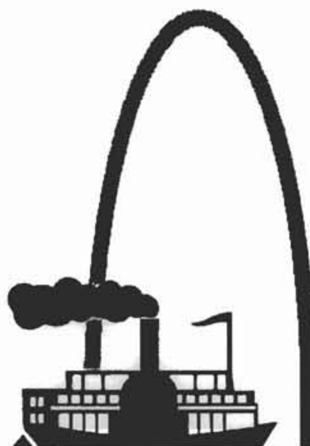

Annual Meeting
August 1-5, 1995
Regal Riverfront Hotel
St. Louis, Missouri

1995 Book of Reports

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NATIONAL COUNCIL®

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

Table of Contents

Tab 1: 1995 Annual Meeting Schedule

1995 Annual Meeting Schedule 1
Hotel Floor Plan 5

Tab 2: Business Agenda/Rules/1995 Recommendations

Business Agenda of the 1995 Delegate Assembly 1
Standing Rules of the Delegate Assembly 3
Summary of Recommendations to the 1995 Delegate Assembly 5

Tab 3: Committee on Nominations

Report of the Committee on Nominations 1

Tab 4: Officer Reports

Report of the President 1
Report of the Vice-President 3
Report of the Secretary 4
Report of the Treasurer 5
Report of the Independent Auditors 6
- Balance Sheets 7
- Statements of Revenue and Expenses 8
- Statements of Changes in Fund Balance 10
- Statements of Cash Flows 11
- Notes to Financial Statements 12

Report of the Area I Director 14
Report of the Area II Director 15
Report of the Area III Director 16
Report of the Area IV Director 17
Report of the Director-at-Large 18

Tab 5: Report of Staff

Report of Staff Activities 1
- Attachment A: National Council Administrative Staff and Organization Charts 8
- Attachment B: Computerized Clinical Simulation Testing (CST®) Project 17
- Attachment C: Unlicensed Assistive Personnel—Literature Review 30
- Attachment D: Literature Review Report 46

Tab 6: Examination Committee Report

Report of the Examination Committee 1
- Attachment A: Draft *NCLEX-PN™ Test Plan* 6

Tab 7: Report of Test Services

Annual Report of Educational Testing Service (ETS) and Sylvan Learning Systems 1
Annual Report of The Psychological Corporation 17
- Attachment A: NACEP Written/Oral Evaluation 19
- Attachment B: NACEP Manual Skills 20

Tab 8: Finance Committee

Report of the Finance Committee 1

Tab 9: Nursing Practice and Education Committee and Subcommittees

Report of the Nursing Practice and Education Committee 1
- Attachment A: Professional Accountability 3

Report of the Essential and Continued Competence Subcommittee 8
- Attachment A: Definition of Competence and Standards for Competence 10
- Attachment B: Developing a Model for Nursing Competence—A Working Draft 11
- Attachment C: Draft Model for Individual Competence Evaluation 18

Report of the Member Board Education Needs Subcommittee 20
Report of the Nursing Regulation Subcommittee 21
Report of the Unlicensed Personnel Subcommittee 23

Tab 10: Report of Board of Directors, Task Forces and Focus Groups

Report of the Board of Directors 1

Task Forces and Focus Groups

Tab 10-A: CAT Evaluation Task Force 1
Tab 10-B: Task Force to Identify Core Competencies for Nurse Practitioners 1
- Attachment A: Nurse Practitioner Core Competencies 3

Tab 10-C: Task Force to Study Feasibility of a Core Competency Exam for Nurse Practitioners 1
Tab 10-D: Task Force to Study Advanced Practice Nurse Mobility 1
Tab 10-E: Nurse Aide Competency Evaluation Program Task Force 1
- Attachment A: 1995 User Survey—Cumulative Results 3
- Attachment B: Comparison of Cumulative Results 5

Tab 10-F: Task Force on Chemical Dependency Issues 1
Tab 10-G: Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group 1
- Attachment A: Disciplinary Guidelines for Managing Sexual Misconduct Cases 5

Tab 10-H: Task Force to Implement Educational Programs for Disciplinary Investigators 1
Tab 10-I: Task Force to Implement Educational Programs for Nursing Education Program Surveyors 1
Tab 10-J: Continuing Education Offerings Task Force 1
Tab 10-K: Educational Programs Task Force 1
Tab 10-L: Executive Officers Network Task Force 1
- Attachment A: Executive Officer Orientation Task Force Report 3

Tab 10-M: Nurse Information System Task Force 1
Tab 10-N: Long Range Planning Task Force 1
- Attachment A: Proposed Organization Plan 3
- Attachment B: Trend Analysis Issues 9
- Attachment C: Rationale Briefs of Proposed Changes to Organization Plan 14

Tab 10-O: Special Services Division .... [illegible]

Tab 11: Resolutions Committee/New Business

Report of the Resolutions Committee/New Business .... [illegible]

Tab 12: Summary of 1994 Delegate Assembly Actions

Summary of 1994 Delegate Assembly Action and Subsequent Implementation .... [illegible]

Tab 13: FY95 Organization Plan and Budget

National Council Organization Plan 1
FY95 Budget by Program 16

Tab 14: Orientation Manual

Orientation Manual 1

Tab 15: Glossary

Glossary 1

Annual Meeting Schedule

Incidental meeting rooms are available throughout the week and may be reserved by calling Sue Davids at the National Council prior to the meeting or via sign-up sheets located at the registration desk. Incidental meeting rooms will be allocated on a first-come, first-served basis.

Monday
July 31

8:00 a.m. - 5:00 p.m.
Nursing Investigators' Program
Jefferson A&B

Tuesday
August 1

8:00 a.m. - 9:00 a.m., 11:30 a.m. - 5:00 p.m.
Registration
Spirit of St. Louis

8:30 a.m. - 11:30 a.m.
Executive Officers' Networking Session
Laclede

11:30 a.m. - 1:00 p.m.
Lunch Break

1:00 p.m. - 2:30 p.m.
Concurrent Educational/Research Sessions
- Monitoring Nurses with Licensure Probation
- "And the Walls Came Tumbling Down": Moving into Community-Based Settings
- The Ethics of Regulation
- Variations in Decision-Making Processes Based on Education

Jefferson A&B, Lewis, Clark, Field

2:30 p.m. - 3:00 p.m.
Poster Session—Refreshment Break
Assembly Area

3:00 p.m. - 4:30 p.m.
Concurrent Educational/Research Sessions
- The Process of Delegation, From Concept to Practice
- Advanced Nurse Practitioners: Role and Regulatory Issues
- You Can Teach a New Dog Old Tricks or The Oklahoma Model for Regulation and Utilization of Advanced Unlicensed Assistive Personnel in Acute Health-Care Settings
- External Degree Graduates at Work: Some Empirical Studies

Jefferson A&B, Lewis, Clark, Field

4:30 p.m. - 5:00 p.m.
Poster Session
Assembly Area

5:00 p.m. - 6:30 p.m.
Early Bird Social
Meramec

Wednesday
August 2

7:30 a.m. - 2:00 p.m.
Registration
Spirit of St. Louis

8:00 a.m. - 9:00 a.m.
Orientation
Jefferson A

9:00 a.m. - 10:30 a.m.
Networking Groups
- Executive Directors
- Board Members
- Board Staff-Education
- Board Staff-Practice/Discipline

Lewis, Clark, Laclede, Field

10:30 a.m. - 11:00 a.m.
Coffee Break
Assembly Area

11:00 a.m. - 12:00 p.m.
Special Interest Groups (SIGS)
- Chemically Impaired Nurse Programs
- Community-Based Education
- LPN/VN Issues
- Public Policy Issues
- NIS Access

Lewis, Clark, Laclede, Field, Shaw

12:00 p.m. - 1:30 p.m.
Lunch Break *(Box lunches to be available for purchase)*
Presenter
Gary Filerman
Pew Health Professions Commission
(Further details to be announced.)

1:30 p.m. - 3:00 p.m.
Guest Speaker
Colleen Conway-Welch, PhD, Dean
Vanderbilt University, School of Nursing
"Impact of Managed Care on State Boards of Nursing"
Missouri & Illinois

3:00 p.m. - 3:15 p.m.
Refreshment Break
Assembly Area

3:15 p.m. - 4:45 p.m.
Concurrent Meetings (open attendance)
- CAT Dialogue
- NCNET Meeting
- Chemically Impaired Nurse Programs (3:00-6:00)
- NIS Access
- Meet the Speaker (Colleen Conway-Welch, PhD)

Lewis, Clark, Laclede, Shaw

6:30 p.m. - 9:30 p.m.
Riverboat Cruise
Sponsored by the Missouri Board of Nursing

Thursday
August 3

8:00 a.m. - 2:00 p.m.
Registration
Spirit of St. Louis

8:00 a.m. - 9:00 a.m.
The Psychological Corporation Breakfast
Meramec

9:00 a.m. - 12:15 p.m.
Informational Forums
Missouri & Illinois

> **9:00 a.m. - 9:15 a.m.**
> Committee on Nominations

> **9:15 a.m. - 9:45 a.m.**
> Standards of Competence

> **9:45 a.m. - 10:00 a.m.**
> Nursing Practice and Education

> **10:00 a.m. - 10:30 a.m.**
> Regulatory Reform Initiatives

10:30 a.m. - 11:00 a.m.
Coffee Break
Assembly Area

> **11:00 a.m. - 11:30 a.m.**
> Unlicensed Personnel

> **11:30 a.m. - 11:45 a.m.**
> Disciplinary Guidelines for Managing Sexual Misconduct Cases

> **11:45 a.m. - 12:15 p.m.**
> Advanced Practice

12:15 p.m. - 1:30 p.m.
Lunch Break

1:30 p.m. - 5:00 p.m.
Business Forums
Missouri & Illinois

> **1:30 p.m. - 2:30 p.m.**
> NCLEX-PN™ Test Plan

> **2:30 p.m. - 3:15 p.m.**
> Feasibility of NP Core Competency Exam

3:15 p.m. - 3:45 p.m.
Refreshment Break
Assembly Area

> **3:45 p.m. - 4:15 p.m.**
> Open Forum

> **4:15 p.m. - 5:00 p.m.**
> Board of Directors' Forum

5:00 p.m. - 6:30 p.m.
Reception for Past/Present National Council Board Members

Friday
August 4

8:00 a.m. - 10:00 a.m.
Registration
Spirit of St. Louis

8:00 a.m. - 9:00 a.m.
Breakfast with ETS
Meramec

9:00 a.m. - 10:00 a.m.
First Delegate Assembly
Missouri & Illinois

10:00 a.m. - 10:30 a.m.
Coffee Break
Assembly Area

10:30 a.m. - 12:30 p.m.
Second Delegate Assembly
Missouri & Illinois

12:30 p.m. - 2:00 p.m.
Area Luncheons
Field, Laclede, Lewis, Clark

2:00 p.m. - 4:00 p.m.
Candidates' Forum
Missouri & Illinois

[illegible]

8:00 a.m. - 9:00 a.m.
Registration
Spirit of St. Louis

8:00 a.m. - 9:00 a.m.
Elections
Shaw

9:00 a.m. - 10:15 a.m.
Business Forums
Missouri & Illinois

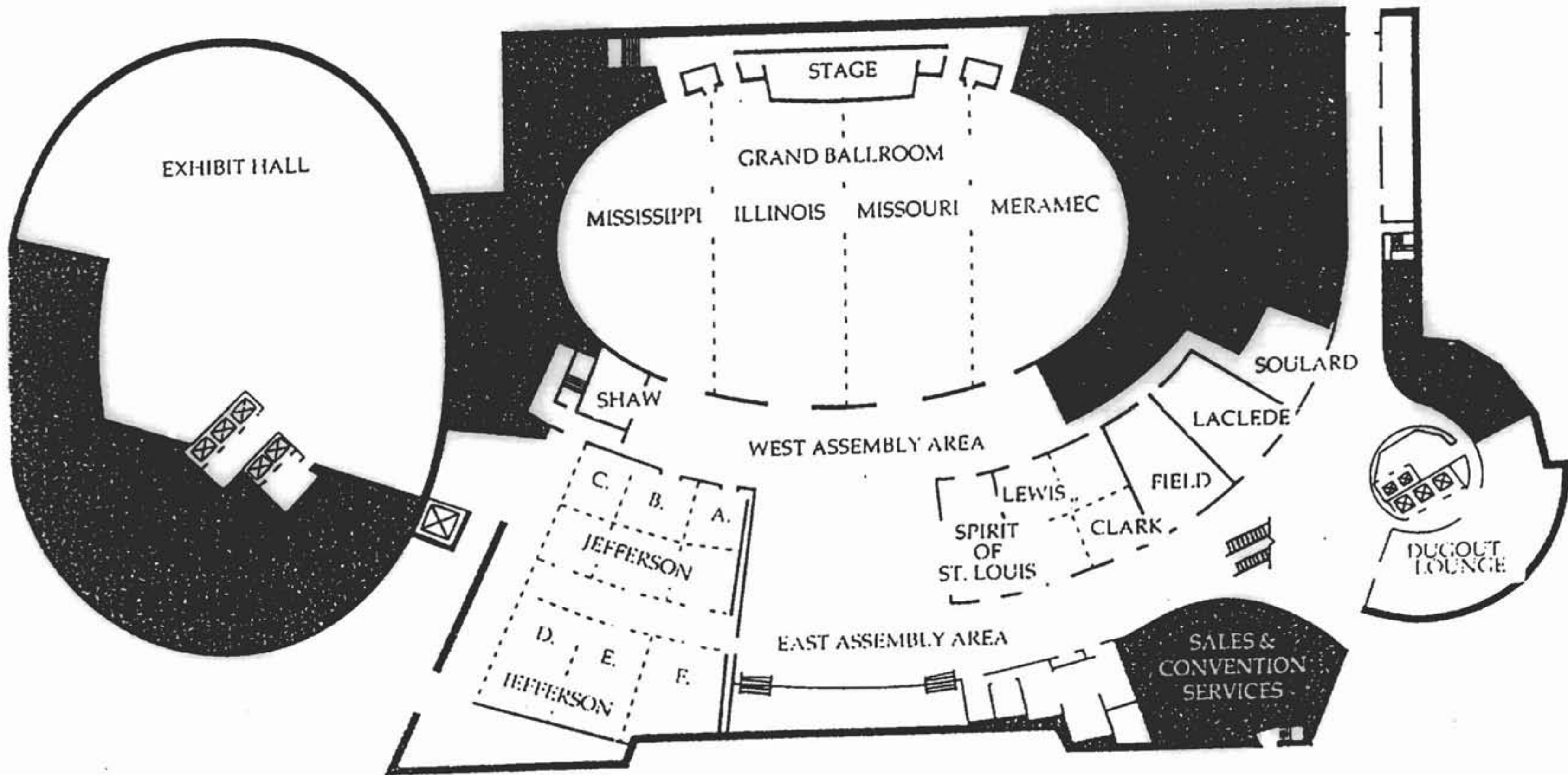
> **9:00 a.m. - 10:00 a.m.**
> Resolutions Forum
>
> **10:00 a.m. - 10:15 a.m.**
> Board of Directors' Forum

10:15 a.m. - 10:45 a.m.
Coffee Break
Assembly Area

10:45 a.m. - 12:15 p.m.
Third Delegate Assembly
Missouri & Illinois

12:15 p.m. - 1:45 p.m.
Awards Luncheon
Meramec

2:00 p.m. - 5:00 p.m.
Fourth Delegate Assembly
Missouri & Illinois


STAGE
GRAND BALLROOM
MISSISSIPPI
ILLINOIS
MISSOURI
MERAMEC
EXHIBIT HALL
SHAW
SOULARD
LACLEDE
WEST ASSEMBLY AREA
FIELD
LEWIS
CLARK
SPIRIT
OF
ST. LOUIS
C.
B.
A.
JEFFERSON
D.
E.
F.
JEFFERSON
EAST ASSEMBLY AREA
SALES &
CONVENTION
SERVICES
DUGOUT
LOUNGE

2

BUSINESS AGENDA

RULES

[illegible] RECOMMENDATIONS

Business Agenda of the 1995 Delegate Assembly

Friday, August 4
9:00 am–10:00 am

Resource Materials and Forums

Agenda Item	Resource Materials and Forums
■ **Opening Ceremonies**	Orientation/Parliamentary Review, Wednesday, 8:00 – 9:00 am Informational Forums, Thursday, 9:00 am – 12:15 pm
• Introductions	
• Announcements	
■ **Opening Reports**	**Tab 2**
• Credentials Committee	
• Rules Committee	Tab 2
• Adoption of Agenda	Tab 2
■ **Report of the Committee on Nominations**	**Tab 3**
• Slate of Candidates	Tab 3, page 3
• Nominations from Floor	
■ **President's Address**	

Friday, August 4
10:30 am–12:30 pm

Agenda Item	Resource Materials and Forums
■ **Officers' Reports**	**Tab 4**
• Treasurer's Report—Audit	Tab 4, page 5
■ **Report of Staff**	**Tab 5**
• National Council Administrative Staff & Organization Charts	Tab 5, page 8
• Computerized Clinical Simulation Testing (CST®) Project	Tab 5, page 17
• Unlicensed Assistive Personnel—Literature Review	Tab 5, page 30
• Literature Review Report	Tab 5, page 46
■ **Examination Committee Report**	**Tab 6**
• Draft *NCLEX-PN™ Test Plan*	Tab 6, page 6 Business Forums, Thursday, 1:30 – 5:00 pm
■ **Report of Test Services**	**Tab 7**
• Educational Testing Service (ETS)	Tab 7, page 1
• The Psychological Corporation	Tab 7, page 17
■ **Finance Committee Report**	**Tab 8**
■ **Nursing Practice and Education Committee Report**	**Tab 9**
• Essential and Continued Competence Subcommittee	Tab 9, page 8
• Member Board Education Needs Subcommittee	Tab 9, page 20
• Nursing Regulation Subcommittee	Tab 9, page 21
• Unlicensed Personnel Subcommittee	Tab 9, page 23 Informational Forums, Thursday, 9:00 am – 12:15 pm

Saturday, August 5
10:45 am–12:15 pm

Resource Materials and Forums

■ **Election of Officers & Committee on Nominations** .... Candidates' Forum, Friday, 2:00 – 4:00 pm *(Elections: 8:00 – 9:00 am, Saturday, in the Regent Room)*

■ **Board of Directors' Report** .... **Tab 10**

Including Reports of Task Forces and Focus Groups

Related to Goal I—Licensure and Credentialing
- CAT Evaluation Task Force .... Tab 10-A
- Task Force to Identify Core Competencies for Nurse Practitioners .... Tab 10-B
- Task Force to Study Feasibility of a Core Competency Exam for Nurse Practitioners .... Tab 10-C
- Task Force to Study Advanced Practice Nurse Mobility .... Tab 10-D
- Nurse Aide Competency Evaluation Program Task Force .... Tab 10-E

Related to Goal II—Nursing Practice
- Task Force on Chemical Dependency Issues .... Tab 10-F
- Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group .... Tab 10-G
- Task Force to Implement Educational Programs for Disciplinary Investigators .... Tab 10-H

Related to Goal III—Nursing Education
- Task Force to Implement Educational Programs for Nursing Education Program Suveyors .... Tab 10-I

Saturday, August 5
2:15 pm–5:00 pm

Related to Goal IV—Information
- Continuing Education Offerings Task Force .... Tab 10-J
- Educational Programs Task Force .... Tab 10-K
- Executive Officers Network Task Force .... Tab 10-L
- Nurse Information System Task Force .... Tab 10-M

Related to Goal V—Organization
- Long Range Planning Task Force .... Tab 10-N
- Special Services Division .... Tab 10-O

Informational Forums, Thursday, 9:00 am – 12:15 pm
Business Forums, Thursday, 1:30 – 5:00 pm

■ **New Business**
- Resolutions Committee Report .... Tab 11

Business Forums, Saturday, 9:00 – 10:15 am

■ **Adjournment**

Standing Rules of the Delegate Assembly

1. Procedures

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

B. Upon registration:
   1. Each delegate and alternate shall receive a badge which must be worn at all meetings.
   2. Each delegate shall receive the appropriate number of voting cards. 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 member registered as an alternate may, upon proper clearance of the Credentials Committee, be transferred from alternate to delegate. The initial delegate may resume delegate status upon clearance by the Credentials Committee.

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

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

F. The Board of Directors will place items viewed as ready for decision making on a "consent" agenda. An item will be removed from the consent agenda at the request of any delegate. All items remaining on the consent agenda will be acted on by the Delegate Assembly in a single vote.

2. Motions

A. The Board of Directors, National Council Standing Committees, and delegates representing Member Boards shall be entitled to make motions. Motions proposed by the Board of Directors or National Council Standing Committees shall be presented by the Board or committee directly to the Delegate Assembly.

B. Motions and resolutions submitted prior to Friday, August 4, at 2:00 p.m., shall be reviewed by the Resolutions Committee according to its Operating Policies and Procedures. Motions and resolutions submitted after the deadline shall be submitted directly to the Delegate Assembly during New Business. All motions and resolutions so submitted will be presented with written analysis of consistency with National Council mission, goals, and objectives; assessment of fiscal impact; and potential legal implications. The Resolutions Committee will meet on Friday, August 4, at 4:00 p.m., with the maker(s) of any new motions or resolutions, not previously disseminated in the *Book of Reports* or supplement.

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

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

3. Debate

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

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

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

D. Members and employees of Member Boards may speak only after all delegates who wish to speak on the motion have spoken. Guests may be recognized by the chair to speak after all delegates, members and employees of Member Boards wishing to speak, have spoken.

E. 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.

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

G. A timekeeper will signal with a red card when the speaker has one minute remaining, and a buzzer will sound when the allotted time has expired.

4. Nominations and Elections

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

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

C. The voting strength for the election is determined by those registered by 9:00 a.m. on the day of the election.

D. Election for officers and members of the Committee on Nominations shall be held Saturday, August 5, 1995, from 8:00 a.m.-9:00 a.m.

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

Summary of Recommendations to the 1995 Delegate Assembly

To provide an overview, the recommendations to be presented to the 1995 Delegate Assembly for consideration are listed below. These recommendations were received by May 3, 1995, the deadline for publication in the 1995 *Book of Reports*. Additional recommendations may be considered during the 1995 Annual Meeting.

Committee on Nominations

1. Adoption of the 1995 Slate of Candidates.

Treasurer

1. That the auditor's report for October 1, 1993, through September 30, 1994, be approved as presented.

Examination Committee

1. That the Delegate Assembly adopt the proposed revisions to the *NCLEX-PN™ Test Plan*.

Board of Directors

1. That the Delegate Assembly adopt the revisions to the National Council's goals and objectives as proposed by the Long Range Planning Task Force.

2. That the Delegate Assembly authorize the National Council to proceed with the development of a core competency examination for Nurse Practitioners which is separate and distinct from specialty content examinations.

3. That the Delegate Assembly adopt the NCLEX™ Administration Stabilization Criteria and authorize the Board of Directors to apply the criteria to specific geographic sites as the need arises.

Resolutions Committee

1. That when directives of the Delegate Assembly require completion of a project which significantly impacts allocation of resources, the Board of Directors will establish a reasonable timeline for completion of such project. Progress reports are to be given to the Delegate Assembly at identified intervals.

2. That the National Council of State Boards of Nursing identify a commonality of language regarding "assessment" as a component of the nursing process which could be incorporated and reflected in the *NCLEX-PN™ Test Plan* after approval by the Delegate Assembly in the normal cycle of test plan revisions.

3

COMMITTEE ON NOMINATIONS

Report of the Committee on Nominations

Committee Members
Charles Bennett, CA-VN, Area I, *Chair*
Iva Boardman, DE, Area IV
Amy Jabcon, GA-PN, Area III
Barbara Jean McClaskey, KS, Area II

Staff
Christopher T. Handzlik, *Editor*

Relationship to Organization Plan
Goal V .... Implement an organizational structure that uses human and fiscal resources efficiently.
Objective C .... Maintain a system of governance that facilitates leadership and decision making.

Recommendation(s)
No recommendations.

Highlights of Activities

■ ***Preparation of Slate***

By the February 17, 1995, deadline, a total of 10 individuals had submitted completed nomination forms for consideration for the 1995 Slate of Candidates. The committee extended the deadline to March 10, 1995, to allow time for additional nominations to be submitted. The committee finalized the slate during its April 26, 1995, telephone conference call. The slate was published in the May 5, 1995, *Newsletter* in addition to being included within this report.

■ ***Policies and Procedures Amendments***

In answer to questions raised during the 1994 Annual Meeting, the committee amended its guidelines regarding candidate campaigning. The new guidelines read as follows:

Functions of the Committee on Nominations relating to campaigning:

To identify campaigning procedures as follows:

A. It is permissible to mail letters of support and/or flyers, and/or make telephone calls prior to the commencement of the annual meeting. Campaigning via videotape or similar electronic methods shall not be permitted. The mailing addresses of the Member Boards shall be furnished to any candidate who requests them for use in mailing letters of support or flyers.

B. Campaigning shall be limited to the information submitted with the candidate nomination form which will be reproduced in the *Book of Reports*, to the candidates' forum, and to informal opportunities for interacting with delegates at the annual meeting. The photo of a candidate submitted to the National Council and the candidate ribbon provided by the National Council shall be the only identifying items permitted for display during the annual meeting by candidates or other individuals.

C. The chair or a member of the Committee on Nominations will monitor compliance with the campaigning guidelines and will be available to address concerns.

To ensure fairness to all candidates by guaranteeing that a candidate unable to attend the Delegate Assembly shall, at his or her request, be granted the right to have his or her personal statement read during

the candidates' forum by a selected representative or a member of the Committee on Nominations. To further ensure fairness to all candidates, videotaped personal statements shall not be permitted. *[Excerpted from the Procedures of the Committee on Nominations. Revised October 1994.]*

- ***Self-evaluation Process***

The committee decided to continue the 1993-1994 Committee on Nominations' practice of preparing a self-evaluation for the purpose of assisting future Committee on Nominations members in more rapidly understanding their role of preparing a slate of qualified candidates. All four current committee members will prepare a document delineating their perspectives on the committee process and its actions throughout the committee's term. The documents will be offered to the 1995-1996 Committee on Nominations members as adjuncts to orientation materials.

Meeting Dates

- October 20-21, 1994
- March 1, 1995, *telephone conference call*
- March 21-22, 1995
- April 11, 1995, *telephone conference call*
- April 24, 1995, *telephone conference call*
- April 26, 1995, *telephone conference call*

Recommendation(s)

No recommendations.

Slate of Candidates

The following is an overview of the slate developed and adopted by the Committee on Nominations. More-detailed information on each candidate is provided in the subsequent pages of this report. This detailed information is taken directly from candidates' nomination forms. Each candidate will have an opportunity to expand on this information during the Candidates' Forum, scheduled to be held Friday, August 4, 1995, from 2:00 p.m. to 4:00 p.m.

Area I Director

Teresa Bello-Jones	California-VN	Area I
Jo Elizabeth Ridenour	Arizona	Area I

Area II Director

Charlet Grooms	Ohio	Area II
Linda Peterson Seppanen	Minnesota	Area II

Area III Director

Nancy K. Durrett	Virginia	Area III
Julia E. Gould	Georgia-RN	Area III

Area IV Director

Marie T. Hilliard	Connecticut	Area IV
A. Joyce Johnston	Pennsylvania	Area IV

Director-at-Large (two positions)

Judy L. Colligan	Oregon	Area I
Roselyn Holloway	Texas-RN	Area III
Patricia L. McKillip	Kansas	Area II
MaryAnn B. Reichenbach	South Carolina	Area III
Janet Wood-Yañez	Texas-VN	Area III

Committee on Nominations

Area I

Charles Bennett	California-VN	Area I
Pat Brown	Washington	Area I

Area II

Marilou Wasseluk	Illinois	Area II
Dorothy Zook	Kansas	Area II

Area III

Bobbie Deloach	Georgia-PN	Area III
Melba Lee-Hosey	Texas-VN	Area III

Area IV

Harriet L. Johnson	New Jersey	Area IV
Cheryl K. Tom-Nelson	Maryland	Area IV

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

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Present employer
4. Educational preparation
5. Offices held or committee membership, including National Council activity
6. Professional organizations
7. Date of term expiration and eligibility for reappointment
8. Personal statement

Area I Director

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

2. Executive Officer, California Board of Vocational Nurse and Psychiatric Technician Examiners

3. California Board of Vocational Nurse and Psychiatric Technician Examiners

4. Golden Gate University, Law, JD, 1980
   University of California-San Francisco, Community Health Nursing, MS, 1971
   San Jose State College, Nursing, BS, 1967

5. National Council
   - Essential and Continued Competence Subcommittee, 1994-1995
   - Committee on Nominations, 1994
   - Disciplinary Case Analysis Focus Group, 1993-1994

   Council on Licensure, Enforcement and Regulation (CLEAR)
   - Management and Administration Subcommittee, 1994
   - Site Selection Committee, 1994

6. National Hispanic Nurses' Association
   Sigma Theta Tau

7. Date of expiraton of term: (NA)
   Eligible for reappointment: (NA)

8. My academic and current professional experience, including those as a National Council delegate and committee member, have provided me with countless opportunities to develop and utilize my leadership, interpersonal, conflict-resolution and problem-solving skills. Additionally, as I wish to excel, I realize that I must continue to face and take on challenges. Therefore, I am ready to accept the challenge of Area I Director. I will utilize my skills for the achievement of the National Council's goals and to actively represent Area I. As such, my priorities will arise from Area I Member Boards. In addition, I believe priorities of our organization must include assessment of our goals and mission to determine necessary changes and continued responsiveness to Member Boards. Our vision has kept us in the vanguard of licensure examination technology. I want to contribute my energy and skills toward sustaining our respected position.

Area I Director

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

2. President, Arizona State Board of Nursing

3. Maricopa Health System, Phoenix, AZ

4. University of Phoenix, Nursing Administration, MNA, 1993
   Arizona State University, Nursing, BSN, 1969

5. National Council
   Finance Committee, 1994-1995
   Arizona Nurses' Association
   Member, 1993-present
   Arizona State Board of Nursing
   President, 1985-1988, 1993-present
   Sigma Theta Tau
   Member, 1990-present

6. Nursing Vision Roundtable-Phoenix Metropolitan Area, 1994-present
   American Organization of Nurse Executives, 1993-present
   Wharton Fellow, 1986-present

7. Date of expiration of term: 6/97
   Eligible for reappointment: Yes

8. The era of rapid changes in the health care delivery system is creating opportunities for regulatory boards to "reform the licensing process in a manner that encourages new practitioners to be competent."

   The Pew Health Professions Commission 1995 has challenged licensure boards to focus on three critical questions: Are regulatory bodies truly accountable to the public? Does regulation respect consumers' rights to choose their own health care providers from a range of safe options? Does regulation encourage a flexible, rational and cost effective care system?

   National Council views the initiatives as a positive challenge. As a candidate for Area I Director, I want to work with you to promote public policy related to designing the "ideal regulatory system for 2001 which demonstrates irrefutable quality in protecting the public."

   I look forward to the transformation of the licensing and relicensing processes, and to continue to emphasize competency-based measures.

Area II Director

1. **Charlet Grooms, Ohio, Area II**

2. Nursing Education Consultant, Ohio Board of Nursing

3. Ohio Board of Nursing, Columbus, OH

4. Ohio State University, Nursing, MS, 1971
   Ohio State University, Nursing, BSN, 1961
   Mt. Sinai Hospital School of Nursing, Nursing, Diploma, 1959

5. National Council
   Area II Regulatory Day of Dialogue Planning Committee, 1994-1995
   Alternate Delegate, 1994
   Nursing Education Mobility Action Group (NEMAG)
   Liaison to NEMAG, 1990-present

6. National League for Nursing
   Ohio League for Nursing

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. Throughout my career in nursing, I have held leadership positions in practice, education and various professional organizations. These experiences have given me an opportunity to develop effective skills in problem solving, organization, communication, and interpersonal relationships.

   As a Nursing Education Consultant for the Ohio Board of Nursing, I have gained an appreciation for and a broader perspective of the regulatory issues related to nursing, especially that of promoting public safety.

   One central focus of the National Council is to respond to the needs of its Member Boards and assist them in their efforts to ensure public safety. A major role of the Area Director is to assure that the issues and concerns arising from its constituent Member Boards are appropriately expressed and represented to the National Council. If elected, this would become my primary goal. It would be an honor and a privilege to serve as Area II Director.

Area II Director

1. **Linda Peterson Seppanen, Minnesota, Area II**

2. Member, Minnesota Board of Nursing

3. Winona State University, Winona, MN

4. University of Alabama, Administration of Higher Education, PhD, 1981
   Catholic University of America, Maternal-Infant Health Nursing, MSN, 1969
   St. Olaf College, Nursing, BSN, 1966

5. National Council
   - Board of Directors, Area II Director, 1994-present

   Kappa Mu, Sigma Theta Tau
   - Treasurer, 1992-present

   Minnesota Board of Nursing
   - Practice Committee, 1994-present
   - Education Committee, 1994-present

   Minnesota League for Nursing
   - Board of Directors, 1986-1993

   National League for Nursing Council of Baccalaureate and Higher Degree Programs
   - Accreditation Site Visitor, 1984-1988; 1991-present

   Winona Arms, Inc.
   - Board of Directors, President, 1987-1995

   WSU Inter-Faculty Organization
   - Faculty Senate, 1992-1994
   - Government Relations, 1991-present

6. Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
   Minnesota Inter-Faculty Organization
   National League for Nursing
   Sigma Theta Tau International

7. Date of expiration of term: 1/97
   Eligible for reappointment: Yes

8. I bring to this position service on the Board of Directors of the National Council and the Minnesota Board of Nursing and its committee. I have a desire to continue to contribute to the organization as a consensus builder. Priorities that I see for the National Council are: 1) articulating the regulatory perspective in the policy-making process, especially at the national level and in North American agreements; 2) articulating the regulatory perspective in the rapidly changing health care delivery system; 3) contributing to meaningful resolution of safe practice concerns in the multiple levels of nursing care—advanced professional practice to

unlicensed; 4) protecting the integrity of the examination processes for the various levels of nursing; and 5) serving as a major source of accurate information about nurses, nursing programs, regulation, and practice problems in order to facilitate good decision-making for quality improvements.

Area III Director

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

2. Assistant Executive Director, Virginia Board of Nursing

3. Virginia Board of Nursing, Richmond, VA

4. Virginia Commonwealth University, Nursing, MS, 1972
   Medical College of Virginia, Nursing, BS, 1958

5. National Council
   Area III Director, 1993-present
   Long Range Planning Committee, 1989-1993
   Virginia Nurses' Association
   Consumer Advocacy Committee, Chair, 1985-1988

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

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. Eleven years of experience as staff to the Virginia Board of Nursing with a variety of assignments, a background in both nursing education and practice, and four years as a member of the Long Range Planning Committee are the strengths I will rely on if re-elected as Area III Director. It takes time to understand and appreciate the myriad issues involved in the operation of National Council. The experience I have gained during my first term will enable me to be an even more effective and accountable board member. I would like the opportunity to again represent Area III and serve National Council as the organization evaluates the effectiveness of CAT, explores the issues of advanced practice and unlicensed assistive personnel, studies the regulatory implication of new methods of delivering health care, and implements the Special Services Division.

Area III Director

1. **Julia E. Gould, Georgia-RN, Area III**

2. Nursing Education Consultant, Georgia Board of Nursing

3. Georgia Board of Nursing, Atlanta, GA

4. University of Michigan, Nursing, MS, 1970
   University of British Columbia, Nursing, BSN, 1964

5. National Council
   Nursing Practice and Education Committee, Chair, 1992-1993
   Nursing Practice and Education Committee, Member, 1989-1993
   Resolutions Committee, 1988
   Task Force to Implement Education Programs for Nursing Education Program Surveyors, 1993-1995
   Commission on Graduates of Foreign Nursing Schools (CGFNS)
   Trilateral Initiative-Workforce on Approval and Accreditation, 1995-present

Georgia League for Nursing
Board Member, 1993-present

6. Georgia League for Nursing
National League for Nursing
Sigma Theta Tau

7. Date of expiration of term: (NA)
Eligible for reappointment: (NA)

8. As the Nursing Education Consultant for the last sixteen years, my responsibilities include communicating with, regulating, and consulting with Georgia's 39 nursing programs. Over the last five years, the Board has adopted education rules and processes which have departed the prescriptive behaviorist paradigm for ones which enable user-friendly flexibility while still requiring evidence of quality. My qualifications include credibility, polished verbal and nonverbal communication skills, open-mindedness, organization, and caring.

Since my employment almost spans National Council's lifetime, I have had the privilege of watching and participating in the organization's growth. Over the years, I have developed comprehensive regulatory expertise, particularly as it relates to nursing education.

Over the next two years, National Council's issues/priorities should address policies concerning health care reform and their impact on nursing, advanced practice, the interface between nurses in education and practice settings, and the disciplinary process.

Area IV Director

1. **Marie T. Hilliard, Connecticut, Area IV**

2. Executive Officer, Connecticut Board of Examiners for Nursing

3. Connecticut Board of Examiners for Nursing, Hartford, CT

4. University of Connecticut, School of Education, Professional Higher Education Administration, PhD, 1986
Boston University, School of Nursing, Maternal Child Nursing, MS, 1973
Catholic University of America, Nursing, BSN, 1972

5. National Council
Board of Directors, Area IV Director, 1994-present
Nurse Information System Committee, Chair, 1991-1994
Nurse Information System Committee, Member, 1988-1994
CAT Readiness Criteria Panel, 1992-1993
Executive Directors' Conference Group, Area IV Representative, 1986-1988
Executive Directors' Conference Group, Coordinator, 1987-1988
Resolutions Committee, 1986

6. American Nurses' Association
Connecticut Nurses' Association
National Federation of Licensed Practical Nurses
National League for Nursing
Connecticut League for Nursing
Phi Delta Kappa
Sigma Theta Tau

7. Date of expiration of term: (NA)
Eligible for reappointment: (NA)

8. Through over ten years of active participation in the National Council, I have had tremendous opportunity to develop skills fostering one primary goal, public safety. As an executive without nursing staff, I am responsible for regulatory oversight of nursing in Connecticut. I have utilized, and contributed to, the extensive support network of the National Council. It is this foundation of public service, and demonstrated networking ability and collegial goal-attainment which I bring to a National Council office. As health care continues to be redesigned with its potential for enhancing or threatening quality of care, National Council has tremendous opportunity to foster a regulatory framework, providing quality care for all. At all levels of practice, from unlicensed to advanced, National Council should be guiding policy development and assisting jurisdictions to foster public safety as health care is redesigned. I can be a positive contributor to this effort.

Area IV Director

1. **A. Joyce Johnston, Pennsylvania, Area IV**

2. Vice Chair, Pennsylvania State Board of Nursing

3. Sewickley Valley Hospital, Sewickley, PA

4. University of Illinois, Executive Development Program, 1983
   University of Pittsburgh, Nursing Education, MLNEd, 1958
   University of Pittsburgh, Nursing, BSN, 1952

5. Pennsylvania League for Nursing
      Bylaws Committee, 1994
   Hospital Association of Pennsylvania
      Bylaws Committee, 1987
   Pennsylvania Organization of Nurse Executives
      Committees (various), 1983-1989
      President-elect, 1988-1989

6. National League for Nursing
   National League for Nursing Council of Diploma Programs
   Sigma Theta Tau

7. Date of expiration of term: 12/97
   Eligible for reappointment: Yes

8. If elected as Area IV Director of the National Council of State Boards of Nursing, Inc., I would be able to contribute to the deliberations on the matters that assist in accomplishing its mission and goals. My forty years of nursing experiences are varied in administration of acute care nursing services, education and participation in professional organizations.

   I have been on the Pennsylvania State Board of Nursing since June 1991, serving as Vice Chair for the past two years.

   National Council's priority issues for the next two years have already been identified and are being addressed appropriately. Their change in focus cannot be further clarified until the outcome of health care reform is known.

Director-at-Large

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

2. Member, Oregon State Board of Nursing

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

4. Portland State University, Health Administration, MPA, 1991
   Oregon Health Sciences University, Nursing, MN, 1984
   Oregon Health Sciences University, Nursing, BSN, 1972
   St. Luke's Hospital, Fargo, ND, Nursing, Diploma, 1969

5. National Council
   - Literature Review Focus Group, 1994
   - Committee on Nominations, 1992-1994
   - Delegate, 1991, 1992, 1994
   - Subcommittee to Study the Regulation of Advanced Practice Nursing, 1990-1993

   Oregon Nurses' Association
   - Cabinet on Human Rights and Ethics, Chair, 1989-1991

   Oregon State Board of Nursing
   - Advanced Practice Task Force, Chair, present
   - OSBN Review Committee, Chair, present
   - NP Prescriptive Council, Chair, 1991-1993
   - Past President, 1991-1993

   Sigma Theta Tau
   - Nominations Committee, Chair, 1992-1994

6. Sigma Theta Tau

7. Date of expiration of term: 12/95
   Eligible for reappointment: No (I will be requesting and expect support for a six-month extension from our governor, if elected to the National Council Board of Directors.)

8. It is with enthusiasm that I submit my name as a candidate for the Director-at-Large position. As a clinician and board member, I am acutely aware of the obligations each Member Board has to its citizens. Similarly, National Council elected officers have obligations to their Member Board constituency.

   During the past five years, I have participated as board member and past president of the Oregon State Board in the complex issues surrounding safe nursing care delivery, nurse monitoring programs, and evolution of the independent nurse practitioner role. At the national level, I have been an active participant in National Council Area I meetings and Delegate Assemblies, Committee on Nominations, Subcommittee to Study the Regulation of Advanced Practice Nursing and Literature Review Focus Group.

   If elected, I promised to contribute to rich, thick, discussions of issues, offer ideas of innovation and encourage good humor!

Director-at-Large

1. **Roselyn Holloway, Texas-RN, Area III**

2. Member, Texas Board of Nurse Examiners

3. Methodist Hospital School of Nursing, Lubbock, TX

4. University of Texas-El Paso, Nursing, MSN, 1984
   Methodist Hospital School of Nursing, Lubbock, TX, Basic Nursing Diploma, 1980
   Huntingdon College, Montgomery, AL, Biology/Teaching, BA, 1962

5. National Council
   - Board of Directors, Director-at-Large, 1994-present

   Arthritis Board of Lubbock
   - Medical Committee, 1992-1994

Jim Burkeholder Foundation, Lubbock
    Board of Directors
Methodist Hospital
    Curriculum Committee, 1992-1994
    School of Nursing Faculty Organization, Secretary, 1990-1991
Texas Nurses' Association
    Education Council, 1992-1994
    Nominations Committee, District 18, 1991-1992
    Budget Committee, District 18, 1989
Transcultural Nursing Society
    Madeleine Leininger Award Committee, 1992
    National Treasurer, 1992-1994

6. American Nurses' Association
   Sigma Theta Tau
   Texas Nurses' Association
   Transcultural Nursing Society

7. Date of expiration of term: 1/99
   Eligible for reappointment: Yes

8. The Director-at-Large presents challenges and opportunities to accomplish the mission of the National Council. Our mission charges us to ensure all state regulatory boards have a voice at the table. I will strive to be that voice, to empower all areas in the National Council and promote collaboration-building in my liaison capacity. As Director-at-Large, I will bring the skills of innovative idea-building or 'thinking from the outside in.' As a regulatory agency, we have a common goal of protection of the public while also making accountability our concern. My contributions to the achievement of the National Council's goals are experience on a state board and concern to protect the public.

   As I envision it, the emerging issues are: 1) the public policy arena and its effect on nursing; 2) the changing demographic trends of expanding culturally diverse populations in the U.S. and their access to health care delivery; and 3) a changing practice environment.

Director-at-Large

1. **Patricia L. McKillip, Kansas, Area II**

2. Education Specialist-Continuing Education, Kansas State Board of Nursing

3. Kansas State Board of Nursing, Topeka, KS

4. Kansas State University, Adult and Continuing Education, PhD, 1992
   Kansas University, Nursing, MN, 1983
   University of Missouri-Kansas City, Psychology, BA, 1977

5. National Council
       Communications Committee, Member, 1992-1994
       Task Force to Study Advanced Practice Nurse Mobility, Member, 1994
   Adult Role Models for Youth
       Board Member, 1992-1994
   Kansas Opera Theater
       Board Member, 1993-present
   St. Mary's College
       Nursing Advisory Board Member, 1984-1990
   University of Kansas Nurse Alumni Association
       Board Member, 1987-1989

6. American Association of Adult Educators
   Kansas Association of Nursing Continuing Education Providers
   Sigma Theta Tau
   Women's Professional Resource Network

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. I am pursuing a Director-at-Large position with the National Council. My participation at the National Council meetings, committees/taskforce has motivated my interest to contribute my abilities and experience to further promote achievement of National Council's mission and goals.

   Throughout my career I have exhibited leadership skills in nursing administration and education, and aptitude for critical analysis, communication and innovation. These personal characteristics are sparked by a spirit for challenge and progress. My KSBN responsibilities have provided regulatory knowledge transferable to regional and national levels.

   Nursing practice parallels national health care trends in expansion and restructuring. Member Boards are challenged to continually respond to subsequent nursing issues with regulatory directives. I have the capability to assist National Council with public policy-making at the national level that will further safe and effective nursing practice and, ultimately, the advancement of public health and safety.

Director-at-Large

1. **MaryAnn B. Reichenbach, South Carolina, Area III**

2. Member, South Carolina Board of Nursing

3. Clemson University, College of Nursing, Clemson, SC

4. University of Pittsburgh, Nursing of Children, PhD, 1985
   University of Pittsburgh, Nursing of Children, MSN, 1981
   West Virginia University, Child Development/Family Relations, MS, 1979
   Simmons College, Nursing, SB, 1960

5. Gamma Mu, Sigma Theta Tau,
      Research Day Committee, President, 1985-1986
   National Association of Practical Nurse Education and Service
      Evaluator, 1977-1979
   National League for Nursing
      Site Evaluator, 1993-1997
   South Carolina Board of Nursing
      President, 1992-1994
      Negotiating Committee for Prescriptive Authority, 1990-1991

6. American Nurses' Association
   National League for Nursing
   Sigma Theta Tau

7. Date of expiration of term: 12/95
   Eligible for reappointment: Yes

8. The National Council is rightfully a major force in nurse licensure and in anticipating and addressing emerging forces which impact the discipline and public health care safety. Still, many nurses are not aware of this organization and the functions which it sustains. I believe that the National Council must maintain autonomy and

clear authority but improve interactions with other nursing organizations to better coordinate goals and approaches as we face major issues of advanced practice and delegation to unlicensed personnel.

I entered nursing from a diploma program and have earned a baccalaureate, two masters, and a PhD in nursing. I have been employed in home health, critical care, general staff and pediatrics, and in five different jurisdictions. I have been a staff nurse, a nurse executive and a nursing faculty member. In addition to my knowledge and experience, I bring personal qualities of commitment, thoroughness, sensitivity to multiple perspectives and humor.

Director-at-Large

1. **Janet Wood-Yañez, Texas-VN, Area III**

2. Member, Texas Board of Vocational Nurse Examiners

3. O'Sana Home Health Agency, Weslaco, TX

4. University of Texas-PAU, Edinburg, ADN Program, Incomplete
   Knapp Memorial Methodist Hospital, School of Vocational Nursing, Certificate, 1974

5. American Cancer Society
      Member, 1991
   Boys and Girls Club
      Building Committee, 1995
   Mercedes Housing Authority
      Board Member, 1994-1996
   School Board-Mercedes ISD
      Board Member, 1989-1992
   Taylor PTO Organization
      President, 1992
   Valley AIDS Council
      Member, 1993

6. Licensed Vocational Nurses' Association of Texas #4611, Division 45

7. Date of expiration of term: 9/99
   Eligible for reappointment: Yes

8. I am presently a LVN practicing in the state of Texas. I have 21 years' experience in multiple types of nursing such as home health nursing, public health, hospital auditing, public school nursing, office nursing in OB/GYN office, surgeon's office and general practitioner's office. Along with these areas, I've worked in hospital nursing. I started as a floater, then worked pediatrics wing and medical wing. I believe very strongly in public safety. I have reviewed the National Council's goals and feel comfortable in working to achieve these goals throughout the nation.

   I feel my different backgrounds in nursing and years of experience bring something special to the National Council. I have leadership experience due to the many different Boards I have represented and look forward in demonstrating these skills while serving the National Council.

Committee on Nominations

<u>Area I</u>

1. **Charles Bennett, California-VN, Area I**

2. President, California Board of Vocational Nurse and Psychiatric Technical Examiners

3. California State Department of Corrections, Sacramento, CA

4. Pineville School for Practical Nurses, Vocational Nursing, 1964

5. National Council
   Committee on Nominations, Chair, 1994-present
   California Board of Vocational Nurse and Psychiatric Technician Examiners
   President, 1993-present
   Enforcement Committee, Chair, 1994-present
   Enforcement Committee, Member, 1991-present
   Budget Committee, Chair, 1992-present
   Executive Committee, Chair, 1992-present
   California Correctional Peace Officers' Association
   Medical Technical Assistant Statewide Chapter, President, 1989-1991
   Medical Technical Assistant Statewide Chapter, Vice-President, 1988-1989

6. California Correctional Peace Officers' Association

7. Date of expiration of term: 6/95
   Eligible for reappointment: Yes

8. I had the privilege to serve as chair of the Committee on Nominations this past year and am also honored to serve as president of my board for the third consecutive year. The opportunity to serve in these roles has enhanced my leadership, knowledge and skills. I discovered this year that my diversity of experience in the nursing profession enabled me to make a valuable contribution to the Committee on Nominations. I truly understand the importance of selecting well qualified, knowledgeable candidates who will support and promote National Council's goals. I am seeking re-election because I am committed to meeting the responsibilities assigned to the committee.

Area I

1. **Pat Brown, Washington, Area I**

2. Executive Director, Washington State Nursing Care Quality Assurance Commission

3. Washington State Nursing Care Quality Assurance Commission, Olympia, WA

4. University of Texas, Nursing, MSN, 1975
   University of Maryland, Nursing, BSN, 1969

5. National Council
   Executive Officer Network, Vice-Chair, 1994-1995
   Nurse Information System Committee, Member, 1992-1995
   Local School District
   Strategic Planning Committee, 1994-1995

6. (None)

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. The individuals who serve Member Boards by holding office on the National Council Board of Directors are key determinants in the continued success of this organization. Recruitment of these individuals is a challenge, one which I would like to step up to at this time. I see greater complexity in this challenge in that the task is not only to identify individuals to present to delegates as candidates, but to also analyze the ideal complement of individuals that will lead to achievement of the organization's goals and objectives. This must include diverse professional backgrounds and expertise, as well as be a reflection of the cultural diversity of our organization.

Area II

1. **Marilou Wasseluk, Illinois, Area II**

2. Board Member, Illinois Department of Professional Regulation

3. Oakton Community College, Des Plaines, IL

4. Loyola University, Educational Leadership and Policy Studies, PhD, Candidate
   DePaul University, Nursing Education and Nursing Administration, MS, 1982
   University of the Philippines, Public Administration, Organization and Management, MPA, 1972
   University of the Philippines, Nursing-Teaching and Supervision, BSN, 1967

5. National Council
   Area II Day of Dialogue Planning Committee, 1994-1995
   Directors of Associate Degree Nursing
   Nominating Committee Member, 1994
   Illinois Council of Deans and Directors of Associate Degree Nursing
   Vice Chair, 1992-1994
   Nominating Committee Member, 1994
   Illinois Department of Professional Regulation
   Impaired Nurse Task Force Committee, 1994-present
   Illinois Organization of Associate Degree Nursing
   Corresponding Secretary, 1992-present
   National Organization of Associate Degree Nursing
   Educational Committee, 1993-1994

6. Illinois Council of Deans and Directors of Associate Degree Nursing
   National League for Nursing
   National Organization of Associate Degree Nursing/Illinois Organization of Associate Degree Nursing
   Transcultural Nursing Society

7. Date of expiration of term: 10/96
   Eligible for reappointment: Yes

8. It has taken years to develop standards/criteria for professional nursing care. We, in the nursing community, need to uphold these standards. With restricting budget cuts and the creation of unlicensed assistive personnel, we need to be careful that we are not moving backwards and endangering the standards of professional nursing care. Being able to choose candidates that will push forward nursing's position and the goals of the National Council—promoting public health, safety and welfare—will be a priority.

Area II

1. **Dorothy Zook, Kansas, Area II**

2. Member, Kansas State Board of Nursing

3. Halstead Hospital, Halstead, KS

4. McPherson School of Practical Nursing, 1969

5. Kansas State Board of Nursing
   Practice Committee, Vice-Chair, 1993-1995
   Continued Education Committee, Chair, 1989-1995
   Kansas Federation of Licensed Practical Nursing
   Hearing Panel, Chair, 1993-1995

Kansas Federation of Licensed Practical Nursing
First Vice-President, 1993-1995
Member, 1969-1993
National Federation of Licensed Practical Nursing
Delegate, 1994
Member, 1969-1995
Tri-County Licensed Practical Nurses' Association
President, 1993-1995
Member, 1969-1995

6. Kansas Federation of Licensed Practical Nursing
National Federation of Licensed Practical Nursing

7. Date of expiration of term: 6/97
Eligible for reappointment: No

8. I have experience working in the field of nursing 2-1/2 years in a doctor's office and 23-1/2 years working as a staff nurse in a hospital. I have been on the Kansas State Board of Nursing for six years. There I have served on the Investigating Panel, Practice Committee, Continued Education Committee and also worked on the task force which paved the way for passing the IV therapy for LPNs in Kansas. I see the importance and need for boards of nursing to make rules and regulations and to get laws passed to protect the public. I have attended National Council's Area II meetings and also National Council's annual meeting. There I listened to the issues and trends and feel I have a broad view of information. The issues and priorities—health care reform, both legislatively and institutionally, delegation to unlicensed personnel and our role as RNs and LPNs in the health care setting.

Area III

1. **Bobbie Deloach, Georgia-PN, Area III**

2. Member, Georgia State Board of Licensed Practical Nurses

3. Athens Dialysis Facility, Inc., Athens, GA

4. MDTA Practical Nursing School, Certificate, 1973

5. Georgia Licensed Practical Nurses
Program Chairman, 1983
Second Vice-President, 1981
Licensed Practical Nurses' Association of Georgia (formerly Georgia Licensed Practical Nurses), 11th District
Membership Chairman, 1995

6. American Nephrology Nurses' Association (ANNA)
Board of Nephrology Examiners-Nursing and Technology (BONENT)
National Association for Practical Nurse Education and Service (NAPNES)
National Association for the Advancement of Colored People (NAACP)

7. Date of expiration of term: 4/97
Eligible for reappointment: Yes

8. I have practiced as a licensed practical nurse for 20 years with varied experiences in all aspects of nursing with inclusion of educating, communicating and proficient nursing skills. I am committed to rendering nursing service with dignity, respect and foremost, individualized care. I regard all nursing personnel with the utmost respect, regardless of nursing level. All licensed nurses have an obligation to the public and themselves to render and strive for higher standards in nursing practice. We must ensure these standards through this council by addressing the many issues surrounding unlicensed personnel.

<u>Area III</u>

1. **Melba Lee-Hosey, Texas-VN, Area III**

2. Member, Texas Board of Vocational Nurse Examiners

3. Private Duty Nurse, Pediatric Special Care, Bellaire, TX

4. Alvin Community College, Mental Health, Certificate, Incomplete
   Houston Community College, Nursing (LVN), 1972

5. National Council
      Elections Committee, 1994
   Licensed Vocational Nurses' Association of Texas
      Second Vice President, 1990-1992
      Legislative Chair, 1990-1992
   National Black Nurses' Association
      Board Member, 1990-1993
      Nominating Committee, present-1997
   Texas Association for Impaired Nurse
      Board Representative, 1992-present

6. Executive Women In Texas Government
   National Black Nurses' Association
   National Women of Achievers
   National Association for Practical Nurse Education and Service (NAPNES)

7. Date of expiration of term: 9/97
   Eligible for reappointment: Yes

8. I presently serve as a member of the Nominating Committee of a national nursing association. I want to continue to be a voice for nursing through education of licensed nurses as well as nursing students.

   I believe top priorities should be given to the utilization of unlicensed personnel.

<u>Area IV</u>

1. **Harriet L. Johnson, New Jersey, Area IV**

2. Assistant Executive Director, New Jersey Board of Nursing

3. New Jersey Board of Nursing, Newark, New Jersey

4. Hunter College of the University of New York, Medical-Surgical Nursing, MS, 1970
   Seton Hall University, Nursing, BS, 1958
   Jersey City Medical Center-School of Nursing, Nursing, Diploma, 1954

5. National Council
      Member Board Education Needs Subcommittee, Chair, 1994-1995
      Disciplinary Case Analysis Focus Group, Chair, 1993-1994
      Examination Committee, Alternate, 1992-present
      Committee on Nominations, 1990-1991
      Examination Committee, Chair, 1985-1988
      Examination Committee, Member, 1982-1988

Seton Hall University
Alumni Committee, Board of Directors, Member, 1991-1995
Advisory Committee for Continuing Education, Member, 1991-1995

6. Jersey City Alumnae
National League for Nursing
Sigma Theta Tau

7. Date of expiration: (NA)
Eligible for reappointment: (NA)

8. If I'm elected to the Committee on Nominations, I will bring to the committee a background of 17 years as a professional staff member on the Board of Nursing in the state of New Jersey and one year of experience serving on a nominating committee. As chair of the Examination Committee, I had the opportunity to work with the Board of Directors on many occasions. This afforded me the advantage of gaining insight into those very special characteristics needed for those candidates who will be elected to run for an office. It's important that those candidates chosen bring a plethora of talents to assist in implementing the goals of the National Council. The issue that should continue to be addressed is the correlation of the roles of the licensed practical nurse and the registered nurse in practice and testing the beginning competencies of each.

<u>Area IV</u>

1. **Cheryl K. Tom-Nelson, Maryland, Area IV**

2. Member, Maryland Board of Nursing

3. Doctors' Community Hospital, Lanham, MD

4. University of Illinois, Nursing, MSN, 1972
University of Michigan, Nursing, BSN, 1967

5. National Council
Panel of Experts to Determine Criticality Levels for the Nurse Aide Job Analysis, April 1995
American Nurses' Association
Congressional District Liaison, 1992-present
Council on Advanced Practice, 1982-1994
N-PAC, 1990-1994
Maryland Nurses' Association
M-PAC, 1990-1995
Prince George's County Hospice
Professional Advisory Committee, 1994-present

6. American Nurses' Association
Maryland Nurses' Association

7. Date of expiration term: 7/96
Eligible for reappointment: Yes

8. I have been an active member and leader in my profession for over 26 years, holding multiple practice and educational positions during that time. I have also worked in many volunteer positions for the benefit of the community and my profession, most recently choosing the political arena as an avenue to influence what happens in nursing. I have always believed that one gets benefit from an organization only if one is willing to put one's own effort and time into the purposes and objectives of that organization, It is with these beliefs and commitments that I would work on the Committee on Nominations to find and select those candidates who will provide vision, leadership and hard work for the National Council in this critical time of change for our profession.

4

OFFICER REPORTS

Report of the President

Marcia M. Rachel, PhD, RN, President
Executive Director, Mississippi Board of Nursing

It is my privilege to welcome you to the Seventeenth Annual Meeting of the National Council of State Boards of Nursing, Inc. On behalf of the Board of Directors, I invite and encourage you to attend, participate in, and contribute to the various activities and decision-making opportunities which will take place during this year's meeting.

As evidenced by the reports contained in this volume and the agenda outlined for the week, volunteers and staff members of the National Council have had a busy and productive year. Most of the revised Bylaws adopted by the 1994 Delegate Assembly were implemented this year and some of the results can be seen when reviewing the number and types of standing and special committees of the National Council. With the ability to appoint various types of special committees as needed, we have been able to respond to identified needs in a timely and efficient manner, using the volunteers best matched to the specific task at hand. In addition, we have been able to tap into and take advantage of a larger pool of resources; therefore, providing additional opportunities for volunteer participation. About 23 committees and special committees, involving over 120 volunteers, have accomplished the work outlined in this *Book of Reports*. They are all due a special word of appreciation and gratitude.

Members of the Board of Directors have spent countless hours preparing for and participating in Board meetings and have represented the National Council at meetings and activities of other organizations. I encourage you to review their reports and to ask questions about those items which are of particular interest to you.

Although I had been told of the major time commitment involved in being President of the National Council, I guess nothing beats being there. Along with Executive Director, Dr. Jennifer Bosma, I have conducted liaison meetings with major organizations such as the Commission on Graduates of Foreign Nursing Schools, the Division of Nursing of the Department of Health and Human Services, the National League for Nursing, the American Nurses' Credentialing Center, the National Organization for Associate Degree Nursing, the American Association of Colleges of Nursing, the Joint Commission on the Accreditation of Healthcare Organizations, the National Federation of Licensed Practical Nurses, the National Association for Practical Nurse Education and Service, and the American Nurses' Association. Dr. Bosma and I were able to communicate the National Council's mission, goals and objectives, to clarify erroneous information, to identify areas of common concern and interest, and to build on many positive foundations which had already been established. I firmly believe that we must maintain open lines of communication with the various nursing and health care groups. The National Council's special knowledge and expertise places us in the position of being their primary source of information about nursing regulation.

I have also participated in several meetings as an invited guest—the Nursing Organization Liaison Forum, Tri-Council, the National Nursing Research Roundtable, the Federation of State Medical Boards and, by the time this is in print, the International Conference on the Regulation of Nursing and Midwifery.

Several projects and opportunities for decision-making have occupied the Board's attention during and between Board meetings. Computerized Adaptive Testing (CAT) implementation passed its first anniversary. Related to this, the CAT Evaluation Task Force has been working on evaluation criteria which will be applied to the program. In addition, the Examination Committee has worked diligently throughout the year as they implemented the Bylaws change which combined the previous two exam-related committees while continuing to make sure the exam program functioned well. Some of the other major issues this year involved Advanced Practice Registered Nurses, access to the Disciplinary Data Bank, the development of a Research Agenda for the National Council, the pilot program for disciplinary investigators, non-U.S. test centers, *NCLEX™ Program Reports*, and the newly created Special Services Division. Reports related to these and other issues are contained in this *Book of Reports*. We request that you read these reports carefully and that you bring your questions and comments to the Annual Meeting forums as we approach some very far-reaching decisions.

All-in-all, this has been a very busy, productive year for the National Council, the Board of Directors, the committees, the staff and for me personally. I am proud of the accomplishments realized and of the progress which has been made. I've known many groups which I felt were either off the track, or on the track but headed in the wrong direction, or on track and headed in the right direction but still sitting in the terminal. I am convinced that the National Council is not only on track and headed in the right direction, but also moving full steam ahead toward a clearly defined mission related to public protection. I am comforted by this fact, and am, therefore, fully supportive of our goals and objectives. I hope you will join me in focusing on the National Council's mission "to promote public policy related to the safe and effective practice of nursing in the interest of public welfare" as we conduct the business of this year's Delegate Assembly. I look forward to seeing you in St. Louis.

Report of the Vice-President

Tom Neumann, MSN, RN, Vice-President
Administrative Officer, Wisconsin Board of Nursing

As Vice-President of the National Council of State Boards of Nursing, I participated in all Board of Directors meetings and conference calls during this past year. I represented the National Council at the American Association of Colleges of Nursing Spring Meeting in Washington, District of Columbia, and at the CLEAR Annual Meeting in Boston, Massachusetts. I also served as a panelist at the National Student Nurses' Association Mid-Year Conference in Milwaukee, Wisconsin, responding from a regulatory perspective to questions related to the theme, "New Directions in Nursing."

During National Council Board meetings, I participated in discussions addressing continued monitoring of CAT implementation, progress regarding CST and NIS, use of disciplinary data bank information, regulatory concerns expressed by the Pew Health Professions Commission, and reports from the variety of committees, subcommittees, task forces, and focus groups. I am most gratified to see that the National Council of State Boards of Nursing is at the forefront, providing leadership in the regulation of nursing through its Member Boards, the Board of Directors and National Council staff. It is crucial during the time ahead that we speak with a unified voice about our mission, purpose and organization plan, as we are called upon to respond to challenges regarding the need for the regulation of nursing as it is currently done in the interest of public protection.

I wish to sincerely thank all of the board members, staff, and others from the National Council jurisdictions who have participated in National Council activities this year, whether on committees, subcommittees, task forces, focus groups, panels, or in other meetings addressing National Council issues. Your interest and commitment contribute to the integrity and leadership of the organization.

Thank you for the opportunity to serve you during the past year as Vice-President on the Board of Directors. I look forward to the second year of my term with anticipation as well as with the greatest respect for my colleagues and friends in regulation.

Report of the Secretary

Cynthia VanWingerden, RN, MS, Secretary
Board Member, Virgin Islands Board of Nurse Licensure

The activities of the Secretary this year included attending all Board meetings and participating in all conference calls. Along with the Executive Director, I kept and reviewed for final approval the minutes of all meetings. I participated in the Minutes Committee and the Rules Committee for the 1994 Annual Meeting. I will chair the Minutes Committee and participate in the Rules Committee for the 1995 Annual Meeting.

I was a member of the Research Focus Group for the Board of Directors, during which we discussed future directions for the National Council's participation in research.

I was pleased to represent the National Council at the annual meeting of the National League for Nursing in June 1995, in Chicago, Illinois, to follow up my participation in the Practical Nurse Educators' Council Meeting from 1994.

I have appreciated the opportunity to serve on this Board with each elected officer. In addition, I continue to be greatly blessed and impressed by the dedication, commitment, and hard work of the National Council staff. I commend them, and thank them for all their efforts in keeping us well informed and well prepared to discuss the issues at hand.

It has been a pleasure to have been a part of this organization during my tenure on the Virgin Islands Board of Nurse Licensure, and as I enter my final year on that Board, I look back on my association with the National Council both through committee work and serving on the Board of Directors, as a time of wonderful challenge professionally and personally, and dynamic growth in my understanding of the whole issue of regulation.

My best to you all. May God Bless you, each one.

Report of the Treasurer

Charlene Kelly, PhD, RN, Treasurer and Chair, Finance Committee
Executive Secretary, Nebraska Board of Nursing

Relationship to the Organization Plan

Goal V .... Implement an organizational structure that uses human resources efficiently.
Objective B........ Maintain a fiscal resource management system.

Recommendation(s)

1. That the auditor's report for October 1, 1993, through September 30, 1994, be approved as presented.

Rationale

The audit was completed in December 1994, and reviewed by the Finance Committee in January 1995. The auditors found no irregularities in the financial statements and expressed an unqualified opinion.

The National Council of State Boards of Nursing, Inc., continues to maintain a strong financial position. Revenue to date has exceeded expenditures; however, the financial forecast projects that a decline in the number of candidates over the next years will result in revenues that may not meet expenditures. In order to protect the organization's financial position, careful assessment and consideration need to be given to the immediate and long-term effects of proposed projects.

During the past year, I attended all meetings and conference calls of the Board of Directors. I also chaired the Finance Committee. Throughout the year, I communicated regularly with Thomas Vicek, Director of Operations, on all financial matters. His guidance and knowledge in the area of finance is a valuable resource for the Treasurer and the Finance Committee.

I would like to thank Jennifer Bosma, Thomas Vicek, and each member of the Finance Committee for the support they have given me.

Report of Independent Auditors

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

We have audited the accompanying balance sheets of National Council of State Boards of Nursing, Inc. as of September 30, 1994 and 1993, and the related statements of revenue and expenses, changes in fund balances, and cash flows for the years then ended. These financial statements are the responsibility of management of National Council of State Boards of Nursing, Inc. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. at September 30, 1994 and 1993, the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young
December 6, 1994

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

	September 30 1994	1993
Assets		
Current assets:		
Cash and cash equivalents	$ 979,443	$ 809,322
Accounts receivable	831,058	92,016
Examination fees due from Member Boards	341,160	192,333
Accrued interest, prepaid expenses, and other	240,894	309,361
Total current assets	2,392,555	1,416,446
Investments, at cost	10,146,747	9,512,367
Property and equipment:		
Furniture, fixtures, and leasehold improvements	185,378	207,740
Equipment and computer software	840,072	900,929
	1,025,450	1,108,669
Less: Accumulated depreciation	581,641	518,220
	443,809	590,449
	12,983,111	$11,519,262

	September 30 1994	1993
Liabilities and fund balances		
Current liabilities:		
Accounts payable	$ 3,436,238	$ 2,670,751
Examination fees due to Member Boards	182,016	236,281
Accrued salaries and payroll taxes	223,097	257,492
Total current liabilities	3,841,351	3,164,524
Deferred revenue:		
Examination fees collected in advance (net of prepaid processing fees of $128,745 in 1993 and $137,914 in 1992)	831,720	1,257,405
Fund balances:		
Unrestricted:		
Undesignated	6,500,506	2,801,952
Designated	1,790,128	4,119,263
	8,290,634	6,921,215
Restricted	19,406	176,118
Total fund balances	8,310,040	7,097,333
	$12,983,111	$11,519,262

See notes to financial statements.

