

CHAPTER 36: APPROVAL: NATIONAL COUNCIL OF STATE BOARDS OF NURSING (NCSBN)

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Dr. Spector takes us through the inception and process of professional regulation, highlighting distinctions and overlap between accreditation and approval. As we look at approval issues as designated by the National Council of State Boards of Nursing (NCSBN), we discover a compelling history. Rationale and preparation for site visits are detailed, along with the recently written Model Nursing Practice Act. We found this chapter a unique contribution for the clarity it brings to the approval process. – Lynn Engelmann and Linda Caputi.

An approval at state boards of nursing

Takes a careful review and conversing

On the health of a school

And meeting each rule.

And that's what this chapter's rehearsing!

Educational Philosophy

I believe more of our resources should be used to teach undergraduate nursing students because they are our nurses of the future. Too often in nursing education our best and brightest teach in graduate programs, never again to step foot in an undergraduate classroom or in clinical settings. Our students learn best from deliberately planned clinical experiences, designed by qualified nursing faculty who coach their students and who provide feedback and opportunities for reflection. I further believe that nursing faculty should have graduate preparation in the science of learning and in clinical practice and should rigorously study the outcomes of nursing education.

-Nancy Spector

Introduction

Professional regulation in nursing is defined as the process whereby governmental agencies grant legal authority for an individual who has met specified qualifications and demonstrated a minimum entry-level competence to practice a chosen profession (Sheets, 1996). This definition is used to provide the framework for this chapter. Although this definition implies that regulation is mandated by governments, others assert that professions are also regulated by certification (as opposed to state-issued certification) and accreditation. This chapter, however, makes a distinction between regulation and licensure versus accreditation and certification because the former are governmental mandates.

Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared and incompetent. The public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners (NCSBN, 2008d).

Regulation can be on four levels (National Council Position Paper, 1993):

- Designation/recognition.
- Registration.
- State-issued certification.
- Licensure.

The least restrictive level is designation/recognition, and regulation at this level does not limit the right of the nurse to practice; neither can the state inquire about incompetence. It merely provides the public with information about nurses with special credentials. Likewise, registration does not involve state inquiry into the scope of practice, or competence; it merely involves providing information to an official roster. These are the most elementary levels of regulation.

The next level is state-issued certification, which allows for the legal authority to practice. A few states issue state certification to advanced practice nurses, though state-issued certification does not include a defined scope of practice. The federal government has used the term *certification* to define credentialing by a nongovernmental agency, and today most of the boards use APRN certification examinations of nursing as one of the requirements for advanced practice licensure (Chornick, 2008). The most restrictive type of regulation is licensure, in which the professional must demonstrate minimal competency to practice and the state has the authority to take disciplinary action should licensees violate the law or rules under which they are regulated (Sheets, 2002).

Brief History of State Approval of Nursing Schools

The approval of nursing programs is part of the regulatory process carried out by the state boards of nursing in the 50 states, territories, and the District of Columbia, in the United States (See Appendix 36-1 for a list of 60 boards of nursing). The approval process can be defined as “official recognition of nursing education programs which meet standards established by the board of nursing” (NCSBN, 2004b). Approval standards are defined by the NCSBN model practice act as: “The board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the Act and board rules” (NCSBN, 2004a). Some boards of nursing use “accreditation” instead of “approval,” but the term “approval” will be used in this chapter to avoid confusion with national nursing accreditation. See Table 36.1 for relevant definitions for nursing regulation.

The early struggle for nursing regulation began in England with what has been termed the ‘Thirty Years’ War. The debate was one of self-regulation versus legal regulation. Some nurses, such as Ethel Bedford Fenwick¹, one of the founders of the British Nurses’ Association, viewed legal regulation as an opportunity to establish uniform qualifications, thus safeguarding the profession and the public. However, others, including Florence Nightingale, believed the focus should be on social and moral standards of the nurse. Nightingale thought Fenwick’s plan for regulation would exclude working-class nurses, and she objected to a written examination on the grounds that it could not test moral and personal character, as well as the application of knowledge to the patients on the wards. While Nightingale did not rule out some system of registration in the future, based on certifying them individually on an apprenticeship model, she thought for the time (late 1800s), nursing needed to continue its progress without interference from the regulators (Bostridge, 2008).

Further, the physicians and hospital administrators feared that legal registration would lessen their control over nurses and grant nurses “undeserved” professional status (International Council of Nurses, 1985; Weisenbeck & Calico, 1991). While this debate was raging, other nations enacted the first registration laws. The first registration law was enacted in Cape Town, South Africa in 1891, and another in New Zealand in 1901, and England didn’t pass registration laws until 1919 (Dorsey & Schowalter, 2008).

Table 36.1

Definition of Regulatory Terms

Accreditation – a voluntary process by private agencies which is an external quality review by peers to assure that an educational program meets established standards for structure, function, and performance (Sheets, 2002).

Approval – official recognition of nursing education programs which meet standards

¹ Also known as Ethel Gordon Fenwick (Griffin, 1995).

established by the board of nursing (NCSBN, 2004b).

Approval standards - The board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the Act and board rules. (NCSBN, 2004a)

APRN – advanced practice registered nurses, including certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs) (NCSBN, 2002b).

Boards of Nursing – serve to protect the public through 4 major domains: (1) approving and enforcing educational standards, (2) licensing on the basis of psychometrically and legally defensible testing, (3) monitoring and decision making related to practice issues, and (4) using the disciplinary process to remove from practice those nurses who fail to maintain standards (Hudspeth, 2008).

Certification – either state-issued or voluntary; if state issued, it allows for the legal authority to practice; if voluntary, it is a professional credential that recognizes that a practitioner has passed a professional certification exam given by a private agency, and it does not grant a legally defined scope of practice (Sheets, 2002).

Designation/Recognition – provides the public with information about nurses with special credentials. It is the least restrictive type of regulation, and it does not limit the right of the nurse to practice, nor can the state inquire about incompetence (NCSBN, 1993).

