INDIANAPOLIS, INDIANA

AUG. 3 - 5, 2011

2011 ANNUAL MEETING

About this Illustration

The illustration used to symbolize the 2011 NCSBN theme, ***Transforming the Future of Regulatory Leadership***, was inspired by a quote attributed to Harriet Tubman, an African-American abolitionist: *"Every great dream begins with a dreamer. Always remember, you have within you the strength, the patience and the passion to reach for the stars to change the world."*

The elements of the illustration were chosen to reflect both the theme and the quote, as well as bring together symbols that evoke images of Indianapolis, the 2011 Annual Meeting host city.

The torch, the sole icon in the flag of Indiana, is depicted here, held aloft by the human figure in the illustration epitomizing the pinnacle of achievement. The illumination sent forth by the torch is a focal point of the design, symbolic of the fact that light is transformative – turning darkness into light, bringing clarity of vision and making a dream a reality.

In its posture of forward momentum the figure itself conveys energy, endurance and dedication. The figure is poised on a base grounded in the present, but positioned above the clouds, emblematic of the high standards that boards of nursing already achieve; the wings evoke transformation, having the means and ability to embark upon a new goal reaching new heights of regulatory leadership.

The buildings that surround the central figure represent the strong foundation of leadership that is the underpinning of regulatory excellence. These buildings also pay homage to the fact that Indianapolis is second only to Washington D.C. for the number of monuments it has within the city limits.

2011 NCSBN Annual Meeting

SECTION I: 2011 NCSBN ANNUAL MEETING

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Informational Reports

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 U.S. territories—American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also seven associate members.

Mission

The National Council of State Boards of Nursing (NCSBN) provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.

Vision

Advance regulatory excellence worldwide.

Values

Collaboration: Forging solutions through respect, diversity and the collective strength of all stakeholders.

Excellence: Striving to be and do the best.

Innovation: Embracing change as an opportunity to better all organizational endeavors and turning new ideas into action.

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

Transparency: Demonstrating and expecting openness, clear communication and accountability of processes and outcomes.

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

2011 NCSBN Annual Meeting

SECTION I: 2011 NCSBN ANNUAL MEETING

Business Agenda of the 2011 Delegate Assembly

Wednesday, Aug. 3, 2011

10:00 am

OPENING CEREMONIES

- Introductions
- Announcements

OPENING REPORTS

- Credentials Report

ADOPTION OF AGENDA

REPORT OF THE LEADERSHIP SUCCESSION COMMITTEE

- Presentation of the 2011 Slate of Candidates
- Nominations from Floor
- Approval of the 2011 Slate of Candidates

PRESIDENT'S ADDRESS

CEO'S ADDRESS

Friday, Aug. 5, 2011

10:45 am

BOARD OF DIRECTORS' RECOMMENDATIONS

- Adopt the proposed revision to the Uniform Licensure Requirements.
- Adopt the Singapore Nursing Board as an Associate Member of NCSBN.
- Adopt the College of Registered Nurses of Nova Scotia as an Associate Member of NCSBN.

NEW BUSINESS

CLOSING CEREMONY

ADJOURNMENT

Special Note

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

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 non-delegates during a business meeting must take place outside the designated delegate area.
6. All attendees have a right to be treated respectfully.
7. There shall be no videotaping, audio recording or photographing of the sessions without the written permission of NCSBN.

3. Agenda

A. Business Agenda

1. The Business Agenda is prepared by the President in consultation with the Chief Executive Officer 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 NCLEX® Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the NCLEX® Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the NCSBN Bylaws.

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 non-procedural 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 Thursday, August 4, 2011, at 4:30 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 Thursday, August 4, 2011, at 4:30 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 non-procedural main motion or resolution after the deadline of 4:30 pm on Thursday, August 4, 2011, 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. Non-delegate 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. Any member who intends to be nominated from the floor is required to submit their completed nomination form and meet with the Leadership Succession Committee the day before adoption of the slate of candidates by the Delegate Assembly.

B. 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 Leadership Succession Committee at the time of the nomination from the floor.

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

D. The voting strength for the election shall be determined by those registered by 5 pm on Wednesday, August 3, 2011.

E. Election for officers, directors, and members of the Leadership Succession Committee shall be held Thursday, August 4, 2011, from 7:30 to 8:30 am.

F. 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.

1. 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.

2. 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.

3. 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 may be scheduled to promote dialogue and discussion on issues by all attendees. Attendee participation determines the topics discussed during an Open Forum. The President will facilitate the Open Forum.

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

Annual Meeting Schedule

TUESDAY, AUG. 2, 2011

2:00–6:00 pm
White River Ballroom A & B
1st Floor

Nurse Licensure Compact Administrators (NLCA) Meeting

3:00–6:00 pm
White River Ballroom Foyer
1st Floor

Registration Opens
Visit the registration desk to receive your registration materials and name badge. Name badges must be worn at all times in order to enter the NCSBN Annual Meeting sessions.

4:00–5:30 pm
Suite 104
1st Floor

New Candidate Interviews with the Leadership Succession Committee (LSC)
Those candidates anticipating being nominated from the floor must submit a nomination form and meet with the LSC. Contact nominations@ncsbn.org to schedule a time.

WEDNESDAY, AUG. 3, 2011

7:30–9:30 am
White River Ballroom Foyer
1st Floor

Continental Breakfast

7:30–10:00 am
White River Ballroom Foyer

Exhibit Showcase
Stop by the Exhibit Showcase to learn about products and services pertinent to the work of boards of nursing.

7:30 am–3:30 pm
White River Ballroom Foyer

Registration
Visit the registration desk to receive your registration materials and name badge. Name badges must be worn at all times in order to enter the NCSBN Annual Meeting sessions.

8:00 –8:30 am
White River Ballroom E-J

Resolutions Committee Meeting
Open to Resolutions Committee members only.

8:30–9:30 am
White River Ballroom E-J

Delegate Orientation
Open to all attendees.

10:00–10:30 am
White River Ballroom E-J

Delegate Assembly: Opening Ceremony
Welcome from the Indiana State Board of Nursing.

- Opening Ceremony
  - Introductions
  - Announcements
- Opening Reports
  - Credentials
  - Adoption of the Standing Rules
- Adoption of Agenda
- Report of the Leadership Succession Committee
  - Presentation of the 2011 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2011 Slate of Candidates

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

10:30–10:45 am
White River Ballroom E-J

President's Address
Myra Broadway, JD, MS, RN, President, NCSBN Board of Directors, Executive Director, Maine State Board of Nursing

10:45–11:00 am
White River Ballroom E-J

CEO's Address
Kathy Apple, MS, RN, FAAN, CEO, NCSBN

11:00–11:15 am
White River Ballroom E-J

Finance Committee Forum

Julia George, MSN, RN, FRE, Treasurer, NCSBN Board of Directors, Executive Director, North Carolina Board of Nursing

11:15 am–12:00 pm
White River Ballroom E-J

Board of Directors Forum

Myra Broadway, JD, MS, RN, President, NCSBN Board of Directors, Executive Director, Maine State Board of Nursing

12:00–1:15 pm
Griffin Hall
2nd floor

Lunch

1:15–2:30 pm
White River Ballroom E-J

Candidate Forum
Barbara Morvant, MN, RN, Chair, Leadership Succession Committee Executive Director, Louisiana State Board of Nursing

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

2:30–3:00 pm
White River Ballroom Foyer

Exhibit Showcase Break

3:00–3:30 pm
White River Ballroom E-J

Uniform Licensure Requirements and Portability Committee Forum
Brenda McDougal, Chair, Uniform Licensure Requirements and Portability Committee Associate Executive Director, North Carolina Board of Nursing

3:30–4:00 pm
White River Ballroom E-J

TERCAP® Committee Forum
Marybeth Thomas, PhD, RN, Chair, TERCAP® Committee Director of Nursing Education and Practice, Texas Board of Nursing

4:00–5:00 pm
White River Ballroom C & D

Candidate Connection
Delegates can take this opportunity to meet the candidates running for office.

4:00–5:00 pm
Suite 101
1st Floor

Parliamentarian Office Hours
Take this opportunity to ask the Parliamentarian questions and/or submit resolutions.

5:30–7:30 pm

NCSBN Welcome Reception: Indianapolis Zoo
NCSBN welcomes all attendees to the 2011 Annual Meeting. Please join us at the Indianapolis Zoo for a networking reception.

Tickets will be included in the registration packets of those who opted to attend during online registration. The reception is open to attendees only. Tickets must be presented to enter the reception.

THURSDAY, AUG. 4, 2011

7:30–8:30 am
Suite 101
1st Floor

Election Voting
Open to delegates only.

7:30–9:00 am
White River Ballroom Foyer
1st Floor

Exhibit Showcase
Stop by the Exhibit Showcase to learn about products and services pertinent to the work of boards of nursing.

7:30–9:00 am
White River Ballroom Foyer

Pearson VUE Sponsored Breakfast
Open to all attendees.

7:30 am–12:00 pm
White River Ballroom Foyer

Registration

9:00 –10:00 am

Knowledge Networks
NCSBN Knowledge Networks are brainstorming discussions regarding regulatory trends and issues. Choose from the following options:

White River Ballroom A

- NCSBN Executive Officers (Open to NCSBN Executive Officers only)

White River Ballroom B

- NCSBN Board Presidents (Open to NCSBN Board Presidents only)

White River Ballroom C & D

- Regulatory Network (Open to Board Staff, Board Members and External Organizations)

Open to all attendees.

10:00–10:30 am
White River Ballroom Foyer

Exhibit Showcase Break

10:30 am–12:00 pm

Knowledge Networks, continued

12:00–1:15 pm
Griffin Hall
2nd floor

Lunch

1:15–2:15 pm
White River Ballroom E-J

High Altitude Leadership: Creating Teams that Summit Despite the Odds
Chris Warner, Earth Treks, Inc.

Warner is an Emmy-nominated film maker, author, expedition leader and entrepreneur (his company of 175 employees serves 400,000 customers each year). He's led teams to the summits of Mount Everest, K2 and hundreds of slightly smaller peaks. With more than 27 years of experience creating and leading high performance teams, he teaches these skills at Wharton, Hopkins and other MBA programs, Fortune 500 companies, CEO groups (YPO, WPO, SmartCEO and Vistage) and to mission critical teams.

2:15–2:30 pm
White River Ballroom Foyer

Break

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

2:30–4:00 pm

Area Meetings: NCSBN Members Only

NCSBN Area Meetings I-IV are open to NCSBN members and staff only. Note that there is a meeting open to external organizations. Associate Members may attend the Area Meeting of their choice.

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

White River Ballroom A

- Area I members include: Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Northern Mariana Islands, Oregon, Utah, Washington and Wyoming

White River Ballroom B

- Area II members include: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia and Wisconsin

White River Ballroom C

- Area III members include: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia

White River Ballroom D

- Area IV members include: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and U.S. Virgin Islands

Suite 101/102
1st Floor

External Organizations Meeting

Join other external organizations for a networking meeting. Open to all NCSBN nonmember attendees.

2:30–4:30 pm
Suite 108

Parliamentarian Office Hours

Take this opportunity to ask the Parliamentarian questions and/or submit resolutions. Resolutions must be submitted by 4:30 pm.

4:30–5:30 pm
Suite 108

Resolutions Committee Meeting

Open to Resolutions Committee members only.

6:00–6:30 pm
Grand Ballroom Foyer

Awards Reception

Evening Cocktail Attire

6:30–9:00 pm
Grand Ballroom V

Awards Dinner

Evening Cocktail Attire

FRIDAY, AUG. 5, 2011

8:00–9:00 am
White River Ballroom Foyer
1st Floor

Continental Breakfast

9:00–10:00 am
White River Ballroom E-J

Acknowledgment

NCSBN Board of Directors acknowledges Barbara Nichols, CEO, CGFNS, for her contributions to NCSBN.

10:00–10:30 am
White River Ballroom E-J

Substance Use Disorder Manual and Guidelines

Kate Driscoll Malliarakis, MSM, CNP, NCADC, Committee on Impaired Nurses, District of Columbia Board of Nursing

10:30–10:45 am
White River Ballroom Foyer

Break

10:45 am–12:00 pm
White River Ballroom E-J

Delegate Assembly

- New Business
- Closing Ceremonies

11:30 am–12:30 pm
White River Ballroom Foyer

Boxed Lunch

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

Summary of Recommendations to the 2011 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors and Leadership Succession Committee propose to the 2011 Delegate Assembly. Additional recommendations may be brought forward during the 2011 Annual Meeting.

Board of Directors' Recommendations

1. ***Adopt the proposed revision to the Uniform Licensure Requirements (ULRs).***

   Rationale:
   The newly revised ULRs are the result of the 2008 Delegate Assembly Resolution that the 1999 Uniform Core Licensure Requirements be reviewed for currency and relevance. The proposed 2011 revised ULRs will set new national standards for licensure and bring uniformity across all jurisdictions. Adoption of the new ULRs will also demonstrate to external stakeholders, the federal government and consumers that boards of nursing are interested in establishing uniformity and easing the portability of nurses in the U.S. The revised ULRs utilized extensive feedback from the membership and are based on available evidence.

   Fiscal Impact:
   None.

2. ***Adopt the Singapore Nursing Board as an Associate Member of NCSBN.***

   Rationale:
   The NCSBN Bylaws state that an Associate Member is "a nursing regulatory body or empowered regulatory authority from another country or territory." The bylaws require approval of the new membership by the full membership of the Delegate Assembly. The current application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, the new associate member will pay a $1,500 annual fee.

3. ***Adopt the College of Registered Nurses of Nova Scotia as an Associate Member of NCSBN.***

   Rationale:
   The NCSBN Bylaws state that an Associate Member is "a nursing regulatory body or empowered regulatory authority from another country or territory." The bylaws require approval of the new membership by the full membership of the Delegate Assembly. The current application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, the new associate member will pay a $1,500 annual fee.

Leadership Succession Committee Recommendation

1. ***Adopt the 2011 Slate of Candidates.***

   Rationale:
   The Leadership Succession Committee has prepared the 2011 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 is posted in the Business Book under the Report of the Leadership Succession Committee. Candidates will present himself or herself at the Candidate's Forum on Wednesday, Aug. 3, 2011.

   Fiscal Impact:
   Incorporated into the fiscal year 2012 (FY12) budget.

Report of the Leadership Succession Committee (LSC)

Recommendation to the Delegate Assembly

1. ***Adopt the 2011 Slate of Candidates.***

   Rationale:
   The LSC has prepared the 2011 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees and attention to the goals and purpose of NCSBN. Full biographical information and personal statement for each candidate is posted in the Business Book under the Report of the Leadership Succession Committee. Candidates will present himself or herself at the Candidate's Forum on Wednesday, Aug. 3, 2011.

Background

At the 2007 Delegate Assembly in Chicago the membership voted to adopt a bylaw revision that would substantially change and transform the Committee on Nominations. The intent of the change was to provide a new structure within NCSBN to ensure leadership development and succession. The membership believed that organizational leadership is a strategic process and that leaders are developed through careful planning, cultivation, orientation, education and involvement in NCSBN.

The charge of this new committee, named the Leadership Succession Committee, as outlined in Article VII of the NCSBN Bylaws, is to:

1. Recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; and
2. 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 (BOD) and LSC.

The first members of the committee were elected at the 2008 Delegate Assembly in Nashville, Tenn. Barbara Morvant, executive officer, Louisiana State Board of Nursing, was appointed by the BOD as chair of the committee. The first undertaking by the LSC was to define leadership succession.

LEADERSHIP SUCCESSION DEFINED

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;
- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

COMPETENCY FRAMEWORK

The second undertaking was to build a framework of leadership competencies congruent with the work of NCSBN. The LSC framed these competencies in two broad categories: self-knowledge and governance leadership. Additionally, the LSC believes that candidates for NCSBN positions should be individuals who possess knowledge of regulation and commitment to the mission, vision and values of NCSBN.

Members

Barbara Morvant, MN, RN
Louisiana-RN, Area III,
Designated Member, Chair

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

Mary Blubaugh, MSN, RN
Kansas, Area II,
Designated Member

Lisa Emrich, MSN, RN
Ohio, Area II Member

Patricia Lane, MBA, RN, HCA
Virginia, Area III,
Designated Member

Brenda McDougal
North Carolina, Area III Member

Paula Meyer, MSN, RN
Washington, Area I,
Designated Member

Sue Petula, PhD, RN, NEA-BC
Pennsylvania, Area IV Member

Staff

Kathy Apple, MS, RN, FAAN
CEO

Linda Olson, PhD, RN, NEA-BC
Institute of Regulatory Excellence
Associate, Nursing Regulation

Kate Jones
Manager, Executive Office

Meeting Dates

- Nov. 8-9, 2010
- Dec. 2-3, 2010
- Jan. 20, 2011 (Conference Call)
- Feb. 23-24, 2011
- April 20-22, 2011

Relationship to Strategic Plan

Strategic Initiative B
NCSBN advances the engagement and leadership potential of all members through education, information and networking.

The competencies are:

Self-knowledge

- Honesty, integrity and courage
- Ability to deal with ambiguity and complexity
- Flexibility and adaptability
- Cultural competence: the ability to work effectively cross culturally
- Interpersonal and communication effectiveness

Governance leadership

- Stewardship, selecting service to the greater good over self-interest
- Strategic and futuristic thinking
- Fiduciary knowledge
- Evidence-based decision making
- Consensus building through strategic alliances, networks and partnerships
- Effective change and risk management, including accountability and transparency
- Diplomatic and politically savvy relationship building
- Creativity and innovation

LEADERSHIP DEVELOPMENT PLAN: *ADVANCING POTENTIAL – DISCOVER THE LEADER WITHIN*

Over the last three years, the LSC has assembled and finalized a plan to assist members in developing their regulatory expertise and furthering their leadership competence. The LSC launched the FY11 Leadership Development Plan at the 2011 NCSBN Midyear Meeting. The intent is to afford all members opportunities to advance their leadership potential regardless of whether or not members run for open elected positions. The LSC believes leadership development for all members will benefit the work of Member Boards and NCSBN. The plan has five overall objectives:

1. Establish an early connection to the resources available from NCSBN;
2. Self-assess and identify personal and professional leadership strengths and opportunities for further development;
3. Engage in leadership development activities;
4. Participate in NCSBN committees, networking groups, webinars and meetings; and
5. Consider being a candidate for office.

The plan identifies and develops leadership through early connectivity where members engage early on in order to understand the mission, vision, values and strategic initiatives of NCSBN; provides opportunities to enhance self-knowledge, skills and abilities; and builds governance expertise.

BUILDING THE SLATE OF CANDIDATES

The LSC continued to develop an open and fair process for building a slate of candidates. The LSC has reframed the preparation of a slate of candidates as an engagement process. The engagement of members to identify and support potential leaders is a collective responsibility of the membership. The LSC asked the membership to identify potential leaders who may be interested in running for election now or at a later time. Early identification of potential leaders provides the opportunity for the LSC to assist, support and mentor members in their leadership journey.

FY11 Highlights and Accomplishments

- The LSC began the year with an orientation to all relevant committee documents and procedures, including implementation of the current committee charges.
- Chair Morvant provided a synopsis of the committee's history, discussing the shift in philosophy and culture, the shift from recruitment to engagement, the creation of a leadership competency framework, the importance of early membership engagement and the body of work related to the organizational leadership development plan.
- The committee reviewed its competency framework, Essential Competencies for Governance Leadership.
- The committee reviewed the positions on the BOD and the LSC that will be open for election in 2011.
- The committee reviewed the role of the BOD per the bylaws and NCSBN Policy 3.1; and the new mission, vision, values and strategic initiatives for 2011-2013.
- The committee reviewed LSC Policy 1.0.
- The committee reviewed and discussed the leadership interface with the Institute for Regulatory Excellence (IRE) program.
- The committee reviewed and revised the call for nomination letter, electronic nomination form and brochure.
- The committee had a discussion on revising interview questions, ensuring that the questions acquire information related to the identified leadership competencies. The committee expanded the pool of competency-based interview questions.
- The committee discussed the importance of early engagement for new members and developing various information resources that executive officers could provide to either new board members or staff.
- The committee also reviewed the NCSBN 101 online course and recommended that the course be separated into four sections.
- The committee finalized the FY11 Leadership Development Plan. The LSC framed the plan as a horizontal rather than a vertical plan, with participants choosing their leadership development options based on their individual needs. It is anticipated that the plan will need to be reviewed and updated on an annual basis to evaluate the use of the plan and identify resources needed in the future.
- The committee brainstormed marketing initiatives and possible incentive programs with Dawn Kappel, director, Marketing & Communications, NCSBN, for future use.
- Committee members, Mary Blubaugh and Paula Meyer, and NCSBN Member Relations Director Alicia Byrd presented information obtained through a survey regarding the current Executive Officer Mentoring Program and how to best utilize this structure for leadership development.
- The committee reviewed and revised the candidate selection assessment process.
- The committee met with Tammy Spangler, director, Interactive Services, NCSBN, regarding the development of an LSC area on the NCSBN website. Alicia Byrd outlined the new areas on the NCSBN website for new members to promote early engagement with NCSBN, including a new member tool kit.
- The new Web sections were launched in March 2011.
- Mary Dickow, deputy director of the UCSF Center for the Health Professions met with the committee to discuss the Center's various leadership programs and how their ideas could be used in the committee's leadership development plan.

- Carol Huston, past president and current leadership succession committee chair of Sigma Theta Tau International (STTI) Nursing Honor Society, met with the committee to discuss STTI's principles of leadership succession and what activities have been successful in the fulfillment of their goals.
- The committee identified a need for an online course on effective board governance.
- The committee identified the necessity to develop a needs-assessment survey to be used for developing leadership resources in the future.
- The committee reviewed the 2010 Delegate Assembly candidate forum evaluations and discussed various ways to conduct and facilitate membership interaction with candidates.

Attachments

A. 2011 Slate of Candidates

B. Essential Competencies for Governance Leadership

C. Leadership Development Plan for FY11

Attachment A

2011 Slate of Candidates

The following is the slate of candidates developed and adopted by the Leadership Succession Committee. Each candidate profile is taken directly from the candidate's nomination form. The Candidate Forum will provide the opportunity for candidates to address the 2011 Delegate Assembly.

Board of Directors

Treasurer (one-year term)

Area I Director

Area III Director

Area IV Director

Director-at-Large (two positions)

Leadership Succession Committee

Designated Member (Employee of Member Board)

None

Designated Member (Board Member of Member Board)

Designated Member (Past Board of Directors Member)

None

Designated Member (Current or Former NCSBN Committee Chair)

Detailed Information on Candidates

Information is 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. Describe all relevant professional, regulatory and community involvement, including service on NCSBN committee(s). (300 word limit)
5. What do you perceive as the top two challenges to nursing regulation (provide two or three strategies you would use to address those challenges)? (300 word limit)
6. What leadership competencies will you bring and what will you contribute to advance the organization? (300 word limit)

Treasurer

Julia George, MSN, RN, FRE

Board Staff, North Carolina, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I have the privilege of serving as current NCSBN Treasurer. I was appointed as Treasurer in February 2011 following the resignation of Randy Hudspeth. This is my fourth year on the Board of Directors, having been elected two terms as Area III Director. My current role as Treasurer and past four years on the Board of Directors give me an excellent working knowledge of NCSBN strategic initiatives, fiscal policies and long range planning. I am the current Executive Director of the North Carolina Board of Nursing. The North Carolina Board of Nursing is the only totally independent board of nursing in the country. I serve as Treasurer for the North Carolina Board of Nursing and am solely responsible for ensuring adequate revenues, managing a multi-million dollar budget and managing risks for all related public funds. In addition to my background in nursing regulation, I also have an undergraduate degree in business and have worked in the business world both in governmental and private sectors. I have been active in NCSBN activities for many years. I have served on the Resolutions Committee, Practice Regulation & Education (PR&E) Subcommittee on Unlicensed Personnel, Board liaison to Disciplinary Resources Committee, Board liaison to TERCAP Committee, and a member of the Nurse Licensure Compact Administrators Compliance Committee. I was part of the inaugural cohort of regulatory fellows, completing a four-year fellowship through the NCSBN Institute of Regulatory Excellence in August 2007.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

Without doubt, there will be many challenges facing nursing over the next few years. The two challenges I see as most important include: 1) As regulators, how do we adapt to the changing landscape in healthcare delivery to ensure public protection with ever shrinking resources? It will become even more important for NCSBN to be sensitive to member boards with limited resources as state coffers dwindle. NCSBN must continue outreach to member boards to meet current and future needs related to licensure/discipline data, competence assessment, workforce data, educational opportunities, networking needs, policy issues and more. 2) How do we ensure that all nurses practice to their full scope of educational preparation and licensure to provide accessible affordable care in the future? We cannot remain entrenched in our current model of healthcare delivery-it simply will not be adequate to provide for the needs of the future. The first recommendation in the Institute of Medicine report on the Future of Nursing calls for removing barriers to scopes of practice. As member boards work toward implementation of this recommendation we will need support from NCSBN. We will also need to reach beyond our traditional nursing colleagues to increase collaboration, gain insight and garner support for policy change.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I bring over 30 years of nursing experience and over 15 years of experience in nursing regulation. My current experience as Executive Director of the North Carolina Board of Nursing, four years as member of NCSBN Board of Directors, and recent responsibilities as NCSBN Treasurer uniquely prepare me for this position. I consider myself to be self-aware as a leader and to be a good communicator. I am a consensus builder and someone who is responsive to the concerns of those around me. I am adaptable to change and comfortable with ambiguity. My past service to NCSBN speaks to my stewardship and fiduciary knowledge. I believe the combination of my business skills, communication skills and leadership abilities enable me to serve you effectively in the position of Treasurer and I would welcome the opportunity to do so.

Treasurer

Rula Harb, MS, RN

Board Staff, Massachusetts, Area IV

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

Rula Harb is the Executive Director for the Massachusetts Board of Registration in Nursing, a position she has held since March 2005. Prior to becoming the ED, she served as the Board's Associate Executive Director, 1999-2005 and as the Nursing Education Coordinator, 1997-1999. Ms. Harb has an earned Bachelor of Science in Nursing from the American University of Beirut and a Master of Science in Nursing Administration from Boston University. She has in-depth knowledge of professional standards, a demonstrated ability in collaborative practice, as well as established leadership and problem solving skills. Ms. Harb has served on many committees and Boards: 2007 – Present as Member, National Council of State Boards of Nursing (NCSBN), Finance Committee; 2005 – 2009: Member, Massachusetts Coalition for the Prevention of Medical Errors Board of Directors; 2006 – 2008: Chair, NCSBN, Executive Officer Network; 2005 – 2007: Member, NCSBN Commitment to Ongoing Regulatory Excellence; 2003 – 2004: Member, Massachusetts Center for Nursing Board of Directors; 1998 – 2004: Member, NCSBN Examination Committee.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The two top challenges to nursing regulations today is the continued concern of managing limited resources and assuring public safety in addressing competency of nurses. Strategies to address challenges include engaging in activities and on-going research to appropriately influence public policy in finding creative evidence based solutions that will assure public protection and better utilize scarce fiscal and human resources. The NCSBN Board of Directors, the Finance Committee members and staff need to continue to exercise thoughtful fiduciary leadership in carrying out responsibilities honestly and with due diligence. As health care reform and nursing regulation evolves we have to cultivate partnerships and collaborative relationships to develop a consistent and uniform regulatory approach to nursing practice and education across state, national and international organizations.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I bring a strong commitment to the mission, vision and values of NCSBN. I would help assure the organization continues to meet its strategic initiatives. I will combine my leadership competencies with all the knowledge and wisdom that I have gained from being a policy maker, regulator, manager and educator. I am a forward thinker, an organized manager that is self-motivated and strongly committed to excellence in nursing regulation. I am very interested in taking on new challenges and serving on NCSBN Board of Directors because I too value integrity, innovation, stewardship and diversity. Thank you for the opportunity to submit my application for your consideration; it would be an honor to continue to work with all NCSBN member boards.

Area I Director

Debra Scott, MSN, RN, FRE

Board Staff, Nevada, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I have had the honor of serving on the NCSBN Board of Directors for the last two years in the position of Director-at-Large. Although I have been an RN for 27 years and have held positions in nursing regulation for more than 15 years, serving the member boards of the NCSBN on our Board of Directors has deepened my understanding of the intricacies involved in supporting our members in meeting our mission of protecting our public.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The challenges to nursing regulation have become more apparent to me as a member of the Board of Directors. Our unprecedented economic crisis has touched most every one of us. When we are faced with media outrage in response to the conduct of a very small percentage of those we regulate, we are forced to come to terms with doing more with less. We must strategize in addressing perceptions rather than actualities. Nursing regulators are expert in meeting our day to day responsibilities, but the environment is asking more of us. Dwindling resources in the face of increased expectations threatens nursing regulation. NCSBN provides a wide array of resources, from financial to education, leadership development to research.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

Leadership competency is knowing what I don't know and developing competence in those areas by utilizing available resources. During my previous bid for election, I talked about having a clear understanding of the role of nursing regulation. I discussed my ability to foster collaboration and having just enough ego to be assertive while being respectful and open-minded. I continue to possess those traits, but have grown stronger and more skilled as a leader. This year, the benefits I have gained from my work on the Board of Directors, participation in several national and international conferences, and a taking advantage of the executive officer coaching program have given me deeper insight into my own leadership style and skill. I have found my ability to question the status quo supports the important generative discussion essential to strong governance. Valuing others opinions, dreams, and beliefs has given me a deeper understanding of our shared vision. I have a deep desire and am committed to advancing our organization through collaboration and hard work.

Date of expiration of term:
June 30, 2013

Eligible for reappointment:
Yes

Area I Director

Rhonda Taylor, MSN, RN

Board Member, Washington, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I have been a Registered Nurse for 34 years. I began my nursing career after graduating from the ADN program where I am currently the director. Over the first 10 years of practice I climbed the rungs of the ladder to my Masters degree. I have worked in Intensive and Coronary Care units as a staff nurse and nurse manager, as a hospital supervisor, and in family practice as a nurse practitioner. I have been an educator for Yakima Valley Community College's nursing program for the past 16 years and director for 11. I was the Vice President for the Workforce Education Division on the executive board for the faculty union. During the nine years in that role I was part of the team that negotiated three faculty contracts. I currently work at a local hospital on the medical and oncology units on an available basis. For the past 20 years I have assisted attorneys in Washington and Oregon in various medical malpractice matters, serving as an expert witness. I am currently the Vice Chair in my second, Governor appointed term on the Washington State Nursing Commission. While on the Commission, I have worked on developing and implementing our continuing competency rules for licensed nurses, in addition to licensing and discipline issues. Last year I was a member of the Governor's task force on health care disparities. I have served on community boards and currently serve as a Deacon in our church where I participate in hospital visitation and visits with home bound individuals.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES).

I believe that one of the top challenges in nursing regulation is responding to the recent IOM report related to the future of nursing. Two recommendations that may present challenges, will be addressed here: 1. 80% of all nurses educated with at least a baccalaureate degree by 2020, and 2. the implementation of nurse residency programs. To achieve the goal regarding educational level of practicing nurses, there must be strong collaboration among education, regulation, and nursing accreditation to promote articulation in LPN, ADN, and BSN programs. The NCSBN can lead in the facilitation of this needed collaboration and develop model rules for board members to adopt that streamline nursing program approval. Another strategy to promote articulation of quality programs is to require all nursing programs to have national accreditation. A second challenge is the development of nurse residency programs. To adequately address consistent standards of practice we must look at the characteristics of the practice environment in terms of what is needed to give each licensed nurse the tools necessary to practice professionally and safely. Studies have shown that there is a significant number of nurses leaving the profession within the first two years of practice. Having solid transition to practice programs in all states may help decrease nurse turnover and promote consistent standards of practice. Incorporating concepts of "Just Culture" into these programs may further enrich the transition from student nurse to licensed nurse. Model programs with measurable outcomes can be shared by member boards. Analysis of cost and benefit of nursing residency programs is needed and should include the cost of nurse turnover. Another strategy is in the collaboration and sharing of costs between nursing education and industry in final clinical courses to assist with transition to practice.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

In addition to my experience on the Nursing Commission, I have been on the Item Review Sub-Committee for the NCSBN for the past 3 years. I have been in leadership positions in various settings for most of my nursing career. I have a great deal of energy and in addition to being a good listener, I try to think creatively. I enjoy working in groups. I am patient. I have enjoyed a well rounded career in nursing and through my leadership position on the Nursing Commission, feel prepared to take what I have learned to the highest level possible.

Date of expiration of term: 2014

Eligible for reappointment: No

Area III Director

Pamela Autrey, PhD, MBA, MSN, RN

Board Member, Alabama, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

Dr. Pamela Autrey has over 30 years of nursing experience in the healthcare setting with an emphasis in administration, quality, and safety. Dr. Autrey is currently the Administrative Director for Medical Nursing at the University of Alabama at Birmingham (UAB) Hospital, with direct responsibility for 14 medical nursing units. She is President of the Alabama Board of Nursing (ABN) and was recently re-appointed for a 2nd four year term. At that time, she was re-elected President of the ABN. She currently serves as Director-at-Large on the Board of Directors for the National Council State Boards of Nursing and recently was appointed by that board to serve as Area III Director. In her board position, Dr. Autrey has served as liaison to the NCLEX Review Committee and the Discipline Resource Committee. In previous years she served on the Disaster Preparedness Committee and the Continued Competence Committee. She was elected to the Governance Committee for the Honor Society of Nursing, Sigma Theta Tau International, 2008-2009 and is the past-President of the Birmingham Regional Organization of Nurse Leaders, as well as a technical advisor to the Health Subcommittee of the Governor's Commission for Action in the Black Belt and the Alabama Rural Action Committee. She continues to teach in the MSN and DNP programs at the UAB School of Nursing and University of South Alabama. Dr. Autrey has current research projects including a qualitative study on nursing workplace violence and a comparison of chlorhexidine rinse, commercially available oral care kit, and standard MICU oral care in the reduction of VAP. In February 2011 she completed a one-year certification in clinical microsystems for practice and educational quality and safety from the Dartmouth Institute for Health Policy and Clinical Practice. The results of her collaborative practice improvement were presented at the AACN Masters Education Conference.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The passage of the H.R. 3590 Patient Protection and Affordable Care Act will create more opportunities in nursing regulation. Increased volume due to extended coverage of currently uninsured Americans will overwhelm our current supply of health care providers in the short term, especially in rural areas; in the long term the bill also provides for increased funding for education of nurses, advanced practice nurses, primary care and general surgery physicians, and those practicing in community-based/ambulatory care centers. The role of advanced practice nurses will undoubtedly change and increased mobility to practice in one or more states will be enhanced. So our challenge, therefore, is to balance all these opportunities with issues of physician opponents to a broadened scope of practice; maintaining and increasing the faith of the public in nurses as safe, effective, efficient, and efficacious providers of care in new and different settings and models of care; and potential new national models of nursing regulation. The second challenge is to meet the demands of a health care consumerism movement. The trust the public holds is that our nurses are safe and competent to practice; nursing regulation from a national perspective will mobilize lawmakers and other regulators to do what is right for the protection of the public through the endorsement and implementation of a national licensing and discipline database. The recent IOM report on the future of nursing combined with the Carnegie Foundation call for radical transformation in nursing education provide opportunities, challenges, and solutions to our current model of regulation: the explicit intermeshing of nursing education with clinical partners will allow for all nurses to safely practice to their fullest educational potential. The next few years in nursing regulation will be most exciting.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I thought my leadership competencies were extensive until I became a member of the Alabama Board of Nursing and NCSBN Board of Directors. There is so much to learn not only about nursing regulation, but board governance as well. That learning has been cumulative over a 4 year period. Being a skilled communicator is an art and a science and I think I excel in this area through mutual trust and respect. I am results-oriented and an analytical thinker, applying evidence based rationale for all decisions while at the same time considering feasibility and practical applications. I am an agent for change, not only in the state of Alabama but the nation as a whole in terms of the role of boards and NCSBN in determining models of nursing regulation. This is a very important attribute for a leader in nursing regulation. I am committed to service and always have been; service is my passion and my experiences with my board and especially NCSBN has been most rewarding in terms of intellectual stimulation, visionary colleagues, self-actualization, and leadership effectiveness. Finally, I have personal integrity and require the same of others in an open and honest collaborative relationship. As I hopefully continue to serve as a board member for NCSBN, I hope to foster the growth and development of those who will follow me as leaders in nursing regulation.

Date of expiration of term:
Feb. 1, 2016

Eligible for reappointment:
No

Area IV Director

Ann O'Sullivan, PhD, FAAN, CRNP

Board Member, Pennsylvania, Area IV

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

For 43 years, from my diploma to PhD in Educational administration and anthropology. I have loved being a nurse. I am a nationally certified pediatric nurse practitioner since 1978, having completed the prestigious RWJ Primary Care Fellows program at the University of Maryland School of Nursing. This program included clinical preceptorships under Dr. Catherine De Angelis at the Johns Hopkins pediatric clinic and with the Frontier Nursing Service in Hyden, Kentucky. Currently, I practice at The Children's Hospital in Philadelphia and am a fellow in the American Academy of Nursing since 1991. In addition, I am Program Director of a PNP and FHNP program at the University of Pennsylvania and have taught there for 39 years with international teaching experiences in Germany, Great Britain, British Columbia, Canada and Peru. My administrative experience emanates from serving as Division head of the Family and Community Health Department at Penn and achieving the RWJ Executive Nurse Fellowship in 1998. I have been the Primary Investigator on multidisciplinary research teams funded by private foundations and the federal government to study the most effective primary care for teenage parents and their children. I have well established qualitative, quantitative and statistical research skills along with experience in budget development, and management skills for large research grants. From a state regulatory perspective, I have been a member, Vice-President and President of the PA SBON since 2004. From a national perspective I have been a delegate to the NCSBN and chair of the APRN committee. These experiences have enhanced my appreciation and knowledge of regulation. I am passionate about working with nurses and in collaborating with legislators and government agencies locally, regionally, and nationally to improve safe and effective primary care.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The two top challenges to nursing regulations are to: 1. maintain a safe and effective nursing work force and 2. assist states in Area IV implement one to two recommendations from the Future of Nursing report. To accomplish this, one strategy is to use evidence based models to support programs that empower nurses (such as negotiation classes) to lead change for safe and effective care for their patients while creating safe, effective practice environments. Another strategy is early recognition of substance abuse by nursing colleagues and effective utilization of voluntary recovery programs (VRP), including how to access them and feel supported rather than punished. Some nursing practice errors could end the career of a great nurse and need to be addressed through effective remediation strategies committee (such as the PA PERC Program) rather than discipline. As a nurse practitioner and educator it is clear that an educational campaign to facilitate all nurses understanding of the initiatives related to The Future of Nursing is key to the report's recommendations and successful implementation. In addition, it is necessary to promote collaboration between educational and practice institutions to effectuate this along with support from key external stakeholders like AARP, Robert Wood Johnson Foundation, Federal Trade Commission and state coalitions.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I have demonstrated the ability to effectively embrace diversity and build consensus among groups of individuals through finely developed listening and negotiating skills. As a department head or president of a professional organization I have led groups in strategic planning and outcome evaluations. I have also had experience in responding to outside evaluations done by students (EBI) of my educational offerings or participants in continuing education programs. I know how to implement revisions to improve a process or content when needed. Each week at Penn I am presented with opportunities to bring NCSBN Model Rules and Regulations to countries outside the USA. Most recently Japan sent nursing leaders to see how to build the regulatory, accreditation, certification and education model for APRN's in their country. They seek me out for advice due to my successful work with NCSBN on regulation and NONPF on curriculum seeing that my programs are rated so high by *U.S. News and World Reports*. Regulations and all of the new national interest in differences and similarities across states and territories continues to intrigue me and offers me opportunities to grow. Many states are having conflicts across professions and have begun to use interdisciplinary task forces with public members to iron out differences before moving legislation to professional licensing committees of the House and Senate. Each of these areas are examples of how I can contribute to NCSBN as well as through my competency related to development, management and adherence to financial budgets; and my appreciation for the framework of regulation in its purpose and complexity. Of course, I have made mistakes, but being open to feedback has saved me each and every time from a greater calamity. I believe I can advance NCSBN's role while staying true to NCSBN's mission.

Director-at-Large

Betsy Houchen, JD, MSN, RN

Board Staff, Ohio, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I have been Executive Director of the Ohio Board of Nursing since September 2005. Prior to that, I was Associate Executive Director and a Staff Attorney for Discipline. My involvement with NCSBN began by attending meetings and serving as an Alternate Delegate and a Delegate for Ohio at the NCSBN Annual Meeting and Delegate Assembly. For the last four years, I have served as Area II Director on the NCSBN Board of Directors and as the Board Liaison to Committees. I have also regularly participated in NCSBN meetings and conferences each year. Through my work at the state board level and with NCSBN, I have demonstrated a commitment to NCSBN's mission, services, policies and programs. Prior to working for the Ohio Board of Nursing, I practiced as a health care attorney for two large law firms; served as Regulatory Counsel and legislative lobbyist for a state trade association; worked as a consultant for a national trade association; authored a health care compliance manual and contributed to an administrative law book; served as a Bureau Chief at the Ohio Department of Health with responsibilities of regulating adult care facilities, home health agencies, hospice care programs, and other health care providers; and was Executive Director of a large home health agency and hospice care program. During that time, I was elected to the Boards of the Ohio Council for Home Care and the National Association for Home Care.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

One major challenge to nursing regulation is for Member Boards to demonstrate innovative regulatory practices while at the same time providing for public protection. NCSBN is in a unique position to assist Member Boards by implementing strategies to meet this challenge. We must work together through NCSBN to identify regulatory barriers that can be removed while providing for public protection; focus on services to licensees and the public; implement effective regulatory practices to expedite disciplinary cases; pilot innovative public-private partnerships; and demonstrate actions to improve efficiency and reduce costs. Strategies include NCSBN: (1) promoting regulatory work of Member Boards that provides for public protection through innovative regulation and related practices; (2) continuing to structure its work and activities to build upon the "common threads" that unite all Member Boards; (3) reflecting Member Board issues and concerns through NCSBN establishing committees with clear direction and charges; (4) gathering input and feedback from Member Boards to establish essential regulatory practices. Another challenge to nursing regulation is the threat that the authority of boards of nursing will be weakened due to budget cuts, consolidation, and non-nursing state boards seeking to regulate nursing. Strategies to address the challenge include: (1) developing an even stronger organization by making NCSBN not only an organization "of" state boards of nursing, but also an organization "for" its Member Boards; (2) focusing the resources of NCSBN for research and data collection to provide even more evidence and data that Member Boards have available to address their specific challenges; and (3) conducting legal research and analysis regarding federal laws impacting Member Boards. NCSBN, by taking actions to become even more proactive for Member Boards and providing needed data, evidence, and legal analysis, can assist Member Boards in meeting these challenges and remaining strong in their mission of public protection.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I have over thirty years of experience in leadership positions and distinguished service in the areas of nursing, health care, administration, regulation, and legislation. I have demonstrated an ability to both govern and to lead. My experience spans both the public and private sectors, providing a unique combination of experiences that have proven beneficial in understanding regulatory and legislative issues. My work on the NCSBN Board and on another national board has given me the opportunity to work with other states, various individuals, and differing points of view. These experiences have enabled me to develop a strong ability to facilitate and participate in processes that result in a group consensus to advance organizational goals. I bring personal integrity, honesty, a tolerance and respect of differing viewpoints, and the ability to listen and work well with others. As a nurse attorney I also bring an analytical approach to nursing regulation. I am able to handle large amounts of information, identify the issues, and formulate strategies to reach the vision or objective. I have the ability to critically analyze, and think clearly and creatively. My work experience, education preparation, and skills have prepared me to advance the mission, vision and strategic initiatives of NCSBN. Further, my recent work on the Board will provide for continuity for Member Boards and NCSBN. Having background knowledge of recent Board discussions and direction can provide valuable insight and consistency. I have a proven track record of successful work that advances the public protection work of the organization. It would be an honor to continue to serve on the Board of Directors.

Director-at-Large

Joey Ridenour, MN, RN, FAAN

Board Staff, Arizona, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

Relevant experiences include over 40 years in nursing roles of staff nurse, educator, vice-president of nursing for 500 bed public hospital, board of nursing member and board of nursing executive director. Arizona State Board of Nursing: Executive Director 1995 to present; Board Member/ President 6 years 1984-1989 & 1993-1995; Chair/AzBN Scope of Practice Committee. National Council State Boards of Nursing: Have had the honor to participate in various positions within NCSBN over the past 18 years. Nurse Licensure Compact Executive Committee 2005-2011/ Current Chair; CORE Committee 2007-present; Chair Leadership Advisory Committee/Institute of Regulatory Excellence 2002-2007; President of NCSBN 1998-2002; NCSBN Board of Directors 1995-1998; Finance Committee 1993-1995. Continuously attended NCSBN Annual Delegate Assemblies for the past 18 years. Community Service: Arizona State University/President's Vision Council 2004-present; American Academy of Nursing Fellow 2007-present; Arizona Hospital & Healthcare Association/Member Healthcare Institute 2007-2009; Board Member/University of Arizona Health Sciences Greater Phoenix Leadership Board 2004-2008; National Board of Directors/Family Nurse Partnerships 2004-2008; Arizona State University College of Nursing/ Dean's Advisory Council 2000-2005.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

In searching for evidence to better understand what member boards collectively see as challenges in nursing regulation, the Executive Officer 130+ web surveys were analyzed for the past 2.5 years since the tools inception in September 2008. The two or three broad topic areas surveyed by EO's most frequently and therefore perceived as the most challenging were related to: queries requesting comparative data/information on various board operations, seeking information related to education/accreditation decisions and requesting information/data on disciplinary processes and decisions. The strategies to address the challenges are related to the evolving science of nursing regulation over the past decade or "evidence based regulation". The Commitment to Ongoing Regulatory Excellence (CORE) Committee charges and over arching goal is to inform board operations as we better understand the data and promising practices of high performing boards. With the assistance of NCSBN staff and outside experts in measurement in government, the CORE Committee continues to increase the reliability and value of the reports. The Institute of Regulatory Excellence (IRE) also provides additional opportunities for developing "evidence based regulation", and the core competencies of board members and staff. The current Board of Directors have in the 2011-2013 NCSBN Strategic Plan efforts and resources focused on promoting evidenced based regulation related to education/ accreditation as well as disciplinary processes that will guide Boards in addressing the challenges in these other two critical areas. The greatest challenge for nursing regulation leadership today is that all our experience is with the past, but all our decisions are about the future. What will an ideal board of nursing look like in the 2020? What would the licensing system look like and how would technology assist us in improving regulatory outcomes? "The best way to predict the future is to create it."

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I am inclusive in working with others to advance regulatory excellence. 1. Understand non-profit governance. The Board of Directors fundamental objective is to build a long term sustainable organization to advance a greater "public good". Hold inviolate the purpose for which NCSBN was incorporated in 1985 in the Commonwealth of Pennsylvania: Educational and charitable purposes including the lessening of the burdens of government by providing an organization through which Boards of Nursing act on matters of common interest and concern affecting the public health, safety and welfare including the development of licensing examinations in nursing. 2. Embed the mission of NCSBN into the organizational fabric and understand every major policy decision should emanate and relate to the mission & vision statements. 3. Support the vision outlined by the Board/CEO in the strategic plan. Member Boards/Associates also need to be invested and accountable for strategic thinking and "strategic unity" as the outcomes/products are utilized by the members. 4. Respect, trust and cooperation is the "organizational superglue." 5. Ensure processes are fair and transparent. Learned member boards don't mind if the decisions do not go their way as long as they are heard. 6. Regulatory change is complex and the board/member boards must be prepared to take the long view when progress is slow. 7. Question and debate issues internally/externally and know when to move on. 8. Continually measure the relevance of NCSBN. The Board owes it to themselves & the Member Boards/Associates to measure the impact of proposed & existing programs to judge the "public good" of what we do. 9. NCSBN leaders need to be great synthesizers. Initiate novel ideas or take old/new concepts and put together in new ways. 10. Facilitate distributing leadership throughout NCSBN as we are all the architects of making NCSBN the best it can be.

Director-at-Large

Emmaline Woodson, DNP, RN, FRE

Board Staff, Maryland, Area IV

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I am the Deputy Director of the Maryland Board of Nursing. I have been employed by the Maryland Board of Nursing since 1990. I was hired as the Director for Discipline and Rehabilitation and held that position until spring of 2001. In 2001, I became the Deputy Director and Director for Advanced Practice. I completed the Doctor of Nursing Practice program from the University Of Maryland School Of Nursing in July 2010. I have been involved with the work of the NCSBN since 1994. Having served on various committees and task forces. I was appointed to the APRN Committee in 2008 and served until March 2011, when I appointed as the Director at Large until the elections take place in August 2011. As a member of Board of Directors, I am the liaison to the APRN Committee. I was elected for a two-year term with the Nomination Committee for Area IV in 2006, and served as Chairperson of this committee for the year 2007 – 2008. I participated in the Institute of Regulatory Excellence program and was inducted into the fellowship in August 2008. I have served on the following committees and task forces for NCSBN: Continued Competency, Discipline Advisory Panel, Commitment to Excellence Workshop, Multi-State Regulation Task Force, Chemically Impaired Nurses Task Force, Literature Review Focus, and casted in the video, "Breaking The Habit: When Your Colleague Is Chemically Dependent." My community involvements include the following: Delta Sigma Theta Sorority Youth Group (Delta Academy), Baltimore Tuskegee Alumni Association-Corresponding Secretary, American Red Cross Disaster Nurses group, The Wayland Baptist Church Sunday School Workers Education group, Community Liaison for the Diabetes Association's Annual Fund Raising Drive and the Maryland Nurses Association.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

One of the major challenges is the budget crisis which has affected all of us at both the state and federal levels. Our state government has been affected in the following ways: staff has been given a number of furlough days in the past two years and we have been unable to hire any additional permanent staff. How have we handled this: one innovative way that we used is to automate as many of our systems as possible, however, a number of the licensure and certification requirements are labor intensive. We have also utilized volunteers to assist us with some of the labor intensive process such as filing and putting together endorsement applications that are not yet automated. Our volunteers are all retired nurses. These retired nurses have committed to working with us for several days a week. This has freed the staff from having to do some of the clerical tasks. The second challenge faced by our Board is the regulation of the Advance Practice Nurse. We were successful in making changes in both the nurse practitioner statues and regulations and the nurse midwife regulations, which have decreased the need to have a committee meetings for review of the collaborative agreements. It was expected that the removal of the requirement for a joint committee composed of representatives of both the nursing and medical community would decrease the processes for nurse practitioners to begin their practice. However, the adjustment period will take approximately one year to move all the nurse practitioners from collaborative agreements to the attestation form.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I have over forty years of nursing experience which include twenty years of regulatory nursing experience. I have had progressively responsible positions in my career. I posses a thorough knowledge of the regulatory process and a thorough knowledge of the legislative process which is the basis for our various statues and regulations by which Boards of Nursing operate. I fully support the mission, vision and core values of the NCSBN. I will bring the following abilities to the position of Director at Large: negotiating with stake holders, establishing and maintaining trusting relationships, engaging and motivating others, communicating clearly and concisely, looking at things objectively. I believe these attributes along with my organization skills will serve this office well. I am very passionate about the work of the National Council of State Boards of Nursing and the Boards of Nursing's need to maintain it's over arching goal which is public protection.

Date of expiration of term:
Aug. 31, 2013

Eligible for reappointment:
No

Leadership Succession Committee Designated Member (Board Member of a Member Board)

Patricia Lane, MBA

Board Member, Virginia, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

My leadership roles focus on improving health for the community based on Neuroscience, Health Policy and Advocacy. I am the Neuroscience Coordinator for St. Francis Medical Center and St. Mary's Hospital, a Senior Leadership position within the Neuroscience Division of Bon Secours Virginia Health System. Specifically, I am the clinical program resource for seven Bon Secours hospitals and a free-standing emergency center. Last year I assisted five facilities in becoming Joint Commission Certified Primary Stroke Care Centers. As a result, our health system has the largest number of certified stroke care centers in the state.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

As a board member, the top challenges nursing regulation faces are portability and important recognition of fallibility.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

Core competencies for my position incorporate clinical and professional leadership, ethical decision making, coaching and guidance, direct clinical practice, research, consultation and collaboration.

Leadership Succession Committee Designated Member (Board Member of a Member Board)

Date of expiration of term: June 30, 2014

Eligible for reappointment: Yes

Suellyn Masek, MS, RN, CNOR

Board Member, Washington, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE.