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

	Year ended September 30	
	1994	1993
Revenue—Unrestricted funds		
Examination fees	$14,484,046	$8,086,107
Less: Cost of development, application, and processing	9,807,274	4,570,087
Net examination fees	4,676,772	3,516,020
Member Board contracts	183,000	187,500
Publications	134,459	219,039
Annual Meeting	63,530	69,626
Honoraria and other	37,391	60,215
Computerized adaptive testing (CAT) income	12,429	102,993
Nurse aide competency evaluation program (NACEP)	428,447	414,129
Investment income	470,120	452,924
Total revenue—Unrestricted funds	6,006,148	5,022,446
Program and organizational expenses—Unrestricted funds		
Member Board contracts	9,755	38,811
Publications	92,949	78,908
Annual Meeting	85,153	111,496
Nurse aide competency evaluation program (NACEP)	18,226	19,513
Job analysis studies	65,430	59,369
Computerized adaptive testing (CAT)	759,947	1,630,082
Role delineation study	4,151	39,618
Computerized clinical simulation testing (CST)	260,428	104,936
Nurse Information System (NIS)	27,998	—
Board meetings and travel	93,651	104,684
Public relations and communications	58,572	53,531
Other committee expenses	232,243	243,354
Total program and organizational expenses—Unrestricted funds	1,708,503	2,484,302
Administrative expenses—Unrestricted funds		
Staff salaries and benefits	2,015,413	1,627,935
Professional fees	85,766	58,962
Office supplies	198,266	173,586
Insurance	32,363	35,151
Rent and utilities	256,801	304,805
Equipment maintenance and rental	85,058	46,133
Depreciation	240,394	113,949
Miscellaneous	14,165	11,153
Total administrative expenses—Unrestricted funds	2,928,226	2,371,674
Total expenses—Unrestricted funds	4,636,729	4,855,976
Revenue in excess of expenses—Unrestricted funds	1,369,419	166,470
Restricted grant revenue		
Computerized clinical simulation testing (CST)	—	100,000
Nurse information system (NIS)	62,203	292,609
	62,203	392,609

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

Expenses related to restricted grants		
Computerized clinical simulation testing (CST)	1,750	119,980
Nurse information system (NIS)	217,165	118,241
	218,915	238,221
Revenue less than expenses—Restricted funds	(156,712)	154,388
Revenue in excess of expenses	$ 1,212,707	$320,858

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statements Of Changes In Fund Balance

	Unrestricted												Restricted		
	Undesignated	Designated for Computerized Adaptive Testing (CAT)	Designated For Crisis Mgmt.	Designated for Working Captial Reserve	Designated for Role Delineation	Designated for Computerized Clinical Simulation Testing (CST)	Designated for Self-Insurance	Designated for CAT Member Boards Computers	Designated for Nurse Information System (NIS)	Designated for Special Service Division	Designated for Chemical Dependency	Total Unrestricted Fund	Computerized Clinical Simulation Testing (CST)	Nurse Information System (NIS)	Total
Fund balance at October 1, 1992	$2,110,775	$2,961,176	$121,836	$956,387	$182,039	$ 37,732	$ 50,000	$334,800	$ 221,875	$-	$-	$6,754,745	$21,730	$-	$6,776,475
Transfer to Board-designated funds	(1,610,136)	248,948	-	138,338	-	922,196	50,000	-	250,654	-	-	-	-	-	-
Transfer to undesignated funds	472,250	-	-	-	-	-	-	(334,800)	(137,450)	-	-	-	-	-	-
Revenue in excess of (less than) expenses	1,829,063	(1,527,089)	-	-	(30,568)	(104,396)	-	-	-	-	-	166,470	(19,980)	174,368	320,858
Fund balances at September 30, 1992	2,801,952	1,683,035	121,836	1,094,725	151,471	854,992	100,000	-	113,204	-	-	6,921,215	1,750	174,368	7,097,333
Transfer to Board-designated funds	(963,038)	-	-	-	-	108,038	-	-	-	600,000	255,000	-	-	-	-
Transfer to undesignated funds	2,252,078	(935,517)	(121,836)	(1,094,725)			(100,000)	-	-	-	-	-	-	-	-
Revenue in excess of (less than) expenses	2,409,514	(747,518)			(4,151)	(260,428)	-	-	(27,998)	-	-	1,369,419	(1,750)	(154,962)	1,212,707
Fund balances at September 30, 1993	$6,500,506	$ -	$ -	$ -	$147,320	$702,602	$ -	$-	$85,206	$600,000	255,000	$8,290,634	$ -	$19,406	$8,310,040

See notes to financial statements.

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

	Year ended September 30	
	1994	1993
Operating activities		
Revenue in excess of expenses	$1,212,707	$ 320,858
Adjustments to reconcile revenue in excess of expenses to net cash provided by operating activities:		
Depreciation	240,394	113,949
Decrease (increase) in accounts receivable and examination fees due from Member Boards	(887,869)	326,564
Decrease (increase) in accrued interest, prepaid expenses, inventories, and other	81,881	200,476
Increase in accounts payable	765,487	774,296
Increase in due to Member Boards	(54,265)	224,077
Increase in accrued salaries and payroll taxes	(34,395)	53,409
Increase (decrease) in deferred revenue	(425,685)	71,079
Net cash provided by operating activities	898,255	2,084,708
Investing activities		
Net additions to property and equipment	(93,754)	(362,966)
Increase in investments, net	(634,380)	(2,363,488)
Net cash used in investing activities	(728,134)	(2,726,454)
Decrease (increase) in cash and cash equivalents	170,134	(641,746)
Cash and cash equivalents at beginning of year	809,322	1,451,068
Cash and cash equivalents at end of year	$ 979,443	$ 809,322

See notes to financial statements.

National Council of State Boards of Nursing, Inc.

Notes To Financial Statements September 30, 1994 and 1993

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

2. **Summary of Significant Accounting Policies**

Examination Fees—Examination fees collected in advance net of processing costs incurred are deferred and recognized as revenue at the date of the examination.

Cash Equivalents—Cash equivalents consist of money market funds.

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

Pension Plan—The National Council maintains a defined-contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The National Council's policy is to fund pension costs accrued. Pension expense was $161,630 and $129,325 for the years ended September 30, 1994 and 1993, respectively.

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

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

	1994		1993	
	Cost	Market Value	Cost	Market Value
U.S. government and government-backed obligations	$ 8,146,747	$ 8,015,311	$6,112,367	$6,167,514
Certificates of deposit and other	2,000,000	2,000,000	3,400,000	3,400,000
	$10,146,747	$10,015,311	$9,512,367	$9,567,514

Board-Designated Funds—The Board of Directors has designated certain funds to be used for specific projects. These projects include the development of a role delineation research study, computerized clinical simulation testing (CST), nursing information system (NIS), special services division, and chemical dependency study. These funds are reflected as designated unrestricted funds in the accompanying financial statements.

Restricted Funds—In 1993, the National Council received a restricted grant from the Robert Wood Johnson Foundation to support the establishment of a national nurse information system. The grant, amounting to $530,110 will be will be fully received by December 31, 1994. Of this amount, the National Council has received $62,203 in fiscal year 1994 and $292,609 in fiscal year 1993.

3. **Commitments**
The National Council leases office space under an operating lease arrangement.
Future noncancelable rental commitments as of September 30, 1994, are as follows:

1995 .... $238,100
1996 242,862
1997 247,721
1998 252,674
1999 257,730

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

Report of the Area I Director

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

As Area I Director of the National Council of State Boards of Nursing, I have attended and been active in all of the Board of Directors' meetings and conference calls. Additionally, I represented the National Council at the 1995 Annual Convention of the National Association for Practical Nurse Education and Service (NAPNES) held in Scottsdale, Arizona, and the Ninth Annual Conference of the International Society of Psychiatric Consultation Liaison Nurses, held in San Diego, California, on March 23-24, 1995.

The 1995 Regulatory Day of Dialogue and Area I Meeting were held in beautiful Couer d'Alene, Idaho, on April 20-21, 1995. The agendas included a number of stimulating topics of particular interest to Area I jurisdictions, including:

- The Emerging Role of Regulation as Health Care Reforms. This session included presentations on the Pew Health Professions Commission and Ontario, Canada's new form of regulation, "Controlled Acts."
- Evolving Scopes of Practice: From Unlicensed to Advanced Practice. This session included panel presentations on the current status of the unlicensed personnel movement, LPN/VN dilemmas due to the expanded use of UAPs, the emerging role of registered nurses with case management and managed care, and advanced practice and health care reform.
- A variety of National Council committee and task force reports and updates.
- An afternoon designated as an Area I roundtable for networking.

Thanks are extended to the Idaho Board of Nursing for their gracious hospitality and to the New Mexico Board of Nursing for their invitation to Area I for the 1996 meetings.

Lastly, my personal thanks to all Area I jurisdictions for supporting me as their representative on the National Council Board of Directors. And to my colleagues, both Board and staff, who helped make serving on the National Council's Board of Directors such a valuable experience. I now stand ready to assist whomever is elected during this Delegate Assembly in their new role as Area I Director.

Report of the Area II Director

Linda Peterson Seppanen, PhD, RN, Area II Director
Board Member, Minnesota Board of Nursing

As Area II Director of the National Council of State Boards of Nursing, I participated in all Board of Directors meetings and conference calls this past year. I participated in the Board task force which addressed issues related to the research agenda. I am representing the National Council at the American Nurses' Association House of Delegates in Washington, D.C., this summer.

The Area II Meeting was held April 1, 1995, in Indianapolis, Indiana. There were 55 participants with all jurisdictions except Michigan represented. Members and staff of the Indiana Board of Nursing graciously hosted the meeting and provided a pleasant reception. Issues and topics discussed at the Area II Meeting included:

- Liaison meetings, especially those with NLN
- CAT implementation and NCLEX™ results
- Advanced practice nursing and regulation
- Disciplinary Data Bank
- Role Delineation Study
- NCLEX-PN™ test plan modifications
- Trend Analysis and proposed Organization Plan revisions
- Research agenda proposal
- National regulatory environment and NAFTA
- Prescriptive Authority rules and regulations
- Overlapping roles, delegation, downsizing in clinical practice
- Boundary violations in nursing practice

Presenters at the meeting included Marcia Rachel, President; Jennifer Bosma, Executive Director; Linda Waters, Educational Testing Service; Mary Vonderheide, Sylvan Learning Systems; Paulette Worcester, Examination Committee; Lorinda Inman, Long Range Planning Task Force; Carolyn Hutcherson, Senior Policy Analyst; Rita Pobanz, Task Force to Study Feasibility of a Core Competency for Nurse Practitioners.

The 1996 Area II Spring Meeting will be hosted by the Illinois Board of Nursing, with plans to hold it in the Chicago area.

The Area II Regulatory Day of Dialogue was held on March 31, 1995, in Indianapolis, Indiana. The topic, Standardization of Nursing Education, was covered in presentations, panels, and general discussions by Karen Macdonald, Charlet Grooms, Linda Seppanen, Barbara Jean McClaskey, and Marilou Wasseluk. Registration numbered 52, which included several from Indiana outside the National Council membership.

I want to thank all the Area II Board members, staff, and others who have participated in National Council activities this past year; nearly all our jurisdictions are represented. Your efforts make this organization a dynamic and responsive voice in regulatory matters.

Thank you for the opportunity to serve you as Area II Director in this challenging and stimulating role. I appreciate your willingness to share ideas and opinions with me.

Report of Area III Director

Nancy Durrett, MSN, RN, Area III Director
Assistant Executive Director, Virginia Board of Nursing

As Area III Director of the National Council of State Boards of Nursing, I have participated in all Board of Directors' meetings and conference calls. I served as the Board liaison to the Long Range Planning Task Force, attending one of its meetings and participating in the conference calls. It was also my privilege to represent the National Council at the Institute for Hospital Clinical Nursing Education of the American Hospital Association in Seattle, Washington.

The Area III Meeting and Regulatory Day of Dialogue were hosted by the Tennessee Board of Nursing at the Opryland Hotel in Nashville, Tennessee, on April 6-7, 1995. We owe a special thanks to the Tennessee Board members who were instrumental in securing this wonderful facility for the meeting.

The Regulatory Day of Dialogue featured a keynote address on advanced practice by Dr. Mary Fenton, Dean, University of Texas, School of Nursing. Roundtable discussions followed on advanced practice and unlicensed assistive personnel. The planning committee was chaired by Linda Murphy, AR; and included Sonja Moffett, AL; Pamela Pitchford, MS; and Kathy Thomas, TX-RN.

The Area Meeting had 60 participants with all Area Member Boards represented. Reports were presented by Marcia Rachel, President; Jennifer Bosma, Executive Director; Linda Waters, Educational Testing Services; and Mary Vonderheide, Sylvan Learning Systems. Chairs and members of several National Council committees and task forces also presented reports of their activities. A discussion of Area-specific concerns and issues followed. Written reports of the activities of the past year by each Member Board were distributed to all participants.

The 1996 Area Meeting will be hosted by the Texas Board of Nurse Examiners and Texas Board of Vocational Nurse Examiners in Austin, Texas.

Area III board members and staff continue to make significant contributions to the National Council through their participation in committees, task forces, focus groups and other activities. Your willingness to volunteer your time and expertise are certainly appreciated.

Thank you for this opportunity to serve as the Area III Director. It has been a very exciting and rewarding experience.

Report of Area IV Director

Marie T. Hilliard, PhD, RN, Area IV Director
Executive Officer, Connecticut Board of Examiners for Nursing

It has been an exciting year representing Area IV on the Board of Directors of the National Council of State Boards of Nursing. It is a critical time in the history of health care and specifically, nursing. We are at a crossroad and difficult choices must be made, impacting the future of public health and safety. The National Council of State Boards of Nursing has been in the forefront of the prerequisite dialogue for sound decision-making. As Area IV Director, I have attempted to provide the broadest base for such dialogue. Each jurisdiction has been of great assistance to me, as we engaged in numerous telephone dialogues.

On behalf of the National Council, I have attended five professional meetings. All of these meetings have a direct relationship to decision-making concerning health care redesign:

- Testimony Regarding Adequacy of Nurse Staffing Submitted to The Institute for Medicine, Washington, DC. Most hearing participants indicated grave concerns for quality of patient care within new models of redesign of nursing care delivery. The scarcity of research data was identified by many as problematic. The National Council has on its agenda research on the utilization of unlicensed assistive personnel. Ongoing participation and monitoring of these events is critical to the health and welfare of our citizens.

- The National Federation of Licensed Practical Nurses, Inc., 45th Annual Convention, Orlando, Florida, "Caring for America's Health."

- 1995 Nurse in Washington Internship, March 5, 1995 - March 8, 1995.

- Connecticut Nurses' Association Annual Convention, October 20, 1994.

- Connecticut Licensed Practical Nurses' Association Annual Convention, May 1, 1995.

The agendas of these meetings directly related to four of the seven significant issues identified by the Board of Directors after the 1994 Annual Meeting: 1) relationships between levels of nursing personnel; 2) political/policy aspects of health care reform; 3) health care system changes; and 4) nursing profession relationships. Input from the National Council, and to the National Council from these activities, is critical to the development of sound public policy recommendations. As we continue our dialogue within numerous forums, we will be better grounded in our policy recommendations. A critical aspect of National Council policy development is the accuracy of information used in decision-making. To this end, research policies, addressing priorities and procedures, need to be established. I am serving on a Board of Directors committee which has been created to assist Member Boards to participate in this process.

The highlight of the year, for me, was the Area IV Meeting hosted by the Maine State Board of Nursing. The Regulatory Day of Dialogue provided an excellent format for all of us to become better educated about "The Americans with Disabilities Act: Implications for Practice and Regulation." The guest speakers, provided by Member Boards, were outstanding. The Area IV Meeting demonstrated the broad expertise of all of our members, who contributed to our enhanced mutual understanding of the regulatory process, current issues, and potential resolutions.

While it has been a challenging year, it has been a very fulfilling year. The work we do is critical to public health and safety. Working with Member Boards has made the challenge a pleasure.

Report of the Director-at-Large

Roselyn Holloway, MSN, RN, Director-At-Large
Board Member, Texas Board of Nurse Examiners

Since the 1994 Delegate Assembly, as Director-at-Large, I have participated in the following activities:

- Attended all meetings of the Board of Directors and participated in Board conference calls
- Participated in the Board Retreat in Chicago, Illinois, in October 1994
- Appointed by Board President to a committee to establish a process for development of the National Council's continuing education programs

Throughout the year, I kept abreast of updates concerning the impact of regulation on nursing education and its progress and changes as they occurred.

In April, I represented the National Council at the National Student Nurses' Annual Meeting in Charlotte, North Carolina. The theme was "NSNA: The Bridge to New Opportunities" and the keynote address was given by Hazel Johnson-Brown, PhD, RN, FAAN, professor and director, Center for Health Policy, College of Nursing and Health Science, George Mason University, Fairfax, VA. She was sponsored by the American Journal of Nursing company. It was refreshing to see all of the interest in the policy of nursing by the youth of our profession. And I felt honored to represent our National Council among such an erudite group at the opening ceremony.

I do appreciate all of your support for the National Council and your efforts in the workings of the Board serving as task force members and members of committees. It has been an honor to serve the National Council as Director-at-Large.

5

REPORT OF STAFF

Report of Staff Activities

Jennifer Bosma, PhD, CAE, Executive Director

In its oversight of the affairs of the organization, the Board of Directors identifies tactics which will lead to accomplishment of the mission, goals and objectives of the National Council. This report is an accounting of staff work focusing on Board-assigned tactics for this past year. For ease of reading, it is organized by program area.

A staff organization chart (Attachment A) accompanies this report. Description of staff responsibilities is found behind Tab 14, Orientation Manual, in this *Book of Reports*.

Testing Programs

National Council Licensure Examinations (NCLEX™)

Program purpose: To provide a legally defensible, psychometrically sound, and progressive entry-level licensure examination with timely and appropriate information flow; to anticipate Member Board support needs and provide appropriate levels of support.

Supporting activities:

- Monitored the first year's implementation of computerized adaptive testing (CAT) for NCLEX™ to approximately 187,000 candidates
- Recruited, screened, and confirmed the attendance of 144 item writers and 50 item reviewers
- Worked with ETS to plan for and publish *NCLEX™ Program Reports*
- Worked with the Examination Committee to develop modifications to the *NCLEX-PN™ Test Plan* based on the 1994 Job Analysis
- Worked with ETS to prepare for implementation of the new *NCLEX-RN™ Test Plan*
- Worked with the CAT Evaluation Task Force to develop the framework for a full-scale NCLEX™ evaluation
- Began work with the Canadian Nurses' Association to explore areas of increased cooperation on examination-related issues

Nurse Aide Competency Evaluation Program (NACEP™)

Program purpose: To provide a legally-defensible, psychometrically sound nurse aide competency evaluation in a competitive environment.

Supporting activities:

- With The Psychological Corporation (TPC) and the NACEP™ Task Force, provided the NACEP™ to 22 states and territories, including nine boards of nursing, for the testing of more than 64,000 nurse aides primarily in long term care, and also home health care and acute care
- Sponsored Sixth Nurse Aide/Assistant Conference in Baltimore, Maryland, which was attended by state and federal regulators, educators and others who work with nurse aides/assistants
- Published *Insight: Newsletter on Nurse Aides and Assistive Personnel* three times annually, with circulation to over 800
- Provided directory of nurse aide registries
- Developed criteria to evaluate TPC performance and determine whether or not to issue an RFP for NACEP™ testing services

Other services:

- Worked with the Task Force to Study the Feasibility of a Core Competency Exam for Nurse Practitioners to develop recommendations to the Board of Directors and Delegate Assembly regarding the regulatory, political, and fiscal ramifications of developing such an examination
- Worked with the research department to evaluate submitted information to keep the APRN Certification Clearinghouse current

Nursing Practice and Education Programs

Licensure and Credentialing
Program purpose: To promote consistency in the licensure and credentialing process.

Supporting activities:
- Monitored trends and issues in licensure and credentialing
- Worked with legal counsel to develop content for *Emerging Issues* on Heartland case
- Worked with the Task Force to Study Advanced Practice Mobility to develop a database of advanced practice nursing requirements
- Participated in the evaluation of the NONPF core curriculum for advanced practice

Models and Positions
Program purpose: To provide resources for Member Boards which outline information, direction and support for regulatory concepts and approaches.

Supporting activities:
- Published revised models which incorporated the advanced practice registered nurse legislative language and rules
- Assisted the Nursing Practice and Education (NP&E) Committee to develop a process to evaluate the usefulness of National Council models and positions
- Supported the NP&E Committee's use of the collaboration model developed in FY94 to develop strategies for promotion of professional accountability
- Analyzed and compared National Council models to ANA's draft model
- Promoted use of positions and models with Member Boards and other entities

Essential and Continued Competence
Program purpose: To develop resources regarding functional abilities (formerly termed non-nursing essential competencies) that can be used by Member Boards to support decisions involving the Americans with Disabilities Act (ADA); to develop resources regarding continued competence that can be used by Member Boards to establish and/or reaffirm the expectation of continued competence as an element of licensure maintenance.

Supporting activities:
- Continued to collect ADA and competence resources
- Worked with the Essential and Continued Competence Subcommittee (ECC) to define competence, identify standards of competence and their application
- Presented program at FARB on continued competence

Discipline-related Services
Program purpose: To provide resources for Member Boards to assist in the investigation of nursing complaints and to facilitate the exchange of information regarding nursing disciplinary actions taken nationwide.

Supporting activities:
- Operated National Council Disciplinary Data Bank (DDB), including promotion of electronic access and exploration of access by other entities
- Implemented HRSA Discipline Project (study contracted with Health Resources and Services Administration)
- Worked with Disciplinary Investigators' Education Programs Task Force to pilot healthcare investigators program with CLEAR and subsequently to revise for a second pilot focused on nursing investigations
- Developed background resources and supported Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group
- Served as National Council representative on the NPDB Executive Committee
- Moderated debate at CLEAR regarding approaches to dealing with the chemically dependent nurse

Nursing Practice

Program purpose: To provide resources which assist and support Member Boards in the regulation of nursing practice.

Supporting activities:

- Monitored trends and issues in nursing practice
- Assisted Member Boards and others through consultation regarding nursing practice issues

Nursing Education

Program purpose: To provide resources which assist and support Member Boards in the regulation of nursing education.

Supporting activities:

- Monitored trends and issues in nursing education
- Coordinated task force efforts to finalize learning modules for nursing education program surveyors
- Assisted focus group to identify education issues and plan session at Annual Meeting
- Assisted Member Boards and others through consultation regarding nursing education issues
- Assisted NP&E Committee to compare National Council models to NLN educational program criteria

Public Policy Programs

Policy Analysis

Program Purpose: To promote the mission of the National Council by providing ongoing analysis of health care, health care reform, environmental and regulatory issues with primary focus on the impact on Member Boards.

Supporting activities:

- Systematically reviewed documents and resources to ensure evaluation of most pertinent and current information on health care reform; federal initiatives; state initiatives; regulatory reform; hospital restructuring; and other policy issues
- Reviewed summary of all state legislation affecting nursing regulation
- Developed contacts with persons in comparable policy positions in other organizations
- Conducted survey of other associations to collect information on governmental affairs programs in similar organizations
- Coordinated activities for internal public policy team to ensure collaborative review and problem solving for a myriad of activities related to nursing, Member Board issues, documents produced by other organizations, etc.

Unlicensed Assistive Personnel

Supporting activities:

- Initiated systematic review of nursing and health care reform periodicals for resource documents related to unlicensed assistive personnel (UAP)
- Participated in several conferences preparing presentations or panel response on the role of the UAP and relationship to the licensed nurse
- Collected UAP documents from Member Boards to provide comprehensive resource data
- Reviewed UAP literature to identify resource documents for subcommittee
- Responded to calls from Member Boards with specific questions about delegation, supervision and the role of the licensed nurse in working with UAP
- Attended White House Mini-Conference on Aging to represent regulatory perspective on utilization of unlicensed providers

Nursing Regulation

Supporting activities:

- Conducted literature review for articles on nursing regulation, specifically the costs and benefits of nursing regulation
- Initiated collection of a definitions of nursing with the ultimate goal of developing a succinct regulatory definition of nursing
- Collected information on the Ontario model, institutional licensure and other potential approaches to a revised regulatory system
- Facilitated review of information and disbursement of material from the Pew Health Professions Commission to relevant individuals within National Council

Licensure Verification

Supporting activities:

- Collected historical documents and coordinated initial teleconference with Electronic Verification Task Force
- Facilitated development of models for review by the Executive Officers at the Annual Meeting
- Coordinated evaluation of computer needs and options to facilitate electronic transfer of licensure data by Member Boards

NAFTA/Trilateral Linkage

Supporting activities:

- Participated in international briefing on implementation of NAFTA and GATS
- Coordinated collection of Member Board concerns related to licensure requirements and the reservations process as specified by NAFTA
- Met with staff of the U.S. Trade Representatives Office
- Participated in development of paper on licensure/registration and standards of practice in the U.S. to ultimately be consolidated with similar papers for Canada and Mexico on their licensing

Research Programs

Job Analysis Research

Program purpose: Support validity arguments for NCLEX-RN™, NCLEX-PN™, and NACEP™.

Supporting activities:

- Completed PN/VN Job Analysis Study
- Completed Nurse Aide Job Analysis Study
- Exploring job analysis study methodology alternatives

Computerized Clinical Simulation Testing (CST)

Program purpose: Provide Member Boards with a state-of-the-art examination methodology that provides a means of assessing problem solving/critical judgment abilities with great fidelity to clinical nursing

Supporting activities:

See project report, Attachment B

Nurse Information System (NIS)

Program purpose: To establish an unduplicated master list of all nurse licensees.

Supporting activities:

- Received a grant of $499,995 from the Robert Wood Johnson Foundation in continued support of the NIS project
- Continued to work with Member Boards to encourage participation through contracts and letters of agreements, and followed up with boards to complete negotiation process
- Continued data collection from Member Boards that do not charge a fee or are using the NIS scan form, and have received data from 35 Member Boards, to date. Will resume collections from all boards beginning July 1995
- Finalized and printed NIS scan form, which will be used by ten Member Boards; continued to work with other Member Boards to determine if and when they plan on using the scan form
- Continued to work with Strategic Technology Resources (STR) to develop the NIS database structure; scheduled for completion in July 1995
- Coordinated 25 Member Boards' participation in the NIS user screen pilot test, conducted during May 1995
- Reviewed all restrictions Member Boards have placed on National Council's release of licensee data in order to standardize the data release rules and compile in a supporting NIS database to form the basis of the NIS data security plan
- Began project to link all Member Board licensee data fields to standard NIS fields, and to match response codes for all Member Board data fields and NIS standard fields
- Developed detailed data completeness and logical consistency checks that will be used to maintain data integrity within NIS
- Analyzed results from the 1995 follow-up marketing research and used to develop preliminary NIS sales forecasts
- Conducted the NIS Technical Advisory Panel's (TAP) fourth meeting on March 22, 1995, at which it reviewed progress in the areas of data collection, contract negotiations, and database development
- Followed up with Member Boards on the original Provider Identification Number survey conducted in 1994 to verify the board's participation levels before sending information to nursing associations, which may be able to provide state-level strategies to facilitate release of further data elements, where such collaboration is desired by Member Boards

Chemical Dependency Regulatory Research

Program purpose: To provide Member Boards with data that informs jurisdiction-level policy decisions; to provide National Council with data that informs development/provision of resources for Member Boards.

Supporting activities:

- Obtained institutional approvals regarding protection of human subjects rights
- Finalized data collection instruments
- Worked with six Member Boards to obtain their participation/cooperation in the study
- Completed sample selection with data collection to be initiated in June 1995

Unlicensed Assistive Personnel - Literature Review

See Attachment C

Literature Review Focus Group Topic Surveys

See Attachment D

Role Delineation Study

Analysis has been completed and a draft disseminated at Area Meetings. The final copy will be published and disseminated to Member Boards in summer 1995.

Communications Programs

Publications and Interorganizational Communications

Program Purpose: To provide communications services and expertise for the National Council which constitute the prime national resource of information and expertise regarding nursing regulation.

Supporting Activities

- Introduced a regular column in the bi-weekly *Newsletter* that focuses on committee and special committee news/activities, and expanded the *Newsletter's* dissemination to include all volunteers
- Published four editions of *Issues*, three editions of *Insight: Nurse Aide News and Issues*, and two editions of *Emerging Issues*
- Published, and made available for sale, a number of publications including the *NCLEX-RN™ Test Plan, Model Nursing Practice Act, Model Nursing Administrative Rules, 1994 Profiles of Member Boards*, and *1994 Licensure and Examination Statistics*
- Published informational brochures regarding National Council's volunteer program, the Resource Network, and National Council as a resource on nursing regulation
- Coordinated the supply to Member Boards of various NCLEX™ and "Master Key" brochures, for the purpose of wide dissemination to nurse candidates, educators and other interested parties
- Represented National Council at meetings of nursing practice, education, and research organizations, as well as organizations concerned with regulatory, testing and consumer matters
- Organized seven interorganizational liaison meetings and promoted the inclusion of National Council viewpoints in relevant issues
- Published articles in several nursing-related journals and made invited presentations to a variety of related professional groups
- Represented National Council by invitation to several task forces and panels studying issues related to nursing regulation
- Exhibited National Council services at 13 meetings of nursing and regulatory groups

Meetings

Program Purpose: To provide opportunities for Member Boards to act and counsel together on matters of common interest regarding the role of nursing regulation in public protection.

Supporting activities:

- Planned and implemented the meeting logistics for the Annual Meeting, four Regulatory Days of Dialogue, four Area Meetings, an advanced practice roundtable, and a national nurse aide conference, including the submission of continuing education units when requested
- Coordinated eight educational sessions and a poster session for the 1994 Annual Meeting; published and distributed the 1995 Call for Papers to all 1994 meeting attendees and educators nationwide
- Coordinated communications among National Council volunteers, travel agency, corporate hotel and office staff regarding committee meetings
- Negotiated and secured appropriate hotel contracts related to National Council's 1995, 1996, and1997 Annual Meetings

Other services:

- Responded to requests from four Member Boards for services of the Resource Network
- Facilitated opportunities for new executive officers to make visits to other boards or the National Council for orientation purposes
- Obtained a registered trademark for CST® (Computerized Clinical Simulation Testing)

Information Resources

Program Purpose: To provide Member Boards and others with valuable, readily accessible information related to all aspects of nursing regulation.

Supporting activities:

- Designed and scheduled a summer 1995 implementation for a software program for electronic submission of disciplinary data by Member Boards to the National Council
- Secured all Member Board Nurse Practice Acts as well as Administrative Rules, and transferred them to an electronic format, to be available to Member Boards via NCNET
- Purchased and installed a new telecommunications system that includes pre-recorded information, an accounting system, and conference calling
- Initiated an on-line clearinghouse service for Member Boards, offering copies of national news releases received at the National Council; responded to over 200 Member Board requests for copies
- Refined the electronic irregularity reporting (EIR) system and designed a software program to internally track and manage NCLEX™ issues, correspondence and calls
- Established an NCNET Help Desk procedure and responded to all calls for NCNET assistance from Member Boards

Operational and Administrative Programs

Planning and Evaluation

Program purpose: To support the governance of the National Council in identification and accomplishment of significant ends related to public protection through nursing regulation.

Supporting activities:

- Maintained records of progress toward accomplishment of all FY95 tactics for the Organization Plan
- Coordinated short-term planning with the aim of maintaining congruence with the Organization Plan vision, and projected availability of resources
- Coordinated long-term planning which will ensure focused movement over the next five years
- Maintained a cumulative organizational assessment in four major areas: outcomes evaluation, performance appraisal, structure/documents assessment, and future needs assessment

Fiscal Management

Program purpose: To provide a fiscal management system that will further the accomplishment of the National Council's program goals and objectives.

Supporting activities:

- Began financial statement reporting by organization plan objectives as well as by responsibility center.
- Issued comparison of National Council financial operation ratios to benchmark ratios.

Attachments

A ....National Council Administrative Staff and Organization Charts, *page 8*
B ....Computerized Clinical Simulation Testing (CST®) Project, *page 17*
C ....Unlicensed Assistive Personnel—Literature Review, *page 30*
D ....Literature Review Report, *page 46*

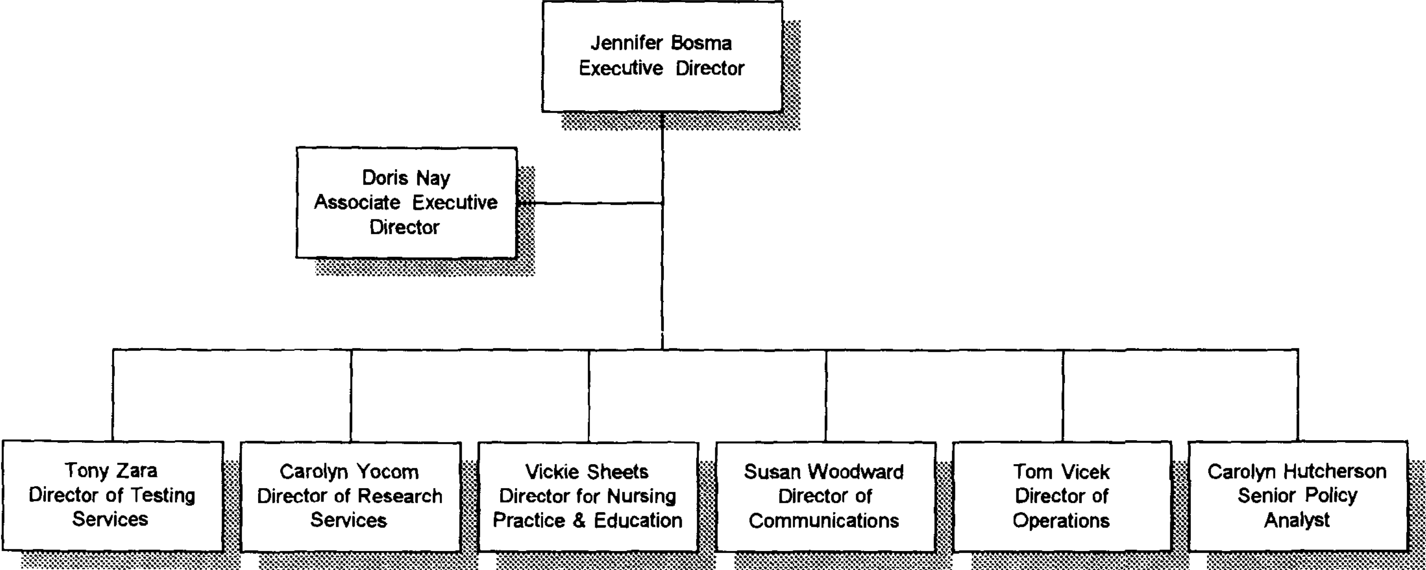
Attachment A

National Council Administrative Staff

Jennifer Bosma, Ph.D., C.A.E. .... Executive Director
Doris Nay, M.A., R.N. .... Associate Executive Director

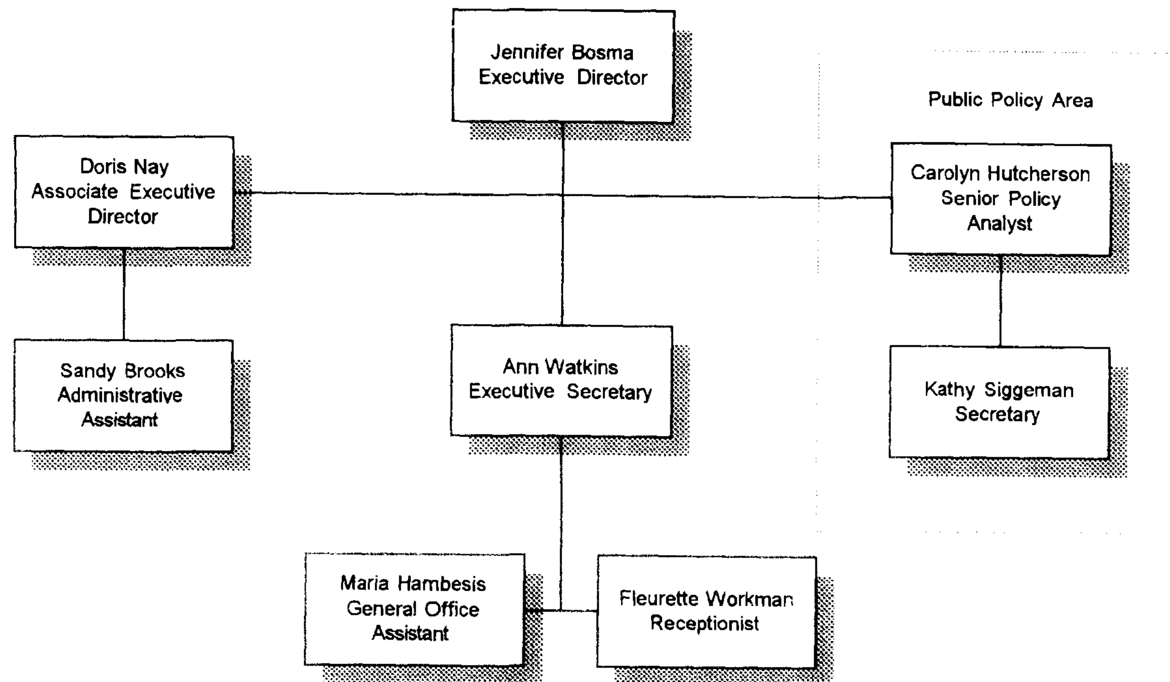
Cynthia Bentel .... Administrative Assistant *(through April 1995)*
Anna Bersky, Ph.D., R.N. .... CST Project Director
Jodi Borger .... NCLEX™ Administrative Assistant
Sandra Brooks .... Administrative Assistant *(beginning May 1995)*
Delores Caruso .... Staff Accountant
Nancy Chornick, Ph.D., R.N. .... Research Associate
Susan Davids, C.M.P. .... Meetings Manager
Ellen Gleason, M.S.I.R., M.S.O.D. .... NACEP Program Manager
Barbara Halsey, M.B.A. .... NCLEX™ Administration Manager
Christopher T. Handzlik .... Editor
Carol Hartigan, M.A. .... NCLEX™ Contract Manager
Linda Heffernan, J.D., M.S.N., R.N. .... Nursing Practice and Education Associate
Carolyn Hutcherson, M.S., R.N. .... Senior Policy Analyst *(beginning December 1994)*
Peggy Iverson .... NIS Administrative Assistant *(beginning Nov. 1994)*
Ellen Julian, Ph.D. .... Psychometrician
June Krawczak, M.S.N., R.N. .... CST Project Associate
Philip J. LaForge, M.B.A. .... Marketing Manager *(beginning June 1995)*
Craig S. Moore .... Network Administrator
Melanie Neal, M.A. .... NIS Program Manager
Bryan M. Newson .... Computer Programmer
Kerry Nowicki .... Publications Manager
Larry Sankey .... Information Resource Manager *(through March 1995)*
Vickie Sheets, J.D., R.N. .... Director for Nursing Practice and Education
Ruth Bernstein Spiro, M.B.A. .... Testing Administrative Coordinator
Tom Vicek, M.B.A., C.P.A. .... Director of Operations
Ann Watkins .... Executive Secretary
Anne Wendt, Ph.D., R.N. .... NCLEX™ Content Manager
Susan Woodward .... Director of Communications
Carolyn J. Yocom, Ph.D., R.N., F.A.A.N. .... Director of Research Services
Anthony R. Zara, Ph.D. .... Director of Testing Services

National Council of State Boards of Nursing
Organizational Chart - Directors



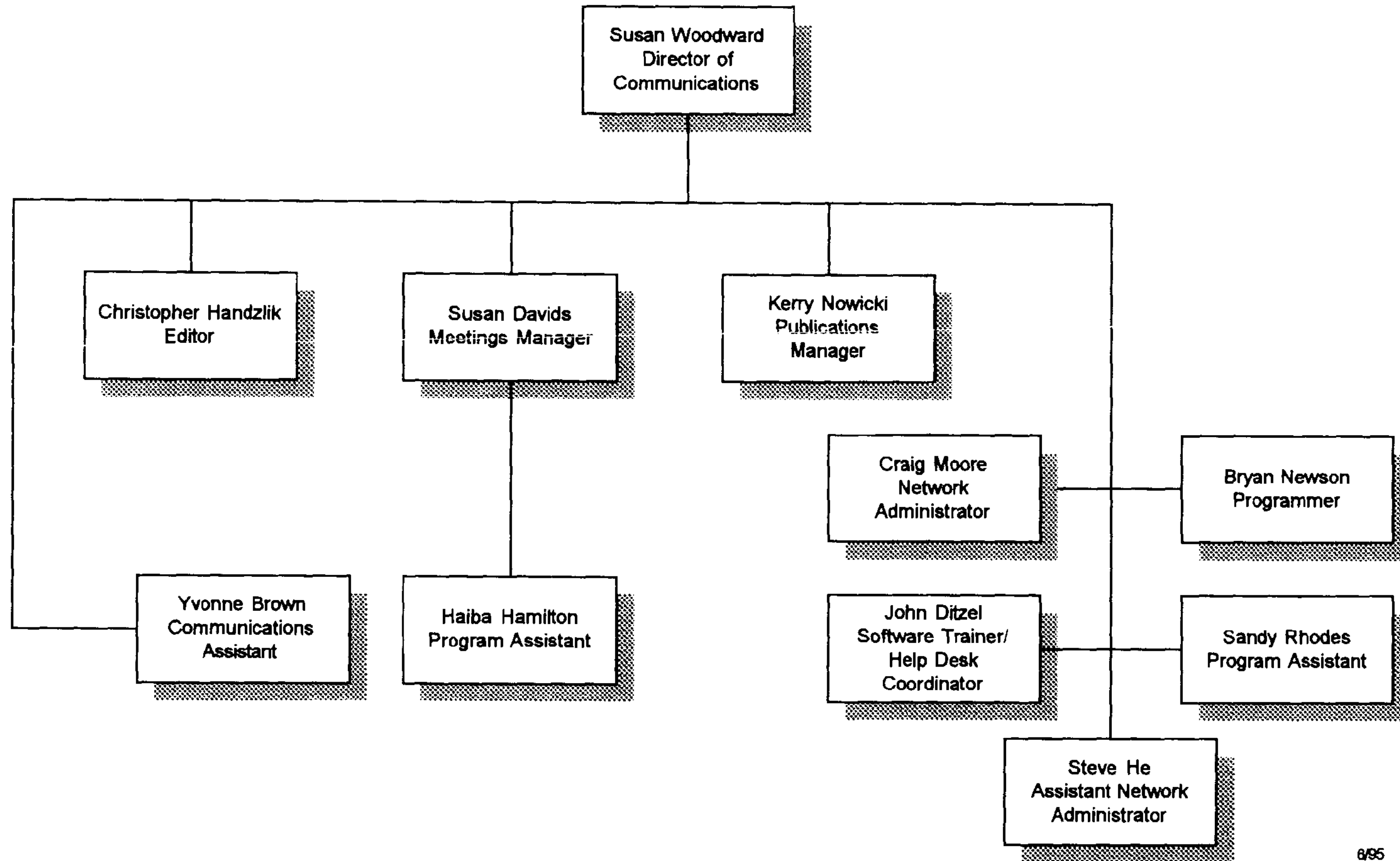
6/95

National Council of State Boards of Nursing Organizational Chart - Administration/Public Policy

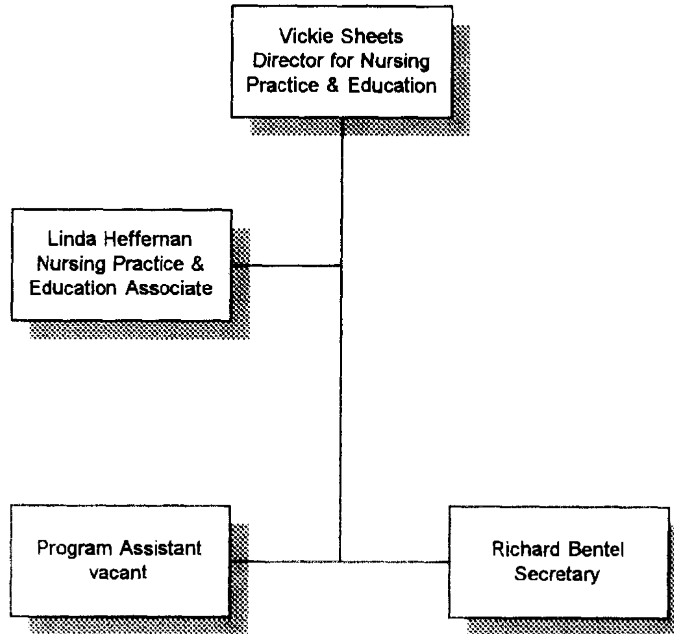


6/95

National Council of State Boards of Nursing
Organizational Chart - Communications



National Council of State Boards of Nursing
Organizational Chart - Nursing Practice & Education



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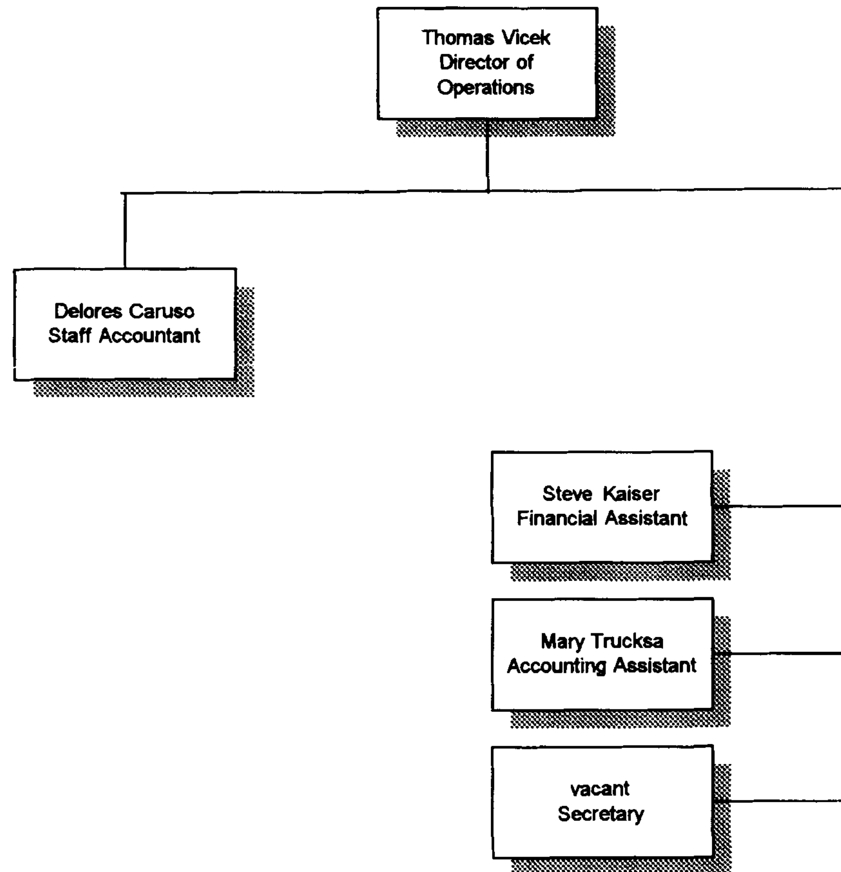
National Council of State Boards of Nursing
Organizational Chart - Operations



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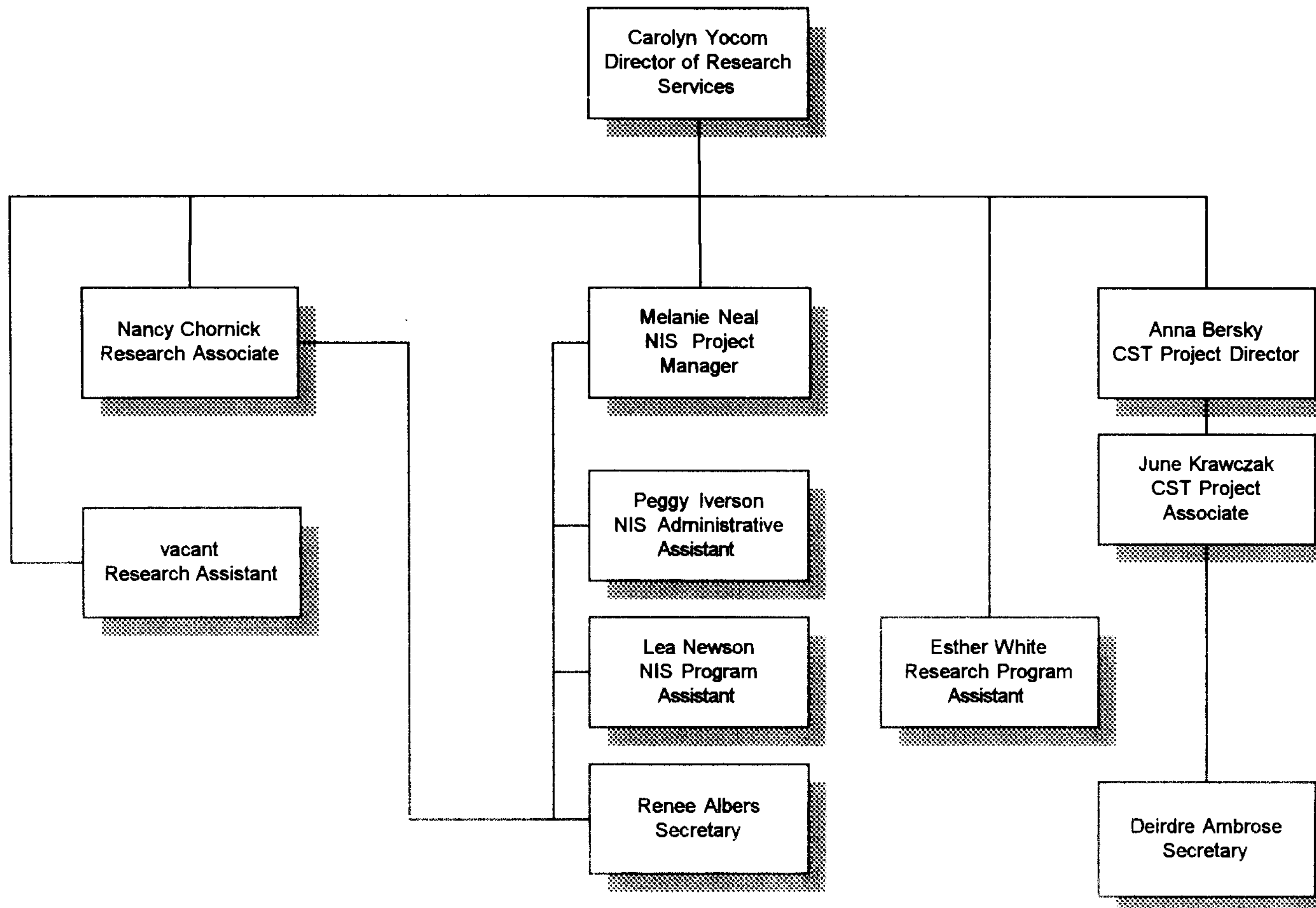
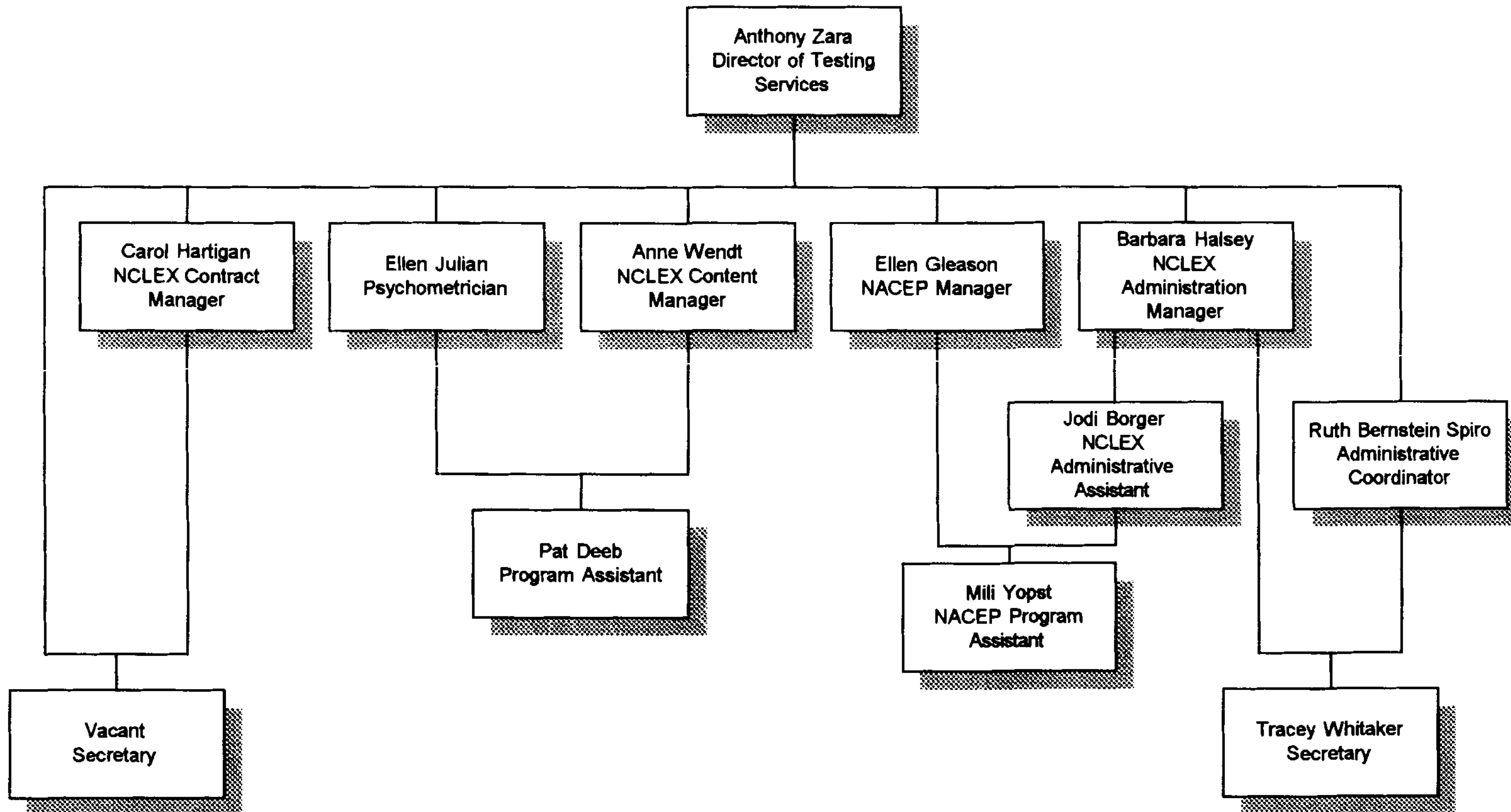
National Council of State Boards of Nursing
Organizational Chart - Research



National Council of State Boards of Nursing
Organizational Chart - Testing



Attachment B

Computerized Clinical Simulation Testing (CST®) Project

Staff

Anna Bersky, *CST® Project Director*
June Krawczak, *CST® Project Associate*

Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective C........ Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Program Purpose

To research and develop a more authentic mechanism for assessing the clinical decision-making activities (assessment and intervention) which are used in the management of client care.

Background

Computerized Clinical Simulation Testing (CST®) has been under research and development since 1988. It is believed that CST permits a more authentic assessment of the decision-making activities used in the management of client needs than traditional assessments such as multiple choice and essay questions because: it eliminates the unnatural cuing of questions and answer options; it is interactive in that the nurse carries out nursing activities which elicit a response from the client; and it is dynamic in that the client condition changes over time in response to nursing action (or non-action) and as the underlying health problem unfolds. At the beginning of each clinical encounter, the examinee is presented with a brief description of the client situation. The examinee then proceeds to the main work screen where requests for nursing activities can be specified. From the main work screen, requests for chart review are selected from a menu and requests for nursing assessments and interventions are specified through free-text entry. When a free-text request is entered, a 25,000+ term nursing activity database is searched for a lexical match to the request.

A primary focus of CST project work during FY95 has been the development of a series of interrelated databases of nursing and medical information. The new simulation software system, being developed for CST by the National Board of Medical Examiners (NBME) will use more efficient mechanisms for refining and managing the information used by the CST system. To facilitate the efficient and flexible construction and delivery of CST cases and scoring keys, a set of databases containing nursing and medical information is being linked through a simple coding scheme which permits quick and efficient identification and capture of the numerous relationships which exist within and across databases.

The accuracy and realism of cases depend on the careful construction, organization, and linkage of these databases which will form the underpinnings of the new automated authoring system. Through automated CST case and scoring key development, the databases will be accessed to prompt the CST case and scoring key authors regarding relationships that should be considered when a certain patient condition exists or when a certain intervention or set of interventions are defined as impacting the patient. This component of the CST system is referred to as the Nursing Information Retrieval System (NIRS©).

Using the NIRS, a case author can start with one idea and work in any direction for developing a case. For example, if a case author wants to build a case about a client requiring certain nursing interventions (i.e., irrigation of a wound, dressing change, tube feeding, and intravenous feeding), these activities can be entered into the computer and all nursing and medical information related to these activities can be quickly accessed and built into a case as desired. On the other hand, an author may wish to build a case for a client with a particular nursing diagnosis or problem, or medical-surgical condition. By entering these into the computer, all nursing and medical information related to any one or combination of conditions can be accessed.

It is anticipated that components of the databases will be tested during FY95 and FY96 as NBME moves along with

the programming of specifications for CST. The databases will, however, require continuous updating and maintenance as new cases are developed, health care changes, and new roles or activities for nurses evolve. The number of terms within each database will vacillate as the databases are restructured and new terms are added, or obsolete terms are removed.

Highlights of Activities

Nursing Information Retrieval System (NIRS©)

This system contains several relational databases of nursing and medical information. Working drafts of several databases are currently under review. The databases are described below.

Nursing Activity Database

This database contains over 1,100 discrete nursing activity parent terms. These are nursing assessment and intervention terms stated in their broadest sense to capture the essence of all synonyms (all the different ways in which free-text requests for a nursing action might be typed in, including terms that have the same meaning as the parent term as well as terms that are subcategories of the parent term) which are connected to them. The total number of parent and synonym terms exceeds 25,000. Included are nursing actions for both the patient and the family/significant other. The terms are structured for compatibility with the CST search algorithms designed for recognition of free-text entries.

This nursing activity database has been in development since 1989. The original list consisted of approximately 250 to 300 discrete nursing activities with their synonyms resulting in approximately 750 terms. These terms were developed by a cadre of nurse consultants representing a broad range of nursing practice areas. A series of CST field and pilot studies, as well as further consultation with experts has contributed substantially to the growth of the CST nursing activity database.

During field and pilot studies, nurses and nurse candidates work through cases by using free-text entries to specify nursing assessments and interventions. All free-text entries that are not recognized by the system are captured and provided in a report following the administration of the examination cases. After careful review, relevant terms are added to the database. Results of CST field studies show that through this process, the system recognition of free-text entries has increased from approximately 72 percent to 92 percent.

The nursing activity database terms are linked, using their unique identification numbers, to the nursing diagnosis/client need database.

Nursing Diagnosis/Client Need Database

This database contains the North American Nursing Diagnosis Association (NANDA) terms as well as other terms which describe client needs or problems. The additional client need/problem terms are being developed to augment the NANDA list and provide a set of database linkages comprehensive enough for CST development. To further facilitate the manipulation and organization of these terms in a variety of ways useful to case and scoring key development as well as to quality control, the terms were assigned to one or more of 33 different categories (e.g., psychosocial terms, bowel function terms, teaching terms). Each of the 33 categories is further subdivided through the use of 16 different codes which further refine the nature of nursing activity membership to a category.

This database is linked to a database containing medical diagnoses and medical/surgical treatments and procedures, a defining characteristics (signs/symptoms) database, and to the nursing activity database.

Defining Characteristics Database

This database includes each defining characteristic (sign/symptom) term along with its unique identifying code number. During the development of this database, signs and symptoms terms are being standardized by using the same wording each time the term is used. For example, the term, chest pain, is broader than the term, angina, so the term, chest pain, is used even when the word, angina, may seem more descriptive. If more flexible wording is needed, synonyms may need to be developed for selected terms, e.g., a list of synonyms or sub categories (including the term, angina) may need to be developed for the term, chest pain.

Medical Diagnosis and Medical/Surgical Treatment and Procedure Database

This database includes each medical diagnosis and medical and surgical treatment and procedure along with its unique identifying (UMLS) code number. It is anticipated that a list of some synonyms/subcategories will need to be developed for selected medical and surgical terms.

Client Outcomes Database

This database, which is currently in the planning phase, will include statements of desired client outcomes. Resources which discuss and describe client outcome statements are being reviewed and potential linkages are being identified. This database would assist case authors in determining desired client outcomes (case-specific responses to nursing actions carried out during a case) and reasonable time frames for changes in client condition.

Default Client Response Database:

This database includes default or normal client (patient or family/significant other) responses for each of the 1,100+ parent terms. A default normal response is the client response that is given when the patient's condition has no impact on, or is unrelated to, the nursing activity requested. Each set of default normal responses represents one of 38 different client response categories which are based on various combinations of attributes including age, gender, presence or absence of pregnancy, and conscious state of the patient. The first draft of this database is complete and is currently being reviewed for accuracy and consistency by CST staff and consultants. This database is linked to the nursing activity database and is critical to the efficiency of CST case authoring.

CST Case Library Database

This database consists of four tables of information about CST cases. Case identification numbers are connected to their related: nursing diagnoses; medical/surgical conditions, treatments and procedures; demographic descriptors; and status descriptors which range from scenario and flowchart development and approval to the development of scoring keys. It is anticipated that additional tables of CST case information will be developed.

Contacts with Outside Groups and Organizations Involved in the Development of Classification or Database Systems of Health-related Terms

Staff have contacted other groups involved in the development of health and/or nursing information classification and/or database systems. Those contacted include: staff for the National Library of Medicine Unified Medical Language System (UMLS) metathesarus; American Nurses' Association group on standardized nursing language; Georgetown University's Home Health Care Classification System (HHCCS); Omaha Visiting Nurse's Association Client Management Information System for Community Health Nursing Agencies; Iowa Project on Nursing Intervention Classifications; and University of Virginia's Patient Care Database Project. The purpose of these contacts was to share information about the NIRS being developed by the National Council and to collect available literature on other like projects. Responses and literature have been received and are being reviewed. Staff from the National Library of Medicine UMLS project and from the American Nurses' Association group on standardized nursing language have expressed an interest in seeing samples of, and learning more about, the CST NIRS.

CST Phase II Agreement with NBME

Phase II of CST will include programming and testing of the new CST software system, adapted from the NBME's completely redesigned computer-based examinations (CBX) software. NBME will begin Phase II programming in August 1995.

Negotiation of the CST License Agreement Amendment

Amendments to the current CST license agreement were completed following approximately two years of negotiation. The primary effect of the amendments is to create a more favorable financial environment relative to: 1) the amount of royalties to be paid to NBME once CST is used in a revenue generating mode; and 2) the cost to National Council for acquisition of CST source code.

Member Board use of CST

Initial plans for exploring and evaluating Member Board use of CST have been developed.

Refinement of CST Research Plan

The CST Research Plan is being refined based on input received from the CST External Research Review Panel and National Council staff.

CST Issues/Policy Issues Document

A draft document outlining issues (and plans and timelines for addressing the issues) which impact CST research and development and/or a future implementation of CST as a component of the licensure exam has been drafted and can be found on pages 13 to 21 of this report.

Future Activities

Tactic 1: Initiate CST case development and continue refinement of research plan and procedures for evaluating the content validity of CST.

It is anticipated that programming of the new CST system will be completed during FY96. This will include: the development of a new, more user friendly CST user interface; further refinement of and testing the use of the NIRS for developing and delivering CST; transfer of four existing CST cases into the new system using NIRS; and, development of a prototype for demonstration purposes.

Tactic 3: Plan for Exploring Member Board Use of CST.

It is anticipated that during FY96 a CST Task Force will begin to provide input regarding potential regulatory uses of CST by Member Boards (other than initial licensure examinations). By spring of FY96, the CST Task Force will finalize the plan for exploring and evaluating Member Board use of CST. It is anticipated that during FY97, a CST Task Force would participate in planning investigating Member Board use of CST, assist in soliciting Member Board participation in the investigation, provide input regarding the CST software to make available to participating Member Boards, and facilitate the initiation of the investigation. It is anticipated that the investigation and evaluation of Member Board uses of CST would continue through FY98.

CST ISSUES/POLICY ISSUES
WORKING DRAFT

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Case Development	1. Level at which case written	1. Cases would reflect a situation that any nurse would encounter 2. Performance expectations would be determined by P/F standard	Review and input into plan by relevant participants Solicit input into policy from relevant participants Draft policies to guide case development during during research phase Based on research findings and input from relevant participants, make regarding level at which cases are to be written recommendations	INTERNAL: CST Task Force Former CST chairs Exam Committee BOD Board Members NP&E staff NP&E committee Public Policy staff NC Testing staff NC Research staff Legal Counsel EXTERNAL: Nurse Consultant Group: Nurses in practice Nursing Faculty Qualifications: knowledgeable regarding health care and nursing school curriculum reform, and anticipated changes in practice settings	April - Nov '95 Review and input received from internal and external resources Winter '96 Draft of proposed policy statements regarding case level . Obtain final input and approval from relevant participants Summer '96 Implement proposed policies for research phase Summer '99 Based on research findings and input from relevant participants, make recommendations regarding level at which cases are to be written

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Case Development	2. Case content & characteristics	1. Method for determining and assuring (for future) importance/relevance of case content Current Method CDC opinion SKDC opinion Expert Opinion Documentation in relevant printed resources 2. Method for determining and assuring (for future) appropriate representation of client demographics and practice settings across cases Current Method CDC opinion SKDC opinion Expert Opinion Documentation in relevant printed resources	Review and input into plan by relevant participants Solicit input into policy from relevant participants Draft policy for assuring importance/ relevance of case content during research phase Based on research findings and input from relevant participants, make recommendations regarding procedures for assuring importance and relevance of case content	INTERNAL: CST Task Force Former CST chairs Exam Committee BOD Board Members NP&E staff NP&E committee Public Policy staff NC Testing staff NC Research staff Legal Counsel EXTERNAL: 1. Nurse Consultant Group: Nurses in practice Nursing Faculty Qualifications: knowledgeable regarding health care and nursing school curriculum reform, and anticipated changes in practice settings 2. Review documents which provide statistics and projections for nursing work settings	April - Nov '95 Review and input received from internal and external resources Winter '96 Draft of proposed policy statements regarding assurance of importance/relevance of case content . Obtain final input and approval from relevant participants Summer '96 Implement proposed policies for research phase Summer '99 Based on research findings and input from relevant participants, make recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Scoring Key Development	1. Level at which scoring key is constructed	1. Scoring key specifies optimal client management and entry-level expectations determined by P/F standard 2. Determine whether same scoring key can be used across practice levels	Review and input into plan by relevant participants Solicit input into policy from relevant participants Draft policy identifying scoring elements to be used for scoring key development during research phase Identify appropriate research analysis procedures for determining whether same scoring key can be used across practice levels (entry level vs experienced nurse) Based on research findings and input from relevant participants, make policy recommendations	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: 1. Nurse Consultant Group: Nurses in practice Nursing Faculty Qualifications: knowledgeable regarding health care and nursing school curriculum reform, and anticipated changes in practice settings 2. NBME consultation 3. External Research Review Panel	Spring '95 to Winter '96 Review and input received from internal and external resources Spring '96 Policy for use during research phase drafted and submitted for approval Summer '96 Policy regarding level at which key constructed in place Policy regarding sample and methods of analysis to be used to determine applicability of single scoring key across levels of practice in place FY97 - FY99 Implement policy and identified research analysis procedures during research phase Summer '99 Based on research findings and input from relevant participants, make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Scoring Key Development	2. Scoring elements to be used to determine ability estimate	Current scoring elements: BENEFITS FLAGS RISKS INAPPROPRIATES 1. Determine which scoring elements to be included in key 2.Determine which scoring elements contribute to ability estimate 3. Determine whether and how scoring elements will be weighted	Solicit, from relevant participaScoring Key Developmentnts, input into plan for identifying and exploring the use of several sets of scoring elements during the CST research phase Identify scoring elements and various analyses procedures to be used during research phase Explore and evaluate the use of the identified scoring elements and analysis procedures Based on research findings and input from relevant participants, make policy recommendations	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: 1. Scoring Panel: Panel discussion/ symposium presented by invited experts with experience in developing innovative scoring procedures for authentic assessment; to be attended by selected NC staff and committee members, and by external research review panel 2. External Research Review Panel attends scoring symposium and provides input into plan for exploring and evaluating various scoring and research approaches	Spring '95 to Winter '96 Review and input received from internal resources Winter '96 Convene Scoring Panel Solicit input from relevant internal and external participants Spring '96 Draft policy regarding scoring elements to be used during research phase Submit for approval Draft policy regarding analysis procedures to be used during research phase FY97 - Spring FY98 Implement policy related to scoring elements during research phase Continue to collect and evaluate information regarding innovative analysis approaches to be used during research phase Summer FY98 Identify any additional research approaches to be used (if any) FY99 Based on research findings and input from relevant participants make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Scoring Key Development	3. Criteria for evaluating validity of scoring key	Determine procedures for evaluating validity of scoring keys	Solicit, from relevant participants, input into plan for identifying and exploring procedures for evaluating the validity of the scoring keys during the CST research phase Identify validation approaches and various research procedures to be used during research phase Explore and evaluate the use of the identified validation and analysis procedures Based on research findings and input from relevant participants, make policy recommendations	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: 1. Scoring Panel: Panel discussion/ symposium presented by invited experts with experience in developing innovative scoring procedures for authentic assessment; to be attended by selected NC staff and committee members, and by external research review panel 2. External Research Review Panel attends scoring symposium and provides input into plan for exploring and evaluating various scoring and analysis approaches	Spring '95 to Winter '96 Review and input received from internal resources Winter '96 Convene Scoring Panel Solicit input from relevant internal and external participants Spring '96 Policy regarding key validation and research procedures to be used during research phase drafted and submitted for approval FY97 - FY99 Implement policy for research phase FY99 Based on research findings and input from relevant participants, make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Estimating Examinee Ability	1. Statistical approach 2. Combining scoring elements 3. Arriving at an estimate of performance across cases.	1. Determine statistical approach to be used for estimating examinee ability 2. Determine how scoring elements will be combined to arrive at a score 3. Determine how performance across cases will be estimated	Solicit, from relevant participants, input into plan for identifying and exploring various (2-3) approaches for estimating examines ability during the CST research phase Identify approaches to be used during research phase Explore and evaluate the use of the identified approaches Based on research findings and input from relevant participants, make recommendations regarding approaches to adopt	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: 1. Scoring Panel: Panel discussion/ symposium presented by invited experts with experience in developing innovative statistical procedures for authentic assessment; to be attended by selected NC staff and committee members, and by external research review panel 2. External Research Review Panel attends scoring symposium and provides input into plan for exploring and evaluating various approaches	Spring '95 to Winter '96 Review and input received from internal resources Winter '96 Convene Scoring Panel Solicit input from relevant internal and external participants FY97 Identify approaches to explore during research phase,but continue to consider and explore new developments in the area for possible incorporation into research plan FY97 - FY98 Continue to consider and explore new developments in the area; implement identified approach as field study data becomes available during case debugging FY98 Explore and evaluate the use of identified approaches during analysis of data from large scale study FY99 Based on research findings and input from relevant participants, make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Construction of Examination Forms	1. Number of cases/exam form 2. Type of cases/exam form	1. Determine how many cases to include in an examination form 2. Determine which case/scoring key variables to consider when constructing an examination form 3. Determine how CST fits with NCLEX-RN™Test Plan 4. Identify which components of test plan are better covered by CST and which are better covered by MCQ NCLEX™	Solicit, from relevant participants, input into plan for identifying number and types of cases which should compose an examination form during the CST research phase Identify approaches to be used during research phase Explore and evaluate the use of the identified approaches Based on research findings and input from relevant participants, make recommendations regarding approaches to adopt	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: External Research Review Panel provides input into plan for assembling examination forms Data from field testing of CST cases NBME Consultation	FY97 Input received from internal and external resources regarding construction of examination forms Approaches for construction of examination forms identified and implemented FY99 Based on research findings and input from relevant participants, make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
Standard Setting for CST	Process and procedures for setting passing standard	1. Identify process and procedures for setting passing standard 2. Determine passing standard for CST	Solicit, from relevant participants, input into plan for identifying process and procedures for setting a passing standard for CST Identify approaches to be explored Explore and evaluate the use of the identified approaches Based on research findings and input from relevant participants, make recommendations regarding approaches to adopt	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: Standard Setting Panel: Panel discussion/ symposium presented by invited experts with experience in developing innovative standard setting procedures for authentic assessment; to be attended by selected NC staff and committee members, and by external research review panel External Research Review Panel: provides input into plan NBME Consultation	FY97 Input received from internal and external resources regarding setting a standard for CST FY98 - FY99 Processes and procedures for setting passing standard for CST identified and implemented FY99 Based on research findings and input from relevant participants, make policy recommendations

TOPIC	ISSUES	CONSIDERATIONS	PROCESS FOR ADDRESSING	RESOURCES	TIMELINES
P/F Decision for Exam which includes both CAT & CST	Process and procedures for combining results of CAT and CST to determine overall candidate P/F status	Identify process and procedures for combining results of CAT and CST to determine overall candidate P/F status	Solicit, from relevant participants, input into plan for identifying process and procedures for combining results of CAT and CST to determine overall candidate P/F status Identify approaches to be used Explore and evaluate the use of the identified approaches Based on research findings and input from relevant participants, make recommendations regarding approaches to adopt	INTERNAL: CST Task Force Exam Committee BOD NC Testing staff NC Research staff Legal Counsel EXTERNAL: Standard Setting Panel: Panel discussion/ symposium presented by invited experts with experience in developing innovative standard setting procedures for authentic assessment; to be attended by selected NC staff and committee members, and by external research review panel External Research Review Panel: provides input into plan NBME consultation	FY97 Convene Standard Setting Panel Input received from internal and external resources regarding combining results and determining P/F status for a CAT and CST exam FY98- FY99 Processes and procedures for combining results and determining P/F status for a CAT and CST exam identified and implemented FY99 Based on research findings and input from relevant participants, make policy recommendations

Attachment C

Literature Review: Impact of Using Licensed and Unlicensed Nursing Personnel on the Quality and Cost of Patient Care

Staff

Frances Vlasses, *Research Assistant*
Carolyn J. Yocom, *Director of Research Services*

Relationship to Organization Plan

Goal II .... Provide documents which provide guidance regarding the regulation of nursing practice.
Objective A .... Develop documents which provide guidance regarding the regulation of nursing practice

Background

The 1994 Delegate Assembly directed that the National Council collect and analyze the results of current and past studies of the utilization of licensed and unlicensed nursing personnel. The analysis should focus on the quality of nursing care delivered to the consumer and cost effectiveness.

