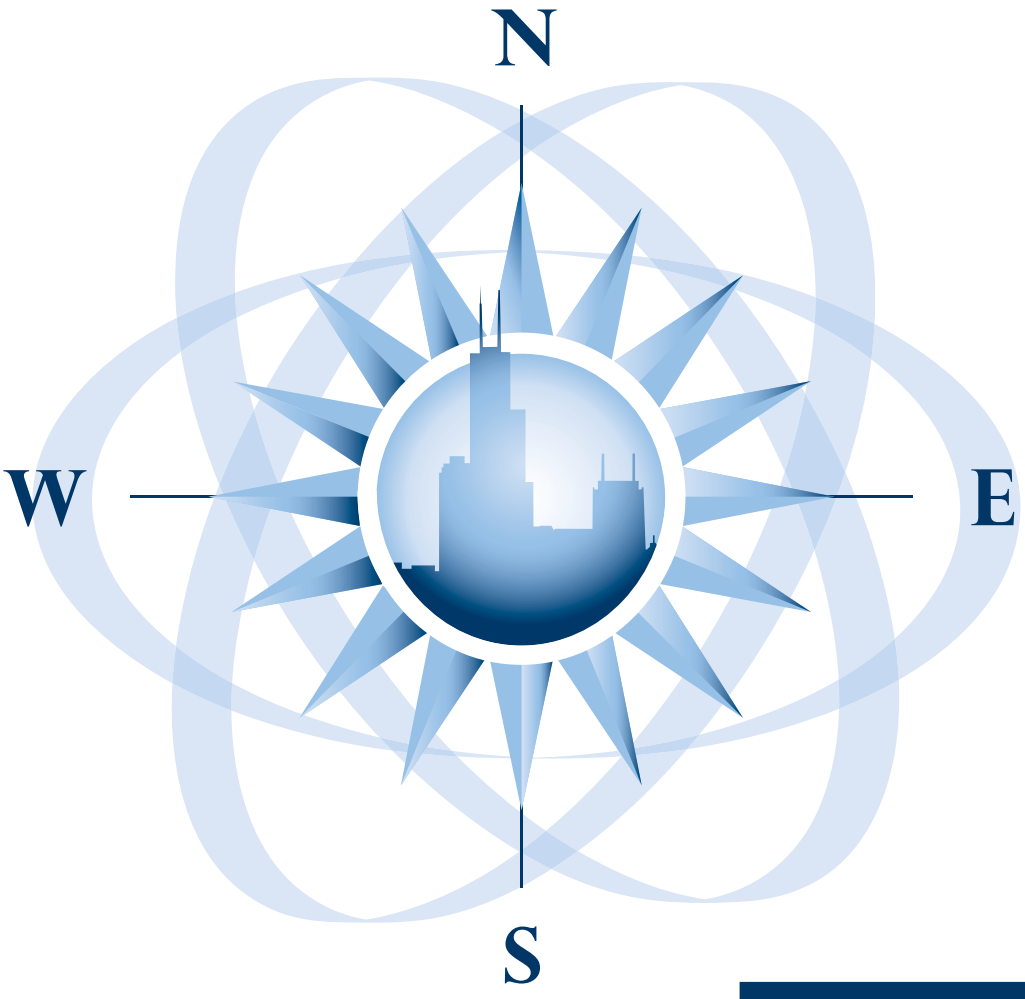
2007 ANNUAL MEETING



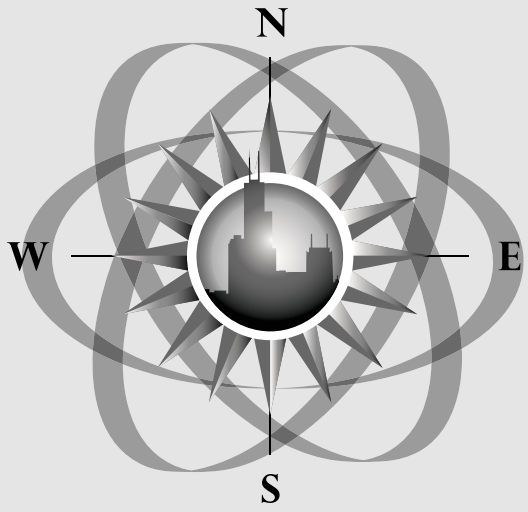
NAVIGATING the Evolution of Nursing Regulation

CHICAGO

AUGUST 7–10, 2007

NCSBN

National Council of State Boards of Nursing



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SECTION III: RESOURCES AND GENERAL INFORMATION

Membership

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit organization whose membership comprises the boards of nursing in the 50 states, the District of Columbia, and four United States territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands.

Mission

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

Vision

Building regulatory expertise worldwide.

Values

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

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

Quality: Pursuing excellence in all endeavors.

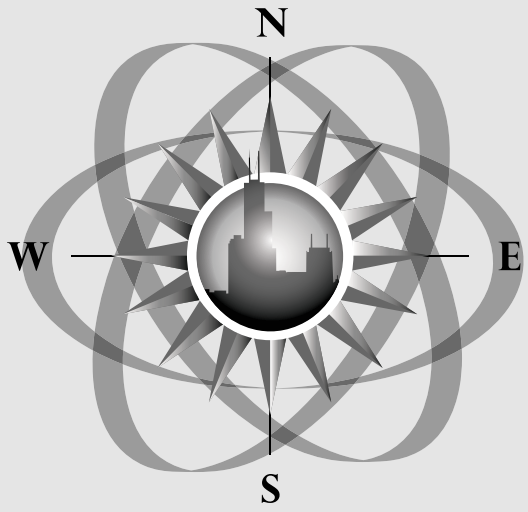
Vision: Using the power of imagination and creative thought to foresee the potential and create the future.

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

Purpose

The purpose of NCSBN is to provide an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

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



Section I

2007 NCSBN Annual Meeting

SECTION I: 2007 NCSBN ANNUAL MEETING

Business Agenda of the 2007 Delegate Assembly

Special Note

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

Tuesday, Aug. 7, 2007

8:30 – 9:45 am

OPENING CEREMONIES

- Introductions
- Announcements

OPENING REPORTS

- Credentials Committee
- Rules Committee

ADOPTION OF AGENDA

REPORT OF THE COMMITTEE ON NOMINATIONS

- Presentation of the 2007 Slate of Candidates
- Nominations from Floor
- Approval of the 2007 Slate of Candidates

PRESIDENT'S ADDRESS

EXECUTIVE DIRECTOR'S ADDRESS

Thursday, Aug. 9, 2007

2:45 – 3:30 pm

BOARD OF DIRECTORS' RECOMMENDATIONS

- Adopt the proposed revisions to the Bylaws of NCSBN.
- Adopt the 2008 – 2010 Strategic Initiatives.
- Adopt the model medication aide curriculum and proceed with the development of a national medication aide competence assessment.
- Adopt the Statement on the Regulatory Implications of Pain Management.
- Adopt the Guiding Principles of Nursing Regulation.
- Renew the NCLEX® Examination contract with Pearson VUE.

EXAMINATION COMMITTEE RECOMMENDATIONS

- Adopt the *2008 NCLEX-PN® Test Plan*.

RESULTS OF ELECTION OF OFFICERS, DIRECTORS AND COMMITTEE ON NOMINATIONS

Friday, Aug. 10, 2007

9:00 am – 12:00 pm

BOARD OF DIRECTORS' RECOMMENDATIONS (CONTINUED)

NEW BUSINESS

- Resolutions Committee

CLOSING CEREMONY

ADJOURNMENT

Standing Rules of the Delegate Assembly

1. Credentialing Procedures and Reports

   A. The president shall appoint the Credentials Committee, which is responsible for registering and accrediting delegates and alternate delegates.

   B. Upon registration, each delegate and alternate shall receive a badge and the appropriate number of voting cards authorized for that delegate. Delegates authorized to cast one vote shall receive one voting card. Delegates authorized to cast two votes shall receive two voting cards. Any transfer of voting cards must be made through the Credentials Committee.

   C. A registered alternate may substitute for a delegate provided the delegate turns in the delegate badge and voting card(s) to the Credentials Committee at which time the alternate is issued a delegate badge. The initial delegate may resume delegate status by the same process.

   D. The Credentials Committee shall give a report at the first business meeting. The report will contain the number of delegates and alternates registered as present with proper credentials, and the number of delegate votes present. At the beginning of each subsequent business meeting, the committee shall present an updated report listing all properly credentialed delegates and alternate delegates present, and the number of delegate votes present.

2. Meeting Conduct

   A. Meeting Conduct

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

3. Agenda

   A. Business Agenda

      1. The Business Agenda is prepared by the president in consultation with the executive director and approved by the Board of Directors.

   B. Consent Agenda

      1. The Consent Agenda contains agenda items that do not recommend actions.
      2. The Board of Directors may place items on the Consent Agenda that may be considered received without discussion or vote.
      3. An item will be removed from the Consent Agenda for discussion or vote at the request of any delegate.
      4. All items remaining on the Consent Agenda will be considered received without discussion or vote.

4. Motions or Resolutions

   A. Only delegates, members of the Board of Directors, and the Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the Bylaws of NCSBN.

   B. All motions, resolutions and amendments shall be in writing and on triplicate motion paper signed by the maker and a second. All motions, resolutions and amendments must be submitted to the Delegate Assembly chair and the parliamentarian. All resolutions and nonprocedural main motions must also be submitted to the chair of the Resolutions Committee before being presented to the Delegate Assembly.

   C. The Resolutions Committee, according to its Operating Policies and Procedures, shall review motions and resolutions submitted before Wednesday, Aug. 8, 2007, at 4 pm. Resolution or motion makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.

   D. The Resolutions Committee will convene its meeting on Wednesday, Aug. 8, 2007, at 4 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion maker. The Resolutions Committee shall meet with the resolution or motion maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its operating policies and procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis, and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.

   E. If a member of the Delegate Assembly wishes to introduce a nonprocedural main motion or resolution after the deadline of 4 pm on Wednesday, Aug. 8, 2007, the request shall be submitted under New Business; provided that the maker first submits the resolution or motion to the chair of the Resolutions Committee. All motions or resolutions submitted after the deadline must be presented with a written analysis that addresses the motion or resolution's consistency with established review criteria, including, but not limited to, the NCSBN mission, purpose and/or functions, strategic initiatives and outcomes; preliminary assessment of fiscal impact; and potential legal implications. The member submitting such a motion or resolution shall provide written copies of the motion or resolution to all delegates. A majority vote of the delegates shall be required to grant the request to introduce this item of business. [The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.]

5. Debate at Business Meetings

   A. Order of Debate: Delegates shall have the first right to speak. Nondelegate members and employees of Member Boards including members of the Board of Directors may speak only after all delegates have spoken.

   B. Any person who wishes to speak shall go to a microphone. When recognized by the chair, the speaker shall state his or her name and Member Board or organization.

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

D. A red card raised at a microphone interrupts business for the purpose of a point of order, a question of privilege, orders of the day, a parliamentary inquiry or an appeal. Any of these motions takes priority over regular debate.

E. A timekeeper will signal when the speaker has one minute remaining, and when the allotted time has expired.

F. The Delegate Assembly may by a majority vote go into executive session. The enacting motion shall specify those permitted to attend.

6. Nominations and Elections

A. A delegate making a nomination from the floor shall have two minutes to list the qualifications of the nominee. Written consent of the nominee and a written statement of qualifications must be submitted to the Committee on Nominations at the time of the nomination from the floor.

B. Electioneering for candidates is prohibited except during the candidate forum.

C. The voting strength for the election shall be determined by those registered by 5 pm on Wednesday, Aug. 8, 2007.

D. Election for officers, directors and members of the Committee on Nominations shall be held Thursday, Aug. 9, 2007, from 7:45 to 8:45 am.

E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall immediately announce run-off candidates and the time for the run-off balloting.

- If no candidate for officer or area director receives a majority on the first ballot, the run-off shall be limited to the two candidates receiving the highest number of votes.
- If no candidate for director-at-large receives a majority on the first ballot, the run-off shall be limited to the four candidates receiving the highest number of votes. If no candidate receives a majority on the second ballot, another run-off shall be limited to the three candidates receiving the highest number of votes.
- If, on the initial ballot, one candidate for director-at-large receives a majority, a run-off shall be limited to the two candidates receiving the next highest number of votes.

7. Forums

A. Scheduled Forums: The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly. Forum facilitators will give preference to voting delegates who wish to raise questions and/or discuss an issue. Guests may be recognized by the chair to speak after all delegates, non-delegate members and employees of Member Boards have spoken.

B. Open Forum: Open forum time will be scheduled to promote dialogue and discussion on issues by all attendees. Attendee participation determines the topics discussed during an Open Forum. The president will facilitate the Open Forum.

C. To ensure fair participation in forums, the forum facilitators may, at their discretion, impose rules of debate.

Annual Meeting Schedule

Monday, Aug. 6, 2007

6:00 – 7:30 pm **Orientation for Delegates**

Mary Blubaugh, MSN, RN, NCSBN Area II Director
Jay Douglas, MSM, RN, CSAC, Executive Director, Virginia State Board of Nursing
Faith Fields, MSN, RN, NCSBN Board President
Julia vonHaam, PRP, Parliamentarian
Are you representing your state as a delegate? Please join us for a review of the parliamentary procedures followed when debating and voting on Delegate Assembly business.

Tuesday, Aug. 7, 2007

7:30 am – 4:30 pm **NCSBN Product Showcase – Nursys® 2.0 *(for NCSBN Members Only)***

7:30 am – 4:30 pm **NCSBN Presentation Showcase – ICN Posters**

7:30 – 8:30 am **Registration/Continental Breakfast**

8:30 – 9:45 am **Delegate Assembly: Opening Ceremony**

Welcome from the Illinois Department of Professional Regulation

- Opening Ceremonies
  - Introductions
  - Announcements
- Opening Reports
  - Credentials Committee
  - Rules Committee
- Adoption of Agenda
- Report of the Committee on Nominations
  - Presentation of the 2007 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2007 Slate of Candidates

9:15 – 9:30 am **President's Address**

Faith Fields, MSN, RN, NCSBN Board President

9:30 – 9:45 am **Executive Director's Address**

Kathy Apple, MS, RN, CAE, NCSBN Executive Director

9:45 – 10:00 am **Finance Committee Forum**

Ruth Ann Terry, MPH, RN, NCSBN Treasurer
Robert Clayborne, MBA, CPA, NCSBN Director, Finance

10:00 – 10:30 am **Break**

10:30 – 11:00 am **Examination Committee Forum**

Sheila Exstrom, PhD, RN, Nebraska, Area II, Chair
Anne Wendt, PhD, MSN, RN, CAE, NCSBN Director, NCLEX® Examinations
Discussion of the proposed *2008 NCLEX-PN® Test Plan* and the implementation timeline.

SCHEDULE SUBJECT TO CHANGE.

11:00 am – 12:00 pm **Candidate Forum**

Lorinda Inman, MSN, RN, Iowa, Area II, Chair, NCSBN Committee on Nominations

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

12:00 – 1:15 pm **Lunch**

1:15 – 2:15 pm **Keynote – Transforming Nursing Practice Through Integrated Information Technology**

Bill Felkey, MS, Professor, Auburn University

Experts feel that the complexity of nursing practice has exceeded the limits of the unaided human mind. All information has the purpose of reducing uncertainty in decision makers. In health care, we need high-quality, evidence-based information on which to base our decisions.

Moreover, we need enterprise-wide connectivity and a single electronic medical record for both inpatient and ambulatory care. Technology is used in two ways in all health care applications. It can completely replace the work of nurses in those tasks that are repetitive and tedious. Technology can also enhance a nurse's ability to perform work. It is imperative that all facets of health care become truly digital. Integration in health care has been identified as the highest priority we face. The extent to which we become paperless will be a key predictor for the long-range success of any practice.

All practice settings are being pressured by HIPAA regulation, medication error publicity, telenursing across state and national borders, the need to assure patient safety through systems such as CPOE and the need to become more efficient and effective to cope with financial exigencies. The good news is that all of the pieces of the technology puzzle currently exist but they are not completely integrated in any setting. This general session will overwhelm you with the possibilities that are ready for immediate adoption. You will be exposed to many practical technologies about which you are unaware.

2:15 – 3:15 pm **Board of Directors Forum**

Faith Fields, MSN, RN, NCSBN Board President

Presentation and discussion related to the proposed 2008 – 2010 NCSBN Strategic Initiatives and the draft of the proposed Guiding Principles for the Future of Regulation.

3:15 – 4:15 pm **Bylaws Committee Forum**

Charlene Kelly, PhD, RN, Nebraska, Area II, Chair, Bylaws Committee

Presentation of the proposed NCSBN Bylaws revisions.

4:15 – 4:30 pm **Break**

4:30 – 5:30 pm **NCSBN/NCLEX® – Pearson VUE Contract Forum**
Executive Session *NCSBN Delegates Only*

Faith Fields, MSN, RN, NCSBN Board President

6:00 – 7:30 pm **Illinois Board of Nursing Reception – Navy Pier**

On Tuesday, Aug. 7, the Illinois Department of Professional Regulation is hosting a "Welcome to Chicago" reception for the attendees to the Annual Meeting and Delegate Assembly of NCSBN. The reception will be held at the Crystal Garden at Chicago's Navy Pier.

Wednesday, Aug. 8, 2007

7:30 – 8:30 am **Registration**

8:30 – 10:30 am **Area Breakfast Meeting**

NCSBN Area breakfasts are open to NCSBN members and staff only.

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

- Area I Breakfast Meeting: NCSBN Members Only
- Area II Breakfast Meeting: NCSBN Members Only
- Area III Breakfast Meeting: NCSBN Members Only
- Area IV Breakfast Meeting: NCSBN Members Only

External Organizations Breakfast Meeting

Guests are invited to attend this breakfast meeting to discuss issues of mutual concern with NCSBN staff.

10:30 – 10:45 am **Break**

10:45 – 11:15 am **Disciplinary Resources Advisory Panel Forum – Pain Management**

Sandra Evans, MAEd, RN, Idaho, Area I, Chair

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

The Disciplinary Resources Advisory Panel Forum will provide an opportunity for discussion of the Statement on the Regulatory Implications of Pain Management that the NCSBN Board of Directors recommended to the 2007 Delegate Assembly for adoption. In addition, the advisory panel chair will share plans for additional pain management resources and solicit ideas for future workshops, disciplinary products and services.

11:15 am – 12:00 pm **Practice, Regulation & Education (PR&E) Committee Forum – Medication Assistants Resolution**

Brenda Jackson, PhD, MSN, RN, Texas, Area III, Chair

Nancy Spector, PhD, RN, NCSBN Director, Education

The PR&E Committee will present the results of the medication assistant job analysis, the feasibility study for administering a competency examination for medication assistive personnel and the model medication assistant curriculum. This is in response to the motion adopted by the 2005 Delegate Assembly to "conduct a job analysis, develop a model medication administration curriculum and conduct a feasibility study for administering a competency examination for medication assistive personnel."

12:00 – 1:15 pm **Lunch**

SCHEDULE SUBJECT TO CHANGE.

1:15 – 2:15 pm **Breakout Sessions**

This year NCSBN is providing attendees with two opportunities to attend the breakout sessions. They will repeat at 2:30 pm and attendees are welcome to attend two if they so choose.

Healthcare Integrity and Protection Data Bank (HIPDB)

Shari Campbell, DPM, MSHS, LCDR, USPHS; Practitioner Data Banks Branch, Bureau of Health Professions, Health Resources and Services Administration

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

This session will provide an update on HIPDB reporting, the new Proactive Disclosure Service (PDS) and the status of the proposed rules to implement §1921 (requiring additional reporting to the NPDB) that were published in March 2007. NCSBN staff will discuss the implications for boards of nursing as well as report on the series of HIPDB update Webinars that were held to support the transition to the use of HIPDB reporting codes (from previous use of Nursys® reporting codes).

Research

Kevin Kenward, PhD, NCSBN Director, Research Services

An update on NCSBN research initiatives will be presented. Projects to be discussed include:

- CORE: A Regulatory Performance Measurement System
- Transition to Practice Studies
- Analysis of Disciplinary Data 1996 – 2005
- Nursing Workforce Supply Data
- Member Board Profiles
- Simulation Study

AACN – Doctorate of Nursing Practice (DNP) and Clinical Nurse Leader

Geraldine Polly Bednash, PhD, RN, FAAN, Executive Director, American Association of Colleges of Nursing

Dr. Bednash will provide members with an update on the doctorate of nursing practice (DNP) and the clinical nurse leader (CNL). This is an opportunity for members to explore any regulatory implications regarding these two AACN initiatives.

This session will repeat at 2:30 pm.

NCLEX 101 – NCSBN Members Only

Anne Wendt, PhD, MSN, RN, CAE, NCSBN Director, NCLEX® Examinations

2:15 – 2:30 pm **Break**

2:30 – 3:30 pm **Breakout Sessions (Repeat of the above sessions)**

The NCSBN breakout sessions will repeat at 2:30 pm; attendees can attend two if they so choose.

4:00 – 5:00 pm **Resolutions Committee Meeting**

Judith Personett, EdD, MA, BSN, RN, Washington, Area I, Chair, Resolutions Committee

SCHEDULE SUBJECT TO CHANGE.

Thursday, Aug. 9, 2007

7:45 – 8:45 am **Election of Candidates**

8:00 – 9:00 am **Pearson VUE Sponsored Breakfast & Registration**

9:00 – 10:00 am **Open Forum**
This is the opportunity for delegates and members to ask questions and discuss any items pertinent to the business agenda.

10:00 – 10:15 am **Break**

10:15 – 11:45 am **Breakout Sessions: Knowledge Networks**
NCSBN Knowledge Networks are brainstorming discussions regarding industry issues. Participants will be asked to brainstorm a list of the top five industry topics with the top three selected for discussion/exploration.

Choose from the following options:

- Executive Officers (NCSBN Members Only)
- Presidents (NCSBN Members Only)
- Board Members
- Discipline/Practice
- Education
- Licensed Practical/Vocational Nurses (LPN/VNs)

11:45 am – 12:00 pm **Break**

12:00 – 2:30 pm **Awards Luncheon & Institute for Regulatory Excellence (IRE) Fellows Ceremony**
Please join us to celebrate the individual and organizational achievements of the NCSBN membership. This year's ceremony is also honoring the 2007 NCSBN Institute of Regulatory Excellence Fellows.

2:30 – 2:45 pm **Break**

2:45 – 3:30 pm **Delegate Assembly Second Meeting**
Continuation from the agenda from the first meeting.

Friday, Aug. 10, 2007

8:00 – 9:00 am **Registration/Continental Breakfast**

9:00 – 10:30 am **Delegate Assembly Third Meeting**
Continuation from the agenda from the second meeting.

10:30 – 10:45 am **Break**

10:45 am – 12:00 pm **Delegate Assembly Closing Ceremony**

SCHEDULE SUBJECT TO CHANGE.

Summary of Recommendations to the 2007 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors, the Examination Committee and the Committee on Nominations propose to the 2007 Delegate Assembly. Additional recommendations may be brought forward during the 2007 Annual Meeting.

Board of Directors' Recommendations

1. ***Adopt the proposed revisions to the Bylaws of NCSBN.***

   Rationale:
   The proposed revisions to the Bylaws were redirected to the Bylaws Committee for further consideration by the 2006 Delegate Assembly. The purpose of the current proposed revisions is to enhance the organizational culture to support change and innovation; implement recommendations to enhance NCSBN's ability to be progressive, creative and responsive to change; provide for new memberships; increase participation on the Board of Directors; and implement structured leadership development.

   Fiscal Impact:
   1. Two additional Board Members: $10,000 per year.
   2. Leadership Succession Committee: $33,000 per year.
   3. Associate Membership Dues: Unknown at this time.
   4. Delegate Assembly sponsorship for two additional boards: $4,200 per year.

2. ***Adopt the 2008 – 2010 Strategic Initiatives.***

   Rationale:
   The Board of Directors developed the proposed 2008 – 2010 Strategic Initiatives through a facilitated strategic planning process and based the initiatives on the suggestions from Member Boards during the 2007 Midyear Meeting. The proposed plan identifies critical strategic initiatives for the next three years that are related to NCSBN's mission and vision.

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

3. ***Adopt the model medication aide curriculum and proceed with the development of national medication aide competence assessment.***

   Rationale:
   The 2005 Delegate Assembly passed the following resolution: "Resolved that NCSBN conduct a job analysis, develop a model medication administration curriculum and conduct a feasibility study for administering a competency examination for medication assistive personnel. The results of the job analysis, course and feasibility study will be reported at the 2006 Delegate Assembly." The Model Curriculum for medication assistants-certified (MA-C) as proposed is a document that is reflective of the current health care environment and will assist Member Boards that now regulate or that may in the future regulate MA-Cs in their mission of public protection. It will allow for uniformity in the education of MA-Cs across Member Boards, and other agencies, that regulate this role.

   Fiscal Impact:
   None

4. ***Adopt the Statement on the Regulatory Implications of Pain Management.***

   Rationale:
   Current standards for the management of pain describe the right of the patient to an appropriate assessment and treatment of pain. Still, pain is under treated and regulation is often seen as a barrier to adequate pain management because of the fear of regulatory scrutiny of prescriptions and administration of controlled substances. A few state boards of nursing have developed statements regarding pain management; however, there is not a national statement from nurse regulators. Adoption of this statement brings together the collective voice of state boards of nursing on this important issue.

   Fiscal Impact:
   None

5. ***Adopt the Guiding Principles of Nursing Regulation.***

   Rationale:
   Guiding principles will provide Member Boards with a framework on which to base policy decisions and actions. The principles will give Member Boards a common set of beliefs and provide direction for meeting the many regulatory challenges now and in the future.

   Fiscal Impact:
   None

6. ***Renew the NCLEX® Examination contract with Pearson VUE.***

   Rationale:
   The purpose is to renew the contract for the ongoing administration of NCLEX® Examinations with Pearson VUE.

   Fiscal Impact:
   To be discussed in Executive Session with Delegates only.

Examination Committee Recommendation

1. ***Adopt the 2008 NCLEX-PN® Test Plan.***

   Rationale:
   The Examination Committee reviewed and accepted the *Report of Findings from the 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2007) as the basis for recommending revisions to the *2005 NCLEX-PN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from the Member Boards and legal counsel, and the professional judgment of the Examination Committee provide support for the recommendation to the Delegate Assembly to adopt the *2008 NCLEX-PN® Test Plan.*

   Fiscal Impact:
   Costs incorporated into the FY08 budget.

Committee on Nominations Recommendation

1. ***Adopt the 2007 Slate of Candidates.***

   Rationale:
   The Committee on Nominations has prepared the 2007 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees and attention to the goals and purpose of NCSBN. Full biographical information and a personal statement for each candidate are posted in the Business Book under the Report of the Committee on Nominations. Each candidate will present himself/herself at the Candidate's Forum on Tuesday, Aug. 7, 2007.

   Fiscal Impact
   Costs incorporated into the FY08 budget.

Report of the Committee on Nominations

Recommendation to the Delegate Assembly

1. ***Adopt the 2007 Slate of Candidates.***

   Rationale:
   The Committee on Nominations has prepared the 2007 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information for each candidate follows. Each candidate will present himself/herself at the Candidate's Forum on Tuesday, Aug. 7, 2007.

   Fiscal Impact:
   Costs incorporated into the FY08 budget.

Background

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

Highlights of FY07 Activities

- The results of the 2006 Committee on Nominations' evaluation were reviewed and discussed.
- The Committee on Nominations' policies were reviewed, discussed and revised.
- The committee reviewed their role per the Bylaws.
- The committee reviewed and discussed the current Bylaws, mission, vision, values, 2005 – 2007 Strategic Initiatives and the NCSBN policy 3.1, Role of the Board of Directors.
- The committee reviewed the roles and responsibilities of the Board positions open for election at the 2007 Delegate Assembly and identified Area I, II, III and IV directors; two director-at-large positions; and Area I and II Committee on Nominations positions as open for election.
- The committee discussed various recruitment strategies and brainstormed possible candidates.
- The committee discussed various aspects of the Candidate Forum and made efficiency recommendations for the procedure.
- The due date for nominations was April 16, 2007.
- The committee discussed the Candidate Forum specific to the time allotted for candidate speeches. Beginning in 2008, presidential candidates will be allowed three minutes.
- The committee designed a recruitment presentation to be given at the 2007 Midyear Meeting.

Attachments

A. 2007 Slate of Candidates

Committee Members

Lorinda Inman, MSN, RN, Chair
Iowa, Area II

Janice Hooper, PhD, RN
Texas, Area III

Paula Meyer, MSN, RN
Washington, Area I

Emmaline Woodson, MS, RN
Maryland, Area IV

Staff

Kathy Apple, RN, MS, CAE
Executive Director

Meeting Dates

- Nov. 1, 2006
- Feb. 12, 2007 (Conference Call)
- April 2, 2007
- April 26, 2007
- May 8, 2007 (Conference Call)
- May 29, 2007 (Candidate Call-In Conference Call)

Attachment A

2007 Slate of Candidates

The following is the slate of candidates developed and adopted by the Committee on Nominations. Each candidate profile is taken directly from the candidate's nomination form. The Candidate Forum will provide the opportunity for candidates to address the 2007 Delegate Assembly on Tuesday, Aug. 7, from 11 am – 12 pm.

Board of Directors

Committee on Nominations

AREA II

None

Detailed Information on Candidates

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

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

Date of expiration of term:
June 30, 2007

Eligible for reappointment:
Yes

Area I Director

Kathy Malloch, PhD, MBA RN, FAAN

Board Member, Arizona, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S).

NCSBN

Facilitator, Executive Officer Seminar, 2004

Facilitator, Delegate Assembly President's Sessions, 2003, 2004

Facilitator/Presenter, Institute of Regulatory Excellence, 2003, 2004, 2005 & 2006

Member, Governance and Leadership Task Force, 2006

Chair and Member, Practice Breakdown Task Force, 1999 – 2006

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

I believe the activities of NCSBN to identify, test and implement the standards for continuing nurse competency to practice will contribute significantly to nurse excellence and positively impact patient safety. This is certainly a very important and timely strategic initiative. In addition, the initiatives to advance the science of nursing regulation through the Institute of Regulatory Excellence (IRE), the opportunities for continuing the development of core competencies through multiple conferences, summits, video/audio conferences, and written materials will have a positive influence in enhancing our knowledge and skills in nursing regulation.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

As Area I director I will continue to support the work of the NCSBN mission and strategic initiatives through continued board member performance as an open-minded, informed professional who is dedicated to make nursing regulation the best that it can be.

Area II Director

Date of expiration of term:
June 30, 2009

Eligible for reappointment:
Yes

Jane Conroy, RN, MS, NP-C, ARNP

Board Member, Kansas, Area II

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

State Level

Board Member, Kansas State Board of Nursing, 2005 to present, 1997 – 2001

President, 1999 – 2001, 2006 to present

Chair, Advanced Practice Committee for multiple years

Finance Committee

Practice Committee

LPN Therapy Committee

Continuing Nursing Education Committee

NCSBN

Trend Analysis Study Focus Group Member, 1998 – 1999

Nomination Committee, 1999 – 2000

Kansas Delegate, 1998 – 2001 Delegate Assembly

Professional Involvement

American Academy of Nurse Practitioners, Member

Kansas Alliance of Advanced Nurse Practitioners, Member, Treasurer, 2003 to present

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

NCSBN is an organization through which state boards of nursing are able to work together on issues that affect nursing and public safety both nationally and internationally. Boards of nursing have many common issues and concerns that are best resolved by working together with one another. By gathering input from Member Boards and resources for evidence-based practice, NCSBN can work toward resolving such issues as: initial and continued competence of nurses, standardization of APRN scopes of practice across the states, creating and maintaining a comprehensive data management system, and advancing evidence based regulation and regulatory solutions for the public protection.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I will bring a Member Board perspective to the leadership of NCSBN. From my experiences gained while serving two terms on the Kansas State Board of Nursing and serving as the current president, I have acquired knowledge and leadership skills. Such skills are needed in carrying out the mission, vision and strategic initiatives of NCSBN. This can only be accomplished with Member Board input. Open dialogue and communication is key to achieving these goals.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Area II Director

Betsy Houchen, RN, MS, JD

Board Staff, Ohio, Area II

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have been executive director of the Ohio Board of Nursing since September 2005. Prior to that time I was associate executive director and an adjudication coordinator for the board. My involvement with NCSBN began with working at the board and by attending meetings and serving as an alternate delegate and a delegate for Ohio. Prior to working at the board, I practiced as a health care attorney for two large law firms, served as regulatory counsel and legislative lobbyist for a state trade association and a consultant for a national trade association, served as a bureau chief at the Ohio Department of Health, and director of large home health and hospice agencies. During that time I was elected to the boards of the Ohio Council for Home Care and the National Association for Home Care. I have over 30 years of experience in leadership positions and distinguished service in both the public and private sectors in the areas of nursing, health care, administration, regulation and legislation.

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

I believe NCSBN is in a position to serve as a resource for state boards of nursing. A major role of NCSBN can be to assist state boards by being responsive, a "negotiator" of the system and a change agent. NCSBN would be an organization "of" the state boards of nursing and "for" states boards of nursing. For example, NCSBN serves as a resource for states with the federal HIPDB system. NCSBN is in a pivotal position to "negotiate" for the resolution of issues and to provide education and information to the states for compliance with the complex HIPDB system. Another example is that NCSBN can be a resource by conducting federal law legal research for members (i.e., PWORA requirements for licensure of internationally educated nurses and federal requirements for handling FBI criminal records check reports.) By assisting states to face regulatory challenges, NCSBN influences positive outcomes for nursing regulation.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I would advance the mission, vision and strategic initiatives of NCSBN by working with members and staff of boards of nursing, and NCSBN members to help assure that the organization is working toward meeting the strategic initiatives and objectives. As a board member, I would be in a unique position to monitor and evaluate the implementation and progress of meeting the strategic objectives and thus advance the strategic initiatives.

Area III Director

Date of expiration of term: N/A
Eligible for reappointment: N/A

Julia George, RN, MSN

Board Staff, North Carolina, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Participant in the Institute of Regulatory Excellence Fellowship Program, 2004 – 2007

NCSBN Resolutions Committee, 2002, 2003

NCSBN PR&E Subcommittee on Delegation and Assistive Personnel, 2003, 2004, 2004

North Carolina Board of Nursing Strategic Planning Committee, 2001, 2005

North Carolina Board of Nursing Continuing Competence Task Force, 2001 – 2004

Presenter, North Carolina Foundation for Nursing Excellence Patient Safety Summit, 2004

Facilitator, North Carolina Foundation for Nursing Excellence, Building an Evidence-Based Transition to Practice

Panel Participant, Citizen Advocacy Center Annual Meeting: Pain Management Colloquium, 2005

Invitee, Rutgers Invitational Forum on Nurse Delegation, 2006

Member, North Carolina Nurses Association

Member, American Nurses Association

Member, Sigma Theta Tau

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

Nursing regulation will continue to be challenged as we deal with issues such as transition to practice, a nursing shortage, globalization of health care, and initial and continued competence of practitioners. A major challenge for regulators will be to stay abreast of emerging issues and have accurate data on which to base decisions. Through continued attention to national and international forces impacting nursing, NCSBN can serve as the central repository of information for Member Boards.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

My experience in regulation and my commitment to NCSBN would enable me to make positive contributions to the mission, vision and strategic initiatives of NCSBN. I have been active in NCSBN and have regularly attended meetings for the past 12 years. My experience at both the state and national level prepare me to deal with the issues that are currently before NCSBN and those issues that may come in the future. I consider myself to be a forward thinker, an effective communicator, a consensus-builder and a thoughtful decision-maker. I will make concerted efforts to listen to the concerns of Area III members and remain cognizant of those concerns in policy deliberations. It would be a privilege to serve as Area III director, and I would welcome that opportunity.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Area IV Director

Gino Chisari, RN, MSN

Board Staff, Massachusetts, Area IV

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

For NCSBN:

Director-at-Large, 2006 – 2007

Practice, Regulation and Education Committee (PR&E), 2002 – 2006

PR&E Chair; 2004 – 2006

Committee on Nominations, 2001 – 2004

Chair, 2001 & 2003

Vice-Chair, 2002

Delegate Assembly Advisory Panel, 2001

Delegate to the 2002 Delegate Assembly

Alternate Delegate to the 2003, 2004, 2005 & 2006 Delegate Assemblies

State Level: For the Massachusetts/Rhode Island League for Nursing:

Board of Directors,1996 – 2000

Vice-Chair, Program Committee, 1996 – 1998

Bylaws Committee, 1998

Hospice at Mission Hill, Member, Foundation and Fund Raising, 1993 – 1996

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

To identify one challenge facing nursing regulation today is a difficult task since so many of the issues before us are equally important. When taken collectively the issue appears to be how to regulate better, smarter, more effectively within the many restraints that we encounter. NCSBN can influence a positive outcome by continuing to provide the membership with tools, resources, education, data, etc. that support and enhance our functions at the state level.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I will be prepared to engage in discussion and make decisions that are free of bias, in concert with the intended meaning of the mission, based on data, and in collaboration with those who are affected by the decisions of the Board of Directors. As a current member of the Board of Directors I have actively listened, participated in the investigation of, carefully weighted options, sought counsel as necessary and made well informed decisions that are designed to benefit the organization as a whole.

Area IV Director

Date of expiration of term: N/A
Eligible for reappointment: N/A

Barbara Zittel, RN, PhD

Board Staff, New York, Area IV

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

National Level:

Committee Member, Member Board Advisory Panel, 2002 – 2003

Committee Member, Member Board Leadership Development Advisory Group, 2003 – 2005

Faculty: Institute for Regulatory Excellence, 2004

Committee Member, Item Review Subcommittee, 2005 to present

State Level:

Executive Secretary to the New York State boards for physical therapy, podiatry, and ophthalmic dispensing. Responsible for licensure, discipline and scope of practice determinations for approximately 25,000 licensees, 1993 – 2000

Executive Secretary to the New York State Board for nursing and respiratory therapy: Responsible for licensure, discipline and scope of practice determinations for approximately 330,000 licensees, 2000 to present

New York State Nurses Association, 1975 to present

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

From its inception, the purpose of NCSBN has been to serve as a forum through which nursing regulatory bodies can gather to join their voices in addressing common concerns related to our charge of protecting the public health, safety and welfare. The founders of NCSBN understood well that there is a direct positive correlation between the degree to which we—jurisdictional regulators of Member Boards—are willing to share of our time, experiences and talents and the degree to which NCSBN can influence current issues. Major national and international challenges facing nursing regulation include maintaining the integrity of our licensing exams, evaluating continuing competence, increasing educational demands for practice in the 21st century, protecting the public from unlicensed persons providing nursing care, determining appropriate regulation of advanced practitioners, and developing strategies to successfully address the nursing shortage.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

As an Area IV director I will attend and listen to the voices of colleagues regionally, nationally and globally and in a collaborative spirit endeavor to apply evidence-based performance to deal with current challenges to nursing regulation. I will seek out and respect the opinions of both large and small jurisdictions and include them in negotiations to create policies and decisions that are flexible and creative. I look forward to the opportunity to share my experience and knowledge in advancing NCSBN's mission and vision.

Date of expiration of term:
Sept. 30, 2008

Eligible for reappointment:
Yes

Director-at-Large

Doreen Begley, MS, RN

Board Member, Nevada, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have been a registered nurse for 37 years, and have successfully been regulated in California, Illinois, Hawaii, and Nevada. While relatively new to NCSBN, I am in the perfect position to run for the one-year director-at-large position. I have one year remaining on my current appointment, and I am an appointed board member of a Member Board. In my past, I have served as an elected officer to the national Emergency Nurses Association, serving terms as a director-at-large and secretary treasurer, spanning seven years. I have experience working in the national arena of nursing policy, and I was also the board liaison to the Board of Certification for Emergency Nursing (BCEN) who, at the time, was the only specialty nursing board that had adopted computerized adaptive testing for our exam footprint. During my three years serving on the Nevada State Board of Nursing I have attended two Annual Meetings and two Midyear Meetings (as our funding would permit). I have participated in two NCLEX exams.

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

It is my opinion that of all the issues that NCSBN addresses, the nursing shortage is one of the most pressing, as its impact affects all of the other areas of concern: patient safety, competence, workplace redesign (increased use and demand for advanced nurse practitioners), etc. Through creative and thoughtful nursing regulation, NCSBN can be the visionary leader it is designed to be by decreasing barriers to practice and encouraging competent and quality nursing policies. The collective state boards of nursing are best positioned to accomplish this goal through visionary leadership and actions.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

If selected to participate on the board as a director-at-large, I will prepare myself to be able to participate in any and all discussions of issues that will come before the board, and will remain open to new ideas, listen actively, and make thoughtful decisions in tandem to the current (and future) mission, vision, and strategic initiatives.

Director-at-Large

Date of expiration of term: N/A
Eligible for reappointment: N/A

Allison Kozeliski, RN, CNA, BC, MBA, MHA

Board Staff, New Mexico, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Member, Past Board of Directors in New Mexico for the New Mexico Nurses Association/American Nurses Association

Member, New Mexico Organization of Nurse Executives

Member, American Association of Diabetes Educators

Member, American Association of Diabetes Educators; National Presenter

Member, McKinley Community Health Alliance

Member, American College of Healthcare Executives

Regional Volunteer, American Diabetes Association

Regional Volunteer, American Cancer Society "Relay for Life"

Past Board/Advisory Member and Chair of University of New Mexico-Gallup ADN Program

Liaison with Navajo Nation Regional Wellness Council

Founding Member, Chair, Gallup McKinley Diabetes Advisory Council: Successfully integrated membership from Zuni and Navajo tribes, local government, tribal government, health care delivery systems, independent providers and consumers.

Developed and administered Regional Diabetes Management Program, successfully implemented program and obtained national recognition for program development.

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

The challenge of education for the "nurse of the future" is one area where the collective voice of NCSBN can make a difference for public protection and professional nursing practice. By promoting ongoing collaboration with national and international groups, we can realize positive approaches for nursing education in order to address in a more consistent, comprehensive "model" that can be a "blueprint for excellence."

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I believe wholeheartedly that when one thinks globally then acts locally that any agenda can be advanced. Making a difference at local levels is what ultimately leads to change(s) in broader arenas. My local and regional "voice" regarding NCSBN's mission, vision, values and strategic initiatives would be heard by my constituents through my everyday activities—that is, my commitment to work for the advancement of public safety by promoting the enhancement of the nursing profession.

Date of expiration of term:
June 30, 2010

Eligible for reappointment:
No

Director-at-Large

Lynne Cooper

Board Member, Virginia, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have been on the Virginia Board of Nursing—as a citizen board member—for five years. I currently serve as the board's vice president. I also serve the Virginia Board of Nursing as its representative on our umbrella board, the Board of Health Professions. While I have been on many social service-type boards and organizations, my qualifications basically come from being a health care consumer and having loved ones who are health care consumers.

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

As I also serve on the Virginia Board of Health Professions as the board of nursing's representative, I have come to understand the importance of NCSBN's work regarding continuing competencies studies. I have already brought NCSBN's work to the attention of our Board of Health Professions and know the outcome of the pilot program and further development of workable solutions will be invaluable to our endeavor in this regard.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

In addition to what I have already explained in question #1, I can only pledge to keep as the foundation of all my energies the underlying purpose of this organization—that of the protection of the health, safety and welfare of the public that is served by nurses of all stripes and categories.

Director-at-Large

Mary Bolt, EdD, RN

Board Member, Maryland, Area IV

Date of expiration of term:
July 1, 2009

Eligible for reappointment:
No

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Governance and Leadership Task Force (Two years)

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

NCSBN can enhance the diversity of its membership by allowing other regulatory boards to become associate members of the organization.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I will support the approved NCSBN mission, vision and strategic initiatives of NCSBN. If elected to the position of director-at-large, I will bring my experience as a board member, former educator and administrator along with experience as a NCSBN committee member. I have attempted to maximize my learning by participating in NCSBN activities. It is crucial to become part of a team and mutually support and share common mission, vision and strategic initiatives. I am willing to support current and future initiatives to maintain forward movement of this organization. I believe that my experiences will contribute significantly to NCSBN mission of being a leader in regulation.

Date of expiration of term:
Sept. 23, 2009

Eligible for reappointment:
Yes

Director-at-Large

Mary Bowen, RN, CRNP, DNS, JD, CNAA

Board Member, Pennsylvania, Area IV

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

NCSBN

Nominating Committee, 2004 – 2006

Chair, Nominating Committee, 2005 – 2006

Pennsylvania State Board of Nursing

Chairman, 2007

Vice Chairman, 2006

Appointed to Pennsylvania Health Careers Task Force, Clinical Education Task Force, 2006

Member, Pennsylvania State Board of Nursing Applications Committee, 2006

Member, Pennsylvania State Board of Nursing Probable Cause Committee, 2005 – 2006

Member, Pennsylvania Regulations Committee, 2003 – 2006

Pennsylvania State Board of Nursing, APRN Committee, 2003 – 2006

Professional Involvement

Vice President, Sigma Theta Tau International, Delta Rho Chapter, 2001 – 2007

Delegate to Sigma Theta Tau International Biennium, 2005

Helene Fuld Fellow grant recipient Academic Nurse Leader Development Program, 2005 – 2006

Member, National Organization of Nurse Practitioner Faculties (NONPF), 1999 to present

Member, American Academy of Nurse Practitioners (AANP), 2000 to present

Member, International Council of Nurse Practitioners, 2004 to present

Member, National League for Nursing (NLN), 2006 to present

Secretary, Arizona Nurses Association, Tucson Region, 1994 – 1997

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

NCSBN has an opportunity to promote dialogue with Member Boards that are facing many challenges nationally and internationally. NCSBN and its Member Boards can develop solutions to regulatory issues surrounding international nursing, nursing shortages, public protection, and nursing licensure. NCSBN and Member Boards can have a positive outcome through evidence-based decisions regarding regulatory excellence, public safety and welfare, licensing examinations in nursing, and national and international public health. Collaborative decisions between internal and external stakeholders and NCSBN members have the potential to create significant health policy development for health delivery systems and nursing education.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

I believe that I can advance the mission, vision, and strategic initiatives of NCSBN through collaborative decision making and evidence-based decisions. I will maintain an open dialogue between Member Boards and stakeholders in an effort to promote regulatory excellence, public health policy, public safety, and quality and integrity in nursing education and licensure. I will remain true to my values of honesty, integrity, and respect in decision making and problem solving potential and real challenges that face Member Boards. Additionally, I will continue to have a passion to serve NCSBN and be a voice for all Member Boards.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Committee on Nominations – Area I

Paula Meyer, RN, MSN

Board Staff, Washington, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Executive Director, Washington Nursing Care Quality Assurance Commission, 1998 to present

NCSBN Board Member, Area I, 2001 – 2003

Past Member, Chair, and Board Liaison, Investigator and Staff Attorney Resources Panel

Past Member, Resolutions Committee

Presenter, NCSBN Annual Meeting, Mandatory Timeline in Washington State, 2000

Current Member, Sigma Theta Tau

Past Member, American Nurses Association (ANA)

Delegate to Annual Meeting, VA Nurses Association

Past Member, ANA Practice Council

Who's Who in American Nursing

St. Michael's Parish, Olympia: Confirmation catechist, 2005 – present, Pastoral Council member and chair, 1996 – 1998, lay minister; St. Michael School, annual SMART Auction chair, 2001 – 2002

PROPOSE HOW THE ACTIVITIES OF NCSBN CAN INFLUENCE A POSITIVE OUTCOME TO A MAJOR CHALLENGE THAT IS CURRENTLY FACING NURSING REGULATION.

Continued Competency: definition of the role of the regulatory bodies. While licensing and disciplinary functions are well established by boards of nursing, there is a gap in the requirements for regulation of continuing competence. NCSBN's PR&E has a subcommittee devoted to continuing competency that is doing wonderful work, providing research that is timely and pertinent, and supporting the boards in this quest.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN.

The purpose of the Nominations Committee is to find qualified individuals that are willing and able to commit the time to the mission and business of NCSBN. As a Nominations Committee member, I consider it my responsibility to work with the boards, staff and members in Area I to find these individuals. It is also the Nominations Committee members' responsibility to provide the applicants with current information related to the Board's actions, time commitment and travel. While the commitment is great, so are the rewards. Serving as a board member or officer is one of the greatest contributions I made as a professional nurse. It was a tremendous learning experience.

2007 Report of the Board of Directors

Highlights of Business Activities Oct. 1, 2006, through May 31, 2007

STRATEGIC PLANNING

The Board of Directors entered into a strategic planning process to develop proposed 2008-2010 Strategic Initiatives for adoption by the 2007 Delegate Assembly. The Board contracted with Dr. Michael Bleich, professor and associate dean, Clinical and Community Affairs, Kansas University School of Nursing; chair, Department of Health Policy and Management, Kansas University School of Medicine; and executive director/COO, Kansas University HealthPartners, Inc., to facilitate this process. The Board assessed the internal strengths of the organization along with external opportunities that will fulfill the mission of NCSBN. Strategic initiatives provide the framework for the Board to make programmatic and financial decisions, address external uncertainties and change and measure organizational effectiveness.

Proposed draft strategic initiatives were presented to the membership at the April 2007 Midyear Meeting. Based on membership feedback, the Board of Directors has proposed the following Strategic Initiatives for adoption by the 2007 Delegate Assembly:

A. NCSBN strategically advances patient safety for the health and welfare of the public.

B. NCSBN contributes to Member Board excellence by providing resources, communication, education and technology.

C. NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection.

D. NCSBN provides comprehensive data management for use by Member Boards and external stakeholders.

E. NCSBN is the premier organization to define and measure entry and continued competence.

F. NCSBN advances the development of regulatory excellence worldwide.

GUIDING PRINCIPLES OF NURSING REGULATION

It is important at times to pause and reflect on the principles that guide the work of organizations. A principle is defined as a rule or code of conduct: a fundamental reason. In anticipation of the potential future challenges to nursing regulatory bodies, it is essential to define the fundamental tenets for public protection. To this end, the Board of Directors has been discussing and debating the principles that should guide nursing regulation today and into the future.

The Board of Directors has sought membership input and incorporated this input into the proposed guiding principles for adoption by the 2007 Delegate Assembly. See Attachment B.

STRATEGIC PARTNERSHIP MEETING ATTENDANCE BY NCSBN BOARD OF DIRECTORS AND/OR STAFF

- Tri-Council September 2006 Meeting
- Georgia Board of Nursing Meeting
- International Council of Nurses (ICN) Credentialing Forum
- Council on Licensure, Enforcement and Regulation (CLEAR) Meeting

Members

August 2006 – July 2007

Faith Fields, MSN, RN
President, Arkansas, Area III

Laura Rhodes, MSN, RN
Vice President, West Virginia-RN, Area II

Ruth Ann Terry, MPH, RN
Treasurer, California-RN, Area I

Kathy Malloch, PhD, MBA, RN, FAAN
Area I Director, Arizona
(January – August 2007)

Mary Blubaugh, MSN, RN
Area II Director, Kansas

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

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

Gino Chisari, MSN, RN
Director-at-Large
Massachusetts, Area IV

Cheryl Koski, MN, RN
Director-at-Large, Wyoming, Area I,
(January – August 2007)

Rolf Olson, JD
Area I Director, Oregon
(August 2005 – December 2006)

Kathy Malloch, PhD, MBA, RN, FAAN
Director-at-Large, Arizona, Area I
(August – December 2006)

Staff

Kathy Apple, RN, MS, CAE
Executive Director

Legal Counsel

Thomas Abram, JD

Board Meeting Dates

- Aug. 4, 2006 – Salt Lake City, UT
- Sept. 8, 2006 – Chicago, IL
- Oct. 4, 2006 – (Conference Call)
- Nov. 13-14, 2006 – Chicago, IL
- Dec. 5-7, 2006 – Chicago, IL
- Feb. 7-9, 2007 – Chicago, IL
- March 12, 2007 – (Conference Call)
- May 9-11, 2007 – Chicago, IL
- May 17, 2007 – (Conference Call)

- The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
- National Academy of State Health Policy (NASHP) Meeting
- National League for Nursing (NLN) Meeting
- American Association of Colleges of Nursing (AACN) Meeting
- National Organization of Associate Degree Nursing (N-OADN) Convention
- American Association of Colleges of Nursing (AACN) Baccalaureate Meeting
- National Student Nurses Association (NSNA) Meeting
- Alliance for Nursing Accreditation Meeting
- The National Federation of Licensed Professional Nurses (NFLPN) Annual Convention
- Philippine Nurses Association
- Federation of Association of Regulatory Boards (FARB)
- Citizens Advocacy Center (CAC) Annual Meeting
- American National Standards Institute (ANSI) Annual Meeting
- Vermont Board of Nursing Meeting
- Accreditation Council for Graduate Medical Education (ACGME)
- Missouri Board of Nursing Visit
- American Association of Colleges of Nursing (AACN) Essentials Stakeholders
- Idaho Board of Nursing Visit
- National Health Policy Meeting (sponsored by Academy Health)
- International Council of Nurses (ICN) Conference and International Regulatory Conference
- American Nurses Association (ANA) Policy Conference
- American Organization of Nurse Executives (AONE)
- Federation of State Medical Boards (FSMB)

FINANCE

- The Board reviewed and approved quarterly financial statements for FY07.
- The Board approved the proposed budget for the fiscal year beginning on Oct. 1, 2006, and ending Sept. 30, 2007.
- The Board approved the independent audit report for the year ending Sept. 30, 2006.
- The Board approved revisions to the Financial Planning Policy 8.2 and Investment Policy 8.5.

GOVERNANCE & POLICY

- The Board reviewed, discussed and implemented an action plan on enhancing organizational trust.
- An environmental scan was discussed at each meeting.
- The Board finalized the Strategic Objectives for FY07.
- The Board finalized the calendar for board member attendance at external organization meetings.

- The Board discussed the 2007 Midyear Meeting agenda and reviewed the evaluations.
- The Board moved to approve the Board of Directors meeting dates for FY08.
- The Board reviewed and revised the NCSBN Board Policy Manual.
- The Board reviewed the work of all committees and prepared a business agenda for the 2007 Delegate Assembly.
- The Board filled all appointments to committee chair and membership for FY07.
- The Board appointed Kathy Malloch to replace Rolf Olson as Area I director who was not reappointed to his respective board of nursing.
- The Board appointed Cheryl Koski to replace Kathy Malloch as director-at-large because Kathy was appointed to the NCSBN Area I director position.
- The Board approved to support the Coalition for Patients' Rights proposed requirements for organizational membership.
- The Board approved the NCSBN position statement entitled "The Ethical Recruitment of Nurses for Licensure."
- The Board adopted the resolution authorizing the executive director to establish banking and brokerage accounts in the name of the National Council of State Boards of Nursing.
- The Board facilitated a Member Board "Dial-In" at each meeting to share information with the membership regarding Board of Directors meeting agenda items and to listen to current issues and concerns from the membership.
- The Board reviewed and discussed the evaluations received related to the 2006 NCSBN Annual Meeting.
- The Board met with Dr. Michael Bleich to facilitate drafting of the 2008 – 2010 NCSBN Strategic Initiatives.
- The Board developed and debated a set of principles to guide nursing regulation.
- The Board reviewed and discussed the organizational communications and marketing plan.
- The Board reviewed, discussed and provided input into the draft ANA altered standards of care during disaster.
- The Board approved a workshop for Member Board operations staff.

EXAMINATIONS

- The Board approved not to support the translated NCLEX®, but continue to monitor and investigate strategically.
- The Board approved the establishment of an international test site for the NCLEX in Manila, Philippines.
- The Board reevaluated and approved raising the passing standard to -0.21 for the NCLEX-RN® examination effective April 1, 2007, through March 31, 2010.
- The Board reviewed and quarterly reports from Pearson VUE.
- The Board reviewed NCLEX security procedures.
- The Board suspended NCLEX administration at the Seoul, South Korea Pearson Professional Center (PPC).

PRACTICE, REGULATION AND EDUCATION

- The Board moved to add to the Drug Screening Standard adopted by the 2006 Delegate Assembly, a Board of Director note, regarding updated drug screen parameters from the 2006 Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory on biomarkers.
- The Board moved to approve funding of a pilot Webcast for part of the 2007 Investigator & Attorney Workshop.
- The Board approved a proposed APRN summit funding for two representatives from each jurisdiction with additional funding for one board legal counsel to attend.
- The Board accepted the findings of the RN and LPN/VN Continued Competence Practice Analyses.
- The Board approved a partial Webcast for the 2007 Investigator & Attorney Workshop.

INFORMATION TECHNOLOGY

- The Board reviewed Nur*sys*® statistics, enhancements and the operational design of the system.
- The Board reviewed the evaluations from the Nur*sys* User Group meeting.

RESEARCH

- The Board accepted data results from the Remediation Outcome Study.
- The Board reviewed the progress of all research projects currently under study.

REVIEW OF STRATEGIC PLAN

- The Board reviewed the year-end NCSBN Balanced Scorecard report for FY06.
- The Board reviewed the progress of the strategic plan quarterly.

Attachment

A. Annual Progress Report, October 2006 – May 2007

B. Guiding Principles of Nursing Regulation

Attachment A

Annual Progress Report, October 2006 – May 2007

Background

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

I. Strategic Initiative: Member Boards

Facilitate Member Board excellence through individual and collective development.

STRATEGIC OBJECTIVE 1

Provide effective education, information sharing and networking opportunities.

Information on the three-year education plan has been posted to the NCSBN Web site. Education sessions held as of May 2007 included the Institute for Regulatory Excellence, Executive Officer/President Leadership Conference, IT Summit, Nursys® User Group Summit, Investigator & Attorney Workshop, NCLEX® Invitational and the Transition to Practice Forum. Two online education resources are under development for education in the role of delegates and the Member Board president governance role. The NCSBN 101 course was reviewed and revised.

Networking sessions have been provided to executive officers, Member Board presidents, advanced practice stakeholders, Member Board education consultants, Member Board practice consultants, policy call participants and Member Board discipline/investigators as of May 2007. Information sharing opportunities included the publication of *Leader to Leader*, *Council Connector*, *Policy Perspectives*, *Directory of Nurse Aide Registries* and the NCLEX® fact sheet. Revisions were made to the International Nurse Manual, the Commitment to Ongoing Regulatory Excellence (CORE) Manual, the NCLEX® Member Board Manual and the Nursys User Manual.

STRATEGIC OBJECTIVE 2

Continuously evaluate the effectiveness of education, information sharing and networking opportunities.

A continuous quality improvement process has been implemented assessing attendance, participation and satisfaction. Improvements to all education sessions, information sharing and networking opportunities have been based on this process.

STRATEGIC OBJECTIVE 3

Recognize excellence.

A clearly articulated and objective process for soliciting and identifying outstanding contributions to the organization has been communicated to the membership and enacted through the NCSBN Awards Program.

II. Strategic Initiative: Regulatory Excellence

Promote evidence-based regulation that provides for public protection.

STRATEGIC OBJECTIVE 1

To identify indicators of regulatory excellence.

There were 42 Member Boards that supplied data for the CORE process. Survey results were tabulated and analysis of the data is underway. CORE performance measures will be refined by the CORE Advisory Panel. Identification of best practices has begun through interviews with top performers.

STRATEGIC OBJECTIVE 2

Provide models and resources for evidenced-based regulation to Member Boards.

Models developed to date include a statement on the regulatory implications of pain management, policies and procedures for the ongoing TERCAP™ data collection, a medication assistant curriculum, transitioning new nurses to practice program and further articulation of a vision for the future of advanced practice regulation. The Licensure Portability Grant obtained by NCSBN provides contract funding to eligible Member Boards who are implementing criminal background checks and the Nurse Licensure Compact.

STRATEGIC OBJECTIVE 3

Collaborate with national organizations in the promotion of evidence-based regulation.

A number of articles on regulatory issues were published through JONA's *Healthcare Law, Ethics, and Regulation*. National presentations have been given at the Oregon Consortium for Nursing Education, N-OADN, Mosby's Faculty Institute, Rhode Island Board of Nursing, Midwest Nursing Research Society, Ohio League for Nursing, American Association of Medical Assistants, Health and Medicine Policy Research Group, FARB and the National Governors Association E-Health Task Force. Multiple joint meetings have been held with various advanced practice stakeholder groups.

III. Strategic Initiative: PERC

Enhance the organizational culture to support change and innovation.

STRATEGIC OBJECTIVE 1

Implement 2006 Bylaw revisions to enhance NCSBN's ability to be progressive, creative and responsive to change.

The Bylaws Committee was supported in their reconsideration of the proposed 2006 Bylaw revisions as directed by the 2006 Delegate Assembly.

STRATEGIC OBJECTIVE 2

Implement recommendations for effective communication within the membership.

An updated organizational communications and marketing plan was implemented to provide more timely and pertinent information to the membership regarding NCSBN organizational activities.

STRATEGIC OBJECTIVE 3

Enhance communication between Member Boards and external stakeholders.

Communication has been facilitated between Member Boards and the National League for Nursing, the American Association of Colleges of Nursing and the American Nurses Association.

STRATEGIC OBJECTIVE 4

Assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

The Finance Committee and the Board of Directors have reviewed investment strategies through an investment asset allocation study, reviewed quarterly financial reports and accepted the FY06 independent audit.

IV. Strategic Initiative: Competence

Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers.

STRATEGIC OBJECTIVE 1

NCLEX is the premier examination for entry into practice.

Test development, psychometric and test delivery metrics developed to ensure adherence to contractual and operational program requirements have been identified. Related performance measures and targets have been identified and successfully achieved. The 2006 LPN/VN Practice Analysis was reviewed and utilized to evaluate the *NCLEX-PN® Test Plan*. Membership feedback was obtained regarding changes to the *NCLEX-PN® Test Plan*.

STRATEGIC OBJECTIVE 2

Continue development of an assessment instrument(s) to measure continued competence of RNs and LPN/VNs.

Competencies in the form of a content outline for both the RN and LPN/VN assessments were identified and established. Content outline was presented to the membership at the 2007 Midyear Meeting.

STRATEGIC OBJECTIVE 3

Maintain the quality of the NNAAP™ exam.

All current contractual obligations have been met. Contract with test service was extended, potential future test vendor options and an alternate exam ownership model were explored.

STRATEGIC OBJECTIVE 4

Continue to explore innovations in testing to measure entry-level competency.

Status report on the Joint Research Committee (JRC) study on innovative items has been reviewed. Innovative item templates have been developed. Usability testing has been initiated.

V. Strategic Initiative: Data

Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues.

STRATEGIC OBJECTIVE 1

Conduct and support research that provides evidence regarding regulatory initiatives that support public protection.

The following research studies were completed: medication assistant job analysis, transition of new nurses to practice, effect of negotiating skills training on the number of disciplinary hearings, nurse practitioner(NP)/clinical nurse specialist (CNS) role delineation, phase one of simulation, NCLEX candidate projections, and licensure and examination statistics.

STRATEGIC OBJECTIVE 2

Maintain a comprehensive national nurse licensure database.

Enhancements to Nur*sys*® were developed and implemented. Information technology staff has visited various Member Boards to identify and address day-to-day issues. The Nur*sys* business design was reviewed and evaluated.

STRATEGIC OBJECTIVE 3

Serve as a national source of nurse workforce data.

A workforce data collection method has been developed and will be piloted with nine Member Boards.

STRATEGIC OBJECTIVE 4

Explore additional services that NCSBN could provide to Member Boards.

An evaluation of education credentialing and verification of licenses for international nurses was conducted to explore alternative services.

VI. Strategic Initiative: U.S./International Partner

Advance NCSBN as a key partner in nursing and health care regulation in the U.S. and internationally.

STRATEGIC OBJECTIVE 1

Develop and maintain collaborative working relationships with key national and international organizations to address major regulatory issues in health care.

Regulatory issues identified for collaboration included advanced practice, innovation in education, transition to practice, medication assistants and international nurses. Collaborative strategies have been implemented.

STRATEGIC OBJECTIVE 2

Administer NCLEX effectively and efficiently at international sites.

Compliance with all testing policies and procedures has been maintained at all international Pearson Professional Centers (PPCs). Violations of candidate agreements led to suspension of NCLEX administration in the Seoul, South Korea PPC.

STRATEGIC OBJECTIVE 3

Facilitate the mobility of safe and competent international nurses by influencing public policy.

Collaborative efforts were facilitated with the American Hospital Association, the American Organization of Nurse Executives, the American Nurses Association, Academy Health and CGFNS. U.S. regulatory information publication *LINK* distributed internationally.

Attachment B

Guiding Principles of Nursing Regulation

State nurse practice acts provide the foundation for regulation of nursing practice. Nursing regulation should not be more restrictive than necessary to protect the public and allow for growth of the profession.

The following guiding principles are the underlying tenets of nursing regulation and provide common ground for decision making. Nursing regulators apply these principles as they work collaboratively with other health care professions in making informed decisions to ensure safe and effective health care.

Protection of the Public

- Nursing regulation exists to protect the health, safety and welfare of the public in their receipt of nursing services.

Competence of All Practitioners Regulated by the Board of Nursing

- Nursing regulation is responsible for upholding licensure requirements for competence of the various levels of nursing practice.
- Competence is assessed at initial licensure/entry and during the career life of all practitioners.

Due Process and Ethical Decision Making

- Nursing regulation is conducted in a manner providing fair, reasoned and consistent decisions providing for due process.
- Boards of nursing hold nurses accountable for ethical decision making and professional responsibility.

Shared Accountability

- Nursing regulation requires shared accountability for distinguishing individual versus system errors and potential for error.

Strategic Collaboration

- Nursing regulation requires collaboration with multiple strategic individuals and agencies in the interest of public protection, patient safety and the education of nurses.