I was appointed to the Nursing Care Quality Assurance Commission in July 2010. Since my recent appointment, I have served as the Chair for Consistent Standards subcommittee and participated as a member of the Legislative, Nominations and Steering committees, as well as reviewing discipline cases and serving on formal disciplinary hearing panels. Other regulatory experiences include membership on the Maryland Commission "The Crisis in Nursing", 2002. I served on Maryland State Retention subcommittee by reviewing data and making recommendations concerning retention issues such as compensation, professional development, mentoring and work place safety. My professional experience consists of 23 years of active duty military service in the United States Army. My military experience is rich and diverse in professional leadership. I have had over 6 months of formal academy instruction on leadership principles as well as countless positions and opportunities both formal and informal to exercise those principles. I have recently retired from the Army with two combat tours in two separate wars. My final position was as the Division Nurse, 25th Infantry Division, Schofield Barracks, HI. This battlefield position would be the equivalent to an executive level position in the civilian community. I was the sole nurse for over 3500 soldiers, with direct training responsibility for 134 combat medics. I was also responsible for developing and instituting procedures to allow enemy detainees access to primary care in Kirkuk, Iraq. Due to the incredibly high operations tempo of military life, my civilian community experience is limited. I did have an opportunity to teach Nursing Leadership as a graduate student, in spring 2002, at The Catholic University of America, Washington, DC, for the undergraduate nursing program. Since retirement, I have been an active member of the Washington State Governor's Mansion Foundation as a docent.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The top two challenges that I see to nursing regulation are regulating nurses taking prescription medications, specifically any Schedule I drug under the Controlled Substances Act, such as medical marijuana while giving patient care. The second challenge is maintaining public safety in healthcare with an increase in the number of consumers due to the Affordable Care Act while State and Federal budgets continue to decrease. Medical Marijuana is legal in my home state of Washington as well as 15 other states including the District of Columbia. This fact necessitates action. The potential strategies I would use to combat this issue are performing a critical assessment at a national leadership level from a nursing regulation, discipline and public safety perspective. I believe we also need to develop an evidenced based regulatory model for nursing practice concerning the use of Scheduled I prescribed medications and perhaps other classifications of prescribed medications. The Department of Transportation and the Federal Aviation Administration already have regulation concerning the use of these drugs by employees and their effect on public safety. The NCSBN could take a proactive leadership approach to collaborate with these other governmental agencies for guidance on this issue. I see public safety and protection as the paramount focus of the NCSBN. To maintain this focus with an increase in healthcare consumption and a decrease in funding will take a multifaceted strategic approach. I would like to expand the Nursys® database to include all states and territories of the United States. I would also like to add advanced practice nurses, nurse aides and other ancillary health care providers to this system through collaborative leadership with other regulating bodies.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I have many leadership competencies in my personal tool kit to bring to Leadership Succession Committee table. The military provided such wonderful opportunities for me to be tested as a leader. I have faced many seemingly impossible situations in my career which forced me by necessity to become a creative problem solver. I have an intimate understanding of hierarchal organizations, team building skills and focusing on mission, vision and values. I am also very adaptable and flexible when the mission changes. This experience has given me the confidence to step outside my comfort zone and volunteer to serve despite the fact that I am a novice member of the Washington Nursing Care Quality Assurance Commission. I have spent my entire adult life living the Army values of Loyalty, Duty, Respect, Selfless Service, Honor, Integrity and Personal Courage and have been evaluated on these values annually. These values mirror the values of NCSBN making the transition seamless. Currently, I am actively working as a part-time operating room nurse. I see the daily challenges nurses face regarding standardization. I feel the constant tension between medicine and nursing while advocating for patient safety. I understand how difficult it is to change the culture of a group, whether it is through collaboration with other professionals or other cultures. I do have a personal global perspective on many issues facing the human condition thanks to my diverse experience and travel. Because I am just starting my journey into the world of nursing regulation, the biggest contribution I have to offer is the willingness to serve and a motivation to learn.

Leadership Succession Committee Designated Member (Current or Former NCSBN Committee Chair)

Mark Majek, MA, PHR

Board Staff, Texas, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY, AND COMMUNITY EXPERIENCE

With the National Council of State Boards of Nursing, served four years as the Area III Director, served on the electronic licensure verification committee and currently serve on the Finance Committee. In the State of Texas, currently serve as the Chair of the Small State Agency Task Force and past Chair of the Texas State Human Resource Association. Currently an active member of the St. Paul Knights of Columbus and a member of the St. Paul Finance Committee and serve as a volunteer to the Austin, Texas Marbridge Community serving adults with cognitive challenges.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

Top Challenge number one: Retaining and/or obtaining resources to carry out fundamental regulatory functions. Strategy 1: Continue to augment state resources with NCSBN resources. Strategy 2: NCSBN continues to provide leadership, training and effective regulatory evidence to states. Top Challenge Number two: Finding and recruiting new leadership for the NCSBN from all levels of the organization. Strategy 1: Provide more opportunities for all state boards to interact with the NCSBN. Strategy 2: Reconsider bylaws and have a minimum number of specific slots for different groups within our organization.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

After serving four years as a NCSBN board member, I can bring to the table a sense of commitment and understanding that is needed to serve on the council. Also, I can testify to the fact that any member of our organization has the potential to be a leader, regardless of their credentials.

Attachment B

Essential Competencies for Governance Leadership

Framework for Governance Leadership Positions

The success of an organization and its mission is inextricably tied to the strength of its leadership and leadership resources. Leaders of an organization must possess self-knowledge and governance leadership competencies to successfully guide and advance an organization.

We believe there is a deliberate path to take that will identify and nurture individuals and secure a legacy of leadership at all levels in order to advance and sustain the organization. That path supports the ongoing performance and growth of NCSBN, and includes a defined organizational strategy to leadership succession. It is essential that the organization creates and sustains such a path to develop these leaders.

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;
- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

ESSENTIAL COMPETENCIES

Candidates for NCSBN positions are individuals who possess knowledge of regulation and commitment to the mission, vision and values of NCSBN and who demonstrate:

Self-knowledge

- Honesty, integrity and courage
- Ability to deal with ambiguity and complexity
- Flexibility and adaptability
- Cultural competence: the ability to work effectively cross culturally
- Interpersonal and communication effectiveness

Governance Leadership

- Stewardship, selecting service to the greater good over self-interest
- Strategic and futuristic thinking
- Fiduciary knowledge
- Evidence-based decision making
- Consensus building through strategic alliances, networks and partnerships
- Effective change and risk management, including accountability and transparency
- Diplomatic and politically savvy relationship building
- Creativity and innovation

Attachment C

Leadership Development Plan for FY11

Every calling is great when greatly pursued.

Oliver Wendell Holmes

Advancing Potential – Discover the Leader Within

The success of an organization and its mission is inextricably tied to the strength of its leadership and leadership resources. Leaders of an organization must possess self-knowledge and governance leadership competencies to successfully guide and advance an organization.

BELIEF STATEMENT: PURPOSE OF LEADERSHIP DEVELOPMENT

NCSBN believes there is a deliberate path to take that will identify and nurture individuals and secure a legacy of leadership at all levels in order to advance and sustain the organization. That path supports the ongoing performance and growth of NCSBN, and includes a defined organizational strategy to leadership succession. It is essential that the organization creates and sustains such a path to develop these leaders.

DEFINITION OF LEADERSHIP SUCCESSION

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;
- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

CANDIDATES FOR NCSBN POSITIONS

Candidates for NCSBN positions are individuals who possess knowledge of regulation and commitment to the mission, vision and values of NCSBN. These individuals also demonstrate the following key competencies in the areas of self-knowledge and governance leadership:

Self-knowledge

- Honesty, integrity and courage
- Ability to deal with ambiguity and complexity
- Flexibility and adaptability
- Cultural competence: the ability to work effectively cross culturally
- Interpersonal and communication effectiveness

Governance Leadership

- Stewardship, selecting service to the greater good over self-interest
- Strategic and futuristic thinking
- Fiduciary knowledge
- Evidence-based decision making
- Consensus building through strategic alliances, networks and partnerships
- Effective change and risk management, including accountability and transparency

- Diplomatic and politically savvy relationship building
- Creativity and innovation

LEADERSHIP DEVELOPMENT

NCSBN advances the engagement and leadership potential of all members through education, information and networking (strategic initiative adopted by the 2010 Delegate Assembly).

Purpose

The purpose of leadership development is to cultivate and recognize leadership within the organization to ensure sustained, progressive viability of the organization. The overall goal of the leadership development plan is to build leadership within and throughout the organization, resulting in an ongoing pool of diverse and qualified candidates. Those individuals targeted for leadership development include new and existing board members with leadership skills who may need additional information on board governance and processes, those who are ready to assume NCSBN office, and board staff with demonstrated leadership skills and potential for assuming leadership positions.

Objectives of Leadership Development

The membership will:

1. Establish an early connection to the resources available from NCSBN;
2. Self-assess and identify personal and professional leadership strengths and opportunities for further development;
3. Engage in leadership development activities;
4. Participate in NCSBN committees, networking groups, webinars and meetings; and
5. Consider being a candidate for office.

NCSBN identifies and develops leaders using the following three methods:

1. Early Connectivity. Members engage early on to understand the mission, vision, values and strategic initiatives of NCSBN.
2. Building Self-knowledge – Self-discovery. Members engage in opportunities for enhancing self-knowledge, skills and abilities.
3. Building Board and Organizational Governance Expertise. Members engage in opportunities to build governance expertise.

LEADERSHIP DEVELOPMENT ACTIVITIES

Leadership development activities serve many purposes, including aiding interested individuals in building leadership competence for personal and professional growth, establishing leadership competencies for serving member boards, and serving NCSBN on the Board of Directors (BOD) and/or the Leadership Succession Committee (LSC). The opportunities described below are not an all-inclusive list nor imply mandatory participation.

Method 1: Early Connectivity

- Executive officer notifies the Member Board password administrator and NCSBN Member Relations director of new board members and/or professional staff. NCSBN will then connect the new NCSBN member by:
  - Entering their member information into iMiS membership database;
  - Helping them access resources and networks specific to their role;
  - Identifying mentorship opportunities, including executive officer mentorship;
  - Establishing an interactive online account and ability to sign into online/Web-based services;

- Complete NCSBN 101; and
- Participate in state-specific orientation unique to their role.

Current NCSBN Resources	External Resources	NCSBN Future Resources Identified
▪ NCSBN website ▪ NCSBN Interactive for online courses, podcasts, recorded webinars and streaming videos ▪ NCSBN 101 ▪ NCLEX® 101 ▪ NCSBN Model Act & Rules ▪ President's Governance Role online course ▪ Executive Officer Mentor Program ▪ Connect with Presidents Network ▪ Connect with special interest network ▪ New Delegate Orientation online course ▪ *Council Connector* ▪ iMiS membership database ▪ NCSBN guide to programs, products and services ▪ Attendance at Midyear Meeting and Delegate Assembly ▪ Participation in NCSBN committees ▪ Use of Resource Fund to attend BOD's meeting ▪ Participate in BOD Member Board dial in call ▪ Annotated bibliography on leadership, leadership development references, books and professional journals ▪ New member toolkit	▪ Parliamentary Procedure/ Robert's Rules of Order ▪ Individual state board of nursing (BON) website ▪ Other BON websites ▪ Other professional boards and national entities ▪ Internet search with key words such as nonprofit associations, administrative law, licensing boards, state-based regulation, orientation, mentorship, coaching, leadership, time management or work-life balance	▪ Develop a checklist (or toolkit) for executive officer mentors for new executive officers ▪ Develop education for executive officer mentor on mentoring, including definitions ▪ Create an introduction to the LSC, leadership development pathways and purpose

Method 2: Building Self-knowledge – Self-discovery

- Complete leadership self-assessment(s).
- Create, implement and evaluate an individual leadership development plan.
- Complete a cultural competence assessment.
- Participate in education offerings relevant to leadership development plan.
- Identify specific leadership development activities to support personal and professional goals.

Current NCSBN Resources	External Resources	NCSBN Future Resources Identified
▪ Member Board Resource Fund to support leadership activities ▪ Executive Officer Mentor Program ▪ Institute for Regulatory Excellence (IRE) Fellowship Program ▪ NCSBN *Journal of Nursing Regulation* ▪ Participation on NCSBN committees ▪ Participation in related state or national committees ▪ Participate as appropriate in NCSBN special interest network conference calls ▪ Executive Office and Executive Coaching Service ▪ Develop a "transcript" of leadership development activities	▪ Book and online assessment of Tom Rath's 2007 book, *Strengths Finder 2.0: Now, Discover Your Strengths* (New York: Gallup Press). Contains a code for online assessment of strengths and identifies top five strengths with an explanation of results. Reading the book is recommended, but not required to complete the assessment. ▪ Sigma Theta Tau International (STTI) Honor Society for Nursing offers free courses on leadership development (member log-in is required; www.nursingsociety.org). ▪ Suite 101 offers several free assessments, such as time management or assertive communication skills, as well as information on leadership development skills (http://suite101.com) ▪ Seek out a personal mentor ▪ Seek out a personal mentee	▪ Develop leadership competence assessment support for members ▪ Identify updated available and reliable leadership and cultural competence assessment tools ▪ Develop mentor or coaching program for other types of members (e.g., practice or education consultants, board members) ▪ Develop seminar on mentoring ▪ Develop candidate readiness program on how to know when to run for office; how to manage a campaign; and how to identify campaign strategies (could include taped interviews with former board members) ▪ Develop a check list for readiness ▪ Develop support program to assist members with putting their own leadership development plan together

Method 3: Building Board and Organizational Governance Expertise

- Understand the fundamental governance principles and practices of high performance BONs related to governance structure, philosophy, mission, vision, values, strategic planning, legal and fiduciary responsibility of board members and staff.
- Understand the similarities and differences between the governance of a national nonprofit association and the governance of a state regulatory agency.

Current NCSBN Resources	External Resources	NCSBN Future Resources Identified
▪ Access NCSBN's Annual Environmental Scan Report on identification of regulatory trends (www.ncsbn.org) ▪ President's Governance Role online course ▪ NCSBN Articles of Incorporation and Bylaws ▪ Current NCSBN strategic initiatives and strategic objectives ▪ Review historical BOD decisions and Delegate Assembly resolutions compendium ▪ Review NCSBN financial reports ▪ Review NCSBN Annual Report ▪ Review handout on Legal Role & Responsibilities of NCSBN as a 501(c)(3) ▪ NCSBN Model Act & Rules ▪ Commitment to Ongoing Regulatory Excellence (CORE) program ▪ NCSBN research ▪ NCSBN Resource Fund Policy for external audit(s) ▪ Annotated bibliography on leadership, leadership development references, books and professional journals	▪ There are a number of organizations that provide information and resources to assist nonprofit organizations and regulatory boards. There is information on their websites that can be accessed by members as well as nonmembers. ▪ BoardSource: www.boardsource.org ▪ Council on Licensure, Enforcement and Regulation (CLEAR): www.clearhq.org ▪ Federation of Associations of Regulatory Boards (FARB): farb.memberclicks.net ▪ Board Café: www.blueavocado.org (provides free information for members of nonprofit boards of directors) ▪ Appraise strategic partnerships to advance the mission of the BON or NCSBN BOD	▪ Develop various online governance education courses: · Legal Role & Responsibility of 501(c)(3) · Fiduciary role of 501(c)(3) · Role of board member, executive officer and board staff · Board member expectations · Governance models and philosophy

2011 Report of the Board of Directors

Highlights of Business Activities Oct. 1, 2010 through May 31, 2011

CONTINUITY AND CHANGE

The 2011 Board of Directors (BOD) began the year with 10 returning members, providing continuity and foundational knowledge to the issues, discussion and challenges to be addressed. The positive impact of the board member continuity was evident immediately with new BOD President Myra Broadway at the helm. The experienced BOD got off to a quick start, providing historical knowledge to a wealth of regulatory issues.

This year, the BOD made a purposeful effort to hold generative conversations at every meeting. In the book, *Governance as Leadership*, author Richard Chait reframed the governance work of nonprofit boards of directors by highlighting traditional fiduciary and strategic work, and adding another dimension: generative governance. Chait made the case that the real power of organizations is in generative thinking through collaboration between board members and senior staff. Governance research shows that board members are more satisfied with their board role when generative thinking is as prevalent as fiduciary and strategic board work. The NCSBN BOD agrees. The benefit is having the opportunity for thoughtful, reflective and futuristic discussions that enable the BOD to better anticipate the future and how to strategically position the organization.

Additionally, the BOD continued close monitoring of the dialogue between the BOD and the Nurse Licensure Compact Administrators (NLCA) Executive Committee to address the relational interface between the two organizations. A policy for resolution of concerns from the membership that will be implemented by both organizations was developed by the two groups.

Recommendations to the Delegate Assembly

1. ***Adopt the proposed revision to the Uniform Licensure Requirements (ULRs).***

   Rationale:
   The newly revised ULRs are the result of the 2008 Delegate Assembly Resolution that the 1999 Uniform Core Licensure Requirements be reviewed for currency and relevance. The proposed 2011 revised ULRs will set new national standards for licensure and bring uniformity across all jurisdictions. Adoption of the new ULRs will also demonstrate to external stakeholders, the federal government and consumers that boards of nursing are interested in establishing uniformity and easing the portability of nurses in the U.S. The revised ULRs utilized extensive feedback from the membership and are based on available evidence.

   Fiscal Impact:
   None.

2. ***Adopt the Singapore Nursing Board as an Associate Member of NCSBN.***

   Rationale:
   The NCSBN Bylaws state that an Associate Member is "a nursing regulatory body or empowered regulatory authority from another country or territory." The bylaws require approval of the new membership by the full membership of the Delegate Assembly. The current application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, the new associate member will pay a $1,500 annual fee.

Members

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

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP
Treasurer, Idaho, Area I
(August 2010-February 2011)

Julia George, MSN, RN
Treasurer, North Carolina, Area III
(appointed February 2011);
Area III Director
(August 2009-February 2011)

Kathy Malloch, PhD, MBA, RN, FAAN
Area I Director, Arizona

Betsy Houchen, JD, MS, RN
Area II Director, Ohio

Pamela Autrey, PhD, MBA, MSN, RN
Area III Director, Alabama
(appointed February 2011);
Director-at-Large
(August 2009-February 2011)

Pamela McCue, MS, RN
Area IV Director, Rhode Island

Katherine Thomas, MN, RN
Director-at-Large, Texas, Area III

Debra Scott, MSN, RN, FRE
Director-at-Large, Nevada, Area I

Julio Santiago, MSN, RN, CCRN
Director-at-Large, Illinois, Area II

Emmaline Woodson, DNP, MS, RN, FRE
Director-at-Large, Maryland, Area IV (appointed February 2011)

Staff

Kathy Apple, MS, RN, FAAN
CEO

Kate Jones
Manager, Executive Office

Board Meeting Dates

- Sept. 8-9, 2010
- Oct. 7, 2010
- Dec. 7-10, 2010
- Feb. 14-16, 2011
- May 11-13, 2011
- May 23, 2011

3. ***Adopt the College of Registered Nurses of Nova Scotia as an Associate Member of NCSBN.***

Rationale:
The NCSBN Bylaws state that an Associate Member is "a nursing regulatory body or empowered regulatory authority from another country or territory." The bylaws require approval of the new membership by the full membership of the Delegate Assembly. The current application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

Fiscal Impact:

Upon acceptance, the new associate member will pay a $1,500 annual fee.

FY11 Highlights and Accomplishments

COLLABORATION WITH EXTERNAL ORGANIZATIONS

Strategic Partnership Meeting Attendance by BOD and/or NCSBN Staff

- Oregon State Board of Nursing
- National Governors Association Annual Meeting
- National Conference of State Legislatures (NCSL) Legislative Summit
- Annual Meeting of the Southern Legislative Conference
- North Carolina Board of Nursing
- American National Standards Institute (ANSI)
- New Mexico Board of Nursing
- Tri-Council Meeting Report
- International Council of Nurses (ICN) Credentialing & Regulatory Forum
- ICN Observatory on Licensure & Registration
- Nursing Organizations Alliance (NOA)
- National Federation of Licensed Practical Nurses (NFLPN)
- Minnesota Board of Nursing
- National Association for Associate Degree Nursing (N-OADN)
- National Student Nurses Association (NSNA)
- American Association of Colleges of Nursing (AACN) Baccalaureate Meeting
- AACN Spring Annual Meeting
- Federation of State Boards of Physical Therapy (FSBPT)
- National League for Nursing (NLN)
- Council on Licensure, Enforcement and Regulation (CLEAR)
- National Academy for State Health Policy Conference
- APRN Licensure Accreditation Certification Education (LACE) Meeting
- Citizens Advocacy Center (CAC) Meeting
- Federation of Associations of Regulatory Boards (FARB) Annual Forum
- Tri-Regulator Meeting
- Council on State Governments (CSG) Annual Conference
- NCSL Fall Forum

- Nurse Practitioner Roundtable
- National Advisory Council on Nurse Education and Practice (NACNEP)
- The American Organization of Nurse Executives (AONE)
- Federation State Medical Boards Annual Meeting
- National Governors Association Winter Meeting

FINANCE

- The BOD participated in a governance orientation session on nonprofit finance, including financial oversight, objectives, business model, performance outcomes, internal controls, audit, investments, liability insurance and financial statement reports.
- The BOD reviewed and approved the 2010 IRS 990 form.
- The BOD approved the budget proposal for the 12-month period beginning Oct. 1, 2010 and ending on Sept. 30, 2011 (fiscal year 2011 [FY11]).
- The BOD accepted the quarterly financial statements for the periods ending Dec. 31, 2010 and March 31, 2011.
- The BOD accepted the audited financial statements and the independent accountant's report affirming the statements present fairly, in all material respects, the financial position of NCSBN as of Sept. 30, 2010.

GOVERNANCE AND POLICY

- The BOD participated in a new BOD orientation session with a governance consultant.
- The BOD finalized a self-assessment performance action plan to be implemented throughout the year in order to improve the BOD's governance effectiveness.
- The BOD participated in an orientation session with legal counsel on the legal foundations for governance, fiduciary obligations, and roles and responsibilities of the BOD.
- The BOD reviewed and discussed the 2010 Delegate Assembly evaluations. Recommended changes to the 2011 Delegate Assembly were initiated as a result.
- The BOD appointed additional committee members to the Committee to Ongoing Regulatory Excellence (CORE) and Nursing Education Committees.
- The BOD approved direct-assistance funding requests, per policy, for the boards of nursing (BONs) from Wyoming, Wisconsin, New Mexico, Colorado, Texas, South Dakota, Rhode Island, Arkansas, Indiana, Maine and the Northern Mariana Islands.
- The BOD approved the minutes of each preceding BOD meeting.
- The BOD facilitated a dialogue with the membership during all BOD meetings by conference call and/or webinar.
- The BOD reviewed current issues and events in the national and international environment at each meeting, including the Annual Environmental Scan Report.
- The BOD endorsed the Tri-Council Position Statement on Educational Advancement.
- The BOD participated in a report and discussion with Prime Policy Group, a Washington D.C. government relations firm at each meeting.
- The BOD facilitated discussion on generative topics pertinent to the future of nurse licensure, the future of nursing, the role of continued competence, membership committees and a new vision for the future of Nursys®.
- The BOD endorsed the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*.

- The BOD met with Linda Stanger, MSA, chair, Canadian Council for Practical Nurse Regulators, and executive director, College of Practical Nurses of Alberta, on the current status of practical nurse regulation in Canada; the comparability of the Canadian practical nurse licensure examination and the NCLEX-PN®; and the competencies taught in Canadian and American licensed practical/vocational nurse (LPN/VN) education programs that might enable reciprocity of licensure.
- The BOD endorsed the *Substance Use Disorders in Nursing: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs* developed by the 2010 Chemical Dependency Committee.
- The BOD reviewed and revised accordingly the entire NCSBN Board Policy Manual.
- The BOD approved an evaluation tool for assessing regulatory trends from visits made by staff to Member Boards.
- The BOD approved funding for two people from every jurisdiction to attend a two-day conference on the implementation of the Nurse Licensure Compact over the past 10 years and a current review of consumer perspectives on the public protection role of health care licensing agencies.
- The BOD approved funding a review of all Member Board websites from a consumer viewpoint.
- The BOD approved FY12 BOD meeting dates.
- The BOD reviewed and discussed the concepts and process regarding the strategic impact of the Balanced Scorecard and the revision to the Continuous Quality Improvement survey.
- The BOD participated in a governance education session on strategic thinking, results orientation and culture of inquiry principles for highly effective BONs.
- The BOD approved the Tri-Regulator Collaborative purpose statement.
- The BOD approved the content for area meeting agendas.
- The BOD reviewed and discussed the work of the Interface Group, which is composed of three members of the NCSBN BOD and three members of the NLCA Executive Committee.
- The BOD approved a memorandum of understanding outlining collaborative efforts among the nurse regulatory bodies of seven countries.
- The BOD reviewed quarterly progress toward accomplishment of the 2011 strategic initiatives and strategic objectives.
- The BOD began drafting strategic objectives for FY12.
- The BOD conducted a debriefing and evaluation at the end of each meeting.
- The BOD reviewed the annual member evaluations of all committees.
- The BOD determined FY12 committees, charges and appointed chairs to each committee.

TESTING

- The BOD approved a new Pearson Professional Center site in Harlingen, Tex.
- The BOD participated in an education session on the process for developing and determining examination passing standards.
- The BOD approved the revised NCLEX-PN passing standard of -.27 logits. This passing standard will be effective from April 1, 2011 through March 31, 2014.
- The BOD routinely reviewed NCLEX®, Medication Aide/Assistant Certification Examination (MACE®) and National Nurse Aide Assessment Program (NNAAP®) reporting data.

- The BOD reviewed an update on the development and implementation of innovative NCLEX item types.

NURSING REGULATION

- The BOD approved the *NCSBN Public Policy Agenda 2011-2013*.
- The BOD reviewed and discussed the APRN Summit evaluations.
- The BOD reviewed and discussed a white paper on state BON structure.

INFORMATION TECHNOLOGY

- The BOD approved a new service for Member Boards to participate in Nur*sys* for the purpose of licensure database comparison for disciplinary actions, registered sex offenders and the Social Security Death Index.
- The BOD reviewed and discussed the current status of the data integrity project.
- The BOD routinely reviewed Nur*sys* program data.
- The BOD discussed Associate Member participation in Nur*sys*.
- The BOD routinely reviewed NCSBN Interactive Services outcomes.

RESEARCH

- The BOD reviewed and discussed all current research projects.
- The BOD reviewed the current award for research grants through the Center for Regulatory Excellence.
- The BOD reviewed and discussed the Practice & Professional Issues National Employers' Survey.
- The BOD reviewed and discussed the national survey of nursing program simulation use, faculty preparation and clinical replacement.
- The BOD reviewed and discussed the research report on the Analysis of APRN Disciplinary Actions 2009.
- The BOD approved a new research proposal related to continued competence.

Attachment

A. Annual Progress Report, October 2010–May 2011

B. Singapore Nursing Board Associate Member Application

C. College of Registered Nurses of Nova Scotia Associate Member Application

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.

Attachment A

Annual Progress Report, October 2010–May 2011

A. NCSBN promotes evidence-based regulation.

STRATEGIC OBJECTIVE 1

Promote regulatory excellence through a performance measurement system

The Commitment to Ongoing Regulatory Excellence (CORE) Committee requested the continued involvement of a performance measurement expert. In addition to reviewing the fiscal year 2009 (FY09) aggregate and state reports, the expert will lend his expertise to the next round of data collection. His responsibilities will include reviewing and refining the CORE logic model based on the FY09 data collection, as well as reviewing the analysis plan, survey instruments, data collection plan and reports from the FY11 data collection. All work products associated with this next survey will be informed by the current logic model.

STRATEGIC OBJECTIVE 2

Provide models and resources for evidence-based regulation

Guidelines were developed for social and electronic media for patient safety, as well as regulatory decision making related to criminal conduct. Improvements on how Member Boards share and act on disciplinary actions taken by other jurisdictions were recommended. Revisions to the Uniform License Requirements were further refined, and a common licensure application and process were developed. In addition, staff developed an education program regarding the Just Culture Model for the 2011 Midyear Meeting.

Data from Member Boards regarding implementation of education program regulations that result in initial and continued approval were analyzed and presented. Differences between boards of nursing (BONs) requirements and accreditation standards for nursing education programs approved by Member Boards were examined. The current and future purpose and focus of BON approval of nursing education programs were assessed. The NCSBN Model Act and Rules were reviewed and revised as needed.

STRATEGIC OBJECTIVE 3

Identify, communicate and promote collaboration on regulatory issues related to the interface of current nurse licensure models.

Solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions were identified and recommended. Communication processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models were developed. A summit on lessons learned from the implementation of the Nurse Licensure Compact was held. NCSBN staff developed a major communication plan to educate nurses on licensure models in the U.S.

STRATEGIC OBJECTIVE 4

Identify practice breakdown trends reported to Member Boards

Trends were reviewed and implications of TERCAP® data determined. Staff was advised on the implementation and evaluation of changes to the data.

STRATEGIC OBJECTIVE 5

Implement Transition to Practice pilot

Pilot states were selected, state coordinators were named and 25 institutions in each state were identified as part of the implementation process for the Transition to Practice pilot study. A total

of six interactive modules and a study protocol were also developed. Additionally, data was collected for Phase One of the study.

STRATEGIC OBJECTIVE 6

Identify information and data on continued competence

A research proposal to investigate methods and the role of continued competence in safe patient care was developed.

STRATEGIC OBJECTIVE 7

Increase consumer involvement

Consumer groups were engaged to audit Member Board websites and recommend web-site standards.

STRATEGIC OBJECTIVE 8

Increase regulatory knowledge data collection and research

The advanced practice registered nurse (APRN) research data were analyzed, reviewed by the BOD and the APRN Committee, and prepared for dissemination. Data from the research study regarding graduates of programs without faculty precepted clinical training were evaluated and stopped due to inference with the subjects that potentially introduces bias into the study. The 2010 licensure and exam statistics were published.

B. NCSBN advances the engagement and leadership potential of all members through education, information and networking.

STRATEGIC OBJECTIVE 1

Increase knowledge of regulation

In its continued effort to provide education, information sharing and networking opportunities in support of its members, NCSBN offered a myriad of resources aimed at strengthening and developing its membership. Members were invited to participate in the Institute for Regulatory Excellence (IRE) Annual Conference; Executive Officer's Summit; Midyear Meeting Leadership Conference for executive officers and Member Board presidents; Attorney/Investigator Conference; IT Conference; NCLEX® Conference; and NCLEX® Regional Workshops. *Leader to Leader, Council Connector, Policy Perspectives* and the *Journal of Nursing Regulation* were published as scheduled.

Member Boards were also encouraged to participate in numerous networking opportunities available, which included NCLEX® Webinars, the APRN Roundtable and networking sessions at Midyear Meeting. Information sharing and networking were also made easier through conference calls in areas such as policy, discipline and practice. Conference calls for education consultants, APRN consultants, executive officers, investigators and TERCAP users were also held.

STRATEGIC OBJECTIVE 2

Develop and promote e-learning opportunities

A course on professional ethics was developed.

STRATEGIC OBJECTIVE 3

Continuous Quality Improvement (CQI) process revised and implemented

The CQI process was revised and will be implemented in the coming fiscal year.

STRATEGIC OBJECTIVE 4

Members are engaged and connected to NCSBN

NCSBN's Leadership Team conducted several onsite visits with Member Boards. New members were also oriented to NCSBN and its resources.

STRATEGIC OBJECTIVE 5

Leadership self-knowledge, governance and regulatory expertise enhanced

Executive Coaching was offered to executive officers. An implementation plan for the Leadership Succession Committee (LSC) Leadership Development was created. The 2011 IRE fellows and mentors were selected, and project proposals and final reports were approved. Staff was advised on issues related to the implementation of the IRE fellowship program. The content of the 2011 IRE Conference was approved and strategies to continue engagement of inducted fellows were explored. Governance courses were identified and proposed, and ongoing governance education was provided to the NCSBN Board of Directors (BOD).

C. NCSBN provides state-of-the-art competence assessments.

STRATEGIC OBJECTIVE 1

NCLEX® development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards' examination needs

Sufficient items for four operational pools were developed. Only valid NCLEX examinations were administered and scored. All NCLEX examinations were administered in accordance with security policies and procedures. Continuous registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) practice analyses were conducted. Areas of innovation in alternate item development continued to be explored and reported to the BOD.

STRATEGIC OBJECTIVE 2

National Nurse Aide Assessment Program (NNAAP®) and Medication Aide/ Assistant Certification Examination (MACE®) development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards' examination needs

Use of the NNAAP and MACE examinations by Member Boards was increased. Sufficient items and skills were built to populate the required number of test forms. Psychometric properties of items, skills and test forms were evaluated.

STRATEGIC OBJECTIVE 3

Explore the use of NCLEX® by other countries and development of an internationally recognized licensing exam

Potential markets continued to be investigated. The BOD met with representatives from Canadian regulatory authorities regarding the use of NCLEX examinations and license reciprocity. NCSBN staff met with another set of Canadian regulatory authorities regarding a comparison of NCLEX knowledge, skills and abilities (KSAs) and Canadian nursing competencies.

D. NCSBN collaborates to advance the evolution of nursing regulation worldwide.

STRATEGIC OBJECTIVE 1

Build North American regional collaborative

NCSBN staff strategized with Canada and the Caribbean Community (CARICOM) to harmonize licensure requirements.

STRATEGIC OBJECTIVE 2

Actively participate in the international regulatory arena

Research partnerships continued to be explored. NCSBN Associate Membership was increased through a focused membership drive. Not only did NCSBN continue to be an active associate member of the European Council of Nursing Regulators (FEPI), but it also supported the organization as needed. A memorandum of understanding was approved to promote active collaboration between and among the nurse regulatory bodies of seven countries.

STRATEGIC OBJECTIVE 3

Promote standards of nursing regulation

NCSBN continued to work towards achieving status as an American National Standards Development Organization.

STRATEGIC OBJECTIVE 4

Collaborate with external stakeholders

The development and collection of a minimum education dataset for use by all relevant nursing education stakeholders including BONs was initiated. A consumer oriented workshop was conducted for the purpose of providing consumer input to Member Boards on current issues. Staff assisted with the APRN Roundtable; APRN Summit; and Licensure, Accreditation, Certification and Education (LACE) meetings. Staff was also advised on how to assist Member Boards with the implementation of the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education. Additionally, the regulatory perspective of the relationship of the model with the doctor of nursing practice (DNP), the three P's (pathophysiology, pharmacology and physical assessment), as well as the definition of the terms lifespan and CORE, in collaboration with LACE and consistent with the model, were described.

E. NCSBN optimizes nursing regulation through efficient use of technology.

STRATEGIC OBJECTIVE 1

Maintain a comprehensive national nurse licensure database

NCSBN continued to support Member Board reporting of disciplinary actions to federal databanks. NCSBN staff investigated the development of a unique identifier for all nurse individuals in Nursys® Web services for the interactive tool, Falsified Identity Tracking System (FITS), were explored. Nursys was enhanced to include approved NCLEX data, international addresses, as well as an investigation tab for all Member Boards per the business requirements provided by the Discipline Resources Committee. APRN data business and system requirements were documented. The Nursys discipline push system was explored and the data services implemented. The Data Integrity Project continued with more than 30 BONs approved for funding.

STRATEGIC OBJECTIVE 2

Develop a national nurse workforce data repository through collaboration

NCSBN continued its partnership with the Forum of State Nursing Workforce Centers and the National Center for Health Workforce Analysis. Member Board data were also submitted.

STRATEGIC OBJECTIVE 3

Explore a licensure management system within Nursys®

The business requirements and functionalities of a licensure management system within Nursys were identified.

Attachment B

Singapore Nursing Board Associate Member Application

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

312.525.3600
www.ncsbn.org

NCSBN Associate Member Application

Applicant Contact Information

Name Ms Pauline Tan Cheng Jee		**Title** Registrar
Phone (65)63259099	**Fax Number** (65)63254969	**E-mail** pauline_tan@moh.gov.sg

Organization Information

Full Name Singapore Nursing Board			**Chief Staff Person** Ms Mun Fun LO
Mailing Address 81 Kim Keat Road, #08-00.			
City Singapore	**State** NA	**Country** Singapore	**Postal Code** 328836
Street Address (if not the same)			
City	**State**	**Country**	**Postal Code**

Phone Number	Fax Number	E-mail	Web site
(65)64785416	(65)63533460	lo_mun_fun@snb.gov.sg	www.snb.gov.sg

Organization Description

1. Please list all the professions your organization regulates:

- Registered Nurses
- Enrolled Nurses
- Registered Midwives
- Advanced Practice Nurses

2. Please list the number of persons regulated (by profession):

- Registered Nurses – 21,575
- Enrolled Nurses – 7,478
- Registered Midwives - 287
- Advanced Practice Nurses - 49

3. Please describe the authority under which your organization regulates:

The Singapore Nursing Board (SNB) is statutory board. It is an autonomous government agency established by an act of Parliament (Nurses and Midwives Act) that specifies the purpose, rights, and powers of the board.

The Ministry of Health (MOH) has policy influence and oversight of SNB through its appointed members. The Minister for Health appoints the members of the Board. In addition, the Registrar of SNB is the Chief Nursing Officer of MOH.

4. Please describe why your organization wants to be an Associate Member of NCSBN:

SNB is the regulatory authority for nurses and midwives in Singapore. Being an associate member of NCSBN will facilitate SNB to learn from a highly regarded and globally recognized regulatory body. The membership will also allow SNB to participate in valuable information sharing, educational sessions, and networking opportunities

5. Is your organization incorporated or not? If yes, are you considered for profit or non-profit?

No

6. Are you a membership organization?

No, SNB is not a member organization. All Board members are appointed by the Minister for Health for their expert knowledge and experience, and they are expected to capably contribute to good regulatory policies. The Board is supported by a team of salaried staff.

7. Are you able to send a copy your Bylaws and Mission Statement? (If so, please submit along with your application)

SNB's scope and functions are defined in the Nurses and Midwives Act[i] for the purpose of registration and enrolment of nurses, the registration of midwives and the certification of Advanced Practice Nurses and related matters.

In addition, its mission, vision, member composition and terms of reference can be accessed from its website at: www.snb.gov.sg

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
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www.ncsbn.org

By signing this application the undersigned understands that, if approved for membership, applicants are required to abide by NCSBN bylaws and the NCSBN Board Policy Manual. Failure to pay annual associate membership fee may result in termination of status. Decisions of the NCSBN Delegate Assembly regarding membership are final.

Ms Pauline Tan Cheng Jee
Registrar, Singapore Nursing Board — 4 Mar 2011

Signature **Title** **Date**

[i] http://statutes.agc.gov.sg/non_version/cgi-bin/cgi_retrieve.pl?actno=REVED-209&doctitle=NURSES%20AND%20MIDWIVES%20ACT&date=latest&method=part&sl=1)

Attachment C

College of Registered Nurses of Nova Scotia Associate Member Application

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

312.525.3600
www.ncsbn.org

NCSBN Associate Member Application

Applicant Contact Information

Name Donna Denney		Title Executive Director
Phone 902-4919744 ext 233	Fax Number 902 491-9510	E-mail ddenney@crnns.ca

Organization Information

Full Name College of Registered Nurses of Nova Scotia			Chief Staff Person Donna Denney
Mailing Address Suite 4005-7071 Bayers Road			
City Halifax	State Nova Scotia	Country Canada	Postal Code B3L 2C2
Street Address (if not the same)			
City	State	Country	Postal Code

Phone Number 902-491-9744	Fax Number 902-491-9510	E-mail sfarouse@crnns.ca (Admin Support) or Info@crnns.ca	Web site www.crnns.ca

Organization Description

1. **Please list all the professions your organization regulates:**

   Registered Nurses and Nurse Practitioners

2. **Please list the number of persons regulated (by profession):**

   Currently Nova Scotia has approximately 10,000 (RNs and NPS) members licensed.

3. Please describe the authority under which your organization regulates:

Nurses in Nova Scotia are regulated under the RN Act (2006) as a separate statute which is governed by a Council of 12 RNs and 6 public representatives. Public representatives are appointed by Council.

4. Please describe why your organization wants to be an Associate Member of NCSBN:

The benefits identified in recent correspondence from the organization are comprehensive and would add significant opportunity for CRNNS to learn from NCSBN. The additional benefit of having access to discipline information is a considerable advantage with the mobility of nurses.

- Invitations to attend NCSBN meetings;
- Access to comprehensive "Members Only" Web site;
- Access to certain areas of the Nursys system containing nurse license and license discipline information provided by boards of nursing;
- Access to a multitude of online course offerings;
- Access to NCSBN publications such as white papers, newsletters and brochures;
- Education, discipline, practice, and policy conference calls.

5. Is your organization incorporated or not? If yes, are you considered for profit or non-profit?

CRNNS is a not-for-profit incorporated entity since 1910, the oldest regulatory body regulating nurses in Canada.

6. Are you a membership organization?

No we are not a membership organization. We regulate the practice of nursing in the public interests.

7**. Are you able to send a copy your Bylaws and Mission Statement? (If so, please submit along with your application)**

RN Act, Regulations, By-Laws and Mission, Vision, Ends statement attached

By signing this application the undersigned understands that, if approved for membership, applicants are required to abide by NCSBN bylaws and the NCSBN Board Policy Manual. Failure to pay annual associate membership fee may result in termination of status. Decisions of the NCSBN Delegate Assembly regarding membership are final.

Donna T Rennecy	Executive Director	March 24, 2011
Signature	Title	Date

Section II

2011 NCSBN Annual Meeting

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Informational Reports

Report of the Uniform Licensure Requirements and Portability Committee

Recommendation to the Delegate Assembly

Adopt the proposed revision to the Uniform Licensure Requirements (ULRs).

Rationale:

The newly revised ULRs are the result of the 2008 Delegate Assembly Resolution that the 1999 Uniform Core Licensure Requirements (UCLRs) be reviewed for currency and relevance. The proposed 2011 revised ULRs will set new national standards for licensure and bring uniformity across all jurisdictions. Adoption of the new ULRs will also demonstrate to external stakeholders, the federal government and consumers that boards of nursing are interested in establishing uniformity and easing the portability of nurses in the U.S. The revised ULRs utilized extensive feedback from the membership and are based on available evidence.

Background

In 1999, NCSBN undertook a major initiative to develop minimal licensure requirements. The goal was to set minimal standards, as well as provide a uniform set of requirements for adoption across all jurisdictions. Upon recommendation by an appointed committee and approval of the NCSBN Board of Directors (BOD), the 1999 UCLRs were adopted by the Delegate Assembly. Enactment by individual boards of nursing (BONs), however, varied to wide degrees. As defined by the 1999 committee, the UCLRs were minimal requirements for BONs. This gave BONs the flexibility to adopt the requirements in many ways, often adding further requirements if their state chose to do so. As a result, many variances emerged and uniformity was not achieved.

During the 10 years that followed, both intrinsic and extrinsic environmental factors have affected the nursing profession. Workforce shortages, a technological boon that rapidly advanced the capabilities of telehealth and globalization, among other factors, have impacted health care delivery and have stakeholders requesting uniformity among state nursing laws and regulations, especially in regards to licensure.

During the 2008 Delegate Assembly, a resolution was passed requesting that the UCLRs be reviewed and updated. In response, the current Uniform Licensure Requirements and Portability (ULR) Committee was established. The committee was originally made up of 10 members: five from compact states and five from noncompact states (although there has been some attrition of members due to various reasons). All four areas of NCSBN are represented on the committee. The committee also consists of members from both umbrella and independent BONs.

The ULR Committee's first set of draft requirements was distributed during fall 2009 to Member Board executive officers and presidents in all jurisdictions. All feedback was carefully reviewed and discussed. Modifications were made based on the Member Boards' feedback and a revised draft was submitted to the BOD in February 2010. The second draft of the ULRs was presented and discussed at the 2010 NCSBN Midyear Meeting. All comments and suggestions were carefully examined and discussed by committee members. Based on this feedback, revisions were made. When the completed document was submitted to the BOD at the May 2010 meeting, the BOD felt as though there was not enough of a consensus by the membership on two issues: (1) whether graduation from a nursing program should be required for licensure; and (2) whether permanent bars to licensure should be required by all states. The BOD requested that the ULR Committee reconvene to find further evidence to support the recommendations related to these issues. In addition, they requested further evidence for removing the ULR functional abilities. The BOD gave the committee an additional charge for fiscal year 2011 (FY11) to develop a common licensure application and process.

The committee has used a variety of resources in its deliberations. It consulted legal counsel; experts in the field of criminal and police psychology and education; thoroughly examined each

Members

Brenda McDougal
North Carolina, Area III, Chair

Karla Bitz, PhD, RN, FRE
North Dakota, Area II

Sue Derouen, RN
Kentucky, Area III

Jennifer L. Filippone
Connecticut, Area IV

Heidi Goodman
California-RN, Area I
(August 2010-January 2011)

Judith Nagel, MS, RN
Idaho, Area I

Barbara Newman, MS, RN
Maryland, Area IV

Katherine Thomas, MN, RN
Texas, Area III, Board Liaison

Staff

Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Oct. 11-12, 2010
- Dec. 6, 2010
- Jan. 5-6, 2011
- Feb. 24-25, 2011
- March 16-17 2011

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

Strategic Objective 2
Provide models and resources for evidenced-based regulation.

state's requirements, as well as variances; considered all comments made at the 2008 UCLR Conference (two members of every BON were invited and sponsored by NCSBN to attend); and considered all feedback provided at the 2010 and 2011 NCSBN Midyear Meetings. In summary, the following resources were used by the committee:

a. 1999 UCLRs;

b. 2008 UCLR Survey to Member Boards;

c. Comments, feedback and concerns that emerged from the small-group breakout sessions at the 2008 UCLR Conference;

d. Positions of the NCSBN Delegate Assembly and BOD that relate to licensure;

e. State information on criminal background checks and fingerprint systems, including the Rap-Back System;

f. Americans with Disabilities Act (ADA);

g. NCSBN Member Board Profiles;

h. An action plan from NCSBN and the Nurse Licensure Compact Administrators (NLCA), which emerged from the 2008 focus groups; and

i. Scientific literature.

For a complete list of references, see Attachment C.

Expert consultation was provided by Victoria Priola Surowiec, PsyD, director of Police Psychology, Adler School of Professional Psychology; Stephen Griffin, PsyD, police and public safety psychologist; Thomas Abram, JD, attorney at law, Vedder Price; Nathan Goldman, JD, general council, Kentucky Board of Nursing; and Karen Holm, PhD, RN, FAAN, professor of nursing, DePaul University.

Highlights of FY11 Activities

FY11 charges:

1. Further refine the proposed revisions to the ULRs.
2. Develop a common licensure application and process.

The following is a comprehensive summary of the committee's accomplishments in meeting these charges:

FURTHER REFINE THE PROPOSED REVISIONS TO THE ULRS.

During FY11, the committee focused primarily on the three licensure requirements that the BOD asked it to review and reconsider:

- Licensure with or without graduation;
- Criminal bars to licensure or case-by-case decisions; and
- Assessment of functional ability prior to licensure.

The following summarizes the committee's decision in each of these areas:

Licensure with or without graduation

While there was no hesitancy on the part of any committee member to recommend that an applicant graduate must receive a degree from a nursing program (or have completed all requirements for the degree/graduation) prior to taking the NCLEX®, it was incumbent upon the committee to take newer models of nursing education into consideration when developing the ULRs. The programs that were of greatest concern to the committee were the 65 direct entry generic master's programs that do not award a degree prior to having students take the NCLEX and obtain licensure. These are nursing programs for non-nurses holding a degree from another discipline. These Member Board-approved programs begin with prelicensure registered

nurse (RN) studies and students continue on through the master's portion of the program without being awarded a bachelor's degree. Schools are unable to award a bachelor's degree at the time the prelicensure portion of the program is completed (for varying logistical reasons); however, they request that students be allowed to take the NCLEX and receive RN licensure if the NCLEX is successfully completed so they can partake in advanced level clinical rotations during the master's portion of the program. Upon program completion, these students are awarded a master's degree. While there are cases where students drop out of the program after receiving an RN license, the majority go on to finish the program (Fitzgerald Miller, & Holm, 2011). In addition to taking an in-depth look at these programs and weighing the consequences of making an exception for these students, the committee also reviewed data from a Member Board survey that focused on these programs. It spoke directly with Holm, one of two principle investigators on a study that specifically looked at the direct entry generic master's programs from a national perspective. The committee concluded that there is no evidence of any higher rates of discipline or other issues related to public protection with these licensees. In keeping with the Institute of Medicine's *The Future of Nursing, Leading Change, Advancing Health* report, the committee wanted to support innovation, advanced education and did not want to place unnecessary regulatory barriers on programs that had excellent reputations. This issue was discussed in Area Meetings at both the 2010 and 2011 NCSBN Midyear Meetings and based on feedback, the committee is recommending the following ULR:

Graduation or eligibility for graduation from a Member Board-approved RN program.

The committee added one exception for students enrolled in a second-degree generic master's program: *Successful completion of all prelicensure nursing courses with attestation from program director or dean.*

Criminal bars to licensure or case by case decisions

The committee studied the literature regarding this subject and consulted two of the leading experts in this field, Priola Surowiec and Griffin. Both have an expertise in the area of criminal and police psychology. The experts pointed the committee to an abundance of data in psychology literature, which provides evidence that licensure decisions should be made on a case-by-case basis. There are numerous factors that can predict whether the individual is likely to recidivate and for this reason, the committee recommended that BONs use evidence-based criteria to make licensure decisions. The experts drew the committee's attention to one very important exception: there is a plethora of scientific evidence that sexual predators and pedophiles should never be licensed. They stated that the recidivism rates for these diagnoses is near 100 percent and these individuals pose a major risk to public safety. They recommend that any individual charged with a sexual offense be evaluated by a BON-approved qualified expert. Any individual diagnosed as a sexual predator or pedophile should be barred from licensure. For this reason, the committee has proposed the following ULR for initial, renewal, reinstatement and endorsement licensure:

Assessment of all misdemeanor convictions, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure on a case-by-case basis to determine board action.

Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure.

Assessment of functional ability prior to licensure

The committee recommends elimination of a ULR related to functional ability. This was determined by reviewing the ADA, several studies related to this topic and consultation with Abram, legal counsel for NCSBN. Goldman, legal counsel for the Kentucky of Board of Nursing, was also consulted. It was the opinion of both attorneys that a question regarding functional abilities should

not be asked on a licensure application. The committee concurred with this recommendation and the discussion was summarized in a memorandum by Abram (see Attachment C).

DEVELOP A COMMON LICENSURE APPLICATION AND PROCESS

The committee has developed a draft licensure application; however, the committee is aware that the ULRs need to be adopted by the Delegate Assembly first. Any changes to the ULRs by the Delegate Assembly will warrant changes in the application (see Attachment D). The committee does not feel this work is completed and did not have an opportunity to develop a common licensure process.

Future Activities

1. Based on the knowledge the committee has acquired, it recommends that the BOD convenes an expert panel (as with the Chemical Dependency Committee) to develop a set of guidelines for BONs to use in the evaluation of criminal convictions.
2. The committee requests reappointment in order to complete the second charge: develop a common licensure application and process.
3. An additional new charge is also recommended: develop toolkit for implementation of the ULRs.

Attachments

A. References

B. 2011 Uniform Licensure Requirements (ULRs)

C. Licensure Decisions Based on Functional Abilities Memorandum

D. Draft of Common Licensure Application

Attachment A

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Attachment B

2011 Uniform Licensure Requirements (ULRs)

ULRs are the essential prerequisites for initial, endorsement, renewal and reinstatement licensure needed across every NCSBN jurisdiction to ensure the safe and competent practice of nursing.

ULRs protect the public by setting consistent standards and promoting a health care system that is fluid and accessible by removing barriers to care and maximizing portability for nurses. They also assure the consumer that a nurse in one state has met the requirements of nursing in every other state. ULRs support the fact that the expectations for the education and responsibilities of a nurse are the same throughout every NCSBN Member Board jurisdiction in the U.S.

It is recommended that NCSBN Member Boards unite in a common goal of adopting the ULRs into their state/territorial practice act/regulations by 2016.

A. 2011 Initial Licensure			
1999 UCLR Education Requirement: RN	**1.A. 2011 Nursing Education Requirements: RN**		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
Graduation from or verification of completion and eligibility for graduation from state-approved registered nurse (RN) program.	▪ Graduation or eligibility for graduation from a Member Board-approved RN program.* *For students enrolled in a second-degree generic master's program, successful completion of all prelicensure nursing courses with attestation from program director or dean is required.	▪ Verification of graduation or eligibility for graduation from a Member Board-approved RN program	1. Language changed to "Member Board," as defined in the ULR definitions, to include all jurisdictions. 2. This requirement applies to full members of NCSBN only, not associate members, as defined by NCSBN. 3. Graduation has been added as a defined exit point and assures the public that all requirements are met. 4. Eligibility for graduation refers to applicants who have completed the entire RN program, fulfilled all requirements for graduation and are awaiting the official conferral of the degree by the school.

*Member Board-approved also applies to states in which the nursing program approval is done through another state agency such as the Commission on Higher Learning.

Administrative code regulations such as child support, payment of taxes, school loans, etc., are not included in these licensure requirements as those are state specific and do not solely apply to the BON.

	Applicant Responsibility	Board Duty	Rationale for Change
			5. The exception is made for students from second-degree, generic master's programs. The ULR allows that these students be allowed to take the NCLEX® after they have completed the prelicensure portion of the master's program. There are 65 direct-entry generic master's programs in the U.S. These schools are well established and students have high NCLEX pass rates. Due to varying logistical reasons, these programs are unable to award a degree at the time the prelicensure portion of the program is completed; however, students enrolled in these programs need an RN license in order to complete the second half (master's portion) of the program. There is no evidence that allowing these students to take the NCLEX and be licensed as RNs prior to completing the master's portion of the program poses any risk to the public.

