Centers across the United States and its territories.

TAA
Test Administration Agency. An organization contracted by a Member Board to administer the NCLEX or NACEP examination.

Tape States
A method of submitting candidate applications for NCLEX. The states develop their own applications, enter the information on to a computer tape, and forward that tape to the Data Center following the examination.

Test Plan
The organizing framework for NCLEX-RN/PN which includes the percentage of items allocated to various categories.

Test Service
The organization which provides test services to the National Council, including test scoring and reporting. CTB is the test services for NCLEX paper-and-pencil; ETS is the test service for NCLEX using CAT; and The Psychological Corporation is the test service for NACEP.

TPC
See Psych Corp.

Validity

The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. The National Council assures the content validity of its examinations by basing each test strictly on the appropriate test plan (RN or PN) or blueprint (NACEP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.