Evidenced-Based Regulation

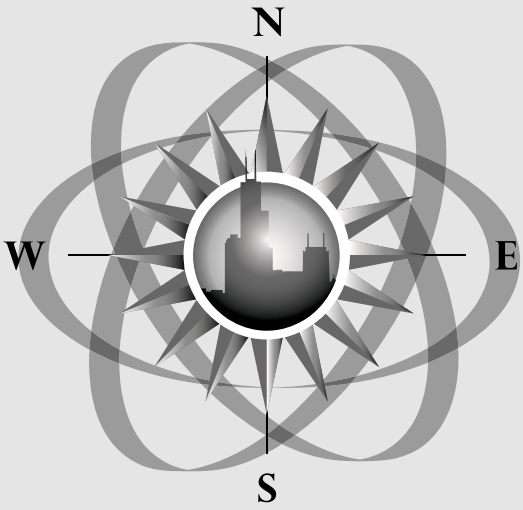
- Nursing regulation uses evidenced-based standards of practice, advances in technology, and demographic and social research in its mission to protect the public.

Response to the Marketplace and Health Care Environment

- Nursing regulation requires timely and thoughtful responsiveness to the evolving marketplace.
- Scope of practice clarity and congruence with the community needs for nursing care are essential.

Globalization of Nursing

- Nursing regulation occurs at the state level and concurrently works to standardize regulations and access to licensure.
- Nursing regulation acknowledges and addresses the social, political and fiscal challenges of globalization.



Section II

2007 NCSBN Annual Meeting

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Informational Reports

Report of the Bylaws Committee

Board of Directors' Recommendation

1. ***Adopt the proposed revisions to the Bylaws of NCSBN.***

Rationale:
The proposed revisions to the Bylaws were redirected to the Bylaws Committee for further consideration by the 2006 Delegate Assembly. The purpose of the current proposed revisions is to enhance the organizational culture to support change and innovation; implement recommendations to enhance NCSBN's ability to be progressive, creative and responsive to change; provide for new memberships; increase participation on the Board of Directors; and implement structured leadership development.

Fiscal Impact:

1. Two additional Board Members: $10,000 per year.
2. Leadership Succession Committee: $33,000 per year.
3. Associate Membership Dues: Unknown at this time.
4. Delegate Assembly sponsorship for two additional boards: $4,200 per year.

Background

The Board of Directors or Delegate Assembly charges the Bylaws Committee with reviewing and making recommendations on proposed Bylaw amendments. For FY07, the 2006 Delegate Assembly directed the Bylaws Committee to reconsider the recommendations from the 2006 Delegate Assembly.

Highlights of FY07 Activities

- The committee reviewed and discussed the charge to the committee; the NCSBN mission, vision and values; and strategic map.
- Bylaw basics were reviewed with a focus on providing a broad framework for the governance of the organization.
- The committee reviewed and discussed membership comments from proposed resolutions and evaluations submitted at the 2006 Delegate Assembly, through e-mail updates and from the 2007 Midyear Meeting.
- The legal foundation for governance of the organization including the 501(c)(3) status, articles of incorporation, bylaws, committees and policies was presented by NCSBN legal counsel.
- The committee concluded that an "international associate member" would enhance the work of the organization.
- The committee reviewed and discussed advanced practice boards of nursing and their inclusion as regular members to prevent disenfranchisement. The implications for voting were discussed at length.
- The committee discussed methods of increasing membership participation and improving continuity in the composition of the Board of Directors.
- Sigma Theta Tau International (STTI) presented their organizational work on leadership succession and defined it as an ongoing process that is interwoven with the strategic directions of the organization and includes systematically identifying, assessing, developing and maximizing the leadership potential in members.

Members

Charlene Kelly, PhD, RN
Chair, Nebraska, Area II

Martha Barr, MSN, RN
Tennessee, Area III

Karla Bitz, PhD, RN
North Dakota, Area II

Iva Boardman, RN, MSN
Delaware, Area IV

Kathryn Busby, JD
Arizona, Area I

Janet Shields, MSN, CRNP, APRN, BC
Pennsylvania, Area IV

Laura Rhodes, MSN, RN
Board Liaison, West Virginia, Area III

Tom Abram, JD, Legal Counsel

Julia vonHaam, PRP, Parliamentarian

Staff

Kathy Apple, MS, RN, CAE
Executive Director

Kristin Garcia, Manager, Executive Office Administration

Meeting Dates

- Nov. 28 – 29, 2006
- Feb. 6, 2007
- April 5, 2007
- April 13, 2007 (Conference Call)
- May 15, 2007 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 1
Implement recommendations to enhance NCSBN's ability to be progressive, creative and responsive to change.

- The committee reviewed, discussed and met their performance measures and targets from the Balanced Scorecard.
- The committee evaluated their meeting performance.

Future Activities

None scheduled at this time.

Attachments

A. Proposed Revisions to the Bylaws Overview of Conceptual Changes Document

B. Proposed Bylaw Revisions with Comparison to Current Bylaws Including Rationale

C. Proposed Bylaw Revisions, Strike-Through Version

D. Proposed Bylaw Revisions, Clean Copy

E. Special Proviso Adopted with the Leadership Succession Committee

F Special Proviso Adopted with the Board of Directors

Attachment A

Proposed Revisions to the Bylaws Overview of Conceptual Changes

Associate Members (AMs)

- Allow a new category of membership for nursing regulatory bodies from other countries or territories.
- AMs would be approved by the Delegate Assembly.
- AM membership fee would be approved by the Delegate Assembly.
- AMs would not have membership voting rights at Delegate Assembly.
- AMs could serve on all committees except for the NCLEX® Examination, Finance, Bylaws and Leadership Succession committees. AMs would be able to vote on committees.

Rationale

- Consistent with strategic plan and vision as it relates to globalization of regulatory nursing standards.
- Provides greater diversity of input into regulatory best practices.
- Increases input, involvement, networking and sharing of regulatory information and issues both nationally and internationally.
- Increases the openness of the organization.

Advanced Practice Boards of Nursing (APBON)

- Allow APBON to be Member Boards of NCSBN.
- Membership would be approved by the Delegate Assembly.
- All boards of nursing would retain two votes per Member Board.

Rationale

- Will provide the opportunity for APBON that are now disenfranchised to have the same input as boards of nursing who currently regulate advanced practice nursing.
- Membership approval will follow the same process by Delegate Assembly as all other Member Boards.
- Currently, four states have separate RN and LPN/VN boards and thus four votes per state, which has not been a problem.
- If board proliferation becomes a problem, it can be addressed through a bylaw change at that time.
- Currently, only two states have a separate APBON that could qualify for membership at this time.
- A state medical board could not be a member unless it had a majority of nurses on the board.
- Membership has the authority to not accept a questionable board as a member.

Board of Directors (BOD)

- Increases composition from nine to 11 members.
- Three officers, four area directors and four directors-at-large.
- All positions are two-year terms.
- Board positions will be staggered.
- Board members could not serve more than four consecutive years in one position.
- Area members will continue to vote for their area director.
- Directors-at-large will be elected by the entire membership.
- BOD would approve test service (test plans approved by Delegate Assembly).
- Gives the same basis for removal of a Board member to both the Delegate Assembly and the BOD.

Rationale

- Increasing the number of Board members increases membership participation and improves continuity; spreads the additional work of the Board through committee liaisons and attendance at external meetings.
- Having all terms last two years improves continuity and opportunity for participation by members.
- The purpose of area directors is to guarantee geographical representation on the BOD.
- Area directors legally represent the organization as a whole.
- Approving the test service is a business decision that appropriately resides with the Board of Directors to "transact the business and affairs" of the organization.
- Deletes specific causes for removal of a Board member by the BOD and replaces with language that is more discretionary and better protects the organization. Appeal process is in place.

National Council of State Boards of Nursing

- Change title to NCSBN.

Rationale

- Change is consistent with how NCSBN is known externally and reflected in the organizational logo.

Executive Director

- Change title to chief executive officer.

Rationale

- Change is consistent with the common title in nonprofit organizations.

Practical Nurse

- Change all references from practical nurse to practical/vocational nurse.

Rationale

- Consistent with language used across states.

Standing Committees

- Change Examination Committee to NCLEX Examination Committee.
- Designate NCLEX Examination and Finance as the standing committees of the organization.
- Change "provide general oversight" to "advise the Board of Directors" for the NCLEX Examination Committee.
- Delete reference to approval of item development panels.

Rationale

- The common practice in nonprofit organizations is to have the least amount of standing committees as possible.
- Standing committees typically are committees whose function and purpose do not change and are essential to the operation of the organization.
- The Examination Committee and the Finance Committee are essential to the operation of the organization.
- The current structure allows for any and all work to be done through the use of special committees.
- Not having status as a standing committee does not mean the work is not important.
- The membership should be assured that all necessary work will get done.
- Issues related to practice, education and regulation (PR&E) will be addressed and facilitated through the use of special committees.
- The current work of the PR&E Committee is important and will continue through the use of special committees, which will allow for increased membership involvement and will provide for supplemental expertise and diversity for each project.
- The increase of emerging PR&E issues is more than one committee can address in a timely manner.
- Increases the use of special committees thereby increasing membership participation.
- Coordination and prevention of duplicative work among committees can be facilitated.
- Approval of item development panels, an operational function, will remain with the NCLEX Examination Committee and staff; it is not necessary for Bylaws. The current Examination Committee is in support of this change.
- Bylaws committee can be convened when needed.
- Resolutions committee can be convened informally for Delegate Assembly as it has been in the past.

Dissolution

- Change voting percentage from 75 percent to a majority for dissolution.

Rationale

- Majority vote is consistent with current Pennsylvania law whereas 75 percent is in violation of Pennsylvania law.

Leadership Succession Committee

- Leadership Succession Committee replaces the Committee on Nominations.
- Composed of eight members all elected by the Delegate Assembly.
- The chair will be appointed by the BOD from the elected members of the committee.
- Four positions designated: one past BOD member, one current or former committee chair, a board member of a Member Board and an employee of a Member Board.
- Four positions will represent each of the four geographic areas.
- Term is two years. May serve two terms.
- Terms will be staggered.
- Charge is:
  - Recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning.
  - Present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the BOD and the Leadership Succession Committee.

Rationale

- Provides structure within the organization to ensure leadership development and succession.
- Organizational leadership is a strategic process.
- Organizational leaders are developed through careful planning, cultivation, orientation, education and involvement.
- Organizational leadership builds upon the diversity and expertise of the membership.
- Continues to allow for nominations from the floor.

Attachment B

Proposed Bylaw Revisions with Comparison to Current Bylaws Including Rationale

**This document addresses articles and sections with substantial changes only. If adopted, the revised Bylaws would include changing the title "National Council of State Boards of Nursing" to "NCSBN," changing all references to "practical" to "practical/vocational," the title "executive director" to "chief executive officer," and minor editorial and format changes. These changes are reflected in the proposed strike-through revision of the Bylaws.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article III		
■ Members		
Article III, Section 1. Definition. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.	***Article III, Section 1. Definitions.*** (a) *State Board of Nursing.* A state board of nursing is the governmental agency, the majority of whose governing board members are licensed practical/vocational, registered and/or advanced practice nurse, that is empowered to license and/or regulate practical/vocational, registered or advanced practice nursing practice in any state, territory or political subdivision of the United States of America.	■ Adds advanced practice boards of nursing as a new member. ■ Membership is approved by the Delegate Assembly. ■ All boards of nursing retain two votes per jurisdiction. ■ Provides opportunity for advanced practice boards who are now disenfranchised to have same input as boards of nursing who currently regulate advanced practice. ■ A state medical board could not be a member unless they have a majority of nurses on their board.
	(b) *Member Board.* A Member Board is a state board of nursing that is approved by the Delegate Assembly as a member of NCSBN.	■ Defines Member Board.
	(c) *Associate Member.* An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.	■ New category of membership for nursing regulatory bodies from other countries or territories. ■ Must be approved by the Delegate Assembly. ■ Membership fee approved by the Delegate Assembly. ■ Do not have voting rights at Delegate Assembly. ■ Can serve on special committees with voting rights. ■ Cannot serve on Exam, Finance, Bylaws or Leadership Succession Committees.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article III, Section 2. Qualifications. Any state board of nursing that agrees to use one or more National Council Licensure Examinations (the "NCLEX® examination") under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council ("Member Board").	***Article III, Section 2. Qualifications.*** To qualify for approval as a Member Board, a state board of nursing that regulates registered nurses and/or practical/ vocational nurses must use one or more NCSBN licensing examinations (the "NCLEX® examination") for licensure of registered nurses and/or practical/ vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.	■ Clarifies intent to require use of NCLEX® for RN and PN/VN licensure while allowing membership for advanced practice boards.
Article III, Section 3. Admission. A state board of nursing shall become a member of the National Council and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination.	***Article III, Section 3. Admission.*** A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.	■ The addition of the words, "where applicable" permits membership of advanced practice boards without requiring the use of NCLEX® RN/PN examinations, since neither of these exams are for advanced practice nurses.
Article III, Section 5. Fees. The annual member fees, as set by the Delegate Assembly, shall be payable each October 1.	***Article III, Section 5. Fees.*** The annual membership fees for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.	■ Requires membership fee for Associate Member.
Article III, Section 6. Privileges. Membership privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.	***Article III, Section 6. Privileges.*** Member Board privileges include, but are not limited to, the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.	■ Ensures that the stated privileges are only provided to Member Boards.
Article III, Section 7. Noncompliance. Any Member Board whose fees remain unpaid after January 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council shall be subject to immediate review and possible termination by the Board of Directors.	***Article III, Section 7. Noncompliance.*** Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.	■ Clarifies noncompliance as applying to any member of the organization.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article III, Section 9. Reinstatement. A Member Board in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.	***Article III, Section 9. Reinstatement.*** A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.	■ Clarifies that both Member Boards and Associate Members, not in good standing for nonpayment of fees, may be reinstated upon payment of current fee and any delinquent fees.
Article IV		
■ Delegate Assembly		
Article IV, Section 2. Voting. (b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.	***Article IV, Section 2. Voting.*** (b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.	■ Clarifies secretary as the "corporate" secretary.
Article V		
■ Officers and Directors		
Article V, Section 2. Directors. The directors of the National Council shall consist of two directors-at-large and a director from each area.	***Article V, Section 2. Directors.*** The directors of the NCSBN shall consist of four directors-at-large and a director from each area.	■ Adds two director-at-large positions. ■ Increases membership opportunities for leadership. ■ Improves continuity. ■ Decreases the amount of individual board commitment as committee liaisons and ambassadors of NCSBN at external organizational meetings.
Article V, Section 3. Qualifications. Members and employees of Member Boards shall be eligible to serve as National Council officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.	***Article V, Section 3. Qualifications.*** Board members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.	■ Clarifies that only members of Member Boards and employees of Member Boards can serve on the Board of Directors.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article V, Section 6. Terms of Office. The president, vice-president, treasurer and Area directors shall be elected for a term of two years or until their successors are elected. Directors-at-large shall be elected for a term of one year or until their successors are elected. The president, vice-president and treasurer shall be elected in even-numbered years. The Area directors shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.	***Article V, Section 6. Terms of Office.*** The president, vice-president, treasurer, area directors and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice-president treasurer and two directors-at-large shall be elected in even-numbered years. The area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.	■ Adds additional director-at-large positions and staggers the election thereof.
Article V, Section 7. Limitations. No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.	***Article V, Section 7. Limitations.*** No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.	■ Changes Committee on Nominations title to Leadership Succession Committee.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article VI, Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly. The Board of Directors may remove any member of the Board of Directors from office upon conviction of a felony, gross misconduct, failure to perform, dereliction of duties or conflict of interest by a two-thirds vote of the Board of Directors. The individual shall be given 30 days' written notice of the proposed removal.	***Article VI, Section 4. Removal from Office.*** A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days' written notice of the proposed removal.	■ Applies same removal standard of with or without cause and a vote of two-thirds for both the Delegate Assembly and the Board of Directors. ■ With or without cause language allows for discretion and better protects the organization. ■ Appeal process in next section provides check and balance.
Article VII	**Article VII**	
■ Nominations and Elections	■ Leadership Succession Committee	■ New title to reflect new concept of this committee.
Article VII, Section 1. Committee on Nominations.	***Article VII, Section 1. Leadership Succession Committee***	■ New title to reflect new concept of this committee.
(a) *Composition*. The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.	(a) *Composition*. The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.	■ Expands the membership of this committee. ■ Ensures expertise, experience and geographical representation needed for the duties of the committee.
(b) *Term*. The term of office shall be two years. One-half of the Committee members shall be elected in even numbered years and one-half in odd number years. Members shall assume duties at the close of the Annual Meeting at which they are elected.	(b) *Term*. The term of office shall be two years. One-half of the Committee members shall be elected in even-numbered years and one-half in odd-numbered years. A Committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.	■ Two-year term and ability to serve two terms ensures continuity.
(c) *Election*. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The member receiving the highest number of votes shall serve as vice-chair in the first year of the member's term and as chair in the second year of the term.	(c) *Election*. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The chair shall be selected by the Board of Directors.	■ Empowers the membership to select the committee.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
(d) *Limitation*. A member elected or appointed to the Committee on Nominations may not be nominated for an officer or director position during the term for which that member was elected or appointed.	(d) *Limitations*. A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.	■ Change name of committee.
(e) *Vacancy*. A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in which the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1a. of this Article. If the vacancy is the chair, the other person serving the second year of a two-year term shall be the chair. If the vacancy is the vice-chair, the other person serving the first year of a two-year term shall become the vice-chair. The person filling the vacancy shall serve the remainder of the term.	(e) *Vacancy*. A vacancy occurring in the Committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.	■ Applies the same concept of filling the vacancy first from remaining candidates and if no remaining candidates available, position is appointed by the Board of Directors. ■ No vice chair proposed in this new model therefore vacancy language related to vice chair not needed.
(f) *Duties*. The Committee on Nominations shall consider the qualifications of all nominees for officers and directors and the Committee on Nominations and present a slate of qualified candidates for vote at the Annual Meeting. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.	(f) *Duties*. The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.	■ New duties describe the charge and purpose of the committee. ■ Concept ensures leadership development and succession planning into the structure of the organization. ■ Facilitates organizational leadership as a strategic process. ■ Leaders are developed through careful planning, cultivation, orientation, education and involvement. ■ Organizational leadership builds upon the diversity and expertise of the membership. ■ Continues to allow for nominations from the floor.
	(g) *Eligibility*. Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.	■ New section that articulates that only Member Boards may be elected to the Leadership Succession Committee.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article X		
■ Committees		
(a) *Examination Committee.* The Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.	(a) *NCLEX® Examination Committee.* The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.	■ Current best practice in nonprofit organizations is to have the least amount of standing committees. ■ Standing committees typically are committees whose function and purpose do not change and are essential to the operation of the organization. ■ Approval of item development panels is an operational function and will remain on the agenda for NCLEX Examination Committee meetings; not necessary in bylaws per the current Examination Committee.
(c) *Practice, Regulation, and Education Committee.* The Practice, Regulation, and Education Committee shall be comprised of at least six members. The Committee shall provide general oversight of nursing practice, regulation, and education issues.	(c) *Practice, Regulation, and Education Committee is deleted.*	■ Issues related to practice, education and regulation will be addressed and facilitated through the use of special committees. ■ The current work of the PR&E Committee is important and will continue through the use of special committees, which will allow for increased membership involvement and will provide for supplemental expertise and diversity for each project. ■ The increase of emerging practice, regulation, and education issues are more than one committee can address in a timely manner. ■ Increases the use of special committees thereby increasing membership participation.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
(d) *Bylaws Committee.* The Bylaws Committee shall be comprised of at least four members. The Committee shall review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly.	(d) *Bylaws Committee is deleted.*	■ Bylaws Committee can be convened when needed as has been done successfully in the past.
(e) *Resolutions Committee.* The Resolutions Committee shall be comprised of at least four members, including one member from the Finance Committee. The Committee shall, in accordance with the Standing Rules, review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards.	(e) *Resolutions Committee is deleted.*	■ Resolutions Committee can be convened informally for Delegate Assembly as has been done successfully in the past.
Article X, Section 4. Committee Membership. (a) *Composition.* Members of Standing and Special committees shall be appointed by the Board of Directors. Standing committees shall include only current members and employees of Member Boards. Special committees may also include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president's delegate, shall be an ex-officio member of all committees except the Committee on Nominations.	(a) *Composition.* Members of standing and special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws or Finance committees. Committees may also include other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each area shall be selected unless a qualified member from each area is not available considering the expertise needed for the committee work. The president, or president's designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.	■ Clarifies that associate members may not serve on NCLEX Examination, Finance nor Bylaws Committees. ■ Clarifies that the president or president's designee may be an ex-officio member except on the Leadership Succession Committee. ■ Allows Associate Members to be voting members of a committee.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
(d) *Committee Duties.* *Budget.* Standing committees shall operate within the assigned budget for the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors. *Policies.* Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors. *Records and Reports.* Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.	(d) *Committee Duties is deleted.*	Duties are best described in policy.
Article XIV		
■ Amendment of Bylaws		
	Article XIV, Section 2. ***Bylaws Committee.*** A Bylaws Committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.	New section to ensure that a Bylaws Committee can be formed when needed by either the Delegate Assembly or the Board of Directors.

CURRENT BYLAWS	PROPOSED BYLAWS	RATIONALE/COMMENTS
Article XV		
■ Dissolution		
Article XV, Section 2. Acceptance of Plan. Such plan shall be acted upon by Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. Seventy-five percent (75%) of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.	***Article XV, Section 2. Acceptance of Plan.*** Such plan shall be acted upon by the Delegate Assembly at an annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.	■ Majority vote is consistent with current Pennsylvania law whereas 75 percent is in violation of Pennsylvania law.

Attachment C

Proposed Bylaw Revisions, Strike-Through Version

Note:
Underlined text is information added to the Bylaws. Strike-through text is information deleted from the Bylaws.

NCSBN
Leading in Nursing Regulation

NCSBN Bylaws

Revisions adopted - 8/29/87
Amended - 8/19/88
Amended - 8/30/90
Amended - 8/01/91
Revisions adopted - 8/05/94
Amended - 8/20/97
Amended - 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03
Revisions adopted – 08/10/07

Article I

■ **Name**

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (~~the "National Council"~~ NCSBN).

Article II

■ **Purpose and Functions**

Section 1. *Purpose.* The purpose of the ~~National Council~~ NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. *Functions.* The ~~National Council's~~ NCSBN's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The ~~National Council~~ NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

■ **Members**

Section 1. *Definitions.*

a) State Board of Nursing. A state board of nursing is the governmental agency, the majority of whose governing board members are licensed practical/vocational, registered and/or advanced practice nurse, which is empowered to license and/or regulate practical/vocational, registered or advanced practice nursing practice in any state, territory or political subdivision of the United States of America.

b) Member Board. A Member Board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.

c) Associate Member. An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. *Qualifications.* To qualify for approval, as a Member Board, ~~Any~~ a state board of nursing that regulates registered nurses and/or practical/vocational nurses must ~~agrees to~~ use one or more ~~National Council~~ NCSBN licensing examinations (the "NCLEX® examination") for licensure of registered nurses and/or practical/vocational nurses, and execute a membership agreement with NCSBN specifying ~~under~~

the terms and conditions ~~specified by the National Council and pays the required fees may be a member of the National Council ("Member Board")~~for the use of the NCLEX® examination(s) where applicable.

Section 3. *Admission.* A state board of nursing shall become a member of the ~~National Council~~ NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.

Section 4. *Areas.* The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on ~~National Council~~ NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. *Fees.* The annual membership fees, for a Member Board and an Associate Member shall be ~~as~~ set by the Delegate Assembly ~~,~~ and shall be payable each October 1.

Section 6. *Privileges.* ~~Membership~~ Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. *Noncompliance.* Any ~~Member Board~~ member whose fees remain unpaid after January 15 is not in good standing. Any ~~Member Board~~ member ~~which~~ who does not comply with the provisions of the bylaws, and where applicable, the membership agreement ~~and contracts of the National Council~~ shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. *Appeal.* Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. *Reinstatement.* A ~~Member Board~~ member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

■ Delegate Assembly

Section 1. *Composition.*

a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.
b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A ~~National Council~~ NCSBN officer or director may not represent a Member Board as a delegate.
c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. *Voting.*

a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the ~~National Council~~ NCSBN or a delegate of another Member Board to cast its votes.

Section 3. *Authority.* The Delegate Assembly, the membership body of the ~~National Council~~NCSBN, shall provide direction for the ~~National Council~~ NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new ~~National Council~~ NCSBN memberships; approve the substance of all NCLEX® examination contracts between the ~~National Council~~ NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; ~~approve the NCLEX® examination test service;~~ and establish the fee for the NCLEX® examination.

Section 4. *Annual Meeting.* The ~~National Council~~ NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the ~~National Council~~ NCSBN.

Section 5. *Special Session.* The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. *Quorum.* The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. *Standing Rules.* The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

■ Officers and Directors

Section 1. *Officers.* The elected officers of the ~~National Council~~ NCSBN shall be a president, a vice-president and a treasurer.

Section 2. *Directors.* The directors of the ~~National Council~~ NCSBN shall consist of ~~two~~ four directors-at-large and a director from each area.

Section 3. *Qualifications.* Board members of Member Boards and employees of Member Boards shall be eligible to serve as ~~National Council~~ NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. *Qualifications for President.* The president shall have served ~~National Council~~ NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. *Election of Officers and Directors.*

a) *Time and Place.* Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.
b) *Officers and Directors-at-Large.* Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.
c) *Area Directors.* Each area shall elect its area director by majority vote of the delegates from each such area.
d) *Run-Off Balloting.* If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.
e) *Voting.* Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write-in votes shall be prohibited.

Section 6. *Terms of Office.* The president, vice-president, treasurer, ~~and~~ Area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. ~~Directors-at-large shall be elected for a term of one year or until their successors are elected.~~ The president, vice-president ~~and~~ treasurer, and two directors-at-large shall be elected in even-numbered years. The Area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. *Limitations.* No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the ~~National Council~~ NCSBN, as determined by the ~~Committee on Nominations~~ Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. *Vacancies.* A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. *Responsibilities of the President.* The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the ~~National Council~~ NCSBN.

Section 10. *Responsibilities of the Vice-President.* The vice-president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. *Responsibilities of the Treasurer.* The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI

■ Board of Directors

Section 1. *Composition.* The Board of Directors shall consist of the elected officers and directors of the ~~National Council~~NCSBN.

Section 2. *Authority.* The Board of Directors shall transact the business and affairs and act on behalf of the ~~National Council~~ NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board's acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.

Section 3. *Meetings of the Board of Directors.* The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. *Removal from Office.* A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly~~. The Board of Directors may remove any member of the Board of Directors from office upon conviction of a felony, gross misconduct, failure to perform, dereliction of duties or conflict of interest by a two-thirds vote of~~ or the Board of Directors. The individual shall be given 30 days' written notice of the proposed removal.

Section 5. *Appeal.* A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

■ **~~Nominations and Elections~~Leadership Succession Committee**

Section 1. *~~Committee on Nominations~~Leadership Succession Committee*

a) *Composition*. The Leadership Succession Committee ~~on Nominations~~ shall be comprised of ~~one person from each Area~~ eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas. ~~Committee members shall be members or employees of Member Boards within the Area.~~

b) *Term*. The term of office shall be two years. One-half of the Committee members shall be elected in even-numbered years and one-half in odd-numbered years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

c) *Election*. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. ~~The member receiving the highest number of votes shall serve as vice-chair in the first year of the member's term and as chair in the second year of the term~~ The chair shall be selected by the Board of Directors.

d) *Limitation*. A member elected or appointed to the Leadership Succession Committee ~~on Nominations~~ may not be nominated for an officer or director position during the term for which that member was elected or appointed.

e) *Vacancy*. A vacancy occurring in the committee shall be filled from the remaining candidates from the ~~Area in which the vacancy occurs~~ previous election, in order of votes received. If no remaining candidates ~~from an Area~~ can serve, the Board of Directors shall fill the vacancy with an individual ~~from the Area~~ who meets the qualifications of Section 1a. of this Article. ~~If the vacancy is the chair, the other person serving the second year of a two-year term shall be the chair. If the vacancy is the~~

~~vice-chair, the other person serving the first year of a two-year term shall become the vice-chair.~~ The person filling the vacancy shall serve the remainder of the term.

f) *Duties.* ~~The Committee on Nominations shall consider the qualifications of all nominees for officers and directors and the Committee on Nominations and present a slate of qualified candidates for vote at the Annual Meeting~~ The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

g) *Eligibility.* Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

Article VIII

■ Meetings

Section 1. *Participation.*

a) *Delegate Assembly Session.*
   (i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).
   (ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

c) *Meetings.* ~~National Council~~NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the ~~National Council~~ NCSBN Office.

e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

■ Chief Executive ~~Director~~Officer

Section 1. *Appointment.* The ~~Executive Director~~ Chief Executive Officer shall be appointed by the Board of Directors. The selection or termination of the ~~Executive Director~~ Chief Executive Officer shall be by a majority vote of the Board of Directors.

Section 2. *Authority.* The ~~Executive Director~~ Chief Executive Officer shall serve as the agent and chief administrative officer of the ~~National Council~~ NCSBN and shall possess the authority and shall perform all duties incident to the office of ~~Executive Director~~ Chief Executive Officer, including the management

and supervision of the office, programs and services of ~~National Council~~ NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The ~~Executive Director~~ Chief Executive Officer shall serve as corporate secretary and oversee maintenance of all documents and records of the ~~National Council~~ NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. *Evaluation.* The Board of Directors shall conduct an annual written performance appraisal of the ~~Executive Director~~ Chief Executive Officer, and shall set the ~~Executive Director's~~ Chief Executive Officer's annual salary.

Article X

■ Committees

Section 1. *Standing Committees.* ~~National Council~~ NCSBN shall maintain the following standing committees.

a) *NCLEX® Examination Committee.* The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall ~~provide general oversight of~~ advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall ~~approve item development panels and~~ recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the ~~National Council's~~ NCSBN's investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

~~c) *Practice, Regulation, and Education Committee.* The Practice, Regulation, and Education Committee shall be comprised of at least six members. The Committee shall provide general oversight of nursing practice, regulation, and education issues.~~

~~d) *Bylaws Committee.* The Bylaws Committee shall be comprised of at least four members. The Committee shall review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly.~~

~~e) *Resolutions Committee.* The Resolutions Committee shall be comprised of at least four members, including one member from the Finance Committee. The Committee shall, in accordance with the Standing Rules, review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards.~~

Section 2. *Special Committees.* The Board of Directors may appoint special committees as needed to accomplish the mission of the ~~National Council~~ NCSBN and to assist any Standing Committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. *Delegate Assembly Committees.* The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. *Committee Membership.*

a) *Composition.* Members of standing and special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance committees.. ~~Standing committees shall include only current members and employees of Member Boards. Special committees may also include consultants or~~ Committees may also include other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each area shall be selected unless a qualified member from each area is not available considering the expertise needed for the committee work. The president, or president's ~~delegate~~designee, shall be an ex-officio member of all committees except the ~~Committee on Nominations~~ Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

~~d)*Committee Duties.*~~

~~1.*Budget.* Standing committees shall operate within the assigned budget for the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.~~

~~2.*Policies.* Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.~~

~~3.*Records and Reports.* Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.~~

Article XI

■ Finance

Section 1. *Audit.* The financial records of the ~~National Council~~ NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. *Fiscal Year.* The fiscal year shall be from October 1 to September 30.

Article XII

■ Indemnification

Section 1. *Direct Indemnification.* To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. *Insurance.* To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. *Additional Rights.* Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and
b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

■ Parliamentary Authority

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the ~~National Council~~ NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the ~~National Council~~ NCSBN.

Article XIV

■ Amendment of Bylaws

Section 1. *Amendment and Notice.* These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or
b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Section 2. *Bylaws Committee.* A Bylaws Committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

Article XV

■ Dissolution

Section 1. *Plan.* The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the ~~National Council~~ NCSBN. The plan shall provide, among other things, that the assets of the ~~National Council~~ NCSBN be applied as follows:

Firstly, all liabilities and obligations of the ~~National Council~~ NCSBN shall be paid or provided for.

Secondly, any assets held by the ~~National Council~~ NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. *Acceptance of Plan.* Such plan shall be acted upon by the Delegate Assembly at an annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. ~~Seventy-five percent (75%)~~ A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. *Conformity to Law.* Such plan to dissolve must conform to the law under which ~~National Council~~ NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.

Attachment D

Proposed Bylaw Revisions, Clean Copy

NCSBN
Leading in Nursing Regulation

NCSBN Bylaws

Revisions adopted - 8/29/87
Amended - 8/19/88
Amended - 8/30/90
Amended - 8/01/91
Revisions adopted - 8/05/94
Amended - 8/20/97
Amended - 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03
Revisions adopted – 08/10/07

Article I

■ **Name**

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN).

Article II

■ **Purpose and Functions**

Section 1. *Purpose.* The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. *Functions.* The NCSBN's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

■ **Members**

Section 1. *Definitions.*

a) State Board of Nursing. A state board of nursing is the governmental agency, the majority of whose governing board members are licensed practical / vocational, registered and / or advanced practice nurse, which is empowered to license and / or regulate practical / vocational, registered or advanced practice nursing practice in any state, territory or political subdivision of the United States of America.
b) Member Board. A Member board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.
c) Associate Member. An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. *Qualifications.* To qualify for approval, as a Member Board, a state board of nursing that regulates registered nurses and / or practical / vocational nurses must use one or more NCSBN Licensing Examinations (the "NCLEX® examination") for licensure of registered nurses and / or practical / vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.

Section 3. *Admission.* A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.

Section 4. *Areas.* The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. *Fees.* The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. *Privileges.* Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. *Noncompliance.* Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. *Appeal.* Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. *Reinstatement.* A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

■ Delegate Assembly

Section 1. *Composition.*

a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.
b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.
c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. *Voting.*

a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.
b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.

Section 3. *Authority.* The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

Section 4. *Annual Meeting.* The NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the NCSBN.

Section 5. *Special Session.* The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. *Quorum.* The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. *Standing Rules.* The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

■ Officers and Directors

Section 1. *Officers.* The elected officers of the NCSBN shall be a president, a vice-president and a treasurer.

Section 2. *Directors.* The directors of the NCSBN shall consist of four directors-at-large and a director from each Area.

Section 3. *Qualifications.* Board Members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. *Qualifications for President.* The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. *Election of Officers and Directors.*

a) *Time and Place.* Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.
b) *Officers and Directors-at-Large.* Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly..
c) *Area Directors.* Each Area shall elect its Area director by majority vote of the delegates from each such Area.

d) *Run-Off Balloting.* If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.
e) *Voting.* Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write-in votes shall be prohibited.

Section 6. *Terms of Office.* The president, vice-president, treasurer, Area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice-president treasurer, and two directors-at-large shall be elected in even-numbered years. The Area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. *Limitations.* No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. *Vacancies.* A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. *Responsibilities of the President.* The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

Section 10. *Responsibilities of the Vice-President.* The vice-president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. *Responsibilities of the Treasurer.* The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI

■ Board of Directors

Section 1. *Composition.* The Board of Directors shall consist of the elected officers and directors of the NCSBN.

Section 2. *Authority.* The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board's acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.

Section 3. *Meetings of the Board of Directors.* The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at

other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. *Removal from Office.* A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days' written notice of the proposed removal.

Section 5. *Appeal.* A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

■ Leadership Succession Committee

Section 1. *Leadership Succession Committee*

a) *Composition*. The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

b) *Term*. The term of office shall be two years. One-half of the Committee members shall be elected in even numbered years and one-half in odd number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

c) *Election*. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The Chair shall be selected by the Board of Directors.

d) *Limitation*. A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

e) *Vacancy*. A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

f) *Duties*. The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

g) *Eligibility*. Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

Article VIII

■ Meetings

Section 1. *Participation.*

a) *Delegate Assembly Session.*

(i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

c) *Meetings.* NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN Office.

e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

■ Chief Executive Officer

Section 1. *Appointment.* The Chief Executive Officer shall be appointed by the Board of Directors. The selection or termination of the Chief Executive Officer shall be by a majority vote of the Board of Directors.

Section 2. *Authority.* The Chief Executive Officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of Chief Executive Officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Chief Executive Officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. *Evaluation.* The Board of Directors shall conduct an annual written performance appraisal of the Chief Executive Officer, and shall set the Chief Executive Officer's annual salary.

Article X

■ Committees

Section 1. *Standing Committees.* NCSBN shall maintain the following standing committees.

a) *NCLEX® Examination Committee.* The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall recommend test

plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the NCSBN's investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

Section 2. *Special Committees.* The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any Standing Committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. *Delegate Assembly Committees.* The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. *Committee Membership.*

a) *Composition.* Members of Standing and Special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance committees. Committees may also include other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president's designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

Article XI

■ Finance

Section 1. *Audit.* The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. *Fiscal Year.* The fiscal year shall be from October 1 to September 30.

Article XII

■ Indemnification

Section 1. *Direct Indemnification.* To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of

another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. *Insurance.* To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. *Additional Rights.* Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and
b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

■ Parliamentary Authority

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV

■ Amendment of Bylaws

Section 1. *Amendment and Notice.* These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or
b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Section 2. *Bylaws Committee.* A Bylaws committee composed of Board Members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

Article XV

■ Dissolution

Section 1. *Plan.* The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.

Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. *Acceptance of Plan.* Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. *Conformity to Law.* Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.

Attachment E

Special Proviso Adopted with the Leadership Succession Committee

1. The revised Bylaws shall become effective on the day and upon the adjournment of the Annual Meeting Session of the Delegate Assembly at which the revisions to the Bylaws are adopted by the Delegate Assembly, except as provided in Paragraph 2 of this Proviso. Officers and directors shall be elected and/or appointed in the years 2007 – 2013 in accordance with the following schedule:

Officer and Director Election Schedule

Positions	2007 Election	2008 Election	2009 Election	2010 Election	2011 Election	2012 Election	2013 Election
President		X (President for Two-Year Term)		X (President)		X	
Vice President		X (Vice President Two-Year Term)		X (Vice President)		X	
Treasurer		X (Treasurer Two-Year Term)		X (Treasurer)		X	
Director-at-Large	X (Director-at-Large One-Year Term)	X (Director-at-Large Two-Year Term)		X (Director-at-Large)		X	
Director-at-Large	X (Director-at-Large One-Year Term)	X (Director-at-Large Two-Year Term)		X (Director-at-Large)		X	
Area I	X (Director Two-Year Term)		X (Area Director)		X		X
Area II	X (Director Two-Year Term)		X (Area Director)		X		X
Area III	X (Director Two-Year Term)		X (Area Director)		X		X
Area IV	X (Director Two-Year Term)		X (Area Director)		X		X
New Director-at-Large		X (Director-at-Large One-Year Term)	X (Director-at-Large Two-Year Term)		X		X
New Director-at-Large		X (Director-at-Large One-Year Term)	X (Director-at-Large Two-Year Term)		X		X

The "X" indicates the year in which a position will be elected.

Attachment F

Special Proviso Adopted with the Board of Directors

2. A member of the Committee on Nominations elected at the 2007 Delegate Assembly may serve his or her entire terms notwithstanding the revisions to Article VII, Sections 1(a) and (b). Members of the Leadership Succession Committee shall be elected and/or appointed in the years 2008 – 2013 in accordance with the following schedule:

Leadership Succession Committee

Positions	2008 Election	2009 Election	2010 Election	2011 Election	2012 Election	2013 Election
Area Member	X (Two-Year Term)		X		X	
Area Member	X (Two-Year Term)		X		X	
Area Member	X (Two-Year Term		X		X	
Area Member	X (Two-Year Term)		X		X	
Designated Member	X (One-Year Term)	X (Two-Year Term)		X		X
Designated Member	X (One-Year Term)	X (Two-Year Term)		X		X
Designated Member	Incumbent No Election	X (Two-Year Term)		X		X
Designated Member	Incumbent No Election	X (Two-Year Term)		X		X

The "X" indicates the year in which a position will be elected.

Report of the Disciplinary Resources Advisory Panel

Board of Directors' Recommendation

1. ***Adopt the Statement on the Regulatory Implications of Pain Management.***

   Rationale:
   Current standards for the management of pain describe the right of the patient to an appropriate assessment and treatment of pain. Still, pain is under treated and regulation is often seen as a barrier to adequate pain management because of the fear of regulatory scrutiny of prescriptions and administration of controlled substances. A few state boards of nursing have developed statements regarding pain management; however, there is not a national statement from nurse regulators. Adoption of this statement brings together the collective voice of state boards of nursing on this important issue. Attachment A is presented in fulfillment of the charge.

   Fiscal Impact:
   None

Background

Pain management presents a variety of issues for nurse licensing boards. The 2006 Disciplinary Resources Advisory Panel (DRAP) began work on an NCSBN statement on the regulatory implications of pain management. As part of their 2007 charge, the newly appointed DRAP members were directed to complete the pain management statement. DRAP identified four unique pain management situations with which boards of nursing may be faced:

1. A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm and suffering for patients.
2. An advanced practice registered nurse (APRN) fails to appropriately prescribe medications for pain management.
3. A nurse's pain or treatment for pain affects his/her ability to practice safely.
4. A chemically dependent nurse requires pharmacologic pain management.

DRAP developed a general statement to identify regulatory issues and the role of the board of nursing related to pain management. Detailed resources for each of the regulatory issues stated above will be created to provide model policies and guidelines that can be used by boards of nursing. The NCSBN Statement on the Regulatory Implications of Pain Management is attached (see Attachment A).

Investigator & Attorney Workshop

DRAP members advised staff in the planning for the 2007 Investigator & Attorney Workshop held May 21 – 23, 2007, in San Francisco. The program's first day was devoted to investigating in a complex and volatile world. Dr. Stephanie Carnes, director of Family Services, Research and Intensive Workshops at Pine Grove Behavioral Health and Addictions Center, addressed how cyber-sex can affect nurse behavior and patient care. Hannah Rose, an attorney with the California Department of Regulation, followed with a discussion of the implications for regulation. Other first day sessions included a presentation on the results of the NCSBN Remediation Study; an update on the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP™); and how various states are using the instrument. The first day concluded with a case study related to investigating in a troubled world.

The second day of the program was dedicated to discipline in the age of technology. Sessions focused on how to obtain and analyze forensic records, case management, Internet resources, collaboration with other agencies and ways to avoid hearings. The day concluded with a case study involving multiple applicants, forensic record analysis and criminal investigations.

Members

Sandra Evans, MAEd, RN
Chair, Idaho, Area I

Emily Brown, JD
Ohio, Area II

Catherine Giessel, MS, RN, ANP
FAANP, Alaska, Area I

Elliot Hochberg, BS
California-RN, Area I

Fred Olmstead, JD
Nevada, Area I

Margaret Sheaffer, RN, JD, BBA
Pennsylvania, Area IV

Jane Tallant, RN, MSN
Mississippi, Area III

Kathy Malloch, PhD, MBA, RN, FAAN,
Board Liaison, Arizona, Area I

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

Meeting Dates

- Oct. 23 – 24, 2006
- Dec. 14 – 15, 2006
- Feb. 5 – 6, 2007
- March 26 – 27, 2007
- May 21 – 23, 2007

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Provide effective education, information sharing and networking opportunities.

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Provide models and resources for evidence-based regulation to Member Boards.

The last day of the workshop focused on hot topics in discipline. In addition to an environment scan pertaining to health care and the implications for discipline, an expert toxicologist discussed drug screening using biomarkers (EtG) and the implications for boards of nursing. The workshop concluded with a discussion of the new opportunities presented by technology—opportunities to support the work of the boards as well as opportunities to generate challenges. Sandy Evans, executive director of the Idaho Board of Nursing and chair of DRAP, offered concluding remarks.

In looking at future workshops, DRAP reviewed the feedback from the evaluations from previous workshops, the disciplinary resources networking calls, feedback from a survey of executive officers and the Building Bridges sessions at Annual Meetings. The advisory panel began to develop ideas for upcoming workshops as well as other types of disciplinary resources. DRAP identified "High Reliability Discipline" as an ongoing theme with yearly emphasis on timely topics. Some suggested topics include:

- Ethics
- Discipline processes and strategies
- Interviewing
- Report writing
- Assessing the situational context of a complaint
- Using TERCAP as a framework for discipline data collection
- Evidence production and maintenance
- Fraud and deceit, including nurse imposters and identity theft
- Implications of paperless licensing
- Standards of proof (spotlight on specific cases)
- Mandatory reporting
- Chemical dependency
- Patient abuse and neglect

The purpose of the workshops is to provide exposure to new ideas, different approaches and strategies for discipline, and a variety of resources. Participants can then take the information back to their boards and implement ideas that are workable for their boards.

Feasibility of Board of Nursing Investigator Certification Program

The third element of the advisory panel's charge was to complete a feasibility study for a certification program for nurse investigators. This project was begun by last year's DRAP members who gathered information from various external sources including the Council on Licensure, Enforcement and Regulation (CLEAR) staff; the Federation of Associations of Regulatory Boards (FARB); as well as investigating possible collaboration with Joseph Buckley, president of Reid and Associates, a private Chicago firm that provides education and training about investigating, interviewing and interrogation skills for businesses, law enforcement and governmental organizations. This year DRAP focused on obtaining feedback from executive officers of boards of nursing regarding whether a certification course was needed and whether a program would be used if it were available. The results of the surveys were mixed (see Attachment B, Summary of 2006 Discipline Needs Survey). While there is a significant interest on the part of 19 boards, 10 boards said the program was not needed and 12 boards responded that it maybe was needed. If it were available, 23 of the responding boards said they would use the program, 11 said they would not and five said maybe they would use the program. Four additional boards did not respond to this question. DRAP members identified the pros and cons of developing an investigator certification program.

Reasons for a certification program:

1. It would provide an opportunity for professional development of investigators.
2. It would be a recognition of the additional education completed by the investigator.
3. It could increase the credibility of the investigators in the eyes of nurses and the public.
4. Significant interest was expressed by many boards.

Reasons against a certification program:

1. A significant number of boards reported that their investigators did not see a need for further training.
2. Level of participation uncertain due to:
   A. Limited state resources
   B. Stability of investigators in many jurisdictions
   C. Investigators assigned to multiple boards
3. Several boards voiced a concern that such a program would duplicate existing state training as well as CLEAR and FARB programs.
4. Several boards expressed a concern that such a program would detract from the annual Investigator & Attorney Workshops that boards have come to expect.
5. A certification program would be costly, requiring additional NCSBN resources (e.g., staff, space, technology).
6. Feedback indicates a substantial need for education and discipline resources that are affordable, timely, flexible and useful for a variety of purposes rather than focusing only in investigators. Such resources could be used in:
   A. Investigator training
   B. Board staff orientation and continuation education
   C. Board member orientation and continuing education
   D. Developing resources for nurses and the public to explain the disciplinary process.

DRAP Recommendation to the Board of Directors

Based on this analysis, the DRAP members concluded that while boards of nursing are requesting disciplinary resources, an investigator certification program would not be the best use of NCSBN resources at this time. Although there was interest in a certification program, only 19 boards (not a majority of the boards) saw a need for the program. And while four additional boards indicated that they would use such a program if it were available (a total of 23) that also was not a majority of the 59 Member Boards. DRAP members recommend that for now, NCSBN focus on developing timely and flexible resources that can be used for multiple purposes. DRAP also advised that this is an issue that should be revisited in the future.

SAMHSA Advisory

The 2006 Delegate Assembly adopted the paper *Drug Screening as a Regulatory Tool*, which included a cutoff level of 500 ng/ml for the EtG test (Ethyl Glucuronide) in testing for alcohol use. Subsequently, in September 2006, the Substance Abuse & Mental Health Services Administration (SAMHSA) issued an alert regarding the use of biomarkers to evaluate alcohol abstinence. The advisory stated that, "the use of an EtG test (Ethyl Glucuronide) in determining abstinence lacks sufficient proven specificity for use as primary or sole evidence that an individual prohibited from drinking, in a criminal justice or a regulatory compliance

context, has truly been drinking. Legal or disciplinary action based solely on a positive EtG, or other test discussed in the Advisory, is inappropriate and scientifically unsupportable at this time. These tests should currently be considered as potential valuable clinical tools, but their use in forensic settings is premature." (SAMHSA Advisory, September 2006).[1] This advisory led at least one state board to discontinue use of EtG in drug screening for alcohol use.

DRAP reviewed the advisory at their December 2006 meeting. The members identified the key language in this statement to be "primary or sole evidence." As pointed out in the drug screening paper, when a nurse disputes the validity of the positive results of an EtG test or any other drug test, the nurse should have the opportunity for a medical review officer (MRO) review of all positive findings as well as consideration of clinical and other information about the individual. However, if a nurse admits to use when faced with a positive EtG, the positive EtG is confirmed by the nurse's admission, so any decision is not "solely" based on the EtG.

The advisory panel recognized that the use of biomarkers is an evolving issue and that it is essential to monitor the scientific developments and recognize that values may need adjustment at times. The members recommended that the level of 500 ng/ml listed in the paper is a reasonable cutoff level for EtG testing. However, a positive EtG should not be used as the sole evidence of drinking activity. Any disputed test must receive further review.

In February 2007, the NCSBN Board of Directors approved adding a statement to *Drug Screening as a Regulatory Tool* regarding the SAMHSA report. A link to the SAMHSA report is included in that statement.

Highlights of FY07 Activities

- Reviewed committee history as part of orientation of new members.
- Surveyed Member Board executive officers regarding the need for and potential use of a certification program for nursing board investigators.
- Recommended to the Board of Directors not to pursue an investigator certification program at this time.
- Recommended to the Board of Directors that a variety of discipline resources be developed that can be used with board staff, investigators and attorneys.
- Recommended topics for and speakers for the discipline networking calls.
- Participated in the discipline networking calls.
- Participated in the 2007 Investigator & Attorney Workshop held May 20 – 23, 2007, at the Hyatt Fisherman's Wharf in San Francisco.
- Conducted pilot videocast of the first morning of the 2007 Investigator & Attorney Workshop.
- Received updates regarding the Healthcare Integrity and Protection Data Bank (HIPDB) and plans to convert to use of HIPDB codes for reporting, and on expectations for a legally sufficient narrative in HIPDB reports.
- Reviewed imposter reporting and made recommendations to the Nursys® User Group.

[1] SAMHSA (2006). "The role of biomarkers in the treatment of alcohol use disorders." Substance Abuse Treatment Advisory, News for the Treatment Field. Washington, DC: U.S. Department of Health and Human Services Accessed May 14, 2007 at http://www.kap.samhsa.gov/products/manuals/advisory/text/0609_biomarkers.htm

Future Activities

- Advise staff regarding the topics for the 2008 Investigator & Attorney Workshop.
- Complete detailed papers for each of the four identified regulatory issues regarding pain management.
- Identify and review existing disciplinary resources and report back to the Board of Directors.

Attachments

A. NCSBN Statement on the Regulatory Implications of Pain Management

B. Summary of 2006 Discipline Needs Survey

Attachment A

NCSBN Statement on the Regulatory Implications of Pain Management

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses. In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant to analgesics or addicted to the medications. Nurses may fear the scrutiny of regulation, especially related to controlled substances. In addition, when a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons there is a need for a national statement identifying the regulatory implications for nursing.

Role of the Board of Nursing

Boards of nursing deal with four unique pain management situations:

- A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm and suffering for patients.
- An advanced practice registered nurse (APRN) fails to appropriately prescribe medications for pain management.
- A nurse's personal pain or treatment for pain affects his/her ability to practice safely.
- A chemically dependent nurse requires pharmacologic pain management.

Boards of nursing can be proactive in their charge to protect the public by:

- Acknowledging the unique regulatory challenges presented by pain management.
- Holding a nurse accountable for:
  - Acquiring the education necessary to effectively manage patients experiencing pain.
  - Adhering to accepted nursing pain management standards.
  - Practicing within the appropriate role for the level of licensure.
  - Evaluating one's own ability to safely and competently practice.
- Imposing appropriate action when a nurse fails to comply with the statutory and regulatory requirements and places patients at risk.
- Collaborating with stakeholders (e.g., regulatory entities, educators, professional organizations, employers and consumers) in implementing regulatory processes that support effective pain management.

NCSBN fully supports the nursing role in the thorough assessment and effective management of pain. Boards' of nursing mandate of public protection includes a responsibility to protect the public from the mismanagement of pain. Boards also must address the impact that being in pain and receiving pain treatment have on the ability of nurses to practice safely.

Future Steps

Additional resources are planned to provide model policies and guidelines for each of the regulatory issues addressed above. This work will support boards of nursing in meeting the regulatory challenges presented by pain management.

Attachment B

Summary of 2006 Discipline Needs Survey

In December 2006, NCSBN staff distributed a Discipline Needs Assessment Survey to executive officers via e-mail. There were 23 boards that responded to the questions regarding discipline services and resources. In January 2007, the survey was resent to executive officers who had not responded in December. Eight additional surveys were received. During the last week of February, staff contacted the remaining boards by telephone to ask the two key questions from the survey, bringing the number of responses for those key questions to 44.

Key Question Results

The responses to the key questions regarding a nursing investigator certification program were tallied.

- Key Question 1: Do you see a need for an investigator certification program? (n = 43, or 73% of all boards responded):

Response	Number of Boards
Yes	19
No	10
Maybe	12
No Response	1

- Key Question 2: Would you use such a program if it were available? (n = 41, or 68% of all boards responded):

Response	Number of Boards
Yes	23
No	11
Maybe	5
No Response	4

Other Results from Survey

The survey asked executive officers to rate a variety of possible discipline resources and products using a scale ranging from 1 (extremely useless) to 5 (extremely useful). The lists below are ordered starting with the resource receiving the most high ratings to the resource receiving the fewest.

Discipline Resources/Products (Based on receiving rating of 5)	Discipline Resources/Products (Based on receiving rating of 4 or 5)
1. Compilation of body of knowledge, skills, strategies and techniques relating to nursing investigations	1. Online courses on nursing investigations
2. Focused pieces presented via Webinar	2. Compilation of body of knowledge, skills, strategies and techniques relating to nursing investigations
3. Online courses on nursing investigations	3. Focused pieces presented via Webinar
4. Written and online resource materials	4. Networking support
5. Networking support	5. Written and online materials
6. Investigator competency standards	6. Investigator competency standards
7. Nursing investigator certification program	7. Guidelines for collaboration
8. Guidelines for collaboration	8. Nursing investigator certification

Discipline Topics Receiving 5 Ratings	Discipline Topics Receiving 4 or 5 Ratings
1. Ethics and investigator code of conduct	1. Beginning an investigation
2. Interviewing skills	2. Develop/maintain/document evidence
3. Beginning an investigation	3. Interviewing skills
4. Develop/maintain/document evidence	4. Ethics and investigator code of conduct
5. Report writing	5. Investigative strategies
6. Discipline process	6. Report writing
7. Assessment of context of allegations, systems, environment, etc.	7. Discipline process
8. Investigative strategies	8. Assessment of context of allegations, systems, environment, etc.
9. Regulatory agencies and administration	9. Regulatory agencies and administration
10. Board decision making	10. Board decision making
11. Safety issues	11. Safety issues
12. Nursys®, Federal databanks, online resources	12. Nursys®, Federal databanks, online resources
13. Testifying as state witness	13. Testifying as state witness
14. Using TERCAP™ for investigation planning and data collection	14. Using TERCAP™ for investigation planning and data collection
15. Negotiation skills	15. Collaborative investigations: planning for coordination
16. Collaborative investigations: planning for coordination with other agencies	16. Inspection of site
17. Inspection of site	17. Negotiation skills

Report of the Examination Committee

Recommendation to the Delegate Assembly

1. ***Adopt the 2008 NCLEX-PN® Test Plan***

Rationale:
The Examination Committee reviewed and accepted the *Report of Findings from the 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2007) as the basis for recommending revisions to the *2005 NCLEX-PN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from the Member Boards and legal counsel, and the professional judgment of the Examination Committee provide support for the recommendation to the Delegate Assembly to adopt the *2008 NCLEX-PN® Test Plan*.

Fiscal Impact:
Costs incorporated into the FY08 budget.

Background

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

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

Highlights of FY07 Activities

ENTRY-LEVEL NURSE COMPETENCE IS ASSESSED BY THE NCLEX® EXAMINATIONS

2008 NCLEX-PN® Test Plan

At its October 2006 meeting, the Examination Committee reviewed the results of the *Report of the Findings from the 2006 PN Practice Analysis: Linking the NCLEX-PN® Examination to Practice*. Empirical data from the 2006 PN Practice Analysis was used to evaluate the *2005 NCLEX-PN® Test Plan* to determine if changes were needed. After an in-depth discussion and careful deliberation, the committee decided to retain the general framework. The percentage of test items allocated to the subcategory Coordinated Care has been revised from 11 – 17% to 12 – 18%, based on empirical data from the practice analysis and psychometric considerations regarding the minimum number of test items that are needed to reliably sample a content category. Also, the subcategory of Physiological Adaptation has been decreased in the percentage of items to 11 – 17% from 12 – 18% for the same reasons. Some of the content listed within each of the proposed test plan categories/subcategories was revised based on the practice analysis task statements. Other revisions were necessary for reasons of conceptual clarity, currency and correction of redundancy.

Members

Examination Committee

Sheila Exstrom, PhD, RN, Chair
Nebraska, Area II

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

Jessie Daniels, MA, RN
Minnesota, Area II

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

Mary Kay Habgood, PhD, RN
Florida, Area III

Lorinda Inman, MSN, RN
Iowa, Area II

Betty Kent-Conant, MSN, RN
Maine, Area IV

Laurette Keiser, MSN, RN
Pennsylvania, Area IV

Cheryl Koski, MN, RN
Wyoming, Area I
(October – November)

Patricia Spurr, EdD, MSN, RN
Kentucky, Area III

Myra Broadway, JD, MS, RN
Board Liaison, Maine, Area IV

Item Review Subcommittee

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

Pamela Ambush-Burris, MSN, RN
Maryland, Area IV

Jean Houin, RN
Louisiana-PN, Area III

Patricia Johnson, LPN
Arizona, Area I

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Illinois, Area II

Barbara Zittel, PhD, RN
New York, Area IV

Staff
Anne Wendt, PhD, MSN, RN, CAE
Director, NCLEX® Examinations

Meeting Dates

- Oct. 25 – 27, 2006 (Examination Committee Business Meeting)
- Dec. 5 – 8, 2006 (Item Review Subcommittee Meeting)
- Jan. 24 – 25, 2007 (Examination Committee Business Meeting)
- Feb. 16, 2007 (Examination Committee Conference Call)
- March 6 – 9, 2007 (Item Review Subcommittee Meeting)
- April 18 – 19, 2007 (Examination Committee Business Meeting)
- June 5 – 8, 2007 (Item Review Subcommittee Meeting)
- June 28, 2007 (Examination Committee Conference Call)
- July 18, 2007 (Examination Committee Conference Call)
- Aug. 14 – 17, 2007 (Item Review Subcommittee Meeting)

Relationship to Strategic Plan

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 3
Enhance communication between Member Boards and external stakeholders.

Strategic Initiative IV
Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers.

Strategic Objective 1
NCLEX® is the premier examination for entry into practice.

A draft of the proposed *2008 NCLEX-PN® Test Plan* was sent to all 59 Member Boards in November 2006 for feedback. During its April 2007 business meeting, the Examination Committee considered all feedback. After discussion and deliberation, a final draft of the proposed *2008 NCLEX-PN® Test Plan* was developed as noted in Attachment B.

CONTINUOUSLY IMPROVE DEVELOPMENT AND ADMINISTRATION OF THE NCLEX EXAMINATIONS

NCLEX Research

Investigation of the new chart/exhibit type items continues to be conducted. Due to the uniqueness of these items (three exhibit tabs with additional information needed to answer the question) writers will continue to target these items to the appropriate difficulty level.

In addition, the committee reviewed research reports on comparing the administration methods of practice analyses. It is anticipated that the results of a continuous (ongoing) Web-based RN practice analysis methodology will be available in December 2007.

Joint Research Committee (JRC)

The JRC is a small group of NCSBN and Pearson VUE testing staff, along with a selected group of testing industry experts, which reviews and conducts psychometric research to provide empirical support for the use of the current NCLEX as well as to investigate possible future enhancements.

Several new pieces of research have either been completed or are near a final draft stage. Examples include: investigations into the effect of multidimensionality on the functioning of the NCLEX-RN, the impact of several possible modifications to current pass-fail decision rules, the stability of item parameters over time, investigation into chart/exhibit items, and a sampled and pooled approach to calculating average group performance.

ADA Advisory Panel

An advisory panel was convened to facilitate the development of guidelines for Member Boards to use when reviewing requests for accommodations under the Americans with Disabilities Act (ADA). The panel was convened on Feb. 12, 2007. Panelists included an attorney employed by several licensing boards, a nursing education adviser from a U.S. board of nursing, a licensed psychologist with expertise in assessing attention deficit hyperactivity disorder and learning disabilities as well as developing ADA guidelines specific to these conditions, a psychometrician, a nurse-psychometrician and a test administration manager. These ADA guidelines are in the process of being reviewed and edited.

NCLEX Innovations

The Examination Committee consistently reviews the present and future of the NCLEX examinations with an eye towards innovations that would maintain the examinations' premier status in licensure. With that in mind, the Examination Committee held a one-day focused meeting regarding enhancements and issues relative to entry-level nursing competencies and the NCLEX. Additionally the committee reviewed research reports on developing innovative items that incorporate video and sound, comparing a Web-based and paper-based administration method for practice analyses and developing item variants.

More information will be presented as the committee reviews and begins to strategize on these topics and how they might affect the examination.

Evaluated and Monitored NCLEX Examination Policies and Procedures

The committee evaluated the efficacy of the Board of Directors' approved examination-related policies and procedures as well as Examination Committee policies and procedures. Revisions were made to pertinent policies and procedures in order to reflect improvements in processes that needed to be changed or refined during the 13th year of the administration of the NCLEX via computerized adaptive testing (CAT).

MONITORED ALL ASPECTS OF EXAMINATION DEVELOPMENT

Conducted Committee and IRSC Sessions

To ensure consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the Examination Committee continue to chair IRSC meetings. The committee and the subcommittee: (1) reviewed RN and PN operational and pretest items, (2) performed face validity of real exams, (3) provided direction regarding RN and PN alternate items; and (4) made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes and integrated processes, and the NCLEX Style Manual. In addition, the subcommittee and staff currently evaluate 100 percent of all validations for pretest items and 25 percent of all validations of operational pool items scheduled for review.

Assistance from the IRSC continues to reduce the Examination Committee item review workload, facilitating the efforts of the Examination Committee toward achieving defined goals. As the item pools continue to grow, review of operational items is critical to ensure that the item pools reflect current entry-level nursing practice. At this time the number of volunteers serving on the subcommittee is 13, with representation from all four NCSBN geographic areas. The orientation for the subcommittee occurs both annually and at each meeting.

Monitored Item Production

Under the direction of the Examination Committee, RN and PN pretest items were written and reviewed by NCLEX Item Development Panels. The NCLEX Item Development Panels' productivity can be seen in Tables 1 and 2. In addition, the IRSC reviewed real examinations for face validity and provided reports to the Examination Committee. As part of the contractual requirements with the test service, items that use alternate formats have been developed and deployed in item pools. Information about items using alternate formats has been made available to Member Boards and candidates in the *NCLEX® Candidate Bulletin* and on the NCSBN Web site.

Table 1. RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	4	47	2,611	7	1,542
April 03 – March 04	2	23	1,097	5	1,446
April 04 – March 05	1	12	301	4	1,415
April 05 – March 06	5	66	2,514	7	2,885
April 06 – March 07	3	47	1,835	6	3,195

Table 2. PN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed
April 02 – March 03	3	33	1,476	6	1,547
April 03 – March 04	2	24	968	5	1,611
April 04 – March 05	1	11	430	3	2,124
April 05 – March 06	4	50	1,938	5	3,682
April 06 – March 07	3	45	2,453	4	1,661

As noted above, the number of PN items written has increased from April 2006 to March 2007 in an effort to increase the number of PN items in the operational pools. In FY06, Pearson VUE increased the number of participants at item writing sessions from 12 to 16 panelists to produce items more efficiently.

Evaluated Item Development Process and Progress

The committee evaluated reports provided at each meeting on item development sessions conducted by the test service. A committee representative was recruited for each panel. The committee representative is either a member of the committee, subcommittee or a staff member. The committee representatives to each panel attended and monitored specific item development sessions and provided feedback to the committee and to the test service. Overall, panelists and Examination Committee representatives in attendance have rated item development sessions favorably.

The IRSC annually reviews the face validity of real exams. The IRSC and NCSBN staff viewed 10 real exams, five RN and five PN, to determine face validity. To ensure congruence among reviewers, the categories and guidelines were defined and agreed upon by the Examination Committee in their workgroup from October 2006. The Examination Committee instituted three additional face validity characteristics as determined from a survey of Member Boards regarding issues in regulation. The additional characteristics include: (1) critical thinking, (2) professional behaviors and (3) professional boundaries. From a regulatory perspective, the reviewers were "comfortable" basing licensure decisions on the content presented in the examinations that were reviewed.

Monitored the Development of Operational NCLEX Item Pools

The Examination Committee monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involves only a few variables; however, the quality control checks performed afterward are based upon both nursing content and psychometric variables. The resulting operational item pools were evaluated extensively with regard to these variables and were found to be within operational specifications. To ensure that operational item pools and the item selection algorithm were functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan content area; it was concluded that the operational item pools and the item selection algorithm were acting in concert to produce exams that were within NCSBN specifications and were comparable to exams drawn from previous NCLEX item pool deployments. These conclusions were reinforced by replicating the analyses using actual candidate data. The Examination Committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Member Board Review of Items

Boards of nursing were provided opportunities to conduct reviews of representative examinations and NCLEX pretest items in April and October of 2006. Boards referred items for Examination Committee review for one of the following reasons: "not entry-level practice," "not consistent with the nurse practice act" or for "other reasons." Items referred for "not entry-level practice" reasons were reviewed by an additional item review panel in advance of the committee's review. Staff provided the committee with feedback on all items queried as part of the review process. The committee provided direction on the resolution of each Member Board item.