1999 UCLR Education Requirement: LPN/VN	2.A. 2011 Nursing Education Requirements: LPN/VN		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
Graduation from or verification of completion and eligibility for graduation from state-approved licensed practical/vocational nurse (LPN/VN) program.	▪ Graduation or eligibility for graduation from a Member Board-approved LPN/VN program.* *Graduates from RN programs who wish to take the NCLEX-PN® must successfully completed a Member Board-approved LPN/VN role delineation course.	▪ Verification of graduation or eligibility for graduation from a Member Board-approved LPN/VN program	1. New language is inclusive of applicants from two-step or ladder programs; however, it will require that these programs confer a certificate or degree to their students once they have completed the LPN/VN requirements of the program in order for the students to be eligible for licensure. 2. This eliminates the requirement that an RN-prepared applicant would have to first fail the NCLEX- RN® exam prior to sitting for the NCLEX-PN exam. 3. Allowing graduates from RN programs to take the NCLEX-PN assists these individuals, as well as the workforce. There is no evidence which supports or reflects an increase in discipline or practice issues when RNs are allowed to work as LPN/VNs. They should however, complete a role delineation course. RN and LPN/VN roles are distinct and individuals wishing to practice in those roles must have a complete understanding of the role and scope of practice. 4. Military Corpsman programs are NOT equivalent to LPN/VN programs and graduates from these programs should not be considered eligible for LPN/VN licensure

*Member Board-approved also applies to states in which the nursing program approval is done through another state agency such as the Commission on Higher Learning.

Administrative code regulations such as child support, payment of taxes, school loans, etc., are not included in these licensure requirements as those are state specific and do not solely apply to the BON.

1999 UCLR Education Requirement for Foreign-Educated Candidates: RN	3.A. 2011 Nursing Education Requirements of International Candidates: RN		
Graduation from nursing programs comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	▪ Graduation from a nursing program comparable to a Member Board-approved RN program.	▪ Verification by a credentials review of graduation from a nursing program comparable to a Member Board-approved RN program.	1. Revision requires graduation from a nursing program. In foreign nursing programs, "program completion" may have different meanings. Graduation is a defined exit point and universally understood. This change will help ensure that nursing education of foreign graduates is consistent across jurisdictions, will make verification easier and may decrease the number of fraudulent applicants. 2. "Comparable" is used to maintain consistency with credentials review agency. 3. The committee considered adding the language that the program must meet the criteria/standards of the country of origin, however, the credentials review agency checks on whether the school has been approved/ accredited by the authority over nursing education or licensure in the country of education.
1999 UCLR Education Requirement for Foreign Educated Candidates: LPN/VN	**4.A. 2011 Nursing Education Requirements of International Candidates: LPN/VN**		
Graduation from nursing programs comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	▪ Graduation from a nursing program comparable to a Member Board-approved LPN/VN program.	▪ Verification by a credentials review of graduation from a nursing program comparable to a Member-Board approved LPN/VN program.	1. Same as 3.A.

1999 UCLR NCLEX® Requirements	5.A. 2011 NCLEX® Requirements		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
▪ U.S. Candidates-RN: NCLEX-RN, unlimited attempts. ▪ U.S. Candidates-LPN/VN: NCLEX-PN, unlimited attempts ▪ Foreign-educated Candidates-RN: NCLEX-RN, unlimited attempts. ▪ Foreign-educated Candidates-LPN/VN: NCLEX-PN, unlimited attempts.	▪ Successful completion of the NCLEX-RN or NCLEX-PN.	▪ Verification applicant successfully completed NCLEX-RN or NCLEX-PN.	1. The number of attempts allowed for a candidate to take the exam should be an individual state decision. Currently, there is no evidence that shows unlimited attempts affect patient safety. In addition, unless a state checks the number of NCLEX attempts by an applicant and sets a limit for endorsement, it does not affect portability. 2. There is no chance that multiple attempts will allow a candidate the opportunity to pass because they have had prior exposure to test questions. If one person takes the exam multiple times within a year, they will see unique items each time. After one year, questions are rotated off.

1999 UCLR Additional Requirements for Foreign-educated Nurses	6.A. 2011 Additional Requirements for Foreign-educated Candidates		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
▪ Foreign-educated RN Candidates: Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English. ▪ Foreign educated LPN/VN Candidates: Credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.	▪ Self-disclosure of nursing licensure status in country of origin, if applicable. ▪ Successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.	▪ Verification of nursing licensure status in country of origin, if applicable. ▪ Verification of successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.	1. Licensure in the country of education is not required; however, if the nurse has been licensed in the country of origin, the board of nursing (BON) should determine whether the license has ever been disciplined. 2. The English proficiency requirement was changed to include four English language testing components. This provides for additional public protection and makes the requirements consistent with the government's minimal eligibility requirements for an occupational visa. 3. Credentials review has been placed under 3.A and 4.A.

1999 UCLR Criminal Background Check Requirements: RN and LPN/VN	7.A. 2011 Additional Public Protection Requirements: Criminal Background Check		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
Self-report regarding all felony convictions and all plea agreements, and misdemeanor convictions of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports. BONs should require psychological evaluation for all sexual offenders by a qualified expert approved by the BON.	▪ Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld). ▪ Submit state and federal fingerprint checks	▪ Assessment of all misdemeanor convictions, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure on a case-by-case basis to determine board action. ▪ Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure.	1. Expanded to provide BONs with maximum information to make licensure decisions regarding all violations of the law. 2. Numerous scientific studies support this requirement. In addition, the requirement is based on the recommendation provided by two nationally recognized experts in the field of criminal psychology.

1999 UCLR Chemical Dependency and Functional Abilities Requirements: RN and LPN/VN	8.A. 2011 Additional Public Protection Requirements: Substance Abuse		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
▪ Chemical Dependency: Self-report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care. ▪ Self-report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.	▪ Self-disclosure of any substance use disorder in the last five years.	▪ Verification of any applicant for licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely.	1. After reviewing the Americans with Disabilities Act (ADA) and in consultation with legal counsel, it was determined that licensure decisions based on self-disclosure regarding physical disabilities is impractical due to the many different practice settings and differing physical demands for each setting. Basing licensure on this information would require BONs to assess the individual, the functional ability deficit and the accommodations that may or may not be needed. The employer is in the best position to determine whether a nurse can function safely in a particular role and setting. 2. According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends BONs inquire about drug or alcohol use that is limited to the last five years.

1999 UCLR Other Licenses, Certifications and Registrations Requirements: RN and LPN/VN	9.A. 2011 Additional Public Protection Requirements: Other Licenses, Certifications and Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification.	▪ Verification of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.	1. This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.

B. 2011 Renewal/Reinstatement Requirements			
	1.B. 2011 Criminal Background Check		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of all misdemeanors and/or felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON.	▪ Verification of all misdemeanors, felony convictions and/or plea agreements (even if adjudication was withheld) not previously reported to the BON for determination of eligibility for renewal or reinstatement of licensure. ▪ State and federal fingerprint checks using automatic criminal background feedback system (such as Rap-Back). ▪ Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure renewal or reinstatement. ▪ Examine all other cases on an individual basis	1. Recommendation adds state and federal fingerprint checks for renewal. This recommendation takes into account future technology of fingerprint and criminal background check systems that will allow for automatic feedback to BONs when a licensee is convicted of a crime at any point in their career (i.e., Rap-Back) system. This will give real-time data to make accurate licensure decisions on behalf of public protection. It is anticipated that the cost will decrease with development and adoption by BONs. This requirement would move the current criminal background check system forward. Fingerprints would be taken at application for initial, renewal or reinstatement of licensure and stored. If a nurse has a criminal violation, the BON would be automatically notified. See NCSBN Model Practice Act Article. 6 § 3. 2. Numerous scientific studies support this requirement. In addition, the requirement is based on the recommendation provided by two nationally recognized experts in the field of criminal psychology.

	2.B. 2011 Substance Abuse		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any substance use disorder in the last five years.	▪ Verification of any applicant for renewal or reinstatement of licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely.	1. According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends BONs inquire about drug or alcohol use that is limited to the last five years.
	3.B. 2011 Nursing Disciplinary Actions		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any Member Board action taken on a nursing license or current/ pending investigation by a Member Board.	▪ Verification of any Member Board action taken on a nursing license or current/ pending investigation by a Member Board. ▪ Check Nursys® for discipline in other jurisdictions.	1. This requirement has been added to ensure that any nursing disciplinary action will be identified and considered prior to renewal/reinstatement of licensure.
	4.B. 2011 Other Licenses, Certifications and Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.	▪ Review of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON and consideration of the individual's ability to practice nursing safely.	1. This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.
	C. 2011 Endorsement Requirements		
	1.C. 2011 Education, Exam and Licensure Verification		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Completion of a Member Board-approved professional nursing or practical nursing education program. ▪ Successful passage of the NCLEX/State Board Test Pool Exam. ▪ Self-disclosure of participation in an alternative to discipline program in any jurisdiction.	▪ Verification of education. ▪ Verification of successful passage of the NCLEX/ State Board Test Pool Exam. ▪ Verification of all nursing licenses.	1. Verification of nursing licensure has been added to determine whether a license from any state has an encumbrance, discipline or pending investigation.

	2.C. 2011 Criminal Background Check		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).	▪ Verification of all misdemeanor and/or felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure. ▪ State and federal fingerprint checks. ▪ Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure ▪ All other convictions should be determined on a case-by-case basis.	
	3.C Substance Use Disorders		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any substance use disorder in the last five years.	▪ Verification of any applicant for licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely.	1. According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends boards inquire about drug or alcohol use that is limited to the last five years.
	4.C Other Licenses, Certifications and Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.	▪ Verification of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.	1. This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.

Attachment C

Licensure Decisions Based on Functional Abilities Memorandum

ATTACHMENT C

MEMORANDUM

TO: Uniform Licensure Requirements Committee and Maryann Alexander

FROM: Thomas G. Abram, NCSBN Legal Counsel

DATE: Janaury 19, 2011

RE: ADA Compliance of Licensure Application Questions Relating to Mental or Physical Conditions

As part of its review of core licensure requirements, the Uniform Licensure Requirements Committee has been reviewing the appropriateness and legality of license application questions that inquire into an applicant's mental or physical condition. The legal consideration centers on such questions' compliance with the Americans with Disabilities Act ("ADA"). Materials reviewed by the Committee gave somewhat conflicting advice as to the extent to which boards of nursing could inquire into an applicant's mental or physical condition without violating the ADA.

A. Applicable Law

The ADA prohibits discrimination against an otherwise qualified individual with a disability by any state agency. 42 U.S.C. § 12132. In turn, the United States Department of Justice ("DOJ"), charged with enforcing the ADA in these respects, has promulgated regulations that explicitly prohibit discrimination in the administration of a state licensing program. 28 C.F.R. §§ 35.130(b)(6)-(8). An individual is a "qualified individual with a disability" if he/she meets the essential eligibility requirements for licensure, with or without reasonable accommodation. Fundamentally, a licensing agency may not refuse to license an individual simply because the person has a disability. Nor may an individual be denied licensure based on

generalizations or stereotypes about the effects that a particular disability and/or diagnosis may have on the ability to practice. In particular, 28 C.F.R. § 35.130(b)(8) provides that a state agency may not apply eligibility criteria that screen out individuals with disabilities unless the agency can show the criteria are necessary for licensure. Rather, the ADA requires that the determination that an individual cannot practice safely and effectively because of a disability be based "on an individualized assessment, based on reasonable judgment that relies on current medical evidence or on the best available objective evidence to determine: the nature, duration, and severity of the risk; the probability that potential injury will actually occur; and whether reasonable modification of policies, practices and procedures will mitigate the risk." 28 C.F.R. pt. 35, app. A at 566.

Furthermore, the DOJ ADA regulations prohibit licensure policies or procedures that unnecessarily impose greater requirements or burdens on otherwise qualified applicants for licensure with disabilities than on nondisabled applicants; see 28 C.F.R. pt. 35, app A at 571-72.

Taken together, the statutory and regulatory provisions of the ADA prohibit nursing boards from asking the following open-ended type of question about an individual's record of mental or physical conditions: "Have you ever been treated or diagnosed for any mental, emotional or nervous condition?" Denial of licensure on the basis of a positive response to this type of question would be taking action solely on the basis of an individual's disability or record of disability without any nexus with the ability to practice or consideration of possible accommodations and the courts have found such questions in violation of the ADA. See, e.g. *Clark v. Virginia Board of Bar Examiners*, 880 F. Supp. 430 (E.D. Virginia 1995); *Ellen S. v. Florida Board of Bar Examiners*, 859 F. Supp. 1489 (S.D. Fla. 1994). In so ruling, these Courts relied upon the DOJ's interpretation that 28 C.F.R. § 35.130(b)(8) prohibits state agencies from

imposing unnecessary requirements or burdens on individuals with disabilities that are not placed on others. The courts reasoned that, in asking such open-ended questions and requiring applicants who responded in the affirmative to provide additional medical records and undergo additional investigation, the state licensing boards were imposing additional burdens on applicants with disabilities without a sufficient basis to believe that the individuals may not be fit to practice based on the initial responses to such broad questions. *Jacobs v. Medical Society of New Jersey*, 1993 WL 413016 (D.N.J. Oct. 5, 1993).

Furthermore, the courts have questioned the legality of questions about an applicant's history of mental illness regardless of its remoteness in time, reasoning that a diagnosis or treatment of a mental condition years ago may have little, if any, bearing on an applicant's current fitness to practice. See, e.g. *In re Petition and Questionnaire for Admission to the Rhode island Bar*, 683 A.2d 1333 (R.I. 1996).

To comply with the ADA, a question as to an applicant's mental condition must be tied to the condition's affect on the applicant's current ability to practice safely and effectively. Accordingly, application questions that inquire as to an individual's current mental or physical conditions without limiting the inquiry to those conditions that may adversely affect the individual's ability to practice are likely to be found impermissible under the ADA.

Reliance on the decision in *Applicants v. Texas Board of Bar Examiners*, 1994 WL 923404, at *1 (W.D. Tex. Nov. 11, 1994), as support for asking more open-ended application questions, probably is misplaced. True, this type of question was, indeed, found permissible in the *Texas Bd. of Bar Ex.* decision. However, in rendering its decision, the Court in *Texas Bd. of Bar Ex.* did not even consider whether these questions imposed an impermissible burden on disabled applicants or the applicable DOJ regulations. Furthermore, to the extent the Court

relied on inferences that a diagnosis of bipolar disorder, schizophrenia and other psychotic disorders would likely impact the ability of a nurse to practice safely and effectively, basing an action on such an inference (notwithstanding its perhaps common sense reasonableness) runs counter to the DOJ regulatory requirements of an individual, fact-based assessment of each applicant with a disability.

In subsequent decisions in *Jacobs*, *Clark* and *Ellen S.*, the Courts found such open-ended questions to be insufficiently tailored to the requirements for practice and to impose an impermissible burden on otherwise qualified applicants with disabilities solely because of their disabilities. See also *Doe v. Judicial Nominating Commission*, 906 F. Supp. 1534 (S.D. Fla. 1995).

These decisions are not dispositive, of course, and there has been no federal circuit court of appeals decision on this issue. Therefore, there is no controlling case precedent. In addition, one might argue that an additional inquiry into the medical condition of any applicant who has been diagnosed with such a psychotic disorder is warranted, not based on any generalization regarding the effect of a diagnosed disability on the ability to practice, but to ascertain the treatment plan for the condition, whether the symptoms are under control and whether there is evidence that the applicant is complying with the treatment plan, e.g. taking the necessary medication. No court has had the occasion to consider and rule on such an argument.

However, on balance, the later decisions after *Texas Bd. of Bar. Ex.*, e.g. *Clark* and *Ellen S.*, are more carefully reasoned and take into account the applicable DOJ regulations. Because there have been no decisions on the merits of these types of questions since the late 1990s, these decisions still provide the best available guidance on what types of questions will be found to

comply with ADA.[1] In addition, the DOJ regulations have not been challenged as imposing obligations and restrictions beyond the DOJ's regulatory authority and the requirements of the ADA. The regulations, accordingly, are entitled to the typical weight and deference afforded regulatory interpretations of federal statutes.

B. Recommendations as to Wording of Questions

In sum, the safer course of action and the one most likely to pass muster in an ADA challenge is to limit any application question about mental or physical disabilities to questions inquiring solely into those current conditions that may affect the applicant's present ability to practice safely and effectively. What time period is considered "current" is, of course, somewhat arbitrary without empirical research data on remission, recurrence, efficacy of treatments to control symptoms, etc. However, the courts have upheld questions limited to any diagnosis or treatment within five years of the application. See, e.g. *O'Brien v. Virginia Baord of Bar Examiners*, 1998 WL 391019 (E.D. Va. Jan. 23, 1998); *In re Petition*, *supra*.

In addition, questions that ask whether the applicant has been "diagnosed" or "treated" for a mental condition are more precise and preferable to those that merely ask whether an individual "has had" or "has suffered" a mental condition, etc. The later type of question asks an applicant to self report the person's own judgment of conditions the applicant may not be qualified to diagnose and invites evasive, as well as honest, but uninformed, responses.[2]

[1] A class recently has been certified challenging Indiana state bar application questions similar to those struck down in these earlier cases. See *Perdue v. Indiana Board of Law Examiners*, 266 F.R.D. 215 (S.D. Ind. 2010).
[2] The implication of this analysis is that I generally concur with the article "Do State Medical Board Applications Violate the (ADA)" and conclude that the questions discussed in the December 4, 2006 Ohio Board of Nursing opinion letter run a substantial risk of being found to violate the ADA because the questions fail to tie explicitly the questions to the applicant's current ability to practice. That opinion's reliance on *Texas Bd. of Bar Ex.* is problematic for the reasons discussed above. Also, the application question at issue in *O'Brien v. Vir. Bd. of Bar Ex.*, also relied upon in the Ohio opinion, did expressly tie the question to an applicant's current ability and the Court in *O'Brien* stated that this was the dispositive difference from the questions struck down in *Clark*.

This memo does not address questions relating to physical disabilities. In discussion with the Committee, it was the members' preliminary assessment, in which I concur, that asking questions regarding physical disabilities is impractical due to the many different practice settings and differing physical demands for each setting and that employers were in a better position to assess the ability of a nurse with a physical disability to practice safely in a specific setting, with or without accommodations. The memo also does not address questions inquiring about conditions expressly exempted from ADA coverage such as current illegal use of drugs, compulsive gambling, pedophilia, etc.

Attachment D

Draft of Common Licensure Application

Attachment D

LICENSURE APPLICATION

Complete this application in its entirety. Failure to submit a complete application and fee will delay the approval of your application. Your application will not be approved until **all** requirements have been met and the background check has been completed and processed. Applications are processed in the order that they are received.

SECTION A: Applicant Information

Indicate your legal name as listed on your driver's license or Picture Identification. Discrepancies in name may result in not being able to verify your identity the day of your examination.

Last Name (Print):_____ First Name: _____Middle Name: _____

Previous Name(s):_____Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____
MO Day Year

_____
(Address) (City) (State/Country) (Zip/Postal Code)

_____ (___)_____
(E-mail Address) Phone Number

Gender: [ ] Male **[ ]** Female **Ethnicity: [ ]** African American **[ ]** Asian **[ ]** Caucasian **[ ]** Hispanic **[ ]** Native American **[ ]** Other

SECTION B: Licensure Information

Type of license you are applying for: **[ ]** RN **[ ]** LPN

Name of Nursing Education Program: _____

_____
(City) (State/Province) (Country)

Type of Nursing Program listed above: **[ ]** RN **[ ]** LPN

Type of Degree or Credential awarded by your Nursing Education Program:
[ ] Diploma [ ] Certificate [ ] Associate Degree **[ ]** Baccalaureate Degree **[ ]** Have met BSN requirements en route to MSN
(Programs known as entry level Masters Programs)

[ ] Masters Degree **[ ]** Doctoral Degree

Date of Program Completion: _____/_____
MO Year

Have you ever taken the NCLEX®? **[ ]** Yes **[ ]** No
If yes, please provide the date: **[ ]** RN _____/_____ **[ ]** LPN _____/_____
MO Year MO Year

SECTION C: Nurse Compact Declaration

In accordance with the Nursing Practice Act, I declare the State of _____ is my primary state of residence and that such constitutes my permanent and principal home for legal purposes. ("Primary state of residence" is defined as the state of a person's declared fixed permanent and principal home for legal purposes; domicile.)

Upon licensure, in which state(s) do you intend to practice? _____

Applicant's Name (PRINT):_____ Social Security Number: _____

Are you currently employed in the U.S. Military (Active Duty) or the U.S. Federal Government? **[ ]** Yes **[ ]** No

Applicant's Signature: _____ **Date:** _____/_____/_____

SECTION D: Regulatory Questions

1.) Have you ever held a nursing license in any state, country, or province? **[ ]** Yes **[ ]** No
If yes, please list all states, countries, and/or provinces: _____

Type of license you held: _____

Is this license still active? **[ ]** Yes **[ ]** No License Number: _____

2.) Have you ever been denied a nursing license (for reasons other than failure to pass State Board Exam/NCLEX®)?
[ ] Yes **[ ]** No

If you answer "**YES**" to any of the following questions, you must attach a letter of explanation indicating the circumstance(s) you are reporting to the Board of Nursing. The document must be signed and dated. This explanation must include the date(s) and location(s), as well as a certified copy of the Board of Nursing or any other licensing agencies action. *Once we have a complete application and required documents, your file will be transferred to our Enforcement Department for review. The Board of nursing **will not** approve an applicant to take the NCLEX® or issue an online permit until a decision has been rendered by our Enforcement Department.*

3.) Have you ever had any disciplinary action on a nursing license or a privilege to practice in any state, country, or province?
[ ] Yes **[ ]** No

4.) Do you have an investigation or complaint pending on a nursing license or a privilege to practice in any state, country, or province?
[ ] Yes **[ ]** No

5.) Have you, in the last 5 years, been diagnosed with a substance use disorder or participated in a chemical dependency and/or alcohol or drug treatment?
[ ] Yes **[ ]** No

6.) Are you currently a participant in an alternative to discipline, diversion, or a peer assistance program? (This includes all confidential programs)
[ ] Yes **[ ]** No

7.) Have you ever had any licensing or regulatory authority in any state, jurisdiction, country, or province revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew or otherwise discipline any other professional or occupational license, certificate, nurse aide registration or multistate privilege to practice that you held?
[ ] Yes **[ ]** No If yes, please name the type of license: _____

8.) For any criminal offense, including those pending appeal, have you:
(You may only exclude minor traffic violations, but must report all DUI charges/convictions)
[ ] been convicted of a misdemeanor?
[ ] been convicted of a felony?
[ ] pled nolo contendere, no contest, or guilty?
[ ] received deferred adjudication?
[ ] been placed on community supervision or court-ordered probation, whether or not adjudicated guilt?
[ ] been sentenced to serve jail or prison time? court-ordered confinement?
[ ] been granted pre-trial diversion?

Applicant's Name (PRINT):_____ Social Security Number: _____

[ ] been arrested or have any pending criminal charges?
[ ] been cited or charged with any violation of the law?
[ ] been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?

NOTE: Expunged and Sealed Offenses: While expunged or sealed offense, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you submit a copy of the Court Order expunging or sealing the record in question to our office with your application. Non-disclosure of relevant offenses raises questions related to truthfulness and character.
NOTE: Orders of Non-Disclosure: If you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. If the Board of Nursing discovers a criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board of Nursing may require you to provide information about any conduct that raises issue of character.

9.) Are you currently the target or subject of a grand jury or governmental agency investigation?
[ ] Yes **[ ]** No

SECTION E: Attestation

I, the NCLEX® Candidate whose name appears within this Application, acknowledge this document is a legal document and I attest that I understand & meet all the requirements for the type of licensure requested.

Further, I understand that is a violation to submit a false statement to a government agency; and I consent to release of confidential information to the Board of Nursing and further authorize the Board to use and to release said information as needed for the evaluation and disposition of my application.

I understand that if I have any questions regarding this affidavit I should contact an attorney or the appropriate professional health provider.

I will immediately notify the Board if at any time after signing this affidavit I no longer meet the eligibility requirements.

Applicant's Signature: _____ **Date:** _____/_____/_____

Report of the APRN Committee

Background

The APRN Committee is a long-standing committee at NCSBN that addresses issues related to advanced practice nursing. Since early 2000, the committee has worked toward uniform regulations for advanced practice registered nurses (APRNs). This endeavor began with the development of the NCSBN Vision Paper for APRN Regulation. While the vision paper was based on the expertise of the committee and input from others outside NCSBN, it sparked controversy in the APRN community. This led to the formation of the APRN Joint Dialogue Group. This group consisted of key representatives from 48 nursing groups who came together to collaborate on a paper that would unite advanced practice nursing, outline model regulations for APRNs and promote uniformity across all jurisdictions. Representatives from NCSBN and the APRN committee sat on the Joint Dialogue group. These individuals represented boards of nursing (BONs) and addressed licensure and other regulatory issues. Leaders from other organizations represented education, accreditation and certification. The resulting document, the Consensus Model for APRN Regulation serves as the standards and model for APRN regulation in the U.S.

Following the development of the Consensus Model, the APRN Committee subsequently developed model legislative language for use by BONs. The model language was adopted by NCSBN's Delegate Assembly in 2008. Since that time, NCSBN has been dedicated to helping states enact the regulations described in the Consensus Model. The APRN Committee has played an important advisory role in this process by lending their expertise and leadership.

Highlights of FY11 Activities

Committee highlights:

- APRN Summit
- Campaign for Consensus
- Identification of issues related to the Consensus Model that require clarification
- APRN Roundtable

ACCOMPLISHMENTS

Fiscal year 2011(FY11) charges:

- Assist staff with the APRN Roundtable; APRN Summit; and Licensure, Accreditation, Certification and Education (LACE) meetings.
- Advise staff on how to assist Member Boards with the implementation of the Consensus Model.
- Describe the regulatory perspective of the relationship of the model with the doctor of nursing practice (DNP), the three P's (pharmacology, pathophysiology and physical assessment) and the definition of terms such as "Lifespan" and "CORE," in collaboration with the LACE group and consistent with the Consensus Model.

Assist staff with the APRN Roundtable, APRN Summit and LACE Meetings

The APRN Roundtable is an annual event held to inform APRN stakeholders of regulatory issues related to advanced practice nursing. This year, the APRN Roundtable was held on May 18, 2011, and focused on updating stakeholders on NCSBN's Campaign for Consensus (the formalized program to help states adopt the requirements in the Consensus Model). The roundtable is a forum for eliciting the needs of APRN organizations and what NCSBN can do to help them facilitate enactment of the regulations in their perspective areas. Legislative efforts by the states was discussed and there was an opportunity for sharing of ideas and strategies.

Members

Ann L. O'Sullivan, PhD, MSN, CRNP, CPNP, FAAN
Pennsylvania, Area IV, Chair

Brenda Bergman-Evans, PhD, APRN-NP, APRN-CNS
Nebraska-APRN, Area II

Matthew Bishop, MS, CRNA
Hawaii, Area I

Kathryn Busby, JD
Arizona, Area I

Darlene Byrd, MNSc, APN
Arkansas, Area III

Victoria Erickson, PhD, PNP-BC, FAANP
Colorado, Area I

Kathleen Lavery, MS, CNM, RN
Michigan, Area II

Martha Lavender, DSN, MSN, RN
Alabama, Area III

Linda Sullivan, DSN, FNP-BC, PNP-BC
Mississippi, Area III

Jolene Zych, MS, RN, WHNP-BC
Texas, Area III

Charlene Hanson, EdD, FNP-BC, FAAN
External Member

Emmaline Woodson, DNP, MS, RN, FRE
Maryland, Area IV, Board Liaison, (February 2011- August 2011); Committee Member (August 2010-February 2011);

Staff

Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Stephanie Fullmer, JD
Legislative Affairs Associate, Nursing Regulation

Meeting Dates

- Sept. 7, 2010
- Nov. 1-2, 2010
- Jan. 4-5, 2011
- Feb. 28-March 1, 2011

Relationship to Strategic Plan

Strategic Initiative B
NCSBN advances the engagement and leadership potential of all members through education, information and networking.

Strategic Objective 1
Increase knowledge of regulation

Strategic Initiative D
NCSBN collaborates to advance the evolution of nursing regulation worldwide.

Strategic Objective 4
Collaborate with external stakeholders.

The 2011 NCSBN APRN Summit was the kick-off event for the APRN Campaign for Consensus. Held in San Diego, Calif. Jan. 12-13, 2011, three representatives from every jurisdiction were invited by NCSBN to attend. The APRN Committee assisted staff in planning the summit agenda. Presentations at the summit focused on providing attendees with information and resources needed to get the Consensus Model regulations enacted in their jurisdiction. The summit evaluations indicated that the educational objectives for the summit were met.

The LACE Group, in which NCSBN represents licensure, is an offspring of the Joint Dialogue Group and is the primary means by which APRN groups communicate regarding their efforts to implement the Consensus Model. This group meets periodically to discuss issues of relevance related to the Consensus Model and to iron out details as they arise. They are also in the process of establishing a website to enable and enrich communication among all groups in LACE. The APRN committee has been instrumental in identifying issues that LACE needs to address. By having the LACE group clarify these issues, the BONs will be provided with answers to questions that have arisen out of the Consensus Model. Issues identified by the APRN Committee for LACE to address include:

- Acute versus primary care for adult/gerontology and pediatric populations (areas that overlap);
- Scope of practice of midwives; and
- Grandfathering: How will this be done and under what circumstances?

Advise staff on how to assist Member Boards with the implementation of the APRN Consensus Model

The committee developed a tool to classify where states were in the adoption of the components of the Consensus Model. They specifically focused on independent practice in order to capture this data. The data from the tool were collected at the summit and will be posted on the campaign website. This will help BONs know the progress of other states in adopting the Consensus Model.

Staff developed a legislative handbook for distribution to legislative staff and the committee gave feedback and suggestions.

The Committee attended the APRN Summit and assisted the staff by providing presentations and moderating sessions. These presentations provided valuable information to the attendees regarding the model and legislative successes and pitfalls.

The committee also developed a definition of independent practice that can be used by BONs:

An advanced practice registered nurse is considered an independent practitioner when given both an RN and APRN license by a state regulator. The APRN shall not be mandated to have an agreement with another health care provider. The APRN shall have full prescriptive privileges that include the administration and prescription of pharmacologic and non-pharmacologic interventions without requirement for collaboration, supervision or oversight by any other health care provider. The APRN prescriptive privilege shall not be limited to a defined formulary.

Describe the regulatory perspective of the relationship of the model with the DNP, the three P's and the definition of terms such as "Lifespan" and "CORE," in collaboration with the LACE group and consistent with the APRN Consensus Model

This charge grew out of a need for clarification of certain aspects of the Consensus Model. These issues have elicited ongoing discussions with LACE. The following are points that have been made by the APRN Committee regarding these topics.

The relationship between the DNP and the Consensus Model:

- BONs require "graduate" education and encourage generic DNP programs to have a common curriculum;
- Graduate education can be at the level of the master's degree or DNP to prepare for the APRN Certification Exam;

- DNPs must meet all APRN education and clinical requirements to be licensed as an APRN; and
- The BON needs to verify the transcript and curriculum for the DNP.

Clarification of the core courses pharmacology, pathophysiology and physical assessment (the three P's):

- Pharmacology: The pharmacology course should have a broad general name to reflect broad general competencies.
- Pathophysiology: Pathophysiology should also be a broad general course with broad, general competencies.
- Advanced Physical Assessment: The current Consensus Model states that all human systems must be covered, but the course may be specific to that role.

Definition of Lifespan: All ages (this requires further clarification through LACE because the certified nurse midwifes (CNMs) describe their practice as being across the lifespan).

CORE: Refers to the three P's.

Future Activities

The APRN Committee has met its charges for FY11, however, work related to the enactment and implementation of the Consensus Model continues.

Many questions are arising about the certification exam criteria and it has been suggested that these criteria be reviewed by the APRN Committee in conjunction with NCSBN's Examinations department to provide updated information to BONs.

Proposed FY12 charges:

1. Develop criteria for evaluation of APRN certification exams for use by BONs.
2. Develop guidelines to help states grandfather individuals.
3. Plan FY12 APRN Roundtable.

Attachments

None

Report of the Awards Committee

Background

The NCSBN awards program recognizes outstanding achievements of members and celebrates significant contributions to nursing regulation. Nominations submitted for an award category are subjected to a "blind review" by the Awards Committee. Award recipients are determined based on the nominee's ability to meet the award criteria for the category in which they are nominated. This year, a member was selected as an honoree in the following award categories: R. Louise McManus, Meritorious Service, Exceptional Leadership, Exceptional Contribution and Regulatory Achievement. There were six executive officers that made contributions to nursing regulation being honored with the Executive Officer Recognition Award. In addition, recognition will be bestowed upon Member Boards celebrating their centennial and Institute of Regulatory Excellence (IRE) Fellows during the presentation ceremony. The awards program will be held as an evening dinner event at the Annual Meeting in Indianapolis, Ind. The awards will be presented by the NCSBN Board of Directors (BOD) president.

Highlights of FY11 Activities

- Conducted a blind review of the award nominations.
- Recommended revisions to the awards brochure to include the NCSBN mission and vision.
- Recommended to the BOD revisions to the Exceptional Leadership Award regarding criteria for selection.
- Recommended to the BOD revisions to the Distinguished Achievement Award regarding eligibility and criteria for selection.
- Identified the Member Boards that are celebrating their centennial in 2011.
- Identified executive officers who are eligible for the Executive Officer Recognition Award for five, 10 and 15 years of service.
- Reported to the BOD the 2011 awards recipients selected by the Awards Committee.
- Sent letters of notification to the award nominees and to the nominators.
- Assigned roles to committee members for participation in the awards ceremony.

2011 AWARD RECIPIENTS:

R. Louise McManus Award

Kathy Malloch, PhD, MBA, RN, FAAN, board vice president, Arizona State Board of Nursing

Meritorious Service Award

Julia George, MSN, RN, FRE, executive director, North Carolina Board of Nursing

Regulatory Achievement Award

Virginia Board of Nursing

Exceptional Leadership Award

Lisa Klenke, MBA, RN, past president, Ohio Board of Nursing

Exceptional Contribution Award

Judith Personett, EdD, RN, CNAA, board member, Washington State Nursing Care Quality Assurance Commission
Mary Beth Thomas, PhD, RN, board staff, Texas Board of Nursing

Members

Marty Alston
West Virginia-RN, Area II

Doreen Begley, MS, RN
Nevada, Area I

Judy Bontrager, MN, RN
Arizona, Area I

Patti Clapp
Texas, Area III

Kathy Leader-Horn, LVN
Texas, Area III

Staff

Alicia Byrd, RN
Director, Member Relations

Meeting Dates

- Nov. 9, 2010 (Conference Call)
- March 28, 2011

Executive Officer Recognition Awards

5 YEARS

- Joan K. Bainer, MN, RN, NE, BC, administrator, South Carolina State Board of Nursing
- Michele Bromberg, MSN, APN, BC, nursing act coordinator, Illinois Board of Nursing
- Pamela McCue, MS, RN, executive officer, Rhode Island Board of Nurse Registration and Nursing Education
- Diane Ruan-Viville, MA, RN, executive director, Virgin Islands Board of Nurse Licensure

10 YEARS

- Lanette Anderson, JD, MSN, RN, executive director, West Virginia State Board of Examiners for Licensed Practical Nurses
- Lori Scheidt, Executive Director, Missouri State Board of Nursing

15 YEARS

- Sandra Evans, MAEd, RN, executive director, Idaho Board of Nursing

MEMBER BOARDS CELEBRATING 100 YEARS OF NURSING REGULATION

- Idaho Board of Nursing
- Oregon State Board of Nursing
- Tennessee State Board of Nursing
- Vermont State Board of Nursing

INSTITUTE OF REGULATORY EXCELLENCE FELLOWS

- Joan K. Bainer, MN, RN, NE, BC, administrator, South Carolina State Board of Nursing
- Linda D. Burhans, PhD, RN, NEA-BC, CPHQ, board staff, North Carolina Board of Nursing

Future Activities

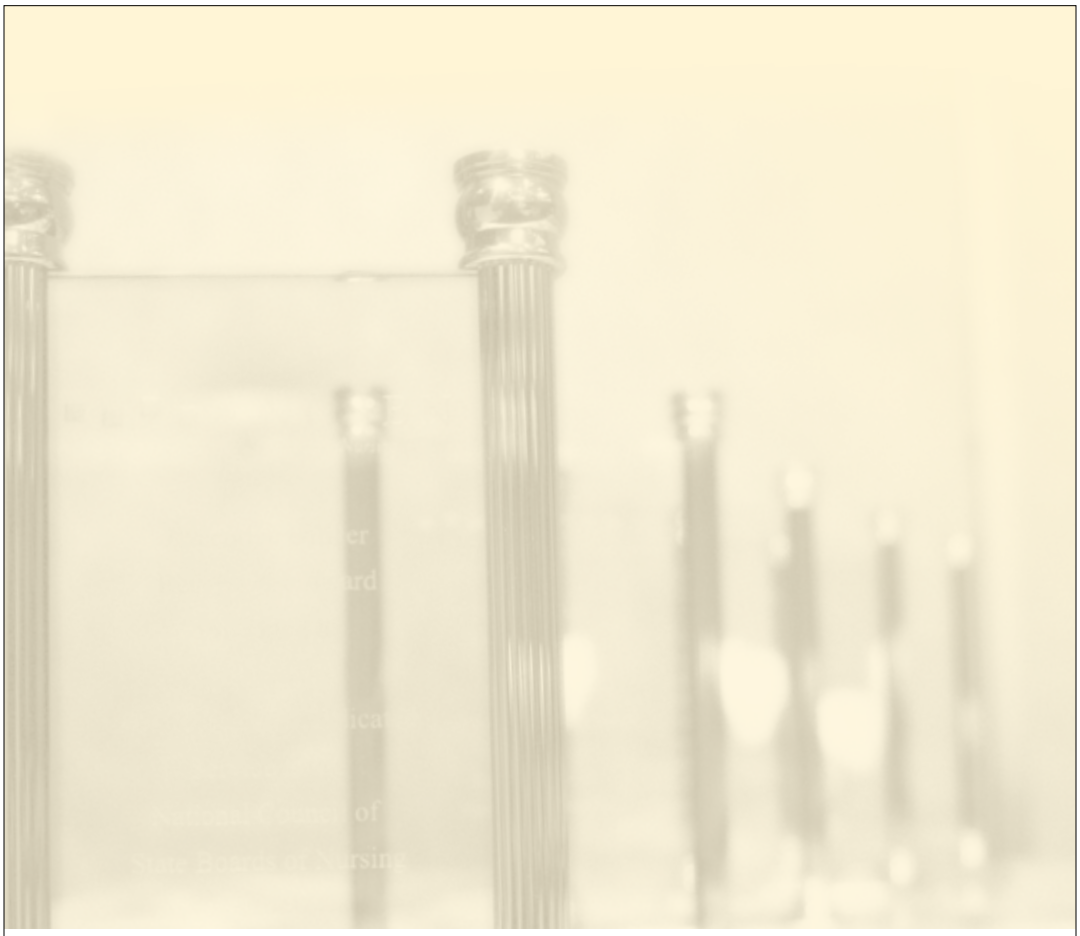
- Select the 2012 awards recipients.

Attachment

A. 2011 Awards Brochure

Attachment A

2011 Awards Brochure



The NCSBN awards will be announced at the 2011 Annual Meeting to recognize the outstanding achievements of NCSBN Member Boards. The awards are designed to celebrate significant contributions to nursing regulation.

Our goal is not only to recognize the successes of our peers, but also to learn what key factors contributed to this success. We encourage all members and their staff to nominate themselves and their peers.

Nomination Procedure and Entry Format

Please carefully read the eligibility requirements and criteria listed for each award. Only entries that meet all the requirements and criteria will be considered. **Electronic submission of all nomination materials is required.**

- Entries must be submitted in one complete e-mail; partial entries will not be considered. All entries must be e-mailed no later than Feb. 18, 2011, to Alicia Byrd, Director, Member Relations, at abyrd@ncsbn.org.
- Individuals may nominate themselves or others. For the Regulatory Achievement Award, Member Boards may nominate themselves or another board.
- Two letters of support are required. Entries must include one letter of support from the executive officer or designee. For the Regulatory Achievement Award, entries must include one letter of support from another Member Board or a representative of a regulatory agency.
- Entries must be typed and presented in a professional manner on the respective award template.
- Entries must be accompanied by the official awards program cover page. Narratives should be no more than 500 words.
- Electronic submission of all materials is required. If you use any program other than Microsoft Word, please call to be sure it is readable at NCSBN.

If you have questions about the Awards Program, contact Alicia Byrd at 312.525.3666.

AWARDS REVIEW AND SELECTION

- To ensure a fair and equitable review and selection process, each individual nomination is subjected to a blind review by each Awards Committee member. The committee then makes the final decision about all award recipients.
- Awards Committee members are not permitted to nominate award recipients, participate in the nomination process or write letters of support during their tenure on the Awards Committee.
- Awards Committee members recuse themselves from both the blind review and the final decisions for the award recipient(s) in categories where their particular board of nursing, board members or board staff are nominated, or in cases where they feel that they cannot be objective about the nominee.
- Entries are evaluated using uniform guidelines for each award category.
- Awards will not necessarily be given in each category.
- Award recipients will be notified prior to the NCSBN Annual Meeting and will be honored at the Annual Meeting.
- The Awards Committee can recommend that a nominee be given an award that is different from the award for which he/she was originally nominated. If this decision were made, the nominator will be contacted to determine if he/she is agreeable to having the nominee be given a different award.

R. LOUISE MCMANUS AWARD

R. Louise McManus (1896-1993) is widely recognized as a major figure in furthering the professionalism of nursing. She worked tirelessly to produce a standardized national approach to nursing licensure. As a patient advocate, she developed the Patient Bill of Rights adopted by the Joint Commission in Accreditation of Hospitals.

ELIGIBILITY
Board member or staff member of a board of nursing

DESCRIPTION OF AWARD
The R. Louise McManus Award is the most prestigious award. Individuals nominated for this award shall have made sustained and significant contributions through the highest commitment and dedication to the purposes of NCSBN.

CRITERIA FOR SELECTION
- Active leadership in NCSBN along with direct and substantial contributions to the improvement of nursing regulation
- Impacts public policy and development to enhance the health and well-being of individuals and the community
- Contributions to the mission of NCSBN over a significant period of time

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

MERITORIOUS SERVICE AWARD

ELIGIBILITY
Board member or staff member of a board of nursing

DESCRIPTION OF AWARD
The Meritorious Service Award is granted to a board or staff member of a Member Board for significant contributions to the purposes of NCSBN.

CRITERIA FOR SELECTION
- Significant promotion of the purposes of NCSBN
- Positive impact on the contributions of NCSBN
- Demonstrated support of NCSBN's mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

EXCEPTIONAL CONTRIBUTION AWARD

ELIGIBILITY
Board member on a board of nursing (not a board president) or staff member of a board of nursing (not an executive officer)

DESCRIPTION OF AWARD
The Exceptional Contribution Award is granted for significant contribution by a board staff member (not an executive officer) or board member (not a board president).

CRITERIA FOR SELECTION
- Significant contributions to NCSBN activities
- Demonstrated support of NCSBN's mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited

REGULATORY ACHIEVEMENT AWARD

ELIGIBILITY
A board of nursing

DESCRIPTION OF AWARD
The Regulatory Achievement Award recognizes the Member Board that has made an identifiable, significant contribution to the purposes of NCSBN in promoting public policy related to the safe and effective practice of nursing in the interest of public welfare.

CRITERIA FOR SELECTION
- Active participation in NCSBN activities by board members and/or board staff
- Effective leadership in the development, implementation and maintenance of licensing and regulatory policies
- Active collaborative relationships among the Member Board, NCSBN, the public and other Member Boards
- Demonstrated advancement of the NCSBN mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

DISTINGUISHED ACHIEVEMENT AWARD

ELIGIBILITY
Individual, organization or group. Award can be given posthumously

CRITERIA FOR SELECTION
- No other award captures the significance of this contribution
- Could be given to an individual/organization/group who is not necessarily a board member or staff member of a Member Board
- Accomplishment/achievement is supportive to NCSBN's mission and goals
- Could be long and lasting contribution or one major accomplishment that impacts the NCSBN mission and goals

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited

EXCEPTIONAL LEADERSHIP AWARD

ELIGIBILITY
Service as a state board of nursing president within the past two years

DESCRIPTION OF AWARD
The Exceptional Leadership Award is granted to an individual who has served as a Member Board president and who has made significant contributions to NCSBN.

CRITERIA FOR SELECTION
- Demonstrated leadership as the Member Board president
- Served as a Member Board president within the past two years
- Overall contributions to the regulation of nursing

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

EXECUTIVE OFFICER RECOGNITION AWARD

ELIGIBILITY
Award given in five-year increments to individuals serving in the Executive Officer role.

DESCRIPTION OF AWARD
The Executive Officer Recognition Award was established to recognize individuals who have made contributions to nursing regulation as an Executive Officer.

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
As applicable

Please note: No nomination is necessary for the Executive Officer Recognition Award as it is presented to Executive Officers based on his or her years of service in five-year increments.

Past NCSBN Award Recipients

R. LOUISE MCMANUS AWARD

2009 – Faith Fields
2008 – Shirley Brekken
2007 – Polly Johnson
2006 – Laura Poe
2005 – Barbara Morvant
2004 – Joey Ridenour
2003 – Sharon M. Weisenbeck
2002 – Katherine Thomas
2001 – Charlie Dickson
1999 – Donna Dorsey
1998 – Jennifer Bosma
Elaine Ellibee
Marcia M. Rachel
1997 – Jean Caron
1996 – Joan Bouchard
1995 – Corinne F. Dorsey
1992 – Renatta S. Loquist
1989 – Marianna Bacigalupo
1986 – Joyce Schowalter
1983 – Mildred Schmidt

MERITORIOUS SERVICE AWARD

2010 – Ann L. O'Sullivan
2009 – Sheila Exstrom
2008 – Sandra Evans
2007 – Mark Majek
2005 – Marcia Hobbs
2004 – Ruth Ann Terry
2001 – Shirley Brekken
2000 – Margaret Howard
1999 – Katherine Thomas
1998 – Helen P. Keefe
Gertrude Malone
1997 – Sister Teresa Harris
Helen Kelley
1996 – Tom O'Brien
1995 – Gail M. McGuill
1994 – Billie Haynes
1993 – Charlie Dickson
1991 – Sharon M. Weisenbeck
1990 – Sister Lucie Leonard
1988 – Merlyn Mary Maillian
1987 – Eileen Dvorak

REGULATORY ACHIEVEMENT AWARD

2010 – Texas Board of Nursing
2009 – Ohio Board of Nursing
2008 – Kentucky Board of Nursing
2007 – Massachusetts Board of Registration in Nursing
2006 – Louisiana State Board of Nursing
2005 – Idaho Board of Nursing
2003 – North Carolina Board of Nursing
2002 – West Virginia State Board of Examiners for Licensed Practical Nurses
2001 – Alabama Board of Nursing

MEMBER BOARD AWARD

2000 – Arkansas Board of Nursing
1998 – Utah State Board of Nursing
1997 – Nebraska Board of Nursing
1994 – Alaska Board of Nursing
1993 – Virginia Board of Nursing
1991 – Wisconsin Board of Nursing
1990 – Texas Board of Nurse Examiners
1988 – Minnesota Board of Nursing
1987 – Kentucky Board of Nursing

EXCEPTIONAL LEADERSHIP AWARD

2010 – Catherine Giessel
2007 – Judith Hiner
2006 – Karen Gilpin
2005 – Robin Vogt
2004 – Christine Alichnie
2003 – Cookie Bible
2002 – Richard Sheehan
2001 – June Bell

NCSBN 30TH ANNIVERSARY SPECIAL AWARD

2008 – Joey Ridenour
Sharon Weisenbeck Malin
Mildred S. Schmidt

EXCEPTIONAL CONTRIBUTION AWARD

2010 – Valerie Smith
Sue Tedford
2009 – Nancy Murphy
2008 – Lisa Emrich
Barbara Newman
Calvina Thomas
2007 – Peggy Fishburn
2005 – William Fred Knight
2004 – Janette Pucci
2003 – Sandra MacKenzie
2002 – Cora Clay
2001 – Julie Gould
Lori Scheidt
Ruth Lindgren

SILVER ACHIEVEMENT AWARD

2000 – Nancy Wilson
1998 – Joyce Schowalter

NCSBN SPECIAL AWARD

2008 – Thomas Abram
2004 – Robert Waters
2002 – Patricia Benner

Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee

Background

CORE was approved by the fiscal year 2002 (FY02) Board of Directors (BOD) to provide an ongoing performance measurement system for nursing regulators. CORE utilizes data collected periodically from boards of nursing (BONs) and stakeholders, and identifies best practices in the provision of regulatory services. By promoting excellence in the provision of regulatory services, BONs can improve their management and delivery of safe, effective nursing care to the public.

BONs have been surveyed four times: 2003, 2006, 2008 and 2010. BONs are surveyed regarding five BON functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) administrative. There were three groups of stakeholders directly affected by BON actions that were also surveyed: (1) employers; (2) nursing programs; and (3) nurses. Random samples of these stakeholders were surveyed to gain their perspectives about interactions with their BON and about the effectiveness of nursing regulation in general.

Highlights of FY11 Activities

In an effort to present comparative performance measurement data more effectively the CORE Committee revised the templates for the FY11 aggregate and state reports. Changes included:

- Organizing the state reports by BON functions: practice, licensure, discipline, education and administrative;
- Combining state, aggregate, umbrella and independent BON data into one table, thus, eliminating the need for several reports;
- Including scatter plots, when applicable, with tables for better interpretation of the data; and
- Determining if BONs are above average, average or below average when comparing their results with the aggregate data.

The FY11 aggregate and individual state reports were distributed to Member Boards in April 2011.

To support the committee in the completion of its FY11 charges, the committee requested the continued involvement of Ted Poister, PhD, MPA, a performance measurement expert. In the past Poister has assisted the committee by reviewing the CORE program and providing refinements to the CORE Logic Model. As part of his FY11 aggregate and state reports review, Poister assisted the committee by helping to identify promising practices and reasons for excellent performance among BONs. Provided that promising practices are identified, Poister will further assist the committee by suggesting strategies to attempt to validate those practices.

Poister will be retained by NCSBN to lend his expertise to the next round of data collection, expected to commence in 2012 as part of the CORE Committee responsibilities for FY12. His responsibilities in this endeavor will include continued refinement of the CORE logic model, as well as reviewing the analysis plan, survey instruments, data collection plan and reports from the FY11 data collection.

To assist BONs in implementing strategies to increase knowledge and use of CORE performance measures, NCSBN retained the services of noted author and consultant Pat Keehley, PhD, to speak at the 2011 NCSBN NLC & Consumer Conference. Keehley has consulted with the CORE Committee previously and is well acquainted with NCSBN's work in performance measurement.

Charge #1: Develop CORE survey tool for data collection in 2012.

The Committee will review the outcomes from the 2010 data collection to revise the 2012 survey tool.

Members

Margaret Walker, EdD, RN, FRE
New Hampshire, Area IV, Chair

Vicki Lynn Allen, RN, CLNC
Idaho, Area I

Jessie Colin, PhD, RN, FAAN
Florida, Area III

Gloria Damgaard, MS, RN
South Dakota, Area II

Richard Gibbs, LVN
Texas, Area III
(August 2010-February 2011)

Marilyn Hudson, MSN, CNS, RN, FRE
Oregon, Area I

Carllene MacMillan, MN, CNAA
Louisiana-RN, Area III

Christine Penney, PhD, MPA, RN, FCCHL
British Columbia, Associate Member

Joey Ridenour, MN, RN, FAAN
Arizona, Area I

Chris Sansom, RN
Nevada, Area I

Calvina Thomas, PhD, RN
Arkansas, Area III
(August 2010-September 2010)

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

Staff

Casey Marks, PhD
Chief Operating Officer

Richard Smiley, MS, MA
Statistician, Research

Melissa Snyder
Project Specialist, Business Operations

Meeting Dates

- Sept. 30-Oct. 1, 2010
- Nov. 19, 2010
- Jan. 10-11, 2011
- Jan. 24, 2011
- March 7, 2011

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

Strategic Objective 1
Promote regulatory excellence through a performance measurement system.

Charge #2: Identify promising practices and reasons for excellent performance.

Upon completion of the 2011 aggregate and state reports, the committee will investigate findings, with the assistance of Poister in an attempt to identify promising practices and reasons for excellent performance.

Charge #3: Validate identified promising practices.

Contingent on promising practices and reasons for excellent performance identification, the committee, with assistant from consultants, will strategize validation of promising practices.

Charge #4: Implement strategies to increase knowledge and use of CORE performance measures.

Keehley spoke at the 2011 NCSBN NLC & Consumer Conference.