Licensure – the most restrictive form of professional regulation where regulated activities are complex, requiring specialized knowledge and skill and independent decision-making. In the licensure process, predetermination of qualifications is made (for example, passing the NCLEX® in nursing), monitoring of qualifications is often ongoing, and licensure provides authority to take disciplinary action if the law or rules are not followed (Sheets, 2002).

Nurse Practice Act – the statutes that authorize the board of nursing to promulgate rules that are necessary for the implementation of the nurse practice act (Weisenbeck & Calico, 1991).

Registration – does not involve state inquiry into the scope of practice or competence; it merely involves providing information to an official roster (NCSBN, 1993).

Regulation – the process whereby governmental agencies grant legal authority for an individual who has met specified qualifications and demonstrated a minimum entry-level competence to practice a chosen profession (Sheets, 1996).

Rules – regulations that are consistent with the nurse practice act. The rules cannot go beyond the law, and once enacted, they have the force of the law. Some states refer to these as the regulations, though this chapter will refer to them as the rules.

The first reference to the employment of nurses in the United States was in 1777, and Sophia Palmer, the editor of the *American Journal of Nursing*, called for regulation of nursing at the New York State Federation of Women’s Clubs in 1899. However, it was not until 1903 that North Carolina enacted the first registration law for nursing, followed by New York, New Jersey, and Virginia (Dorsey & Schowalter, 2008; Flanagan, 1976; Weisenbeck & Calico,

1991). Soon thereafter, boards of nursing began to emerge for the purpose of regulating nurses. By 1906, inspectors of schools or hospitals with nurse training programs began making program visits for approval. Annie Damer, of New York, was a member of the first Board of Nurse Examiners, where they inspected nursing programs, and she later became its president (American Nurses Association, 2008).

The early regulation of nurses protected the title of those who met a minimum set of criteria for registration. Those requirements included:

- Completion of an educational program that met standards set by the board of nursing.
- Successful completion of a written and performance examination.
- Evaluation of moral and character fitness. (Weisenbeck & Calico, 1991)

While the early laws made provisions for the above, absent from these laws was a definition of practice. New York (in 1938) became the first state to define the scope of practice and to adopt a mandatory licensure law. While it took several years for the law to be fully implemented because of World War II and other societal changes, it was a landmark law that all boards of nursing subsequently followed. This new law also delineated two classes of licenses, the professional nurse and the practical nurse, and it listed specific violations whereby a license could be suspended or revoked for just cause (Dorsey & Schowalter, 2008).

Resistance to mandatory licensure came from hospital administrators who realized there would be an economic effect from adopting a compulsory law. Therefore, it was not until the mid-1960s that all states had adopted definitions of nursing, delineating the scope of practice along with mandatory licensure.

Safriet (2002) asserted that nursing was “relegated to a scope of practice that was by definition ‘carved out’ of medicine’s universal domain” (p. 308). Because physicians were the first to secure licensure, Safriet stated, the rest of the healthcare fields had to defer to physicians, whose scope of practice is extremely pervasive. According to Safriet a physician could practice gynecology, oncology, orthopedics, pediatrics, retinal surgery, or psychiatry using outdated treatment modalities--all with the same license that the physician obtained years ago. Realistically, physicians do not do this, though Safriet contended that it is not the law that constrains them. Safriet reminded nurses that only three decades ago, nurses needed orders for starting IVs or taking a blood pressure. Until the 1970s, only physicians had the authority to pierce ears.

The mission of boards of nursing includes developing rules and approving nursing education programs for the purpose of protecting the health, safety, and welfare of the public. Boards also have the legal authority to license nurses and to discipline nurses for unsafe practice. Although approval is mandated by the boards of nursing for the purpose of protecting the health, safety, and welfare of the public, accreditation is a voluntary, nongovernmental, peer-review process to assure that programs are meeting standards of structure, function, and performance. The first

nursing accreditation program began in 1916, and currently, two private agencies accredit nursing programs. The National League for Nursing Accrediting Commission (NLNAC) accredits practical, associate-degree, diploma, baccalaureate, master's and clinical doctorate nursing programs (NLNAC, 2008), while the Commission on Collegiate Nursing Education (CCNE) accredits baccalaureate, master's, and doctor of nursing practice (DNP) programs. In 2008 CCNE finalized standards for accrediting post-baccalaureate residency programs (CCNE, 2008).

Historically, most professions have had only one accrediting agency. The competitive model is a new concept to nursing and bears watching. Boards of nursing approve practical, associate-degree, diploma, and baccalaureate programs, and some boards approve RN to BSN programs and advanced practice nursing programs. Although there is some redundancy in the process, boards of nursing and accrediting agencies are working together to make the process more seamless for schools of nursing.

In 2004 NCSBN published a white paper on the state of the art of approval processes in boards of nursing (NCSBN, 2004b), which was approved by the 2004 NCSBN Board of Directors. This document presented the 5 templates that Boards of Nursing use to approve the nursing programs in their jurisdictions, along with the advantages and disadvantages of each. See Box 36-1 for a summary of the approval templates used by boards of nursing.

Box 36-1

Approval Templates in Boards of Nursing

- I. Boards of nursing act independently to approve/accredit nursing programs
- II. Boards of nursing collaborate with national nursing accreditors, on site visits or with the program reports, when approving programs.
- III. Boards of nursing deem national nursing accreditation as meeting state approvals.
 - III a. Boards of nursing deem accreditation as meeting approvals, though they require further documentation.
- IV. Boards of nursing require national nursing accreditation.
- V. Boards of nursing are not involved with the approval system at all.²

The following are some major differences between approval and accreditation (Gloor, 2001):

² In these two states, while the nursing programs are not approved by the board of nursing, they are approved by the Board of Higher Education and that is done by PhD educated nurses.