Highlights of Activities

An extensive search for published and unpublished reports of research and evaluation studies was undertaken using electronic databases, wide dissemination of a call for information, and personal contact with other organizations and groups. A total of 17 relevant documents were identified, 16 of which had been published. Of these 17, three addressed aspects of the quality of care delivered, eight addressed both quality and cost of care, and six addressed the cost of care. A major problem encountered in reviewing this body of literature was a lack of sufficient statistical data which could be used to perform a meta-analysis. Therefore, a traditional approach to performance of a literature review was undertaken. The final report of this review follows.

Literature Review: Impact of Using Licensed and Unlicensed Nursing Personnel on the Quality and Cost of Patient Care

Purpose

The purpose of this study was to identify literature addressing a question which underpins the current work redesign initiative in the health care industry; that is, how do changes in the mix of licensed and unlicensed nursing personnel impact the quality and cost of nursing care.

Conceptual Framework

Although there "is no universally accepted definition of quality" (Carter, Mills, Homan, Blaesing, Heater, Stoll, Momin and Corrigan, 1988, p.332), researchers are working to define the variables associated with quality nursing care. Further, these variables are located within and interact with multiple variables within the total patient care system (Carter et al., 1988).

The complexity of relationships surrounding health care organizations, nursing practice, quality and cost is represented in the literature in conceptual models put forth by O'Brien-Pallas (1995); Lewin-VHI, Inc. (1995); and Lengacher, Mabe, Bowling, Heinemann, Kent, and Van Cott (1993). The conceptual framework for this study (Figure 1) is based on these sources. This framework is based on the condition that quality of care and cost of care are dependent upon adequate and appropriately skilled nursing personnel. The framework outlines basic components of quality and cost as defined in the literature.

As outlined in Figure 1, quality of care is often assessed in terms of: (1) patient focused outcomes; (2) process of care indicators, which generally reflect methods of monitoring what the nurse does; and (3) nurse indicators or the nurse's evaluation/perception of quality/satisfaction. While there is an extensive and growing literature on nurse indicators (Huber, Blegen, & McCloskey, 1994; Shindul-Rothschild, 1994) and because these are more widely distributed and self-evident, this study attempts to synthesize literature that addresses patient-focused outcomes and process of care indicators.

Figure 1 also demonstrates that cost of care is related to both personnel costs and material consumption. Since skill mix relates to personnel costs in this literature, costs related to materials are either addressed indirectly, since increased material consumption is a by-product of increased length of stay (LOS) or, more commonly, is not addressed at all.

Figure 1. Conceptual Model

A. Quality of Care

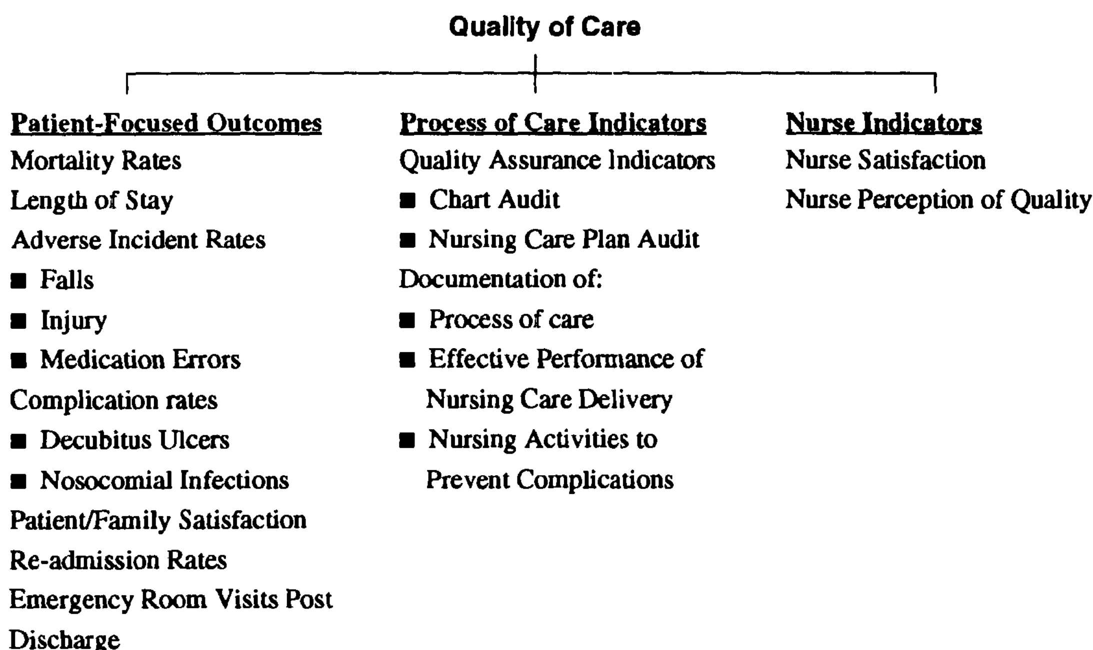
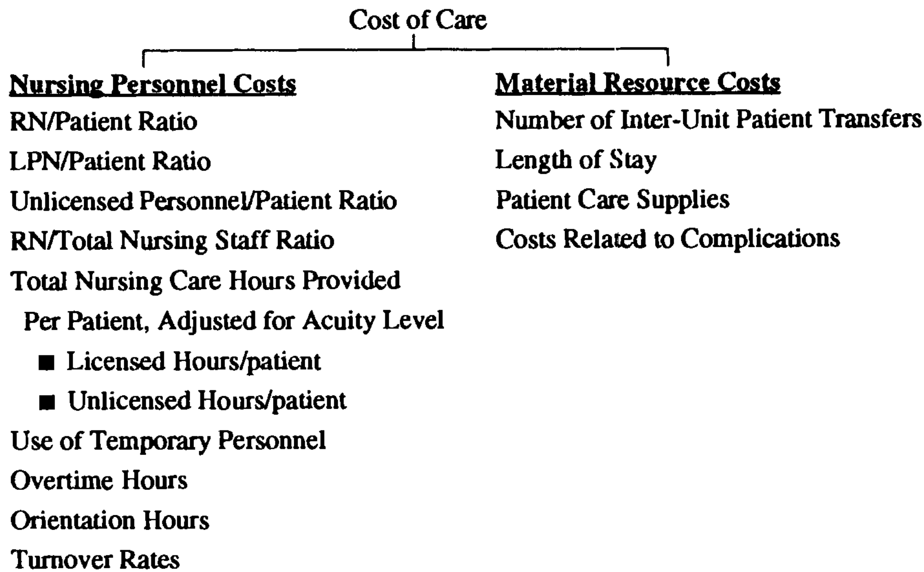


Figure 1. Conceptual Model (continued)

B. Cost of Care



Methods

The search for relevant work was directed towards an identification of research and/or evaluation studies using the ratio of licensed to unlicensed nursing personnel as the independent variable and patient quality of care indicators or cost of care as the dependent variable.

The search procedure incorporated published work, unpublished work and works-in-progress and included community-based, long term care and acute care settings. Published articles from 1988 to the present were sought via the following electronic databases: 1) CINAHL; 2) Health and ABInform; 3) World Cat; 4) HSTAR/HSTAT; 5) Dissertation Abstracts, and 6) Infotrac-General Business File and Expanded Academic ASAP. In addition, one journal, *Nursing Economics*, was hand-searched because of its potential relevance to this project. Using ancestry method, reference lists of relevant or related studies and review papers were examined to identify other related studies.

Search terms included but were not limited to: quality; quality/cost; licensed/unlicensed personnel; quality of health care and providers; quality of care and economics; quality of nursing care, cost of nursing care, cost control in health care, patient-focused care, labor costs in hospitals and statistical data; innovations/quality/cost; business process re-engineering/cost; quality of service; and health care/cost/quality personnel. Redundancy was used as the criterion for completeness.

Identification of Unpublished Work

In order to identify unpublished work, a call for information on the topic was published by the American Organization of Nurse Executives and the University Hospital Consortium Nurse Executive Council. This request for information was also sent to the deans of all nursing programs with a graduate school of nursing. An announcement regarding the nature of the project was made at several meetings on case management and nursing worklife research held in March 1995. Responses from these calls yielded a contact list of approximately 64 individuals. Each source was called personally and asked about the nature of their study involvement, the availability of results and additional referrals.

Other Resources

Deliberate efforts were made to contact individuals with a national perspective and/or knowledge of research initiatives outside of the nursing discipline. As a result, 14 different groups were contacted (See Table 1) via phone in an effort to expand the search to include interdisciplinary perspectives.

Table 1. Groups contacted to identify unpublished literature

American Nurses' Association
American Organization of Nurse Executives
American Organization of Operating Room Nurses
American College of Health Care Executives
Association for Health Services Research
Center for Health Policy Studies, Columbia, Maryland
George Washington University Center for Health Policy Research
National League for Nursing
National Multi-skilled Health Practitioner Clearinghouse
Patient-Focused Care Association, Inc.
The Advisory Board Company
State of New York, Work Force Demonstration Project Group
Strengthening Hospital Nursing Project
Voluntary Hospitals of America

Selection Criteria

Over 135 published and unpublished documents were individually examined for possible inclusion in this study. To be included in the study, documents had to contain (1) data from project evaluation or research; (2) a skill mix indicator that quantified the ratio of licensed/unlicensed nursing personnel; (3) patient-focused indicators of quality; and/or (4) a measure(s) of cost.

Characteristics of Sample

Seventeen documents met these criteria. Of these, sixteen were published, one was in limited distribution; ten were studies conducted by nurses; others were conducted by teams led by MBAs, pharmacists, economists, physicians and others. The studies were primarily conducted in acute care settings. One was conducted in a nursing home and one focused on intensive care units. Table 2 lists the sample articles, categorized by dependent variable.

Table 2. Articles included in the sample, categorized by dependent variable

Quality of Care	Quality of Care and Cost of Care	Cost of Care
Beck, 1995	Burruss et al., 1993	Eastaugh, 1990
Carter et al., 1988	Fritz & Cheeseman, 1994	Eastaugh & Regan-Donovan, 1990
Munroe, 1990	Helt & Jelinek, 1988	Garfink et al., 1991
	Kostovich et al., 1994	Glandon, Colbert & Thomasma, 1989
	Neidlinger, Bostrum, Stricker, Hild & Zhang, 1993	Lengacher et al., 1993
	Powers, Dicky & Ford, 1990	Pearson & Schwartz, 1991
	Tidikis & Strasen, 1994	
	Bostrum & Zimmerman, 1993	

Results

The research problems associated with studying the costing out nursing services and outcomes of care have been primarily addressed in studies about RN usage. Until recently, consideration of the use of unlicensed personnel has not been a primary concern to nursing. In fact, research evaluating new models of care, which include unlicensed assistive personnel as a variable, has been very limited (Bostrum and Zimmerman, 1993).

Independent Variable: Licensed/Unlicensed Personnel; Dependent Variable: Quality of Care

Studies in this section address the relationship between the mix of nursing staff and the quality of patient care from different measurement perspectives. Carter et al., (1988) monitored process of care indicators based on chart and care plan audits. While licensed and unlicensed personnel are listed as independent variables in this study, the authors report the RN/LPN ratio is the most significant predictor of changes in quality indices. As the proportion of LPNs increases, the quality of care decreases. In their conclusions, the authors cautioned that staff substitution should be done cautiously as patient acuity increases.

Munroe (1990) examined the effect of staff configuration on nursing home quality. She argued that although 71 percent of nursing home care is provided by unskilled personnel (Munroe citing IOM, 1986), care must be taken to increase the RN percentage within the skill mix in order to address increased patient complexity in long term care settings. She reported a significant positive relationship between the ratio of RN to LPN hours of care per resident day and facility quality. It is not clear how or if data were collected on any other staffing configuration. Munroe notes that she chose to accept a significance level of 0.10 or less because the project represents a new research area.

In 1995, Beck used a quasi-experimental, comparison group evaluation design to study a partnership relationship between registered nurses and an unlicensed provider, called a Patient Care Apprentice (PCA), in a hospital setting. By using a work sampling methodology, the researcher was able to document that nurses partnered with PCAs were able to perform a greater percentage of professional activities (assessment, planning coordination, patient education/support) (55%) than control nurses (32%). Control nurses reported more tasks that could be delegated (34%) compared to PCA partnered nurses (23%). Significance levels were not reported. Beck concluded that the use of unlicensed care partners increases the effective utilization of RNs by improving the amount of time RNs can spend on professional activities. Beck also reported the use of short structured interviews to evaluate patients' perceptions of quality. The results suggest an improvement in patient perception of quality due to increased time available for personal care and comfort interventions.

Burruss, Ashworth and Arikian (1993) report a study evaluating medication administration by unlicensed medication administration technicians (UMAT). Medication errors were used as a quality indicator. Based on 7,140 reported doses where RNs were responsible for 39 percent of the doses and UMATS responsible for the remaining doses, the RNs were responsible for 88 percent of reported errors or 11.38 times as many errors as UMATs. This difference was statistically significant ($p < .001$).

Fritz and Cheeseman (1994) evaluated the use of nurse extenders in critical care. This project decreased the RN staffing percentage from 100 percent to 75 percent through the addition of critical care technicians. Although no statistics were cited, they report "a positive trend in the quality indicators of pressure sore management and patient teaching" (p.329) and an improvement in patient/family satisfaction.

A pre/post-test randomized study to evaluate care delivery system redesign was conducted in a 600-bed tertiary care facility by Bostrum and Zimmerman (1993). The planned change included the introduction of certified nursing assistants; an increase in RN to patient ratio; the addition of an automated IV drug administration system; and the addition of LPNs to the night shift personnel. Frequency of incident reports was used as a proxy for changes in quality. There was no statistically significant difference between the frequencies of incident reports filed during the pre-and post-test three-month data collection periods. Each unit stayed well below or close to the hospital incident report average for the same time period. Patient satisfaction, a patient-focused outcome quality indicator in our conceptual framework, was also monitored before and after the redesign intervention. No statistically significant changes in levels of patient satisfaction were detected.

The implementation of a new type of unlicensed assistant, the clinical technician, in one agency was discussed by Kostovich, Mahneke, Meyers and Healy (1994). This new type of provider is a multiskilled worker functioning "at a more advanced level" (p.52). Success was measured using structural process indicators of quality. Following implementation, STAT blood work turnaround time improved 61 percent. In addition, the number of different hospital employees seen by patients decreased from 54 to 19 for a three-day period, thus, indicating evidence of streamlining hospital systems. Patients' overall ratings of satisfaction with nursing care rose from 66 percent to 73 percent.

Neidlinger, Bostrum, Stricker, Hild and Zhang (1993) evaluated a pilot project using a nonrandomized, control group, time series design to determine the effect of pairing nursing assistive personnel (NAP) with registered nurses in a university hospital with a resistant RN vacancy rate of 68 per month. Nurse compliance with standards for documenting patient care was the dependent variable. While statistical analysis data were not reported, the authors report essentially negative findings for indicators collected before the change and one year after. The experimental units reported a decline in compliance with documentation standards from 97 percent to 81 percent after implementation of NAPs. The control units averaged a compliance rate of 84 percent before and 87 percent afterwards. Patient satisfaction improved slightly from 92.9 to 95.6 on the experimental units. However, the control units stayed stable at the higher rating of 95.6.

The use of unlicensed assistants working in partnership with RNs was evaluated by Powers, Dickey, and Ford (1990) in the implementation of a RN/co-worker model in a university hospital setting. The MDAX Patient Classification System (*MDAX, Nursing Information Systems is a trademark of MDAX Corporation) was used to measure staffing and quality. When compared to the national database, the authors report a downward trend in quality indicators for care planning (9 point decrease), physical needs (12 point decrease), and documentation (21 point decrease). The scores for physical needs and documentation were 12 and 14 points below the national database scores. The decrease in documentation also was felt to be related to a hospital-wide change in its documentation system. No tests of statistical significance were reported.

The use of unlicensed and/or multiskilled personnel is often integrated within a workplace restructuring process known as "patient-focused care." Improving both quality and cost outcomes are the basic objectives of patient-focused care delivery models. However, it is difficult to evaluate the effectiveness of the changes in skill mix in this body of literature since these changes are usually taking place simultaneously with implementation of a variety of other structural changes.

A study by Tidikis and Strasen (1994) is representative of the type of data currently available from a patient-focused care implementation project using pre/post implementation satisfaction surveys. No statistical analysis data are reported. The patient satisfaction rate was essentially unchanged; 87 percent satisfaction in July 1992 and 88.6 percent in May, 1993. Other quality indicators included length of stay, which decreased from 7.1 to 6.6 days; total number of contacts with different staff members, which decreased from 50 to less than 20 per hospital stay; and a nosocomial infection rate of 2.9 in FY93 compared to 2.2 in FY94. This study also demonstrated a 5.6 percent increase in response rate to call lights and an improvement in the average time needed to administer the first dose of antibiotics (i.e., from 2.5 hours to <30 minutes).

An earlier study on quality by Helt and Jelinek (1988) claims that an increase in RN hours contributes to both quality and productivity but is not necessarily as expensive as salary costs suggest. Their conclusion was based on the results of four separate studies, conducted between 1983 and 1985, which used Medicus data from 46 to 72 hospitals. The researchers used length of stay (LOS) and the Medicus Nursing Productivity and Quality (NPAQ)* System to generate health care outcome measures. Although statistical analysis data were not included, they reported a decrease in LOS from 9.2 to 7.3 days even though there was a concurrent increase in patient acuity levels. Although the specific quality indicators used were not listed, Helt and Jelinek reported that quality scores for the six objectives of the Quality Monitoring Methodology showed consistent improvement across the time period with the percentage of scores improving greater than those staying the same or declining.

The literature reported in this section represents different types of quality indicators, staff configurations, measurement approaches and care settings. Based on data reported in this body of literature, it is impossible to draw a conclusion as to the impact of changing the ratio of licensed to unlicensed nursing personnel on quality of care

outcomes. It will continue to be difficult to generalize conclusions about how the use of licensed and unlicensed personnel impacts quality of care until research in each of these areas develops in quantity and depth.

Independent Variable: Licensed/Unlicensed Personnel; Dependent Variable: Cost of Care

Studies in this section address the relationship between the mix of nursing staff and the cost of delivering nursing care. Eastaugh's (1990) productivity study supports the claim that the use of nurse extenders can improve the utilization of RNs. He argues from essentially a personnel cost perspective and uses productivity measures to justify staffing changes. Of 29 hospitals studied, the five with the highest levels of productivity made extensive use of nurse extenders. In these cases the nurse extender/RN ratio ranged from .71 to .79 and did not vary by the type of nursing care delivery model that was in place.

In another study, Eastaugh and Regan-Donovan (1990) reported similar cost efficiency gains by adding nurse extenders to the staff mix. They reported a nursing budget reduction of 9.3 percent, even with a 12.5 percent RN salary increase, while achieving a 28 percent improvement in the amount of time spent on care tasks. These two studies acknowledge that organization of work is an essential co-variate along with skill mix in improving patient care. Huber, Blegen, and McCloskey (1994) suggest that Estaugh's conclusions need to be viewed cautiously since minor changes in the data analysis approaches used to analyze this type of data can result in different outcomes.

Garfink, Kirby, Bachman, and Stark (1991) evaluated implementation of a university hospital's nurse extender program and provided preliminary data on costs. Although no statistical data were reported, study units had lower average hourly wages than the control units while providing more hours of direct care. However, these savings were not realized because patient costs per day increased due to the impact of multiple other hospital variables.

Glandon, Colbert, and Thomasma (1989) examined costs related to the type of nursing care delivery model in place and skill mix. Team, modular, total patient care and primary care delivery models were compared using a variable set which included nursing dollars per patient day, RN dollars per patient day, nursing dollars per unit of workload, the percent of RN staff, average patient acuity level and number of beds. Cost comparisons of the four nursing care delivery models demonstrated statistically significant differences relative to nursing dollars per patient day and RN dollars per patient day. The primary care and total patient care units were the most expensive and had higher patient acuity levels. Team nursing units had the lowest costs per day and also had the lowest patient acuity levels. This study identified that specific variables (i.e., number of patient beds, reliance on registered nurses and type of nursing care delivery model) each had a significant influence on nursing labor costs. The results of this study may be confounded by interrelationships between and among a number of variables. Because differences in quality of care are not accounted for in this study, further research is needed to explain the relationship between nursing care delivery systems, quality and cost. The results of this study raise the question: Can an evaluation of personnel costs, in isolation, serve as an adequate indicator of economic efficiency?

Lengacher et al., (1993) looked at one model, Partners in Patient Care, to evaluate the effect of its implementation on personnel costs. Because this model is less RN dependent, the number of RN full-time equivalents (FTEs) can be reduced while increasing the number of unlicensed FTEs. They reported that the results of their study indicated the model was budget neutral since staffing changes in other departments allowed nursing to assume additional responsibilities and acquire additional FTEs.

Personnel cost savings due to conversion of RN positions to nursing assistant positions were examined by Pearson and Schwartz (1991) in an evaluation of the impact of implementing a primary practice partner model. They reported one hospital saved $832,688 in the first five months of 1991 and projected savings in excess of one million dollars when all conversions are completed. Savings were also reported as a result of decreases in orientation costs for nursing assistants versus those for registered nurses and to a decreased use of agency personnel and overtime.

Labor costs were also examined by Bostrum and Zimmerman (1993). Following introduction of certified nursing assistants, acuity adjusted costs per patient day on three units were reduced by $8, $13, and $88 for an annualized savings of more than $750,000. However, the authors qualified the $88 savings as being artificially large due to the introduction of additional staffing changes on the unit under study.

Burruss et al., (1993) gathered personnel expense data in their study of non-RN medication technicians. They considered hourly wage, shift differential, benefits and an adjustment for training and supervision costs for unlicensed medication administration technicians. Their analysis predicts an annualized savings of $174,136 for a 300-bed acute care medical-surgical facility with moderate patient acuity levels.

Fritz and Cheeseman (1994) evaluated the fiscal impact of changing the staff mix, in a critical care setting, from 100 percent RN to 75 percent RN and 25 percent nurse extender. When viewed from the perspective of personnel expenses, this change in staff mix is reported to be a "deliberate step towards cost savings" (p. 326). This staffing pattern, with concurrent task redefinition resulted in a reduction in hours per patient day from 22.4 to 19.3. Because their evaluation of cost implications are preliminary, actual cost savings are not reported.

The study by Helt and Jelinek (1988) was completed at a time when hospitals were reducing overall numbers of staff. However, since the RN category was reduced the least, the result was a skill mix with a higher RN/patient ratio. They reported that RNs, as a percentage of direct care staff, increased almost 10 percent in this time period. Furthermore, the authors claim that, because the RN performs the widest range of tasks, the change in skill mix explains a concurrent increase in productivity despite staff reductions. For example, even with RN's salary levels 75 percent higher than those of an LPN or aide, the increase to a 60 percent - 70 percent RN staffing level resulted in only a 5 percent increase in labor costs. Since the actual hours of nursing care per patient workload decreased from 4.1 to 3.7 (representing increased productivity), a 10 percent savings in nursing hours was realized. Statistical analysis of these data was not reported. Although Helt and Jelinek are reporting data from a time period not generally included in this study, it is included because it represents an example of a study that considers the impact of staffing on both productivity and cost.

Kostovich et al., (1994) reported outcomes associated with attempts to introduce a multiskilled worker into patient care units. For every job that was eliminated in a support department, two clinical technicians were added to the nursing unit. Because of the transition expenses involved and the difficulty experienced in re-aligning work responsibilities, hospital-wide implementation was discontinued. The authors predicted that it would take about two years following implementation of the clinical technician program for the hospital to achieve budget neutrality.

Unexplained increases in personnel costs per patient day occurred in both experimental and control units in a study by Neidlinger et al., (1993). Work sampling demonstrated that RNs spent more time performing treatment-related procedures and assessments following introduction of nursing assistive personnel (NAP). Provision of patient hygiene became the major activity of NAPs'. However, 21 percent of the NAPs' time was categorized as "idle"; this also has implications for cost. In general, the outcomes of this study were equivocal. The authors felt that perhaps the outcome measures were not sensitive enough to detect the direct impact of the intervention.

In a study by Powers et al., (1990), the initial cost implications of implementing an RN/co-worker model was based on the notion that one RN FTE could be converted to two nursing assistant positions. However, the occurrence of an increase in sick time hours, which was attributed to the non-professional co-worker group, required an increase in overtime and on-call hours in order to maintain adequate staffing complements. Also, because the study unit was staffed with the minimum number of RNs, any loss of RN time had to be covered with overtime or on-call hours. These factors resulted in additional unexpected personnel costs. However, with the addition of the co-workers, changes in workload hours made it possible for the average RN patient load to increase from four to six or seven. This translates to a financial savings in RN salaries. The authors also reported a significant cost benefit due to lost revenue avoidance (2.2 million dollars in six months) since, due to inadequate staffing, 13 beds would have been closed if the co-worker model had not been implemented.

Tidikis and Strasen (1994) report cost data for a patient-focused care unit introduced in a 211-bed community hospital. Training costs exceeded budgeted amounts by $47,000 for the first two units due to the extensive training needs of unlicensed staff. Labor costs (not broken out by nursing) after less than a full year of implementation, showed a 4 percent increase in FY93 as opposed to the anticipated 12 percent increase. They also report salaries, wages and benefits at 10 percent below budget for FY93.

The use of licensed and unlicensed nursing personnel and the exploration of more efficient work designs has been driven by economic forces in health care. This literature suggests that, in addition to personnel costs, there are more

complex factors to consider in future research in order to realize the cost savings potential associated with the introduction of changes in staff mix.

Additional Literature

In order to answer questions about the use and impact of unlicensed providers, research design methodology must address the measurement of quality, patient outcomes and nursing costs. Although not yet at an optimal level, research strategies to address each of these areas is progressing. This is demonstrated by a body of existing research on the impact of RN staffing on quality and cost. Although this literature, as exemplified by the studies summarized below, does not specifically address the use of nurse extenders, it informs our understanding of the issues surrounding an evaluation of the impact of changes in skill mix. It does this by addressing questionsgenerated from the perspective of evaluating the impact of the most highly skilled and knowledgeable nurse provider rather than the least skilled.

Hartz, Krakauer, Kuhn, et al. (1989) used regression analysis to study the association between hospital characteristics and the dependent variable, mortality, for 3,100 hospitals. They report significantly lower mortality rates ($p<0.01$) when a higher percentage of the total nursing staff are registered nurses. The independent variable is defined as the ratio of RNs to all nurses. For the hospitals included in this study, the RN population comprised 45 percent to 75 percent of all the nurses. It is unclear as to whether the term "all nurses" includes unlicensed nursing personnel.

Aiken, Smith, and Lake (1994) provide the most recent information in a study of mortality rate within magnet and non-magnet hospitals. This study was not included in the sample for this study because the skill mix ratios are not defined. However, the study does suggest that the relationship between RN staff levels and mortality is a function of a set of complex, interacting variables derived from organizational structure and nursing care delivery system.

In her review of the literature, Prescott (1993) identified several trends in research findings related to cost and quality. She cites the positive influence of RNs on decreased length of stay and on cost savings based on the outcomes of studies on case management, short staffing, discharge planning and increased percentages of RNs to total nursing staff. She also cites an extensive literature demonstrating nursing's impact on decreasing hospital mortality rates. Prescott concludes, "It is clear that nurse staffing levels and skill mix make a difference in the outcomes of hospitalized patients" (p. 196). What is lacking is a gold standard for skill mix in relation to patient outcome to guide staffing decisions.

Studies that demonstrate direct salary cost savings may be misleading because they fail to acknowledge the importance of staff changes in productivity and quality. Again, Prescott (1993) identifies a research trend that demonstrates how the use of RNs is economical when considered in light of broader models which include overall productivity, turnover, morale and patient outcomes.

Summary

This study demonstrates the sparseness of research literature which addresses how changes in the mix of licensed and unlicensed nursing personnel impact the quality and cost of nursing care. From a research perspective, redesign of the health care delivery environment is still relatively new since the current focus on designing and implementation change, and the pace of these changes does not lend itself to doing the type of in-depth, longitudinal research necessary to address these types of questions. Consequently, the available literature focuses, primarily, on single site implementation studies. As described in preceding sections of this report and summarized in Table 3, the results are equivocal for both dependent variables. Therefore, it is difficult to draw strong conclusions about the impact of changes in skill mix until additional studies are completed.

Three projects, currently underway, are of particular interest to this topic. The Strengthening Hospital Nursing Program, funded by The Robert Wood Johnson Foundation and by the Pew Charitable Trust, has encouraged the development of creative, collaborative health care redesign initiatives with a focus on quality and efficiency. This program, which funded 211 projects for one year and 20 in-depth projects for five years, will conclude in 1995. The results of these innovations will add to our understanding of nursing care delivery systems, staff configuration and outcome measurement.

Table 3. Summary of studies included in the literature review

Author	Independent Variable	Dependent Variable	Findings
A. Quality of Care			
Beck, 1995	Patient Care Apprentice (PCA) introduction	1. Performance of professional activities 2. Delegation of activities 3. Patient perception of quality	RNs partnered with PCAs had : 1. Higher % of professional activities performed by RNs 2. Decreased identification of additional delegatable activities 3. Increased perception of quality (No statistical significance data reported)
Burruss et al., 1993	Unlicensed Medication Administration Technicians (UMAT) introduction	Medication errors	Higher % of errors by RNs ($p < 0.001$)
Bostrum & Zimmerman, 1993	Certified nursing assistant introduction	1. Frequency of incident reports 2. Patient satisfaction	No statistically significant changes
Carter et al., 1988	Use of licensed and unlicensed personnel	Process of care -- as identified in chart and care plan audits	Most significant predictor was RN/LPN ratio; as the proportion of LPNs increased, quality decreased (No statistical significance data reported)
Fritz & Cheeseman, 1994	Critical care technician introduction	1. Pressure sore management 2. Patient teaching	Positive trend in pressure sore management and patient teaching (No statistical significance data reported)
Helt & Jelinek, 1988	Hours of direct care provided by RNs, LPNs, and Nurse Aides	1. Length of stay 2. Medicus quality indicators	1. Decreased length of stay associated with increased percent of RNs on direct care staff 2. Consistent improvement in quality scores (No statistical significance data reported)

Table 3 (cont.). Summary of studies included in the literature review

Author	Independent Variable	Dependent Variable	Findings
A. Quality of care (cont.)			
Kostovich et al., 1991	Clinical technician introduction	1. Turn around time re: STAT blood work 2. Number of personnel in contact with patient 3. Patient satisfaction	1. 61% improvement in turn around time 2. Number of personnel decreased from 54 to 19 in 3-day period 3. Increased patient satisfaction (No statistical significance data reported)
Munroe, 1990	Nursing staff configuration (ratio of RN hours per patient day to LPN hours)	Number of patient health related deficiencies	Positive relationship between quality and number of RN hours of care ($p < 0.10$)
Neidlinger et al., 1993	Nursing assistive personnel introduction	1. Compliance with standards for documenting care 2. Patient satisfaction	1. Decreased compliance 2. Slight increase in satisfaction (No statistical significance data reported)
Powers et al., 1990	Unlicensed co-worker introduction	1. Documentation of patient care 2. Patient satisfaction	1. Compliance rate declined from 97% to 81% on experimental units; slight increase on control units 2. Slight improvement in satisfaction on experimental units (from 92.9% to 95.6%) (No statistical significance data reported)
Tidikis & Strasen, 1994	Patient-focused care introduction	1. Length of stay 2. Number of personnel in contact with patient 3. Patient satisfaction 4. Nosocomial infection rate	1. Length of stay decreased from 7.1 to 6.6 days 2. Number of staff patient in contact with 3. No change in satisfaction 4. Infection rate decreased from 2.9 (FY93) to 2.2 (FY94)

Table 3 (cont.). Summary of studies included in the literature review

Author	Independent Variable	Dependent Variable	Findings
A. Quality of care (cont.)			
Tidikis & Strasen, 1994 (cont.)		5. Response rate to call lights 6. time required to administer first dose of antibiotics decreased from 50 to < 20 per day	5. 5.6% increase in response rate to call lights 6. Time to administer first dose decreased from 2.5 hours to < 30 minutes (No statistical significance data reported)
B. Cost of Care			
Burruss, 1993	Unlicensed Medication Administration Technicians (UMAT) introduction	Cost (hourly wages, shift differential, benefits, and training/supervision costs)	Predict annualized savings of $174,136
Estaugh, 1990	Nurse extender introduction	Productivity	Of 29 hospitals, the 5 with highest levels of productivity used nurse extenders
Estaugh & Regan-Donovan, 1990	Nurse extender introduction	1. Productivity 2. Cost savings	1. 28% increase in productivity 2. 9.3% budget reduction
Fritz & Cheeseman, 1994	Critical care technician introduction	Cost savings	Positive step towards cost savings (no data reported)
Garfink et al., 1991	Nurse extender introduction	Hourly wages	Lower wages on study units (no data reported)
Glandon et al., 1989	Type of nursing care model and skill mix	Cost (RN dollars /day, nursing dollars/unit of workload)	Primary care and Total Patient Care models more expensive than Team and Modular models ($p < 0.05$)
Helt & Jelinek, 1988	Hours of direct care provided by RNs, LPNs, and Nurse Aides	Labor costs	Increase in RN staff levels resulted in 10% savings in labor hours

Table 3 (cont.). Summary of studies included in the literature review

Author	Independent Variable	Dependent Variable	Findings
B. Cost of care (cont.)			
Kostovich et al., 1991	Clinical technician introduction	Labor costs	Will take 2 years to achieve budget neutrality
Lengacher et al., 1993)	Partners in patient care introduction	Personnel costs	Budget neutrality
Neidlinger et al., 1993	Nursing assistive personnel introduction	1. Labor costs 2. Productivity	1. Increased labor costs (unexplainable) 2. RNs spent more time performing treatment-related procedures and assessments; 21% of assistive personnel's time was "idle"
Pearson & Schwartz, 1991	Primary practice partner model introduction	Labor costs	Savings of $832,688 in 5 months
Powers et al., 1990	Unlicensed co-worker introduction	Labor costs: overtime and on-call hours, RN:patient ratio	1. Increased need for RN overtime and on-call hours due to sick time → increased costs 2. RN:patient ratio increase from 1:4 to 1:6 or 7 → decreased costs
Tidikis & Strasen, 1994	Patient-focused care introduction	Labor costs	8% decrease in costs

In 1993, the Congress of the United States, in response to hearings on nurse staffing in hospitals and nursing homes, directed that a study be done by the Institute of Medicine (IOM). This 22-month study focuses on the "overall question of the adequacy of the numbers and mix of nurses in hospitals and nursing homes" (IOM, Committee on the Adequacy of Nurse Staffing). Two papers have been commissioned by IOM to synthesize research in long term care, under the guidance of Drs. M. Mass and K. Buckwalter and in acute care settings, under the guidance of Dr. J. Verran. These results will not be available until the report is released (hopefully in 1996) (G. S. Wunderlich, personal communication, February, 1995).

The last project of particular interest is taking place in New York State. In 1990, a state authorized initiative, the Hospital Workforce Demonstration Project, provided three years of funding for studies in 25 different agencies. Many of these address cross-training, case management and redesign issues. Evaluation models include attention to cost, quality, productivity and outcomes. Unfortunately, these reports are not yet available (B. Balicki, R. Martiniano, personnel communication, March 1995). Additionally, in 1994, the State of New York initiated a new funding cycle in support of additional health care innovation projects that are also relevant to this topic.

The current re-engineering movement in health care is a popular and powerful management innovation which underscores the need to understand how skill mix impacts quality and cost of care. The difficulty in evaluating this innovation is described by McCloskey, Mass, et al., (1994). Innovations such as patient-focused care are often complex and poorly defined. They are often part of a system of changes so that the direct impact of one aspect, nursing, is difficult to capture. Since innovations are often introduced via implementation projects involving a few pilot units or a single institution, a large sample size is difficult to obtain. In summary, "studies are site specific, are not based on the results of prior research and do not employ experimental designs with controls to identify the effect of innovation" (McCloskey et al, 1994, p.41).

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Attachment D

Literature Review Report

Staff

Nancy Chornick, *Research Associate*

Relationship to Organization Plan

Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective D .... Provide for Member Board needs related to disciplinary activities.

Background

During the 1993 Delegate Assembly, a Literature Review Focus Group was formed as a result of a resolution submitted by the Washington State Board of Nursing. The charge to the focus group was: "...establish and maintain a central repository of reviews of literature of common nursing practice issues which bring nurses before Boards of Nursing for disciplinary action. In the first year, six reviews shall be produced and shall be available to Member Boards upon request."

The Focus Group met in spring 1994. Following the group's charge, members identified six common issues which the group believed were currently of concern to Member Boards. They are: 1) dishonesty/ethics, 2) abandonment, 3) abuse (physical/verbal), 4) sexual misconduct, 5) psychiatric disorders, and 6) practice outside of scope. The focus group compiled a summary report on the available literature as well as an analysis of the literature. Following this process, it was the consensus of the group that the literature reviews, per se, would not be a valuable resource to Member Boards because there is very little published literature on the discipline topics.

Information about the activities of other Member Boards regarding common practice issues, which bring nurses to their boards for disciplinary action, was identified by the group as the most useful type of information for Member Boards. However, this type of information is very time consuming for Member Boards to obtain.

In its report to the 1994 Delegate Assembly, the Literature Review Focus Group recommended that the National Council conduct a survey on Member Board actions, decisions, positions and opinions on the six common issues identified by the focus group and to request information on the common practice issues which bring nurses to their boards for disciplinary action. This recommendation was adopted by the 1994 Delegate Assembly.

Highlights of Activities

A survey requesting information on the six common issues identified by the focus group was sent to Member Boards during the first week of February 1995. Member Boards were requested to provide positions statements, board opinions, rules and regulations, policy statements, attorney general opinions and other documents which related to the topics. Member Boards were also asked to identify other disciplinary topics of current concern. The focus group felt that by asking about disciplinary topics about which Member Boards were currently concerned, that early identification of trends could be identified.

Completed surveys were received from 32 Member Boards. Two additional Member Boards reported that they were not able to respond due to time constraints. Information about the activities of 32 Member Boards regarding the six topics of concern is shown in the following table. The table indicates documents that pertain to the six topics of concern by state. Rules and regulations were the most frequently reported source of information for the six topics of concern. Position statements exist in all topics. The topic, 'Practice Outside of Scope,' contained the most varied scope of information ranging from specific methods of medication administration to decision-making models. An asterisk (*) indicates those documents that have been submitted to the National Council and are available upon request to Member Boards.

The foremost right column in the table lists those topics identified by Member Boards as being current concerns. Documents that have been developed regarding these topics are also listed. Nine Member Boards identified additional concerns. Only one topic, 'Felony Convictions,' was identified by more than one Member Board.

Conclusion

No future activities related to this project are anticipated. The report is submitted in its entirety.

LITERATURE REVIEW SURVEY RESULTS

Documents Related to Topics Identified by Focus Group							MB Identified Topics
State	Dishonesty/Ethics	Abandonment	Abuse	Sexual Misconduct	Psychiatric Disorders	Practice Outside Scope	*Topics of Current Concern/* Available Documents
AR	-	-	-	-	-	Policy Statement -IV conc sed.	-
AZ	NPA* R&R*	R&R* Board Opinion -Abandonment*	NPA*	-	NPA*	NPA* R&R* Board Opinion -Decision-making model*	-
CA-RN	Other* -Guide for Educational Programs on Ethics	Position Statement -Abandonment*	R&R* Policy Statement -Failure to report child abuse*	R&R* Other -Disciplinary Guidelines*	R&R* Other -Disciplinary Guidelines*	R&R*	-
CA-PN	R&R*	R&R*	R&R*	R&R*	R&R*	R&R*	-
CO	-	-	-	-	-	-	-
CT	-	Position Statement -Abandonment*	-	NPA*	NPA*	Declaratory Ruling -LPNs -RN 1st assistant -Advanced practice	-
FL	R&R*	R&R*	R&R*	R&R*	R&R*	R&R*	-
GA-PN	-	R&R*	R&R*	-	R&R*	-	-
IA	R&R* Other -Ethics statement for board members	-	-	-	-	Other -Delegation to UAPs in community settings	-

[1] A listing of available opinion statements, by topic, is available.

* Indicates that the document is available from the National Council

Documents Related to Topics Identified by Focus Group							MB Identified Topics
State	Dishonesty/Ethics	Abandonment	Abuse	Sexual Misconduct	Psychiatric Disorders	Practice Outside Scope	*Topics of Current Concern/* Available Documents
ID	R&R*	R&R* Policy Statement -Abandonment*	R&R*	R&R*	R&R*	R&R*	-
IL	-	-	-	-	-	-	-
KY[1]	-	Board Opinion -Responsibility & accountability of nurses*	-	-	-	-	-
MD	R&R*	Policy Statement -Abandonment*	-	-	-	-	*School Health Nursing* Guidelines*
ME	R&R*	R&R* Position Statement -Abandonment*	R&R*	R&R*	R&R*	R&R*	
MN	-	-	-	-	-	-	-
MO	Position Statement -Participation in capital punishment*	-	-	-	-	Board Opinions	*Teaching UAPs Nursing Functions* Position Statement - Delegation to UAPs*
MT	R&R*	R&R*	R&R*	R&R*	R&R*	R&R*	-
ND	Other -Conflict of interest policy	Position Statement -Temporary resignment policy	-	-	-	-	*Duty to Report*
NE	-	Position Statement -Abandonment*	-	-	-	-	-
NM	-	R&R*	-	R&R*	-	R&R*	-

[1] A listing of available opinion statements, by topic, is available.
* Indicates that the document is available from the National Council.

Documents Related to Topics Identified by Focus Group							MB Identified Topics
State	Dishonesty/Ethics	Abandonment	Abuse	Sexual Misconduct	Psychiatric Disorders	Practice Outside Scope	*Topics of Current Concern/* Available Documents
NV	R&R*	Other -Newsletter Article*	R&R*	R&R*	-	R&R*	-
OH	R&R*	R&R*	R&R*	R&R*	R&R*	R&R*	*Verbal Abuse*
OR	R&R* Position Statement -Criminal conviction*	R&R* Position Statement - Abandonment*	R&R*	R&R*	R&R*	R&R* Declaratory Ruling -UAP role in school setting	*Boundary Issues*
PA	-	-	-	-	-	-	*Mental/Physical Health Challenges*
SD	Other -Ethics self-study learning module used in disciplinary cases (RN&PN)*	Other -Informal position to guide actions on disciplinary complaints*	-	R&R*	-	Other -Practice decision-making model*	*Felony Convictions*
TN	R&R*	R&R*	R&R*	R&R*	NPA*	R&R*	*Licensure Applicants with Convictions*

A listing of available opinion statements, by topic, is available.

* Indicates that the document is available from the National Council

Documents Related to Topics Identified by Focus Group							MB Identified Topics
State	Dishonesty/Ethics	Abandonment	Abuse	Sexual Misconduct	Psychiatric Disorders	Practice Outside Scope	*Topics of Current Concern/* Available Documents
TX-RN	R&R* AG opinions	R&R*	R&R*	R&R*	R&R*	Position Papers -PAs* -RNs* -Education mobility* -Standing orders* -Epidural & intrathecal medication* -IV conscious sedation* -Laser therapy* -Board jurisdiction* -Delegated medical acts* -DSM-III (R) diagnoses* -School nurse* R&R* AG opinions	-
TX-PN	-	Position Statement -Abandonment*	-	-	-	Position Statement -General statement* -IV therapy* -Epidural catheter*	-
UT	R&R*	-	-	R&R*	-	-	-
WI	R&R*	Board Opinion -Abandonment*	R&R*	R&R*	R&R*	R&R* Position Statement -Medication administration by UAPs*	*Delegation* Position statement -Delegation*
WV	R&R*	R&R*	R&R*	R&R*	R&R*	R&R* Position Statements	*Impaired Nurse* Position Statement -Impaired nurses*
WV-PN	R&R *	R&R*	R&R*	-	-	Policy Statements -Guidelines*	-

[1] A listing of available opinion statements, by topic, is available.
* Indicates that the document is available from the National Council.

6

EXAMINATION COMMITTEE

Report of the Examination Committee

Committee Members

Paulette Worcester, IN, Area II, *Chair*
Susan Boone, OH, Area II
Betty Clark, ME, Area IV
Cora Clay, TX-VN, Area I
Constance Conell, AZ, Area I
Belle Cunningham, AK, Area I
Louisa Gomez, CA-RN, Area I
Renatta Loquist, SC, Area III
Carol McGuire, KY, Area III
Milene Megel, NY, Area IV
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Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B........ Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation(s)

1. That the Delegate Assembly adopt the proposed revisions of the *NCLEX-PN™ Test Plan* (Attachment A).

Rationale

A subset of the Examination Committee (EC) reviewed the results of the 1993-94 PN Job Analysis. Empirical evidence provided by the Research Department from job incumbents, the professional judgment of the committee members in collaboration with National Council and Educational Testing Service (ETS) staff and legal counsel, a survey of Member Boards regarding PN/VN practice, and feedback from Member Boards, garnered through survey and Area Meeting reports, supports revision in the *NCLEX-PN™ Test Plan* (Attachment A).

Implementation Timing for New *NCLEX-PN™ Test Plan*

After consulting with ETS and legal counsel, the committee determined that the new *NCLEX-PN™ Test Plan* could be implemented no sooner than October 1996. This timeline would enable the National Council, Member Boards and ETS to effectively plan for and communicate the *NCLEX-PN™ Test Plan* changes to all appropriate individuals and agencies. In addition, this timeline will enable a Panel of Judges to use the newly approved *NCLEX-PN™ Test Plan* in its criterion-referenced standard setting process in February 1996. Any changes in the PN/VN passing standard will be implemented with the test plan change. This timeline will allow information about a new PN/VN passing standard to be communicated to all the relevant individuals and agencies.

Highlights of Activities

Item Development

- **Developed and Monitored Policies and Procedures**

  The committee reviewed, revised and monitored the effectiveness of numerous new examination-related policies and procedures which were revised and developed particularly for computerized adaptive testing (CAT) in the interim proceeding CAT implementation.

- **Conducted Committee Item Review Sessions**

  Of particular interest to the committee was the desire to preserve consistency in the manner in which NCLEX™ items are reviewed before becoming operational. Previously, all newly developed items and one-fourth of the existing item pools have been reviewed by the committee each year over five meetings. To accommodate the large numbers of new items being produced, initially the committee formed small groups of three or four members with one National Council staff and one or two ETS staff to review items. Later in the year, the committee decided to review items only after they have been tried out and carry accompanying statistics, and to do so at its May meeting. The committee expects this change in item review to enhance the consistency of the process.

- **Evaluated Item Development Process and Progress**

  The committee evaluated the ETS item writing and item review sessions for process and productivity. From July 1994 through March 1995, RN item writers produced 1,428 items and PN item writers produced 2,037 items. From July 1994 through March 1995, RN item reviewers approved 1,594 items and PN item reviewers approved 1,424 items. Although the number of items produced by panel members is somewhat less than estimated by ETS, the committee noted improvement in the quality of tryout items over the course of the year. Committee representatives monitored 18 of the 20 item development sessions. Feedback was provided to ETS and improvement in the item development sessions was noted.

  From August 1994 to July 1995, the committee made 271 appointments to the NCLEX test development panels and twelve appointments to the RN Standard Setting Panel of Judges. This is the largest number of appointments made to item development panels since the inception of the current item development process in 1985. To improve the recruitment of NCLEX panel members and reduce the workload of Member Boards, the National Council continues to process NCLEX panel applicants and solicit Member Board approval of applicants prior to contacting the applicant to serve at a session.

  To facilitate the item development process, the committee reviewed and approved revised *Guidelines for NCLEX-RN™ Item Writers* and *Guidelines for NCLEX-PN™ Item Writers*, and approved additions to the Operational Definitions during the Item Review section of each meeting.

  As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX items and examinations. For example, the committee reviewed RN and PN items that were designated by Member Boards as inconsistent with state statutes and/or not reflective of entry-level practice. The

committee directed ETS to develop a cumulative list of those concepts which were designated as inconsistent with state statutes.

Psychometric Issues

■ **Monitored Examination Analysis**

The committee periodically evaluated the NCLEX by reviewing ETS reports on item and candidate performance, including item exposure rates, overlap among the items seen by different candidates, non-test-plan content coverage, questioned or challenged items, precision of competence estimates and pass/fail decisions, and passing rates and examination-completion rates for many subgroups of candidates. These reports support that the NCLEX meets National Council and industry-wide quality standards.

■ **Monitored the Operational Item Pools**

The committee monitored the process for the configuration and implementation of two parallel RN and PN item pools. After consideration of the implications of quarterly vs. semi-annual rotation of item pools, and review of research reports pertaining to creating the item pools based on simulations conducted by ETS, the committee decided that both the RN and PN pools be rotated semi-annually for the period of April 1995 through March 1996, as they were during the first year of CAT. Discussion was held regarding methods to change pools at all sites at the same time, and the determination was made to suspend testing for a few days while the pools are rotated. The committee affirmed that no candidate will test with the previous pool on or after the designated item pool rotation date.

■ **Monitored Differential Item Functioning**

The committee reviewed reports from ETS regarding differential item functioning (DIF) analyses and of the DIF Panel convened to review items flagged by the statistics. Concern was expressed about the number of items which could not be evaluated for DIF due to the small number of candidates being administered some items, and the complicating factor of missing ethnicity/gender information for almost one third of the candidates, due to differing application methods and data transmittal used by Member Boards. Two optional questions, one on ethnicity and one on gender will be added at the end of the examination and before the Candidate Exit Evaluation to solicit demographic data from each candidate. DIF analyses are used to detect potential item bias and to remove differentialing content not directly related to assessment of nursing competence.

NCLEX Administration

■ **Monitored Procedures for Longitudinal Candidate Tracking; Candidate Matching Algorithm**

As there have been individual cases of candidates being able to elude the matching algorithm and test more frequently than is allowed, and test without previous items being blocked, the committee worked with ETS to remedy the problem. An automatic rematch procedure was implemented in January 1995 as well as new procedures for handling missing Social Security numbers and dates of birth.

The data system has also been changed to edit incoming data more stringently such as reasonableness of birth and graduation dates, and zip code-state correspondence. In addition, the committee determined that whenever a registration form sent to ETS does not contain data for the required (as stated in Candidate Bulletin), that registration will be rejected until the missing data is obtained by ETS.

When implementing the automatic re-matching system, it was discovered that the MBOS system did not correctly count an individual candidate's examination attempts for those candidates who were repeating the computerized adaptive NCLEX. This problem was communicated to ETS and has been remedied. The status and effectiveness of the candidate matching algorithm will be a standing agenda item for the Examination Committee.

■ **Directed MBOS Fixes and Enhancements**

As Member Boards, committee members, National Council staff and ETS staff identify problems with the MBOS system, or enhancements which would improve the ease of use and accuracy, these recommendations are submitted to the Examination Committee for action. National Council keeps a running list of the fixes/

enhancements requested prioritizes the requests, and asks ETS staff to estimate the cost of each enhancement (if any), and the date that the enhancement could be implemented. Each request is also considered with respect to its effects on non-MBOS boards. Requests are fulfilled based on priority and available funds.

- **Monitored Electronic Irregularity Reports and Site Compliance**

  The committee reviews Electronic Irregularity Report (EIR) data, site compliance reports filed by Member Boards and National Council staff as well as written or telephone complaints from candidates, Member Boards, schools of nursing, legislators, and other stakeholders to determine if the Sylvan Learning Systems (SLS) sites are in compliance with existing procedures and security requirements.

  Based on this information, the committee has directed additional compliance investigation at one site and has closely monitored the progress of the start-up of the testing centers in the island jurisdictions. Testing was interrupted for a period of time at the Virgin Islands sites, and has not yet begun in American Samoa. The committee has made recommendations to ETS and SLS to ensure site compliance.

- **Monitored Testing Compliance According to the Americans with Disabilities Act (ADA)**

  The committee approved a policy to route all approved requests for ADA modifications to one individual at the SLS National Registration Center (NRC) so that these candidates can be carefully monitored to prevent scheduling noncompliance or legal complaints. This has provided more consistency in the scheduling of candidates and the provision of modifications as requested, and the committee hopes to further improve on these processes in the coming year.

- **Facilitated Development of SLS Quality Assurance Plan**

  A subcommittee of the examination committee met three times this year by conference call to assist in the development and refinement of a comprehensive quality assurance plan for Sylvan Corporate and its test centers as relates to NCLEX administration. In addition, the subcommittee held a meeting by conference call to develop and evaluate NCLEX Administration Stabilization Criteria as directed by the Board of Directors, which was subsequently approved by the total committee at its May meeting.

- **Considered Requests for Candidate Rescheduling Policy Change**

  At the requests of several Member Boards and candidates, the committee re-examined the issue of the three-day reschedule policy at each of their meetings. After much discussion, the committee decided to maintain the current policy which states that changes in appointments can be made up to three business days in advance of the appointment by calling the local test center or the 800 number. Changes made less than three business days in advance of the appointment will result in forfeiture of the registration fee. This policy will be considered again at the committee's July meeting.

Future Considerations

Large scale item development will continue for FY96 to move toward the creation of three optimal NCLEX-RN™ and NCLEX-PN™ item pools. Using the CAT Master Plan and the work of the CAT Evaluation Task Force as guides, the committee will contribute to the evaluation of all aspects of the NCLEX. The finalization of a comprehensive quality assurance plan for SLS, further improvements in procedures for meeting the needs of ADA candidates, separation of the PN/VN *Quarterly Reports* by type of degree awarded, further enhancements to MBOS, improvement in the quality of the candidate database, and the accuracy of the matching algorithm remain high priority items for the committee in the coming year.

Meeting Dates

- October 23-28, 1994
- December 8-13, 1994
- February 10-15, 1995
- March 10, 1995, *telephone conference call*
- May 7-12, 1995
- July 7-12, 1995

Recommendation(s)

1. That the Delegate Assembly adopt the proposed revisions to the *NCLEX-PN™ Test Plan (Attachment A).*

Attachments

A ....Proposed Revisions to the *NCLEX-PN™ Test Plan, page 6*

Attachment A

Test Plan for the National Council Licensure Examination for Practical Nurses NCLEX-PN™

Entry into the practice of nursing in the United States and its territories is regulated by the licensing authorities in the jurisdictions. Each jurisdiction requires a candidate for licensure to pass an examination that measures the minimum competencies needed to perform safely and effectively as a newly licensed entry-level practical nurse. An entry-level practical nurse is defined as a newly licensed practical nurse who has been employed for six months or less. Throughout this document the term "practical nurse" will be used to denote a licensed practical and/or vocational nurse. *The National Council Licensure Examination for Practical Nurses (NCLEX-PN™)* developed by the National Council of State Boards of Nursing, Inc., is the examination used by those jurisdictions whose boards of nursing are National Council members.

The initial step in developing the NCLEX-PN is preparation of the test plan to guide selection of content and behaviors to be tested. The plan provides for an examination reflecting entry-level nursing practice as identified by the *1994 Job Analysis Study of Entry Level Licensed Practical/Vocational Nurses* (Chornick, Yocom and Jacobson, 1994). The activities identified in the job analysis study were analyzed in relation to the frequency of their performance, their impact on maintaining client safety and the various settings where they were performed.

This analysis resulted in the identification of a framework for entry-level performance that incorporates the nursing process and specific client needs. The basic framework is similar to that used in the test plan for the *National Council Licensure Examination for Registered Nurses (NCLEX-RN™)*, which reflects the continuum of nursing practice. The NCLEX-PN Test Plan is distinguished from the NCLEX-RN Test Plan by the scope of practice as defined by member jurisdictions, by the practical nurse job analyses, and by the tested levels of cognitive abilities. The test plan derived from this framework provides a concise summary of the content and scope of the examination, and serves as a guide for candidates preparing to take the examination as well as for those individuals involved in its development.

Based on the test plan, each NCLEX-PN examination reflects the knowledge, skills, and abilities essential for application of the nursing process to meet the needs of clients with commonly occurring health problems having predictable outcomes. The following sections describe beliefs about nursing and clients, the levels of cognitive ability that will be tested in the examination, definition of terms, and the specific components of the NCLEX-PN Test Plan.

Beliefs

Beliefs about the nature of people and nursing underlie the test plan. The profession of nursing has a unique concern toward helping clients to achieve an optimal state of health. The client is an individual in need of assistance that involves the maintenance of life and promotion of health, coping with health problems, adapting to or recovering from the effects of disease or injury, and/or supporting dying with dignity. People are viewed as finite beings with varying capacities to function in society. They are unique persons defining their own systems of daily living which reflect values, lifestyles, and culture. Additionally, individuals are viewed as having the right to make decisions regarding their health care needs and to participate in meeting those needs.

The nature of nursing is dynamic and evolving. Nursing is perceived as deliberate action of a personal and assisting nature. The goal of nursing is to promote health and to assist individuals in attaining an optimal level of functioning. To assist individuals in attaining an optimal level of health, nurses respond to the needs, conditions, or events that result from actual or potential health problems (American Nurses' Association, 1981). The domain of nursing and the relevant

knowledge, skills and abilities exist along a continuum and are organized and defined by professional and legal parameters.

Practical nurses "utilize specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 1991). The practical nurse collects and organizes relevant health care data and assists in the identification of the health needs/problems of clients throughout the clients' life span and in a variety of settings. In addition, the practical nurse, under appropriate supervision, contributes to planning nursing interventions to meet identified client needs and participates in evaluating the extent to which identified outcomes are achieved. The practice of practical nursing requires essential knowledge of: (1) the phases of the nursing process; (2) the coordination of a safe and effective care environment; (3) the physiological integrity needs of a client; (4) the psychosocial needs of a client; and (5) the promotion and maintenance of health.

Levels of Cognitive Ability

The examination includes test questions at the cognitive levels of knowledge, comprehension, and application (Bloom et al., 1956).

Definition of Terms

Client .... an individual within a family and/or group

Essential .... fundamental, basic, initial and/or necessary

Framework .... a systematic set of relationships

Nursing diagnosis .... a classification of client needs and/or problems according to presumed natural relationships, e.g., use of North American Nursing Diagnosis Association (NANDA) approved nursing diagnosis

Practical nurse .... a licensed practical and/or vocational nurse

COMPONENTS OF THE TEST PLAN

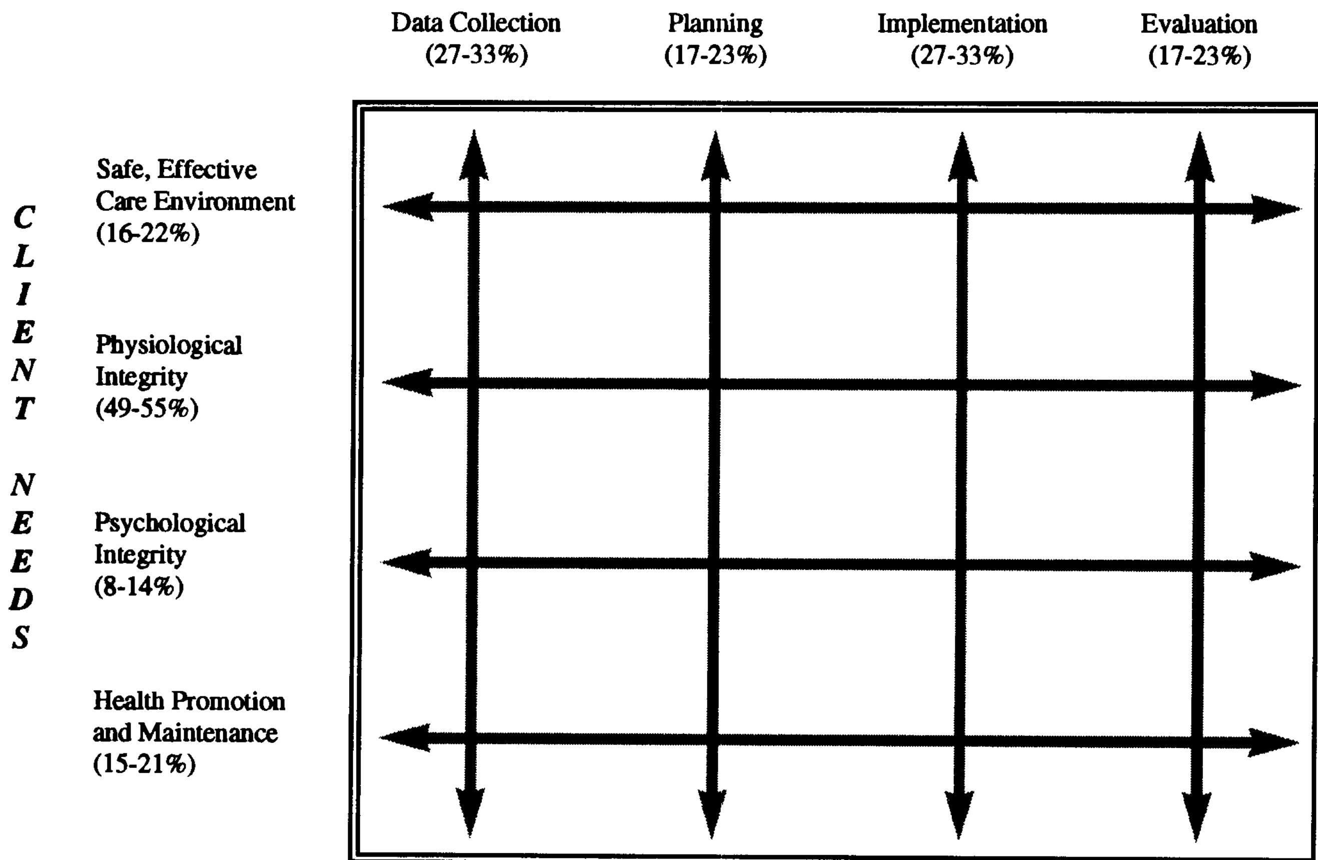
Within the framework of the test plan, two components are addressed:

1) Phases of the Nursing Process
2) Client Needs

These two components are detailed in this publication.

STRUCTURE OF TEST PLAN

The following grid illustrates the inter-relatedness of the two test plan components. Each examination question represents a phase of the nursing process (component #1) and a client need category (component #2).



The percentage of test questions in the client needs categories and phases of the nursing process categories is based on an analysis of the results of an LPN/LVN job analysis study completed in 1994 (Chornick, Yocom & Jacobson, 1994).

Phases of the Nursing Process

The practical nurse uses the following four phases of the nursing process: data collection, planning, implementation and evaluation. The practical nurse acts in a more dependent role when participating in the planning and evaluation phases of the nursing process and acts in a more independent role when participating in the data collection and implementation phases of the nursing process.

The four phases of the nursing process include:

I. Data collection: Participate in establishing a data base.

A. *Gather information relative to the client:*
- Collect information from the client, significant others, and/or health care team members; and current and prior health records.
- Recognize significant findings.
- Determine the need for more information.

B. *Communicate information gained in data collection:*
- Document findings thoroughly and accurately.
- Report findings to relevant members of the health care team.

C. *Contribute to the formulation of nursing diagnoses:*
- Assist in organizing relevant health care data.
- Assist in determining significant relationships between data and client needs and/or problems.

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

A. *Assist in the formulation of goals of care:*
- Participate in the identification of nursing interventions required to achieve goals.
- Communicate client needs that may require alteration of the goals of care.

B. *Assist in the development of a plan of care:*
- Involve the client and health care team members in selecting nursing interventions.
- Plan for the client's safety, comfort and maintenance of optimal functioning.
- Select nursing interventions for delivery of client's care.

III. Implementation: Initiate and complete actions necessary to accomplish the defined goals.

A. Assist with organizing and managing the client's care:
- Implement the established plan of care.
- Participate in a client care conference.

B. *Provide care to achieve established goals of care:*
- Use safe and appropriate techniques when administering client care.
- Use precautionary and preventive interventions in providing care to client.
- Prepare client for procedures.
- Institute nursing interventions to compensate for adverse responses.
- Initiate life-saving interventions for emergency situations.
- Provide an environment conducive to attainment of goals of care.

- Provide care in accordance with client's needs and/or preferences.
- Encourage client to follow a treatment regime.
- Assist client to maintain optimal functioning.
- Reinforce teaching on principles, procedures and techniques for maintenance and promotion of health.
- Monitor client care provided by unlicensed nursing personnel.

C. *Communicate nursing interventions:*
- Record actual client responses, nursing interventions and other information relevant to implementation of care.
- Provide complete, accurate reports on assigned client(s) to relevant members of the health care team.

IV. Evaluation: Participate in determining the extent to which goals have been achieved and interventions have been successful.

A. Compare actual outcomes with expected outcomes of client care:
- Assist in determining the client's response to nursing care.
- Assist to identify factors that may interfere with the client's ability to implement the plan of care.
- Assist to determine the extent to which identified outcomes of the care plan are achieved.

B. *Communicate findings:*
- Document client's response to care, therapy, and/or teaching.
- Report client's response to care, therapy, and/or teaching to relevant members of the health care team.

Client Needs

The four categories of client needs are described as follows:

A. Safe and Effective Care Environment.

The practical nurse participates as a member of the health care team to meet the client's need for a safe and effective care environment by providing nursing care that meets the following client needs:

- **Coordinated care** - collaborate with other health care team members to facilitate integrated client care, including activities related to ethical and legal issues.
- **Environmental safety** - assist in managing the health care delivery setting to protect clients and health care personnel.
- **Safe and effective treatments and procedures** - prepare and/or care for clients undergoing diagnostic procedures and various therapies.

Knowledge, Skills and Abilities

To meet the client's need for a safe and effective care environment, the practical nurse should possess essential knowledge, skills, and abilities that include, but are not limited to, the following:

- Advance directives
- Communication skills
- Confidentiality
- Continuity of care
- Environmental and personal
- Expected outcomes of various treatments
- General and specific protective interventions
- Informed consent
- Knowledge and use of equipment used to provide nursing care
- Legal accountability
- Quality assurance
- Client rights
- Spread and control of infectious agents
- Team participation

B. Physiological Integrity.

The practical nurse participates as a member of the health care team by providing nursing care to meet the physiological integrity needs of clients with acute and chronic health problems that occur throughout the life span and have predictable outcomes. The practical nurse assists the authorized health care provider in caring for clients with more complex health problems. The practical nurse provides nursing care that meets the following client needs:

- **Physiological adaptation** - provide care during the acute and chronic phases of existing conditions, including emergency situations.
- **Reduction of risk potential** - reduce the client's potential for developing complications and/or health problems, including monitoring changes in client status and the administration of medications.
- **Provision of basic care** - assist the client to perform activities of daily living including those that have been modified because of health deviations.

Knowledge, Skills and Abilities

To meet the client's need for physiological integrity, the practical nurse should possess **essential** knowledge, skills and abilities that include, but are not limited to, the following:

- Activities of daily living
- Basic pathophysiology
- Body mechanics
- Comfort interventions
- Effects of immobility
- Emergency interventions
- Expected response to therapies
- Fluid balance
- Invasive procedures
- Medication administration
- Normal body structure and function
- Nutritional therapies
- Pharmacological actions
- Skin and wound care
- Use of special equipment

C. Psychosocial Integrity

The practical nurse participates as a member of the health care team to meet the client's need for psychosocial integrity throughout the life span by providing nursing care that meets the following client needs:

- **Psychosocial adaptation** - provide for needs of the client with emotional and mental health problems.
- **Coping/Adaptation** - promote the client's ability to cope, adapt and/or problem solve situations related to illness, injury, or stressful events.

Knowledge, Skills and Abilities

To meet the client's need for psychosocial integrity, the practical nurse should possess **essential** knowledge, skills and abilities that include, but are not limited to, the following:

- Behavior norms
- Chemical dependency
- Common treatment modalities
- Cultural, religious and spiritual influences on health
- Mental health concepts
- Therapeutic communication

D. Health Promotion and Maintenance

The practical nurse participates as a member of the health care team to meet the client's need for health promotion and maintenance throughout the life span by providing nursing care that meets the following client needs:

- **Growth and development through the life span** - assist the client through the stages of normal growth and development.
- **Self-care and support systems** - (1) promote client self-care; (2) provide support to families in order to enhance client care; and (3) reinforce teaching related to self-care.
- **Prevention and early treatment of disease** - provide for the needs of the client in the prevention and early detection of health problems and disease.