Staff provided Member Boards with feedback on the Examination Committee's decisions on all referred items. The Examination Committee encourages each Member Board to take advantage of the semiannual opportunities to review NCLEX items.

Item-Related Incident Reports

Electronically filed incident reports may be submitted at Pearson Professional Centers (PPCs) when candidates question item content. Pearson VUE staff and NCSBN staff investigate each incident and report their findings to the Examination Committee for decisions related to retention of the item.

MONITORED ALL ASPECTS OF EXAMINATION ADMINISTRATION

Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm

The Examination Committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semiannual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months. The most recent check covered the period from April 2006 through September 2006, and compared over 120,000 candidate records. The result of that check revealed that there were no duplicate candidate records and that no repeat candidate records were treated by the system as separate individuals.

Monitored the Security of the NCLEX Examination Administrations and Item Pools

In the last year, the Examination Committee has continued to approach security proactively. The Examination Committee has worked to draft procedures to describe how certain categories of security-related investigations and actions are executed.

In addition to providing mechanisms and opportunities for people to inform NCSBN about issues, NCSBN has also enlisted the aid of a second security firm to search the Internet for Web sites and Internet forums that might attempt to trade in NCLEX items. NCSBN staff has also visited many of the international centers to review the physical and procedural security measures that are in place. In FY07, staff visited and/or anticipates visiting PPCs in Canada, South Korea, England, Hong Kong and India. NCSBN staff, Pearson VUE staff and the Examination Committee continue to be vigilant regarding the administration and the security of the NCLEX examination in domestic and international test sites.

Additionally, the committee developed a matrix and procedures for evaluating test centers and recommending the opening and/or suspending of NCLEX administration in order to ensure the integrity and security of the NCLEX.

Compliance with the 30/45-Day Scheduling Rule for Domestic PPCs

The Examination Committee monitors compliance with the 30/45-day scheduling rule. For the period of Nov. 1, 2005, to Dec. 31, 2006, there was one candidate scheduled out of compliance in domestic sites, out of approximately 300,000 candidates testing. A dedicated department at Pearson VUE continues to analyze center utilization levels in order to project future testing volumes and meet the testing needs of all of their testing clients. As an early indicator of center usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites go over 80 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX Examination Administration

As part of its activities, the Examination Committee and NCSBN's NCLEX Examinations Department staff responded to Member Boards' questions and concerns regarding administration of the NCLEX examinations.

More specific information regarding the performance of the NCLEX test service, Pearson VUE, can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX) available in Attachment C of this report.

ADMINISTER NCLEX EFFECTIVELY AND EFFICIENTLY AT INTERNATIONAL SITES

Beginning Jan. 1, 2005, NCSBN began to schedule candidates at international test centers. The three locations of these centers were Hong Kong, China; London, England; and Seoul, South Korea. Fourteen additional international testing centers were opened in 2006. Additionally, on Sept. 16, 2006, the Puerto Rico testing center became an international site as Puerto Rico is no longer a Member Board. These centers meet the same security specifications and follow the same administration procedures as the professional centers

located in Member Board jurisdictions. See Attachment C of this report for the 2006 candidate volumes and pass rates for the international testing centers.

STAKEHOLDERS ARE EDUCATED ABOUT THE NCLEX EXAMINATION PROGRAM AND RELATED PRODUCTS/SERVICES

NCLEX Research Presentations

A research symposium was accepted and presented at the 2007 American Educational Research Association (AERA) annual meeting: *Security Issues and Licensing Examinations*. AERA is an internationally recognized professional organization with the primary goal of advancing educational research and its practical application. Additionally, a poster presentation on job analysis methodologies was accepted at the International Council of Nurses (ICN) Conference in Yokohama, Japan. Acceptance in these programs not only helps NCSBN share expertise on best testing practices worldwide, but also allows NCSBN to move ahead in psychometric testing solutions through the collective strength of internal and external stakeholders. Furthermore, collaborating on psychometric testing issues with external communities allows NCSBN to remain at the forefront of the testing industry.

Presentations

NCSBN's NCLEX Examinations Department staff conducted numerous NCLEX informational presentations and workshops. In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX Examinations Department hosted two informational conference calls for Member Boards. Additionally, as part of the department's outreach activities, staff conducted a second regional workshop regarding the NCLEX that was sponsored by the Mississippi Board of Nursing. Regional workshops are presented for the purpose of providing information to educators preparing students to take the NCLEX examination. These opportunities assist NCSBN to educate stakeholders about the examination as well as recruit for NCSBN item development panels.

Publications

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process. This year the *2007 NCLEX-RN® Test Plan* and *2007 NCLEX-RN® Detailed Test Plan* were published, distributed to Member Boards, and made available to the public at no charge on the NCSBN Web site. The *2006 PN Practice Analysis: Linking the NCLEX-PN® to Practice* was also published and distributed to the boards of nursing. Five other articles were written and published by NCSBN staff: "Monitoring Entry-Level Practice," *Nurse Educator*, Vol. 32, No. 2; "Assessing Critical Thinking Using a Talk-Aloud Protocol," *CLEAR Exam Review*, Winter 2007; "Setting the Passing Standard for the National Council Licensure Examination for Registered Nurses," *Nurse Educator*, Vol. 32, No. 3; "Assessing the Impact of English as a Second Language Status on Licensure Examinations," *CLEAR Exam Review*, Winter 2006; and "Comparability of Practice Analysis Survey Results Across Modes of Administration," *CLEAR Exam Review*, Summer 2006.

NCLEX Invitational

Historically, the NCLEX Examinations Department staff has coordinated and hosted an NCLEX Invitational in order to provide Member Boards, educators and other stakeholders an opportunity to learn about the NCLEX program. The 2006 NCLEX Invitational was held at the Sheraton Society Hill, Philadelphia, Pennsylvania, on Sept. 11, 2006, with approximately 285 participants. The 2007 NCLEX Invitational is scheduled for Monday, Sept. 24, 2007, at the InterContinental, Chicago.

NCLEX Program Reports

The committee monitored production of the NCLEX Program Reports. Program Reports can be ordered, paid for and downloaded via a Web-based system that permits program directors to receive reports faster and in a more portable electronic format. Now subscribers will have the ability to e-mail the reports to those people who need it most—the faculty and staff that design curriculum and teach students. Subscribers will have the ability to copy and paste relevant data, including tables and charts, into their own reports and presentations. This will be particularly beneficial if the program uses these reports to supplement the academic accreditation process.

NCLEX Unofficial Quick Results Service

Boards of nursing, through NCSBN, offer candidates the opportunity to learn their "unofficial results" (official results are available only from the boards of nursing) through the NCLEX® Quick Results Service. A candidate may call or use the Internet to access their unofficial result after two business days from completion of their examination. Currently, 40 boards of nursing participate in offering this service to their candidates. In 2006, approximately 129,000 candidates utilized this service.

Future Activities

- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Initiate a 2008 RN Practice Analysis.
- Develop a *2008 NCLEX-PN® Detailed Test Plan*.
- Conduct a PN Standard Setting Workshop.
- Investigate continuous online RN and LPN/VN Practice Analyses.
- Evaluate enhancements to NCLEX examination process.
- Evaluate NCLEX informational initiatives such as the NCLEX Invitational, regional workshops and other presentations.
- Evaluate ongoing international testing.
- Host the 2007 NCLEX Invitational.

Attachments

A. Proposed *2008 NCLEX-PN® Test Plan* – Strike-Through Copy

B. Proposed *2008 NCLEX-PN® Test Plan* – Clean Copy

C. Annual Report of Pearson VUE for the NCLEX

Attachment A

Proposed 2008 NCLEX-PN® Test Plan – Strike-Through Copy

Note:
Highlighted text is information added to the test plan. Strike-through text is information deleted from the test plan.

NCLEX-PN® Test Plan (Track Changes 2005 to 2008)

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

Introduction

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

Several steps occur in the development of the *NCLEX-PN® Test Plan*. The first step is conducting a practice analysis that is used to collect data on the current practice of entry-level practical/vocational nurses (*Report of Findings from the ~~2003~~ 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice ~~[Smith & Crawford, 2003]~~* [NCSBN, 2006]). ~~Four thousand~~ Newly licensed practical/vocational nurses are asked about the frequency and priority of performing more than ~~150~~ 147 nursing care activities. ~~The activity statements~~ Nursing care activities are then analyzed in relation to the frequency of performance, ~~and the~~ impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes that are fundamental to the practice of nursing. The next step is ~~the writing~~ the development of the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are considered in the development of the test plan.

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

Beliefs

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

Nursing is both an art and a science. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and within the environment. The nature of nursing is continually evolving. Nursing practice is founded on a professional body of knowledge that integrates concepts from the biological, behavioral and social sciences. The goal of nursing is to promote comfort and quality health care. The nurse assists individuals throughout their life spans to attain optimal levels of functioning by responding to the needs, conditions and events that result from actual or potential health problems.

The practical/vocational nurse uses "specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 2003). The practical/vocational nurse uses a clinical problem-solving process (the nursing process) to collect and organize relevant health care data, assist in the identification of the health needs/problems throughout the client's life span and contribute to the interdisciplinary team in a variety of settings. The entry-level practical/vocational nurse demonstrates the essential competencies needed to care for clients with commonly occurring health problems that have predictable outcomes. "Competency implies knowledge, understanding, and skills that transcend specific tasks and is guided by a commitment to ethical/legal principles" (NAPNES, ~~2003~~ 2004).

Classification of Cognitive Levels

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

Test Plan Structure

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

Client Needs

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

Safe and Effective Care Environment
- Coordinated Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

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

Integrated Processes

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

- *Clinical Problem-Solving Process (Nursing Process)* – a scientific approach to client care that includes data collection, planning, implementation and evaluation.

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

- *Communication and Documentation* –verbal and nonverbal interactions between the practical/vocational nurse and clients, families, significant others and members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.

- *Teaching and Learning* – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting positive changes in behavior.

Distribution of Content

The percentage of test items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Report of Findings from the ~~2003~~ 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice ~~(Smith & Crawford, 2003)~~* (NCSBN, 2006), and expert judgment provided by members of the NCSBN Examination Committee.

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

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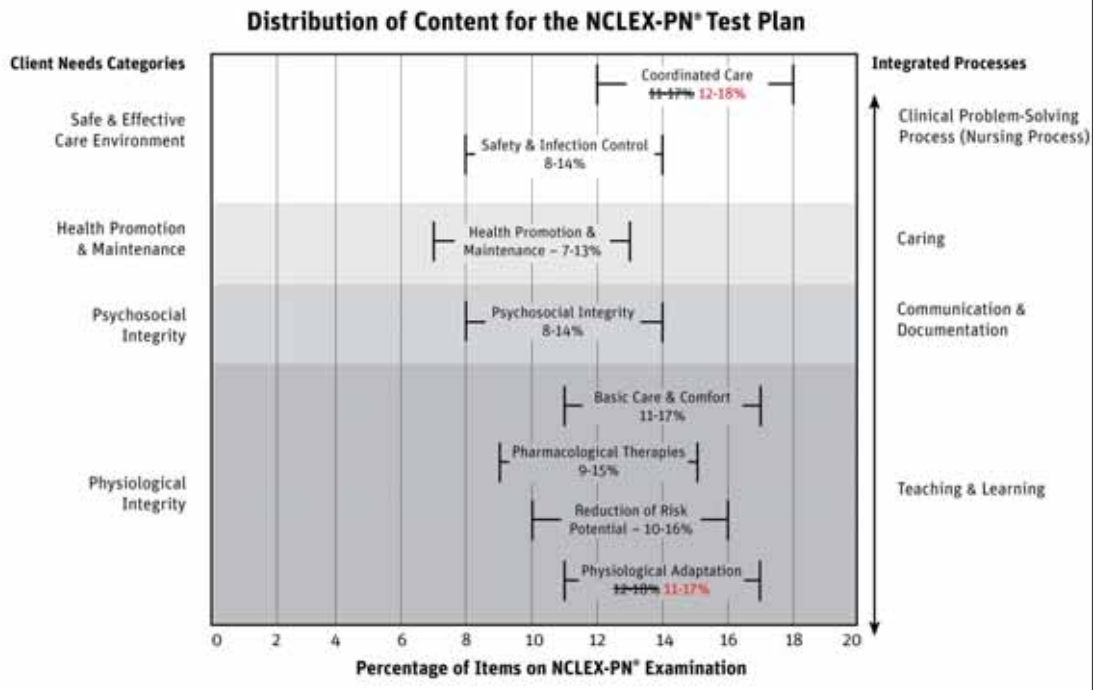

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Overview of Content

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

Safe and Effective Care Environment

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

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

  Related content includes but is not limited to:

  - Advance Directives
  - Advocacy
  - Client Care Assignments
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management and Supervision
  - Confidentiality/Information Security
  - ~~Consultation with Members of the Health Care Team~~
  - Continuity of Care
  - Establishing Priorities
  - Ethical Practice
  - Informed Consent
  - Information Technology
  - Legal Responsibilities
  - Performance Improvement (Quality ~~Assurance~~ Improvement)
  - Referral Process
  - Resource Management
  - Staff Education

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

  Related content includes but is not limited to:

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

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

Health Promotion and Maintenance

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

Related content includes but is not limited to:

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

Psychosocial Integrity

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

Related content includes but is not limited to:

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

Physiological Integrity

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

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

  Related content includes but is not limited to:

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

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

  Related content includes but is not limited to:

  - Adverse Effects
  - Contraindications and Compatibilities
  - Dosage Calculations
  - Expected Effects
  - Medication Administration
  - Pharmacological Actions
  - Pharmacological Agents
  - Side-Effects

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

  Related content includes but is not limited to:

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

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

  Related content includes but is not limited to:

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

Administration of the NCLEX-PN® Examination

The *NCLEX-PN® Examination* is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. An extensive multi-step process is followed in the development of items. Examination items are primarily four-option and multiple-choice. Other types of item formats include multiple response, fill-in-the-blank ~~(e.g., calculation, ordered response),~~ hotspot, drag and drop and chart/exhibits. All item formats, including standard multiple-choice, may have charts, tables or graphic images. For current information about alternate items access NCSBN's Web site http://www.ncsbn.org

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

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

Attachment B

Proposed 2008 NCLEX-PN® Test Plan – Clean Copy

NCLEX-PN® Test Plan 2008

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

Introduction

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

Several steps occur in the development of the *NCLEX-PN® Test Plan*. The first step is conducting a practice analysis that is used to collect data on the current practice of entry-level practical/vocational nurses (*Report of Findings from the 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* [NCSBN, 2006]). Newly licensed practical/vocational nurses are asked about the frequency and priority of performing more than 147 nursing care activities. Nursing care activities are then analyzed in relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes that are fundamental to the practice of nursing. The next step is the development of the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are considered in the development of the test plan.

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

Beliefs

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

Nursing is both an art and a science. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and within the environment. The nature of nursing is continually evolving. Nursing practice is founded on a professional body of knowledge that integrates concepts from the biological, behavioral and social sciences. The goal of nursing is to promote comfort and quality health care. The nurse assists individuals throughout their life spans to attain optimal levels of functioning by responding to the needs, conditions and events that result from actual or potential health problems.

The practical/vocational nurse uses "specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 2003). The practical/vocational nurse uses a clinical problem-solving process (the nursing process) to collect and organize relevant health care data, assist in the identification of the health needs/problems throughout the client's life span and contribute to the interdisciplinary team in a variety of settings. The entry-level practical/vocational nurse demonstrates the essential competencies needed to care for clients with commonly occurring health problems that have predictable outcomes. "Competency implies knowledge, understanding, and skills that transcend specific tasks and is guided by a commitment to ethical/legal principles" (NAPNES, 2004).

Classification of Cognitive Levels

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

Test Plan Structure

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

Client Needs

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

Safe and Effective Care Environment
- Coordinated Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

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

Integrated Processes

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

- *Clinical Problem-Solving Process (Nursing Process)* – a scientific approach to client care that includes data collection, planning, implementation and evaluation.

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

- *Communication and Documentation* –verbal and nonverbal interactions between the practical/vocational nurse and clients, families, significant others and members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.

- *Teaching and Learning* – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting positive changes in behavior.

Distribution of Content

The percentage of test items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Report of Findings from the 2006 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2006), and expert judgment provided by members of the NCSBN Examination Committee.

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

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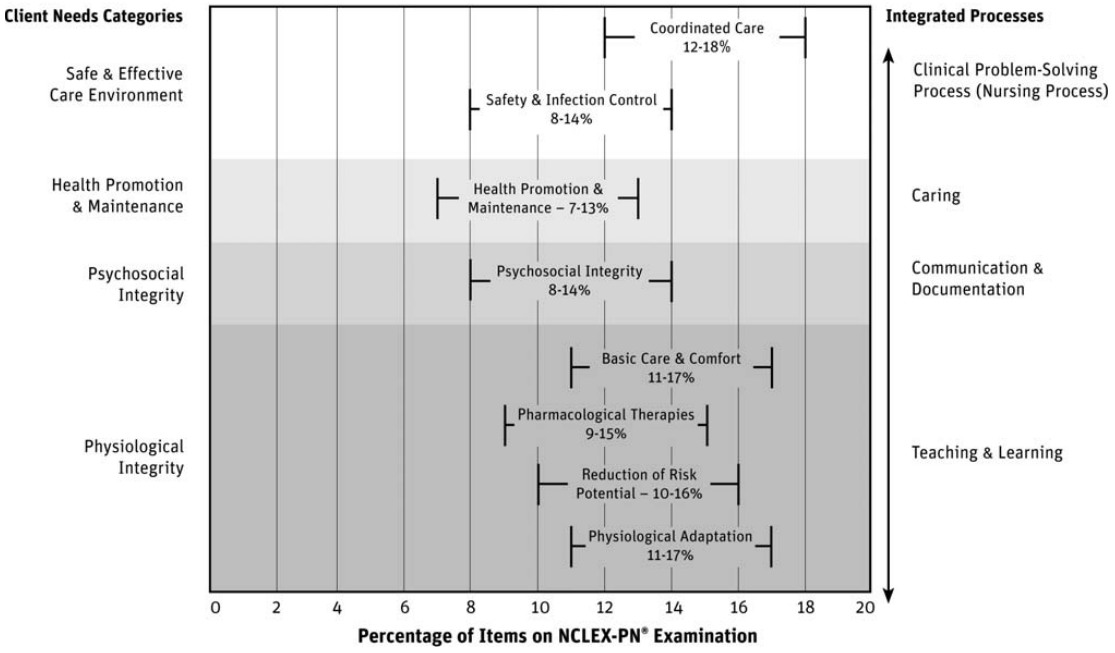
Distribution of Content for the NCLEX-PN® Test Plan



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3

Overview of Content

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

Safe and Effective Care Environment

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

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

  Related content includes but is not limited to:

  - Advance Directives
  - Advocacy
  - Client Care Assignments
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management and Supervision
  - Confidentiality/Information Security
  - Continuity of Care
  - Establishing Priorities
  - Ethical Practice
  - Informed Consent
  - Information Technology
  - Legal Responsibilities
  - Performance Improvement (Quality Improvement)
  - Referral Process
  - Resource Management
  - Staff Education

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

  Related content includes but is not limited to:

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

Health Promotion and Maintenance

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

Related content includes but is not limited to:

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

Psychosocial Integrity

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

Related content includes but is not limited to:

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

Physiological Integrity

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

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

  Related content includes but is not limited to:

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

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

  Related content includes but is not limited to:

  - Adverse Effects
  - Contraindications and Compatibilities
  - Dosage Calculations
  - Expected Effects
  - Medication Administration
  - Pharmacological Actions
  - Pharmacological Agents
  - Side-Effects

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

  Related content includes but is not limited to:

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

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

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

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

Administration of the NCLEX-PN® Examination

The *NCLEX-PN® Examination* is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. An extensive multi-step process is followed in the development of items. Examination items are primarily four-option and multiple-choice. Other types of item formats include multiple response, fill-in-the-blank hotspot, drag and drop and chart/exhibits. All item formats, including standard multiple-choice, may have charts, tables or graphic images. For current information about alternate items access NCSBN's website http://www.ncsbn.org

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

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

Attachment C

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

This report represents information gained during Pearson VUE's fourth full year of providing test delivery services for the NCLEX® examination program to the National Council of State Boards of Nursing, Inc. (NCSBN). This report summarizes the activities of the past year.

Pearson VUE Organizational Change

Beth Hassel assumed a new role working as the business development manager for the NCLEX program. In this role, she works with NCSBN primarily on contract-related items as well as project scopes. She also oversees the completion of enhancement requests.

Lisa Englund was assigned as the NCLEX program manager. Englund has been with Pearson VUE since 2002 working in Pearson Professional Centers (PPC) support, capacity management and program management.

Kelly Hauer was the program coordinator for the NCLEX program for the past four years. During 2006, she migrated into a program support specialist role on the program management team, supporting the NCLEX program.

Ellie Michalowski joined Pearson VUE in April 2006 as the NCLEX content manager. She has a master of science degree in nursing from Northern Illinois University and obtained her BSN from University of Illinois Chicago. Michalowski comes with a strong background in pain management, hospice care, pediatrics, obstetrics and public health. She has more than five years of experience in program management from a local public health department and pain service.

Pearson VUE Visits to NCSBN:

- Jan. 20, 2006 (Security Meeting)
- Jan. 26 – 27, 2006 (Examination Committee Business Meeting)
- March 8 – 10, 2006 (Item Review Subcommittee Meeting)
- March 13 – 15, 2006 (NCSBN Midyear Meeting)
- April 26 – 28, 2006 (Examination Committee Business Meeting)
- June 1, 2006 (Contract Evaluation Meeting)
- June 13 – 16, 2006 (Item Review Subcommittee Meeting)
- July 19, 2006 (Exam Committee Conference Call)
- July 31 – Aug. 4, 2006 (Annual Meeting)
- Aug. 15 – 18, 2006 (Item Review Subcommittee Meeting)
- Oct. 25 – 27, 2006 (Examination Committee Business Meeting)
- Dec. 5 – 8, 2006 (Item Review Subcommittee Meeting)

NCSBN Visits to Pearson VUE:

- Nov. 6, 2006 (Technical Summit): Pearson VUE hosted NCSBN staff for a Technical Summit. The agenda included discussion on: program discussion, CERTS, test delivery, data forensics and the test delivery channel. The meeting was very productive for both Pearson VUE and NCSBN, and it will be held annually moving forward.

Monthly Meetings/Conference Calls:

- Weekly conference calls between NCSBN, test development and operations.
- Monthly operations conference call between Pearson VUE and NCSBN.
- Conference calls between Pearson VUE and NCSBN content staffs are held periodically as needed.
- Other visits and conference calls are conducted on an as-needed basis.

Test Development

Psychometric and statistical analyses of NCLEX data continue to be conducted and documented as required. Pearson VUE staff are continuing to develop multiple-choice items as well as items in alternate formats, such as multiple-response, drag-and-drop ordered response and chart/exhibit items. Pearson VUE staff continue to focus on producing both the traditional and alternate-format items at targeted difficulty levels and in sufficient quantities to meet their contractual obligations.

Pearson VUE has begun a major initiative to refine the item coding and categorization process and definitions to make it possible to inventory the item pool and evaluate pool development needs more readily and effectively. The item development process has been enhanced from last year in several ways (e.g., revamping panelist orientation materials and changing how item writing workshops, sensitivity reviews and differential item functioning [DIF] panel meetings are conducted) to increase both productivity and effectiveness. In addition, Pearson VUE staff are actively participating in several Joint Research Committee (JRC) research initiatives aimed at enhancing the NCLEX item pools.

Summary of NCLEX Examination Results and Administration for the 2006 Calendar Year

Longitudinal summary statistics are provided in Tables 1 to 8 below. Results can be compared to data from the previous testing year to identify trends in candidate performance and item characteristics over time.

Compared to 2005, the overall candidate volumes were higher for both the NCLEX-RN® (about +14.3%) and NCLEX-PN® (about +8.3%). The RN passing rate for the overall group was 0.8 percentage points higher for this testing period than for the same period in 2005, and the passing rate for the reference group was 0.8 percentage points higher for this period compared to 2005. In 2005, the PN passing rates dropped 1.3 percentage points for the overall group and 1.2 percentage points for the reference group. These passing rates are consistent with expected variations in passing rates and are heavily influenced by demographic characteristics of the candidate populations and by changes in testing patterns from year to year.

The following points are candidate highlights of the 2006 testing year for the NCLEX-RN examination.

- Overall, 177,029 NCLEX-RN examination candidates tested during 2006, as compared to 154,908 during the 2005 testing year. This represents an increase of approximately 14.3%. (Tables 1 & 2)
- The candidate population reflected 110,712 first-time, U.S.-educated candidates who tested during 2006, as compared to 99,188 for the 2005 testing year, representing an 11.6% increase. (Tables 1 & 2)
- The overall passing rate was 73.8% in 2006 compared to 73.0% in 2005. The passing rate for the reference group was 88.1% in 2006 and 87.3% in 2005. (Tables 1 & 2)
- Approximately 50.7% of the total group and 54.0% of the reference group ended their tests after a minimum of 75 items were administered. This is slightly higher than the

2005 testing year, in which 48.9% of the total group and 51.9% of the reference group took minimum-length exams. (Tables 1 & 2)

- The percentage of maximum-length test takers was 14.3 for the total group and 12.7 for the reference group. This is slightly lower than last year's figures (15.8% for the total group and 14.5% for the reference group). (Tables 1 & 2)
- The average time needed to take the NCLEX-RN examination during the 2006 testing period was 2.45 hours for the overall group and 2.16 hours for the reference group (approximately the same as last year's average times of 2.50 and 2.23, respectively). (Tables 1 & 2)
- A total of 56.0% of the candidates chose to take a break during their examinations (compared to 56.8% last year). (Tables 1 & 2)
- Overall, 1.9% of the total group and 0.8% of the reference group ran out of time before completing the test. These percentages of candidates timing out were approximately the same as the corresponding percentages for candidates during the 2005 testing year (1.8% and 0.7%, respectively). (Tables 1 & 2)
- In general, the NCLEX-RN examination summary statistics for the 2006 testing period indicated patterns that were similar to those observed for the 2005 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following points are candidate highlights of the 2006 testing year for the NCLEX-PN examination:

- Overall, 70,822 PN candidates tested in 2006, as compared to 65,415 PN candidates tested during 2005. This represents an increase of approximately 8.3%. (Tables 5 & 6)
- The candidate population reflected 56,946 first-time, U.S.-educated candidates who tested in 2006, as compared to 53,214 for the 2005 testing year (an increase of approximately 7.0%). (Tables 5 & 6)
- The overall passing rate was 78.8% in 2006 compared to 80.1% in 2005, and the reference group passing rate was 87.9% in 2006 compared to 89.1% in 2005. (Tables 5 & 6)
- There were 55.9% of the total group and 60.6% of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly lower than those from the 2005 testing year in which 56.7% of the total group and 61.0% of the reference group took minimum-length exams. (Tables 5 & 6)
- The percentage of maximum-length test takers was 16.0% for the total group and 13.4% for the reference group. These figures are the same as last year's percentages. (Tables 5 & 6)
- The average time needed to take the NCLEX-PN examination during the 2006 testing period was 2.14 hours for the overall group, and 1.96 hours for the reference group (not appreciably different from last year's times of 2.15 and 1.97 hours, respectively). (Tables 5 & 6)
- Overall, 1.6% of the total group and 0.8% of the reference group ran out of time before completing the test (compared to last year's figures of 1.4% and 0.6%, respectively). (Tables 5 & 6)
- In general, the NCLEX-PN examination summary statistics for the 2006 testing period indicated patterns that were similar to those observed for the 2005 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.

NCLEX Examination Operations

NCSBN has approved Pearson VUE to deliver the NCLEX program in 18 international Pearson Professional Centers in 11 countries. The NCLEX is currently being administered in England, South Korea*, Hong Kong, Australia, Canada, Mexico, Germany, Taiwan, Japan and India. These additions raise the number of PPCs delivering the NCLEX to a total of 219 sites. At the request of NCSBN, the Puerto Rico PPC was transitioned to become an international testing center after its board of nursing changed its membership status with NCSBN. This change was implemented in mid-September 2006. Based on the Board of Directors' direction, Pearson VUE is planning to add Manila, Philippines, as an international testing center for the NCLEX program, and is anticipated to begin delivering NCLEX examinations in August 2007. International summary statistics are provided in Tables 9 through 12 on pages 122 to 128.

* Since the submission of this report by Pearson VUE, NCSBN's Board of Directors has suspended NCLEX administration at the Seoul, South Korea Pearson Professional Center (PPC).

Table 1: Longitudinal Technical Summary for the NCLEX-RN Examination: Group Statistics for 2006 Testing Year

	Jan. 06 – March 06		April 06 – June 06		July 06 – Sept. 06		Oct. 06 – Dec. 06		Cumulative 2006	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	36,513	23,280	46,531	30,964	65,369	47,491	28,616	8,977	177,029	110,712
Percent Passing	73.7	87.9	76.7	90.5	78.2	87.9	59.2	81.5	73.8	88.1
Ave. # Items Taken	119.5	113.6	118.4	112.3	121.8	118.5	128.7	123.6	121.5	116.1
% Taking Min # Items	52.6	56.5	52.6	56.5	50.0	52.0	47.0	49.9	50.7	54.0
% Taking Max # Items	13.5	11.8	13.0	11.3	14.4	13.5	17.2	15.3	14.3	12.7
Ave. Test Time	2.40	2.12	2.34	2.04	2.40	2.21	2.78	2.40	2.45	2.16
% Taking Break	53.8	44.7	52.3	41.8	54.8	48.4	67.7	54.5	56.0	46.3
% Timing Out	1.8	0.7	1.7	0.6	1.6	0.8	2.9	1.4	1.9	0.8

Table 2. Longitudinal Technical Summary for the NCLEX-RN Examination: Group Statistics for 2005 Testing Year

	Jan. 05 – March 05		April 05 – June 05		July 05 – Sept. 05		Oct. 05 – Dec. 05		Cumulative 2005	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	32,244	20,438	41,065	27,566	57,406	43,079	24,193	8,105	154,908	99,188
Percent Passing	71.8	87.1	76.3	90.7	77.0	86.4	59.7	80.7	73.0	87.3
Ave. # Items Taken	123.4	119.2	121.9	115.0	127.2	124.1	128.8	121.8	125.3	120.4
% Taking Min # Items	50.7	53.4	51.4	55.4	47.4	49.2	46.1	50.7	48.9	51.9
% Taking Max # Items	15.5	14.5	14.4	12.3	16.5	15.8	16.8	14.8	15.8	14.5
Ave. Test Time	2.46	2.21	2.42	2.09	2.48	2.31	2.71	2.32	2.50	2.23
% Taking Break	56.0	46.7	53.7	42.6	56.4	50.3	64.2	51.3	56.8	47.5
% Timing Out	1.6	0.7	1.7	0.5	1.5	0.8	2.8	1.2	1.8	0.7

Table 3: Longitudinal Technical Summary for the NCLEX-RN Examination: Item Statistics for 2006 Testing Year

Operational Item Statistics										
	Jan. 06 – March 06		April 06 – June 06		July 06 – Sept. 06		Oct. 06 – Dec. 06		Cumulative 2006	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.19	0.08	0.19	0.08	N/A	N/A
Z-Statistic	0.30	2.55	0.29	2.32	0.38	2.57	0.18	2.07	N/A	N/A
Ave. Item Time (secs)	69.7	16.4	69.3	19.7	68.9	19.7	76.4	30.4	N/A	N/A
Pretest Item Statistics										
# of Items	347		403		984		246		1980	
Ave. Sample Size	1,006		1,057		667		542		790	
Mean Point-Biserial	0.08		0.09		0.07		0.08		0.08	
Mean P+	0.54		0.56		0.56		0.59		0.56	
Mean B-Value	0.00		-0.07		-0.12		-0.32		-0.11	
SD B-Value	1.44		1.46		1.46		1.30		1.44	
Total Number Flagged	129		137		410		104		780	
Percent Items Flagged	37.2%		34.0%		41.7%		42.3%		39.4%	

Table 4. Longitudinal Technical Summary for the NCLEX-RN Examination: Item Statistics for 2005 Testing Year

Operational Item Statistics										
	Jan. 05 – March 05		April 05 – June 05		July 05 – Sept. 05		Oct. 05 – Dec. 05		Cumulative 2005	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.09	0.20	0.08	0.19	0.08	N/A	N/A
Z-Statistic	0.33	2.47	0.27	2.59	0.38	2.76	0.15	2.34	N/A	N/A
Ave. Item Time (secs)	72.3	26.2	68.5	19.7	66.6	15.8	73.3	17.5	N/A	N/A
Pretest Item Statistics										
# of Items	465		305		785		N/A		1,555	
Ave. Sample Size	597		1,133		581		N/A		694	
Mean Point-Biserial	0.08		0.07		0.09		N/A		0.08	
Mean P+	0.62		0.58		0.57		N/A		0.59	
Mean B-Value	-0.48		-0.39		-0.29		N/A		-0.37	
SD B-Value	1.5		1.8		1.73		N/A		1.68	
Total Number Flagged	195		143		333		N/A		671	
Percent Items Flagged	41.9%		46.9%		42.4%		N/A		43.2%	

Table 5: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2006 Testing Year

	Jan. 06 – March 06		April 06 – June 06		July 06 – Sept. 06		Oct. 06 – Dec. 06		Cumulative 2006	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	14,830	11,780	14,857	11,337	25,036	21,745	16,099	12,084	70,822	56,946
Percent Passing	78.3	88.2	75.9	86.9	83.9	90.0	74.1	84.6	78.8	87.9
Ave. # Items Taken	115.8	110.9	116.1	110.6	111.0	107.7	119.3	114.4	115.0	110.4
% Taking Min # Items	55.4	60.4	54.7	60.4	59.7	63.0	51.6	56.6	55.9	60.6
% Taking Max # Items	16.6	13.8	16.7	13.6	13.6	11.7	18.6	15.7	16.0	13.4
Ave. Test Time	2.17	1.98	2.21	1.99	2.02	1.89	2.25	2.05	2.14	1.96
% Taking Break	51.4	43.9	53.6	45.2	45.8	40.6	56.0	48.2	50.9	43.8
% Timing Out	1.5	0.7	1.9	0.8	1.2	0.7	1.9	0.9	1.6	0.8

Table 6. Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2005 Testing Year

	Jan. 05 – March 05		April 05 – June 05		July 05 – Sept. 05		Oct. 05 – Dec. 05		Cumulative 2005	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	15,041	12,090	12,221	9,211	22,839	19,931	15,314	11,982	65,415	53,214
Percent Passing	81.7	90.6	75.8	88.3	83.8	90.2	76.6	86.3	80.1	89.1
Ave. # Items Taken	113.1	108.1	116.4	111.1	111.9	108.8	118.7	114.6	114.6	110.4
% Taking Min # Items	57.6	62.5	55.1	60.4	60.3	63.5	51.6	55.9	56.7	61.0
% Taking Max # Items	14.9	11.7	17.0	13.9	14.3	12.6	18.7	16.2	16.0	13.4
Ave. Test Time	2.10	1.91	2.25	2.03	2.08	1.95	2.21	2.03	2.15	1.97
% Taking Break	47.4	39.8	54.9	46.1	47.5	42.3	53.8	46.5	50.3	43.3
% Timing Out	1.5	0.6	1.8	0.7	1.1	0.5	1.5	0.9	1.4	0.6

Table 7: Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2006 Testing Year

Operational Item Statistics										
	Jan. 06 – March 06		April 06 – June 06		July 06 – Sept. 06		Oct. 06 – Dec. 06		Cumulative 2006	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.19	0.07	0.20	0.07	0.20	0.08	N/A	N/A
Z-Statistic	0.18	2.56	0.14	2.11	0.26	2.16	0.16	2.43	N/A	N/A
Ave. Item Time (secs)	63.3	16	65.6	17.3	62.7	16.6	65.8	18.1	N/A	N/A
Pretest Item Statistics										
# of Items	198		198		683		594		1,673	
Ave. Sample Size	1,487		1,424		760		507		835	
Mean Point-Biserial	0.11		0.09		0.09		0.10		0.10	
Mean P+	0.52		0.51		0.50		0.55		0.52	
Mean B-Value	-0.03		0.09		0.21		-0.19		0.03	
SD B-Value	1.46		1.31		1.60		1.29		1.46	
Total Number Flagged	63		76		274		212		625	
Percent Items Flagged	31.8%		38.4%		40.1%		35.7%		37.4%	

Table 8. Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2005 Testing Year

Operational Item Statistics										
	Jan. 05 – March 05		April 05 – June 05		July 05 – Sept. 05		Oct. 05 – Dec. 05		Cumulative 2005	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.21	0.08	0.21	0.08	0.21	0.08	0.20	0.08	N/A	N/A
Z-Statistic	0.20	2.26	0.10	2.18	0.21	2.32	0.20	2.53	N/A	N/A
Ave. Item Time (secs)	65.1	19.5	64.8	17.9	61.3	16.2	64.0	16.2	N/A	N/A
Pretest Item Statistics										
# of Items	421		257		547		N/A		1225	
Ave. Sample Size	649		815		679		N/A		697	
Mean Point-Biserial	0.11		0.12		0.09		N/A		0.10	
Mean P+	0.61		0.60		0.52		N/A		0.57	
Mean B-Value	-0.56		-0.48		0.10		N/A		-0.25	
SD B-Value	1.44		1.36		1.89		N/A		1.67	
Total Number Flagged	141		69		235		N/A		445	
Percent Items Flagged	33.5%		26.8%		43.0%		N/A		36.3%	

Table 9. NCLEX International Test Center Volume by Member Board* (Jan. 1 – Dec. 31, 2006)

Member Board	Total	Bangalore, India	Burnaby (Vancouver), BC, Canada	Chennai, India	Chiyoda-ku (Tokyo)	Frankfurt, Germany	Hong Kong	Hyderabad, India	London, England	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico**	Seoul, South Korea	St. Leonards (Sydney), Australia	Taipei, Taiwan	Toronto, ON, Canada	Yokohama City, Japan
Alabama	13	0	0	0	0	0	11	0	0	0	0	0	0	2	0	0	0	0	0
Alaska	13	0	0	0	0	0	8	0	2	0	0	0	0	0	0	1	0	2	0
Arizona	216	19	1	31	0	0	57	4	35	0	0	1	60	2	0	2	1	3	0
Arkansas	8	0	0	0	0	0	4	0	1	0	0	0	0	1	0	1	0	1	0
California-RN	3,915	27	59	21	5	19	2,803	7	559	2	5	16	69	1	34	16	196	74	2
California-VN	2	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Colorado	26	0	0	0	0	1	15	0	6	0	1	0	0	0	0	2	0	1	0
Connecticut	90	14	0	8	0	0	55	2	0	0	0	6	2	0	0	0	0	3	0
District of Columbia	9	0	0	0	0	0	3	0	5	0	0	0	0	1	0	0	0	0	0
Florida	356	93	1	16	0	3	92	27	47	0	2	17	44	6	1	1	2	4	0
Georgia-PN	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Georgia-RN	61	0	0	0	0	1	23	1	29	0	0	0	0	6	0	1	0	0	0
Hawaii	58	0	0	2	2	2	39	1	11	0	0	0	1	0	0	0	0	0	0
Idaho	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Illinois	105	4	0	1	2	2	80	0	11	0	0	2	1	1	0	0	0	1	0
Indiana	5	1	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Kansas	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Kentucky	35	7	0	13	0	0	8	0	3	0	0	4	0	0	0	0	0	0	0
Louisiana-PN	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Maryland	104	1	0	0	0	0	75	2	20	0	0	0	0	0	0	1	2	3	0
Massachusetts	127	23	0	14	0	0	11	10	9	0	0	26	11	0	22	1	0	0	0
Michigan	138	36	0	12	0	1	43	6	1	0	2	22	6	0	0	1	1	7	0
Minnesota	150	0	43	0	0	1	6	0	2	1	15	0	0	0	3	0	0	79	0
Missouri	5	0	0	0	0	1	3	0	1	0	0	0	0	0	0	0	0	0	0
Nebraska	19	0	6	0	0	1	0	0	1	0	0	0	0	0	0	0	0	11	0
Nevada	140	12	1	14	0	0	85	9	6	0	0	3	3	0	1	0	5	1	0
New Hampshire	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0
New Jersey	150	1	0	0	0	1	90	1	7	0	0	15	32	0	1	1	1	0	0
New Mexico	1,853	121	1	74	0	9	654	17	753	1	0	97	48	1	24	16	32	5	0
New York	3,028	46	5	31	1	2	144	8	93	0	5	32	28	2	2,586	4	21	20	0
North Carolina	108	21	0	22	0	2	37	2	8	0	1	9	3	1	0	1	0	1	0
Northern Mariana Islands	441	1	0	0	1	0	408	0	9	0	0	0	0	0	11	0	10	0	1

* Only Member Boards with data are represented within this table.

** The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table 9. NCLEX International Test Center Volume by Member Board* (Jan. 1 – Dec. 31, 2006)

Member Board	Total	Bangalore, India	Burnaby (Vancouver), BC, Canada	Chennai, India	Chiyoda-ku (Tokyo)	Frankfurt, Germany	Hong Kong	Hyderabad, India	London, England	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico**	Seoul, South Korea	St. Leonards (Sydney), Australia	Taipei, Taiwan	Toronto, ON, Canada	Yokohama City, Japan
Ohio	39	0	1	0	0	0	17	1	17	0	0	0	0	2	0	1	0	0	0
Oklahoma	3	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0
Oregon	23	0	0	0	0	1	15	0	6	0	0	0	0	0	0	1	0	0	0
Pennsylvania	89	2	0	5	0	1	34	4	34	0	0	5	2	1	0	0	0	1	0
Puerto Rico*	15	0	0	0	0	0	0	0	0	0	0	0	0	15	0	0	0	0	0
Rhode Island	29	4	0	13	0	0	3	2	0	0	0	1	6	0	0	0	0	0	0
South Carolina	4	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
South Dakota	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	9	0	0	1	0	0	4	1	3	0	0	0	0	0	0	0	0	0	0
Texas	177	12	3	4	0	0	102	7	27	0	1	0	1	13	3	1	0	3	0
Utah	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Vermont	1,908	135	1	152	0	2	763	51	301	1	0	110	336	0	4	39	7	5	1
Virgin Islands	7	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0
Virginia	111	16	0	26	0	0	9	28	5	0	0	13	14	0	0	0	0	0	0
Washington	23	0	7	0	0	0	12	0	1	0	0	0	0	0	0	2	1	0	0
West Virginia-PN	5	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0
Wisconsin	14	1	0	5	0	0	3	0	0	0	0	0	5	0	0	0	0	0	0
Total	**13,640**	**598**	**130**	**465**	**11**	**51**	**5,734**	**191**	**2,014**	**5**	**32**	**379**	**673**	**62**	**2,692**	**93**	**279**	**227**	**4**

* Only Member Boards with data are represented within this table.

** The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table 10. NCLEX Exams Delivered by International Testing Center (Jan. 1 – Dec. 30, 2006)

Location	Total	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Bangalore India	598	0	0	0	54	62	57	73	61	84	64	44	99
Burnaby (Vancouver), Canada	130	0	0	0	7	13	13	18	19	19	16	11	14
Chennai, India	465	0	0	0	39	18	56	61	53	52	39	67	80
Chiyoda-ku (Tokyo), Japan	11	0	0	0	0	0	0	2	0	0	1	4	4
Frankfurt, Germany	51	0	0	0	2	4	4	6	2	9	7	11	6
Hong Kong	5,734	333	383	400	367	396	464	590	593	569	529	603	507
Hyderabad, India	191	0	0	0	7	1	11	6	26	25	27	35	53
London, United Kingdom	2,014	139	115	150	122	149	153	170	196	155	207	250	208
Mexico City, Mexico	5	0	0	0	0	0	0	2	0	2	0	1	0
Montreal, Canada	32	0	0	0	1	1	2	5	7	5	4	1	6
Mumbai, India	379	0	0	0	39	24	29	39	40	54	34	64	56
New Delhi, India	673	0	0	0	66	41	56	71	84	56	78	78	143
San Juan, Puerto Rico*	62	5	3	3	3	4	17	4	6	6	2	4	5
Seoul, South Korea	2,692	200	193	219	185	182	196	207	239	270	175	282	344
St. Leonards (Sydney), Australia	93	0	0	0	8	4	5	12	17	9	14	16	8
Taipei, Taiwan	279	0	0	0	27	27	28	26	32	26	25	43	45
Toronto, Canada	227	0	0	0	13	25	30	15	30	34	27	39	14
Yokohama City, Japan	4	0	0	0	0	0	0	1	0	1	2	0	0
Total	**13,640**	**677**	**694**	**772**	**940**	**951**	**1,121**	**1,308**	**1,405**	**1,376**	**1,251**	**1,553**	**1,592**

* The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table 11. NCLEX International Test Center Volume by Country of Education (Jan. 1 – Dec. 31, 2006)

Country	Total	Bangalore, India	Burnaby (Vancouver), BC, Canada	Chennai, India	Chiyoda-ku (Tokyo)	Frankfurt, Germany	Hong Kong	Hyderabad, India	London, England	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico*	Seoul, South Korea	St. Leonards (Sydney), Australia	Taipei, Taiwan	Toronto, ON, Canada	Yokohama City, Japan
Antigua and Barbuda	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Argentina	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Australia	32	0	0	0	0	0	6	1	4	0	0	0	0	0	1	20	0	0	0
Austria	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Barbados	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Belgium	4	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0
Botswana	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Bulgaria	5	0	0	0	0	1	1	0	3	0	0	0	0	0	0	0	0	0	0
Canada	203	0	52	0	0	1	0	1	2	1	25	0	0	0	3	0	0	118	0
China	167	0	3	0	0	0	146	0	7	0	0	0	1	0	1	3	1	5	0
Colombia	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Croatia	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Cuba	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Denmark	3	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0
Dominica	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Egypt	3	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0
Ethiopia	12	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0
Fiji	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Gambia	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Germany	13	0	0	0	0	8	0	0	4	0	0	0	0	0	0	1	0	0	0
Ghana	28	0	0	0	0	0	5	0	20	0	0	0	0	0	1	1	0	1	0
Grenada	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Guyana	9	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0
Hong Kong	6	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0
India	2,805	576	2	449	0	1	123	183	458	0	1	317	651	0	22	9	3	10	0
Indonesia	8	2	0	0	0	0	4	0	0	0	0	0	0	0	0	0	2	0	0
Iran	16	2	4	0	0	0	5	0	2	0	0	0	2	0	0	0	0	1	0
Ireland	8	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0
Israel	25	0	0	0	0	7	1	0	17	0	0	0	0	0	0	0	0	0	0
Italy	3	0	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0
Jamaica	22	0	0	0	0	0	0	0	22	0	0	0	0	0	0	0	0	0	0
Japan	10	0	1	0	4	0	0	0	0	0	0	0	0	0	3	0	0	0	2
Jordan	3	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0
Kenya	32	0	0	0	0	0	10	0	18	0	0	2	1	0	1	0	0	0	0

* The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table 11. NCLEX International Test Center Volume by Country of Education (Jan. 1 – Dec. 31, 2006)

Country	Total	Bangalore, India	Burnaby (Vancouver), BC, Canada	Chennai, India	Chiyoda-ku (Tokyo)	Frankfurt, Germany	Hong Kong	Hyderabad, India	London, England	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico*	Seoul, South Korea	St. Leonards (Sydney), Australia	Taipei, Taiwan	Toronto, ON, Canada	Yokohama City, Japan
Korea, North	6	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0
Korea, South	2,597	0	1	0	1	0	0	0	0	0	0	0	0	0	2,590	2	1	2	0
Kuwait	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Lebanon	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Lesotho	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Malaysia	6	0	0	0	0	0	4	0	1	0	0	0	0	0	0	0	1	0	0
Malta	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Mauritius	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Mexico	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Moldova	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Myanmar	5	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0
Namibia	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Nepal	2	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0
Netherlands	6	0	0	0	0	3	0	0	3	0	0	0	0	0	0	0	0	0	0
New Zealand	12	0	0	0	0	0	3	0	0	0	0	0	0	0	0	9	0	0	0
Nigeria	41	0	0	0	0	0	0	0	34	1	0	3	1	0	0	0	0	2	0
Northern Mariana Islands	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Norway	3	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0
Pakistan	6	0	0	0	0	0	1	0	3	0	0	0	0	0	0	0	0	2	0
Philippines	6,696	14	59	13	6	12	5,258	6	1,037	0	4	36	14	0	51	38	69	78	1
Pitcairn	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Poland	8	0	0	0	0	2	0	0	6	0	0	0	0	0	0	0	0	0	0
Puerto Rico	51	0	0	0	0	0	0	0	0	0	0	0	0	51	0	0	0	0	0
Romania	12	0	0	0	0	5	1	0	4	0	0	1	0	0	0	0	0	1	0
Russian Federation	5	0	0	0	0	1	0	0	3	0	0	0	1	0	0	0	0	0	0
Saint Lucia	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Saudi Arabia	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Sierra Leone	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Singapore	24	1	0	3	0	0	15	0	0	0	0	1	0	0	0	1	3	0	0
Somalia	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
South Africa	57	0	0	0	0	0	1	0	55	0	0	1	0	0	0	0	0	0	0
Spain	6	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0
Sri Lanka	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0

* The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table 11. NCLEX International Test Center Volume by Country of Education (Jan. 1 – Dec. 31, 2006)

Country	Total	Bangalore, India	Burnaby (Vancouver), BC, Canada	Chennai, India	Chiyoda-ku (Tokyo)	Frankfurt, Germany	Hong Kong	Hyderabad, India	London, England	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico*	Seoul, South Korea	St. Leonards (Sydney), Australia	Taipei, Taiwan	Toronto, ON, Canada	Yokohama City, Japan
St. Vincent and Grenadines	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Swaziland	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Sweden	5	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0
Switzerland	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
Taiwan	225	0	2	0	0	0	38	0	0	0	0	0	0	0	1	0	184	0	0
Thailand	87	0	0	0	0	0	76	0	0	0	0	0	0	0	0	0	11	0	0
Trinidad and Tobago	5	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0
Uganda	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0
Ukraine	28	0	0	0	0	0	0	0	27	0	0	0	0	0	0	0	0	1	0
United Arab Emirates	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
United Kingdom	181	0	1	0	0	1	1	0	174	0	0	0	0	0	0	3	0	1	0
United States	73	1	5	0	0	7	16	0	17	1	0	0	1	3	11	2	4	4	0
U.S. Minor Outlying Islands	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
Virgin Islands, British	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Virgin Islands, U.S.	3	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0
Zambia	20	0	0	0	0	0	2	0	18	0	0	0	0	0	0	0	0	0	0
Zimbabwe	9	0	0	0	0	0	0	0	7	0	0	0	0	0	0	2	0	0	0
Total	**13,640**	**598**	**130**	**465**	**11**	**51**	**5,734**	**191**	**2,014**	**5**	**32**	**379**	**673**	**62**	**2,692**	**93**	**279**	**227**	**4**

* The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Table. 12. NCLEX Exams Delivered and Pass Rates by International Testing Center

City/Country	Total Taken	Total Passed	Percent Passed	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Bangalore, India	598	502	83.9%	0.0%	0.0%	0.0%	81.5%	88.7%	86.0%	84.9%	88.5%	86.9%	87.5%	75.0%	76.8%
Burnaby (Vancouver), Canada	130	76	58.5%	0.0%	0.0%	0.0%	71.4%	76.9%	46.2%	55.6%	68.4%	63.2%	56.3%	54.5%	35.7%
Chennai, India	465	390	83.9%	0.0%	0.0%	0.0%	89.7%	100.0%	87.5%	88.5%	84.9%	82.7%	84.6%	77.6%	76.3%
Chiyoda-ku (Tokyo), Japan	11	5	45.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	75.0%	25.0%
Frankfurt, Germany	51	29	56.9%	0.0%	0.0%	0.0%	100.0%	50.0%	100.0%	66.7%	50.0%	55.6%	42.9%	54.5%	33.3%
Hong Kong	5,734	3,667	64.0%	67.3%	66.6%	68.8%	66.8%	66.4%	69.0%	63.2%	64.8%	61.0%	60.9%	60.7%	57.8%
Hyderabad, India	191	165	86.4%	0.0%	0.0%	0.0%	71.4%	100.0%	100.0%	83.3%	88.5%	96.0%	81.5%	85.7%	83.0%
London, United Kingdom	2,014	1,019	50.6%	43.2%	53.0%	59.3%	47.5%	48.3%	49.0%	52.4%	50.5%	60.6%	51.7%	44.4%	50.0%
Mexico City, Mexico	5	3	60.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Montreal, Canada	32	16	50.0%	0.0%	0.0%	0.0%	100.0%	100.0%	50.0%	60.0%	57.1%	40.0%	0.0%	0.0%	66.7%
Mumbai, India	379	294	77.6%	0.0%	0.0%	0.0%	66.7%	79.2%	86.2%	74.4%	85.0%	87.0%	76.5%	78.1%	67.9%
New Delhi, India	673	581	86.3%	0.0%	0.0%	0.0%	92.4%	87.8%	85.7%	91.5%	85.7%	87.5%	87.2%	79.5%	83.9%
San Juan, Puerto Rico*	62	18	29.0%	0.0%	0.0%	33.3%	66.7%	75.0%	23.5%	0.0%	33.3%	33.3%	0.0%	50.0%	40.0%
Seoul, South Korea	2,692	1,618	60.1%	67.0%	72.0%	63.9%	53.5%	63.7%	62.2%	58.0%	57.7%	61.1%	52.0%	55.3%	57.6%
St. Leonards (Sydney), Australia	93	52	55.9%	0.0%	0.0%	0.0%	62.5%	100.0%	100.0%	58.3%	64.7%	55.6%	42.9%	37.5%	37.5%
Taipei, Taiwan	279	149	53.4%	0.0%	0.0%	0.0%	59.3%	51.9%	46.4%	50.0%	56.3%	50.0%	60.0%	60.5%	46.7%
Toronto, Canada	227	101	44.5%	0.0%	0.0%	0.0%	30.8%	56.0%	46.7%	60.0%	43.3%	52.9%	29.6%	43.6%	28.6%
Yokohama City, Japan	4	1	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**13,640**	**8,686**	**N/A**	**9.9%**	**10.6%**	**12.5%**	**58.9%**	**63.6%**	**57.7%**	**60.9%**	**54.4%**	**59.6%**	**50.7%**	**51.8%**	**48.1%**

* The Puerto Rico testing center was considered an international testing site as of Sept. 16, 2006.

Report of the Practice, Regulation and Education (PR&E) Committee

Board of Directors' Recommendation

1. ***Adopt the model medication aide curriculum and proceed with the development of national medication aide competence assessment.***

   Rationale:
   The 2005 Delegate Assembly passed the following resolution: "Resolved that NCSBN conduct a job analysis, develop a model medication administration curriculum and conduct a feasibility study for administering a competency examination for medication assistive personnel. The results of the job analysis, course and feasibility study will be reported at the 2006 Delegate Assembly." The Model Curriculum for medication assistants-certified (MA-C) as proposed is a document that is reflective of the current health care environment and will assist Member Boards that now regulate or that may in the future regulate MA-Cs in their mission of public protection. It will allow for uniformity in the education of MA-Cs across Member Boards, and other agencies, that regulate this role.

   Fiscal Impact:
   None.

Background

2006 – 2007 CHARGES RELATED TO MEDICATION ASSISTANTS:

- Analyze results of the medication assistant job analysis and feasibility study and present the findings to the 2007 Delegate Assembly.
- Revise the medication assistant curriculum, based on feedback from NCSBN members, and present final curriculum to the 2007 Delegate Assembly.

The PR&E Committee members considered all comments regarding the MA-C curriculum that were made at the 2006 Delegate Assembly and revised the model MA-C curriculum accordingly (for details, see Attachments A and A1). The PR&E Committee reviewed the medication assistant job analysis and made recommendations to Anne Wendt (see Attachment B). Casey Marks presented the feasibility study for administering a medication assistant competency exam, and the committee gave him feedback.

2006 – 2007 CHARGES RELATED TO TRANSITIONING NEW NURSES TO PRACTICE:

- Develop an evidence-based model(s) for transitioning new nurses to practice.
- Advise staff on content for a Transition to Practice Summit in 2007.

Further details for these charges can be found in Attachments C and C1. PR&E Committee members planned and hosted a Transition Forum on Feb. 22, 2007, which attracted 200 nurses from regulation, education and practice. DVDs from the Transition Forum were sent to all the boards of nursing. As can be seen in Attachment C, PR&E Committee members prepared an evidence-based report on their work with transition and made recommendations for developing a national, standardized transition model. Attachment C1 is the executive summary of NCSBN's 2006 transition study, which was presented at the Transition Forum.

Members

Brenda Jackson, PhD, MSN, RN, Chair
Texas, Area III

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

Barbara Knopp, MS, RN
North Carolina, Area III

Barbara Newman, MS, RN
Maryland, Area IV

LePaine Sharp-McHenry, MS, FACDONA, RN, Arkansas, Area III

Therese Shipps, DNSc, RN
Maine, Area IV

Cynthia VanWingerden, MS, BSN, RN
U.S. Virgin Islands, Area IV

Debra Werner, MSN, RN
New Mexico, Area I

Mary Blubaugh, MSN, RN
Board Liaison, Kansas, Area II

Staff

Nancy Spector, PhD, RN
Director, Education

Suling Li, PhD, RN
Associate Director, Research

Mary Doherty, JD, RN
Associate, Practice, Regulation and Education

Meeting Dates

- Sept. 21 – 22, 2006
- Dec. 16, 2006 (Webinar)
- Feb. 21 – 23, 2007
- March 16, 2007 (Conference Call)
- June 14, 2007 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Provide effective education, information sharing and networking opportunities.

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Provides models and resources for evidence-based regulation to Member Boards.

Strategic Initiative V
Advance NCSBN as the leading source of data, information, and research regarding nursing regulation and related health care issues.

Strategic Objective 1
Conduct and support research that provides evidence regarding regulatory initiatives that support public protection.

2006 – 2007 CHARGE RELATED TO FACULTY QUALIFICATIONS AND RESOURCES:

- Explore faculty qualifications and the utilization of educational resources in collaboration with nursing education organizations.

PR&E Committee members collected data on this charge, surveying nursing organizations and the boards of nursing. See Attachment D, which is PR&E's report on the faculty survey sent to the boards of nursing. This survey queried the boards about the severity of the faculty shortage in each jurisdiction (36 boards of nursing responded) and about actions they are taking to alleviate the faculty shortage, while at the same time maintaining faculty qualifications. These data will be used by PR&E next year to make recommendations to the Board of Directors about innovative models for utilizing faculty.

PR&E Committee members also collected data (see Attachment D1) from the documents of several nursing organizations on the following areas of interest:

- Education of the nursing faculty member
- Definition of nursing education
- Definition of nursing faculty
- Adjunct faculty members, including preceptors
- Definition of and criteria for clinical experiences
- Definition of and criteria for didactic education.

The nursing organizations included: NCSBN (Model Administrative Rules, Evidence-Based Nursing Education for Regulation and Member Board Profiles), American Association of Colleges of Nursing (AACN), National Association for Practical Nurse Education & Service (NAPNES), National League for Nursing (NLN), National League for Nursing Accrediting Commission (NLNAC) and the Commission on Collegiate Nursing Education (CCNE). The organizations were all contacted by e-mail and given the opportunity to verify the information NCSBN collected. This document will be useful to PR&E for next year's charge of presenting innovative models for the effective utilization of faculty. The boards of nursing will also be interested in seeing how their qualifications compare with the other boards of nursing, NCSBN's model administrative rules, the national nursing accreditors and with the nursing education organizations.

During the September 2007 PR&E meeting, the members will hold a conference call with the above organizations to collect further information on any faculty initiatives that they are working with that address the faculty shortage. The committee members are especially interested in effective models on maintaining faculty qualifications while concomitantly working to alleviate the faculty shortage. It is hoped that this preliminary conversation will set the stage for some collaborative projects.

PR&E committee members also are recommending that NCSBN host a summit next year to address the faculty shortage and cooperative efforts to alleviate it. Possible topics include: implementing statewide clinical placement software, innovative projects with initiatives for alleviating the faculty shortage while maintaining qualifications, the regulatory perspective on the use of simulation (or other strategies) to complement nursing education and NCSBN's simulation study results. Many boards are now struggling with how simulation can be used in conjunction with clinical experiences with actual patients; the latter presentation could provide some direction to boards of nursing.

Highlights of FY07 Activities

- Reviewed the MA-C job analysis and made suggestions.
- Provided input on the feasibility study for developing and administering a competency exam for MA-Cs.

- Considered the input received from the Member Boards on the MA-C curriculum and revised the MA-C curriculum, and approved final version.
- Surveyed the boards of nursing to learn of the severity of the faculty shortage in their jurisdictions and about strategies they may be implementing to alleviate the faculty shortage.
- Collaborated with the nursing education organizations to develop a document that compares faculty qualifications across organizations.
- Reviewed the literature on transitioning new nurses to practice and the information presented at the 2007 Transition Forum and then wrote an evidence-based report on transition program recommendations.
- Held a national Transition Forum, Feb. 22, 2007, for regulators, educators and practice to address transition challenges from multiple perspectives. There were 200 attendees from 41 states and five countries represented. A DVD of the presentations was prepared and was sent to all boards of nursing.

Future Activities

- Explore the feasibility of designing a comprehensive national and standardized transition regulatory model, and make recommendations to the 2007 – 2008 Board of Directors.
- Advise staff on content for a Faculty Shortage Summit.
- Review and present innovative models for the utilization of nursing faculty.

Attachments

A. Medication Assistant-Certified (MA-C) Model Curriculum

A1. Quick Reference to MA-C Curriculum

B. PR&E Committee Medication Assistant Job Analysis Report

C. PR&E Committee Transition Report

C1. Transition Study

D. PR&E Committee Faculty Shortage Survey

D1. PR&E Committee Comparison of Faculty Qualifications in National Documents

Attachment A

Medication Assistant-Certified (MA-C) Model Curriculum

Preamble

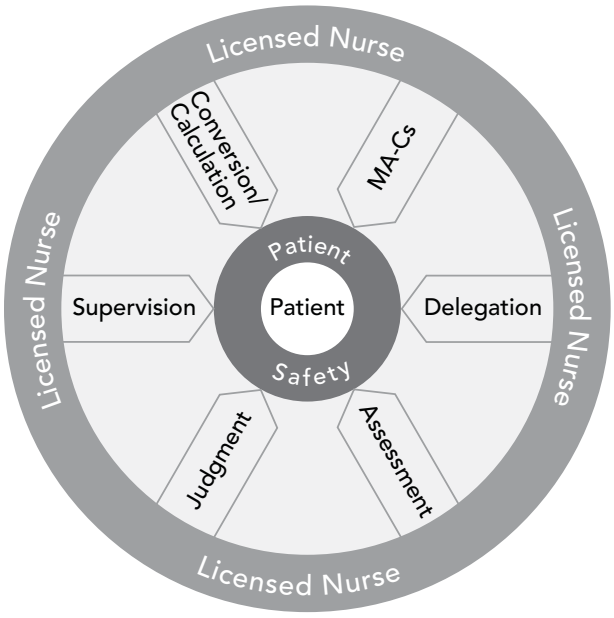
Background

At the 2005 Delegate Assembly, following a motion from the floor, the delegates passed this resolution: "Resolved that NCSBN conduct a job analysis, develop a model medication administration curriculum and conduct a feasibility study for administering a competency examination for medication assistive personnel. The results of the job analysis, course and feasibility study shall be reported to the 2006 Delegate Assembly."

The Practice, Regulation and Education (PR&E) Committee was charged with the execution of the resolution. A draft Model Curriculum for medication assistants-certified (MA-Cs) was presented to the Delegate Assembly in August 2006. Feedback was solicited, received and incorporated into the MA-C Model Curriculum, along with the results of the medication assistant job analysis. Documents reviewed included: medication assistant curriculums and other relevant state or territory documents; pharmacology texts; and national standards from organizations, such as the National Coordinating Council for Medication Error Reporting and Prevention, MEDMARX® and the National Quality Forum Endorsed Set of Safe Practices.

Overview

The purpose of this Model Curriculum is to provide the boards with a curriculum for MA-Cs that will assist the boards in their mission of public protection. Further, the curriculum will allow for uniformity in the education of MA-Cs across boards, and other agencies, that regulate this role. This comprehensive document can be adopted in full, or it can be adapted to meet the individual needs of jurisdictions. The goal of the Model Curriculum is to provide a document that is reflective of the current health care environment in states where MA-Cs are among the various unlicensed assistive personnel (UAPs) who assist in providing nursing-related functions to clients in many health care settings and other settings as well.



Under the state and territory practice acts, medication administration is the responsibility of licensed registered nurses (RNs) and licensed practical and vocational nurses (LPN/VNs). Licensed nurses may delegate selected tasks of medication administration to MA-Cs, and therefore licensed nurses are accountable for the delegation and supervision of MA-Cs. MA-Cs cannot replace the licensed nurse's role in the administration of medications, as nurses must still exercise their judgment when administering medications, such as deciding when to administer a PRN drug; assessing clients such as evaluating the need for, or response to, medication; educating the patient; and performing the conversions or calculations of drug dosages whenever necessary. The MA-C's role is to assist the nurse in one of the many tasks related to the safe administration of medication. See Figure 1 for an illustration of how the MA-Cs can assist licensed nurses to safely administer medications.