- Boards of nursing approve nursing programs for minimal standards of practice and from the point of view of public protection. Because of this, the criteria from boards of nursing must be met, rather than being met at different levels, as is the case with accreditation.
- Boards of nursing monitor and sanction nursing programs through statutory authority. The professional accreditation process, however, focuses on the quality and integrity of nursing programs (CCNE, 2008; NLNAC, 2008).
- With the accrediting process, schools can lose their accreditation status, but they cannot be shut down. The boards of nursing, through legal authority, can close programs that do not meet their criteria, after the programs have been given a reasonable opportunity to comply with the standards. Typically boards of nursing collaborate closely with programs that don't meet their standards.
- In nursing accreditation is voluntary, while approval is mandatory.
- By law, the boards of nursing monitor the licensure exams so they align with current practice. To do this, comprehensive studies and job analyses are conducted. Although private accreditors often conduct their own research, the law does not mandate that they do so.
- Boards of nursing may make emergency visits to the nursing program if problems are reported to them.
- Boards of nursing are in the unique position of being able to demonstrate great awareness of statewide nursing education needs, but accreditation is a national process.
- Boards of nursing do all of this at little cost to nursing programs, but private accreditation can be quite costly.

In addition to approval and accreditation, nursing programs must also meet standards of other agencies. For example, they must meet the standards of the Occupational Safety and Health Administration (OSHA), as well as be in compliance with the Americans with Disabilities Act (ADA). The parent institutions may be required to meet standards set by various state or regional agencies, such as, North Central Association of Colleges and Schools in the Midwest or the Southern Association of Colleges and Schools (SACS) in the South. Practice settings also must follow regulations set by federal and state agencies, and many of them seek voluntary accreditation, such as accreditation awarded to hospitals by the Joint Commission.

Rationale and Evidence for Regulation of Nursing Education Programs

Boards of nursing exist to protect the public health, safety and welfare of individuals. Approval of nursing programs ensures that nursing is practiced by minimally competent licensed nurses within an authorized scope of practice. There is worldwide agreement by nurse leaders that there is a direct relationship between safe patient care and the quality of nursing programs (Gloor, 2001; ICN, 1997). This is particularly important for boards of nursing since their mission is to protect the public. Furthermore, the release of the Institute of Medicine's report on medical errors (Kohn, Corrigan & Donaldson, 1999), followed by other national reports on safety in health care, has created national attention on patient safety. However, nurse researchers need to

conduct more studies that describe the relationship between education programs and teaching strategies to patient outcomes.

Additionally, it is important for educators to remember that licensure of new nurses is a two-pronged process, involving the faculty members and the regulators. While each new nurse must pass the NCLEX[®] before being licensed, the new nurse must first graduate (the legislative language varies with jurisdictions) from an approved nursing program before the student is eligible to take the NCLEX[®]. Therefore, while regulators have the responsibility for approving nursing programs, educators have the responsibility for deciding whether the student should graduate, thereby affirming that the student is safe and competent enough to take the NCLEX[®]. This decision by faculty members should not be taken lightly.

Effective communication with many stakeholders in regulation, such as nursing programs, nurse educators, practice partners, accrediting agencies, nursing organizations, and the community are necessary for an effective approval process. Approval can also present unique opportunities to nursing because it can provide databases and information sharing to individual boards as well as to the nursing education community and nursing organizations (Gloor, 2001).

The approval process is carried out somewhat differently by each of the 60 boards of nursing because nursing regulation is state-based, with the underlying assumption being that there are many ways to effectively regulate nursing education. Creative and visionary ways for regulating nursing programs are shared among the various boards of nursing. NCSBN facilitates this communication by hosting monthly education conference calls, holding education meetings at NCSBN's annual Delegate Assembly, and developing electronic means of communication, such as use of Wikis and Web surveys. An NCSBN committee found that most of the 60 boards of nursing share the following roles (Gloor, 2001):

- Granting approval to basic nursing education programs
- Monitoring and sanctioning programs at risk, according to statutes
- Demonstrating awareness of state nursing education needs
- Participating in setting standards for nursing programs

This same committee identified some of the quality indicators that nurse regulators look for in nursing education programs can be seen in Box 36-2.

Box 36-2

Quality Indicators of Nursing Education Programs: Regulatory Perspective

- 1) Consistency of program outcomes with state laws and administrative rules.
- 2) Consistency of program outcomes with general standards of practice.
- 3) Consistency of program outcomes with needs and expectations of consumers.
- 4) Consistency of program outcomes with comprehensive systematic evaluation plan that

- incorporates continuous quality improvement.
- 5) Evidence of faculty and student participation in program planning.
- 6) Consistency of program outcomes with curriculum that provides diverse learning experiences.
- 7) Fiscal, human, physical, and learning resources that support program outcomes and quality improvement.
- 8) Program administrator who is a professionally and academically qualified registered nurse with institutional authority and administrative responsibility.
- 9) Professionally and academically qualified nurse faculty sufficient in number and expertise to accomplish program outcomes and quality improvement.
- 10) Evidence that information communicated by the nursing program is fair, accurate, inclusive and consistent.

The boards of nursing use the available evidence to support their administrative education rules. To assist with evidence-based nursing regulation, NCSBN, through its research and committee work, provides data to the boards of nursing. In 2005 NCSBN released an evidence-based position paper (NCSBN, 2005) on the necessity of clinical experiences, at the level of licensure, in prelicensure nursing programs. This paper has been frequently used by the boards of nursing to support their regulations related to prelicensure clinical practice experiences. While most boards of nursing don't set specific numbers of clinical hours (see Box 36-3) in their education administrative rules, the boards of nursing do require sufficient clinical experiences, under the guidance of qualified faculty, to meet the program's outcomes. Furthermore, this position paper, which was adopted by the NCSBN membership, explicitly calls for students to directly care for patients in their prelicensure programs. While the use of simulation and laboratory experiences in nursing education are excellent teaching methodologies, they cannot replace actual experiences with patients.