Knowledge, Skills and Abilities

To meet the client's need for health promotion and maintenance, the practical nurse should possess essential knowledge, skills and abilities that include, but are not limited to, the following:

- Community resources
- Concepts of wellness
- Death and dying
- Disease prevention
- Growth and development through the life span
- Human sexuality
- Parenting
- Principles of immunity
- Reproductive cycle
- Teaching appropriate to the scope of practice

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7

REPORT OF
TEST SERVICES

Report of Educational Testing Service/Sylvan Learning Systems

Introduction

April 1, 1995, marked the one-year anniversary of NCLEX™ using computerized adaptive testing (CAT). Overall, the move to CAT has been very successful, a compliment for the Members Boards and the National Council. The number of major problems encountered has been minimal considering the testing volume. The retest rate is less than 0.05 percent of all candidates tested. Reasons for retest are attributable to human errors, acts of nature such as loss of electrical power during a storm, and hardware/software malfunctions. In all cases, candidates are offered retests as quickly as possible.

Though challenges and surprises are still present, daily testing via computer has become relatively routine for candidates. There has been a noticeable change in the level of understanding of CAT methodology of candidates calling the ETS 800 telephone number. Whereas a year ago candidates typically called ETS to question the methodology of CAT and its fairness, now they are calling more with logistical questions.

From the viewpoint of ETS and Sylvan, Members Boards have made a remarkable adjustment to the demands that daily testing have brought to their offices. The Member Board Office System (MBOS) Hotline, which one year ago had regular and heavy volume, now sits idle waiting for the few calls that are received weekly. ETS and Sylvan receive relatively few inquiries per week from Member Boards about candidate concerns.

Over 200,000 nurse licensure candidates have now taken NCLEX using CAT. However, despite the overall volume, the number of foreign-educated candidates who have tested, particularly in the large volume states of New York and California, has fallen far short of the predicted numbers based on historical volume. Explanations for this vary, with the most plausible, perhaps, being lack of job opportunities for these candidates.

ETS and Sylvan staff have enjoyed working with the members of the former Examination Committe-Team One and Examination Committee-Team Two, as well as the current Examination Committee members. The issues discussed at each meeting have clarified the challenges in designing and implementing a new testing program. The committees' members have provided sound advice, encouragement, and support.

Candidate Bulletins

The *NCLEX™ Candidate Bulletin* was revised and approximately 250,000 copies were distributed to Member Boards in late December 1994 and early January 1995. On the basis of input obtained at last year's Area Meetings and discussions with the Examination Committee, information was combined for PN/VN and RN candidates into one bulletin for 1995. The listing of education program codes for PN/VN and RN programs was printed as a separate document that will enable revisions more often. Extra registration forms and envelopes were also sent to each Member Board.

Scheduling and Taking Your NCLEX™, the bulletin sent by ETS to candidates along with the Authorization to Test, has been revised and will be printed in late spring 1995. Based on input from Member Boards, the Examination Committee, and National Council staff, this bulletin has been expanded to include new sections on results reporting, questions about a candidate's test session, and information on the methodology of computerized adaptive testing for the NCLEX. Copies of the revised bulletin will be provided to each Member Board and the National Council.

Joint Research Committee

The purpose of the Joint Research Committee (JRC) is to sponsor research to address current NCLEX operational issues as well as long-term research issues related to further improving testing for NCLEX and other related computer-based testing programs. The first meeting of the Joint Research Committee took place on December 10, 1994. The committee is composed of eight members, three each representing the National Council and ETS, and two external researchers jointly selected by the National Council and ETS. Dr. Suzanne Lane from the University of Pittsburgh and Dr. Gage Kingsbury from Portland Public Schools are the 1994-1995 external members. Representing the National Council are Ellen Julian, Carolyn Yocom, and Anthony Zara while Eric Bradlow, Linda Waters, and Denny Way are representing ETS.

Two JRC research projects are currently in progress and scheduled to be completed by late June 1995: standard setting research and item calibration research. In addition, a proposal for a study to investigate factors that affect item difficulty was submitted to the JRC and will be funded. National Council and ETS staff are in the process of writing proposals for two additional research projects. One of these projects will investigate alternative pass/fail decision rules

for candidates who run out of time before completing the NCLEX. A second project proposal will examine methods of detecting unusual (or aberrant) item responses on CAT. Plans for the second meeting of the JRC are currently underway. This meeting will take place in June or July in Princeton, New Jersey.

NCLEX™ Program Reports

The first edition of the *NCLEX™ Program Reports* was produced and mailed to 560 educational program subscribers in two cycles: at the end of December 1994 and, for late subscribers, at the end of January 1995. (The *NCLEX™ Program Reports* replace the CTB Summary Profiles in providing information to nursing programs about performance of their candidates on the NCLEX.) The first production cycle covered the period of April through September 1994.

The second edition of program reports, mailed in late April 1995, covered the test dates of October 1, 1994, through March 31, 1995. More subscribers were added for a total subscriber volume of approximately 650 educational programs. The cover letter that accompanied this edition of the *NCLEX™ Program Reports* called attention to the errors that have occurred with gridding of the education program codes. If a candidate grids an incorrect code for the school from which they graduated yet the code is a legitimate code that is in the database, the NCLEX database has no way of recognizing that as incorrect information. Several subscribers called following receipt of the first edition of the *NCLEX™ Program Reports* to question why the numbers of graduates reported did not match the numbers of graduates from the school. In each case information was gathered from the program and compared against the NCLEX database. Program code errors combined with some graduates not yet taking the NCLEX accounted for all candidates. The second edition of the program reports was enhanced with the addition of the education program code to the program name heading in the program reports with the goal of reminding programs of the code number candidates should use when registering for the NCLEX.

Included in each edition of the *NCLEX™ Program Reports* is a 13-item, Likert-type evaluation form that subscribers are asked to complete and return. Space is also provided for narrative comments to be added. To date, 22 completed forms have been received. While this number represents only a small sample of the total subscribers, the responses and comments have been "very positive."

Graduate Record Examination Publicity

In late December 1994, ETS was informed by the Kaplan organization that Kaplan was in possession of items from the Graduate Record Examination (GRE) General Test. Kaplan indicated that over a three-week period in late 1994 they had sent operatives into testing centers for the purpose of memorizing test questions, supposedly to demonstrate a potential security weakness of computer-based test delivery.

Kaplan's activities are believed to have been prompted both by its antipathy toward computer testing and by its desire for publicity in its competition with other major commercial test preparation firms, particularly Princeton Review.

ETS, the Graduate Record Examination Board, and Sylvan Learning Systems have filed suit in federal district court in Maryland. The four counts in the complaint are:

1. Copyright Infringement - Based on taking copyrighted questions from a computer screen and reproducing these questions without authorization.
2. Breach of Contract - Based on the terms and conditions in the GRE Bulletin which are legally binding. The test taker is informed that unauthorized use of the test questions is prohibited. Also, prior to taking the examination the test taker agrees (by signing a printed statement and by clicking on the computer to proceed with the testing) to maintain the confidentiality of the test questions.
3. Common Law Fraud - Based on the test takers' deliberate misrepresentations in their agreement to maintain the confidentiality of secure test questions when they intended to break that confidentiality by memorizing these questions for Kaplan's use.
4. Violation of the Federal Stored Electronic Communications Record Access Act -Based on the test takers' violations of the conditions of access to secure materials delivered via an electronic format.

Currently, ETS and Kaplan have a "standstill" agreement which prohibits Kaplan from this type of activity. Agreed upon in lieu of a temporary restraining order, this agreement has been in effect since the beginning of January.

Managing Data about Candidates and Transmitting Data between Member Boards and ETS

ETS has made the Member Board Office System (MBOS) available to all boards. This software, which runs on the personal computers provided by the National Council, maintains an NCLEX candidate database and permits Member Boards to retrieve and view candidate records, make candidates eligible to test, correct or change information about candidates and print a variety of reports about candidates. Part of the MBOS package is a program called Expedite/PC which takes data from MBOS and transmits it to the Data Center (via the IBM Advantis network) and takes data from the Data Center and sends it to MBOS.

Fifty-two Member Boards use MBOS and Expedite/PC to perform the daily tasks of candidate processing and the nightly communication with the Data Center. Nine boards have developed their own unique systems: California-RN, California-VN, Florida, Illinois, Massachusetts, Minnesota, New York, North Carolina and Virginia. All of these nine except North Carolina use Expedite/PC to perform the nightly communications with the Data Center. In addition, the California Boards continue to use MBOS to supplement their internally developed system. LGR, the vendor providing operational services to New York and Massachusetts, uses both their own system and MBOS. Massachusetts also maintains and operates MBOS at the board offices. Florida, Illinois, Minnesota and Virginia operate their internally-developed systems in lieu of MBOS but use Expedite/PC for the nightly communications with the Data Center.

From May 1, 1994, through April 15, 1995, five updates to MBOS which provided enhancements to the system have been released to Member Boards.

Although MBOS is functioning accurately in allowing candidate data to be exchanged between boards of nursing and the ETS Data Center, several Member Boards, the Examination Committee, and National Council staff have requested that changes and/or enhancements be made. Both National Council and ETS staffs maintain a running list of MBOS changes suggested by the Examination Committee, by Member Boards, or by staff. When a suggested change is added to the list, the entry contains a brief description of the change, the source of the suggestion, and an initial estimate of level of effort required to implement the change. The Examination Committee reviews the suggested changes at each meeting and assigns a priority. ETS staff then provides a cost estimate for all high and medium priority entries. The Examination Committee and Council staff identify funds to implement the most desirable changes and authorize ETS to proceed. ETS staff schedules the change and informs National Council staff and the Examination Committee of the planned release date. This new procedure seems to be working well.

MBOS Hotline

The level of activity of the MBOS Hotline has decreased steadily as Member Boards have become experienced MBOS users. In general, approximately twenty calls are received per week, except immediately following an MBOS release when the call rate increases.

Operations

NCLEX Operations staff answer the toll-free 800 candidate inquiry and telephone registration line; respond to requests from candidates, Member Boards, and the National Council; monitor and report NCLEX Data Center activity; perform quality control of all systems output; resolve rejected candidate registration records due to gridding errors or other system-established reject reasons; prepare mailings to jurisdictions and candidates; maintain the database for candidates requesting special testing accommodations; staff the MBOS hotline; assemble and mail the *NCLEX™ Program Reports*; and resolve daily electronic irregularity reports (EIRs).

Telephone Activity

For the year ending March 31, 1995, over 158,000 calls were answered by NCLEX Operations Customer Service Representatives; telephone registrations accounted for approximately 12 percent of those calls. Figure 1 displays the numbers of calls per month. A total of 211,925 original Authorizations to Test (ATTs) and 5,571 duplicated ATTs were produced for this period and mailed to candidates.

Analysis of phone activity for the first year revealed some interesting findings. Mondays are peak call days while the fewest calls are received on Fridays. Phone activity is highest during the lunch hour and the early morning hours in each respective time zone and after 4 p.m. Eastern Time. Calls received the first day immediately following a major holiday increase dramatically. Phone activity was extremely high following Memorial Day, Christmas, and New Year's Day.

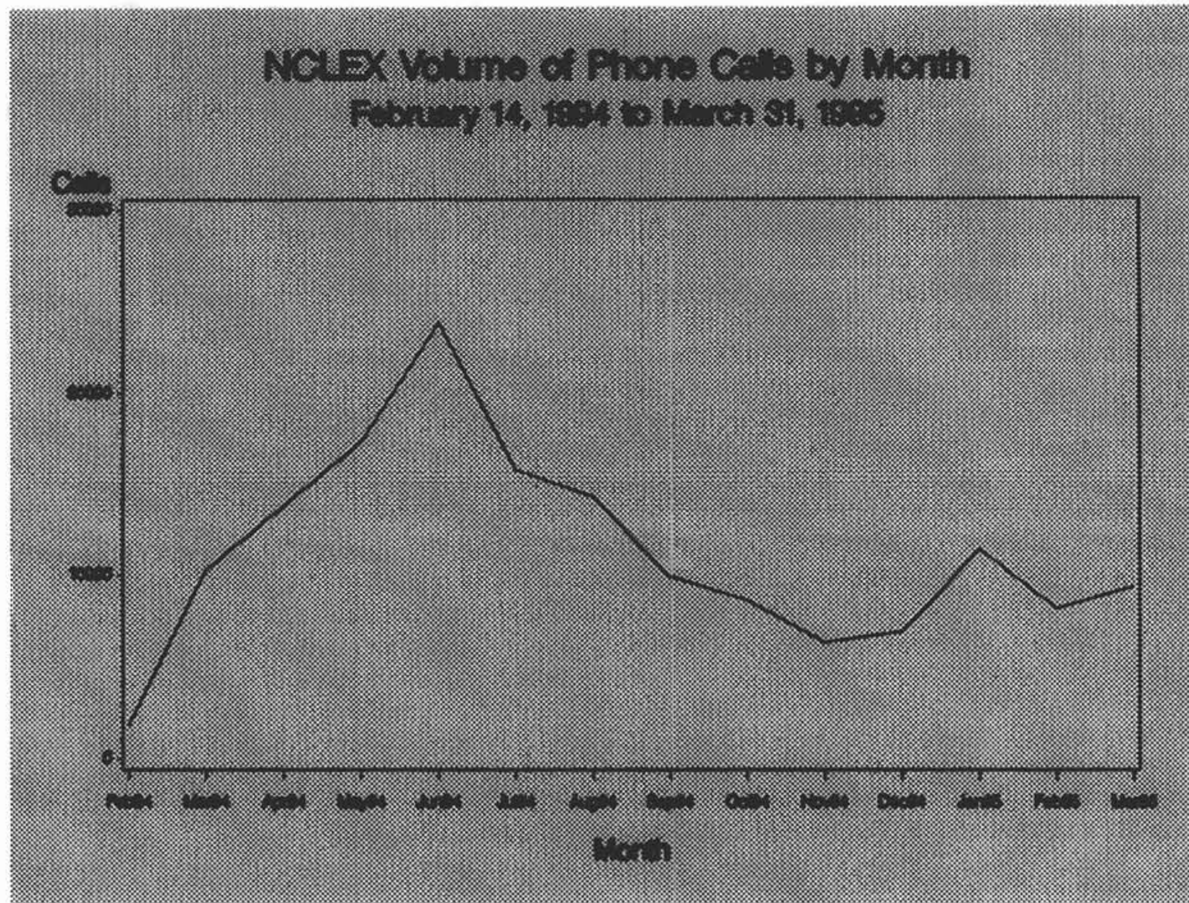

Figure 1

Customer Satisfaction Survey

To determine the level of customer satisfaction with the NCLEX Operations activities, surveys are mailed to randomly selected NCLEX callers and are summarized on a quarterly basis. Overall, the results have demonstrated a very high approval rate of the services provided by the customer service group in NCLEX Operations. The free-form comments in general are highly complimentary of both the telephone staff and the quality of the service.

Candidate Matching

As part of the planned review of processes and procedures for delivering NCLEX and based on feedback from the Examination Committee, ETS has conducted retrospective studies on the process by which registrations for the same person are matched to create a single database record. The first study began in mid-October 1994, by searching the database for pairs of records that appeared to represent the same person. Three different search routines were used in the scans to increase the likelihood of detecting unmatched candidate records. This process yielded 13 pairs of unmatched records, each representing a candidate who had tested twice. Since the records did not match, the system treated them as different people. These findings were reported to National Council staff and to the Examination Committee.

Based on an analysis of the findings and recognition of where problems occurred, changes were identified to eliminate these causes of unmatched records. For example, many of the records that did not match were later corrected either at ETS or by the candidates' boards of nursing. As a result, a change was made so that the system now attempts to match again any record to which changes have been made to the fields critical for matching. In that way, as fields such as name or date of birth are corrected, the corrected data are "recycled" in an attempt to match the candidate against other records.

Another factor noticed was that in many cases the failure to match was caused by inaccurate identifying information about the candidate. As a result, a number of new edit routines were implemented to identify the erroneous information

so that it can be corrected before the attempt to match is made. In addition, edits for education program codes and graduation dates have been tightened. These edits have doubled the number of cases that are reviewed by staff prior to being loaded into the database. On the assumption that candidates who make errors that are detected by the edit routines are also likely to make errors that cannot be detected by the routines, ETS staff now visually inspect the entire record that is displayed for error resolution. Staff then corrects obvious errors in other fields in addition to the error that caused the record to be displayed. These changes should enhance the quality of the information contained in the NCLEX database.

A second full database scan was recently completed which yielded five pairs of unmatched records, mostly attributable to errors in Social Security numbers as reported in candidates' registration data. The scan of the database for pairs of records that may represent the same person will continue. If cases where matches have not occurred are found, the circumstances for non-match will be analyzed and steps taken to cause similar cases to match in the future. The effectiveness of these changes will be evaluated by yet another scan of the database. The process of scanning the database, analyzing the findings, and adjusting the system will continue until the results are satisfactory.

Quarterly Reports

Quarterly Reports, formerly "green sheets," are distributed to each Member Board approximately three weeks following the end of the quarter. Over the past year, each version of the *Quarterly Reports* has been slightly different as improvements or edits suggested by Member Boards have been included. The report produced in April 1995 was the first report to display data for the first full year of testing via CAT.

A new table has been requested that will provide passing rates by type of education program for PNs/VNs. Currently, the PN/VN education programs have not been coded for type of program. The *Quarterly Reports* will be modified to include this table after National Council staff have determined a coding structure.

There has also been discussion of two issues related to *Quarterly Reports*: 1) concerns about the accuracy of candidate-reported program codes and graduation dates; and 2) a desire by many boards to have access to data about candidates educated within the jurisdiction who have sought a license in another jurisdiction.

In response to the issue of the accuracy of candidate-reported data, edits have been added to procedures to identify and correct the most serious errors (e.g., a missing or invalid program code). However, legitimate data that are incorrect (e.g., a reasonable but incorrect graduation date is provided by a candidate) cannot be detected. After discussion of this issue, several boards have adopted procedures to verify the accuracy of the program code and graduation dates when candidate eligibility is recorded. Exploration is continuing about ways in which MBOS screens may be modified so that program code and graduation date can be readily displayed.

The privacy regulations of several states do not permit the reporting of examination results to third parties without the consent of the candidate. Therefore, data about candidates seeking licensure outside the jurisdiction in which they were educated cannot be routinely supplied to the educating jurisdiction. The Examination Committee and National Council staff are exploring the possibility of providing that information for all states willing to share it.

Testing Candidates Requesting Special Accommodations

For the testing period of April 1, 1994, through March 31, 1995, a total of 264 candidates (209 RN candidates and 55 PN/VN candidates) requesting special accommodations tested. The most frequently requested accommodations were extended time (either time-and-one-half or double-time), separate room, reader, and testing over multiple days. Other accommodations requested less frequently were calculator, recorder, screen magnification, and modifiable screen colors. It was not unusual for candidates to request several accommodations for one test session. Special accommodation candidates tested in every month of the testing year with the volume varying with the overall testing volume.

The average test time for these candidates was approximately three hours and 19 minutes. The average difference between allocated test time and actual test time was about five hours and five minutes. Taken together, this means that most candidates used less than one-half of the time they were allocated. For example, candidates who were given seven and one-half hours to test took an average of three hours and 25 minutes, while candidates who were allocated 11 hours to test averaged four hours and ten minutes. Only a small percentage of the candidates (2.3 percent) timed out after five hours.

All ADA scheduling is now being performed by Sylvan's National Registration Center (NRC). In January 1995, Sylvan developed and staffed a new position of Special Conditions Coordinator at the NRC. All ADA appointments are scheduled through this person, who then sends notification to the applicable center defining the candidate's Member Board and National Council-approved special accommodations and the written procedures to follow when conducting

the session. Center staff are contacted by phone the week before the scheduled event to ensure that the documentation has been received and is understood. Procedures detailing the most typical accommodations are on file at the NRC and are revised on an "as needed" basis. Occasionally, unique accommodations are approved and candidate-specific documentation must be developed. When this occurs, Sylvan's Program Manager contacts ETS for guidance and then writes the documentation. All ADA events are tracked by the Sylvan Program Manager from the time that approval is granted by the Member Board and National Council through completion of the testing session. A listing of all candidates who have been approved for special accommodations is forwarded weekly to the Special Conditions Coordinator, Client Inquiry, and Technical Support Departments. The Program Manager tracks 30/45-day compliance weekly based on the appointments scheduled the week prior. When a candidate's initial request cannot be accommodated within the 30/40-day schedule, Sylvan works with the candidate to identify other testing centers that would be available. All non-compliant appointments are noted in the monthly 30/45-day compliance report which is submitted to the National Council.

National Council, ETS, and Sylvan staff are evaluating the services provided to candidates requesting special testing accommodations determining where process and systems changes are needed. A meeting is scheduled for mid-May.

Test Centers

Sylvan Technology Centers

The test center network presently includes 218 active technology centers housing 1,690 workstations. While the expectation is that the total number of centers in the network will increase over time, Sylvan will continue to analyze the utilization levels at each site to determine whether centers and workstations should be increased, reduced, or eliminated. During the last year, two centers were closed in California due to significant underutilization of the sites in the Los Angeles market. One center in the Northeast was closed for contractual reasons. The center in the U.S. Virgin Islands discontinued service abruptly. Delays were encountered in establishing a new center. In the interim period of approximately three months, candidates testing for the U.S. Virgin Islands were flown to Puerto Rico. Overall, the market continues to be adequately served by the remaining centers in these areas. Three new centers were added, one each in Indiana, Iowa, and North Carolina. Approximately 10 percent of the centers have relocated within the same market area during the last year.

ETS Institutional Sites

Six ETS Institutional Centers are used for NCLEX™ testing. These sites are situated within colleges in Hawaii, Nebraska, New Mexico, Michigan, Washington, and Wisconsin in locations that are not served by a Sylvan Technology Center. To date, these centers have administered less than one percent of the total NCLEX examinations delivered. Each center is operated under the same security, procedural, and staffing specifications as Sylvan Technology Centers. Because of an unplanned move, one institutional center failed to meet all compliance requirements. This deficiency was discovered during a visit to the center by ETS staff and staff from the Member Board. The center was instructed to correct the deficiency immediately. When this corrective action did not occur, testing was suspended until all compliance requirements were met.

Sylvan Quality Assurance Plan

A comprehensive Quality Assurance (QA) Plan for the Sylvan Technology Centers was reviewed by a subcommittee of the Examination Committee in three conference calls and was reviewed by the Examination Committee in May 1995. The QA Plan outlines quality assurance procedures currently in use.

Test Center Administrator's Manual

The Test Center Administrator's Manual is updated annually by ETS, Sylvan, and National Council to reflect the most current policies and procedures. A copy of the manual is provided to each test center, Member Board, and the National Council. The 1995 manual will be distributed when all revisions are completed, now scheduled for late spring. Exploration is now underway to allow computerized "on-line" access of selected manual contents to center staff.

Capacity Issues

To address potential concerns regarding specific center capacity, reports are run daily. Any centers with higher than 80 percent utilization for the next 30 days are identified and notification is sent to National Council of these

centers. Any centers with greater than 70 percent utilization are identified and notification is sent to franchise consultants who work with the sites to open additional hours and days beyond the contracted operating hours. Past history has shown that centers are typically responsive to these requests. Monthly reports are provided to the National Council regarding compliance with 30/45-day scheduling. Utilization in the national network over the last testing year averaged in the 25 percent range with the highest capacity, not surprisingly, in June and July.

Analysis of projected volumes for June and July 1995 has provided assurance that compliance will not be a general problem. Capacity in specific sites may be a challenge depending on how registrations and eligibilities are received this year. Last year was the first year for scheduling and may not have been representative of subsequent years. It was anticipated that capacity problems might exist in California, for instance, but did not occur. Further analysis of peak period utilization is under way and may result in specific recommendations to assure candidates' satisfaction with their scheduling options. Communiques have been sent to Sylvan Technology Centers advising how to best set hours for the peak NCLEX testing period in June and July so that centers are able to respond to the need for third shifts when required. Analysis is being done on which centers are most likely to experience high fill rates and specific plans are being developed with these centers to meet anticipated candidate requirements.

Examinee Exit Evaluations

From April 1, 1994, through March 31, 1995, all candidates completing the NCLEX were asked to provide anonymous responses to a 16-question on-line Examinee Exit Evaluation. These questions were designed to solicit information from the candidates about scheduling their NCLEX appointments as well as their experiences at the test centers. The results of these evaluations are summarized in several ways. Data from all centers across the test center network are provided monthly to National Council, ETS, and Sylvan staff. Quarterly summaries of responses network-wide, by jurisdiction, and for each individual test center are produced and distributed to the appropriate Member Board as well as National Council, ETS, and Sylvan. The results of these Examinee Exit Evaluations are reviewed by staff to detect any differences in performance in selected centers or by state. In addition, these evaluations are examined when problems have been identified at specific centers or when Member Boards have received complaints from candidates.

As of April 1, 1995, the Examinee Exit Evaluation was revised based on revisions provided by the Examination Committee and National Council staff. Questions were rephrased and reordered and additional questions added. Member Boards will receive the first summaries of the revised Examinee Exit Evaluations following the end of testing quarter in June 1995. Exploration is currently underway to determine different ways in which this information may be shared with Member Boards.

Candidate Comments

In addition to the information gathered in the Examinee Exit Evaluation, candidates are also provided the opportunity to submit narrative comments about their testing experiences. These comments, reported verbatim, have generally been positive and supportive of the move to computer-based testing.

Electronic Irregularity Reports

Electronic Irregularity Reports (EIRs) are filed by Sylvan Technology staff whenever an "unusual" event occurs at the test center. These events range from the very serious (examinee misconduct or hardware failure) to information exchange (candidate did not bring the Authorization to Test and was admitted after a secondary match was performed). Each EIR received may affect more than one candidate depending on the number of candidates present when the event occurred. Since testing began in April 1994 through April 15, 1995, Sylvan Technology Center staff have filed 5,260 Electronic Irregularity Reports (EIRs), a rate of 2.7 percent of the testing events delivered. This represents a dramatically lower-than-expected rate based on predictions from the 1993 Beta Test.

Currently, EIRs are transmitted electronically from the test centers to Sylvan Corporate, ETS, and the National Council. At the National Council, the EIRs are sorted by jurisdiction of licensure for each testing candidate affected and transmitted via NCNET to the appropriate Member Boards. Two transmissions per EIR occur. The first transmission provides the EIR as filed by the test center staff; the second transmission provides a closing comment detailing the resolution of that EIR and may indicate that the EIR was miscoded.

EIRs are tracked by category and by site at ETS and Sylvan to identify trends or patterns of performance at test centers, possible abnormalities in test results, and the need for center staff retraining.

Operational Pool Rotations

Under current procedures approved by the Examination Committee, operational item pools are currently scheduled for rotation twice annually in April and October. Pool rotation throughout the entire Sylvan network cannot be assured to occur within a 24-hour period because communications systems are not sufficiently robust to guarantee that all centers can receive the new operational pool simultaneously. Communication failures may occur because of natural occurrences (thunderstorms), human error (failure to set the computer system to receive transmissions), and communication errors (transmission interruptions while files are being transmitted).

At the December 1994 meeting, the Examination Committee provided direction to ETS and Sylvan regarding scheduling NCLEX operational pool rotations to occur simultaneously, so that all centers would be administering NCLEX with the same operational pools throughout the network.

To accomplish this objective, the committee approved a phase-in process that was first implemented for the April 1995 pool rotation. This process resulted in a three-day interruption of testing at most centers. There was a one-day suspension of all NCLEX testing and limited testing for two days at selected centers to allow time to confirm that all test centers made the switch to the new operational pool and to confirm that the software performed as expected. This process was successfully implemented for the April 1995 operational pool rotation.

Test Development Activities

Item Writing Workshops

The third phase of item writing workshops began in July 1994 and will conclude in May 1995. For NCLEX-RN, four workshops were held through March 1995 with a total of 48 item writers. The total number of items written was 1,428. For NCLEX-PN, five sessions were held with a total of 63 writers producing 2,037 items. For RN, 21 of the item writers had attended workshops during earlier phases of item development, and for PN, 30 writers had participated previously.

The sessions were conducted by members of the Princeton-based and Atlanta-based ETS test development staff at ETS offices in four locations: Princeton, New Jersey; Tucker, Georgia; Evanston, Illinois; and Emeryville, California. Representatives from each of the four National Council geographic areas attended each of the workshops. For this phase, the major area of content expertise of the item writers was medical/surgical nursing. Members of the National Council Examination Committee and National Council staff also audited the workshops.

Selecting Item Writers

Potential workshop participants who have met National Council criteria for item writers are asked to complete an item writing exercise. This prescreening instrument includes a letter of explanation and a booklet with information about NCLEX and creating accurate and well- constructed items that are appropriate for entry level. The potential writers are asked to develop three items that are linked to specific components of the respective test plans and supported in current nursing texts. The test development team reviews the items and validations for content and technical appropriateness and then recommends to the National Council staff and the Examination Committee writers who meet the criteria. Panel members are then approved for attendance at workshops by the Examination Committee.

Over the last year, recruitment efforts by National Council have been intensified to help ETS meet the goals for the large numbers of items needed as tryouts for the pretest pools. The responses from potential PN item writers fell short of the goal for phase three of item development, which would have enabled ETS to have a larger pool of applicants from which to screen and then recommend item writers. We believe that the combined efforts of staff and the Examination Committee will lead to the identification of additional well-qualified, potential item writers for the year ahead.

Item Review Meetings

The six NCLEX-RN Item Review Panels that met between May 1994 and March 1995 approved 1,594 of the 1,816 items reviewed, while five NCLEX-PN Item Review Panels that met between June 1994 and March 1995 approved 1,424 of the 1,589 items reviewed. These meetings were also conducted at the four ETS sites used for the item writing workshops, with representation from each of the four National Council geographic areas at each session. Examination Committee members and National Council staff also audited these meetings.

Item Review at the Examination Committee Meetings

Newly developed items approved by the Item Review Panels at the meetings held between March 1994 and January 1995 were presented to the Examination Committee for review at four meetings held between May 1994 and February 1995. A total of 1,621 NCLEX-RN and 1,643 NCLEX-PN items of the 1,856 RN and 1,796 PN items available for review were approved by the Examination Committee for use as "tryout" items.

Targeting Item Difficulty

The ETS/NCLEX test development team has intensified its efforts in targeting item difficulty for the NCLEX pools. Several complementary approaches have been initiated. These include the following: expanding discussion of item difficulty during the didactic portion of item writing workshops and item review meetings, with numerous item exemplars; using a more systematic approach for evaluating distracters and revising any that panel members feel a minimally qualified or unqualified candidate would eliminate; rewriting items that are based on appropriate content but which have not met NCLEX statistical criteria; and providing National Council staff with recommendations for extending invitations to experienced item writers for returning to subsequent workshops.

The statistical analyses of the most recent tryout pools (October 1994) indicated an increase in the mean difficulty of the items in comparison to the tryout pools from the first two quarters.

Monitoring

Retaining the currency of items over time for the NCLEX CAT pools is of critical importance. The ETS/NCLEX test development team performed ongoing monitoring of items in the existing RN and PN pools for content accuracy, currency, and appropriateness prior to the transmittal of the CAT pools for the October 1994 administration and again prior to the start of the April 1995 administrations. Items that were flagged for content and sensitivity concerns were presented to the Examination Committee for disposition and removed from the relevant pools as needed over the course of the year.

Additionally, items that contain references to time-sensitive content, such as tuberculosis and AIDS, have been coded in the ETS item-banking system for more frequent reviews, and content, such as heat lamps and double-bagging, has been identified as "outdated" and removed from the active pool.

Construction of 1995 CAT Pools

A summary of the source of items for the "base" pools from which the parallel pairs of CAT pools for 1995 were configured is provided in Table 1.

Table 1. "Base" Pools for Construction of 1995 CAT Pools

Potentially Useable Items	RN	PN
April and October 1994 CAT pools	3596	2968
April 1994 pretest pools (EC approved 10/94)	260	277
July 1994 pretest pools (EC reviewed 2/95)	433	458
Additional 792 tryouts (EC approved 10/94)	43	NA
294 tryouts from paper-and-pencil exam (EC approved 12/94)	454	NA
Pretest "anchor" items from April and July 1994 pretest pools (EC approved 10/94 and 12/94	42	48
(Total)	4828	3751

After the items for the "base" pools were identified, items in a number of different categories had to be excluded. The numbers of items excluded by category are provided in Table 2. Please note that a total is not provided here because some of the excluded items were flagged in more than one category (e.g., case-linked items/flagged by Statistical Analysis staff).

Table 2. Items "Excluded" From 1995 CAT Pools

Categories of Items Excluded from the "Base" Pools for 1995	RN	PN
Items flagged for disposition by EC	129	69
Case-linked items in April 1994 pool not approved by EC	175	204
Case-linked items in October 1994 pool	232	189
Items flagged by Statistical Analysis in April 1994 CAT pool	205	159
Pretest "anchor" items from April and July 1994 pretest pools	18	22
1995 anchors for pretest pools	70	70
Borderline point biserial	23	0

Progress Towards Optimal Pools

At the February 1995 meeting of the Examination Committee, ETS staff presented a report titled, "Assessment and Analysis of the Item Pools." This document provided an up-to-date description of the available items used to construct two parallel CAT item pools for the 1995-96 testing year, as well as an accounting of items that were excluded from these pools for a variety of reasons (see Tables 1 and 2). As part of this document, a discussion of optimal item pools was provided which included specific proposed criteria for defining optimal item pools. National Council and ETS staffs are currently working together to refine these proposed criteria.

ETS staff will use computer simulations research to determine the numbers and characteristics of items that are necessary to satisfy the optimal pool criteria. An update on this work will be provided in a report to the Examination Committee at the July 1995 meeting.

Face Validity Reviews

The ETS/NCLEX test development team routinely reviews "real" and simulated CAT examinations based on criteria established by the Examination Committee. The criteria include non-test plan content areas such as maternal/child, infection control, medications, pediatrics, and geriatrics that are not controlled by the CAT selection algorithm. The review also includes the identification of items based on similar content within a CAT examination.

The actual candidate and simulated CAT examinations reviewed for face validity are generated at five ability levels: low ability, moderately low ability, borderline (pass/fail) ability, moderately high ability, and high ability.

The face validity review of the actual CAT examinations from the October 1994 CAT pools revealed that for both NCLEX-RN and NCLEX-PN, no similar content (i.e., overlap) was noted in three of the five CAT examinations. For RN, the most significant overlap was noted in a 250-item examination of middle ability for a failing candidate. There were four content areas represented by two to three items. For PN, a 144-item examination of moderately low ability for a failing candidate contained the most significant overlap, with three content areas being tested by two to three items.

For the simulated CAT examinations, no overlap was noted in six of the ten RN and PN CAT examinations. Again, content overlap was most noticeable in the examinations containing the largest numbers of items. The two 250-item RN CAT examinations contained five pairs of items testing similar content. For PN, one of the 180-item CAT examinations contained two pairs of overlapping items and the other 180-item CAT contained four pairs of items with overlap in content.

In both the actual candidate and simulated CAT examinations, the Test Plan subcategory for both NCLEX-RN and NCLEX-PN that was not consistently covered was the Client Need entitled "Prevention and Early Treatment of Disease." This subcategory is listed under the broad category of "Health Promotion/Maintenance," which also includes the subcategory that contains items based on maternal/newborn content.

Sensitivity Reviews

In-house sensitivity reviews are required for all tests generated at ETS. The reviews are based on item-level and test-level concerns and are conducted by trained individuals drawn from across the (non-NCLEX) ETS staff. Using guidelines reviewed by the Examination Committee, the new items for the NCLEX pools undergo a sensitivity review as they are processed for meetings with the Item Review Panels.

To address test-level concerns such as gender balance and juxtaposition of items, sensitivity reviews are done on the simulated CAT examinations generated for the respective CAT pools. The review of the April 1995 CAT pools indicated that the pools are generally in accord with ETS sensitivity guidelines. Two potential problem areas noted by the sensitivity reviewers were the references to "elderly" clients instead of clients with specific ages, and gender references which at times were unnecessary. As the Examination Committee proceeds with its planned systematic review of the existing pool, these sensitivity issues can be easily resolved as editorial changes are made to address these concerns.

NCLEX Differential Item Functioning (DIF) Review Panel Meeting

The first NCLEX-DIF Review Panel Meeting was held on January 26, 1995, at ETS in Princeton, New Jersey. In preparation for the meeting, ETS staff had previously identified individuals to serve on the panel who met the criteria approved by the Examination Committee and forwarded the names of the nominees to National Council staff for approval. The criteria for the NCLEX DIF Review Panel are:

1. **Size**: five members
2. **Gender**: at least one male
3. **Ethnic/Cultural representation**: at least one representative of three of the ethnic focal groups of NCLEX test takers
4. **DIF Experience**: at least one individual with prior experience on a DIF Review Panel
5. **Linguistic Experience**: at least one individual with a general linguistic background
6. **Educational Background**: at least one currently licensed registered nurse

DIF statistics are computed comparing the performance of males with females, and of Whites with other ethnic/focal groups: Blacks, Hispanics, Asian Indians, Asian Others, Native Americans, and Pacific Islanders. Items are categorized as A, B, or C depending on the level of demonstrated DIF, with category C items containing moderate to large DIF. The category C items were reviewed at the January 1995 panel meeting.

The source of the items to be analyzed for DIF prior to the meeting included the April 1994 CAT pool, which contained 1,798 RN and 1,484 PN items, and the July 1994 tryout pool, which contained 684 RN and 718 PN items. Because of the interaction of the adaptive testing methodology and sample-size requirements for DIF analyses, only about one-half of the operational items and almost none of the tryout items had analyses reported. Fewer than ten percent of the RN items analyzed and 14 percent of the PN items showed significant DIF for at least one group of interest.

The panel members reviewed a total of 85 RN and 102 PN items from the April 1994 CAT pools and 15 PN items from the April 1994 tryout pool. The panel recommended the referral of 12 RN and nine PN items from the April 1994

CAT pools for consideration by the Examination Committee. The reasons for referral included idiomatic use of language, assumptions regarding the nuclear family and dominant culture, and judgments related to "role-playing" by the nurse in hypothetical situations.

At the February 1995 meeting, the committee reviewed the referred items and made decisions regarding their use in the future. Items were either approved for reuse in the operational pools, put on "hold" for revising, or removed from the pool.

Other attendees at the first NCLEX DIF Review Panel meeting included members of the ETS test development team, the chair of the Examination Committee, and the NCLEX Content Manager from National Council. The next meeting of the panel is planned for August 1995.

Readability Levels of CAT Pools

The Fry method of determining readability levels was used to calculate the reading levels of the NCLEX-RN and NCLEX-PN CAT pools for October 1994 and April 1995. This method calculates readability based on non-medical terminology. According to the Fry index, the estimated reading levels of the October 1994 and April 1995 RN CAT pools are 6.9 and 7.2, respectively, and the estimated reading levels of the October 1994 and April 1995 PN CAT pools are 6.6 and 6.7, respectively. These levels are below the National Council policy for a maximum reading level of tenth grade for NCLEX-RN and of eighth grade for NCLEX-PN.

Member Board Reviews

Each spring and fall, Member Boards have the opportunity to conduct item reviews at Sylvan Technology Centers. Since CAT was implemented in late spring 1994, the first Member Board review session was held in July/August before moving to the planned March/April and October/November schedules. Member Boards can review on-line newly developed items (i.e., tryouts) and/or simulated CAT examinations for high, medium, and low achievers for both NCLEX-RN and NCLEX-PN.

To date, 23 Member Boards have attended a review session with three boards attending all three sessions held, six boards attending two sessions, and 14 boards attending one.

All comments received from Member Board reviews are forwarded from the National Council to the ETS test development staff for review, with any question about nursing practice and/or appropriateness for entry-level practice referred to the Examination Committee.

Candidate Review and Challenge

Eight candidates have participated in review and challenge sessions since the start of NCLEX testing last year. Of those eight candidates, seven sessions have been delivered to test takers from one jurisdiction, with three of those sessions occurring at the same center on the same day.

An item challenge form received for one RN item in January 1995 was forwarded to ETS. A recommendation on the disposition of the item was forwarded by the Examination Committee to the Board of Directors, which upheld the validity of the item during a March 1995 conference call.

Standard Setting

The passing standard for the NCLEX is set every three years. The implementation of NCLEX using CAT requires new approaches to standard setting. Previous standard setting studies for NCLEX applied a modified-Angoff method to a specific test form. With CAT, the concept of an item pool replaces the concept of a test form, and the numbers of items in the pool far exceed the limit of what can be reasonably judged by a group of judges.

The NCLEX-RN standard setting workshop took place on February 22-26, 1995, in Princeton, New Jersey. There were 12 judges who participated in the workshop. All judges were registered nurses with clinical backgrounds in medical-surgical, maternity, neurological, gerontological, psychiatric, and pediatric nursing. Two of the judges were members of ethnic minority groups. One of the judges was a recently licensed registered nurse. The 12 judges were selected to equally represent the four National Council geographic areas.

There were three different standard setting methods utilized in the standard setting workshop: 1) a modified Angoff standard setting where a 200-question "reference form" was examined; 2) a standard setting approach called "comparative judgements," where judges evaluated sets of ten questions that were homogeneous in difficulty; and 3) a "standard setting via CAT" approach, where judges evaluated items "on-line" by taking a CAT examination as if they were a "minimally competent" candidate. Considerable data were obtained using the first two approaches, however, computer hardware problems severely limited the standard setting data that could be collected using the last approach.

Because of the use of multiple methods, the results of the RN standard setting provided several different perspectives on an appropriate passing standard that were reported to the National Council Board of Directors for consideration at the May meeting.

Summary of NCLEX Results for April 1, 1994, through March 31, 1995

Tables 3 and 4 (at the end of this report) provide a technical summary of the NCLEX results from April 1994 through March 1995. Summary statistics for the total group of candidates and for the reference group of candidates (first-time, U.S. educated candidates) are presented in Table 3 for the NCLEX-RN and in Table 4 for the NCLEX-PN. Table 3 indicates that 124,151 NCLEX-RN candidates were included in the statistical analyses for the testing year. Of these, 94,245 were reference group candidates. The passing rates were 81.6 percent for the total group and 90.0 percent for the reference group. These passing rates are consistent with historical passing rates for paper-and-pencil NCLEX-RN.

Table 3 also indicates that for the testing period, 54.3 percent of the total group, and 58.9 percent of the reference group, completed testing after a minimum of 75 items were administered. In contrast, 11.5 percent of the total group, and 9.8 percent of the reference group, were administered the maximum number of 265 items. The average number of items taken by the total group was 117. The average time needed to take the NCLEX-RN during the testing period was 2.12 hours (or two hours seven minutes) for the overall group, and 1.95 hours (one hour 57 minutes) for the reference group. Approximately 32 percent of the candidates took the mandatory break which occurs after two hours of testing, and less than three percent of the candidates elected to take the optional break. Overall, 3.2 percent for the total group, and 1.9 percent of the reference group ran out of time before completing the test. These statistics reflect the characteristics of the candidates testing during the testing interval and provide continued evidence that CAT administration is psychometrically sound.

Table 4 indicates that 68,358 NCLEX-PN candidates were included in the statistical analyses for the testing year. Of these, 54,644 were reference group candidates. The passing rates were 81.9 percent for the total group and 89.8 percent for the reference group. Table 4 also indicates that during the testing interval, 59.6 percent of the total group, and 63.7 percent of the reference group, completed testing after a minimum of 85 items were administered. In contrast, 15.8 percent of the total group, and 13.0 percent of the reference group, were administered the maximum number of 205 items. The average number of items taken was 113. The average time needed to take the NCLEX-PN was 1.97 hours (one hour 58 minutes) for the overall group and 1.83 hours (one hour 50 minutes) for the reference group. About 29 percent of the total group and 24 percent of the reference group took the mandatory break which occurs after two hours of testing. However, less than two percent of the PN candidates elected to take the optional break, and less than one percent of candidates ran out of time before they could complete the test. The NCLEX-PN summary statistics for the testing interval indicate that CAT administration is psychometrically sound.

Statistical Analysis Reports

ETS staff completed several reports that were requested by and shared with the Examination Committee. These included reports on the statistical performance based on CAT of converted case-bound items and items that previously appeared in paper-and-pencil test forms where breaches of security were reported. The reports indicated that performance on these items in CAT was not adversely affected.

Diagnostic Profiles

The format for the Candidate Diagnostic Profiles was revised in early 1995. The main revision consisted of removing the numbers indicating "Percentage of the Test Plan Mastered." These numbers were part of a graphical depiction of performance as indicated by an "X" within a rectangular box. Although this scale was intended to provide failing candidates with a numerical indication of "how close" they were to passing, many candidates appeared to be confused by the numbers. To eliminate this confusion, the Examination Committee and National Council staff requested that the numbers be removed from the diagnostic profiles. After the revision, the diagnostic profiles provided "Overall Performance Assessment" as indicated by an "X" within the rectangular box which was labelled as "failing range."

Quarterly Technical Reports

Quarterly Technical Reports defining characteristics of test takers and examination items are produced and provided to the National Council. Quarterly reports were completed for the April through June, July through September, October through December, and January through March testing periods, respectively.

DIF Reports

ETS staff provide reports to the National Council summarizing statistical analyses of Differential Item Functioning (DIF). These reports include analyses of both tryout items and operational CAT items. DIF analyses are routinely completed after operational CAT item pools are rotated out of the field (twice per year), although ETS staff completed a special report for the National Council based on the first quarter of operational CAT testing.

Simulations Report

ETS staff provide reports to the National Council summarizing the statistical characteristics of operational CAT item pools based on computer simulations. These simulations document the expected statistical properties of the CAT item pools before the pools are rotated into the field. As documented in the 1995 simulations report, computer simulations were used to reduce the size of the CAT item pools by identifying items that were infrequently administered. These simulations provided evidence that removing infrequently administered items would not adversely affect the exposure of the remaining items in the pools.

Meetings Attended

ETS and Sylvan staff attended the following meetings over the past year:

Examination Committee
- October 23-28, 1994, Chicago
- December 8-13,1994, Chicago
- February 10-15, 1995, Chicago
- May 7-12, 1995, Chicago

Examination Committee-Team One
- May 5-6, 1994, Chicago
- August 21-25, 1994, Chicago

Examination Committee-Team Two
- May 2-4, 1994, Chicago
- July 6-7, 1994, Princeton

Area Meetings
- Area I, April 21, 1995, Coeur D'Alene, ID
- Area II, April 1, 1995, Indianapolis, IN
- Area III, April 7, 1995, Nashville, TN
- Area IV, April 28, 1995, Portland, ME

Delegate Assembly
- August 3-6, 1994, Chicago

ETS hosted the following meetings in Princeton:
- Examination Committee-Team Two, July 6-7, 1994
- NCLEX DIF Review Panel, January 26, 1995
- NCLEX Standard Setting Meeting, February 22-26, 1995

Staff Meetings
- September 13-14, 1995, staff retreat in Baltimore, Maryland
- December 14, 1995 in Chicago, Illinois

Table 3. Longitudinal Technical Summary for NCLEX-RN, Group Statistics for 1994-1995 Testing Year

	Apr 94 - Jun 94		Jul 94 - Sep 94		Oct 94 - Dec 94		Jan 95 - Mar 95		Cumulative 94-95	
	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	30,083	25,948	52,742	44,188	15,548	5,877	25,778	18,232	124,151	94,245
Percent Passing	89.1	93.3	84.1	89.4	63.5	80.0	78.5	90.1	81.6	90.0
Ave. # Items Taken	110.5	105.1	114.4	111.2	133.2	123.1	117.7	111.0	116.5	110.2
% Taking Min # Items	59.4	63.5	55.5	57.9	41.9	48.6	53.4	58.0	54.3	58.9
% Taking Max # Items	10.1	8.5	10.9	10.2	16.0	12.9	11.6	9.8	11.5	9.8
Ave. Test. Time (Hrs)	1.94	1.81	2.07	1.97	2.51	2.23	2.19	2.00	2.12	1.95
% Taking Mand. Break	25.5	21.2	30.4	27.0	45.7	36.3	34.1	27.8	31.9	26.1
% Taking Opt. Break	1.7	1.0	2.0	1.4	4.7	2.9	2.7	1.8	2.4	1.5
% Timing Out	2.1	1.2	2.7	1.8	6.3	4.4	3.6	2.4	3.2	1.9

Table 4. Longitudinal Technical Summary for NCLEX-PN, Group Statistics for 1994-1995 Testing Year

	Apr 94 - Jun 94		Jul 94 - Sep 94		Oct 94 - Dec 94		Jan 95 - Mar 95		Cumulative 94-95	
	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	18,890	14,958	22,224	18,888	15,490	12,324	11,754	8,474	68,358	54,644
Percent Passing	83.2	90.5	85.3	91.2	79.2	87.8	76.9	88.3	81.9	89.8
Ave. # Items Taken	113.0	107.9	109.2	106.2	116.9	112.8	116.0	110.6	113.2	108.8
% Taking Min # Items	59.7	64.7	63.6	66.5	55.7	59.3	57.1	62.0	59.6	63.7
% Taking Max # Items	15.6	12.3	13.2	11.4	18.4	15.6	17.9	14.3	15.8	13.0
Ave. Test. Time (Hrs)	1.93	1.78	1.83	1.72	2.06	1.92	2.06	1.89	1.97	1.83
% Taking Mand. Break	28.5	22.2	24.4	20.0	33.8	28.1	33.5	26.7	29.2	23.5
% Taking Opt. Break	1.3	0.6	1.1	0.6	1.6	0.9	1.9	1.0	1.4	0.7
% Timing Out	0.7	0.3	0.7	0.4	1.0	0.6	1.2	0.7	0.9	0.5

Annual Report of The Psychological Corporation (TPC)

This report provides a summary of The Psychological Corporation's activity for the Nurse Aide Competency Evaluation Program (NACEP™) of the National Council from March 1994 through February 1995.

Highlights of Activities

- ***Psychometrics***

For this report year, five forms of the Written Evaluation and nine Manual Skills situations were available throughout the year. This included the two additional situations assessing catheter care and perineal care that were first administered in November 1993. The response from client states using the new skills has been positive and we have not experienced any problems with sites not having the necessary additional equipment to test these particular skills.

The annual summary statistics between the 1994-1995 and 1993-1994 periods indicate stable passing rates. For the Written Evaluation, the 1994-1995 passing rate is 85.7 percent; the Manual Skills Evaluation's passing rate is 92.8 percent. Reliability coefficients (KR20s) ranged from .82 to .84 for the Written Evaluations, consistent with prior data. There was an increase in the number of candidates taking the oral version of the examination with Colorado having a significantly higher rate of oral administration requests than any other client state.

During the November NACEP Task Force meeting, Lucille Dungan gave a presentation of psychometric concepts and terms including the concepts of validity, reliability, passing standards, and Item Response Theory (IRT) equating from materials prepared by Dr. Ellen Julian of the National Council staff.

Final revisions for the first published *NACEP™ Technical Report* (reporting 1993 data) were reviewed with Dr. Julian and the TPC psychometric staff via a telephone conference call in August 1994. Minor revisions were incorporated into the 1993 *Technical Report*. More substantial revisions were written into the new *NACEP Technical Report* for 1994 data which were received in April 1995.

For the new National Council study guide, rationale for the correct answers for the written practice test were finalized and forwarded to the National Council. Camera-ready copy for the new practice test was completed and sent in January 1995.

- ***Operations***

In 1994, NACEP™ Operations scored 39,690 Written Evaluations and 32,736 Manual Skills Evaluations, a drop of approximately 10 percent from the previous year. The July candidate survey showed a good level of satisfaction. Lorie Lopez, who has been with TPC in the NACEP program for a number of years, was promoted to a new position as liaison between users and the TPC operational area. This has worked extremely well, to the benefit of both TPC and the user states.

A scoring issue in Colorado was uncovered in the last quarter of 1994. This was the result of continuation of scoring of the reading comprehension section of the Written Evaluation's oral administration which was in conflict with the Colorado requirements. The six candidates who were incorrectly scored were notified, as was the Colorado Board of Nursing. Revised score reports and refunds were issued as appropriate. Changes were immediately made in the scoring system to permanently correct the problem.

A visit in San Antonio with two staff from the Oregon Board of Nursing's Nurse Aide Program resulted in a better understanding by Oregon of how TPC's internal operations functions and what processes could be streamlined to better meet the needs of Oregon. Some summary reporting changes were initiated by TPC, resulting in much more useful information for the Oregon Board of Nursing.

Improvements in the operations area were discussed by Sue Traweek at the November NACEP Task Force meeting. These included the new telephone system and reorganization of the operations area. The changes have been successful, resulting in faster, more accurate response to candidate and client inquiries. Additional changes such as a voice-activated registry system are planned for the near future.

Ongoing discussions and research continue into alternative methods of test delivery using new technologies. We anticipate decisions on the direction TPC will be taking by the fall of 1995, after consulting with the National Council and the NACEP™ Task Force.

Marketing

For the period of this report, contract renewals were approved for Colorado, Delaware, Idaho, Maryland, North Dakota, Oregon, South Dakota, Virginia, Rhode Island, and the District of Columbia. Maine also signed a contract in which they changed from Co-op level to Full Service level. Wyoming is in the process of renewing their contract and deciding the level of service that best meets their needs. We are also awaiting the signing of a new contract by the Virgin Islands.

The first comprehensive written marketing plan since the beginning of the NACEP™ program was presented to the National Council in July 1994. This written report summarized results from a national marketing survey, trends in the nurse aide industry, and action plans for TPC. A significant sales initiative was undertaken with the utilization of TPC's clinical sales representatives throughout regions of the U.S. for NACEP direct sales. A full-day training session for the clinical sales representatives was scheduled in January 1995. Ellen Gleason attended this session which included presentations on all aspects of the NACEP™ program. The representatives found this very successful. The clinical representatives have already visited a number of states including California, Wyoming, Kansas, Tennessee, Texas, Oregon, Washington, and Utah as well as attending several pre-proposal meetings.

Significant progress was made in meeting the action plans as outlined in the marketing report. The primary focus was on the design and development of marketing brochures for use by the clinical representatives in direct mail and conference exhibits. In addition, a sponsor survey (of the long-term care facilities and training institutions) was developed and distributed.

Another highlight was a well-planned trip in December to Florida to do a presentation on the NACEP™ We were delighted when Florida then approved TPC as the sole vendor for their nurse aide testing. This will increase our candidate volume by approximately 50 percent. In addition, we were awarded the contract for the state of Washington. All staff has been heavily involved in strategizing and planning for getting these new clients up and running.

Staff was also very busy responding to numerous RFPs during the beginning of 1995. They included Minnesota, Pennsylvania, Massachusetts and Connecticut. Pennsylvania has awarded its contract to its current vendor, Assessment Systems, Inc. (ASI), and Massachusetts went with the Red Cross and Educational Testing Service (ETS). Vermont (a former TPC state) awarded their contract to the Red Cross in the fall of 1994.

Meeting Dates

- Delegate Assembly, August 3-5, 1994
- NACEP Task Force Meeting, November 10, 1994
- NACEP Task Force Meeting, June 6-7, 1995

Attachments

A .... Table 1 - NACEP Number Tested and Percent Passing Rate, Written/Oral, page 19
B .... Table 2 - NACEP Number Tested and Percent Passing Rate, Manual Skills, page 20

Table 1. NACEP Written/Oral Evaluation
Number Tested and Percent Passing by State
March 1, 1994 - February 28, 1995

State	Written/Oral		Written		Oral[b]	
	Number Tested	Percent Passing	Number Tested	Percent Passing	Number Tested	Percent Passing
Alabama	3,591	81.2	3,510	82.2	81	37.0
Alaska	248	93.5	248	93.5	a	a
Arizona	3,684	91.4	3,582	92.5	102	52.0
California	62	96.8	61	96.7	1	100.0
Colorado	3,928	90.7	3,739	92.4	189	56.6
Delaware	928	79.3	888	80.7	40	47.5
District of Columbia	751	74.4	1,009	74.4	a	a
Idaho	1,940	95.8	1,917	96.1	23	69.6
Louisiana	741	73.5	708	74.9	33	45.5
Maine	430	94.9	430	94.9	a	a
Maryland	3,388	80.3	3,331	81.0	57	36.8
Nevada	920	91.0	915	91.5	5	100.0
New Hampshire	66	97.0	66	97.0	a	a
North Dakota	1,466	96.7	1,450	97.0	16	68.8
Oregon	3,143	94.6	3,092	95.3	51	49.0
Rhode Island	1,987	86.5	1,944	87.7	43	34.9
South Carolina	4,648	77.6	4,501	78.8	147	42.2
South Dakota	1,006	92.0	987	92.2	19	84.2
*Vermont	363	94.5	354	95.2	9	66.7
Virgin Islands	94	85.1	94	85.1	a	a
Virginia	6,638	85.0	6,528	85.7	110	43.6
Wyoming	1,053	96.5	1,048	96.6	5	80.0
Total	41,333	86.6	40,402	87.4	931	46.7

a No oral evaluations administered
b Includes Spanish
*Partial year only
Table prepared 04/26/95

Attachment A

Attachment B

Table 2. NACEP Manual Skills
Number Tested and Percent Passing by State
March 1, 1994 - February 28, 1995

State	Number Tested	Number Passing	Percent Passing
Alabama	3,260	3,032	93.0
Alaska	240	236	98.3
Arizona	1,991	1,837	92.3
California	58	57	98.3
Colorado	3,698	3,513	95.0
Delaware	844	804	95.6
District of Columbia	863	771	89.3
Louisiana	647	593	91.5
Maine	443	403	91.0
Maryland	2,972	2,845	95.7
Nevada	939	879	93.6
New Hampshire	65	62	95.4
North Dakota	1,468	1,409	96.0
Oregon	2,964	2,735	92.3
South Carolina	4,117	3,654	88.8
South Dakota	1,329	1,268	95.4
*Vermont	357	346	96.9
Virgin Islands	77	69	89.6
Virginia	6,262	5,803	92.7
Wyoming	1,099	1,053	95.7
Total	33,693	31,370	93.1

*for partial year only

Table prepared 04/26/95

8

FINANCE COMMITTEE

Report of the Finance Committee

Committee Members

Charlene Kelly, NE, Area II, *Treasurer and Chair*
Barbara Morvant, LA-RN, Area III
Jo Elizabeth Ridenour, AZ, Area I
Richard Sheehan, ME, Area IV
Lawrence Stump, MI, Area II

Staff

Jennifer Bosma, *Executive Director*
Thomas Vicek, *Director of Operations*

Relationship to Organization Plan

Goal V .... Implement an organizational structure that uses human resources efficiently.
Objective B .... Maintain a fiscal resource management system.

Recommendation(s)

Recommendations are made throughout the year to the Board of Directors regarding fiscal impact of proposed activities.

Highlights of Activities

- Reviewed FY95 budget adjustments resulting from Delegate Assembly action.
- Reviewed the committee's responsibilities based on the contents of a publication, *The Financial Responsibilities of Nonprofit Boards*, and interacted with auditors and staff relating to those responsibilities.
- Reviewed all funding proposals, provided feedback and made recommendations regarding designated funds as deemed appropriate.
- Monitored quarterly financial reports, including significant variances from budget.
- Met with the auditors and reviewed the FY94 audited financial statements and staff response to the management letter.
- Monitored insurance coverage, investments, all expenditures over $15,000, and financial policies.
- Approved the FY96 budget assumptions and FY96-FY00 financial forecast assumptions.
- Reviewed the FY96 budget by responsibility center and by Organization Plan objective, including capital acquisitions, and presented a tentative budget to the Board at its June meeting. The final budget, with any budget adjustments resulting from Delegate Assembly action, will be approved by the Board for implementation October 1, 1995.

Meeting Dates

- October 21, 1994
- January 20, 1995
- April 14, 1995
- June 1-2, 1995

Recommendation(s)

Recommendations are made throughout the year to the Board of Directors regarding fiscal impact of proposed activities.

9

NURSING PRACTICE &
EDUCATION COMMITTEE
AND SUBCOMMITTEES

Report of the Nursing Practice and Education Committee

Committee Members
Karen Macdonald, ND, Area II, *Chair*
Betty Hunt, NC, Area III
Dula Pacquiao, NJ, Area IV
Jan Zubieni, CO, Area I

Staff
Linda F. Heffernan, *Nursing Practice and Education Associate*
Vickie R. Sheets, *Director for Nursing Practice and Education*

Relationship to the Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Promote consistency in the licensure and credentialing process.

Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B .... Develop documents regarding health care issues which affect safe and effective nursing practice.

Bylaws .... Provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Recommendation(s)
No recommendations.

Highlights of Activities

- **Process for Evaluation of Usefulness of National Council Documents**

A tactic under Goal I states, "develop a process for evaluation of usefulness of models, practice actions and other position documents." The Nursing Practice and Education Committee developed a process which involves obtaining feedback on each document distributed. The document user will be asked to provide information about how the document was used and if it met the needs of the user.

A schedule for periodic review of documents is included to provide for regular evaluation of documents' timeliness and currency. Factors involved in document review include: volume of distribution; number of requests; feedback from Member Boards and other users; and internal staff feedback. A recommendation will be made to the Board of Directors as to the disposition of each document.

The evaluation process will be piloted on selected Nursing Practice and Education documents during FY96. A report on the pilot will be submitted to the Board of Directors.

- **Development of Strategies to Promote Professional Accountability**

A tactic under Goal II states, "identify and articulate board of nursing strategies in promoting professional accountability in licensed nurses." The Nursing Practice and Education Committee hosted a collaborative meeting with educators, practitioners and regulators on the issue of professional accountability. The group identified the critical elements of professional accountability and the behaviors that demonstrate these elements. The meeting was modeled on the collaborative model that was developed by the Nursing Practice and Education Committee during FY94. A full report of the meeting is found in Attachment A.

The Nursing Practice and Education Committee planned the second part of the professional accountability project, a qualitative study of selected discipline cases looking for evidence of behaviors that demonstrate a lack of professional accountability. This information will be used to develop proactive strategies to promote professional accountability for Member Boards to use.

■ **Coordination Role**

The Bylaws of the National Council of State Boards of Nursing state that the Nursing Practice and Education Committee "provides general oversight of nursing practice and education issues by coordinating related subcommittees."

The Nursing Practice and Education Committee coordinated four subcommittees: Essential and Continued Competence Subcommittee; Nursing Regulation Subcommittee; Member Board Education Needs Subcommittee, and Unlicensed Personnel Subcommittee. A member of the committee was designated as liaison with each subcommittee. The committee reviewed reports of the subcommittees and provided feedback.

The committee met with the chair of the Essential and Continued Competence Subcommittee, providing the direction for the subcommittee. In addition, the Nursing Practice and Education liaison was included in several conference calls. The Nursing Practice and Education Committee responded to the framework for the concept paper from the Unlicensed Personnel Subcommittee providing detailed commentary. The Nursing Practice and Education Committee met by conference call with the staff of the Nursing Regulation Subcommittee responding to the various regulation models, e.g., Ontario Plan, institutional licensure. The Nursing Practice and Education liaison for the Member Board Education Needs Subcommittee met via conference call with the subcommittee to assist in selecting the topic of focus for the subcommittee's activities.

In June, the Nursing Practice and Education Committee will be reviewing the final reports from each of the subcommittees and providing a response to the Board of Directors along with any recommendations. This report will be included in the supplement to the *Book of Reports*.

Future Activities

■ **Evaluation of National Council Positions and Documents**

A pilot project evaluating the usefulness of National Council positions and documents will be conducted and a report prepared for the Board of Directors in FY96.

■ **Professional Accountability**

The elements of professional accountability and the behavioral indicators identified by the Nursing Practice and Education Committee will be used as the basis for a qualitative study of selected discipline cases. The data obtained will be used to develop proactive strategies for boards of nursing to use in order to promote professional accountability.

Meeting Dates

- November 14-15, 1994
- February 26-27, 1995
- June 4-5, 1995

Recommendation(s)

No recommendations.

Attachment

A ....Professional Accountability - Using the Collaboration Model for the Identification of Strategies for the Promotion of Professional Accountability, *page 3*

Attachment A

Professional Accountability—Using the Collaboration Model for the Identification of Strategies for the Promotion of Professional Accountability

Background

The work of the Nursing Practice and Education (NP&E) Committee in developing strategies to promote professional accountability among licensed nurses builds upon two previous committee activities. First was the NP&E Committee's Paradigm Shift Regarding Competence paper of 1993, when the committee began to consider the whole of competence, including elements such as professional accountability. Second, in 1994, in response to a 1993 resolution by the Washington Board of Nursing for a pilot study to develop proactive strategies to prevent common nursing practice deficiencies, the NP&E Committee conducted a pilot study focusing on collaboration among nursing education, service and regulation to identify strategies for prevention of common nursing practice deficiencies. The Collaboration Model applied to the topic of professional accountability includes the following:

- **Phase One: Literature Review of Selected Topic**
- **Phase Two: Selection of an Expert Panel**
  - Assessment of nurses recognized as being highly professionally accountable - when, how did the nurse learn and incorporate as practice priority? Why is it a practice priority?
  - Identification of roles of nursing educators, nursing service and regulatory boards in promoting professional accountability
  - Identification of innovative strategies to promote professional accountability
  - Development of plan for implementation and evaluation
- **Phase Three: Report Findings**
- **Phase Four: Evaluation**

Phase One: Literature Review

Professional accountability is a fundamental value and forms the foundation for the development of a professional. The American Nurses' Association Code of Ethics is based on the accountability of the professional. (see for example, Kozier, 1991) Nursing texts contain chapters on legal and ethical considerations in professional practice. Literature dealing with competence and continued competence emphasize the role of professional accountability in the maintenance of competence. Inherent in the literature is the underlying obligation to be accountable and to participate in activities to maintain that competence.

The need to emphasize professional accountability in nursing education was highlighted in a study of academic misconduct among nursing students. The study was conducted because of the concerns regarding the potential risks of graduating inadequately prepared health care professionals. (Daniel, 1993) It was noted the "academic misconduct among nursing students in clinical settings is not merely an esoteric concern, but rather a display of intentional disregard for patient's needs." (Daniel, 1993)

Nursing Practice Acts include professional accountability among the Standards of Practice. Failure to meet the standards of practice is a ground for discipline. In addition, some practice acts specifically include the failure to accept responsibility for decisions and actions as a ground for disciplinary action. (National Council, 1994)

The Ontario College of Nurses revised its Standards of Nursing Practice and placed a strong emphasis on the individual's responsibility and accountability for the maintenance of professional competence. A process of "reflective practice" is an important aspect of professional competence. The individual nurse selects an approach for maintaining professional competence: he/she may participate in activities such agency assessment, formal education, developing a professional improvement profile, or building a professional portfolio. (McCrone, 1994) Professional accountability, or professional attitude, is a key component of Ontario's ongoing efforts to promote quality assurance.

Phase Two: Selection of the Work Group

A. *Creating the Work Group*

The committee identified the type of consultants that members believed would be needed to work with this topic. Selected participants represented nursing education (an undergraduate nursing instructor and a graduate-level educator), nursing service (licensed practical nurse from an acute care setting and a family nurse practitioner from the community) and public health (an urban department of public health nursing). Committee members represented boards of nursing. It was desirable to have representation from a variety of settings and nursing areas within the constraints of the model and time frame. Strong representation from education reflected the important role education plays in establishing professional values.

B. *Pre-panel Assignment*

The consultants were asked to identify nurses in their practice area who they believed regularly and routinely incorporated the following elements (from the National Council Model Nursing Administrative Rule Standards) into their nursing practice:

1. The nurse functions within the legal framework and scope of nursing practice set forth in the jurisdiction's Nursing Practice Act and Rules.
2. The nurse accepts responsibility for actions, competence and behavior.
3. The nurse retains accountability for delegated tasks.
4. The nurse respects client rights and property, and the property of others.
5. The nurse respects client confidentiality.

The panel members were instructed not to select individuals currently experiencing change in values (e.g., practicing nurses involved in current formal education). In addition to the responses to questions, demographic data were obtained about each nurse.

C. *Meeting of the Expert Panel*

After introductions and further explanation of the purpose of the meeting, the pilot group discussed the responses of the nurses interviewed. The information and experience that each panel member brought to the work group and the responses from the interviewed nurses contributed to identification of roles and innovative strategies to promote professional accountability.

Phase Three: Report Findings

A. *Work Product*

Professional accountability was defined by the work group as an obligation or willingness to accept responsibility. It provides a *gestalt* for practice, a structure that allows the integration of other elements of nursing practice. Professional accountability is being answerable for decisions and actions (external authority), and is the stimulus that compels a professional to deliver high quality services (internal conscience).

Each individual has a personal world view, thus a different starting point for considering aspects of professional accountability. As a nurse grows in knowledge, experience and judgment, the nurse moves from a "black or white" perspective toward the ability to see shades of gray. The nurse develops the ability to prioritize and recognize when the group's need prevails over an individual's, but also when the individual's need may take precedence over the group. Professional accountability involves both conscious thought and automatic response. Many aspects of accountability require careful consideration. Others, especially as they become internalized (e.g., response in an emergency situation) are automatic.

Maintaining flexibility in the interest of the client while learning to identify professional boundaries is an important aspect of professional accountability. Nurses strive in each contact to make a positive impact on the client. The complexity of each client, each decision, and each situation brings a richness to nursing practice. It is important that professional accountability be evaluated in the situation at hand, and not taken out of context.

B. *Identification of Roles of Education, Service and Regulation*

- **Nursing Education**—Obviously, nursing educators have the first chance to offer students knowledge, to provide role models and the opportunity to discuss and analyze challenging situations, and to begin to incorporate professional accountability as a practice value and priority.

- **Nursing Service**—The consultants involved in nursing service emphasized that professional accountability can be promoted by expecting professional attitude and behavior from nurses. Role modeling is also an important strategy in the practice setting.

- **Nursing Regulation**—The regulators indicated that the failure to be professionally accountable is often a factor in disciplinary cases. They believed that boards of nursing could take a more proactive role in promotion by drawing attention to the importance of professional accountability, educating students and licensed nurses as to expectations of the board, and involving the public in dialogue regarding this topic.

C. Identification of critical elements of professional accountability

The panel members conducted a total of seventeen interviews. The interviews were based upon elements of the standards related to professional responsibility in the National Council's *Model Nursing Administrative Rules.* Based the responses and ensuing discussion, the following critical elements of professional accountability were identified:

1. **The nurse is responsible for actions, practice and decisions.**
   This element reflects the need for any professional to accept responsibility for knowing the legal, ethical, and professional parameters of practice, maintaining those boundaries, and acknowledging when a decision or action has not been in the best interest of a client while taking corrective action in the client's behalf.

2. **The nurse demonstrates honesty and integrity.**
   This element reflects the fundamental values needed by a professional that permeate all aspects of nursing practice.

3. **The nurse knows and incorporates professional standards into nursing practice.**
   This elements reflects the need to achieve the necessary knowledge, skills and abilities, so that professional decisions are based on that knowledge and the expectations delineated in professional standards.