Because the mission of the boards of nursing is to protect the public, they have the responsibility to ensure that the nurses and other health care workers whom they regulate are safe and competent before they enter the workforce. Therefore, this curriculum requires that the MA-Cs be educated as a certified nursing assistant (CNA) before entering an MA-C program because those essential abilities are necessary before the MA-C can accept additional responsibilities related to these selected tasks of medication administration.

The model curriculum consists of 60 hours of didactic training, which will include work in a skills lab and/or simulation facility, in addition to 40 hours of supervised clinical practicum. The elements of this standardized curriculum include the essential content, practical/actual experience, demonstration of skills and a competency examination. The content modules comprising the didactic portion are provided in five modules. Assigned times are recommended, based on review of other MA-C curriculums and the experiences of those teaching these classes. Jurisdictions may choose to adjust the hours, considering the particular situation in their states or territories. Content areas in the curriculum include: medication fundamentals, safety, communication and documentation, medication administration, ethical and legal issues, and a practicum. There is an instructor's Quick Reference to the Curriculum available for assessing whether students have mastered the major content areas of the curriculum. Successful completion of a final comprehensive examination including content and performance of medication administration skills is required for certification. Once certified, the MA-C is minimally competent, at an entry-level position, to administer medications as described in the model curriculum to individuals, in settings as determined by state and federal laws, under the supervision of a licensed nurse.

The NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18, respectively) include MA-Cs as one of the nursing assistive personnel who should be regulated by boards of nursing. Qualifications for the MA-C in the NCSBN Model Act and Rules include: assistive personnel standards; range of functions; minimal qualifications including being a CNA, which includes additional training prior to administering medications; successful completion of a board-approved MA-C training program conducted in a manner that assures that clients receive safe and competent care; and successful completion of a board-approved competency examination. Minimal requirements for an MA-C, as are required for a CNA, must include the ability to read, speak, and write English, and demonstrate basic math skills. Continued competency throughout the career of the MA-C is also necessary, particularly given the increased complexity of care and the continued changes being made in the pharmacological management of clients.

Definition of Terms

Assessment – The gathering of objective and subjective information relative to a client, confirmation of the data and communication of the information (sources: *NCLEX-RN® Test Plan*; NCSBN's *Working with Others: A Position Paper,* 2005).

Assign – When a nurse directs an individual to do something the individual is authorized to do (source: *Joint Statement on Delegation*, American Nurses Association and National Council of State Board of Nursing, 2006).

Assignment – The distribution of work each staff member is responsible for during a given work period (source: *Joint Statement on Delegation*, American Nurses Association and NCSBN, 2006).

Certified Nursing Assistant (CNA) – CNAs are trained and certified to help nurses by providing nonmedical assistance to patients, such as help with bathing, dressing and using the bathroom (source: Centers for Medicaid and Medicare Services (CMS) http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=C&Language=English). Federal nurse aide training regulations are mandated in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). State-approved training programs must be a minimum of 75 hours and include 16 hours of supervised clinical training. Aides who complete the program are known as CNAs and are placed on the state registry of nursing aides. To maintain certification, all nurse aides must complete 12 hours of continuing education annually (source: Wikipedia http://en.wikipedia.org/wiki/Certified_Nursing_Assistant).

Delegation – The process for a nurse to direct another person to perform nursing tasks and activities (source: *Joint Statement on Delegation*, American Nurses Association and National Council of State Board of Nursing, 2006).

Gastrostomy Route – Medication/nutritional supplements are instilled through a tube into the stomach. (source: *Taber's Cyclopedic Medical Dictionary*, 18th Ed.).

Jejunostomy Route – Medication/nutritional supplements are instilled through a tube into the jejunum. (source: *Taber's Cyclopedic Medical Dictionary*, 18th Ed.).

Medication Assistant-Certified (MA-C) – An individual who receives specialized training preparing for a role in administering medications (with the exception of parenteral routes and enteral routes through nasogastric, gastrostomy or jejunostomy tubes) and who works under the supervision of a licensed nurse (source: Modified from NCSBN's *Working with Others: A Position Paper*).

Nasogastric Route – Medication/nutritional supplements are instilled through a tube that enters the nasal passage, proceeds through the esophagus and ends in the stomach. (source: *Taber's Cyclopedic Medical Dictionary*, 18th Ed.).

Parenteral – Denoting any medication route other than the alimentary canal such as intravenous, subcutaneous, intramuscular or mucosal (source: *Taber's Cyclopedic Medical Dictionary*, 18th Ed.).

Practicum – A progressive clinical experience under the supervision of a qualified instructor, where the instructor observes, evaluates and records the performance of the student.

Supervision – The provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a nursing task delegated to nursing assistive personnel (source: NCSBN's *Working with Others: A Position Paper*).

- Suggested minimal admission requirements:
  - Able to read, speak and write English
  - Competent in basic mathematics skills
  - Earned high school diploma or successfully passed the general educational development (GED) test
  - Certified nursing assistant (CNA)
  - 18 years old or older
  - Cardiopulmonary resuscitation (CPR) certification.

Module: Medication Fundamentals – Recommended 20 Hours of Didactic (including four hours of skills lab)

Objective/The Learner Will:	Content Outline	Evaluation Criteria
Describe the different documents on which medications can be ordered and recorded. Detail the elements of a complete medication order for safe administration. Discuss the various tasks to be performed for medications to be safely stored. Identify conditions necessitating disposal of medication or questioning an incomplete medication order.	**Medication Orders, Documentation, Storage and Disposal** A. Medication prescription/ order 1. Recorded on patient record 2. Complete order ▪ Signed ▪ Legible ▪ Drug name ▪ Dose ▪ Route ▪ Time ▪ Frequency 3. MA-C should not take verbal or telephone orders 4. Questioning an incomplete medication order B. Medication documentation system 1. Documentation of orders onto agency's medication document 2. Medication administration record (MAR) 3. Controlled substance medication log C. Medication Storage 1. Storage area 2. Medication room 3. Medication cart 4. Medication tray D. Disposal of outdated, contaminated or unused medication	Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module. Before actual patient contact, skills lab exercises and evaluations are recommended for: reading the elements of the order, discerning between the systems of measurement, observing the different forms of medications, practice with terminology and abbreviations, practicing the six rights of medication administration and practicing the basic steps of medication administration. **Suggested Reference** Member Boards or educational providers may provide additional resources to be used as reference as it is specific to that jurisdiction's needs. National Coordinating Council for Medication Error Reporting and Prevention Recommendations: www.nccmerp.org/council/council1999-06-29.html MEDMARX®: http://www.usp.org/patientSafety/medmarx/ National Quality Forum Recommendations: http://www.ahrq.gov/qual/nqfpract.htm Look-alike/Sound-alike drugs: http://www.jcaho.org/NR/rdonlyres/C92AAB3F-A9BD-431C-8628-11DD2D1D53CC/0/lasa.pdf
State the ways to measure medications.	**Mathematics, Weights and Measures** A. MA-C does not convert medications dosages. B. Systems of measurement 1. Apothecaries' system 2. Metric system 3. Common household measures 4. Roman numerals – drams or grains 5. Weight is grain 6. Volume is minim	
State the different forms in which medication can be manufactured.	**Forms of Medication** A. Liquid 1. Aerosol 2. Inhalant 3. Drops 4. Elixir 5. Spray 6. Solution 7. Suspension (needs mixing/shaking) 8. Syrup 9. Tincture B. Solid and semi-solids 1. Capsules 2. Tablet (dissolve) 3. Scored versus unscored 4. Caplets 5. Time-released 6. Covered with a special coating (not to be crushed) 7. Lozenges (dissolve) 8. Ointment 9. Paste 10. Powder 11. Cream 12. Lotion 13. Liniment	

<table>
<tr><th colspan="3">Module: Medication Fundamentals – Recommended 20 Hours of Didactic (including four hours of skills lab)</th></tr>
<tr><th>Objective/The Learner Will:</th><th>Content Outline</th><th>Evaluation Criteria</th></tr>
<tr><td rowspan="2">Recognize that the same medication may have different names.

Identify accepted abbreviations.

Recognize the abbreviations that should not be used.

List the different effects medications can cause, locally and systemically.

State the types of information that should be known about a specific medication prior to giving that medication.</td><td colspan="2">Medication Basics</td><td rowspan="4">Official JCAHO "Do Not Use List": http://www.jointcommission.org/NR/rdonlyres/2329F8F5-6EC5-4E21-B932-54B2B7D53F00/0/06_dnu_list.pdf</td></tr>
<tr><td>A. Terminology
1. Medication names
■ Generic
■ Brand or trade name
B. Abbreviations
1. Use standardized abbreviations, acronyms and symbols
2. Do not use abbreviations that should no longer be in use
C. Dosage range
D. Actions (how drug causes chemical changes in body)
E. Implications for administration (what medical conditions are treated by the drug)
F. Therapeutic effects (desired effect)
G. Side effects (reaction not part of main effect desired)
H. Precautions (anticipate or prepare for conditions that may change effect of drug)</td><td>I. Contraindications (condition making drug dangerous to use)
J. Allergic reactions (life threatening – anaphylaxis)
K. Adverse reactions (unpleasant or serious side effects, other than desired)
L. Tolerance (body adapts to drug and may be resistant/less effective)
M. Interactions
1. Specific administration information (e.g., do not take with grapefruit juice)
2. Certain classes of medications that should not be prescribed at the same time
N. Additive (synergistic) or antagonist effect
O. Idiosyncratic effect (drug has unusual effect)
P. Paradoxical effect (drug works in opposite way</td></tr>
<tr><td>List the three safety checks of medication administration.

Identify the six rights of medication administration.</td><td colspan="2">Safety and Rights of Medication Administration</td></tr>
<tr><td>A. Three safety checks:
1. When removing the medication package from storage (drawer/shelf)
2. When removing the medication from the package/container it is kept in
3. When returning the package to where it is stored</td><td>B. Six rights of medication administration
1. Right client
2. Right drug
3. Right dose
4. Right route
5. Right time
6. Right documentation</td></tr>
<tr><td>Describe basic steps of medication preparation prior to administration.</td><td colspan="2">Preparation and Actual Medication Administration</td></tr>
<tr><td>A. Wash hands
B. Review medications that require checking of pulse or blood pressure before administering
C. Identify the client
D. Introduce yourself
E. Explain what you are going to do</td><td>F. Glove if necessary
G. Position the client
H. Do what you explained
I. Wash your hands
J. Special considerations
K. Document</td></tr>
</table>

<table>
<tr><th colspan="4">Module: Communication and Documentation – Recommended Eight Hours of Didactic (including two hours of skills lab)</th></tr>
<tr><th>Objective/The Learner Will:</th><th colspan="2">Content Outline</th><th>Evaluation Criteria</th></tr>
<tr><td rowspan="3">Identify information needed about the patient and the medication prior to medication administration.</td><td colspan="2">Prevention of Medication Errors</td><td rowspan="4">Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module.

Before direct client contact, skills lab exercises and evaluations are recommended for safely administering a medication.

Suggested References:

Institute of Medicine's report brief on "Preventing Medication Errors": http://www.iom.edu/Object.File/Master/35/943/medication%20errors%20new.pdf

Institute of Medicine's fact sheet on "What You Can Do to Avoid Medication Errors": http://www.iom.edu/Object.File/Master/35/945/medication%20errors%20fact%20sheet.pdf

Member Boards or educational provider may provide additional resources to be used as reference as it is specific to that jurisdiction's needs.</td></tr>
<tr><td colspan="2">A. Know the following before administering medications:</td></tr>
<tr><td>1. Name (generic and trade)
2. Purpose
3. Effect
4. Length of time to take effect
5. Side effects</td><td>6. Adverse effects
7. Interactions
8. Special instructions
9. Where to get help</td></tr>
<tr><td rowspan="2">Identify common causes of medication errors.

State what steps should be taken when a medication error occurs.</td><td colspan="2">Causes and Reporting of Medication Errors</td></tr>
<tr><td>A. Failure to follow physician's orders exactly.
B. Failure to follow manufacturer's specifications/directions for use.
C. Failure to follow accepted standards for medication administration.</td><td>D. Failure to listen to a client's or family's concerns.
E. Notify the agency's nurse/supervisor/pharmacist/physician according to the agency policy.
F. Complete a medication error or incident report</td></tr>
</table>

Module: Communication and Documentation – Recommended Eight Hours of Didactic (including two hours of skills lab)		
Objective/The Learner Will:	**Content Outline**	**Evaluation Criteria**
Discuss building relationships (review from CNA training).	**Building Relationships** A. Review the communication process. B. Review barriers to effective listening and communication. C. Setting boundaries D. Review team building.	Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module. Before direct client contact, skills lab exercises and evaluations are recommended for practicing communication skills; practicing measurement of vital signs; and practicing documentation. **Suggested Reference** Member Boards or educational providers may provide additional resources to be used as reference as it is specific to that jurisdiction's needs. NCSBN's "A Nurse's Guide to the Importance of Appropriate Professional Boundaries": https://www.ncsbn.org/ProfessionalBoundariesbrochure.pdf NCSBN Learning Extension course: "Respecting Professional Boundaries" http://www.learningext.com/products/generalce/boundaries/boundariesabout.asp
State when the nurse must be notified of a change in the client's normal condition.	**Reporting of Symptoms or Side Effects** A. Observe, monitor and report any change that is different from the client's normal condition. B. Notify the nurse as soon as possible with as much information as available. C. Record changes.	
Discuss when the nurse should be notified about vital sign changes. State when the nurse should be notified of a client's pain. Identify other alterations of conditions that should be reported to the nurse.	**Report Any Change from the Client's Normal Condition** A. Temperature B. Pulse C. Respirations D. Blood Pressure E. Observe and report complaints of pain F. Other changes in condition (e.g., urinary output, mental status, activity, etc.).	
State documentation requirements for medication administration.	**Documentation of Medication Administration** A. Identifying initials and time on MAR. B. Circle and document the reasons that a client may not take a medication. C. PRN medication per facility/agency policy	
Explain the responsibilities of the delegating/supervising nurse when delegating medication administration to the MA-C.	**Role of the Delegating/Supervising Nurse** A. The nurse must determine the level of supervision, monitoring and accessibility she or he must provide for nursing assistive personnel. B. The nurse continues to have responsibility for the overall nursing care. C. To delegate effectively, nurses need to be able to rely on nursing assistive personnel's credentials and job descriptions, especially for a first time assignment. D. Nursing administration (typically through human resources/personnel) has the responsibility for validating credentials and qualifications of employees. E. Both nurse and MA-C need the appropriate interpersonal and communication skills and organizational support to successfully resolve delegation issues. F. Trust is central to the working relationships between nurses and assistive personnel. Good relationships have two-way communication, initiative, appreciation and willingness to help each other.	**Suggested References** NCSBN Model Practice Act relating to nursing assistive personnel: www.ncsbn.org/Model_Language_NAP.pdf ANA and NCSBN Joint Statement on Delegation: www.ncsbn.org/Joint_statement.pdf

<table>
<tr><th colspan="4">Module: Medication Administration – Recommended 20 Hours of Didactic (including two hours of skills lab)</th></tr>
<tr><th>Objective/The Learner Will:</th><th colspan="2">Content Outline</th><th>Evaluation Criteria</th></tr>
<tr><td rowspan="2">Identify common methods of medication administration.</td><td colspan="3">Routes of Administration</td><td rowspan="8">Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module. Before direct client contact, skills lab exercises and evaluations are recommended for practicing with routes of administration.
Suggested References
Member Boards or educational provider may provide additional resources to be used as reference as it is specific to that jurisdiction's needs.
Patient education for a metered-dose inhaler: http://familydoctor.org/040.xml and www.mayoclinic.com/health/asthma-inhalers/HQ01081

Poison Control Center: 1.800.122.2222</td></tr>
<tr><td>A. Oral
B. Buccal
C. Sublingual
D. Inhaler (metered dose)
E. Nebulizer</td><td>F. Nasal
G. Eye (ophthalmic)
H. Ear (otic)
I. Topical
J. Dressings</td><td>K. Soaks
L. Transdermal (e.g., patch)
M. Suppositories (rectal and vaginal)</td></tr>
<tr><td rowspan="2">Identify factors that may affect how the body uses medication.</td><td colspan="3">Factors Affecting How the Body Uses Medication</td></tr>
<tr><td>A. Age
B. Size
C. Family traits</td><td>D. Diet
E. Disease
F. Psychological issues</td><td>G. Gender and basic metabolic rate
H. Dosage</td></tr>
<tr><td rowspan="2">Identify the classifications of medications; state common effects of medication on the body.</td><td colspan="3">Classes of Medications Related to Body Systems and Common Actions</td></tr>
<tr><td>A. Antimicrobials
■ Controls or prevents growth of bacteria, fungus, virus or other microorganisms.
B. Cardiovascular
■ Corrects an irregular, fast or slow heart rate.
■ Prevents blood from clotting.
■ Lowers blood pressure.
C. Dermatological
■ Antiinfective
■ Antiinflammatory
D. Endocrine
■ Antidiabetic
■ Reduces inflammation
■ Hormones
E. Gastrointestinal
■ Promotes bowel movements
■ Antacids
■ Antidiarrheal
■ Reduces gastric acid</td><td>F. Musculoskeletal
■ Relaxes muscles
G. Neurological
■ Prevents seizures
■ Relieves pain
■ Lowers body temperature
■ Anti-Parkinsonian
■ Antidepressants
■ Promotes sleep
■ Relieves anxiety
■ Antipsychotics
■ Mood stabilizer
H. Nutrients/Vitamins/Minerals
■ Replaces chemicals missing or low in the body
I. Respiratory
■ Decreases mucus production
■ Bronchodilation
■ Cough depressant/expectorant
■ Decongestant</td><td>I. Respiratory
■ Decreases mucus production
■ Bronchodilation
■ Cough depressant/expectorant
■ Decongestant
J. Sensory
■ Antiglaucoma
■ Artificial tears
■ Earwax emulsifiers
K. Urinary
■ Increase water loss through kidneys</td></tr>
<tr><td>Identify resource materials and professionals to contact for clarification of medication questions.</td><td colspan="3">Location of Resources and References</td></tr>
<tr><td colspan="2">A. Nurse
B. Pharmacist
C. Physician</td><td colspan="2">D. Package/drug insert (brochure)
E. Drug reference manuals</td></tr>
</table>

Module: Ethical and Legal – Recommended Five Hours (including one hour of skills lab)		
Objective/The Learner Will:	**Content Outline**	**Evaluation Criteria**
Identify when a delegated task should or should not be performed by the MA-C. Recognize when and how to report errors. Recognize what should be reported to the licensed nurse.	**Role of MA-C** A. MA-C may perform a task involving administration of medications if: 1. MA-C's assignment is to administer medications under the supervision of a licensed nurse in accordance with provisions of this act and rules; and 2. The delegation is not prohibited by any provision of this act and rules. B. Role of the MA-C includes medication administration as a delegated nursing function under nursing supervision. The following acts **shall not** be delegated to MA-C: 1. Conversion or calculation of medication dosage; 2. Assessment of client need for or response to medication; 3. Nursing judgment regarding the administration of PRN medications; or 4. Medications to be given via parenteral routes and through nasogastric, gastrostomy or jejunostomy routes. C. MA-C **shall not** perform a task involving the administration of medication if: 1. The medication administration requires an assessment of the client's need for medication, a calculation of the dosage of the medication or the conversion of the dosage; 2. The supervising nurse is unavailable to monitor the progress of the client and the effect on the client of the medication; or 3. The client is not stable or has changing needs. D. Any MA-C who has any reason to believe that he/she has made an error in the administration of medication shall follow facility policy and procedure to report the possible or known error to the appropriate superior and shall assist in completing any required documentation of the medication error. E. Medication Administration Policies 1. MA-C shall report to the supervising nurse: a. Signs or symptoms that appear life-threatening; b. Events that appear health-threatening; and c. Medications that produce no results or undesirable effects as reported by the client. 2. A licensed nurse shall supervise MA-C. 3. A licensed nurse shall review periodically the following: a. Authorized provider orders; and b. Client medication records.	Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module. Before direct client contact, skills lab exercises and evaluations are recommended for practicing delegation. **Suggested Reference** Member Boards or educational provider may provide additional resources to be used as reference as it is specific to that jurisdiction's needs. NCSBN Model Practice Act, relating to nursing assistive personnel: https://www.ncsbn.org/Model_Language_NAP.pdf ANA and NCSBN Joint Statement on Delegation: https://www.ncsbn.org/Joint_statement.pdf

Module: Ethical and Legal – Recommended Five Hours (including one hour of skills lab)		
Objective/The Learner Will:	**Content Outline**	**Evaluation Criteria**
Distinguish between the tasks a MA-C can and cannot accept. Define redelegation. Identify skills that enhance the delegation process.	**The responsibility of MA-C when accepting delegation tasks** A. The MA-C has the responsibility not to accept a delegation that she/he knows is beyond her/his knowledge and skills. B. Delegation is client specific. Having done a task for one client does not automatically mean assistive personnel can do the task for all clients. In addition, delegation is also situation specific; doing a task for one client in one situation does not mean the nursing assistive personnel may perform that task for this client in all situations. C. A task delegated to assistive personnel cannot be redelegated by the nursing assistive personnel. D. The MA-C is expected to speak up and ask for training and assistance in performing the delegation, or request not to be delegated a particular task/ function/activity. E. Both nurse and MA-C need the appropriate interpersonal and communication skills and organizational support to successfully resolve delegation issues.	Successful completion of the objectives is demonstrated through multiple-choice examinations, return demonstrations or other appropriate measure of achieving the outcomes of the module. **Suggested Reference** Member Boards or educational provider may provide additional resources to be used as reference as it is specific to that jurisdiction's needs. NCSBN Model Practice Act relating to nursing assistive personnel: www.ncsbn.org/Model_Language_NAP.pdf NCSBN's "A Nurse's Guide to the Importance of Appropriate Professional Boundaries": www.ncsbn.org/professionalBoundaries brochure.pdf NCSBN Learning Extension course: "Respecting Professional Boundaries" http://www.learningext.com/products/generalce/boundaries/boundariesabout.asp
Describe the rights of the client.	**Rights of Individuals** A. Maintaining confidentiality B. Respecting client's rights C. Respecting client's privacy D. Respecting client's individuality and autonomy E. Communicating respectfully F. Respecting client's wishes whenever possible G. Right to refuse medication H. Right to be informed	
Discuss the types of abuse that must be reported. Describe examples of the types of legal problems that can occur.	**Specific Legal and Ethical Issues** A. Abuse and/or neglect 1. Identify types of abuse a. Physical b. Verbal c. Psychological d. Sexual e. Financial 2. Preventive measures 3. Duty to report B. Exposure to medical malpractice/ negligence claims/ lawsuits C. Fraud D. Theft E. Diversion	
List the three steps to take before medication is safe to give. Recognize the numerous rights that must be followed before and after medication is administered.	**Safety and Rights of Medication Administration** A. Review the three safety checks B. Review the six rights of medication administration	

Module: Practicum		
Objective/The Learner Will:	**Content Outline**	**Evaluation Criteria**
Demonstrate safe administration of medications to clients in a clinical setting.	40 hours of supervised clinical practicum, which should be progressive, where the instructor observes medication administration; gradually, the instructor increases the number of clients to whom the student administers medications.	Successfully complete all assigned skills per a checklist, which incorporates the didactic modules of: 1. Medication fundamentals 2. Safety 3. Communication and documentation 4. Medication administration 5. Ethical and legal issues **Suggested Reference** CMS Web site: http://www.cms.hhs.gov/Manuals/

Attachment A1

Quick Reference to Medication Assistant-Certified (MA-C) Curriculum

The nurse *shall not* delegate to MA-C any of the following acts:

A. Conversion or calculation of drug dosage
B. Assessment of client need for or response to medication
C. Nursing judgment regarding the administration of PRN medications
D. Medications to be given via parenteral routes and nasogastric, gastrostomy or jejunostomy routes.

Medication Fundamentals

Medication Orders, Documentation, Storage and Disposal:

❒ Medication prescription/order	❒ Medication storage
❒ Medication documentation system	❒ Disposal of outdated, contaminated or unused medication

Mathematics, Weights and Measures:

❒ MA-C does not convert medication dosages	❒ Systems of measurement

Forms of Medication:

❒ Liquid	❒ Solid and semi-solid

Medication Basics:

❒ Terminology	❒ Therapeutic effects	❒ Adverse reactions
❒ Abbreviations	❒ Side effects	❒ Tolerance
❒ Dosage range	❒ Precautions	❒ Interactions
❒ Actions	❒ Contraindications	❒ Additive or antagonist effect
❒ Implications for administration	❒ Allergic reactions	❒ Idiosyncratic effect
		❒ Paradoxical effect

Safety and Rights of Medication Administration:

❒ Three safety checks	❒ Six rights of medication administration

Preparation and Actual Medication Administration:

❒ Wash hands before	❒ Introduce yourself	❒ Do what you explained
❒ Review medications that require checking of pulse or blood pressure before administering	❒ Glove if necessary	❒ Wash hands after
	❒ Position the client	❒ Special considerations
❒ Identify the client	❒ Explain what you are going to do	❒ Document

Safety

Prevention of Medication Errors:

❒ What to know before administering medications

Causes and Reporting of Medication Errors:

❒ Failure to follow physician's orders	❒ Failure to follow accepted standards	❒ Follow policy to notify care providers
❒ Failure to follow manufacturer's directions	❒ Failure to listen to client or family	❒ Complete a medication error report

Note: This Quick Reference document is a two-page handout. It appears here on three pages for the sake of consistency and readability.

Communication and Documentation

Building Relationships:

- ❒ Review the communication process
- ❒ Review barriers to effective listening and communications
- ❒ Setting boundaries
- ❒ Review team building

Reporting of Symptoms or Side Effects:

- ❒ Observe, monitor and report any change that is different from the client's normal condition
- ❒ Notify the nurse as soon as possible with as much information as is available
- ❒ Record changes

Report Any Change from the Client's Normal Condition:

- ❒ Temperature
- ❒ Pulse
- ❒ Respirations
- ❒ Blood pressure
- ❒ Observe and report complaints of pain
- ❒ Other changes in condition

Documentation of Medication Administration:

- ❒ Identifying initials and time on medication administration record (MAR)
- ❒ Circle and document the reasons that a client may not take a medication
- ❒ PRN medication per facility/agency policy

Role of the Delegating/Supervising Nurse:

- ❒ Nurse determines level of supervision, monitoring and accessibility to be provided for nursing assistive personnel.
- ❒ Nurse continues to have responsibility for the overall nursing care.
- ❒ To delegate effectively, nurses need to be able to rely on nursing assistive personnel's credentials and job descriptions.
- ❒ Nursing administration has the responsibility for validating credentials and qualifications of employees.
- ❒ Both nurse and MA-C need the appropriate interpersonal and communication skills, and organizational support.
- ❒ Trust is central to the working relationship.

Medication Administration

Routes of Administration:

- ❒ Oral
- ❒ Buccal
- ❒ Sublingual
- ❒ Inhaler (metered dose)
- ❒ Nebulizer
- ❒ Nasal
- ❒ Eye (opthalmic)
- ❒ Ear (otic)
- ❒ Topical
- ❒ Dressings
- ❒ Soaks
- ❒ Transdermal (e.g., patch)
- ❒ Suppositories (rectal and vaginal)

Factors Affecting How the Body Uses Medication:

- ❒ Age
- ❒ Size
- ❒ Family Traits
- ❒ Diet
- ❒ Disease
- ❒ Psychological issues
- ❒ Gender and base metabolic rate
- ❒ Dosage

Classes of Medications Related to Body Systems and Common Actions:

- ❒ Antimicrobials
- ❒ Cardiovascular
- ❒ Dermatological
- ❒ Endocrine
- ❒ Gastrointestinal
- ❒ Musculoskeletal
- ❒ Neurological
- ❒ Nutrients/vitamins/minerals
- ❒ Respiratory
- ❒ Sensory
- ❒ Urinary

Location of Resources and References:

- ❒ Nurse
- ❒ Pharmacist
- ❒ Physician
- ❒ Package/drug insert
- ❒ Drug reference materials

Ethical and Legal Issues

Role of MA-C:

- ❒ Task is a delegated nursing function under nursing supervision.
- ❒ The following acts *shall not* be delegated to MA-Cs:
  1. Conversion or calculation of medication dosage;
  2. Assessment of client need for or response to medication;
  3. Nursing judgment regarding the administration of PRN
  4. Medications or medications to be given via parenteral routes and through nasogastric, gastrostomy or jejunostomy routes.
- ❒ May perform a task involving administration of medications if:
  1. The MA-C's assignment is to administer medications under the supervision of a licensed nurse in accordance with provisions of this act and rules; and
  2. The delegation is not prohibited.
- ❒ *Shall not* perform a task involving the administration of medication if:
  1. The medication administration requires an assessment of the client's need for medication, a calculation of the dosage of the medication or the conversion of the dosage;
  2. The supervising nurse is unavailable to monitor the progress of the client and the effect on the client of the medication; or
  3. The client is not stable or has changing needs.
- ❒ If there is any error in the administration of medication, follow facility policy and procedure to report.
- ❒ Follow medication administration policies.

Responsibility of MA-C When Accepting Delegated Tasks:

- ❒ Not to accept a delegation that is beyond MA-Cs knowledge and skills.
- ❒ Delegation is client specific.
- ❒ Task cannot be redelegated by MA-C.
- ❒ Speak up, ask for training and assistance in performing the delegation, or request not to be delegated particular task.
- ❒ Need the appropriate interpersonal and communication skills.

Rights of Individuals:

- ❒ Maintaining confidentiality
- ❒ Respecting client's rights
- ❒ Respecting client's privacy
- ❒ Respecting client's individuality and autonomy
- ❒ Communicating respectfully
- ❒ Respecting client's wishes whenever possible
- ❒ Right to refuse medication
- ❒ Right to be informed

Specific Legal and Ethical Issues:

- ❒ Abuse and/or neglect
- ❒ Exposure to legal claims/lawsuits
- ❒ Fraud
- ❒ Theft
- ❒ Diversion

Safety and Rights of Medication Administration:

- ❒ Three safety checks
- ❒ Six rights of medication administration

Practicum

Supervised and Progressive Clinical Experience in Administering Medications that Incorporates the Didactic Modules of:

- ❒ Medication fundamentals
- ❒ Safety
- ❒ Communication and documentation
- ❒ Medication administration
- ❒ Ethical and legal issues

Attachment B

PR&E Committee
Medication Assistants Job Analysis Report

March 25, 2007

Background and Procedure

At the 2005 NCSBN Annual Meeting, the Delegate Assembly approved a resolution that "NCSBN conduct a job analysis, develop a model medication administration curriculum and conduct a feasibility study for administering a competency examination for medication assistive personnel. The results of the job analysis, course and feasibility study shall be reported at the 2006 Delegate Assembly." To that end, NCSBN conducted a medication assistant (MA) job analysis.

In preparation, the study protocol for this practice analysis was reviewed and approved by NCSBN's executive director for compliance with organizational guidelines for research studies involving human subjects. Moreover, an External Panel of Practice Analysis Methodology Experts (see Table 1) reviewed and approved the methodology used for the MA practice analysis.

In the fall of 2005, boards of nursing were asked to submit the names of nurses who were familiar with MA activities in a variety of settings in order to serve on a panel of subject matter experts (SMEs) (see Table 2). There were 13 nurses and one certified MA selected to serve on the panel. All of the major practice settings, nursing specialties and NCSBN geographic areas were represented by the panel members. In addition, two representatives from the Practice, Regulation and Education (PR&E) Committee served as liaisons to the panel, which met Dec. 1 – 3, 2005. All of the members of the panel participated and there was no domination by any one member of the panel.

Prior to the SME panel meeting, members were asked to submit daily logs from at least three MAs working in their setting. In addition, panelists submitted job orientation guidelines, procedure manuals, evaluation checklists and job descriptions. All of the aforementioned documents, as well as MA curricula, were used by the expert panelists to develop a comprehensive list of MA activities. After an extensive orientation to the project, the panel created a final list of 104 MA activities. In addition, the panel provided feedback on how to access the names of MAs in a variety of settings (e.g., schools, home health, long-term care, assisted living) in order develop a list of names from which to draw a "representative" sample.

The PR&E Committee reviewed the general methodology, the activity statements and survey form at their January 2006 meeting. In addition, the committee requested that MAs in a variety of settings be included in the sample and that the survey instrument be pilot tested and the results used as needed for revisions.

The survey instrument was pilot tested in February 2006. The survey was conducted in May and June of 2006 and results were reviewed by the PR&E Committee members at their September 2006 meeting.

Results

There were 7,000 surveys mailed, 1,433 returned, and of those, 1,288 were analyzable with a response rate of 22.5%. The characteristics of the respondents were:

- Gender = 91.9% Female
- Average Age = 43 years
- Ethnicity = 64.6% White/Non-Hispanic, 20.4% African American and 6.9% Hispanic

- Years of Experience = 20.8% 1 year or less; 38.1% 2 to 5 years; 19.5% 6 to 10 years; 9.3% 11 to 15 years; and 12.2% more than 15 years.

The preparation of these MAs included:

- 49.8% received training from their employer
- 89.4% were required to complete specific MA training
- The majority had 60 hours or less of classroom training and 40 hours or less of clinical training
- 77.1% said that being a certified nursing aide (CNA)/assistant was an additional requirement to become an MA
- 67.6% said a high school diploma/GED was required.

The majority of the MAs worked in the following settings:

- Worked in long-term care facilities (56.1%)
- Worked eight hours per shift (53.6%)
- Worked an average 28.89 hours each week
- Cared for clients aged 65 to 85 years (77.6%)
- Cared for clients with behavioral/emotional conditions (66.9%), stable chronic conditions (59.9%) and those at the "end of life" (52.0%)
- Administered medication to an average of 28 clients per shift.

There were a total of 104 activity statements in the survey with a reliability estimate of 0.98 for the survey instrument. Additionally, 79.5% of respondents thought the activities were representative of their practice.

Those activities performed by the fewest respondents were:

- "Administer medications by nasogastric (NG) tube" (89.10% not performed)
- "Mix insulin from two different vials for client" (88.08% not performed).

Those activities performed by the most respondents were:

- "Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment (PPE)" (1.50% not performed)
- "Maintain clean work environment" (1.43% not performed).

Those activities that received the lowest total group mean frequency ratings were:

- "Perform Cardiopulmonary Resuscitation (CPR)" (0.3)
- "Initiate emergency care for a client who is choking" (0.5).

Those activities that received the highest total group mean frequency ratings were:

- "Use six 'rights' when administering medications (right drug, right dose, right client, right time, right route, right documentation)" (3.78)
- "Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment [PPE])" (3.87).

Those activities with the lowest importance rating were:

- "Participate in performance improvement/quality assurance activity (e.g. collecting data, serving on performance improvement committee)" (2.96)
- "Use restraints according to agency policy" (2.97).

Those activities with the highest importance rating were:

- "Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment [PPE])" (3.94)
- "Use six 'rights' when administering medications (right drug, right dose, right client, right time, right route, right documentation)" (3.96).

The mean importance ratings were similar across years of experience, and similarly the mean importance ratings for most of the activity statements were comparable for the various work settings. Likewise, the mean importance ratings for the activity statements were consistent based on NCSBN's four geographic areas.

Conclusions

A nonexperimental, descriptive study was conducted to explore the importance and frequency of activities performed by MAs. Results of this study can be used to determine MA practice across various work settings, years of experience and the four NCSBN geographic areas.

Table 1: External Practice Analysis Methodology Experts

Name	Affiliation	Biography
Barbara Showers, PhD	Wisconsin Department of Regulation & Licensing Office of Education and Examination	Director of Wisconsin's Department of Regulation & Licensing's Office of Education and Examination. Showers is nationally recognized as an expert in licensure testing and has substantial experience with regard to the defensibility of licensure tests.
Richard Smith, PhD	*Journal of Applied Measurement*	Editor of the *Journal of Applied Measurement* and a well-published scholar who specializes in testing and measurement. Smith has supervised the development of licensing examinations and is very knowledgeable regarding practice analyses and issues regarding connecting test content to practice.
Jim Fidler, PhD	American Medical Technologists	Director of Testing and Competency Assurance for the American Medical Technologists. Fidler has more than 15 years of experience working with certification testing and supervising the development of several certification examinations.
Gene Kramer, PhD	American Dental Association	Director of Testing for the American Dental Association. In this capacity, Kramer is responsible for the practice analyses that provide the basis for their national licensing examinations. He has managed these practice analyses and other psychometric analyses for more than 20 years.
Matthew Schulz, PhD	American College Testing	Has worked for American College Testing for many years in several psychometric roles. Schulz is knowledgeable about common practices and industry standards with regard to job analyses and practice analyses. He is also familiar with the NCLEX® Examination as he was NCSBN's director of testing in the 1980s.

Table 2: Medication Assistant Subject Matter Panel of Experts					
Area I					
Name	**Credential**	**Title**	**Jurisdiction**	**Specialty**	**Setting**
Mary Calkins*	PhD, RN	Professional Nursing Development Coordinator Cheyenne Regional Medical Center	Wyoming	Nephrology	Nursing Regulation
Chuck Cumiskey	BSN, RN, MBA	Nurse Practice Manager for Health Professions Quality Assurance Department of Health Washington State	Washington	Health Care Policy	Nursing Regulation
Roxann Hofer	LPN	Health Care Manager Riverside Senior Living	Montana	Geriatrics	Assisted Living
Patricia Latona	MSN, RN	Special Education Nurse/Department of Integrated Instructional Services Alamogordo Public Schools	New Mexico	Pediatrics/Medically Fragile Student Population	School Nursing
Judi Murphy	RN, CDDN	Health Care Director ARCA	New Mexico	Developmental Disabilities	School Nursing/ Developmental Disabilities
Area II					
Name	**Credential**	**Title**	**Jurisdiction**	**Specialty**	**Setting**
Barb Goosic**	RN	Director of Nursing Franklin Health Care Center	Nebraska	Geriatrics	Long-Term Care
Janet Mai	BSN, RN	Director of Staff Development St. Joseph Village	Kansas	Staff Education	Long-Term Care
Gena Munoz	CMA	Certified Medication Assistant St. Joseph Village	Kansas	Geriatrics	Long-Term Care
Mary Stassi	RN, C	Health Occupations Coordinator St. Charles Community College	Missouri	Geriatrics, Geriatric Education	Long-Term Care
Gail Mallow**	MSN, RN	Staff Development Coordinator Hi-Acres Manor Nursing Center	North Dakota	Geriatrics	Long-Term Care
Area III					
Name	**Credential**	**Title**	**Jurisdiction**	**Specialty**	**Setting**
Angela Cobb	RN	Nurse Education Director North Carolina Department of Corrections	North Carolina	Correctional Nursing	Public Health/ Correctional Facility
Martha Holloway	MSHA, BS, RN	Education Administrator Alabama State Department of Education	Alabama	Pediatric Community Health	School Nursing

Table 2: Medication Assistant Subject Matter Panel of Experts					
Area IV					
Name	**Credential**	**Title**	**Jurisdiction**	**Specialty**	**Setting**
Lepaine Sharp-McHenry*	RN, MS, FACDONA	Independent Long-Term Care Nursing Consultant	Arkansas	Geriatrics, Mental Health	Long-Term Care/ Nursing Regulation
Deborah Churchey	RN	Director of Nurses ARC of Washington County	Maryland	Developmental Disabilities	Community/ Home Health
Josephine Seinkiewicz	MSN, RN	Director of Education and Clinical Practice Home Care Association of New Jersey	New Jersey	Home Care	Home Care/ Assisted Living
Margaret Walker	MA, RN	Associate Dean of Academics SUNY Brockport/REOC	New York	LPN Education	Nursing Education

* Practice Regulation and Education Committee Liaison

** Available by telephone conference call

Attachment C

PR&E Committee Transition Report

Introduction

The 2006 – 2007 charge to Practice, Regulation and Education (PR&E) Committee was to develop an evidence-based model(s) for transitioning new nurses to practice. This charge was related to the following strategic initiative: *Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related healthcare issues* and the following strategic objective: *Conduct and support research that provides evidence regarding regulatory initiatives that supports public protections.*

Background

Prior to the mid-1990s, new nurses received an automatic transition period when they worked under the supervision of a licensed nurse until they successfully passed the NCLEX®. In those days it was often months before nurses received their test results; today, with computer testing, new nurses can become licensed in a matter of days. Additionally, the perspectives of more than 50 percent of health care employers surveyed by NCSBN in 2001 and 2003 were that new nursing graduates were not prepared to provide safe and effective care (Smith & Crawford, 2002; Smith & Crawford, 2004a).

NCSBN has responded to this transition issue, seeing it as an opportunity to collaborate across practice, education and regulation. At the 2002 Delegate Assembly the Practice, Education and Regulation in Congruence (PERC) Committee recommended the following to the Member Boards: "Identify and promote effective models to facilitate a successful transition of new nurses from education to practice" and "Participate in strategies for retention of the new graduate." These recommendations were adopted by the NCSBN membership. The PR&E Committee was charged with working toward developing effective transition models for the boards of nursing.

LITERATURE

The difficulty of transitioning new nurses to practice is not new, having been described in detail in Kramer's *Reality Shock: Why Nurses Leave Nursing* back in 1974. Yet that "reality shock" of new graduates to practice continues, especially during these times of increased complexity in health care and the nursing shortage.

In more than 20 years of work using the Dreyfus model, Benner has identified the following stages of skill acquisition in nursing: novice, advanced beginner, competent, proficiency and expertise. In order to transition from an advanced beginner (new graduate) to the competent stage, Benner's (2004) work shows the need for support, coaching, constructive feedback and opportunities for reflection. Santucci's (2004) research supports Benner's work, recommending that transition programs include clearly stated expectations for competent performance, constructive feedback, adequate resources and support systems, and a safe and trusting environment. From reviewing the transition program literature, Santucci (2004) found the following to be important elements of transition programs: role integration, clinical and interpersonal skills, and reshaping of values.

To support the work of Benner, empirical evidence from Norway (Bjørk & Kirkevold, 1999) finds that it is essential for new nurses to receive feedback from competent nurses and to actively reflect on their practice. This well-designed, longitudinal study researched the development of practical clinical skills in four new nurses. The nurses, who had only three weeks of orientation, were videotaped during a period of over eight to 14 months as they performed dressing changes and ambulated patients. Furthermore, both the patients and the nurses were interviewed after the nurses performed the skills. The assumption has always been that more experience would improve the nursing care. However, the findings were the opposite; while efficiency improved, even after a year of performing the skills, the same omissions and

faults occurred. For example, the nurses still contaminated the wounds, failed to wash their hands, dangerously removed drains, gave new postoperative patients inadequate physical support, failed to provide privacy to patients and showed decreased caring. The authors concluded, "They performed many of the same mistakes, but with higher flow and speed" (Bjørk & Kirkevold, 1999, p.80). It is clear that experience *per se* is not enough for new nurses to become competent. They need a structured transition program where qualified nurses will give them constructive feedback and assist them to reflect upon their practice.

Studies of outcomes of transition program models are being conducted nationally and internationally, and the results are beginning to be published. Many transition programs look at retention and satisfaction (Altier & Krsek, 2006; Halfer, 2007; Krugman et al., 2006; Pine & Tart, 2007), finding retention rates for the first year in nursing to be far better when new nurses have structured transition programs. For example, Krugman et al. (2006) found their nurses in a yearlong residency program had an 8 percent turnover rate in the first year, compared to national data ranging from 20 to 40 percent or even higher. Krugman et al also found that their yearlong transition program showed decreased stress, increased organization and priority setting, and increased satisfaction over the first year in practice.

Studies are also beginning to look at the cost benefit of transition programs, though most of this work has been done in urban medical centers. Pine & Tart (2007) and Halfer (2007) each found a cost benefit to yearlong residency programs; Pine & Tart found a cost savings of $823,680 for a yearlong residency program, while Halfer found a cost savings of $707,608 for a similar length program. Each of these studies looked at their turnover rate before the transition program was in effect, compared to afterwards, thus calculating the money saved by not having to replace these nurses. They then compared those savings to the costs of the transition programs, coming up with a respectable cost benefit. Often employers worry that transition programs will be costly, but at this point the evidence does not support that supposition.

National studies show that the design and length of transition programs in the U.S. is variable (Boyer, 2002; Kenward & Zhong, 2006; Krugman et al., 2006; Spector & Li, 2007), ranging from none at all to yearlong (or even longer) programs. NCSBN's 2004 data on both LPN/VN and RN transition programs (Kenward & Zhong, 2006) found that LPN/VNs are more apt to receive shorter transition programs or none at all; indeed, 7.4 percent of the 519 LPN/VN respondents received no transition of any kind after graduation, not even an orientation program (Kenward & Zhong, 2006).

PR&E developed a more detailed literature review for the 2006 Delegate Assembly that can be found on NCSBN's Web site: https://www.ncsbn.org/363.htm

REVIEW OF NCSBN'S WORK WITH TRANSITION

In 2002 – 2003, PR&E developed some evidence-based recommendations for transitioning new nurses to practice, based on NCSBN's research (Smith & Crawford, 2003; Smith & Crawford, 2004b):

Knowledge Type – A transition program should be structured with a certain amount of general knowledge, but should also focus on the specialty content where the nurse will be working.

Placement – While structured transition courses at the end of nursing school, where students are paired with preceptors in an immersion program, are very important, posthire structured transition programs are also essential.

Same Mentor – Students and new nurses benefit most when they work together with one preceptor, following that preceptor's schedule.

During 2004 researchers at NCSBN conducted the transition study (NCSBN, 2006) that was cited above, finding that while a majority of RNs and LPN/VNs participated in a routine

orientation or other transition program, there is considerable inconsistency in the programs being offered across the U.S., and other national studies validate this same variability of length and quality of transition programs (Spector & Li, 2007). NCSBN (2006) also found that LPN/VNs were, on average, assigned to care for patients earlier than RNs and that their case load was heavier. Additionally, more RNs than LPN/VNs participated in internships/externships, preceptorships or mentorships, along with orientation, than their LPN/VN colleagues (38.9 percent versus 16.2 percent).

In the fall of 2005, PR&E Committee members met with NCSBN's Research Department and reviewed a new instrument that was specifically created for conducting transition research. This tool was designed to pair the responses of new nurses with their preceptors in order to validate the perceptions of the new nurses. The research instrument contained questions measuring clinical competence of newly licensed nurses and queried new nurses about their practice errors and practice breakdown; the questions on practice breakdown were adapted from NCSBN's Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP™) tool. NCSBN's Research Department collected data using this new tool in the summer of 2006. Also in 2006, PR&E Committee members conducted a focused literature review on the challenge of transitioning new nurses to practice, and this was made available to the Member Boards on our Web site and in the Delegate Assembly Business Book.

2006 – 2007 PR&E Work

During the spring of 2006 the PR&E Committee members began to plan a Transition Forum for the purpose of addressing the transition of new nurses from education to practice from a variety of perspectives, including global and interdisciplinary views.

REPORT FROM TRANSITION FORUM

The 2006 – 2007 PR&E Committee held the Transition of New Nurses to Practice: A Regulatory Perspective Forum on Feb. 22, 2007, attracting participants in practice, regulation and education from 41 states and five countries. PR&E Committee members gained much information, from a variety of perspectives, to use when developing a regulatory model for the boards. The objectives of this Transition Forum were: (1) discuss the vision of transitioning new graduates from a broad health care perspective; (2) examine the national and international perspectives of transitioning new nurses to practice; and (3) seek input from stakeholders and participants about models for effectively transitioning new nurses.

Mary Blubaugh, MSN, RN, PR&E's liaison from the NCSBN Board of Directors; Brenda Jackson, PhD, RN, PR&E's chair; and Nancy Spector, PhD, RN, NCSBN's director, education, gave introductory remarks. The keynote speaker at the Transition Forum was David Leach, MD, executive director of the Accreditation Council of Graduate Medical Education (ACGME). Leach provided an interdisciplinary vision of transitioning new graduates; his presentation was entitled, "Transition to Practice: A Journey to Authenticity." Next Cathy Krsek, MSN, MBA, RN, University HealthSystem Consortium, director, Operational Benchmarking and Nursing Leadership, discussed her employers yearlong residency program with a presentation entitled, "UHC/AACN Nurse Residency Program." Carol Dobson, RMN, BA, MAEd, programme director of Scotland's Flying Start, described their national transition program with a presentation entitled, "An International Perspective on the Transition of New Nurses into Practice." In the afternoon, Suling Li, PhD, RN, NCSBN's associate director, research, presented preliminary results of NCSBN's 2006 transition study, presenting the group with a regulatory perspective. Dr. Li's presentation, entitled, "The Impact of Transition Experience on Practice of Newly Licensed Nurses," provided the audience with evidence that transition programs have a positive impact on the clinical competence and safe practice of new nurses. Also from a regulatory perspective, Patricia Spurr, PhD, RN, education consultant at the Kentucky Board of Nursing, shared that state's experience with legislation that mandates a transition program in a presentation entitled, "A Regulatory Initiative to Bridge Education & Practice." Lastly, Susan Boyer, MSN, RN, of the Vermont Nurse Internship Program, described Vermont's collaborative experience

with transition, across regulation, practice and education, in a presentation titled, "Vermont Nurse Internship Program." See Appendix 1 for speaker highlights.

While the speakers provided various perspectives and data for transitioning new nurses to practice, it was also important to hear from our stakeholders in nursing. Therefore, a distinguished panel was convened with representatives from the following organizations:

American Association of Colleges of Nursing – Polly Bednash, PhD, RN, FAAN, Executive Director

American Nurses Association – Linda Stiele, MSN, RN, CNAA, BC, Executive Director and Chief Executive Officer

American Organization of Nurse Executives – Linda Q. Everett, PhD, RN, FAAN, CNAA, BC, President

National Association for Practical Nurse Education and Service – Patrick Mahan, LPN, CWF, Executive Director

National League for Nursing – Eileen Zungolo, PhD, RN, FAAN, CNE, Past President

The panelists had been sent two questions, which they addressed during the panel:

1. Based on your expertise and what you've heard today, what do you see as the essential components for a future transition model for public protection?
2. How can practice, regulation and education work together to support the transition of new nurses to practice?

Appendix 1 summarizes the discussion from the panelists.

At the end of the day the audience, who had been purposely assigned to tables with equal numbers of regulators, educators and practice partners, answered one of the six questions that we had placed on the tables. The groups recorded their results, which the PR&E members have reviewed (see Appendix 1), and some of the tables shared their discussions at the end of the day. Dr. Jackson and Dr. Spector ended the day with closing remarks. The speaker presentations were videotaped, and a DVD of these presentations was sent to all boards of nursing. The speakers' PowerPoints are also available at www.ncsbn.org/363.

One theme shared across speakers, panelists and the audience was the desire to develop a national, standardized transition program, across settings and through regulation. Several groups from the audience cited the research presented that day and thought a six- to 12- month transition program should be required. There was much discussion from both from the speakers and from the audience on the need to prepare preceptors for the role. Much discussion ensued around the need to highlight the data that has been collected and to disseminate it to practice, education and regulation, as the audience stressed the need to develop partnerships across practice, regulation and education. The group talked about education being the foundation of nursing, while practice is the application of that foundation, and regulation is the check/balance system. The use of the preceptor was identified as the stepping stone between education and practice. A running thread throughout the day was the importance of doing the right thing for the right reasons, especially during these times of turmoil in the health care system.

THE FUTURE OF TRANSITION: THE EVIDENCE

After the February 2007 Transition Forum, PR&E met to discuss the implications of the information gathered for NCSBN. To date, most transition research has focused on improving retention rates, confidence levels and job satisfaction. Since the mission of regulation is to protect the public, NCSBN's most recent study (NCSBN, 2007) addressed clinical competence and safe nursing practice, including practice errors and risk for practice breakdown. NCSBN's (2007) findings show that during the first three months of practice, new nurses who had primary preceptors practiced at higher competency levels. However,

during the three- to six-month period, when new nurses practiced more independently and without the assistance of preceptors, they practiced less competently. As expected, NCSBN (2007) also found a significant relationship between decreased competence and increased numbers of practice errors.

NCSBN's research also shows a significant relationship between the number of practice errors and the amount of stress reported by the new nurses (NCSBN, 2007). Stress in the NCSBN study was defined by any of the following selections chosen by the new nurse: "felt overwhelmed by care responsibilities," "feared harming the client due to inexperience," and "felt expectations were unrealistic." There was also an interesting link between transition programs and decreased stress. New nurses who had internship programs and transition programs that addressed specialty knowledge had significantly less stress than those who did not. The perceived stress in this study began to decrease, for all nurses, after about nine to 12 months in practice. Similarly, at this time period, the clinical competence ratings began to improve.

NCSBN's findings (NCSBN, 2007) were reflected in some of the discussion at the Transition Forum. That is, the Transition Forum participants identified communication and clinical reasoning to be essential competencies for the new nurse. NCSBN's study (NCSBN, 2007) found that when new nurses reported significantly more competence (and this perceived competency was validated by their paired preceptors) in the areas of clinical reasoning ability and communication, they made significantly fewer practice errors.

Krsek's presentation at the Transition Forum (Krsek, 2007), reporting on the University HealthSystem Consortium's and the American Association of Colleges of Nursing's collaborative yearlong nursing residency, had results similar to NCSBN's (NCSBN, 2007) with stress and the new nurse. She found that stress decreased in the new nurses from six to 12 months, and other outcome measures (control over practice, satisfaction, organize and prioritize, communication and leadership, and professional satisfaction measures) all began to increase in the six- to 12-month time period. These two national studies (Krsek, 2007; Li, 2007) were quite complementary in identifying the need for a six- to 12-month period of supervised practice, after graduation, in order for new nurses to practice competently. It is striking that two national studies, each with different goals and measurement instruments, conducted on different populations and with different methodologies, had such similar findings.

NCSBN's research (NCSBN, 2007) is the first study to link postgraduation transition programs to patient safety. Since it is the mission of the boards of nursing to protect the public, developing a required transition regulatory program after graduation would seem to be an important next step for NCSBN. Therefore, the PR&E Committee members recommend that the boards of nursing further explore transition programs and their relation to public safety.

VISION FOR A FUTURE TRANSITION REGULATORY MODEL

The evidence supports regulators need to further explore the development of a national, standardized nursing transition program, and the time for action is now. While regulators can mandate and oversee such a program, it is also essential to form partnerships with nursing practice and education in this ambitious undertaking. Nurse educators can work with practice and regulation to identify best practices and to design learning experiences for new graduates, while practice partners provide that crucial link where new graduates can have planned experiences with seasoned nurses.

Therefore, PR&E recommends that NCSBN design a transition regulatory model for six to 12 months in length, based on the evidence. To achieve this goal, NCSBN will need to create consensus in the boards of nursing and across practice and education. Similarly, there must be buy-in from diverse external stakeholders including the Joint Commission, the American Hospital Association, and the Centers for Medicaid and Medicare Services. This model must be comprehensive, taking place across all work settings and across all education levels.

Some of the premises for this model are:

- The failure to transition new nurses to practice is a public safety and health economics issue.
- Transition to practice is facilitated by active engagement of the new nurse with a preceptor.
- A transition program will improve practice, decrease errors and prevent harm.
- A standardized transition program, which is designed collaboratively and is available in all settings and to all levels of education, will benefit the profession.
- A standardized transition program will improve nurse retention.

The framework for this model should include:

- Structure including type, duration, setting and preceptor involvement.
- Content including theoretical, clinical experiences, and learning lab or simulation.
- Characteristics, training and qualifications of the preceptor.
- Expectations of newly licensed nurses (suggest using the quality and safety education for nurses [QSEN] competencies, which include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics).
- Development of the new nurse and preceptor partnership.
- Institutional support of the newly licensed nurse and preceptor.

PR&E recommendations include:

- PR&E develop a six- to 12-month regulatory transition model for nurses where the nurse is licensed, but works under supervision.
- The new graduate would take and successfully pass the NCLEX, become licensed and then work through the six- to 12-month-long program. In order for renewal, the new nurse would have to successfully complete the program. Another suggestion would be for boards to require new nurses to have a provisional license, which would become a full license after the nurse successfully completes the program. This idea needs to be discussed with the boards of nursing.
- PR&E members will work to gain consensus on this model across a variety of organizations and disciplines.
- The model must be robust so that it can be used across settings and across education levels, yet flexible enough so that there are various ways to meet the requirements.
- There must be preceptor training with this model.
- Explore the feasibility of building a national Web site for access from some of our more rural areas, especially for allowing sharing and reflective conversations between new nurses and preceptors. Perhaps designing this Web site could be a collaborative effort across education, regulation and practice.
- The content of the program needs to be developed collaboratively with practice and education.
- A pilot study of 10 states will be conducted to collect data for building the model and making improvements.

PR&E Recommended Charge for 2007 – 2008

PR&E will explore the feasibility of designing a comprehensive national, standardized transition regulatory model and will make recommendations to the 2007 – 2008 Board of Directors.

Rationale:

Because of recent evidence showing that transition programs protect the public, PR&E Committee members decided the development of this model should be well thought out and planned. This is a comprehensive recommendation that will require building coalitions and working collaboratively. It will also require action by the boards of nursing, either for rewriting their rules or possibly enacting a provisional license into law. Therefore, the charge for this is broad and it will take some pilot work in order to fully implement it.

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Appendix I

Highlights from Speakers, Panelists and Audience

Speakers

- Keep remembering: The purpose is improved patient care.
- Doing the right thing for the right reasons.
- Consider the context of health care today: frenzy.
- Going back to your primary values: integrity, altruism, practical wisdom.
- A national transition Web site has been very effectively used in Scotland.
- Transition is a global issue in nursing.
- Models work better when preceptors are adequately trained.
- A statewide model requiring transition shows similar NCLEX® pass rates before and after implementation of a 120 hour mandatory transition program.
- National studies show that new graduates need one year of in a transition program.
- Retention is increased with an organized transition program, thus ameliorating some of the financial worries.
- Stress decreases in an organized transition program.
- Stress in new graduates is related to significantly more practice errors.
- Fewer practice errors were made when nurses reported competence in the areas of clinical reasoning; communication and interpersonal relations.
- Taking part in an organized, postgraduation transition program, with a primary preceptor, was significantly linked to higher competency.
- New nurses with specialty knowledge in their transition programs made fewer errors.

Panelists

- Practice, regulation and education are willing to collaborate on transitioning new nurses to practice.
- The participants and panelists favored a standard, national model.
- Focus on the retention aspect for practice buy-in.

Audience

Question 1 – What would be the key components of a transition model, considering feasible to administer, credible to the public, acceptable to the profession, legally defensible and economical?

- Link a transition program to magnet status/JCAHO accreditation
- Develop a standard curriculum/common language
- Educate preceptors
- Collect evidence on programs
- Get vendors (e.g., drug companies) or endowments to support pilot programs
- Look at different needs (i.e., educational, rural, accessibility)
- Certification
- Make interactive

- Critical thinking a must
- Stress accountability
- Team building/interdisciplinary collaboration

Question 2 – What actions could be taken to inspire nursing programs, boards of nursing and health care facilities to collaborate and facilitate a seamless transition from education to practice for the new nursing graduate?

- Meetings between service, education and regulators reexamine minimum standards.
- NCSBN should gather data on all transition programs.
- We need leadership in nursing: A facilitator to move forward a nursing agenda, rather than working with each stakeholder group. How do we develop professional consensus?
- Education on the win/win situation: increased retention, protecting the patient and reducing financial burden.
- Collaborate with the student groups too.
- Need data/evidence about the best models.
- Financial incentives.

Question 3 – Thinking outside the box, and without worrying about constraints (i.e., funding and resources), what would an exemplary program for new graduates look like?

- Apply to all graduates
- Apply to all areas of nursing
- Design in developmental phases defined by NCSBN research, one year or four quarters with evolving independence.
- Preceptor preparedness and recognition.
- Organizational and agency support is crucial for postlicensure residencies.
- Rethink nursing education to allow for more synthesis of clinical experiences.
- Incorporate education, regulation and practice into the design.
- Design to maintain the joy of nursing (related to negative nurses of the past).
- Minimum time: six months to a year.
- After passing the NCLEX.
- Incorporate rounds, case presentations.
- Follow-up after transition program over and may be our next preceptors.
- Must begin with nursing program.
- Use simulation.
- Continued feedback essential.

Question 4 – What are the desired outcomes of a transition regulatory model? Compare and contrast regulatory, practice and educational models that transition new nurse to practice.

- Facilitate graduate into practitioner role, increase competence to provide safe and competent care, improve critical thinking and seeing the whole picture, reduce turnover, and create stronger partnership with practice and education.

- Increase pass rates of NCLEX, decrease error rates, increase retention and standardized scale for measuring stress.
- Foster cohorts:
  - Make preceptor resources available through NCSBN
  - Blog between preceptors and new nurses
  - Explore others who do this work
  - Relationship building of new nurses and seasoned nurses
  - Regulate the preceptor
  - Evidence based.
- Enhance critical thinking; novice to competence is an evolution; safe, independently practicing nurse; common denominator: protect the public.
- Education: building block to practice; regulation: check/balance; and practice is the application in the foundation. The preceptor is the stepping stone between education and practice.
- Patient: enhanced patient safety; better patient outcomes; decreased length of stay; decreased cost; increased health; increased community of care; and more cost effective. New graduate: enhanced satisfaction; enhanced professional development. Facility: enhanced retention; enhanced competency of employees; improved outcomes.
- Needs of programs: development of preceptor; consider NCSBN's practice analyses with transition programs.
- Need structure … but also needs to be adaptable.
- Don't want a competency list for skills lab or simulation lab: make it experiential.
- Many variables to consider … how would a 30-bed hospital implement a yearlong residency? Yet, an extended residency is needed.
- Discussion groups with facilities a must.

Question 5 – How can NCSBN assist in generating partnerships for designing effective transition programs, considering some of the obstacles, such as funding and resources?

- Make a case with evidence
- Showcase best practices
- Don't preach to the choir. Get message to hospital administrators, medicine, current staff and the public.
- Form a common dialogue
- Seek grants
- The regulatory perspective will aid in the kind of consistency that would never happen in education or practice.
- Today is a start — need more free conferences.
- Sponsor work groups to disseminate and develop standards.
- Preceptor development
- Educate political champions
- Build a business case for safety
- Expand and model partnerships

- Influence accreditation and other regulatory bodies (e.g., Joint Commission, CMS)
- Standardize competencies

Question 6 – What factors are integral in promotion of a transition model with employers, with new graduates and with education programs?

- Preceptor training
- Standardized transition program across the U.S.
- Sense of protection of our new graduates
- Programs need to be one year
- Peer support
- Role delineation (employees, nursing education, new graduates)
- For employees address cost, show evidence (preceptor training, increased retention, decreased errors); for education increase communication with practice partners; for new graduates show that benefits will provide that much-needed support.
- New graduates: No promotion needed! Who will pay for it? What should new graduates look like? Return on investment (ROI) data is needed. We should quantify the investment. Need qualified preceptors and clinical faculty in education programs.

Attachment C1

The Impact of Transition Experience on Practice of Newly Licensed Registered Nurses

Executive Summary

BACKGROUND AND AIMS

The National Council of State Boards of Nursing (NCSBN) is responsible for assisting its members, the boards of nursing in the U.S. and four territories, in their mission of public protection through safe nursing practice. To assist the Practice, Regulation and Education (PR&E) Committee in establishing a regulatory model on transitioning newly licensed nurses into practice, NCSBN conducted a study on transition. The purpose of this project was to identify factors that influence transitions into practice and to examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed registered nurses (RNs) and licensed practical nurses (LPN/VNs). At this point only the RN data have been analyzed, but the LPN/VN data will be analyzed soon. Therefore, the current report only reports the RN findings.

The transition is a process in which new RNs progress from an advanced beginner to a competent practitioner. It is a period when the practice of new RNs evolves from a dependent to a relatively independent state. While successfully transitioning new RNs into entry-level practice is a long-standing issue, several factors prompted the current NCSBN transition initiative. First, new RNs continue to struggle with mastery of clinical skills such as managing and organizing an increased and complex patient care assignment, communicating with physicians and delegating tasks. Turnover rate for new RNs within the first year of practice remains high, ranging from 33-50%. In addition, the continuing nursing shortages may negatively impact preceptor availability and continuity, which is vital to the development of the partnership between new and experienced nurses during transition. Furthermore, functioning in highly technological, complex and systems-driven environments demands new RNs to be highly competent.

A number of transition programs nationwide with various goals, objectives and structures are available to help new RNs during transition, which is the period with the highest learning curve in a nurse's professional life. However, the best practice model(s) for designing a transition program has yet to be established. The goal of this study was to generate evidence-based information to assist the PR&E Committee in the development of an evidence-based regulatory model for transitioning newly licensed nurses. This study aimed to: (1) describe the transition experience of new RNs, (2) identify factors that influence the transition experience, and (3) examine the impact of the transition experience on clinical competence and safe practice issues of new RNs.

METHODOLOGY

Design & Sample

The study employed a nonexperimental, comparative, nurse-preceptor dyad design. As the mission of regulation is to protect the public, the primary outcomes of interest were clinical competency and safe practice issues, including practice errors and risks for practice breakdown. The secondary outcomes included perceived stress level and job turnover rate. Measuring clinical competence and safe practice issues of new RNs addresses a regulatory concern, which is in contrast to a number of transition studies in the literature that examined only the nurse turnover/retention, nurse satisfaction and nurse confidence.