Box 36-3
Boards Requiring Numbers of Clinical Hours

- PN programs – 17 boards
- RN diploma programs – 3 boards
- RN ADN programs – 8 boards
- RN BSN programs – 7 boards

In 2005 NCSBN conducted a systematic review of nursing education outcomes (Spector, 2005) to support the boards' education administrative rules. This document, along with the position paper on clinical instruction in prelicensure programs (NCSBN, 2005) and NCSBN's national study of elements of nursing education (NCSBN, 2006b), was used by an NCSBN committee to develop Evidence-Based Nursing Education for Regulation or EBNER (NCSBN, 2006a), which is a valuable document for boards of nursing to use as a foundation for their education administrative rules. EBNER identifies the evidence supporting several elements of nursing education that boards might assess when approving programs. The major categories include the

following, and the subcategories, along with a discussion, can be found in the publication:

- Adjunctive teaching methods
- Assimilation to the role of nursing
- Deliberate practice with actual patients
- Faculty-student relationships
- Teaching methodologies

Other NCSBN research is being conducted by NCSBN's Continuing Ongoing Regulatory Excellence (CORE) Committee, where educators are asked for their views on the effectiveness of the board of nursing approval processes. Preliminary results show that educators perceive the approval process to be effective and to meet the goal of protecting the public. Further, when asked whether nursing programs have too much, too little, or adequate regulation, the preliminary aggregate response is that it is adequate.

Legal Basis of the Board of Nursing's Authority to Regulate Nursing

The boards of nursing have authority over their licensees, which, depending on the board, can include advanced practice nurses, registered nurses, licensed practical nurses, certified nurse assistants, medication assistants, dialysis technicians, and other related fields. These governmental agencies carry out their role in a variety of ways, including, but not limited to, the following (Wright, 2005):

- Establishing standards for nursing education programs
- Establishing requirements for applicants seeking licensure
- Issuing and renewing licenses, certificates, and certificates to prescribe drugs
- Investigating alleged violations to nursing law
- Disciplining licensees who violate the Nurse Practice Act and administrative rules

Although laws generally state that boards of nursing have the responsibility to establish criteria for licensure, thereby protecting public health and safety, the states vary in their statutes and regulations regarding approval of nursing programs. Of the 60 boards of nursing (see Appendix 36-1 for a list of the 60 state boards of nursing), 58 boards have statutory authority to approve nursing education programs. In the other two states (Mississippi and New York), nursing programs are approved by the Board of Higher Education by PhD education nurses.

Licensure and the state-based regulatory system in the United States are founded in the 10th Amendment of the U.S. Constitution, thus falling under "individual state jurisdiction with its inevitable variations and uniqueness" (Poe, 2008, p. 268). Each state and territory enacts nurse practice acts that describe the scope of practice for nurses. The statutory language is written in broad terms to allow for evolution of practice. Boards of nursing then develop administrative rules that are consistent with the nurse practice act. These rules can not go beyond the law, and once enacted, they have the force of the law. During the development of the rules, public

comment periods are allowed so practitioners can attend hearings and participate in rule making (Sheets, 2002). NCSBN has developed a model nurse practice act and model administrative rules to provide direction when the boards of nursing enact laws or promulgate administrative rules. The model practice act and accompanying rules have been approved by the NCSBN membership, and they are continually revised and updated (2004a).

The Process of Approving Nursing Programs

Up to this point, we've established the background of approving nursing programs, the evidence and rationale supporting program approval, and the legal basis of board of nursing approval processes. However, how do the boards of nursing accomplish this task? Because nursing regulation is state-based, the approval process varies from jurisdiction to jurisdiction. Please see Box 36-1 for the templates various boards of nursing use. This discussion of approval guidelines is based on the education model administrative rules, as adopted by the NCSBN membership, and the work of a subcommittee of education consultants as they developed guidelines for program approval.

Education Consultants

Most boards of nursing have education consultants to represent the board of nursing in the regulation of nursing education and through the approval process. Indeed, some states have five education consultants. Smaller states, however, might have the executive director of the board of nursing serving in the role of the education consultant, and sometimes board members serve in this role. In 2007, an NCSBN subcommittee of education consultants developed the essential competencies of the education consultant (see Box 36-4), along with a list of resources that they might find useful and recommendations for future directions.

The education consultants are usually prepared at least at the master's degree level, and often they are doctorally prepared. While most site visitor have had experience in academia, it is imperative for the visitor to have the ability to evaluate nursing curricula.

Box 36-4

Education Consultant Competencies

- I. Knowledge
 - Nursing education
 - Pedagogy
 - Curriculum
 - Models of nursing education
 - Clinical education
 - Broad discipline of nursing knowledge
 - Informatics
 - Regulation

<ul style="list-style-type: none"> ○ Practice act ○ Administrative rules ○ Mission ▪ Research process <ul style="list-style-type: none"> ○ Evidence-based practice ▪ Life-long learning
<p>II. Systematic approach</p> <ul style="list-style-type: none"> ▪ Anticipate and communicate trends ▪ Strategic planning ▪ Quality improvement ▪ Management
<p>III. Communication</p> <ul style="list-style-type: none"> ▪ Oral ▪ Written ▪ Public speaking ▪ Cultural competence ▪ Openness
<p>IV. Leadership</p> <ul style="list-style-type: none"> ▪ Collaboration ▪ Inter/intra-disciplinary ▪ Team player ▪ Self care ▪ Build trust and credibility ▪ Responsive to stakeholders ▪ Flexibility ▪ Ethical ▪ Integrity ▪ Accountability

In these changing times of health care, and with national reports calling for a transformation of nursing education (Benner, 2008; Greiner & Knebel, 2003), it is imperative for education consultants to be flexible and knowledgeable about the science of teaching and learning so that they can effectively evaluate innovations in nursing education. An NCSBN committee is currently developing model administrative rules for innovative education proposals to give the boards of nursing direction.