4. **The nurse maintains continued competence.**
   This element reflects the need to continually learn and apply to practice new knowledge and techniques in the client's interest.

5. **The nurse is self-reflective, critically reviewing actions, practice and decisions.**
   This element reflects the need for the nurse to "know thyself"—to be self-reflective, to review critically decisions, actions, and practice. The nurse needs to know what she/he knows, know what she/he does not know, recognize when it matters to know, and seek appropriate assistance, supervision and/or counsel.

D. Behaviors Which Evidence Professional Accountability

The panel members held a brainstorming session to identify behavioral indicators for each critical element of professional accountability. Those indicators are the collective work of the panel and are listed below. The categorization of the behavioral indicators represent a work in progress and may change upon further investigation of the critical elements.

1. **Responsibility**
   - The nurse performs competently, achieving desired outcome and intended effect.
   - The nurse demonstrates knowledge of Nursing Practice Act and the professional standards related to practice.
   - The nurse utilizes knowledge to govern actions, decisions and practice (knowledge based actions).
   - The nurse meets responsibilities based on professional standards.
   - The nurse advocates for clients.
   - The nurse internalizes professional standards.
   - The nurse intervenes as a response to an unexpected outcome.
   - The nurse admits mistakes and takes any necessary action to safeguard clients.

- The nurse monitors performance of delegated tasks.
- The nurse consults with other nurses and other health care team members.
- The nurse establishes policies and guidelines reflective of legal and professional standards.
- The nurse works within identified parameters (Nursing Practice Act, professional standards, agency policies and guidelines).

2. Honesty\Integrity

- The nurse demonstrates honesty and integrity in practice by:
  a. documenting accurately, completely and in a timely manner;
  b. presenting reports congruent with first rounds (allowing for clinical instability);
  c. having what is documented and reported by nurse correspond to what is observed by others (again, allowing for clinical instability).
- The nurse "owns" her/his own actions.
- The nurse demonstrates a willingness to pursue solutions.
- The nurse initiates actions.

3. Professional Standards

- The nurse exhibits behavior consistent with professional standards.
- The nurse knows limitations and understands the framework provided by professional standards.
- The nurse is ethical.

4. Continued Competence

- The nurse assesses self, using Nursing Practice Act and standards of practice as guide.
- The nurse plans and initiates the necessary strategies to maintain and advance competence.
- The nurse evaluates the effectiveness of strategies.
- The nurse shares outcomes of self-assessment and professional development with others to promote similar actions by others.
- The nurse keeps current.
- The nurse provides learning opportunities for others.

5. "Know Thyself"

- The nurse acknowledges herself/himself in behaviors and actions; articulates that, "I had a part in that..." and uses to a) build on the positive experience or b) learn from the negative experience.
- The nurse is open to receive other perceptions, new knowledge, feedback.
- The nurse recognizes standards and other perspectives - "there's something bigger out there than me."
- The nurse asks for assistance appropriately.
- The nurse identifies her/his role within the community of the group (unit culture) as evidenced by communicating information to appropriate health team members.
- The nurse differentiates between "positive" and "negative" accountability: "positive" accountability is triggered by concerns for client; "negative" accountability is triggered by fear for reputation, self.
- The nurse recognizes that she/he is not the only accountable member of the health care team, and trusts appropriately.
- The nurse tracks and documents professional development and growth (portfolio, other means).

These elements and indicators are the first step toward articulating standards and guidelines that can be used in a variety of nursing settings.

Phase Four: Evaluation

Panel members were enthusiastic about the critical elements and behavioral indicators identified. The educators plan to use these concepts in teaching and evaluating nursing students. The nurses in practice plan to use them to reinforce learning and to promote professional accountability among staff.

The Nursing Practice and Education Committee members plan to use the critical elements and behavioral indicators to develop a framework to guide a retrospective review of disciplinary cases. The committee's hypothesis is that the behavioral indicators, thus the critical elements of professional accountability, may be

missing in these cases. The Nursing Practice and Education Committee proposes to develop this project in FY96.

The evaluation of the usefulness of the critical elements and behavioral indicators can be addressed when other NP&E documents are reviewed by the NP&E Committee next year. In addition, follow-up is planned with panel participants regarding how they used the material in their respective areas of education and practice.

Conclusion

The committee again found the collaboration approach very effective. The model is straightforward and simple. It is envisioned that any of the parties in the collaborative process could activate the process. The model is designed so that it could be used as a part of a board meeting or a day workshop or as a conference. The cost of implementation of the model will vary dependent upon the complexity of the nursing practice deficiency identified. The costs of implementing identified strategies would depend upon the complexity of the topic considered.

The NP&E Committee members believe that the Collaborative Model provides a flexible framework for dealing with a variety of nursing practice issues. The literature review step adds breadth to the discussion, the approach of identifying positive practice models rather than deficient models was interesting and innovative. A side product of the process with the interaction between the nursing educator, the nursing service representatives and the NP&E Committee members. It was an opportunity for the NP&E Committee members to educate about regulation and the role of boards of nursing. It was an opportunity for the NP&E Committee members to be educated about the education and service roles and environments represented.

Nursing is not just a job—it is a profession. Being a member of a profession requires accepting the responsibility of being accountable to professional, legal and ethical standards. The critical components of professional accountability can be used by educators, nurses in practice and regulators to promote competence and quality assurance.

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Report of the Essential and Continued Competence Subcommittee

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Teresa Bello-Jones, CA-VN, Area I
Marjorie Bronk, TX-VN, Area III
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Vickie R. Sheets, *Director for Nursing Practice and Education*

Relationship to the Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective F .... Investigate mechanisms for evaluating continued competence.

Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective A .... Develop documents which provide guidance regarding the regulation of nursing practice.

Recommendation(s)
No recommendations.

Highlights of Activities

■ ***Development of Definition of Competence and Standards for Competence***

A tactic under Goal I states, "identify continuing competencies that cross all areas of practice." The Essential and Continued Competence Subcommittee determined that in order to identify continuing competencies or continuing competence, competence must be defined.

The subcommittee reviewed the prior work of various National Council committees in the area of competence and continued competence, the Non-Nursing Essential Competencies Study, the Role Delineation Study, and a fax survey of Member Boards regarding the Americans with Disabilities Act. A review of the literature was also conducted.

The subcommittee identified the elements of competence and articulated a definition of competence (Attachment A). The subcommittee also developed Standards for Competence which can be used by individuals, boards of nursing, employers, nursing educators and the public as a guide in the evaluation of professional competence (Attachment A). A complete discussion of the definition of competence and the Standards for Competence is contained in Attachment B, "Developing a Model for Nursing Competence: A Working Draft."

■ ***Application of Standards for Competence***

The Essential and Continued Competence Subcommittee posits that the Standards for Competence may be applied by the individual nurse as a self-assessment of competence. A Draft Model for Individual Competence Evaluation was developed based on the Standards for Competence (Attachment C). This model serves as the guide for an organized, periodic, focused and reflective assessment of competence by an individual nurse measured against the Standards for Competence. The Essential and Continued Competence Subcommittee considered how the Standards for Competence may be used by the individual nurse, Member Boards, employers, educators and the public.

The subcommittee identified the regulatory responsibilities related to competence. The development of a regulatory model must consider the role of a board of nursing in assuring competence of licensees as well as what a license conveys to the public regarding the nurse's competence. A consideration of the subcommittee is that the

public perceives that "a current license means current competence" while the current reality is closer to "a current license means that at the point of entry the nurse demonstrated competence (through education and NCLEX™) and has maintained an unencumbered license." Continued competence mechanisms, e.g., continuing education, may be involved in maintaining a license, but does this equal competence assurance? The subcommittee recognizes public education is needed to bridge this cognitive dissonance. In addition, movement by boards to a more proactive stance regarding competence is needed. The subcommittee proposes that the individual nurse is responsible for competence, and a board's role is to adopt standards and to educate various publics regarding this responsibility.

- ***Functional Abilities Validation Study***

  A tactic under Goal II states, "develop a list of essential nursing competencies to assist Member Boards in the interpretation of the Americans with Disabilities Act. Begin a list of non-nursing essential competencies." The Essential and Continued Competence Subcommittee has identified functional abilities (formerly termed "non-nursing essential competencies") which are essential for nursing practice, e.g., reading competence, hearing, analytical thinking. The subcommittee developed descriptive statements and some indicators for each identified functional ability. The subcommittee met with research staff to plan a study to validate the identified functional abilities. The subcommittee requested that the validation study be completed by January 1, 1996.

Future Activities

- ***Application of Standards for Competence***

  The subcommittee acknowledges that further development of the application of the Standards for Competence to the regulatory, practice and educational domains is needed. The next major step is to refine the regulatory model for competence, which includes assisting boards of nursing to promote the Draft Model for Individual Competence Evaluation, and identifying strategies for disciplining those who fail to maintain competence. In addition, a methodology for the assessment of the competence of the nurse with a disability must be incorporated into the model.

- ***Validation Study of Functional Abilities***

  Research staff will be conducting a validation study of functional abilities. Following evaluation of results, recommendations will be formulated.

Meeting Dates

- November 16-17, 1994
- February 23-24, 1995
- April 10-11, 1995
- April 25, 1995, *telephone conference call*

Recommendation(s)

No recommendations.

Attachments

A ....Definition of Competence and Standards for Competence, page 10
B ....Developing a Model for Nursing Competence: A Working Draft, page 11
C ....Draft Model for Individual Competence Evaluation, page 18

Attachment A

Definition of Competence and Standards for Competence

DEFINITION

The ability of a nurse to apply interpersonal, decision-making, and psychomotor skills at the level of knowledge expected for the nurse's current nursing practice role.

STANDARDS FOR COMPETENCE

1. Apply knowledge and skills at the level required for a particular practice situation.
2. Implement personal guidelines reflective of professional, ethical, and legal standards of practice.
3. Assure that clients' welfare prevails, and empower clients to participate in health care decisions and outcomes.
4. Implement professional development activities needed for nursing practice decisions and actions.
5. Demonstrate responsibility and accountability for nursing practice decisions and actions.
6. Exercise sound nursing judgment.
7. Use collaborative and interdependent activities to coordinate client health care.
8. Acknowledge the effect of a nurse's cognitive and functional abilities on the nurse's practice.

National Council of State Boards of Nursing, Inc.
April 1995

Attachment B

Developing a Model for Nursing Competence: A Working Draft

Abstract

Increasingly, consumer advocates challenge licensing bodies to assure the public that continuing competence is an attendant factor in continuing licensure. This paper proposes a working draft of a *Model for Nursing Competence* and specifies the components of the model: a definition of competence, standards for competence, and the application of the standards to the nursing regulatory domain. The draft model is in the early stages of development but is offered to Member Boards for review and response because discussion of the model is essential to facilitate its maturation. Evaluation and research are necessary for further development.

Introduction

The issue of competence has become one of the most controversial topics in meetings, forums, classrooms, health care settings, and legislatures around the country. Several aspects of competence have provided the focus for these debates. Competence has been discussed in relation to consumer protection, quality assurance, continued competence, the effects of disability on practice, and the disciplinary process. For boards of nursing, the driving force underlying this debate is the obligation to protect the public through the development and enforcement of reasonable and uniform standards for nursing education and practice.

Background

In the 1960s and 70s, the consumer movement raised the issue of the continued competence of licensees which led, in part, to the passage of Sunset legislation. As an outcome of the Sunset review process, many professional and occupational boards, including nursing, were mandated to establish mechanisms for assuring the continued competence of their licensees. The most common measure adopted was continuing education: however, the effectiveness of continuing education as a means to assure competence is much debated.

In 1985, the National Council published a position paper on continued competence. The paper described the status of continued competence across the country; defined continued competence; outlined general regulatory implications; provided guidelines for their establishment by jurisdictions; and recommended strategies for validating continued competence.

In 1991, the National Council published a *Conceptual Framework for Continued Competence*. The paper considered the measurement of competence from empirical and standard-setting perspectives. The 1985 premises were reviewed and new ones were added. Mechanisms for assessing competence and strategies to achieve or maintain competence were discussed. A model for continued competence depicting the processes of assessment, the identification and correction of deficits, and reassessment was developed for use by boards of nursing, employers and professional associations. The licensee's accountability for individual competence was not evident in the model.

In 1993, the Nursing Practice and Education Committee presented a *Paradigm Shift Regarding Competence*. The basic assumption in the new paradigm was the acknowledgement that "licensees, not the regulatory body, are primarily responsible for their own competence." A Board's envisioned role in the assurance of competence changed from that of the primary entity responsible for assuring competence to that of a collaborator with licensees and employers. Boards of nursing were identified as being responsible for enforcing compliance with statutory requirements or mandates.

The paradigm shift envisions a positive plan for competence to facilitate the collaboration between boards, licensees and employers. The focal point of the plan is the individual licensee's responsibility for self assessment and self limitation. The plan includes consideration of a nondisciplinary process that would enable the licensee who either has or acquires a disability to practice through accommodation rather than sanction.

In 1994, the Nursing Practice and Education Committee incorporated some of the concepts proposed in the *Paradigm Shift* into the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*. A "Special License" section was included in the model which authorizes a license that requires the individual nurse to practice only within a modified scope of practice or with accommodations or both, as specified by the board of nursing. The model rules procedure for granting a special license is a nondisciplinary process.

In 1994, the Board of Directors directed the Essential and Continued Competence Subcommittee to identify continuing competencies that cross all areas of practice and to develop a list of essential nursing competencies and non nursing essential competencies. The subcommittee's initial step was to examine the foundations of prior work in the area of competence, the responsibilities of boards of nursing regarding competence and the meaning of licensure.

Identified Challenge

The public expects practitioners to be competent to practice nursing, and, further, believes that a board of nursing is responsible to assure the competence of every nurse. This expectation poses a significant challenge to the individual nurse and to the board. The development of a model for competence enhances the ability of a board to meet the challenge.

Developing a model for nursing competence requires: articulating a definition, including the elements of competence; setting the standards to compare and evaluate the competence of individual nurses; and determining how individual nurses, boards of nursing, the public, nursing educators, and employers apply the standards.

Board of Nursing Responsibility

Boards of nursing exercise their inherent police power to protect the health, safety and welfare of the public by regulating nursing practice. Traditionally, boards of nursing have met this responsibility by licensing qualified individuals to practice nursing and by disciplining those individuals who are incompetent, negligent or violating the nurse practice act.

The usual qualifications for licensure are educational preparation and passing the licensure examination. When a board of nursing issues a license to a new practitioner or renews or restores a nurse's authority to practice, the board is authorizing the individual to practice nursing because the individual has met these pre-determined qualifications. The public, however, recognizes the license as assurance that the practitioner is competent.

Boards of nursing have, in the past, set the parameters for the scope of practice of nursing based on a traditional model for the delivery of nursing care. Specifically, the focus has been on clinical nursing using a process approach; however, the health care delivery system has changed dramatically. To articulate the knowledge, skills and abilities required of every nurse in every nursing care situation is unrealistic. A more credible expectation is to identify the criteria for evaluation of a nurse's ability to practice safely and competently. Boards of nursing now must focus broadly on the expected competencies of every nurse across every setting across every practice dimension.

The literature has reflected much study and discussion related to whether or not a license that is issued to a beginning practitioner has the same meaning as the subsequent continued renewal of that authorization to practice. A model of competence which bases its foundation on standards for competence provides the board with a dynamic means to measure the competence of every nurse. The model would remain applicable despite changes in the health care delivery system and changes in the roles and responsiblities of licensed nurses.

Defining Competence

Defining competence is a difficult undertaking because of the complexity of the concept. A beginning or novice practitioner is a generalist. An experienced practitioner has focused on a particular area of practice. Is the expectation of competence the same for both? Should the definition of competence be inclusive of both?

Black's *Law Dictionary* defines competent as being "duly qualified; answering all requirements; having sufficientability or authority; and possessing the requisite natural or legal requirements." Webster provides a similar definition: "having requisite or ability or qualities; legally qualified or adequate; having the capacity to function or respond." The National League for Nursing Council of Practical Nursing Programs defines competency as "cognitive, affective, and/or psychomotor capability demonstrated by the licensed ... nurse in various roles in the practice settings." (NLN, 1989) Kane, in *The Assessment of Professional Competence*, states that professional competence is "the degree to which an individual can use the knowledge, skills and judgment associated with the profession to perform effectively in the domain of possible encounters defining the scope of professional practice."

The elements of competence are a specific knowledge base, awareness of practice standards, psychomotor skills, decision-making skills, communication skills, experience and attitude. The idea of "wholeness" may be used to envision competence as more than the sum of many individual elements. If one element is missing, the nurse is not considered to be competent. For example, a nurse may be knowledgeable, technically proficient, experienced, and caring but is unable to relate to the client in a therapeutic and supportive manner. A synthesis of the elements of competence results in a definition: the ability of the nurse to apply interpersonal, technical and decision-making skills at the level of knowledge expected for the nurse's current nursing practice role.

Elements of Competence

Competence requires that the nurse have a knowledge base of sufficient breadth and depth for safe and effective nursing practice. The knowledge base essential for competence includes principles of nursing science, as well as principles from the humanities, and the biological, physical and social sciences. The knowledge base provides the nurse with the fundamental information necessary to make sound decisions.

Providing care for clients involves many kinds of nursing skills. A second element of competence is having the psychomotor skills needed to collect the information about a particular client and to perform the interventions required for the particular nursing situation. The knowledge base and psychomotor skills enable the nurse to gather the information necessary to make nursing decisions about nursing problems and desired client outcomes.

Decision-making is the ability to process information prudently to determine a logical, deliberate and well-grounded conclusion. The information used must be accurate and collected appropriately. The outcome of decision-making is choosing the right action, at the right time, using the right resources.

Previous experience is an essential element of a nurse's knowledge base, skills and decision-making. Experience is the transference of learning from previous nursing situations where the nurse had direct observation and participation. Experience assists the practitioner to make astute observations and judgments, learn new skills more quickly and process new information more easily.

The gathering and processing of information is pointless unless the practitioner communicates that information accurately, appropriately, and in a timely manner. Communication is the ability to interact therapeutically and exchange information with clients, families and other health care professionals.

The concept of competence encompasses the adherence to standards of practice expected of the professional. These standards include professional standards of practice, specialty practice standards, institutional standards, as well as ethical codes and legal standards.

Competence includes professional attitude. Attitude is the mental posture of the practitioner. It is the manner in which the professional interacts, the way the nurse attaches to responsibility and the behavior of the professional. It is also the integrity of the nurse to acknowledge personal limitations in knowledge and skills, i.e., to know what one knows and does not know, and to remediate those limitations. Personal and professional values form the core of professional attitude.

The elements of competence are bound together by the responsibility and accountability of the practitioner to practice nursing safely and effectively.

Standards for Competence

Competence is universal in concept but is specific in application. *Standards for Competence* must address the universal concepts with application in the specific. The *Standards for Competence* must reflect the essential behaviors necessary for safe and effective practice of nursing. They must be applicable to every nurse in every nursing dimension, but they must also be applicable to a specific nurse in a specific nursing situation. The standards must address the elements that cross all practice arenas. The standards must state clear expectations so that they are easily understood and applied. *Standards for Competence* should be used by individual nurses, boards of nursing, employers, educators and the public.

- **Standard 1: Apply knowledge and skills at the level required for a particular practice situation.**

  Rationale: A nurse is expected to have a base of knowledge and skills that can be transferred from setting to setting, client to client. In addition to the transfer of knowledge and skills is the ability to apply and adapt the knowledge and skills to the particular nursing dimension. Care in the hospital and care in the home require particular application of the same skills. Two clients with the same condition may require different assessments and skills. In addition, the nurse is expected to possess the knowledge and skills that are particular to a specific area of practice. This expertise must also be maintained at the level required for safe and effective nursing practice.

- **Standard 2: Implement personal guidelines reflective of professional, ethical and legal standards of practice.**

  Rationale: A nurse is expected to know and understand the standards of practice that govern and guide nursing. These guidelines should be incorporated into the practice of the individual nurse to promote safe and effective nursing practice.

- **Standard 3: Assure the client's welfare prevails and empower clients to participate in health care decisions and outcomes.**

  Rationale: The client's interest must come before the nurse's interests. This does not mean that the client is always right. A nurse must respect the client's position and provide the client with the knowledge and resources necessary for the client to make informed health care decisions and direct outcomes.

- **Standard 4: Implement professional development activities needed for nursing practice decisions and actions.**

  Rationale: A nurse must keep knowledge and skills current to maintain safe nursing practice. Nursing is a dynamic profession which is changing rapidly in response to the changing health care delivery system. Therefore, a practitioner is required to participate in activities which will maintain or increase knowledge base and skills.

- **Standard 5: Demonstrate responsibility and accountability for nursing practice decisions and actions.**

  Rationale: A nurse is responsible for the safe performance of skills; accurate assessments; careful decision-making; and execution of duties associated with the nurse's particular role. A nurse is accountable for the consequences of actions and decisions to self, the client, the profession, the employer, the board of nursing, and to society at large.

- **Standard 6: Exercise sound nursing judgment.**

  Rationale: Nursing judgment is based on careful assessment and analysis of data. The nurse must know what information is needed to make a sound nursing judgment and how to gather that information. The nurse employs decision-making skills to process the information. Nursing judgment implies that a decision is made regarding nursing interventions and outcomes that are appropriate to the particular client situation. The decision is made after an analysis of the effectiveness and efficiency of the interventions in relation to the desired outcomes.

- **Standard 7: Use collaborative and interdependent activities to coordinate client health care.**

  Rationale: A nurse is part of a health care team. The nurse must contribute information that will assist the team to plan and provide comprehensive care to the client. The nurse must be aware of the services available to clients and obtain the services required or make the proper referrals.

- **Standard 8: Acknowledge the effect of his or her cognitive and functional abilities on his or her practice.**

  Rationale: The Americans with Disabilities Act has encouraged nurses, educators, employers and regulators to identify the essential abilities needed by nurses to practice safely. The nurse must be aware of the abilities required for safe nursing practice and of any personal limitations with respect to these abilities. The nurse should either make or request the accommodations needed to practice nursing safely.

The subcommittee has identified a list of functional abilities (formerly known as "non-nursing essential competencies), a descriptive statement and behavioral indicators for each. These functional abilities support nursing competence. Without these functional abilities, the nurse cannot practice safely. These functional abilities cross all areas of nursing practice.

Application of Standards

The final component of the *Model for Nursing Competence* is the determination of how individual nurses, boards of nursing, the public, nursing educators, and employers use the *Standards for Competence.*

- **Individual**

  A standard may be used as a measure for competence assessment, i.e., to compare and evaluate the competence of an individual nurse. Included in the proposed *Model for Competence* is a *Draft Model for Individual Competence Evaluation* based on the *Standards for Competence*. The individual nurse is expected to conduct a periodic, focused and reflective assessment to determine individual knowledge and identify learning needs required of the nurse's specific practice role. Inherent in the evaluation process is the practitioner operationalizing the responsibility for learning and development as a continual part of the nursing life. A method for demonstrating accountability that is useful and applicable to all dimensions of nursing is the professional portfolio.

- **Regulatory**

  Setting competence standards is a method boards can employ to identify the responsibility of every nurse to be accountable for individual competence. Competence standards reflect the elements that the board determines are essential for the safe and effective practice of nursing. Since standards are compared to actual performance, a board identifies a model for evaluation that the individual nurse, the employer and the public can use to determine the competence of a practitioner.

  Once a board of nursing has determined the standards for competence, the board communicates the standards for competence to the public, nurses, nursing educators, and employers. That communication should emphasize the individual responsibility of every nurse to be accountable.

  Boards of nursing are obligated to take appropriate measures against a practitioner who is incompetent, i.e., fails to meet the standards, and to determine what provisions are necessary for the nurse to become competent. Discipline remedies are fashioned to relate to the standards not met. Boards should also consider nondisciplinary provisions for disabled practitioners that relate to the standards not met.

- **Public**

  A particular challenge to the development of the *Model for Nursing Competence* is the responsibility to identify use of the *Standards for Competence* by the consumer of the nurse's services. Assurance of competence requires assessment of the nurse's practice in relation to those standards. The development of a consumer-use survey which facilitates the consumer to objectively compare the actual outcomes to the expected behaviors identified in the standards is an intriguing consideration.

- **Educators**

  The *Model for Nursing Competence* requires nursing educators to incorporate the *Standards for Competence* into curriculum requirements of basic education programs, continuing education and refresher courses. The outcome of socializing nursing students to the expected behaviors will serve as a core for the acceptance of the personal responsibility which is the primary requisite for assurance of continuing competence throughout a nurse's career.

- **Employers**

  Employers may apply the *Standards for Competence* to develop a competence appraisal system. Such a system could provide the framework for ongoing practitioner improvement activities and the establishment of a mechanism to document competence in a specific nursing dimension. The model purports that it is the responsibility of employers to provide opportunities for nurses to facilitate their continued competence.

Conclusions and Future Directions

The increasingly complex health care environment, rapid advances in health care science and growing public sophistication create an expectation that boards of nursing provide assurance that the licensed nurse is competent. The unique characteristic of the proposed *Model for Nursing Competence* is its universality of application. The model may be applied to every nurse in every dimension. The standard-setting approach addresses the continuum of practitioner experience, i.e., competence to practice at entry, continuing competence and restoring competence upon reentry to practice. User application has a wide scope. The model may be operationalized by the individual nurse to determine learning and development needs. Boards of nursing may apply standards to address licensee remediation or accommodation. Nursing educators and staff developers may develop educational strategies based on the *Standards*

for Competence. In addition, the model may provide a basis for researchers to develop reliable and valid instruments and to examine relationships within the model.

The *Model for Nursing Competence* is based on identified standards for competence which must be validated in all dimensions of nursing. The operationalization of the model requires further development of the application of the standards to the regulatory, practice, educational, and public domains. The essential functional abilities which have been identified must be validated through research.

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Attachment C

Draft Model for Individual Competence Evaluation*

The nurse:

1. Conducts an organized, periodic, focused and reflective assessment to understand the knowledge and skills required for his or her current or prospective practice role.

   a. Identify role expectations (determine the knowledge and skills needed for the role)
   Sources: position description
   review of literature
   networking (talk to someone doing the role)
   observe and/or shadow another nurse (mentor, preceptor)

   b. Self evaluation (determine individual level of knowledge and skills needed for the role)
   Sources: skill inventory
   assessment test
   cognitive appraisal
   peer review

   c. Identify strengths and learning needs
   Source: cognitive comparison of role expectations and individual abilities.

   d. Develop and implement a learning plan (identify and carry out learning activities needed by the learner)
   Sources: orientation
   formal or continuing education
   independent study
   refresher course
   precepted learning experience
   simulated learning experience
   other experiential learning

   e. Evaluate the effectiveness of learning and its impact on the practice role
   Sources: reassessment (formal or informal)
   testing
   peer review
   performance evaluation

2. Articulates an awareness of regulatory, professional and ethical standards.
   Sources: Nursing Practice Act
   American Nurses' Association Code of Ethics

3. Demonstrates a respect for client individualism.

   a. Articulates a respect for the social, cultural and spiritual diversity of clients
   b. Maintains therapeutic boundaries
   c. Facilitates client decision-making by providing information, identifying choices and possible outcomes, and supporting client decisions

4. Develops professional growth and development criteria recognizing the individual level of experience.

5. Accepts the legal and ethical obligations of the profession and answers for one's own actions and decisions.

6. Demonstrates critical thinking by:

   a. Synthesizing knowledge and skills relevant to client needs in carrying out the nursing role
   b. Delegating nursing activities appropriately
   c. Identifying cause and effect relationships
   d. Recognizing limits of knowledge and skills
   e. Using resources appropriately

7. Evaluates the effectiveness of collaborative efforts by:

   a. Differentiating nursing functions from functions of other providers
   b. Communicating with the health care team
   c. Assessing the effectiveness of referrals
   d. Assessing the impact of collaboration on health promotion, maintenance, illness prevention for the client

8. Limits nursing practice and/or implements accommodations for practice because of cognitive, mental, or physical disabilities to ensure that such disabilities have no detrimental impact upon client safety.

**Based on "Standards for Competence," National Council of State Boards of Nursing, Inc., April 1995.*

Report of the Member Board Education Needs Subcommittee

Committee Members
Harriet Johnson, NJ, Area IV, *Chair*
Alice Enderlin, IL, Area II
Mary Anne Hanley, TX-RN, Area III
Michael McCleery, WY, Area I

Staff
Linda F. Heffernan, *Nursing Practice and Education Associate*

Relationship to the Organization Plan
Goal III .... Provide Information, analysis and standards regarding the regulation of nursing education.
Objective A .... Provide documents which provide guidance regarding the regulation of nursing education.

Recommendation(s)
No recommendations.

Highlights of Activities

- ***Community-Based Education Program Planned***

  A tactic under Goal III, Objective A, states, "based on a review of Member Board role in the regulation of nursing education, identify needs and plan strategies for assisting Member Boards." The Member Board Education Needs Subcommittee reviewed the Trend Analysis Study, Standards for Nursing Education from the *Model Nursing Administrative Rules* and the feedback from the Education Staff Networking Session at the 1994 Annual Meeting. The subcommittee identified community-based education as a major issue in education. The subcommittee reviewed literature on the subject prior to the meeting.

  The subcommittee elected to present a discussion of the issues involved in the use of community based settings for learning as a special interest group at the 1995 Annual Meeting. The discussion will emphasize strategies to facilitate the movement of education out of institutions into community settings.

Meeting Dates
- November 30, 1994, *telephone conference call*
- March 6, 1995

Future Activities
- If approved by the Board of Directors, the Member Board Education Needs Subcommittee will assist the Board of Directors in identification of Member Board needs related to the regulation of nursing education.

Recommendation(s)
No recommendations.

Report of the Nursing Regulation Subcommittee

Committee Members

Libby Lund, TN, Area III, *Chair*
Cheryl Graves, NE, Area II
Sr. Teresa Harris, NJ, Area IV
Ann Torres, AZ, Area I

Staff

Carolyn Hutcherson, *Senior Policy Analyst*

Relationship to Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Promote consistency in the licensure and credentialing process.

Recommendation(s)

No recommendations.

Highlights of Activities

The Nursing Regulation Subcommittee of the Nursing Practice and Education Committee held three meetings and one conference call. The specific charge to the subcommittee was to develop a methodology to identify the benefits and costs of nursing regulation. Concurrent with the subcommittee's initial exploration of strategies to accomplish this directive, a number of documents were distributed by the Pew Health Professions Commission (Pew) describing their goals, strategies for state initiatives and proposed healthcare provider competencies. Grants were awarded by Pew in at least eight jurisdictions to study educational and regulatory reform. The approach to these projects reflected the Pew philosophy that workforce changes would impact both the educational and regulatory system at the state level. Among the questions raised by Pew were concerns about the usefulness and efficiency of state level regulation. The subcommittee identified foundational principles of current nursing regulation and considered at length problems arising from consumer expectations of the regulatory community. Numerous surveys were reviewed which validated consumer confusion and uncertainty about what role various regulatory entities play in the overall healthcare delivery picture.

A brainstorming session was held identifying what boards of nursing do, why they should do what they do, and whether any other entity could perform this function. Additionally, the subcommittee identified a number of fundamental beliefs about nursing regulation and developed a comprehensive list of functions which currently fall within the regulatory domain. From this list, a questionnaire was developed for completion by Member Boards. Respondents were asked to indicate the extent to which they agreed with specific philosophical statements about nursing regulation. A second portion of the survey asked boards to select the five most crucial regulatory functions and the five least essential regulatory functions from an identified list. Responses to the survey will be utilized as a component of comparison and analysis of the various regulatory approaches. Five potential regulatory approaches were identified: a) the current state board system; b) institutional licensure; c) the Ontario model (controlled acts); d) regulation by professional associations (other Canadian provinces); and e) national licensure/regulation. Based on subcommittee recommendations to the Board of Directors, dialogue was initiated between the Pew Health Professions Commission and National Council. Additionally, a speaker was recommended for the Annual Meeting with managed care experience as well as knowledge of the regulatory implications emanating from managed care implementation.

Area Meetings provided a forum for subcommittee members to glean updates on state activities about proposals for modification in board function and/or structure. Subcommittee members unanimously affirmed their perceptions from the Area Meetings that boards are committed to maximize the opportunity for exploration and evaluation of new ideas. The subcommittee encourages National Council to assume a leadership role in designing a regulatory system for the future which ensures safe and effective nursing care.

Future Activities

The Nursing Regulation Subcommittee will prepare a report based on the survey on regulatory philosophy and the essential function of regulation, prior to the 1995 Annual Meeting. Additionally, an analysis of the various regulatory

models will be provided based on the identified essential functions of regulation. A comprehensive approach will be presented for development of a regulatory description of nursing within a reformed healthcare delivery system as well as for proposal of an ideal regulatory model for the future. Review of emerging data on the benefits and costs of various restructuring initiatives and development of a method for identifying the benefits and costs of nursing regulation should occur during FY96.

Meeting Dates

- December 13-14, 1994
- January 19-20, 1995
- March 14, 1995, *telephone conference call*
- May 1-2, 1995

Recommendations

No recommendations.

Attachments

A ....Nursing Regulation Questionnaire and Results *(to be mailed in late June)*
B ....Draft Criteria for Evaluation of Proposed Regulatory Approaches *(to be mailed in late June)*

Attachment A

Nursing Regulation Questionnaire and Results

Rank Ordered Member Board Survey Results

Fundamental Beliefs About the Regulation of Nursing

Average Rating	
3.00	1. Consumers have a right to expect nurses to meet ethical, professional and legal standards.
2.98	2. Nursing regulations should be administered in a fair, ethical and impartial manner.
2.95	3. A license to practice nursing is a privilege; nurses must be accountable for obeying all laws governing practice.
2.93	4. Nursing regulations should be based on rationality as opposed to being arbitrary or capricious.
2.84	5. Nursing regulations should be administered in a cost effective and cost conscious manner.
2.77	6. Professional regulation encompasses the enforcement of laws governing practice.
2.72	7. Nursing regulations should be at the least restrictive level needed to ensure public safety.
2.67	8. Protection of the public includes dissemination of information about disciplinary action within the jurisdiction.
2.67	9. Protection of the public includes provision of information about disciplinary activity across jurisdictional boundaries.
2.59	10. Consumer participation in the regulatory process is valuable in assuring greater responsiveness to the public's needs.
2.56	11. Nursing regulators must rely upon research findings, experience and collaboration with others to improve the regulatory system.
2.49	12. Nursing regulation should exist solely to protect/benefit the health, safety and welfare of the public.
2.31	13. Nursing regulation should include provisions which ensure protection of the rights of the nurse.
2.31	14. The profession being regulated should bear the cost of its regulation.
2.07	15. Nursing regulation should facilitate rehabilitation of nurses within the boundaries of safe and effective nursing care.

Rank Ordered Member Board Survey Results

Essential Functions of Regulation

Average **Rating**	
2.75	1. Administer the Nurse Practice Act as passed by the state legislature.
2.73	2. Discipline nurses who have violated the Nurse Practice Act.
2.57	3. Set minimum standards for safe and effective nursing care.
2.39	4. Determine requirements for initial licensure.
2.32	5. Set standards for approval/accreditation* of nursing education programs.
2.16	6. Participate in development of regulatory policy at the state and national level.
2.09	7. Investigate nurses who (may) have violated the Nurse Practice Act.
1.77	8. Establish standards for continuing competence.
1.77	9. Establish standards for professional conduct.
1.68	10. Determine standards for license renewal.
1.68	11. Serve as an information resource about laws, rules and regulations pertaining to nursing.
1.57	12. Process licenses for applicants who meet licensure requirements.
1.50	13. Monitor and/or provide for rehabilitation for nurses who have been disciplined.
1.50	14. Provide for public access to information about disciplinary action taken against licensees.

**use term indicated by state to denote state process*

Attachment B

Criteria for Evaluation of Proposed Regulatory Approaches

NURSING REGULATION...

Exists to protect/benefit the health, safety and welfare of the public.

Requires adherence to ethical, professional and legal standards.

Is administered in a fair, ethical and impartial manner.

Requires anyone practicing nursing to be accountable for obeying all laws governing practice.

Is based on sound reason as opposed to being arbitrary or capricious.

Is administered in a cost effective and cost conscious manner.

Encompasses the enforcement of laws governing practice.

Is at the least restrictive level needed to ensure public safety.

Ensures licensed nurse has demonstrated the knowledge, skills and abilities to provide safe and effective nursing care. *

Provides for protection of the public by dissemination of information about disciplinary action within the jurisdiction.

Includes provision of information about disciplinary activity across jurisdictional boundaries.

Includes participation in development of regulatory policy at the state and national level. *

Includes setting and monitoring of standards for nursing education. *

Ensures consumer participation in the regulatory process.

Is based upon research findings, experience and collaboration with others.

Includes provisions which ensure protection of due process for all parties.

Provides for costs to be born by those regulated.

Provides for remediation of nurses within the boundaries of the laws governing nursing.

* *From Essential Functions survey*

Report of the Unlicensed Personnel Subcommittee

Committee Members
Harriett Clark, CA-RN, Area I, *Chair*
Edna Fannin, LA-PN, Area III
Marie Fisher, ME, Area IV
LaRee Rowan, MN, Area II

Staff
Carolyn Hutcherson, *Senior Policy Analyst*

Relationship to Organization Plan
Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective A .... Develop documents which provide guidance regarding the regulation of nursing practice.

Recommendation(s)
No recommendations.

Highlights of Activities
The initial charge to the Unlicensed Personnel Subcommittee was to develop strategies for addressing issues related to the provision of nursing care by unlicensed assistive personnel (UAP) by monitoring trends, analyzing public benefit of unlicensed assistive personnel, and studying role delineation data. Additionally, the subcommittee was asked to explore the benefits of a comprehensive study on the effects of nurse aide/assistant training on care provided in nursing homes.

After review of background documents from National Council, OBRA, NACEP, and Member Boards related to the role and utilization of unlicensed providers, the subcommittee decided to prepare a comprehensive outline of issues impacting the UAP, the licensed nurse, the practice setting and the regulatory system. Among the concerns expressed most frequently by Member Boards were issues related to delegation, supervision and accountability. The Unlicensed Assistive Personnel Issues Outline was distributed to Member Boards for feedback and comment. Comments accompanying responses to the outline verified the pressure Member Boards are experiencing as they attempt to respond to very complex questions while developing policies which ensure public safety related to utilization of unlicensed assistive personnel. Several major themes emerged from review of Member Board comments on the outline:

- quality and safety concerns are the same for the client, regardless of the qualification of the provider
- preparation and training for all UAPs should be augmented and standardized
- only persons with authority to perform nursing can delegate and supervise nursing
- delegation must be based on sound clinical judgment and regulatory principles
- consumers are confused about qualifications of providers
- research data must be gathered to ascertain the impact of substitution of unlicensed providers for licensed providers
- protection of the public must be paramount in all decisions regarding patient care

By consensus, the subcommittee accepted the fundamental premise that when the unlicensed person is performing a nursing task, performance of that task must meet the same standard as if the task were performed by a licensed nurse. Since proliferation and variation in titles used to describe the unlicensed provider are adding to the confusion in the health care system, the subcommittee suggested that unless otherwise required by external regulations such as OBRA, the term Unlicensed Assistive Personnel (UAP) should be used for any non-licensed provider who assists with nursing activities.

Future Activities
The Unlicensed Personnel Subcommittee has identified a number of resources which could assist Member Boards. The Concept Paper on Delegation will be revised and updated to reflect changes in the healthcare delivery system as well as the impact of restructuring/redesign proposals. The Delegation Decision Model (a component of the Concept

Paper on Delegation) will be based on a compilation of processes identified in Member Board position statements and declaratory rulings on delegation and utilization of unlicensed assistive personnel. The purpose for preparation of the decision model is to assist Member Boards by providing a resource for the nurse in clinical practice who is expected to make sound delegatory decisions. In FY96, preparation of documents should be undertaken to assist Member Boards who have statutory authority for regulation of UAPs as well as for those Member Boards that do not regulate the UAP but must respond to questions and inquiries about the relationship of the licensed nurse to the unlicensed assistive provider.

Meeting Dates

- December 15-16, 1994
- January 13, 1995, *telephone conference call*
- March 17-18, 1995
- May 15-16, 1995

Recommendation(s)

No recommendations.

Attachments

A .... Working Draft, Concept Paper on Delegation *(to be mailed in late June)*

Attachment A

National Council of State Boards of Nursing Delegation Decision-Making Process

Introduction

In considering the number and complexity of issues related to delegation, it was determined that the most immediate need was for practical guidelines to direct the process for making delegatory decisions. These guidelines are consistent with National Council's 1990 *Concept Paper on Delegation.*

Purpose

The purpose of this paper is to provide a resource for Boards of Nursing on delegation and the roles of licensed and unlicensed health care workers. This paper emphasizes and clarifies the responsibility of Boards of Nursing for the regulation of nursing, including nursing tasks performed by unlicensed health care workers, and the responsibility of licensed nurses to delegate nursing tasks in accord with their legal scopes of practice. Each person involved in the delegation process is accountable for his or her own actions or inaction and is potentially liable if competent, safe care is not provided.

Premises

1. All decisions related to delegation of nursing tasks be based on the fundamental principle of protection of the health, safety and welfare of the public.

2. Boards of Nursing are responsible for the regulation of nursing. Any activity labeled as nursing or provision of any care which constitutes nursing is a regulatory responsibility of Boards of Nursing.

3. Boards of Nursing should articulate clear principles for delegation, augmented by clearly defined guidelines for delegation decisions.

4. The licensed nurse is responsible and accountable for the provision of nursing care.

5. The licensed nurse should be involved in all decisions related to the provision and delegation of nursing care.

6. While nursing tasks may be delegated, the practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated.

7. When a nursing task is delegated, the task must be performed according to the same level of skill as if the task were performed by a licensed nurse.

8. The licensed nurse determines and is accountable for the appropriateness of delegated nursing tasks. Inappropriate delegation may lead to disciplinary action by the Board of Nursing and criminal prosecution for the unlicensed person.

9. There is a need and a place for competent, appropriately supervised, unlicensed assistive personnel in the delivery of affordable, quality health care. However, it must be remembered that unlicensed assistive personnel are to assist--not replace--the nurse. Thus, unlicensed assistive personnel should be assigned to assist the nurse rather than to patients.

10. A task delegated to an unlicensed assistive person cannot be redelegated by the unlicensed assistive person.

11. Nursing is a process discipline and cannot be reduced solely to a list of tasks. The licensed nurse's specialized education, professional judgment and discretion are essential for quality nursing care.

Definitions

Accountability: .... Being responsible and answerable for actions or inactions of self or others in the context of delegation.

Delegation: .... Transferring to a competent individual authority to perform a selected nursing task in a selected situation. Each person involved in the delegation process is accountable for his or her own actions or inaction.

Delegator: .... The person making the delegation.

Delegatee: .... The person receiving the delegation.

Supervision: .... The provision of guidance or direction, monitoring, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.

Unlicensed
Assistive
Personnel (UAP): ..... Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.

Regulatory Perspective

Boards of Nursing have the legal responsibility to regulate nursing and provide guidance regarding delegation. Registered nurses (RNs) may delegate certain nursing tasks to Licensed Practical Nurses/Licensed Vocational Nurses (LPNs/VNs) and unlicensed assistive personnel (UAPs). In some jurisdictions, LPNs/VNs may also delegate certain tasks within their scope of practice to unlicensed persons. The licensed nurse has a responsibility to assure that the delegated task is performed according to the same level of skill as if the task were performed by a licensed nurse. The nurse who delegates retains accountability for the task delegated.

The regulatory system should serve as a framework for managerial policies related to the employment and utilization of licensed nurses and unlicensed assistive personnel. It is the nurse who assesses and determines the clients' nursing needs and plans appropriate nursing care. It is the nurse who should decide and is accountable for delegation. If the nurse decides that delegation may not appropriately take place, but nevertheless delegates, that nurse may be disciplined by the Board of Nursing.

Acceptable Use of the Authority to Delegate

The delegating nurse is responsible for an individualized assessment of the patient and circumstances, and for ascertaining the competence of the delegatee before delegating any task. Thepractice-pervasive functions of assessment, evaluation and nursing judgment should not be delegated. Supervision, monitoring, evaluation and follow-up by the nurse are crucial components of delegation. The delegatee is accountable for accepting the delegation and for his/her own actions in carrying out the task.

The decision to delegate should be consistent with the time-honored and well established nursing process, i.e., appropriate assessment, planning, implementation and evaluation by the nurse delegator. This necessarily precludes a list of nursing tasks that can be routinely and uniformly delegated for all patients in all situations. Rather, the nursing process and decision to delegate must be based on careful analysis of the patient and circumstances. The authority and qualifications of the proposed nurse delegator are critical to delegation decisions. Two guidelines that may help to facilitate appropriate delegation decisions are provided: 1) the Five Rights of Delegation; and 2) the accompanying Delegation Decision Process.

The Five Rights of Delegation

RIGHT TASK
One that is delegable for a specific patient.

RIGHT PERSON
Right person is delegating or assigning the right task to the right person to be performed on the right person.

RIGHT DIRECTION/COMMUNICATION
Clear, concise description of the task, including its objective, limits and expectations.

RIGHT SUPERVISION
Appropriate monitoring, evaluation, intervention, as needed, and feedback.

RIGHT CIRCUMSTANCES
Appropriate patient setting, available resources, etc.

Once the decision to delegate has been made, the nurse must ensure appropriate planning, implementation and evaluation, a continuous process which is described by the following delegation model.

The decision to delegate should be based on the following:

Delegation Decision Process

I. Assessment
   A. Needs of the patient identified
   B. Circumstances/setting considered
   C. Adequate resources (including supervision) available

II. Identify specific task(s) to be delegated
   A. Nature of task(s)
   B. Implications for patient
   C. Implications for other patients

III. Delegation criteria
   A. Nursing Practice Act
      1. Permits delegation
      2. Authorizes task(s) to be delegated or authorizes the nurse to decide on delegation
   B. Delegator qualifications
      1. Within scope of authority to delegate
      2. Appropriate education, skills & experience
      3. Documented/demonstrated evidence of current competency
   C. Delegatee qualifications
      1. Appropriate education, training, skills & experience
      2. Documented/demonstrated evidence of current competency

IV. Accountability
   A. Qualified delegator accepts accountability for performance of the task(s)
   B. Qualified delegatee accepts the delegation and performs task(s) correctly

V. Performance/supervision of the task
   A. Provide directions and clear expectations of how the task(s) is to be performed
   B. Monitor performance of the task(s)
   C. Intervene if necessary
   D. Assure compliance with established standards of practice/policies and procedures
   E. Document performance of the task(s) in the patient record

VI. Evaluate entire process
   A. Evaluate patient
   B. Evaluate performance of task(s)
   C. Obtain and provide feedback

VII. Reassessment--adjust overall plan of care as needed

Supplemental Report of the Nursing Practice and Education Committee

Committee Members
Karen Macdonald, ND, Area II, *Chair*
Betty Hunt, NC, Area III
Dula Pacquiao, NJ, Area IV
Jan Zubieni, CO, Area I

Staff
Linda F. Heffernan, *Nursing Practice and Education Associate*
Vickie R. Sheets, *Director for Nursing Practice and Education*

Relationship to the Organizational Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Promote consistency in the licensure and credentialing process.

Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective B .... Develop documents regarding health care issues which affect safe and effective nursing practice.

Bylaws .... Provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Recommendation(s)
No recommendations.

Highlights of Activities

- ***Comparison of National Council Standards for Education with National League for Nursing Criteria and Guidelines***

Representatives of the National League for Nursing (NLN) reported at a liaison meeting with National Council representatives their plans to work with selected Boards of Nursing to present workshops for educators and others comparing the roles and criteria for state education program approval and the NLN Criteria and Guidelines. In anticipation of these upcoming workshops, the Nursing Practice and Education (NP&E) Committee compared the Education Standards from the *Model Nursing Administrative Rules* with the NLN Criteria and Guidelines from each educational level council. The comparison data will be the basis for additional work regarding educational program criteria.

- ***Coordination Role - Recommendations to the Board of Directors regarding Subcommittees***

Essential and Continued Competence Subcommittee

The NP&E Committee believes that the Essential and Continued Competence Subcommittee has made significant progress by developing a definition of competence, identifying Standards for Competence, and developing a Draft Model for Individual Competence Evaluation. The NP&E Committee supports the Board of Directors' decision that this subcommittee continue its work on competence as well as proceed with planned research regarding functional abilities and the development of a regulatory model for competence.

Nursing Regulation Subcommittee

This subcommittee was charged with developing a methodology for a benefit/costs analysis of regulation. The NP&E Committee provided input into the key elements of regulation identified by the subcommittee. The NP&E Committee recommends that this subcommittee continue its work, but believes this issue is broader than the nursing practice and education domain. The cost/benefit analysis is sorely needed to deal with challenges to

regulation and legislative control. Because of the potentially controversial and broad implications of this group's work, the NP&E Committee suggested that it be assigned as a Task Force that reports directly to the Board of Directors. The NP&E Committee finds the topic interesting and is most willing to assist this group in a consultive role regarding particular nursing practice and education related issues.

Unlicensed Personnel Subcommittee

The NP&E Committee provided written comments as to the original outline developed by the subcommittee as well as reviewed a draft of an updated delegation paper. One of the NP&E Committee's major concerns was the use of the title "unlicensed assistive personnel" or "UAP." This may well be the best category that can be identified for such a large, diverse group, and the NP&E Committee recognizes that in some settings, the decision to not use the title "nursing assistant" or other name reflecting a nursing component can be a deliberate mechanism to avoid dealing with nursing regulation and nursing principles. However, the NP&E Committee suggests that any title designated for unlicensed assistive personnel should receive discussion on the floor of the Delegate Assembly rather than be assumed by default as the term used by the National Council. The NP&E Committee chair provided comments regarding the draft paper related to delegation, sharing a concern regarding titling and suggesting that an important premise to include in the paper is that "unlicensed does not necessarily mean unregulated."

Member Board Education Needs Subcommittee

The NP&E Committee had concerns regarding this subcommittee's use of the term "community-based education," suggesting that in the subcommittee's report it is not well defined. Community-based education could be either clinical experiences in the community, or could be community as a focus of care. The NP&E Committee requested the subcommittee make this clarification prior to the networking group planned for the Annual Meeting.

Future Activities

- **Nursing Education Program Approval Criteria**

The NP&E Committee plans to compare each jurisdiction's education approval rules with the education standards in the *Model Nursing Administrative Rules.* A preliminary survey will be conducted to identify those Member Boards that have already completed such comparisons. An individual state's comparison with the model education standards will be shared with that Member Board as well as a document comparing the model education standards to the NLN criteria and outcomes. Each Member Board would be encouraged to also compare their requirements the NLN criteria and outcomes.

The NP&E Committee plans to develop strategies to identify the elements of nursing education approval that are essential for the protection of public health, safety and welfare. The report of this group could be used by each Member Board, but also provide the basis for ongoing work to promote a consensus as to the essentials for education program approval as well as facilitating mobility of nurses from state to state.

Recommendation(s)

No recommendations

10 BOARD OF DIRECTORS

Report of the Board of Directors

Board Members

Marcia M. Rachel, MS, *Area III, President*
Tom Neumann, WI, *Area II, Vice-President*
Cindy VanWingerden, VI, *Area IV, Secretary*
Charlene Kelly, NE, *Area II, Treasurer*
Fran Roberts, AZ, *Area I Director*
Linda Seppanen, MN, *Area II Director*
Nancy Durrett, VA, *Area III Director*
Marie Hilliard, CT, *Area IV Director*
Roselyn Holloway, TX-RN, *Area III, Director-at-Large*

Staff

Jennifer Bosma, Executive Director
Doris Nay, Associate Executive Director

Under the National Council's Organization Plan, the Board of Directors is responsible for tactics relating to planning and governance, including:

- reach organizational consensus on future direction;
- implement a process for long range planning which will ensure focused movement toward attaining the vision over the next five years;
- identify needs for and create tasks forces and other committees to address specific topics important to the National Council's mission;
- review and evaluate articles of incorporation, bylaws, and policies to promote an appropriate organizational framework; and
- assess organizational coordination and effectiveness.

The recommendations and activities which follow stem from the Board's fulfillment of those responsibilities during the past year.

Recommendations

1. That the Delegate Assembly adopt the revisions to the National Council's goals and objectives as proposed by the Long Range Planning Task Force (see report of task force, Tab 10-N).

   Rationale
   The Board concurs with the Long Range Planning Task Force's report and conclusions (see Tab 10-N), and supports the proposed changes as based on Member Board input communicated through the Trend Analysis study and at Spring 1995 Area Meetings.

2. That the Delegate Assembly authorize the National Council to proceed with the development of a core competency examination for Nurse Practitioners which is separate and distinct from specialty content examinations (see report of task force, Tab 10-C, Model 1).

   Rationale
   The Board concurs with the analysis of the Task Force to Study the Feasibility of a Core Competency Examination for Nurse Practitioners (see Tab 10-C) and with the conclusion that this would be an effective response to an identified need of a number of Member Boards. While there are risks (political, financial), the potential benefit in terms of enhancing Member Boards' resources to carry out their regulatory responsibilities seems to outweigh those risks.

3. That the Delegate Assembly adopt the NCLEX™ Administration Stabilization Criteria and authorize the Board of Directors to apply the criteria to specific geographic sites as the need arises.

Rationale

The NCLEX™ Administration Stabilization Criteria are founded upon an approved and operational Sylvan Quality Assurance Plan. The Plan, a working version of which is currently being implemented, does or will include measurable criteria in all of the areas listed below:

- Security is maintained in accordance with established criteria
- Compliance with the Americans with Disabilities Act (ADA) accessibility requirements
- Compliance with ADA-approved accommodations and procedures
- Test center staff training, certification and retraining/recertification are conducted using approved materials and examinations within timelines specified by the QA Plan and Contract
- A minimum of one operational testing site is located in each jurisdiction
- Sufficient sites exist in each jurisdiction to enable NCLEX™ candidates to be tested in accordance with the 30/45-day compliance requirements
- Island jurisdiction service levels are consistent with all policies and procedures
- Number of restarts consistently decreasing
- Percentage of candidates responding negatively to each exit evaluation question consistently decreasing to under 5 percent
- Quality assurance documentation is forwarded to the National Council according to the approved timelines
- Test Center Administrators (TCAs) are administering the NCLEX™ according to requirements and procedures listed in the Contract and *TCA Manual*

When all of the above criteria are consistently maintained for all Member Board jurisdictions, the Board of Directors believes that administration stability will have been achieved. After this point, the Board would consider on a case-by-case basis situations representing opportunity to utilize testing centers in non-Member Board jurisdictions in order to better serve needs of Member Boards and their applicants for licensure. The primary consideration would be whether or not the stability of NCLEX™ administration would be maintained not only in the additional centers, but in all other operational centers as well.

Responses to Special Committee Recommendations

Task Force to Study Advanced Nursing Practice Mobility

The Board concurred that a publication containing jurisdictional regulatory requirements for Advanced Practice Registered Nurses (APRNs) be prepared and distributed to all Member Boards. The Board directed that the data be provided as a resource to appropriate groups for related work in the future, and that the communications department of the National Council incorporate promotion of this information in appropriate vehicles. The Board also noted that the *Model Nursing Practice Act* and the *Model Nursing Administrative Rules* described ideal approaches to APRN regulation which would also enhance consistency and, thereby, facilitate mobility.

Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group

The Board of Directors authorized the focus group to continue in FY96 to complete work outlined in the focus group's recommendations #1 and #2, i.e., develop a Member Board education packet regarding the continuum of sexual misconduct and develop a pamphlet/fact sheet regarding boundary and sexual misconduct cases. After review by the Research Advisory Panel, the Board directed staff to implement the study described in recommendation #3. Recommendations #4, #5, and #6 will be carried out by the Board of Directors.

Continuing Education Offerings Task Force

The Board directed that a block of informational forum time be set aside at future Annual Meetings for discussion of trends impacting nursing regulation. The Board also decided to establish an ongoing process for providing educational offerings for Member Board members and staff to expand and enhance knowledge of issues and activities that impact the regulation of nursing.

Long Range Planning Task Force

See recommendation #1 above.

Task Force to Study the Feasibility of a Core Competency Examination for Nurse Practitioners

See recommendation #2 above.

Major Accomplishments of the Board of Directors in FY95

Goal I. Licensure and Credentialing

- Monitored the first-year computerized adaptive testing (CAT) implementation of NCLEX™ and ETS/Sylvan performance, including assessment of administration stability
- Re-evaluated the NCLEX-RN™ passing standard, and after consideration of the Panel of Judges' recommendation and other data, decided to raise the standard slightly [from -.48 to -.42 (on the NCLEX™ measurement scale)] effective October 1995
- Monitored the launch of *NCLEX™ Program Reports*, subscription service for nursing education programs
- Monitored NAFTA "reservations" process and supported participation in various tri-country information exchanges
- Created special committees to deal with licensure and credentialing issues, including essential and continued competence, nursing regulation, CAT evaluation, NACEP™, Advanced Practice Nurse mobility, feasibility of a core competency examination for Nurse Practitioners, and licensure verification

Goal II. Nursing Practice

- Approved the conduct of two pilot educational programs for discipline investigators
- Surveyed Member Boards regarding access to data from the Disciplinary Data Bank, and directed staff to prepare a detailed plan for access by governmental entities and nurse certifying bodies to disciplinary data
- Created special committees on practice issues, including sexual misconduct, chemical dependency, unlicensed assistive personnel, and educational programs for disciplinary investigators

Goal III. Nursing Education

- Monitored the completion and publication of educational self-study modules for nursing education program surveyors
- Created special committees to consider Member Board education needs and educational programming for education program surveyors

Goal IV. Information

- Represented the National Council at 17 meetings of organizations with related areas of concern
- Met with chief elected and staff officers of American Association of Colleges of Nursing, American Nurses' Association, American Organization of Nurse Executives, Commission on Graduates of Foreign Nursing Schools, National Association for Practical Nurse Education and Service, National Federation for Licensed Practical Nursing, National League for Nursing, and National Organization for Associate Degree Nursing for liaison purposes
- Provided direction for the development of a program for shaping policy related to nursing regulation on the national level
- Directed monitoring of issues related to Provider Identification Numbers (PINs) and other information technology issues on the national level, including production of an *Emerging Issues* on telecommunications use in nursing practice
- Directed analysis of implications of the Supreme Court decision regarding LPNs as supervisors, resulting in a publication of *Emerging Issues*
- Created special committees to consider continuing education offerings for Member Boards, to select educational programs to be conducted at the 1995 Annual Meeting, to develop policies for the Nurse Information System, and to identify core competencies for nurse practitioners

- Established a process for determining issues to be included in the National Council's research agenda, and for determining who should perform the research; the process includes a research advisory panel which will provide input regarding the research agenda, assist representatives of Member Boards in framing researchable issues and identifying timelines, provide input to the Resolutions Committee and delegates regarding proposed resolutions, and provide consultation to staff regarding methodological issues

Goal V. Organization

- Focused on the National Council's Organization Plan (mission, goals and objectives) as guidance for governing the organization throughout the year
- Appointed 121 individuals representing 50 boards of nursing to 23 committees and special groups to accomplish 32 tactics
- Maintained the coordination and accountability of all committees, task forces, focus groups, and staff for performance of tactics assigned through quarterly reviews of progress
- Based on information supplied by members participating in a "future directions" session at the 1994 Annual Meeting, trend analysis results, and recommendation of the Long Range Planning Task Force, designed a five-year long range planning process and decided to use as an internal working statement of the National Council's vision: "The National Council will be a worldwide leader in the regulation of nursing"
- Planned agendas for and conducted Area Meetings and Annual Meeting
- Maintained general oversight of the development of the Special Services Division
- Approved and monitored current year fiscal operations and the implementation of the annual budget
- Based on the recommendation of committees and staff, approved policies for Regulatory Day of Dialogue, President's duties, reporting relationship for committees, and administrative guidelines for Special Services Division
- Assessed the effectiveness of orientation and development programs for National Council leadership based on feedback of participants, and identified approaches for board and committees
- Assessed the organization's performance in terms of outcomes, processes, structure, and future needs
- Evaluated the performance of major contractors, committees, the executive director, and the Board itself

Meeting Dates

- August 7, 1994
- September 12, 1994, *telephone conference call*
- October 27-28, 1994
- February 1-3, 1995
- February 28, 1995, *telephone conference call*
- May 3-5, 1995
- June 21-23, 1995

Supplemental Report of the Board of Directors

Board Members
Marcia M. Rachel, MS, *Area III, President*
Tom Neumann, WI, *Area II, Vice-President*
Cindy VanWingerden, VI, *Area IV, Secretary*
Charlene Kelly, NE, *Area II, Treasurer*
Fran Roberts, AZ, *Area I Director*
Linda Seppanen, MN, *Area II Director*
Nancy Durrett, VA, *Area III Director*
Marie Hilliard, CT, *Area IV Director*
Roselyn Holloway, TX-RN, *Area III, Director-at-Large*

Staff
Jennifer Bosma, Executive Director
Doris Nay, Associate Executive Director

During its June 21-23, 1995, meeting, the Board of Directors further discussed issues related to the feasibility of a core competency examination for Nurse Practitioners. Following this discussion, the Board rescinded its prior recommendation to the Delegate Assembly which supported a particular model (see recommendation #2 on page 1). The Board believes that, in view of the Delegate Assembly's origination of the resolution in 1994, a full discussion of the report of the Task Force and the models described therein, by the delegates and attendees at the Annual Meeting, is the most effective means to support decision-making regarding a future course(s) of action. There will be opportunities for this discussion during the Advanced Practice Forum, the Feasibility of Core Competency Examination Forum, and the Board of Directors' Forum, all on Thursday, August 3, 1995.

10-A

CAT EVALUATION
TASK FORCE

Report of the CAT Evaluation Task Force

Task Force Members
Deborah Feldman, MD, Area IV, *Chair*
Joan Bouchard, OR, Area I
Faith Fields, AR, Area III
Lori Scheidt, MO, Area II
Rosa Lee Weinert, OH, Area II

Staff
Carol Hartigan, *NCLEX™ Contract Manager*
Anthony Zara, *Director of Testing Services*

Relationship to Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B .... Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation(s) to the Board of Directors
No recommendations.

Highlights of Activities
The CAT Evaluation Task Force was appointed by the Board of Directors to complete planning for and implement post-CAT implementation NCLEX evaluation and follow-up. The task force conducted an in-depth brainstorming session to identify major areas of NCLEX program evaluation as well as primary and secondary evaluators. Primary evaluators of the NCLEX program included Member Boards, candidates, and the National Council. Secondary stakeholders identified were nursing educators, nursing service, health care consumers, the regulatory community, the testing service, legal counsel, the psychometric community, legislators, and the general public. The task force was particularly interested in the dual role played by Member Boards and the National Council who are *primary evaluators*, as well as *participants who will be evaluated* due to their responsibility for key areas of the NCLEX program.

The task force began validation of the elements of its proposed evaluation plan by surveying Member Boards through use of a nominal listing process of the positive and negative aspects of the total NCLEX program. The task force adopted a conceptual model for program evaluation, developed a matrix model of continuous program evaluation for NCLEX, and constructed an outline for use in establishing evaluative criteria. At its April 1995 meeting, the task force reviewed the instruments returned by Member Boards and found that much useful input was obtained both by adding critical areas of evaluation not considered by the task force, as well as prioritized problem areas in the NCLEX program for careful evaluation and follow-up.

National Council staff added to the original framework of the conceptual model for program evaluation by using the Test Service Contract, Testing Policies and Procedures, and specific manuals to supply evaluation criteria and evaluation frequency in some areas. Many of the key areas of evaluation hinge on the completion and acceptance by the Examination Committee of a comprehensive Quality Assurance Plan for Sylvan Learning Systems.

Future Activities
The task force suggests that similar input be obtained from other stakeholders as mentioned above, such as educators, employers, etc. The task force also believes that once more than one year of CAT testing is completed, some problems which have arisen in the transitional phase of the program will have been resolved, thus eliminating the need to continuously evaluate some elements. The report on these and other aspects of the continuous evaluation program will coincide with the large-scale, formal test service evaluation, also scheduled to be completed during FY96.

Meeting Dates
- January 19-20, 1995
- April 10-11, 1995

Recommendation(s) to the Board of Directors

No recommendations.

Report of the Task Force to Identify Core Competencies for Nurse Practitioners

Task Force Members

Carla A. Lee, KS, Area II, *Chair*
Mary Pat Curtis, MS, Area III
Genevieve Deutsch, CA-RN, Area I
William Greiner, NY, Area IV
Barbara Hatcher, DC, Area IV
Melodie Olson, SC, Area III
Pamela Randolph, AZ, Area I
Ida Rigley, ND, Area II

Staff

Carolyn J. Yocom, *Director of Research Services*
Ann Sossong, *Research Assistant*

Relationship to Organization Plan

Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective E .... Conduct and disseminate research pertinent to the mission of the National Council.

Recommendation(s) to the Board of Directors

No recommendations.

Highlights of Activities

As a result of action taken by the 1994 Delegate Assembly, the task force was charged with the responsibility of identifying the core competencies of Nurse Practitioners (NPs). The task force began its work by reviewing numerous background documents compiled by staff. These included curricular materials provided by educational programs offering various types of NP programs, relevant documents from other groups (e.g., National Organization of Nurse Practitioner Faculties, National Association of Boards of Pharmacy, National Institute for Nursing Research, American Association of Colleges of Nursing), and National Council documents (e.g., position paper on regulation of advanced practice registered nurses, *Model Nursing Practice Act*, role delineation study results), and published journal articles. Based on this foundation and their own experiences as NPs, the task force identified key characteristics, roles and functions of all types of NPs working in all types of settings.

Using the above materials, the task force generated a list of 26 competency statements grouped within three categories: 1) health assessment and management, 2) roles and relationships, and 3) health care policy and systems. In addition, the group drafted introductory text addressing the NP's social contract with society, roles and functions of NPs, and definitions.

External validation of the list of competencies was sought from NPs and from Member Boards. The directors/chairs of 107 NP educational programs were requested to ask a key faculty member and two additional NPs employed full time in practice, to each complete a questionnaire requesting information about their level of agreement that each core competency statement, as proposed by the task force, represented a core competency essential for NPs to possess in order to fulfill their role requirements within legal and professional scopes of practice. Responses were received from 147 individuals, representing 64 programs (60% response rate) and all types of NP specialty areas. A similar questionnaire was mailed to the 56 Member Boards regulating registered nurse practice. Responses were received from 41 (73% response rate).

Based on input from Member Boards, NP faculty, NPs in full-time practice, and others, the task force revised the list of core competency statements and accompanying text. A total of 21 competency statements were identified, categorized within three domains: management of client care, management of health care delivery systems, and management of professional relationships. The completed document is provided as Attachment A. During the process of developing the core competency statements, this task force's work was shared with the Task Force to Study the

Feasibility of a Core Competency Examination for Nurse Practitioners for use in completing its charge. In addition, the Task Force to Identify Core Competencies for Nurse Practitioners believes that the core competency document can be used by Member Boards when evaluating the educational preparation of NPs applying for legal recognition (licensure, certification, etc.) within a jurisdiction.

Meeting Dates

- November 29-30, 1994
- December 19, 1994, *telephone conference call*
- February 24-25, 1995
- March 13, 1995, *telephone conference call*

Recommendation(s) to the Board of Directors

No recommendations.

Attachment

A ....Nurse Practitioner Core Competencies, *page 3*

Attachment A

Nurse Practitioner Core Competencies

Introduction

The explication of essential knowledge, skills and abilities is crucial to the development of a professional discipline. Furthermore, a determination of the roles and functions of a profession is guided by the social contract with the client or society served. Essential services that are responsive to public health, safety and general welfare determine the core competencies of the provider of the societal service. These core competencies define the essence of the profession and set the standard for accountability or social contract with society.

Full utilization of a professional's capabilities to meet client and societal needs entails the development of unique roles and functions. From a regulatory perspective, the core role of the nurse practitioner is as a health care provider who is accountable for practicing within accepted professional and legal standards. This role encompasses the management of client care, health care delivery systems, and professional relationships.

Assumptions

Preparation for nurse practitioner practice is based upon the knowledge, skills, and abilities acquired through basic nursing education and previous registered nurse practice. Therefore, it is assumed that the registered nurse desiring to prepare for advanced practice as a nurse practitioner has previously mastered the following:

- knowledge of professional and legal components of nursing practice
- demonstration of clinical and technical competencies including those of communication, teaching, problem-solving, and leadership
- ability to modify practice based on appropriateness for the client and the milieu
- understanding of and ability to apply research findings to practice
- demonstration of competence in caring for ethnically and culturally diverse populations

Definition: Nurse Practitioner

The practice of nursing by a nurse practitioner is based on the knowledge, skills and abilities acquired during advanced educational preparation preferably leading to a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category. The practice of the nurse practitioner includes the use of advanced knowledge, skills and abilities in nursing and the bio-psycho-social sciences as they apply to health assessment; differential diagnosis; therapeutics, including pharmacological and technological interventions; and management of health care (National Council, 1994).

Core Competencies

The nurse practitioner must demonstrate attainment of essential core competencies to fulfill role requirements. A core competency is defined as a knowledge-based skill and/or ability which forms the basis of safe and effective care and which is common to all those practicing in a role, regardless of population or setting. Therefore, the competencies are not dependent upon delivery of care in primary, secondary and/or tertiary care settings. The core competencies are categorized into three domains: management of client care, management of health care delivery systems, and management of professional relationships.

Domain: Management of client care

The management of client care encompasses functions of assessment, planning, intervention and evaluation. Nurse practitioner decision-making and clinical judgment are supported by information derived from the analysis and synthesis of data and the integration of multiple theories. The essential core competencies in this domain are:

1. Elicits a comprehensive health history
2. Performs a comprehensive physical examination
3. Orders diagnostic tests
4. Analyzes client data to determine health status
5. Formulates a list of differential diagnoses
6. Verifies diagnosis(es) based on findings
7. Determines appropriate pharmacological, behavioral, and other non-pharmacological treatment modalities in developing a plan of care
8. Designs a plan of care to attain/promote, maintain, and/or restore health
9. Executes the plan of care
10. Evaluates client outcomes in relation to the plan of care
11. Modifies the plan of care when indicated
12. Uses principles of ethical decision-making in selecting treatment modalities
13. Promotes principles of client advocacy in client interactions and in the selection of treatment modalities
14. Incorporates risk/benefit factors in developing a plan of care

Domain: Management of health care delivery system

The management of a health care delivery system encompasses use of accountability mechanisms that ensure safe and effective health care. The nurse practitioner has the essential business ability, incorporating entrepreneurial and socialization skills, to function as an independent health care provider. The essential core competencies in this domain are:

15 Maintains clinical records that reflect diagnostic and therapeutic reasoning
16. Applies knowledge of the regulatory processes to deliver safe, effective client care
17. Develops a quality assurance/improvement plan to evaluate and modify practice
18. Delivers cost-effective care which demonstrates knowledge of client payment systems and provider reimbursement systems

Domain: Management of professional relationships

The management of professional relationships assumes the nurse practitioner is a key member of the health care team. The nurse practitioner uses comprehensive and complex strategies to interact with the health care environment. The essential core competencies in this domain are:

19. Articulates the nurse practitioner role and scope of practice
20. Collaborates with health care professionals to meet client health care needs
21. Refers clients to other health care professionals when indicated by client health care needs

DEFINITIONS

Client .... Individual, family, group or community which serves as the focus of care.