In this study, clinical competence was defined as a habitual capability of applying knowledge and skills in practice. The assessment of the habitual capability requires a relationship developed over time that makes it possible to judge an individual's performance. Believing

that preceptors were in the ideal position to evaluate a new nurse's competence in addition to the nurse's self-evaluation, NCSBN obtained the perspectives of both the new RN and his/her preceptor/mentor. In the case where there was no preceptor, supervisors' perspectives were obtained.

Characteristics of transition experience (including pregraduation versus post-graduation timing, type, length, nature of preceptor involvement, and focus of the program) and characteristics of preceptors (including working experience, precepting experience, qualifications, and incentives such as reduced work load) were also obtained.

Surveys were sent to 2,230 new RNs who were randomly selected from all candidates demonstrating success on NCLEX-RN® from July 1 through Sept. 30, 2005, from 33 jurisdictions that approved release of the data. A return rate of 28% was obtained. The sample was stratified by type of educational preparation and jurisdictions. The corresponding preceptors were also surveyed. After excluding cases with invalid addresses and those who were not currently employed, 560 new RNs and 231 preceptors remained in the analysis.

Data Collection Instruments

Separate questionnaires were developed and used for the new RN and the preceptor surveys. The questionnaire for new RNs contained five sections. In the first section, questions related to the new RN's work environment included work setting, work hours, schedule and shift worked. The second section requested information about transition experience including timing, types, duration, and focus of the program and other characteristics of the transition experience. The third section contained questions related to outcome measures including both primary and secondary outcomes. The fourth section contained demographic questions and the fifth section was for comments. The questionnaire took approximately 30 to 40 minutes to complete.

To examine the outcomes, assessment scales were developed to evaluate clinical competence and safe practice issues including practice errors and risks for practice breakdown of new RNs. The scales were developed to fit the goal and the population of the study. The development process involved: (1) identifying a theoretical model for the intended concepts; (2) generating items with literature review and experts in nursing education, regulation and research; and (3) obtaining expert acceptability of the scale, as determined by the PR&E committee. To assess clinical competence, 35 items were generated to reveal the newly licensed nurses' capability to engage in a core set of functions relevant to competent practice. The assumption was that the acquisition of competence proceeds along a continuum and newly licensed nurses in transition are at the various stages of the development of a habitual capability of applying knowledge and skills in practice. The new RN and his/her preceptor were asked to rate how the RN functioned during the past 30 days on the continuum of "Almost never" performs this function competently to "Almost always" performs this function competently with a scale of 0 to 4. This scale has an excellent reliability and validity (Cronbach's Alpha = 0.93). The content validity was supported by a group of experts and construct validity was established by a factor analysis, which yielded four subscales: (1) clinical reasoning and judgment, (2) patient care delivery and management skills, (3) communication and interpersonal relationships, and (4) recognizing limits and seeking help.

To assess practice errors and risks for practice breakdown, 21 common practice errors were included. Of the 21 items, five were modified from previous NCSBN research instruments and 16 from NCSBN's practice breakdown assessment tool (TERCAP™). Practice errors were defined as incidents or occurrences that resulted in harm to clients or had the potential to place a client at risk for harm. A practice error could also be the lack of any aspect of good practice. Examples of practice errors included medical errors, patient falls, contributed to delay of treatment, missed identifying changes in patient conditions and charted on wrong medical records. An error index indicating risks for practice breakdown was then generated from the measures obtained.

The questionnaire for the preceptor survey was created by modifying the questionnaire for the new RN. The preceptors were asked to rate the new RNs' performance on the same items measuring clinical competence and safe practice issues in the new RN survey so comparisons could be made between responses of new RNs and that of preceptors.

RESULTS

Sample Characteristics

Characteristics of the New RNs

Demographics

Of the 560 new RNs that participated in the study, 32.8% were BSN graduates and 60.7% were associate degree nurses (ADNs). The majority of the new RNs were female (BSNs 94.4%, ADNs 93.7%). About 79% of the BSNs and 81.9% of the ADNs were White, 3.4% of BSNs and 3.0% of ADNs were Asian, and 1.1% of BSNs and 2.1% of ADNs were Hispanic. The percentage of new RNs from an African American background was higher for the ADNs (11.9%) than for the BSNs (8.5%). On average, the BSNs (mean age 28 years) were about 6 years younger than the ADNs (mean age 34 years). This profile is similar to what NCSBN obtained on new RNs from past research.

Employing Facilities and Specialty Areas

More BSNs (93.3%) than ADNs (83.0%) were employed in hospitals, while more ADNs (10.3%) than BSNs (1.1%) were employed in long-term care facilities. Nearly 38% of the BSNs and 41% of the ADNs worked in medical-surgical units and about 41% of BSN graduates and 29.2% of ADN graduates worked in critical care units. Higher percentages of BSN participants (55.6%) than ADN (43.5%) were employed in urban area. About one-fifth of the participants (19.9%) worked as a LPN/VN before becoming a RN.

Length of Employment and Hours Worked

After receiving licenses, the BSNs were employed in their current position an average of 9.6 months and the ADNs 9.3 months. The majority of the new RNs (BSNs 93.8%, ADNs 89.6%) worked full time. The BSNs worked an average of 36.9 regular hours per week, while the ADN graduates worked 35.4 hours per week. More than half of the BSN (60.1%) and the ADN (59.1%) graduates were scheduled to work nonmandatory overtime. Less than one-tenth of the BSN (5.7%) and ADN (8.7%) graduates reported working mandatory overtime.

Shifts Worked

More than 78% of the BSNs and 65.4% of the ADNs reported working 12-hour shifts. About 20% of the BSNs and 31.2% of ADNs worked eight-hour shifts. The majority (80.6%) of the RNs worked either straight day (33.6%), evening (10.8%) or night (34.3%) shifts while about 20% worked with rotating shift schedules.

Characteristics of Preceptors

Of the 231 preceptors that participated, about half were ADN graduates (49.7%) and less than a third (31.5%) were BSN graduates. It is interesting to note that about 11% of the preceptors were diploma graduates. The preceptors (average age 42.2) were about 10 years older than the new RNs (average age 32.4). The majority of the preceptors were White (88.8%) and female (92.2%).

The preceptors had extensive experiences in nursing in general (mean 13.7 years) and about nine years of practice in their current position (mean 8.6 years). However, it is interesting to note that about 20% of preceptors worked in their current position for less than a year. On average, the preceptors worked with the new RNs for about 3.6 months and had a precepting experience for about 4 years. Nearly half of the preceptors (49%) received standardized training and 11% reported taking courses on their own about precepting new graduates. To serve as a preceptor, 74% reported that it was necessary to receive recommendations from supervisors.

Reducing workload of preceptors may be one way an institution supports the transition of new RNs to practice. Preceptors were asked whether they received a reduced workload. A little less than half of the preceptors (45.8%) reported that they were precepting the new RNs on top of their regular full work load while about one-third (31.7%) reported having a reduced workload and less than one-fourth (22.5%) did not have patient care assignments of their own when precepting the new RNs.

Transition Experience

Pregraduation Synthesis Experience

To examine the transition experience of the new RNs, it is important to consider the pregraduation synthesis experiences. Prior to graduation, many nursing programs had a clinical course at the end of the program to help students synthesize knowledge and practice skills in an intensive manner. Though the course may have been labeled as synthesis, management, or transition course, it has the common feature of students assigned to work under the supervision of a preceptor rather than an instructor and typically work the same schedule as that of the preceptor. In this sample, about two-thirds of the BSN graduates (68.2%) had a transition course before graduation and that course lasted about 10 weeks on average. In contrast, one-third of the ADN graduates (33.8%) had a transition course before graduation and the course lasted about seven weeks on average.

Transition Experience Postgraduation

Postgraduation transition occurs in the form of orientation, internships (could also be labeled as preceptorship/mentorship) or both. The new RNs were asked whether they had a routine orientation and/or any internship experience for transitioning to practice. While the routine orientation was defined as any type of skills lab or classroom work and/or supervised work with clients without an assigned mentor or preceptor, the internship experience included an assigned preceptor/mentor. The majority of the new RNs (73.8%) had an internship experience, while about a quarter of the new RNs (24.3%) received routine orientation only. A small percentage (2.0%) of RNs did not receive an orientation or an internship experience.

Types of work settings affect whether a new RN receives an internship experience. The RNs who worked in hospital settings (81%) were more likely to receive internship experiences than those in the nonhospital settings (31%), which included ambulatory care, long-term care, community health and public health settings. The BSN graduates (82.3%) were more likely than ADN graduates (66.9%) to have an orientation with an internship experience. Even within the hospital setting, more BSNs (87%) received internship experiences than the ADNs (74%).

The duration of the transition experience of the new RNs varied across work settings. The majority of the new RNs (81%) in the nonhospital settings received a transition of eight weeks or less while the majority of the new RNs (67.2%) in the hospital setting received a transition eight weeks or longer. About one-fifth of the RNs (20.9%) in the hospital setting had a transition longer than 12 weeks.

Preceptor involvement is vital to the success of a transition program. The new RNs' experiences with preceptors varied across work settings. The new RNs who worked in hospital settings were more likely to have a designated preceptor for every shift (56%), to have a primary preceptor (62%), to share assignments with a preceptor (68%) and to work the same schedule as the preceptor (60%), compared to those who worked in nonhospital settings (42%, 37%, 37% and 46% respectively).

The content of transition programs was important in evaluation of transition experience. The new RNs were asked about the content of their transition programs (i.e., whether it was focused on improving the general knowledge or addressing the specialty knowledge for the preparation of practice in a specialty area). About two-thirds (61.2%) of the new RNs in nonhospital settings reported that their transition programs focused on the improvement of general nursing knowledge, while more than half (55.7%) of those in hospital settings reported that their programs addressed knowledge related to specialty areas.

To understand the expectations of work settings for new RNs, the new RNs were asked about how soon they received their first assignment, with and without the supervision of an experienced nurse, after being hired into a nursing position. In nonhospital settings, it took an average of 5.1 days for the new RNs to receive their first dependent assignment; while in hospital setting, it took an average of 6.1 days. The RNs in hospital settings had approximately 50% more days of practice under supervision before receiving their first independent assignment (49.7 days) than those in nonhospital settings (25.6 days).

Regarding the initial workload, on average, new RNs received about half of the workload expected of experienced nurses. Specifically, new RNs in hospital settings started out with two to three patients (mean 2.8) and their workload gradually increased to about four patients (mean 4.1) by the time they became independent. For those in nonhospital settings, they started out with about 16 patients and by the time they became independent they had about 23.

To further understand the expectations of work settings for new RNs during the first year of practice, NCSBN compared the workload of the new RNs during the initial period of independence to that of experienced nurses. It was found that the workload for new RNs at the initial period of independence was less than what was expected of the experienced nurses regardless of work settings (New nurse [4.1] versus experienced nurse [4.9] in hospital settings and new nurse [23.4] versus experienced nurse [25.2] in nonhospital settings). In general, the new RNs were not treated as experienced nurses in terms of workload during their first year of practice.

Outcome Measures and Their Relationships with Transition Experience

Clinical Competence

The new RNs and their preceptors rated the new RNs' progression of clinical competence on a scale of 0-4 with higher numbers indicating higher levels of clinical competence. Based on paired comparison, there was no significant difference in the ratings of clinical competence between the new RN (mean total score 3.46) and the preceptor (mean total score 3.50). At each individual item level, no differences were found in 32 out of 35 items. On the three items that differed (i.e., recognize when demands exceed capability, seek assistance from experienced nurses, and appropriately utilize research findings), the preceptors rated the new RNs better than new RNs themselves. Since the reported clinical competence ratings by the nurses and the preceptors were similar, the ratings by the nurses were used in the subsequent analysis.

Examining the different dimensions of clinical competence, NCSBN found that the new RNs were more competent in the areas of patient care delivery and management skills (mean score 3.52) followed by the communications and interpersonal relationships (mean score 3.44). The new RNs were relatively less competent in the areas of clinical reasoning and judgment (mean score 3.27) as well as recognizing limits and seeking help (mean score 3.20).

A higher percentage of the new RNs felt they could perform the following functions competently "Almost always": administer medications accurately (92.3%), maintain safe and respectful environment (83.6%), accurately perform client assessment (80.2%), perform technical skills accurately (79.7%) and do what is right for clients no matter what (73.4%). These areas are consistent across different phases of the first year of practice.

There were areas that a lower percentage of the new RNs felt they could perform competently "Almost always." These areas include appropriately utilizing research findings (32.7%), recognizing when demands exceed capability (47.4%) and strategically delegating and supervising others (41.7%).

To examine clinical competence during different phases of the first year of practice, NCSBN found that the new RNs practiced at a higher competency level initially when most of the new RNs were under the supervision of an experienced nurse. During the initial phase of independent practice (i.e., three to six months of practice), the new RNs practiced at relatively

less competent levels compared to the other periods of the first year of practice. Then their competence levels gradually rose after that period.

The same pattern holds true for the different dimensions of clinical competence. Again, during the period of three to six months of practice, the new RNs functioned at relatively less competent levels compared to the other periods of time for all four dimensions measured. Clinical reasoning and judgment skills, as well as recognizing limits and seeking help, ranked lower across all phases of the first year of practice compared to the other two dimensions.

Two factors are associated with the clinical competence of the new RNs: type of work settings and availability of primary preceptors. The new RNs in hospital settings consistently practiced at a higher competence level than those in the nonhospital setting during all phases of the first year of practice. In addition, during first three months of practice, new RNs who had a primary preceptor tended to perform at higher competent levels (ß = .45), especially in the areas of communication and interpersonal relationships (ß = .51), as well as recognizing limits and seeking help (ß = .49).

Practice Errors and Risks for Practice Breakdown

The next major outcome measure is practice errors. According to self-report, practice errors made by the new RNs were prevalent. The following were the most common types of errors: charted on wrong client record (55.2%), made medication errors (43.2%), contributed to treatment delays (39.3%); had client falls (34.9%) and missed physician/provider order (38.5%). More than 10% of the new RNs reported making these errors more than once. While it is understandable that the majority of these errors may not result in patient harm, the persons who make more practice errors are at higher risk for practice breakdown (i.e., adverse events). It is important to note it is unknown whether these errors are more or less prevalent among new RNs than experienced RNs.

Based on the practice errors reported, a practice error index was generated to predict risks for practice breakdown. Based on paired comparison on practice error index, the new RNs reported more practice errors (practice error index = .32) than those known by the preceptors (practice error index = .15) ($p<.000$). It appears that the preceptors knew about only half of the errors that the new RNs reported having made.

Examining the relationship between transition and practice errors revealed that the type of practice settings (ß = .11) and content of transition programs made a difference. The new RNs in the hospital setting committed more practice errors than those in the nonhospital settings. Within the hospital setting, the new RNs whose transition programs included preparing for specialty practice made fewer practice errors.

To examine the relationship between clinical competence and practice errors, a negative correlation between clinical competence and practice errors was found: the more competent the new RNs, the fewer practice errors made. All dimensions of clinical competence (r = -.35), especially clinical reasoning and judgment (ß = -.38), as well as communication and interpersonal relationships (ß = -.33) were important in predicting practice errors. While the patient management and delivery skills were important, they were not as important as the clinical reasoning and judgment, as well as communication and interpersonal relationships in predicting practice errors.

New RN Turnover

Another outcome measure was nurse turnover. About one-fifth (21%) of the new RNs reported that they had changed positions since being licensed and 23% reported that they were planning to leave their current position within the next six months. Combining the two statistics reported above, during the first year of practice, 40% of the new RNs either had changed their position or were planning to leave their current position within the next six months.

Examination of the relationship between transition experience and nurse turnover yielded that the new RNs with an internship experience were less likely to leave their current position

within the next six months. While 19% of the new RNs with an internship experience indicated their intention to leave their current position in the next six months, 33% of those without internship experiences reported the same intention.

Perceived Stress

As a secondary outcome, stress was measured by how often the new RNs experienced the following: (1) "felt overwhelmed by care responsibilities," (2) "feared harming the client due to inexperience" and (3) "felt expectations were unrealistic." Nearly a quarter of the new RNs (24%) felt overwhelmed with patient care responsibilities often/always; 3% experienced fear that they may harm patients due to inexperience often/always; and 16% felt that the patient care expectations for them were unrealistic often/always. The stress level was the highest among the new RNs in three to six months of practice compared to other periods of the first year of practice. It is interesting to note that three to six months was also the period that the new RNs practiced at the relatively least competent levels compared to other periods during the first year of practice.

To examine the relationship between the transition experience and perceived stress, NCSBN found that the further along the new RNs were in their first year of practice, the less they feared harming the patients (ß = -.11). The new RNs who had an internship during transition (ß = -.11) and the new RNs who had a transition program that addressed specialty knowledge (ß = -.10) were less likely to feel the expectations were unrealistic.

There was a positive correlation between stress and practice errors. The more stressed the new nurses are, the more practice errors they make.

SUMMARY OF FINDINGS

1. Transition experiences of new RNs vary across practice settings; new RNs in hospital settings were more likely to receive internship experience and longer transition compared to those in nonhospital settings.
2. New RNs were more competent in the areas of patient care delivery and management, compared to the areas of clinical reasoning and judgment skills as well as recognizing limits and seeking help.
3. During the first three months of practice, new RNs who had a primary preceptor practiced at higher competency levels, especially in the areas of (1) communication and interpersonal relationships, and (2) recognizing limits and seeking help.
4. Without the assistance of preceptors, new RNs practiced at less competent levels during their initial phase of independent practice (three to six months of practice).
5. New RNs whose transition programs included preparation for specialty practice made fewer errors compared to those who did not have specialty preparation.
6. New RNs who had an internship experience were less likely to leave during the next six months.
7. Less competent and/or stressed new RNs made more practice errors.

CONCLUSION

In conclusion, internship experiences have a positive impact on the clinical competence and safe practice of new RNs; the LPN/VN data will be analyzed soon. It is beneficial to have transition programs that are six months or longer and that address specialty knowledge. Internship experiences benefit the new RN and his/her organization by decreasing stress and nurse turnover respectively.

From a regulatory perspective, the ultimate goal of transition programs is to increase competence of new nurses, and consequently augment the quality and safety of health care provided to all patients. Currently, there is no national standard for transitioning new RNs from education to practice and very few states have regulations for the development of

nurses during the first year of practice after graduating from a nursing program. In addition, the most common form of transition program is a corporate model where new RNs receive transition preparation at the workplace. The lack of standardized transition programs and the use of a corporate model may pose threats to the progression of competence development of some new nurses. Given that transition is a vulnerable time for new RNs and the initial learning curve is steep, it is an obligation of education, practice and regulation to design proper transition programs for all new RNs.

Attachment D

PR&E Committee
Faculty Shortage Survey – March 2007

Introduction

As part of PR&E's charge of exploring faculty qualifications, they conducted a survey of the Member Boards was conducted to determine the extent of the faculty shortage in their jurisdictions and the actions they are taking to limit the adverse effects of the faculty shortage. PR&E Committee members thought this data would be valuable for the boards of nursing in dealing with faculty shortage issues in their states. Further, PR&E members will use the results of this survey next year as they continue with this charge.

Brief Summary of Results

A total of 36 boards of nursing replied to this survey, with the majority having faculty shortage issues across the state that are manageable (20) or very bad (12). No state reported having no faculty shortages and no state reported "severe" shortages. Several states indicated that they have statewide initiatives in place to address the faculty shortage.

The most common action taken to assist educators with the faculty shortage was for states to allow waivers for faculty qualifications. When boards of nursing do allow waivers, they often have rules that limit the percentage of waivers allowed in programs. For boards of nursing that do allow faculty waivers, a large majority have allowed waivers for less than 10 percent of the faculty in their state. Besides allowing limited numbers of waivers, it is rare for a state to lower faculty qualifications, and, in fact, several respondents spoke out about that. The following were typical comments:

- "A faculty shortage is not a reason to decrease faculty requirements. With the increasing technology and acuity of patient care, the requirements are increasing. More energy needs to look at sharing of resources between programs, and between program and agencies."
- "It is essential that boards of nursing maintain standards for faculty education, while at the same time, supporting efforts to recruit new faculty."
- "It is a real problem, but it would seem that lowering the educational requirements would be the same as saying that if we have a shortage of brain surgeons that it would be okay for general practitioners to do brain surgery."

Most of the boards of nursing reported they did not have rules that limit the use of preceptors (only one reported limits). Few boards have rules at this point about the use of simulation (five allow its use instead of clinical experiences and six do not), and most do not have rules that address the percent of simulation that can be used for clinical experiences. Of those boards of nursing that do have rules addressing the percent of simulation to be used in lieu of clinical experiences, those percents ranged from 15 to 30 percent.

The respondents often identified low faculty salaries as a major problem. The need to be more creative and innovative with nursing education was also identified. Sharing resources was suggested, especially with simulation centers.

Responses

N = 36

1. Boards of Nursing

- Arizona
- Arkansas
- California-RN
- California-VN
- Colorado
- District of Columbia
- Hawaii
- Idaho
- Illinois
- Iowa
- Kansas
- Kentucky
- Louisiana-RN
- Maine
- Massachusetts
- Michigan
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Mexico
- New York
- North Carolina
- North Dakota
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Texas
- Utah
- Virginia
- Washington
- West Virginia-RN
- Wisconsin
- Wyoming

2. Please rate the extent of the faculty shortage in your state or territory:

	Total
1 = None	0
2 = Local or regional	3
3 = Across the state or territory, but manageable	20
4 = Across the state or territory, and very bad	12
5 = Severe	0
Did not answer	1

3. What are some of the actions your state or territory has taken to alleviate the shortage?

Statewide pilot projects

- System-wide consortium set up at the university and community colleges.
- Funding provided to University of North Carolina system to increase programs for preparing faculty.
- One school and one hospital are piloting a clinical practicum model where each student is given a BSN preceptor. The preceptor is a staff nurse at the hospital.
- Started the Illinois Center for Nursing.
- Development of an MSN with education focus.
- Nurse Faculty Intern Pilot Study employs graduate students as nursing faculty with faculty mentors and academic consultants guiding their practice of teaching during their educational pursuits.
- Workforce Group studied the nursing shortage in the north central region of West Virginia. Surveyed nursing education programs regarding such things as faculty turnover, vacancies, etc.

- A statewide plan to increase numbers of graduates will be recommended to the legislature. Currently, the board accepts proposals for pilot programs regarding innovative professional nursing education.
- Task force created to address issue. Legislation to increase faculty salaries.
- Funding by legislature for faculty to obtain higher degrees and to fund faculty positions.
- Education task force for the past six years and the Montana Initiative for Nursing Transformation (MINT).

Rules changed affecting faculty qualifications

- For the past several years we allow a BSN who is actively enrolled in a MSN program to receive a waiver for as long as he/she is actively enrolled in the MSN program.
- Currently being discussed. Rhode Island requires MSN for all nurse faculty. Seems to be general consensus to allow a master's degree in another field such as education.
- Allowing a degree other than master's in nursing. Consider additional education and clinical expertise.
- Provide exceptions to hire if nurse has expertise in clinical and is working on advanced degree.
- Faculty waiver: BSN clinical faculty if enrolled in graduate program. At least 75 percent of faculty must have MSN.
- In 2000, WV 19CSR1-11 was revised.
- Faculty waivers may be requested.
- Wavier of the regulations in the appointment of faculty to registered nurse programs for the purpose of clinical or skills laboratory instruction.
- More formal process for waivers.
- No

Regional projects

- Clinical teaching associate program to move practitioners into the faculty role. Joint positions with school and agency.
- Consortia of ADN/BSN programs and potential PN program consortia with shared curriculum, use of distance learning, and shared faculty recourses; discussions regarding the development of a faculty database.
- Partnerships with clinical agencies allowing some of the clinical RNs to work as faculty provided they meet the qualifications mandated by the board of nursing.
- The hospital associations in the St. Louis and Kansas City areas have partnered with area nursing programs and prepared staff nurses who can serve as clinical faculty.
- University of Nevada, Las Vegas increased salary range.
- As stated above, Workforce Project; West Virginia Nursing Shortage Study Commission; West Virginia Center for Nursing (2004); West Virginia Association of Deans and Directors meet and discuss faculty issues; MSN nursing education programs.
- Midwestern State University has an innovative clinical simulation program.

- A Healthcare Workforce Resources Center has been formed through legislation. One of their foci is related to faculty shortage. In addition, the Oklahoma Regents have allocated money for MSN education.

Meetings locally and/or regionally, but no action yet

- Legislative initiatives in process.
- Working with area health education centers (AHECs) to provide common simulation facilities and sharing of faculty resources.
- Many meetings.
- Several initiatives mandated by the governor to alleviate the shortage.
- Hospital association NNA.

Statewide meetings, but no action yet

- We have a faculty shortage task force which has completed a faculty shortage survey and is working on recommendations.
- Rhode Island nurse leaders have been meeting for over five years. A lot of good discussion but no action yet.
- Legislation to provide loan forgiveness and scholarships.
- Annual meeting to discuss strategies.
- Have a Nursing Supply and Demand Commission established by act of the legislature; had legislative stipend funding for master's degree candidates committing to teach.
- Governor's Task Force met and made recommendations in November 2006. Idaho has a new governor as of January 2007.
- Stakeholders are collaborating to produce a statewide plan. The board's Advisory Committee on Education is discussing this issue.
- Nurse educators have formed an Institute of Nursing Education, partially to address nursing/faculty shortage issues.
- No, but are planning it.
- Nothing, but we're interested in doing something.
- Discussions about collaboration between nurse and education bargaining units regarding education salaries; joint appointments.

Other activities

- Funding made available for faculty who are pursuing advanced degrees in nursing education.
- The rules provide for schools to file for exceptions to the required degrees, as long as the person is working on the higher degree.
- Legislation from Hospital Association to give a $2,000 tax break for nurse educators. No movement on this bill.
- Requests are being made to the state legislature to allocate additional funds for faculty salaries. They were give nonrecurring funds and now are asking for recurring funding.
- Regulations remain same. Up to schools to find qualified faculty.

- The legislature passed a bill to loan persons working on an MSN up to $5,000 a year for three years and have the loan forgiven for each year teaching in a nursing education program in Nebraska.
- Last year the legislature provided funding for 50 scholarships for nurse educators. This year there is a bill in the legislature to extend this funding.
- Enacted waivers.
- State funds made available to increase faculty salaries in public institutions.
- Do have standards that permit faculty exceptions to qualifications.
- Fighting legislative proposal to permanently lower the educational requirements of faculty to BSN with two years experience to teach clinical.
- Nursing leadership has secured legislation for funding of faculty and also loan repayment programs. Furthermore, most of the programs are staggering admissions so that most schools have increased enrollment.
- Increased school budgets to increase existing faculty salaries and also money to University of Connecticut to fund teaching MS education program.
- There has been conversation among the programs, but no formal action has been taken.

4. Do your rules limit the number of preceptors that programs can use?
Yes – 1
No – 26

If so, what do your rules say?

- Preceptors can only be used in courses where a student has received clinical and didactic instruction from program faculty in all basic areas for that course or specific learning experience.
- The rule defines a preceptor as providing a 1:1 experience to a student after the student has had instruction in each of the specialty areas.
- Rules do not limit numbers of preceptors but permit them only to be used in last semester of the program.
- The numbers are limited only by the required ratios.
- Guidelines state, "Program faculty electing to use a preceptorial learning experience should have a preceptor responsible for directly facilitating learning activities of no more than two (2) students at one time."
- Preceptors are not limited by number, but precepted clinical experiences can only be used for a small percentage of the total clinical experience.
- 1:15 ratio
- The preceptor will be assigned no more than two students. The maximum ratio of faculty to students in precepted clinical learning experiences is one faculty to 15 students (1:15 ratio).

5. Do your rules allow for simulation and/or learning lab experiences in place of clinical experiences with actual patients?
Yes – 5
No – 6

If so, what percentage of clinical instruction can simulation/learning labs replace?

- We do not specify a percentage. There must be clinical instruction across the lifespan.

- Rhode Island rules are silent in this area, thus there is nothing to prohibit this.
- Cannot substitute, but can enhance and supplement.
- There is no set percentage. The area is too new to set percentages.
- There is no percentage. A rule of thumb is that "nursing lab hours" can't be more than 25 percent of the clinical hours; this would include simulation.
- 15 percent along with an explanation that demonstrates equivalency.
- Not specifically mentioned in the rules—since it is not in the rules on percent—we encourage them to do no more the 25 percent.
- No state percentage. Each program is reviewed individually to determine the appropriate use of simulation.
- Not more than 25 percent of the experiences can be simulated.
- Clinical definition is proposed that leaves number out. Maintain responsibility to have clinical with actual patients across lifespan utilizing concepts from NCSBN paper. Must have reflection and increasing confidence.
- There is no specific clinical requirement in WV 19CSR1.
- Currently, there is no percentage; however, the issue is being discussed.
- Our rules do not forbid such practice and in fact encourage "creativity."
- Law and rules are silent, by policy has allowed 30 percent of clinical hours to be simulation/lab experiences.

6. What are your current minimum qualifications for RN faculty in your state or territory? (For those boards that regulate RNs)

A. Minimum education for RN nursing program administrators

	Response Total
Doctorate	2
Master's degree in nursing	29
Other master's degree	2
BSN	0
ADN and/or diploma	0
No requirements	1

Other, please explain (specify if you have different qualifications for ADN, diploma or BSN administrators):

- Rules in process requiring a master's degree for all nursing faculty including clinical beginning 2015. For BSN, current requirement is a doctoral degree in nursing or an MSN and doctoral degree in related field.
- The law does not specify minimum requirements, but we require working toward the master's or doctoral degree.
- MSN for ADN and diploma; MSN plus doctorate for BSN.
- Must also meet the institution's requirements and have evidence of experience in education, administration and practice sufficient to administer the program.
- MSN and doctorate in nursing or related field for BSN program, MSN for ADN program.

- The doctorate is required to serve as an administrator for a BSN or MSN (alternate entry) program and the MSN is required for ADN and diploma programs.
- Doctorate for BSN, Master's for ADN, no diploma programs.
- Baccalaureate programs: Doctorate with at least one post-graduate degree in nursing; Associate programs: Master's in nursing minimum.

B. Minimum education for RN faculty teaching didactic courses

	Response Total
Doctorate	0
Master's degree in nursing	27
Other master's degree	6
BSN	7
ADN and/or diploma	1
No requirements	0

Other, please explain (specify if you have different qualifications for ADN, diploma or BSN faculty teaching didactic courses):

- Rule in process to require master's for all faculty beginning 2015.
- Exceptions allowed for nurses pursuing required qualifications or short-term appointment (one year).
- BSN enrolled in master's degree program; can do "faculty notification."
- BSN with plan demonstrating progression in obtaining an MSN.
- Require that instructor have education at least one level above what they are teaching.
- Depends on type of RN program.
- In order to be considered an instructor you must have master's, however occasionally a person with a BSN can lecture, but cannot be in charge of a course.
- For BSN programs, at least 75 percent of the faculty must have MSN. The other 25 percent are to have a BSN and a master's in a related field. For ADN and diploma programs, faculty are to be BSN prepared.
- This requirement is for faculty that have primary responsibility for planning, implementing and evaluating the curriculum.
- 75 percent must have MSN; 25 percent can have master's in related field.
- WV 19CSR1-11.1.a. requires a graduate degree with a major in nursing. Board may grant exception: bachelor's degree with a major in nursing and admitted/enrolled in a MSN program within one year of employment.
- Individuals without a master's degree in nursing may be considered for a non-emergency or an emergency faculty waiver.
- If BSN-prepared, must be working towards MSN at a rate of at least six credit hours per calendar year.
- BSN faculty must be MSN upon hire; ADN faculty must have BSN and then have six years to obtain the MSN.
- Depends upon whether it is an ADN or baccalaureate program.

C. Minimum education for RN faculty teaching clinical courses

	Response Total
Doctorate	0
Master's degree in nursing	20
Other master's degree	4
BSN	12
ADN and/or diploma	2
No requirements	0

Other, please explain (specify if you have different qualifications for ADN, diploma or BSN faculty teaching clinical courses):

- Rule in process to require master's for all faculty beginning 2015.
- Any faculty with less than a master's must enroll in a nursing program one year after start of employment. Preference is BSN.
- Can do "faculty notification" if BSN enrolled in master's degree program.
- BSN with plan demonstrating progression in obtaining a graduate degree in nursing.
- Have degree at or above the level they are teaching.
- The classification of clinical teaching assistant for clinical supervision only is at the ADN level.
- This requirement is for faculty that have responsibility for planning, implementing and evaluating the curriculum.
- BSN with waiver from executive director and in graduate school.
- WV 19CSR1-11.1a.1.B.: The board may grant an exception if faculty have BSN and are only part-time working with students in lab and clinical setting.
- Individuals without a master's degree in nursing may be considered for a non-emergency or an emergency faculty waiver.
- Must be an RN but can be the same level as instructing.

D. Minimum education for RN faculty in a learning or simulation lab

	Response Total
Doctorate	0
Master's degree in nursing	14
Other master's degree	2
BSN	8
ADN and/or diploma	4
Non-nurse instructor	0
No requirements	5

Other, please explain (specify if you have different qualifications for ADN, diploma or BSN faculty in a learning or simulation lab):

- Rule requiring master's for all faculty beginning 2015 in process.
- The MSN faculty designs the experience. The non-MSN faculty can observe the student performing the skill demonstration.

- BSN if the faculty has primary teaching responsibility; ADN if assisting with instruction.
- As above; "faculty notification" if BSN but enrolled in master's degree program.
- Not addressed—would be same as other instructors.
- Most of the skills lab faculty today have a master's but it is not required.
- The minimum standards are not specific about this. If the person is considered as faculty, he/she must meet the requirements as stated above.
- BSN prepared individuals without a master's degree in nursing may be considered for a non-emergency or an emergency faculty waiver.
- If BSN-prepared, must be working towards MSN at a rate of at least six credit hours per calendar year.
- We do not differentiate.
- Same as clinical faculty.

E. Minimum education for RN preceptor faculty

	Response Total
Doctorate	0
Master's degree in nursing	3
Other master's degree	0
BSN	9
ADN and/or diploma	10
No requirements	5

Other, please explain (specify if you have different qualifications for ADN, diploma or BSN preceptor faculty):

- Must be RN.
- No preceptor language in rules.
- Preceptors are not considered faculty.
- Must be RN.
- Degree at or above the level of the nursing education program.
- Must have clinical expertise; education not an issue.
- RN license.
- Must follow preceptorship guidelines of having documented education and current license.
- Must be the same level as the program.
- Preceptors are not considered faculty. For professional nursing programs, the preceptor is an RN with two years of experience.
- The preceptors shall be credentialed at or above the level for which the student is preparing.
- RN with orientation and in-service.
- WV 19CSR1 requires preceptors to have BSN. Rule is currently in legislative process w/proposed changes that include: "Education preparation at or above the level for which the student is preparing."

- The preceptor must be prepared at or above the level of education in which the student is enrolled.
- Must be at least at the level of the student (i.e., ADN with ADN and BSN with BSN).
- This is determined by the program.
- Depends on program (ADN or BSN)

7. Have your RN faculty qualifications changed because of the current faculty shortage?
Yes – 4
No – 30

If so, how (please explain)

- The previous change occurred about four years ago. We are discussing other minor ones now.
- Allowing other than MSN. Master's degree in other areas as well as clinical expertise considered.
- 75 percent waiver rule for MSN and the waiver for BSN clinical faculty.
- The last changes to WV19CSR1 occurred in the 2000 West Virginia Legislative Session.
- We are considering new rules designed to address the faculty shortage.
- Allow waivers for post-graduate degree not in nursing.

8. Does your state or territory allow waivers of RN faculty qualifications?
Yes – 8
No – 8

If so, please explain the specifics

- Rules in process allow for a five year waiver to meet master's requirement.
- BSN's may teach if they are enrolled in a master's program and within one year of graduation. The school must have at least 80 percent master's prepared in order to get a variance.
- Allowed exceptions include (1) equivalent education, (2) BSN and MS or doctorate in related field, relevant experience; (3) pursuing required qualifications; (4) one year appointment with option to extend an additional year.
- The board has a faculty hire exception in regulations. This is good for one year, and then the program must reapply for the exception. Programs look for candidates with appropriate work experience.
- Can do "faculty notification" if BSN enrolled in master's degree program.
- Nurse must have clinical expertise, be working on advanced degree and work under a qualified faculty member.
- Can request an exception approved by executive director or the board.
- Permit use for a limited time for BSN prepared individuals; if used more than a year, must be enrolled in an MSN program.
- Rule allows a graduate student to be employed (outside of the NFI Pilot study). No more than 15 percent of the faculty may be under-qualified.
- Faculty can be approved on the contingency that the person is actively pursuing the degree needed and submits such proof to the board.

- A faculty person may be approved by the board if they have a BSN and a plan approved by the board for accomplishment of the MSN within three years of appointment.
- WV 19CSR1-11.1.a.1.C states "have qualifications other than those set forth in this subsection which are acceptable to the board."
- BSNs with 50 percent of credits for MSN; or BSNs with master's in other fields may be waived with six graduate nursing credits to teach in Diploma/ADN program or 12 graduate nursing credits for BSN or MSN.
- It is the policy of the Massachusetts Board of Nursing that prospective instructors who meet one of three waiver options may be appointed to the faculty of RN programs for the purpose of clinical or skills lab instruction only.
- Must still have 80 percent master's prepared; must demonstrate it is an emergency; must show effort to recruit master's prepared.
- Up to 15 percent can teach while enrolled in a master's program.
- No more than two or 10 percent of total FTEs, whichever is less.

9. If you do allow waivers for RN faculty qualifications and considering all the RN faculty in your state or territory, approximately what is the percentage of waivers that you give annually?

	Response Total
Fewer than 10%	18
Between 11 and 20%	4
Between 21 and 30%	3
Between 31 and 40%	0
Between 41 and 50%	0
Between 51 and 60%	0
Between 61 and 70%	0
Between 71 and 80%	0
Between 81 and 90%	0
Between 91 and 100%	0

10. What are your current minimum qualifications for PN faculty?

A. Minimum education for PN nursing program administrators

	Response Total
Doctorate	0
Master's degree in nursing	15
Other master's degree	4
BSN	13
ADN and/or diploma	1
No requirements	0

Other:

- Rules in process require a master's degree beginning 2015.
- Bachelor's in nursing or another field.

B. Minimum education for PN faculty teaching didactic courses

	Response Total
Doctorate	0
Master's degree in nursing	6
Other master's degree	0
BSN	19
ADN and/or diploma	4
No requirements	0

Other:

- Rules in process require a master's degree beginning 2015.
- Same as RN programs.
- BS
- BS or teaching credential or one year teaching nursing in last five years or met community college/university teaching requirements in California.
- Two-thirds of the faculty must have BSN so one-third can be ADN and/or diploma prepared.
- If ADN/diploma prepared, must have at least 15 credit hours towards a higher degree.

C. Minimum education for PN faculty teaching clinical courses

	Response Total
Doctorate	0
Master's degree in nursing	3
Other master's degree	0
BSN	19
ADN and/or diploma	3
No requirements	0

Other:

- Rules in process require a master's degree beginning 2015.
- Same as RN programs.
- BSN
- ADN or diploma and a written plan demonstrating progression in obtaining a BSN degree.
- Clinical expertise—can be LPN if they are functioning with the RN faculty member.
- Current state licensure as Practical/Vocational Nurse.
- If ADN/diploma prepared, must have at least 15 credit hours towards a higher degree.
- No differentiation.
- RN licensure.

D. Minimum education for PN faculty in a learning or simulation lab

	Response Total
Doctorate	0
Master's degree in nursing	4
Other master's degree	0
BSN	10
ADN and/or diploma	4
Non-nurse instructor	0
No requirements	0

Other:

- Rules in process require master's degree beginning 2015.
- Same as RN programs.
- BS.
- "Faculty" must be BSN. Some labs have 'lab assistants' who are PNs.
- LPN license
- Same as with RN programs. If considered faculty must have BSN.
- Current state licensure as Practical/Vocational Nurse.
- No differentiation.
- RN licensure.

E. Minimum education for PN preceptor faculty

	Response Total
Doctorate	0
Master's degree in nursing	2
Other master's degree	0
BSN	3
ADN and/or diploma	5
No requirements	5

Other:

- Must be RN.
- BS
- As determined by VN school director.
- Again, preceptors are not considered faculty.
- PN programs do not have precepted experiences at this time.
- Preceptors must be licensed at or above the level for which the student is preparing.
- LPN/VN
- Clinical expertise.
- Do not allow preceptorships in PN programs.
- LPN licensure.

- Preceptors are not considered faculty and can be LPN or RN with two years of experience.
- Idaho does not consider preceptors faculty. A preceptor must be credentialed at or above the level for which the student is preparing.
- Current state licensure as Practical/Vocational Nurse.
- PN programs are not utilizing preceptors.
- The preceptor may be an LPN or RN.
- No differentiation.
- LPN/VN
- This is the decision of the program.
- Our regulations do not provide for preceptors in PN programs.
- Licensed RN.

11. Have your PN faculty qualifications changed because of the current faculty shortage?
Yes – 1
No – 30

If so, how? (please explain)

- Although we would prefer MSN for clinical instructors, we have had to require only a BSN in order to have the governor approve our regulations—so I guess the answer should be "yes."

12. Does your state or territory allow waivers of PN faculty qualifications?
Yes – 13
No – 14

If so, please explain the specifics

- Rules in process allow five-year window to obtain master's degree.
- See above explanation for RN waivers.
- In an emergency for one semester only.
- Issue has not come up.
- Same as RN.
- Only for the didactic faculty in the same manner as for the RN programs.
- Faculty can be approved on contingency if he/she is actively enrolled in a BSN program and submits proof of such to the board.
- An ADN with a plan approved by the board for accomplishment of the BSN within three years of appointment is required.
- We have never been asked.
- Two or 10 percent of total FTE, whichever is less.

13. If you do allow waivers for PN faculty qualifications and considering all the PN faculty in your state or territory, approximately what is the percentage of waivers that you give annually?

	Response Total
Fewer than 10%	16
Between 11 and 20%	0
Between 21 and 30%	1
Between 31 and 40%	0
Between 41 and 50%	0
Between 51 and 60%	0
Between 61 and 70%	0
Between 71 and 80%	0
Between 81 and 90%	0
Between 91 and 100%	0

14. Do you have any additional comments about the faculty shortage?

- A faculty shortage is not a reason to decrease faculty requirements. With the increasing technology and acuity of patient care, the requirements are increasing. More energy needs to be focused on sharing of resources between programs, between program and agency. There is increased technology available to provide for better utilization of faculty. We need to rethink nursing education to meet the projected needs and not continue to try and do the same thing and expect different results. The North Carolina Board of Nursing has supported moving to a conceptual-based program and away from a content-focused program. Faculty development is aimed at changing the mentality of "covering all the content" to making the nurse a knowledge worker utilizing resources and embracing the five IOM competencies for all health professionals.
- Thank you for collecting this information!
- We are looking at requiring a BSN in 10 years for any nurse who initially licenses in New Mexico after a certain date. This requirement will produce BSNs who may want to teach. We also have money in place from the legislature that helps educators with the expense of schooling. Most of our ADN programs offer a BSN completion program and MSN on-site program.
- The major problem appears to be salary inequity between clinical practice settings and education, not too few nurses with required education and experience. Administrative rules for nursing education are currently under review and faculty roles/qualifications are anticipated to consume a great deal of attention! Agreement that as simulation assumes more importance as an instructional tool, it requires faculty with more experience and education, not less.
- It is a real problem, but it would seem to lower the educational requirements would be the same as saying that if we have a shortage of brain surgeons that it would be okay for general practitioners to do brain surgery. Nursing education is a specialty that is not always recognized and as such we have a number of nurse practitioners teaching who have had no education courses—this also can be a problem. We do say faculty need to be MSN-prepared or making annual progress toward an MSN—which is to be completed in six years.

- We have had significant expansion of the number of programs and the number of students admitted to existing programs. Low salaries, weekend/evening clinicals, and master's degree requirements all present their own deterrents to filling positions.
- The shortage has increased in severity over the past two years. One factor has to do with salaries. MSN prepared nurses can generally earn more in the practice setting than the academic one.
- Salary increases have made a tremendous difference in the shortage in our state. We are hoping peer pressure will result in improved salaries at all schools.
- It is essential that boards of nursing maintain standards for faculty education, while at the same time, support efforts to recruit new faculty. There has been discussion in our state about the possibility of allowing an individual with a master's in another field to obtain a post-master's certificate in nursing education. This would require rule changes, but is an interesting discussion.
- I think we need to do things differently with what we have. For example, take a clean sheet of paper and indicate with six faculty and 60 pupils, what is the best way to achieve our goals—something like that.

Attachment D1

PR&E Committee
Comparison of Faculty Qualifications in National Documents

Comparison of Faculty Qualifications in National Documents	
Sources	**Education of the Nursing Faculty Member**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; *AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs*, 2007)	*The Essentials of Master's Education for Advanced Practice Nursing* states on page 3: **Doctoral education for baccalaureate programs:** "A nurse prepared at the master's level also is clearly able to serve important functions as an expert clinician as a faculty member in a nursing education program. **However, the primary focus of the master's education program should be the clinical role**." (their emphasis). Further, it says that the doctoral degree is the desired credential for a career as a nurse educator. *The Essentials of Doctoral Education for Advanced Practice* states that the doctor of nursing practice (DNP) will be the preferred degree for advanced nursing practice (page 6). It goes on to say: "However, the DNP curriculum does not prepare the graduate for a faculty teaching role any more than the PhD curriculum does. Graduates of either program planning a faculty career will need preparation in teaching methodologies, curriculum design and development, and program evaluation. This preparation is in addition to that required for their area of specialized nursing practice or research in the case of the PhD graduate." *AACN Board Expectations* states: "The AACN Board recently approved a set of *Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs*. These expectations were developed to provide a uniform set of expectations to be used by the board in making policy decisions. They address the desired education level and role responsibilities for full- and part-time faculty, clinical instructors and preceptors. Expectations include: "Qualifications and performance of ranked full-time nursing faculty will be congruent with accepted university standards for assistant, associate, and full professors. Consistent with academy expectations that all faculty will hold a terminal degree, faculty teaching didactic courses in baccalaureate, master's and doctoral programs will have doctoral preparation that contributes to their productivity as a teacher, scholar and clinician." And: "Nursing courses will be taught by faculty with advanced expertise in the areas of content they teach. Doctorally prepared faculty have overall responsibility for all courses. Clinical instructors, at minimum, are master's prepared with a practice focus and may be full- or part-time."
CCNE Standards (2003)	No specific criteria. From the online document, *Standards for Accreditation of Baccalaureate and Graduate Nursing Programs*: Standard II. Program Quality: Institutional Commitment and Resources: Key Element II-D.: "The chief nursing administrator is academically and experientially qualified and is vested with authority required to accomplish the mission, goals, and expected outcomes. The chief nurse administrator provides effective leadership to the nursing unit in achieving its mission, goals, and expected outcomes." Key Element II-E.: Faculty members are academically and experientially qualified and sufficient in number to accomplish the mission, goals, and expected outcomes of the program." Standard IV. Program Effectiveness: Student Performance and Faculty Accomplishments: "Faculty outcomes demonstrate achievement of the program's mission, goals, and expected outcomes, and enhance program quality and effectiveness." For the chief nurse administrator they write, "The registered nurse with a graduate degree who serves as the administrative head of the nursing unit."

Comparison of Faculty Qualifications in National Documents	
Sources	**Education of the Nursing Faculty Member**
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *Elements of Nursing Education* (2006)	The EBNER findings imply master's degrees because the research supports high-level interaction with students and faculty assisting with the application of current nursing knowledge. The research supports the following: ■ Faculty teaches clinical and didactic courses. ■ Faculty is available to assist with and demonstrate clinical skills and activities. ■ Faculty assists with classroom projects. ■ Faculty is available during clinical and didactic learning. ■ Faculty provides current information. ■ Critical thinking is integrated into the curriculum. ■ Evidence-based practice is integrated into the curriculum. ■ Information technology is integrated into the curriculum. ■ Pathophysiology is integrated into the curriculum. ■ Students demonstrate skills to faculty. ■ Promote faculty-student interaction with online learning. *A National Survey on Elements of Nursing Education* (NCSBN, 2006) reported from a stratified random study of nursing programs (410 respondents) that 24.2 percent of the faculty in LPN/VN programs had master's degrees, 59.5 percent of the faculty from RN programs had master's degrees and 13.9 percent of faculty from RN programs had doctoral degrees.

Comparison of Faculty Qualifications in National Documents

Sources	Education of the Nursing Faculty Member
NCSBN Member Board Profiles (2007)	■ Minimum educational qualifications for LPN program administrators: ▪ MSN = 12 ▪ MSN preferred = 4 ▪ MS = 2 ▪ BSN = 12 ▪ BSN preferred = 1 ▪ BS = 2 ▪ Other = 4 ■ Minimum educational requirements for RN baccalaureate administrators: ▪ Earned doctorate in nursing = 3 ▪ Earned doctorate other = 7 ▪ Doctorate preferred = 3 ▪ MSN = 17 ▪ MS = 3 ▪ Master's other = 1 ▪ Other = 4 ■ For ADN administrators: ▪ Earned doctorate = 1 ▪ MSN = 24 ▪ MSN preferred = 3 ▪ MS = 7 ▪ Other = 7 ■ For diploma administrators: ▪ MSN = 11 ▪ MSN preferred = 3 ▪ MS = 3 ▪ BSN = 2 ▪ Other = 4 ■ Minimum educational qualifications for LPN program faculty: ▪ MSN = 3 ▪ MSN preferred = 3 ▪ BSN = 17 ▪ BSN preferred = 2 ▪ BS = 2 ▪ Other = 11 ■ Minimum educational qualifications for RN baccalaureate degree program faculty: ▪ Doctorate preferred = 2 ▪ MSN = 17 ▪ MSN preferred = 4 ▪ MS = 4 ▪ Master's other = 1 ▪ BSN = 5 ▪ BSN = 1 ▪ Other = 4 ■ For ADN faculty: ▪ MSN = 16 ▪ MSN preferred = 6 ▪ MS = 3 ▪ Master's other = 1 ▪ BSN = 8 ▪ BS = 1 ▪ Other = 3 ■ For diploma faculty: ▪ MSN = 7 ▪ MSN preferred = 5 ▪ MS = 2 ▪ BSN = 5 ▪ BS = 1 ▪ Other = 3

Comparison of Faculty Qualifications in National Documents	
Sources	**Education of the Nursing Faculty Member**
NCSBN Model Rules (2004)	■ *LPN administrator*: BSN and master's in a related nursing field or a doctorate. ■ *LPN educators*: Sufficient numbers; BSN and preparation in teaching and learning principles for adult education, including curriculum development and implementation. ■ *RN administrator:* Doctoral degree in nursing, or a master's degree in nursing and doctoral degree in another field. Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration, and at least two years of clinical experience and current knowledge of RN nursing practice. ■ *RN educator*: Sufficient numbers have a minimum of a master's degree in nursing or a nursing doctorate, have preparation in teaching and learning principles for adult education including curriculum development, and have current knowledge of RN nursing practice.
NLNAC Accreditation Manual (2006)	II. 5. Faculty in LPN/VN programs: majority (at least 50 percent) of full-time nursing faculty engaged in didactic teaching have a minimum of a master's degree. The remaining faculty, full- and part-time, need a BSN degree, with progress toward a master's degree or evidence of course work, continued education or relevant certification. They may provide rationale for acceptance of other than the minimum required graduate credential. II. 5. Faculty in ADN, diploma or BSN programs: ■ Minimum of MSN. ■ Rationale of acceptance of other than the minimum. For all programs, the faculty/student ratios are sufficient; utilization of full- and part-time faculty is consistent with the program; and number and type of faculty are adequate to carry out the objectives of the program. The nurse administrator is the individual with responsibility and authority for the administrative and instructional activities of the nursing education unit within the governing organization (e.g., dean, chairperson, director). The qualifications for the administrator in an LPN/VN program are a graduate degree with a major in nursing; explain acceptance of other graduate credentials. The qualifications for the administrator in a BSN program are a graduate degree with a major in nursing and an doctorate earned from a regionally accredited institution; explain acceptance of other graduate credentials for the nurse administrator. Administrator qualifications for ADN and diploma programs include a graduate degree with a major in nursing; explain acceptance of other graduate credentials for the nurse administrator.
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	An NLN Hallmark of Excellence in nursing education, page 7: "All faculty should have structured preparation for the faculty role, as well as competence in their area(s) of teaching responsibility." Page 13: "competence is recognized through master's and/or doctoral education, post-master's certificate programs, continuing professional development, mentoring activities, and professional certification as a faculty member."
NAPNES	■ Valid unencumbered license in state where employed. ■ BSN with two to four years of recent clinical experience in related field.

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of Nursing Education**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; *AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs*, 2007)	N/A
CCNE Standards (2003)	N/A
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *A National Survey on Elements of Nursing Education* (2006)	N/A
NCSBN Member Board Profiles (2007)	N/A
NCSBN Model Rules (2004)	N/A
NLNAC Accreditation Manual (2006)	N/A
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	The process of facilitating learning through curriculum design, teaching, evaluation, advisement and other activities undertaken by faculty in schools of nursing. Academic nursing education is a specialty area and an advanced practice role within professional nursing.
NAPNES	Nursing education is the thorough and effective process of acquisition of knowledge, skill and appropriate clinical judgments consistent with the standards of the controlling state agency.

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of Nursing Faculty**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; *AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs*, 2007)	Much of this is addressed in the previous table, *Definition of Nursing Education*.
CCNE Standards (2003)	Standard II. "Program Quality: Institutional Commitment and Resources": "The faculty, as a resource of the program, enables the achievement of the mission, goals, and expected outcomes of the program."
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *A National Survey on Elements of Nursing Education* (2006)	N/A
NCSBN Member Board Profiles (2007)	N/A
NCSBN Model Rules (2004)	■ *Nursing program faculty:* Individuals employed full- or part-time by the academic institution; they are responsible for developing, implementing, evaluating and updating curricula. ■ Faculty-directed clinical practice is defined as the role of nursing program faculty in overseeing student clinical learning including those programs utilizing preceptors.
NLNAC Accreditation Manual (2006)	■ Full-time faculty is the person who teaches nursing and has full-time faculty employment status as defined by the governing organization and the nursing education unit. Ideally, full-time faculty have a major commitment to the governing organization and to the nursing education unit, and handle the governance activities and committee work (i.e., advisement and counseling; curriculum planning, maintenance and revision; and program evaluation). ■ Part-time faculty is the person who teaches nursing and who has a part-time faculty employment status as defined by the governing organization and the nursing education unit. Usually the individual has a narrower set of responsibilities than full-time faculty.
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	N/A
NAPNES	Nursing faculty consists of registered professional nurses who possess comprehensive knowledge and clinical expertise. Nursing faculty apply critical judgment in the utilization of the nursing process in both the didactic and the clinical setting. Ideally, nursing faculty serve as role models for their students.

Comparison of Faculty Qualifications in National Documents	
Sources	**Adjunct Faculty Members, Including Preceptors**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; *AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs*, 2007)	AACN Board Expectations: "As a professional academic enterprise, nursing needs to balance its stature within the academy with its concurrent responsibility to prepare graduates for the practice environment. Thus, the mix of faculty expertise, roles, and responsibilities may vary according to the mission of the academic program. The ratio of full and part-time faculty needs to be sufficient to accomplish program outcomes." And: "Preceptors whose primary role is direct or indirect patient care (not faculty) serve as role models for the design, organization, and implementation of patient care. They also work with clinical course faculty, work part-time, and at minimum are baccalaureate-prepared."
CCNE Standards (2003)	N/A
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *A National Survey on Elements of Nursing Education* (2006)	A National Survey on Elements of Nursing Education (NCSBN, 2006) reported 50.8 percent of LPN/VN programs used preceptors/clinical adjuncts and 82.1 percent of the RN programs used them. Preceptors/clinical adjuncts taught about 20 percent of the clinical experiences in programs that used these individuals.
NCSBN Member Board Profiles (2007)	LPN/VN student preceptor ratio: ■ 1:1 – 9 ■ 2:1 – 5 ■ More than 4:1 – 2 RN student preceptor ratio: ■ 1:1 – 11 ■ 2:1 – 7 ■ More than 4:1 – 1
NCSBN Model Rules (2004)	■ Adjunct faculty are temporary nursing faculty, in addition to regular program faculty, used to enrich student experiences. ■ Preceptors are defined as individuals at or above the level of licensure that an assigned student is seeking, who may serve as a teacher, mentor, role model and/or supervisor in a clinical setting.
NLNAC Accreditation Manual (2006)	***Adjunct***: Person who has been contracted to teach a specific course (theory/clinical) or component of a course.
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	N/A
NAPNES	Individuals who possess the required educational qualifications or a specific skill set in fields related to nursing and who provide content that supplements and/or enhances the nursing education program.

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of and Criteria for Clinical Experiences**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; *AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs, 2007*)	AACN Board Expectations: "Clinical instructors, at minimum, are master's-prepared with a practice focus and may be full or part-time (joint, adjunct, etc.). They may coach and mentor preceptors to facilitate critical thinking and clinical decision-making."
CCNE Standards (2003)	N/A
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *A National Survey on Elements of Nursing Education* (2006)	*A National Survey on Elements of Nursing Education* (NCSBN, 2006) reported that means of student faculty ratios, across all settings, was 6.3 to 9.4. Deliberate Practice with Actual Patients ▪ Provide experiences for relationship building with patients. ▪ Provide clinical experiences with actual patients. ▪ Provide experiences for gaining confidence. ▪ Provide opportunities for reflection. ▪ Provide feedback. Assimilation to the Role of Nursing ▪ Provide experiences for relationship building with professionals. ▪ Provide experiences for students to gain comfort in nursing role. ▪ Provide teamwork experiences. ▪ Provide transition programs.
NCSBN Member Board Profiles (2007)	Clinical Experiences (a) Boards require number of clinical hours? ▪ LPN: yes/10; no/29; Did Not Answer/3 ▪ LPN/VN associate degree: yes/4; no/30; Did Not Answer/8 ▪ Diploma: yes/1; no/29; Did Not Answer/12 ▪ ADN: yes/3; no/37; Did Not Answer/2 ▪ BSN: yes/3; no/37; Did Not Answer/2 (b) Student faculty ratios are prescribed for basic nursing education programs: yes/31; no/11 Ratios vary from: ▪ LPN/VN: 8:1 to 15:1 ▪ RN: 8:1 to 12:1 (c) Pre-licensed nursing standards in clinical settings are regulated by the boards? Yes/12; no/29 (d) Board requiring clinical experiences in the following: LPN/VNs ▪ Obstetrics: 32/32 ▪ Adult health: 31/32 ▪ Pediatrics: 32/32 ▪ Psychiatric: 21/32 ▪ Community health: 9/32 RNs ▪ Obstetrics: 32/32 ▪ Adult health: 31/32 ▪ Pediatrics: 32/32 ▪ Psychiatric: 30/32 ▪ Community health: 21/32

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of and Criteria for Clinical Experiences**
NCSBN Model Rules (2004)	Supervised clinical practice shall include development of skill in making clinical judgments, management and care of groups of clients, and delegation to and supervision of other health care providers. (a) Clinical experiences shall be comprised of sufficient hours to meet these standards; be supervised by qualified faculty and ensure students' ability to practice at an entry level. (b) All student clinical experiences, including those with preceptors, shall be directed by faculty.
NLNAC Accreditation Manual (2006)	Facilities used for clinical practice are adequate and the resources support sufficient experiences.
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	N/A
NAPNES	Under the supervision of designated faculty, the students will learn the application of the nursing process in selected clinical settings. This may include, but is not limited to: promotion of health; organization, rendering, and documentation of care; and effective communication with the patient and the health care team.

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of and Criteria for Didactic Education**
AACN (*The Essentials of Master's Education for Advanced Practice Nursing*, 1996; *The Essentials of Doctoral Education for Advanced Practice*, 2006; AACN Board Expectations Regarding Faculty Teaching in Baccalaureate and Graduate Nursing Programs, 2007)	N/A
CCNE Standards (2003)	N/A
EBNER (*Evidence Based Nursing Education for Regulation*, 2006) and *A National Survey on Elements of Nursing Education* (2006)	▪ Adjunctive ▪ Use simulation ▪ Combine online and traditional strategies ▪ Integrate critical thinking ▪ Integrate evidence-based practice ▪ Integrate information technology ▪ Integrate pathophysiology ▪ Teach population courses separately ▪ Demonstration opportunities
NCSBN Member Board Profiles (2007)	LPN/VN programs – Minimum theory hours: yes/12; no/26; Did Not Answer/4 LPN/VN Associate degree programs: yes/5; no/28; Did Not Answer/9 Diploma programs – Minimum theory hours: yes/3; no/29; Did Not Answer/10 ADN programs – Minimum theory hours: yes/4; no/35; Did Not Answer/3 BSN programs – Minimum theory hours: yes/4; no/35; Did Not Answer/3 Boards require didactic content in the following: LPN/VNs ▪ Obstetrics: 34/34 ▪ Adult health: 33/34 ▪ Pediatrics: 34/34 ▪ Psychiatric: 26/34 ▪ Community health: 11/34 RNs ▪ Obstetrics: 34/34 ▪ Adult health: 34/34 ▪ Pediatrics: 34/34 ▪ Psychiatric: 33/34 ▪ Community health: 24/34

Comparison of Faculty Qualifications in National Documents	
Sources	**Definition of and Criteria for Didactic Education**
NCSBN Model Rules (2004)	The curriculum of the nursing education program shall enable the student to develop nursing knowledge, skills and competencies necessary for the level, scope and standards of nursing practice consistent with the level of licensure. The curriculum shall include: (a) Content regarding legal and ethical issues, history and trends in nursing and healthcare, and professional responsibilities. (b) Experiences that promote the development of clinical judgment, leadership and management skills, and professional socialization consistent with the level of licensure. This includes demonstration of the ability to supervise others and provide leadership of the profession. (c) Learning experiences and methods of instruction, including distance learning methods, consistent with the written curriculum plans. (d) Specifics regarding coursework can be found here: https://www.ncsbn.org/chapter8.pdf
NLNAC Accreditation Manual (2006)	▪ *LPN/VN*: Clock and clinical hours meet individual state board of nursing/state department of education requirements. ▪ *Diploma*: Clock and clinical hours meet individual state board of nursing/state department of education requirements. ▪ *ADN*: 60 – 72 semester credits or 90 – 108 quarter credits, with a 1:3 credit hour ratio for clinical experiences. No more than 60 percent of the courses should be allocated to nursing courses. ▪ *BSN*: majority of course work in nursing is at the upper division level.
NLN (*The Scope of Practice for Academic Nurse Educators*, 2005)	N/A
NAPNES	The transmission of information in nonclinical settings that is specific to the nursing education curriculum and as defined by the controlling state agency.

Report of the APRN Advisory Panel

Background

The APRN Advisory Panel has worked with certification programs to ensure the legal defensibility of APRN certification examinations and with all APRN stakeholders to promote communication regarding APRN regulatory issues. Regular updates regarding all activities pertaining to APRN regulatory events have been sent to boards of nursing.

The APRN Advisory Panel has continued to revise the draft APRN Vision Paper based on their discussions with the many APRN stakeholders they have met with this year. Although great strides have been made, the APRN Vision Paper has not been completed and it is anticipated that an additional year will be needed to finish it.

Highlights of FY07 Activities

- Held the APRN roundtable in Chicago on March 22, 2007.
- Continued to review draft APRN Vision Paper on the future of APRN regulation.
- Maintained an APRN list serve to enhance communication among Member Boards regarding APRN regulatory issues.
- Met with the American Association of Critical Care Nurses to discuss their new acute care nurse practitioner examination.
- Met with APRN certifying bodies to discuss issues of common concern.
- Met with a variety of other APRN stakeholders to discuss APRN regulatory issues including: American Association of Nurse Anesthetists, American College of Nurse Midwives, American Nurses Association, Council of Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives Division of Accreditation, Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Organization of Nurse Practitioner Faculties and the American Association of Colleges of Nursing.
- Held the APRN Summit for members in Chicago on Jan. 26, 2007.
- Reviewed the NCSBN research brief, *Role Delineation Study of Nurse Practitioners and Clinical Nurse Specialists*.
- Formed the APRN Joint Dialogue Group (subgroup of the APRN Advisory Panel and subgroup of the APN Consensus Group) to work on APRN issues. The goal of this group is to produce two papers that do not conflict with each other, create an ongoing process of communication of the licensure, accreditation, certification and education entities and to identify an APRN regulatory model that all can put forward and support. The APRN Joint Dialogue group met four times.
- Reviewed proposed Medicare regulations to establish criteria for APRN certifying bodies.

Future Activities

- Continue the APRN roundtable.
- Maintain and enhance communication among APRN stakeholders, Member Boards and NCSBN.
- Complete the APRN Vision Paper based on feedback and meetings with stakeholders.

Attachments

A. None

Members

Katherine Thomas, MN, RN, Chair
Texas, Area III

Patty Brown, RN, BSN, MS
Kansas, Area II

Marcia Hobbs DSN, RN
Kentucky, Area III

Randall Hudspeth, MS, APRN-BC
Idaho, Area I

Ann O'Sullivan, PhD, CRNP, CPNP, FAAN, Pennsylvania, Area IV

Laura Poe, MS, RN
Utah, Area I

John Preston, CRNA, DNSc, APN
Tennessee, Area III

James Luther Raper, DSN, CRNP
Alabama, Area III

Linda Rice, MSN, APRN, FNP
Vermont, Area IV

Cristiana Rosa, RN, MSN
Rhode Island, Area IV

Cathy Williamson, RN, CNS, MSN
Mississippi, Area III

Janet Younger, PhD, RN
Virginia, Consultant

Charlene Hanson, EdD, RN, CS, FNP, FAAN, Consultant

Faith Fields, MSN, RN
Board Liaison, Arkansas, Area III

Staff

Nancy Chornick, PhD, RN, CAE
Director, Practice & Credentialing

Meeting Dates

- Oct. 3 – 4, 2007
- Nov. 30 – Dec. 1, 2007
- Jan. 25 – 26, 2007
- March 21 & 23, 2007

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Provide effective education, information sharing and networking opportunities.