Future Activities

Recommended charges for FY12 include:

1. Produce CORE 2012 research reports.
2. Identify promising practices
3. Promote increased use of CORE information.

Attachments

None

Report of the Disciplinary Resources Committee (DRC)

Background

The DRC is a long-standing NCSBN committee that has developed resources and guidelines related to disciplinary decision making for Member Boards. In the last few years this committee has worked on revising model rules to be more specific related to professional boundaries, as this has been an issue with boards of nursing (BONs). This year's charge on developing guidelines for social media evolved from that work. Also related to professional boundaries, the committee has worked on developing an ethical decision-making online course. It provided the BONs with a video of the disciplinary hearing process, thus assisting the BONs with educating the public about the disciplinary process. This year the Board of Directors charged the DRC to:

1. Explore how Member Boards share and act on disciplinary action taken by other jurisdictions and recommend improvements;
2. Develop guidelines for social and electronic media to protect patient privacy; and
3. Develop guidelines for regulatory decision making related to criminal conduct.

Highlights of FY11 Activities

Explored how Member Boards shared and acted on disciplinary action taken by other jurisdictions and recommended improvements.

Activities included:

- Holding discussions with NCSBN staff, Nur Rajwany, director, Information Technology, and Jim Puente, Nurse Licensure Compact (NLC) associate, Executive Office, to learn from their expertise;
- Meeting with the executive committee of the NLC to discuss recommendations for sharing disciplinary data; and
- Conducting and analyzing a comprehensive survey that was sent to BONs regarding the sharing of investigations, pending disciplinary actions and final disciplinary actions.

For this charge, the committee members developed seven recommendations (Attachment A) to encourage states to share licensure data with other BONs via Nursys®:

1. NCSBN and the DRC should communicate to Member Boards the advantages of the Nurse Alert feature for sharing information about their licensees.
2. NLC states might consider using the Nurse Alert feature, rather than the Compact Tab.
3. Inform the BONs about the Automatic Discipline Alert Speed Memo. Remove the word "alert" from this system to decrease confusion between this functionality and the Nurse Alert feature.
4. Inform the BONs about sharing discipline board orders and other official documents via Nursys.
5. Inform BONs about utilizing the electronic discipline check service.
6. Inform BONs about using the Nursys. Discipline report on a regular basis.
7. All BONs should share their discipline with other Member Boards via Nursys within 10 business days of action being taken by their BON.

Developed guidelines for social and electronic media to protect patient privacy.

Activities included:

- Reviewing literature about the appropriate use of social and electronic media in health care;
- Reviewing several health care institutions' guidelines about use of social media;

Members

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Nancy Spector, PhD, RN
Director, Regulatory Innovations

Meeting Dates

- Sept. 21-22, 2010
- Dec. 6-7, 2010
- Jan. 20, 2011 (Conference Call)
- Feb. 28-March 1, 2011
- March 21, 2011 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

Strategic Objective 1
Provide models and resources for evidence-based regulation.

- Reviewing recommendations from Canada and the U.K. on the appropriate use of social media in health care;
- Conducting and analyzing a survey on the BONs' experiences with the inappropriate use of social media; and
- Meeting with Dawn Kappel, director, Marketing & Communications, NCSBN, to learn about ways to disseminate information to nurses about the appropriate use of social media.

The committee wrote the white paper "A Nurse's Guide to the Use of Social Media" (Attachment B). The report addresses confidentiality and privacy (including HIPAA concerns); possible consequences, including BON implications; common myths about the use of social media; and suggestions on avoiding problems. The committee included seven actual cases, presenting outcomes and how the situation could have been prevented. The committee reviewed the American Nursing Association's statement on social media guidelines and suggested that NCSBN move forward to collaborate with them. Based on discussions with Kappel, the committee also recommended that NCSBN staff develop a video for nurses about the appropriate use of social media in health care to be posted on YouTube and develop a brochure that can be widely distributed, based on the committee's report.

Developed guidelines for regulatory decision making related to criminal conduct.
Activities included:

- Reviewing the literature in criminal behavior;
- Meeting with two experts in forensic psychology to learn about recidivism in criminal behavior;
- Conducting a survey about criminal behavior;
- Reviewing guidelines obtained from six states and two Canadian provinces; and
- Holding a collaborative meeting with the Uniform Licensure Requirements and Portability Committee to discuss a mutual charge on criminal behavior.

The committee developed a systematic process by providing a grid for BONs to use when making decisions about criminal behavior (Attachment E) in an attempt to promote consistency with decision making. A step-by-step process is provided, with directions on how to integrate mitigating and aggravating factors into the decision-making process. Mitigating and aggravating factors were identified from the literature and BON experiences, and when possible, evidence supporting the factors was cited.

Future Activities

The committee recommends the following charge for next year:

- Work with NCSBN's Information Technology, Interactive Services and Marketing & Communication deparments to design strategies to disseminate recommendations about sharing disciplinary data.

Attachments

A. Recommendations for Sharing Disciplinary Data
B. Summary of Survey Results
C. White Paper: A Nurse's Guide to the Use of Social Media
D. Summary of Social Networking Survey to Boards of Nursing (BONs)
E. Guidelines for Regulatory Decision Making Related to Criminal Conduct

Attachment A

Recommendations for Sharing Disciplinary Data

NCSBN's Board of Directors (BOD) charged the Disciplinary Resource Committee (DRC) to explore how Member Boards share and act on disciplinary action taken by other jurisdictions and to recommend improvements. To explore how boards of nursing (BONs) share and act on disciplinary actions taken by other BONs, the DRC conducted a survey of Member Boards (see Attachment B for a summary of the findings). The DRC also held meetings with Nur Rajwany, director, Information Technology, NCSBN; the Nurse Licensure Compact (NLC) chair; and the NLC Executive Committee.

The following recommendations encourage states to share licensure data with other BONs via Nur*sys*®. To assist with this, NCSBN's BOD has worked to finalize a new business model that allows states to keep verification monies and the license verification process while allowing states to share licensure data with each other, as well as limited data elements with the public and emergency response organizations.

RECOMMENDATIONS

Recommendation #1: NCSBN and the DRC should communicate to Member Boards the advantages of the Nurse Alert feature for sharing information about their licensees.

Background

The Nurse Alert feature of Nur*sys* was implemented in September 2009. This feature is available for use by the entire membership. A survey conducted by the DRC suggests that many BONs are not aware of this feature and there is much confusion about it. While 21 BONs reported using this feature, only four BONs were using it at the time the survey was conducted.

The Nurse Alert feature differs from the Compact Tab. It was designed for use by all Member Boards and allows participating BONs to alert other BONs about the status of a licensee. This feature can be customized to fit the BONs' needs. If a BON chooses, it can adopt a standard message or customize its own messages. The Nurse Alert feature can be extended to the public license lookup and/or the nurse license verification service. Member Boards have the option to block the alert messages to the public and/or nurse. The Nurse Alert feature may be used by any Member Board for any reason and does not need to be associated with receipt of a complaint or an open investigation.

Summary for using the Nurse Alert feature:

- Control the display of the licensees' license status without associating this option with specific verbiage, such as "investigation"; and
- Share licensure data, other than formal discipline, with other BONs via Nur*sys*.

Recommendation #2: NLC states might consider using the Nurse Alert feature, rather than the Compact Tab.

Background

The Compact Tab, developed 10 years ago, allows NLC jurisdictions to share investigative alerts with other NLC jurisdictions; there is no information regarding the content in this particular alert. A review of Nur*sys* has found that this function has not been consistently used by NLC states. This functionality could be replaced by the new and more comprehensive Nurse Alert feature, as described above.

Advantages of using the Nurse Alert feature instead of the Compact Tab include:

- States are still able to alert other NLC states;
- All jurisdictions would be included (currently neighboring non-NLC states are not part of the Compact tab);

- Messages can be individualized to what is optimal for that jurisdiction as standardized messages can also be developed by NLC; and
- Confusion might arise for NLC board staff if NLC states use both the Compact Tab and the Nurse Alert feature.

Recommendation #3: Inform the BONs about the Automatic Discipline Alert Speed Memo. BONs are confused between the Automatic Discipline Alert Speed Memo and the Nurse Alert feature because they each use the word "alert." The DRC recommends that the word "alert" be removed from the Automatic Alert Speed Memo, making it simply the Automatic Discipline Speed Memo, which is what it is referred to as below.

Background

The Automatic Discipline Speed Memo was implemented in May 2010. The option to send a Discipline Speed Memo while entering a discipline case into Nur*sys* has always been available to all Member Boards. This option, however, was dependent upon the Member Board staff entering and selecting the other jurisdictions to be notified. This resulted in gaps in notifications in some cases and unnecessary alerts in others. To address the issue, NCSBN's BOD requested that NCSBN's Information Technology (IT) department develop an automatic discipline alert feature where the Nur*sys* system will take control of sending a discipline speed memo automatically upon creation of a discipline case in Nur*sys*. Therefore, the Nur*sys* system can now automatically send a discipline speed memo to all jurisdictions where the individual holds a license in the Nur*sys* database. This is important to BONs because many indicated in the DRC survey that they can be overwhelmed by speed memos that are not relevant. Member Board staff members retain the ability to select additional jurisdictions to be notified, though this is a manual process and would take more time.

Summary for using this Automatic Discipline Speed Memo:

- Rely on the system to select the jurisdictions where the disciplined nurses are licensed and to automatically send those jurisdictions the notification of discipline. This will limit the number of speed memos that are sent to Member Boards, as they have complained about being overwhelmed by speed memos; and
- By sharing licensure data via Nur*sys*, Member Boards will receive the Automatic Discipline Speed Memos.

Recommendation #4: Inform the BONs about sharing discipline board orders and other official documents via Nur*sys*.

Background

This feature was implemented in December 2010. It was discussed and requested by the executive officers during the 2010 Delegate Assembly. Discussions brought to light that Member Boards would accept electronic board orders shared by the primary source Member Board for most of their operational work. For most BONs, a certified copy would only be required for a court hearing. Optionally, a BON may choose to "electronically stamp" (digital signature) the board orders as being certified and still offer electronic board orders via Nur*sys* as the certified copy. The DRC survey also indicated that many BONs would like official documents to be shared via Nur*sys*. Member Boards who fully participate in Nur*sys* also have the option to allow public access to the board orders via Nur*sys*.com.

Suggestions when sharing official documents via Nur*sys* include:

- Use of this functionality of Nur*sys* saves time and resources for BON operations staff, thus enhancing efficiency and reducing costs;
- Attach discipline board orders when entering a discipline case in Nur*sys*. Attach other relevant documents, to the extent permitted by law and BON policy; and
- Apply for funding/resources from NCSBN, if not budgeted, to attach past discipline board orders for the benefit of the membership.

Recommendation #5: Inform the BONs about utilizing the electronic discipline check service.

Background

This feature was introduced in early 2010 to close the current gap for BONs not being able to electronically check on the license status of their licensees in other jurisdictions. BONs can program their renewal systems to automatically electronically check if their licensees have any encumbrances on their license from other jurisdictions. BONs can utilize this electronic discipline check at any time, for any reason. This was developed due to feedback provided by the membership identifying a functionality gap of not being able to check Nursys for discipline status during renewals. The DRC survey found that fewer BONs asked renewal candidates about investigations or pending disciplinary actions in other jurisdictions than of initial candidates. Further, most indicated only checking on licensees who said they were being investigated or had pending disciplinary actions and not on those who answered "no" to that question.

Suggestions for this new function of Nursys include:

- BONs working with NCSBN's IT department to reconfigure their own systems so that the two systems can communicate; and
- Once the BON can use the system, the renewal checks could be automatic.

Recommendation #6: Inform the BONs about using the Nursys® Discipline Report on a regular basis.

Background

This is not a new feature, but it can be valuable to BONs. Nursys Discipline Reports provide BONs with a list of their unencumbered licensees with discipline in other jurisdictions that report licensure data to Nursys.

Suggestions for this function of Nursys:

- Initially a BON should run the discipline report for all of their licensees against the entire Nursys disciplinary database, creating a report and investigating the results, as needed.
- After the initial report is run, on a daily basis, the BON should run the report from the day before.
- This is a quick and easy process that will allow the BONs to stay proactive.

Recommendation #7: All BONs should share their discipline with other Member Boards via Nursys within 10 business days of action taken by their BON.

By timely sharing disciplinary actions in Nursys, the entire membership will be made aware of any actions that they may need to take if the individual is licensed in their state. The membership will:

- Receive appropriate Automatic Discipline Speed Memos;
- Receive action items on their discipline reports; and
- Receive discipline alerts when the discipline status is checked via electronic means during renewals or any other time as warranted.

Attachment B

Summary of Survey Results

A survey was developed at the September 2010 meeting of the Disciplinary Resources Committee (DRC) seeking information about how boards of nursing (BONs) share disciplinary action taken by other jurisdictions. This survey was developed in relationship to the committee's charge to explore how Member Boards share and act on disciplinary action taken by other jurisdictions, and recommend improvements.

The survey was reviewed by an NCSBN expert in survey design and by Nur Rajwany, director, Information Technology, NCSBN. In October 2010 the survey was sent to all BON executive directors, as well as all members of the Disciplinary Resource Network. The survey asked that only one response from each BON be submitted. After three reminders to BONs that hadn't completed the survey were sent, the DRC received a response rate of 44 (73 percent). The following is a summary of the results.

I. Strategies of staying abreast of other states' disciplinary actions

1. When BONs were asked how they become aware of actions taken in other jurisdictions, many indicated multiple ways. The following themes were identified:

Nursys®	38
BON contacts	16
Applicant	10
Media	6
Citizen's Report	3
National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Data Bank (HIPDB)	2
Law Enforcement	1

There were six BONs (13.6 percent) that reported quering HIPDB. When asked to what extent/ in what circumstances those six BONs queried HIPDB, the following was reported (number of jurisdictions in parentheses):

- For action on medication assistants or dialysis technicians (1);
- All advanced practice registered nurse (APRN)/certified registered nurse anesthetist (CRNA) applicants are cleared before issuing final certificates (1);
- Applicants are required to provide a self-query (1);
- When a case is sent to their attorney general (1);
- Queried it 20 times in 2010 (1);
- Queried it daily;
- All applications and newly opened investigations (1);
- Malpractice (2);
- Criminal actions (1); and
- Sister state actions (2).

The cost to query HIPDB was reported as between $4.25-$4.75 per query.

2. There were five BONs (11.4 percent) that reported querying NPDB. When asked to what extent/in what circumstances those five BONs queried NPDB, the following was reported (number of jurisdictions in parentheses):

- All new APRN applicants (1);
- 20 queries in 2010 (1);
- Applicants are required to provide a self-query (1);
- When a case is sent to their attorney general (1);
- Malpractice (1);
- Actions in other jurisdictions (1);
- Criminal actions (1); and
- Initial or endorsement licensures (1).

The cost to query NPDB was reported as between $4.50-$4.75 per query.

3. Of the 44 BONs responding to the survey, 38 (86.4 percent) reported querying Nursys. When asked to what extent/in what circumstances those 38 BONs queried Nursys, the following was reported (number of jurisdictions in parentheses):

- Validate licensure (38);
- Action taken in other states (23);
- When investigations are opened (8);
- Statistical information (1);
- When audited for continuing education requirement (1);
- Media reports (1);
- Daily (10);
- Weekly (6); and
- Monthly (2).

4. There were 37 (84.1 percent) BONs that responded to asking initial applicants if they are being investigated in another jurisdiction; of those, 33 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Check Nursys (13);
- Contact jurisdiction (11);
- Request copies of disciplinary action (7);
- Only validate those who answer "yes" (2);
- FBI (1);
- CRC (1); and
- HIPDB/NPDB (1).

5. There were 33 (75 percent) BONs that responded to asking initial applicants if there is pending disciplinary actions in another jurisdiction; of those, 31 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Contact other BON (17);
- Nursys (8);
- Request copies of documents (6);
- Only validate those who answer "yes" (2);
- CRC (1);

- HIPDB/NPDB (1); and
- Employer (1).

6. There were 42 (95.5 percent) BONs that responded to asking initial applicants about final disciplinary actions in other jurisdictions; 41 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Nur*sys* (16);
- Obtain copy of the order (16);
- Contact other BON (13);
- Only validate those who answer "yes" (1); and
- HIPDB/NPDB (1).

7. Of the 44 BONs that responded to the survey, 31 (70.5 percent) reported asking renewal candidates (as opposed to initial candidates) if they were being investigated in other jurisdictions; 28 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Contact other BON (9);
- Nur*sys* (5); and
- Request documents (3).

8. There were 29 (65.9 percent) BONs that reported asking renewal candidates (as opposed to initial candidates) if there is pending discipline in other jurisdictions; 26 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Contact other BON (7);
- Nur*sys* (5);
- Request documents (2); and
- HIPDB/NPDB (1).

9. More BONs (39 or 88.6 percent) reported asking renewal candidates about final disciplinary actions in other jurisdictions than they do about being investigated or having pending disciplinary actions. Of those 39 BONs, 37 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Nur*sys* (10);
- Request documents (10);
- Contact BON (5);
- Open a case (1);
- Check with authorities (1); and
- HIPDB/NPDB (1).

10. There were 37 (88.1 percent) BONs that indicated they have a process in place for a staff member to take action when a Nur*sys*® Auto Alert speed memo is received. BONs frequently check those Nur*sys*® Auto Alert speed memos (note that 41 BONs answered this question):

- Daily: 19 (51.4 percent);
- Weekly: 16 (43.2 percent);
- Monthly: 1 (2.7 percent);
- Quarterly: 1 (2.7 percent); and

- Other:
  - Use Discipline Report (2);
  - Find Nursys® Auto Alert speed memos problematic because of the volume, creating unnecessary work (2); and
  - Use it throughout day with pop-up alerts (2).

II. Taking action based on other states' discipline

11. Of the 44 BONs responding, only one (2.3 percent) cannot take disciplinary action based on another state's action.
12. Of the 43 BONs responding, 37 (86 percent) reported that taking action based on another state's action depends on the nature of the offense. Comments included (number of jurisdictions in parentheses):

- Must be a violation in their state (10);
- Case-by-case (4);
- Not on minor violations (2); and
- Depends on whether the nurse is active or inactive (1).

13. There were 36 BONs that discussed the information/documentation needed to take disciplinary action based on another state's discipline, including the following (number of jurisdictions in parentheses):

- Board order/disciplinary records (25);
- Certified copy of action (10);
- Findings of fact (4);
- Licensee's response (2);
- Nursys printout (2);
- Status of licensee (1);
- Address of license (1);
- Recommendations to other BONs (1); and
- Evidence of remediation (1).

III. Reporting and sharing of disciplinary actions

14. Reporting systems used when taking disciplinary action (44 respondents)

	Yes	No
Nursys®	39	3
HIPDB	23	12
NPDB	18	16
Other National Reporting System	5	20

If BONs use other national reporting systems, what are they?

- Office of Inspector General (OIG) (2);
- Regional Medicare/Medicaid (1); and
- State Bureau of Health Facilities (1).

15. Beyond an automatic Nursys alert, what other forms of notifications are used to alert jurisdictions of actions taken by a BON (42 respondents)?

	Yes	No
Speed Memo in Nursys®	33	5
Email	24	10
Telephone	24	11
Other	12	15

If BONs use other forms of notification to alert jurisdictions of actions taken by a BON, what are they (number of jurisdictions in parentheses)?

- U.S. mail (8);
- Website (3); and
- Fax (1).

16. There were 21 BONs that indicated they were using the new Nurse Alert feature in Nursys, which alerts the BON, the public and the nurse with a message prepared by the BON; 16 BONs are not using this feature. Reasons given for either using or not using this feature include (number of jurisdictions in parentheses):

- Not familiar with this (4);
- Doesn't alert nurses without discipline (2);
- Only alert if the investigation is active (1); and
- Plan to use in the future (1).

When this question was asked, only four BONs were actually using the Nurse Alert feature, thereby illustrating their confusion about this feature.

17. There were 34 BONs that indicated they have a dedicated staff person for reporting the BON's disciplinary action to Nursys; seven BONs do not.

18. Disciplinary action is entered into Nursys after it has been finalized within the following timeframe (number of jurisdictions in parentheses):

- 1-3 days (11);
- 4-14 days (16);
- 5-30 days (10);
- 31-60 days (1);
- 61-120 days (1); and
- N/A-Don't use Nursys (3).

19. The following reports are considered public and can be shared with either the public or other BONs:

	Shared with BONs - Yes	Shared with BONs - No	Shared with Public - Yes	Shared with Public - No
Complaint	18	7	3	11
Investigation	21	6	1	11
Charges/notice	15	2	15	5
Action	19	0	23	0

20. Recommendations for sharing disciplinary data across jurisdictions include (number of jurisdictions in parentheses):

- Ability to upload official documents on Nursys (7);
- More selective use of speed memos (5);
- Get all states to use Nursys in a timely manner (5);
- Encourage legislation to permit sharing of investigative information (3);
- NCSBN defray cost of HIPDB/NPDB (2);
- Add investigations to Nursys for all states, and not just the NLC (2);
- Allow investigations to be shared whether or not the license is active (1);
- More personnel for the BON (1);
- Nursys for APRNs (1);
- Allow entry to Nursys without name as the sole criterion (1);
- Uniform processing of disciplinary actions (1); and
- Routine inclusion of factual findings (1).

IV. Conclusions

1. BONs are using Nursys for staying abreast of disciplinary actions, taking actions and sharing discipline. They also contact other BONs and share official documents. They do this by sending speed memos in Nursys, telephone or sending documents through email, U.S. mail or via fax.
2. HIPDB/NPDB are not used nearly as often as cost seems to be one issue; two BONs would like NCSBN to defray this cost.
3. Processes are in place at BONs for staff to report disciplinary action to Nursys and to take action when speed memos are sent.
4. BONs recommend that all BONs use Nursys for reporting discipline in a timely way.
5. BONs want a process whereby official documents can be shared.
6. BONs would like BONs to share investigative information, whenever this can be done.
7. Of the BONs answering this survey, 95 percent check Nursys® Discipline Alert Speed Memos at least weekly; 88 percent enter a finalized disciplinary action within 30 days.
8. There is confusion as to what the new Nurse Alert feature is; 21 jurisdictions reported using it when in fact only four use it at this time. Education of what is available and what will be is important.

Attachment C

White Paper: A Nurse's Guide to the Use of Social Media

Introduction

The use of social media and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Nurses often use electronic media both personally and professionally. Instances of inappropriate use of electronic media by nurses have been reported to boards of nursing (BONs) and, in some cases, reported in nursing literature and the media. This document is intended to provide guidance to nurses using electronic media in a manner that maintains patient privacy and confidentiality.

Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals.

Nurses are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the nurse to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in nursing practice. The Internet provides an alternative media for nurses to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the nurse disclosing too much information and violating patient privacy and confidentiality.

Health care organizations that utilize electronic and social media typically have policies governing employee use of such media in the workplace. Components of such policies often address personal use of employer computers and equipment, and personal computing during work hours. The policies may address types of websites that may or may not be accessed from employer computers. Health care organizations also maintain careful control of websites maintained by or associated with the organization, limiting what may be posted to the site and by whom.

The employer's policies, however, typically do not address the nurse's use of social media outside of the workplace. It is in this context that the nurse may face potentially serious consequences for inappropriate use of social media.

Confidentiality and Privacy

To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the health care context. Confidentiality and privacy are related, but distinct concepts. Any patient information learned by the nurse during the course of treatment must be safeguarded by that nurse. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient's informed consent, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nurse's obligation to safeguard such confidential information is universal.

Privacy relates to the patient's expectation and right to be treated with dignity and respect. Effective nurse-patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nurse. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate "need to know." Any breach of this trust, even inadvertent, damages the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

Federal law reinforces and further defines privacy through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations are intended to protect patient privacy by defining

individually identifiable information and establishing how this information may be used, by whom and under what circumstances. The definition of individually identifiable information includes any information that relates to the past, present or future physical or mental health of an individual, or provides enough information that leads someone to believe the information could be used to identify an individual.

Breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Nurses may breach confidentiality or privacy with information he or she posts via social media. Examples may include comments on social networking sites in which a patient is described with sufficient detail to be identified, referring to patients in a degrading or demeaning manner, or posting video or photos of patients. Additional examples are included at the end of this document.

Possible Consequences

Potential consequences for inappropriate use of social and electronic media by a nurse are varied. The potential consequences will depend, in part, on the particular nature of the nurse's conduct.

BON Implications

Instances of inappropriate use of social and electronic media may be reported to the BON. The laws outlining the basis for disciplinary action by a BON vary between jurisidictions. Depending on the laws of a jurisdiction, a BON may investigate reports of inappropriate disclosures on social media by a nurse on the grounds of:

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismanagement of patient records;
- Revealing a privileged communication; and
- Breach of confidentiality.

If the allegations are found to be true, the nurse may face disciplinary action by the BON, including a reprimand or sanction, assessment of a monetary fine, or temporary or permanent loss of licensure.

A 2010 survey of BONs conducted by NCSBN indicated an overwhelming majority of responding BONs (33 of the 46 respondents) reported receiving complaints of nurses who have violated patient privacy by posting photos or information about patients on social networking sites. The majority (26 of the 33) of BONs reported taking disciplinary actions based on these complaints. Actions taken by the BONs included censure of the nurse, issuing a letter of concern, placing conditions on the nurse's license or suspension of the nurse's license.

Other Consequences

Improper use of social media by nurses may violate state and federal laws established to protect patient privacy and confidentiality. Such violations may result in both civil and criminal penalties, including fines and possible jail time. A nurse may face personal liability. The nurse may be individually sued for defamation, invasion of privacy or harassment. Particularly flagrant misconduct on social media websites may also raise liability under state or federal regulations focused on preventing patient abuse or exploitation.

If the nurse's conduct violates the policies of the employer, the nurse may face employment consequences, including termination. Additionally, the actions of the nurse may damage the reputation of the health care organization, or subject the organization to a law suit or regulatory consequences.

Another concern with the misuse of social media is its effect on team-based patient care. Online comments by a nurse regarding co-workers, even if posted from home during nonwork hours, may constitute as lateral violence. Lateral violence is receiving greater attention as more is learned about its impact on patient safety and quality clinical outcomes. Lateral violence includes disruptive behaviors of intimidation and bullying, which may be perpetuated in person or via the Internet, sometimes referred to as "cyber bullying." Such activity is cause for concern for current and future employers and regulators because of the patient-safety ramifications. The line between speech protected by labor laws, the First Amendment and the ability of an employer to impose expectations on employees outside of work is still being determined. Nonetheless, such comments can be detrimental to a cohesive health care delivery team and may result in sanctions against the nurse.

Common Myths and Misunderstandings of Social Media

While instances of intentional or malicious misuse of social media have occurred, in most cases, the inappropriate disclosure or posting is unintentional. A number of factors may contribute to a nurse inadvertently violating patient privacy and confidentiality while using social media. These may include:

- A mistaken belief that the communication or post is private and accessible only to the intended recipient. The nurse may fail to recognize that content once posted or sent can be disseminated to others. In fact, the terms of using a social media site may include an extremely broad waiver of rights to limit use of content.[1] The solitary use of the Internet, even while posting to a social media site, can create an illusion of privacy.
- A mistaken belief that content that has been deleted from a site is no longer accessible.
- A mistaken belief that it is harmless if private information about patients is disclosed if the communication is accessed only by the intended recipient. This is still a breach of confidentiality.
- A mistaken belief that it is acceptable to discuss or refer to patients if they are not identified by name, but referred to by a nickname, room number, diagnosis or condition. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.
- Confusion between a patient's right to disclose personal information about himself/herself (or a health care organization's right to disclose otherwise protected information with a patient's consent) and the need for health care providers to refrain from disclosing patient information without a care-related need for the disclosure.
- The ease of posting and commonplace nature of sharing information via social media may appear to blur the line between one's personal and professional lives. The quick, easy and efficient technology enabling use of social media reduces the amount of time it takes to post content and simultaneously, the time to consider whether the post is appropriate and the ramifications of inappropriate content.

How to Avoid Problems

It is important to recognize that instances of inappropriate use of social media can and do occur, but with awareness and caution, nurses can avoid inadvertently disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risks of using social media:

- First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.

1 One such waiver states, "By posting user content to any part of the site, you automatically grant the company an irrevocable, perpetual, nonexclusive transferable, fully paid, worldwide license to use, copy, publicly perform, publicly display, reformat, translate, excerpt (in whole or in part), distribute such user content for any purpose." Privacy Commission of Canada. (2007, November 7). Privacy and social networks [Video file]. Retrieved from http://www.youtube.com/watch?v=X7gWEgHeXcA

- Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.
- Do not share, post or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so.
- Do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.
- Do not refer to patients in a disparaging manner, even if the patient is not identified.
- Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.
- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.
- Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.
- Promptly report any identified breach of confidentiality or privacy.
- Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place.
- Do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.
- Do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer.

Conclusion

Social and electronic media possess tremendous potential for strengthening personal relationships and providing valuable information to health care consumers. Nurses need to be aware of the potential ramifications of disclosing patient-related information via social media. Nurses should be mindful of employer policies, relevant state and federal laws, and professional standards regarding patient privacy and confidentiality and its application to social and electronic media. By being careful and conscientious, nurses may enjoy the personal and professional benefits of social and electronic media without violating patient privacy and confidentiality.

Illustrative Cases

The following cases, based on events reported to BONs, depict inappropriate uses of social and electronic media. The outcomes will vary from jurisdiction to jurisdiction.

SCENARIO 1

Bob, a licensed practical/vocational (LPN/VN) nurse with 20 years of experience used his personal cell phone to take photos of a resident in the group home where he worked. Prior

to taking the photo, Bob asked the resident's brother if it was okay for him to take the photo. The brother agreed. The resident was unable to give consent due to her mental and physical condition. That evening, Bob saw a former employee of the group home at a local bar and showed him the photo. Bob also discussed the resident's condition with the former coworker. The administrator of the group home learned of Bob's actions and terminated his employment. The matter was also reported to the BON. Bob told the BON he thought it was acceptable for him to take the resident's photo because he had the consent of a family member. He also thought it was acceptable for him to discuss the resident's condition because the former employee was now employed at another facility within the company and had worked with the resident. The nurse acknowledged he had no legitimate purpose for taking or showing the photo or discussing the resident's condition. The BON imposed disciplinary action on Bob's license requiring him to complete continuing education on patient privacy and confidentiality, ethics and professional boundaries.

This case demonstrates the need to obtain valid consent before taking photographs of patients; the impropriety of using a personal device to take a patient's photo; and that confidential information should not be disclosed to persons no longer involved in the care of a patient.

SCENARIO 2

Sally, a nurse employed at a large long-term care facility arrived at work one morning and found a strange email on her laptop. She could not tell the source of the email, only that it was sent during the previous nightshift. Attached to the email was a photo of what appeared to be an elderly female wearing a gown with an exposed backside bending over near her bed. Sally asked the other dayshift staff about the email/photo and some confirmed they had received the same photo on their office computers. Nobody knew anything about the source of the email or the identity of the woman, although the background appeared to be a resident's room at the facility. In an effort to find out whether any of the staff knew anything about the email, Sally forwarded it to the computers and cell phones of several staff members who said they had not received it. Some staff discussed the photo with an air of concern, but others were laughing about it as they found it amusing. Somebody on staff started an office betting pool to guess the identity of the resident. At least one staff member posted the photo on her blog.

Although no staff member had bothered to bring it to the attention of a supervisor, by midday, the director of nursing and facility management had become aware of the photo and began an investigation as they were very concerned about the patient's rights. The local media also became aware of the matter and law enforcement was called to investigate whether any crimes involving sexual exploitation had been committed.

While the county prosecutor, after reviewing the police report, declined to prosecute, the story was heavily covered by local media and even made the national news. The facility's management placed several staff members on administrative leave while they looked into violations of facility rules that emphasize patient rights, dignity and protection. Management reported the matter to the BON, which opened investigations to determine whether state or federal regulations against "exploitation of vulnerable adults" were violated. Although the originator of the photo was never discovered, nursing staff also faced potential liability for their willingness to electronically share the photo within and outside the facility, thus exacerbating the patient privacy violations, while at the same time, failing to bring it to management's attention in accordance with facility policies and procedures. The patient in the photo was ultimately identified and her family threatened to sue the facility and all the staff involved. The BON's complaint is pending and this matter was referred to the agency that oversees long-term care agencies.

This scenario shows how important it is for nurses to carefully consider their actions. The nurses had a duty to immediately report the incident to their supervisor to protect patient privacy and maintain professionalism. Instead, the situation escalated to involving the BON, the county prosecutor and even the national media. Since the patient was ultimately identified, the family was embarrassed and the organization faced possible legal consequences. The organization was also embarrassed because of the national media focus.

SCENARIO 3

A 20-year-old junior nursing student, Emily, was excited to be in her pediatrics rotation. She had always wanted to be a pediatric nurse. Emily was caring for Tommy, a three-year-old patient in a major academic medical center's pediatric unit. Tommy was receiving chemotherapy for leukemia. He was a happy little guy who was doing quite well and Emily enjoyed caring for him. Emily knew he would likely be going home soon, so when his mom went to the cafeteria for a cup of coffee, Emily asked him if he minded if she took his picture. Tommy, a little "ham," consented immediately. Emily took his picture with her cell phone as she wheeled him into his room because she wanted to remember his room number.

When Emily got home that day she excitedly posted Tommy's photo on her Facebook page so her fellow nursing students could see how lucky she was to be caring for such a cute little patient. Along with the photo, she commented, "This is my 3-year-old leukemia patient who is bravely receiving chemotherapy. I watched the nurse administer his chemotherapy today and it made me so proud to be a nurse." In the photo, Room 324 of the pediatric unit was easily visible.

Three days later, the dean of the nursing program called Emily into her office. A nurse from the hospital was browsing Facebook and found the photo Emily posted of Tommy. She reported it to hospital officials who promptly called the nursing program. While Emily never intended to breach the patient's confidentiality, it didn't matter. Not only was the patient's privacy compromised, but the hospital faced a HIPAA violation. People were able to identify Tommy as a "cancer patient," and the hospital was identified as well. The nursing program had a policy about breaching patient confidentiality and HIPAA violations. Following a hearing with the student, school officials and the student's professor, Emily was expelled from the program. The nursing program was barred from using the pediatric unit for their students, which was very problematic because clinical sites for acute pediatrics are difficult to find. The hospital contacted federal officials about the HIPAA violation and began to institute more strict policies about use of cell phones at the hospital.

This scenario highlights several points. First of all, even if the student had deleted the photo, it is still available. Therefore, it would still be discoverable in a court of law. Anything that exists on a server is there forever and could be resurrected later, even after deletion. Further, someone can access Facebook, take a screen shot and post it on a public website.

Secondly, this scenario elucidates confidentiality and privacy breaches, which not only violate HIPAA and the nurse practice act in that state, but also could put the student, hospital and nursing program at risk for a lawsuit. It is clear in this situation that the student was well-intended, and yet the post was still inappropriate. While the patient was not identified by name, he and the hospital were still readily identifiable.

SCENARIO 4

A BON received a complaint that a nurse had blogged on a local newspaper's online chat room. The complaint noted that the nurse bragged about taking care of her "little handicapper." Because they lived in a small town, the complainant could identify the nurse and the patient. The complainant stated that the nurse was violating "privacy laws" of the child and his family. It was also discovered that there appeared to be debate between the complainant and the nurse on the blog over local issues. These debates and disagreements resulted in the other blogger filing a complaint about the nurse.

A check of the newspaper website confirmed that the nurse appeared to write affectionately about the handicapped child for whom she provided care. In addition to making notes about her "little handicapper," there were comments about a wheelchair and the child's age. The comments were not meant to be offensive, but did provide personal information about the patient. There was no specific identifying information found on the blog about the patient, but if you knew the nurse, the patient or the patient's family, it would be possible to identify who was being discussed.

The board investigator contacted the nurse about the issue. The nurse admitted she is a frequent blogger on the local newspaper site; she explained that she does not have a television and

blogging is what she does for entertainment. The investigator discussed that as a nurse, she must be careful not to provide any information about her home care patients in a public forum.

The BON could have taken disciplinary action for the nurse failing to maintain the confidentiality of patient information. The BON decided a warning was sufficient and sent the nurse a letter advising her that further evidence of the release of personal information about patients will result in disciplinary action.

This scenario illustrates that nurses need to be careful not to mention work issues in their private use of websites, including posting on blogs, discussion boards, etc. The site used by the nurse was not specifically associated with her like a personal blog is; nonetheless the nurse posted sufficient information to identify herself and the patient.

SCENARIO 5

Nursing students at a local college had organized a group on Facebook that allowed the student nurses' association to post announcements and where students could frequently blog, sharing day-to-day study tips and arranging study groups. A student-related clinical error occurred in a local facility and the student was dismissed from clinical for the day pending an evaluation of the error. That evening, the students blogged about the error, perceived fairness and unfairness of the discipline, and projected the student's future. The clinical error was described, and since the college only utilized two facilities for clinical experiences, it was easy to discern where the error took place. The page and blog could be accessed by friends of the students, as well as the general public.

The students in this scenario could face possible expulsion and discipline. These blogs can be accessed by the public and the patient could be identified because this is a small community. It is a myth that it can only be accessed by that small group, and as in Scenario 3, once posted, the information is available forever. Additionally, information can be quickly spread to a wide audience, so someone could have taken a screen shot of the situation and posted it on a public site. This is a violation of employee/university policies.

SCENARIO 6

Chris Smith, the brother of nursing home resident Edward Smith, submitted a complaint to the BON. Chris was at a party when his friend, John, picked up his wife's phone to read her a text message. The message noted that she was to "get a drug screen for resident Edward Smith." The people at the party who heard the orders were immediately aware that Edward Smith was the quadriplegic brother of Chris. Chris did not want to get the nurse in trouble, but was angered that personal information about his brother's medical information was released in front of others.

The BON opened an investigation and learned that the physician had been texting orders to the personal phone number of nurses at the nursing home. This saved time because the nurses would get the orders directly and the physician would not have to dictate orders by phone. The use of cell phones also provided the ability for nurses to get orders while they worked with other residents. The practice was widely known within the facility, but was not the approved method of communicating orders.

The BON learned that on the night of the party, the nurse had left the facility early. A couple hours prior to leaving her shift she had called the physician for new orders for Edward Smith. She passed this information onto the nurse who relieved her. She explained that the physician must not have gotten a text from her co-worker before he texted her the orders.

The BON contacted the nursing home and spoke to the director of nursing. The BON indicated that if the physician wanted to use cell phones to text orders, he or the facility would need to provide a dedicated cell phone to staff. The cell phone could remain in a secured, private area at the nursing home or with the nurse during her shift.

The BON issued a warning to the nurse. In addition, the case information was passed along to the health board and medical board to follow up with the facility and physician.

This scenario illustrates the need for nurses to question practices that may result in violations of confidentiality and privacy. Nurse managers should be aware of these situations and take steps to minimize such risks.

SCENARIO 7

Jamie has been a nurse for 12 years, working in hospice for the last six years. One of Jamie's current patients, Maria, maintained a hospital-sponsored communication page to keep friends and family updated on her battle with cancer. Jamie periodically read Maria's postings, but had never left any online comments. One day, Maria posted about her depression and difficulty finding an effective combination of medications to relieve her pain without unbearable side effects. Jamie knew Maria had been struggling and wanted to provide support, so she wrote a comment in response to the post, stating, "I know the last week has been difficult. Hopefully the new happy pill will help, along with the increased dose of morphine. I will see you on Wednesday." The site automatically listed the user's name with each comment. The next day, Jamie was shopping at the local grocery store when a friend stopped her and said, "I didn't know you were taking care of Maria. I saw your message to her on the communication page. I can tell you really care about her and I am glad she has you. She's an old family friend, you know. We've been praying for her but it doesn't look like a miracle is going to happen. How long do you think she has left?" Jamie was instantly horrified to realize her expression of concern on the webpage had been an inappropriate disclosure. She thanked her friend for being concerned, but said she couldn't discuss Maria's condition. She immediately went home and attempted to remove her comments, but that wasn't possible. Further, others could have copied and pasted the comments elsewhere.

At her next visit with Maria, Jamie explained what had happened and apologized for her actions. Maria accepted the apology, but asked Jamie not to post any further comments. Jamie self-reported to the BON and is awaiting the BON's decision.

This scenario emphasizes the importance for nurses to carefully consider the implications of posting any information about patients on any type of website. While this website was hospital sponsored, it was available to friends and family. In some contexts it is appropriate for a nurse to communicate empathy and support for patients, but they should be cautious not to disclose private information, such as types of medications the patient is taking.

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Attachment D

Summary of Social Networking Survey to Boards of Nursing (BONs)

This survey was conducted in November 2010. Of the 46 BONs that responded, 33 have received complaints about nurses who have violated patient privacy by posting information about patients or photos on social networking sites. Of these 33 BONs, 26 have disciplined nurses for violating patient privacy in the following ways:

- Censuring;
- Letters of concern;
- Voluntary action (such as agreeing to conditions on practice or voluntary suspension) to resolve the complaint; and
- Informal discipline and education.

The BONs indicated that they are making decisions on a case-by-case basis.

When asked whether BONs have social networking guidelines in place for protecting patient privacy, most do not (40 BONs). Of the six BONs that do, they referred to their general guidelines on protecting patient confidentiality.

General comments included:

- Need for social networking guidelines/information (nine BONs);
- Suggest using confidentiality/privacy regulations (four BONs); and
- Challenges for regulators:
  - Difficult to get access to the information posted;
  - Sites ignore subpoenas;
  - Nurses don't realize that the Internet is public;
  - How far should regulation go? We can't regulation personal lives. Need to let nurses debrief;
  - Generational vs. societal values are clashing;
  - In the future nurses may change their identity so the information cannot be used against them; and
  - We should focus on prevention, rather than disciplining bad outcomes.

Attachment E

Guidelines for Regulatory Decision Making Related to Criminal Conduct

NCSBN's Disciplinary Resources Committee developed a systematic process for boards of nursing (BONs) to use that promotes more consistency as they make difficult decisions related to criminal behavior. As a foundation for this work, the committee reviewed the literature, met with experts in criminal background behavior and surveyed BONs for any guidelines.

This process allows for each BON to integrate its unique laws and definitions into the process and was developed with the assumption that generally, decisions are made on a case-by-case basis. However, absolute bars can be added.

Mitigating and aggravating circumstances were identified from BON experiences and the literature reviewed. Research supporting these factors is provided to promote evidence-based regulatory decision making; however, more work needs to be done in this area.

Reviewing the grid below, there is a two-step process for individualizing it to a BON:

1. BONs will determine their own tier descriptions under Nature/Severity based on their law and the nature/severity of the criminal offense (see below for additional guidance).
2. BONs will determine their range of disciplinary sanctions, which may be different from those illustrated in the grid.

Disciplinary Outcomes Depending on Unique Circumstances of Case					
Nature/ Severity	**Minimum: Fine/ Reprimand**	**Oversight for 1-2 years via Probationary Conditions/ Restrictions**	**Oversight for 2-5 years via Probationary Conditions/ Restrictions**	**Suspension: Time Period Varies**	**Maximum: Revocation/**
Low (Non-serious)	X	X	X		
Moderate (More serious)		X	X	X	
Severe (Egregious)			X	X	X

GUIDANCE ON USE OF THIS GRID

When presented with a case, BONs will determine which tier the nurse's crime fits based on its nature/severity (low, moderate or severe). As BONs develop their own tier descriptions, options to distinguish between "lower" gravity offenses and "more serious" criminal offenses might include their state's classifications of crimes, e.g., misdemeanors for the "low" tier and Class A felonies for the "severe" tier. BONs could also develop their own crime categories for the tier analysis, such as crimes "against property" versus "crimes against persons"; "nonviolent versus violent"; crimes involving "deceit" versus "other" crimes, etc. In cases where there are multiple convictions this can be viewed as a significant aggravating factor.

Next, the BON will determine the range of disciplinary actions, based on the unique factors of the case. The BON identifies the unique, salient facts of the nurse's past criminal conduct and using these "aggravating" or "mitigating" factors, selects the severity of the sanction within the identified tier. Aggravating factors move the appropriate sanctions towards the maximum end of the tier range. Mitigating factors move the appropriate sanctions towards the minimum end of the tier range. BONs should start at the middle range – oversight for two years.

The goal is not to remove all discretion and establish a rigid formula for meting out sanctions, but instead imbue the BON's decision-making process with an analytical framework to ensure that sanctions are not viewed as arbitrary or inconsistent. BONs should complete the above grid with notes as to which tier was identified as appropriate and which unique factors were used to arrive at the appropriate sanction.

MITIGATING AND AGGRAVATING CIRCUMSTANCES TO CONSIDER

The following nonexclusive list identifies factors that may mitigate or aggravate the sanctions that should be imposed.

Aggravating Factors

- Sexual predator: Recommended to be an absolute bar. Research particularly finds the following range of behaviors to be predictors of recidivism in sexual offenders, though no single factor is absolutely linked to recidivism. The single strongest predictor is sexual interest in children as measured by phallometric measurement (r=0.32, with a total sample of 4,853 and a total of seven studies). The next five include:
  - Any deviant sexual preference (r=0.22; sample size 570; five studies);
  - Prior sexual offenses (r=-0.19; sample size 11,294; 29 studies);
  - Treatment drop out (r=-0.17; sample size 806; six studies);
  - Any stranger victims (r=0.15; sample size 465; four studies); and
  - Anti-social personality (r=0.14; sample size 811; six studies).

  (Hanson & Bussière, 1998; Hanson, 2000)

Investigators should be required to check the sex offender registry or the Falsified Identity Tracking System (FITS) to see if the nurse being investigated is on the list.

- "Criminal thinkers" (as described by Surowiec, 2010): There is a strong link between antisocial personality, and particularly psychopathy[1] with criminal behavior. Psychopathy is a more severe disorder where the individual lacks remorse and shows antisocial behaviors (Surowiec, 2010). See Appendix I for guidance on psychological tests for assessing criminality and Appendix II for selecting an evaluator.
- Repeat offenders: The *Boston University Law Review* reports that all states consider prior convictions to be an aggravating sentencing factor (Hessick, 2008). Bouffard, Bry, Smith and Bry (2008) found that hypothetical criminal decision making differed in a sample of known offenders relative to a sample of university students, which suggests that repeat offenders are "criminal thinkers." However, this group should be considered cautiously, as repeat offending is not a reliable measure of recidivism, and yet it is widely considered when sentencing (Surowiec, 2010).
- Recency of the crime: If it has been more than five years since the last crime, nurses are less likely to recidivate (based on BON experiences).
- Status of the victim: The relationship between the victim and the perpetrator and any unique vulnerabilities attributed to the victim should be considered. Crimes against strangers are linked to higher recidivism (Hanson & Bussière, 1998; Hanson, 2000).
- Nurse's attitude and degree of responsibility for the outcome: Lack of remorse, candor, admission of key facts and whether they self-reported and/or cooperated with the BON investigation should be considered (based on BON experiences, though lack of remorse can be associated with a psychopathic personality and psychological testing might be considered [American Psychiataric Association, 2000; Surowiec, 2010]).

1 Salekin, Rogers, Ustad and Sewell (1998) report that 15 to 30 percent of incarcerated offenders are psychopathic.

- Abuse of trust: Did the crime involve professional boundary violations, breach of fiduciary duty, privacy or anything that abuses the relationship? Did the nurse take advantage of the victim? (based on BON experiences)
- Intentional or deliberative act(s): Degree of intent (forethought, planning, etc.), selfish motivation; a dishonest act done for personal gain (based on BON experiences).
- Past disciplinary record: Particularly if it indicates a pattern (Zhong, Kenward, Sheets, Doherty & Gross, 2009), though must evaluate cautiously.
- Obstruction of the investigation or discipline process or proceedings: For example, presenting false evidence, statements or deceptive practices during the investigation or discipline process or proceedings (deceit is one of the characteristics of antisocial personality disorder, which is a well-established link to criminal behavior [American Psychiatric Association, 2000; Surowiec, 2010]).

Mitigating Factors

- Co-morbidity: Mental health issues at the time of the crime; however, mental illness when combined with substance abuse has been identified as an aggravating factor (Elbogen & Johnson, 2009; Castillo & Alarid, 2011).
- Personal circumstances at the time of the crime: Such as poverty or good support system (based on BON experiences).
- Evidence of good character or moral fitness: For example, presenting good character references from work associates who can vouch for nurse's reliability since crime (based on BON experiences; Hessick [2008] does not present research findings, but she analyzes why bad acts are considered in sentencing, though good acts often are not. She suggests that courts should consider good acts to be a mitigating sentence factor.).
- Offender socio-demographic variables: This is a complex relationship, but generally increasing age and violence against a family member is associated with decreased recidivism. Yet, one study suggests that with increasing age, one is significantly more likely to be involved in an acquaintance or family homicide, but significantly less likely to be involved with a stranger homicide (Cao, Hou, & Huang, 2008).
- Voluntary restitution: Remedial action (based on BON experiences; Hessick, 2008, as above).
- Evidence of successful rehabilitation: For example, education and work experience; presents evidence of competence to practice (based on BON experiences; Hessick, 2008, as above).

PSYCHOLOGICAL TESTS FOR CRIMINALITY

The link between anti-social personality disorder (APD) and criminal behavior is well established, according to Surowiec (2010). Studies have found that APD can negatively impact how people perceive and interact with the world, causing poor judgment and behavior problems (Surowiec, 2010; Sevecke, Lehmkuhl, & Krischer, 2009). Psychopathy is an even more severe form of APD because these individuals experience a lack of remorse or guilt about their actions and demonstrate antisocial behavior. Salekin, Rogers, Ustad and Sewell (1998) assert that 15-30 percent of all incarcerated offenders are psychopathic. Substance abuse and certain mental illnesses (e.g., schizophrenia, bipolar disorder, major depression) can further increase the chance of criminal activity in people with antisocial traits (Gendreau, Little, & Goggin, 1996; Surowiec, 2010).

Therefore, when BONs evaluate criminal behavior in nurses, it is highly recommended that the nurse be comprehensively evaluated by a qualified psychologist. The following are three recommended tools for assessing criminality:

1. Psychological Inventory of Criminal Thinking Styles (PICTS) is a well-researched tool developed to identify criminal-thinking behaviors. It not only identifies maintaining criminal lifestyles, but also is useful in predicting recidivism (Surowiec, 2010; Gonsalvez, Scalora & Huss, 2009; Walters, 2002; Walters, 2010).
2. It is recommended that PICTS be used with the Psychopathy Checklist-Revised (PCL-R) (Hare, 2003) to look at recidivism. PICTS does not incorporate behavioral items and a combination of cognitive and behavioral items may improve prediction of future criminal behavior (Gonsalvez et al., 2009; Surowiec, 2010).
3. The Historical, Clinical and Risk Management Scales (HCR-20) have also been used to predict violent behavior (Douglas, Ogloff, Nicholls, & Grant, 1999; Douglas & Webster, 1999; Grann, Belfrage, & Tengstrom, 2000; Surowiec, 2010; Strand, Belfrage, Fransson, & Levander, 1998). These scales evaluate clinical state and effectiveness of risk management strategies.

SELECTING AN EVALUATOR FOR CRIMINAL BEHAVIOR

Predicting whether criminal offenders will recidivate is very difficult (Surowiec, 2010). Selecting a qualified evaluator for assessing criminal thinking in the offender will be very important. Psychological tests should be administered by a trained professional, such as a licensed clinical psychologist. Evaluators should be selected based on their membership in and adherence to the practice and ethical standards espoused by the professional associations and BONs, such as the American Psychological Association.

BONs can visit http://locator.apa.org to find a psychologist as an evaluator in their area.

The following is a list of qualified professionals that BONs may want to contact:

- David M. Corey, PhD (Oregon and Washington)
- Phil Trompetter, PhD (California)
- Jocelyn Roland, PsyD (California)
- John Nicoletti, PhD (Colorado)
- Jeni McCutcheon, PsyD (Arizona)
- Doug Craig, PsyD (Illinois)
- Matt Guller, PhD, JD (New Jersey)
- Greg DeClue, PhD (Florida)
- Heather McElroy, PhD (Georgia)
- Herb Gupton, PhD (Hawaii)
- Gary Fischler, PhD (Minnesota)
- Byron Greenberg, PhD (Virginia)
- Darren Higginbotham, PsyD (Indiana)
- Terry McDaniel, PhD (Tennessee)
- Hank Paine, PhD (Alabama)
- Susan Hurt, PhD (North Carolina)
- Jon Moss, PhD (Virginia)
- Jay Supnick, PhD (New York)
- Peter Weiss, PhD (Connecticut)

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Report of the Finance Committee

Background

The Finance Committee advises the NCSBN Board of Directors (BOD) on the overall direction and control of the finances of the organization. The committee reviews and recommends a budget to the BOD. The committee monitors income, expenditures and program activities against projections, and presents quarterly financial statements to the BOD.

The Finance Committee oversees the financial reporting process; the systems of internal accounting and financial controls; the performance and independence of the auditors; and the annual independent audit of NCSBN financial statements. The committee recommends to the BOD the appointment of a firm to serve as auditors.

The Finance Committee makes recommendations to the BOD with respect to investment policy and assures that the organization maintains adequate insurance coverage.