Site Visits

As a part of the approval process often representatives from boards of nursing, usually their education consultants, make site visits to nursing programs. Many boards send two site visitors to survey the nursing programs. When there are two site visitors, tasks can be divided, thus shortening the length of the visit. Moreover, if there are conflicts during a survey, a second perspective can be invaluable. In the case of two visitors, a “lead visitor” is usually designated,

and the responsibilities of each are clarified before the visit.

The primary goal of the site visit is to gather information to determine if the school is meeting the criteria set in the board of nursing's rules (NCSBN, 2004a). Site visits are routinely made for initial approval of a new school. After initial approvals, visits are ordinarily made at regular intervals, which may differ from state to state (see Table 36.2), and 37 jurisdictions (NCSBN, 2007) also require annual reports from nursing programs.

Table 36.2 - Length of Time for Continuing Approval

Years	# of Boards
1 Year	10
2 Years	2
3 Years	2
4 Years	3
5 Years	9
>5 Years	15
Variable	14
Source: NCSBN, 2007 Profiles of Member Boards (NCSBN, 2007)	

Boards may also schedule a visit if the program is initiating an off-campus offering or if the nursing program is about to initiate a major curriculum change. Further, an emergency visit may be made if there are reports of noncompliance with the administrative education rules. The site visits ordinarily take from a few hours to a few days, depending on the nature of the visit.

Since the regulation of nursing is state-based, approval processes vary across states (see Box 36-1 for the individual templates). Many jurisdictions coordinate their site visits with the national nursing accrediting agencies in an attempt to streamline the process and to avoid duplication of efforts. In a few states, national accreditation is required of all nursing programs. See Box 36-5 for some of the differences between the boards of nursing when coordinating site visits with national accreditors, such as NLNAC or CCNE.

Box 36-5			
Coordination with National Nursing Accreditors			
Approval Template	Yes	No	Certain Conditions
Approval is automatically granted without onsite visit to programs that meet national nursing accreditation standards	4 boards	41 boards	12
Board of nursing collaborates/coordinates with other accreditation bodies for on-site visits	11 boards -always 23 boards-sometimes 8 boards -rarely	15 boards	n/a

When surveying nursing programs, the education consultants must be effective communicators. The oral and written communication should be clear, though the consultants also must listen and interview carefully. The use of clarification and verification is important. The perceptive consultants will be able to pick up subtle nuances, thus moving the discussion in another, more pertinent, direction. For example, sometimes the program looks fine from the outset, but as the education consultants interview the faculty and students, something does not fit. At first the consultants can not put their fingers on what is wrong, but with effective communication it soon comes to light. To facilitate effective communication, the site visitor must create an environment in which a candid exchange can take place. When a milieu of objectivity, adaptability, and openness is achieved, the process becomes positive for the nursing program as well as for the visitors.

During the site visit, it is important to develop collegiality with the program administrator and faculty. Some examples of collegiality within the role of education consultant include:

- Promote confidence and trust with all parties; the faculty should have the confidence that

the education consultant possesses the knowledge to assist them to meet the standards of the board of nursing.

- Foster mutual support, so that all parties will have a shared vision as they work together to solve the problems that threaten educational integrity.
- Advocate for the program by communicating positive feedback.
- Communicate openly and promote interactive discussions.

Although site visitors take on various roles when visiting nursing programs, their major role is that of a **regulator** for the purpose of safeguarding the public. In this role, visitors provide information about compliance and noncompliance with the administrative education rules. In the **consultant** role, the visitor can make clarifications and provide new information. As a **facilitator**, the site visitor can encourage the participants to share information in an open environment. Site visitors are **fact finders** because they comprehensively gather information from a variety of sources. Lastly, site visitors take on the role of **problem solver**, thus assisting programs to identify ways to meet the requirements of the state boards of nursing (NCSBN, 1995).

Preparation for the Site Visitors

Initial contact with program directors should provide nursing programs with adequate time to submit requested materials and to prepare for the site visit. The nursing program should know the reason for the visit and have a clear idea of the agenda, including identification of documents to review, which individuals are to be interviewed, and which facilities are to be toured. If possible, the nursing program should participate in setting the schedule. The site visitor may alert the administrator of the parent institution of the purpose and dates of the visit.

Submission of Documents

Most boards of nursing require a self-study or self-evaluation document prior to the approval process. When boards and accrediting bodies collaborate on the approval visit, sometimes the board accepts the self-study written for accreditation, perhaps with an addendum addressing where the document addresses the boards' rules. The Model Education Rules (NCSBN, 2004a) give an overview of the documentation that is generally required. Each board of nursing differs as to when the program should submit written materials. One jurisdiction may ask for submission of the self-study prior to the visit, although others may ask for documentation at the time of the site visit. Other boards may ask for a combination of pre-visit and on-site document review.

Boards may request materials pertaining to the organization and administration of the nursing program. Many states require documentation that the institution is regionally accredited within their jurisdiction. Organizational charts of the nursing school as well as the parent organization are often requested. Careful review of these charts can clarify the administrative authority of the head of the program. Job descriptions of faculty/ staff are often reviewed for consistency with current practice and appropriateness to the nursing program. Review of the nursing program's budget is important for ascertaining the adequacy of resources to meet the goals and objectives of the school. Often, this review includes state allocation, subsidized salaries, tuition, grants, special initiative funds, endowments, aggregate faculty and staff salaries, and operating costs of the program. There is a careful review of funds allocated for professional development and travel as well as the library and learning resources. Contracts with each practice setting should delineate each party's responsibilities as well as the time frame and termination clause. Contracts with non-practice settings may also be reviewed; for example, there may be contracts with off-campus offices or simulation centers. Boards may also require a total program evaluation plan to review all aspects of the nursing program from recruitment to graduate evaluation. This plan is a tool, and validation of its implementation should be found in faculty minutes, course materials, NCLEX[®] results, etc.