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Provide models and resources for evidenced based regulation to Member Boards.

Strategic Objective 3
Collaborate with national organizations in the promotion of evidence-based regulation.

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 3
Enhance communication between Member Boards and external stakeholders.

Report of the Awards Panel

Background

The Board of Directors established the Awards Panel in FY01 to review and evaluate the NCSBN Awards program. The panel was charged with selection of award recipients and developing an awards program that ensured consistency, fairness and celebrate the contributions and accomplishment of the membership. The panel has continued to refine the award categories, objectives and eligibility criteria.

Highlights of FY07 Activities

- Selected the 2007 award recipients.
- Reported to the Board of Directors the 2007 recipients selected by the awards panel.
- Identified executive officers that are eligible to receive the Executive Officer Recognition Award.
- Identified boards of nursing that are celebrating 100 years of nursing regulation in 2007.
- Launched the awards program as a complete electronic process.
- Evaluated the strategies for early promotion of award recipients and determined the following strategies should continue:
  - Recipients were notified early, in May, following the Board of Directors' meeting.
  - A news release was sent over the wire in June, and another will be sent in August following Annual Meeting.
  - A news release will be sent to the recipients' boards of nursing for release to local papers and newsletters.
  - Annual meeting will have a display of recipients' photographs.
  - Special colored registration ribbon will be provided for recipients at Annual Meeting.
  - There will be a slide show projected on large screen prior to presentation of award to recipient.
  - Recipients' biographies will be read by members of the Awards Panel.

2007 AWARD RECIPIENTS:

R. Louise McManus Award
Polly Johnson, Executive Director, North Carolina Board of Nursing

Meritorious Service Award
Mark Majek, Board Staff, Texas Board of Nurse Examiners

Regulatory Achievement Award
Massachusetts Board of Registration in Nursing

Exceptional Leadership Award
Judith Hiner, Board Member, Kansas State Board of Nursing

Exceptional Contribution Award
Peggy Fishburn, Board Member, Kentucky Board of Nursing

Members

Marty Alston
West Virginia-RN, Area II

Joan Bainer, MN, RN, CAN, BC
South Carolina, Area III

Rachel Gomez, LVN
Texas, Area III

Valerie Smith, MS, RN
Arizona, Area I

Susan Woods, PhD, RN
Washington, Area I

Staff
Alicia Byrd
Director, Member Relations

Meeting Dates

Oct. 5, 2006 (Conference Call)

March 16, 2007

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 3
Recognize excellence.

Executive Officer Recognition Awards

FIVE YEARS

- Karen Scipio-Skinner, District of Columbia
- Sylvia Bond, Georgia Board of Nursing-RN
- Debra Scott, Nevada
- Rosa Tudela, Northern Mariana Islands
- Laurette Keiser, Pennsylvania
- Gloria Damgaard, South Dakota
- Jay Douglas, Virginia
- Margaret Walker, New Hampshire

10 YEARS

- Polly Johnson, North Carolina

100th Anniversaries

Continuing in the yearly tradition of acknowledging each of NCSBN's Member Boards as they celebrate their 100th Anniversary, we recognize the following boards on reaching this significant milestone. We congratulate their accomplishments and honor their many contributions to nursing regulation in service to public welfare and safety.

- District of Columbia Board of Nursing
- Iowa Board of Nursing
- Illinois Nurse Practice Act
- Georgia Board of Nursing-RN
- Minnesota Board of Nursing
- New Hampshire Board of Nursing
- West Virginia Board of Examiners for Registered Professional Nurses

Report of the Continued Competence Advisory Panel

Background

Boards of nursing have a responsibility to assure the competency of their licensees. This pertains not only to new graduates or internationally educated nurses applying for licensure by examination, but it also pertains to post entry-level nurses providing patient care. Currently, there is a lack of uniformity among states as to what, if anything, should be required of post-entry licensees. Many boards of nursing find themselves struggling to answer questions concerning how to assure the public that nurses maintain competency throughout their careers and how to determine whether an individual that has left nursing practice for an extended period of time is competent to return to patient care.

Although states have attempted various approaches to ensure competency for nurses, there are no evidence-based methods, with the exception of the NCLEX® exam, that measure or support this endeavor. In a review of 58 (no information was available for American Samoa) Member Board nurse practice acts conducted by NCSBN in November 2005, 28 states required continuing education for license renewal; four states required practice hours; six states had a combined requirement of both continuing education and practice hours; and nine states (an additional two states had proposed legislation) provided licensees with various options such as peer review and reflective practice. Nine states had no continued competency requirements. The issue of what method is most efficient and effective continues to confound nursing regulators who are looking to NCSBN for its leadership in this matter.

The need for ongoing competency requirements is not isolated to nursing. Continued competency of health care providers has been addressed by the Institute of Medicine (IOM) (2004, 2003, 2003, 2001, 2000) and a host of other commissions and organizations including: The Citizens Advocacy Center (1996, 2004), The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (2006), and the PEW Health Professions Commission (1995). All have advocated for a process that will objectively measure competence among post entry-level health care professionals. NCSBN has long recognized the necessity to assess ongoing competence and has been at the forefront addressing this issue. Since 1985, when the first continued competence paper was written (Kelly, 1985), NCSBN has addressed, supported and promoted the development of a continued competence assessment for nurses.

The current work on continued competence began with the Board's Strategic Initiatives for 2005 – 2007 (position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers). A Continued Competence Task Force was initiated by the Board and task force members chosen. Two consultants, Fran Hicks, PhD, RN, and David Swankin, served on the task force as well. The charges for 2006, given by the NCSBN Board of Directors, requested that the task force develop a continued competence assessment tool, a continued competence regulatory model and a communication plan. In preparation, the 2006 Continued Competence Task Force reviewed, discussed and analyzed numerous documents including: NCSBN position papers on continued competence written over the last 20 years, articles from external journals, feedback from the membership, reports from other organizations including the continuing competence requirements of other health professions, the continuing competence requirements for nurses in other countries and Member Boards' continued competency requirements. This information was examined to determine whether any feasible evidence-based methods to measure competency were already in existence. These methods were also analyzed according to the APPLE criteria (administratively feasible, publicly credible, professionally acceptable, legally defensible and economically feasible). At the conclusion of their review, the task force decided that there were no evidenced-based methods in existence that would meet the APPLE criteria, accurately and reliably assess the continued competence of a nurse in the U.S. and meet the needs of the NCSBN Member Boards.

Members

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Staff

Maryann Alexander, PhD, RN
Associate Executive Director, Regulatory Programs

Mary Doherty, JD, BSN, RN
Associate, Practice, Regulation and Education

Meeting Dates

- Aug. 29 – Sept. 1, 2006
- Oct. 16 – 18, 2006
- Dec. 13 – 15, 2006
- Feb. 28 – March 2, 2007

Relationship to Strategic Plan

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Provide models and resources for evidence-based regulation to Member Boards.

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 2
Implement recommendations for effective communication within the membership.

Strategic Initiative IV

Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers.

Strategic Objective 2
Continue development of an assessment instrument(s) to measure continued competence of RNs and LPN/VNs.

Work then began on the development of an evidenced-based tool that would evaluate general nurse competence beyond entry-level (first six months of practice), in accordance with the APPLE criteria, for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). The first step was to determine whether any core activities existed across all nursing specialties. This preliminary analysis was accomplished through the LPN/VN and RN continued competence practice analyses. Results of these studies revealed that core activities do exist across all nursing specialties and there are core knowledge and skills that are required of all practicing nurses regardless of their specialty. This information was integral to this project and served as the impetus for the task force to move forward. Throughout the year, the task force extensively discussed and identified the components they felt should be incorporated into a continued competence regulatory model. Progress and a potential framework for a regulatory model were communicated to the membership at the 2006 Midyear Meeting and feedback was received. Work continued, and during the 2006 Annual Meeting the task force presented a draft rudimentary regulatory model to the Delegate Assembly. The opportunity for comment and questions was provided, but none were offered. This work laid the foundation for the current 2007 Continued Competence Advisory Panel.

The 2006 – 2007 Continued Competence Advisory Panel has been addressing the following charges:

1. Develop a content outline for continued competence assessments.
2. Conduct preliminary feasibility studies for continued competence assessments.
3. Continue to develop and implement a communication plan on continued competence.
4. Continue development of a continued competence regulatory model that can be used by Member Boards in order to assure the continued competence of the nurse.

Below is a summary of their work to date.

Develop a content outline for continued competence assessments

Using the data from the 2006 RN and LPN/VN post entry-level practice analyses, the 2007 advisory panel devoted two three-day meetings to examining the core activity statements and developing a content outline for the RN and LPN/VN pilot assessment tools. Under the guidance of a consultant, major content areas were identified by the survey respondents answering the practice analysis questionnaires as being performed frequently while doing their job and/or were highly important to their practice as an RN or LPN/VN. These were used to develop core competencies for the RN and LPN/VN assessment tools. The major six content areas for RN continued competence (with weights) were identified as: clinical judgment in provisions of care (29 percent), professional responsibilities (20 percent), communication (8 percent), inter/intradisciplinary collaboration (9 percent), supervision/management (6 percent) and safety (28 percent). In each of these six categories are specific domains of nursing practice that are integral to quality patient care. Together, these categories make up the general competencies required for all RNs providing patient care in the U.S. These categories and domains will serve as the content outline for the RN assessment pilot tool (see Attachment A).

The advisory panel has also completed work on the specification of content areas and weights for LPN/VNs. Using the core activity statements from the 2005 Post Entry-Level Practice Analysis for LPN/VNs the advisory panel developed a content outline for the LPN/VN pilot assessment tool. Under the guidance of the consultant, major content areas were identified by the survey respondents answering the practice analysis questionnaire as being performed frequently while doing their job and/or were highly important to their practice as an LPN/VN. These were used to develop core competencies. The six major content areas for LPN/VN continued competence (with weights) were identified as: provision of care (40 percent), legal/ethical responsibilities (15 percent), communication (15 percent), inter/intradisciplinary collaboration (10 percent) and safety (20 percent). Under each of these six categories are specific subcategories that describe the knowledge, skills and abilities LPN/VNs required to

provide safe and quality patient care. These categories will serve as the content outline for the LPN/VN assessment pilot tool (see Attachment B).

Of note, all of the IOM competencies (deliver patient centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics) have been incorporated into the six categories/domains and will be a fundamental part of an assessment tool that is developed by NCSBN.

Conduct preliminary feasibility studies for continued competence assessments

Utilizing the RN and LPN/VN test specification reports and the professional judgment of the advisory panel, staff has engaged an external consultant to submit a proposal to construct and conduct a national pilot test of the proposed assessment tools. Staff has queried the advisory panel regarding assessment tool preferences and requirements. Staff will bring the consultant up to speed in order to facilitate production of the proposal for the pilot test.

Continue to develop and implement a communication plan on continued competence

The advisory panel felt it important that communication to the Member Boards as well as to external organizations be concise, accurate and provide consistent answers to questions. The advisory panel has addressed, as part of the communication plan, the three most important questions to date that will be asked regarding this project and has given extensive thought to the responses.

1. Why do we need a continued competence assessment?
   - Public safety requires it.
   - The public demands it.
   - It will improve quality of care.
   - In most cases, it will provide an affirmation of competency.
   - It is part of the NCSBN strategic plan.
2. Why now?
   - Public demands it.
   - Care is becoming increasingly complex.
   - There is data to support the need.
   - There is a national health care movement in this direction.
3. Why NCSBN?
   - This is part of our mission and NCSBN has the resources to undertake the project.
   - This has been a part of the NCSBN agenda for more than 20 years (historically, NCSBN has spearheaded this).
   - NCSBN has the leadership to take this on and to standardize competency on a national basis.
   - The project is too large for any one board, but NCSBN can accomplish this with credibility.

Minutes of all meetings have been posted on the NCSBN Web site. Also, the Midyear PowerPoint Presentation is posted on the Continued Competence Web page. As part of the communication plan, the advisory panel provided the attendees at the NCSBN 2007 Midyear Meeting an update of their progress and work to date. Continued competence was also placed on the executive officer retreat agenda to answer questions that may have arisen after the Midyear presentation.

Continue development of a continued competence regulatory model that can be used by Member Boards in order to assure the continued competence of the nurse.

The 2007 Continued Competence Advisory Panel has extensively discussed this, decided that revisions are needed on the draft model presented at the 2006 Annual Meeting and examined a new potential model. At this point, however, the advisory panel is not ready to make any recommendations. The panel feels the tool being developed requires a pilot test prior to developing a regulatory model.

This is what the advisory panel has decided upon thus far concerning a regulatory model:

1. Collaboration among many stakeholders will be essential.
2. The assessment should take place in a secured environment.
3. In order to successfully implement the assessment, the states will need to mandate the assessment.
4. The assessment will be diagnostic in nature.
5. RN and LPN/VN responsibility and accountability is essential.

Highlights of FY07 Activities

- Development of RN content plan
- Development of LPN/VN content plan
- Refinement of the communication plan
- Thorough examination of potential elements in a continued competence assessment.

Future Activities

- Content plans for RNs and LPN/VNs will be further developed into assessment tools.
- Work on feasibility study will continue and will be reported to Board of Directors when complete.
- Development of a pilot study to test instruments and collect evidence regarding its validity and reliability. Member Boards will be asked to volunteer to test assessments.
- The overall assessment plan for both the RN and LPN/VN assessment tools need extensive development including content definition, assessment specifications, item development, assessment tool design and assembly, and assessment production. Once designed, the assessment production, administration, results processing and reporting, and quality control mechanisms will need to be developed and employed. This will be accomplished with the assistance of an external consultant that will be hired as the project manager.

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Task Force on Health Care Workforce Regulation: *Reforming Healthcare Workforce Regulation: Policy Consideration for the 21st Century*. San Francisco: PEW Health Professions Commission; 1995.

Attachments

A. Categories of Continued Competence for LPN/VNs

B. Categories of Continued Competence for RNs

Attachment A

Categories of Continued Competence for LPN/VNs

Category One
Provision of Care (40 percent)

a. Identify client needs
b. Contribute to a plan of care
c. Provide patient centered care
d. Administer medications
e. Perform treatments/procedures
f. Promote health

Category Two
Legal/Ethical Responsibilities (15 percent)

a. Act as an advocate
b. Adhere to federal, state and agency regulations
c. Utilize ethical and legal principles
d. Demonstrate accountability
e. Recognize scope and level of competence

Category Three
Communication (15 percent)

a. Communicate accurately and effectively using various modalities
b. Document within legal and professional standards
c. Contribute to the teaching and learning process

Category Four
Inter/Intradisciplinary Collaboration (10 percent)

a. Function as a team member
b. Participate in patient centered decision making
c. Utilize principles of delegation and/or assignment
d. Use chain of command to resolve conflict

Category Five
Safety (20 percent)

a. Perform focused risk assessment
b. Employ attentiveness and surveillance
c. Utilize safety measures
d. Participate in quality improvement
e. Implement follow-up measures

Attachment B

Categories of Continued Competence for RNs

Category One
Clinical Judgment in Provision of Care (29 percent)

a. Practice patient centered care
b. Exercise assessment skills
c. Integrate client-specific data
d. Implement critical thinking
e. Utilize evidence-based knowledge
f. Employ ongoing evaluation

Category Two
Professional Responsibilities (20 percent)

a. Act as an advocate
b. Understand federal and state health care regulations
c. Implement ethical and legal principles
d. Demonstrate accountability
e. Maintain/improve professional knowledge and skills

Category Three
Communication (8 percent)

a. Communicate effectively utilizing various modalities
b. Document within legal and professional standards
c. Apply the teaching and learning process
d. Utilize technology to manage, access and process information

Category Four
Inter/Intradisciplinary Collaboration (9 percent)

a. Function as a team member
b. Participate in patient-centered decision making
c. Participate in conflict resolution

Category Five
Supervision/Management (6 percent)

a. Implement principles of delegation/assignment
b. Implement principles of case management
c. Manage resources

Category Six
Safety (28 percent)

a. Perform comprehensive risk assessment

b. Employ attentiveness/surveillance

c. Implement safety measures

d. Participate in quality improvement

Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee

Background

The Commitment to Ongoing Regulatory Excellence project (CORE) was approved by the FY02 Board of Directors to provide an ongoing performance measurement system for nursing regulators. Founded upon an earlier project, the Commitment to Public Protection through Excellence in Nursing Regulation project, CORE utilizes data collected periodically from boards of nursing and stakeholders and identifies best practices in the provision of regulatory services. By promoting excellence in the provision of regulatory services, boards can improve their management and delivery of safe, effective nursing care to the public.

In 2006, the boards of nursing were surveyed regarding the five functions of boards: (1) discipline, (2) practice, (3) education program approval, (4) licensure and (5) governance. Six stakeholder groups that were directly affected by boards' actions were surveyed in 2006. These six groups included: (1) employers, (2) nursing programs, (3) associations, (4) nurses, (5) nurses who were the subjects of complaints and (6) persons who made a complaint. Random samples of these stakeholders were surveyed to gain their perspectives about interactions with their board of nursing and about the effectiveness of nursing regulation in general.

Highlights of FY07 Activities

- There were 42 boards of nursing that participated in the CORE survey.
- At least one board of nursing began incorporating CORE best practices into their strategic objectives.
- CORE data assisted one board of nursing in obtaining an additional investigator and an additional attorney from the attorney general's office.
- The CORE committee chair telephoned nonresponding boards of nursing in an attempt to increase response rates.
- Data collection and analysis continued throughout the summer of 2006.
- A final Board report was sent to all committee members and states participating in the qualitative interviews. All boards of nursing received a copy of the final report consisting of the boards of nursing and stakeholder survey results by the end of April 2007. Each state received their state-level results along with aggregate findings. Comparisons were also made between "like" boards (e.g., size, independence).
- Qualitative interviews were conducted with nine boards of nursing to identify themes and characteristics of high-performing boards. The comparison of practices, procedures and performance will help to determine best practices and how to adopt the best practice.

Future Activities

- Disseminate individual state reports and aggregate results.
- Analyze qualitative data derived from interviews with high and low performing boards of nursing.
- Identify possible research projects to confirm best practices.
- Assist boards of nursing in implementing best practices.
- Review all CORE surveys and modify and refine questions that will be used for collection of data in 2008.

Members

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

Kay Buchanan, MSN, RN
Minnesota, Area II

Madeline Coleman, RN, JD
Tennessee, Area III

Katie Daugherty, RN, MN
California-RN, Area I

Rula Harb, MS, RN
Massachusetts, Area IV

Cynthia Morris, MSN, RN, APRN-BC
Louisiana-RN, Area III

Margaret Walker, MBA, BSN, RN
New Hampshire, Area IV

Rose Kearney-Nunnery, PhD, RN, CNE
South Carolina, Area III, Board Liaison

Staff
Kevin Kenward, PhD
Director, Research

Meeting Dates

Oct. 30 – Nov. 1, 2006

Jan. 11, 2007 (Conference Call)

Feb. 5 – 6, 2007

July 23 – 24, 2007

Relationship to Strategic Plan

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 1
To identify indicators of regulatory excellence.

Attachments

A. Board Participation FY07

Attachment A

Board Participation FY07

Boards of Nursing	Board	Nurses	NCA*	PMC**	Association	Employer	SON***	Total
Arkansas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Florida	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Louisiana-RN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Missouri	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Oregon	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Texas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
West Virginia-PN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7
Kansas	Yes	Yes	Yes		Yes	Yes	Yes	6
New Mexico		Yes	Yes	Yes	Yes	Yes	Yes	6
West Virginia-RN	Yes		Yes	Yes	Yes	Yes	Yes	6
Iowa	Yes	Yes			Yes	Yes	Yes	5
Idaho	Yes	Yes			Yes	Yes	Yes	5
Massachusetts	Yes	Yes			Yes	Yes	Yes	5
Nebraska		Yes	Yes		Yes	Yes	Yes	5
District of Columbia		Yes	Yes			Yes	Yes	4
Delaware		Yes	Yes			Yes	Yes	4
Illinois		Yes	Yes			Yes	Yes	4
Maryland	Yes	Yes						2
Pennsylvania	Yes						Yes	2
California-RN	Yes							1
Connecticut	Yes							1
Georgia-RN	Yes							1
Hawaii	Yes							1
Indiana	Yes							1
Maine		Yes						1
Mississippi	Yes							1
New Hampshire	Yes							1
New York	Yes							1
Ohio	Yes							1
South Carolina	Yes							1
Tennessee		Yes						1

*NCA = Nurses Complained Against Nurses (Subject of a Complaint)
**PMC = Persons Making a Complaint
***SON = Survey of Nurses

Boards of Nursing	Board	Nurses	NCA*	PMC**	Association	Employer	SON***	Total
Utah		Yes						1
Washington	Yes							1
Wisconsin	Yes							1
Total	**34**	**28**	**22**	**17**	**22**	**25**	**26**	

*NCA = Nurses Complained Against Nurses (Subject of a Complaint)
**PMC = Persons Making a Complaint
***SON = Survey of Nurses

Report of the Finance Committee

Background

The Finance Committee advises the Board on the overall direction and control of the finances of the organization. The Committee reviews and recommends a budget to the Board. The Committee monitors income, expenditures and program activities against projections, and presents quarterly financial statements to the Board.

The Finance Committee oversees the financial reporting process, the systems of internal accounting and financial controls, the performance and independence of the independent auditors, and the annual independent audit of NCSBN financial statements. The Committee recommends to the Board the appointment of a firm to serve as independent auditors.

The Finance Committee makes recommendations to the Board with respect to investment policy and assures that the organization maintains adequate insurance coverage.

Highlights of FY07 Activities

- Reviewed and discussed with management and the organization's independent accountant, Legacy Professionals LLP, the organization's audited financial statements as of and for the fiscal year that ended Sept. 30, 2006. With and without management present, the Finance Committee discussed and reviewed the results of the independent accountant's examination of the internal controls and the financial statements. Based on the review and discussions referred to above, the Finance Committee recommended to the Board of Directors that the financial statements and the Report of the Auditors be accepted and provided to the Membership. See Attachment B.
- Reviewed and discussed the long range forecast and proposed NCSBN budget for FY07. Recommended approval of the FY07 budget to the Board.
- Reviewed and discussed the financial statements and supporting schedules quarterly, and made recommendations to the Board of Directors to accept the reports and post them to the Members Only section of the NCSBN Web site.
- Reviewed and discussed the performance of NCSBN investments with representatives from the organization's investment consultant, Becker Burke, and the organization's bond investment manager, Richmond Capital Management. Approved the performance of the investment manager. Reviewed and discussed the results of an asset allocation study prepared by Becker Burke. Based on the review and discussions of the results of the study, the Finance Committee recommended revisions to the investment policy and asset allocation.
- Reviewed and discussed the property and professional liability coverage for NCSBN with the insurance brokers from USI Midwest. Informed the Board that insurance coverage for the organization was adequate.
- Advised the Board and made recommendations related to the finances of program activities. Reviewed and discussed with staff a report on the use of the resource fund by Member Boards. Recommended to the Board of Directors to consider revising the NCSBN travel policy to accommodate an extra day's lodging for members traveling longer distances.

Future Activities

- Review the budget proposal for the fiscal year beginning Oct. 1, 2007.
- Select a manager for NCSBN real estate fund investments.
- Review the auditors' report on test vendor contract compliance with pricing arrangements.

Members

Ruth Ann Terry, MPH, RN
Treasurer, California-RN, Area I

Nancy Bafundo, BSN, MS, RN
Connecticut, Area IV

Elizabeth Lund, MSN, RN
Tennessee, Area III

Kathleen Sullivan, MBA, RN
Wisconsin, Area II

Bonnie Benetato, RN, MSN, C-APN, MBA
Washington, D.C., Area IV

Ronald Lazenby, BS, CGFM
Alabama, Area III

Gayle Bellamy, BA
North Carolina, Area III

Stan Yankellow, BS
Maryland, Area IV

Staff
Robert Clayborne, CPA, MBA
Director, Finance

Meeting Dates

- Nov. 28, 2006
- Feb. 2, 2007
- April 23, 2007
- July 6, 2007

Relationship to Strategic Plan

Strategic Initiative III
Enhance the organizational culture to support change and innovation (PERC).

Strategic Objective 4
Assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

Attachments

A. Financial Summary Report for the period Oct. 1, 2006, to March 31, 2007

B. Report of the Independent Auditors FY06

Attachment A

Financial Summary Report for the Period Oct. 1, 2006, to March 31, 2007

At March 31, 2007, the net cash position (cash and marketable securities less current liabilities) equaled $81.6 million. The financial statements do not reflect the expected $2.5 million near-term liability for research grant expenditures. Grantees have been identified and funds should be distributed before the end of the fiscal year. NCSBN has no significant long-term liabilities except the lease for office space. Net assets increased by $10.3 million during the first half of the fiscal year.

Revenue

NCLEX® examination revenue for the first six months of FY07 increased by $4.1 million from the prior year for the same period. For the six-month period that ended March 31, 2007, 114,325 paid registrations were processed. This was a 17% increase over the FY06 count of 97,858. There were 10,727 registrations at international test sites during the first half of the fiscal year compared to 5,528 for the same period last year.

There are 35 boards currently using Nur*sys*® for licensure by endorsement. Fee revenue totaled $1,103,000 for Nur*sys* verifications, which is on target to exceed the budgeted amount for the year.

NCSBN Learning Extension sales revenue increased by 36% for the first six months of FY07 compared to the same period for the prior year. Sales revenue has been growing annually at a rate between 18 percent and 20 percent for the last three years.

A 4.8 percent return on stock and bond investments along with a 2.6 percent return on cash (certificates of deposit) provided earnings of $2.9 million during the first half of FY07.

Expenditures

The FY07 budget includes $5 million for external research grants. Although no funds were distributed for research grants by March 31, 2007, $2.5 million has been committed to fund grant awards during this fiscal year. The balance will be carried over to FY08.

Through the end of March, only $412,000 of the $5.9 million information technology (IT) budget for computer hardware and software has been expended. IT projects with a budgeted cost of $905,000 have been deferred until next fiscal year. The cost of increasing network storage for Nur*sys* and the development of the Enterprise Nurse Licensure System will offset much of the savings from the deferred projects. These two projects with an expected cost of $770,000 were not budgeted for FY07.

During the first six months of the fiscal year, the Board of Directors has approved $700,000 in additional spending for FY07: to fund NCSBN Interactive, to host the APRN Summit and the Member Board Operations Staff Conference, and to pilot a Webcast for the Investigator & Attorney Workshop. This additional spending will be more than offset by the favorable budget variance for NCLEX volume discounts. Volume discounts were budgeted at a lower rate than the projected actual for this year. The difference between the budgeted and actual amounts should be approximately $1.3 million.

Financial Position

Although NCLEX registrations are up 17% over the FY06 count for the same period, it is too early to project whether this rate of increase will continue throughout the year. The third quarter is critical as NCSBN typically earns 39% of annual NCLEX revenue during that period. The net cash position is projected to equal $78.9 million by the end of FY07.

Six Months Summary

- The number of NCLEX registrations remains up 17%.
- Larger volume discounts are projected to be $1.3 million favorable to budget.
- The 4.2% return on investments equals $2.9 million earnings.
- Other major revenue sources continue to be ahead of budget and exceed prior year amounts.
- Approved $700,000 in unbudgeted expenses.
- $2.5 million (of a $5 million budget) committed for external research grants. The balance will be carried over to FY08.
- Only a small portion (7%) of the IT capital budget expended to date.
- Other significant spending variances are still assumed to be timing differences.
- There is 10% growth projected for cash position and $78.9 million expected by fiscal year end.

NCSBN Statement of Revenue and Expense

Revenue	Year to Date Actual at 3/31/07	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date Actual as a % of Annual Budget
NCLEX Revenue	24,482,542	49,300,000	55,198,000	5,898,000	12%	50%
NCLEX Program Reports Royalty	71,520	60,000	85,000	25,000	42%	119%
NCLEX Quick Results	199,764	396,000	540,000	144,000	36%	50%
NNAAP royalty Income	119,538	239,000	239,000	0	0%	50%
Learning Extension	679,564	1,398,000	1,700,000	302,000	22%	49%
Nursys License Verification Fees	1,103,020	1,998,000	2,206,000	208,000	10%	55%
Nursys Data Query Fees	6,300	10,000	10,000	0	0%	63%
Meeting Revenue	45,175	177,000	177,000	0	0%	26%
Other Publication Sales	13,220	22,000	22,000	0	0%	60%
Membership Fees	177,000	177,000	177,000	0	0%	100%
Investment Income	2,947,479	2,600,000	3,200,000	600,000	23%	113%
NCLA Fees	43,000	43,000	43,000	0	0%	100%
Other Revenue	399	0	0	0		
Total Revenue	**29,888,521**	**56,420,000**	**63,597,000**	**7,177,000**	**13%**	**53%**

Expense	Year to Date Actual at 3/31/07	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date Actual as a % of Annual Budget
Salaries	2,526,864	5,315,000	5,270,000	45,000	1%	48%
Fringe Benefits	671,407	1,389,000	1,382,000	7,000	1%	48%
NCLEX Processing Costs	12,327,188	26,070,000	26,377,000	(307,000)	-1%	47%
Other Professional Service Fees	1,016,756	5,191,000	5,682,000	(491,000)	-9%	20%
Supplies & Materials	33,245	133,000	133,000	0	0%	25%
Meetings & Travel	770,720	2,713,000	2,913,000	(200,000)	-7%	28%
Telephone & Communications	94,417	387,000	387,000	0	0%	24%
Postage & Shipping	47,985	239,000	239,000	0	0%	20%
Occupancy	421,184	904,000	904,000	0	0%	47%
Printing, Copying & Publications	111,847	575,000	575,000	0	0%	19%
Library/Memberships	24,991	68,000	68,000	0	0%	37%
Insurance	50,935	56,000	56,000	0	0%	91%
Equipment Rental & Maintenance	665,438	1,184,000	1,184,000	0	0%	56%
Depreciation & Amortization	866,637	3,586,000	3,586,000	0	0%	24%
Other Expenses	17,221	5,353,000	2,853,000	2,500,000	47%	0%
Total Expense	**19,646,835**	**53,163,000**	**51,609,000**	**1,554,000**	**3%**	**37%**
Surplus/(Deficit)	10,241,686	3,257,000	11,988,000	8,731,000		
Capital	532,560	5,938,000	5,938,000	0		

This statement has not been audited. Projected amounts are estimates.

Attachment B

Report of the Independent Auditors FY06

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

FINANCIAL STATEMENTS

SEPTEMBER 30, 2006 AND 2005

CONTENTS

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS

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

We have audited the accompanying statements of financial position of National Council of State Boards of Nursing, Inc. (NCSBN) as of September 30, 2006 and 2005 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the NCSBN's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our 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. as of September 30, 2006 and 2005 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Legacy Professionals LLP

November 15, 2006

30 North LaSalle Street | Suite 4200 | Chicago, IL 60602 | 312.368.0500 | 312.368.0746 Fax | www.legacycpas.com

National Council of State Boards of Nursing, Inc.

Statements of Financial Position

September 30, 2006 and 2005

	2006	2005
Assets		
Current assets		
Cash	$ 27,785,453	$ 8,956,446
Accounts receivable	271,110	239,632
Due from test vendor	4,895,016	2,591,454
Accrued investment income	518,971	398,778
Prepaid expenses	956,861	767,190
Total current assets	34,427,411	12,953,500
Investments	49,567,618	50,664,555
Property and equipment		
Furniture and equipment	1,155,528	1,125,141
Course development costs	271,729	271,729
Computer hardware and software	9,477,770	7,930,188
Leasehold improvements	325,998	325,998
	11,231,025	9,653,056
Less accumulated depreciation and amortization	(7,953,180)	(6,379,434)
Net property and equipment	3,277,845	3,273,622
Cash held for others	439,651	388,132
Total assets	$ 87,712,525	$ 67,279,809
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 459,531	$ 636,118
Accrued payroll, payroll taxes and compensated absences	303,954	391,221
Due to test vendor	8,441,758	7,087,469
Deferred revenue	347,467	219,066
Total current liabilities	9,552,710	8,333,874
Other liabilities		
Deferred rent credits	473,058	547,756
Cash held for others	439,651	388,132
Total other liabilities	912,709	935,888
Total liabilities	10,465,419	9,269,762
Unrestricted net assets	77,247,106	58,010,047
Total liabilities and net assets	$ 87,712,525	$ 67,279,809

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF ACTIVITIES

YEARS ENDED SEPTEMBER 30, 2006 AND 2005

	2006	2005
REVENUE		
Examination fees	$ 53,290,140	$ 46,710,135
Other program services income	4,502,710	3,854,701
Net realized and unrealized gain (loss) on investments	428,805	(482,292)
Net realized (loss) on disposal of property and equipment	-	(11,792)
Interest and dividend income	3,105,970	2,175,360
Membership fees	177,000	180,000
Total revenue	61,504,625	52,426,112
EXPENSES		
Program services		
Nurse competence	30,784,338	29,295,600
Nurse practice and regulatory outcome	4,123,184	3,688,826
Information	5,294,590	5,161,465
Total program services	40,202,112	38,145,891
Supporting services		
Management and general	2,065,454	1,846,688
Total expenses	42,267,566	39,992,579
NET INCREASE	19,237,059	12,433,533
UNRESTRICTED NET ASSETS		
Beginning of year	58,010,047	45,576,514
End of year	$ 77,247,106	$ 58,010,047

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Cash Flows

Years Ended September 30, 2006 and 2005

	2006	2005
Cash flows from operating activities		
Net increase	$ 19,237,059	$ 12,433,533
Adjustments to reconcile net increase to net cash provided by (used in) operating activities		
Depreciation and amortization	1,622,619	1,579,255
Net realized and unrealized (gain) loss on investments	(428,805)	482,292
Net realized loss on disposal of property and equipment	-	11,792
(Increase) decrease in assets		
Accounts receivable	(31,478)	78,214
Due from test vendor	(2,303,562)	(1,291,725)
Accrued investment income	(120,193)	(46,597)
Prepaid expenses	(189,671)	(218,768)
Increase (decrease) in liabilities		
Accounts payable	(176,587)	68,276
Accrued payroll, payroll taxes and compensated absences	(87,267)	(31,548)
Due to test vendor	1,354,289	1,331,672
Deferred revenue	128,401	(35,230)
Deferred rent credits	(74,698)	(29,048)
Net cash provided by operating activities	18,930,107	14,332,118
Cash flows from investing activities		
Purchases of property and equipment	(1,626,842)	(1,682,404)
Purchases of investments	(20,355,505)	(37,869,906)
Proceeds on sale of investments	21,881,247	22,805,026
Net cash (used in) investing activities	(101,100)	(16,747,284)
Net increase (decrease)	18,829,007	(2,415,166)
Cash		
Beginning of year	8,956,446	11,371,612
End of year	$ 27,785,453	$ 8,956,446

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2006 AND 2005

NOTE 1. DESCRIPTION OF THE ORGANIZATION

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of NCSBN is to serve as a charitable and educational organization through which state boards of nursing act on matters of common interest and concern to promote safe and effective nursing practice in the interest of protecting public health and welfare including the development of licensing examinations in nursing.

The program services of NCSBN are defined as follows:

Nurse Competence - Assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.

Nurse Practice and Regulatory Outcome - Assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. Analyze the changing health care environment to develop state and national strategies to impact public policy and regulation affecting public protection.

Information - Develop information technology solutions valued and utilized by Member Boards to enhance regulatory efficiency.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The accompanying financial statements have been prepared on the accrual basis of accounting.

Basis of Presentation - Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, NCSBN is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. Net assets are generally reported as unrestricted unless assets are received from donors with explicit stipulations that limit the use of the asset. NCSBN does not have any temporarily or permanently restricted net assets.

Investments - Investments are carried at fair value which generally represents quoted market price as of the last business day of the year.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed using the straight-line method over the following estimated useful lives:

Furniture and equipment	5 - 7 years
Course development costs	2 - 5 years
Computer hardware and software	2 - 5 years
Leasehold improvements	10 years

Due from Test Vendor - Due from test vendor represents amounts owed by Pearson VUE for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by Pearson VUE at September 30, 2006 and 2005 were $4,895,016 and $2,591,454 respectively.

Due to Test Vendor - Due to test vendor represents unpaid amounts to Pearson VUE for candidate testing, which includes approximately $5,704,000 at September 30, 2006 and $4,658,000 at September 30, 2005 for registered candidates who as of year end had not taken the exam. The amounts owed to Pearson VUE at September 30, 2006 and 2005 were $8,441,758 and $7,087,469 respectively.

Pearson VUE performs substantially all testing services for NCSBN.

Deferred Revenue - Deferred revenue consists of membership fees of $177,000 for 2006 and $174,000 for 2005 and online course revenue of $170,467 for 2006 and $45,066 for 2005.

Deferred Rent Credits - Deferred rent credits were established in conjunction with taking possession of new leased office space in 2003. The landlord abated a portion of the monthly rent and made cash disbursements to NCSBN in connection with the lease. These amounts are amortized to reduce rent expense over the term of the lease.

Bad Debt Expense - NCSBN uses the direct write-off method for bad debts. An allowance for uncollectible accounts is considered unnecessary and is not provided.

Statement of Cash Flows - For purposes of the statement of cash flows, NCSBN considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions, petty cash and certificates of deposit with a maturity date of less than three months when purchased. It does not include cash held for others.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

NOTE 3. TAX STATUS

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on income related to its exempt purpose pursuant to Section 501(a) of the Code and has been classified as an organization which is not a private foundation under Section 509(a).

NOTE 4. CASH CONCENTRATIONS

The cash balance as of September 30, 2006 and 2005 consisted of the following:

	2006	2005
JP Morgan Chase		
Checking account	$ 9,202,558	$ 4,487,166
Money market account	5,556,369	1,314,152
Certificates of deposit	12,849,144	3,000,000
Wells Fargo Bank:		
Checking account	168,458	152,583
Credit card merchant accounts	8,674	2,295
Petty cash	250	250
Total	$ 27,785,453	$ 8,956,446

NCSBN places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.

NOTE 5. OPERATING LEASE

In July 2002, NCSBN entered into a lease agreement for new office space which commenced February 1, 2003 and expires January 31, 2013. In 2004, NCSBN signed two amendments to the lease for additional space, one commencing in January 2004 and the other in January 2005. The following is a summary by year of future minimum lease payments required under the new office lease as of September 30, 2006:

Year ending September 30,	
2007	$ 477,047
2008	491,910
2009	506,950
2010	522,343
2011	538,011
Thereafter	740,944
Total	$ 3,277,205

Rent expense for the years ended September 30, 2006 and 2005 was $837,396 and $809,731 respectively.

NOTE 6. INVESTMENTS

The composition of investments at September 30, 2006 and 2005 is as follows:

	2006	2005
U.S. Government and Government Agency obligations	$ 15,404,798	$ 10,789,761
Corporate bonds	20,452,563	23,759,748
Mutual funds	10,061,517	13,024,780
Money market fund	55,983	90,266
Certificates of deposit	3,592,757	3,000,000
Total	$ 49,567,618	$ 50,664,555

NOTE 7. RETIREMENT PLAN

NCSBN maintains a defined contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. NCSBN's policy is to fund accrued pension contributions. Pension expense was $379,895 and $348,484 for the years ended September 30, 2006 and 2005, respectively.

NOTE 8. COMMITMENTS

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled.

NCSBN has also entered into various contracts for futures services. At September 30, 2006, the requirements to fulfill these commitments approximated $155,000.

Report of the Member Board Leadership Development Advisory Panel

Background

The Member Board Leadership Development Advisory Panel is charged with developing leadership development programs for Member Board presidents and executive officers and providing orientation for newly appointed presidents and executive officers. It provides oversight for the Institute of Regulatory Excellence (IRE), assures the functioning of an executive officer mentorship program and reviews recommendations of the board presidents participating in the network session.

Highlights of FY07 Activities

- Conducted the fourth annual Institute of Regulatory Excellence (IRE): Organizational Structure and Behavior in San Diego, California, on Jan. 8 – 10, 2007.
- Planned for the fifth annual Institute of Regulatory Excellence: Public Policy Development and the Role of Nursing Regulators.
- Evaluated the first completed cycle of four IRE program sessions and recommended changes to enhance the programs' outcomes.
- Continued to have the IRE Research Panel assist in the review of projects and research submitted in the Fellowship Program.
- Assigned executive officers as coaches to new executive officers.
- Reviewed the agenda and program objectives for the 2007 Executive Officer Orientation.
- Planned and developed the objectives for the 2007 Midyear Leadership Program for Member Board presidents and executive officers.
- Planned programs for the 2007 Midyear and 2007 Annual Meeting Presidents Networking Sessions.
- Developed objectives and planned the agenda for the educational conference for Member Board operations and licensing staff for FY08.
- Collaborated with NCSBN Learning Extension to develop a Web-based educational module as a resource for Member Boards' presidents in their governance role.
- Reviewed the summary of executive officer comments on BoardSource Membership and did not recommend renewal of the membership for members in 2007.

Future Activities

- Oversee the annual Institute of Regulatory Excellence.
- Conduct the Member Board Operations and Licensing Staff Conference Nov. 19, 2007.
- Work with the NCSBN Marketing and Communications Department to complete development of DVDs for the first cycle of IRE programs and finalize recommendations for distribution to Member Boards.

Members

Joey Ridenour, MN, RN
Chair, Arizona, Area I

Joan Bouchard, MN, RN
Oregon, Area I

Judith Hiner, RN, BSN, CNA
Kansas, Area II

Connie Kalanek, PhD, RN
North Dakota, Area II

Mark Majek, MA, PHR
Texas, Area III

Teri Murray, PhD, RN
Missouri, Area II

Myra Broadway, JD, MS, RN
Board Liaison, Maryland, Area IV

Staff
Nancy Chornick, PhD, RN, CAE
Director, Practice & Credentialing

Alicia Byrd
Director, Member Relations

Meeting Dates

- Nov. 28 – 29, 2006
- Jan. 30 – 31, 2007
- March 6 – 7, 2007

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Provide effective education, information sharing and networking opportunities.

Strategic Objective 2
Continuously evaluate the effectiveness of education, information sharing and networking opportunities.

Attachment A

2004 – 2007 Institute of Regulatory Excellence (IRE) Fellows

Listed below are the IRE fellows who have completed research projects during their four years in the program.

Fellow	2004 Project	2005 Project	2006 Project	2007 Project
Betty Sims Nurse Consultant, Education Texas Board of Nurse Examiners	Ethics Course	Ethics Course	Disciplinary Action Effectiveness	Disciplinary Action Effectiveness
Lorinda Inman Executive Director Iowa Board of Nursing	Ethics Course	Ethics Course	Disciplinary Action Effectiveness	Disciplinary Action Effectiveness
Dorothy Fulton Past Executive Director Alaska Board of Nursing	Ethics Course	Ethics Course	Disciplinary Action Effectiveness	Disciplinary Action Effectiveness
Charlene Kelly Executive Director Nebraska Board of Nursing	Refinement and Presentation of a Conceptual Model For Determining Who Should Be Regulated In Order To Ensure Public Protection	Correlation Between Reported Pre-Licensure Criminal Conviction and Post Licensure Disciplinary Action: An Exploratory Study	Nursing Licensure: An Examination of the Relationship Between Criminal Convictions and Disciplinary Actions	Leadership Succession Planning for Boards of Nursing
Constance Kalanek Executive Director North Dakota Board of Nursing	Implementation of Mandatory Continuing Education	Continuing Education: Development and Implementation of a Continued Competence Mandate for Licensed Nurses in North Dakota	Continuing Education: Development and Implementation of a Continued Competence Mandate for Licensed Nurses in North Dakota	Continuing Education: Development and Implementation of a Continued Competence Mandate for Licensed Nurses in North Dakota
Gloria Damgaard Executive Director South Dakota Board of Nursing	Development of Scenarios on Nurse Licensure Compact: Impact on Consumers - Publication: Dakota Nurse Connection: "Message From the Executive Secretary, January 2005". PowerPoint Presentation to Nurse Licensure Compact Summit, December 2004 Compact Evaluation "Nurse Licensure Compact: Impact on Boards of Nursing, Licensees, and Employers"	Project Proposal: Telling the Story Paper: Telling the Story Case Scenarios Presentation: NCSBN 2005 Investigator & Attorney Workshop, Denver, Colorado, May 25, 2005. "Overview of the Nurse Licensure Compact" Poster Presentation: "Telling the Story: Multi-State Disciplinary Process and Outcomes" NCSBN Delegate Assembly, Washington, DC, August 2005.	Develop Education Program for Worksite Monitors and Identify Perceived Level of Effectiveness of the Educational Program Delivered.	South Dakota Health Professionals Assistance Program Work Site Monitors: Education and Support
Julia George Practice Consultant North Carolina Board of Nursing	Delegation to Unlicensed Assistive Personnel	E-Learning - Legal Scope of Practice	Effectiveness of Practice Remediation	"Just Culture" Decision Tree to Guide Employers in Reporting Practice Errors to the Board.
Karla Bitz Associate Director North Dakota Board of Nursing	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators
Val Smith Associate Director Nursing Practice & Investigations Arizona State Board of Nursing	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators	Identification of Core Competencies of Board of Nursing Investigators
Margaret Walker Executive Director New Hampshire Board of Nursing	Public Policy Development & the Role of Nursing Regulators Research Study Plan (2004)	Efficacy of Individualized Contracts With Licensees in Recovery Programs Public Policy Development & The Role Of Nursing Regulators Research Study Plan, Year Two	Public Policy Development and the Role of Nursing Regulators Research Study Plan - Board Time and Resource Commitment to Adjudicatory Function	Nursing Competence and Evaluation/Remediation Strategies Research Study Plan - Efficacy of Individualized Contracts for Impaired Licensees Having Disciplinary Contracts with the New Hampshire Board of Nursing
Randall Steven Hudspeth Director of Professional Practice Saint Alphonsus RMC Idaho Board of Nursing, Board Member	Project received: Substance Abuse & Drug Diversion: A Resource Manual for Rural Nurse Managers	Survey of Advanced Practice Registered Nurses Disciplinary Action	Survey of Advanced Practice Registered Nurses Disciplinary Action	Survey of Advanced Practice Registered Nurses Disciplinary Action

Report of the Nursys® Advisory Panel

Background

The Nursys® Advisory Panel is convened from the membership to enhance the Nursys database system and address Member Boards' day-to-day Nursys-related issues.

Highlights of FY07 Activities

- NCSBN hosted the second Nursys User Group meeting in Chicago. There were 49 Member Board staff representing 35 boards of nursing in attendance.
- Enhanced www.nursys.org to address feedback from users. Some of the enhancements included: redesign of www.nursys.org home page, prototypes for Speed Memo redesign and enhanced functionality.
- Held joint meeting with the Nursys Business Design Advisory Panel to review and assign Strategic Objectives on the Strategic Initiatives.
- Prepared agenda and scheduled speakers for the 2007 IT Summit to be held in Portland, Oregon.
- Made a recommendation to the NCSBN Board of Directors regarding future Nursys User Groups.
- Increased the number of boards for which NCSBN is the Healthcare Integrity and Protection Data Bank (HIPDB) agent. With these two additional boards, the total is now 37.
- Increased the number of participating boards of nursing to 36. Washington and Wyoming will be submitting their data.
- Finalized case study tools that were completed by Minnesota, Arkansas and Texas (see Attachments A, B and C). These case studies are an example of the potential revenue loss by a board of nursing as they join Nursys. A blank form has also been developed for all boards to complete and use as a reference. These case studies are available on the www.nursys.org home page.
- Added content to the Nursys Participating Member Board page and HIPDB Agent page in www.nursys.org.
- Included license issue date on the Multiple Compact License report.
- Worked very closely with the Nurse Licensure Compact Group to develop requirements to track compact history in Nursys as well as automate the discipline against a compact license or privilege to practice.
- Worked with Nursys participating Member Boards to collect full data dumps. As a result of this, NCSBN has collapsed more than 100,000 records that were duplicated.

Future Activities

- Redesign www.nursys.org and www.nursys.com both the front end and back end of the application.
- Convert current Nursys discipline codes to HIPDB codes.

Attachments

A. Minnesota Nursys case study

B. Arkansas Nursys case study

C. Texas Nursys case study

Members

Adrian Guerrero
Chair, Kansas, Area II

Michelle Cartee
Missouri, Area II

Adam Henriksen
Arizona, Area I

Polly Johnson, RN, MSN, FAAN
North Carolina, Area III

Sheree Zbylot, RN, BSN, MHS
Mississippi, Area III

Ruth Ann Terry, MPH, RN
Board Liaison, California-RN, Area I

Staff
Sandy Rhodes
Manager, Nursys® Program

Meeting Dates

- Aug. 16, 2006 (Conference Call)
- Sept. 18, 2006
- Oct. 3, 2006 (Conference Call)
- Nov. 27 – 28, 2006
- Jan. 17, 2007 (Conference Call)
- March 5, 2007

Relationship to Strategic Plan

Strategic Initiative V
Advance NCSBN as the leading source of data, information, and research regarding nursing regulation and related health care issues.

Strategic Objective 2
Maintain a comprehensive national nurse licensure database.

Attachment A

Minnesota Nursys® Case Study

Attachment A

NURSYS Case Study - Minnesota Board of Nursing

	FY02	FY03	FY04	FY05
Total revenue	4,300,000	4,600,000	4,600,000	4,700,000
Revenue from verifications	90,000	55,000	29,000	26,000
% of revenue from verifications	2%	1%	1%	1%
Began submitting licensure data to NURSYS 11/2004		FY03 reflects change in processing verifications		

Fiscal Impact

	FY02	FY03	FY04	FY05
Number of verifications processed internally	4,500	2,750	1,450	1,300
Revenue from verifications • # of verifications X $20.00	90,0000	55,000	29,000	26,000
Less salary costs • ½ FTE processing verification and payment (salary, FICA, insurance and retirement) • average 1 FTE salary at $42,000	½ FTE -21,000	61% of 4,500 verifications processed, so 61% of ½ FTE -12,800	32% of 4,500 verifications processed, so 32% of ½ FTE -6,800	28% of 4,500 verifications processed, so 28% of ½ FTE -6,000
Less postage costs • # of verifications X .37 cents	-1,665	-1,017.50	-536.50	-481
Less paper, envelope, etc. costs • # of verifications X paper, envelope, copy and storage costs of .05 cents	-225	-137.50	-72.50	-65
Total costs to produce revenue	(22,890)	(13,955)	(7,409)	(6,546)
Net revenue	**$67,110**	**$41,045**	**$21,591**	**$19,454**

- MBN provides individual online "verification" at no charge to the public. For example, if an employer or public customer wants to verify if an individual is currently licensed, they access that information at the Board's website at no charge.
- No fees such as the endorsement or verification fee were increased or affected by the change to NURSYS.
- MBN continues to process verifications for:
  - Canadian residents requiring verification for Visa screen purposes
  - International applicants requiring verification
  - Regulatory agencies, other than nursing, requiring verification, i.e. doctor, physician assistants, etc.
  - Credentialing services, i.e. case mangers recertification
  -

Attachment B

NURSYS® Case Study – Arkansas State Board of Nursing

	FY01	FY02	FY03	FY04	FY05
Total revenue	1,248,058	1,574,751	1,675,140	1,696,925	1,785,355
Revenue from verifications	37,440	2,100	2,190	3,150	2,730
% of revenue from verifications	3%	0.13%	0.13%	0.19	0.15%
Began submitting licensure data to NURSYS 10/18/2000		FY01 begins change in processing verifications			

Net revenue analysis

	FY01	FY02	FY03	FY04	FY05
Number of verifications processed internally	1872	70	73	105	91
Revenue from verifications # of verifications X $20 FY01 $30 beginning FY02	37,440	2,100	2,190	3,150	2,730
Less salary costs • 0.75 FTE processing verifications (salary+ est. 20% benefits, FICA, insurance, etc) FTE=$35,155 (salary) + 7,031 (benefits) X 0.75	-31,640	(4% of verifications processed, so 4% of 0.75 FTE) – -1,266	(4% of verifications processed, so 4% of 0.75) -1,266	(6% of verifications processed, so 6% of 0.75) -1,898	(5% of verifications processed, so 5% of 0.75) -1,582
Less postage costs # of verifications X 0.37 cents	-693	-26	-27	-39	-34
Less paper, envelope, etc. costs # of verifications X paper, envelope, copy and storage costs of .05 cents	-94	-4	-4	-5	-5
Total costs to produce revenue	(32,427)	(1,296)	(1,297)	(1,942)	(1,671)
Net revenue	**$5,013**	**$804**	**$893**	**$1208**	**$1059**

ASBN continues to process verifications for:

- Canadians requiring verification for Visa screen purposes
- Entities who do not have access to Nursys® for verification: Regulatory agencies, Credentialing services, Military

Attachment B

Efficiency/Effectiveness Comparison			
	Data in Nursys	Not in Nursys, paper verification	Not in Nursys, no paper verification
Staff effort	Negative	3 times greater	10 times greater
Success rate	98%	98%	50% or less
Political repercussions	Neutral	Neutral	Potentially negative
Applicant satisfaction	99%	80%	0 – 20%
Employer satisfaction	99%	80%	0 – 20%
Productivity	No change	No change	Negative change
Public perception	Positive	Positive	Negative

Value		Benefit		
		Board of Nursing	Licensee	Public
Resource reduction or redirection	• Resources previously required for verifications can be redirected to other licensing functions. • Benefit to all stakeholders making resources available to other functions. • Creates job satisfaction and customer satisfaction.	√	√	√
Standardization of verification process	• Standardization streamlines process for all stakeholders.	√	√	√
Increased accessibility	• Boards and licensees have significant increased accessibility. • Verifications are not impacted by factors such as time change, office hours, staff schedules, etc. • Verification is immediate.	√	√	√
Standardization of data	• Endorsing state gets matched record. • Records between states become consistent.	√	√	√
Data cleansing and error reduction	• Opportunity for data clean up and error correction.	√	√	√
Cost effective	• Licensee pays one fee for verifying to multiple states. • Board revenue loss is minimal when weighed against benefits.	√	√	√
Disaster recovery	• Creates an offsite disaster recovery site for licensure and discipline data as current as your last upload to NURSYS. • This is an invaluable insurance against government shutdown, technology or natural disasters.	√	√	√
Public safety	• Public safety is enhanced because records are more consistent; licensees are able to process their applications faster and more efficiently therefore getting nurses into workforce sooner. • Provides for immediate identification of disciplined nurses	√	√	√

Attachment C

NURSYS Case Study - Texas Board of Nursing

	FY02	FY03	FY04	FY05
Total revenue	4,875,000	4,900,000	6,200,000	6,800,000
Revenue from verifications	12,000	9,700	18,000	24,800
% of revenue from verifications	.0025%	.002%	.003%	.0036%
Began submitting licensure data to NURSYS in 1999 and discontinued paper verifications to member boards.		Verification revenue is from verifications to Canada, Visa Screen and other regulatory agencies.		

Fiscal Impact

Revenue/Cost Savings

	FY02	FY03	FY04	FY05
Revenue from verifications • # of verifications X $20.00	12,000	9,700	18,000	24,800
Revenue from moving verification fee to the endorsement process # of endorsements X $25.00	3,864 X $25 = 96,600	4,215 X $25 = 105,375	4,084 X $25 = 102,100	5,153 X $25 = $128,825
Cost savings • ¾ of FTE @ $34,000	25,500	25,500	25,500	25,500
Cost savings of postage costs • # of verifications X .37 cents	1,480	1,480	1,480	1,480
Cost savings of paper, envelope, etc. costs • average of 4,000 verifications X paper, envelope, copy and storage costs of .05	200	200	200	200
Total Revenue/Cost Savings	**$135,780**	**$142,255**	**$147,280**	**$180,805**

Verification Costs/Expenditures

	FY02	FY03	FY04	FY05
Number of verifications processed internally	600	485	900	1240
Less postage costs # of verifications X .37	-222	-179	-333	-459
Less paper, envelope, etc. costs # of verifications X paper, envelope, copy and storage costs of .05	-30	-24	-45	-62
Less salary costs of 3 FTE to process verifications Avg. salary of 1 FTE at $34,000	-8,500	-8,500	-8,500	-8,500
Total Verification Costs	**(8,752)**	**(8,703)**	**(8,878)**	**(9,021)**

Report of the Nursys® Business Design Advisory Panel

Background

The Board of Directors established the Nursys® Business Design Advisory Panel to review and evaluate Nursys business design and rules, along with associated policies and procedures, and make recommendations.

Highlights of FY07 Activities

The panel produced a comprehensive set of recommendations to improve Nursys. The following is a list of recommendations:

1. Implement a unique identifier for every nurse.

   Rationale
   Panel strongly recommends that all Member Boards use a unique identifier for each nurse. This unique identifier can be extracted from the current testing vendor or could be issued by a single source for all Member Boards. This will allow Member Boards to identify a nurse in the absence of Social Security number, date of birth, different spelling of first/maiden/last name and other data elements that can create the possibility of multiple records of the same individual in the database. Member Boards can use this unique identifier without any privacy breach concerns. A unique identifier will not compromise any state or federal privacy laws and has been successfully implemented by various industries in their own environments.

   Based on the Uniform Data Submission policy survey (see Attachment A) it is evident that some Member Boards will not be able to provide Social Security numbers and other data elements due to individual state statutory regulations. This gap in data elements at times creates issues with collapsing of multiple "same individual" records. Therefore, it is imperative that a unique identifier be implemented for every licensed nurse.

2. Enhance Nursys training and communication between Nursys users and communication to the public.

   Rationale
   An opportunity exists to enhance communication between Nursys users above and beyond regular Nursys training and Nursys Users Group conference.

   a. Implement online blog for Nursys users monitored by Nursys super user group and/or Nursys administrator, which would create another venue to generate feedback and a list of future Nursys enhancements.

   b. Offer a continuing education program for Nursys users and Nursys super users group. Continuing education could be linked with the privilege to maintain a valid Nursys login ID. Nursys super users group could help in monitoring the blog and provide general advice to users of how some of their specific issues can be mitigated by implementing certain procedures and processes at their board utilizing the Nursys application.

   c. Market Nursys to the public as a tool for boards of nursing to safeguard the public.

3. Develop measurable Nursys metrics and statistics.

   Rationale
   This will create a baseline for data accuracy, trends and help to define quality indicators. This baseline can be used to measure Nursys customer service, and Nursys application and process performance.

Members

Allison Kozeliski, RNCNA, MBA, MHA
Chair, New Mexico, Area I

Kimberly Bolden
Florida, Area III

Mike Coleman
North Carolina, Area III

Gloria Damgaard, RN, MS
South Dakota, Area II

Heidi Goodman, BS
California-RN, Area I

DeWayne Hatcher, BS, MBA
Oregon, Area I

Mary Blubaugh, MSN, RN
Board Liaison, Kansas, Area II

Staff
Nur Rajwany, MS
Director, Information Technology

Meeting Dates

- July 25, 2006
- Oct. 11, 2006 (Conference Call)
- Nov. 27, 2006
- Nov. 28, 2006 (Meeting held with Nursys Advisory Panel members)
- Jan. 8, 2007 (Conference Call)
- Feb. 21, 2007
- March 23, 2007 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative V
Advance NCSBN as the leading source of data, information, and research regarding nursing regulation and related health care issues.

Strategic Objective 2
Maintain a comprehensive national nurse licensure database.

4. Develop a Nursys push system.

   Rationale
   Different kinds of services and information can be pushed to external customers for a fee and thus generate revenues from the public. Services may include subscription service to push public discipline information and license status.

5. Develop a more profitable licensure verification model.

   Rationale
   Emulate Member Boards who charge a fee for each verification as opposed to the existing model, which now allows a nurse unlimited verifications from unlimited number of Member Boards over a period of 90 days for a one time fee of $30. Currently this is the primary source of revenue for Nursys.

6. Get licensure data from every board of nursing.

   Rationale
   Panel recommends that NCSBN obtain licensure data from every board of nursing even if NCSBN has to pay to get the data. Once Nursys has all the boards' data then different services can be offered to external customers, which could generate a better source of revenue. Work with each board of nursing individually to mitigate their concerns of sharing licensure data.

7. Implement a fraudulent and imposter license alert application.

   Rationale
   Develop an interactive, searchable alert application to track fraudulent and imposter licenses, individuals, agencies, schools and incidents. The application should have the ability to contain pictures and documents for visual reference. This will enhance Member Boards' ability to quickly share this information with other Member Boards, which is another step towards better public protection.

8. Develop a licensure application for boards of nursing.

   Rationale
   Due to concerns such as lack of availability of vendor support for board of nursing licensure applications, high cost of acquisition and maintenance and lack of functionality in the existing licensure products, it is recommended that NCSBN develop a licensure application specifically geared towards the needs of Member Boards.

   Licensure application should provide customization for Member Boards to maintain their identity at the front end to their customers and have full control of their own data. Develop modules for licensure, discipline, investigation and accounting. Application should include online licensure renewal and options to scan/upload document records (credentials), pictures and fingerprints associated with a license. Application should have the ability to securely communicate upon approval with external agencies, which provide services such as criminal background checks.

9. Get Nursys infrastructure and application process certified.

   Rationale
   To improve the credibility of Nursys with respect to security, infrastructure and the application development process, it is recommended that NCSBN explore the option to achieve certification and/or conform to documented standards. This will enhance credibility of the application.

   - Panel developed and conducted Nursys Uniform Data Submission Policy Survey with guidance from Board of Directors. See Attachment A.

- Panel worked out a strategy to provide Member Boards with their own data from Pearson VUE to help the boards fill in the gaps in their database.
- Panel developed a vision and defined "Perfect System" as:

A. 100 percent timely participation by Member Boards with 100 percent confidence in reliability of data to include:
   - Seamless communication between data systems.
   - User "friendliness."
   - Data recovery mechanism.
   - Open architecture.

B. Focus on employer requirements:
   - Ease and efficiency.
   - Service to public.
   - Panel reviewed and updated the Nursys® Policy Manual and presented a final version to the Board of Directors for approval.
   - Upon request, panel discussed the possibility of NCSBN developing a nurse licensure application. Much work needs to be done in this area and after few discussions it was recommended that this needs to be explored further, which would help write up functional requirements. Panel suggested that this could potentially be discussed further at the IT summit.
   - Collaborated with Nursys Advisory Panel and held a joint meeting. Provided feedback to Nursys Advisory Panel and NCSBN staff in regards to Nursys 2.0 enhancements such as Member Board dashboard, profile management tool, security of data in general and tracking mechanism for speed memos.

Future Activities

As charged by the Board of Directors, panel reviewed Nursys business design and rules, and proposed recommendations that can be implemented by NCSBN staff upon approval.