Highlights of FY11 Activities

- Reviewed and discussed with management and the organization's independent accountant the organization's audited financial statements as of and for the fiscal year ending Sept. 30, 2010. With and without management present, the committee discussed and reviewed the results of the independent accountant's examination of the internal controls and financial statements. Based on the review and discussions referred to above, the Finance Committee recommended to the BOD that the financial statements and the Report of the Auditors be accepted and provided to the membership.
- Recommended the engagement of Blackman Kallick, LLP to audit the NCSBN financial statements for the period ending Sept. 30, 2011.
- Reviewed and discussed the long-range financial reserve forecast.
- Reviewed and discussed the financial statements and supporting schedules quarterly, and made recommendations that the reports be accepted by the BOD.
- Reviewed and discussed the performance of NCSBN investments with NCSBN staff and the organization's investment consultant, Becker Burke, quarterly. Informed the BOD that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed with the insurance brokers from USI Midwest the property and professional liability coverage for NCSBN. Informed BOD that the organization is appropriately insured.
- Recommended revisions to financial policies.

Future Activities

- There are no recommendations. The purpose of this report is for information only.
- At a future meeting, the committee will review the budget proposal for the fiscal year beginning Oct. 1, 2011.

Attachments

A. Report of the Independent Auditors FY10

Members

Julia George, MSN, RN, FRE
North Carolina, Area III, Treasurer
(February 2011-August 2011)

Randall Hudspeth, MS, APRN, CNS/NP
Idaho, Area I, Treasurer
(August 2010-February 2011)

Cynthia Burroughs, PhD
Arkansas, Area III

Daniel Hudgins
North Carolina, Area III

Rula Harb, MS, RN
Massachusetts, Area IV

Mark Majek, MA, PHR
Texas, Area III

Diane M. Sanders, MN, RN, NEA-BC
Washington, Area I

Staff

Robert Clayborne, MBA, CPA
Director, Finance

Meeting Dates

- Dec. 1, 2010
- Feb. 4, 2011
- April 26, 2011
- July 6, 2011

Attachment A

Report of the Independent Auditors FY10

Blackman Kallick

Blackman Kallick, LLP
10 South Riverside Plaza, 9th Floor
Chicago, IL 60606

Phone 312-207-1040

Report of Independent Auditors

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

We have audited the accompanying statement of financial position of **National Council of State Boards of Nursing, Inc.** (NCSBN) as of September 30, 2010, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of NCSBN's management. Our responsibility is to express an opinion on these financial statements based on our audit. The financial statements of **National Council of State Board of Nursing, Inc.** as of and for the year ended September 30, 2009 were audited by other auditors whose report, dated December 10, 2009, expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides 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, 2010, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Blackman Kallick, LLP

December 13, 2010

National Council of State Boards of Nursing, Inc.

Statements of Financial Position

September 30, 2010 and 2009

	2010	2009
ASSETS		
Cash	$ 55,782,985	$ 29,246,205
Accounts receivable	137,100	108,618
Due from test vendor	7,473,879	5,811,596
Accrued investment income	348,850	560,601
Prepaid expenses	1,689,167	1,450,468
Investments	88,580,701	101,666,473
Property and equipment - net	4,666,506	4,670,912
Intangible asset - net	1,031,250	1,156,250
Cash held for others	452,292	409,060
Total assets	$ 160,162,730	$ 145,080,183
LIABILITIES AND NET ASSETS		
LIABILITIES		
Accounts payable	$ 1,238,299	$ 1,071,956
Accrued payroll, payroll taxes and compensated absences	646,765	568,047
Due to test vendor	10,472,628	10,260,493
Deferred revenue	187,500	311,552
Grants payable	636,717	562,570
Deferred rent credits	174,264	248,962
Cash held for others	452,292	409,060
Total liabilities	13,808,465	13,432,640
UNRESTRICTED NET ASSETS	146,354,265	131,647,543
Total liabilities and net assets	$ 160,162,730	$ 145,080,183

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Activities

Years Ended September 30, 2010 and 2009

	2010	2009
REVENUE		
Examination fees	$ 59,431,200	$ 60,650,700
Other program services income	6,055,024	5,583,909
Net realized and change in unrealized gain (loss) on investments	4,747,266	(722,547)
Interest and dividend income	3,249,677	3,651,908
Membership fees	186,000	181,500
Total revenue	73,669,167	69,345,470
EXPENSES		
Program services		
Nurse competence	41,264,703	36,320,749
Nurse practice and regulatory outcome	6,552,005	5,085,136
Information	8,186,682	7,070,994
Total program services	56,003,390	48,476,879
Supporting services		
Management and general	2,959,055	2,957,949
Total expenses	58,962,445	51,434,828
NET INCREASE	14,706,722	17,910,642
UNRESTRICTED NET ASSETS		
Beginning of year	131,647,543	113,736,901
End of year	$ 146,354,265	$ 131,647,543

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Cash Flows

Years Ended September 30, 2010 and 2009

	2010	2009
CASH FLOWS FROM OPERATING ACTIVITIES		
Net increase	$ 14,706,722	$ 17,910,642
Adjustments to reconcile net increase to net cash provided by operating activities		
Depreciation and amortization	2,887,546	2,503,815
Net realized and change in unrealized (gain) loss on investments	(4,747,266)	722,547
(Increase) decrease in assets		
Accounts receivable	(28,482)	81,497
Due from test vendor	(1,662,283)	28,517
Accrued investment income	211,751	(52,889)
Prepaid expenses	(238,699)	(132,827)
Increase (decrease) in liabilities		
Accounts payable	166,343	(222,099)
Accrued payroll, payroll taxes and compensated absences	78,718	19,938
Due to test vendor	212,135	318,752
Deferred revenue	(124,052)	(26,858)
Grants payable	74,147	(759,077)
Deferred rent credits	(74,698)	(74,699)
Net cash provided by operating activities	11,461,882	20,317,259
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of property and equipment	(2,758,140)	(2,950,774)
Purchase of intangible assets	-	(1,250,000)
Purchases of investments	(17,962,958)	(73,142,286)
Proceeds on sale of investments	35,795,996	37,650,175
Net cash provided by (used in) investing activities	15,074,898	(39,692,885)
Net increase (decrease)	26,536,780	(19,375,626)
CASH		
Beginning of year	29,246,205	48,621,831
End of year	$ 55,782,985	$ 29,246,205

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2010 AND 2009

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 as a whole have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America (GAAPUSA).

Basis of Presentation - 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.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue Recognition - Revenue from NCLEX fees is recognized when an exam registration is complete, rather than when the registrant either takes the examination or is no longer eligible to do so. NCSBN does not believe its policy regarding this revenue and the corresponding test vendor costs to be a significant departure from GAAPUSA.

Revenue from member dues is recorded in the applicable membership period.

Revenue from member service conference fees is recognized in the period the conference is held.

Revenue for E-Learning Course sales is recognized at registration when access is granted to the course.

Revenue for licensure verification fees is recognized when a verification request is submitted.

Revenue from publication sales is recognized when customers complete the subscription process.

Accounts Receivable - Represents amounts owed to NCSBN for services dealing with board membership fees, meeting fees and online course revenue. Accounts receivable at September 30, 2010 and 2009 were $137,100 and $108,618, respectively. An allowance for doubtful accounts was not considered necessary.

Investments - NCSBN assets are invested in various securities, including United States government securities, corporate debt instruments and unit investment trust securities. Investment securities, in general, are exposed to various risks, such as interest rate risk, credit risk and overall market volatility. NCSBN invests in securities with contractual cash flows, such as asset backed securities, collateralized mortgage obligations and commercial mortgage backed securities. The value, liquidity and related income of these securities are sensitive to changes in economic conditions, including real estate value, delinquencies or defaults, or both, and may be adversely affected by shifts in the market's perception of the issuers and changes in interest rates. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

Investments of NCSBN are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price).

Money market funds are valued at fair value.

Certificates of deposit values are determined from new issue market and direct dealer quotes.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Purchases and sales of the investments are reflected on a trade-date basis.

Dividend income is recorded on the ex-dividend date. Interest income is recorded on the accrual basis.

Fair Value Measurements - During 2009, NCSBN adopted the new GAAPUSA guidance on fair value measurements and disclosures for all financial assets and liabilities carried at fair value. The new guidance defined fair value, established a framework for measuring fair value and expanded disclosures about fair value measurements. In September 2009, NCSBN adopted the guidance for nonrecurring fair value measurements of certain debt securities, which guidance had been previously deferred. The adoption of this guidance had no material effect on NCSBN's financial statements.

In September 2009, the Financial Accounting Standards Board (FASB) issued new guidance regarding the use of net asset value per share provided by the investee as a practical expedient to estimate the fair value of alternative investments. NCSBN's adoption of this new guidance had no material effect on its financial statements, but did result in additional, or changed, disclosures.

Due from Test Vendor - Due from test vendor represents amounts due from Pearson VUE for accrued volume discounts. NCSBN has contracted with Pearson VUE to administer and deliver nurse licensure examinations. Pearson VUE uses a tier-based volume pricing schedule to determine its fee price to provide the examination. Base price fees before calculating discounts are paid to Pearson VUE for administered exams during the year. Volume discounts are accrued during the year. The amounts owed by Pearson VUE at September 30, 2010 and 2009 were $7,473,879 and $5,811,596, respectively.

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	useful life or life of lease

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Intangible Asset - The intangible asset represents the purchase of the intellectual property rights for the National Nurse Aide Assessment Program nurse aid certification examination and the medication aid certification examination. The investment is carried at cost and amortization is computed using the straight-line method over a 10-year period. Amortization expense for the years ended September 30, 2010 and 2009 was $125,000 and $93,750, respectively.

	2010	2009
Intellectual property	$ 1,250,000	$ 1,250,000
Less accumulated amortization	(218,750)	(93,750)
	$ 1,031,250	$ 1,156,250

Due to Test Vendor - NCSBN accrues a base price fee for each candidate for whom a completed candidate application to take NCLEX is processed by Pearson VUE. At the end of each month, NCSBN pays an amount equal to the base price multiplied by the number of candidates who were administered the examinations during the preceding month.

Due to test vendor includes accrued amounts totaling $6,775,400 at September 30, 2010 and $7,033,000 at September 30, 2009 for registered candidates who at year end had not taken the exam. Also included is the amount payable to Pearson VUE for administered exams that had not been paid at the end of the year.

Deferred Revenue - Deferred revenue consists of membership fees of $187,500 for 2010 and $181,500 for 2009 and online course revenue of $0 for 2010 and $130,052 for 2009.

Grants Payable - Grants payable represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded four grants ranging in amounts from $150,300 to $300,000 during the current year. At September 30, 2010, the amount remaining to be paid on grants awarded for 2010 and 2009 is $561,767 and $74,950, respectively.

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.

Statement of Cash Flows - For purposes of the statement of cash flows, cash includes only monies held on deposit at banking institutions, petty cash and certificates of deposit with an initial maturity date of less than three months when purchased. It does not include cash held for others.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimates - The preparation of financial statements in conformity with GAAPUSA 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.

Subsequent Events - NCSBN has evaluated subsequent events through December 13, 2010, the date the 2010 financial statements were available to be issued and December 10, 2009 with respect to the comparative 2009 financial statements.

NOTE 3. INCOME TAX

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the 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).

NCSBN's adoption of the Income Tax Topic regarding uncertain tax positions of GAAPUSA on September 30, 2009 had no effect on its financial position as management believes NCSBN has no material unrecognized income tax benefits, including any potential risk of loss of its not-for-profit status. NCSBN would account for any potential interest or penalties related to possible future liabilities for unrecognized income tax benefits as interest, which would be included in the statement of activities supporting services management and general expenses. NCSBN is no longer subject to examination by federal, state or local tax authorities before 2007. Prior to adoption of the Income Tax Topic, NCSBN accounted for tax positions under a contingent loss model, requiring recognition of a tax liability when it was both (1) probable that it had been incurred at fiscal year-end and (2) the amount could be reasonably estimated.

NOTE 4. CASH CONCENTRATIONS

The cash balance at September 30, 2010 and 2009 consisted of the following:

	2010	2009
JP Morgan Chase		
Checking account	$ 7,395	$ 5,153,039
Money market account	14,043,202	23,372,418
Savings account	16,403,892	-
Wells Fargo Bank		
Checking account	799,684	672,777
Harris Bank		
Money market account	24,486,471	100
Credit card merchant accounts	42,091	47,621
Petty cash	250	250
Total	$ 55,782,985	$ 29,246,205

NCSBN places its cash with financial institutions deemed to be creditworthy. Effective October 3, 2008, balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 and balances in non-interest bearing transaction accounts are insured without limit. The $250,000 limit will be in effect through December 31, 2013. Balances in non-interest bearing transaction accounts are fully insured through December 31, 2012. The majority of the balances in the accounts above exceed insured limits.

NOTE 5. FAIR VALUE MEASUREMENTS

GAAPUSA defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. GAAPUSA describes three approaches to measuring the fair value of assets and liabilities: the market approach, the income approach and the cost approach. Each approach includes multiple valuation techniques. The topic does not prescribe which valuation technique should be used when measuring fair value, but does establish a fair value hierarchy that prioritizes the inputs used in applying the various techniques. Inputs broadly refer to the assumptions that market participants use to make pricing decisions, including assumptions about risk. Level 1 inputs are given the highest priority in the hierarchy while Level 3 inputs are given the lowest priority. Financial assets and liabilities carried at fair value are classified in one of the following three categories based upon the inputs to the valuation technique used:

- Level 1 - Observable inputs that reflect unadjusted quoted prices for identical assets or liabilities in active markets at the reporting date. Active markets are those in which transactions for the asset or liability occur in sufficient frequency and volume to provide pricing information on an ongoing basis.

NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

- Level 2 - Observable market-based inputs or unobservable inputs that are corroborated by market data.

- Level 3 - Unobservable inputs that are not corroborated by market data. These inputs reflect management's best estimate of fair value using its own assumptions about the assumptions a market participant would use in pricing the asset or liability.

The following tables set forth by level within the fair value hierarchy NCSBN's financial assets and liabilities that were accounted for at fair value on a recurring basis at September 30, 2010 and 2009. As required by GAAPUSA, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. NCSBN's assessment of the significance of a particular input to the fair value measurement requires judgment, and may affect their placement within the fair value hierarchy levels. Total NCSBN investment assets at fair value classified within Level 3 were $3,987,136 and $2,741,621 at September 30, 2010 and 2009, respectively, which consists of NCSBN's real estate investment trust funds. Such amounts were approximately 4% and 3% of total investments as reported on the statement of net assets available for benefits at fair value at September 30, 2010 and 2009, respectively.

		Recurring Fair Value Measurements as of Reporting Date Using:		
	Fair Values as of September 30, 2010	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Fixed Income				
U.S. Government and Government Agency obligations	$ 31,389,093	$ 17,555,214	$ 13,833,879	$ -
Corporate bonds	12,395,676	-	12,395,676	-
Mutual funds				
Spartan Extended Market Index Fund	8,195,830	8,195,830	-	-
Spartan International Index Fund	4,763,500	4,763,500	-	-
DWS Equity 500 Index Fund	24,035,652	24,035,652	-	-
Other	63,570	63,570	-	-
International equity fund - Limited liability company	3,467,847	-	3,467,847	-
Real estate investment trust	3,987,136	-	-	3,987,13
Total	$ 88,298,304	$ 54,613,766	$ 29,697,402	$ 3,987,13

NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

	Recurring Fair Value Measurements as of Reporting Date Using:			
	Fair Values as of September 30, 2009	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Fixed Income				
U.S. Government and Government Agency obligations	$ 27,869,552	$ 14,780,962	$ 13,088,590	$ -
Corporate bonds	12,207,601	-	12,207,601	-
Mutual funds				
Spartan Extended Market Index Fund	6,476,947	6,476,947	-	-
Spartan International Index Fund	4,615,274	4,615,274	-	-
DWS Equity 500 Index Fund	20,196,047	20,196,047	-	-
Other	47,199	47,199	-	-
International equity fund - Limited liability company	3,163,536	-	3,163,536	-
Real estate investment trust	2,741,621	-	-	2,741,62
Total	$ 77,317,777	$ 46,116,429	$ 28,459,727	$ 2,741,62

Not included in the tables is $282,397 and $24,348,696 in money market funds and certificates of deposit at September 30, 2010 and 2009, respectively.

LEVEL 1

Fixed Income
The estimated fair values for NCSBN's fixed income securities were based on quoted market prices in an active market.

Mutual Funds
The respective fair values of these investments are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value.

NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

LEVEL 2

Fixed Income
Fixed income securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. To the extent that quoted prices are not available, fair value is determined based on a valuation model that include inputs such as interest rate yield curves and credit spreads. Securities traded in markets that are not considered active are valued based on quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency.

International Equity Fund - Limited Liability Company
In 2010, the estimated fair value of the international equity fund is based on net asset values, which is determined by reference to the fund's underlying assets and liabilities.

In 2009, the estimated fair value was based off prices on one or more national securities or commodities exchanges or generally accepted pricing services to determine the fair value of publicly traded assets.

LEVEL 3

Real Estate Investment Trust
In 2010, the estimated fair value of the real estate investment trust was based on net asset values, which is determined by reference to the fund's underlying assets and liabilities.

In 2009, the fair value was determined by reference to the fund's underlying assets, which are principally real estate properties. The value of interests held in the real estate investment trust is determined by the general partner, based upon third-party appraisals of the underlying real estate assets.

NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

The tables below set forth a summary of changes in the fair value of Level 3 assets for the years ended September 30, 2010 and 2009:

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)
	Real Estate Investment Trust
Balance at 10/1/09	$ 2,741,621
Contributions	1,000,000
Net realized and unrealized gain on investments	45,356
Interest and dividend income	244,897
Sale of investments	(44,738)
Balance at 9/30/10	$ 3,987,136

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)
	Real Estate Investment Trust
Balance at 10/1/08	$ 5,224,499
Net realized and unrealized loss on investments	(2,580,399)
Interest and dividend income	148,478
Sale of investments	(50,957)
Balance at 9/30/09	$ 2,741,621

	Fair Value	Unfunded Commitments	Redemption Frequency (If Currently Eligible)	Redemption Notice Period
International equity fund - Limited liability company (a)	$ 3,467,847	$ -	Monthly	10 days
Real estate investment trust (b)	$ 3,987,136	$ -	Quarterly	90 days

NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

(a) The international equity fund invests in equity securities of issuers: which are organized, headquartered, or domiciled in any country included in the Europe Australasia Far East Index (the EAFE Index), or whose principal listing is on a securities exchange in any country included in the EAFE Index. Under normal conditions, the fund will invest in a minimum of 30 issuers, and is restricted from investing more than 10% of its total assets in the equity securities of any single issuer.

(b) The real estate investment trust represents an ownership interest in a private equity fund. The real estate investment trust invests in a diversified portfolio of primarily institutional quality real estate assets within the United States. The fund has a long-term investment objective of delivering an 8-10% total return over a market cycle. All portfolio assets are acquired through Clarion Lion Properties Fund Holdings, L.P., a limited partnership. The properties within the portfolio are valued on a quarterly basis to establish market value estimates of the fund's assets for the purpose of establishing the fund's net asset value. Ownership interests and redemptions are calculated based upon net asset value. The values of the properties are established in accordance with the fund's independent property valuation policy. Each property is appraised by third-party appraisal firms identified and supervised by an independent appraisal management firm retained by the investment manager. Shares will be redeemed at the net asset value at the last day of the calendar quarter immediately preceding the redemption date. To the extent that liquid assets are insufficient to satisfy redemption requests, interests will be redeemed as liquid assets become available.

NOTE 6. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2010 and 2009 is as follows:

	2010	2009
Property and equipment		
Furniture and equipment	$ 1,437,865	$ 1,437,879
Course development costs	271,729	271,729
Computer hardware and software	18,880,967	16,288,240
Leasehold improvements	440,183	440,183
	21,030,744	18,438,031
Less accumulated depreciation and amortization	(16,364,238)	(13,767,119)
Net property and equipment	$ 4,666,506	$ 4,670,912

Depreciation and amortization expense was $2,762,546 and $2,410,065 for the years ended September 30, 2010 and 2009, respectively. Amortization expense on the intangible asset is not included in the above amount.

NOTE 7. OPERATING LEASE

NCSBN has a lease agreement for office and storage space which expires on January 31, 2013. The following is a summary by year of future minimum lease payments required under the office and storage space lease at September 30, 2010:

Year ending September 30,	
2011	$ 549,019
2012	565,469
2013	190,412
Total	$ 1,304,900

Rent expense for the years ended September 30, 2010 and 2009 was $533,173 and $517,610, respectively. Property taxes and common area maintenance expenses for the years ended September 30, 2010 and 2009 were $423,351 and $402,681, respectively.

NOTE 8. RETIREMENT PLANS

NCSBN maintains a 403(b) defined contribution pension plan covering all employees who complete six months of employment. Contributions are made at 8% of participants' compensation. NCSBN's policy is to fund accrued pension contributions. Retirement plan expense was $506,591 and $479,696 for the years ended September 30, 2010 and 2009, respectively.

In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan covering an employee with a contractual arrangement. The benefits under the plan are contingent upon completion of contractual obligations and are valued on an annual basis to reflect the return on NCSBN's investments.

NOTE 9. 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 was canceled or if guarantees for room blocks are not fulfilled. At September 30, 2010, the requirements to fulfill these commitments approximated $132,106.

NCSBN has also entered into various contracts for future services. At September 30, 2010, the requirements to fulfill these commitments approximate $1,269,375 and are expected to be completed within one year.

Report of the Institute of Regulatory Excellence (IRE) Committee

Background

Fiscal year 2010-2011 (FY10-11) was the eighth year of the IRE Fellowship Program, a four-year educational and professional development program for nursing regulators. Board members and staff, as well as associate board members and staff, are qualified to apply for participation in the program. The program requires the application of evidence-based concepts in decision making and leadership, prepares its graduates to be leaders in nursing regulation, and is designed to contribute to the body of knowledge related to nursing regulation through research and scholarly work. Throughout the program, participants design and implement a project that contributes to nursing regulation and networks with other participants and regulators, as well as with a mentor who assists them in their projects. They also participate in an annual IRE Conference, which focuses on four overall themes:

1. Public protection/role development of regulators;
2. Discipline;
3. Competency and evaluation/remediation strategies; and
4. Organizational structure/behavior (leadership and management).

Currently, there are a total of 23 participants in the program. They belong to the following cohorts:

- Year 4 (2008 cohort): Three fellows (one will move to the 2009 cohort, and two are completing in 2011)
- Year 3 (2009 cohort): Seven fellows (one will move to the 2010 cohort)
- Year 2 (2010 cohort): Five fellows
- Year 1 (2011 cohort): Eight fellows

Highlights of FY11 Activities

The following is a report on the committee's 2010 charges:

- Select 2011 IRE fellows and mentors, and approve project proposals and final reports.
  - There were eight applicants to the program for the 2011 cohort. The committee reviewed all applications for admission to the fellowship and determined they all met the criteria for an IRE fellowship.
  - Although the committee has now decided that mentors are to be chosen during the second year of the fellowship program, the 2011 fellows are actively engaged in identifying an appropriate mentor.
  - Literature reviews, project proposals and project reports have been reviewed, and feedback has been provided to the fellows.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
  - Evaluation of the fellowship program is ongoing with the goal of continuous improvement.
  - Based on feedback from IRE participants and staff, review and approval of projects by an Institutional Review Board (IRB) will be required for all proposals. This will provide assurance of protection of human subjects' confidentiality and anonymity. All fellows are expected to communicate their findings by presentation and publication.

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Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Linda L. Olson, PhD, RN, NEA-BC
Institute of Regulatory Excellence Associate, Nursing Regulation

Meeting Dates

- Oct. 7, 2010
- Dec. 13, 2010 (Conference Call)
- Jan. 10, 2011 (Conference Call)
- March 30, 2011 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative B
NCSBN advances the engagement and leadership potential of all members through education, information and networking.

Strategic Objective 1
Increase knowledge of regulation.

Strategic Objective 5
Leadership self-knowledge, governance and regulatory expertise enhanced.

- Approve the content of the annual IRE conference.
  - The theme of the 2011 conference centered around leadership and management: "Leadership: Using the Power of Imagination to Ignite Excellence." Presentations at the preconference included an overview of the research process, writing a literature review and preparing a proposal. New content was added on IRB history and process, as well as writing an IRB application. The evaluations of speakers and content from both the preconference and conference were highly positive.
  - The 2012 IRE Conference will be held in San Antonio, Tex. on the theme of public protection and role development of regulators.
- Explore strategies to continue engagement of inducted Fellows.
  - The committee discussed several strategies, such as inviting inducted Fellows to the IRE conference, and having a celebration at Midyear or Annual Meeting. It was decided to continue this charge for further discussion as part of the 2012 IRE Committee.

Future Activities

FY12 charges:

- Select 2012 IRE Fellows and mentors, and approve project proposals and final reports.
- Advise staff on continuous improvement of the IRE Fellowship program.
- Collaborate to determine the content of the annual IRE conference.
- Explore strategies to continue engagement of inducted IRE Fellows.

Attachments

None

Report of the Model Act & Rules Committee

Background

Since the adoption of the original NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules, several subsequent additions and alterations have been made to the substance and format of the document. The Model Act and Rules were revised by the 2004 NCSBN Delegate Assembly. Article XVIII was added and adopted by the 2005 NCSBN Delegate Assembly. Additional language regarding the authority to conduct criminal background checks was adopted in 2006 and the APRN legislative language was adopted during the 2008 NCSBN Delegate Assembly.

In fiscal year 2011 (FY11), the Model Act and Rules Committee was formed to ensure organization, consistency and relevancy of all the Model Act and Rules provisions.

Highlights of FY11 Activities

The committee was charged to:

- Review and revise the NCSBN Model Act and Rules as needed.

To this end, the committee has accomplished the following during FY11:

The committee surveyed the Member Boards for input to guide the direction of their revisions. According to their feedback, Member Boards recommended that the Model Act and Rules be more concise and consistent. The committee used these recommendations in their in-depth review of the Model Act and Rules. The committee focused their revisions on streamlining and clarifying the entire model.

The committee first determined a common format and organization for the Model Act and Rules. The committee decided that the Model Act and Rules should be published in two formats: act and rule side-by-side, as well as separate documents. Certain articles and sections were shifted and/or combined to increase clarity and readability of the document. Uniform word choice was also decided. For example, "jurisdiction" was chosen to replace "state" in order to include all Member Boards; the term "patient" is used instead of "client" due to the recent trend in literature that favors the use of that term.

The committee reformatted and revised a substantial portion of the Model Act and Rules, including the following sections: Title and Purpose; Definitions; The Board of Nursing; Violations and Penalties; Discipline and Proceedings; Emergency Relief; Reporting; and Revenue and Fees. Additionally, the committee began revising the nursing scope of practice and nursing assistive personnel articles and sections. For the definitions, the committee reviewed the use of each definition to determine whether inclusion or revision of those terms was appropriate. Legal definitions and other definitions deemed unnecessary were removed. In the committee's revision of the discipline provisions, language from the HIPDB/Nursys® Action Codes was incorporated into the act and rules. This was done in order to more closely align the Model Act and Rules with the HIPDB reporting terms and categories.

Revision of the licensure, education, and compact articles and sections were deferred for recommendation from the respective committees/groups.

Future Activities

Due to the detailed manner of the work required and the concurrent objectives with other committees, the Model Act & Rules Committee recommends the continuation of their work through FY12. The committee anticipates revising the remaining articles and sections according to the recommendations of the committee and per any language adopted at the 2011 Delegate Assembly. The committee feels it is important that the recommendations be incorporated by the Model Act and Rules Committee to maintain consistency and organization.

Members

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Ohio, Area II, Board Liaison

Staff

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Legislative Affairs Associate, Nursing Regulation

Meeting Dates

- Oct. 26-27, 2010
- Jan. 18-19, 2011
- April 4-5, 2011

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

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

Attachments

None

Report of the NCLEX® Examination Committee (NEC)

Background

As a standing committee of NCSBN, the NEC is charged with advising the NCSBN Board of Directors (BOD) 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. In order to accomplish this, 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 profession. The NEC also recommends test plans to the Delegate Assembly.

Additionally, the committee oversees the activities of the NCLEX® Item Review Subcommittee (NIRSC), which assists with the item development and review processes. Individual NEC members act as chair of the subcommittee on a rotating basis. Highlights of the NEC and NIRSC activities follow.

Highlights of FY11 Activities

The following lists the highlights and accomplishments in fulfilling the NEC charge for fiscal year 2011 (FY11).

Joint Research Committee (JRC)

The JRC is composed of NCSBN and Pearson VUE psychometric staff, along with a selected group of testing and measurement experts, which reviews and conducts psychometric research to provide empirical support for the use of the NCLEX examination as a valid measurement of initial nursing licensure. The JRC also investigates possible future enhancements to the examination programs.

Several new pieces of research have been completed. These projects include a validation study of NCLEX pass/fail decision criteria; a simulation study on alternate item rubrics; an investigation of examinee behaviors when interacting with various innovative item types; and a study comparing the efficacy of various hybrid item selection procedures to use in a computerized adaptive testing (CAT) examination.

The JRC also reviewed a number of research proposals during FY11. These proposals included a study of alternate Rasch testing models of the innovative item types; an examination of the effect of skills and response latency on the NCLEX; an investigation of the robustness of NCLEX ability estimates; and a comparison of scores and passing decisions on various item pool designs.

RN and PN Continuous Practice Analysis Studies

In 2009, NCSBN began development on the 2009 RN Continuous Practice Analysis study. Using the Internet, NCSBN began administering the 2009 RN Continuous Practice Analysis survey instruments in June 2009. The study was separated into four periods of administration and four forms of the survey instrument were administered in each period. The four survey forms contained a demographic survey and job task statements relevant to entry-level nursing practice.

Following each period, data sets from each survey form were combined, and demographic frequency analyses, as well as average rating analyses, were reported. Following the fourth period, all period data sets were analyzed collectively. The purpose of the 2009 RN Continuous Practice Analysis is to more readily evaluate the content of the NCLEX-RN to ensure it reflects current practice of registered nurses (RNs) in the U.S. and its Member Board territories. In addition, the study provides validity evidence for the appropriateness of NCLEX-RN content. Data analyses and final report of this study are near completion.

Currently, the 2011 RN Continuous Practice Analysis and 2011 PN Continuous Practice Analysis studies are underway. Data collection for these two studies began in December 2010. The data

Members

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Nicole Williams, MSN, RN
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Ada Woo, PhD
Senior Psychometrician, Examinations

Meeting Dates

- Oct. 25-26, 2010 (NCLEX® Examination Committee Business Meeting)
- Dec. 6-9, 2010 (NCLEX® Item Review Subcommittee Meeting)
- Jan. 24-26, 2011 (NCLEX® Examination Committee Business Meeting)
- March 28-31, 2011 (NCLEX® Item Review Subcommittee Meeting)
- June 27-30, 2011 (NCLEX® Item Review Subcommittee Meeting)
- August 22-25, 2011 (NCLEX® Item Review Subcommittee Meeting)

sampling design for the current studies are similar to that employed in the 2009 RN Continuous Practice Analysis study. Data collection will occur over four periods, with two survey forms administered in each period for each study. Individuals who successfully completed the NCLEX examinations from July 2010 to June 2011 will be sampled for the current studies. These studies are expected to be completed in FY12.

RN Practice Analysis and Knowledge Skills and Ability (KSA) Study

The triennial NCLEX-RN practice analysis and KSA study are currently underway. In November 2010, an RN panel of subject matter experts (SMEs) met to develop a comprehensive list of entry-level nursing activity statements that will be used to inform the test plan. A separate panel of SMEs was convened in the same month to generate knowledge statements relevant to entry-level registered nursing to survey new graduates, faculty and supervisors. The KSA survey will be used to inform item development for the NCLEX-RN. Both studies are scheduled to be completed in FY12.

PN Standard Setting Workshop

Every three years, NCSBN conducts a practice analysis for entry-level practical nurse licensure. Based on the practice analysis, NCSBN makes appropriate changes to the NCLEX-PN Test Plan if necessary and establishes a new passing standard based on the new test plan. These steps help ensure that the NCLEX-PN continues to reflect current nursing practice and that nurses who pass the NCLEX-PN will continue to meet minimal levels of nursing competence.

A panel of SMEs convened in Chicago Sept. 20-22, 2010, to conduct a criterion-referenced NCLEX-PN® Standard Setting Workshop. The SME panel was composed of nurses who represented all four NCSBN geographic areas and practiced in a variety of settings. The panel's findings supported the creation of a higher passing standard. The NCSBN BOD used the workshop results and recommendations from the panel as part of its considerations for the revised NCLEX-PN passing standard implemented on April 1, 2011. The new passing standard is -0.27 logits.

Item Pool Rotation Plan

NCSBN has been working to reduce the amount of time that it takes to bring examination items from conception to operational usage. Rather than having operational item pools deployed for six months, a three-month deployment would reduce the amount of time it takes to place new items into operational usage. Security could also be enhanced by reducing the window of availability for any given operational item pool. In preparation for the implementation of the quarterly item pools, the JRC conducted a series of studies to develop optimal NCLEX item pool design. The guiding principle for these studies is that the NCLEX CAT examinations generated from quarterly pools will be comparable to the semi-annual pools and will not show significant adverse impacts in terms of measurement precision, decision consistency, content validity or overall item exposure rates. Rigorous planning and research have been conducted to permit the transition from semi-annual to quarterly pool rotation.

Based on the information obtained from the aforementioned research studies, the NCLEX operational item pools were deployed quarterly beginning April 2010. Empirical data from the operational quarterly item pools deployed thus far suggested that the psychometric properties of the quarterly pools are comparable to those of the previous semi-annual pools.

NCLEX® Alternate Item Types

The NEC consistently reviews the present and future of the NCLEX examinations with an eye toward innovations that would maintain the examination's premier status in licensure. In keeping with this plan, the NCSBN Examinations content staff and Pearson VUE content staff finalized a strategy for the development and delivery of alternate item types that can include multimedia.

NCLEX® Test Center Enhancements

Pearson VUE opened two new Pearson Professional Centers (PPCs) in the U.S. and expanded seating capacity at seven other test centers during 2010. Based on the Memorandum of

Understanding and through research on test center capacity, NCSBN identified Harlingen, Tex. as a new PPC, which opened in June 2011. In addition, Pearson VUE will be opening 12 new PPCs in the U.S., two in Canada and will expand seating at 10 domestic PPCs in 2011. Member Boards are notified of these PPC updates prior to implementation.

Evaluated and Monitored NCLEX® Examination Policies and Procedures

The committee reviews the BOD's examination-related policies and procedures, as well as the NEC's policies and procedures annually, and updates them as necessary.

MONITORED ASPECTS OF EXAMINATION DEVELOPMENT

Conducted NEC and NIRSC Sessions

To ensure consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the NEC continue to chair NIRSC meetings. The NEC and the NIRSC (1) reviewed RN and PN operational and pretest items; (2) provided direction regarding RN and PN multiple-choice and alternate format items; and (3) made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes, integrated processes and the *NCLEX® Style Manual*. In addition to 100 percent validation by Pearson VUE staff, the NIRSC and NCSBN staff currently evaluate 10 percent of all validations for pretest items and 10 percent of all validations of master pool items scheduled for review.

Assistance from the NIRSC continues to reduce the NEC's item review workload, facilitating its efforts 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 16, with representation from all four NCSBN geographic areas. Orientation to the NIRSC occurs annually and at each meeting.

Monitored Item Production

Under the direction of the NEC, RN and PN pretest items were written and reviewed by NCLEX® Item Development Panels. NCLEX® Item Development Panels' productivity can be seen in Tables 1 and 2. As part of the contractual requirements with the test service, items that use alternate formats (i.e., any format other than multiple-choice) have been developed and deployed in item pools. Information about items using alternate formats is available to Member Boards and candidates in the *NCLEX® Candidate Bulletin*, candidate tutorial and on the NCSBN website.

Table 1. RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	4	47	2611	7	1542
April 03 – March 04	2	23	1097	5	1446
April 04 – March 05	1	12	301	4	1415
April 05 – March 06	5	66	2514	7	2885
April 06 – March 07	3	47	1835	6	3195
April 07 – March 08	3	47	1815	5	2556
April 08 – March 09	3	39	1724	5	3036
April 09 – March 10	6	66	1931	14	7948
April 10 – March 11	11	126	3208	15	7638

- April 11-12, 2011 (NCLEX® Examination Committee Business Meeting)
- July 19, 2011 (NCLEX® Examination Committee Conference Call)
- Sept. 26-29, 2011 (NCLEX® Item Review Subcommittee Meeting)

Relationship to Strategic Plan

Strategic Initiative C
NCSBN provides state-of-the-art competence assessments.

Strategic Objective 1
NCLEX development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards examination needs.

Table 2. PN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	3	33	1476	6	1547
April 03 – March 04	2	24	968	5	1611
April 04 – March 05	1	11	430	3	2124
April 05 – March 06	4	50	1938	5	3682
April 06 – March 07	3	45	2453	4	1661
April 07 – March 08	3	48	2378	6	3304
April 08 – March 09	1	16	551	6	2829
April 09 – March 10	2	24	869	5	1578
April 10 – March 11	3	35	1267	12	5776

NCSBN Item Development Sessions Held at Pearson VUE

Pearson VUE continues to work to improve item development sessions and increase the quality and quantity of NCLEX items.

Monitored Item Sensitivity Review

NCLEX® Pretest Item Sensitivity Review procedures are designed to eliminate item wording that could be elitist, stereotypical, have different meanings for different ethnic or geographic groups, or have an inappropriate tone. Review panels are composed of members who represent the diversity of NCLEX candidates. Prior to pretesting, items are reviewed by sensitivity panels and any items identified by the group are referred to the NEC for final disposition.

Evaluated Item Development Process and Progress

The NEC evaluated reports provided at each meeting on item development sessions conducted by the test service. NCLEX staff and scheduled committee representatives continue to oversee each panel. Overall, panelists and committee representatives in attendance have rated item development sessions favorably.

Monitored Development of Operational NCLEX® Item Pools

The NEC monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involves a few critical variables outlined in the NCLEX test plan; however, the quality control checks performed afterward are based on 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 committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Member Board Review of Items

BONs are provided opportunities to conduct reviews of NCLEX pretest and operational items twice a year. Based on this review, BONs may refer items to the NEC for review and comment for one of the following reasons: not entry-level practice, not consistent with the nurse practice act or for other reasons. In October 2010 the committee reviewed the items referred from the April 2010 Member Board Review. The NEC provided direction on the resolution of each item and staff gave Member Boards feedback on the NEC's decisions on all referred items. The NEC

encourages each Member Board to take advantage of the semi-annual opportunities to review NCLEX items. For the October 2010 review, six Member Boards participated; in April 2011, there were eight.

Item-related Incident Reports (IRs)

Electronically filed IRs may be submitted at PPCs when candidates question item content. Pearson VUE and NCSBN staff investigate each incident and report their findings to the NEC for decisions related to retention of the item.

MONITOR EXAMINATION ADMINISTRATION

Monitored Procedures for Candidate Tracking: Candidate-matching Algorithm

The NEC continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semi-annual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months.

Monitored the Security Related to Publication and Administration of the NCLEX®

The NEC continues to approach security proactively, and has developed and implemented formal evaluation procedures to identify and correct potential breaches of security.

NCSBN and Pearson VUE provide mechanisms and opportunities for individuals to inform NCSBN about possible examination eligibility and administration violations. In addition, NCSBN works directly with two third party security firms to patrol the Internet for websites and social media sites that may contain secure examination material/information or provide an environment for electronic dissemination of secure examination materials/information.

NCSBN also develops and maintains an annual site visit plan for its domestic and international test centers. The plan is designed to conduct unannounced onsite visits of test centers for the purpose of ensuring that NSCBN's established procedural/security measures are being consistently implemented by Pearson VUE test administration staff. NCSBN, Pearson VUE and the NEC are committed to vigilance in ensuring the security of the NCLEX examination

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

The NEC monitors compliance with the 30-/45-day scheduling rule. For the period of Jan. 1, 2010 to Dec. 31, 2010, Pearson VUE reported four potential violations against compliance; each of which was resolved. Pearson VUE has a dedicated department that 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 exceed 80 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX® Examination Administration

As part of its activities, the NEC and NCSBN Examinations 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 provider, Pearson VUE, can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®), available in Attachment A of this report.

Administered NCLEX® at International Sites

International test centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. See Attachment A of this report for the 2010 candidate volumes and pass rates for international testing centers.

EDUCATE STAKEHOLDERS

NCLEX® Research Presentations

At the 2011 American Educational Research Association (AERA) and National Council of Measurement in Education (NCME) joint annual meeting, two papers, "Extended Time Accommodations and Their Impact on High-stakes Licensure Examinations Differential Item Functioning" and "Assessing Drift in Item Parameters and Item Response Times in Computerized Adaptive Tests" were presented. AERA and NCME are internationally recognized professional organizations with the primary goal of advancing educational research and its practical application.

In addition to presenting scientific papers, NCSBN and test service psychometric staff conducted a workshop on item response theory (IRT) at the 2010 Association of Test Publishers (ATP) Annual Conference. This workshop provided a basic introduction to the principles, procedures and interpretations of IRT for nontechnical persons in the testing industry. ATP is an organization representing providers of tests, assessment tools and services. Its annual conference provides a venue where researchers and practitioners come together to improve practice and advance the field of testing and measurement. 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 and Publications

NCSBN Examinations staff conducted numerous NCLEX informational presentations, webinars and workshops. This included the following presentations:

- "Extended Time Accommodations and Their Impact on High-stakes Licensure Examinations Differential Item Functioning" and "Assessing Drift in Item Parameters and Item Response Times in Computerized Adaptive Tests" at the Joint Annual Meetings of AERA and NCME in New Orleans, La.;
- "Item Response Theory" and "Security Best Practices and Communicating Your Test Security Message" at the ATP Annual Conference in Phoenix, Ariz.; and
- "Test Security Strategies – Prevention, Investigation and Enforcement" and "Job Analysis Studies: What Works and What Doesn't" at the 2010 Institute for Credentialing Excellence (ICE) Annual Educational Conference in Atlanta, Ga.

In collaboration with test service, Examinations staff also published an article entitled "Understanding the Impact of Enemy Items on Test Validity and Measurement Precision" in the *CLEAR Exam Review*, which is published by the Council of Licensure, Enforcement and Regulation. It focuses on issues relevant to the licensure testing community and is geared toward a general audience.

In order to ensure NCSBN membership was kept current on the NCLEX program, the Examinations department hosted four informational webinars for Member Boards.

Additionally, as part of the department's outreach activities, content staff conducted seven NCLEX® Regional Workshops. Regional workshops are presented for the purpose of providing information to educators who are preparing students to take the NCLEX examination. The BONs that hosted a regional workshop were Florida, Illinois, Missouri, Nebraska, New Jersey, New York and Oklahoma. These opportunities assist NCSBN's Examinations department in educating stakeholders about the examination, as well as recruit for NCSBN item development panels.

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

NCLEX® Member Board Manual

The *NCLEX® Member Board Manual* contains policies and procedures related to the development and administration of the NCLEX examination. Each quarter, NCSBN updates the Member Board Manual to reflect any changes to policy and procedures. Recent changes included updates on readability, clarity and the addition of hyperlinks for easy access to forms and to the Member Board Review process.

NCLEX® Candidate Bulletin and *NCLEX® Candidate Bulletin At-A-Glance*

The candidate bulletin contains procedures and key information specific to candidates preparing to test for the NCLEX examination. The candidate bulletin is updated on an annual basis and can be obtained in electronic and/or hard copy format. An abbreviated at-a-glance version is also available.

NCLEX® Invitational

Historically, Examinations 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 2010 NCLEX® Invitational was held in Atlanta, Ga. on Sept. 13, 2010, with approximately 338 participants. In 2011, the name for the NCLEX Invitational changed to the NCLEX Conference. The 2011 NCLEX® Conference is scheduled for Sept. 26, 2011, at the Hotel Nikko in San Francisco, Calif.

NCLEX® Program Reports

Examinations staff monitors production of the NCLEX® Program Reports as delivered by the vendor. Program reports can be ordered, paid for and downloaded via a Web-based system that permits program directors and staff to receive reports quickly and in a more portable, electronic format. The Web-based system also allows subscribers to distribute the reports via email to people who need them most: faculty and staff that design curriculum and teach students. Subscribers may also copy and paste relevant data, including tables and charts, into their own reports and presentations. This is particularly beneficial if the program uses these reports to supplement the academic accreditation process.

Historically, NCLEX® Program Reports are offered on a semi-annual basis. Starting with the April 2010 reporting cycle, subscribers can now purchase an annual report, in addition to semi-annual reports. This allows subscribers to have an aggregate annual summary of graduate performance on the NCLEX. This also benefits smaller nursing programs that may not otherwise benefit from the semi-annual reports due to small graduating classes.

NCLEX® Unofficial Quick Results Service

BONs, through NCSBN, offer candidates the opportunity to obtain their "unofficial results" (official results are only available from the BONs) through the NCLEX® Quick Results Service. A candidate may call or use the Internet to access their unofficial result two business days after completing their examination. Currently, 47 BONs participate in offering this service to their candidates. In 2010, approximately 145,000 candidates utilized this service.

Future Activities

- Complete the continuous online RN and PN practice analyses.
- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate all aspects of the NCLEX program and initiate additional quality assurance processes as needed.
- Evaluate NCLEX informational initiatives such as the NCLEX Conference, NCLEX® Regional Workshops and other presentations.
- Evaluate ongoing international testing.

- Host the 2011 NCLEX® Conference.
- Introduce additional alternate format item types.
- Explore additional item writing strategies for the NCLEX.
- Conduct the RN practice analysis and KSA Study

Attachment

A. Annual Report of Pearson VUE for the NCLEX®

Attachment A

Annual Report of Pearson VUE for the NCLEX®

This report represents information gained during Pearson VUE's eighth full year of providing test delivery services for the NCLEX® examination program to NCSBN®. This report summarizes the activities of the past year.

Pearson VUE Organizational Changes

Jason Schwartz assumed the role of director of Test Development for the Pearson VUE NCLEX® team on Jan. 19, 2010. Schwartz's core areas of expertise are content development and online assessment. He was most recently the director of publishing systems for Pacific Metrics in Monterey, Calif., where he designed innovative tools and processes to automate and streamline the company's online publishing activities. While at Pacific Metrics and in his earlier work with CTB/McGraw-Hill, Schwartz made major contributions to the planning, design and implementation of numerous state, national, and international testing programs, including working with the Maryland State Department of Education, Louisiana Department of Education, Florida Department of Education, Wisconsin Department of Public Instruction and the U.S. Department of Defense. Schwartz has been a frequent presenter at conferences for such organizations as National Council of Teachers of Mathematics (NCTM), American Educational Research Association (AERA), and Council of Chief State School Officers (CCSSO). He has a Master of Science (MS) degree in mathematics from the University of Oregon and a Bachelor of Arts (BA) degree in mathematics from the University of California, Berkeley, where he graduated Phi Beta Kappa.

In July 2010, James Mooney joined the Pearson VUE NCLEX team as program manager. Before joining Pearson VUE in 2007, Mooney served as program manager for the National Association of Boards of Pharmacy (NABP) and the Pharmacy Technician Certification Board (PTCB). Prior assessment experience includes working for the College Board as associate director of Program Management. Responsibilities included coordinating strategic planning for the Advanced Placement (AP) Program and the PSAT, and working with the U.S. Department of Education and state education agencies to implement programs expanding professional development opportunities and student access to advanced education. A graduate of Marshall University, Mooney is currently pursuing an MBA at the University of Minnesota.

Greg Applegate assumed the role of psychometric intern for the Pearson VUE NCLEX team in August 2010. Applegate's core area of expertise is in item development. He is currently working on completing his dissertation in educational psychology with a specialty in educational measurement from Purdue University in West Lafayette, Ind. Before coming to Pearson VUE, Applegate taught courses in educational psychology and statistics. He holds BA and Master of Business Administration (MBA) degrees from Indiana University.

Test Development

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

NCLEX® Examinations Operations

NCSBN approved a quarterly cycle for operational pool deployment for the NCLEX-RN® and NCLEX-PN® examinations beginning April 1, 2010. The goal is to improve the operational pools with quarterly rotations enabling NCSBN to introduce new nursing content into the operational pools more quickly and reducing the time period in which a pool of operational items has

been exposed to the testing population. Starting from April 1, 2010, the standard NCLEX-RN® Examination pool contains 1,472 items and the standard NCLEX-PN® Examination pool contains 1,239 items.

Along with the change of pool deployment cycle, NCSBN has approved the NCLEX-RN cut-score to be raised from -0.21 logits to -0.16 logits beginning April 1, 2010. A new NCLEX-RN Test Plan was also approved and went into effect on April 1, 2010. Although the RN cut-score was raised in April 2010, there is no noticeable pattern of change in the passing rates for the overall candidates or first-time U.S.-educated candidates. The yearly statistics indicate that the NCLEX-RN Examination continues to be psychometrically sound. In addition, the NCLEX-PN® Standard Setting Workshop was conducted in Chicago Sept. 20-22, 2010. The standard setting was conducted using the modified Angoff method with 11 judges' ratings. The NCLEX-PN cut-score will be changed from -0.37 logits to -0.27 logits in effect on April 1, 2011.

Measurement and Research

The Joint Research Committee (JRC) met at the Pearson offices in Chicago on Aug. 20, 2010. In attendance were JRC members Gage Kingsbury, Mark Reckase, Steve Wise and Ed Wolfe; NCSBN staff Phil Dickison, Sarah Hagge, Weiwei Liu, Casey Marks and Ada Woo; and Pearson VUE staff Betty Bergstrom, Jerry Gorham, Shu-chuan Kao and Xin Li. There were four JRC guest researchers also present: Kirk Becker, Ira Bernstein, Kathy Haynie and Hong Jiao.

The JRC received updates on several ongoing projects, including the Decision Rule Study by Kingsbury; the Polytomous Item Scoring Study by Haynie, Jiao, Wolfe et al.; the Examinee Behavior with Innovative Items Study by Harmes and Wise; the Enemy Item Relation Study by Becker and Lai; and the Comparison of Hybrid Progressive Item Selection Procedures for Adaptive Tests Study by Bontempo, Kingsbury and Zara. Final reports of these studies were approved. The Partial Credit Scoring Study by Wolfe et al. is ongoing and an update was presented at the March 2011 meeting. The JRC also included discussion of Pretest Items Selection Criteria and NCLEX® Item Inventory Status.

Pearson VUE Meetings with NCSBN

- Jan. 25-26, 2010 NCLEX® Examination Committee Business Meeting
- March 4, 2010 NCSBN Test Content Meeting
- March 8-10, 2010 Midyear Meeting
- April 1, 2010 NCLEX® Development Meeting
- April 12-13, 2010 NCLEX® Examination Committee Business Meeting
- April 22-23, 2010 NCLEX® Operational Meeting
- May 20, 2010 NCSBN® Business Review
- June 3, 2010 NCLEX® Development Meeting
- July 20, 2010 NCLEX® Examination Committee Business Meeting
- Aug. 5, 2010 NCLEX® Channel/Security Meeting
- Aug. 10-13, 2010 NCSBN Annual Meeting
- Sept. 2, 2010 NCLEX® Development Meeting
- Sept. 13, 2010 2010 NCLEX® Invitational
- Oct. 25-26, 2010 NCLEX® Examination Committee Business Meeting
- Nov. 30, 2010 NCSBN Contract Evaluation Meeting
- Dec. 2, 2010 NCLEX® Development Meeting
- Dec. 3, 2010 NCLEX® Channel/Security Meeting

Monthly Meetings/Conference Calls

- Monthly conference calls are held with NCSBN, test development and operations, and scheduled more frequently, as needed.
- Conference calls with Pearson VUE and NCSBN content staff are held periodically, as needed.
- Other visits and conference calls are conducted on an as-needed basis.