Boards of nursing may ask for documentation regarding the curriculum and course materials. Although the Model Education Rules (NCSBN, 2004a) are broadly stated, many state rules are more specific for curricular requirements, such as numbers of didactic or clinical hours. Some of

the materials that may be reviewed are the philosophy and mission of the program and the overall curricular plan. Individual syllabi with accompanying course goals, content, and learning activities may be evaluated. Evaluation tools, examples of students' work, and course evaluations often are requested. Courses are reviewed for relevancy, and the reference lists are evaluated for being up-to-date. The same criteria are used for evaluating distance-learning courses and for reviewing other courses.

The program is evaluated for internal consistency, meaning that the individual components of the curriculum relate to each other and to the theoretical framework of the program. Internal consistency suggests that a curriculum progresses logically within the program's framework. For example, the program's philosophy may describe the students as mature, responsible, and self-directed, whereas its policies may contain inflexible student requirements or its curriculum may not provide for self-direction (NCSBN, 1995). A combination of reviewing written documents and interviewing faculty and students is often the best method of evaluating the curriculum.

Faculty qualifications are also reviewed, in terms of licensure status, educational degrees, employment history, teaching responsibilities, and professional development. Teaching and non-teaching responsibilities of the faculty are carefully considered. In August of 2008, NCSBN's membership adopted faculty qualifications to meet the health care challenges of the future, and these have been incorporated into NCSBN's model administrative rules (NCSBN, 2004a). These qualifications were based on the best available evidence (NCSBN, 2008c).

Faculty/student ratios are often reviewed, as is the ratio of full-time to part-time faculty, though NCSBN's model education rules do not have recommendations for faculty/student ratios. The process of faculty evaluation and promotion is reviewed, and the visitors look for evidence of student input into faculty evaluations. The faculty handbook and bylaws are often excellent sources of faculty data.

Reviewers may request documentation about current preceptors, including licensure status, educational qualifications, employment, and relevancy of student placements. In 2008, NCSBN's membership adopted model rules that require the preceptor to be educated at the level to which the student is aspiring (NCSBN, 2004a; NCSBN, 2008c). Boards of nursing may also request information about the nursing student body. Policies regarding admission, progression, graduation, and health requirements are investigated, and it is important that these policies be published in the appropriate catalogues and handbooks. The boards of nursing vary widely in their requirements for reviewing student records, though confidentiality always must be maintained.

Documentation of the students' NCLEX[®] scores may be requested. Forty-four state boards of nursing have required NCLEX[®] pass rates for first-time writers of the exam (NCSBN, 2007). If a program's pass rate falls below the mandated level, the board usually requests a plan from the

program for improving its scores within a reasonable timeframe to regain compliance with this rule.

Visitors tour the facilities and carefully evaluate the resources of nursing programs. Classrooms, learning resource centers, and equipment should be adequate in number, size, and quality so the program's goals can be met. Offices and meeting space should be adequate for the number of faculty. Library and audiovisual resources should be comprehensive and current, and they should be accessible to all students. This is especially important when students take distance-learning courses. There should be adequate support services for faculty and students alike. Documentation regarding clinical agencies may include accrediting status, opportunities for learning experiences, facilities, and resources.

Planned Meetings and Tours

In preparation for site visitors, a schedule of meetings and tours is usually planned. Meetings are intended to clarify and/or verify the documents submitted. Separate meetings with the program administrator, faculty, and students allow for an objective exchange of information. Agendas of the meetings should be carefully planned, and the length should be between 30 and 60 minutes. Site visitors usually want to meet with the administrator of the parent institution as well. Tours of the campus, classrooms, faculty offices, libraries, conference rooms, and resource centers should also be planned. Site visitors often tour the clinical agency, although this depends on the individual jurisdiction.

The initial site visit is with the program dean or director, and this sets the tone for the visit. This meeting covers changes in the program since the last visit, any upcoming changes, a general description of the facilities and financial resources, and issues to be raised with the administrator of the parent institution. The visitors meet with the faculty members and adjunct faculty to discuss the curriculum, the program's strengths and weaknesses, the clinical agencies, and the faculty workload. Site visitors may take the opportunity to discuss any trends of regulation in that particular jurisdiction (NCSBN, 1995).

Meetings are scheduled with students – or consumers – of the program. These meetings may take place in the classroom or in the clinical agency. The site visitors may discuss the students' perceptions of the program and its strengths and weaknesses, faculty-student interactions, learning activities, clinical practice settings, and regulatory issues. If students raise internal issues that are not within the jurisdiction of the state board of nursing, the visitors should direct them to the appropriate resources, always remaining objective and nonjudgmental (NCSBN, 1995).

Not all jurisdictions visit the practice setting, although several do. If the board of nursing collaborates with NLNAC or CCNE when making site visits, representatives typically survey the clinical agency with the accreditors. If the visitors do tour the practice arena, they evaluate

the learning experiences offered in these facilities, the client population, and the communication process between faculty and nurses in the setting.

When meeting with the administrator of the parent institution, visitors review the purpose of the visit and discuss possible outcomes. The dean or director of the program should be present at this meeting, and the discussion may include nursing shortage information, future plans or innovations, financial support of the nursing program, and the patterns of present and future enrollment of the college as well as the nursing program.

The last meeting during the site visit is sometimes termed the exit interview. All findings and recommendations are shared at this time, and they must be documented and referenced to the board's rules. At this time, the date at which the report is to be presented to the board of nursing is specified. Some jurisdictions require that the dean or director of the nursing program be present at this meeting. Site visitors should remind the nursing program that their findings are only recommendations and that the board of nursing will make the final decision on approval status.

Board of Nursing's Report

It is the responsibility of the site visitors to complete an accurate and detailed report of the visit, based on the program's compliance with the education rules of that jurisdiction. Some boards require documentation on how the program is in compliance with each rule, although others may require documentation only in the areas of noncompliance. If the program is in noncompliance with the rules, it is important that clear recommendations are made to bring the program in compliance.