Attachment

A. Nursys Uniform Data Submission Policy Survey

Attachment A

Nursys® Uniform Data Submission Policy Survey

Nursys Data Submission Policy Results			# of Answers/Boards	%
1. HIPDB requires Street Address, City, State and Zip. Our Board is:				
■ Able to provide			49	96%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
South Dakota	H	P		
West Virginia-RN	–	--		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			0	0%
■ Unable to provide because of a statutory requirement			2	4%
Location	**HIPDB**	**Nursys**		
New York	–	–		
Hawaii	–	–		
■ Unable to provide because we do not have the technical expertise to extract the data from our system			0	0%
2. HIPDB requires Date of Birth. Our Board is:				
■ Able to provide			48	94%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			3	6%
Location	**HIPDB**	**Nursys**		
Delaware	H	P		
Hawaii	–	–		
New York	–	–		
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			0	0%
3. HIPDB requires Social Security number. Our Board is:				
■ Able to provide			45	88%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
■ Unable to provide because we do not collect and/or retain that information			2	4%
Location	**HIPDB**	**Nursys**		
Virginia	–	P		
Pennsylvania	–	–		
■ Unable to provide because of a statutory requirement			4	8%
Location	**HIPDB**	**Nursys**		
New York	–	–		
Massachusetts	–	P		
Vermont	–	P		
Hawaii	–	–		
■ Unable to provide because we do not have the technical expertise to extract the data from our system			0	0%
4. HIPDB requires Gender. Our Board is:				
■ Able to provide			36	80%
Location	**HIPDB**	**Nursys**		
West Virginia–PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
South Dakota	H	P		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
California-RN	H	–		
Maryland	H	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
■ Unable to provide because we do not collect and/or retain that information			8	16%
Location	**HIPDB**	**Nursys**		
Virginia	–	P		
Delaware	H	P		
Massachusetts	–	P		
Vermont	–	–		
Alabama	–	–		
New Mexico	H	P		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
Maine	H	P		
Pennsylvania	–	–		
■ Unable to provide because of a statutory requirement			2	4%
Location	**HIPDB**	**Nursys**		
New York	–	–		
Hawaii	–	–		
■ Unable to provide because we do not have the technical expertise to extract the data from our system			0	0%
5. Numerous Speed Memos are generated as a result of missing Status of License (Active or Inactive). Our Board is:				
■ Able to provide			50	98%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
New York	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			1	2%
Location	**HIPDB**	**Nursys**		
District of Columbia	–	–		
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			0	0%
6. HIPDB requires School Name or Program Name. Our Board is:				
■ Able to provide			47	92%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
Florida	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		
Colorado	H	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			2	4%
Location	**HIPDB**	**Nursys**		
Kansas	H	–		
Indiana	–	P		
■ Unable to provide because of a statutory requirement			1	2%
Location	**HIPDB**	**Nursys**		
New York	–	–		
■ Unable to provide because we do not have the technical expertise to extract the data from our system			1	2%
Location	**HIPDB**	**Nursys**		
Wisconsin	–	P		
7. Numerous Speed Memos are generated as a result of missing Current License Issue Date. Our Board is:				
■ Able to provide			48	94%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
New York	–	–		
Illinois	–	–		
Colorado	H	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			1	2%
Location	**HIPDB**	**Nursys**		
District of Columbia	–	–		
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			2	4%
Location	**HIPDB**	**Nursys**		
Rhode Island	H	–		
Wisconsin	–	P		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
8. Numerous Speed Memos are generated as a result of missing Date of Original License in Your Jurisdiction. Our Board is:				
■ Able to provide			48	94%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
New York	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		

H = NCSBN is the HIPDB agent for this board of nursing
P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			2	4%
Location	**HIPDB**	**Nursys**		
District of Columbia	–	–		
Maryland	H	P		
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			1	2%
Location	**HIPDB**	**Nursys**		
Rhode Island	H	–		
9. HIPDB requires Graduation Date. Our Board is:				
■ Able to provide			46	90%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
New Mexico	H	P		

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P = This board of nursing provides licensure data to Nursys®

Nursys Data Submission Policy Results			# of Answers/Boards	%
California-RN	H	–		
Maryland	H	P		
Virginia	--	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Rhode Island	H	–		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			2	4%
Location	**HIPDB**	**Nursys**		
Kansas	H	–		
Illinois	–	–		
■ Unable to provide because of a statutory requirement			1	2%
Location	**HIPDB**	**Nursys**		
New York	–	–		
■ Unable to provide because we do not have the technical expertise to extract the data from our system			1	2%
Location	**HIPDB**	**Nursys**		
Maine	H	P		
■ Sometimes – some files missing this information			1	2%
Location	**HIPDB**	**Nursys**		
Nevada	H	–		
10. Numerous Speed Memos are generated as a result of missing Examination Date. Our Board is:				
■ Able to provide			47	92%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
District of Columbia	–	–		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Oklahoma	H	–		
Wyoming	H	–		
Delaware	H	P		
Massachusetts	–	P		
Nebraska	H	P		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
North Carolina	H	P		
Kentucky	H	P		
Vermont	–	P		
New Hampshire	H	P		
Oregon	H	P		
Iowa	H	P		
Mississippi	H	P		
Minnesota	H	P		
Alabama	–	–		
Hawaii	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Nevada	H	–		
New Mexico	H	P		
Maine	H	P		
California-RN	H	–		
Maryland	H	P		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
New York	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Alaska	–	P		
Utah	H	P		
Washington	–	P		
Pennsylvania	–	–		
■ Unable to provide because we do not collect and/or retain that information			3	6%
Location	**HIPDB**	**Nursys**		
Kansas	H	–		
South Dakota	H	P		
Illinois	–	–		
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			1	2%
Location	**HIPDB**	**Nursys**		
Rhode Island	H	–		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
11. Some Boards have expressed an interest in Nursys collecting the Most Current Update Date for Each Field Supplied. Our Board is:				
■ Able to provide			22	43%
Location	**HIPDB**	**Nursys**		
West Virginia-PN	H	P		
Tennessee	–	P		
Ohio	H	P		
Texas	H	P		
Missouri	H	P		
Wyoming	H	–		
Delaware	H	P		
Vermont	--	P		
New Hampshire	H	P		
Minnesota	H	P		
Florida	–	P		
Indiana	--	P		
Arizona	H	P		
Arkansas	H	P		
South Carolina	H	P		
Maryland	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
Connecticut	–	–		
Illinois	–	–		
Georgia-PN	–	–		
Washington	–	P		
■ Unable to provide because we do not collect and/or retain that information			18	35%
Location	**HIPDB**	**Nursys**		
District of Columbia	–	–		
North Dakota	H	P		
Oklahoma	H	–		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Oregon	H	P		
Iowa	H	P		
Kansas	H	–		
New Mexico	H	P		
California-RN	H	–		
Virginia	–	P		
Idaho	H	P		
Montana	H	P		
Colorado	H	P		
Alaska	–	P		
Utah	H	P		
Pennsylvania	–	–		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
■ Unable to provide because of a statutory requirement			0	0%
■ Unable to provide because we do not have the technical expertise to extract the data from our system			9	18%
Location	**HIPDB**	**Nursys**		
Massachusetts	–	P		
Mississippi	H	P		
Alabama	–	–		
South Dakota	H	P		
Hawaii	–	–		
West Virginia-RN	–	–		
Maine	H	P		
Wisconsin	–	P		
Rhode Island	H	–		
■ Other			1	2%
Location	**HIPDB**	**Nursys**		
New York	–	–		
■ We are not part of online endorsement			1	2%
Location	**HIPDB**	**Nursys**		
Nevada	H	–		
12. If NCSBN were able to obtain a Unique Identifier for Each Nurse through the Testing Vendor, our Board would:				
■ Other			17	33%
Location	**HIPDB**	**Nursys**		
Mississippi	H	P		
Alabama	–	–		
West Virginia-RN	–	–		
Florida	–	P		
Indiana	–	P		
Arkansas	H	P		
South Carolina	H	P		
Maine	H	P		
Connecticut	–	–		
New York	–	–		
Illinois	–	–		
Colorado	H	P		
Wisconsin	–	P		
Georgia-PN	–	–		
Utah	H	P		
Washington	–	P		
Pennsylvania	–	–		
■ Use this identifier			5	10%
Location	**HIPDB**	**Nursys**		
District of Columbia	–	–		
Massachusetts	–	P		
New Mexico	H	P		
Maryland	H	P		
Virginia	–	P		

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Nursys Data Submission Policy Results			# of Answers/Boards	%
■ Be able to store this identifier in our database			12	24%
Location	**HIPDB**	**Nursys**		
North Dakota	H	P		
Ohio	H	P		
Texas	H	P		
Wyoming	H	–		
Delaware	H	P		
Nebraska	H	P		
North Carolina	H	P		
Kentucky	H	P		
Oregon	H	P		
Minnesota	H	P		
Arizona	H	P		
Nevada	H	–		
■ Not be able to use this due to statutory rules			3	6%
Location	**HIPDB**	**Nursys**		
Tennessee	–	P		
Oklahoma	H	–		
Hawaii	–	–		
■ Use the identifier but do not have the technical expertise to import the data into our system			14	27%
Location	**HIPDB**	**Nursys**		
Idaho	H	P		
Montana	H	P		
Georgia-RN	–	–		
Louisiana-RN	H	–		
West Virginia-PN	H	P		
Missouri	H	P		
Vermont	–	P		
New Hampshire	H	P		
Iowa	H	P		
Kansas	H	–		
South Dakota	H	P		
Alaska	–	P		
Rhode Island	H	–		
California-RN	H	–		

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P = This board of nursing provides licensure data to Nursys®

Report of the Resolutions Committee

Background

The Resolutions Committee convened on Nov. 20, 2006, via conference call for their first FY07 meeting. At that time, the committee reviewed and evaluated the resolutions meeting process, the operating policies and procedures, motions/resolutions submission form and resolutions fiscal form. The committee concluded no revisions were needed.

The annual call-in for the membership to propose resolutions or ask questions about the process was held on April 30, 2007. All members of the resolutions committee and seven boards participated in the call.

The Resolutions Committee is convening at the Annual Meeting on Aug. 8, 2007. This is the official meeting during which the committee will address resolutions and motions submitted for the Delegate Assembly.

Highlights of FY07 Activities

- Approved the current forms, policies and procedures, and resolutions process for the 2007 Delegate Assembly.
- Held call-in for membership to answer questions and clarify resolutions process.
- Present at 2007 Delegate Assembly to fulfill charge.

Attachments

A. Resolutions Solicitation Letter

B. Resolutions Committee Operating Policies and Procedures

C. Motions/Resolutions Submission Form

D. Resolutions Fiscal Form

Members

Judith Personett, EdD, MA, BSN, RN
Chair, Washington, Area I

Doreen Begley, MS, RN
Nevada, Area I

Gloria Damgaard, RN, MS
South Dakota, Area II

Richard Gibbs, LVN
Texas, Area III

Ruth Ann Terry, MPH, RN
California-RN, Area I

Marguerite Witmer, MSN, MPA, RN-C
Pennsylvania, Area IV

Staff

Maryann Alexander, PhD, RN
Associate Executive Director,
Regulatory Programs

Meeting Dates

- Nov. 20, 2006 (Conference Call)
- April 4, 2007
- April 30, 2007 (Conference Call with Member Boards)
- Aug. 7 – 8, 2007

Relationship to Strategic Plan

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 2
Implement recommendations for effective communication within the membership.

Attachment A

Resolutions Solicitation Letter

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277
312.525.3600
www.ncsbn.org

TO: Executive Officers
Member Board Presidents

FROM: The FY2007 Resolutions Committee

Chairperson
Judith D. Personett, Ed.D, MA, BSN, RN

Committee Members
Doreen K. Begley, MS, RN
Gloria Damgaard, RN, MS
Richard Gibbs, LVN
Marguerite (Peggy) Whitmer, MSN, MPA, RN-C
Ruth Ann Terry, MPH, RN, Board Liaison
Maryann Alexander, PhD, RN, NCSBN staff

RE: Call for Motions/Resolutions to the 2007 Delegate Assembly

The Resolutions Committee is seeking motions/resolutions for consideration by the Delegate Assembly at the 2007 NCSBN Annual Meeting, August 7-10, 2007, in Chicago.

To assist in the development of motions/resolutions that conform to the NCSBN Bylaws, Standing Rules and the Resolutions Committee Operating Policies and Procedures, the following documents are available on the *Members Only* side of the NCSBN website (click on Governance-Member and then Delegate Assembly):

- Resolutions Committee Operating Policies and Procedures
- Motions/Resolutions Submission Form
- Fiscal Impact Statement
- NCSBN Bylaws

The Resolutions Committee encourages you to submit motions/resolutions early. Please use the Motions/Resolutions form and Fiscal Impact Statement when submitting a motion. These forms will also be available in a printable version on the NCSBN website.

Resolutions Committee Open Membership Call:
The Resolutions Committee will be hosting a call on **Monday, April 30, 2007 at 12:30 PM (CST)** to give the membership a chance to interact with the committee members, ask questions or raise issues regarding the submission process or their particular motions/resolutions. The Dial –In information for the call is listed below:

Passcode: **NCSBN**
Leader: **Maryann Alexander**
Number: **888 323 2711**

Motions/resolutions may be submitted at any time up to and through Delegate Assembly. Submission forms can be done electronically. The form can be printed, signed and sent via fax (312) 279-1032 to the attention of Maryann Alexander. As a reminder, only delegates, the National Council Board of Directors, and the Examination Committee (for approval of test plans) may make motions/resolutions at the Delegate Assembly.

Please contact Maryann Alexander if you have any questions at (312) 525-3695 or malexander@ncsbn.org**.**

Attachment B

Resolutions Committee Operating Policies and Procedures

Purpose

The Resolutions Committee is a standing committee of the Delegate Assembly established under Article X (1)(e) of the NCSBN Bylaws to review, evaluate and report on all motions and resolutions submitted to the Committee by a delegate. The operating policies and procedures serve to guide the work of the Committee and the formulation of motions and resolutions by makers.

Policy

1. All resolutions and nonprocedural main motions unrelated to the election of officers and directors must first be submitted to the chair of the Resolutions Committee before being presented to Delegate Assembly.
2. The Resolutions Committee will receive and analyze all motions and resolutions submitted to it by authorized motion makers. The analysis shall consist of:
   a. Determination of consistency with NCSBN articles of incorporation, bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies;
   b. Determination of relationship to ongoing programs;
   c. Assessment for duplication with other proposed motions;
   d. Legal implications;
   e. Financial impact.
3. The Resolutions Committee chairperson will present to the Delegate Assembly oral and/or written reports of all motions and resolutions submitted to it. The report for each motion and resolution shall include the following analyses performed by the Resolutions Committee:
   a. Determination of consistency with NCSBN articles of incorporation, Bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies
      - Consistent
      - Not Consistent (with rationale)
   b. Determination of relationship to ongoing programs
      - Not in current Strategic Plan
      - In current Strategic Plan (site identified)
   c. Assessment for potential duplication with other proposed motion or ongoing programs
      - No duplication
      - Duplication (area of duplication specified)
   d. Legal implications
      - None
      - Implications identified
   e. Financial impact
      - None
      - Impact identified

In the event a motion or resolution is submitted too late for the Resolutions Committee to perform its analysis, the Committee will report to Delegate Assembly the absence of any review.

Procedures

1. Motions and resolutions must be submitted by a delegate in accordance with the bylaws and the Standing Rules. The person seconding the motion must also sign all motions. A fiscal impact statement must accompany the motion or resolution.
2. It is desirable to have the motion or resolution submitted in time to include in the mailing to Member Boards 45 days before the Annual Meeting. However, motions and resolutions not submitted in time to meet the 45-day mailing prior to the Annual Meeting should be submitted to the Resolutions Committee by the time and date proscribed in the Standing Rules.
3. The Resolutions Committee may schedule a conference call and/or an informal meeting with members wanting to make a motion at Delegate Assembly to enable makers an opportunity to receive assistance in the formulation of the motion/resolution.
4. Makers may submit motions to the Resolutions Committee until the Delegate Assembly concludes its business at the Annual Meeting to allow for all matters to be addressed. However, motions and resolutions not submitted to the Committee by the established deadline may not be reviewed and analyzed by the Resolutions Committee.
5. The deadline for submitting motions and resolutions to the Resolutions Committee shall appear in the Standing Rules for the Delegate Assembly.
6. The Resolutions Committee will meet with each maker in accordance with the schedule and guidelines established. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the Committee's business. Once discussion is concluded, the Committee will meet in executive session to prepare the motion or resolution for submission to the Delegate Assembly.
7. Courtesy resolutions are proposed directly by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted to the Resolutions Committee by the deadlines published in the NCSBN newsletter, *Council Connector*, member mailing, NCSBN Web site, or other form of notice in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. Motions and resolutions submitted in advance of the Annual Meeting will be presented at the Resolutions Forum.
3. The person(s) submitting a motion or resolution must be prepared to attend and discuss the motion or resolution with Resolution Committee at its scheduled meeting and speak to the motion or resolution to the Delegate Assembly.

Motions and Resolutions Received After the Resolutions Committee Meeting

1. A motion or resolution not submitted to the Resolutions Committee by the established deadline at the Delegate Assembly may be presented directly to the Delegate Assembly as new business, provided that the maker first submits the resolution to the chair of the Resolutions Committee. The Resolutions Committee may make a reasonable attempt to meet with the motion maker to discuss any such motions and resolutions, time permitting, but the Committee may report to the Delegate Assembly that it was unable to perform its analysis and review of the motion.

2. The maker is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be accompanied by a written analysis of consistency with NCSBN mission, purpose and functions, strategic initiatives, outcomes, assessment of fiscal impact and potential legal implications. The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.

Definitions

Motions/Resolutions

Business items proposed by Delegates, the Board of Directors or the Examination Committee for consideration at the Delegate Assembly. Such proposals are submitted to the Resolutions Committee where they are processed for clarification and consistency.

Revisions Dates:

- May 1990
- January 1996
- February 2002

Attachment C

Motions/Resolutions Submission Form

National Council of State Boards of Nursing
Motions/Resolutions Submission Form

You may type directly on this form

Name of Motion/Resolution:

Maker:

Date: **Phone #:** **E-mail Address:**

I move that:

Rationale for Motion:

Signature of Maker: _____

Member Board: _____

Signature of Second: _____

Member Board: _____

I. Describe the relationship of the motion/resolution to National Council's:

a) Bylaws, mission, strategic initiatives and outcomes (see NCSBN Web site and/or current Delegate Assembly business book)

b) Ongoing programs and policies

II. Identify potential legal implications.

III. Attach a completed Fiscal Impact Statement.

Attachment D

Resolutions Fiscal Form

National Council of State Boards of Nursing
Fiscal Impact Statement

You may type directly on this form

Title of Motion/Resolution: _____

Proposed by:

I. PROJECTED DATES

A) Beginning: _____

B) Completion: _____

II. RESOURCES ANTICIPATED

Check those resources needed to accomplish motion/resolution

A) Does this proposal require a committee? ❑Yes ❑No ❑Unsure

1. Number of members anticipated including the chair?_____ ❑Unsure
2. How many meetings anticipated?_____
3. Time span of resources: ❑1 year ❑2 years ❑3 or more years ❑Unsure

B) Does this proposal require printings, mailings, or electronic access (e.g., Web)?
❑Yes ❑No

1. Please describe any expected surveys.
2. Please describe other expected printings (special reports, mailings).
3. Please describe any expected electronic resources (e.g., Web site).

C) Will this proposal require outside consultation? ❑Yes ❑No
If yes, please select all that apply:

- ❑ Legal Counsel
- ❑ Nursing
- ❑ Testing/Psychometric
- ❑ Policy/Regulation
- ❑ Technical (including computer)
- ❑ Other (please describe) _____

D) Will this proposal require other resources? ❑Yes ❑No
If yes, please complete the following:

1. Please describe expected travel (other than committee meetings).
2. Other (please describe).

II. OTHER COMMENTS REGARDING FISCAL IMPACT.

Report of the TERCAP™ Task Force

Background

In FY07, the newly appointed TERCAP™ Task Force continued the work of the Practice Breakdown Advisory Panel that began in 1999, when the Board of Directors appointed a Task Force to develop new knowledge about the causes of nursing practice breakdown. The basis of the work was to allow the Board of Directors and Member Boards to have a rich source of data that could determine sources of nursing error. The goal of Taxonomy of Error, Root Cause Analysis Practice-responsibility (TERCAP™) continues to be to learn from the experiences of nurses who have had episodes of practice breakdown and to discover characteristics of nurses at risk. The overall aim is to promote patient safety by better understanding nursing practice breakdown and by improving the effectiveness of nursing regulation.

The major charge of the TERCAP Task Force has been to promote the use of TERCAP by Member Boards. TERCAP was finalized and became available online in February 2007. Access to using TERCAP online is currently limited to Member Boards that have attended an NCSBN educational offering about TERCAP, either through a Webinar or hands-on training, and obtained authorization from the executive director of the Member Board interested in using TERCAP. This will help with security and quality control by limiting access to TERCAP to those who are properly trained and authorized to enter data.

As of May 1, 2007, 30 Member Boards, consisting of 131 participants, attended 10 TERCAP Webinars on Jan. 11, 16, 25 and 31; Feb. 8 and 23; March 13 and 22; April 12; and May 9. Following the Webinars, Member Boards that were interested in using TERCAP were asked to submit a TERCAP 2007 Member Board Only User Access Request Form. Completion of the access User Form authorized each identified staff member of that jurisdiction to have NCSBN Members Only Web access to the TERCAP tools. Since the initial offering, 11 Member Boards submitted User Forms for their jurisdictions.

On March 20, 2007, NCSBN received the first case submitted online through TERCAP. Because TERCAP was designed to be used prospectively, as cases are reported to Member Boards and the time for investigations and determination of the Board's decision regarding discipline can take months, if not a year at times, it will take some period of time for the hundreds of cases that are needed for informative data analysis to be submitted to NCSBN. The Task Force plans to discuss the feasibility of a successful roundtable, dependent upon the number of TERCAP cases submitted to NCSBN and the time needed for data analysis, at its June meeting. The Task Force feels that the roundtable is an important Member Board benefit for boards using TERCAP as well as boards that may need more information to make the decision to use TERCAP. To assure a successful roundtable, and for it to be a valuable opportunity for the time invested by board members to attend the event, the discussion needs to be robust and meaningful for all participants. For that to occur there needs to be a sufficient number of cases and adequate time for data analysis.

The TERCAP Task Force is planning on limiting the attendance at the initial TERCAP roundtable to Member Boards, rather that including invited stakeholders. The TERCAP Task Force is planning to evaluate the TERCAP procedure, instrument, protocol and ease of boards' use, as well as the data collection and analysis from the first 300 cases, prior to sharing results with external stakeholders. The sharing of TERCAP with external stakeholders will be an important part of the success of TERCAP. Timing will be key to that success and the Task Force wants to proceed with those plans as soon as its success will be feasible.

Highlights of FY07 Activities

- Revised the TERCAP Instrument and Protocol.
- Adapted revisions into the electronic online TERCAP and Protocol.

Members

Lisa Emrich, MSN, RN, Chair
Ohio, Area II

Charlotte Beason, EdD, RN, CNAA
Kentucky, Area III

Karla Bitz, PhD, RN
North Dakota, Area II

Karen Bowen, MS, RN
Nebraska, Area II

Thania Elliott, RN, MPH, JD
Louisiana-RN, Area III

Sue Petula, Pennsylvania, PhD, RN, CNAA, Pennsylvania, Area IV

Kathryn Schwed, JD
New Jersey, Area IV

Mary Beth Thomas, MSN, RN
Texas, Area III

Carol Camille Walker, MS, RN
North Carolina, Area III

Marie Farrell, EdD, MPH, RN, FAAN
Consultant

Kathy Scott, RN, PhD, CHE
Consultant

Gino Chisari, MSN, RN, Board Liaison
Massachusetts, Area IV

Staff

Mary Doherty, JD, RN
Associate, Practice, Regulation & Education

Kevin Kenward, PhD
Director, Research

Meeting Dates

- Nov. 8 – 9, 2006
- Jan. 4, 2007 (Conference Call)
- Feb. 26 – 27, 2007
- June 20 – 21, 2007

Relationship to Strategic Plan

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Provide models and resources for evidenced-based regulation to Member Boards.

- Created a short, online version of TERCAP and a six-page TERCAP questionnaire for investigators.
- Prepared and presented TERCAP Webinars.
- Developed Frequently Asked Questions (FAQs) with answers.
- Developed and revised the TERCAP Policy Manual.
- Determined the TERCAP Study Questions — Guidelines for the Analysis of TERCAP Generated Data.
- Enlisted 17 percent of Member Boards to participate as users in TERCAP data collection.
- Published an a article concerning TERCAP in *Council Connector*.
- Revised and updated the TERCAP Web pages.
- Obtained reprint permission for the *Harvard Policy Review Journal* article that featured TERCAP.
- Requested trademark protection for TERCAP from trademark (™) to registered trademark (®) .
- Assisted the NCSBN Marketing and Communications Department with the development of a TERCAP tagline and promotional materials.
- Made final edits to the book *Nursing Pathways for Safe Health Care* and discussed publication process.

Future Activities

- Continue to promote the use of TERCAP by Member Boards.
- Presentation by Lisa Emrich, TERCAP chair, at the Investigator & Attorney Workshop.
- Provide hands-on TERCAP training to interested Investigator & Attorney Workshop participants.
- Enlist an additional 12 percent of Member Boards to participate in TERCAP data collection.
- Collect data from participating Member Boards.
- Conduct quarterly analysis of cases submitted.
- Submit formal reports concerning TERCAP data analysis.
- Plan roundtable to include presentation of data analysis.
- Create user forums.
- Continue to present TERCAP Webinars.
- Create a DVD of and/or online link to a TERCAP Webinar.
- Develop additional TERCAP resources and products.
- Continue to update and revise TERCAP Web pages.
- Develop TERCAP continuous quality improvement plan.
- Submit book, *Nursing Pathways for Safe Health Care*, for publication.
- Gather comments submitted about TERCAP and use it to evaluate TERCAP approximately one year after submission of cases.

Attachments

A. TERCAP Practice Breakdown Categories

B. TERCAP Data Collection Instrument

C. TERCAP Study Questions – Guidelines for the Analysis of TERCAP Generated Data

D. TERCAP Policy Manual, Version 1.1

Attachment A

TERCAP™ 2007 Practice Breakdown Categories

Practice Breakdown is defined as the disruption or absence of any of the aspects of good practice

1. Safe Medication Administration: The nurse administers the right dose of the right medication via the right route to the right patient at the right time for the right reason.
2. Documentation: The nurse ensures complete, accurate and timely documentation.
3. Attentiveness/Surveillance: The nurse monitors what is happening with the patient and staff. The nurse observes the patient's clinical condition; if the nurse has not observed the patient, then s/he cannot identify changes if they occurred and/or make knowledgeable discernments and decisions about the patient.
4. Clinical Reasoning: Nurses interpret patient signs, symptoms and responses to therapies. Nurses evaluate the relevance of changes in patient signs and symptoms and ensure that patient care providers are notified and that patient care is adjusted appropriately. Nurses titrate drugs and other therapies according to their assessment of patient responses (e.g., change patient positioning in response to patient shock, titrate IV medications to maintain the patient's vital signs within acceptable parameters, assess patient pain and adjust pain medication, and administer sliding scale insulin in response to patient blood sugars).
5. Prevention: The nurse follows usual and customary measures to prevent risks, hazards or complications due to illness or hospitalization. These include measures such as fall precautions, preventing hazards of immobility, contractures and stasis pneumonia.
6. Intervention: The nurse properly executes health care procedures aimed at specific therapeutic goals. Interventions are implemented in a timely manner. Nurses perform the right intervention on the right patient.
7. Interpretation of Authorized Provider's Orders: The nurse interprets authorized provider's orders.
8. Professional Responsibility/Patient Advocacy: Advocacy refers to the expectation that a nurse acts responsibly in protecting patient/family vulnerabilities and in advocating to see that patient needs/concerns are addressed. The nurse demonstrates professional responsibility and understands the nature of the nurse-patient relationship.

Attachment B

TERCAP™ Data Collection Instrument

TERCAP™
Taxonomy of Error, Root Cause Analysis and Practice-responsibility

Data Collection Instrument

TERCAP Case ID Number _____

1. Full Name of Reviewer _____

2. State Board of Nursing _____ **3. Date of incident** _____ or □ Unknown

4. Patient age _____ or □ Unknown

5. Patient gender □ Female □ Male or □ Unknown

6. Were the patient's family and/or friends present at the time of the practice breakdown?
□Yes □ No □ Unknown

7. Indicate whether the patient exhibited any of the following at the time of the practice breakdown
□ Agitation /Combativeness □ Altered level of consciousness □ Cognitive impairment
□ Communication /Language difficulty □ Depression / Anxiety □ Inadequate coping /stress management
□ Incontinence □ Insomnia □ Pain Management □ Sensory deficits (hearing, vision, touch)

8. Indicate the patient's diagnosis. Check no more than two diagnoses, those that contributed to the reported situation.
□ Alzheimer's disease and other dementias (confusion) □ Arthritis □ Asthma □ Back problems □ Cancer
□ Congestive heart failure □ Depression and anxiety disorders □ Diabetes □ Emphysema □ Fractures
□ Gall bladder disease □ Gastrointestinal disorders □ HIV / AIDS □ Hypertension □ Infections
□ Ischemic heart disease (CAD, MI) □ Nervous system disorders □ Pneumonia □ Pregnancy
□ Renal / urinary system disorders □ Skin disorders □ Stomach ulcers □ Stroke (CVA)
□ Unknown □ Other - please specify _____

9. What happened to the patient?
□ Patient fell □ Patient departed without authorization
□ Patient received wrong medication □ Patient received wrong treatment □ Patient received wrong therapy
□ Patient acquired nosocomial (hospital acquired) infection □ Patient suffered hemolytic transfusion reaction
□ Patient suffered severe allergic reaction / anaphylaxis □ Patient was abducted
□ Patient was assaulted □ Patient suicide □ Patient homicide
□ Unknown / not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

10. Patient Harm
□ No harm - An error occurred but with no harm to the patient
□ Harm - An error occurred which caused a minor negative change in the patient's condition.
□ Significant harm - Significant harm involves serious physical or psychological injury. Serious injury specifically includes loss of function or limb.
□ Patient death - An error occurred that may have contributed to or resulted in patient death.

11. Type of community
□ Rural (lowly populated, farm, ranch land communities 10,000 or less)
□ Suburban (towns, communities of 10,000 to 50,000) □ Urban (any city over 50,000) □ Unknown

12. Type of facility or environment
□ Ambulatory Care □ Assisted Living □ Behavioral Health □ Critical Access Hospital
□ Home Care □ Hospitals □ Long Term Care □ Office - based Surgery
□ Physician / Provider Office or Clinic □ Unknown □ Other - please specify _____

1

13. Facility Size
□ 5 or fewer beds □ 6-24 beds □ 25-49 beds □ 50-99 beds □ 100-199 beds
□ 200-299 beds □ 300-399 beds □ 400-499 beds □ 500 or more beds □ Unknown / Not applicable

14. Medical record system
□ Electronic documentation □ Electronic physician orders □ Electronic medication administration system
□ Combination paper / electronic record □ Paper documentation □ Unknown

15. Communication Factors
□ Communication systems equipment failure
□ Interdepartmental communication breakdown / conflict
□ Shift change (patient hand-offs)
□ Patient transfer (hand-offs)
□ No adequate channels for resolving disagreements
□ Preprinted orders inappropriately used (other than medications)
□ Medical record not accessible
□ Patient name similar / same
□ Patient identification failure
□ Computer system failure
□ Lack of or inadequate orientation / training
□ Lack of ongoing education / training
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

16. Leadership / Management Factors
□ Poor supervision / support by others
□ Unclear scope and limits of authority / responsibility
□ Inadequate / outdated policies / procedures
□ Assignment or placement of inexperienced personnel
□ Nurse shortage, sustained, at institution level
□ Inadequate patient classification (acuity) system to support appropriate staff assignments
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

17. Backup and Support Factors
□ Ineffective system for provider coverage
□ Lack of adequate provider response
□ Lack of nursing expertise system for support
□ Forced choice in critical circumstances
□ Lack of adequate response by lab / x-ray / pharmacy or other department
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

18. Environmental Factors
□ Poor lighting □ Increased noise level □ Frequent interruptions / distractions
□ Lack of adequate supplies / equipment □ Equipment failure □ Physical hazards
□ Multiple emergency situations □ Similar / misleading labels (other than medications)
□ Code situation
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

19. Health team members involved in the practice breakdown
□ Supervisory nurse / personnel
□ Physician (may be attending, resident or other)
□ Other prescribing provider
□ Pharmacist
□ Staff nurse
□ Floating / temporary staff
□ Other Health professional (e.g., PT, OT, RR)
□ Health profession student
□ Medication assistant
□ Unlicensed Assistive Personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)
□ Other support staff □ Patient □ Patient's Family / friends
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

20. Staffing issues contributed to the practice breakdown
□ Lack of supervisory / management support □ Lack of experienced nurses □ Lack of nursing support staff
□ Lack of clerical support □ Lack of other health care team support
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

21. Health Care Team
□ Intradepartmental conflict / non-supportive environment □ Breakdown of health care team communication
□ Lack of multidisciplinary care planning □ Intimidating / threatening behavior
□ Lack of patient involvement in plan of care
□ Care impeded by policies or unwritten norms that restrict communication
□ Majority of staff had not worked together previously □ Illegible handwriting
□ Lack of patient education □ Lack of family / caregiver education
□ None / Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

22. Nurse's year of birth _____ □ Unknown

23. Nurse gender □ Female □ Male □ Unknown

24. Where nurse received nursing education
□ Unknown □ US □ Non-US, please list country _____

25. Indicate all degrees the nurse holds

Degree(s)	Year of Graduation(s)	Year of Initial Licensure(s)	Unknown
_____	_____	_____	□
_____	_____	_____	□

26. Current Licensure Status *Check all license(s) active at the time of the reported practice breakdown*
□ LPN/VN □ RN □ APRN

27. Is English the nurse's primary language?
□ Yes □ No □ Unknown

28. Did the nurse report completion of any continued competence activities or professional development activities in the last five years?
□ Yes □ No □ Unknown

29. Indicate the category of Advanced Practice Registered Nurse (APRN)
□ Not applicable since not an APRN □ Nurse Practitioner □ Nurse Anesthetist □ Nurse Midwife
□ Clinical Nurse Specialist □ APRN Category unknown □ Other - please specify _____

30. Work start and end times (*military format*) when the practice breakdown occurred
Start time _____ am/pm End time _____ am/pm Time of incident _____ am/pm

31. Length of time nurse had worked for the organization where the practice breakdown occurred
□ Less than one month □ One month - Twelve months □ One - Two years
□ Three - Five years □ More than five years □ Unknown

32. Length of time nurse had worked in patient care location where the practice breakdown occurred
□ Less than one month □ One month - Twelve months □ One - Two years
□ Three - Five years □ More than five years □ Unknown

33. Length of time nurse had been in the specific nursing role at the time of the practice breakdown
□ Less than one month □ One month - Twelve months □ One - Two years
□ Three - Five years □ More than five years □ Unknown

34. Type of shift
□ 8 hour □ 10 hour □ 12 hour □ On call □ Unknown □ Other - please specify

35. Days worked in a row at the time of the practice breakdown (include all positions / employment)
□ First day back after time off □ Two - Three days □ Four - Five days □ Six or more days □ Unknown

36. Was the nurse working in a temporary capacity?
□ Yes □ No □ Unknown / Not applicable

37. Assignment of the nurse at time of the practice breakdown
□ Direct patient care □ Team leader □ Charge nurse □ Nurse manager / supervisor
□ Combination patient care / leadership role □ Unknown

38. How many direct care patients were assigned to the nurse at the time of the practice breakdown?
Number of Patients _____ □ Unknown

39. How many staff members was the nurse responsible for supervising at the time of the practice breakdown?
Number of Staff _____ □ Unknown

40. How many patients was the nurse responsible for overall (counting direct care patients and the patients of the staff the nurse was supervising at the time of the practice breakdown)?
Number of Patients _____ □ Unknown

41. Nurse's reported perception of factors that contributed to the practice breakdown
□ Nurse's language barriers
□ Nurse's cognitive impairment
□ Nurse's high work volume / stress
□ Nurse's fatigue / lack of sleep
□ Nurse's drug / alcohol impairment / substance abuse
□ Nurse's functional ability deficit
□ Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
□ No rest breaks / meal breaks
□ Nurse's lack of orientation / training
□ Nurse's overwhelming assignment(s)
□ Nurse's lack of team support
□ Nurse's mental health issues
□ Nurse's conflict with team members
□ Nurse's personal pain management
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

42. Supervisor or employer's perception of factors that contributed to the practice breakdown
□ Nurse's language barriers
□ Nurse's cognitive impairment
□ Nurse's high work volume / stress
□ Nurse's fatigue / lack of sleep
□ Nurse's drug / alcohol impairment / substance abuse
□ Nurse's functional ability deficit
□ Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
□ No rest breaks / meal breaks
□ Nurse's lack of orientation / training
□ Nurse's overwhelming assignment(s)
□ Nurse's lack of team support
□ Nurse's mental health issues
□ Nurse's conflict with team members
□ Nurse's personal pain management
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

43. Previous discipline history by employer(s) for practice issues
□ Yes □ No □ Unknown

44. Terminated or resigned in lieu of termination from previous employment
□ Yes □ No □ Unknown

45. Previous discipline by a board of nursing
□ Yes □ No □ Unknown

Please provide the previous Case Identifier(s), if available, or any other information describing the type of practice breakdown that resulted in previous discipline. *Our goal is to be able to analyze cases in which a nurse had repeat / multiple practice breakdown issues*

_____
_____

46. Previous criminal convictions
□ Yes □ No □ Unknown

47. Employment Outcome
□ Employer retained nurse □ Nurse resigned □ Nurse resigned in lieu of termination
□ Employer terminated / dismissed nurse
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

48. Did the reported incident involve intentional misconduct or criminal behavior?
□ No
□ Yes: Changed or falsified charting □ Yes: Deliberately covering up error
□ Yes: Theft (including drug diversion) □ Yes: Fraud (including misrepresentation)
□ Yes: Patient abuse (verbal, physical, emotional or sexual)
□ Yes: Criminal conviction □ Yes: Other - please specify _____

49. Did the practice breakdown involve a medication error?
□ Yes □ No

50. Name of drug involved in the practice breakdown (*include complete order)*
Drug ordered _____ Drug actually given _____ □ Unknown

51. The type of medication error identifies the form or mode of the error, or how the error was manifested
□ Drug prepared incorrectly □ Extra dose □ Improper dose / quantity □ Mislabeling □ Omission
□ Prescribing □ Unauthorized drug □ Wrong administration technique □ Wrong dosage form
□ Wrong drug □ Wrong patient □ Wrong route □ Wrong time
□ Wrong reason □ Abbreviations
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Other - please specify _____

52. Select contributing factors related to the medication error
□ Blanket orders □ Performance deficit □ Brand names look alike
□ Brand names sound alike □ Brand / generic drugs look alike □ Calculation error
□ Communication □ Computer entry □ Computerized prescriber order entry
□ Computer software □ Contra-indicated, drug allergy □ Contra-indicated, drug / drug
□ Contra-indicated in disease □ Contra-indicated in pregnancy / breastfeeding
□ Decimal point □ Dilutant wrong □ Dispensing device involved
□ Documentation inaccurate / lacking □ Dosage form confusion □ Drug devices *
□ Drug distribution system □ Drug shortage □ Equipment design confusing / inadequate
□ Equipment (not pumps) failure / malfunction □ Fax / Scanner involved □ Generic names look alike
□ Generic names sound alike □ Handwriting illegible / unclear □ Incorrect medication activation
□ Information management system □ Knowledge deficit □ Label - Manufacturer design
□ Label - Your facility's design □ Leading / Missing zero □ Measuring device inaccurate / inappropriate
□ Monitoring inadequate / inappropriate □ Non-formulary drug □ Non-metric units used
□ Packaging / container design □ Patient identification failure □ Performance (human) deficit
□ Prefix / Suffix misinterpreted □ Preprinted medication order form □ Procedure / Protocol not followed
□ Pump: failure / malfunction □ Pump: improper use □ Reconciliation – Admission
□ Reconciliation – Discharge □ Reconciliation material confusing / inaccurate
□ Repackaging by your facility □ Repackaging by other facility □ Similar packaging / labeling
□ Similar products □ Storage proximity □ System safeguard(s) inadequate
□ Trailing / terminal zero □ Transcription inaccurate / omitted □ Verbal order
□ Written order □ Workflow disruption
□ Unknown / Not applicable (If you select this option, do not select any other choices.)
□ Medication available as floor stock □ Other - please specify _____

53. Did the practice breakdown involve a documentation error?
□ Yes □ No
If Yes, *the practice breakdown documentation error involved:*
□ Pre-charting / untimely charting □ Incomplete or lack of charting
□ Charting incorrect information □ Charting on wrong patient record
□ Other - please specify _____

+ + + + *TERCAP ROOT CAUSE ANALYSIS of the PRACTICE BREAKDOWN* + + + +

54. If Attentiveness / Surveillance was a factor in the Practice Breakdown, check all that apply
□ Patient not observed for an unsafe period of time □ Staff performance not observed for an unsafe period of time
□ Other - please specify _____

55. If Clinical Reasoning was a factor in the Practice Breakdown, check all that apply
□ Clinical implications of patient signs, symptoms and/or responses to interventions not recognized
□ Clinical implications of patient signs, symptoms and/or interventions misinterpreted
□ Following orders, routine (rote system) without considering specific patient condition
□ Poor judgment in delegation and the supervision of other staff members
□ Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
□ Lack of knowledge □ Other - please specify _____

56. If Prevention was a factor in the Practice Breakdown, check all that apply
Preventive measure for patient well-being not taken
Breach of infection precautions
Did not conduct safety checks prior to use of equipment
□ Other - please specify _____

57. If Intervention was a factor in the Practice Breakdown, check all that apply
□ Did not intervene for patient □ Did not provide timely intervention □ Did not provide skillful intervention
□ Intervened on wrong patient □ Other - please specify _____

58. If Interpretation of Authorized Provider's Orders was a factor in the Practice Breakdown, check all that apply
□ Did not follow standard protocol / order □ Missed authorized provider's order
□ Unauthorized intervention (not ordered by an authorized provider)
□ Misinterpreted telephone or verbal order □ Misinterpreted authorized provider handwriting
□ Undetected authorized provider error resulting in execution of an inappropriate order
□ Other - please specify _____

59. If Professional Responsibility / Patient Advocacy was a factor in the Practice Breakdown, check all that apply
□ Nurse fails to advocate for patient safety and clinical stability
□ Nurse did not recognize limits of own knowledge and experience
□ Nurse does not refer patient to additional services as needed
□ Specific patient requests or concerns unattended
□ Lack of respect for patient / family concerns and dignity
□ Patient abandonment □ Boundary crossings / violations □ Breach of confidentiality
□ Nurse attributes responsibility to others □ Other - please specify _____

Select which Practice Breakdown categories you selected above is most significant (*primary*)
□ Attentiveness/Surveillance
□ Clinical Reasoning
□ Prevention
□ Intervention
□ Interpretation of provider's orders
□ Professional responsibility / patient advocacy

Select which of the Practice Breakdown categories you selected above is the second most significant (*secondary*)
□ Attentiveness/Surveillance
□ Clinical Reasoning
□ Prevention
□ Intervention
□ Interpretation of provider's orders
□ Professional responsibility / patient advocacy

60. Board of Nursing Outcomes
□ Dismissed, no action
□ Referral to another oversight agency
□ Recommendations to the health care agency involved in the practice breakdown
□ Non-disciplinary action (e.g., letter of concern)
□ Alternative Program – The nurse was given the opportunity to participate in a non-discipline program to address practice and / or impairment concerns
□ Board of Nursing disciplinary action

Attachment C

TERCAP™ 2007 Study Questions

1. What patient characteristics are associated with different types of practice breakdown? (Section One of TERCAP™ Instrument)
2. What nurse characteristics (demographic data) are associated with different types of practice breakdown? (Section Six of TERCAP™ Instrument)
3. What nurse practice history factors (scheduling, staffing levels and/or timing of incidents) are associated with different types of practice breakdown? (Section Six of TERCAP™ Instrument)
4. What licensure types are associated with different types of practice breakdown? (Section Six of TERCAP™ Instrument)
5. What educational characteristics are associated with different types of practice breakdown? (Section Six of TERCAP™ Instrument)
6. What types of setting factors are associated with different types of practice breakdown? (Section Three of TERCAP™ Instrument)
7. What types of health care system factors are associated with different types of practice breakdown? (Section Four of TERCAP™ Instrument)
8. What types of health care team factors are associated with different types of practice breakdown? (Section Five of TERCAP™ Instrument)
9. What clusters of practice breakdown are associated with the primary types of error? (Section Eight of TERCAP™ Instrument)
10. What types of practice breakdown are associated with patient outcome? (Section Two of TERCAP™ Instrument)
11. What types of patient medical record documentation are associated with different types of practice breakdown? (Section Three, Question 14 of TERCAP™ Instrument)

Attachment D

TERCAP™ 2007 Policy Manual

Version 1.1, March 7, 2007

Introduction

This TERCAP™ 2007 Policy Manual is a tool for Member Boards interested in using the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP) Instrument and receiving data analysis based on the information submitted by participating Member Boards. TERCAP is designed as an intake instrument for capturing data from discipline cases. It allows for consistent and comprehensive data collection that can be provided to the National Council of State Boards of Nursing (NCSBN) to feed into a national data set.

General Overview

TERCAP was designed through years of work by many members of NCSBN, including committees such as Practice Breakdown and TERCAP, as well as the Member Boards who participated in piloting the TERCAP Instrument and other tools. In 1999, the NCSBN Board of Directors appointed a Task Force to develop new knowledge about the causes of nursing practice breakdown. The basis of the work would allow the Board of Directors and Member Boards to have a rich source of data that can help determine sources of nursing error. In 2004, the third Institute of Medicine (IOM) Report on patient safety, Keeping Patients Safe, Transforming the Work Environments of Nurses (2004) made a recommendation that NCSBN undertake an initiative. IOM's recommendation 7.2 stated: "NCSBN, in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their applicability by state boards of nursing and other state regulatory bodies" (IOM, 2004, p. 15).

The TERCAP Instrument, which was initially developed, has been piloted and revised. It is now in electronic form available online through the Members Only section of the NCSBN Web site. An online TERCAP Protocol, which is linked through the TERCAP Instrument, provides guidelines for answering questions in the TERCAP Instrument.

Access to TERCAP™ 2007

In order to have access to the TERCAP™ 2007 Instrument and Protocol, Member Boards will be required to participate in an NCSBN TERCAP educational offering and the Member Board executive director will need to complete a TERCAP™ 2007 Member Board User Access Request Form ("User Form"). Educational offerings include a TERCAP Webinar and/or a TERCAP hands-on training session offered by NCSBN staff. The executive director of the participating Member Board will designate who will be an authorized user of TERCAP. The User Access Form will allow the executive director to add, change or remove authorized users to or from using TERCAP on behalf of their Member Board. Each time the User Form is completed, NCSBN will ask that the name of the Member Board TERCAP contact person be identified, to ensure that there is a contact person at each Member Board.

TERCAP Contact Person

A Member Board TERCAP contact person is a resource person between a participating Member Board and NCSBN. It is someone a Member Board staff can go to for questions, who will also be the primary contact person for NCSBN staff. Ideally the Member Board TERCAP contact person is quality assurance person that NCSBN and the participating Member Board can rely on to assure that the TERCAP™ 2007 data is being entered correctly.

TERCAP Policy for Each Participating Board

Each participating Member Board may develop their own policy regarding TERCAP. Some of the decisions boards can include will detail what type of discipline case will initially, and with familiarity with TERCAP subsequently, be entered into TERCAP, who collects the data, who enters data into the online TERCAP, when the cases in which data is entered into TERCAP are submitted to NCSBN, and who determines the category of practice breakdown using the TERCAP™ 2007 Instrument and Protocol.

TERCAP Educational Resources

To educate and inform all Member Boards about TERCAP, NCSBN will offer a variety of educational resources. These resources will provide a better understanding of TERCAP, create an opportunity to explain and discuss TERCAP, demonstrate how to use TERCAP online, and/or allow for hands-on practice with the electronic TERCAP Instrument and Protocol.

TOOLKIT

The Toolkit that was previously provided to Member Boards during the pilot phases of TERCAP has been updated. It will include a Development Executive Summary, a description of the online TERCAP™ 2007 Instrument and Protocol, the TERCAP™ 2007 Practice Breakdown Categories, TERCAP frequently asked questions (FAQs) and abstracts with citations to publications written about TERCAP. Additional resources may be added to the Toolkit as they are developed.

TUTORIAL

An online tutorial will briefly explain the steps for using the TERCAP™ 2007 Instrument and Protocol online. This will include: accessing the Members Only section of NCSBN's Web site, how to access and navigate the electronic TERCAP, open the electronic instrument, where the unique case identifier is to be entered, the navigation buttons of "Next" and "Back," how to submit a case to NCSBN, close the instrument, access a case that was previously started or submitted and view the jurisdiction-specific report of completed cases.

WEBINARS

Webinars will be one of the primary educational resources for Member Boards to obtain information about TERCAP and learn how to use it. Webinar participants will be asked to register for educational offerings or hands-on training at an NCSBN meeting. NCSBN staff will also ask for attendance verification at a TERCAP Webinar and will follow up with those who participated to determine their interest in using TERCAP™ 2007. The TERCAP Webinars will be offered frequently when the TERCAP Instrument is initially made available and then on an as-needed basis. The hands-on training opportunities will be offered, when feasible, at NCSBN meetings such as the Investigator & Attorney Workshop.

TEST CASES

In order to allow Member Boards practice with the TERCAP Instrument and Protocol before entering and submitting actual data, test cases will be available online. These test cases can be used by all participating Member Boards. The information entered into the test case may change, as other Member Boards may be using the same test case online. The test case data will not actually be submitted to NCSBN for data collection nor will any such data be analyzed.

TERCAP™ 2007 Online Instrument and Online Protocol

ONLINE INSTRUMENT

There are 10 sections in the TERCAP™ 2007 Instrument. Detailed explanations about the questions in each section are available electronically through the TERCAP Protocol. The

instrument requires that all questions are answered, except for a few areas of inquiry at the end, in order to proceed to the next page and to eventually complete and submit the data.

The TERCAP Instrument will initially ask for a case identifier (Case ID). It is recommended that a consistent case identification system be used by all participating Member Boards. The recommended system will include: two or four Member Board's (jurisdiction's) initials, four digits for the year the case was received by the Member Board, three initials for the person entering/inputting data into the instrument, and a number that should increase chronologically as each person (identified with the three initials) opens a TERCAP case. (Examples JJJJYYYYIII#, IL2005TAK1 or CAVN2006TCB1.)

In addition to the Case ID and the name of the person who completes the instrument—referred to as a reviewer—the 10 sections in TERCAP™ 2007 include:

- Section One – Patient Profile
- Section Two – Patient Outcome
- Section Three – Setting
- Section Four – System Issues
- Section Five – Health Care Team
- Section Six – Nurse Profile
- Section Seven – Intentional Misconduct/Criminal Behavior
- Section Eight – Practice Breakdown Category: Safe Medication Administration
- Section Nine – Practice Breakdown Category: Documentation
- Section Ten – Other Practice Breakdown Categories:
  - Attentiveness/Surveillance
  - Clinical Reasoning
  - Prevention
  - Intervention
  - Interpretation of Authorized Provider's Orders
  - Professional Responsibility/Patient Advocacy

Board of Nursing Outcomes

ONLINE PROTOCOL

The online TERCAP Protocol provides detailed explanations for each section of the TERCAP™ 2007 Instrument. There is a [?] at the end of each of the questions in the TERCAP™ 2007 Instrument. When the [?] is clicked, it brings the reviewer to that specific section of the online protocol. The protocol provides complete information regarding specific TERCAP™ 2007 Instrument data questions and examples for each element.

Printable Versions of TERCAP™ 2007 Instrument and Protocol

The TERCAP™ 2007 Online Instrument and Online Protocol are available for printing in hard copy from the TERCAP Members Only Web pages. The instrument can be printed as a blank document in a short version (32 pages). The long version that is actually online contains many questions that are not seen when the user is filling out the instrument online. There is logic controlling which questions are presented to the user so repetitive questions are not asked online. The short hard-copy version does not include the repetitive type questions. The full protocol can also be printed, as a reference document, when a reviewer is working with the instrument off-line.

Submission of Cases to NCSBN

TERCAP was designed to track all practice breakdown cases and determine the root cause of the breakdown that occurred. The initial goal, after TERCAP's launch on Feb. 1, 2007, was to include all practice breakdown cases from all participating Member Boards. The instrument is also capable of being used on other types of investigatory cases that may not initially be thought to involve practice breakdown. Whether or not it is determined that the case involves practice breakdown, all the data entered into TERCAP can be submitted to NCSBN. The analysis of the data, and the types of reports that may then become available, will depend on the data submitted and the types of cases for which each jurisdiction decides to use TERCAP.

The electronic version of the TERCAP Instrument automatically saves the data entered, as long as the data on each page is completed and the "Next" button at the bottom of the page is clicked. Automatic saving of the data allows the reviewer to return at a later time to enter additional data or when there is a more convenient time to enter the data. The data that is automatically saved in each case will be considered an "uncompleted case" until the case is submitted. The case can be submitted electronically at any time to NCSBN, once the TERCAP Instrument is complete, by using the "Submit" button at the end of the TERCAP Instrument. A dialog box will then appear to thank reviewers for using TERCAP. The appearance of this dialog box means that the data has been sent to NCSBN. There are a few additional questions at the end of the instrument that are optional, after the mandatory question concerning board of nursing outcomes, including the length of time from receiving the case to resolution, as well as feedback regarding TERCAP.

Reports

TERCAP reports can be found on the Members Only TERCAP section of NCSBN's Web site. Each participating Member Board will have the opportunity to view all the cases submitted to NCSBN by that participating Member Board.

Data submitted by individual Member Boards using TERCAP™ 2007 will be reported in the aggregate under Jurisdiction Specific Reports. Two types of case lists will be automatically compiled and be accessible to participating Member Boards: a case list of all completed cases for <your jurisdiction>; and a case list of all uncompleted cases for <your jurisdiction>. The participating Member Board case reports will be accessible only to NCSBN and that participating Member Board. Only NCSBN and Member Boards participating in TERCAP will have access to their own jurisdiction's TERCAP reports and cases.

Data Analysis

NCSBN will have access to the data submitted by all participating Member Boards for the purpose of research through data analysis. NCSBN will use the national data, reported in the aggregate by each participating Member Board, without identification of the patient, particular setting or individual nurse involved. The national data, compiled from all the participating Member Boards, shall be for NCSBN use only. NCSBN will generate formal reports based on the analysis of the data submitted into the national data set. Once the data is compiled, analyzed and formally reported, it will become available to all Members Boards and the public. The national data analysis may be available in the future, after it is reported, under Summary Report of Cases for All Jurisdictions. The research department may also conduct analysis on participating individual Member Board data, upon the request of and only accessible to that participating Member Board.

Master List

To comply with standard research requirements, NCSBN may at some time in the future need to compare a certain percentage of the actual TERCAP cases submitted to NCSBN with the data actually entered into the TERCAP™ 2007 Instrument by participating individual Member Boards. Therefore, each Member Board will need to keep a master list of all the

cases submitted to NCSBN. This will also allow Member Boards to verify that the cases they wanted to submit to NCSBN through TERCAP were in fact submitted. This master list can also be used to compare the completed and uncompleted cases submitted to NCSBN.

NCSBN Assistance

NCSBN will offer assistance to those participating Member Boards that may have questions relating to TERCAP™ 2007, such as accessing the instrument, navigating through the TERCAP Electronic Instrument and/or Protocol, questions concerning the instrument or protocol, or other issues that arise.

WEBMASTER

NCSBN has an online connection to a webmaster that will answer, or direct other NCSBN staff to answer, questions that are related to TERCAP.

TRAINING INSTRUCTOR

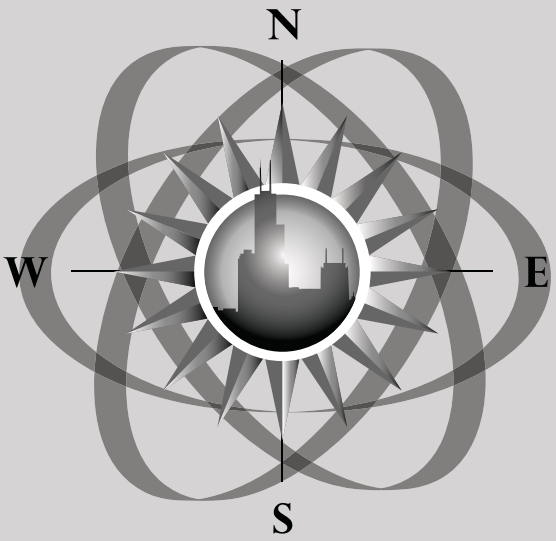
A training instructor, well versed on electronic software and familiar with providing instructions online, will be available to Member Boards using the electronic version of the TERCAP™ 2007 Instrument and Protocol.

- Training instructor: traininginstructor@ncsbn.org

PRACTICE & REGULATION STAFF

NCSBN staff familiar with TERCAP will be available to answer questions that relate to the TERCAP™ 2007 Instrument and/or Protocol.

- NCSBN practice and regulation staff: tercapinfo@ncsbn.org



Section III

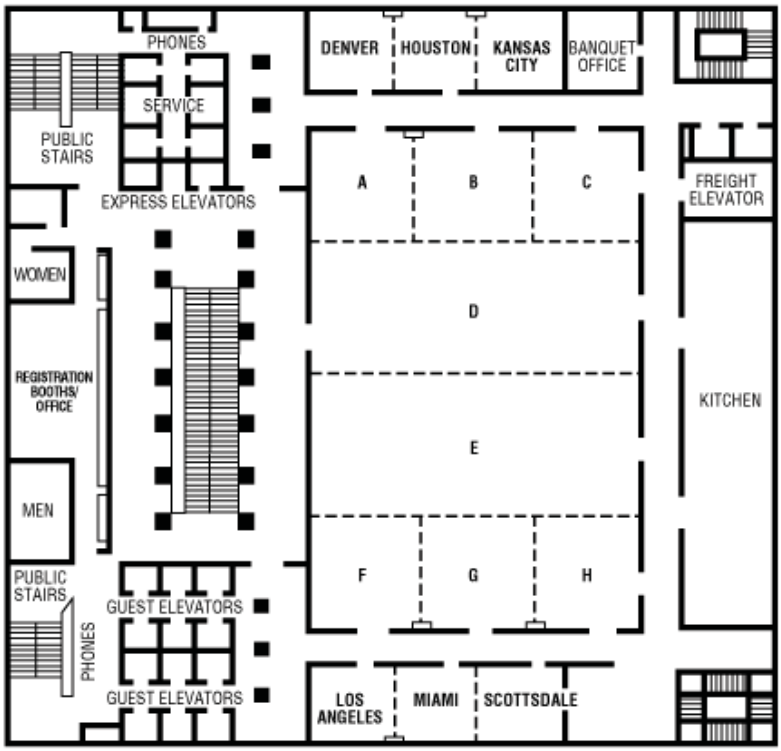
2007 NCSBN Annual Meeting

SECTION III: RESOURCES AND GENERAL INFORMATION

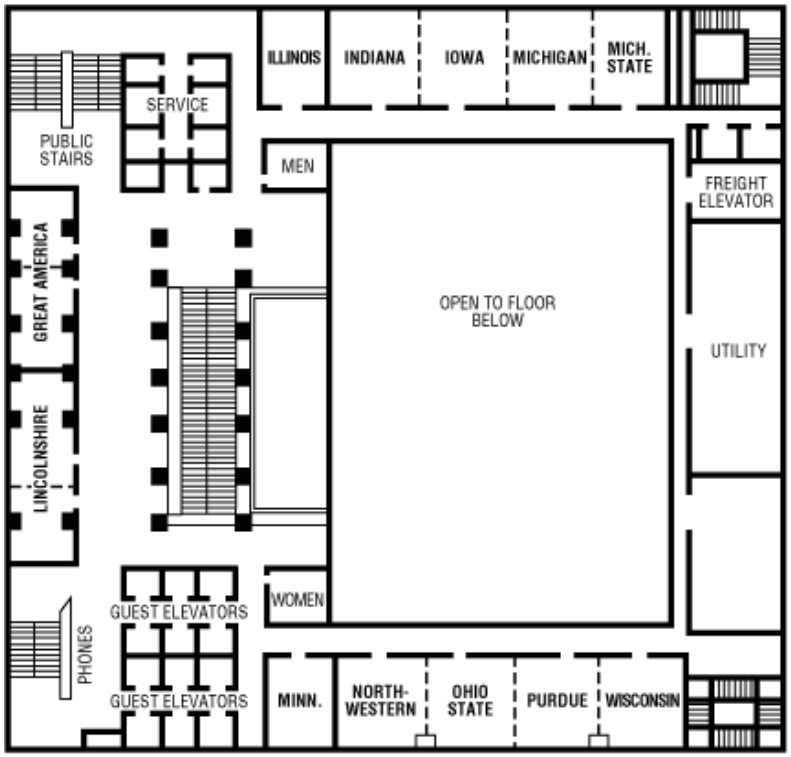
For resolutions policy, procedures and forms, see the Resolutions Committee report on page 259.

Chicago Marriott Downtown Hotel Map

5th Floor

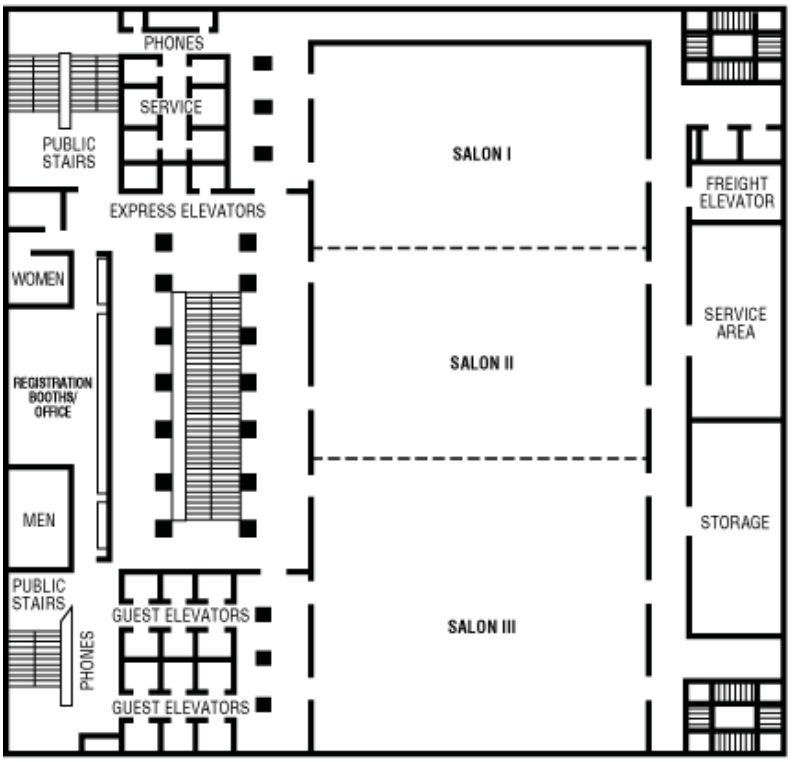


6th Floor



Chicago Marriott Downtown Hotel Map

7th Floor



Orientation Manual for Delegate Assembly Participants

The purpose of the Orientation Manual is to provide information about the mission, governance and operations of NCSBN. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as the Board of Directors and committee members.

Following a brief discussion of NCSBN's history, this manual will describe the organization's structure, functions, policies and procedures.

History

The concept of an organization such as NCSBN had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for people involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE), which, in 1932, became the ANA's Department of Education. In 1933, by agreement with ANA, NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published *A Curriculum Guide for Schools of Nursing*. Two years later, NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine-scorable form. In 1943, the NLNE board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the State Board Test Pool Examination or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA board appointed the Committee for the Bureau of State Boards of Nurse Examiners, which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that a council replace it. Although council status was achieved, many people continued to be concerned about potential conflicts of interest and recognized the often-heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body. At the council's

1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from ANA to form the National Council of State Boards of Nursing.

Organizational Mission, Strategic Initiatives and Outcomes

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

The Strategic Initiatives for 2005 – 2007, adopted by the 2004 Delegate Assembly, are:

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

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which tactics for achieving these outcomes are developed, assessed and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors evaluates the accomplishment of strategic initiatives and outcomes and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by NCSBN. At the present time, there are 59 Member Boards, including those from the District of Columbia, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees and execution of a contract for using the NCLEX-RN® examination and/or the NCLEX-PN® examination.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of NCSBN's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards that fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

AREAS

NCSBN's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues and provide diversity of board and committee representation. Delegates elect area directors from their respective Areas through a majority vote of the Delegate Assembly. In addition, there are two directors-at-large who are elected by all delegates voting at the Annual Meeting. See Glossary on page 307 for list of jurisdictions by Area.

DELEGATE ASSEMBLY

The Delegate Assembly is the membership body of NCSBN and comprises delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in late July/early August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among Areas.

At the Annual Meeting, delegates elect officers and directors and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and to receive a copy of the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement and strategic initiatives of NCSBN and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, and adopts test plans to be used for the development of the NCLEX examination and the NCLEX examination test service and establishes the fee for the NCLEX examination.

OFFICERS AND DIRECTORS

NCSBN officers include the president, vice president and treasurer. Directors consist of four area directors and two directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The President shall have served as a delegate, a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice president and treasurer are elected for terms of two years or until their successors are elected. The president, vice president and treasurer are elected in even-numbered years.

The four area directors are elected for terms of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term.

Officers and directors are elected by ballot during the annual session of the Delegate Assembly. Delegates elect area directors from their respective areas.

Election is by a majority vote. Write-in votes are prohibited. In the event a majority is not established, the bylaws dictate the reballoting process.

Officers and directors assume their duties at the close of the session at which they were elected. The vice president fills a vacancy in the office of president. Board appointees fill other officer vacancies until the term expires.

BOARD OF DIRECTORS

The Board of Directors, the administrative body of NCSBN, consists of the nine elected officers. The Board is responsible for the general supervision of the affairs of NCSBN between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between NCSBN and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to NCSBN's purpose, and provision for the establishment and maintenance of the administrative offices.

MEETINGS OF THE BOARD OF DIRECTORS

All Board meetings are typically held in Chicago, with the exception of the pre- and post-Annual Meeting Board meetings that are held at the location of the Annual Meeting. Board officers and directors are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials are mailed to board officers and directors two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the NCSBN Web site (www.ncsbn.org).

A memo or report that describes the item's background and indicates the Board action needed accompanies items for Board discussion and action. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting. A summary of the Board's major decisions is provided for dissemination prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each board officer and director for use during board meetings. These materials, which are updated periodically throughout the year, are kept at the NCSBN office and include copies of the articles of incorporation and bylaws, strategic plan, policies and procedures, contracts, budget, test plan, committee rosters, minutes and personnel manual.

COMMUNICATIONS WITH THE BOARD OF DIRECTORS

Communication between Board meetings takes place in several different ways. The executive director communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. In most instances, the executive director is the person responsible for communicating with NCSBN consultants about legal, financial and accounting concerns.

This practice was adopted primarily as a way to monitor and control the costs of consultant services. Conference calls can be scheduled, if so desired, by the president. Written materials are generally forwarded to Board Members in advance of the call. These materials include committee or staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board Members use NCSBN letterhead when communicating as representatives of NCSBN.

COMMITTEE ON NOMINATIONS

NCSBN delegates elect representatives to the Committee on Nominations. The committee consists of four people, one from each area, who may be either Board Members or staff of Member Boards. Committee members are elected to two-year terms. One-half of the committee members are elected in even-numbered years and one-half in odd-number years. They are elected by ballot with a plurality vote. The member receiving the highest number of votes shall serve as vice chair in the first year of the member's term and as chair in the second year of the term. The first meeting of the committee is held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director officers and for the committee itself and to prepare a slate of qualified candidates. During the Delegate Assembly, additional nominations may be made from the floor.