Summary of NCLEX® Examination Results for the 2010 Calendar Year

Longitudinal summary statistics are provided in Tables 1-8. Results can be compared to data from the previous testing year to identify trends in candidate performance and item characteristics over time. Compared to 2009, the overall candidate volumes were lower for the NCLEX-RN (about -2.1 percent), but higher for the NCLEX-PN (about +2.1 percent). The RN passing rate for the overall group was 1.0 percentage points higher for 2010 than for 2009 and the passing rate for the reference group was 1.0 percentage points lower for this period compared to 2009. The PN overall passing rate was higher by 2.2 percentage points from 2009 and the PN reference group passing rate was 1.4 percentage points higher than in 2009. 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 2010 testing year for the NCLEX-RN Examination:

- Overall, 197,776 NCLEX-RN Examination candidates tested during 2010, as compared to 202,029 during the 2009 testing year. This represents a decrease of approximately 2.1 percent.
- The candidate population reflected 140,887 first-time, U.S.-educated candidates who tested during 2010, as compared to 134,725 for the 2009 testing year, representing a 4.6 percent increase.
- The overall passing rate was 74.2 percent in 2010, compared to 73.2 percent in 2009. The passing rate for the reference group was 87.4 percent in 2010 and 88.4 percent in 2009.
- Approximately 49.5 percent of the total group and 51.9 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than in the 2009 testing year in which 51.7 percent of the total group and 55.4 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 14.4 percent for the total group and 13.1 percent for the reference group. This is slightly higher than last year's figures (14.3 percent for the total group and 12.5 percent for the reference group).
- The average time needed to take the NCLEX-RN Examination during the 2010 testing period was 2.5 hours for the overall group and 2.3 hours for the reference group (close to last year's average times of 2.5 hours and 2.2 hours, respectively).
- A total of 56.6 percent of the candidates chose to take a break during their examinations (compared to 56.0 percent last year).
- Overall, 1.9 percent of the total group and 1.0 percent 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 2009 testing year (2.2 percent and 1.0 percent, respectively).
- In general, the NCLEX-RN Examination summary statistics for the 2010 testing period indicated patterns that were similar to those observed for the 2009 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 2010 testing year for the NCLEX-PN Examination:

- Overall, 82,519 PN candidates tested in 2010, as compared to 80,854 PN candidates tested during 2009. This represents an increase of approximately 2.1 percent.
- The candidate population reflected 66,830 first-time, U.S. educated candidates who tested in 2010, as compared to 63,534 for the 2009 testing year (an increase of approximately 5.2 percent).
- The overall passing rate was 78.1 percent in 2010 compared to 75.9 percent in 2009, and the reference group passing rate was 87.1 percent in 2010 compared to 85.7 percent in 2009.
- There were 56.2 percent of the total group and 60.8 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly higher than those from the 2009 testing year in which 55.1 percent of the total group and 59.6 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 15.8 percent for the total group and 13.4 percent for the reference group. These figures are slightly lower than last year's percentages (16.5 percent for the total group and 14.1 percent for the reference group).
- The average time needed to take the NCLEX-PN Examination during the 2010 testing period was 2.3 hours for the overall group and 2.1 hours for the reference group (very similar to last year's times of 2.3 and 2.1 hours, respectively).
- A total of 55.1 percent of the candidates chose to take a break during their examinations (compared to 55.2 percent last year).
- Overall, 1.7 percent of the total group and 0.9 percent of the reference group ran out of time before completing the test (slightly lower than last year's figures of 2.0 percent and 1.0 percent, respectively).
- In general, the NCLEX-PN Examination summary statistics for the 2010 testing period indicated patterns that were similar to those observed for the 2009 testing period. These results provide continued evidence that the administration of the NCLEX-PN Examination is psychometrically sound.

Table 1: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2010 Testing Year										
	Jan 10 - Mar 10		Apr 10 - Jun 10		Jul 10 - Sep 10		Oct 10 - Dec 10		Cumulative 2010	
	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	49,595	35,259	52,766	40,250	68,602	53,341	26,813	12,037	197,776	140,887
Percent Passing	76.1	89.9	77.7	90.3	75.4	84.9	60.5	81.7	74.2	87.4
Ave. # Items Taken	117.8	112.6	119.7	115.3	123.7	121.2	131.5	125.1	122.2	117.7
% Taking Min # Items	53.0	55.8	51.4	53.9	47.7	49.0	43.6	47.1	49.5	51.9
% Taking Max # Items	12.7	10.9	14.1	12.8	14.9	14.2	16.9	15.3	14.4	13.1
Ave. Test Time (hours)	2.5	2.3	2.3	2.1	2.5	2.4	3.0	2.6	2.5	2.3
% Taking Break	56.6	49.4	50.1	42.9	56.3	51.9	69.8	60.9	56.6	49.5
% Timing Out	2.2	1.1	1.3	0.5	1.5	1.0	3.9	2.3	1.9	1.0

Table 2: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2009 Testing Year										
	Jan 09 - Mar 09		Apr 09 - Jun 09		Jul 09 - Sep 09		Oct 09 - Dec 09		Cumulative 2009	
	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	46,891	31,060	52,565	35,468	73,790	56,440	28,783	11,757	202,029	134,725
Percent Passing	71.8	88.1	74.8	90.8	77.9	88.2	60.3	83.3	73.2	88.4
Ave. # Items Taken	120.8	115.2	118.4	110.9	120.8	116.4	127.7	120.5	121.2	115.1
% Taking Min # Items	52.1	55.9	54.0	58.5	51.9	54.4	46.2	49.4	51.7	55.4
% Taking Max # Items	14.1	12.3	13.4	11.2	14.5	13.1	16.1	13.6	14.3	12.5
Ave. Test Time (hours)	2.5	2.2	2.4	2.1	2.4	2.2	2.8	2.4	2.5	2.2
% Taking Break	56.3	48.8	53.4	43.0	54.3	48.3	64.6	53.2	56.0	47.5
% Timing Out	2.0	1.0	2.1	0.7	1.9	1.1	3.3	1.5	2.2	1.0

Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2010 Testing Year*										
Operational Item Statistics										
	Jan 10 - Mar 10		Apr 10 - Jun 10		Jul 10 - Sep 10		Oct 10 - Dec 10		Cumulative 2010	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.21	0.09	0.22	0.09	0.21	0.09	0.21	0.09	NA	NA
Ave. Item Time (secs)	74.2	34.5	71.4	32.5	71.1	25.4	79.8	36.5	NA	NA
Pretest Item Statistics										
# of Items	714		1,090		1,762		202		3,768	
Ave. Sample Size	655		553		449		530		522	
Mean Point-Biserial	0.08		0.08		0.08		0.09		0.08	
Mean P+	0.50		0.61		0.56		0.55		0.56	
Mean b	0.30		-0.33		-0.09		-0.10		-0.09	
SD b	1.63		1.67		1.84		1.72		1.76	
Total Number Flagged	321		495		792		93		1,701	
Percent Items Flagged	45.0		45.4		44.9		46.0		45.1	
*Data does not include research and retest items.										

Table 4: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2009 Testing Year*										
Operational Item Statistics										
	Jan 09 - Mar 09		**Apr 09 - Jun 09**		**Jul 09 - Sep 09**		**Oct 09 - Dec 09**		**Cumulative 2009**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.20	0.08	0.21	0.09	0.21	0.09	0.20	0.08	NA	NA
Ave. Item Time (secs)	71.8	17.4	73.9	36.5	72.8	35.9	76.6	36.4	NA	NA
Pretest Item Statistics										
# of Items	826		305		657		316		2,104	
Ave. Sample Size	532		1,542		586		513		692	
Mean Point-Biserial	0.08		0.07		0.07		0.08		0.08	
Mean P+	0.52		0.50		0.52		0.50		0.51	
Mean b	0.17		0.34		0.15		0.25		0.20	
SD b	1.79		1.76		1.62		1.35		1.67	
Total Number Flagged	368		154		315		116		953	
Percent Items Flagged	44.6		50.5		47.9		36.7		45.3	
*Data do not include research and retest items.										

Table 5: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2010 Testing Year										
	Jan 10 - Mar 10		**Apr 10 - Jun 10**		**Jul 10 - Sep 10**		**Oct 10 - Dec 10**		**Cumulative 2010**	
	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	18,793	15,099	18,006	13,926	26,673	22,953	19,047	14,852	82,519	66,830
Percent Passing	77.2	86.3	74.8	85.2	81.8	89.1	76.8	86.3	78.1	87.1
Ave. # Items Taken	116.0	111.8	116.8	111.6	111.4	108.2	115.3	110.6	114.5	110.3
% Taking Min # Items	54.0	58.4	54.2	59.7	59.8	63.4	55.4	60.1	56.2	60.8
% Taking Max # Items	16.4	14.1	17.2	14.1	14.3	12.4	16.2	13.4	15.8	13.4
Ave. Test Time (hours)	2.3	2.1	2.3	2.1	2.2	2.0	2.3	2.1	2.3	2.1
% Taking Break	57.4	51.1	56.3	49.0	50.7	45.8	57.8	51.2	55.1	48.9
% Timing Out	2.0	0.9	2.0	1.0	1.2	0.5	2.0	1.2	1.7	0.9

Table 6: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2009 Testing Year										
	Jan 09 - Mar 09		**Apr 09 - Jun 09**		**Jul 09 - Sep 09**		**Oct 09 - Dec 09**		**Cumulative 2009**	
	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	18,684	14,683	16,873	12,302	26,849	22,572	18,448	13,977	80,854	63,534
Percent Passing	74.1	84.0	72.2	84.2	80.4	88.0	74.5	85.1	75.9	85.7
Ave. # Items Taken	116.6	113.1	117.1	111.5	112.7	109.2	117.4	112.6	115.6	111.3
% Taking Min # Items	53.7	57.5	53.9	59.7	58.6	62.4	52.3	56.9	55.1	59.6
% Taking Max # Items	16.9	15.0	17.6	14.5	15.0	13.0	17.3	14.5	16.5	14.1
Ave. Test Time (hours)	2.2	2.1	2.3	2.1	2.1	2.0	2.4	2.2	2.3	2.1
% Taking Break	53.7	47.1	57.4	48.9	50.8	45.2	61.2	54.3	55.2	48.3
% Timing Out	1.8	1.0	2.4	1.2	1.7	0.9	2.1	1.1	2.0	1.0

Table 7: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2010 Testing Year*										
Operational Item Statistics										
	Jan 10 - Mar 10		**Apr 10 - Jun 10**		**Jul 10 - Sep 10**		**Oct 10 - Dec 10**		**Cumulative 2010**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.21	0.08	0.22	0.08	0.22	0.09	0.22	0.08	NA	NA
Ave. Item Time (secs)	67.4	22.4	67.9	19.4	65.5	23.5	68.8	20.7	NA	NA
Pretest Item Statistics										
# of Items	627		540		1,091		604		2,862	
Ave. Sample Size	586		645		500		563		560	
Mean Point-Biserial	0.09		0.12		0.11		0.13		0.11	
Mean P+	0.41		0.46		0.52		0.52		0.49	
Mean b	0.62		0.37		0.09		0.02		0.24	
SD b	1.44		1.57		1.70		1.66		1.63	
Total Number Flagged	283		185		413		177		1,058	
Percent Items Flagged	45.1		34.3		37.9		29.3		37.0	
*Data do not include research and retest items.										

Table 8: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2009 Testing Year*										
Operational Item Statistics										
	Jan 09 - Mar 09		**Apr 09 - Jun 09**		**Jul 09 - Sep 09**		**Oct 09 - Dec 09**		**Cumulative 2009**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.20	0.07	0.20	0.08	0.21	0.08	0.21	0.08	NA	NA
Ave. Item Time (secs)	65.8	16.5	69.2	27.5	66.0	25.8	69.2	23.2	NA	NA
Pretest Item Statistics										
# of Items	303		572		866		356		2,097	
Ave. Sample Size	1,157		489		651		493		653	
Mean Point-Biserial	0.11		0.11		0.09		0.09		0.10	
Mean P+	0.51		0.47		0.41		0.42		0.44	
Mean b	0.05		0.35		0.70		0.55		0.49	
SD b	1.63		1.69		1.56		1.46		1.61	
Total Number Flagged	102		218		387		149		856	
Percent Items Flagged	33.7		38.1		44.7		41.9		40.8	
*Data do not include research and retest items.										

International Testing Update

Pearson VUE has a total of 219 PPCs in the U.S. and 18 PPCs internationally in Australia, Canada, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom, for a total of 236 test centers globally.

Represented in the following tables are international volume by Member Board, country of education, test center and pass/fail rate, respectively.

Table 9: NCLEX® International Test Center Volume by Member Board* Jan. 1–Dec. 31, 2010

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	New Delhi, India	Hyderabad, India	Mumbai, India	Chiyoda-ku, Japan	Osaka-shi, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Alabama	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0
Alaska	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3	0	0	0
Arizona	40	1	3	1	5	0	0	0	1	0	0	0	0	0	0	26	0	0	3
Arkansas	119	3	0	0	1	0	0	0	0	0	0	0	0	0	0	113	0	0	2
California-RN	5448	35	68	22	105	11	160	16	23	62	2	8	25	3	6	4568	3	85	246
California-VN	12	0	1	0	0	1	0	0	0	0	0	0	1	0	0	9	0	0	0
Colorado	7	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	4
Connecticut	6	0	0	0	0	0	0	0	0	0	0	1	0	0	0	5	0	0	0
Delaware	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0
District of Columbia	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0
Florida	110	2	0	0	4	1	4	3	2	0	1	0	0	0	0	74	3	0	16
Georgia-PN	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Georgia-RN	9	0	0	0	1	1	0	0	0	0	0	1	0	0	0	1	0	0	5
Hawaii	32	2	4	0	0	0	0	0	0	0	0	0	2	1	0	15	3	0	5
Idaho	2	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
Illinois	223	0	0	0	1	0	2	10	1	0	0	1	0	0	0	203	0	0	5
Indiana	7	0	0	0	0	0	0	0	1	1	0	0	0	0	0	3	2	0	0
Kansas	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Kentucky	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Maryland	53	0	0	0	1	7	3	1	0	0	0	0	0	1	0	30	0	0	10
Massachusetts	20	0	1	0	3	0	0	0	1	0	0	0	0	0	0	8	1	0	6
Michigan	52	1	2	0	11	0	1	1	0	1	0	0	1	0	0	33	0	0	1
Minnesota	167	1	35	14	92	2	1	0	1	0	0	0	0	0	1	19	0	0	1
Missouri	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5
Nevada	36	1	0	0	1	0	1	0	0	2	0	0	0	0	1	29	0	1	0

Table 9: NCLEX® International Test Center Volume by Member Board* Jan. 1–Dec. 31, 2010

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	New Delhi, India	Hyderabad, India	Mumbai, India	Chiyoda-ku, Japan	Osaka-shi, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
New Hampshire	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
New Jersey	48	0	3	0	2	0	0	0	0	0	0	0	1	0	0	37	1	0	4
New Mexico	103	1	0	0	0	2	2	0	0	1	0	0	1	0	0	91	0	0	5
New York	1340	13	11	6	25	2	236	9	4	8	0	0	415	198	0	280	12	93	28
North Carolina	22	0	1	1	3	1	0	0	0	1	0	0	0	0	0	10	1	0	4
Northern Mariana Islands	217	1	0	0	0	0	8	0	0	0	0	0	0	0	0	208	0	0	0
Ohio	24	0	0	0	0	1	0	0	1	0	0	0	0	0	0	18	0	0	4
Oregon	20	2	3	0	1	0	0	0	0	0	0	0	0	1	0	10	0	0	3
Pennsylvania	11	0	0	0	2	0	1	0	0	0	0	0	0	0	0	6	1	0	1
Rhode Island	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
South Carolina	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	1	0	0
Texas	122	2	3	1	7	3	3	2	1	0	2	0	0	1	7	77	2	0	11
Utah	2	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Vermont	1539	6	5	3	15	0	21	71	74	60	8	31	0	0	2	1161	0	1	81
Virgin Islands	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Virginia	10	0	1	0	0	0	1	0	1	1	0	0	1	0	0	2	2	0	1
Washington	16	1	9	0	1	0	0	0	0	2	0	0	0	0	0	2	0	0	1
West Virginia-PN	19	0	0	0	0	0	2	0	0	0	0	0	0	0	0	17	0	0	0
Wisconsin	37	0	1	0	0	0	0	0	0	0	0	0	0	0	0	4	32	0	0
Total	9911	74	151	48	282	35	447	113	113	140	13	43	448	206	17	7082	65	180	454

*Only Member Boards with international test center candidate data are represented.

Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2010

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	New Delhi, India	Hyderabad, India	Mumbai, India	Chiyoda-ku, Japan	Osaka-shi, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Australia	24	20	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Barbados	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Bulgaria	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cambodia	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Canada	233	0	65	24	142	0	1	0	0	0	0	0	0	0	0	1	0	0	0
China	49	2	1	1	2	0	37	0	0	0	0	0	0	0	0	0	0	0	6
Costa Rica	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Egypt	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ethiopia	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Finland	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
France	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gambia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Germany	12	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	5
Ghana	5	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Guyana	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Haiti	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hong Kong	4	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
India	438	0	9	0	17	0	0	109	92	123	13	34	0	0	0	0	0	0	41
Indonesia	6	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5	0	0	0
Iran	6	1	0	0	2	0	0	0	0	0	0	2	0	0	0	0	0	0	1
Ireland	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Israel	6	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	5
Jamaica	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Japan	28	0	0	0	0	0	0	0	0	0	0	0	25	3	0	0	0	0	0
Jordan	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Kenya	2	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
Korea, South	920	8	3	0	4	0	225	0	0	1	0	0	409	196	0	21	0	52	1
Lebanon	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Malaysia	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Mexico	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0

Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2010

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	New Delhi, India	Hyderabad, India	Mumbai, India	Chiyoda-ku, Japan	Osaka-shi, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Moldova	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Myanmar	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Nepal	5	0	0	0	0	1	0	0	0	4	0	0	0	0	0	0	0	0	0
Netherlands	5	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	4
New Zealand	13	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nigeria	35	0	1	1	5	2	0	0	0	0	0	1	0	0	4	0	0	0	21
Norway	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pakistan	7	0	0	1	4	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Philippines	7612	26	56	19	88	3	128	4	0	5	0	3	8	1	0	7037	0	3	231
Portugal	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Puerto Rico	62	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	62	0	0
Romania	8	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	7
Russian Federation	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Saint Lucia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sierra Leone	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Singapore	5	0	0	0	0	0	2	0	1	0	0	0	0	0	0	1	0	1	0
South Africa	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Spain	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sri Lanka	19	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	0	0	0
Sweden	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Taiwan	126	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	123	0
Thailand	43	0	1	0	0	0	42	0	0	0	0	0	0	0	0	0	0	0	0
Turkey	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ukraine	10	0	0	0	1	7	0	0	0	2	0	0	0	0	0	0	0	0	0
United Kingdom	83	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	81
United States	82	2	10	0	11	10	3	0	1	2	0	0	6	6	1	14	2	1	13
Uzbekistan	4	0	0	0	0	1	0	0	0	3	0	0	0	0	0	0	0	0	0
Viet Nam	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Virgin Islands, US	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Zimbabwe	4	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Total	9911	74	151	48	282	35	447	113	113	140	13	43	448	206	17	7082	65	180	454

Table 11: NCLEX® International Volume by Testing Center Jan. 1–Dec. 31, 2010

Site ID	City	Country	Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50482	Sydney	Australia	74	6	4	8	13	5	6	4	0	7	3	10	8
50486	Burnaby	Canada	151	6	9	23	9	14	15	19	13	7	13	12	11
50485	Montreal	Canada	48	6	3	7	2	2	3	5	3	3	8	2	4
50484	Toronto	Canada	282	24	17	37	26	26	28	26	21	26	17	13	21
50491	Frankfurt	Germany	35	7	4	8	9	3	4	0	0	0	0	0	0
50493	Hong Kong	Hong Kong	447	39	42	72	31	44	57	31	28	25	17	32	29
50497	Bangalore	India	113	8	8	17	8	6	13	17	6	7	10	7	6
50498	Chennai	India	113	8	7	14	8	11	9	7	10	15	10	2	12
50495	New Delhi	India	140	18	18	15	9	10	10	11	13	12	10	5	9
50496	Hyderabad	India	13	1	0	2	1	0	0	2	1	1	3	0	2
50494	Mumbai	India	43	2	1	3	7	2	5	5	4	4	5	4	1
50500	Chiyoda-ku	Japan	448	44	52	63	50	41	43	41	18	35	14	22	25
57585	Osaka-shi	Japan	206	1	7	34	9	14	14	19	14	26	24	24	20
50503	Mexico City	Mexico	17	0	1	3	0	4	1	0	2	0	2	0	4
54555	Manila	Philippines	7082	634	637	1032	689	589	708	541	489	519	463	372	409
47108	San Juan	Puerto Rico	65	2	2	10	2	2	4	9	4	4	7	8	11
50506	Taipei	Taiwan	180	20	15	29	11	17	14	9	14	8	17	16	10
50140	London	United Kingdom	454	42	39	50	41	44	42	39	27	32	33	47	18
		Total	9911	868	866	1427	925	834	976	785	667	731	656	576	600

Table 12: NCLEX® International Testing Volume Pass Rate: Jan. 1–Dec. 31, 2010

Site ID	City	Country	Total Taken	Total Passed	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50482	Sydney	Australia	74	29	6/3 (50.00%)	4/2 (50.00%)	8/1 (12.50%)	13/6 (46.15%)	5/1 (20.00%)	6/4 (66.67%)	4/1 (25.00%)	0/0 (0.00%)	7/4 (57.14%)	3/0 (0.00%)	10/5 (50.00%)	8/2 (25.00%)
50486	Burnaby	Canada	151	70	6/3 (50.00%)	9/6 (66.67%)	23/12 (52.17%)	9/2 (22.22%)	14/6 (42.86%)	15/7 (46.67%)	19/9 (47.37%)	13/4 (30.77%)	7/2 (28.57%)	13/7 (53.85%)	12/4 (33.33%)	11/8 (72.73%)
50485	Montreal	Canada	48	19	6/2 (33.33%)	3/2 (66.67%)	7/3 (42.86%)	2/1 (50.00%)	2/1 (50.00%)	3/2 (66.67%)	5/1 (20.00%)	3/0 (0.00%)	3/1 (33.33%)	8/2 (25.00%)	2/1 (50.00%)	4/3 (75.00%)
50484	Toronto	Canada	282	94	24/11 (45.83%)	17/8 (47.06%)	37/11 (29.73%)	26/5 (19.23%)	26/7 (26.92%)	28/9 (32.14%)	26/11 (42.31%)	21/6 (28.57%)	26/7 (26.92%)	17/6 (35.29%)	13/6 (46.15%)	21/7 (33.33%)
50491	Frankfurt	Germany	35	19	7/4 (57.14%)	4/2 (50.00%)	8/5 (62.50%)	9/5 (55.56%)	3/1 (33.33%)	4/2 (50.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)
50493	Hong Kong	Hong Kong	447	193	39/17 (43.59%)	42/23 (54.76%)	72/30 (41.67%)	31/13 (41.94%)	44/17 (38.64%)	57/22 (38.60%)	31/13 (41.94%)	28/13 (46.43%)	25/10 (40.00%)	17/5 (29.41%)	32/17 (53.13%)	29/13 (44.83%)
50497	Bangalore	India	113	44	8/3 (37.50%)	8/3 (37.50%)	17/8 (47.06%)	8/5 (62.50%)	6/3 (50.00%)	13/7 (53.85%)	17/4 (23.53%)	6/0 (0.00%)	7/2 (28.57%)	10/5 (50.00%)	7/3 (42.86%)	6/1 (16.67%)
50498	Chennai	India	113	30	8/5 (62.50%)	7/3 (42.86%)	14/3 (21.43%)	8/5 (62.5%0)	11/2 (18.18%)	9/5 (55.56%)	7/1 (14.29%)	10/3 (30.00%)	15/0 (0.00%)	10/2 (20.00%)	2/0 (0.00%)	12/1 (8.33%)
50495	Delhi	India	140	35	18/6 (33.33%)	18/6 (33.33%)	15/2 (13.33%)	9/1 (11.11%)	10/3 (30.00%)	10/2 (20.00%)	11/2 (18.18%)	13/1 (7.69%)	12/5 (41.67%)	10/3 (30.00%)	5/2 (40.00%)	9/2 (22.22%)
50496	Hyderabad	India	13	4	1/0 (0.00%)	0/0 (0.00%)	2/1 (50.00%)	1/1 (100.00%)	0/0 (0.00%)	0/0 (0.00%)	2/1 (50.00%)	1/0 (0.00%)	1/0 (0.00%)	3/1 (33.33%)	0/0 (0.00%)	2/0 (0.00%)
50494	Mumbai	India	43	24	2/0 (0.00%)	1/0 (0.00%)	3/2 (66.67%)	7/5 (71.43%)	2/1 (50.00%)	5/3 (60.00%)	5/1 (20.00%)	4/3 (75.00%)	4/1 (25.00%)	5/4 (80.00%)	4/3 (75.00%)	1/1 (100.00%)
50500	Chiyoda-ku	Japan	448	257	44/28 (63.64%)	52/34 (65.38%)	63/38 (60.32%)	50/29 (58.00%)	41/20 (48.78%)	43/21 (48.84%)	41/24 (58.54%)	18/6 (33.33%)	35/18 (51.43%)	14/8 (57.14%)	22/15 (68.18%)	25/16 (64.00%)
57585	Osaka-shi	Japan	206	121	1/1 (100.00%)	7/5 (71.43%)	34/23 (67.65%)	9/6 (66.67%)	14/9 (64.29%)	14/10 (71.43%)	19/9 (47.37%)	14/7 (50.00%)	26/15 (57.69%)	24/12 (50.00%)	24/12 (50.00%)	20/12 (60.00%)
50503	Mexico City	Mexico	17	5	0/0 (0.00%)	1/0 (0.00%)	3/1 (33.33%)	0/0 (0.00%)	4/1 (25.00%)	1/0 (0.00%)	0/0 (0.00%)	2/2 (100.00%)	0/0 (0.00%)	2/0 (0.00%)	0/0 (0.00%)	4/1 (25.00%)
54555	Manila	Philippines	7082	3040	634/267 (42.11%	637/277 (43.49%)	1032/556 (53.88%)	689/292 (42.38%)	589/248 (42.11%)	708/303 (42.80%)	541/230 (42.51%)	489/192 (39.26%)	519/193 (37.19%)	463/181 (39.09%)	372/147 (39.52%)	409/154 (37.65%)
47108	San Juan	Puerto Rico	65	23	2/1 (50.00%)	2/2 (100.00%)	10/4 (40.00%)	2/0 (0.00%)	2/1 (50.00%)	4/2 (50.00%)	9/5 (55.56%)	4/1 (25.00%)	4/2 (50.00%)	7/3 (42.86%)	8/1 (12.50%)	11/1 (9.09%)
50506	Taipei	Taiwan	180	71	20/7 (535.00%)	15/9 (60.00%)	29/14 (48.28%)	11/5 (45.45%)	17/7 (41.18%)	14/3 (21.43%)	9/0 (0.00%)	14/6 (42.86%)	8/2 (25.00%)	17/8 (47.06%)	16/8 (50.00%)	10/2 (20.00%)
50140	London	United Kingdom	454	122	42/13 (30.95%)	39/15 (38.46%)	50/18 (36.00%)	41/12 (29.27%)	44/13 (29.55%)	42/9 (21.43%)	39/12 (30.77%)	27/4 (14.81%)	32/5 (15.63%)	33/8 (24.24%)	47/10 (21.28%)	18/3 (16.67%)
		Total	9911	4200	868/371 (42.74%)	866/397 (45.84%)	1427/732 (51.30%)	925/393 (42.49%)	834/341 (40.89%)	976/411 (42.11%)	785/324 (41.27%)	667/248 (37.18%)	731/267 (36.53%)	656/255 (38.87%)	576/234 (40.63%)	600/227 (37.83%)

Report of the Nurse Licensure Models Committee

Background

During fiscal year 2010 (FY10), the Uniform Licensure Requirements (ULR) Committee was charged with recommending "solutions for issues identified regarding the interface between the two licensure models." In its report to the NCSBN Board of Directors (BOD), the ULR committee made many recommendations and among them, it proposed that a group comprised of members representing both licensure models be convened to further explore the issues they identified. In response, the BOD established the Nurse Licensure Models Committee. The committee consists of representatives from both compact and noncompact states, including the dual appointment of the committee chairs.

Highlights of FY11 Activities

In FY11, the committee was charged to:

- Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions.
- Develop communication processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models.

The following is a review of the committee's fulfillment of these charges.

Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions

The committee reviewed the recommendations of the 2010 ULR Committee and had extensive discussions regarding these issues and others that were identified. Its primary focus was on public protection and licensure. During its dialogue, the committee also identified additional issues that affect the interface of the two licensure models. All of these were incorporated into the Issues, Solutions and Strategies Table (see Attachment A).

The committee disseminated a draft of Issues, Solutions and Strategies to the Member Board executive officers for their input. While 15 executive officers responded, the committee would like to provide more time for the executive officers to review the recommendations and provide further feedback.

Develop communication processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models

In response to this charge, the committee has made the following recommendations:

1. Boards of nursing (BONs) should use NCSBN's Nurse Alert Feature available to Member Boards as a tool to help communicate investigative and other information regarding a licensee. This will assist with the sharing of information.
2. Allow time for a dialogue at the Executive Officer's Seminar to discuss regulation and the licensure models. Nonattendees should be allowed participation by conference call. Gather input and develop a plan based on the executive officers' feedback. This will assist the communication process overall.
3. Structure opportunities for a routine dialogue on this subject for attendees at various meetings to keep communication lines open. Communication between BONs about licensure issues is imperative to public protection. This should be an ongoing process and opportunities should be interspersed during regularly scheduled meetings such as the Midyear and the Annual Meetings.

Members

Charlotte Beason, EdD, RN, NEA
Kentucky, Area III, Co-Chair

Nancy Sanders, PhD, RN
Alaska, Area I, Co-Chair

Amy L. Allen, MPA
Michigan, Area II
(August 2010-January 2011)

Helga Bryant, MScA, RN
Manitoba, Associate Member
(August 2010-October 2010)

Sandra Evans, MAEd, RN
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Debra Scott, MSN, RN, FRE
Nevada, Area I, Board Liaison

Staff

Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Nov. 1-2, 2010
- Jan. 24-25, 2011
- March 17, 2011

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

Strategic Objective 3
Identify, communicate and promote collaboration on regulatory issues related to the interface of current nurse licensure models.

Highlights:

- Identification of issues, solutions and strategies related to licensure that will enhance public protection.
- Feedback from Member Boards.
- Recommendations for improved communication among all BONs.

Assessment:

- Further work is needed on Issues, Solutions and Strategies. The committee would like to identify best practices for communication among varying licensure models and identify who will be responsible. It would also like more feedback from Member Boards.
- The committee believes more work could be done on developing the communication processes outlined in Charge #2.
- The committee suggests that a plan for implementation of the strategies outlined in Issues, Solutions and Strategies be developed by the committee as a next step.

Future Activities

Recommended charges for FY12:

1. Review Issues, Solutions and Strategies, obtain further input from Member Boards and refine recommendations.
2. Develop a plan to implement the strategies identified in Issues, Solutions and Strategies.
3. Continue work to develop communication processes for regular sharing of information and dialogue to enhance the interface among all licensure models.

Attachment

A. Issues, Solutions and Strategies Table

Attachment A

Issues, Solutions and Strategies Table

Issues	Solutions	Strategies

1. Timeliness in resolving discipline cases varies from state to state.
2. Sharing of discipline and/or investigative information or notice that an investigation has been initiated.
▪ Some states are prevented by law to not allow for the sharing of investigative information.
▪ Some states do not have processes in place to allow sharing of investigative information.
	▪ Sharing of investigative information by all boards of nursing (BONs) will allow states to make an informed decisions regarding licensure of an individual, even if the investigation is not complete and the case is not resolved.	▪ Participation in Nursys® by all jurisdictions
		  ▪ Utilization of the alert feature
		  ▪ Access applicable discipline reports
		▪ Reform state laws to allow sharing of investigative information among all jurisdictions.
		▪ Expedite the removal of nurses from practice when there is an immediate threat to the public.
		▪ Adoption of model language for sharing investigative information (being developed by Model Act and Rules Committee) and then enactment by BONs.
		▪ Arrange for an open dialogue of issues at Executive Officer's Seminar.
		▪ Identify existing state models for handling discipline and due process. Merge with CORE data to identify promising or best practices.
		▪ Present models of efficient and effective state discipline processes at Attorney/Investigator Conference.
		▪ Identify methods to streamline case resolution.

Issues	Solutions	Strategies
3. Perceptions, government structure and policies, and other issues that prevent states from revising their nursing laws with legislation that would allow sharing of information.	▪ Individual state issues/ challenges/needs are identified and assistance is provided where needed. ▪ Education and resources are available that address this.	▪ Focus a presentation at the Leadership and Public Policy Seminar on "Opening the Practice Act." ▪ Develop talking points to help states with legislative barriers. ▪ Develop a toolkit for implementing legislative change. ▪ Initiate dialogue at strategic meetings and webcast when relevant.
4. State and federal fingerprint-based criminal background checks (CBCs) done in all jurisdictions.	▪ Adoption of state and federal fingerprint checks by all states for initial licensure, at minimum.	▪ Continue to supply resources and support to states needing to adopt CBCs. ▪ Share stories among BONs (Anecdotal Evidence Bank). These can be used for legislative testimony. ▪ Monitor movement at the federal level regarding ability to share fingerprint results.
5. Employer verification of nursing licenses. There are inconsistencies in verifying authority to work by employers.	▪ Education of employers, nurses and the public. ▪ Employers check Nur*sys* for up-to-date information on nurses they are hiring.	▪ Develop video to educate employers. ▪ Link to Nur*sys* on BON website.
6. Mandatory reporting requirements for reporting nurse practice act violations to the BON.	▪ Mandatory reporting or otherwise obligate licensees to take steps to protect the public when they identify an unsafe practitioner.	▪ Recommend to the Model Act and Rules Committee that language is incorporated into the updated Model Act and Rules. ▪ Enactment of immunity legislation for reporting nurse practice act violations.

Issues	Solutions	Strategies
7. Decisions made in one jurisdiction or licensure model can impact other jurisdictions and/or licensure models.	▪ Recognition that decisions made in one jurisdiction or licensure model can impact other jurisdictions or licensure models.	▪ Education sessions at appropriate meetings. ▪ Structure a presentation for the Executive Officer Seminar and/or Midyear Meeting to focus on regulatory issues among states and "The Chain Reaction of Board Decisions." ▪ Structure opportunities for open dialogue on this subject for attendees at various meetings. ▪ Utilize the work by the Nurse Licensure Models Interface group. ▪ Address newly emerging issues. ▪ Continue to collect date regarding the value of nursing regulation on public protection.
8. Alternative to discipline programs vary from state to state. Variances in: ▪ Participation following recidivism; ▪ Response to relapse; and ▪ Management of contract violators.	▪ Consistency across all jurisdictions. ▪ Knowledge by BON as to who is participating in the Alternative to Discipline Program in their state.	▪ Adoption (by all states) of the new model guidelines for substance use published in *Substance Use Disorder in Nursing.* ▪ BONs wishing to reform their programs should consult the Citizen's Advocacy Center. It is able to evaluate programs and make recommendations. ▪ Periodic education on substance use disorder via presentations and in the *Journal of Nursing Regulation*. ▪ Adoption of legislation that lets BONs know who is enrolled in an alternative program or an agreement between the program and BON that the BON will be notified when a nurse relapses.

Issues	Solutions	Strategies
9. Consistency in licensure decisions.	▪ Consistent application of standard criteria.	▪ Adoption of Uniform Licensure Requirements (ULRs) by Delegate Assembly followed by enactment and implementation of ULRs by Member Board jurisdictions. ▪ Provide toolkit for the adoption of ULRs.

Report of the Nursing Education Committee

Background

Recently the approval process has presented some challenges to boards of nursing (BONs). New programs are burgeoning, taking much BON staff time and yet, state resources are shrinking. According to a survey sent to the BONs, they estimate it costs them, on average, $2,000 for each initial approval of a program and $1,800 for continuing approval. The question was asked: Why are BONs involved in the approval process? Based on these concerns, in September 2010 the NCSBN Board of Directors (BOD) convened the Nursing Education Committee and charged it to:

1. Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.
2. Examine differences between BONs' requirements and accreditation standards for nursing education programs approved by Member Boards.
3. Assess the current and future purpose and focus for BON approval of nursing education programs.

Highlights of FY11 Activities

- Analyze and present data from Member Boards implementation of education program regulations that result in initial and continued approval compliance actions.
  - Conducted a comprehensive survey of the Member Boards (Attachment B).
  - Reviewed the literature and past NCSBN work, including a white paper on approval, and two surveys to education consultants from 2010 (joint site visits) and 2009 (fees for approval).
  - Reviewed current and proposed NCSBN model education rules and met with the Model Act & Rules Committee to discuss mutual charges.
  - Reviewed the Member Board Profiles chapter on education.
- Examine differences between BONs requirements and accreditation standards for nursing education programs approved by Member Boards.
  - Held a collaborative conference call with the two national nursing accreditors (National League for Nursing Accrediting Commission [NLNAC] and the Commission on Collegiate Nursing Education [CCNE]) to clarify questions about the accreditation process, with follow-up written responses to questions.
  - Held conference call with the education consultants from the BONs to discuss advantages and disadvantages of joint site visits.
  - Held conference call with staff from BONs that currently require accreditation to learn the advantages and challenges.
  - Analyzed crosswalks for approval versus accreditation from Texas and Minnesota Boards of Nursing.
- Assess the current and future purpose and focus for BON approval of nursing education programs.
  - Asked nurse leaders (Patricia Benner, PhD, RN, FAAN, Carnegie Study of Nursing Education; Susan Hassmiller, PhD, RN, FAAN, Robert Wood Johnson Foundation; Polly Bednash, PhD, RN, FAAN, American Association of Colleges of Nursing; and Beverly Malone, PhD, RN, FAAN, National League for Nursing) to respond to questions about the preferred future of the approval process.
  - Reviewed the Institute of Medicine's (IOM's) Future of Nursing report.

Members

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Washington, Area I, Chair

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Meeting Dates

- Dec. 14-15, 2010
- Jan. 18-19, 2011
- March 22-23, 2011
- March 31, 2011 (Conference Call)
- April 4, 2011 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

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

- Reviewed Carnegie Study of Nursing Education.
- Wrote a report entitled "A Preferred Future for Prelicensure Nursing Program Approval" (Attachment A), which integrates the work of all three charges and outlines the following recommendations for BONs:
  - Work toward requiring national nursing accreditation of all prelicensure nursing programs (licensed practical/vocational nurse, associate degree in nursing, diploma, baccalaureate and master's entry) by the year 2020.
  - BONs would retain the following responsibilities:
    - Have statutory authority over nursing programs;
    - Make initial approval visits and decisions;
    - Make individual or joint visits with the accreditors for complaints or issues that arise; and
    - Accept the accreditors' annual and site visit reports.
  - NCSBN will support the BONs as they move toward requiring national nursing accreditation by:
    - Establishing best practices for assisting nonaccredited programs to become accredited;
    - Assessing the funding situation for programs to become accredited and develop some recommendations for BONs;
    - Developing guidelines for BONs to make joint visits with the accreditors;
    - Meeting with the national nursing accreditors to develop a shared understanding so that requiring accreditation will be successful; and
    - Hosting a conference with national nursing accreditors, BONs and educators to dialogue about how to make the accreditation requirement a success.

Future Activities

Recommended charges for FY12 include:

1. Facilitate a conversation with CCNE and NLNAC about a shared understanding of nursing program approval processes and accreditation.
2. Hold a Collaborative Nursing Education Program Accreditation and Approval Summit no later than February 2012 to meet the deadline of the Model Act & Rules Committee.
3. Make recommendations to the Model Act & Rules Committee.
4. Examine best practices for assisting schools for attaining initial accreditation.

Attachment

A. A Preferred Future for Prelicensure Nursing Program Approval

B. Survey on Prelicensure Nursing Education Program Approval

Attachment A

A Preferred Future for Prelicensure Nursing Program Approval

NURSING EDUCATION COMMITTEE MEMBERS

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Joe Baker, Jr., executive director, Florida Board of Nursing

Katie Dougherty, MN, RN, board staff, California Board of Registered Nursing

Katie Drake-Speer, MSN, RN, board staff, Alabama Board of Nursing

Margaret Hourigan, EdD, RN, board member, Maine State Board of Nursing

Marilyn Krasowski, EdD, RN, board member, Minnesota Board of Nursing

Peggy Matteson, PhD, FCN, RN, board member, Rhode Island Board of Nurse Registration and Nursing Education

Tish Smyer, DNSc, RN, CNE, board member, Nevada State Board of Nursing

Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN

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Shirley Brekken, MN, RN, executive director, Minnesota Board of Nursing; vice president, NCSBN Board of Directors

EXECUTIVE SUMMARY

NCSBN's Board of Directors (BOD) convened a Nursing Education Committee in September 2011 and charged it to:

- Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.
- Examine differences between boards of nursing (BONs) requirements and accreditation standards for nursing education programs approved by Member Boards.
- Assess the current and future purpose and focus for BON approval of nursing education programs.

The Nursing Education Committee integrated their findings into a report updating NCSBN's 2004 white paper (NCSBN, 2004) on the approval processes in BONs. Since that time, there has been more research supporting evidence-based nursing education strategies and two major national reports (Benner, Sutphen, Leonard, & Day, 2010; Committee, 2011) on nursing education. Both national reports call for nurses to have higher levels of nursing education and a system that promotes seamless academic progression. The Institute of Medicine (IOM)'s Future of Nursing report recommends that by 2020, 80 percent of the nursing workforce be educated with a baccalaureate degree. In order for nurses to continue their education, they must graduate from accredited nursing programs.

Since 2004, approval process models used by BONs have changed and increased from the five outlined in the white paper to the seven reflected in Appendix 1. The majority of BONs continue to approve nursing education programs separately from national nursing accreditation. Yet, in a 2011 comprehensive survey to BONs (N=51; Attachment B), a majority of BONs see collaboration with the accreditors as their preferred future for program approval.

The differences between accreditation and approval are outlined and a crosswalk of the standards between the national nursing accreditor's standards, the NCSBN model education rules and NCSBN's Member Board Profiles is provided.

Recommendations for BONs were identified and include:

1. Work toward requiring national nursing accreditation of all prelicensure nursing programs (licensed practical/vocational nurse [LPN/VN], associate degree in nursing [ADN], diploma, baccalaureate and master's entry) by the year 2020.
2. BONs would retain the following responsibilities:

- Have statutory authority over nursing programs;
- Make initial approval visits and decisions;
- Make individual or joint visits with the accreditors for complaints or issues that arise; and
- Accept the accreditors' annual and site visit reports.

3. NCSBN will support the BONs as they move toward requiring national nursing accreditation by:

- Establishing best practices for assisting nonaccredited programs to become accredited;
- Assessing the funding situation for programs to become accredited and develop some recommendations for BONs;
- Developing guidelines for BONs to make joint visits with the accreditors;
- Meeting with national nursing accreditors to develop a shared understanding so that requiring accreditation will be successful; and
- Hosting a conference with national nursing accreditors, BONs and educators to dialogue about how to make the accreditation requirement a success.

In summary, if the BONs were to harmonize their processes with national nursing accreditors, they could benefit by saving on resources expended during the approval process and still protect the public.

INTRODUCTION

In 2004 NCSBN published a white paper (NCSBN, 2004), approved by the BOD, which appraised the status of the prelicensure approval processes in BONs. This white paper explored the history of the approval process in BONs; reviewed earlier work by NCSBN on the approval process, including that of the Practice, Education and Regulation in Congruence Committee; analyzed the International Council of Nursing (ICN)'s perspective on approval; and identified five models that BONs were then using to approve nursing programs. The IOM competencies across health care professions (Greiner & Knebel, 2003) had just been released (patient-centered care, interdisciplinary teams, evidence-based practice, informatics and quality improvement), and one recommendation for the future was that approval processes should incorporate these in their program assessments. The paper also examined new education programs that were being developed at the time (clinical nurse leader, doctorate of nursing practice) and recommended moving toward evidence-based nursing education practices. Additionally, the paper addressed the possibility of program approval for APRN programs.

Nursing has made great strides since that paper was published. The clinical nurse leader and doctorate of nursing practice programs are flourishing, and the APRN Consensus Model

(Chorniak, 2010) has recommended preapproval of programs by the national nursing accrediting bodies. The body of research supporting nursing education has grown (Adams & Valiga, 2009; Ard & Valiga, 2009; Benner et al., 2010; Halstead, 2007; Lasater & Nielsen, 2009; Oermann, M., 2007; Schultz, 2009), thus providing more foundation for nurse educators, though much more needs to be done to advance nursing education into the future (Benner et al., 2010; Committee, 2011). This updated report on approval processes makes some bold evidence-based recommendations for the future.

BACKGROUND

Recently the approval process has presented some challenges to BONs (Smyer & Colosimo, 2011). New programs are burgeoning[1] (Spector, 2010), taking much BON staff time, and yet state resources are shrinking. According to a survey sent to the BONs (Attachment B), BONs estimate it costs them, on average, $2,000 for each initial approval of a program and $1,800 for continuing approval. The question was asked: Why are BONs involved in the approval process? Based on these concerns, the NCSBN BOD convened the Nursing Education Committee and charged it with the following:

1. Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.
2. Examine differences between BONs requirements and accreditation standards for nursing education programs approved by Member Boards.
3. Assess the current and future purpose and focus for BON approval of nursing education programs.

In order to answer the proceeding questions, the following evidence was collected and reviewed from September 2010 to March 2011:

- Conducted comprehensive survey sent to all BONs with a response rate of 51 (see Attachment B);
- Held a collaborative conference call with the two national nursing accreditors (National League for Nursing Accrediting Commission [NLNAC] and the Commission on Collegiate Nursing Education [CCNE]) on Jan. 18, 2011, to clarify questions about the accreditation process with follow-up written responses to questions;
- Reviewed past NCSBN work, including a white paper (NCSBN, 2004) on approval, book chapter on approval (Spector, 2010) and two surveys sent to education consultants from 2010 (joint site visits) and 2009 (fees for approval);
- Held conference calls with the education consultants from the BONs to discuss advantages and disadvantages of joint site visits;
- Asked nurse leaders (Patricia Benner, PhD, RN, FAAN, Carnegie Study of Nursing Education; Susan Hassmiller, PhD, RN, FAAN, Robert Wood Johnson Foundation; Polly Bednash, PhD, RN, FAAN, American Association of Colleges of Nursing; and Beverly Malone, PhD, RN, FAAN, National League for Nursing) to respond to questions about the preferred future of the approval process;
- Held conference calls with staff from BONs that currently require accreditation to learn of the advantages and any challenges or issues;
- Reviewed IOM Future of Nursing report (Committee, 2011);
- Reviewed Carnegie Study of Nursing Education (Benner et al., 2010);
- Reviewed current and proposed NCSBN model education rules and met with the Model Act & Rules Committee to discuss our mutual charges;

1 NCLEX® program codes show that 264 new registered nurse (RN) programs and 320 new programs were established between 2001-2005 while 421 new RN programs and 388 new LPN/VN programs were established between 2006-2010.

- Reviewed Member Board Profiles chapter on education; and
- Analyzed crosswalks for approval versus accreditation from Texas and Minnesota Boards of Nursing.

AN ANALYSIS OF THE CONTEXT OF THE BON APPROVAL PROCESS

Most BONs have authority to grant initial and continuing approval of nursing education programs. Exceptions are the Mississippi and New York State Boards of Nursing, which are not involved in program approval as this is done by another state agency in those states. Additionally, the Florida Board of Nursing is engaged in initial program approval (only if a nursing education program is not nationally accredited) and continuing approval under specific statutory guidelines.

This regulatory mandate varies across states. See Appendix 1 for the seven approval models that were identified and how many BONs are in each category. No significant differences (p=0.8) were found in NCLEX® pass rates across the templates, though there were small numbers in some of the categories.

In a February 2011 survey of BONs (Attachment B), 27 out of 53 respondents approve programs separately from the national nursing accreditors, NLNAC and CCNE. Additionally, 100 percent of respondents indicated that they do the initial approval of nursing programs. Fewer (35 of 50 respondents), however, approve nursing education programs on a continuing basis.

When asked in the survey (Attachment B) about their "preferred future" for program approval, fewer BONs preferred the separate approval process (37 percent), while the majority preferred a collaborative model (61 percent) and more consistency among BONs. For example, one survey respondent said, "I'd like to see a conference devoted to approval of education programs…the nitty gritty. I realize states differ, but there must be some general guidelines." Yet, they report that they were satisfied with their current initial and continuing approval processes (67 percent and 84 percent, respectively). These findings suggest the BONs perceive that their current approval model is accomplishing their missions of public protection, though they are interested in evaluating additional models as they move into the future.

BONs approve nursing programs as part of their mission of public protection. BONs recognize that nursing is a practice discipline where clinicians make life and death decisions daily about patients. Additionally, BONs are concerned about patient safety, which has become a national focus in health care; medical injuries affect 10 percent of hospitalized patients and cause hundreds of thousands of deaths per year (Leape, 2009). Therefore, maintaining minimum standards of nursing education programs is crucial for public protection because nurses are often the last line of defense for the patients (Benner et al., 2010).

Yet, some have asked, Why is nursing one of the only professions to be involved in program approval? In most other professions, such as medicine, pharmacy or physical therapy, the regulatory boards do not approve their programs. After all, the national nursing accreditors, NLNAC and CCNE, evaluate many of the same parameters that BONs review. One difference is that unlike many health care professions, prelicensure nursing programs generally are at the undergraduate level; thus, there are many more nursing programs to track.[2] Further, nursing has two accrediting bodies[3], whereas most other health care professions have one and accreditation is not required in most states. Also unlike other health professions, nursing has multiple points of entry and exit, including LPN/VN (diploma or associate degree), diploma, associate degree and baccalaureate or master's educated RNs. Considering this last point, if nursing is to move to 80 percent baccalaureate educated nurses by 2020 as recommended by the IOM's Future of Nursing report (Committee, 2011), then the accreditation of programs will be an important factor for promoting educational mobility.

However, a more comprehensive answer to this question lies in the heart of nursing regulation. Licensure in nursing is a two-pronged system. In order for nursing graduates to be eligible to take

2 In 2010 there were 197,775 RN and 82,519 LPN/VN candidates who passed the NCLEX.

3 The Carnegie Study of Nursing Education recommends collaboration between the two national nursing accrediting bodies to ensure that articulation efforts are successful (Benner et. al, 2010, p. 229).

the NCLEX, the U.S. nursing regulatory model dictates that the new nurse must show evidence of graduating from a BON-approved nursing program. By making students eligible to take the NCLEX, nursing faculty verify that nursing students are competent to practice. Therefore, nurse educators have enormous power in the licensure model in the U.S. BONs rely on each other to make sound program approval decisions so that mobility across jurisdictions can be as seamless as possible.

There is no doubt that redundancy exists between program approval by BONs and national nursing accreditation. A summary comparison of NLNAC, American Association of Critical-Care Nurses (AACN), NCSBN model education rules (adopted by NCSBN's membership) and Member Board Profiles (a comparison of education requirements across jurisdictions) can be found in Appendix 2; this summary highlights many of the overlaps between BON approval and accreditation. If the BONs were to harmonize their processes with the national nursing accreditors, they could benefit by saving on resources expended during the approval process, while still protecting the public.

While there is redundancy in program approval and accreditation, there are also uniquenesses that support the BONs having legal authority in the approval process. These are highlighted below:

- The missions of national nursing accreditations and BONs approval differ; the accreditors assess quality and continuous quality improvement, while BONs, with their missions of public protection, evaluate and enforce minimum standards.
- BONs are strategically positioned to assure that all of these programs meet minimal standards. BONs are particularly in close touch with developing programs.
- BONs, by virtue of being state/jurisdiction-based, have the unique opportunity of being able to understand the nursing education issues in that specific jurisdiction, as compared to the national accreditors.
- National nursing accreditation is voluntary in most states, while BON approval is required. Were approval removed from the authority of the BON, some programs (particularly practical nursing and associate degree nursing) would have no oversight at all.
- The national nursing accreditors do not have the authority to close nursing programs that don't meet their standards, while BONs have this legal authority over programs. In medicine, for example, if a school is not accredited, it affects their federal funding, so the school immediately reacts.
- BONs often investigate fraudulent nursing programs, working closely with state agencies to issue cease and desist orders.
- A BON's oversight of nursing education programs serves the public's best interest by curtailing programs that are shown to have high attrition and/or licensure exam failure rates.
- BONs share information about fraudulent programs through conference calls and webinars and they are able to communicate with each other about questionable programs through NCSBN's Members-only, Web-based program, the Falsified Identity Tracking System (FITS).

THE FUTURE OF APPROVAL

Given recent calls for innovations in nursing education (Benner et al., 2010; Committee, 2011) and the BONs' desires to consider a new model for the future (Appendix B), the time is ripe for BONs to work toward harmonizing their approval processes with the national nursing accreditors. Therefore, based on the evidence reviewed, NCSBN recommends requiring national accreditation by 2020. This date is in line with the IOM's Future of Nursing report, which recommends increasing the proportion of nurses with a baccalaureate degree to 80 percent by 2020 (Committee, 2011). If nurses from LPN/VN, ADN or diploma program graduate from nonaccredited programs, it will be more difficult for them to further their education.

It is clear, however, that this change cannot be accomplished quickly and will require working with NLNAC, CCNE, educators and BONs. Currently statistics show (See Appendix 3) that whereas virtually all Bachelor of Science in Nursing (BSN) programs are accredited (some are accredited by both CCNE and NLNAC) 54 percent of ADN programs, 78 percent of diploma programs, and only nine percent of LPN/VN programs are accredited, so there is much to be done. For this to happen, BONs, NLNAC, CCNE and educators need to collaborate to create a shared understanding. As Benner et al. recommended in their study of nursing education, it would be essential for CCNE and NLNAC to work together cooperatively in order to promote seamless academic progression, as well as to develop consistency between their standards (2010).