Some boards of nursing send the school a copy of the initial report of the site visit to allow faculty an opportunity to respond, and others send the initial report to their board.. Most reports are discussed with the board within four to eight weeks after the visit has been conducted. The presence of the dean or director of the program is sometimes required at the board meeting, depending on the jurisdiction. The board acts upon the recommendations presented in the report of the site visit.

The NCSBN model practice act and rules (NCSBN, 2004a) detail recommendations to boards of how new nursing programs should apply for approval. This is done in three phases. In **Phase I** of approval the program applies to the board of nursing, submitting documents, verifying the availability of qualified faculty and a pool of available students, etc. In **Phase II** the program receives approval for admitting students after submitting a list of documents, such as the overview of the curriculum, program evaluation plan, and student policies. In **Phase III Continuing Approval** is designated every few years (see Table 36-2), at the board's discretion. With continuing approval the board might look at accreditation reports or trends on the NCLEX[®], faculty turnover, or other criteria (NCSBN, 2004a). **Denial** or **Withdrawal** of approval is given when programs fail to substantially meet the standards or fail to correct identified deficiencies. **Conditional Approval** is another option that the boards might use. This

is when the program is given a reasonable period of time to correct deficiencies. **Reinstatement of Approval** is obtained when the program submits evidence of compliance with the education standards within the specified timeframe. While the terminology for approval status varies from board to board, the definitions generally are similar.

Regulation of Advanced Practice Registered Nurses (APRNs)

In the 1960s, several events led to the development of the advanced practice role in nursing. Medicare and Medicaid increased the number of people who received federal funds for health care, and at the same time, the federal government forecasted a shortage of physicians. The emerging women's movement in the U.S. led to an increased demand for personal and professional autonomy of women. Thus, more women were seeking nurse midwives for care rather than the traditional male obstetrician. Specialized care units, such as ICUs and neonatal care units, were being established in hospitals with the resultant need for better prepared nurses (Safriet, 1992). Nurse practitioner programs were established. In 1971, Idaho became the first state to legislate diagnosis and treatment as a part of the scope of practice of advanced practice nurses. Although it was pathbreaking at the time, it was somewhat restrictive. Since then, most states have statutorily recognized advanced practice roles of nurses to various degrees.

Currently, 54 boards of nursing report that they specifically regulate/recognize advanced practice nursing as a separate group within their jurisdictions (NCSBN, 2007). In 2002, NCSBN (2002b) published a position paper regarding regulation of advanced practice nursing, which incorporated a review of the background of regulation of advanced practice nursing as well as a review of education, certification, and accreditation as a basis for regulation. In this paper, one recommendation was that **advanced practice registered nurse (APRN)** be used as an umbrella term to designate appropriately credentialed and educated nurses, such as nurse anesthetists, nurse midwives, nurse practitioners, and clinical nurse specialists, who have primary responsibility in the direct care of patients. NCSBN further suggested that licensure be granted only when the APRN education program and the area of the certification exam are congruent. A history of NCSBN's work with advance practice regulation can be found on the NCSBN Web site (NCSBN, 2008a).

Current regulatory recommendations are that APRNs be educated at the graduate level. The specialty should be consistent with the certification that the individual is seeking. The nursing curriculum should be broad and include biological, behavioral, medical, and nursing sciences relevant to the population foci, and there should be a minimum of 500 supervised clinical hours. Clinical experience should be directly related to the population foci, and the preceptor should be appropriately educated and licensed for that role. For licensure, it is recommended that the APRN graduate from an accredited educational program. It is critical that the APRN program meet established standards such as those set by the National Task Force on Quality Nurse Practitioner Education (2008). It is also important for boards to have criteria for evaluating APRN programs for regulatory purposes, so NCSBN developed Requirements for Accrediting

Agencies and Criteria for APRN Certification Programs (NCSBN, 2002a).

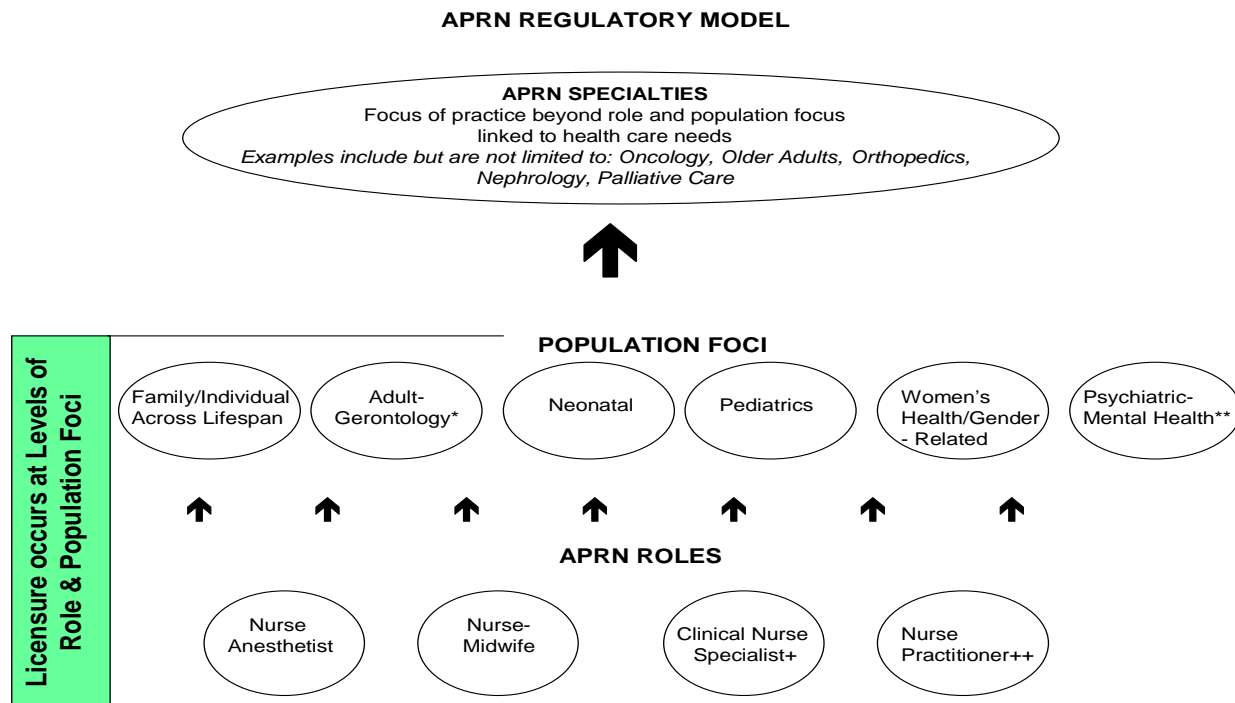
As health care has evolved over the last few decades, APRNs have become integral to patient care and management. However, because of a lack of uniformity across the nation due to state-based regulation, APRNs cannot easily move from state to state to practice. Each state independently determines the APRN legal scope of practice, the recognized roles, the entry to advanced practice criteria, and the acceptable certification examinations for entry-level competence assessment. Furthermore, educational programs, certification agencies and accreditation agencies each face considerable differences within their own disciplines. This leads to practice barriers and decreased access to care for patients. Therefore, in an attempt to promote more congruency between jurisdictions with APRN practice, in September of 2008, the NCSBN Board of Directors endorsed the *Consensus Model for APRN regulation: Licensure, Accreditation, Certification and Education* paper (NCSBN, 2008a). In August of 2008 the NCSBN membership adopted revised APRN Model Act and rules to parallel this model.