COMMITTEES

Many of NCSBN's objectives are accomplished through the committee process. Every year the committees report on their activities and make recommendations to the Board of Directors. At the present time, NCSBN has five standing committees: Examination; Finance;

Practice, Regulation and Education; Bylaws; and Resolutions. Subcommittees, such as the Item Review Subcommittee (Examination), may assist standing committees.

In addition to standing committees, special committees are appointed by the Board of Directors for a defined term to address special issues and concerns. NCSBN conducts an annual call for committee member nominations prior to the beginning of each fiscal year. Committees are governed by their specific charge, and NCSBN policies and procedures. The appointment of Committee chairs and committee members is a responsibility of the Board of Directors. Committee membership is extended to all current members and staff of Member Boards.

In the appointment process, every effort is made to match the expertise of each individual with the needs of NCSBN. Also considered is balanced representation, whenever possible, among areas, Board Members and staff; registered and licensed practical/vocational nurses; and consumers. Nonmembers may be appointed to special committees as consultants to provide specialized expertise to committees. A Board of Director liaison and an NCSBN staff member are assigned to assist each committee. The respective roles of Board liaison, committee chairperson and committee staff are provided in NCSBN's policy. Each work collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the Board liaison nor the NCSBN staff are entitled to a vote, but can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

EXAMINATION COMMITTEE

The Examination Committee is comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board of nursing. The Committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce and deliver the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests enhancements, based on research that is important to the development of licensure examinations.

The Examination Committee provides general oversight of National Council Licensure Examination (NCLEX®) process, including psychometrics, item development, test security and administration, and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis, and test and candidate statistics.

One of NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: (1) whether or not the examination actually measures competencies required for safe and effective job performance, and (2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation.

There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe

and effective practice. The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a passing standard to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected to recommend a series of passing standards for this process. Judges are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a series of recommended passing standards. Taking these recommendations along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard that distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes and utilizing item construction and test delivery processes based on sound psychometric principles constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

FINANCE COMMITTEE

The Finance Committee is comprised of at least four members and the treasurer, who serves as the chair. The committee's primary purpose is to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis and provides the Board of Directors with a proposed annual budget prior to each new fiscal year.

PRACTICE, REGULATION AND EDUCATION COMMITTEE

The Practice, Regulation and Education Committee is comprised of at least six members. The committee's purpose is to provide general oversight of nursing practice, regulation and education issues. It periodically reviews and revises the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, and recommends white papers, guidelines or other resources to the Board of Director for Member Board use. It also reviews NCSBN research data, conducts membership surveys and disseminates information to Member Boards and other interested parties. In the past, the committee has utilized subcommittees to study various issues (e.g., continued competence, foreign nurse issues and accreditation/approval in nursing education).

RESOLUTIONS COMMITTEE

The Resolutions Committee is comprised of at least four members generally representing each of the four NCSBN geographic areas and also includes one member of the Finance Committee. The committee's purpose is to review, evaluate and report to the Delegate

Assembly on all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the bylaws.

BYLAWS COMMITTEE

The Bylaws Committee is comprised of at least four members. The committee reviews and makes recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly. The bylaws may be amended at any annual meeting or special session of the Delegate Assembly upon written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting or written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present, and in no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

NCSBN STAFF

NCSBN staff members are hired by the executive director. Their primary role is to implement the Delegate Assembly's and Board of Directors' policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

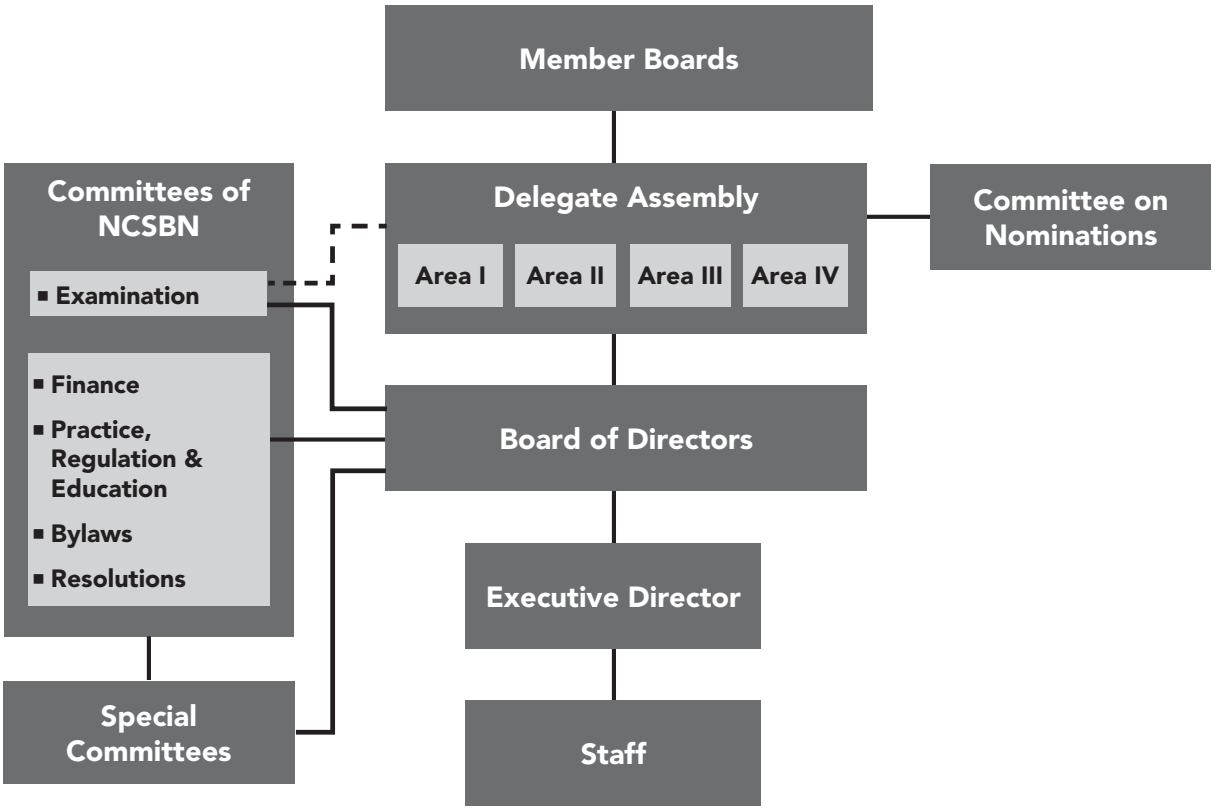
Agendas for each session of the Delegate Assembly are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants, which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and outcomes.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials and elections committees as well as the committee to approve minutes. The president must also appoint a timekeeper, a parliamentarian and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes that the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits and evaluates all others in terms of their relationship to NCSBN's mission and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

The parliamentarian keeps minutes of the Delegate Assembly. These minutes are then reviewed, corrected as necessary and approved by the committee to approve minutes, which includes the executive director who serves as corporate secretary.

NCSBN Organizational Chart



NCSBN Bylaws

Revisions adopted – 8/29/87
Amended – 8/19/88
Amended – 8/30/90
Amended – 8/01/91
Revisions adopted – 8/05/94
Amended – 8/20/97
Amended – 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03

Article I

NAME

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (the "National Council").

Article II

PURPOSE AND FUNCTIONS

Section 1. Purpose. The purpose of the National Council is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. Functions. The National Council's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The National Council provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

MEMBERS

Section 1. Definition. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

Section 2. Qualifications. Any state board of nursing that agrees to use one or more National Council Licensing Examinations (the "NCLEX® examination") under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council ("Member Board").

Section 3. Admission. A state board of nursing shall become a member of the National Council and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination.

Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose

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

Section 5. Fees. The annual member fees, as set by the Delegate Assembly, shall be payable each October 1.

Section 6. Privileges. Membership privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any Member Board whose fees remain unpaid after January 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A Member Board in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership that has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

DELEGATE ASSEMBLY

Section 1. Composition.

(a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.

(b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A National Council officer or director may not represent a Member Board as a delegate.

(c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

(a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

(b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the National Council, shall provide direction for the National Council through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new National Council memberships; approve the substance of all NCLEX® examination contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX®

examination; approve the NCLEX® examination test service; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The National Council Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the National Council.

Section 5. Special Session. The Board of Directors may call and, upon written petition of at least 10 Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least 10 days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

OFFICERS AND DIRECTORS

Section 1. Officers. The elected officers of the National Council shall be a President, a Vice President and a Treasurer.

Section 2. Directors. The directors of the National Council shall consist of two Directors-at-Large and a Director from each Area.

Section 3. Qualifications. Members and employees of Member Boards shall be eligible to serve as National Council officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. Qualifications for President. The President shall have served National Council as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

(a) *Time and Place.* Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

(b) *Officers and Directors-at-Large.* Officers and Directors-at-Large shall be elected by majority vote of the Delegate Assembly.

(c) *Area Directors.* Each Area shall elect its Area Director by majority vote of the delegates from each such Area.

(d) *Run-Off Balloting.* If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.

(e) *Voting.* Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write-in votes shall be prohibited.

Section 6. Terms of Office. The President, Vice President, Treasurer and Area Directors shall be elected for a term of two years or until their successors are elected. Directors-at-Large shall be elected for a term of one year or until their successors are elected. The President, Vice President and Treasurer shall be elected in even numbered years. The Area Directors shall be elected in odd numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. Limitations. No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. Vacancies. A vacancy in the office of President shall be filled by the Vice President. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. Responsibilities of the President. The President shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of President, and speak on behalf of and communicate the policies of the National Council.

Section 10. Responsibilities of the Vice President. The Vice President shall assist the President, perform the duties of the President in the President's absence, and fill any vacancy in the office of the President until the next Annual Meeting.

Section 11. Responsibilities of the Treasurer. The Treasurer shall serve as the Chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI

BOARD OF DIRECTORS

Section 1. Composition. The Board of Directors shall consist of the elected officers and directors of the National Council.

Section 2. Authority. The Board of Directors shall transact the business and affairs and act on behalf of the National Council except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board's acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly.

Section 3. Meetings of the Board of Directors. The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the President or shall be called upon written request of at least three members of the Board of Directors. At least 24 hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly. The Board of Directors may remove any member of the Board of Directors from office upon conviction of a felony, gross misconduct, failure to perform, dereliction of duties or conflict of interest by a two-thirds vote of the Board of Directors. The individual shall be given 30 days written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

NOMINATIONS AND ELECTIONS

Section 1. Committee on Nominations.

(a) *Composition.* The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.

(b) *Term.* The term of office shall be two years. One half of the Committee members shall be elected in even-numbered years and one-half in odd-number years. Members shall assume duties at the close of the Annual Meeting at which they are elected.

(c) *Election.* The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The member receiving the highest number of votes shall serve as Vice Chair in the first year of the member's term and as Chair in the second year of the term.

(d) *Limitation.* A member elected or appointed to the Committee on Nominations may not be nominated for an officer or director position during the term for which that member was elected or appointed.

(e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in which the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1(a) of this Article. If the vacancy is the Chair, the other person serving the second year of a two-year term shall be the Chair. If the vacancy is the Vice Chair, the other person serving the first year of a two-year term shall become the Vice Chair. The person filling the vacancy shall serve the remainder of the term.

(f) *Duties.* The Committee on Nominations shall consider the qualifications of all nominees for officers and directors and the Committee on Nominations and present a slate of qualified candidates for vote at the Annual Meeting. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

Article VIII

MEETINGS

Section 1. Participation.

(a) *Delegate Assembly Session.*

(i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

(b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

(c) *Meetings.* National Council, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

(d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the National Council Office.

(e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

EXECUTIVE DIRECTOR

Section 1. Appointment. The Executive Director shall be appointed by the Board of Directors. The selection or termination of the Executive Director shall be by a majority vote of the Board of Directors.

Section 2. Authority. The Executive Director shall serve as the agent and Chief Administrative Officer of the National Council and shall possess the authority and shall perform all duties incident to the office of Executive Director, including the management and supervision of the office, programs and services of National Council, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Executive Director shall serve as Corporate Secretary and oversee maintenance of all documents and records of the National Council and shall perform such additional duties as may be defined and directed by the Board.

Section 3. Evaluation. The Board of Directors shall conduct an annual written performance appraisal of the Executive Director, and shall set the Executive Director's annual salary.

Article X

COMMITTEES

Section 1. Standing Committees. National Council shall maintain the following standing committees.

(a) *Examination Committee.* The Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The Committee Chair shall have served as a member of the committee prior to being appointed as Chair. The Examination Committee shall provide general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

(b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the Treasurer, who shall serve as Chair. The Finance Committee shall review the annual budget, the National Council's investments and the audit. The Committee shall recommend a budget to the Board of Directors and advise the Board on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

(c) *Practice, Regulation, and Education Committee.* The Practice, Regulation and Education Committee shall be comprised of at least six members. The Committee shall provide general oversight of nursing practice, regulation and education issues.

(d) *Bylaws Committee.* The Bylaws Committee shall be comprised of at least four members. The Committee shall review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly.

(e) *Resolutions Committee.* The Resolutions Committee shall be comprised of at least four members, including one member from the Finance Committee. The Committee shall, in accordance with the Standing Rules, review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards.

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the National Council and to assist any standing committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. Delegate Assembly Committees. The President shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. Committee Membership.

(a) *Composition.* Members of standing and special committees shall be appointed by the Board of Directors. Standing committees shall include only current members and employees of Member Boards. Special committees may also include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The President, or President's delegate, shall be an ex-officio member of all committees except the Committee on Nominations.

(b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for reappointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

(c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

(d) *Committee Duties.*

1. *Budget.* Standing committees shall operate within the assigned budget for the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.
2. *Policies.* Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.
3. *Records and Reports.* Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.

Article XI

FINANCE

Section 1. Audit. The financial records of the National Council shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. Fiscal Year. The fiscal year shall be from October 1 to September 30.

Article XII

INDEMNIFICATION

Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on be-half of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any

person who is or was a director, officer, employee, agent or representative of the corporation; or performs or has performed volunteer services for or on behalf of the corporation; or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

(a) Not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

(b) Continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

PARLIAMENTARY AUTHORITY

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the National Council in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the National Council.

Article XIV

AMENDMENT OF BYLAWS

These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

(a) Written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

(b) Written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Article XV

DISSOLUTION

Section 1. Plan. The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the National Council. The plan shall provide, among other things, that the assets of the National Council be applied as follows:

Firstly, all liabilities and obligations of the National Council shall be paid or provided for.

Secondly, any assets held by the National Council that require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. Acceptance of Plan. Such plan shall be acted upon by Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. Seventy-five percent (75%) of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. Conformity to Law. Such plan to dissolve must conform to the law under which National Council is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.

NCSBN Glossary

A

Acclimation of International Nurses into U.S. Nursing Practice
Online course offered through NCSBN Learning Extension. Learners earn 6.6 contact hours for completing the course.

Accredit
To recognize (an educational institution) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice. [1]

Accrediting Agency
See also *Nursing School Accrediting Agency* entry.

ACNM Certification Council Inc. (ACC)
National certifying body for certified-nurse midwives (CNMs) and certified midwives (CMs). ACC's mission is to protect and serve the public by providing the certification standard for individuals educated in the profession of midwifery. [2]

Administrative Rules
Used by boards of nursing to promulgate rules/regulations to further interpret and implement the Nursing Practice Act, as authorized in most jurisdictions. Rules/regulations cannot conflict with law and once adopted, have the force and effect of law.

Advanced Practice Registered Nurse (APRN)
A master's prepared nurse holding a graduate degree in nursing, who has completed a program of study in a specialty area in an accredited nursing program, has taken a licensing examination in the same area and has been granted a license to practice as an APRN. The hallmark of APRN practice is the assumption by the APRN of primary responsibility for the direct care of patients/clients in relation to their human needs, disease states, and therapeutic and technologic interventions. Subcategories of APRN licensure include: nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) and clinical nurse specialist (CNS). A nurse seeking recognition as an APRN must be academically prepared for the expanded scope of practice described as APRN nursing.

Agent Role
NCSBN once served as an agent for 41 boards of nursing for reporting past, or legacy data (1996–1999). NCSBN continues to serve as an agent (for ongoing discipline reporting) for 32 boards as of Jan. 24, 2007, with five contracts still out and expected to be signed. NCSBN Member Boards continue to share discipline data through Nursys®. NCSBN is also working to obtain discipline information from states that either directly report to the HIPDB or use another agent, so that the discipline data NCSBN has is complete. Although all boards of nursing are authorized to query the HIPDB, there is also a fee; NCSBN continues to provide discipline data for use by member boards at no charge.

Alternative Dispute Resolution (ADR)
A forum or means for resolving disputes (as arbitration or private judging) that exists outside the state or federal judicial system. [3]

Alternative Item Format
Previously known as an innovative item format; an NCLEX® examination item (question) that takes advantage of technology and uses a format other than standard, four-option, multiple-choice items to assess candidate ability. Alternative item formats may include multiple-response items (requiring a candidate to select one or more than one response), fill-in-the-blank items (requiring a candidate to type in number(s) within a calculation item), hot spot items (asking a candidate to identify an area on a picture or graphic), a chart/exhibit format (where candidates are presented with a problem and use the information in the chart/exhibit to answer the problem), and a drag-and-drop item type (requiring a candidate to rank or move options to provide the correct answer). Any item format, including standard multiple-choice items, may include charts, tables or graphic images.

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3. Dictionary.com Web site. s.v. *Alternative dispute resolution*. (n.d.) Retrieved 18 April 2005, from http://dictionary.reference.com/search?q=Alternative%20Dispute%20Resolution

4. American Academy of Nurse Practitioners Web site. (n.d.) *American academy of nurse practitioners fact sheet*. Retrieved 4 April 2005, from http://www.aanp.org/About+AANP/AANP+Information/About+AANP.htm
5. American Association of Colleges of Nursing Web site. (n.d.) *About AACN*. Retrieved 4 April 2005, from http://www.aacn.nche.edu/ContactUs/index.htm
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7. American Association of Nurse Anesthetists Web site. (n.d.) *About the American association of nurse anesthetists – who we are*. Retrieved 4 April 2005, from http://www.aana.com/Default.asp
8. *American College of Nurse-Midwives Web site*. Retrieved 4 April 2005, from http://www.midwife.org/about/
9. *American Dental Association Home Page*. Retrieved 4 April 2005, from http://www.ada.org/
10. American Dietetic Association Web site. (n.d.) *What is ADA*? Retrieved 4 April 2005, from http://www.eatright.org/Public/index_adafaq.cfm
11. AILA.org Web site. (n.d.) *About AILA*. Retrieved 4 April 2005, from http://www.aila.org/contentViewer.aspx?bc=39
12. American Medical Association Web site. (n.d.) *About AMA*. Retrieved 4 April 2005, from http://www.ama-assn.org/ama/pub/category/1815.html

Alternative Program
A voluntary, private opportunity for chemically dependent nurses who meet specified criteria to have their recovery closely monitored by program staff in lieu of disciplinary action.

American Academy of Nurse Practitioners (AANP)
The largest and only full-service professional membership organization in the U.S. for nurse practitioners of all specialties. [4]

American Association of Colleges of Nursing (AACN)
A national voice for America's baccalaureate and higher degree nursing education programs. AACN's educational, research, governmental advocacy, data collection, publications and other programs work to establish quality standards for bachelor- and graduate-degree nursing education, assist deans and directors to implement those standards, influence the nursing profession to improve health care, and promote public support of baccalaureate and graduate education, research and practice in nursing—the nation's largest health care profession. [5]

American Association of Critical Care Nurses (AACN)
Provides and inspires leadership to establish work and care environments that are respectful, healing and humane. AACN is committed to providing the highest quality resources to maximize nurses' contribution to caring and improving the health care of critically ill patients and their families. [6]

American Association of Nurse Anesthetists (AANA)
A professional association representing more than 30,000 certified registered nurse anesthetists (CRNAs) nationwide. The AANA promulgates education, practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice. [7]

American College of Nurse Midwives (ACNM)
Provides research, accredits midwifery education programs, administers and promotes continuing education programs, establishes clinical practice standards, and creates liaisons with state and federal agencies and members of Congress. The mission of ACNM is to promote the health and well being of women and infants within their families and communities through the development and support of the profession of midwifery as practiced by certified nurse-midwives (CNMs), and certified midwives (CMs). The philosophy inherent in the profession states that nurse-midwives believe every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations. [8]

American Dental Association (ADA)
A professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards. [9]

American Dietetic Association (ADA)
The nation's largest organization of food and nutrition professionals. [10]

American Immigration Lawyers Association (AILA)
A national association of more than 8,000 attorneys and law professors who practice and teach immigration law. AILA member attorneys represent tens of thousands of U.S. families who have applied for permanent residence for their spouses, children, and other close relatives to lawfully enter and reside in the U.S. AILA members also represent thousands of U.S. businesses and industries that sponsor highly skilled foreign workers seeking to enter the U.S. on a temporary or—having proven the unavailability of U.S. workers—permanent basis. AILA members also represent foreign students, entertainers, athletes, and asylum seekers, often on a pro bono basis. [11]

American Medical Association (AMA)
The national professional organization for all physicians. The AMA serves as the steward of medicine and leader of the medical profession. The AMA speaks out on issues important to patients and the nation's health. [12]

American Nurses Association (ANA)
The only full-service professional organization representing the nation's 2.7 million RNs through its 54 constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic

and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying Congress and regulatory agencies on health care issues affecting nurses and the public. [13]

American Nurses Credentialing Center (ANCC)
A subsidiary of the American Nurses Association that provides tangible recognition of professional achievement in a defined functional or clinical area of nursing. More than 150,000 nurses throughout the U.S. and its territories in 40 specialty and advanced practice areas of nursing carry ANCC certification. While the role for nurses continues to evolve, ANCC has responded positively to the reconceptualization of certification with Open Door 2000, a program that enables all qualified RNs, regardless of their educational preparation, to become certified in any of five specialty areas: Gerontology, Medical-Surgical, Pediatrics, Perinatal and Psychiatric and Mental Health Nursing. [14]

American Organization of Nurse Executives (AONE)
A subsidiary of the American Hospital Association, and national organization of nearly 4,000 nurses who design, facilitate and manage care. Its mission is to represent nurse leaders who improve health care. AONE members are leaders in collaboration and catalysts for innovation. [15]

Americans for Nursing Shortage Relief (ANSR)
An alliance of 49 national nursing organizations and five friends of nursing organizations and companies. ANSR is committed to promoting legislative and regulatory solutions to the current and impending nursing shortage. [16]

Americans with Disabilities Act (ADA)
Effective July 26, 1992, this federal law prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment. An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment. [17]

APRN Certification Programs
In January 2002, the Board of Directors approved criteria for both the certification programs and the accrediting agencies that were developed by the Advanced Practice Task Force. The Requirements for Accrediting Agencies and the Criteria for Certification Programs (available for download at www.ncsbn.org) represent required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses.

APRN Compact
Addresses the need to promote consistent access to quality, advanced practice nursing care within states and across state lines. The Uniform APRN Licensure/Authority to Practice Requirements, developed by NCSBN with APRN stakeholders in 2000, establishes the foundation for this APRN Compact. Similar to the existing Nurse Licensure Compact for recognition of RN and LPN licenses, the APRN Compact offers states the mechanism for mutually recognizing APRN licenses/authority to practice. This is a significant step forward for the increasing access and accessibility to qualified APRNs. A state must either be a member of the current nurse licensure compact for RN and LPN, or choose to enter into both compacts simultaneously to be eligible for the APRN Compact.

Area
One of four designated geographic regions of NCSBN 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	Rhode Island
N. Mariana Islands	West Virginia	Texas	Vermont
Oregon	Wisconsin	Virginia	U.S. Virgin Islands
Utah			
Washington			
Wyoming			

13. ANA Nursing World Web site. (n.d.) *About the American nurses association*. Retrieved 4 April 2005, from http://www.nursingworld.org/about/
14. ANCC: American Nurses Credentialing Center Web Site. (n.d.) *American nurses credentialing center – certified nursing excellence*. Retrieved 4 April 2005, from http://www.nursingworld.org/ancc/inside.html
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16. Association of Women's Health, Obstetric and Neonatal Nurses Web site. (n.d.) *Americans for Nursing Shortage Relief*. Retrieved 26 May 2005, from http://www.awhonn.org/awhonn/?pg=875-12550-3260-7650
17. EEOC U.S. Equal Employment Opportunity Commission Web site. (n.d.) *Facts about the Americans with disabilities act*. Retrieved 4 April 2005, from http://www.eeoc.gov/facts/fs-ada.html

18. *All Nursing Schools Web site*. (n.d.) Retrieved 11 May 2007, from http://www.allnursingschools.com/faqs/cnm.php

Area Director
Type of NCSBN board member. A director is elected for each of NCSBN's geographic areas: I, II, III and IV. Responsibilities include attending area meetings of the Member Boards at Midyear and Annual Meetings and communicating with their respective jurisdictions pre- and post- Board of Director meetings.

Assessment of Critical Thinking
Online course offered through NCSBN Learning Extension for nursing educators to assist in writing test items in the NCLEX style at higher cognitive levels. Learners earn 15.6 contact hours for completing the course. Formerly called "Advanced Assessment Strategies: Assessing Higher Level Thinking."

Assessment Strategies
Test service for Canadian Nurses Association.

B

Blueprint
The organizing framework for an examination that includes the percentage of items allocated to various categories. Also known as a test plan.

Board of Nursing
The authorized state entity with the legal authority to regulate nursing. Legislatures enact the Nurse Practice Act for each state. Boards of nursing have the legal authority to license nurses and to discipline nurses for unsafe practice. The mission of boards of nursing is to protect the health, safety and welfare of the public.

Bylaws
The rules that govern the internal affairs of an organization.

Bylaws Committee
A standing committee of NCSBN.

C

Canadian Nurses Association
A federation of 11 provincial and territorial nursing associations representing more than 123,000 RNs.

Canadian Registered Nurse Examination (CRNE)
Canadian Nurses Association nurse licensure examinations.

Candidate Bulletin
Document that serves as a guideline for candidates preparing to take the NCLEX®. Candidate Bulletins contain information regarding registration, scheduling, information on the testing experience and other useful information for candidates.

Candidate Performance Report (CPR)
An individualized, two-page document sent to candidates who fail the NCLEX® examination. The CPR reflects candidate performance on various aspects of the NCLEX examination by test plan content area.

Centers for Medicare & Medicaid Services (CMS)
An agency of the U.S. Department of Health & Human Services (HHS); formerly called the Health Care Financing Administration (HCFA).

Certification
A credential issued by a national certifying body that is used as a requirement for certain types of licensure, meeting specified requirements acceptable to the board of nursing.

Certification Program
An examination designed by a certifying body to evaluate candidates for advanced practice nursing.

Certified Nurse-Midwife (CNM)
Certified nurse-midwives (CNMs) are RNs who are also certified. To become certified, they must graduate from a nurse-midwifery program accredited by the American College of Nurse-Midwives, and pass a national certification exam. CNMs are educated in both nursing and midwifery and can practice anywhere in the U.S.[18]

See also *Advanced Practice Registered Nurse* entry.

Certified Registered Nurse Anesthetist (CRNA)
Nurse anesthesia is an advanced clinical nursing specialty. As anesthesia specialists, CRNAs administer approximately 65 percent of the 26 million anesthetics given to patients in the U.S. each year. [19]

See also *Advanced Practice Registered Nurse* entry.

Certifying Body for Nurses
A nongovernmental agency that validates by examination, based on predetermined standards, an individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing.

Citizen Advocacy Center (CAC)
A nonprofit, nonpartisan community legal organization dedicated to building democracy for the 21st century. Center community lawyers and volunteers focus on strengthening the citizenry's capacity and motivation to participate in civic affairs, building community resources and improving democratic protocols within our community institutions. Through public education, community organizing, issue advocacy, and precedent-setting litigation in state and federal courts, the Center forges ahead with programs to advance civic life. The Center is a free public resource to the community. [20]

Clinical Nurse Specialist (CNS)
A licensed RN who has graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist.

See also *Advanced Practice Registered Nurse* entry.

Commission on Collegiate Nursing Education (CCNE)
An autonomous accrediting agency contributing to the improvement of the public's health. CCNE ensures the quality and integrity of baccalaureate and graduate education programs focused on preparing effective nurses. CCNE serves the public interest by assessing and identifying programs that engage in effective educational practices. As a voluntary, self-regulatory process, CCNE accreditation supports and encourages continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education. [21]

Commission on Graduates of Foreign Nursing Schools (CGFNS)
Internationally recognized authority on education, registration and licensure of nurses and other health care professionals worldwide. CGFNS protects the public by ensuring that nurses and other health care professionals educated in countries other than the U.S. are eligible and qualified to meet licensure, immigration and other practice requirements in the U.S. The agency provides credentialing services for foreign-educated nurses, as well as a certification program designed to predict success on the NCLEX-RN® examination. [22]

Commitment to Ongoing Regulatory Excellence (CORE)
A system of performance measurement to determine best practices for nursing regulation, initially established to implement NCSBN's Commitment to Excellence in Nursing Regulation project.

Committee on Nominations
The elected committee of NCSBN responsible for preparing a slate of qualified candidates for each year's elections. Members serve one-year terms.

Computerized Adaptive Testing (CAT)
A testing methodology used to administer NCLEX® on a computer; the computer selects the items candidates receive as they take the examination, which gives them the best opportunity to demonstrate their competence. Each examinee's test is dynamically constructed, with each item selected to provide the maximum possible information, given responses made to previous items.

Confronting Colleague Chemical Dependency
Online CE course offered through NCSBN Learning Extension, released in 2005. Based on NCSBN's Video and Facilitation Package "Breaking the Habit: When Your Colleague is Chemically Dependent." Learners earn 3.3 contact hours for completing the course.

Continued Competence Accountability Profile (CCAP)
No longer an active project of NCSBN, this project provided a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation of the achievements of goals/objectives. It is an expected

19. American Association of Nurse Anesthetists Web site. (n.d.) *Questions and Answers: A Career in Nurse Anesthesia*. Retrieved 11 May 2007, from http://www.aana.com/becomingcrna.aspx?ucNavMenu_SMenuTargetID=103&ucNavMenu_SMenuTargetType=4&ucNavMenu_TSMenuID=6&id=110
20. Building Democracy in the 21st Century – Citizens Advocacy Center. (n.d.) *About CAC*. Retrieved 11 May 2007, from http://www.citizenadvocacycenter.org/about-cac.htm
21. American Association of Colleges of Nursing (AACN) Web site. (n.d.) *Mission Statement and Goals:Commission on Collegiate Nursing Education*. Retrieved 11 May 2007, from http://www.aacn.nche.edu/Accreditation/mission.htm
22. Commission on Graduates of Foreign Nursing Schools (CGFNS) Web site. (n.d.) *Who We Are/What We Do*. Retrieved 11 May 2007, from http://www.cgfns.org/sections/about/

23. The Council of State Governments Web site. (n.d.) *Frequently asked questions*. Retrieved 11 May 2007, from http://www.csg.org/about/faqs.aspx
24. American Council of Nurse Anesthetists Web site. (n.d.) Council on Certification. *Council on certification of nurse anesthetists (CCNA)*. Retrieved 4 April 2005, from http://www.aana.com/council/default1.asp

activity of all licensed nurses to reflect upon lifelong learning activities and their application to daily practice. The profile was, in essence, the application of the nursing process to one's own competence, professional development and accountability.

Continuing Education Unit (CEU)
Represents 10 contact hours in a formal education program.

Council Connector
One of the main sources for information on what is happening at NCSBN. The bimonthly public newsletter contains news about committee activities, updates from NCSBN departments, information about upcoming events and other information related to the work of NCSBN.

Council of State Governments (CSG)
Provides a network for identifying and sharing ideas with state leaders and is founded on the premise that the states are the best sources of insight and innovation. NCSBN is a member at the associate level. [23]

Council on Certification of Nurse Anesthetists (CCNA)
An autonomous, multidisciplinary body existing under the corporate structure of the American Association of Nurse Anesthetists (AANA). Responsible for the certification of RN anesthetists who have fulfilled educational and other criteria for the practice of nurse anesthesia. CCNA is charged with protecting and serving the public by assuring that individuals who are credentialed have met predetermined qualifications or standards for providing nurse anesthesia services. [24]

Council on Licensure, Enforcement and Regulation (CLEAR)
An organization of regulatory boards and agencies.

D

Delegate Assembly (DA)
The voting body of NCSBN that comprises 59 Member Boards. Provides direction through adoption of the mission, strategic initiatives and outcomes, and adoption of position statements and actions. Each Member Board is entitled to two votes.

Delegating Effectively
Online continuing education course offered through NCSBN Learning Extension, released in 2006. Based on NCSBN's video and facilitation package called "Delegating Effectively: Working Through and With Assistive Personnel." Learners earn 4.2 contact hours for completing the course.

Delegation
Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The licensed nurse retains accountability for the delegation.

Differential Item Functioning (DIF)
A statistical measure of potential item bias.

Direct Registration
Method(s) by which NCLEX® candidates register for the NCLEX through test service. NCLEX registrations are processed one of three ways: scan form, Internet or phone. The NCLEX registration fee of $200 is due at time of processing.

Director-at-Large
NCSBN Board of Directors position. Two directors are elected and represent the perspectives of the membership at large during meetings of the board.

Disciplinary Actions: What Every Nurse Should Know
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 4.8 contact hours for completing the course.

Disciplinary Data Bank (DDB)
An NCSBN data management system used between 1981 and 2000 to provide a database of disciplinary actions reported by Member Boards. The DDB data was incorporated into Nur*sys*®, which continues to provide tracking of disciplinary data reported by boards of nursing.

Discipline
The actions taken, as well as the process used, to investigate and resolve complaints received by boards of nursing regarding the practice and/or conduct of licensed nurses. Boards follow their jurisdiction's Administrative Procedures Act, as well as the State Nurse Practice Act and Nursing Administrative Rules/Regulations in providing due process (i.e., the procedural safeguards for the nurse of receiving notice,

having an opportunity to respond to allegations and having a fair and objective decision-maker) in the enforcement of nursing laws and rules.

Diversity: Building Cultural Competence
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.0 contact hours for completing the course.

Documentation: A Critical Aspect of Client Care
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.0 contact hours for completing the course.

E

End-of-Life Care and Pain Management
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 3.0 contact hours for completing the course.

English as a Second Language (ESL)
NCSBN asks NCLEX candidates to self identify their primary language. The possible categories are: (1) English, (2) English and another language, (3) another language and (4) missing. Candidates who report their primary language as "English and another language" or "another language" are considered for research purposes to be ESL candidates.

Ethics of Nursing Practice
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 4.8 contact hours for completing the course.

Examination Committee (EC)
A standing committee of NCSBN. The Item Review Subcommittee is a subcommittee of the EC.

F

Federation of Associations of Regulatory Boards (FARB)
An organization made up of an association of licensing boards, FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law. NCSBN holds a seat on the FARB Board of Directors.

Fiscal Year (FY)
Oct. 1 to Sept. 30 at NCSBN.

Finance Committee
A standing committee of NCSBN.

H

Health Insurance Portability and Accountability Act (HIPAA)
Passed in 1996 to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health care delivery; to promote the use of medical savings accounts, to improve access to long-term care services and coverage; and to simplify the administration of health insurance and for other purposes.

Health Resources and Services Administration (HRSA)
The agency of the federal government under the Department of Health and Human Services that includes the Practitioner Database Branch and Division of Nursing.

Healthcare Integrity and Protection Data Bank (HIPDB)
A national data collection program mandated and operated by the Health Resources and Services Administration (HRSA) for the reporting of final adverse actions against health care providers, suppliers or practitioners, as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I

Incident Reports (IRs)
Reports written by test center staff regarding irregularities that may occur during an NCLEX® candidate's examination. IRs may also be generated when a candidate calls NCLEX Candidate Services or in the event that special examination accommo-

25. Institute of Medicine of the National Academies Web site. (n.d.) *About.* Retrieved 11 May 2007, from http://www.iom.edu/CMS/3239.aspx
26. International Council of Nurses Web site. (n.d.) *About ICN*. Retrieved 11 May 2007, from http://www.icn.ch/abouticn.htm

dations are requested. IRs are entered in the Pearson VUE system so NCSBN and Member Boards can view them from the NCLEX Administration Web site.

Institute of Medicine (IOM)
A nonprofit organization specifically created for science-based advice on matters of biomedical science, medicine and health as well as an honorific membership organization. The IOM's mission is to serve as adviser to the nation to improve health. The IOM provides unbiased, evidence-based and authoritative information and advice concerning health and science policy to policymakers, professionals and leaders in every sector of society and the public at large. [25]

Institute of Regulatory Excellence (IRE)
NCSBN created this program in 2004 to assist regulators in their professional development by providing opportunities for both education and networking.

Interagency Collaborative on Nursing Statistics (ICONS)
ICONS promotes the generation and utilization of data, information and research about nurses, nursing education and the nursing workforce. ICONS is an association of individuals from a variety of organizations that are responsible for the development, compilation and analysis of data on nurses and the settings in which they practice.

International Council of Nurses (ICN)
A federation of national nurses' associations (NNAs), representing nurses in more than 120 countries. ICN is the world's first and widest-reaching international organization for health professionals. ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce. [26]

International Scheduling Fee
The charge associated with scheduling an NCLEX® examination appointment in an international testing center ($150 plus a value added tax (VAT) where applicable). These nonrefundable fees must be paid by credit card and will be charged when a candidate schedules an examination appointment.

International Testing Centers
There are Pearson Professional Center (PPC) test center locations in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, Puerto Rico, Taiwan, Philippines and United Kingdom that administer the NCLEX® for the purposes of domestic licensure.

Interprofessional Workgroup on Health Professions Regulation (IWHPR)
A coalition of organizations representing millions of health care practitioners in more than 15 separate health disciplines.

Interstate Compact
An agreement (contract, usually adopted by legislation) between two or more states that has the force and effect of statutory law.

Item
A question on one of the NCLEX® examinations.

Item Development
Process by which items for examinations are created, reviewed and validated, in order to become operational.

Item Development Panels
Comprised of volunteers who meet specific criteria to participate in the item development process.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. Their use enables many measurement benefits

See also *Rasch Measurement Model* entry.

Item Reviewers
Individuals who review items developed for the NCLEX-RN® and NCLEX-PN® examinations. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writers
Individuals who write items for the NCLEX-RN® and NCLEX-PN® examinations. Item writers must meet specific criteria in order to participate on a panel.

Item Writing
Process by which examination items are created.

J

Joint Commission
Formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the U.S. It is the nation's predominant standard-setting and accrediting body in health care. The Joint Commissions' mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. [27]

Joint Research Committee (JRC)
Committee consisting of three NCSBN and three test service staff members as well as four external researchers. The committee is the vehicle through which research is funded for the NCLEX® examination program. Funding is provided jointly by the NCSBN and the test service.

K

Knowledge, Skill and Ability Statements (KSA)
The attributes required to perform a job, generally demonstrated through qualifying service, education or training. Knowledge is a body of information applied directly to the performance of a function. Skill is an observable competence to perform a learned psychomotor act. Ability is competence to perform an observable behavior or a behavior that results in an observable product. [28]

L

Leader to Leader
NCSBN semiannual newsletter sent to nursing schools.

License
In nursing, current authority to practice nursing as a RN, LPN/VN or APRN.

Licensed Practical Nurse (LPN)
A graduate of a school of practical nursing who has passed the practical/vocational nursing examination and is licensed to administer care.

Licensed Vocational Nurse (LVN or VN)
A graduate of a vocational nursing program who has passed the practical/vocational nursing examination and is licensed to administer care.

Licensing Board
A state's regulatory body responsible for issuing licenses for RN and LPN/VN licensure as well as APRN licensure / authority to practice.

Licensure by Endorsement
The granting of authority to practice based on an individual's licensure in another jurisdiction.

Licensure by Examination
The granting of authority to practice based on an individual's passing of a board-required examination.

Licensure Portability Grant (LPG)
A grant NCSBN received from the Health Resources and Services Administration's (HRSA) Office for the Advancement of Telehealth to work with state boards of nursing to reduce licensure barriers impacting telehealth and interstate nursing practice.

Logit
A unit of measurement used in item response theory (IRT) models. The logarithmic transformation of an odds ratio creates an equal interval logit scale on which item difficulty and person ability may be jointly represented.

M

Master Pool Items
NCLEX® operational items. The bank of test items from which examinations are developed.

Medication Errors: Detection and Prevention
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.9 contact hours for completing the course.

27. The Joint Commission Web site. (n.d.) *Facts about the Joint Commission*, Retrieved 11 May 2007, from http://www.jointcommission.org/AboutUs/joint_commission_facts.htm

28. U.S. Office of Personnel Management Web site. (n.d.) *Operating Manual: Qualification Standards for General Schedule Positions, General Policy and Procedures Part C and D.* Retrieved 11 May 2007, from http://www.opm.gov/qualifications/SEC-II/s2-c-d.asp

29. National Association for Practical Nurse Education & Services, Inc. (NAPNES) Web site. (n.d.) *About NAPNES*. Retrieved 11 May 2007, from http://www.napnes.org/about.htm
30. National Association of Hispanic Nurses Web site. (n.d.) *NAHN At a Glance*. Retrieved 11 May 2007, from http://www.thehispanicnurses.org/
31. National Black Nurses Association, Inc. (NBNA) Web site. (n.d.) *Who Are We?* Retrieved 11 May 2007, from http://www.nbna.org/whoare-we.htm
32. National Certification Board of Pediatric Nurse Practitioners and Nurses Web site. (n.d.) *Welcome*. Retrieved 11 May 2007, from http://www.people.virginia.edu/~sep3y/certification.htm

Member Board
A jurisdiction that is a member of NCSBN.

Member Board Editorial Advisory Pool (MBEAP)
Voluntary editorial pool consisting of boards of nursing staff for the purpose of reviewing and providing input for NCSBN Learning Extension course development.

Model Nursing Administrative Rules (MNAR)
Serve to clarify and further interpret and implement the *Model Nursing Practice Act*. Models can be used to identify essential elements needed for rules/regulations to the *Model Nurse Practice Act*. Rules must be consistent with the law, cannot go beyond the law, and once enacted have the force and effect of law. MNAR are available on NCSBN's Web site.

Model Nursing Practice Act (MNPA)
A publication of NCSBN, approved at the Delegate Assembly in Kansas City, Missouri in 2004 with additional content on assistive personnel adopted in 2005 and on criminal background checks in 2006. The Model Acts and Rules were first adopted in 1983 and were created to serve as a guide to boards who were deliberating changes to state nurse practice acts and nursing administrative rules. Some boards look to the models for new ideas and different approaches for regulation. Other boards may use them in evaluating their existing regulatory language. Some boards use the framework and/or language in developing amendments and revisions to state laws and rules. The models may assist in the development of rationale for rules as part of the rule promulgation process. Models can be used to identify essential elements for legislation. While there will always be some variation with state nursing statutes, models are a way to advance a degree of uniformity among the several states to promote a common nationwide understanding of what constitutes the practice of nursing. The MNPA are available on NCSBN's Web site.

Motion Papers
Available at Annual Meeting and used for accurate record keeping.

Mutual Recognition
A model for nurse licensure that allows a nurse licensed in his or her state of residency to practice in other compact states (both physical and electronic), subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. In order to achieve mutual recognition, each state must enact legislation authorizing the Nurse Licensure Compact.

See also *Nurse Licensure Compact* entry.

N

National Association for Practical Nurse Education and Service (NAPNES)
Advocates for the education and practice of practical/vocational nurses. It is the organization responsible for the legislation that provides for the licensure and education of practical nursing. [29]

National Association of Hispanic Nurses (NAHN)
Designed and committed to work toward improvement of the quality of health and nursing care for Hispanic consumers and toward providing equal access to educational, professional and economic opportunities for Hispanic nurses. [30]

National Black Nurses Association (NBNA)
Provides a forum for collective action by African American nurses to investigate, define and determine what the health care needs of African Americans are and to implement change to make available to African Americans and other minorities health care commensurate with that of the larger society. [31]

National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNP/N)
Provides high-quality certification services to nurses in pediatric practice through the provision of certification exams and certification maintenance programs. The NCBPNP/N remains the largest certification organization for pediatric nursing. [32]

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)
A nonprofit association that provides its

buyers with national credentialing and continuing education programs in the fields of obstetrics, gynecology and neonatal care. NCC buyers are primarily inpatient obstetric nurses, women's health care nurse practitioners and neonatal intensive care nurses. [33]

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
Formed so that leading national health care organizations could meet, collaborate and cooperate to address the interdisciplinary causes of errors and to promote the safe use of medications. [34]

National Council Licensure Exam for Licensed Practical/Vocational Nurses (NCLEX-PN® Examination)
The NCLEX-PN® Examination is used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

National Council Licensure Exam for Registered Nurses (NCLEX-RN® Examination)
The NCLEX-RN® examination is used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

National Council of State Legislatures (NCSL)
A bipartisan organization that serves the legislators and staff of the nation's 50 states, its commonwealths and territories. NCSL provides research, technical assistance and opportunities for policy makers to exchange ideas on the most pressing state issues. NCSL is an effective and respected advocate for the interests of state governments before Congress and federal agencies. [35]

National Federation of Licensed Practical Nurses (NFLPN)
A professional organization for LPNs, LVNs and practical/vocational nursing students in the U.S. [36]

National Institute of Nursing Research (NINR)
NINR is part of the National Institutes of Health and improves the health and health care of Americans through the funding of nursing research and research training. Its mission is to promote and improve the health of individuals, families, communities, and populations. This mission is accomplished through support of research in a number of scientific areas. Among those areas of research are chronic and acute diseases, health promotion and maintenance, symptom management, health disparities, caregiving, self-management, and the end of life. NINR also supports the training of new investigators who bring new ideas and help to further expand research programs. The ultimate goal of NINR's research is its dissemination into clinical practice and into the daily lives of individuals and families.

National League for Nursing (NLN)
A national organization created to identify the nursing needs of society and to foster programs designed to meet these needs; to develop and support services for the improvement of nursing service and nursing education through consultation, continuing education, testing, accreditation, evaluation and other activities; to work with voluntary, governmental and other agencies, groups and organizations for the advancement of nursing and toward the achievement of comprehensive health care; and to respond in appropriate ways to universal nursing needs.[37]

National League for Nursing Accrediting Commission, Inc. (NLNAC)
Responsible for the specialized accreditation of nursing education programs, both post-secondary and higher degree. NLNAC has authority and accountability for carrying out the responsibilities inherent in the application of standards and criteria, accreditation processes, and the affairs, management, policy-making, and general administration of the NLNAC. NLNAC is a nationally recognized specialized accrediting agency for all types of nursing programs. [38]

National Nurse Aide Assessment Program (NNAAP™)
The nurse aide certification examination developed by NCSBN and Promissor, Inc.

See also *Promissor* entry.

National Practitioner Data Bank (NPDB)
A federally mandated program for collecting data regarding health care practitioners. The

33. National Certification Corporation for the Obstetric, Gynecologic & Neonatal Nursing Specialties (NCC) Web Site. *What is NCC?* Retrieved 11 May 2007, from http://www.nccnet.org/public/pages/index.cfm?pageid=61
34. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Web site. (n.d.) *About NCC MERP*. Retrieved 11 May 2007, from http://www.nccmerp.org/aboutNCCMERP.html
35. National Conference of State Legislatures (NCSL) Web site. (n.d.) *About NCSL*. Retrieved 11 Mat 2007, from http://www.ncsl.org/public/ncsl/nav_aboutNCSL.htm
36. The National Federation of Licensed Practical Nurses, Inc. Web site. (n.d.) *All About NFLPN*. Retrieved 11 May 2007, from http://www.nflpn.org/allaboutnflpn.htm
37. National League for Nursing (NLN) Web site. (n.d.) *Bylaws*. Retrieved 11 May 2007, from http://www.nln.org/aboutnln/Bylaws/index.htm
38. National League for Nursing Accrediting Commission (NLNAC) Web site. (n.d.) *About NLNAC*. Retrieved 11 May 2007, from http://www.nlnac.org/About NLNAC/whatsnew.htm

39. National Student Nurses Association (NSNA) Web site. (n.d.) *NSNA Mission Statement*. Retrieved 11 May 2007, from http://www.nsna.org/about_us.asp

NPDB has been in operation for 10 years and requires medical malpractice payment reports for all health care practitioners, and reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by section 1921 of the Social Security Act (originally enacted in P.L.100-93, section five). Proposed rules to implement section 1921 were published in March 2006 and final rules are expected in 2007.

National Provider Identifier (NPI)
Planned to be a new, unique eight-character alpha-numeric identifier. Created in response to the posting of rules in the Federal Register on May 7, 1998, which proposed a standard for a national health care provider identifier and requirements for its use by health plans, health care clearing houses and health care providers.

National Student Nurses' Association (NSNA)
Organizes, represents and mentors students preparing for initial licensure as RNs, as well as those enrolled in baccalaureate completion programs and conveys the standards and ethics of the nursing profession. NSNA promotes development of the skills that students will need as responsible and accountable members of the nursing profession and advocates for high-quality health care in addition to advocating for and contributing to advances in nursing education, and developing nursing students who are prepared to lead the profession in the future. [39]

NCLEX® Administration Web Site
Allows Member Boards to process and manage NCLEX® candidate records. Member Boards use the site to perform tasks including: setting candidate eligibility status, entering candidate accommodations requests and viewing candidate results.

Please Note: A user name and password is needed to enter this site.

NCLEX® Invitational
An annual one-day educational conference with sessions related to the NCLEX® program and NCLEX Examinations Department products and services.

NCLEX® Program Reports
Published twice per year for subscribing schools of nursing, the NCLEX® Program Reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX examination. Included in the NCLEX® Program Reports is information about a given program's performance by the *NCLEX Test Plan* dimensions and content areas, and data regarding the program's rank at both national and state levels.

NCLEX® Quarterly Reports
Reports that summarize the performance of all first-time candidates educated in a given jurisdiction and tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates.

NCLEX® Quick Results Service
Candidates in select jurisdictions may access their "unofficial" results via the NCLEX® Candidate Web site or through the NCLEX Quick Results Line. "Unofficial" results are available two business days after taking the test. There is a charge for the service.

NCLEX® Regional Workshop
A one-day educational conference for educators related to the NCLEX examinations. It is produced at the request of individual Member Boards.

NCSBN Board of Directors (BOD)
Administrative body of NCSBN, consisting of nine elected officers, whose authority is to transact the business and bylaws of the affairs of NCSBN.

NCSBN Learning Extension
Branded name for the online campus located at www.learningext.com where NCSBN promotes educational products and provides online course access to learners.

NCSBN Strategic Plan
The strategic initiatives and outcomes of NCSBN spanning a three-year period.

NCSBN Vice President
NCSBN Board of Directors leader that assists the president as needed, performs the president's duties in the president's absence, fills any vacancy in the office of the president until the next annual meeting and is responsible for continuing Board development.

NCSBN 101
Online course about the history, structure and purpose of the NCSBN organization for Member Board members and staff and NCSBN staff. The course is free through Member Relations and NCSBN Learning Extension. Learners earn 4.8 contact hours upon successful course completion.

NCSBN's Review for the NCLEX-PN® Examination
Online course offered through NCSBN Learning Extension for NCLEX-PN® candidates.

NCSBN's Review for the NCLEX-RN® Examination
Online course offered through NCSBN Learning Extension for NCLEX-RN® candidates.

North American Free Trade Agreement (NAFTA)
Agreement between Canada, Mexico and the U.S. that addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

Nurse Aide Registry
NCSBN publication that contains a listing of all the Nurse Aide Registries by state along with contact information for those responsible for registry maintenance and complaint investigation. Updated annually.

Nursing Assistant Workshop
An annual one-day program offered to NCSBN members and other stakeholders to address the current regulation of nursing assistants.

Nurse Licensure Compact (NLC)
An agreement establishing mutual recognition and reciprocal licensing arrangements between party states for LPN/VNs and RNs. In August 2002, NCSBN delegates voted to expand the compact to include APRNs.

Nurse Licensure Compact Administrators (NLCA)
Organized body of nurse licensing boards that have implemented and administer the Nurse Licensure Compact.

Nurse Practice Acts Continuing Education Course
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 2.0 contact hours for completing the course.

Nurse Practitioner (NP)
A RN with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A NP provides some care previously offered only by physicians and in most states has the ability to prescribe medications. NPs focus largely on health maintenance, disease prevention, counseling and patient education in a wide variety of settings. NPs are educated through programs that grant either a certificate or a master's degree. The scope of an NP's practice varies depending upon each state's regulations. Unnecessary obstacles to an NP's practice contribute to the rising costs and inaccessibility of health care for all Americans. [40]

See also *Advanced Practice Registered Nurse* entry.

Nursing Assistive Personnel (NAP)
Any unlicensed person, regardless of title, who performs tasks delegated by a nurse. Also known as unlicensed assistive personnel (UAP).

Nursing Practice Act (NPA)
Statutes governing the regulation of nursing practice in a jurisdiction, typically empowering a board of nursing to license individuals who meet specified requirements.

Nursing Practice and Education Committee (NP&E)
The former name of a standing committee of NCSBN, now called PR&E Committee.

Nursing Practice and Education Consortium (N-PEC)
A group founded in 1997 that comprised 10 nursing organizations. N-PEC member representatives held four workshops and five conference calls in 2000 to draft, review and produce a consensus report. The project resulted in a 13-page series of ideas entitled "Vision 2020 for Nursing: A Strategic Work Plan to Transform U.S. Nursing Practice and Education." [41]

Nursing Program
The authorized state entity with the legal authority to regulate nursing. Legislatures

40. American College of Nurse Practitioners Web site. (n.d.) *About NPs.* Retrieved 11 May 2007, from http://www.npcentral.net/consumer/about.nps.shtml

41. Robert Wood Johnson Foundation Web site. (n.d.) *Grant Results Report.* Retrieved 3 June 2005, from http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=038622.htm&iaid=137#int_appendix

enact the Nurse Practice Act for each state. Boards of nursing have the legal authority to license nurses and to discipline nurses for unsafe practice.

Nursing School Accrediting Agency
An organization that establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

Nursing Shortage
A nursing shortage occurs when the demand for nurses exceeds the supply available.

Nur*sys*®
A database developed by NCSBN to contain demographic information on all licensed nurses (in the U.S.) and an unduplicated count of licensees. Nur*sys*® serves as a foundation for a variety of services, including the disciplinary tracking system, licensure verification, interstate compact functions and research on nurses.

Nur*sys*® Advisory Panel (NAP)
NCSBN committee charged with identifying and addressing Nur*sys* day-to-day Member Board issues and enhancing the database system. Responsible for advising NCSBN staff regarding content of Nur*sys* Users Group and IT Summit as well as the need for its continuation.

Nur*sys*® Business Design Advisory Panel (NBDAP)
NCSBN committee charged with evaluating the Nur*sys*® business design and rules, along with associated policies and procedures.

Nur*sys*® Licensure QuickConfirm
Nur*sys*® Licensure QuickConfirm provides online detailed nurse license verification reports to employers and others.

O

Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)
Contains requirements for nurse aide training and competency evaluation.

P

Panel of Judges
A panel of experts used for the standard setting process; an NCSBN panel composed of nurses who participate in the NCLEX® standard setting process.

Parliamentarian
Assists the president in presiding, ensures proper parliamentary procedure is followed and prepares a written record of the proceedings.

Passing Standard
The minimum level of knowledge, skill and ability required for safe and effective entry-level nursing practice. The NCSBN Board of Directors reevaluates the passing standard once every three years, based upon the results of a standard-setting exercise performed by a panel of experts with the assistance of professional psychometricians; the historical record of the passing standard with summaries of the candidate performance associated with those standards; the results of a standard-setting survey sent to educators and employers; and information describing the educational readiness of high school graduates who express an interest in nursing.

Once the passing standard is set, it is imposed uniformly on every test record according to the procedures laid out. To pass an NCLEX® examination, a candidate must exceed the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

Patient Privacy Continuing Education Course
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Pearson Professional Testing Network
Network of Pearson Professional Centers (PPCs) where candidates take the NCLEX® examinations. There are more than 200 domestic and 18 international PPCs that administer the NCLEX.

See also *Pearson VUE* entry.

Pearson VUE
Contracted test service provider for NCSBN since 2002 to assist with the NCLEX® program.

Pew Task Force on Health Care
Charged by the Task Force on Health Care Workforce Regulation to identify and explore how regulation protects the public's health and propose new approaches to health care workforce regulation to better serve the public's interest. The task force was composed of eight individuals with legal, policy and public health expertise. Its recommendations were issued in late 1995.

Plurality Vote
Voting process where each voter votes for one candidate, and the candidate with the plurality (most votes) wins, regardless of whether that candidate gets a majority or not.

Practice (Job) Analysis
Research study conducted by the NCLEX Examinations Department that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

Practice and Professional Issues Survey (PPI)
A survey conducted twice each year to collect information from entry-level nurses on practice activities.

Practice, Regulation and Education Committee (PR&E)
A standing committee of NCSBN, comprised of at least six members. The committee's purpose is to provide general oversight of nursing practice, regulation and education issues.

Practitioner Remediation and Enhancement Partnership (PreP)
A partnership of licensing boards and health care organizations whose goal is to jointly identify, remediate and monitor practitioners whose practice is not up to standard, but whose actions do not require discipline. This project is sponsored by the Citizen's Advocacy Center (CAC). NCSBN is a member of the national advisory board.

Prep-4-Patient Safety
A pilot project funded by a grant from the Health Resources and Services Administration (HRSA) that provides tools for state medical and nursing boards to work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners (now limited to physicians and nurses) with deficiencies that do not rise to the level of disciplinary action. This improves patient safety by allowing organizations and licensing boards to work together to identify providers with clinical deficiencies in a nonpunitive environment. [42]

NCSBN is a member of the national advisory board. Many boards of nursing are participating or planning to join.

President
NCSBN Board of Directors leader that guides the Board in the enforcement of all policies and regulations relating to NCSBN and performs all other duties normally incumbent upon the Board President.

Pretest Items
Newly written test questions placed within the NCLEX® examinations for gathering statistics. Pretest items are not used in determining the pass/fail result.

Privilege to Practice
This refers to the multistate licensure privilege, which is the authority to practice nursing in any compact state that is not the state of residency. Additional license is not granted for this authority.

See also *Nurse Licensure Compact* entry.

Professional Accountability & Legal Liability for Nurses
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Professional Boundaries
The space between the nurse's power and the client's vulnerability—the power of the nurse comes from the professional position and access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client's needs. Complimentary professional boundaries materials are available from NCSBN.

42. 4 Patient Safety Web site. (n.d.) *Home Page*. Retrieved 11 May 2007, from http://www.4patientsafety.net/

Profiles of Member Boards
NCSBN publication that provides an overview of the regulatory environment in which state boards of nursing function. Includes data by jurisdiction on board structure, educational programs, entry into practice, licensure requirements, continued competency mechanisms, nurse aide competency evaluations and advanced practice. Available on NCSBN's Web site.

Promissor, Inc.
Promissor is a Pearson Vue Company. It is the test service for the National Nurse Aide Assessment Program (NNAAP™). Formerly known as CAT*ASI.

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude and mastery as measured by testing instruments.

Public Policy
Policy formed by governmental bodies. These include all decisions, rules, actions and procedures established in the public interest.

R

Rasch Measurement Model
A logistic latent trait model of probabilities, which analyzes items and people independently, and then expresses both item difficulty and person ability on a single continuum. These models are derived not from data but from the structure necessary for measurement. The dichotomous Rasch model is the item response theory (IRT) model used to develop the NCLEX® examination measurement scale.

Registered Nurse (RN)
A nurse who has graduated from a state-approved school of nursing, has passed the professional nursing state board examination and has been granted a license to practice within a given state.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. For adaptively administered examinations, such as the NCLEX® examination, the "decision consistency statistic" is the preferred statistic for assessing reliability. NCSBN uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the National Nurse Aide Assessment Program (NNAAP™).

Resolutions Committee
Comprised of at least four members generally representing each of the four NCSBN geographical areas and includes one member of the Finance Committee. Reviews, evaluates and reports to the Delegate Assembly all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the Bylaws.

Respecting Professional Boundaries
Online continuing education course offered through NCSBN Learning Extension, released in 2005. Based on NCSBN's video and facilitation package called "Crossing the Line: When Professional Boundaries are Violated." Learners earn 3.9 contact hours for completing the course.

S

Scope of Practice
Practicing within the limits of the issued health care provider license.

Sharpening Critical Thinking Skills for Competent Nursing Practice
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 3.6 contact hours for completing the course.

Standard Setting
The process by which the Board of Directors determines the passing standard for an examination, at or above which examinees pass the examination and below which they fail. This standard denotes the minimum level of knowledge, skill and ability required for safe and effective entry-level nursing practice. NCSBN uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is con-

ducted every three years for each NCLEX® examination.

Standard Setting Panel of Judges
A group of individuals that contributes to the recommendation of potential NCLEX® passing standards to the NCSBN Board of Directors.

Standing Committee
A permanent committee established by the NCSBN Bylaws.

Statistical Criteria
Guidelines that all proposed NCLEX® items must meet in order to become operational.

Strategic Initiative
A goal, or generalized statement, of where an organization wants to be at some future time; the end toward which effort is directed.

Strategic Objective
Desired result; a translation of the strategic initiative into tangible results, a statement of what the strategy must achieve and the elements that are critical to its success.

T

Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP™)
An instrument developed for NCSBN's practice breakdown research.

Test Administrator (TA)
Test service staff person who is responsible for day-to-day operation of the center and for proctoring of examinations.

Test Development
Process by which items for examinations are created, reviewed and validated in order to become operational.

Test Development and Item Writing
Online course offered through NCSBN Learning Extension for nursing educators to assist in writing in the NCLEX style. Learners earn 19.5 contact hours for completing the course. Formerly called "Assessment Strategies for Nursing Educators: Test Development and Item Writing."

Test Plan
The organizing framework for the NCLEX-RN® and NCLEX-PN® examinations that includes the percentage of items allocated to various categories.

Test Service
The vendor that provides services to NCSBN, including test scoring and reporting. Pearson VUE is the contracted test service for the NCLEX® examinations, and Promissor is the contracted test service for NNAAP™.
See also *Pearson VUE* and *Promissor* entries.

Treasurer
NCSBN Board of Directors position that serves as the Chairperson of the Finance Committee and manages the Board's review of and action related to the Board's financial responsibilities.

U

U.S. Department of Education (DOE)
The agency of the federal government that establishes policy for, administers and coordinates most federal assistance to education. [43]

U.S. Department of Health & Human Services (HHS)
The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. [44]

U.S. Department of Homeland Security (DHS)
Leverages resources within federal, state and local governments, coordinating the transition of multiple agencies and programs into a single, integrated agency focused on protecting the American people and their homeland. DHS is comprised of five major divisions or directorates: Border & Transportation Security; Emergency Preparedness & Response; Science & Technology; Information Analysis & Infrastructure Protection; and Management. Besides the five directorates of DHS, several other critical agencies are folding into the new department or being newly created. [45]

U.S. Drug Enforcement Administration (DEA)
Federal agency charged to enforce the controlled substances laws and regulations of the U.S. and bring to the criminal and civil

43. U.S. Department of Education Web site. (n.d.) Overview," Retrieved 11 May 2007, from http://www.ed.gov/about/overview/focus/whattoc.html?src=ln
44. U.S. Department of Health & Human Services Web site. (n.d.) What we do," Retrieved 5 May 2007, from http://www.hhs.gov/about/whatwedo.html/
45. U.S. Department of Homeland Security Web site. (n.d.) FAQs," "DHS Organization," Retrieved 6 June 2005, from http://www.dhs.gov/dhspublic/faq.jsp, http://www.dhs.gov/dhspublic/display?theme=13

46. U.S. Drug Enforcement Administration Web site. (n.d.) DEA Mission Statement. Retrieved 6 June 2005, from http://www.usdoj.gov/dea/agency/mission

47. "Delegation Concepts and Decision-Making Process." NCSBN Position Paper, 1995.

justice system of the U.S., or any other competent jurisdiction, those organizations and principal members of organizations involved in the growing, manufacture or distribution of controlled substances appearing in or destined for illicit traffic in the U.S.; and to recommend and support nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. [46]

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements
Developed by NCSBN with APRN stakeholders in 2000; establishes the foundation for the APRN Compact.

Uniform Core Licensure Requirements for Registered Nurse/Licensed Practical/Vocational Nurse
Developed in 1999, the requirements promote consistency in licensure requirements for initial entry into the nursing profession.

Unlicensed Assistive Personnel (UAP)
Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.[47]

V

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. NCSBN assures the content validity of its examinations by basing each test strictly on the appropriate test plan (NCLEX-RN® or NCLEX-PN® examination) or blueprint (NNAAP™). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.

VTN Technologies, Inc.
E-learning courseware provider for online courses offered through NCSBN Learning Extension.

VisaScreen®
A screening program that certain health care professionals must successfully complete before receiving an occupational visa, including the H-1B, H-2B, TN status, and permanent (green card) visas, as required by Section 343 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996 (IIRIRA). This service is provided by The Commission on Graduates of Foreign Nursing Schools (CGFNS); however, the NCLEX® examination(s) maybe used to fulfill one component of the *VisaScreen®* process. The *VisaScreen®* itself is a trademarked product of CGFNS and currently is the only federally accepted organization to perform screening on nurses immigrating to the U.S.

See also *Commission on Graduates of Foreign Nursing Schools (CGFNS)* entry.

W

White Paper
A detailed policy document issued by NCSBN, widely disseminated to external groups, to discuss issues or to encourage dialogue about a particular regulatory subject.