See the figure below for a visual description of the preferred future for approval. Some of the unique differences between the BON approval process and national nursing accreditation can be seen in the stand-alone sections of the two circles. The overlap of the circles is larger, and represents the shared responsibilities and accountabilities of BONs and the accreditors, and is the preferred future of the BON program approval.

Premises for the preferred future for approval include:

1. Accreditation and BONs enhance patient safety and quality of programs.
2. BONs have legal authority over programs in their missions of public protection.
3. There is a need for more consistency in education rules and regulations to promote seamless transitions between jurisdictions.
4. There is a considerable overlap of the BONs' and accreditors' standards and requirements.
5. Utilization of resources will be improved by reducing duplication of continuing approval processes.
6. Articulation is fostered when students graduate from accredited programs.

The recommendations for BONs include:

1. Work toward requiring national nursing accreditation of all prelicensure nursing programs (LPN/VN, ADN, diploma, baccalaureate and master's entry) by the year 2020.

2. BONs will retain the following responsibilities:

- Have statutory authority over nursing programs.

  Rationale: National nursing accreditors only have the authority to deny accreditation; they cannot stop a program from operating.

- Make initial approval visits and decisions.

  Rationale: BONs are better able to understand the local/regional issues in their jurisdictions than accreditors are, particularly related to feasibility of approving new programs, the scarcity of clinical placements and qualified faculty, the increasing numbers of fraudulent programs, etc.

- Make individual or joint visits with accreditors for complaints or issues that arise.

  Rationale: The accreditation cycle is eight to 10 years, and in the interim, BONs can receive complaints, hear about sudden faculty or student attrition, or other critical situations.

- BONs will not require a separate report from the programs, but instead will review the accreditors' annual and site visit reports.

  Rationale: There is duplication between BONs and accreditors' annual and approval reports, creating more work for faculty and BONs.

3. NCSBN will support the BON in this endeavor:

- The Nursing Education Committee will establish, for BONs, best practices for assisting nonaccredited programs with becoming accredited.
- A major concern for some programs will be funding. The Nursing Education Committee will assess the funding situation and develop some recommendations for BONs.
- NCSBN will work with accreditors to develop guidelines for BONs to make joint visits with accreditors. This will be a first step as BONs move forward with requiring accreditation in order to learn about the process. According to the NCSBN survey, currently only 23 BONs make joint visits with accreditors. BONs also may want to make joint visits with accreditors occasionally, once they begin to require accreditation.
- The Nursing Education Committee will meet with the national nursing accreditors to work out some issues so that requiring accreditation will be successful.
  - Currently accreditation reports are not shared with BONs. The BONs, given their legal authority of program approval, want to see a summary of the accreditors' reports.
  - During a faculty shortage, many BONs give program waivers/exemptions for meeting faculty qualifications. Accreditors, by virtue of their missions to evaluate program quality, have more rigorous standards. Some level of understanding will need to be developed so that programs that struggle to find qualified faculty can stay open if their outcomes are satisfactory.
  - Given that nursing is a practice profession, BONs require sufficient clinical experiences at the level of licensure being sought to meet program outcomes (NCSBN, 2005). The accreditors and BONs need to develop a shared understanding of this requirement.
  - Develop cooperation between the accreditors' reporting of data and accreditation cycles.
  - Accreditors expressed interest in NCSBN working with them to collect annual pass rate data.
- NCSBN will host a conference with national nursing accreditors, BONs and educators to dialogue about BONs requiring national nursing accreditation, and to begin a conversation about setting quality indicators for nursing education programs.

CONCLUSION

BONs currently use seven different models for approving nursing programs, and nursing education rules and regulations in BONs are not consistent across jurisdictions. As nursing moves to the future and implements the IOM's Future of Nursing report, it will become essential for students to graduate from accredited programs. Now is the time for BONs to require national nursing accreditation by 2020. This date is consistent with IOM's Future of Nursing date for increasing the proportion of BSN-educated nurses to 80 percent. NCSBN will support the BONs as they move ahead with this, recognizing the challenges that BONs may experience.

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APPENDIX 1: PRELICENSURE NURSING EDUCATION PROGRAM APPROVAL PROCESSES IN BONS

1. **BONs are independent of the national nursing accreditors (27 BONs).**
   These BONs approve nursing programs separately and distinctly from the national nursing accrediting bodies. Initial approval processes are conducted before accreditation takes place.
2. **Collaboration of BONs and national nursing accreditors (five BONs).**
   BONs share reports with the national nursing accrediting bodies and/or make visits with them, sharing information. However, the final decision about approval is made by the BON, independent of decisions by national nursing accreditors. Initial approval processes are conducted before accreditation takes place.
3. **Accept national nursing accreditation as meeting BON approval (four BONs).**
   BONs accept national nursing accreditation as meeting state approvals, though they continue to approve those schools that don't voluntarily get accredited. The BON is available for assistance with statewide issues (e.g., the nursing shortage in that state); BONs retain the ability to make emergency visits to schools of nursing, if requested to do so by a party reporting serious problems; and the BON has the authority to close a school of nursing, either on the advice of national nursing accreditors or after making an emergency visit with evidence that the school of nursing is causing harm to the public. Initial approval processes are conducted before accreditation takes place.
4. **Accept national nursing accreditation as meeting BON approval with further documentation (eight BONs).**
   Similar to Process #3, these BONs accept national nursing accreditation as meeting state approvals, but they may require more documentation, such as complaints, NCLEX results, excessive student attrition, excessive faculty turnover or lack of clinical sites. Initial approval processes are conducted before accreditation takes place.
5. **BONs require national nursing accreditation (six BONs).**
   BONs require their nursing programs to become accredited by a national nursing accreditation body and will use Process #3 or #4 to approve them. Initial approval processes are conducted before accreditation takes place.
6. **BONs have no jurisdiction over programs that have national nursing accreditation (one BON).**
   Nonaccredited programs are only initially approved by the BON and under specific statutory requirements.
7. **BONs are not involved with the approval system at all (two BONs).**
   The BON is not given the authority to approve nursing programs; this is done by another state/jurisdiction authority.

APPENDIX 2: SUMMARY OF DIFFERENCES BETWEEN MODEL EDUCATION RULES AND NATIONAL NURSING ACCREDITATION STANDARDS

NLNAC (2008)	CCNE (2009)	NCSBN Model Rules	Member Board Profiles
Standard I: Mission and Administrative Capacity ▪ Mission reflects core values. ▪ Specifics on program administrator qualifications.	Standard I: Mission and Governance ▪ Mission congruent with parent institution. ▪ Reference BON approval status.	Chapter 9 – Education Practice Act and Rules ▪ Less emphasis on institution. ▪ Administrator qualifications specified.	▪ Less emphasis on institution. ▪ Administrator qualifications specified, but vary across jurisdictions.
Standard II: Faculty and Staff ▪ Specific criteria with percentages of Master of Science in Nursing (MSN) or doctorates. ▪ Scholarship of faculty and use of evidence-based teaching strategies.	Standard II: Institutional Commitment and Resources ▪ More general chief nurse/ faculty criteria with rationale for not having graduate degrees. ▪ Faculty-student ratios meet regulatory requirements. ▪ Preceptors are an extension of faculty. ▪ Program encourages teaching, scholarship and service.	▪ Specific faculty qualifications (updated August 2008). ▪ No faculty-student ratios in model rules. ▪ Nothing related to scholarship of faculty. ▪ Definition of preceptors with specific credentials.	▪ Faculty qualifications specified, but vary across jurisdictions. ▪ 47 states specify faculty-student ratios. ▪ Nothing related to scholarship of faculty.
Standard III: Students ▪ Policies are congruent with mission. ▪ Services meet student needs. ▪ Student records are within state and federal guidelines.	▪ Student policies in Standard I.	▪ Accurate program information. ▪ Students participate in planning.	▪ Question not addressed.

NLNAC (2008)	CCNE (2009)	NCSBN Model Rules	Member Board Profiles
Standard IV: Curriculum (relates to CCNE Standard III) ▪ Program length is congruent with outcomes. ▪ Methodologies reflect good practice and innovations are fostered. ▪ Clinical experiences reflect best practices and patient health and safety goals.	Standard III: Curriculum and Teaching-Learning Practices ▪ Expected outcomes are clear. ▪ Essentials of Baccalaureate Education for Professional Nursing Practice are used (specify need for clinical experiences). ▪ Regular evaluations of students.	▪ Use of IOM competencies ▪ Clinical experiences sufficient to meet program outcomes. ▪ Across lifespan.	▪ Some jurisdictions dictate numbers of hours of clinical experiences and didactic teaching. ▪ A few dictate percentage of simulation replacing clinical experiences. ▪ Some dictate actual courses, while others say across the lifespan.
Standard V: Resources ▪ Resources are sufficient to promote stated outcomes.	▪ Standard II: Addressed Resources	▪ Resources adequate to support program processes, security and outcomes.	▪ Question not addressed.

Standard VI: Outcomes
▪ Systematic plan for evaluation.
▪ Outcomes identified as:
  ▪ NCLEX at national norm;
  ▪ Program completion;
  ▪ Program satisfaction; and
  ▪ Job placement.
	Standard IV: Aggregate Student and Faculty
	▪ Student outcomes identified include, but are not limited to: NCLEX, certification, employment rates and graduation.
	▪ Faculty outcomes consistent with mission of institution.
	▪ Formal complaints are used as evidence.
		▪ Systematic plan for evaluation and continuous improvement.	▪ There are 49 BONs that require a specified NCLEX pass rate.

APPENDIX 3: ACCREDITATION DATA FROM NATIONAL NURSING ACCREDITORS (NUMBER OF PROGRAMS BY NCLEX® CODES FOR 2010)

Degree Program	NCLEX® Codes	Accreditation		% Accredited
		NLNAC	CCNE	
Baccalaureate	740	230	540	100
Associate	1246	671	-	54
Diploma	68	53	-	78
Practical	1722	163	-	9

Attachment B

Survey on Prelicensure Nursing Education Program Approval

EXECUTIVE SUMMARY

Of the 59 boards of nursing (BONs) that approve prelicensure registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) programs, 51 completed a survey in February 2011. The survey was sent to NCSBN's listserv for 59 education consultants, which includes all jurisdictions. It should be noted that while the survey asked for the BON's perspective, the education consultants, in most cases, did not take the survey to the BON and replied as to what they thought their BONs' perspectives were.

There were seven different approval processes identified and the BONs were asked which one best describes their current approval process[1]:

- 51 percent (27 BONs) approve programs separately from accreditors.
- 32 percent (17 BONs) have shared responsibilities with accreditors, by making joint visits with them, accepting accreditation as meeting approval standards or both.
- 11 percent (six BONs) require accreditation or will be requiring it shortly[2].
- Four percent (two BONs) do not have authority to approve nursing education programs; that is done by another state agency.
- Two percent (one BON) only initially approves programs that are not nationally accredited and this approval is done under specific statutory requirements.

When asked about their "preferred future" in program approval, fewer BONs preferred the separate approval process (37 percent), while the majority preferred a collaborative model (61 percent). This finding suggests BONs are interested in evaluating additional models as they move into the future. Yet, they report that they were satisfied with their current initial and continuing approval processes, 67 percent and 84 percent, respectively. This finding indicates that it's their perception that their current approval model is accomplishing their mission of public protection. 100 percent of the respondents (n=50) reported that they require initial approval of nursing programs.

Staffing is the biggest barrier to a BON's current approval process. The BONs estimated that they spend, on average, $2,000 for their initial approval processes and $1,800 for their continuing approval processes, though this amount varied widely. Yet, a majority of BONs do not charge fees for initial program approval (42 percent of the 49 responses) and only 12 (26 percent) charge fees for continuing program approval.

Overwhelmingly, BONs reported that joint visits with accreditors were satisfactory or better (92 percent). When asked whether national nursing accreditors adequately meet BON requirements, the BONs were divided (45 percent agreed, while 56 percent did not). Some of the differences included statutory authority over nursing programs, assessment of faculty qualifications/roles, and their mission. When asked for possible unintended consequences of their BONs requiring national nursing accreditation, the most frequently mentioned factors included programs needing increased resources to accomplish this, programs not being able to meet faculty qualifications requirements, and no one would have legal authority over the programs.

These results indicate that BONs are ready to move to a different approval model, though they think the jurisdiction should retain its legal authority over programs. They acknowledged that while they would suggest some changes, they would also like to retain parts of their current processes.

1 53 BONs are listed because NCSBN staff identified two states' processes from their online regulations.
2 One of these six BONs may remove the required accreditation from its rules because the faculty qualifications are too hard for their programs to meet.

SURVEY RESULTS

Q1 – What is the BON's approval process? (N=51)

Currently, more than 50 percent of the respondents (27) approve programs separately from the accreditors, while five collaborate with the accreditors; four accept accreditation as meeting approval standards; seven accept accreditation as meeting approval standards with further documentation; seven require, or will soon require, national nursing accreditation; one initially approves nonaccredited programs and under statutory requirements; and two have no authority over nursing programs as the Board of Higher Education approves nursing programs in that state.

Themes from comments:

- Clarity around collaborative visits (7);
- BON is updating their education rules and regulations (2); and
- BON requires the national nursing accreditation report (1).

Q2 – What is your preferred future? (N=49)

This question showed that BONs are not entirely satisfied with the status quo. Few chose to approve programs separately from accreditors (18), while more chose to collaborate with accreditors (19) or to require accreditation (9).

Q3 – Could your BON's preferred future be standardized? (N=46)

YES: 31

NO: 12

Themes from comments:

- Each state is different and rules/regulations are inconsistent (16);
- Final authority should be with the BON (5);
- Sharing between regulators and accreditors is beneficial (3);
- Legislation would be needed (3);
- Funding issues prevent standardization (2);
- There is nothing specific about our state (1);
- No interest in changing (1);
- Accreditors do not review regulations (1);
- Cannot accept accreditation in lieu of approval (1); and
- Checks and balances (1).

Q4 – Requirement of current approval process? (N=51)

- Feasibility study (34)
- Self study (35)
- Annual report (42)
- Site visits (45)
- Other (18)

Themes of "other" include:

- NCLEX® (3);
- No site visits if accredited (3);

- Qualified faculty (2);
- Clinical site visits (1);
- Waive site visits (1);
- Monitor (1);
- LPN site visit only (1);
- Complaints (1);
- Regulatory compliance (1); and
- Curriculum (1).

Q5 – Program outcomes assessed? (N=51)

- NCLEX (50);
- Student satisfaction (29);
- Employment (16);
- Systematic plan for evaluation (43);
- Employer satisfaction (21); and
- Other (21).

Themes of "other" include:

- Attrition and graduation rates (5);
- Faculty qualifications (3);
- Resources (4);
- Compliance with regulations (2);
- Competencies (2);
- Governance (2);
- Curriculum (2);
- Transition to practice (1);
- Admission rates (1);
- Clinical agencies (1); and
- Administration (1).

Q6 – Cost of initial approval (N=46)

- 0-$500 (8)
- $501-$750 (1)
- $751-$1000 (3)
- $1001-$1500 (7)
- $1501-$2000 (4)
- $2001-$2500 (7)
- $2501-$3000 (4)
- $3001-$4000 (4)

- $4001-$5000 (1)
- >$5001 (7)

Approximate mean = $2000

Q7 – Cost of continuing approval (N=45)

- 0 - $500 (11)
- $501-$750 (2)
- $751-$1000 (7)
- $1001-$1500 (5)
- $1501-$2000 (5)
- $2001-$2500 (4)
- $2501-$3000 (1)
- $3001-$4000 (4)
- $4001-$5000 (2)
- >$5001 (4)

Approximate mean = $1800

Q8 – Charge an initial fee? (N=49)

- YES: 21
- NO: 28

Fees charged ranged from $50 - $10000. Fees varied.

Q9 – Charge a fee for continuing approval? (N=49)

- YES: 12
- NO: 35

Fees ranged from $150 to $1300. One BON stated that it will charge $3000 if the program is out of compliance and is trying to comply with the rules and regulations.

Q10 – Does your BON accept accreditation in lieu of initial approval? (N=50)

- NO: 50 (100 percent)

Q11 – Does your BON accept accreditation in lieu of continuing approval? (N=50)

- YES: 15
- NO: 35

Themes from comments:

- NCLEX pass rates monitored (2);
- High attrition, faculty turnover and NCLEX pass rates do not rise to the same level for the accreditors as they do for the BON (3);
- Are attempting to eliminate site visits in favor of accreditation (1); and
- BON reviews regulatory requirements (1).

Q12 – Rate experience of joint site visits (N=23)

- Excellent: 5
- Very Good: 8
- Satisfactory: 9
- Disappointing: 2

Themes from comments:

- Review was separate, though visit was joint (1);
- Lack of consistency with site visitors (1);
- Clearly different standards are evaluated (1);
- Saves time and resources (1);
- Focus on the accreditation visit (1);
- More communication needed between BON and accreditors (1); and
- Problems obtaining documents (1).

Q13 – Do national nursing accreditation standards meet your requirements to protect the public? (N=42)

- YES: 19
- NO: 23

Themes from comments:

- BON statutory authority (8);
- Faculty qualifications/role evaluated differently (7);
- Missions are different (4);
- Clinical experiences (3);
- Curricular elements (3);
- More emphasis by BONs on NCLEX (2);
- No enforcement by accreditors (2);
- Different emphasis (1);
- Issue is how they are evaluating the elements (1);
- Accreditation is more general (1);
- Accreditation is not updated as often (1); and
- Accreditation is not measureable (1).

Q14 – What are the barriers, if any, to successful implementation of your education rules/regulations? (Could select more than one barrier) (N=48)

- Staffing (17)
- Funding (9)
- Legislature (9)
- None (22)

46 percent of the BONs reported having no barriers to implementing their education rules/regulations. Comments included:

- Political with for-profits (3);
- Legislation not focused on public safety, but other issues (1);
- Education not given priority (1); and
- Increasing number of programs (1).

Q15 – Is your BON currently satisfied with its initial approval process? (N=49)

- YES: 33
- NO: 16

A majority of the BONs are satisfied with their initial approval processes. Comments included:

- Overwhelmed by new programs (particularly proprietary) (9);
- Need a fee (2);
- Hard to evaluate quality without site visits (1);
- Regulation education rules are static, not dynamic (1);
- Availability of clinical sites is a problem (local issues) (1);
- Defer initial site visit (1); and
- Need more efficiency (1).

Q16 – Is your BON satisfied with its current continuing approval process? (N=50)

- YES: 42
- NO: 8

BONs are even more satisfied with their continuing approval process. Some comments included:

- Would like national accreditation to be required (2);
- Would like to see some changes if they increase efficiency and save resources (1);
- Are in the process of deleting the national accreditation requirement (1);
- Key is asking the right questions (1);
- Regulation education rules are static, not dynamic (1);
- Eliminate site visits (1);
- Need a fee (1); and
- Would like the programs to share their national accreditation reports (1).

Q17 – What would be the unintended consequences of requiring national nursing accreditation? (N=44)

Overwhelmingly the BONs worried about additional costs and resources, particularly for the LPN/VN BONs. Comments included:

- Lack of resources (fiscal and personnel) (15);
- Faculty qualification requirements (9);
- No one would have legal authority over the programs (5);
- None (4);
- None as long as BON collaborates (1);

- Differences in standards (4);
- Monitoring issues (length of time between accreditation visits) (3);
- Political pressure to accredit programs (2);
- Local issues not addressed (such as clinical experiences) (2);
- Patient safety would not be enhanced by requiring accreditation (1); and
- PN high school programs would discontinue (1).

Q18 – Are there differences between BON approval processes for LPN/VN programs versus RN programs? (N=47)

- YES: 10
- NO: 37

Generally, the approval process is the same across programs. Comments included:

- Separate BONs or regulations (6);
- Process same, but different requirements (2); and
- LPN/VN programs have hour requirements (1).

Q19 – Other information you would like to share with us? (N=21)

There were 21 general comments that were categorized into the following themes:

- Shared site visits are important (2);
- Requesting approval conference for general and consistent guidelines (2);
- Concerns about length of time between accreditation visits (1);
- Considering requiring regional accreditation (1);
- BON advantage is they frequently monitor programs (1);
- Need to reduce duplication (1);
- Requiring accreditation for ADN's and LPN/VNs would be burdensome (1);
- Missions of accreditation/regulation are different (1); and
- Outcome data not available for new programs, and yet they get accredited (1).

Report of the TERCAP® Committee

Background

Begun in 1999, the Taxonomy of Error, Root Cause Analysis and Practice-Responsibility (TERCAP®) project grew out of the emerging need to learn more about medical errors and their root causes. The original goal of this project, which continues in 2011, is to learn from the experience of nurses who have had episodes of practice breakdown (defined as the absence of "good practice") and discover characteristics of nurses at risk.

Over the last decade, the TERCAP® Committee (formerly the Practice Breakdown Advisory Panel) was charged with various aspects of the development of the TERCAP data collection tool. The uniqueness of TERCAP is that it attempts to capture the human causes of error and at the same time, allow for the analysis of complex system-related issues that often occur within the health care environment. The TERCAP tool, which attempts to capture detailed data regarding practice breakdown, has undergone many reiterations. Most recently in 2011, after the TERCAP® Committee analyzed data collected from the tool, the committee realized certain questions could be eliminated to make the tool shorter and easier to use. It was also noted that some questions required clarification in order to elicit accurate answers. These changes were made to the newest version, TERCAP® 2011, which is currently in use.

While TERCAP was originally developed as a research study, during the spring of 2010 the committee made a decision to change TERCAP's focus from that of a research project to one of an adverse events reporting database. This continues to allow for the determination of the root cause of practice breakdown, but eliminates concerns about case selection bias and the need for a high number of cases for statistical analysis. In addition, most research projects have a finite point in which data collection ends and analysis begins. Since TERCAP was envisioned to be an ongoing project, it seemed more appropriate to classify it as an adverse events reporting database. These types of databases are ongoing data collection systems and allow for the calculation of frequencies and analysis of trends. In addition, it provides increased flexibility. Adverse events databases do not require the same precision in case selection and fastidious attention to methodology as research projects require. This decision was discussed with Patricia Benner, PhD, RN, FAAN (one of the developers of the TERCAP tool), and was approved by the NCSBN Board of Directors (BOD) in 2010.

Data collection using the TERCAP tool began in 2008. Currently, there are 21 boards of nursing (BONs) that have entered cases into the database. Arkansas is the newest TERCAP participant. New York has begun entering cases as well. As of March 2011, there were a total of 1,282 cases submitted into the database with 953 of these completed.

Highlights of FY11 Activities

- Development of a shorter more precise TERCAP tool.
- Report of the analysis of 861 TERCAP cases.
- Update of TERCAP protocol, policies and teaching materials.
- Development of a TERCAP toolkit.
- Plan to roll out the newly revised TERCAP® 2011 tool and a recruitment strategy for more participants.

Accomplishments:

1. Review trends and determine implications of TERCAP data.

Data from 861 cases entered into the TERCAP database have been analyzed. See Attachment A for a full report, including the trends and implications of the data.

Members

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Associate, Nursing Research

Meeting Dates

- Sept. 13-14, 2010
- Nov. 16-17, 2010
- Jan. 26, 2011
- March 2-3, 2011

Relationship to Strategic Plan

Strategic Initiative A
NCSBN promotes evidence-based regulation.

Strategic Objective 4
Identify practice breakdown trends reported to Member Boards.

2. Advise staff on implementation and evaluation of changes to the TERCAP project.

The focus of the TERCAP® Committee has been on data analysis and tool revision. Based on feedback from TERCAP users and input from Benner, the TERCAP tool has been streamlined to make it shorter and easier to enter data. After evaluating the data, the committee noted that there were possible discrepancies in the answers selected by users. This may have been caused by a lack of clarity of certain questions or overlapping categories within the answer choices, among other issues. These concerns have been addressed and modifications were made to the revised tool. The committee removed 16 questions from the main body of the tool; however, they have been placed in an optional section at the end of the tool and BONs wishing to answer them can still do so.

After completion of the tool changes and the analysis of the 861 cases, the committee developed an implementation plan. The first step was to introduce the tool changes to the TERCAP® Users Group (designated individuals from BONs who are participating in the TERCAP project). This was done via a webinar and the purpose was not only to introduce the changes made to the tool, it was also to gather input and allow for some preliminary evaluation of the changes. The TERCAP® Users Group had excellent suggestions and these were incorporated into the final phase of tool modifications. They gave very positive feedback about the 2011 TERCAP tool. TERCAP® 2011 went live on April 1, 2011.

In order to accommodate data entry into the new tool, the committee also worked on modifications to the TERCAP protocol. In addition, all TERCAP policies and procedures were revised to coincide with the newly revised tool. TERCAP training will also be updated to accommodate these changes and new users will be asked to use the tool during investigations and submit all eligible cases into the database.

As part of the implementation plan a TERCAP toolkit has been developed by the committee. This includes a reference file, a PowerPoint presentation for education purposes, a training file with case studies, a flow chart for helping analyze cases, FAQs, and the TERCAP policies, protocol, tool and user sign-up form. The plan is also to have an edited video that can be used for instructional purposes. All of these have been made available online.

The TERCAP tool and the results from the data analysis (with the BOD's approval) will be presented at the Annual Meeting as part of the implementation plan roll-out. The focus will be on reintroducing TERCAP as a shorter, more concise tool. In addition, by sharing TERCAP data with the members, the committee hopes that more BONs will become interested in participating in the project. As part of the implementation plan, the committee plans on giving a formal presentation, having an exhibit booth with demonstrations of the new tool, presenting participants with TERCAP give-a-ways and having committee members available in area meetings to answer questions.

TERCAP training took place in June for the Washington and Oregon State Boards of Nursing, both of which wish to become TERCAP participants.

Future Activities

1. Devise a method for measuring the efficiency and cost-effectiveness of participating in TERCAP and using the TERCAP tool.
2. Develop more stringent criteria for participation in TERCAP, a recognition ladder to identify levels of commitment and identify barriers to participation.
3. Share data by submitting an article to the *Journal of Nursing Administration*.

Attachment

A. TERCAP® Report: Analysis of Nurse Practice Breakdown Cases in 20 States

Attachment A

TERCAP® Report: Analysis of Nurse Practice Breakdown Cases in 20 States

April 4, 2011

ABSTRACT

Objective: The ultimate goal of the establishment of the TERCAP® (Taxonomy of Error, Root Cause Analysis and Practice-Responsibility) adverse event reporting database is to identify factors that contribute to practice breakdown.

Methods: A 60-item online instrument was developed and used to investigate the records of registered nurses (RNs), licensed practical nurses/vocational nurses (LPNs/VNs) and advanced practice registered nurses (APRNs) who were reported to the boards of nursing (BONs) for practice breakdown. The cases were submitted by 20 BONs to NCSBN's TERCAP database between February 2008 and December 2010. The submission of the practice breakdown cases to the TERCAP database is voluntary and confidential.

Main Findings: Overall, 72 percent of the cases were unintentional human errors. Among the nurses who were reported to BONs for committing practice breakdown, 60 percent were RNs, 37 percent were LPNs/VNs, one percent were APRNs and three percent held multiple licenses. A significant association between the nurses' employment history (discipline and termination by employers) and the practice breakdown was found.

The complete employment history on a nurse's previous discipline and termination by their employers for practice issues was available for 725 (84 percent) of the 861 nurses. Among the 725 nurses, 60 percent (n=437) had been disciplined and/or terminated by their employers previously. Furthermore, our data indicate that 55 percent (n=476) of practice breakdowns occurred when a nurse worked in a patient care position for two years or less, whereas 73 percent (n=348) of these nurses had been licensed for two years or longer. Among the 348 nurses, 36 percent (n=125) had been disciplined by their employers before and 38 percent (n=131) had their employment terminated by their previous employers.

The current data show that a disproportionally higher percentage of male nurses and LPNs/VNs committed a practice breakdown over the percentage in the nursing workforce. Additionally, LPNs/VNs had committed similar types of practice breakdown. The current data set does not reveal significant association between the system factors that we have assessed and any types of practice breakdowns.

Conclusions: A statistically significant link between the employment history and the risk of committing additional practice breakdown is established by the current analysis. This finding indicates that the nurses' employment history can serve as a useful tool to identify a small group of nurses with a high risk of committing violations. We were not able to identify sufficient association between system factors and the practice breakdown, possibly due to constraints in sample size.

BACKGROUND

Begun in 1999, the TERCAP project grew out of emerging needs to learn more about medical errors and their root causes. The original goal of this project, which continues in 2011, is to learn from the experience of nurses who have had episodes of practice breakdown (defined as the absence of "good practice") and discover characteristics of nurses at risk. The TERCAP project meets the recommendation made in the Institute of Medicine's (IOM) report *Keeping Patients Safe, Transforming the Work Environment of Nurses* (Page, 2003). The TERCAP instrument is designed to collect the practice breakdown data from BONs to identify the root causes of nursing practice breakdown from systems and individual perspectives. This approach will facilitate the development of strategic interventions to minimize the risk factors that may endanger patient safety.

Objectives

The current report addresses the following questions:

1. What is the nature of the practice breakdown committed by nurses?
2. How are personal characteristics associated with practice breakdown?
3. Do system factors contribute to practice breakdown?

METHODS

Survey instrument development

The TERCAP® 2008 online survey instrument was released in February 2008 and consisted of 60 questions including: (1) patient profile; (2) patient outcome; (3) work setting; (4) system issues; (5) health care team; (6) nurse profile; (7) intentional misconduct or criminal behavior; and (8) types of practice breakdown. The TERCAP instrument was developed by various NCSBN committees and external consultants, including Patricia Benner, PhD, RN, FAAN, and Marie Ferrell, PhD, RN, FAAN.

Case selection criteria

Cases that met the following criteria were used for data analysis: (1) a nurse was involved in the practice breakdown; (2) one or more identifiable patients were involved; and (3) the case was not fully dismissed by the BON (i.e., the BON took disciplinary or nondisciplinary action, the nurse enrolled in an alternative program, or the BON issued a letter of concern). These criteria were established for the TERCAP project in 2007.

Confidentiality

A unique number was assigned to each case by the TERCAP users from the BONs using a standardized coding system. The database does not contain any information which may lead to the individual's identity; therefore, neither individual patient nor the nurse can be identified.

Participating BONs and data collection

The number of BONs submitting cases to the TERCAP database has increased 67 percent, from 12 to 20 since 2008. The 20 BONs who have submitted cases are: (1) Texas Board of Nursing; (2) North Carolina Board of Nursing; (3) Arizona State Board of Nursing; (4) North Dakota Board of Nursing; (5) Idaho Board of Nursing; (6) Minnesota Board of Nursing; (7) Kentucky Board of Nursing; (8) Oklahoma Board of Nursing; (9) Ohio Board of Nursing; (10) Alaska Board of Nursing; (11) Nevada State Board of Nursing; (12) New Hampshire Board of Nursing; (13) New Jersey Board of Nursing; (14) Maine State Board of Nursing; (15) Mississippi Board of Nursing; (16) Virginia Board of Nursing; (17) New Mexico Board of Nursing; (18) West Virginia Board of Examiners for Registered Professional Nurses; (19) Louisiana State Board of Practical Nurse Examiners; and (20) West Virginia State Board of Examiners for Licensed Practical Nurses.

These participating BONs voluntarily submit practice breakdown cases to the TERCAP database. It is not explicitly required that all practice breakdown cases reported to the BONs need to be submitted to the TERCAP database. As of Dec. 1, 2010, the total number of cases submitted to the TERCAP database was 884. There were two BONs (the Arkansas State Board of Nursing and the New York State Board of Nursing) that started to submit practice breakdown cases to NCSBN after Dec. 1, 2010.

The number of cases that have been submitted by each individual board vary from one to 240. The majority of cases (68 percent) came from Texas, North Carolina and Arizona.

RESULTS

The key findings of the analysis are presented in the following sections: (1) overview of practice breakdown cases; (2) characteristics of nurses that committed a practice breakdown; (3) system factors; and (4) factors that may contribute to the practice breakdown.

Overview of practice breakdown cases

Among the 884 cases submitted to the TERCAP database, 23 failed to meet the case selection criteria: 14 of them were dismissed by the BONs and nine cases did not involve patients. Therefore, these cases were excluded from the analysis. The current analysis was based on 861 cases.

Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. The eight categories of nursing practice breakdown are listed in Table 1. Lack of professional responsibility (77 percent of the cases), lack of clinical reasoning (51 percent of the cases) and lack of intervention (50 percent of the cases) are the most frequently selected practice breakdown categories; 89 percent (n=766) of the cases were classified in more than one practice breakdown category (Table 2) indicating the complexity of error commission. For those cases that were classified in more than one practice breakdown category, TERCAP users were asked to pick the category that was primary to the practice breakdown event. Lack of professional responsibility (28 percent, n=212) and lack of clinical reasoning (23 percent, n=177) were listed as the most significant categories.

Table 1. Practice Breakdown Categories

Practice Breakdown Category	Number of Cases in the Practice Breakdown Category/Percent of Total*
Lack of Professional Responsibility	665 (77.24)
Lack of Clinical Reasoning	441(51.22)
Lack of Intervention	434 (50.41)
Documentation Error	380 (44.13)
Lack of Interpretation	343 (39.84)
Medication Error	278 (32.29)
Lack of Attentiveness	219 (25.44)
Lack of Prevention	208 (24.16)

* The total number of cases in the practice breakdown categories exceeds 861 since some cases were classified in more than one category.

Table 2. Total Number of Practice Breakdown Categories Selected

Total Number of Practice Breakdown Categories	Total Number of Cases/ Percent of Total
1 category	92 (10.69)
2 categories	158 (18.35)
3 categories	205 (23.81)
4 categories	196 (22.76)
5 categories	120 (13.94)
6 categories	56 (6.50)
7 categories	23 (2.67)
8 categories	8 (0.93)
Missing	3 (0.35)
Total	861 (100)

Following the IOM recommendations, users were also asked to identify those cases that involved intentional misconduct or criminal behavior. In summary, 72 percent of the cases (n=618) involved unintentional human errors, while 27 percent of the cases (n=234) involved intentional misconduct or criminal behavior. This information was reported unknown in nine (one percent) cases. More than half of the practice breakdown cases (52 percent, n=446) did not cause any harm to patients. Of the cases investigated (n=508), 59 percent resulted in disciplinary actions and 23 percent (n=200) of the cases were sanctioned nondisciplinary actions. In 18 percent (n=151) of the cases, the nurses were given the opportunity to participate in an alternative program.

Characteristics of the nurses that committed a practice breakdown

The majority of the nurses involved in a practice breakdown are U.S. educated (93 percent, n=804) and English is their primary language (90 percent, n=776).

Distribution of gender and age

Of those involved in the practice breakdown 83 percent of the nurses (n=716) were female and 17 percent (n=143) were male. Gender data are missing in two cases. The proportion of male nurses who committed a practice breakdown is about two times higher than the national composition of the nursing workforce, that is, since 2000, 9.6 percent of the nursing population were male in the U.S. (NCSBN, 2010). This finding is consistent with the reports from previous studies indicating that male nurses are more vulnerable to practice breakdown (Green, Crismon, Waddill, & Fitzpatrick, 1995; Zhong, Kenward, Sheets, Doherty, & Gross, 2009; NCSBN, 2009).

The average age of the nurses was 46.2 years (SD=11.6, n=834), ranging from 21 to 77. The demographic characteristics of the nurses involved in practice breakdown are in line with previous NCSBN reports (Zhong at al., 2009; NCSBN, 2009).

Types of license

Approximately 60 percent of nurses held RN licenses, while 37 percent held LPN/VN licenses (Table 3), and 1 percent held an APRN license. The NCSBN Licensure Statistics show that in 2009, 22 percent of the nurses practicing in the 20 states held LPN/VN licenses and 73 percent held RN licenses (Kenward, Woo, Gross, & Liu, 2010). Therefore, the proportion of LPNs/VNs who committed practice breakdown is higher than the proportion of LPNs/VNs in the workforce.

Table 3. Types of Licenses Held by Nurses Who Committed a Practice Breakdown and the State License Composition in the Workforce

Type of License	Total Number of Cases/Percent of Total (n=861)*	Total Number of Licensees/Percent of Total (n=1,543,871)
RN	513 (59.58)	1,134,574 (73.49)
LPN/VN	319 (37.05)	345,575 (22.38)
APRN	5 (0.58)	63,722 (4.13)

*24 (three percent) nurses who committed a practice breakdown held multiple licenses (RN, LPN/VN and/or APRN licenses).

Employment settings

About 38 percent of the practice breakdowns occurred in hospitals, 32 percent in long-term care facilities/assisted living, 17 percent in outpatient settings and three percent in behavioral health.

Table 4. Employment Setting When Practice Breakdown Occurred	
Employment Setting	**Total Number of Cases/ Percent of Total**
Hospital	322 (37.40)
Long-term Care	250 (29.04)
Home Care	102 (11.85)
Physician/Provider Office or Clinic	33 (3.83)
Assisted Living	27 (3.14)
Behavioral Health	27 (3.14)
Ambulatory Care	11 (1.28)
Critical Access Hospital	9 (1.05)
Office-based Surgery	1 (0.12)
Other	79 (9.18)
Total	861 (100)

At the time when the practice breakdown occurred, 56 percent of LPNs/VNs (n=177) and 14 percent of RNs (n=69) worked in long-term care facilities. The high proportion of LPNs/VNs working in long-term care facilities was also reported in the NCSBN remediation study (Zhong et al., 2009).

Length of licensure

At the time when the practice breakdown occurred, these nurses had been licensed for an average length of 14.3 years (SD=11.1, n=708), ranging from the minimum of less than one year to a maximum of 54 years. The length of licensure was reported unknown for 153 nurses (Table 5).

Table 5. Length of Licensure When the Practice Breakdown Occurred	
Length of Licensure	**Total Number of Cases/ Percent of Total**
Less than 5 years	171 (19.86)
5 to 10 years	148 (17.19)
11 to 20 years	191 (22.18)
21 to 30 years	126 (14.63)
More than 30 years	72 (8.36)
Missing	153 (17.77)
Total	861 (100)

Employment history

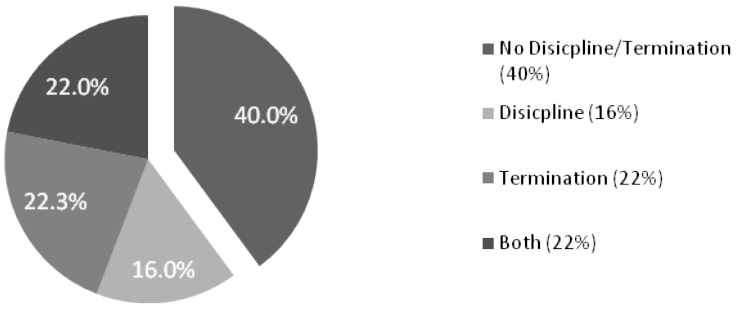
A review of the nurses' employment history shows that 37 percent (n=319) of nurses were disciplined by their employers for practice issues in the past and 39 percent (n=334) were terminated by their employers (Tables 6 and 7). Among the 334 nurses who were terminated by their previous employers, 49 percent (n=162) were also disciplined by their current or previous employers. The previous discipline history was unknown for 13 (four percent) cases. According to these data, nurses who had a violation history were more likely to recidivate, which is consistent with findings reported in NCSBN's remediation study (Zhong et al., 2009).

Table 6. Discipline by Employers for All Involved Nurses	
Discipline	**Total Number of Cases/ Percent of Total**
Yes	319 (37.05)
No	481 (55.87)
Unknown	61 (7.08)
Total	861 (100)

Table 7. Termination by Previous Employers	
Termination	**Total Number of Cases/ Percent of Total**
Yes	334 (38.79)
No	417 (48.43)
Unknown	110 (12.78)
Total	861 (100)

A review of the 725 cases with known employment history for discipline and termination information shows that 60 percent of the nurses involved in practice breakdown were either disciplined by their employers for practice related issues in the past and/or terminated by their previous employers (Figure 1).

Figure 1. Employment History (n=725)



We also examined the employment outcomes of these nurses after they had been reported to the BONs for the practice breakdown. As a result of the current investigation, 56 percent (n=479) of the nurses were terminated by their employers and seven percent (n=56) resigned in lieu of termination. Only 28 percent of the nurses involved (n=237) were retained by their employers.

System factors

In the current database, TERCAP users were also asked to identify the system factors that may have contributed to the practice breakdown. Health team members was reported as a contributing factor for the practice breakdown by 65 percent of the cases (n=556) (Table 8). Over 51 percent of these (286 of 556) cited a staff nurse as being a contributing cause to the practice breakdown.

Communication was the second most frequently reported contributing factor to the practice breakdown, cited in 42 percent (n=359) of cases. This is in line with a previous study on medication errors (Hughes & Blegen, 2008). Of the 359 cases that reported communication as a contributing factor, 39 percent (n=140) cited interdepartmental breakdown/conflict as being the main cause; 31 percent (n=110) cited lack of ongoing education or inadequate orientation/training; and 25

percent (n=88) attributed a shift change to the practice breakdown.

Less than 30 percent of the practice breakdowns claimed staffing, environment, or backup and support as contributing factors. Further analysis shows that over 53 percent (n=456) of the practice breakdowns were identified as having more than one contributing factor (Table 9).

Table 8. Contributing Factors to Practice Breakdown

Contributing Factor	Total Number of Cases/Percent of Total
Health team members	556 (64.58)
Communication	359 (41.70)
Leadership	287 (33.33)
Staffing	204 (23.69)
Environment	195 (22.65)
Backup and support	178 (20.67)

Table 9. Total Number of Contributing Factors

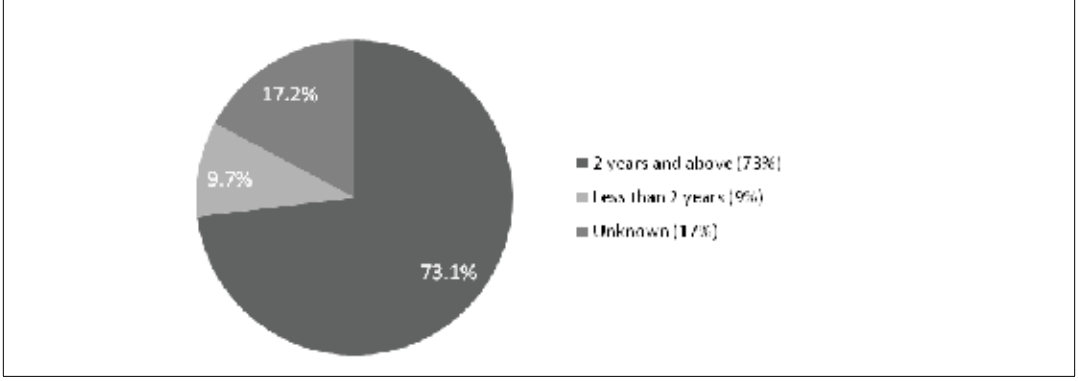
Total Number of Factors Involved	Total Number of Cases/Percent of Total
1 contributing factor	256 (29.73)
2 contributing factors	162 (18.82)
3 contributing factors	108 (12.54)
4 contributing factors	88 (10.22)
5 contributing factors	65 (7.55)
6 contributing factors	33 (3.83)
Missing	149 (17.31)
Total	861 (100)

Factors that may be associated with practice breakdown

Previous employment history

It was reported that more than half (55 percent, n=476) of the practice breakdowns occurred when a nurse had worked in a patient care location for two years or less. This information was unknown in 10 percent (n=89) of the cases. Interestingly, a further review shows that even though the 476 nurses committed a practice breakdown in the location they had worked for two years or less, 73 percent (n=348) of them had been licensed for two years or longer. This information was not available in 17 percent (n=82) of the cases (Figure 2).

Figure 2. Composition of Length of Licensure for Nurses Committing Practice Breakdown Who Had Worked in A Patient Care Location for Two Years or Less



On the other hand, among the 348 nurses who had been licensed for two years or longer, 36 percent of them were disciplined by their current or previous employers for practice related issues and 38 percent of them were terminated by their previous employers (Table 10). This trend is in line with the previous findings from the nurses who committed practice breakdown in general (Tables 6 and 7).

Table 10. Employment History of Nurses Who Committed Practice Breakdown When Working in a Location for Two Years or Less But Had Been Licensed for Two Years or Longer

Employment History (n=348)	Yes # of Cases/ Percentage	No # of Cases/ Percentage	Unknown # of Cases/ Percentage
Discipline	125 (35.9)	200 (57.5)	23 (6.6)
Termination	131 (37.6)	174 (50.0)	43 (12.4)

System *factors contributing to practice breakdown*

We were not able to identify significant associations between any contributing factors and certain types of practice breakdowns. Health team members is the most dominant contributing factor involved in all types of practice breakdown categories (Table 11). A further review of the subcategories of the health team members shows that staff nurse, supervisory nurse/personnel, and unlicensed assistive personnel were claimed as having been involved in all types of practice breakdown categories.

Table 11. Involvement of Different Factors in Practice Breakdown Categories

	Communication	Leadership	Environment	Backup and Support	Health Team Members	Staffing
Lack of Professional Responsibility (n=665)	42.0%	34.0%	22.1%	21.2%	68.1%	24.2%
Lack of Clinical Reasoning (n=441)	48.5%	42.2%	24.9%	26.3%	73.7%	28.8%
Lack of Intervention (n=434)	46.8%	38.0%	26.5%	24.2%	73.0%	29.5%
Documentation Error (n=380)	40.8%	34.2%	24.7%	19.2%	61.8%	21.3%
Lack of Interpretation (n=343)	46.6%	37.9%	26.2%	27.4%	63.3%	25.7%
Medication Error (n=278)	45.6%	36.0%	25.9%	24.8%	61.5%	23.7%
Lack of Attentiveness (n=219)	43.8%	36.1%	25.1%	23.3%	70.3%	25.6%
Lack of Prevention (n=208)	0.0%	40.0%	26.4%	27.4%	67.8%	25.5%

Other miscellaneous factors

Gender

Even though about 17 percent of nurses involved in a practice breakdown were male, which is two times higher than the proportion of male nurses in the national nursing workforce, the current data did not reveal any significant particular patterns of violations committed by male nurses in the practice (data not shown due to the constraints in the case number). For example, 85 percent (121 of 143) of male nurses versus 76 percent (544 of 716) of female nurses committed a lack of professional responsibility practice breakdown; 51 percent of male (73 of 143) and female (368 of 716) nurses committed violations of a lack of clinical reasoning, respectively, while 27 percent of male (39 of 143) and female nurses (195 of 716) were involved in intentional misconduct,

respectively. Furthermore, there is no difference in the consequences of practice breakdown caused by male and female nurses; 55 percent (79 of 143) of male nurses versus 51 percent (366 of 716) of female nurses did not cause any harm to patients. A previous study shows that male nurses are more likely to work in critical and acute care settings and the intense nature of this work may put them at higher risk for committing violations (Carruth & Booth, 1999).

Type of licensure

Even though the data show that there were a higher percentage of LPNs/VNs (37 percent) reported to BONs for committing a practice breakdown than the proportion of nurses who held LPN/VN licenses (22 percent) in the work force in the 20 states that submitted data, a further review shows that the types of practice breakdowns committed by LPNs/VNs are similar to those committed by RNs. Approximately 79 percent (251 of 319) of LPN/VNs committed errors related to a lack of professional responsibility, whereas 76 percent (390 of 513) of RNs committed the same type of error, and 52 percent (167 of 319) of LPNs/VNs and 50 percent (254 of 513) of RNs committed errors related to a lack of clinical reasoning. A previous NCSBN study shows that the higher discipline rate of LPNs/VNs was associated with the fact that the majority of LPNs/VNs worked in long-term care facilities where the reporting of violations of state or federal regulations is strictly required (NCSBN, 2009).

Shifts and employment status

A review of the current data shows that there is no sufficient association between the types of breakdowns and the types of shifts the nurses worked (eight-hour versus 12-hour). A lack of professional responsibility is the most frequently reported error that occurred on both the eight-hour shifts (79 percent, 281 of 356) and 12-hour shifts (77 percent, 234 of 303). Additionally, no difference could be identified regarding what happened to the patients on the different shifts. For the nurses on eight-hour shifts, 12 percent (43 of 356) provided wrong treatment to patients, while this rate was 11 percent (32 of 303) during the 12-hour shifts.

We also examined if there were any differences in the types of errors committed by temporary and permanent nurses. The data show no significant difference regarding the types of practice breakdowns committed by the temporary and the permanent nurses: 70 percent (77 of 110) of the temporary nurses versus 78 percent (581 of 742) of permanent nurses committed errors relating to a lack of professional responsibility. There is no sufficient data to elucidate the consequences of the practice breakdowns committed by temporary and permanent nurses.

Limitations

This analysis was based on the available data from 20 BONs who voluntarily submitted their data to the TERCAP database. The case number is not sufficient for detailed analysis of each subcategory. Additionally, missing data and incomplete records in the current database may have a negative impact on the significance of the findings. By design, the TERCAP adverse event reporting database only focused on the factors associated with practice breakdown. No direct comparison of the characteristics between the nurses who committed practice breakdown and the nurses who met the safe practice standard can be carried out. In some circumstances, lack of control group data restrained our ability to draw definitive conclusions.

DISCUSSION

This report indicates that previous employment history is associated with a nurse's future practice, i.e., nurses who had been disciplined or even terminated by their employers for practice issues tended to commit additional violation(s); 60 percent of the nurses who were reported as having committed a practice breakdown in the current database were either disciplined and/or terminated by their current or previous employers for practice related issues. This report also indicates that the causality of practice breakdown is a complicated issue; 89 percent of the cases involved had more than one type of practice breakdown category and over 53 percent of the cases were identified as having more than one contributing factor.

Currently, there are no published studies that specifically address the relationship between the risk of committing practice breakdown and having discipline or termination history by nursing employers. The current data show that employment history could be useful for BONs and nursing employers to identify nurses who are at a higher risk of committing violations and provide proactive intervention to prevent or reduce additional harm to the public.

The data show that more than half of the practice breakdowns occurred by those nurses who worked at a location two years or less and that 73 percent had been licensed for two years or longer. Among those who had been licensed for two years or longer, 36 percent were known to have been disciplined by their current or previous employers for practice issues before and 38 percent were terminated by their previous employers.

Current data show that after being reported to the BONs for committing a practice breakdown, about 56 percent of the nurses were terminated by their employers. This data suggest a potentially high risk of these nurses engaging in practice breakdown that is reportable to the BON. The public, including employers, should be aware of any practice breakdown that results in a board action. For instance, in the state of Texas, all nursing employers are mandated to report any nurse who was terminated for nursing practice issues and the BON evaluates these nurses to determine if a violation of the BON's rules occurred. In this way, if a nurse is fired from one job and seeks another, the new employers would be aware of the violation and could provide proper support and supervision for the nurse.

Current data do not reveal any meaningful associations between system factors and types of practice breakdown. It is possible that health care facilities have already corrected system errors that obviously caused practice breakdown due to the feedback report they received from the BONs or other healthcare regulators. The multi-faceted nature of contributing factors and involvement of multiple practice breakdown categories could have made it more difficult to capture the system factors for practice breakdown from the current limited data set. Those cases that involved purely system issues could be dismissed by the BONs, and therefore, were not reported/analyzed. It is possible that the individual factors rather than the system factors predominantly contributed to the practice breakdown, as suggested by a previous study on medication errors (Hughes & Blegen, 2008).

Current data show that the majority (72 percent) of the cases investigated involved unintentional human errors and LPNs/VNs committed similar practice breakdown. Additionally, male nurses and LPNs/VNs were over-represented in the groups of nurses who committed a practice breakdown. Whether these resulted from work setting and the reporting requirements as suggested by previous NCSBN studies remains elusive because they are out of the current scope of the TERCAP database (Zhong et al., 2009; NCSBN, 2009).

We are currently in the early stages of an exploratory analysis and a more detailed and comprehensive analysis can be expected with an increase in the case numbers.