The Consensus Model was the result of a multiyear collaboration between NCSBN and the APRN Consensus Process Work Group (NCSBN, 2008a). The document presents an APRN regulatory model created by APRN educators, accreditors, certifiers and licensure bodies, and it establishes a set of standards that protects the public, improves mobility and expands access to safe, quality APRN care.

The consensus paper defines APRN practice, describes the APRN regulatory model (see figure 36-1) and presents strategies for implementation. The model recommends independent APRN practice; licensure at the role (certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners) and population foci level (family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health). APRN specialties (such as oncology or palliative care) are not regulated in this model, though the APRNs will be certified in their area of specialty. The model allows for the emergence of new APRN roles and population foci.

In the APRN consensus paper that was endorsed by NCSBN's Board of Directors, there is a recommendation for a new group to be formed, whose members will include licensing bodies, accreditors, certification bodies and educators; the acronym for this group will be LACE. They will assist in implementing the APRN regulatory model, and they will facilitate communication across those bodies. The LACE group first met July 24-25, 2008, in Washington DC, and they agreed that their mission will be to maximize congruence among licensure, accreditation, certification, and education to enhance the capacity of APRNs to deliver safe and effective care (personal communication: N. Chornick).

Figure 36-1



Conclusion

Approval in prelicensure nursing programs is similar to accreditation, although there are some distinct differences. Although approval is for the purpose of ongoing safe practice and protection of the public, accreditation sets standards for quality education programs. In order to limit redundancy for nursing programs, site visits for accreditation and approval often are collaborative, and this is the trend for the future. In the regulation of APRN programs, educational consistency across programs and a broad education are important for public protection and are thus important in approvals. Approval of prelicensure and APRN nursing programs is an integral part of nursing regulation.

Please visit the National Council of State Board of Nursing at www.ncsbn.org. For easy launching, this address is located on the CD accompanying this book. Simply launch your internet browser, put the CD-ROM in the drive, go to Chapter 36 on the CD, and then click on the website address.

Learning Activities

1. Knowing that the mission of boards of nursing is to protect the public, do the boards of nursing have a duty to advocate for nurses in their jurisdiction? Why or why not? (See Wright, 2005, for a discussion of this.)
2. You are the education consultant for a board of nursing and are to visit a private university's baccalaureate nursing program for continuing approval. This program admits students as freshman and also as transfer students. It was accredited by CCNE seven years ago, being given the full 10-year standing. The most recent report of pass rates for the program was 75%, and the state's standards are 80%. Using the NCSBN (2004a) Model Education Rules and the information in this chapter, discuss what steps you would take in your approval site visit.
3. As the Director of Education at NCSBN, you are asked to develop evidence-based quality indicators for the boards of nursing to use when approving schools. Outline a proposal for this project. What will be your timeline? What are some of the criteria that you will use? How will you support these criteria with evidence?
4. You are scheduled to visit a large ADN program in a community college. What meetings will you schedule to achieve the goals of your visit? Which documents will you consider essential to review? Will you want to coordinate your visit with an upcoming accreditation visit? Why or why not?
5. The APRN Consensus Process Work Group has recommended that an organization, LACE (licensure, accreditation, certification, and education), form for implementing the new APRN model and for facilitating communication. Anticipate the challenges, and opportunities, that this group might face. With your knowledge of the differences between regulation and accreditation, what might the different perspectives in the four groups be?

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Appendix 36-1 – The 60 State Boards of Nursing

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Deleware
Arizona	Iowa	Florida	District of Columbia
California-PN and California-RN	Kansas	Georgia-PN and Georgia-RN	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana-PN and Louisiana-RN	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska and Nebraska-APRN	North Carolina	New Jersey
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Rhode Island
Northern Mariana Islands	West Virginia-PN and West Virginia-RN	Texas	Vermont
Oregon	Wisconsin	Virginia	U.S. Virgin Islands
Utah			
Washington			
Wyoming			

* Please note: California, West Virginia, Georgia, and Louisiana all have separate RN and PN Boards of Nursing; Nebraska has a separate APRN Board of Nursing. As of August, 2008, British Columbia has become NCSBN's first Associate Member.