Core Competencies .... Those knowledge-based skills and abilities which form the basis of competent nurse practitioner care and which are common to all those practicing in the role, regardless of population or setting.

Health Care Team .... The client and those professional caregivers who coordinate and render care and direct non-professional caregivers for the purpose of attaining, maintaining, or regaining optimal health.

Ethnic/Cultural Diversity .... The ethical and moral behavior, mores and customs of population groups that represent varied ethnic and cultural backgrounds and practices.

Population.. Specific groups of clients who are the focus of care. A group may be defined based on a distinguishing characteristic such as developmental stage, diagnosis, or type of care or program required.

Practice .... The day-to-day operations of a practitioner in any type/level of setting.

Primary Care Setting .... Place in which initial care, or care-related education is delivered, such as ambulatory clinics, offices, industry or other community settings.

Secondary Care Setting .... Place where care requiring specialist input and/or specialized technology can be provided, such as in a hospital or surgical setting.

Tertiary Care Setting .... A major referral center for highly specialized care, such as a neonatal intensive care unit.

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B. Curriculum materials supplied by Nurse Practitioner Programs in the following colleges and universities

Arizona State University: Adult Health, Child Care/Pediatrics, Community Health, Family Health and Women's Health Nurse Practitioners

Catholic University of America: Adult and Pediatric Nurse Practitioners

Georgia Southern University: Rural Family and Family Nurse Practitioners

Fort Hays State University: Family Nurse Practitioner

Husson College: Family and Community Nurse Practitioners

John Hopkins University: Adult and Pediatric Nurse Practitioners

Marshall University: Family Nurse Practitioner

Medical University of South Carolina: Family Health and Neonatal Health Nurse Practitioners, Nurse Midwifery, and Nurse Anesthesia

Northwestern State University of Louisiana: Family Nurse Practitioner

Rocky Mountain Planned Parenthood: OB/GYN Nurse Practitioner

Rush University: Family Nurse Practitioner

Seton Hall University: Adult, Gerontological, Pediatric, School and Women's Health Nurse Practitioners

Simmons College: Adult, Gerontological, Occupational Health, Pediatric, School and Women's Health Nurse Practitioners

Stanford University School of Medicine: Family Nurse Practitioner

University of California, Los Angeles: Pediatric, Occupational Health, Family, and Gerontological Nurse Practitioners

University of California, San Francisco: Occupational Health, Adult, Pediatric, Gerontological, Women's Health, Family, Adult Psychiatric, Neonatal and School Health Nurse Practitioners

University of Connecticut: Primary Care Adult Nurse Practitioner

University of Hawaii at Manoa: Family, Pediatric, and Women's Health Nurse Practitioners

University of Kansas: Family Nurse Practitioner

University of Kentucky: Family, Adult and Geriatric Nurse Practitioners

University of Maine: Rural Family Nurse Practitioner

University of Mary: Gerontological Nurse Practitioner

University of Michigan: OB/GYN, Adult, Family, Pediatric and Occupational Health Nurse Practitioners

University of Mississippi Medical Center: Family and Adult Health Nurse Practitioners

University of Nebraska Medical Center: Rural Family and Family Nurse Practitioners

University of New Mexico: Family Nurse Practitioner

University of North Dakota College of Nursing: Family Nurse Practitioner

University of Pennsylvania: Pediatric Critical Care, Adult Critical Care, Home Care, Neonatal, Women's Health Care, Pediatric Acute/Chronic Care, Tertiary, Occupational Health, Perinatal, Gerontological, and Adult Nurse Practitioners

University of Rochester: Adult, Med/Surg, Cardiopulmonary, Critical Care, Oncology, Family, Women's Health Care Nurse Practitioners

University of San Diego: Family Health, School Health, and Adult/Gerontological Nurse Practitioners

University of Vermont: Adult Nurse Practitioner

University of Washington: Family, Pediatric, Women's Primary Care, Adult/Older and Adult Psychosocial Nurse Practitioners

University of Wyoming: Rural Health Family Nurse Practitioner

Vanderbilt University: Family Nurse Practitioner

Yale School of Nursing: Adult, Family, and Pediatric Nurse Practitioners

10-B

TASK FORCE TO IDENTIFY
CORE COMPETENCIES/
NURSE PRACTITIONERS

Report of the Task Force to Study the Feasibility of a Core Competency Exam for Nurse Practitioners

Task Force Members

Katherine Thomas, TX-RN, Area III, *Chair*
Kathy Apple, NV, Area I
Genevieve Deutsch, CA-RN, Area I
Carla Lee, KS, Area II
Doris Nuttelman, NH, Area IV
Rita Pobanz, OH, Area II

Staff

Anthony R. Zara, *Director of Testing Services*

Relationship to the Organization Plan

Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Promote consistency in the licensure and credentialing process.

Recommendation(s) to the Board of Directors

1. That the National Council proceed with the development of an entry-level core competency examination for nurse practitioners under Model 1 (National Council develops and offers to Member Boards a core competency examination; the specialty groups continue to develop and offer their specialty content examinations).

Background

The 1994 Delegate Assembly directed "that the National Council perform a study exploring the regulatory, fiscal, and political implications of developing a "core" competency examination for nurse practitioners (NPs) with a report to the 1995 Delegate Assembly." The task force was convened by the Board of Directors and met during January 25-27, 1995, and March 28-30, 1995, to meet its charge. The task force discussed the issues thoroughly and reached the following conclusions in terms of the current and desired regulatory situations:

Current Regulatory Reality:

1) NP certification examination quality is unknown, uneven, generally not targeted to entry;
2) There are non-standard education requirements for NPs;
3) The NP population is increasing;
4) The number of NP educational programs is increasing;
5) Most Member Boards do not accredit NP programs;
6) Member Boards do not require integrated experience (internship) prior to NP recognition;
7) The NP scope of practice is increasing, with more independent practice;
8) There is fragmentation of interest groups within the NP domain; and
9) Although the current effort is focused on NPs, there will be a need to apply regulatory requirements to all advanced practice groups (e.g., CNSs, CNMs, CRNAs).

Desired Regulatory Reality Includes:

1) A valid, legally-defensible measure of entry-level minimal competence for advanced practice;
2) Standard educational requirements for advanced practice; and
3) Interstate mobility (facilitated by a standard credential).

Based on feedback and discussion with the task force charged with developing the core competencies for nurse practitioners, there are a set of identifiable core competencies which nurse practitioners must manifest. Based on this year's work, the task force has concluded:

1) There is enough content to produce measurable core competencies for nurse practitioner practice.
2) To optimally accomplish their regulatory roles, Member Boards need entry-level core competency measurement and entry-level specialty content measurement; (the specialties identified as of March 30, 1995, include family,

pediatrics, psych, adult, gerontology, school, women's, neonatal, ER/trauma). In a survey conducted by the task force, 30 of 39 Member Boards responded that a core competency examination for nurse practitioners would facilitate regulation. Twenty-two of 38 boards also responded that entry-level specialty content examinations would facilitate regulation of nurse practitioners.

3) In terms of a realistic development scheme, it would be acceptable to create a core competency measurement, then make a subsequent determination regarding the development of specialty measurements.
4) There are a number of alternative development models for accomplishing #1 - #3 to a greater or lesser degree. The task force wants to emphasize that although its charge only included investigating the feasibility of a core competency examination for nurse practitioners, the issues surrounding regulation of clinical nurse specialists and other advanced practitioners must also be dealt with.

Potential Examination Development Models

Potential development models discussed by the task force included: 1) National Council develops (and offers/administers) a core examination separate from the specialty groups who continue to develop the specialty content examinations; 2) National Council develops both the core and entry-level specialty examinations; 3) National Council develops the core test plan, distributes it to the specialty groups and attempts to influence them to incorporate the necessary content in their examinations; 4) National Council develops the core content and offers it for sale to specialty groups to incorporate into their examinations; and 5) National Council develops the core test plan, distributes it to the specialty groups, and evaluates their examinations to determine whether they adequately measure the necessary content (similar to a "Good Housekeeping seal of approval").

The task force believes that the levels of fiscal commitment, political implications, and meeting the regulatory need are dependent on the model of examination development chosen. The task force discussed the potential political implications of National Council development of a core competency examination in some detail. The political issues were framed by a matrix describing potential stakeholders as organizations and individuals both within and outside of nursing. This 2 x 2 conception provided a method for evaluating the entire political environment and not overlooking key stakeholders.

The following is a summary of the development models considered by the task force in terms of their corresponding regulatory, fiscal, and political implications:

Model 1: National Council Develops Core Examination

Regulatory Strengths:

1. Uniformity across states would be enhanced.
2. It would provide a psychometrically sound examination.
3. Enhancement of practitioner mobility.
4. The examination would fill a currently unmet need by measuring minimal entry-level competence to enhance public safety.
5. The examination would provide validation data for evaluation of NP education programs.
6. Regulation defines scope of practice; therefore, regulation should also define the competencies required to perform the scope.

Regulatory Weaknesses

1. A core examination would lack specialty content.
2. Currently, there is no generalist nurse practitioner role, the credential is generally based on specialty. A core examination is necessary but not sufficient.
3. Other advanced practice groups are not included (NP only).

Fiscal Implications

The cost to National Council of activities needed to administer eight forms of a core competency examination are estimated to be $1,208,657 (with National Council conducting item development and a test service providing application and administration services). With a test service providing all the needed services, the cost is rough-estimated to be $1,800,000. Also, this type of examination is not currently required by Member Boards prior to legal recognition of nurse practitioners, so the prospect for revenue to cover these expenses is somewhat uncertain.

10-C

TASK FORCE TO STUDY
FEASIBILITY OF NP CORE
COMPETENCY EXAM

Report of the Task Force to Study the Feasibility of a Core Competency Exam for Nurse Practitioners

Task Force Members

Katherine Thomas, TX-RN, Area III, *Chair*
Kathy Apple, NV, Area I
Genevieve Deutsch, CA-RN, Area I
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1) There is enough content to produce measurable core competencies for nurse practitioner practice.
2) To optimally accomplish their regulatory roles, Member Boards need entry-level core competency measurement and entry-level specialty content measurement; (the specialties identified as of March 30, 1995, include family,

pediatrics, psych, adult, gerontology, school, women's, neonatal, ER/trauma). In a survey conducted by the task force, 30 of 39 Member Boards responded that a core competency examination for nurse practitioners would facilitate regulation. Twenty-two of 38 boards also responded that entry-level specialty content examinations would facilitate regulation of nurse practitioners.

3) In terms of a realistic development scheme, it would be acceptable to create a core competency measurement, then make a subsequent determination regarding the development of specialty measurements.
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Potential Examination Development Models

Potential development models discussed by the task force included: 1) National Council develops (and offers/administers) a core examination separate from the specialty groups who continue to develop the specialty content examinations; 2) National Council develops both the core and entry-level specialty examinations; 3) National Council develops the core test plan, distributes it to the specialty groups and attempts to influence them to incorporate the necessary content in their examinations; 4) National Council develops the core content and offers it for sale to specialty groups to incorporate into their examinations; and 5) National Council develops the core test plan, distributes it to the specialty groups, and evaluates their examinations to determine whether they adequately measure the necessary content (similar to a "Good Housekeeping seal of approval").

The task force believes that the levels of fiscal commitment, political implications, and meeting the regulatory need are dependent on the model of examination development chosen. The task force discussed the potential political implications of National Council development of a core competency examination in some detail. The political issues were framed by a matrix describing potential stakeholders as organizations and individuals both within and outside of nursing. This 2 x 2 conception provided a method for evaluating the entire political environment and not overlooking key stakeholders.

The following is a summary of the development models considered by the task force in terms of their corresponding regulatory, fiscal, and political implications:

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5. The examination would provide validation data for evaluation of NP education programs.
6. Regulation defines scope of practice; therefore, regulation should also define the competencies required to perform the scope.

Regulatory Weaknesses

1. A core examination would lack specialty content.
2. Currently, there is no generalist nurse practitioner role, the credential is generally based on specialty. A core examination is necessary but not sufficient.
3. Other advanced practice groups are not included (NP only).

Fiscal Implications

The cost to National Council of activities needed to administer eight forms of a core competency examination are estimated to be $1,208,657 (with National Council conducting item development and a test service providing application and administration services). With a test service providing all the needed services, the cost is rough-estimated to be $1,800,000. Also, this type of examination is not currently required by Member Boards prior to legal recognition of nurse practitioners, so the prospect for revenue to cover these expenses is somewhat uncertain.

Political Implications

Although it is difficult to predict the specific reactions of stakeholders, based on previous reactions to National Council actions, the task force attempted to evaluate the potential political effects of developing a core competency examination. The task force surmised that organizations could be educated that the core examination is complementary to, and not in competition with, existing specialty exams. Some groups, however, will likely see this as a competitive examination. Some specialty organizations will contend that their examinations do measure entry-level. Some organizations may argue that this type of examination will be a costly barrier to practice and that there is little data available to support the need for an entry-level examination. Organizations that have developed competency lists will contend that the National Council-developed core competencies are not exactly congruent with theirs. An entry-level core competency examination will move the process for legal recognition more into the regulatory realm, rather than relying on certification in many cases. No matter which examination development model, if any, is chosen, it will provide an opportunity to unearth the professional arguments that boards shouldn't be regulating this class of practitioners. Also, many Member Boards have expressed that to require a core examination, they will need to change laws or rules or regulations.

Model 2: National Council Develops Core and Specialty Examinations

Regulatory Strengths

1. Same as all of Model 1.
2. The examinations would provide a comprehensive assessment of entry-level specialty competence which would be linked to credential offered by most Member Boards.
3. These examinations would provide both necessary and sufficient information for optimal regulation of nurse practitioners.

Regulatory Weaknesses

1. These examinations would only target NPs and not other classes of advanced practice.
2. Developing this number of examinations would limit flexibility in responding to emerging nurse practitioner specialties.

Fiscal Implications

The fiscal implications for Model 2 entail all the expense of Model 1, plus the expense for developing eight additional specialty examinations. The same concern about these examinations not being currently required by Member Boards prior to legal recognition of nurse practitioners is again true here, so the prospect for revenue to cover expenses is even more uncertain. Also, the candidate volume for each specialty will be very small relative to the fixed costs of examination development.

Political Implications

The task force hypothesized that this development model would entail all the potential political problems of Model 1. It would, though, provide a user-friendly, one-stop examination process for Member Boards. It may be perceived as being more directly in competition with specialty certifying groups. Also, based on the survey responses, there appears to be less Member Board support for National Council development of specialty content nurse practitioner examinations (22 of 38 boards vs. 30 of 39 boards for a core examination).

Model 3: National Council Develops Core Test Plan

Regulatory Strengths

1. National Council's beliefs about necessary core competencies will be distributed to organizations developing certification examinations.

Regulatory Weaknesses

1. There is no guarantee that the certification organizations would incorporate the needed core competency content into their examinations.
2. The validity of the certification examinations for measuring entry-level competence as a basis for legal recognition is still questionable.

3. The quality of the test development process cannot be assured.

Fiscal Implications

National Council would incur the costs of developing the test plan, estimated at $44,866.

Political Implications

Most of the hypothesized political issues concerning stakeholders would not be alleviated by this model.

Model 4: National Council Develops Core Test Plan and Examination Content

Regulatory Strengths

1. National Council's determination of necessary content (examination items) would be available for certification organizations to purchase.
2. The quality of the content would be assured.

Regulatory Weaknesses

1. There is no guarantee that the certification organizations would incorporate the needed core competency content into their examinations.
2. The validity of the specialty certification examinations outside of the National Council-developed core items could not be assured.

Fiscal Implications

National Council would incur the costs of developing the test plan, estimated at $44,866, and the large item development costs estimated to be (for eight forms) $381,233, totalling $426,099. There would be no guarantee that National Council would sell the content to any organizations, thus potential revenue is very uncertain.

Political Implications

Most of the hypothesized political issues concerning stakeholders would not be alleviated by this model. Costs of the specialty examinations would likely increase.

Model 5: National Council Develops Core Test Plan and Evaluates Certification Examinations

Regulatory Strengths

1. National Council would provide a determination whether the necessary content was included in the certification examinations.
2. The quality of the content of evaluated/approved examinations would be assured.

Regulatory Weaknesses

1. There is no guarantee that the certification organizations would incorporate the needed core competency content into their examinations.
2. The accountability for the examinations would be very complicated when proffering National Council "approval."
3. Significant legal hurdles would need to be crossed to permit this model.

Fiscal Implications

National Council would incur the costs of developing the test plan, estimated at $44,866. Costs for evaluating the specialty examinations could be offset with charges for the service. There would be no guarantee that National Council would sell the review process to any organizations, thus potential revenue is uncertain.

Political Implications

Most of the hypothesized political issues concerning stakeholders would not be alleviated by this model. In fact, it may be more volatile to offer National Council "approval" of other organizations' examinations.

Potential Strategies for the Political Implications

The task force discussed potential strategies for working through the potential political effects of developing a core competency examination for nurse practitioners. The task force believes that information sharing will be a key to communicating the regulatory need for this type of assessment and for clarifying National Council's activities. Early contact with the stakeholder groups would be helpful. Face-to-face meetings, such as the National Council's Annual Advanced Practice Roundtable, could provide important opportunities for candid give-and-take and demystification of the process. The use of stakeholder groups for consensus building for content input (e.g., the job analysis design, test plan development) can help to alleviate misunderstandings. The task force believes that the regulatory need is sufficiently compelling that open communications and invitations for input will be very effective in building allies.

Conclusions

In formulating conclusions, based on the Delegate Assembly request and this year's work, the task force determined that Member Boards do believe that additional leadership from National Council would be assistive in their roles regulating nurse practitioners. With this in mind, the different models for approaching the issue of nurse practitioner core competencies each have different strengths and weaknesses. The task force's evaluation of the regulatory issues, suggests that Model 2 would provide Member Boards with the best service. A significant drawback to Model 2, though, is the very high cost of developing the examinations. The task force's analysis of the political implications suggests that Model 3 would provide the least disruption to the stakeholder entities, but would also provide relatively weak regulatory assurances for Member Boards. Based on the fiscal implications of costs vs. potential revenues, it appears that Model 5 would be the most conservative, although the regulatory assurances also would be weak and the political issues are potentially volatile. The fiscal realities and projected candidate volumes suggest that Model 1 would provide a better opportunity for National Council to produce a self-sustaining service to Member Boards than Model 2, yet also provide important regulatory assurances.

All considered, the task force supports development of a core competency examination for nurse practitioners. Conceptually and considering regulatory implications, Model 2 is best, but from a pragmatic and feasibility standpoint, Model 1 is recommended to the Board of Directors. A suggested timeline for development includes: FY96 - complete a logical job analysis process through the development of a test plan, begin item writing, and begin contract negotiations with states and vendors; August 1996 - Delegate Assembly approval of NP Test Plan; FY97 - continue item development, prepare to administer examination; Summer 1997 - begin administering examinations; FY99 - initiate formal evaluation of program; August 2000 - Delegate Assembly decision on program continuation.

Meeting Dates

- January 25-27, 1995
- March 28-30, 1995
- April 13, 1995, *telephone conference call*

Recommendation(s) to the Board of Directors

1. That the National Council proceed with the development of an entry-level core competency examination for nurse practitioners under Model 1 (National Council develops and offers to Member Boards a core competency examination; the specialty groups continue to develop and offer their specialty content examinations).

10-D

TASK FORCE TO STUDY
ADVANCED PRACTICE
NURSE MOBILITY

Report of the Task Force to Study Advanced Nursing Practice Mobility

Task Force Members
Judi Crume, AL, Area III, *Chair*
Dorothy Fiorino, OH, Area II
Winifred Garfield, VI, Area IV
Carolyn Hunter, WA, Area I
Elizabeth Lindberg, MA, Area IV
Patricia McKillip, KS, Area II
Linda Murphey, AR, Area III
Audrey Rath, AZ, Area I

Staff
Vickie Sheets, *Director for Nursing Practice and Education*
Carolyn J. Yocom, *Director of Research Services*

Relationship to Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E .... Promote consistency in the licensure and credentialing process.

Recommendation(s) to the Board of Directors
1. That the information contained in the Advanced Practice Registered Nurse (APRN) database of state-by-state requirements for the regulation of APRNs be referred to the appropriate committees.

   Rationale
   The information obtained from Member Boards by this year's survey and the information already available in the *Profiles of Member Boards* provide the most complete assessment of the regulation of APRNs in the United States. This information can be used to support other activities of the National Council related to advanced nursing practice, and should be the foundation of work done by the other relevant groups.

2. That the Board of Directors promote Member Board use of the APRN database information for the purposes of facilitating the mobility of APRNs and as a basis for examining their requirements in relationship to those of other jurisdictions.

   Rationale
   The survey results confirm that there is still a "crazy quilt" of approaches and requirements for the regulation of advanced nursing practice. The task force members believe that having a resource of specific state-by-state requirements will assist Member Boards in evaluating the credentials of an APRN who is/was practicing in another jurisdiction. Having this information readily available will facilitate identification of states which have comparable requirements.
   The task force identified two categories of barriers or perceived barriers to APRN mobility. The first are statutory requirements that need legislative action to change, and must be planned and timed carefully. A second type is a more procedural, "red tape" process that may be written in rules or board procedures. Member Boards should be encouraged to conduct periodic evaluations of their APRN requirements, to identify what elements are needed for public protection and those elements which may be out-dated, and to articulate the rationale for this determination. In addition, Boards of Nursing should be encouraged to review their jurisdictional requirements to determine if greater consistency with other jurisdictions is desirable and feasible.

Highlights of Activities
The task force worked with staff to design a survey of information to supplement the *Profiles of Member Boards* and provide more specific information regarding the state-by-state requirements for APRN practice. The task force

determined to compile a database of state-by-state requirements for the regulation of APRNs. This compilation will be distributed this summer to Member Boards.

Future Activities

The task force will provide a summary of the survey results in the supplement to the *Book of Reports*.

Meeting Dates

- December 12-13, 1994
- April 25, 1995, *telephone conference call*

Recommendation(s) to the Board of Directors

1. That the information contained in the Advanced Practice Registered Nurse (APRN) database of state-by-state requirements for the regulation of APRNs be referred to the appropriate committees.

2. That the Board of Directors promote Member Board use of the APRN database information for the purposes of facilitating the mobility of APRNs and as a basis for examining their requirements in relationship to those of other jurisdictions.

Attachment A

Advanced Nursing Practice Mobility Executive Summary

There is no doubt about it: lack of uniform regulation between states and strict guidelines for reimbursement, prescriptive authority, and physician supervision can be harmful both to the public who demands access to cost-effective primary health care and to the practitioners who wish to provide it. (Wilken, 1995)

The 1994 National Council of State Boards of Nursing Delegate Assembly adopted a resolution directing the National Council to establish a task force to: 1) develop a data base of advanced practice credentialing requirements (licensure, recognition, certification, authority to practice, etc.) for each Member Board with enough specificity for other Member Boards to make credentialing decisions; and 2) study whether additional mechanisms could be developed to facilitate interstate mobility of advanced practice nurses. Wilken's statement reflects the concerns of the Member Boards that led to the resolution. The Board of Directors established the Task Force to Study Advanced Nursing Practice Mobility to implement this resolution.

A survey of information to supplement the *Profiles of Member Boards* was conducted on behalf of the task force. The results of this survey will be published this summer. [A summary of survey results is presented in this report.] The task force chose to limit the survey to the most widely statutorily recognized Advanced Practice Registered Nurse categories of Certified Registered Nurse Anesthetists, Certified Nurse Midwives, and Nurse Practitioners. The survey questionnaire was designed to obtain current information about these categories. Specific questions addressed the elements of minimum education requirements, curriculum (including pharmacology, physical assessment and other content requirements), preceptors, practice characteristics and certification requirements for each category. This survey, when combined with the information in the *Profiles of Member Boards*, will provide an overall view of the regulatory environment for individuals beginning practice as Advanced Practice Registered Nurses (APRN) in the categories of Certified Registered Nurse Anesthetists, Certified Nurse Midwives, and Nurse Practitioners. Brief capsules of the responses regarding these APRN categories are provided in this executive summary.

The task force members believe that having a resource of specific state-by-state requirements will assist Boards of Nursing in evaluating the credentials of an APRN who is/was practicing in another jurisdiction. Boards are encouraged to identify jurisdictions which have comparable requirements and use this information to facilitate endorsement of Advanced Practice Registered Nurses. The database can facilitate networking between boards, by identifying states which may have dealt with particular issues. In addition, studying other jurisdictions' approaches can either validate a board's requirements or provide suggestions for new approaches when designing rules and regulations.

Certified Registered Nurse Anesthetists

Thirty-four Member Boards answered the questions pertaining to the regulation of Certified Registered Nurse Anesthetists.

Minimum Education - The majority of responding boards have minimum educational requirements for a post basic program taken after completion of an associate degree, a diploma or a baccalaureate degree. Six boards required that the anesthesia program be completed after completion of a baccalaureate degree. Three boards stated that a masters program was required for nurse anesthesia. Seven boards specified program length. These requirements ranged from one board which required 225 hours theory with 480 hours clinical/preceptor to four boards which required at least an academic year to one board specifying masters.

Curriculum - Advanced pharmacology was not specifically required by a majority of the boards answering these questions. One board specified content relating to specialty area. Only seven boards indicated that advanced

pharmacology was required for CRNAs to have prescriptive authority. The majority of boards recognize the requirements established by the national certification body.

Only one state indicated that advanced physical assessment was required for CRNAs. One board commented that this content is inherent in nurse anesthesia programs. The majority of respondents indicated that the board recognizes the requirements established by the national certification body and/or educational program.

Preceptors - Twelve boards responded that preceptorships must be completed. The majority of boards indicated that preceptorships were part of the educational program. Those few boards that specified the type of preceptor indicated that either a physician or an experienced CRNA was acceptable in this role. The timing of the preceptored experience varied greatly, ranging from concurrent with didactic to one board saying that a future requirement will be preceptorship after the completion of all didactic elements. Most respondents accepted the timing specified by the educational program and/or national certification body.

Practice Characteristics - One board required previous Registered Nurse experience prior to legal authorization to practice as a CRNA. One board required a physician sponsor before a nurse can be legally authorized as a CRNA. Seven boards require identification of a collaborating/cooperating physician at the time CRNA begins practice. Four boards require identification of a collaborating/cooperating physician as a prerequisite for renewal/ continuation as a legally authorized CRNA.

Certification - The majority of responding boards require professional certification by a national certification body as a requirement for legal recognition as a CRNA. Half of the responding boards require that the certification body meet specified board of nursing requirements.

Certified Nurse Midwives

Thirty-five Member Boards answered the questions pertaining to the regulation of Certified Nurse Midwives.

Minimum Education - The majority of responding boards have minimum educational requirements for a post basic program taken after completion of an associate degree, a diploma or a baccalaureate degree. Four boards required that the nurse midwifery program be completed after completion of a baccalaureate degree. Four boards stated that masters program is required for nurse midwifery. Eleven boards specified program length, typically one academic year.

Curriculum - Advanced pharmacology was not specifically required by majority of the boards answering these questions. Two boards specified content relating to specialty area. Thirteen boards indicated that advanced pharmacology was required for CNMs to have prescriptive authority. The majority of boards recognize the requirements established by the educational program and/or national certification body.

Three states indicated that advanced physical assessment was required for CNMs. Seven boards specified content specific to the practice area. The majority of respondents indicated that the board recognizes the requirements established by the national certification body and/or educational program.

Only a few other curriculum elements were identified, including psychosocial assessment, transmittal prescriptions, legal/ethical, role alignment and advanced pathophysiology. The majority of respondents indicated that the board recognizes the requirements established by the national certification body and/or educational program.

Preceptors - Fourteen boards responded that preceptorships must be completed. The majority of boards indicated that preceptorships were part of the educational program. Those few boards that specified the type of preceptor indicated that either a physician or an experienced CNM were acceptable in this role. One board would also accept an osteopathic doctor in the preceptor role. The timing of the preceptor experience typically was concurrent with didactic and as determined by the educational program and/or national certification body.

Practice Characteristics - One board requires previous Registered Nurse experience prior to legal authorization to practice as a CNM. Eight boards require a physician sponsor before a nurse can be legally authorized as a CNM. Thirteen boards require identification of a collaborating/cooperating physician at the time the CNM begins practice. Ten boards require identification of a collaborating/cooperating physician be identified as a prerequisite

for renewal/continuation as a legally authorized CNM.

Certification - The majority of responding boards require professional certification by a national certification body as a requirement for legal recognition as a CNM. Half of the responding boards require that the certification body meetspecified board of nursing requirements.

Nurse Practitioner

Thirty-eight Member Boards answered the questions pertaining to the regulation of Nurse Practitioners.

Minimum Education - The majority of these boards have minimum educational requirements for a post basic program nurse practitioner taken after completion of an associate degree, a diploma or a baccalaureate degree. Four boards required that the nurse practitioner program be completed after completion of a baccalaureate degree. Eight boards stated that a masters program was required for a nurse practitioner. Twenty boards specified program length, ranging from one board which required 30 semester hours (12 hours clinical 18 hours theory) to the 15 boards which required at least one academic year.

Curriculum - advanced pharmacology was not specifically required by majority of the boards answering these questions, while thirteen boards did require. One board specified content relating to specialty area, one board required content relating to the specialty area plus state prescriptive laws and recordkeeping, and one board specified evidence of pharmacological interventions/content. Fifteen boards indicated that advanced pharmacology was required for prescriptive authority, with ten boards setting a number of required hours or number of required credits.

While six boards required advanced physical assessment, the majority of boards did not specifically require this content. Four boards specified the content be related to the scope of practice or the specialty area. The majority of board recognized the requirements established by the educational program and/or the national certification body.

Responses regarding other specific curriculum requirements set by boards were scattered among elements such as advanced psychosocial assessment, advanced nursing intervention and management, history taking, communications and interviews, health teaching/counseling, ethical/legal, diagnostic procedures, and advanced pathophysiology. Three boards require curriculum addressing roles and role alignment.

Preceptors - The use of preceptors was required by a majority of responding boards. Only seven boards specified preceptorship length, indicating varying durations. The timing of preceptor work varied from concurrent with didactic to after completion of didactic. The majority of respondents indicated approval of the timing specified by the educational program and/or national certification body.

Practice Characteristics - Only one board requires previous Registered Nurse experience prior to legal authorization as a Nurse Practitioner. Five boards require a physician sponsor before a nurse can be legally authorized as a Nurse Practitioner. Eight boards require identification of a collaborating/cooperating physician at the time Nurse Practitioner begins practice. Eight boards require identification of a collaborating/cooperating physician as a prerequisite for renewal/continuation as a legally authorized Nurse Practitioner.

Certification - The majority of responding boards require professional certification by a national certification body and require that the certification body meet specified board of nursing requirements.

Conclusion

Specific elements related to the regulation of Advanced Practice Registered Nurses which vary greatly from jurisdiction to jurisdiction include: prescriptive authority (or the lack thereof); the scope of practice authorized for an Advanced Practice Registered Nurse category; whether physician supervision, collaboration and/or back-up is required; the criteria for national certification used in the regulatory process; and requirements for continued competence maintenance.

Reference

Wilken, M. (1995). Non-physician providers: How regulation affects availability and access to care. Nursing Policy Forum, 1 (2), 28-37.

10-E

NADEP TASK FORCE

Report of the Nurse Aide Competency Evaluation Program (NACEP) Task Force

Task Force Members
Cindy Lyons, OK, Area III, *Chair*
Dorothy Fulton, AK, Area I
Patricia Hill, ND, Area II
Mary Kinson, NH, Area IV
Orpha Swiger, WV-PN, Area II
Anna Yoder, MA, Area IV
Sarah Greene Burger, DC, *Consultant*

Staff
Ellen Gleason, *NACEP Program Manager*

Relationship to Organization Plan
Goal I .... Provide Member Boards with examinations and standards for licensure and credentialing
Objective D .... Provide a competency evaluation for nurse aides.

Recommendation(s) to the Board of Directors
No recommendations.

Highlights of Activities

Psychometrics
An activity under Objective D, Tactic 1 of Goal I states, "Maintain and enhance the Nurse Aide Competency Evaluation Program." The task force reviewed the results of the nurse aide job analysis which was conducted in the Fall of 1994. Results were used in determining areas of the Nurse Aide Competency Evaluation Program (NACEP™) blueprint which need to be modified to reflect changes in the roles and responsibilities of nurse aides. The task force will review the blueprint and make recommendations for modifications in the blueprint (if necessary) to the Board of Directors in the Fall of 1995.

The task force reviewed semi-annual statistical reports which were presented by the test service at the June meeting. The passing rate for the written evaluation has remained stable over the past year at 85.7 percent. The passing rate for the manual skills evaluation has increased slightly, from 90.5 percent to 92.8 percent. The number of oral administrations increased from 541 to 931.

Marketing
The test service presented the completed NACEP marketing package to the task force at its June meeting. The marketing package consists of a NACEP folder with stand-alone informational sheets on the NACEP, brochures describing the NACEP and the NACEP practice test, overhead transparencies describing the NACEP, and table top displays and wall posters describing the NACEP. The marketing materials were developed in conjunction with National Council staff and were developed for use by the test service clinical sales representatives and others who might make NACEP presentations.

In December, National Council staff and test service staff made a presentation to the Florida Bureau of Professional Regulation. In February, Florida selected The Psychological Corporation, and thus the NACEP, as the sole vendor for the state of Florida. In February, the state of Washington awarded a contract to The Psychological Corporation to provide NACEP. Candidate volumes in Florida and Washington are projected at 20,000 candidates/year and 8,400 candidates/year, respectively. Addition of these states will double the total annual NACEP volume to over 64,000 candidates/year.

User Survey
The results of the 1995 user survey were reviewed and discussed by the task force (see Attachments A and B). The survey indicated an increase in the overall satisfaction level of users over last year. Strategies to further enhance

user satisfaction, particularly satisfaction with day-to-day activities, were discussed by the task force, the test service and National Council staff. Action plans for further enhancement of the NACEP include: use of technology to expedite operations processes such as scoring and reporting of results; frequent contact with users; and continued informal surveys of users.

Communications

The Sixth Nurse Aide Conference was held in Baltimore, Maryland, on May 8-9, 1995, and was attended by over 60 individuals. Nurse aide training, recertification, the nurse aide registry and the disciplinary process were discussed. In addition, the enforcement rules for the survey process in long term care facilities were discussed by representatives from the Health Care Financing Administration. The conference concluded with a discussion on unlicensed assistive personnel and the ramifications of using unlicensed assistive personnel for those who supervise and regulate nurse aides.

The *NACEP Study Guide* was completed in April 1995. Distribution of the study guide, which contains the sample written evaluation used by the test service, rationale for correct answers on the written evaluation, a sample manual skills scenario with rationale for correct answers and a listing of all manual skills, began in June 1995.

Insight--Newsletter on Nurse Aides and Assistive Personnel entered its third year of publication. In the Fall of 1994, the title of *Insight* was changed from *Insight—NACEP News & Issues* to *Insight—Newsletter on Nurse Aides and Assistive Personnel* to reflect the interests of a broader audience. *Insight* is distributed to more than 800 individuals in a wide variety of settings including long term care facilities, home health agencies, training facilities, etc.

Future Activities

The task force will begin to revise the *NACEP Evaluation Blueprint* based on information obtained from the nurse aide job analysis. Both the manual skills evaluation and the written evaluation will be revised. The manual skills evaluation will be revised in 1995-1996 and the written evaluation will be revised in 1996-1997, as it is estimated that it will take the task force a year to complete the revision of the manual skills evaluation.

Meeting Dates

- November 10, 1994
- March 9, 1995, *telephone conference call*
- June 5-6, 1995

Recommendation(s) to the Board of Directors

No recommendations.

Attachments

A ....1995 User State Agency Survey, Cumulative Results, page 3
B ....Comparison of Cumulative Results, page 5

Attachment A

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
NURSE AIDE COMPETENCY EVALUATION PROGRAM
FEBRUARY 1995 USER STATE AGENCY SURVEY - CUMULATIVE RESULTS
N = 21

		SA	A	D	SD	Other*
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	9	10	1		1
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	6	13	1		1
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	6	12	2		1
4.	NACEP meets all the legal requirements in this jurisdiction:					
	a. for aides employed in long term care.	9	11			1
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	6	7	2	1	5
	c. for aides employed in acute care settings (hospitals).	5	9	3	1	3
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	5	14	2		
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	7	10	2	1	1
7.	The test service provides accurate and necessary information regarding the NACEP.	6	14	1		
8.	The test service answers inquiries from this agency in a reasonable amount of time.	4	15	2		
9.	Evaluation materials from the test service arrive on time at test sites.	4	11	3		3
10.	Candidates receive score reports within the time period specified by your contract.	2	13	2	1	3

11.	The state agency score reports have been received in a timely manner.	4	12	2	1	[illegible]
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	4	14	1	1	1
13.	NACEP security measures are effective.	6	14			1
14.	Feedback on the NACEP from nurse aides has been positive.	3	13	1	1	3
15.	Feedback on the NACEP from facilities has been positive.	1	15	3	1	1
16.	The application process is easy for candidates and sponsors to compete.	3	14	1	2	1
17.	NACEP is an effective evaluation for home health aides (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as long term care aides.	3	9	3		6
18.	The Nurse Aide Practice Test has been useful.	5	11	1		4

		Yes	No	Other*
22.	In your jurisdiction, are you currently using NACEP to evaluate:			
	a. aides employed in long term care settings	18	1	2
	b. aides employed in home health settings	12	6	3
	c. aides employed in acute care (hospital) settings	11	8	2

		Low	Med	High	Very High	Other*
26.	Overall, how satisfied is this agency with the Nurse Aide Competency Evaluation Program (NACEP) offered by the National Council of State Boards of Nursing and The Psychological Corporation . Please respond on a scale of 1 to 5, with 1 indicating a very low level of satisfaction.	1	3	13	5	1 NR = 1

SA = Strongly Agree
A = Agree
D = Disagree
SD = Strongly Disagree

**Other includes responses such as no answer given, not applicable, perhaps, etc.*

Responses to open-ended questions (19-21 and 23-25) are available upon request.

Attachment B

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

		1995	1994	1993
1.	The Nurse Aide Competency Evaluation Program (NACEP) is a psychometrically sound and legally defensible evaluation of nurse aide competence.	3.40	3.27	3.60
2.	The NACEP written evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.25	3.00	3.43
3.	The NACEP manual skills evaluation is a valid measure of the knowledge, skills and abilities a nurse aide needs to perform competently on the job.	3.20	2.76	3.25
4.	NACEP meets all the legal requirements in this jurisdiction:			
	a. for aides employed in long term care.	3.45	3.45	3.50
	b. for aides employed in home health (when used with the Home Health Aide Supplemental Checklist).	3.13	3.25	3.06
	c. for aides employed in acute care settings (hospitals).	3.00	2.76	3.19
5.	The quality of the NACEP as an evaluation of nurse aide competence is high.	3.14	3.05	3.24
6.	The contractual relationship between The Psychological Corporation and this agency is satisfactory.	3.15	2.90	3.35
7.	The test service provides accurate and necessary information regarding the NACEP.	3.24	3.14	3.09
8.	The test service answers inquiries from this agency in a reasonable amount of time.	3.10	3.09	2.86
9.	Evaluation materials from the test service arrive on time at test sites.	2.83	2.94	3.00

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

10.	Candidates receive score reports within the time period specified by your contract.	2.89	2.75	2.75
11.	The state agency score reports have been received in a timely manner.	2.79	2.76	2.59
12.	Any implementation problems which occurred were resolved satisfactorily with the test service.	2.65	2.86	3.04
13.	NACEP security measures are effective.	3.00	3.09	3.18
14.	Feedback on the NACEP from nurse aides has been positive.	3.00	2.76	3.19
15.	Feedback on the NACEP from facilities has been positive.	2.95	2.70	3.14
16.	The application process is easy for candidates and sponsors to complete.	2.90	2.78	2.90
17.	NACEP is an effective evaluation for home health aides (when used in conjunction with the Home Health Aide Supplemental Checklist) as well as long term care aides.	3.00	2.92	3.20
18.	The Nurse Aide Practice Test has been useful.	3.23	3.31	3.47

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

10-F

TASK FORCE ON
CHEMICAL DEPENDENCY
ISSUES

Report of the Task Force on Chemical Dependency Issues

Task Force Members
Jean Sullivan, WA, Area I, *Chair*
Maggie Johnson, SC, Area III
Marsha Straus OH, Area II
Emmaline Woodson, MD, Area IV
Mary Haack, *Consultant, The George Washington University*

Staff
Carolyn J. Yocom, *Director of Research Services*

Relationship to Organization Plan
Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective C .... Conduct research on regulatory issues related to disciplinary activities.

Recommendation(s) to the Board of Directors
No recommendations.

Highlights of Activities
The primary activity of task force members has been to provide consultation and assistance to staff relative to obtaining Member Board participation in a research study and content validation of data collection instruments. Approved in August 1994 by the Board of Directors, the purpose of the study, *A Comparison of Two Regulatory Approaches to the Management of Chemically Impaired Nurses*, is to provide Member Boards with comparative information about the effectiveness and costs of two different regulatory approaches to the management of chemically impaired nurses. It employs a longitudinal, quasi-experimental, cross-section design to compare the effectiveness and costs of a traditional disciplinary approach and a nondisciplinary alternative approach to the regulatory management of chemically dependent nurses. The three Member Boards agreeing to represent jurisdictions using a disciplinary approach are Ohio, South Carolina and Virginia. The Member Boards in Florida and Maryland have agreed to represent jurisdictions using an alternative, nondisciplinary approach. Although the board in Washington has agreed to participate, the necessary approvals by other governmental agencies are still being obtained. Sample selection (approximately 40 individuals from within each jurisdiction) is scheduled for May 1995 with data collection occurring between June and December. The protocol for protecting study participants' rights has been approved by the Institutional Review Board of The George Washington University, Washington, DC, and by the executive director of the National Council of State Boards of Nursing.

The task force also reviewed and provided input relative to the development of a pre-proposal submitted to The Robert Wood Johnson Foundation in May 1995, in response to an announcement of funding availability for research and evaluation projects producing policy-relevant information about ways to reduce harm caused by the use of tobacco, alcohol and illegal drugs.

Future Activities
Following completion of data collection in FY96, the task force will assist with interpretation of study findings. It is anticipated that selected preliminary findings will be available during the Spring 1996 Area Meetings. A more comprehensive report of findings will be provided at the 1996 Annual Meeting.

Meeting Dates
April 13, 1995, *telephone conference call*

Recommendation(s) to the Board of Directors
No recommendations.

10-G

DISC. GUIDELINES FOR
MANAGING SEXUAL
MISCONDUCT CASES

Report of the Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group

Focus Group Members

Jean Stevens, WA, Area I, *Chair*
Judith Ryan, MD, Area IV
Neysa Somple, OH, Area II
Betty Ann Taylor, FL, Area III

Staff

Vickie Sheets, *Director for Nursing Practice and Education*

Relationship to the Organization Plan

Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective D .... Provide for Member Board needs related to disciplinary activities.

Recommendation(s) to the Board of Directors

1. Develop a Member Board education packet to include information regarding the continuum of sexual misconduct (boundary crossings to sexual misconduct), with materials prepared for use with specific audiences, e.g., board members, board professional staff, attorneys, investigators and board support staff.

2. Develop a pamphlet/fact sheet for nurses regarding boundary and sexual misconduct cases that may be used by Member Boards to educate their licensees regarding the continuum of sexual misconduct (could be used in Member Board newsletters as articles, or handouts when Member Board representatives speak to nurses).

Rationale (1 and 2)

A review of the number of nursing discipline cases involving sexual misconduct reported to the National Council Disciplinary Data Bank (DDB) between March 1, 1994, and March 31, 1995, was 43 cases (23 RNs and 20 LPN/VNs), a small percentage (0.6 percent) of the 6,931 total cases (3,920 RNs and 3,011 LPN/VNs) reported during that time period. Although such cases are few in number, one sexual misconduct case is likely to cause great harm to the victim, may consume extraordinary resources for a board of nursing to pursue, and damage may result to the credibility of a board of nursing that fails to pursue such cases.

The focus group's charge was to study the issue of sexual misconduct as it relates to nurses' practice and to develop model(s) to assist Member Boards in making decisions regarding disciplinary action. Early in their discussions, focus group members became convinced that boards of nursing need to promote education of students, nurses and consumers as well as Board members and staff. There are proactive measures that can be undertaken, education being the most important.

3. Conduct a prospective study of sexual misconduct cases for recidivism after Board action, using a modification of the methodology used to perform a disciplinary effectiveness study.

Rationale

The recommendation for a research study would look at recidivism among sexual misconduct cases after board action. Cases would be identified quarterly from reports submitted to the DDB and Member Boards contacted to obtain the public documents related to those cases. After two years, the cases would be analyzed to identify the relationships between the disciplinary action imposed, the process used to arrive at the action, and recidivism rates. This method would allow using very timely cases and would be less burdensome for Member Boards than having to produce multiple case documents at one time.

4. Promote a collaborative educational effort with the National Council and other professional organizations (FARB, ANA, Tri-Council) to encourage dialogue for collaboration on the education of nurses on the nurse-client relationship and boundary issues/violations.

Rationale
The focus group members believe that the Board of Directors and organization leadership would be in the best position to promote a collaborative educational effort with National Council and other professional organizations. Dialogue regarding collaboration to promote nurse understanding of the nurse-client relationship and boundary issues would be another proactive approach to prevent problems before they rise to the level of requiring board intervention.

5. Promote the availability of focus group members as resources (speakers) on the topic.

Rationale
Because of the vast reading and preparation that the focus group members completed to fulfill their charge, they are each a resource for their state and Area. They are all willing and able to speak on the topic for various audiences, and would hope that the Board of Directors would consider promoting their availability to present on this topic.

6. Suggest boundary issues/violations and sexual misconduct as one of the topics for 1996 Regulatory Days of Dialogue.

Rationale
The focus group suggests that boundary issues/violations and sexual misconduct be considered as a topic for the 1996 Regulatory Days of Dialogue. The regulatory days could provide an established educational forum for Member Board members and staff, as well as an opportunity to discuss the challenges and possible approaches for managing these difficult disciplinary cases. This suggestion will be presented to the Area Directors for discussion at the Area Meetings held during the 1995 Annual Meeting.

Background

Board of nursing concerns about discipline cases involving sexual misconduct resulted in the 1994 National Council Delegate Assembly adopting a resolution to study and develop guidelines to manage this type of allegation. The Board of Directors appointed the Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group to study this topic and develop guidelines as a resource for Member Boards dealing with complaints of this nature.

It is difficult to think that nurses are sometimes involved in sexual misconduct. But the very nature of the care that nurses provide creates an opportunity for the naive as well as the unscrupulous nurse to take advantage of clients who trust. It is a topic that warrants careful consideration.

The focus group found this to be a complex phenomenon that tends to be avoided until something terrible occurs. While the focus group focused its attention on complying with the Delegate Assembly charge, to study professional sexual misconduct and to develop guidelines for use by boards of nursing in managing this type of disciplinary case, members believe there is a great need for education of nurses, educators, students, employers, legislators and consumers regarding the topic. Therefore, the focus group recommends that the Board of Directors reappoint this group of volunteers to continue efforts focused on developing educational resources as a proactive approach.

Highlights of Activities

- Literature Review

  Assisted by Research Assistant, Carol Ritchell, the focus group conducted an extensive literature review, looking not only at nursing resources but broadening into other health care disciplines. The nursing articles on the topic were limited, but as expected, a wealth of information was available regarding psychologists and psychiatrists. The focus group members believe that much of the experience of psychotherapists can be applied to nursing.

- Case Review

  The focus group conducted an e-mail survey of Member Boards to determine which jurisdictions had taken action in cases involving sexual misconduct. Thirty-one states responded yes; approximately two-thirds of that group provided public documents regarding the actions. The focus group reviewed these cases, focusing on the types of actions taken.

- State Approaches

  The focus group also reviewed the approaches that have been developed by several jurisdictions to deal with sexual misconduct cases.

- Consultation

  The focus group spent the first day of their meeting working with an expert in the assessment and rehabilitation of professionals who have admitted sexual misconduct. Gary Schoener is a psychologist from Minnesota, Director of the Minneapolis Walk-In Clinic, who is nationally and internationally recognized for his work in this area.

- Concept Paper and Guidelines

  Based on all the information studied, the focus group has prepared a concept paper which includes guidelines for Member Boards in the management of sexual misconduct cases (see Attachment A).

- Recommendations

  The focus group developed recommendations for future National Council activities to promote education and research efforts regarding this topic.

Recommendations

1. Develop a Member Board education packet to include information regarding the continuum of sexual misconduct (boundary crossings to sexual misconduct), with materials prepared for use with specific audiences, e.g., board members, board professional staff, attorneys, investigators and board support staff.

2. Develop a pamphlet/fact sheet for nurses regarding boundary and sexual misconduct cases that may be used by Member Boards to educate their licensees regarding the continuum of sexual misconduct (could be used in Member Board newsletters as articles, or handouts when Member Board representatives speak to nurses).

3. Conduct a prospective study of sexual misconduct cases for recidivism after Board action, using a modification of the methodology used to perform a disciplinary effectiveness study.

4. Promote a collaborative educational effort with National Council and other professional organizations (FARB, ANA, Tri-Council) to encourage dialogue for collaboration on education of nurses on the nurse-client relationship and boundary issues/violations.

5. Promote the availability of focus group members as resources (speakers) on the topic.

6. Suggest boundary issues/violations and sexual misconduct as one of the topics for 1996 Regulatory Days of Dialogue.

Future Activities

- Develop a Member Board education packet, including a pamphlet/fact sheet regarding boundary and sexual misconduct cases.

Meeting Dates

- January 31, 1995
- March 16-18, 1995
- April 12, 1995
- April 27, 1995

Attachment

A ....Disciplinary Guidelines for Managing Sexual Misconduct Cases, *page 4*

Disciplinary Guidelines for Managing Sexual Misconduct Cases

Executive Summary

The 1994 National Council Delegate Assembly adopted a resolution to study and develop guidelines to manage nursing disciplinary cases involving sexual misconduct. The focus group conducted an extensive literature search, reviewed cases which have been brought before Boards of Nursing in a number of jurisdictions, looked at approaches already developed by several states, and consulted with a nationally recognized expert in the assessment, treatment and selective rehabilitation of professionals who have admitted to sexual misconduct.

The review of nursing literature found mostly anecdotal reports of individual nurses' cases. Only two studies were found involving nursing and sexual behaviors. Both studies confirmed that professional sexual misconduct does occur and pointed out the need for additional research. The majority of the work studying the phenomenon of professional sexual misconduct has addressed psychiatrists and psychologists and provided much information relevant to the nursing profession. Public and professional awareness of professional sexual misconduct has been raised in states which have passed legislation to criminalize this offense.

Professional sexual misconduct is about power. For a nurse, it is an abuse of the nurse-client relationship. It is putting the nurse's needs first. It is using the position of being a nurse to access privileged client information, to seek opportunity and to use influence over the client to obtain sexual gratification, romantic partners or sexually deviant outlets. It is a breach of trust. Any behavior by a nurse that is seductive, sexually demeaning, harassing or reasonably interpreted by a client as sexual is an example of sexual misconduct.

Professional sexual misconduct is extraordinarily complex and diverse. It happens in a variety of settings and situations. It can develop gradually, over a period of time and circumstances. It can begin gradually and suddenly intensify. It can happen in a moment of opportunity seized by a predator. Authors have found it helpful to describe categories of professional sexual misconduct, which have been used to convey the nature of the offense, and some examples of categorizations are provided in this paper. Post-termination relationships, professional boundaries, boundary crossings and boundary violations are also discussed, including a conceptualization of a continuum of professional behavior.

Specific guidelines are provided to assist Boards of Nursing in the management of disciplinary cases involving sexual misconduct. Sample legislative language is provided, as well as other resources regarding the phenomenon of professional sexual misconduct. The guidelines include suggestions for communicating with victim/complainants when complaints are received and throughout the discipline process. The investigation section addresses investigative plans, interviews (victims, identified nurses and other witnesses), specific suggestions for other evidentiary resources, and the investigative report.

Indicators that may assist to confirm probable cause for a complaint as well as factors which may disconfirm allegations are provided. Factors are also identified to assist determination of whether or not there is an immediate need for emergency action to remove a nurse from practice in order to protect the public from imminent harm. Suggestions for case prosecution are discussed, as well as approaches to working with other licensing boards to identify well-trained professionals to serve as mental health evaluators in these cases.

Finally, the role of the Board of Nursing in disciplinary decision-making is reviewed. Considerations to guide the Board's review of sexual misconduct cases are listed as well as sanctioning guidelines for Boards. The Boards' challenge when making rehabilitation and reentry decisions is discussed, including suggestions for reentry provisions.

While the focus group directed most attention on completing its charge to develop guidelines for use by Boards of Nursing in managing this type of disciplinary case, focus group members believe strongly that there is a great need for education of nurses, educators, students, employers, legislators and consumers regarding the topic. A proactive educational approach may increase sensitivity to the issue, and several education approaches are suggested.

Attachment A

Disciplinary Guidelines for Managing Sexual Misconduct Cases

Introduction

It is late afternoon, and only one patient remained in the Recovery Room. An operating room (OR) nurse entered the area and observed a male nurse up on a stretcher straddling an unconscious 15-year-old female patient. The male nurse's pants are down to his knees and he is naked from his waist down. From his position and the thrusting motion of his pelvis toward the patient's pelvis, the OR nurse believed that the male nurse was having intercourse with the patient. This sensational Florida case also involved several other patients who came forward after recognizing the licensee's picture in a newspaper article. The Florida Board of Nursing revoked this nurse's license to practice.

This horrific case has drawn national media attention. It is the type of incident that can cause irreparable harm to the victim, liability for the employer, and discredit to the profession. Although reported cases are few in number, when it happens, sexual misconduct poses a terrible threat to vulnerable clients. Sexual misconduct cases are likely to consume extraordinary resources for a board of nursing to investigate and prosecute, yet can be very damaging to the credibility of a Board of Nursing that fails to pursue such cases. Investigating and managing sexual misconduct cases demand knowledge and strategies that have not been within the traditional nursing education experience.

Professional sexual misconduct is a breach of trust. It is a specific type of professional misconduct that involves the use of power, influence and/or knowledge inherent in one's profession in order to obtain sexual gratification, romantic partners and/or sexually deviant outlets. Any behavior by a nurse that is seductive, sexually demeaning, harassing or reasonably interpreted by a client as sexual is a violation of the nurse's fiduciary responsibility to the client. If the client consents, even if the client initiated the sexual contact, it is still considered sexual misconduct because it is an exploitation of the nurse-client relationship.

While it is difficult to think that nurses would be involved in sexual misconduct, the nature of the care that nurses provide creates an opportunity for the naive and/or uninformed nurse as well as the unscrupulous nurse to take advantage of those who trust them. Increasing client vulnerability to abuse parallels the growing elderly population, changes in family structure, and changing social mores. Rising numbers of reported cases may reflect increased societal awareness and willingness to come forward with complaints. Many Boards of Nursing have had limited experience or knowledge in the management of this type of disciplinary allegation. It is a topic that warrants careful consideration.

The difficulty experienced and need for further information and education by Member Boards in dealing with sexual misconduct disciplinary cases resulted in the 1994 National Council Delegate Assembly adopting a resolution, proposed by the Maryland Board of Nursing, to study and develop guidelines to manage this type of allegation. The National Council's Board of Directors appointed the Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group to complete this charge.

The focus group conducted an extensive literature search, reviewed cases which have been brought before Boards of Nursing in a number of jurisdictions, looked at approaches already developed by several states, and consulted with Gary R. Schoener, a psychologist who is nationally recognized as an expert in the assessment, treatment and selective rehabilitation of professionals who have admitted sexual misconduct.

This paper includes a description of what was found in the literature, a review of selected state cases/approaches and a discussion of the phenomenon of professional sexual misconduct in nursing. Guidelines are presented to assist Boards of Nursing dealing with these cases as well as recommendations for future activities by the National Council. In addition, a glossary of terms and an extensive bibliography are included for readers needing further information on the subject.

Literature Review

Nursing

Most of the nursing articles reviewed focused on anecdotal reports of individual nurses' cases and did not provide research-supported work in the area of professional sexual misconduct by nurses. Only two studies were found involving nursing and sexual behaviors. The first was a 1974 ethics survey, conducted by Nursing '74, thatwas answered by over 11,000 nurses. The survey questionnaire incorporated a few questions regarding sexual behavior. One in 170 nurses reported having had intercourse with a patient, one in 30 had responded to a patient's sexual overtures but without sex play or intercourse, and one in eight reported being secretly tempted. (Nursing '74)

The only other research study found was published in the Journal of Psychosocial Nursing. Over 500 psychiatric hospitals were surveyed about suspected, alleged or verified sexual interactions between staff and patients over a two-year period. The authors reported a 57 percent response rate, which they attributed to high interest in the topic. One hundred sixty-nine hospitals reported 629 events. However, the events were not categorized by whether an event was suspicious, alleged or verified. The study also did not identify the level or type of staff involved in the event. The authors concluded that staff-patient sexual interaction occurs, and that much more research is needed. (Munsat & Riordan, 1990)

Gallop, a nursing faculty member at the University of Toronto, has also written regarding sexual contact between nurses and patients. She observed that patient exploitation by nurses can and does occur because of the power differential that exists. The nurse has access to privileged information and the opportunity to exploit patient vulnerability. Gallop noted that the patient's relationship with the treatment facility was affected when a staff member has sexual contact with the patient. Chronic patients may be particularly vulnerable. Setting clear boundaries prevents the patient from confusion, exploitation, and keeps the facility available for future patient use. Although Gallop focused on psychiatric settings, she opined that the questions and dilemmas can be generalized to other practice settings. (Gallop, 1993) Other settings where a client resides for an period of time, such as a physical rehabilitation center, or requires repeated episodes of care, such as a renal dialysis unit, are examples of extended nurse-client relationships where the nurse must carefully delineate professional and personal boundaries. As more health care is provided in community and home settings, with less supervision and more potential exposure for clients, nurses need to consider the types of concerns, problems and dilemmas that may be presented.

Gafner, who with his colleagues developed a workshop to assist Veterans Administration (VA) nurses deal with boundary issues, reported a strong resistance to boundary discussions, particularly from nurses in psychiatric and chemical dependency settings. For some nurses, this topic seemed to strike at the heart of caring. However, the negative consequences of inadequate boundaries range from misunderstandings and hurt feelings to impaired therapeutic relationships; from poor public relations to litigation resulting from client injuries. The workshop is used in VA settings to raise awareness, anticipate possible negative consequences and identify ways to extricate from a situation. (Pennington, Gafner, Schilit, & Bechtel, 1993)

Misconduct by professionals is not a new phenomenon. From the time of Hippocrates, examples of abuse of professional power and authority can be found. Although there were few nursing articles regarding this topic, much can be learned from the work of psychotherapists. The majority of work studying the phenomenon of professional sexual misconduct has addressed psychiatrists and psychologists. The focus group members found many of the principles and approaches of psychotherapy to be relevant to nursing.

Psychotherapy

The intimate, one-to-one, and frequently long-term psychotherapeutic relationship can result in therapists being drawn into inappropriate relationships. In a 1986 survey conducted by Gantrell of over 1,400 psychiatrists, 7.1 percent of the males and 3.1 percent of the females acknowledged sexual contact with a patient. A third of that group, all males, reported repeated contact. (Gartrell, 1986) Surveys of psychologists reflected similar percentages. (Pogrebin, 1992)

Films and television programs, long intrigued with the topic, deliver plots involving professional indiscretions. Books and articles have focused on sexual involvement of clients and professionals. Some authors have expressed concern that professionals look the other way, failing to report to appropriate agencies. "But the conspiracy of silence is fast breaking. A spate of widely publicized cases, a series of tell-all books and Hollywood's growing infatuation with

the topic are forcing the profession to take stronger action." (Beck, Springen & Foote, 1992) Zelen attributes increasing awareness of the problem to the rise in consumerism, the changes in psychotherapeutic practices and the feminist movement. (Zelen, 1985)

During the last decade, the professional literature in psychology and psychiatry has undergone a veritable explosion. An annotated bibliography published by Lerman in 1984 had 373 reference listings. The second edition which came out in 1990 contained over 2,000. Sexual misconduct has been a leading source of licensure complaints in psychology and psychiatry for two decades, and in psychology it accounts for 53 percent of dollars paid in defense and awards in malpractice actions against psychologists. (Lerman, 1990)

Review of Cases and State Approaches

The number of disciplinary cases reported to the National Council Disciplinary Data Bank involving sexual misconduct were reviewed for the period beginning March 1, 1994, and ending March 31, 1995. This time period was selected to provide a year of data using revised report forms which include a specific section for sexual misconduct. Forty-three cases (23 RNs and 20 LPN/VNs) listed grounds for sexual misconduct, a small percentage (0.6%) of the 6,931 total cases (3,920 RNs and 3,011 LPN/VNs) reported during that period. (National Council, 1995) A curious aspect of the reporting of cases was the distribution. Many jurisdictions reported no cases at all, while a few states reported several cases.

The Minnesota Experience

One of the few states that reported several cases is Minnesota, where statutes specifically include, as a ground for disciplinary action by the Minnesota Board of Nursing, "...engaging in conduct with a patient that is sexual or may reasonably be interpreted as sexual or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient." (Minnesota Statutes Section 148.261, Subdivision 1, 1992) In addition, Minnesota state law requires the inclusion of a summary of each discipline case involving possible sexual contact (complaint or other communication) in a Biennial Report to the governor and legislature. The Minnesota Legislature monitors both the incidence and Minnesota professional licensing boards' response to these cases.

The Minnesota Board of Nursing Biennial Report for July 1, 1992, through June 30, 1994, listed a total of 25 complaints involving possible sexual contact, ten of which were pending from the previous year. Of these 25 cases, the Minnesota Board reported the following outcomes: one stipulation to cease practice, three suspensions, three limited and conditional licenses, seven conditional licenses, three warnings, two dismissals, one case closed (and referred, individual was not a nurse) and five cases remained pending. Since 1986, Biennial Reports have identified between ten and thirty cases each two-year period. (Minnesota Biennial Reports)

The National Council's focus group hypothesized that professional sexual misconduct was not occurring more frequently in Minnesota, but that consumers and professionals alike were sensitized to the issue. A Minnesota Board of Nursing member had chaired the Task Force on Sexual Exploitation by Counselors and Psychotherapists which was created by the state legislature to study the problem and recommend changes in Minnesota laws and policies. Public and professional awareness was raised considerably by these efforts, and mandatory reporting was added to the Nursing Practice Act, mirroring changes in the Medical Practice Act.

Selected Cases From Other Jurisdictions

Fourteen other Boards of Nursing provided the public documents relating to 32 sexual misconduct cases in response to the focus group's request for public documents. In this small sample, the sexual encounters involved a variety of settings (e.g., hospitals, mental health facilities, correctional institutions, a mortuary, an office, and homes). Twenty-six cases involved male nurses and six involved female nurses. The majority of the victims were females. The types of behaviors ranged from obscene phone calls and mailing sexually explicit letters, to verbal suggestion; from inappropriate hugging and kissing, to sexual grooming, indecent exposure; from oral sex, to sexual assault and rape.

State Approaches to Sexual Misconduct Cases

Several states have studied professional sexual misconduct and developed their own approaches for dealing with these cases. The focus group found the following documents to be informative.

- ***Florida***

The Florida Board of Nursing, faced with some sensational cases, studied a model developed by Richard Irons, M.D. and workshop materials developed by that state's Physician's Professional Network. The Intervention Program for Nurses (IPN) in Florida has developed requirements for referral/monitoring of nurse applicants/ licensees with history of psychosexual disorders/sexual addiction. Some of their approaches have been incorporated into the guidelines developed by the focus group. (B. Taylor, personal communication, March 17, 1995)

- ***Kentucky***

As a follow up to work done in the area of child sexual abuse, the Kentucky legislature amended licensure laws for health professionals, including nurses, to require boards to investigate stringently and punish sexual misconduct. An Attorney General's task force is developing guidelines to assist licensing boards. The focus group reviewed a draft of these guidelines which provided assistance in the areas of investigation and sanctioning by Boards. (Jordan & Walker, 1995)

- ***Washington***

In 1992, each health care professional board was directed by the Secretary of Health to develop a policy on sexual misconduct. The purpose of the policy developed by the Washington State Board of Nursing (now the Washington State Nursing Care Quality Assurance Commission) was to define what is sexual misconduct by a nurse as it related to the Washington Uniform Disciplinary Act. The policy identified factors to be considered in the termination of the nurse-client relationship, defined sexual contact, and discussed appropriate nursing assessment and intervention. The policy emphasized that a client's consent "...does not change the nature of the conduct nor lift the statutory prohibition." (Washington Board of Nursing, 1994) The Board also provided recommendations to guide nurses in the compliance with the policy. See Table 1.

Table 1. Washington State Board of Nursing (now Washington State Nursing Care Quality Commission) Recommendations to Guide Nurses

1. Nurses should be aware of any feelings of sexual attraction to a patient, and should discuss such feelings with a supervisor or trusted colleague. Under no circumstances should a nurse act on these feelings or reveal/discuss them with the patient.
2. Nurses should transfer the care of a patient to whom the nurse is sexually attracted to another nurse. Recognizing that such feelings in themselves are neither wrong or abnormal, nurses should seek help in understanding and resolving them.
3. Nurses must be alert to signs that a patient may be interested in or encouraging a sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.
4. Nurses must respect a patient's dignity and privacy at all times. They should be particularly aware that examinations and treatments involving the sexual or private parts of the body can [increase the patient's vulnerability and take steps to] prevent or minimize any such trauma.
5. Nurses should provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the nurse['s] intentions and the care being given.
6. Nurses' communications with patients should be clear, appropriate and professional.
7. Nurses should never engage in communications with patients that could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.
8. Nurses should not discuss their personal problems, or any aspects of their intimate lives with patients.

Note: Adapted from Washington Board of Nursing, 1994

Professional Sexual Misconduct in Nursing

What Is It?

Professional sexual misconduct is about power. For a nurse, it is the abuse of the nurse-client relationship. It is putting the nurse's needs first. It is using the position of being a nurse to access privileged client information, to seek opportunity and to use influence over the client to obtain sexual gratification, romantic partners or sexually deviant outlets. It is exploitation. It is about impairment and irresponsibility. A nurse with a psychological disorder fails to seek help and instead engages in harmful contact with clients. It is an extremely serious type of professional misconduct, a violation of a fiduciary responsibility. It is a breach of trust. Any behavior by a nurse that is seductive, sexually demeaning, harassing or reasonably interpreted by a client as sexual is an example of sexual misconduct.

Parallels to Incest

The abused client's experience parallels the experience of a incest victim. Like a trusted parent, a professional is trusted to be working only in the client's best interest. When a professional sexually abuses the client, that trust is violated. There are analogous dynamics between the incestuous relationship and the professional sexual encounter. Both are characterized by secrecy, isolation, lack of restraint, breakdown of sexual privacy and denial. The incest analogy addresses the "love-hate" relationship seen in both. There may be a significant age difference between the professional and the client. There is inherent unequal power, with authoritarian qualities attributed to the professional and the psychological vulnerability of a client. The client may exhibit an extreme desire to please the professional. (Luepker, 1989)

Who is at Risk? The Client

Authorities do not agree as to whether there is a victim profile that can help predict which clients may be at greater risk. In psychotherapy, some writers observe that clients with certain histories, such as incest victims or borderline personality disorders, may be more vulnerable. (Pope, 1994) Kluft posits a "sitting duck syndrome" in which clients with a history of victimization may be revictimized. (Kluft, 1994) However, Schoener and colleagues have not detected any client characteristics which predict abuse in their experience with over 3,000 cases and focus on the characteristics of the offending professional as the only predictors of who may be abused. (G.R. Schoener, personal communication, May 5, 1995) Abuse may happen when it happens because of opportunity and pure chance.

The impact of professional sexual misconduct varies by individual. The harm may be complicated by the trauma of cessation of the sexual involvement. The client's response may range from embarrassment, humiliation and a sense of exploitation to depression and suicidal crises. The breach of trust is usually far more serious than the actual sexual contact. Working with a support group (to know that they are not alone) and taking action against the abusing professional may be better than therapy in helping the victim recover from the experience. Confronting the abuser often assists in the healing process. (G.R. Schoener, personal communication, March 16, 1995)

The Public

It is difficult for the colleagues of professionals who have been charged or found guilty of sexual misconduct to understand the complex dynamics at play, let alone the public. The perception of a silent conspiracy among some health care professionals has aggravated public concerns. Repercussions may include the erosion of confidence in health care, and may lead some clients to avoid needed care. Recognition of the seriousness of professional sexual misconduct has led some legislatures to enact criminal sanctions in addition to regulatory penalties. Wisconsin criminalized therapist-client sex in 1984 and Minnesota followed in 1985. At the time of this report, eleven others have also done so: Colorado, North Dakota, South Dakota, California, Iowa, Maine, Florida, New Hampshire, Georgia, New Mexico, and Texas. Several states have legislative task forces studying the problem and others are considering bills. (G.R. Schoener, personal communication, May 5, 1995)

The Professional

There have been efforts to identify those psychotherapists who become involved in professional sexual misconduct. Gabbard sorts offenders into four groups: 1) psychotic disorders; 2) predatory psychopathy and paraphilias; 3) lovesickness; and 4) masochistic surrender. The first two correspond to the Schoener/Gonsiorek categories described below, and masochistic surrender refers to the professional who responds to frustration over patient resistance to treatment by becoming intimately involved. His "lovesick" category includes a variety of situations, including:

unconscious re-enactment of incestuous longings; a wish for maternal nuturance is misperceived as a sexual overture; fantasy that love in and of itself is curative; manic defense against mourning and grief at termination; conflicts around sexual orientation; and a number of other dynamics. (Gabbard, 1995)

Epstein and Simon devised an Exploitation Index to serve as an early warning indicator of boundary violations in psychotherapy. This tool is divided into several subcategories, and poses questions for clinicians to ask themselves about their practice. The subcategories include general boundary violations, eroticism, exhibitionalism, dependency, power seeking, greed, and enabling. Questions are answered on a scale of never, rarely (yearly), sometimes (quarterly), or often (monthly). Many of the questions used in the index are relevant to nursing. Examples are included in Table 2.