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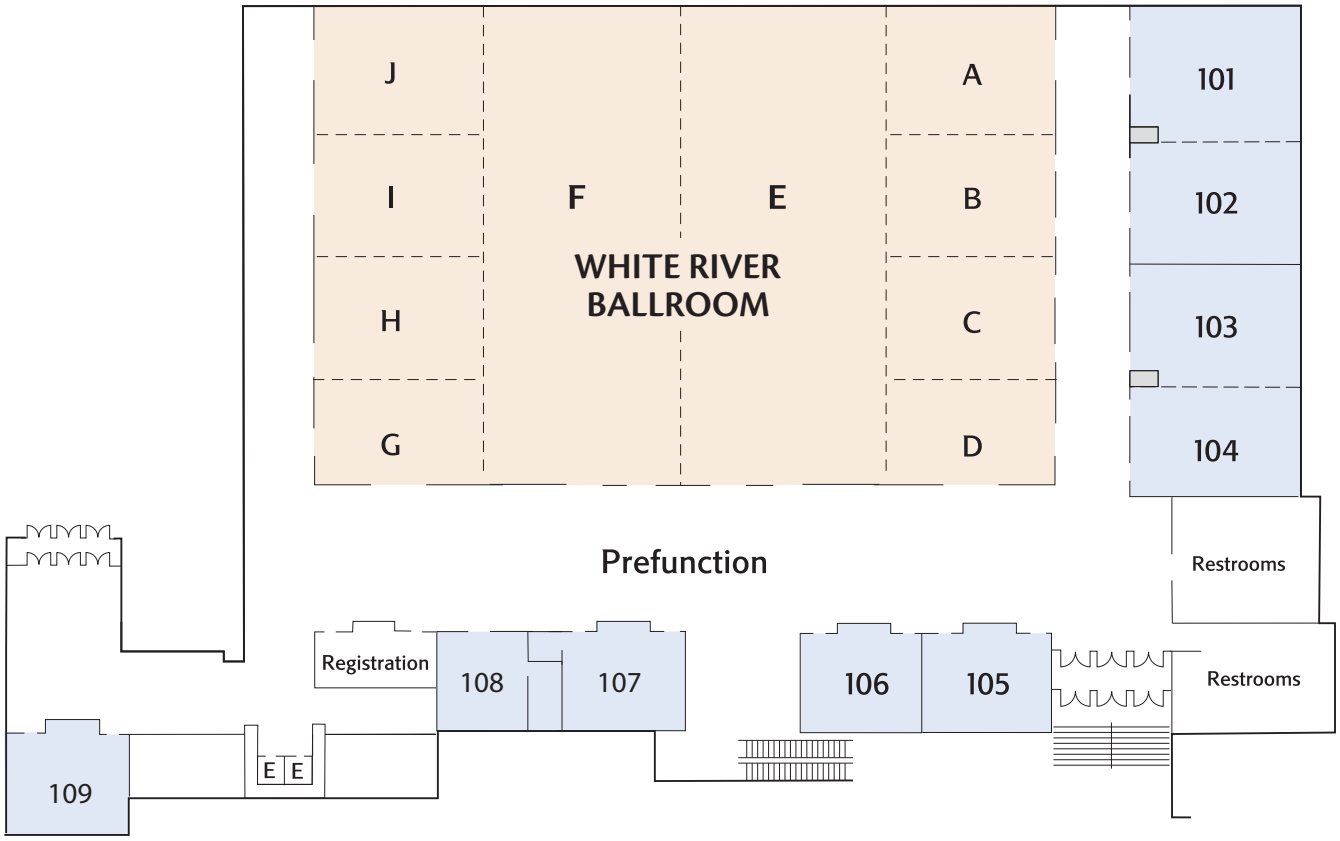
Section III

2011 NCSBN Annual Meeting

Section III: Resources and General Information

JW Marriott Indianapolis Map



First Floor

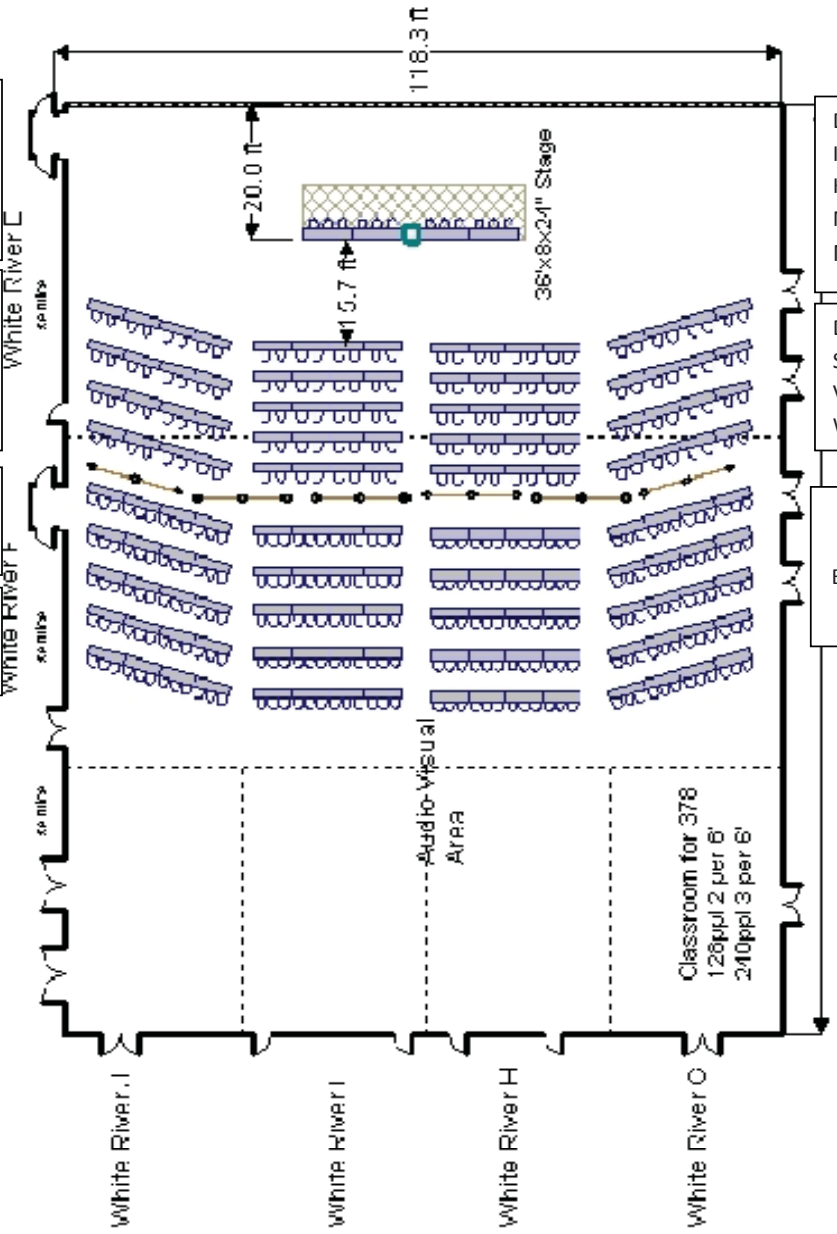
2011 NCSBN Annual Meeting Seating Diagram

Delegates Row 1 (L-R):
AL, AK, AS, AZ
AR CA-RN, CA-VN, CO
CT, DE, DC, FL
GA-LPN, GA, GU, HI

Delegates Row 3 (L-R):
NE-APRN, NE, NV, NH
NJ, NM, NY, NC
ND, NMI, OH, OK
OR, PA, RI, SC

1st two rows behind ropes: Reserved for Members

Last row behind ropes: Reserved for NCSBN Staff



Delegates Row 2 (L-R):
ID, IL, IN, IA
KS, KY, LA-, LA-PN
ME, MD, MA, MI
MN, MS, MO, MT

Delegates Row 4 (L-R):
SD, TN, TX, UT
VT, USVI, VI, WA
WV-RN, WV-LPN, WI

2nd two rows behind ropes: Reserved for External Organizations and Guests

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) provides education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.

NCSBN currently has five strategic initiatives for FY 2011-2013:

- Promote evidenced-based regulation.
- Advance the engagement and leadership potential of all members through education, information, and networking.
- Provide state of the art competence assessments.
- Collaborate to advance the evolution of nursing regulation worldwide.
- Optimize nursing regulation through efficient use of technology.

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which performance measures 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 objectives, and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by NCSBN. At the present time, there are 60 Member Boards, including those from the District of Columbia, the U.S. Virgin Islands, 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. Revisions to the bylaws by the membership in 2007 also allow for advanced practice nurse boards to become full members.

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.

Associate Members are authorized nurse regulatory bodies from other countries, must pay an annual membership feed and be approved for membership by the Delegate Assembly. The following are Associate Members:

- Bermuda Nursing Council
- College of Licensed Practical Nurses of Alberta
- College of Registered Nurses of Alberta
- College of Licensed Practical Nurses of British Columbia
- College of Registered Nurses of British Columbia

- College of Registered Nurses of Manitoba
- College of Nurses of Ontario

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 four elected directors-at-large. (See Glossary for list of jurisdictions by Area.)

DELEGATE ASSEMBLY

The Delegate Assembly is the membership body of NCSBN and comprises delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in 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 Leadership Succession Committee by majority and plurality vote respectively. They also receive and respond to reports from officers and committees. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement, strategic initiatives of NCSBN, and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, adopts test plans to be used for the development of the NCLEX examination, 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 four 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. Four directors-at-large will be elected for terms of two years. Two directors-at-large will be elected in even-numbered years or until their successors are elected and two directors-at-large will be elected in odd-numbered years or until their successors are elected.

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 eleven 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 approval of the NCLEX® examination test service, 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 may be held at the location of the Annual Meeting. 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 website (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.

Resource materials are available to each Board officer and director for use during Board meetings. These materials are updated periodically throughout the year 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 chief executive officer communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Monthly updates are provided to the full board by the chief executive officer.

LEADERSHIP SUCCESSION COMMITTEE

The Leadership Succession Committee consists of eight elected members. Four members are elected from each area and are elected for two-year terms in even-numbered years. Four designated members are elected for two-year terms in odd-numbered years, and include a current or former committee chair; a board member of a member board, a staff of a member board, and a past member of the NCSBN Board of Directors. Members are elected by ballot with a plurality vote.

The Leadership Succession Committee's function is to 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.

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 two standing committees: NCLEX Examinations and Finance. Subcommittees, such as the Item Review Subcommittee (Exam), may assist standing committees.

In addition to standing committees, special committees are appointed by the Board of Directors for a defined term to address special issues and concerns. NCSBN conducts an annual call for committee member nominations prior to the beginning of each fiscal year. Committees are governed by their specific charge and NCSBN policies and procedures. The appointment of committee chairs and committee members is a responsibility of the Board of Directors. Committee membership is extended to all current members and staff of Member Boards, consultants and external stakeholders.

In the appointment process, every effort is made to match the expertise of each individual with the charge of the committee. Also considered is balanced representation whenever possible, among areas, board members and board staff, registered and licensed practical/vocational nurses, and consumers. Nonmembers may be appointed to special committees to provide specialized expertise. A Board of Director liaison and an NCSBN staff member are assigned to assist each committee. The respective roles of Board liaison, committee chair and committee staff are provided in NCSBN policy. Each work collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the Board liaison nor the NCSBN staff are entitled to a vote, but respectively can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

NCLEX® EXAMINATION COMMITTEE

The NLCEX® Examination Committee comprises at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board of nursing. The committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce and deliver the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests enhancements, based on research that is important to the development of licensure examinations.

The Examination Committee advises the Board of Directors on matters related to the NCLEX® examination process, including psychometrics, item development, test security and administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test, and candidate statistics.

One of NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation.

There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice. The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a passing standard to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected to recommend a series of passing standards for this process. Judges are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a series of recommended passing standards. Taking these recommendations along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard that distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes and utilizing item construction and test delivery processes based on sound psychometric principles constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

FINANCE COMMITTEE

The Finance Committee comprises at least four members and the treasurer, who serves as the chair. The Committee reviews the annual budget, monitors NCSBN investments, and facilitates the annual independent audit. The Committee recommends the budget to the Board of Directors and advises the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis.

NCSBN STAFF

NCSBN staff members are hired by the chief executive officer. 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

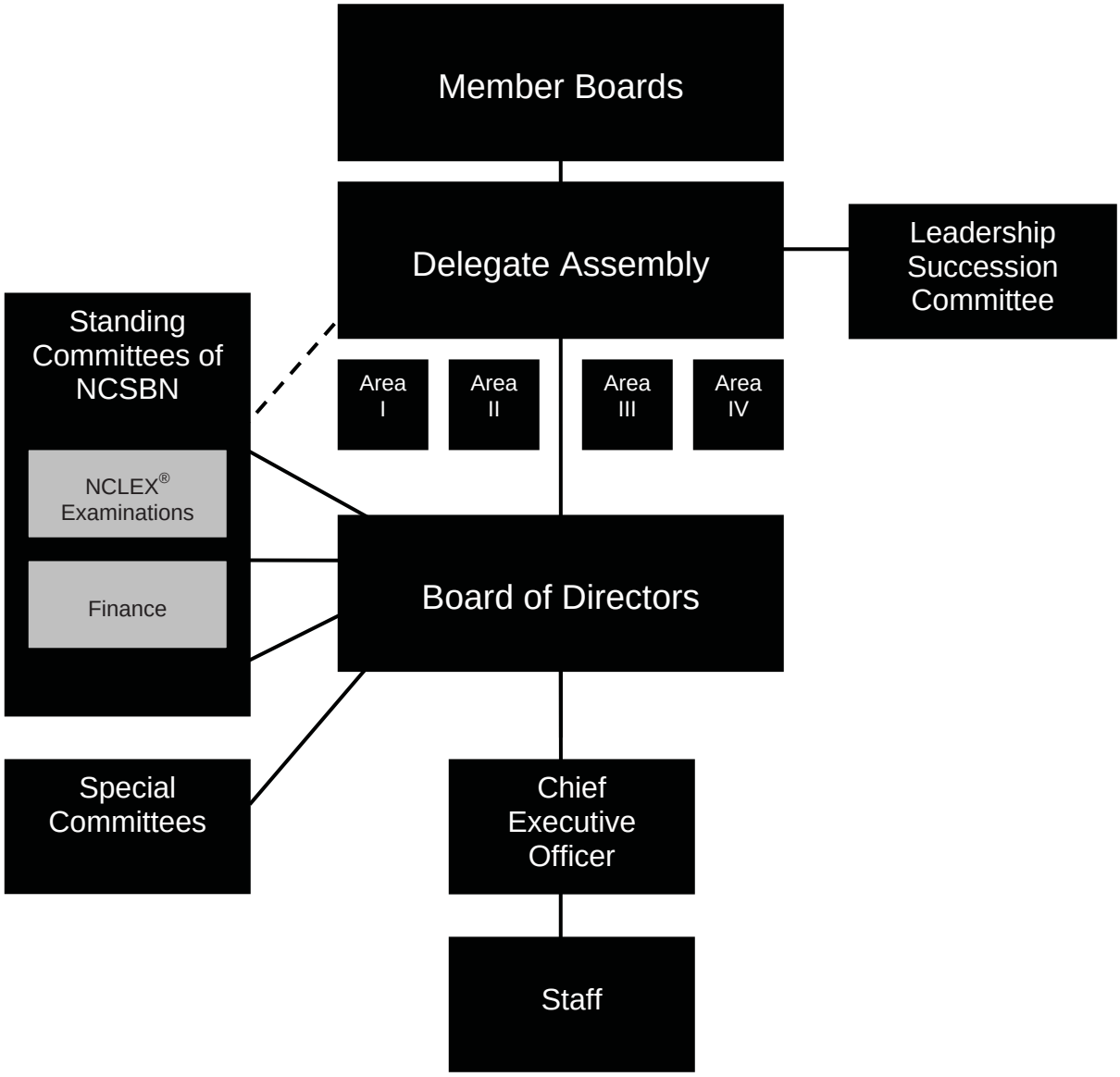
The business agenda of the Delegate Assembly is prepared and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and objectives.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials, resolutions, and elections committees, as well as the Committee to Approve Minutes. The president may also appoint a timekeeper, a parliamentarian and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and the Leadership Succession Committee. 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 chief executive officer 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
Revisions adopted – 08/08/07
Amended – 8/13/10

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. Definition.

(a) *State Board of Nursing*. 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.

(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.

(f) Notwithstanding any provision of this Section, in the event there is only one candidate for an officer or director position, election for that position shall be declared by acclamation. No ballot shall be necessary.

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 win an 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. In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary. 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. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.

(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.

NCSBN Glossary

A

Accredit
To recognize (such as an educational institution or certification agency) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice.

Accrediting Agency
An organization that establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.
See Nursing School Accrediting Agency entry.

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 nurse:

- who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
- who has passed a national certification examination that measures APRN role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
- who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients; as well as a component of indirect care; however the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;
- who's practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
- who has been educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis and management of patient problems, which includes the use and prescription of pharmacologic and nonpharmacologic interventions;
- who has clinical experience of sufficient depth and breadth to reflect the intended license; and
- who has obtained a license as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) or certified nurse practitioner (CNP).

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.

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); an exhibit format (where candidates are presented with a problem and use the information in the exhibit to answer the problem); and a drag-and-drop item type (requiring a candidate to move

References

1. American Academy of Nurse Practitioners website. *About AANP*. Retrieved 2 March 2009, from http://www.aanp.org/AANPCMS2/AboutAANP/
2. American Association of Colleges of Nursing website. *About AACN*. Retrieved 2 March 2009, from http://www.aacn.nche.edu/ContactUs/index.htm
3. American Association of Critical Care Nurses website. *AACN fact sheet*. Retrieved 2 March 2009, from http://classic.aacn.org/AACN/mrkt.nsf/vwdoc/CNFactSheet?opendocument
4. American Association of Nurse Anesthetists website. *About AANA*. Retrieved 2 June 2010, from http://www.aana.com/about.aspx?=46
5. American College of Nurse-Midwives website. *About us*. Retrieved 2 March 2009, from http://www.midwife.org/about.cfm
6. American Dental Association website. *ADA mission & values*. Retrieved 2 March 2009, from http://www.ada.org/ada/about/mission/index.asp
7. American Dietetic Association website. Retrieved 2 March 2009, from http://www.eatright.org
8. AILA.org website. *About AILA*. Retrieved 2 March 2009, from http://www.aila.org/content/default.aspx?docid=1021
9. American Medical Association website. *Our mission*. Retrieved 2 March 2009, from http://www.ama-assn.org/ama/pub/about-ama/our-mission.shtml

and sequence options to provide the correct answer). Any item format, including standard multiple-choice items, may include charts, tables or graphic images.

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)
A full-service professional membership organization in the U.S. for nurse practitioners of all specialties.[1]

American Association of Colleges of Nursing (AACN)
The 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.[2]

American Association of Critical Care Nurses (AACN)
The largest specialty nursing organization in the world, representing the interests of more than 500,000 nurses who are charged with the responsibility of caring for acutely and critically ill patients. The association is dedicated to providing their members with the knowledge and resources necessary to provide optimal care to critically ill patients.[3]

American Association of Nurse Anesthetists (AANA)
A professional association representing more than 40,000 certified registered nurse anesthetists (CRNAs) and student nurse anesthetists nationwide. The AANA promulgates education, practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice.[4]

American College of Nurse-Midwives (ACNM)
A professional association that 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).[5]

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.[6]

American Dietetic Association (ADA)
The nation's largest organization of food and nutrition professionals committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy. [7]

American Immigration Lawyers Association (AILA)
A national association of more than 11,000 attorneys and law professors who practice and teach immigration law. AILA member attorneys represent U.S. families seeking permanent residence for close family members, as well as U.S. businesses seeking talent from the global marketplace. AILA members also represent foreign students, entertainers, athletes and asylum seekers, often on a pro bono basis.[8]

American Medical Association (AMA)
The national professional organization for all physicians; helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues.[9]

American Midwifery Certification Board (AMCB)
The national certifying body for certified nurse-midwives (CNMs) and certified midwives (CMs); formerly known as the ACNM Certification Council, Inc. (ACC).ACC's mis-

sion is to protect and serve the public by providing the certification standard for individuals educated in the profession of midwifery.[10]

American Nurses Association (ANA)
The only full-service professional organization representing the interests of the nation's 3.1 million registered nurses. 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.[11]

American Nurses Credentialing Center (ANCC)
A subsidiary of the American Nurses Association, the ANCC provides credentialing programs that certify nurses in specialty practice areas; recognizes health care organizations for promoting safe, positive work environments; and accredits providers of continuing nursing education.[12]

American Organization of Nurse Executives (AONE)
A subsidiary of the American Hospital Association and a national organization of more than 7,000 nurses who design, facilitate and manage care. AONE provides leadership, professional development, advocacy and research to advance nursing practice and patient care, promote nursing leadership excellence and shape public policy for health care.[13]

Americans for Nursing Shortage Relief (ANSR)
ANSR is comprised of 49 national nursing organizations that have united to address the nursing shortage and the nursing faculty shortage. Since 2001, ANSR has worked to change public policy to alleviate the nursing shortage.[14]

Americans with Disabilities Act (ADA)
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.[15]

Annual Report
A yearly summary of both financial accounting information and the activities of the organization. It highlights the strategic plan and future goals, as well as discussing the environmental context in which NCSBN operates. Its primary function is to serve as a marketing communications tool to reinforce branding efforts to NCSBN's diverse target audiences.

Application for License
The form(s) an individual submits to a board of nursing to request a license to practice nursing in that state or jurisdiction.

Application Packet
All information necessary to apply to a board of nursing for a nursing license.

APRN Annual Certification Program Survey
Results of an annual survey of APRN certification programs regarding their certification examination. Contains information such as accreditation status, credential granted, exceptions and pass rates.

APRN 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.

APRN Certification Programs
Certification programs developed for APRNs. In January 2002, the NCSBN Board of Directors approved criteria for both certification programs that were developed by the Advanced Practice Task Force. The *Requirements for Accrediting Agencies* and the *Criteria for Certification Programs* represent required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses.

10. AMCB website. *About us.* Retrieved 2 March 2009, from http://www.amcbmidwife.org/c/104/about-us
11. ANA Nursing World website. *About the ANA.* Retrieved 2 June 2010, from http://www.nursingworld.org/FunctionalMenuCategories/AboutANA.aspx
12. American Nurses Credentialing Center website. Retrieved 2 March 2009, from http://www.nursecredentialing.org/
13. Hospitalconnect.com: AONE website. *Welcome to AONE.* Retrieved 2 June 2010, from http://www.aone.org/aone/about/home.html
14. AWHONN: Association of Women's Health, Obstetric and Neonatal Nurses website. *Health policy & legislation.* Retrieved 2 June 2010, from http://www.awhonn.org/awhonn/content.do?name=05_ealthPolicyLegislation%2F5E1_ANSR.htm
15. EEOC U.S. Equal Employment Opportunity Commission website. *Facts about the Americans with disabilities act.* Retrieved 2 March 2009, from http://www.eeoc.gov/facts/fs-ada.html

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.

APRN Criterion Comparison Paper (Members Only)
A comparison of APRN certification examinations with the NCSBN criteria.

APRN ListServ
Open to board members, executive officers of boards of nursing and staff who work with APRN issues. Used for discussion of APRN regulatory issues.

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-RN	Kansas	Georgia-RN	Maine
California-VN	Michigan	Georgia-PN	Maryland
Colorado	Minnesota	Kentucky	Massachusetts
Guam	Missouri	Louisiana-RN	New Hampshire
Hawaii	Nebraska	Louisiana-PN	New Jersey
Idaho	Nebraska APRN Board	Mississippi	New York
Montana	N. Dakota	N. Carolina	Pennsylvania
Nevada	Ohio	Oklahoma	Rhode Island
New Mexico	S. Dakota	S. Carolina	Vermont
N. Mariana Islands	W. Virginia-RN	Tennessee	U.S. Virgin Islands
Oregon	West Virginia-PN	Texas	
Utah	Wisconsin	Virginia	
Washington			
Wyoming			

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.

Assessment Strategies
Test service for Canadian Nurses Association.

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.

Awards Committee
A committee of NCSBN charged with selection of annual award recipients and continuous review of the awards program.

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 Members Knowledge Network at Delegate Assembly
Provides an opportunity at Delegate Assembly for board members from the boards of nursing to network, share information and discuss emerging regulatory issues.

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 discipline nurses for unsafe practice. The mission of boards of nursing is to protect the health, safety and welfare of the public.

Business Book
The Business Book contains the annual proceedings of Delegate Assembly, including the Business Agenda and Standing Rules, committee recommendations, rationale and fiscal impact statement, slate of candidates, and annual reports of the president, board of directors, each standing committee, and test services.

Bylaws
The rules that govern the internal affairs of an organization.

C

Canadian Nurses Association
A federation of 11 provincial and territorial nursing associations representing more than 123,000 RNs.

Canadian Registered Nurse Examination (CRNE)
The Canadian Nurses Association nurse licensure examinations.

Candidate Performance Report (CPR)
An individualized, two-page document sent to candidates who fail the NCLEX exam. The CPR reflects candidate performance on various aspects of the NCLEX exam 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
The voluntary process by which a nongovernmental entity grants a time-limited recognition and use of a credential to an individual after verifying that he or she has met predetermined and standardized criteria. It is the vehicle that a profession or occupation uses to differentiate among its members using standards sometimes developed through a consensus-driven process based on existing legal and psychometric requirements.[16]

Certification Program
An examination designed by a certifying body to evaluate candidates for advanced practice nursing.

Certified Funds
Certified check, cashiers check or money order are the forms of certified funds acceptable to NCSBN.

Certified Nurse-Midwife (CNM)
Certified nurse-midwives (CNMs) are RNs with additional training around delivering babies and providing prenatal and postpartum care to women. To become certified, CNMs 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.[17]
See Advanced Practice Registered Nurse entry.

Certified Registered Nurse Anesthetist (CRNA)
Anesthesia professionals who safely administer approximately 30 million anesthetics to U.S. patients each year.[18]
See 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 non-profit, non-partisan 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.[19]

Clinical Nurse Specialist (CNS)
An APRN 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

16. Institute for Credentialing Excellence website. *NOCA's Basic Guide to Credentialing Terminology*. Retrieved 2 June 2010, from http://www.credentialingexcellence.org/portals/0/nocasbasicguidetocredentialingterminology.pdf
17. *All Nursing Schools website. Become a certified nurse-midwife.* Retrieved 2 March 2009, from http://www.allnursingschools.com/faqs/cnm.php
18. American Association of Nurse Anesthetists website. (n.d.) *Questions and Answers: A Career in Nurse Anesthesia.* Retrieved 2 June 2010, from http://www.aana.com/qualifications.aspx
19. Citizen Advocacy Center website. *About us.* Retrieved 2 March 2009, from http://www.citizenadvocacycenter.org/about.html

continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education.[20]

CGFNS (Commission on Graduates of Foreign Nursing Schools) International
An immigration-neutral nonprofit organization that is internationally recognized as an authority on credentials evaluation pertaining to the education, registration and licensure of nurses and other health care professionals worldwide. It provides products and services that validate international professional credentials and supports international regulatory and educational standards for health care professionals. CGFNS International 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.[21]

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.

Compendium on NCSBN Policy and Position Statements
Collection of NCSBN policy and position statements; updated twice a year. Available online at www.ncsbn.org/149.htm.

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.

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 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.

Continuous Quality Improvement Survey (CQI)
Results of this annual survey sent to Member Boards are analyzed for program and service improvements.

CORE Committee
A committee of NCSBN whose purpose is to provide oversight and guide development of a performance measurement system to be utilized by boards of nursing and to identify best practices.

CORE Reports
Provides information and resources to NCSBN Member Boards to assist them in the development and implementation of a performance measurement system.

Council Connector
One of the main sources for information on what is happening at NCSBN. The bimonthly, online 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 on Certification of Nurse Anesthetists (CCNA)
Responsible for the certification of registered nurse anesthetists who meet all the criteria for entry into practice as a certified nurse anesthetist (CRNA). CCNA is also responsible for the development and administration of the National Certification Examination (NCE).[22]

Council on Licensure, Enforcement and Regulation (CLEAR)
An organization of regulatory boards and agencies.

20. American Association of Colleges of Nursing (AACN) website. *CCNE accreditation.* Retrieved 2 March 2009, from http://www.aacn.nche.edu/Accreditation/
21. CGFNS International website. *Who we are/what we do.* Retrieved 2 March 2009, from www.cgfns.org/sections/about/
22. National Board on Certification & Recertification of Nurse Anesthetists website. Retrieved 2 June 2010, from www.nbcrna.com/certification.html

D

Delegate Assembly (DA)
The membership body of NCSBN comprised of 60 Member Boards. It provides direction through adoption of the mission and strategic initiatives; approves all new memberships; approves the substance of all NCLEX exam contracts between the NCSBN and Member Boards; adopts test plans to be used for the development of the NCLEX exam; and establishes the fee for the NCLEX exam. Each Member Board is entitled to two votes.

Delegate Orientation
Online continuing education course offered through NCSBN Interactive. This course is designed for boards of nursing staff members and board members who are new delegates and require an overview and understanding of the NCSBN Delegate Assembly.

Delegation
Transferring authority to a competent individual to perform a selected nursing task in a selected situation. A licensed nurse retains accountability for the delegation.

Differential Item Functioning (DIF)
A statistical measure of potential item bias between two groups of candidates (e.g., male/female, Caucasian/African-American).

Director-at-Large
NCSBN Board of Directors position. Four directors are elected and represent the perspectives of the membership at large during meetings of the board.

Directory of Medication Aide Programs
An annual publication available on the NCSBN website with contact information for states that offer medication aide programs.

Directory of Nurse Aide Registries
An annual publication of contact information for state nurse aide registries including who maintains the registry and who investigates complaints for the state.

Disciplinary Action Information
Information pertaining to disciplinary actions taken against and reported for a nursing license.

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 Nursys®, 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.

Discipline/Investigator Conference Call
A bimonthly conference call for investigators, attorneys and board staff who work with discipline cases. The format is to have a speaker offer a short presentation, often sending out handouts in advance, and then have a speaker dialogue with participants.

E

Education Conference Call
A monthly conference call (except in August) for the boards' Education Consultants and other staff who work with education issues to network and discuss education issues.

Education Information
Information pertaining to an individual's education relative to nursing and licensure.

Education Knowledge Network at Delegate Assembly
A meeting at Delegate Assembly where board staff and board members, as well as interested external guests, network and discuss issues related to the regulation of nursing education.

E-mail Alerts
Breaking news targeted for executive officers and/or member board presidents that is beneficial and/or time sensitive as it relates to the work of boards of nursing or the external environment.

Encrypted Cookie
A small file that is stored as encrypted information on one's computer so that others are not able to read it.

English as a Second Language (ESL)
NCSBN asks NCLEX candidates to 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.

Examinee Performance Report (EPR)
Detailed report of a candidate's examination performance including item responses and response times.

Executive Officer Coach Program
A one-on-one program intended to enhance the professional development of a new executive officer. The coaching program provides the opportunity for an experienced executive officer to facilitate the learning process for a new executive officer.

Executive Officer Conference Call
Held every other month and designed for the executive officer of each board of nursing or one designee. The call provides for discussion of executive management.

Executive Officer Network
Comprises of executive officers of all boards of nursing or board staff members designated by the executive officer. The network provides peer support and a communications network for executive officers.

Executive Officer Networking Session at Delegate Assembly
Held every August at Delegate Assembly. This session is designed for the executive officer of each board of nursing, or one designee, and provides a peer support group and communication network for executive officers.

Executive Officer Networking Session at Midyear Meeting
Held annually at the Midyear Meeting. This session is designed for the executive officer of each board of nursing, or one designee, and provides a peer support group and communication network for executive officers.

Executive Officer Seminar
A two-day program for the executive officers of boards of nursing; designed to promote leadership and business management skill development.

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.

Fellow of Regulatory Excellence Institute (FRE)
A credential bestowed upon an individual who completed the four-year comprehensive educational and professional development curriculum within the Institute of Regulatory Excellence (IRE) Fellowship Program.

Finance Committee
A standing committee of NCSBN charged to review the organization's annual budget, investments and audit.

Fiscal Year (FY)
Oct. 1 to Sept. 30 at NCSBN.

G

Guaranteed Funds
Certified check, cashier's check, or a money order are the forms of guaranteed funds acceptable by 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 U.S. Department of Health & 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 HRSA for the reporting of final adverse actions against health care providers, suppliers or practitioners, as required by HIPAA.

HIPDB Agent Role
NCSBN is the authorized organization that the various Member Boards have designated to query or report information to HRSA on their behalf.

HIPDB Resource Pack
An assortment of resources to support Member Boards in complying with the federal mandate to report nurse disciplinary actions to HIPDB.

HIPDB Webinars
A series of conference calls, with documents available online, that are held to support the transition to reporting nurse disciplinary actions to HIPDB using HIPDB action and basis for action codes.

I

Immigration and Naturalization Services
An agency of the U.S. Department of Justice.

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 accommodations are requested. IRs are entered in the Pearson VUE system so NCSBN and Member Boards can view them from the NCLEX® Administration website.

Institute of Medicine (IOM)
A nonprofit organization specifically created to provide science-based advice on matters of biomedical science, medicine and health. The IOM's mission is to serve as adviser to the nation to improve health. IOM provides unbiased, evidence-based, authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society and the public at large.[23]

Institute of Regulatory Excellence (IRE)
Created by NCSBN in 2004 to assist regulators in their professional development by providing opportunities for both education and networking. An annual conference is held to provide nurse regulators with regulatory knowledge in the areas of discipline, role development, competency evaluation/remediation strategies and organizational structure/behavior.

Institute of Regulatory Excellence (IRE) Committee
An NCSBN committee that provides an ongoing evaluation of the IRE program.

Interagency Collaborative on Nursing Statistics (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 128 countries. ICN is the world's first and widest-reaching international organization for health professionals. ICN works to en-

23. Institute of Medicine of the National Academies website. Retrieved 2 March 2009, from http://www.iom.edu/CMS/3239.aspx

sure 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.[24]

24. International Council of Nurses website. *About ICN*. Retrieved 2 March 2009, from http://www.icn.ch/abouticn.htm

International Scheduling Fee
The charge associated with scheduling an NCLEX exam appointment in an international testing center ($150 plus a value added tax [VAT] where applicable). This nonrefundable fee 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 (or contract, usually adopted by legislation) between two or more states that has the force and effect of statutory law.

Investigator and Attorney Workshop
Sessions focusing on meeting the educational needs of investigators, attorneys and board discipline staff. The two and one-half day meetings are held annually in the spring and present topics of interest related to the investigation, prosecution and resolution of complaints reported to boards of nursing.

IT Summit
The annual IT Summit is held every spring and provides member boards' technical staff the opportunity to learn what technology other boards are using and implementing. Encourages Member Board staff to learn about latest and greatest technologies while networking with their peers from other boards of nursing.

Item
A question on one of the NCLEX, NNAAP and MACE exams.

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, NCLEX-PN, NNAAP and MACE exams. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writers
Individuals who write items for the NCLEX-RN, NCLEX-PN, NNAAP and MACE exams. 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
Accredits and certifies more than 15,000 health care organizations and programs in the U.S. The Joint Commission's 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.[25]

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 NCSBN and the test service.

JONA's Healthcare Law, Ethics and Regulation
NCSBN has a regular column in this journal on NCSBN initiatives that are of interest to employers, attorneys and regulators. Some examples of content have included: the medication assistant curriculum; discussions of our research; articles on fraud in nursing; and discussions of our initiatives.

Jurisdiction
With regard to boards of nursing, jurisdiction refers to the state or territory that a board of nursing regulates. Most boards of nursing regulate all types of nurses within their states or territories. California, Georgia, Louisiana and West Virginia have separate boards of nursing to regulate RNs and LPNs/VNs.

K

Knowledge, Skill and Ability Statements (KSAs)
The attributes required to perform a job, generally demonstrated through qualifying experience, 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.[26]

L

Leader to Leader
A biannual publication sent to all nursing programs and boards of nursing, updating educators on NCSBN initiatives relevant to nursing education.

Leadership Succession Committee (LSC)
Composed of eight members elected by the Delegate Assembly. Duties are to recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning, and to 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 LSC.

License
In nursing, current authority to practice nursing as an RN, LPN/VN or APRN.

License Information
Information about an individual's nursing license(s), which includes license number, license type, jurisdiction and expiration date.

License Verification
Proof of existing nurse licensure.

License Verification Request
The request for proof of licensure.

Licensed Practical Nurse (LPN)
A nurse who has completed a practical nursing program and is licensed by a state to provide patient care, as defined by the board of nursing.

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
The act or instance of granting a license.

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.

25. The Joint Commission website. *About us.* Retrieved 2 March 2009, from http://www.jointcommission.org/AboutUs/
26. U.S. Office of Personnel Management Website. *Policies and instructions.* Retrieved 2 June 2010, from http://www.opm.gov/qualifications/policy/Terms.asp

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 Aide Certification Exam (MACE®)
The medication aide certification examination owned by NCSBN and administered by Pearson Vue.

Medication Assistant – Certified (MA-C)
A person who is certified to administer medication.

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

Member Board Profiles
An online publication that provides an overview of the regulatory environment in which the 60 boards of nursing function. This has been recently updated to include responses from all 60 boards of nursing.

This NCSBN publication also 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 website.

Merchant Account
An account that enables a merchant to accept and process credit cards for payment of goods and services.

Midyear Leadership Forum
A forum presented each year at NCSBN's Midyear Meeting for presidents and executive officers with speakers addressing issues of governance and other areas of interest for nursing regulatory leaders.

Midyear Meeting
The spring meeting for all boards of nursing focusing on current initiatives of NCSBN and emerging regulatory issues.

Model Nursing Administrative Rules
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. Available on NCSBN's website.

Model Nursing Practice Act (MNPA)
A publication of NCSBN, approved at the Delegate Assembly in Kansas City, Mo. in 2004 with additional content on assistive personnel adopted in 2005 and on criminal background checks in 2006. The Model Acts and Rules was first adopted in 1983 and 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. Available on NCSBN's website.

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/her state of residency to practice in other compact states (both physically and electronically), 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.[27]

National Association of Clinical Nurse Specialists (NACNS)
Enhances and promotes the unique, high value contribution of the clinical nurse specialist to the health and well-being of individuals, families, groups and communities, and to promote and advance the practice of nursing.[28]

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.[29]

National Black Nurses Association (NBNA)
Provides a forum for collective action by African American nurses to investigate, define and determine the health care needs of African-Americans and implement change; and to make health care available to African-Americans and other minorities.[30]

National Certification Corporation (NCC)
A nonprofit association that provides a national credentialing program for nurses, physicians and other licensed health care personnel who work in the obstetric, gynecologic, neonatal and telephone nursing specialties, in addition to the subspecialty areas of electronic fetal monitoring, breastfeeding, gynecologic health care and menopause.[31]

National Conference of State Legislatures (NCSL)
A bipartisan organization that serves the legislators and staff of the 50 states and 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.[32]

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
Works towards maximizing the safe use of medications and increasing awareness of medication errors through open communication, increased reporting and promotion of medication error prevention strategies.[33]

National Council Licensure Exam for Licensed Practical/Vocational Nurses (NCLEX-PN® Examination)
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)
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 Boards of Nursing, Inc. (NCSBN)
A nonprofit organization whose membership comprises boards of nursing in the 50 states, the District of Columbia and four U.S. territories – American Samoa, Guam, Northern Marina Islands and the Virgin Islands. There are also four associate members. 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.

27. National Association for Practical Nurse Education and Services, Inc. (NAPNEP) website. *About us.* Retrieved 2 June 2010, from http://www.napnes.org/about/index.htm
28. National Association of Clinical Nurse Specialists website. Retrieved 25 August 2009, from http://www.nacns.org/
29. National Association of Hispanic Nurses website. Retrieved 3 March 2009, from http://www.thehispanicnurses.org/
30. National Black Nurses Association, Inc. (NBNA) website. *Who we are.* Retrieved 2 March 2009, from http://www.nbna.org/index.php?option=com_content&view=article&id=44&Itemid=60
31. The National Coordinating Council for Medication Error Reporting and Prevention website. *About NCC MERP.* Retrieved 2 June 2010, from http://www.nccwebsite/org/about-ncc.aspx
32. National Certification Corporation website. *What is NCC?* Retrieved 2 March 2009, from http://www.nccnet.org/public/pages/index.cfm?pageid=61
33. National Conference of State Legislatures (NCSL) website. *Mission.* Retrieved 2 June 2010, from http://www.ncsl.org/AboutUs/tabid/305/Defualt.aspx

34. The National Federation of Licensed Practical Nurses, Inc. website. *All About NFLPN*. Retrieved 2 March 2009, from http://www.nflpn.org/allabout-nflpn.htm
35. National League for Nursing (NLN) website. *National League for Nursing Bylaws*. Retrieved 2 March 2009, from http://www.nln.org/aboutnln/Bylaws/index.htm
36. National League for Nursing Accrediting Commission, Inc. (NLNAC) website. *About NLNAC*. Retrieved 2 March 2009, from http://www.nlnac.org/About NLNAC/whatsnew.htm
37. National Student Nurses Association website. Retrieved 2 June 2010, from www.nsna.org

National Federation of Licensed Practical Nurses (NFLPN)
A professional organization for LPNs, LVNs and practical/vocational nursing students in the U.S.[34]

National Institute of Nursing Research (NINR)
Part of the National Institutes of Health; works toward improving 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 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.[35]

National League for Nursing Accrediting Commission (NLNAC)
Responsible for the specialized accreditation of nursing education programs, both post-secondary and higher degrees. The NLNAC Board of Commissioners 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.[36]

National Nurse Aide Assessment Program (NNAAP®)
The nurse aide certification examination owned by NCSBN and administered by Pearson VUE.

National Practitioner Data Bank (NPDB)
A federally mandated program for collecting data regarding health care practitioners. The NPDB has been in operation for 10 years and requires medical malpractice payment reports for all health care practitioners, and reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by section 1921 of the Social Security Act (originally enacted in P.L.100-93, section 5). Proposed rules to implement section 1921 were published in March 2006 and final rules were published in January 2010.

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 clearinghouses and health care providers.

National Student Nurses Association (NSNA)
With a membership of approximately 50,000 nationwide, NSNA mentors the professional development of future nurses and facilitates their entrance into the profession by providing educational resources, leadership opportunities and career guidance.[37]

NCLEX® Administration Website
Allows Member Boards to process and manage NCLEX candidate records. Member Boards use the site to perform tasks such as 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® 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.

NCLEX® Candidate Services
Pearson VUE's facility for processing registrations, scheduling candidates and responding to inquiries for the NCLEX examinations.

NCLEX® Examination Committee (NEC)
A standing committee of NCSBN that provides general oversight of the NCLEX examination process, including item development, examination security, psychometrics, examination administration and quality assurance to ensure consistency with the Member Boards' need for examinations. This committee also approves item development panels and recommends test plans to the Delegate Assembly.

NCLEX® Examination Department Informational Call
In order to ensure the NCSBN membership is apprised regarding the NCLEX program, the NCSBN NCLEX® Examinations Department hosts two annual informational calls for Member Boards.

NCLEX® Facts Sheets
Documents available to the general public via the NCSBN website that provide a brief summary, NCLEX volume and pass rates. It includes the volume of candidates broken out by a few subpopulations of interest, the pass rates for those subpopulations and the volume of candidates coming from other countries (top 5 only).

NCLEX® Invitational
An annual, one-day educational conference that familiarizes attendees with the components of the NCLEX exams and enlightens them about the development and administration of the NCLEX-RN® and NCLEX-PN® Examinations. The intended audience is nursing regulators, nursing educators and other stakeholders.

NCLEX® Item Review Subcommittee
An NCSBN committee that assists the NCLEX® Examination Committee with item review.

NCLEX® Member Board Manual
Provides all the information Member Board staff need to know regarding the NCLEX exam and the NCLEX process. The manual is intended for use by Member Board staff and is located on the members-only side of the NCSBN website. It is updated as changes occur to the NCLEX program.

NCLEX® Program Reports
Published twice a year for subscribing schools of nursing, reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX exam. Included in the reports: 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 conference for nurse educators held at the request and in conjunction with a board of nursing. This conference is intended to give the educators information regarding the preparation of students to take the NCLEX exam, including such topics as the test plan, alternate items, psychometrics, program reports and writing questions in the NCLEX style. The NCLEX® Regional is offered in any one of the four areas where the NCLEX® Invitational in not being held that year.

NCLEX® Registration Methods
Method(s) by which NCLEX candidates register for the NCLEX through the 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.

NCSBN Board of Directors (BOD)
Administrative body of NCSBN, consisting of 11 elected officers whose authority is to transact the business and bylaws of the affairs of NCSBN. The BOD is composed of the president, vice president, treasurer, four area directors and four directors-at-large.

NCSBN Interactive
Brand name for the online portal for e-learning offerings for Member Board members and staff and NCSBN staff located at www.ncsbninteractive.org. Types of e-learning offerings include wikis, online courses, streaming videos, podcasts, recorded webinars and live webinars.

NCSBN Learning Extension
The campus for online continuing education (CE) courses for nurses, NCLEX prep for students, and test development and item writing courses for faculty. The purpose of these courses is to promote safe, effective nursing practice and build regulatory awareness. Visit www.learningext.com for the catalog and detailed descriptions of courses. The following are the courses currently being offered:

- Acclimation of International Nurses into U.S. Nursing Practice
- Assessment of Critical Thinking
- Confronting Colleague Chemical Dependency
- Delegating Effectively
- Disciplinary Actions: What Every Nurse Should Know
- Diversity: Building Cultural Competence
- Documentation: A Critical Aspect of Client Care
- End-of-Life Care and Pain Management
- Ethics of Nursing Practice
- Medication Errors: Detection and Prevention
- NCSBN 101
- NCSBN's Review for the NCLEX-PN® Examination
- NCSBN's Review for the NCLEX-RN® Examination
- Nurse Practice Acts CE Courses (Participants: AR, IA, ID, KY, MA, MN, MO, NC, ND, NM, NV, OH, VA, WV-PN/RN)
- Patient Privacy
- Professional Accountability and Legal Liability for Nurses
- Sharpening Critical Thinking Skills
- Test Development and Item Writing

NCSBN Learning Extension Member Board Editorial Advisory Pool
NCSBN develops several new online continuing education (CE) courses each year on topics that are important to the nursing community. These topics are selected based on feedback from surveys of Member Board executive officers. To simplify the feedback process and to increase Member Board participation, NCSBN retains a pool of volunteers that provide editorial feedback on these courses as they are developed.

NCSBN Member's Only Website
The private side of NCSBN's website, which provides access to nonpublic NCSBN documents, meeting minutes and works in progress. Accessible only by a preassigned password.

NCSBN Public Website
NCSBN's public website (www.ncsbn.org) that anyone can access without a password.

NCSBN Strategic Plan
The strategic initiatives, objectives and performance measures covering a three-year period of time. Provides the direction of the organization.

NCSBN Vice President
NCSBN Board of Directors leader who 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 BOD development.

Nonlicensure Participating Board of Nursing
A board of nursing that is not supplying license information on a regular basis. However, nonparticipating boards of nursing do supply information to Nursys® for disciplined nurse licenses and have access to all Nursys information.

North American Free Trade Agreement (NAFTA)
An 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 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 Practitioner (NP)
An 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. An 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.
See 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 the PR&E Committee.

Nursing Program
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.

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.

Nursys®
A database developed by NCSBN to contain demographic information on all licensed nurses (in the U.S.) and an unduplicated count of licensees. Nursys serves as a foundation for a variety of services, including the disciplinary tracking system, licensure verification, interstate compact functions and research on nurses.

Nursys® Licensure QuickConfirm
Provides online nurse license verification reports to employers and others.

Nursys® Training
Web conferences that are offered to Member Board users, and by special request, for licensure, discipline and other board staff, for the purpose of learning how to use Nursys.

O

Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)
Contains requirements for nurse aide training and competency evaluation.

Online Nursys® Verification Request Application
The electronic application that a nurse completes to request verification of existing licenses from participating boards of nursing in Nursys.

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.

Participating Board of Nursing
A board of nursing that is supplying personal, education, license and discipline information to Nursys on a regular basis.

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 exam, a candidate must exceed the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

PDF
A file format developed by Adobe Systems used to display documents. Adobe Acrobat Reader is a free program that is required to open, view and print PDF documents.

Pearson Professional Centers (PPCs)
Pearson Professional Centers are testing locations where candidates take the NCLEX exams.
See Pearson Professional Testing entry.

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 for the administration of the NCLEX, NNAAP and MACE exams.

Pediatric Nursing Certification Board (PNCB)
Provides certification services to nurses and APRNs in pediatric practice through the provision of certification exams and certification maintenance programs. The PNCB is the largest certification organization for pediatric nursing.

Personal Information
Information pertaining to an individual's identity such as name, date of birth and gender.

Plurality Vote
Voting process which 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.

PN/VN Knowledge Network
Provides an opportunity at Delegate Assembly for members interested in the practice and regulation of practical or vocational nurses to network and share information regarding current and emerging regulatory issues.

Podcasts
Audio programs or content delivered over the Web using streaming media or syndication formats for playback on mobile devices and/or personal computers.

Policy Conference Call
Bimonthly calls intended for executive officers (and/or their designated policy contact on staff) and Member Board presidents to focus on policy and government relations issues facing boards of nursing. Additionally, standing agenda items focus on providing members with Nurse Licensure Compact information and other externally related news that could impact nursing regulation.

Policy Perspectives
An internal newsletter intended exclusively for NCSBN membership use and insight. The publication reports on international, national and regional developments bearing on nursing regulation, including key groups and individuals influencing the direction of NCSBN policy and action.

Practice (Job) Analysis
Research study conducted by the NCLEX®, and NNAAP™ & MACE™ Examinations departments 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 Consultant Conference Call
Monthly calls for boards of nursing practice consultants to discuss practice issues.

Practice Knowledge Network at Delegate Assembly
Provides an opportunity at Delegate Assembly for members interested in practice to network and share information regarding current and emerging regulatory 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.

President
NCSBN Board of Directors leader that guides the BOD in the enforcement of all policies and regulations relating to NCSBN and performs all other duties normally incumbent upon the BOD president.

President's Governance Role on a Board of Nursing
An online course for Member Board presidents and members that facilitates an understanding of the leadership role of the president in the state regulatory environment. Learners earn 6.7 contact hours for completing the course.

Presidents Networking Session at Delegate Assembly
Held every August at Delegate Assembly. It provides an opportunity for presidents to network and share best practices and may include an educational program.

Presidents Networking Sessions at Midyear Meeting
Held annually at the Midyear Meeting. It provides an opportunity for presidents to network and share best practices and may include an educational program.

Pretest Items
Newly written test questions placed within the NCLEX, NNAAP and MACE exams 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 and 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.

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.

Q

Quick Results Service
A service provided to candidates where they can access their "unofficial" results within two business days of taking their examination via the phone or Internet for a fee. This is only available to candidates whose licensure board participates in the service.

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.

Recorded Webinar
A seminar conducted over the Web for recorded, on-demand playback of audio, video and/or presentation materials.

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 exam, 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.

Resource Manual for International Nurses
User-friendly resource on the members-only NCSBN website, which includes information on the education, English proficiency and immigration of international nurses.

Respecting Professional Boundaries
Online continuing education course offered through NCSBN Learning Extension; based on NCSBN's video and facilitation package, "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.

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 conducted every three years for each NCLEX exam.

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 be 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.

Streaming Video
Video programs or content delivered over the Web using streaming technology. After a short period of initial buffering, the browser will play the media file and continue to play it while the rest of the file downloads.

T

Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®)
A data collection instrument designed to collect information for the purpose of identifying the root cause(s) of nursing practice breakdown. The instrument allows for standardized, comprehensive and consistent data collection concerning matters reported to boards of nursing. The aggregate data collected from participating Member Boards will be used by NCSBN for ongoing research, allowing for identification of categories of practice breakdown to better enable Member Boards to proactively protect the public health, safety and welfare of its citizens.

Temporary License
Temporary authorization to practice nursing.

TERCAP® Committee
An NCSBN committee charged with the implementation of the TERCAP project.

TERCAP® Users' Conference Calls
Held every two months at 1:00 pm (CST) on the second Tuesday of odd months. Participants include executive officers, investigators, attorneys and board staff who work with discipline cases that are submitted to NCSBN through the online TERCAP data collection instrument. The purpose is to assist participants with any TERCAP related questions, share strategies on successful implementation, and have an opportunity for dialogue with new and experienced TERCAP users.

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 Plan
The organizing framework for the NCLEX-RN, NCLEX-PN, NNAAP and MACE exams that includes the percentage of items allocated to various categories.

Test Service
The vendor that provides services to NCSBN, including examination delivery, examination scoring and reporting. Pearson VUE is the contracted test service for the NCLEX, NNAAP and MACE examinations.

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.

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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.[38]

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.[39]

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. More than 87,000 different governmental jurisdictions at the federal, state, and local level have homeland security responsibilities. The comprehensive national strategy seeks to develop a complementary system connecting all levels of government without duplicating effort. Homeland Security is truly a "national mission."[40]

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 justice system of the U.S., or any other competent jurisdiction, those organizations and principal members of organizations involved in growing, manufacturing or distributing controlled substances appearing in or destined for illicit traffic in the U.S.; recommend and support nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.[41]

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements
Developed by NCSBN with APRN stakeholders in 2000; uniform requirements that established 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.

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.

Verification Department
NCSBN employees who process nurse license verifications in Nur*sys*.

Verification Fee
The monetary payment required from an applicant for license verification via Nur*sys*.

***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 CGFNS; however, the NCLEX exams may be 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

Webcast
A seminar conducted or a program broadcasted over the Web for live, realtime delivery of audio, video and/or presentation materials.

White Paper
A detailed document issued by NCSBN, disseminated to external groups used to educate audiences about a particular topic, discuss issues or encourage dialogue about a particular regulatory subject.

Wiki
A wiki is a Web application that allows users to collaborate on content. Wikis can be permissions-enabled and monitored. Wiki users can set up e-mail notifications, conduct discussions and view/revert to past versions of pages.

Workshop on the Regulation of the Nursing Assistant and Medication Aide
Workshop presented by NCSBN each year to provide current information on regulatory issues with unlicensed nursing personnel and to provide a forum for boards of nursing and other interested stakeholders to discuss emerging issues and to network.

The National Council of State Boards of Nursing (NCSBN) provides education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.

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