Table 2. Selected Epstein/Simon Exploitive Index Questions Related to Nursing

- Do you seek social contact with patients outside of clinically scheduled visits?
- Do you tell patients personal things about yourself in order to impress them?
- Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?
- Do you take pleasure in romantic daydreams about a patient?
- When a patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?
- Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity?)
- Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?
- Do you accept gifts or bequests from patients?

Note: Adapted from Epstein & Simon, 1990

This learning instrument for psychotherapists could be adapted to address similar aspects of nurse-client relationships and used to increase awareness of boundary issues as well as to help identify problems early rather than later. (Epstein & Simon, 1990)

Authors have found it helpful to describe categories of professional sexual misconduct, which have been used to convey the nature of the offense. Schoener and Gonsiorek have classified six categories of offenders in their typology. Either actual cases or hypothetical examples are included to illustrate the six categories.

1. Psychotic or Severe Borderline Personality

   These individuals exhibit impulsivity due to poor controls; sexual contact due to bizarre belief systems or theories; poor social judgment concerning actions and words. This category includes manic states, acute psychosis secondary to drug reactions and organic or neurological problems. These persons are seriously disturbed with very questionable reality perception, so are often readily detected. (Schoener & Gonsiorek, 1989)

   A hypothetical example of this category would be a nurse suffering from severe schizophrenia who hears voices telling her that she can save the male patients entrusted to her care by having their babies. She attempts to initiate sex so that she can act upon those voices' commands.

2. Sociopaths and Severe Narcissistic Character Disorders

These individuals are self-centered and gratification-oriented. Their sexual acting out varies and they are often good at manipulating themselves out of trouble. They have no concern for harm to others. These persons are more cunning, intimidating and concealing to cover multiple abuses. (Schoener & Gonsiorek, 1989)

The nurse profiled in the introduction of this paper is an example of this category. This nurse had victimized several clients and managed to avoid detection before being caught in the act.

3. Impulse Control Disorders

These individuals have longstanding, ingrained impulsiveness. They may or may not be addicted. These disorders include both sexual impulse control disorders and general impulse control disorders. These persons may harass staff members as well as clients, and may frequently be detected because of poor judgment. (Schoener & Gonsiorek, 1989)

An example of an impulse control disorder is the notorious case involving a nurse, licensed in seven states, who volunteered to assist in a mortuary. He used that opportunity to take photos of the genitalia of corpses. The nurse's attorney challenged the Oregon Board of Nursing's revocation of the nurse's license, saying that the nurse's sexual stimulation obsessive-compulsive disorder would not harm patients because the nurse was preoccupied with dead bodies and paraphilia. The Oregon Board of Nursing successfully argued that the nurse, a Certified Registered Nurse Anesthetist (CRNA), regularly sees patients undressed and lifeless-like under anesthesia, and that the nurse's significant chronic disorder places patients at risk for invasion of their privacy.

4. Severely Neurotic and/or Socially Isolated

These individuals suffer from longstanding problems, are emotionally unfulfilled and overinvested in work. These persons are typically overly involved with clients emotionally. Sexual contact develops secondary to emotional involvement, but can become a repetitive pattern. (Schoener & Gonsiorek, 1989)

A hypothetical example of this category would be a nurse, a workaholic immersed in the emotional lives of her clients. She engages in a personal relationship with a client, that includes giving a personal loan and progresses to intimate sexual contact.

5. Mildly Neurotic and Situational Breakdown in otherwise Healthy Person

These individuals have had more serious pathologies ruled out. They are usually remorseful one-time offenders who yielded to temptation under the stress of the situation, the situational factors and timing having played a major role (the "distressed practitioner"). (Schoener & Gonsiorek, 1989)

A hypothetical example would be a nurse, going through a difficult separation, missing his children and home terribly. The nurse has always been considered an excellent staff member. He begins to spend extended periods of time with a young woman client in the mental health facility where he works. Although the client consents to first a dating and then an intimate relationship, her psychiatrist became aware and concerned because of the client's history of repeated involvement with married men and the nurse's inappropriate relationship with his client.

6. Uninformed/Naive

These individuals have had more serious pathologies ruled out. These persons are unaware of professional boundaries, ethics, responsibilities. A lack of training and good organizational structure and supports may have set the stage for the involvement. To be considered as uninformed or naive, the individual must be a non-predator, there should be remorse, and explanations cannot be rationalizations or excuses. This person may have a distorted view of the professional helping relationship, not distinguishing it from friendship. (Schoener & Gonsiorek, 1989)

A hypothetical example of this category would be a graduate nurse who develops a personal relationship with an older adolescent client who is terminally ill. The nurse decides to do something about the client's fear of dying a virgin, not thinking about the ethical implications of her behavior.

Irons' Archetypal Categorization has six categories very similar to Schoener and Gonsiorek's Professional Sexual Misconduct Categories. (Irons, 1991) A comparison of the models is found in Table 3.

Table 3. Comparison of Irons' Archetypal Categorization to the Schoener-Gonsiorek's Professional Sexual Misconduct Categories

The Naive Prince or Princess—poor training/judgment
Compares to 1. Uninformed/Naive—person who is unaware of professional boundaries, ethics, responsibilities.

The Wounded Warrior—situationally impaired professional
Compares to 2. Healthy/Situational Breakdown—person who yields to temptation under the stress of the situation, usually a remorseful one-time offender.

The Self-serving Martyr—neurotic, lonely
Compares to 3. Severely Neurotic and/or Socially Isolated—person suffering from longstanding problems, emotionally unfulfilled and overinvested in work.

The False Lover—impulsive character disorders
Compares to 4. Impulsive or Compulsive Character Disorder—person may sexually harass staff members and others, frequently detected rapidly because of poor judgment.

The Dark King or Queen—exploiters
Compares to 5. Sociopathic or Narcissistic Character Disorder—person is more cunning, intimidating, concealing to cover multiple abuses.

The Wild Card—serious reality-testing problems
Compares to 6. Psychotic or Borderline Personality—person is seriously disturbed, reality orientation very questionable, often readily detected.

Note: Adapted from Irons, 1991 and Schoener & Gonsiorek, 1989

Most of the work on offenders has concerned male offenders since they have predominated to date. However, Schoener and colleagues report that about 25 percent of their offenders are female, with the majority involved in female-female sexual contact. They report that offenders fall into all of the categories presented earlier, with the only difference being that a large percentage are to be found in substance abuse and criminal justice related work. (G.R. Schoener, personal communication, May 5, 1995) Benowitz, who studied female-female cases, reports considerable similarity to the heterosexual male-female relationships. (Benowitz, 1995; Gartrell, 1992) Guntheil describes two types of situations he has seen in cases involving female therapists, and one of the four cases described by Strean in his book on treating professional offenders is that of a female therapist. (Edelwich & Brodsky, 1992; Strean, 1993) Gabbard describes several situations which might involve female practitioners in particular: where a sexual identity struggle in the practitioner leads her to experiment with a patient, and the situation where the rescue fantasies tied to the cultural myth that even the most character-disordered man can be "fixed" by the "right woman." (Gabbard, 1994)

The Profession

Sexual misconduct cases are often high profile and headline grabbing. They may involve lengthy proceedings which pit one person's word against another. They make public potentially embarrassing and distressful information. The victim, the Board of Nursing, and the alleged perpetrator are put in very uncomfortable circumstances. These cases consume considerable human and fiscal resources. Given the human proclivity to focus on what is bad, a few cases of professional sexual misconduct can color the profession's self perception as well as the public's perception of the profession. Those inclined toward seeing situations as black or white may question the system that allowed such an individual to practice. Those who are more attuned to the gray in all human interactions may question their own practices and professional identities. Rutter and Gabbard remind us that almost any professional may be capable of abuse, given an extreme combination of circumstances and opportunity. (Rutter, 1989; Gabbard, 1994)

After exploring how sexual misconduct relates to the client, the public, the professional, and to the profession itself, it is important to examine the active unfolding of sexual misconduct—how it happens.

How It Happens—Opportunity

Nursing is a unique field with possibly the greatest challenges in setting appropriate boundaries. In long-term, sustained relationships, with intimate and personal therapeutic activities, nurses cannot help but become close to their clients. Continuity of care frequently contributes to nurse effectiveness with clients, but the same continuity that supports care can be a factor leading to misconduct. In the institutional setting, the nurse is with the client for long stretches of time over a given shift. The community or home setting presents less public, less supervised, even more personal circumstances where nurses and clients interact. Consider, for example, the increasing use of home care nurses, where the nurse spends extended periods of time in the client's home.

The client may experience an idealization of the nurse who is providing support and assistance and/or the psychological phenomenon of transference, an unconscious transfer of emotions and beliefs about significant others onto the therapist. Clients do experience transference with nurses. Nurses are human, too, and may experience counter-transference, reciprocal feelings. Health professionals must be sensitized to these dynamics, and delineate clear limits on the relationship. The establishment of treatment boundaries is the responsibility of the professional, not the client. (Simon, 1995)

These challenges are complicated further by where a nurse lives and works. In a small community, be it a rural village or an urban ethnic center, nurses sometimes cannot avoid involvement with clients outside the therapeutic setting. Everyone knows everyone, and often almost everything about everybody. The nurse must learn to distinguish professional and personal interactions.

Predators go hunting for victims, and nursing can provide vulnerable clients as well as opportunity. Like the milieu of psychotherapy which creates a "slippery slope," where the dynamics of therapy may contribute toward the occurrence of misconduct (Strasburger, Jorgenson & Sutherland, 1992) nursing can also be a "slippery slope" where the slope may be paved with good intentions waiting to trip naive or uninformed nurses.

Post-termination Relationships

Post-termination relationships pose thorny questions that have been dealt with differently by a variety of professional groups struggling with them. Setting appropriate standards in this area is very difficult - if the standards do not fit into real life, they do not work and undermine authority. If a standard is disregarded, it will be disobeyed and unreported. (G.R. Schoener, personal communication, March 16, 1995)

The American Medical Association standard requires termination with referral of the client to another physician, and a discussion with the client about implications. The Task Force on Sexual Abuse of Patients of the College of Physicians & Surgeons of Ontario recommended no sexual contact for two years after the last professional contact. Psychiatrists have taken a much stricter approach. In 1993, the American Psychiatric Association adopted an absolute prohibition - no relationships with clients, ever. Ontario psychiatrists have a similar ban. (Schoener, 1995)

Recently, the American Psychological Association, after many years of debate, created an absolute prohibition for two years following the termination of therapy. In relationships beginning after the two years, the burden of showing that there has been no exploitation is upon the psychologist, and certain clients, such as those with a history of sexual abuse, are forever excluded. The American Association of Marriage and Family Therapists adopted a two-year post-termination waiting period in 1986, but the National Association of Social Workers has a less precise prohibition against a post-termination relationship which arose out of the therapy relationship. (Schoener, 1989)

The Ontario College of Nursing has included guidelines regarding post-termination relationships in published expectations for professional behavior. Nurses may initiate or engage in a relationship with a client if it is anticipated that the client will not require future care from the nurse. However, if the nature of the nurse-client relationship was psychotherapeutic, the nurse must not engage in a romantic or sexual relationship for one year post termination, and then only if in the nurse's judgment the relationship would not have a negative impact on the client's well-being. (Schoener, 1989)

The American Nurses Association (ANA) Code of Ethics does not specifically address post-termination relationships, although there is a reference to private ethics. Gafner and his colleagues recommend that the ANA Code

be amended to make explicit the prohibition of sexual misconduct as well as warn to other boundary issues. (Pennington et al., 1993)

Important criteria to consider when discussing post-termination relationships include the type of therapy received and the length/nature of the nurse-client relationship. Clients with a known history of child abuse and severely disturbed clients are very vulnerable to exploitation. The issue "when clients may need additional treatment" becomes "has the nurse-client relationship really terminated?" Anytime a nurse could use knowledge of a patient to meet the nurse's needs, a red flag should be raised by the power imbalance.

Boundaries

Most authors agree that sexual misconduct often begins with boundary violations. "Boundaries are the limits that allow for a safe connection [with the client] based on the client's needs. When these limits are altered, what is allowed in the relationship becomes ambiguous. Such ambiguity is often experienced as an intrusion into the sphere of safety. The pain from a violation is frequently delayed, and the violation may not be recognized or felt until harmful consequences occur." (Peterson, 1992) It is the duty of the professional to establish and maintain treatment boundaries consistent with the provision of good clinical care. "Boundary violations, and even sexual misconduct, are occupational hazards of the mental health professional." (Simon, 1995) Simon identified five principles regarding the establishment of boundaries, noting that the first question to ask is "...whether the treatment intervention is made for the benefit of the therapist or for the sake of the patient's therapy." (Simon, 1995) Simon's principles are:

- the rule of abstinence—a professional must abstain from personal gratification at the client's expense;
- the duty to neutrality, not to interfere in a client's personal relationships;
- the promotion of client autonomy and self determination;
- the fiduciary relationship, which requires the professional to act in the best interest of the client; and
- the respect for human dignity, which underlies all of the above. (Simon, 1995)

Problems develop with boundaries when too many of them are crossed, so that the relationship begins to resemble a personal one rather than a professional one. However, the difference between a caring professional relationship and seduction is narrow. At the present time, there is not clear evidence that professionals who are looser with boundaries, e.g., touch more frequently, get into trouble more. Neither does the data suggest that rural practitioners are more of a problem than urban practitioners. (G.R. Schoener, personal communication, May 5, 1995)

Boundary Crossings

There is a gray area of clinical decisions where the best course of action is not readily apparent. A decision to deviate from an established boundary, a "boundary crossing," may enhance the therapeutic alliance, especially if properly examined within therapy. Frick gives examples of boundary crossings as appointment changes, extension of payments, small gifts to the therapist, or requests (from the client) for disclosure of bits of personal information (by the therapist). (Frick, 1994) Boundary crossings may be trivial. The danger may arise if there is an increase in the frequency and severity of the crossings. (Simon, 1995)

Boundary Violations

"Boundary crossings" can be distinguished from "boundary violations." Boundary violations are characterized by a reversal of roles, secrecy, the creation of a double bind for the client and the indulgence of personal privilege by the professional. (Peterson, 1992) Often, the first step down that slippery slope is excessive personal disclosure by the professional. There is a confusion of the professional's needs with the client's needs and the use of rationalization to justify the behavior. (Schoener,1989) The professional may fantasize that love, in and of itself, will be curative. Frequently, there may be re-enactment of incestuous involvements from the client's past. (Gabbard, 1991)

One approach to analysis of boundary violations is suggested by the Florida Physicians Professional Network, which describes five stages of boundary infringement. Applied to nursing, Stage I involves inadvertent crossing, where a nurse failed to set limits with the client. Stage II begins when the nurse attends to the client in special ways. In Stage III, the nurse provides secrecy for special favors, the client becomes significantly enmeshed and the nurse may cause actual harm to patients. Stage IV involves overt exploitation, active involvement of the client and the exchange of gifts and other activities with each other. By Stage V, a rationalized delusional system has developed which justifies and permits sexual misconduct. These rationalizations can lead to secret meetings and affairs. (Physicians Professional

Network, 1994) The real danger in stages I and II may be the tendency to progress to other stages that truly exploit the client. These stages help to conceptualize the variations of boundary problems. Not all boundary violations lead to sexual misconduct, however. Serious sexual misconduct can occur suddenly, without progressing through the stages, when opportunity presents itself to a disturbed professional.

One common form of boundary violation is the dual role, where the professional assumes an additional role in the life of the client, e.g., friend. Even nonsexual dual relationships are potentially exploitive. The practitioner's influence and the client's vulnerability carry over into the second relationship. "The practitioner is in a position to subordinate the client's interest to his or her own." (Kagle, 1994) Conflicts between roles occur when expectations and responsibilities of one role conflict with another. The incompatibility of the role expectations and the divergence of the professional's obligations combined with the authority of the professional conflict with the client's need for help. Such situations may result in lost objectivity of the professional and neglect of the well-being of the client.

Sexual Misconduct

Sexual misconduct by professionals, as discussed on page one of this paper, means the use of the power, influence and/or knowledge inherent in one's profession in order to meet one's own sexual needs. The most extreme types of sexual misconduct involve actual sexual contact, intercourse and rape. It could be the action of a predator, such as the Florida example. It could be the action of a more cunning predator who carefully manipulates over time to seduce. It could be the love-sick, one-time offender who yields to temptation.

Conceptualization of a Continuum

The focus group found it helpful to visualize a continuum of behavior, illustrated in Table 4. The continuum has under-involvement on one extreme, over-involvement on the other, with a center zone of helpfulness. Every nurse-client interaction can be plotted on the continuum. The majority of nurse-client interactions occur within the zone of helpfulness. The continuum helps to conceptualize that harm can be done on either end of the continuum, although at the present we are focused on the over-involvement end of things.

Table 4. A Continuum of Professional Behavior Suggested by Schoener

Under-involvement: cold, distant	The zone of helpfulness	Over-involvement: boundary violations*

* sexual misconduct is the most extreme over-involvement

Note: G.R. Schoener, personal communication, May 5, 1995. Used with permission.

Conceptualization of a continuum of professional behavior may assist Board of Nursing members by giving them a frame of reference for evaluating the circumstances presented in a case. (G.R. Schoener, personal communication, May 5, 1995) In addition to the Board members who make discipline decisions, conceptualization of a continuum can assist in the education of staff and attorneys who assist Boards in the disciplinary process, of nursing employers, nurses and student nurses, and consumers.

The continuum can be used to illustrate:

- the importance of professional boundaries,
- the harm that can occur on either end of the continuum,
- the behavior that is expected of nurses and other health care professionals, and
- the reporting requirements and expectations for the jurisdiction.

Professional sexual misconduct involves complex situations which the must be carefully considered on a case-by-case basis. The rape cases are obvious decisions, the boundary violations are often much less clear. Boundary crossings may in fact be in the best interest of the client. To further complicate, the same action may be viewed as a boundary crossing in one set of circumstances, a boundary violation in another. Consider the following hypothetical situations.

- **Hypothetical situation A.** A discouraged young man is struggling to recover from multiple injuries sustained in a auto accident. His nurse learns that his favorite college team is also her alma mater. She brings him a college sweatshirt from that school. This fact pattern describes a boundary crossing, where the nurse gives the gift for the client to wear as he relearns how to walk in physical therapy. It is intended to motivate the client, to support his therapy. Here the giving of the gift, while crossing the usual expectation that nurses do not give gifts to clients, had a therapeutic purpose. The nurse would do well to carefully assess her feelings and actions, seek counsel of colleagues and/or supervisor, and not make additional boundary crossings with this client.

- **Hypothetical situation B.** Same young client, but upon learning that the client was a fan of the college team, the nurse discloses how she had always wanted to be a cheerleader. She shared that she never even attended a game because she had to work while she was in school and still had student loans to pay. Then she gives the client the sweatshirt surreptitiously, admonishing him that this gift was their secret, or she would be in trouble, and that what she really wants is for him to go to a game with her wearing the shirt.

The same action, giving the gift of a sweatshirt, takes on a different flavor because the gift is less for the need of the client and more for the need of the nurse. The two hypotheticals illustrate that cases involving boundaries are very complex, and that the same action may be therapeutic in one set of circumstances and a boundary violation in another.

Guidelines for Member Boards

Legislative Language

Specific legislative language relating to sexual misconduct demonstrates to the public how seriously such behavior is viewed by the Legislature and Board of Nursing. It gives Boards firm legal authorization for disciplinary action. It puts licensed nurses on notice that sexual misconduct is grounds for disciplinary action. It is helpful to prosecuting attorneys to have specific language to quote to attorneys representing nurses, and to cite in a variety of documents. It can be also be useful when educating nurses, students, and the public. Some sample legislative language is included in Table 5.

Table 5. Sample Legislative Language

"Engages in sexual harassment of a patient or client..." (District of Columbia Nursing Practice Act)

"Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient..." (Minnesota Nurse Practice Act)

"Exercised influence within the nurse-patient relationship for the purpose of engaging a patient in sexual activity. For the purpose of this subdivision, the patient is presumed incapable of giving free, full and informed consent to sexual activity with the nurse... Engaged in gross sexual harassment or sexual contact..." (South Dakota Nurse Practice Act)

"...Other violations... Conviction of a crime involving physical abuse or sexual abuse relating to the practice of nursing..." (Washington Nursing Practice Act)

"Has engaged in sexual conduct with a patient, or conduct that may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient." (National Council Model Nursing Practice Act, 1993)

While it is helpful to have specific legislative language, sexual misconduct cases can be successfully charged under several other grounds, depending upon what is included in the jurisdiction's statutes and the circumstances of the case. For example, the Ohio Revised Code 4723.28 states as a ground for discipline, "Conviction of or plea of guilt to a

judicial finding of guilt of any felony or of any crime involving gross immorality or moral turpitude." States often have grounds pertaining to unethical conduct. Clearly, sexual misconduct is a most extreme case of unprofessional conduct, which many states include as a ground for discipline. Given the nature of the harm that can occur when professional trust is breached by sexual misconduct, a ground pertaining to behavior which creates an undue risk of harm to a client could be appropriately charged. Finally, grounds pertaining to inability to practice because of mental or emotional disorders could be argued if there appears to be a psychological or psychiatric disorder underlying the alleged behavior of the identified nurse.

Resources for Board Members and Staff

The focus group members believe that background information summarized in this section will familiarize Board members and staff with some of the behaviors and terminology that may be encountered when there are allegations of sexual misconduct.

- ***Categories of offenders***

  Categories of offenders were previously discussed and summarized in Table 3 on page 12.

- ***Varieties of Sexual Misconduct***

  Board of Nursing members who make decisions in sexual misconduct cases need to understand the language used to describe the types of behaviors. Sexual misconduct by professionals ranges widely. The categories listed are not mutually exclusive, cases may overlap several categories. Professional sexual misconduct can involve any age, and any gender pairing. Gender pairing does not necessarily indicate the sexual identity of either party. Table 6 lists a variety of behaviors that Schoener described to the focus group. (G. R. Schoener, personal communication, March 16, 1995)

Table 6. Varieties of Professional Sexual Misconduct Described by Schoener

- Rape (as traditionally defined)
  1. Anesthetized patient
  2. Use of drugs or hypnosis to diminish ability to resist
  3. Forcible sexual assault
- Statutory Rape—Sex with a Minor (child or adolescent)
- Sex by Fraud—Sex Disguised as Treatment
  1. Unnecessary breast exams, pelvic exams, touching of genitals
  2. Improper examinations - e.g., "testing clitoral reflexes"
  3. "You need to learn to love"
- Sneaky Sex
  1. Surreptitious touch during hug or other encounter
  2. Frotteurism—sexual gratification from illicit tactile stimulation
  3. Watching while undressing; voyeurism
- Sexual Harassment
  1. Sexual comments, voyeuristic inquiry
  2. Pressuring for dates
  3. Unwanted touch
- Intensely Sexual Interaction—Verbal and Fantasy
- Romantic-like Relationship Solely Within the Professional Context (with or without claim of love or promise of "future together")
- Romantic Involvement Which Goes Outside of the Office
  1. During the professional relationship
  2. Following the termination of the professional relationship (real or bogus termination)
  3. Involving marriage or long-term commitment

Note: G.R. Schoener, Personal communication, March 16, 1995. Used with permission.

■ *Boundary Warning Signs*

Another valuable tool for Boards of Nursing to use in educating members, staff and others regarding boundaries is a list of danger signs that can warn that professional boundaries may be blurring or in jeopardy. See Table 7.

Table 7. Danger Signals in Nurse-client Relationships

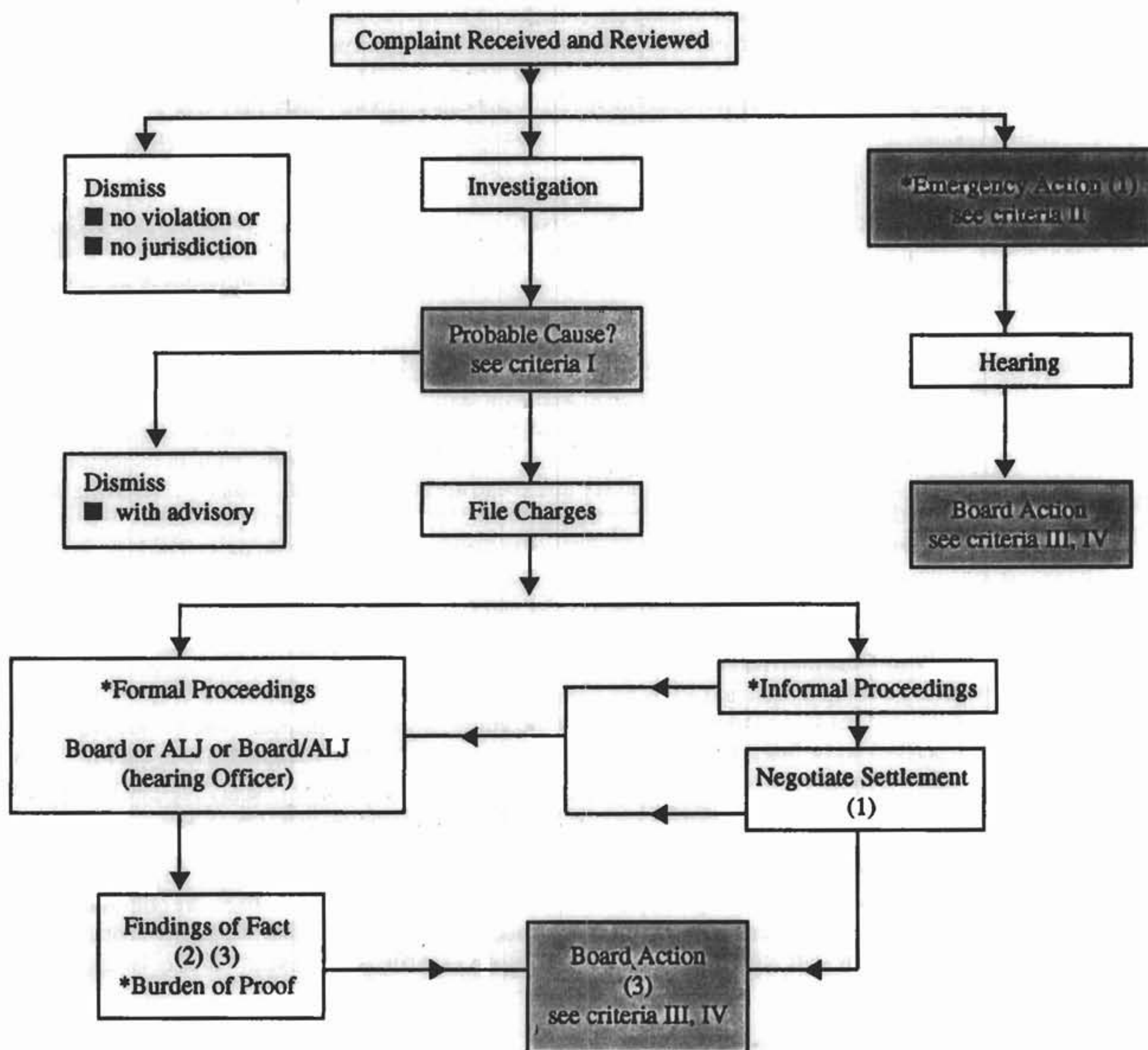
1. You are spending a disproportionate amount of time with a patient.
2. You are with the patient when you are "off duty".
3. Your patient remains awake to see you when you are on the night shift. He/She dresses in a particular fashion prior to your arrival on duty.
4. You feel that you are the only one who understands the patient, that other staff are too critical of the patient, others are jealous of your relationship with the patient, or that they are "acting out" and that their criticism of your relationship is "their own problem".
5. You tend to keep secrets with the patient.
6. You tend to report and communicate only negative or positive aspects of the patient's behavior.
7. You "swap" patient assignments.
8. You are guarded and defensive when someone questions your interaction or relationship with the patient.
9. Your patient talks freely and spontaneously with you, especially in light superficial conversation and perhaps even with sexual overtones but remains silent and defensive with other staff, or may avoid them altogether.
10. Your style of dress for work has changed since you started working with this patient.
11. You receive visits, gifts, cards, letters or telephone calls from the patient after the patient's discharge.
12. You tend not to accept the fact that the patient is a patient.
13. You view the patient as "your" patient in a possessive way.
14. You choose sides with your patient against wife, husband or children.
15. You answer your patient's personal questions of you in a vague manner or you give your patient "double messages".
16. You respond to a request for medications, passes, and the like differently for different patients.
17. The patient continues to return to you because "other staff members are all busy".
18. You tend to think that you are immune from fostering a nontherapeutic relationship. (Coltrane, 1978)

Note: Adapted from Coltrane & Pugh, 1978

Disciplinary Process Guidelines

The following is a step-by-step guide for the management of a professional sexual misconduct case. These cases create a complex series of interactions between the staff, the victim, the healthcare worker, and regulatory and law enforcement agencies. (Physicians Professional Network, 1994) Jurisdictions may vary in the sequence and who conducts selected aspects of the disciplinary process. This guide follows the steps identified in the Disciplinary Process Form Sheet developed in 1994 in by the National Council's Disciplinary Case Analysis Focus Group. (National Council, 1994) See Table 9. In addition, much of the following has been adopted from suggestions by the Kentucky Attorney General's Office for interviewing victim/complainants (Jordan & Walker, 1995); Council on Licensure, Enforcement and Regulation's (CLEAR) National Certified Investigator/Inspector Training (NCIT) course; Federation of Associations of Regulatory Boards (FARB) Conference handouts; the National Council Disciplinary Case Analysis Report; materials from the National Council/CLEAR Specialized Healthcare Investigators Program (1994); and conversations with Gary Schoener.

Table 8. Disciplinary Process Flow Sheet
***Jurisdictions vary per NPAs, rules/regs, state APA**



Designates major Board of Nursing decision points

(1) Negotiated settlement, emergency action opportunities are available throughout process as needed
(2) Remedy is determined per facts
(3) Based on witness credibility, weight of evidence

Note: National Council of State Boards of Nursing, Case Analysis Report, 1994

Case Received and Reviewed

It is often difficult for victims of sexual misconduct to come forward. They may blame themselves for the betrayal or may fear not being believed, especially if their nurse is well known in the community. Complaints may also come from the client's family, a friend of the client or another client. Other professionals, particularly subsequently treating therapists, may report the allegations.

The psycho-dynamics of sexual victimization are complex. Victims are angry when they realize they have been violated yet fearful of ruining their own life as well as the offender's by exposure of what happened. They may fear the loss of control that occurs if they "go public." Spouses and significant others may blame the victim. Victims may dread the idea of the administrative procedures, including cross examination. They may fear allegations of false accusations. They may experience retaliation. They may refuse to follow through with a written complaint or testimony.

Why then do victims report? Schoener observes that reporting to appropriate agencies or individuals, and/or having an opportunity to confront the offender can contribute to the victim's overcoming the experience. Other motives may also be involved, such as revenge or maneuvering to get the offender back into the relationship or as support for a malpractice suit.

- ***Case Intake***

  All levels of Board staff need to be prepared to deal with sexual misconduct cases. The support staff may be the first contact a victim has with the agency. Support and professional staff should be trained to receive complaints professionally. That means the complaint will be listened to objectively, credibly and without prejudice. Support staff need clear guidelines as to when a call should be referred to a professional staff member. If referring the caller, support staff should explain that the call is being transferred and to whom. The staff person may need to request the caller's phone number, either because of busy lines or to assure follow-up should the call be lost. Staff should recognize that the caller may not wish to give their phone number at this point and respect that decision. Staff should watch to make sure the caller gets through to the correct party.

- ***Assist with Filing Complaints***

  Staff receiving a complaint should allow the caller to tell the story, provide information about the discipline process and explain what information is needed for the complaint to be pursued. The victim expects to be discounted, so he/she may be listening as closely to tone and expression of the staff person as to the words spoken. It may be a delicate balance between conveying support and concern while observing appropriate boundaries for receiving information. Staff might consider role plays to practice answering this type of call.

  With a victim/complainant, staff can reinforce that it is important to report, and assure that all complaints are carefully reviewed. Staff should avoid promises or predictions. It is important to answer any question about who will have access to the information and to be realistic about timelines. It may assist an ambivalent complainant to tell them that they can start the complaint with "this report is difficult because..." It may be appropriate to encourage a victim get help.

- ***How to Proceed if Anonymous Complaint is Received***

  Many jurisdictions have procedural requirements for a written complaint signed by the complainant. In most situations, this is the most practical method to initiate a case. Boards should consider working with their attorney to develop some means of pursuing selected anonymous complaints or cases identified in a less traditional manner. This might be done by having a staff person write a memorandum of a telephone conversation or attach a newspaper article. The staff person can sign the complaint. To conserve investigation resources, Boards may need to limit the initiation of such complaints to those serious situations which place the public at risk of imminent harm.

- ***Staff Communication with Complainant During Process***

  The victim has already experienced a breach of trust, and the system should not abuse him or her further. It is important that staff be honest and frank with the victim regarding how long the process can take, the implications of pursuing an investigation and if there are any problems with the complaint on its face. Be upfront with timelines and the complaint process realities. Assure that each complaint is carefully reviewed, but don't make promises

or predict outcomes. "Boards can do more damage than the perpetrator if not trustworthy." (G.R. Schoener, personal communication, March 16, 1995)

Staff should understand clearly any limitations on communicating with complainants during the discipline process, and know how to stay in touch without breaking any rules. The complainant can be typically be advised that the complaint is being reviewed, or investigated, and that the case is proceeding. Staff should advise when more details cannot be shared because of the risk that providing more specific information could provide potential grounds for future appeal.

Complaint Investigation

Investigations are fact-finding activities, which include interviews with the complainant, identified nurse and other witnesses, as well locating documents and other materials. The objective of an investigation is to gather evidence. It is incumbent upon the investigator to have an objective/nonprejudicial approach to the work. The investigator should be familiar with the jurisdictional laws, rules, policies and procedures relevant to complaint investigation. The investigator should also be well informed regarding any special expectations regarding advisement or warnings to licensees and witnesses.

The Board, in consultation with its attorney, will have to decide what investigative tools are appropriate in its jurisdiction. Most licensure boards send investigators to meet with the nurse and witnesses. Some boards, dependent upon jurisdictional statutes and regulations, may authorize the taping of phone calls wherein admissions are made. A hidden camera has been used in some cases.

Consideration should be given to the type of situation under review. Sometimes assigning the same gender investigator as the complainant may make it easier for the victim/complainant to share information. Boards or supervising attorneys who have some flexibility in who can be assigned to a given case are encouraged to give some thought to making the assignment.

The Investigative Plan

This document provides organization and structure to an investigation. It keeps an investigation on track and provides goals and benchmarks to monitor progress. The "Five W's Test" helps the investigator plan what information is needed and what to do at an interview or site visit.

- Who is the complainant, the respondent, and what is the relationship between the two?
- What is alleged in the complaint?
- Where did the alleged situation(s) occur?
- When did it happen?
- Why did it happen (possible motivations, causes)?

The investigator should consider some additional questions to guide case development, both initially and throughout the investigatory process.

- What law or regulations may have been violated? What are the elements of the violation(s)?
- What evidence will be needed to prove or disprove the allegations? How can the evidence be collected and maintained?
- What sources of information are available? Who might be witnesses?
- Will subpoenas (if available) be needed to obtain information?
- What problems might be anticipated in conducting the investigation? What are possible approaches?
- What cost and geographic considerations should go into planning? (CLEAR, 1994)

The sequence of interviews, data collection and site visits is dependent upon the investigator's style, the specifics of the circumstances of a particular case, and the availability of potential witnesses.

Interviewing Victims/Complainants

It may be advisable to do some checking on the complainant, regarding employment history and personal background.

- ***The Initial Call to the Victim/Complainant***

The investigator contacts the complainant to schedule an appointment for an interview. The call should be formal, polite, and facilitative. Flexibility is desirable in allowing the complainant to establish the time, date and to suggest a location. The investigator should exercise reasonable caution in determining a meeting place. A public location is desirable, not a situation that could place investigator at risk. A complainant who is a minor or person with a guardian may have a guardian present. Other persons should only be present under unusual circumstances (e.g., if a female complainant expresses discomfort at being alone with male investigator).

- ***The Meeting***

The investigator should introduce self and present identification. The investigator should comply with any state requirements for giving advisement, obtaining consent, or meeting other required procedures. Authorization to release records is needed if confidentiality or privileged communication laws apply. The investigator should advise that notes will be taken.

- ***The Interview***

The investigator should make the complainant feel as comfortable as possible by tone and approach. The investigator should avoid pushiness, overbearing posture or actions, or an authoritarian approach.

The investigator should ask the nature of the complaint and encourage the complainant to tell the story by asking for a narration of the relationship with the nurse and what happened. This allows the victim to use their own words and set the pace. The investigator should learn to be comfortable with pauses - this type of allegation is hard to relate to a stranger. Telling the story in their own manner may reduce the anxiety of the victim/ complainant. The investigator can pick up on details and bits of information that may lead to other sources. Although some investigators prefer to hear the whole story first, Schoener finds asking questions for clarification keeps the victim/complainant focused and shows that the interviewer is actively listening.

The investigator should be objective and non-judgmental throughout the interview, and should record thorough notes, including representative exact quotes. The names of potential witnesses, their addresses if known and how to reach them are vital information. Also ask about other staff, patients and visitors. Ask about times and locations. For example, take note of things such as the time of interactions with the nurse - did the interactions occur after other staff were gone? Detailed descriptions of locations and observational details are important. For example, have the witness describe the address, furnishings and provide specific details of where the alleged activities occurred.

If overt sexual misconduct is alleged, the investigator should ask for descriptions of the nurse's body, including any characteristics that would be known only if the person was seen unclothed, e.g., scars, moles, tatoos, or blemishes on any part of the body that is normally clothed, the color of pubic hair, and type/color of underwear. The investigator should also ask if there are any medical records or test results to support the testimony (e.g., disease, pregnancy).

The purpose of the interview is to allow the investigator to understand the complainant's story and learn as much as possible about what happened from the victim/complainant's perspective. There may be additional violations revealed that the victim did not know were violations. The investigator should gather data to develop a coherent narrative that can be contrasted with the nurse's perception of the situation.

It is important to reinforce the complainant's understanding of the disciplinary process, including possible timeframes. The investigator should not make statements regarding the probable outcome of any complaint investigation. In addition, the investigator should not lead the witness nor attempt to motivate. Should there be indications that the complainant has clinical needs, the investigator should advise the victim to seek professional assistance. Resources for referral may be provided. However, the investigator role is not to provide clinical

intervention for the victim.

The investigator should be aware of any mandatory referrals dictated by law, and should contact the case supervisor with any questions regarding reporting obligations.

Interviewing Other Witnesses

Other witnesses may be identified by either the complainant or the nurse. An individual may have seen the complainant and nurse together in a place where they should not have been together, e.g., at a bar or a hotel. Even witnesses who have just heard the complainant discuss the professional may provide helpful observations or indirect confirmation of dates or events. The number of tangential witnesses interviewed depends on the circumstances, whether new information is being uncovered or confirmation of previous revelations, and the resources available. If in doubt, the investigator should consult with the case supervisor.

■ *The Initial Call to the Witness*

The investigator contacts the witness to schedule an appointment for an interview. The call should be formal, polite, and facilitative. Flexibility is desirable in allowing the witness to establish the time, date and to suggest alocation. The investigator should exercise reasonable caution in determining a meeting place. A public location is desirable, not a situation that could place investigator at risk. A witness who is a minor or person with a guardian may have a guardian present. Other persons should only be present under unusual circumstances (e.g., if a female witness expresses discomfort at being alone with male investigator).

■ *The Meeting and Interview*

The investigator should identify self as an investigator, show proof of identify, state purpose of interview and the matter at hand, and comply with any procedural requirements. The investigator should determine the relationship of the witness to the victim and/or the professional and ask if there has been any personal experience with the professional, e.g., as a client. The investigator should allow the witness tell their own story about what has been observed or is otherwise known about the situation. Avoid disclosing matters raised by the complainant or other witnesses. While questions may convey some degree of information about the case, avoid leading or confirmatory questions. Investigators should be alert to the possibility of discovering additional victims.

Interviewing the Nurse Identified in Complaint

The investigator should consider other sources of information about the nurse before the actual interview. A credential check can be undertaken regarding the nurse. Information regarding previous nursing disciplinary actions is available from the National Council of State Boards of Nursing's Disciplinary Data Bank, accessible by all Boards of Nursing via electronic access. The National Practitioner Data Bank is a source of malpractice payments made on behalf of nurses, and can be queried by licensing boards. States vary in accessibility of criminal data, but this resource should not be overlooked.

The investigator should follow accepted state procedures as to whether or not the complainant can be given a copy of the complaint. A handout describing the Board's duty to investigate and the discipline process may be helpful. Having such a publication available can assure that all persons interviewed are given consistent information. It is important that the process be clear to the nurse.

The investigator should notify the case supervisor and suggest removal if the investigator knows the nurse or has biases toward the individual.

■ *Initial Call to the Nurse*

The investigator should contact the nurse and request an appointment, scheduling sufficient time to allow for a thorough interview. It is better to complete the interview at one sitting and not allow the flow of information to be disrupted, or allow the nurse to regroup and implement a defensive strategy. Schedule the time and place at the convenience of the nurse within reason, but do not place the investigator at risk. If the nurse requests the presence of his or her attorney, the investigator should follow state or agency procedure, or check with the supervising attorney as to how to proceed.

- ***The Meeting***

The investigator should identify self as an investigator for the Board of Nursing, state the purpose of the interview and the matter at hand, and comply with any state procedural requirements.

- ***The Interview***

The investigator should ask questions about the nurse's background, education, and work history. Identify gaps of time in the work history and ask about them. Ask about other licensure - other states, another level of nursing, and other health care professions.

The investigator should deflect the nurse's attempts to ask questions about the complainant. Focus should be on the content of the complaint and the situation described. The investigator should use the complainant's information without directly attributing the information to the complainant.

Questioning should be conducted in an objective, matter-of-fact, and polite manner with no hint of bias. The investigator should attempt to understand the professional's story and listen for details to emerge that can be very telling.

As with the complainant, the investigator can have the nurse narrate the entire history of involvement with the alleged victim, from first meeting through the present. This historical approach allows the comparison of narratives, to see the commonalities and the discrepancies.

An inductive approach to the interview is useful, gathering specific bits of information and building toward a direct confrontation at the end of the session as to whether the nurse denies or confirms the allegation. If the nurse makes blanket denials, it may be possible to focus on an element or piece of the story and ask if that is true. Schoener has found that offenders may admit to an element or elements of an offense after making a blanket denial of the whole situation.

The investigator should always listen closely for potential leads to other witnesses. Ask for the nurse's explanation of the alleged situation. Ask if there are conditions, such as chemical use, or problems that might have bearing on the matter at hand. Questions about lifestyle and social traits may reveal evidence of social isolation, personal difficulties, and boundary violations, but need to be handled carefully. The nurse may balk at sharing this type of information at this stage in the investigation.

The investigator should also make notes of observations about the nurse - behavior, mannerisms, demeanor, affect and appearance. Describe the nonverbal behavior observed, e.g., downcast eyes, avoiding eye contact, staring, slumped posture, straight posture, rigid, sprawled, drumming fingers, restless, not sitting still, moving legs, and doodling. Does the nurse speak loudly or whisper? Don't list opinions - describe what gave the impression.

Other Resources

- ***Site Visits***

It may be helpful to visit the location where the situation was alleged to have occurred. Seeing the actual geography can give a completely different perspective on the understanding of an event. Describe the setting - are the details consistent with the observations of witnesses? Is the location isolated or public? Dark or well lighted? Lonely or populated?

- ***Diaries, Appointment Books, Organizers***

If accessible, this type of information source can provide descriptions, times, dates, places and identify potential witnesses. These may require a subpoena to access. Look for patterns and symbols, e.g., a particular symbol might be a code for sex.

- ***Client Health/Medical Records***

Make sure that the investigator has appropriate knowledge and experience to review the records, or can work with someone with such background. Review the client records for consistency with witness recollections and

statements. Absence of records during the time of the alleged incidents may be significant. Look for indications that documentation is false, e.g., documentation indicates that a third party is always present, but that person denies being there. Other details or possible leads may be gleaned from these records.

- ***Gifts***

  Ask about any gifts allegedly given by the nurse to the patient, receipts or other records related to the gift-giving.

- ***Phone Records or Credit Card Receipts***

  Look for records documenting travel, overnight stays, etc.

- ***Audiotapes, Videotapes, or Photographs***

  These audiovisual records may have been made by the complainant/victim, or others, and may record admissions or document claims.

The Investigative Report

The investigator should maintain an objective/non-prejudicial approach when preparing the written report. The investigator serves as the eyes and ears for the Board and needs to present a clear picture of the facts. Exculpatory (exonerating) as well as incriminating evidence should be included.

- ***Report Preparation***

  The investigator should review copies of documentation, notes of interviews, site visits and other written materials. Read them carefully for congruence of written and oral accounts. Look for discrepancies. How consistent are the various accounts from the complainant, nurse and other witnesses?

- ***Report Content***

  The final written report should be formatted as required by the agency and/or jurisdiction and include the following information:

  - names, addresses, telephone numbers of all persons interviewed
  - time, date and location of each interview
  - content of statements, and observations for each interview
  - description of behavior and other observations
  - impressions may be included if clearly labelled as such (this may be jurisdiction-specific)

  Copies of records, other written material gathered during interviews should be labelled, logically organized and attached to the report summary. All records should kept in a secure environment to protect the confidentiality of parties.

  The investigator's summary of findings should present facts, not opinions, and indicate whether the facts are consistent with or inconsistent with the allegations contained in the complaint. Pertinent quotes from various witnesses may be included. The report should be concise, factual, logically organized, well-written, documented and verifiable.

Probable Cause Determination

The decision to go forward with a case is determined by the Board in some states, and by Board attorneys and staff in other jurisdictions. Is there reasonable belief in the existence of facts warranting administrative action? It is important to conduct a careful review of the investigation report and supporting documents in order to make this determination.

Schoener stated that in his experience false complaints of sexual misconduct are rare. More frequently, a victim may embellish the allegations. He identified some indicators that may assist to confirm a complaint. These include:

- admission by the professional
- witness statements
- contemporaneous notes, diaries, photos
- contemporaneous revelations
- letters, gifts
- audiotapes, videotapes
- knowledge of the body
- knowledge of the inside of home, life details

Factors which may disconfirm allegations include:

- admission by complainant (false allegation)
- witness statements
- records
- consultations with other professionals
- letters
- audiotapes

Schoener identified indicators that may assist to disconfirm a complaint, while noting that absence of knowledge does not disconfirm.

Schoener also described some types of false and misleading complaints. Sometimes there may be a misunderstanding by a follow-up helper. Words or touch can be misinterpreted, or there may be mistaken identity of the offender. A client can exaggerate or distort an event. A sexual contact may occur in a personal rather than a professional relationship. Occasionally, a hostile and aggressive client can have an agenda, or make an apparent fabrication. Clients can have false memories, either spontaneous (a suggestible client) or induced through relaxation technique, imaging, or hypnosis. (G.R. Schoener, personal communication, March 16, 1995) (A thorough discussion of false memories is beyond the scope of this paper. The readers is advised to seek additional information regarding this controversial topic if it is an issue in a case.)

Upon the determination of probable cause, charges are filed following procedures prescribed by the jurisdiction.

Emergency Action

An important decision point for the Board is whether or not emergency action is needed when a grave risk of harm exists for the public. Standards and procedures for the use of emergency actions are strict because of due process considerations. The roles of Board members, Board staff and the Board attorney, as well as the procedures used, may differ from state to state.

Factors to consider when determining whether or not to take emergency action in a case alleging professional sexual misconduct by a nurse include:

- multiple complaints showing a pattern of behavior
- actions which are life-threatening to victim
- admission of sexually abusing a child or other very vulnerable victim
- setting—isolated practice
- risk of "geographic cure"—traveling nurse, or several states of licensure
- condition (stability) of alleged offender
- nature of the alleged violation (how serious)

Emergency actions are taken when there is an immediate need to remove the nurse from practice in order to protect the public from imminent harm. (National Council, 1994)

Case Prosecution

■ *Attorney Working with Victims*

Attorneys working with this type of case are encouraged to become familiar with the information presented in this paper. Such background information can facilitate working with victims, as well as other witnesses, investigators, and boards. Schoener suggests to not underestimate the strength of a victim who may be willing to assist in gathering information. For the licensee, he suggests looking for documentation of what was not done as well as what was done.

■ *Case Development*

Do not always focus on the most severe offense, a pattern of behavior can also cause great harm. Verbal harassment can destroy. Assess the current status of relationship between the victim and the nurse, and the vulnerability of the victim, e.g., if the misconduct involves the first sexual experience for a teen, it is extremely damaging. When boundary violations are involved, it is significant when a nurse does not document, report, or get help in handling a difficult situation. For example, if a nurse counselor who has been accused of being sexually involved with a client states that the patient jumped up and kissed her, check the session records. If this incident is not recorded, plan on asking the nurse a series of questions: Was this an unusual event? What did you do? Then what did you do? Why is this not in your notes? Don't you usually record unusual events in your notes? Where is the record of your consultation (with supervisor)?

■ *Expert Witnesses*

The attorney should evaluate the credentials and the reputation of a potential expert witness. A witness who will agree to say what you want rather than their own opinion should be avoided. Interview the expert, but also speak with others who have used their services to obtain feedback as to how have they performed in court, especially under cross-examination. Cost is another factor to consider. Make sure that an expert you are considering knows ground rules - that this is an administrative proceeding, not criminal. Someone who has testified for both prosecution and defense may be viewed as more objective than a "gun for the prosecution." Get a copy of the expert's opinion in advance to review.

■ *Evaluations*

Some state statutes authorize licensing agencies to mandate mental health, chemical dependency or physical evaluations upon determination of probable cause. Other states may not be able to require evaluations until the administrative hearing unless agreed upon as part of informal negotiations with the nurse and the nurse's legal counsel. An assessment by a professional experienced in the evaluation of professional sexual misconduct and approved by the Board can provide valuable information to assist the Board in evaluating the case.

Boards of Nursing may wish to work with other licensing boards to identify well-trained professionals to conduct the mental health evaluations in these cases. Boundary violations and sexual misconduct certainly are not unique to nursing - the psychodynamics of professional sexual misconduct are similar for many health care professionals. Collaboration between boards to establish a list of effective evaluators can facilitate obtaining assessments in a timely manner.

■ *Other*

The attorney should be aware of any required reporting, e.g., if a criminal statute has been violated. During the course of an investigation, there may be a need to report other implicated licensed professionals to their respective administrative agencies.

Notice—Ward advises to allege the offense with specificity, and to amend the Notice if new facts or violations become apparent. A well-plead notice can be a psychological advantage. (Ward, 1993)

Informal Process— Many Boards of Nursing utilize informal proceedings to manage cases. Consent agreements can be an effective means to resolve cases. In this type of case, Board attorneys are advised to pay particular attention to detail, e.g., obtaining all necessary waivers and including acknowledgement clauses in the public documents. With professional sexual misconduct cases, Boards are likely to reject settlements that result in too lenient sanctions.

Defenses—The attorney representing the Board of Nursing may expect some common defenses to professional sexual misconduct cases. A nurse's attorney may argue lack of notice or specificity of notice. Credibility of witnesses, particularly the victim, will be at issue. The motive of the victim will be raised. The defense may say that the sexual activity is consensual.

Discovery—As noted in the section on investigations, client authorization for release of information should be obtained. If administrative subpoenas are used, the document should demonstrate how and why the records sought bear a rational relationship to the alleged misconduct. Attorneys should be aware of any jurisdictional statutes that may affect disclosure of information.

Administrative Proceeding/Hearing—Even a strong victim becomes vulnerable during a legal proceeding. The attorney should prepare the victim for what to expect procedurally - describe the location, who will be at the hearing, and the anticipated sequence of events. Also prepare the victim for how the Board's attorney has planned to present the testimony. Most importantly, the Board's attorney must prepare the victim for the type of questions that she/he may be exposed to in cross-examination.

Decision-Making by Boards of Nursing

Regardless of whether the case is handled through formal or informal proceedings, there comes a point where the Board of Nursing must make decisions. If the Board cannot direct a licensee to undergo a mental health evaluation until into the hearing process, this may be the first decision to be made.

Schoener suggests that the Board of Nursing make tentative findings and condition the findings upon the nurse having a thorough evaluation by a Board-approved evaluator. The evaluator's assessment can then be incorporated into the final order. If there is discrepancy between the Board's findings and the outcomes of the evaluation there may need to be re-consideration by the Board. The discipline ordered should be based on the proven misconduct. Schoener indicates that it is not appropriate to use a rehabilitation plan as the basis for determining the remedy. (Schoener, personal communication, March 16, 1995) In other words, the Board needs the opinion of a professional evaluator to help it identify the type of offender. It is not appropriate to use the recommended treatment as the punishment. The disciplinary action should be based on the behavior and the resulting harm or risk of harm to the client.

When all information is available, the Board of Nursing must decide whether or not discipline is warranted and, if so, what discipline is warranted. In negotiated settlements, the Board must focus on whether the proposed remedy is congruent with the facts admitted or stipulated. In the hearing process, the Board must focus on the allegations in the charging document and determine whether the state has proved the case. Does evidence support guilt or innocence? Boards should consider:

- Are the charges proved by the state? Do facts support the charges?
  - Identify uncontested facts, admissions, prior criminal convictions, no evidence presented.
  - Review evidence presented - physical evidence, documents and records, pictures, etc.
  - Review the testimony.
    - Are stories consistent?
    - Are details consistent?
    - How credible are the witnesses?
    - What information does a mental health evaluation provide regarding the nurse? Does the evaluator's opinion assist in determining the offender category, what the Board is dealing with?

- Is Discipline Warranted?
  - Was there a violation? How does it plot on the continuum?
  - What was the severity of the risk?
  - What was the client outcome?
  - Are there special circumstances?
    - Uninformed/Naive
    - Healthy/Situational Breakdown
    - Severely Neurotic and/or Socially Isolated

Impulsive or Compulsive Character Disorder
Sociopathic or Narcissistic Character Disorder
Psychotic or Borderline Personality

- If Discipline is Not Warranted:
  - Consider admonishment or advisory
  - Inform victim of decision

If insufficient findings, determine how can data be saved for future case building (establishing a pattern).

What Discipline Is Warranted? Sanctioning Guidelines for Boards of Nursing

Evidence of sexual misconduct compels a Board of Nursing to address public protection over the rehabilitation of an offending professional. Each Board will have to arrive at some estimation of the degree of harm caused by the professional and the probability of future harm should the person return to practice. The threshold question is should the nurse be out of practice to protect the public? The Board should consider the seriousness of the violation(potential risk as well as actual harm), aggravating factors - a pattern of behavior, the intent to harm, dishonesty and/or depravity.

Choosing Appropriate Remedies in Professional Misconduct Cases

If sexual misconduct involves a sex crime against a child, the use of threat or coercion with a client of any age —revocation is the most appropriate course. The substantial rate of recidivism for this type of sexual offense warrants this extreme position. (Pope, 1994) Serious sexual misconduct involves intentional acts and a knowing, willful commission of actions. Anyone who is psychotic, actively delusional or a predator must not be allowed to practice nursing. When sexual misconduct involves non-forcible contact with adults reflecting a boundary violation in the professional relationship, less severe sanctions in which both public protection and offender rehabilitation are addressed may be appropriate. Boundary violations may be the result of lack of knowledge, poor decision-making and poor judgment.

Therapy is often required and often appropriate. However, Boards should be aware that it is not a panacea. Mandatory therapy comes with its own set of problems (e.g., privacy, advocacy, subjectivity of the therapist).

Limited practice options used in Board orders may include a change of practice environment and change in client populations as well as requiring supervision and monitoring of practice. The remedy should include a plan for safe and responsible practice and how the nurse can work toward successful rehabilitation. Supervision in these cases is difficult. Supervisors should be well prepared—made aware of the situations that resulted in Board action as well as the nature of the sanctions. Boards may consider providing supervisors with information about boundary violations and professional sexual misconduct. A reporting format or protocol can be established to distribute to all parties affected by the Board decision. Expectations regarding the frequency and content of regular and routine reporting should made clear to all parties.

The term of the order, and the period of supervision, should be sufficiently long to allow time for learning about boundaries, ethical responsibilities, application to practice, and feedback from supervisors and others regarding the nurse's job performance. The actual term of the order should be determined on a case-by-case basis, focusing on the nature of the offense, the severity of risk presented, the professional assessment, and any special circumstances.

Rehabilitation and Re-entry

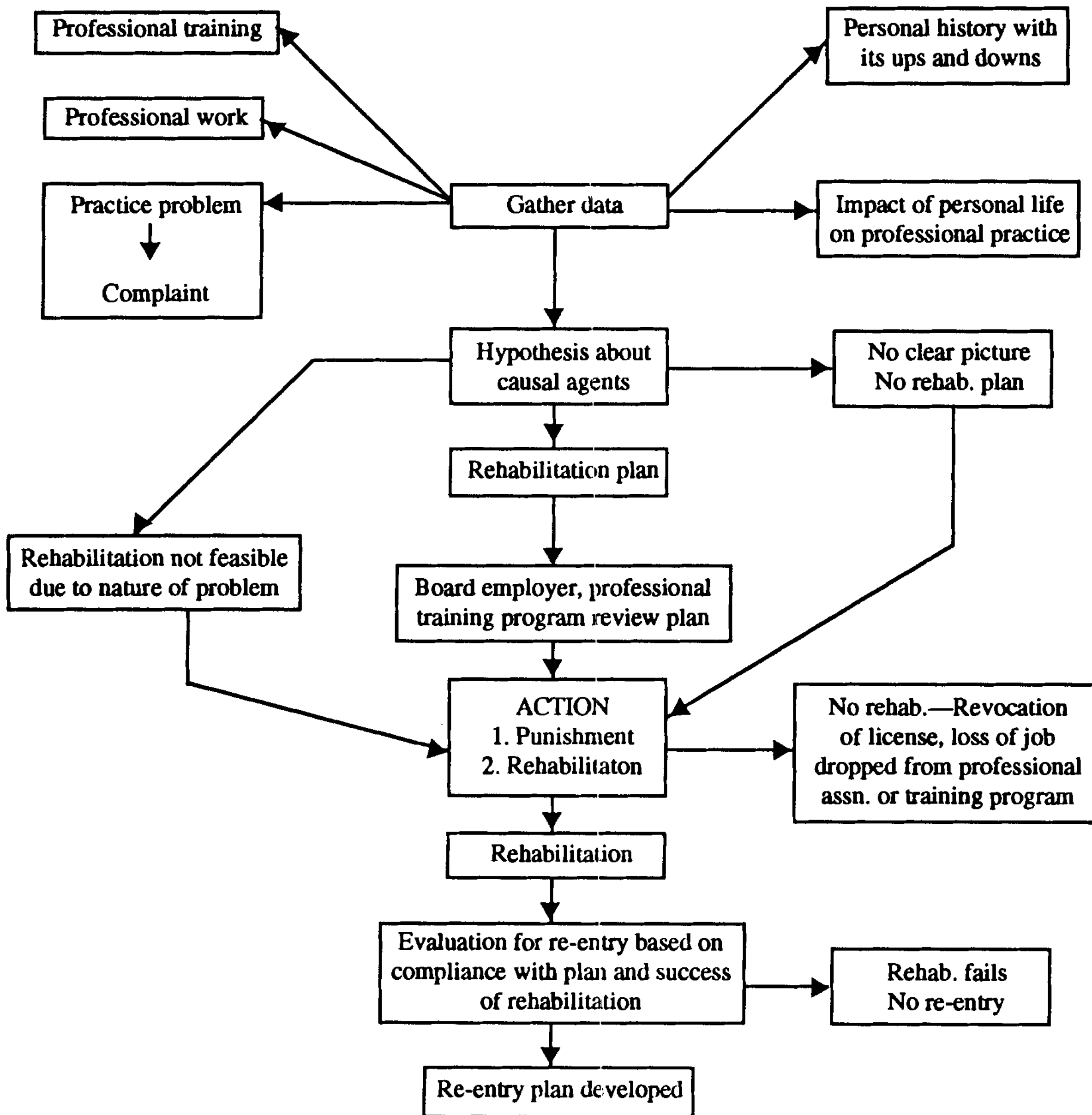
A tremendous challenge awaits Boards of Nursing faced with a decision as to whether a licensee is ready for re-entry after removal from practice for a period of time. The threshold question is should the nurse remain out of practice to protect the public? The Board should consider the seriousness of the original violation and aggravating factors, as well as the evidence of rehabilitation presented by the nurse seeking reinstatement.

If sexual misconduct involves a sex crime against a child, the use of threat or coercion with a client of any age, then reinstatement after revocation is questionable. The rate of recidivism, the risk of recurrence, is very great. A

predator must not be allowed to return to practice. The nature of some sexual misconduct is so severe, rehabilitation is simply not feasible. (O'Connor, 1992; Pope, 1994; G.R. Schoener, personal communication, March 16, 1995)

Schoener presented a model which is an overview of the assessment process for a professional who has had sexual involvement with a client. See Table 9. He advised that the majority of professional sexual misconduct cases do not reach the point of re-entry: 5-10 percent of the total number of sexual misconduct offenders refuse to be evaluated; 20-40 percent of the total are either repeat offenders or are in denial, showing no remorse or even realization that they have caused harm; and for 10 - 20 percent of the total, rehabilitation is not possible due to the nature of the mental illness.

Table 9. Schoener & Gonsiorek's Overview of Assessment Process



Note: Schoener & Gonsiorek, 1989. Used with Permission.

Another 5 percent are eliminated because it is impossible to determine what is wrong, and if the cause is not identified, rehabilitation cannot occur. Approximately 25 percent of the total of sex offenders may be theoretically rehabilitative. However, treatment and rehabilitation is very expensive, time consuming, and there are no guarantees of success. Even if allowed to practice, the reinstatement plan may be very restrictive and may limit employment opportunities. Realistic vocational counseling may be in the professional's best interest. Another 5 - 10 percent of the total number of offenders are lost when rehabilitation is not completed. (G.R. Schoener, personal communication, May 5, 1995)

If the professional complies with treatment recommendations, it is essential to assess how successful the rehabilitation. This cannot be a paper compliance. Schoener recommends independent comprehensive evaluation by a Board-approved team for re-entry. (The list of evaluators developed by collaborating licensing boards may be of assistance to ensure that regulatory concerns are adequately addressed.)

The independent assessment should include review of records from initial evaluation and treatment, discussions with the treatment team, and other persons in the professional's life (not just interviews with the professional). Schoener also suggested requesting assurance from the treatment team that they believe, to the best of their knowledge, that the professional is able to practice the profession with reasonable skill and safety. The treatment team should also indicate specific boundaries that they would recommend for practice. An excellent way to phrase the question is, "Would you allow your daughter or son, wife or husband or other family member be cared for by this professional?" (G.R. Schoener, personal communication, March 16, 1995)

The Board of Nursing must use its judgment and maintain its role of public protector. It is appropriate for a Board to have the opportunity to meet with the petitioning nurse and ask the litmus questions of the nurse regarding his/her rehabilitation. The Board of Nursing, with its collective nursing knowledge and experience, may interpret information, events, or statements differently than an evaluator, and may disagree as to how dangerous the nurse is. In these situations, the Board should use its judgment and use its discretion as decision-makers, focusing on safety of the public over the rehabilitation of the individual nurse.

Should the Board find that there is sufficient evidence that a nurse has been successful in treatment, provisions for the return to practice must be determined. Irons believes that sexually addicted professionals who successfully complete primary treatment can return to practice and has identified contractual provisions for re-entry. While these were designed to be used in a contractual agreement for a recovery program, many of the provisions could also be considered as elements in a reinstatement order. (Irons , 1990) See Table 10.

Some nurses may resist disclosure because it can potentially result in discredit and rejection. However, it protects all involved parties. Resistance to disclosure, or attempts to minimize disclosure, provides some evidence of how well the professional is handling the re-entry process.

Prevention—Working with Employers

Boards of Nursing can encourage employers to develop procedures for immediate investigation of allegations of professional sexual misconduct and emphasize the importance of reporting these complaints to the Board. Organizations involved in providing health care need to provide for risk management and prevention of sexual misconduct. Safeguards may include thorough record-keeping, careful hiring practices, policies and procedures (including complaint resolution), staff support and adequate supervision. (Schoener, Historical overview, 1995).

Conclusions and Recommendations

The focus group has conducted an extensive literature review, reviewed cases which have been brought before Boards of Nursing in a number of jurisdictions, looked at approaches already developed by several states, and consulted with a psychologist who is expert in the assessment and rehabilitation of professionals who have admitted sexual misconduct.

Table 10. Irons' Contractual Provisions for Re-entry

1. Acknowledges sexual disorder and agrees to abstain from certain specific behaviors in personal and professional life.

2. Establishes and defines a recovery network - trusted friends, mentors, sponsors, work colleagues - meet initially and as needed to ensure that all understand the terms of the contract and the established boundaries.

3. Continues in treatment with an experienced therapist, either individual or group; quarterly written reports are submitted by therapist.

4. Identifies a primary care physician; sees on a regular basis and participates in recovery network.

5. Agrees to respect, defend, and uphold specific practice boundaries established and supported by all concernedparties.

6. Agrees to monitoring of practice boundaries by a clinical associate, peer professional, or supervisor. (The success or failure of re-entry depends upon this provision.)

7. Agrees to provide body fluid samples upon request.

8. Agrees to monitoring of prescribed medication compliance with reports to the program.

9. Agrees to participate actively in a twelve-step program for sexual addiction that promotes only healthy non-sexual relationships among group members.

10. Encourage twelve step program participation for family members and victims of the psychosexual disorder

11. Agrees to complete professional education or vocational retraining, if requested.

12. Agrees to terms of contract, especially the practice boundaries and agrees that they will be disclosed to others, including patients on a "need to know" basis.

13. Agrees to program obligation to report sexual offenses, professional impairment, and sexual misconduct as defined by state law, including to the licensing board.

14. Agrees to provide timely written reports to regulatory bodies, as required, and acknowledges the availability of advocacy and continuing reentry support from the recovery program.

15. Agrees to continue participation in a recovery program for a defined period of time with annual review of contract terms.

Note: Adapted from Irons, 1990

Professional sexual misconduct is extraordinarily complex and diverse. It happens in a variety of settings and situations. It often happens gradually, over a period of time and circumstances. It can begin gradually then suddenly intensify, like a slippery slope that suddenly turns into a steep cliff. It can happen in a moment of opportunity seized by a predator.

The focus group found professional sexual misconduct to be a phenomenon that, while very dangerous to the clients nurses serve, tends to be avoided by everyone until something terrible happens. It is a phenomenon that has not been well-researched nor frequently addressed in the nursing literature. Unfortunately, professional sexual misconduct

reflects what is occurring in society in general. While the focus group directed most attention on completing its charge to develop guidelines for use by Boards of Nursing in managing this type of disciplinary case, focus group members elieve strongly that there is a great need for education of nurses, educators, students, employers, legislators and consumers regarding the topic.

The focus group made several recommendations to the Board of Directors regarding continuing National Council activities related to the prevention and early detection of professional sexual misconduct. Those recommendations included developing and promoting materials and opportunities to educate on a variety of levels regarding professional sexual misconduct and conducting research on the subject. A proactive educational approach may increase sensitivity to the issue, as has been observed in states that have devoted time and resources to the problem. All sexual misconduct may not be prevented. Education may assist the naive and uninformed to recognize the need for professional boundaries.

The focus group recommends dialogue among professional organizations, which will each act to promote nurse understanding of the nurse-client relationship and boundary issues among their members. Heightened awareness by professionals of the problem, including the opportunities that may be presented in the changing health care environment, will facilitate holding professionals accountable for their actions. Rehabilitation potential may or may not exist, this is an area where more research is needed. The early detection of cases and skillful prosecution of offenders remains the best public protection against certain categories of abusers.

Collaboration is also recommended with consumer groups. Better informed clients who have clear understanding of what is to be expected and what is out of bounds when receiving nursing care, and the options available to them when care is problematic, can be more effective consumers of care.

To be sure, the numbers of reported cases of professional sexual misconduct by nurses are small, but they are growing. The irreparable harm they cause to the victim, to the public trust and to the profession must be recognized and confronted. Protecting the public is the obligation, the primary responsibility of the Board of Nursing.

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Glossary

Boundaries
The limits of the professional relationship that allow for a safe therapeutic connection between the professional and the client. Irons identified five principles to guide the establishment of the boundaries of professional relationships: 1) a rule of abstinence (avoid personal gratification at a client's expense); 2) a duty to neutrality (not to interfere in a client's personal relationship; 3) a promotion of client autonomy and self determination; 4) a fiduciary relationship; and 5) a respect for human dignity. (Irons, 1995) "Laws create some boundaries; others are sanctioned by licensing agencies; and others are established by... [the individual professional]." (Gonsiorek, 1994, p. 86)

Boundary crossing
A decision to deviate from an established boundary for a therapeutic purpose, e.g., appointment changes, disclosure of bits of personal information, small gifts. (Frick, 1994) These are brief excursions across boundaries, with a return to the established limits of the professional relationship. Boundary crossings may be trivial, but have the potential of progressing to a boundary violation if there is an increase in the frequency and/or severity of the crossings.

Boundary violation
The phenomenon that occurs when there is confusion of the professional's needs with the client's needs. The professional may use rationalization to justify the behavior. A boundary violation is typically characterized by a reversal of roles, secrecy, the creation of a double bind for the client and the indulgence of personal privilege by the professional. "The pain from a violation is frequently delayed, and the violation may not be recognized or felt until harmful consequences occur." (Peterson, 1992)

Categories of offenders
Classifications used by authors to convey the nature of the sexual offense, e.g., Schoener-Gonsiorek classified the following six categories: 1) psychotic or severe borderline personality; 2) sociopaths and severe narcissistic character disorders; 3) impulse control disorders; 4) severely neurotic and/or socially isolated; 5) mildly neurotic and situational breakdown in otherwise healthy person; and 6) uninformed/naive. (Schoener & Gonsiorek, 1989)

Consent
To give assent or approval, agree to action or behavior. When used with the law of rape, consent "...means consent of the will... ...There must be an exercise of intelligence based on knowledge of its significance and moral quality and there must be a choice between resistance and assent." (Black, 1979, p. 27)

Counter-transference
A transference reaction of a profession to a client, an emotional reaction that is a reflection of the analyst's own inner needs and conflicts (see also transference). (Miller-Keane, 1992)

Dark King or Queen
Iron's archetypal category for the person who is an exploiter, and is more cunning, intimidating and concealing to cover multiple abuses. (Irons, 1991)

Dual role/relationship
A common type of boundary violation where the professional assumes an additional role in the life of the client, e.g., friend; even nonsexual dual relationships are potentially exploitative because the practitioner's influence and the client's vulnerability carry over into the second relationship. (Kagle, 1994)

Eroticism
Sexual instinct or desire, the expression of one's instinctual energy or drive. (Miller-Keane, 1992)

Exhibitionalism
A paraphilia characterized by repeated acts of genital exposure with no attempt for further sexual activity (see also paraphilia). (Miller-Keane, 1993)

Exploitation Index
A tool designed by Epstein and Simon to serve as an early warning indicator of boundary violations in psychotherapy. (Epstein & Simon, 1990)

False Lover
Iron's archetypal category for the person with an impulsive or compulsive character disorder who may sexually harass staff members and others, frequently detected rapidly because of poor judgment. (Irons, 1991)

False memory
Untrue memory, may occur naturally or be induced. (G.R. Schoener, personal communication, March 16, 1995)

Fiduciary responsibility
"A person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking. As an adjective it means of the nature of a trust...relating to or founded upon a trust or confidence." (Black, 1979, p. 564) Fiduciary responsibility exists where there is special confidence in a professional who is bound to act in good faith and with due regard to the interests of the client.

Frotteurism
A paraphilia in which there is sexual gratification from illicit tactile stimulation, often acted out in a public place (see also paraphilia). (Miller-Keane, 1992)

Geographic cure
A phenomenon where the professional who has violated the professional practice act but attempts to avoid or deny problems by leaving a jurisdiction before licensure disciplinary action is taken. The professional obtains licensure and begins practice in a new jurisdiction. Ultimately, the authorities may deal with the errant professional, but clients in the meantime have been at risk.

Impulse Control Disorder
One of Schoener and Gonsiorek's typology of offender categories, these individuals have long-standing, ingrained impulsiveness; they may or may not be addicted; these disorders include both sexual impulse control disorders and general impulse control disorders. (Schoener & Gonsiorek, 1989)

Incest
"The crime of sexual intercourse or cohabitation between a man and woman who are related to each other within the degrees wherein marriage is prohibited by law...includes blood relationships without regard to legitimacy, and relationship of parent and child." (Black, 1979, p. 685)

Intensely Sexual Interaction
One of the varieties of professional sexual misconduct described by Schoener which consists of verbal expression and fantasy. (G.R. Schoener, personal communication, March 16, 1995)

Lovesickness
Describes a variety of situations for the health care professional: unconscious reenactment of incestuous longings; a wish for maternal nurturance which is misperceived as a sexual overture; fantasy that love in and of itself is curative; manic defense against mourning and grief at termination; conflicts around sexual orientation; and a number of other dynamics. (Gabbard, 1995)

Masochistic surrender
A professional responds to frustration over patient resistance to treatment by becoming intimately involved. (Gabbard, 1995)

Mildly Neurotic and Situational Breakdown in otherwise Healthy Person
One of Schoener and Gonsiorek's typology of offender categories, these individuals have had more serious pathologies ruled out; they are usually remorseful, one-time offenders who yielded to temptation under the stress of the situation, the situational factors and timing having played a major role (the "distressed practitioner"). (Schoener& Gonsiorek, 1989)

Naive Prince or Princess
Iron's archetypal category for the person with poor training and/or poor judgment who is unaware of professional boundaries, ethics, responsibilities. (Irons, 1991)

Narcissism
Excessive concern for oneself and one's own needs; love of or sexual desire for one's own body. (Merriam Webster, 1993)

National Practitioner Data Bank
A federally mandated clearinghouse of information related to malpractice payments made on behalf of all licensed health care practitioners, and disciplinary actions taken against physicians and dentists (a legislative mandate to collect disciplinary data regarding other health care professionals has not yet been implemented).

National Council Disciplinary Data Bank
A National Council data management system, established in 1981, that serves as a database of disciplinary actions against nurses' licenses reported by Boards of Nursing.

Neurotic
An individual afflicted with neurosis, a category of mental disorders characterized by anxiety and avoidance behavior, symptoms are distressing the person, reality testing is intact, behavior does not violate gross social norms and there is no apparent organic etiology. (Miller-Keane, 1992)

Nurse-client relationship
The therapeutic relationship between the nurse and client based on the knowledge and skills obtained by the nurse through nursing education, designed to meet the needs of the client and developed through a series of therapeutic interactions.

Paraphilia
A sexual disorder in which sexual arousal requires unusual or bizarre fantasies; acts involving use of a nonhuman object; sexual activity with humans in which real or simulated suffering or humiliation occurs; or sexual activity with non-consenting partners. (Miller-Keane, 1992)

Post-termination relationship
While some professionals may interpret the end of therapeutic encounters to free them to pursue a romantic relationship with a former client, different professions have set standards for when relationships with former client can be appropriately entered into, ranging from absolute prohibition (e.g., American Psychiatric Association), to a specified period of time following the completion of therapy (American Psychological Association), to less specific prohibitions (American Association of Social Workers). (Schoener, 1989)

Predator
Individuals who fit those categories of professional sexual misconduct offenders which include psychopaths, sociopaths, impulsive character disorders, exploiters, and those with serious reality testing problems. These very serious offenders are extremely disturbed, opportunistic and often cunning and intimidating to cover multiple abuses. (Irons, 1991; Schoener & Gonsiorek, 1989; G.R. Schoener, personal communication, March 16, 1995)

Predatory psychopathy
Any disease of the mind which involves exploiting and injuring others for personal gain, profit or pleasure. (Miller-Keane, 1992; Merriam Webster, 1993)

Professional sexual misconduct
The use of power, influence and/or knowledge inherent in one's profession to obtain sexual gratification, romantic partners and/or sexually deviant outlets. (Gonsiorek, 1994)

Psychosexual disorder
Disturbance in the normal functions of the mental, emotional and behavioral aspects of sexual development and activity. (Miller-Keane, 1992)

Psychosis
Fundamental mental derangement characterized by defective or lost contact with reality. (Miller-Keane, 1992)

Psychotic or Severe Borderline Personality
One of Schoener and Gonsiorek's typology of offender categories, these individuals exhibit impulsivity due to poor controls; sexual contact due to bizarre belief systems or theories; poor social judgment concerning actions and words; the category includes manic states, acute psychosis secondary to drug reactions and organic or neurological problems; these persons are severely disturbed with very questionable reality perception. (Schoener & Gonsiorek, 1989)

Rape
"Sexual assault or abuse; sexual intercourse (vaginal or anal penetration) against the will and without the consent of the individual." (Miller-Keane, 1992, p. 1269) One of the varieties of professional sexual misconduct described by Schoener where a predator assaults an anesthetized patient, uses drugs or hypnosis to diminish the patient's ability to resist or uses force to sexually assault (G.R. Schoener, personal communication, March 16, 1995)

Romantic-like Relationship Solely Within the Professional Context
One of the varieties of professional sexual misconduct described by Schoener where a professional conducts sexual contacts within the opportunity provided by professional encounters, with or without claim of love or promise of a "future together." (G.R. Schoener, personal communication, March 16, 1995)

Romantic Involvement Which Goes Outside of the Office
One of the varieties of professional sexual misconduct described by Schoener where a professional conducts sexual contacts during the professional relationship, following the termination of the professional relationship (real or bogus termination), or involving marriage or long-term commitment. (G.R. Schoener, personal communication, March 16, 1995)

Self-serving Martyr
Irons' archetypal category for the neurotic, lonely person who suffers from long-standing problems, is emotionally unfulfilled and overinvested in work. (Irons, 1991)

Severely Neurotic and/or Socially Isolated
One of Schoener and Gonsiorek's typology of offender categories, these individuals suffer from long-standing problems, are emotionally unfulfilled and overinvested in work; typically overly involved with clients emotionally; sexual contact develops secondary to emotional involvement, but can become a repetitive pattern. (Schoener & Gonsiorek, 1989)

Sex by Fraud
A variety of professional sexual misconduct described by Schoener where sexual gratification is disguised as treatment. (G.R. Schoener, personal communication, March 16, 1995)

Sneaky Sex
A variety of professional sexual misconduct described by Schoener where sexual gratification is obtained through surreptitious touch or observation (G.R. Schoener, personal communication, March 16, 1995)

Sexual addiction
An obsessive devotion or surrender to pursuing sexual gratification, activity or paraphilias.

Sexual contact
Refers to any sexual or sexualized behavior (physical or verbal) and/or involvement with a client (inside or outside the professional setting), which may be reasonably interpreted as romantic involvement, is intended for the sexual arousal/ gratification of the professional, the client or both, and may be reasonably interpreted by the client as being sexual in its intention. (Washington, For Your Information, 1994)

Sexual Harassment
A variety of professional sexual misconduct described by Schoener where sexual gratification is obtained through sexual comments, voyeuristic inquiry, pressuring for dates and unwanted touch. (G.R. Schoener, personal communication, March 16, 1995)

Sociopaths and Severe Narcissistic Character Disorders
One of Schoener and Gonsiorek's typology of offender categories, these individuals are self-centered and gratification-oriented. Their sexual acting out varies and they are often good at manipulating themselves out of trouble; they have no concern for harm to others, these persons are cunning, intimidating and concealing to cover multiple abuses, they are predators. (Schoener & Gonsiorek, 1989)

Sociopath
Characterized by asocial or antisocial behavior, or a psychopathic personality (Miller-Keane, 1992)

Statutory Rape
The unlawful sexual intercourse with a person under the age of consent. (Black, 1979) A variety of professional sexual misconduct described by Schoener where sexual gratification is obtained through sex with a minor child or adolescent. (G.R. Schoener, personal communication, March 16, 1995)

Transference
The redirection of feelings and desires, especially those unconsciously retained from childhood, toward a new object, such as the professional (see also counter-transference). (Miller-Keane, 1992)

Uninformed/naive
One of Schoener and Gonsiorek's typology of offender categories, this person has had more serious pathologies ruled out, is unaware of professional boundaries, ethics, responsibilities (sometimes a lack of training or institutional supports sets the stage for the involvement); is a non-predator; is remorseful; and may have a distorted view of the professional helping relationship, not distinguishing it from friendship. (Schoener & Gonsiorek, 1989)

Voyeuristic Inquiry
The use of questioning about sexual and personal matters to obtain sexual gratification, a prying observer seeking sexual stimulation. (Miller-Keane, 1992)

Wild Card
Irons' archetypal category for the person with serious reality-testing problems who is seriously disturbed, reality orientation is very questionable, often readily detected. (Irons, 1991)

Wounded Warrior
Irons' archetypal category for the situationally impaired professional, a person who yields to temptation under the stress of the situational, usually a remorseful, one-time offender. (Irons, 1991)

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10-H

TASK FORCE FOR DISCIPLINARY INVESTIGATORS

Report of the Task Force to Implement Education Programs for Disciplinary Investigators

Task Force Members
Florence Stillman, MO, Area II, *Chair*
Patricia Molloy, RI, Area IV
M. Teresa Mullin, VA, Area III
Dianne Wickham, MT, Area I

Staff
Vickie R. Sheets, *Director for Nursing Practice and Education*

Relationship to Organization Plan
Goal II .... Provide information, analyses and standards regarding the regulation of nursing practice.
Objective D .... Provide for Member Board needs related to disciplinary activities.

Recommendation(s) to the Board of Directors
No recommendations.

Background
The 1993 Delegate Assembly adopted a recommendation from the Communications Committee that the Board of Directors determine the methodology to implement educational programs for discipline investigators that best meets the needs of the membership within the National Council's Organization Plan. The task force appointed by the Board of Directors recommended that the National Council collaborate with CLEAR to develop an "add-on" component to the NCIT program. At its March 1994 meeting, the Board of Directors authorized the task force to continue collaboration with CLEAR to develop a pilot program conditional upon reaching satisfactory agreement with regard to pricing and program policies between the National Council and CLEAR, which was subsequently achieved.

Highlight of Activities

- ***Presentation of Specialized Healthcare Investigators Program with CLEAR***

  The pilot of the Specialized Healthcare Investigators program was held September 29 and 30, 1994, in conjunction with the CLEAR Annual Conference in Boston. Thirty participants were enrolled; thirteen of whom were affiliated with boards of nursing. The primary faculty for the program were task force members Patricia Molloy and Teresa Mullin, supported by task force chair, Florence Stillman, and National Council staff, Vickie Sheets.

  Overall, reaction to the program was positive, with many participants sharing comments and suggestions with the presenters. CLEAR reported that the participants rated the general program evaluation 4.10 on a 6-1 scale (mode of good). Participants rated the usefulness of the program 4.05 (mode of acceptable).

- ***Revised Specialized Healthcare Investigators Program***

  The task force reviewed the CLEAR summary report and evaluated the pilot program. The task force recommended that a modified program, focusing on nursing investigations, be held in conjunction with the 1995 Annual Meeting in St. Louis. The Board of Directors adopted this recommendation. Promotional flyers were distributed at the Area Meetings and included in the *Newsletter.*

Future Activities
The Nursing Investigators Program will be held Monday, July 31, 1995, prior to the National Council's Annual Meeting. It will be a one-day program. Continuing education credit will be offered for nurses.

The task force will review evaluations and feedback after the presentation of the Nursing Investigators Program and report back to the Board of Directors.

Meeting Dates

- December 16-17, 1994
- March 6-8, 1995

Recommendation(s) to the Board of Directors

No recommendations.

10-1

TASK FORCE FOR
NURSING EDUCATION
PROGRAM SURVEYORS

Report of the Task Force to Implement Education Programs for Nursing Education Program Surveyors

Task Force Members
Ruth Ann Terry, CA-RN, Area I, *Chair*
M. Christine Alichnie, PA, Area IV
Eileen Gloor, IA, Area II
Julia Gould, GA-RN, Area III

Staff
Linda F. Heffernan, *Nursing Practice and Education Associate*

Relationship to the Organization Plan
Goal III .... Provide information, analyses and standards regarding the regulation of nursing education.
Objective C .... Provide for Member Board needs related to the approval process of nursing education programs.

Recommendation(s) to the Board of Directors
No recommendations.

Highlights of Activities

- ***Publication of Learning Guidelines***
  The Task Force to Implement Education Programs for Nursing Education Programs completed revisions of the learning modules that were developed during 1993-1994. Six separate modules had been developed to assist the novice nursing education program surveyor learn the role and tasks of a program surveyor. They were also designed to help experienced nursing education program surveyors gain new perspectives on the role and help orientate new board members to the survey process.

  The learning modules entitled *Guidelines for Education Program Surveyors: A Series of Learning Modules* were published in May 1995, and distributed to Member Boards. Evaluations will be collected and used as a guide for any revisions or future directions.

Future Considerations for the National Council

The National Council should consider sponsoring educational sessions for nursing education program surveyors as enrichment for the experienced program surveyor.

Meeting Dates
None.

Recommendation(s) to the Board of Directors
No recommendations.

10-J CONTINUING EDUCATION OFFERINGS TASK FORCE

Report of the Continuing Education Offerings Task Force

Task Force Members

Carol Osman, NC, Area III, *Chair*
Vada Arrowood, MO, Area II
Mary Ellen Furkey, NJ, Area IV
Joan Rielly, WA, Area I

Staff

Kerry Nowicki, *Publications Manager*
Susan Woodward, *Director of Communications*

Relationship to Organization Plan

Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective D........ Maintain and enhance meeting opportunities between the National Council and Member Boards.

Recommendations to the Board of Directors

1. That starting at the Annual Meeting in 1996 and every year thereafter, a two-hour block of informational forum time is set aside to discuss trends impacting nursing regulation.

   Rationale:

   The task force noted high response from Member Boards to the task force's survey in favor of continuing education on "trends in nursing." The task force decided this need could be addressed during forum time at the Annual Meeting. The task force discussed nursing regulation trends and issues in past years, and agreed that there is a continuous need for Member Board discussion on this topic. Therefore, the task force recommended to the Board of Directors that starting at the Annual Meeting in 1996 and every year thereafter, a two-hour block of informational forum time be set aside to discuss trends impacting nursing regulation.

2. That the Board of Directors establish on ongoing program for providing education offerings for its Member Boards (board members and board staff) to expand and enhance knowledge of issues and activities that impact the regulation of nursing.

   Rationale

   The task force asked the question "Should the National Council provide continuing education?" The task force agreed that the responses to its survey of Member Boards highly favored continuing education and warrant the need for the National Council to offer continuing education. The task force also noted that there is no other organization that can provide this service for Member Boards as well as the National Council. More detailed information regarding the task force's discussion and recommendations is included in this report.

3. That if the Board approves recommendation #2, it is recommended that the following tactic be added to the Organization Plan: Tactic—Provide education offerings for National Council's Member Boards (board members and board staff) to expand and enhance knowledge of issues and activities that impact the regulation of nursing.

   Rationale

   The tactic would support the creation of an education offerings program as recommended by the task force.

Highlights of Activities

The Continuing Education Offerings Task Force created a survey at its December meeting that was distributed to all boards of nursing and returned with responses. The tallied responses were reviewed by the entire task force at its

March meeting, and the following conclusions were drawn:

- There is an interest in continuing education offerings for Member Boards.
- The topics listed on the survey are important to the membership.
- The task force must look at options in addition to free-standing meetings, due to cost restraint concerns repeatedly mentioned by survey respondents.

After reviewing responses to the survey, the task force asked the question "Should the National Council provide continuing education?" The answer the task force unanimously agreed upon was "Yes. The National Council should provide continuing education created for Member Boards." The task force agreed that the responses to the survey highly favored continuing education and warrant the need for the National Council to offer continuing education. The task force added that there is no other organization that can provide this service for Member Boards as well as the National Council.

The task force noted high response to the survey in favor of continuing education on "trends in nursing," and decided this need could be addressed during forum time at the Annual Meeting. The task force discussed nursing regulation trends and issues in past years, and agreed that there is a continuous need for Member Board discussion on this topic. Therefore, the task force recommended to the Board of Directors that starting at the Annual Meeting in 1996 and every year thereafter, a two-hour block of informational forum time is set aside to discuss trends impacting nursing regulation.

The task force reviewed the existing channels for providing continuing education, including the educational sessions at the Annual Meeting and past NCLEX™ workshops. When discussing the current process used when a committee or group identifies a need for continuing education, the task force found that there are no set procedures in place that prudently match the request to Member Board needs. The task force determined there is a need for organizing the process through which education offerings are created.

The task force agreed that there should be an entity through which any kind of education offering is funnelled. This entity should act as a clearinghouse ensuring that there is no duplication of education offerings, and that there is a need and an audience for each offering. The entity must understand the needs of Member Boards, be knowledgeable of the different mediums through which education can be offered, and be cognizant of the structural units of the National Council. The task force referred to this group as the "Coordinating Group."

The following outlines the process for creation of education offerings as the Continuing Education Offerings Task Force recommended to the Board of Directors at its May meeting.

Education Offerings by the National Council

Background: A survey conducted by the Continuing Education Offerings Task Force indicates a need for education offerings and an interest in such programs by Member Boards. The majority of boards indicated that there would be value in National Council providing education offerings on the topics listed, and also indicated that their board members and staff would be interested in attending.

Purpose: "The National Council will provide education offerings for its Member Boards (board members and board staff) to expand and enhance knowledge of issues and activities that impact the regulation of nursing."

Since National Council is already providing education offerings in an intermittent manner through various committees and task forces, the Continuing Education Offerings Task Force felt that a better service would be offered if the education offerings were coordinated in a timely, planned schedule. A regular schedule would allow Member Boards to plan on attending, and therefore make budget arrangements, if possible. This may assist some boards with the financial concerns mentioned in the survey.

Process: Establishment of a "Coordinating Group" for education offerings that reports to the Board of Directors. The function of the Coordinating Group will be oversight of all education opportunities offered by the National Council, assuring quality of those offerings, and evaluating the overall program's success.

Coordinating Group Composition

Four members, plus communications staff.
Qualifications listed below are numbered by importance:

1. Continuing education experience
2a. Minimum two-year Member Board experience
2b. National Council knowledge
3. Geographical representation

Calendar

The Coordinating Group will develop and implement education offerings on a three-year cycle. The first Coordinating Group will plan/execute the current year, and plan the next two years. The following year's Coordinating Group will execute their current year, and reevaluate and plan for the next two years, and so forth.

Coordinating Group Functions/Responsibilities

The following outlines the functions of the Coordinating Group, and details the responsibilities of the group according to these functions. Although listed in order, some of the functions may occur simultaneously.

- **Call for Topics, Member Board Needs Survey**

  Ideas for education offerings will come from two sources: National Council "structural units" (committees, task forces, the Board of Directors, staff, other nursing organizations, etc.) and through ideas generated by Member Boards.

  Call for Topics—Structural units will have the opportunity to propose an education offering through an annual Call for Topics. The structural unit proposing the idea will submit a skeleton outline of the offering that includes the name of the offering, its general subject matter, its audience, etc.

  Member Board Needs Survey—Member Boards will be able to request certain topics for consideration through an annual Member Board Needs Survey. When there is an overwhelming need for a topic area to be discussed as identified by Member Boards through this survey, the Coordinating Group will explore offering continuing education on that topic.

- **Needs Identification/Prioritization**

  The Member Board Needs Survey will function as a benchmark for Member Board need and interest against which every education offering idea is measured. On this survey, Member Boards will be asked to respond to and rank their preference in a variety of topic areas for education offerings. The rankings will be tallied and the Coordinating Group will identify and prioritize the education needs of Member Boards. Variety of topics is not essential if Member Board education need is focused on one topic area.

  The top five topic areas identified by Member Boards will be noted by the Coordinating Group and will direct the choice and implementation of education offerings by the Coordinating Group.

- **Match Needs with Proposals**

  The Coordinating Group will review the proposals returned in response to the Call for Topics and the recommendations from the Member Board Needs Survey. With these suggestions for education offerings, the Coordinating Group will match the proposals with the ranking of Member Board needs to identify the education offerings that are most appropriately delivered in response to Member Board priorities.

- **Identify Delivery Method**

  The Coordinating Group will be kept informed on all up-to-date education technology, including printing formats, computer disks, video and video disk, electronic messaging, teleconferencing, and meeting logistics. Using this information, keeping in mind fiscal responsibility and considering the impact on Member Boards, the Coordinating Group will be able to identify the best delivery method for each proposed education offering.

- **Choose Education Offerings According to Needs**

  After identifying the delivery vehicle for each proposed education offering, the Coordinating Group will select the education offerings that best meet the needs of Member Boards. Member Board priority of needs is the most important factor in the selection process. The delivery vehicle is also a component of this choice because the Coordinating Group will need to assess financial implications of each offering in comparison to

the overall budget. The Coordinating Group may also want to provide a variety of vehicles throughout the year to provide options Member Boards.

- **Refer Topics to Appropriate Structural Units**
  The Coordinating Group will be informed on all National Council structural units (task forces, committees, etc.) including their expertise, workload, term of appointment, etc. Knowing all available resources, the Coordinating Group will be able to identify which structural unit best matches the education need identified. The Coordinating Group will then request that the existing structural unit develop the education offering. The Coordinating Group will provide the structural unit with a purpose, an approved outline, the delivery method, and a budget. If the request expands the already budgeted amount of meeting time, the education budget will include funds needed to increase the number of meeting days to accommodate development of the educational offering, as needed.

- **Recommend to Board of Directors Focus Group Assignment for Specific Needs**
  When the topic is selected by the Coordinating Group from input through the Member Boards Needs Survey, the Coordinating Group will look for an existing structural unit that can develop the education offering. If an existing committee is over-burdened or if no appropriate committee exists, the Coordinating Group will ask the Board of Directors to create a Focus Group specifically assigned to the development of the education offering. The Coordinating Group will develop the purpose of the Focus Group, and recommend the background of its membership.

- **Program Development**
  The Coordinating Group will not be involved in actual development of education offerings. The Coordinating Group will assign development of the offering back to the group that originated the idea or to a Focus Group specifically created to develop the offering. The Coordinating Group will give the direction for creation of the offering, including the medium that should be developed and the budget allowed for the offering. Content development will be fulfilled by the Focus Group. The Coordinating Group will oversee the development through reports submitted by the assigned Focus Group (or existing committee), to ensure quality and fiscal responsibility.

- **Conduct Evaluation Activities**
  Evaluation will be done by both the Coordinating Group and the Focus Group (existing committee) involved. The Coordinating Group will look at the overall program's effectiveness for Member Board needs, and the Focus Group will evaluate the specific offering itself.

- **Coordinate Education Offerings by Developing a Three-year Plan and Reevaluate Each Year**
  The Coordinating Group will develop a working master calendar of education activities. This calendar will reflect its three-year planning. Using this calendar, the Coordinating Group can plan activities on a regular basis (i.e., meetings at a certain time of the year, written materials released at certain times of year), ensure no topic overlap, promote education offerings accordingly and in advance, evaluate programs in a timely fashion, and utilize information gained from evaluation to develop or revise future offerings.

- **Quality Assurance**
  The Coordinating Group will review and select proposals with Member Board needs foremost. Also, since all education offerings will be funnelled through the Coordinating Group, the group will be in the unique position to identify overlap of education programs, need for more specific programming in a certain topic area, best use of delivery methods, etc. And, as evaluations of the education offerings are compiled, the Coordinating Group will have the information on the successes and failures of past offerings, and be able to utilize this feedback in creating more effective, successful offerings.

- **Deal with Emerging Issues**
  Occasionally, issues emerge that necessitate education of Member Boards. When this happens, the Coordinating Group will have the flexibility to rearrange its three-year plan to accommodate any unexpected education need. Emerging issues will be identified or verified by the Member Board Needs Survey.

- **Budget Annually**
  The Coordinating Group suggests that it work from a designated fund for all education offerings. A fee will be charged for education offerings, and monies collected as fees will be returned to this fund.

Fiscal Impact

The task force recommended that a budget be created yearly for education offerings in general, under the direction of the Coordinating Group. For budgeting purposes, the task force selected three mediums to provide education offerings: one face-to-face meeting, one 15-minute video, and one printed self-study piece. The selection of the topic and the medium will be driven by Member Board needs; the Coordinating Group will be allowed some flexibility when determining the best means of conveying the education opportunity. Also included in the budget will be monies for the Coordinating Group's meetings and conference calls, as well as meetings and conference calls for three focus groups.

The Coordinating Group will fund proposals through this budget. Therefore, funds will not be allocated to each committee/structural unit's individual budget, but will be compiled in one general fund.

The Continuing Education Offerings Task Force recommends that money be provided in a designated fund for an education program. By establishing a designated fund, the Board would be earmarking funds sufficient to take the program from start-up to full implementation. This would be a multi-year effort and if undertaken, the full cost should be "counted" from the beginning. Each fiscal year, an operating budget would be requested by the Coordinating Group, to be drawn from the designated fund, for the anticipated activities for the year. At year-end, expenditures and revenues can be reviewed and used to make adjustments in the operating budget for the following fiscal year. With revenues from educational offerings to be added to the designated fund, it will be possible to accurately assess over time whether the program is a break-even, a net cost, or a net revenue producer.

The task force believes that once education offerings are provided more regularly and in a planned calendar, Member Boards will come to expect the offerings and plan for participating in National Council's education offering rather than directing their funds elsewhere. Also, if a fee is associated with each offering, some Member Boards may be able to plan to budget for the offering. When this fee is collected, it can be returned to the designated fund, and be redirected for future education offerings. The fees may not support the entire budget each year, but will rejuvenate the fund to a point that less and less monies will be required to refill the fund to its necessary level.

These recommendations and ideas for the development of a continuing education offerings program were presented to the Board of Directors at its May meeting.

Future Activities

None.

Meeting Dates

- December 5-6, 1994
- March 13-14, 1995
- May 15, 1995, *telephone conference call*

Recommendations to the Board of Directors

1. That starting at the Annual Meeting in 1996 and every year thereafter, a two-hour block of informational forum time is set aside to discuss trends impacting nursing regulation.

2. That the Board of Directors establish on ongoing program for providing education offerings for its Member Boards (board members and board staff) to expand and enhance knowledge of issues and activities that impact the regulation of nursing.

3. That if the Board approves recommendation #2, it is recommended that the following tactic be added to the Organization Plan: Tactic—Provide education offerings for National Council's Member Boards (board members and board staff) to expand and enhance knowledge of issues and activities that impact the regulation of nursing.

10-K

EDUCATIONAL PROGRAMS TASK FORCE

Report of the Educational Programs Task Force

Task Force Members

Margaret Howard, NJ, Area IV, *Chair*
Lucille Baldwin, AL, Area III
Peggy Hawkins, NE, Area II
Toma Nisbet, WY, Area I

Staff

Sue Davids, *Meetings Manager*

Relationship to the Organization Plan

Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Tactic 5 .... Plan and select National Council-sponsored continuing education programs.

Recommendation(s) to the Board of Directors

No recommendations.

Highlights of Activities

The 1995 Call For Papers was distributed at the 1994 Annual Meeting to all attendees who received a copy of the proceedings book. It was mailed to Member Boards in October and December with the *Newsletter*. It was mailed to every accredited school of nursing across the country in October. Twenty-nine abstracts were received, with nine from Member Boards and 20 from educators. The task force reviewed all abstracts, selecting eight presentations and one alternate to complete the 1995 Educational/Research Session at the Annual Meeting. Letters of selection were mailed and all presentations (including the alternate) were confirmed. Information regarding the programs was published in the Annual Meeting brochure.

The task force reviewed the role of volunteer moderator and recommended that the position become standard for all future educational/research sessions. Invitations to serve as a moderator are extended in the spring with the general "Call for Volunteers" in the *Newsletter*.

The task force revised the Call for Papers and recommended that the distribution schedule continue as in 1995. They discussed the lack of Member Board submissions and felt that the deadline could be extended as it was in 1995 for Member Boards, if necessary, to try and encourage submissions up until the group met to review the abstracts.

Based on attendee evaluations, the task force recommended that the proceedings book be distributed prior to the Educational/Research Session. A disclaimer will again be published in the proceedings book that indicates that the papers published within are the work and opinions of the respective authors and not of the National Council.

The task force recommended that poster sessions be continued for 1995 and evaluated for future meetings. Two out of four abstracts selected have accepted the invitation for a poster session.

Future Activities

Plan and select National Council sponsored continuing education programs to be held in conjunction with the 1996 Annual Meeting.

Meeting Dates

March 6-7, 1995

Recommendation(s) to the Board of Directors

No recommendations.

10-L

EXECUTIVE OFFICERS
NETWORK TASK FORCE

Report of the Executive Officers' Network

Members
Executive Officer of each Board of Nursing
Joyce Schowalter, MN, Area II, *Chair*
Pat Brown, WA, Area I, *Vice-Chair*

Staff
Doris E. Nay, *Associate Executive Director*

Relationship to Organization Plan
Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective D .... Facilitate communication between National Council, Member Boards and related entities.

Recommendation(s)
No recommendations.

Highlights of Activities
The 1993 Delegate Assembly passed a resolution authorizing the Executive Directors' Networking Group to establish a committee to develop structures and procedures to facilitate the functioning of the Member Board executive directors. The proposed structures and procedures were reported to the Board of Directors and approved by the Executive Directors' Networking Group at its August 5, 1994, meeting. The Executive Directors' Networking Group, now known as the Executive Officers' Network, identified a need to develop an orientation program for new executive officers, and to publish a roster of executive officers for internal use by executive officers.

At the 1994 post-Delegate Assembly Board of Directors meeting, funds were budgeted for a task force to develop a program of orientation for Member Board executive officers aimed to develop leaders in nursing regulation and administration, and to publish a roster of executive officers. The report of the Executive Officer Orientation Task Force can be found as Attachment A. The roster has been developed and distributed to executive officers.

Joyce Schowalter, Chair, and Pat Brown, Vice-Chair, met via conference call to develop the agenda for the Executive Officers' Network meeting to be held during the Annual Meeting on August 1-2, 1995.

Future Activities
The orientation program will be available to new executive officers after the August 1, 1995, meeting.

Meeting Dates
- March 22, 1995, *telephone conference call*
- August 1-2, 1995

Recommendation(s)
No recommendations.

Attachments
A .... Executive Officer Orientation Task Force Report, *page 3*

Attachment A

Executive Officer Orientation Task Force

Task Force Members
Corinne Dorsey, Virginia, Area III
Lorinda Inman, Iowa, Area II
Laura Poe, Utah, Area I
Patricia Molloy, RI, Area IV

Staff
Kerry Nowicki, *Publications Manager*

Recommendation(s)
None.

Highlights of Activities

Focusing on its charge "to create a program for orientation of Member Board executive officers aimed to develop leaders in nursing regulation and administration," the Executive Officer Orientation Task Force created a program for orientation of new executive officers and fully developed each piece of the orientation program.

As part of the orientation program, an orientation manual was designed as a tangible resource for new executive officers. The manual will be printed and made available to every executive officer at the Executive Officer Networking Group at the 1995 Annual Meeting. After distribution to the full group, the manual will be made available only to new executive officers.

August 1, 1995, will be the official starting date for the orientation program. The entire orientation program will be reviewed by the Executive Officer Networking Group after a three-year pilot run.

Meeting Dates
- December 12-13, 1994
- March 9-10, 1995

Recommendation(s)
None.

10-M

NURSE INFORMATION
SYSTEM TASK FORCE

Report of the Nurse Information System (NIS) Task Force

Task Force Members
Patricia Brown, WA, Area I, *Chair*
Vicky Burbach, NE, Area II
Brenda Butler Smith, VT, Area IV
Anna Ferguson, OK, Area III
Brenda Smith, IN, Area II

Staff
Melanie L. Neal, *NIS Program Manager*
Peggy Iverson, *NIS Administrative Assistant*

Relationship to Organization Plan
Goal IV .... Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective B .... Establish a nurse information system for use by Member Boards and others, contingent upon receipt of substantial external funding.

Recommendation(s) to the Board of Directors
No recommendations.

Highlights of Activities

NIS Policy Development
The NIS Task Force has developed policies to guide the NIS project through development and as an ongoing program of the National Council:

- Agreements for access and use of Member Board data
- Guidelines for data transfer from Member Boards
- Schedule for and frequency of data collection
- NIS data elements
- Data importation, standardization, and conversion
- Unduplicated count
- Data maintained in accordance with NIS data collection agreements
- Retention of inactive records
- File back-up
- Maintenance of historical records
- Member Board approval for release of data
- Release of data
- Data security
- Marketing philosophy

During its December 5, 1994, conference call, the NIS Task Force identified several areas for future policy development, including guidelines on the minimum number of NIS data elements needed for Member Board participation and the pricing structure for the sale of NIS data. The NIS Task Force also plans to conduct annual reviews of all NIS policies until NIS is operational to ensure that policies are consistent with NIS development.

NIS Task Force Chair's Attendance At NIS Technical Advisory Panel (TAP) Meeting
NIS Task Force Chair, Patricia Brown, attended the NIS TAP meeting on March 22, 1995, to review current NIS policies and to receive suggestions for policy development. The NIS Technical Advisory Panel was formed at the request of the Robert Wood Johnson Foundation, for the purpose of providing advice on the technical matters related to the NIS project. NIS TAP members agreed to provide their input on future policy development issues.

Future Considerations for the National Council

The NIS Task Force and staff expect to continue policy development in preparation for the NIS becoming fully operational. It is anticipated that the NIS will be available on a limited basis after March 1996 and will be fully operational by January 1997. Data availability, however, will be determined by Member Board participation and data collection schedules.

Meeting Dates

- December 5, 1994, *telephone conference call*
- June 26, 1995

Recommendation(s) to the Board of Directors

No recommendations.

10-N

LONG RANGE PLANNING TASK FORCE

Report of the Long Range Planning Task Force

Task Force Members
Leola Daniels, ID, Area I, *Chair*
Jean Caron, ME, Area IV
Nancy Durrett, VA, Area III, *Board of Directors Liaison*
Lorinda Inman, IA, Area II
Judie Ritter, FL, Area III

Staff
Doris E. Nay, *Associate Executive Director*

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

Recommendation(s) to the Board of Directors
1. That the recommended revisions to the National Council goals and objectives as presented in the Organization Plan (Attachment A) be forwarded to the 1995 Delegate Assembly for adoption.

Rationale
The 1992 Delegate Assembly adopted the current Organization Plan. In the preparation of the recommended revisions, the task force used multiple resources including: the current goals and objectives; results of the 1993 Objective Importance and Effectiveness Survey; results of the 1994 Trend Analysis Survey; the mission statement; ideas generated at the 1994 Area Meetings/Regulatory Days of Dialogue; and input from the Board of Directors, committees/special committees, and staff. For its analysis, the task force developed a grid to reflect the major issues identified in the 1994 Trend Analysis Survey (Attachment B). Also, in order to provide Member Boards with background information regarding each proposed change to the Organization Plan, the task force prepared the document, Rationale Briefs of Proposed Changes to Organization Plan (Attachment C). Both attachments, together with a copy of the proposed revisions, were provided at the 1995 Area Meetings. Subsequently, the proposed Organization Plan was finalized by the task force and presented to the Board of Directors for consideration, with the recommendation that it be forwarded to the 1995 Delegate Assembly.

Highlights of Activities

The Long Range Planning Task Force developed proposed tactics for FY96 to implement the Organization Plan. Consistent with the Annual Planning System, the Board of Directors adopts the tactics to implement the Organization Plan. The tactics are used to guide the FY96 budget planning.

The task force updated the Long Range Plan Internal Working Document. In 1994, the Board of Directors adopted this document to be used as a guide for the Long Range Planning Task Force and Board of Directors. The document contains directional goals and benchmark tactics extending five years into the future for each objective in the Organization Plan. Each year, the Long Range Planning Task Force reviews the document, considers all available resources and prepares an updated plan for consideration by the Board of Directors.

Future Activities

During FY96, the task force will review and evaluate the mission statement, conduct a study to determine the importance of the objectives, and conduct an environmental scan to identify external trends and issues that impact regulation. With results of the environmental scan, papers will be developed in the following areas: society, nursing education, nursing practice, legislation/regulation, and testing/assessment.

Meeting Dates

- December 5-6, 1994
- March 23-24, 1995
- May 1, 1995, *telephone conference call*

Recommendation(s) to the Board of Directors

1. That the recommended revisions to the National Council's goals and objectives as presented in the Organization Plan (Attachment A) be forwarded to the 1995 Delegate Assembly for adoption.

Attachments

A ....Proposed Organization Plan, *page 3*
B ....Trend Analysis Issues, *page 9*
C ....Rationale Briefs of Proposed Changes to Organization Plan, *page 14*

Attachment A

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

PROPOSED ORGANIZATION PLAN

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

Goal I. **Licensure and Credentialing**

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

Objective A. **Conduct job analysis studies to serve as the basis for examinations.**

Objective B. **Provide examinations that are based on current accepted psychometric principles and legal considerations.**

Objective C. **Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.**

Objective D. **Provide a competency evaluation program for nurse aides.**

Objective E. **Provide a comprehensive approach for the regulation of advanced nursing practice.**

Objective F. **Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.**

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Goal I. (continued)

Objective E G. **Promote consistency in the licensure and credentialing process.**

Objective F H. **~~Investigate mechanisms for evaluating continued competence.~~**

Identify the role of a Board of Nursing related to continued competence.

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Goal II. Nursing Practice

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

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

Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

Objective B. ~~**Develop documents regarding health care issues which affect safe and effective nursing practice.**~~

Provide resources regarding health care issues which affect the regulation of nursing practice.

Objective C. **Conduct research on regulatory issues related to disciplinary activities.**

Objective D. **Provide for Member Board needs related to disciplinary activities.**

~~**Objective E.**~~ ~~**Review and analyze actions of government and other entities that affect the regulation of nursing practice.**~~

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Redline = New Text

Goal III. Nursing Education

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

Objective A. ~~Develop documents which provide guidance regarding the regulation of nursing education.~~

Analyze the health care environment for trends and issues affecting the regulation of nursing education.

Objective B. ~~Develop documents regarding issues that affect the regulation of nursing education.~~

Provide resources regarding issues that affect the regulation of nursing education.

~~**Objective C.**~~ ~~Provide for Member Board needs related to the approval process of nursing education programs.~~

~~**Objective D.**~~ ~~Review and analyze the actions of government and other entities that affect the regulation of nursing education~~

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Redline = New Text

<u>Goal IV.</u> **<u>Information</u>**

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

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

Objective B. **Establish a nurse information system (NIS) for use by Member Boards and others. ~~contingent upon receipt of substantial external funding.~~**

~~Objective C.~~ **~~Provide consultative services for Member Boards.~~**

Objective ~~D~~ C. **Facilitate communication between National Council, Member Boards and related entities.**

Objective ~~E~~ D. **Conduct and disseminate research pertinent to the mission of the National Council.**

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Goal V. Organization

~~Implement an organizational structure that uses human and fiscal resources efficiently~~

Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective A. Implement a planning system to guide the National Council.

Objective B. Maintain a fiscal sound resource management system for the National Council.

Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Objective D. Provide consultation and services to meet unique Member Board needs.

Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

Objective G. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

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NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.
Long Range Planning Task Force

TREND ANALYSIS ISSUES

This document contains the major issues identified in the 1994 Trend Analysis Study. The modal response for these issues, unless otherwise noted, was "Completely Agree" (i.e., mode = 6).

	Part I **Issues or trends having the greatest impact on the regulation of nursing within the next 5 years.**	**Part II** **Issues or trends having the greatest impact on board structure/ operation within the next 5 years.**	**Part III** **National Council activities that can assist Boards of Nursing in addressing issues/trends within the next 5 years.**
Goal I Licensure/ Credentialing	Health Care Reform Federal initiatives for health care reform. Unlicensed Personnel Increased use of unlicensed personnel in non-institutional settings (e.g., home health, etc.) Nursing Regulation Authority of the board of nursing versus that of other regulatory agencies relative to the regulation of nursing practice. Advanced Practice * Inter-state consistency in the regulation of and the definition of the legal scope of practice of advanced nurse practitioners. Regulation of advanced nurse practitioners solely by the board of nursing. * Psychometric and legal soundness of advanced nursing practice certification examinations.	Legislation Increased need to monitor legislative issues/action.	NCLEX Engage in activities/research to ensure the legal and psychometric soundness of the licensure examinations (NCLEX). Federal Legislation Analyze federal legislation/ policy on state-level regulation of nursing.

* = mode of 5/6 or 5 (Mostly Agree)

	Part I **Issues or trends having the greatest impact on the regulation of nursing within the next 5 years.**	Part II **Issues or trends having the greatest impact on board structure/ operation within the next 5 years.**	Part III **National Council activities that can assist Boards of Nursing in addressing issues/trends within the next 5 years.**
Goal II Nursing Practice	Unlicensed Personnel Increased use of unlicensed personnel in institutional settings (e.g., hospitals, nursing homes) Encroachment of other health care providers (e.g., EMTs, paramedics, physicians' assistants, etc.) Delineation of the role of unlicensed health care providers Delegation of nursing activities to unlicensed personnel Expanded roles and responsibilities of unlicensed personnel Increased use of unlicensed personnel in settings with little or no direct nursing supervision Advanced Practice Increased use of advanced nurse practitioners in non-traditional roles and settings Independent prescriptive authority for advanced nurse practitioners * Psychometric and legal soundness of advanced nursing practice certification examinations Other Increased emphasis on home/ community-based nursing care Increased use of registered nurses in non-traditional roles and settings	Discipline Increased workload relative to disciplinary complaints/ investigations/monitoring	Discipline Provide electronic access to National Council's disciplinary data bank, including read and report functions Obtain 100 percent participation of boards of nursing in nursing disciplinary data bank Provide a comprehensive database regarding information on discipline, disciplinary action, recidivism rates Unlicensed Personnel Monitor trends related to the delivery of nursing care by unlicensed and licensed personnel Nursing Regulation Monitor and report state and federal court cases affecting nursing regulation

* = mode of 5/6 or 5 (Mostly Agree)

	Part I **Issues or trends having the greatest impact on the regulation of nursing within the next 5 years.**	**Part II** **Issues or trends having the greatest impact on board structure/ operation within the next 5 years.**	**Part III** **National Council activities that can assist Boards of Nursing in addressing issues/trends within the next 5 years.**
Goal III Education	Advanced Practice * Standardization of educational requirements for advanced nursing practice		

* = mode of 5/6 or 5 (Mostly Agree)

	Part I **Issues or trends having the greatest impact on the regulation of nursing within the next 5 years.**	**Part II** **Issues or trends having the greatest impact on board structure/ operation within the next 5 years.**	**Part III** **National Council activities that can assist Boards of Nursing in addressing issues/trends within the next 5 years.**
Goal IV Communication			Communication Communicate information regarding regulatory issues Provide information clearinghouse services on nursing regulation issues, trends and activities Facilitate electronic data exchange between and among boards of nursing and other entities Provide position statements resulting from national and international trends in regulation * Provide continuing education programs for board members and staff * Facilitate inter-board communications Nursing Regulation Gather and report national-, regional-, and state-level nursing statistics related to nursing regulation

* = mode of 5/6 or 5 (Mostly Agree)

	Part I **Issues or trends having the greatest impact on the regulation of nursing within the next 5 years.**	**Part II** **Issues or trends having the greatest impact on board structure/ operation within the next 5 years.**	**Part III** **National Council activities that can assist Boards of Nursing in addressing issues/trends within the next 5 years.**
Goal V Organization			Nursing Regulation Influence development of federal regulations that impact nursing regulation Represent and speak for nursing regulation on a national level Influence development of national/federal policy that impacts nursing regulation Member Board Services * Perform services upon request of an individual board of nursing (e.g., surveys, data analysis, brochures, etc.)

* = mode of 5/6 or 5 (Mostly Agree)

Attachment C

Rationale Briefs of Proposed Changes to Organization Plan

Goal I. Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.

Advanced practice issues are ranked very high in the 1994 trend analysis data and many boards are currently involved in legislative initiatives related to APRNs.

Goal I. Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.

The purpose of this new objective is to ensure a comprehensive evaluation of issues related to the unlicensed assistive personnel. The issues are ranked very high on the trend analysis data, the topic was "hot" at the 1994 Annual Meeting and continues to be a frequent agenda item for other organizations addressing the health care delivery system.

Goal I. Objective H. Identify the role of a Board of Nursing related to continued competence.

As the health care environment evolves, Boards are being challenged to identify the on-going meaning of a license, beyond the point in time when the licensee met initial licensure requirements. The change better identifies the intent of the objective than the prior reference only to continued competency assessment mechanisms.

Goal II. Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

This objective focuses the monitoring of the health care environment as it relates to nursing practice in one objective, it now incorporates the purpose of Goal II, Objective E of the 1992 Organization Plan.

Goal II. Objective B. Provide resources regarding health care issues which affect the regulation of nursing practice.

This objective combines the 1992 Objectives A and B of Goal II. Documents and other resources which provide assistance, support and guidance regarding the regulation of nursing practice will be developed and distributed.

Goal III. Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing education.

This objective focuses the monitoring of the health care environment as it relates to nursing education into one objective and incorporates Objective D of Goal III of the 1992 Organization Plan.

Goal III. Objective B. Provide resources regarding issues that affect the regulation of nursing education.

This objective combines the 1992 Objectives A and B of Goal III. Documents and other resources which provide assistance, support and guidance regarding the regulation of nursing education will be developed and distributed.

Goal III. Objective C. is incorporated as a tactic under Goal III. Objective B.

It is at the level of specificity usually associated with tactics.

Goal IV. Objective B. Establish a nurse information system (NIS) for use by Member Boards and others.

In 1992, the Delegate Assembly adopted the Board of Directors' recommendation for the National Council to implement a NIS, contingent upon the receipt of substantial external funding for development and initiation of the system. In October 1992, the Robert Wood Johnson Foundation awarded the National Council a grant of $530,110 over a two-year period. An additional two-year award of $ 499,995 was granted by the Robert Wood Johnson Foundation beginning February 1, 1995.

Goal IV. Objective C has been incorporated into Goal V. Objective D.

The purpose of the objective fits better under the proposed Goal V because of the broader focus of the Goal.

Goal V. Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

The rewording of this goal provides for a broader focus designed to address the regulatory interests and needs of Member Boards and the National Council. Objectives E. and F. relating to public policy issues are found under this goal.

Goal V. Objective B. Maintain a sound resource management system for the National Council.

The objective is broadened to include financial and human resources necessary to accomplish the mission.

Goal V. Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Governance ensures that the "owners" of the organization, the boards of nursing, control the leadership, to ensure that needs of all the members are served.

Goal V. Objective D. Provide consultation and services to meet unique Member Board needs.

Acknowledges that Member Boards will have needs unique to their jurisdictions, and that to a limited extent, National Council can provide expertise which will assist individual boards in developing and implementing public policy which promotes safe and effective nursing care of the public within their respective jurisdictions.

Goal V. Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

To take a more proactive approach in response to proposals about changing regulatory approaches. To establish creditability as a resource on regulatory issues. To develop mechanisms to achieve a collective national voice. The issues related to "policy shaping" are ranked very high on the Trend Analysis data.

Goal V. Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

Identify potential regulatory approaches resulting from ongoing health care restructuring proposals. Develop a comprehensive baseline of information and analysis of state regulation systems/approaches. The issues related to legislation and nursing regulation are ranked very high on the Trend Analysis data. The objective represents a fundamental responsibility of the National Council.

Goal V. Objective G. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

The 1994 Delegate Assembly authorized the establishment of a special services division of the National Council through the addition of an article to the Bylaws. The mission is accomplished through generating revenue to support additional programming which serves common Member Board needs.

10-O

SPECIAL SERVICES DIVISION

Report of the Special Services Division

Jennifer Bosma, PhD, CAE, Executive Director

The Special Services Division (SSD) was created by action of the 1994 Delegate Assembly. Its purpose is to advance the mission of the National Council by offering services and products which will allow infusion of revenue to support programs for Member Boards. The first-year activities of the division will be described below in four areas: idea generation, service and product development, compliance with administrative guidelines, and future plans.

Idea Generation

Individuals from Member Boards have generated numerous ideas for the SSD. Two focus groups comprised of board members and staff were convened in Chicago, one in November and the other in May. The first group identified significant trends and events in the licensure, education, and practice arenas which provide opportunities for development of new services and products. They provided feedback on a number of previously submitted ideas, and generated more of their own. The second group focused on the educational market, within both educational and practice settings.

Ideas were generated by individuals as well as the focus groups. Individuals from boards and staff wrote descriptions of their ideas, working cooperatively with staff or consultants with relevant expertise to test them and refine them further.

As ideas were generated, they were screened according to the process identified in discussions with the Member Boards last year. One idea, electronic licensure verification, was determined during this screening process to more properly belong within the regular program activities of the National Council because it potentially represents a common Member Board need. The Board of Directors subsequently established exploration of electronic licensure verification as a tactic for FY95 and appointed a task force to explore possible approaches.

Two activities which have ties to the regular programs of the organization were determined to be appropriate for specific development within SSD: 1) workshops for educators, related to NCLEX™ and testing; and 2) "spin-off" products built on the nursing activity and other databases underlying computerized clinical simulation testing (CST®).

Service and Product Development

Development activities typically began with a small group meeting or teleconference designed to refine the features of the potential service or product. Often, some type of market research was the next step. Member Boards received surveys related to two ideas: a speakers bureau for topics related to NCLEX and a consultation service for Boards setting up alternative-to-discipline programs for chemically impaired licensees. The survey feedback was used to refine the ideas and determine the further course of development.

Other ideas were developed, potential markets identified, and then products prototyped for pilot tests. These include an automated care plan tool with potential uses for nursing students and educators, a certification in long term care for LPNs, and a modular-design workshop/manual on test development for nurse educators. These are the ideas farthest in development at this time. Business plans are being developed for each; these will govern the release of funds for further development through establishment of benchmarks for success along the way.

Compliance with Administrative Guidelines

These policies, established by the Board of Directors at its post-Delegate Assembly Board meeting in August 1994, have been observed, as follows:

1. **No revenue generation activity shall detract in any manner from: the protection of the public health, safety and welfare; the promotion of nursing competence; and the reputation of the National Council.** All ideas considered have been subjected to this screen, and none advanced which would detract in any manner. Most ideas advanced would, in fact, if successful, have a positive impact in each of these areas.

2. **Consideration shall be given to the consequences of a project for the benefits to National Council which are derived from relationships with other organizations.** While most projects considered would not have any significant impact on interorganizational relations, those few that could were thoroughly discussed with regard to the potential drawbacks in view of the potential benefits (non-monetary as well as monetary). Decisions were made to proceed or not after these discussions were shared with the Board of Directors.

3. **Before each project is approved for implementation it must have a business plan which includes at least the following components: anticipated benefits and consequences of the project, resources needed (money, time, expertise), market analysis, return on investment projections, potential exit strategies, and milestones (financial and other) which must be met for project completion.** No projects have yet been approved for full-scale implementation. Market analysis is currently underway for several, and business plan writing is underway for those projects which are farthest along in development.

4. **Before approving a project for implementation, the governing entity shall direct that the data in the business plan be validated from sources independent of the persons proposing the project (i.e., perform "due diligence"). The larger the investment involved, the greater the expectation that these sources will be external to the National Council.** No business plans have been completed at this point; however, in the course of market research, independent opinions of members and staff of Member Boards have been sought.

5. **Every approved project should have an anticipated rate of return greater than the return that could be obtained by investing the funds in investment vehicles specified in the organization's investment policies.** While no projects have yet been approved for implementation, progression of ideas from one stage of development to the next has depended in part on projections for revenue potential.

6. **If a project involves a market or a technology which is new to the National Council, a joint venture should be considered.** Several currently active ideas are being considered in the context of partnerships with other relevant organizations.

7. **Six-hundred thousand dollars shall be allocated from the National Council's undesignated, unrestricted fund balance for financing potential revenue-generating projects. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.** The Board of Directors authorized $100,000 for the FY95 budget. Of this amount, expenditures to date have been under $40,000. With the recent addition of support staff and a marketing director to coordinate development activities (along with work on regular programs such as the Nurse Information System), expenses will increase in the next several months, but are anticipated to remain within the $100,000 budgeted for the fiscal year.

8. **Any net revenue over expense generated shall be reviewed annually by the Board of Directors who shall determine the extent to which such funds shall be transferred to the unrestricted/undesignated fund balance. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.** While it is anticipated that revenue will be generated within the next several months in connection with some of the pilot activities, it is not anticipated that there will be any net revenue in the first year.

Future Plans

Generation of ideas will continue to be encouraged by individuals from Member Boards and staff through various means. Staff and consultants will participate, based on expertise and availability, in the development of ideas into actual services and products. The marketing director, Mr. Philip LaForge, will assume day-to-day responsibility for market research and business plan development, with executive oversight maintained by the National Council's executive director and policy oversight by the Board of Directors with the assistance of the Finance Committee.

The activities of the first year for the SSD mark excellent progress toward the goal of offering quality, reputable services and products based on National Council's experience and expertise, with ultimate benefit for Member Board services support. The quality of the initial ideas, the willingness of members and staff to work voluntarily to develop them, and the shaping of several promising services and products have provided evidence that the 1994 delegates' vision for the SSD may well be realized in the near future.

11

RESOLUTIONS
COMMITTEE &
NEW BUSINESS

Report of the Resolutions Committee/New Business

Committee Members
Leola Daniels, ID, Area I, *Chair*
Jean Caron, ME, Area IV
Lorinda Inman, IA, Area II
Jo Elizabeth Ridenour, AZ, Area I, *Finance Committee Liaison*

Staff
Jennifer Bosma, *Executive Director*
Doris Nay, *Associate Executive Director*

Relationship to Organization Plan
Goal V .... Implement an organizational structure that uses human and fiscal resources efficiently.
Objective C .... Maintain a system of governance that facilitates leadership and decision making.

Recommendation(s)

1. That when directives of the Delegate Assembly require completion of a project which significantly impact allocation of resources, the Board of Directors will establish a reasonable timeline for completion of such project. Progress reports are to be given to the Delegate Assembly at identified intervals. (For background information, the complete motion, including rationale, follows as Attachment A.)

The Resolutions Committee offers no recommendations.

Rationale

The bylaws and other National Council documents are silent on this particular matter.

Legal review of the motion has determined that the adoption would not be binding on the Delegate Assembly unless embodied in bylaws; i.e., any Delegate Assembly action which incorporates a specific timeline would take precedence.

Fiscal impact of this motion: none.

2. That the National Council of State Boards of Nursing identify a commonality of language regarding "assessment" as a component of the nursing process which could be incorporated and reflected in the *NCLEX-PN™ Test Plan* after approval by the Delegate Assembly in the normal cycle of test plan revisions. (For background information, the complete resolution follows as Attachment B.)

The Resolutions Committee recommends a no vote.

Rationale

There is concern whether this an achievable activity given the diversity among jurisdictions, i.e., practice acts, administrative rules, clinical practice and education. In the process of revising the PN job analysis methodology, activities related to assessment will be reviewed.

Legal counsel questions whether this is achievable given the definitions embodied in some practice acts.

Fiscal impact of this motion is as follows:	**FY96**
Out-of-pocket expense (committee travel, mailings)	$ 9,377.00
Existing staff time expense	$ 5,850.00
Additional staff/temporary help required	$ 2,102.00
Net expense	$17,329.00

This activity would be scheduled to be completed during FY96 in order for the information to be incorporated into the PN Job Analysis instrument. The PN Job Analysis is scheduled to begin in FY97.

Highlights of Activities

Review of Motions

The committee held telephone conference calls on Monday, May 1, 1995, and Thursday, May 11, 1995, to review the resolutions received. Following the policies and procedures established by the Board of Directors, the committee prepared the resolutions for inclusion in the *Book of Reports*. The committee will meet on Friday, August 4, 1995, to review any additional resolutions received by 2:00 p.m. on Friday, August 4, 1995.

Resolutions Forum

All resolutions received will be presented by the committee at the Resolutions Forum which will be held at 9:00 a.m. on Saturday, August 5, 1995.

Meeting Dates

- May 1, 1995, *telephone conference call*
- May 11, 1995, *telephone conference call*

Attachments

A ....Motion for the Board of Directors to establish reasonable timelines for completion of projects directed by the Delegate Assembly, *page 3.*

B ....Resolution to identify a commonality of language regarding "assessment" as a component of the nursing process, *page 5.*

Attachment A

Motion for the Board of Directors to establish reasonable timelines for completion of projects directed by the Delegate Assembly.

MOTION, When directives of the Delegate Assembly require completion of a project which significantly impact allocation of resources, the Board of Directors will establish a reasonable timeline for completion of such project. Progress reports are to be given to the Delegate Assembly at identified intervals.

RATIONALE FOR MOTION, Directives such as studies, surveys, and position papers, that require researching a variety of resources in order that a thoroughly developed recommendation is proposed, should be allocated a feasible timeline for completion. Currently, most studies are being conducted on a very short timeline after the Delegate Assembly to completion of the study before May 1. Currently, Member Boards are deluged with questionnaires from several sources to be completed in a very short turn-around time so that the study is complete in time for printing in the *Book of Reports*.

For clarification: Delegates proposing a motion which has time sensitivity may request a preferred timeline to be considered by the Board of Directors in establishing the project timeline.

Submitted by:
Ohio Board of Nursing

Resolutions Committee Action:
No recommendations.

Attachment B

Resolution to identify a commonality of language regarding "assessment" as a component of the nursing process.

WHEREAS,	There is a wide discrepancy in the interpretation of the word "assessment" within the nursing community as it applies to licensed practical nurse (LPN)/licensed vocational nurse (LVN) practice; and
WHEREAS,	The nursing process including assessment and the participatory role of LPNs/LVNs are taught nationally in programs of practical/vocational nursing; and
WHEREAS,	The discrepancy in interpreting the meaning of "assessment" as a component of the nursing process affects the preparation and content of the National Council Licensure Examination for Practical (Vocational) Nurses (NCLEX-PN™); be it therefore
RESOLVED,	That the National Council of State Boards of Nursing (NCSBN) identify a commonality of language regarding "assessment" as a component of the nursing process which could be incorporated and reflected in the *NCLEX-PN™ Test Plan* after approval by the Delegate Assembly in the normal cycle of test plan revisions.

Submitted by:
California Board of Vocational Nurse and Psychiatric Technician Examiners

Resolutions Committee Action:
Recommended not to adopt.

12

SUMMARY OF 1994
D.A. ACTIONS

Summary of 1994 Delegate Assembly Action and Subsequent Implementation

The 1994 Delegate Assembly passed motions directing:

1. **Adoption of the revised Bylaws, as amended.**
   Implementation: The standing committees, Examination, Finance, and Nursing Practice and Education, were constituted. The Examination Committee included a LPN as a member. The Nursing Practice and Education Committee was charged with the coordination of four subcommittees. Revised offices and terms of office are reflected in the current slate presented by the Committee on Nominations.

2. **Adoption of the proposed revisions to the *NCLEX-RN™ Test Plan.***
   Implementation: Implementation of the *NCLEX-RN Test Plan* revision is scheduled for October 1995; antecedent activities such as re-evaluation of the passing standard and recoding of the item pool are underway and reported in other reports in this *Book of Reports*. Announcements of the revision and implementation date were made to educators via press release and *Issues* over the course of the year.

3. **Adoption of the revised *Model Nursing Administrative Rules*, and the changes to the *Model Nursing Practice Act.***
   Implementation: The changes were published and disseminated to Member Boards in November 1994. The revised versions have been provided to requestors.

4. **That the National Council provide Member Boards with a one-time list of foreign educated nurse credentialing agencies evaluated by the National Council based on the selection criteria established by the National Council.**
   Implementation: The list was provided to Member Boards; no further activity has occurred in this area.

5. **Adoption of the Model Guidelines: A Nondisciplinary Alternative Program for Chemically Impaired Nurses.**
   Implementation: The guidelines were distributed in the 1994 *Book of Reports* and are available, upon request, from the National Council.

6. **Establishment of a Special Services Division (SSD) to provide services or products primarily to parties other than Member Boards, in order to support the mission and programs and services of the National Council.**
   Implementation: A designated fund of $600,000 for the Special Services Division was authorized by the Board of Directors; administrative guidelines were adopted by the Board; Jennifer Bosma was appointed executive of the division; a report on the progress of the SSD is found in this *Book of Reports*.

7. **Authorization of the Board of Directors to provide internal funding for the study of the regulatory management of chemically impaired nurses.**
   Implementation: The Board of Directors established a designated fund of $255,000 for the study. The study is underway (see report in this *Book of Reports*) and completion is expected in FY96.

8. **That a central repository of literature review not be maintained, and rather that the National Council conduct a survey on Member Board actions, decisions, positions and opinions on the six common issues identified by the focus group and request information on the common practice issues which bring nurses to their boards for disciplinary action.**
   Implementation: The survey has been conducted, and is reported as an attachment to the Report of Staff Activities in this *Book of Reports*.

9. **That the *Disciplinary Process Flow Sheet and Criteria* be promoted as a resource for orientation of Member Board members and staff, and a framework for analysis that Member Boards may use in their discipline cases, and that additional disciplinary case analyses by a National Council focus group be developed only when identified by a specific need.**
   Implementation: Encouragement for use of the *Disciplinary Process Flow Sheet* for Member Boards has occurred by means of the *Newsletter* and in response to callers to the National Council. This framework has been used as a resource by the Disciplinary Investigators Task Force and by the Task Force to Study Regulatory Approaches to Sexual Misconduct Cases, which was a topic specifically requested by the 1994 Delegate Assembly.

10. **That the National Council study the issue of sexual misconduct as it relates to nurses' practice and that a model(s) be developed to assist Member Boards in making decisions regarding disciplinary action and that a progress report be presented at the next Delegate Assembly.**
    Implementation: A focus group was convened, and has prepared a report which is in this *Book of Reports.*

11. **That the Annual Meeting of the National Council be increased by one additional day, as soon as is feasible. At least one day of the Annual Meeting shall conclude no later than 4:00 p.m.**
    Implementation: It was possible for the new schedule to be implemented beginning with the 1995 Annual Meeting.

12. **That the National Council collect and analyze the results of current and past studies of the utilization of licensed and unlicensed nursing personnel with a report to the 1995 Delegate Assembly. The analysis should focus on the quality of nursing care delivered to the consumer and cost effectiveness.**
    Implementation: A thorough search of the literature was performed and all studies related to this topic were reviewed. A report is presented as an attachment to the Report of Staff in this *Book of Reports.*

13. **That the National Council write a letter to the American Hospital Association, American Organization of Nurse Executives, American Association of Homes for the Aging, American Nurses' Association, National League for Nursing, Citizen Advocacy Center, National Association of Practical Nurse Education and Service, National Federation for Licensed Practical Nurses, National Black Nurses' Association, American Health Care Association, American Medical Association, American College of Nurse-Midwives, National Association of Directors of Nursing in Long Term Care, National Hospice Association, American Association of Retired Persons, Federation of State Medical Boards, and such other organizations as the Board of Directors shall deem appropriate to express the National Council's position in unequivocal terms regarding the inappropriate use of unlicensed personnel in lieu of licensed nurses for the delivery of quality nursing care for the consumer as an expression of the National Council's commitment to the protection of the public health, safety and welfare.**
    Implementation: The letter was written and sent to the above-listed associations and others, dated August 24, 1994. It was also used as the basis for presentation of oral and written testimony before the Institute of Medicine panel studying the adequacy of nurse staffing.

14. **That the National Council perform a study exploring the regulatory, fiscal, and political implications of developing a "core" competency examination for nurse practitioners with a report to the 1995 Delegate Assembly; and that the National Council perform a study to identify core competencies of nurse practitioners with a report to the 1995 Delegate Assembly.**
    Implementation: Two task forces, with overlapping membership, were convened to perform these charges. Their reports appear in this *Book of Reports.*

15. **That the National Council establish a task force to: 1) develop a data base of advanced practice credentialing requirements (licensure, recognition, certification, authority to practice, etc.) for each Member Board with enough specificity for other Member Boards to**

make credentialing decisions; and 2) study whether additional mechanisms could be developed to facilitate interstate mobility of advanced practice nurses with a report to the 1995 Delegate Assembly.

Implementation: A task force was convened to perform this charge; its report appears in this *Book of Reports.*

13

FY95 ORGANIZATION PLAN AND BUDGET

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

Organization Plan

Including
FY95 Tactics

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its member boards of nursing on matters of common interest and concern affecting the public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

Goal I. **Licensure and Credentialing**

Provide Member Boards with examinations and standards for licensure and Credentialing.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

Tactic 1. Conduct a nurse aide job analysis study. (Staff)

Tactic 2. Evaluate alternative methodologies for conducting RN/PN job analysis studies. (Staff)

Tactic 3. Plan RN job analysis study. (Staff)

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

Tactic 1. Maintain and enhance licensure examinations based on current job analysis studies, including revision of the PN test plan and re-evaluation of the RN passing standard. (EC)

Tactic 2. Develop and implement mechanisms and policies for NCLEX content development, scoring, and performance analysis, including process for exploring new item types for NCLEX. (EC)

Goal I.B. (continued)

Tactic 3. Assure NCLEX is administered according to approved procedures; review and revise policies. (EC)

Tactic 4. Identify information needs and facilitate development of appropriate content for communications activities. (Staff)

Tactic 5. Maintain and enhance vendor relationships. (Staff)

Tactic 6. Complete planning for and implement post CAT implementation evaluation and follow-up. (CAT Evaluation Task Force)

Tactic 7. Assure education program reports for NCLEX are produced. (Staff and External focus group)

Tactic 8. Explore mechanisms to share NCLEX results among Member Boards. (Staff)

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

Tactic 1. Continue research and development on CST for use in initial RN licensure examinations including design of pilot study methodology. (Staff)

Tactic 2. Implement market research agenda. (Staff with consultant)

Tactic 3. Plan for development of applications of CST for nursing practice and education; as supported by market analysis. (Staff)

Tactic 4. Identify information needs and facilitate development of appropriate content for communications activities. (Staff)

Objective D. Provide a competency evaluation program for nurse aides.

Tactic 1. Maintain and enhance NACEP and related services. (NACEP Task Force)

Tactic 2. Identify information needs and facilitate development of appropriate content for communications activities. (Staff)

Goal I.D. (continued)

Tactic 3. Review efficacy of The Psychological Corporation's NACEP marketing plan and revise as necessary. (Staff)

Tactic 4. Conduct evaluation of The Psychological Corporation as NACEP test service. (Staff)

Tactic 5. Explore the possibility of Insight and the annual Nurse Aide conference as being revenue-producing endeavors. (Staff)

Objective E. Promote consistency in the licensure and credentialing process.

Tactic 1. Develop methodology to identify benefits and costs of nursing regulation. (Nursing Regulation Subcommittee)

Tactic 2. Develop a process for evaluation of the usefulness of models, practice acts and other position documents. (NP&E)

Tactic 3. Monitor issues related to licensure and credentialing including generic, advanced and special. (Staff)

Tactic 4. Monitor requirements under NAFTA, including reservations process. (Staff)

Tactic 5. Maintain clearinghouse of information regarding advanced nursing practice certification programs. (Staff)

Tactic 6. Explore the regulatory, fiscal and political implications of developing a "core" competency examination for nurse practitioners. (Task Force to Study Feasibility of a Core Competency Examination for Nurse Practitioners)

Tactic 7. Identify information needs and facilitate development of appropriate content for communications activities including promotion of advanced practice models to Member Boards. (Staff)

Tactic 8. Develop a database of advanced practice credentialing requirements. Study whether additional mechanisms could be developed to facilitate interstate mobility of advanced practice nurses. (Task Force to Study Advanced Practice Nurse Mobility)

Goal I.E. (continued)

Tactic 9. Provide information to Member Boards regarding issues affecting licensure, including generic, advanced, and special licenses. (Staff)

Tactic 10. Develop a licensure verification program to facilitate interstate endorsement. (Licensure Verification Task Force)

Objective F. Investigate mechanisms for evaluating continued competence.

Tactic 1. Identify continuing competencies that cross all areas of practice. (Essential and Continued Competence Subcommittee)

Tactic 2. Explore and evaluate options for assessing continued competence in multiple nursing settings. (Staff)

Tactic 3. Identify, explore, and evaluate potential tools to be used for the assessment of continued competence. (Staff)

Goal II. **Nursing Practice**

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

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

Tactic 1. Conduct validation study regarding non-nursing essential competencies. (Staff)

Tactic 2. Develop list of essential nursing competencies to assist Member Boards in the interpretation of the Americans with Disabilities Act. Begin list of non-nursing essential competencies. (Essential and Continued Competence Subcommittee)

Tactic 3. Develop strategies for addressing issues related to the provision of nursing care by unlicensed assistive personnel. Explore the benefits of a comprehensive study on the effects of nurse aide/assistant training on care provided in nursing homes. (Unlicensed Personnel Subcommittee)

Tactic 4. Work toward a description of the scope of nursing practice and nursing roles which would be useful in the context of a regulatory definition of nursing. (Staff)

Tactic 5. Identify needs for and facilitate development of content for communication activities including Delegation Paper. (Staff)

Tactic 6. Collect and analyze the results of current and past studies of the utilization of licensed and unlicensed nursing personnel. The analysis should focus on the quality of nursing care delivered to the consumer and cost effectiveness. (Staff)

Objective B. Develop documents regarding health care issues which affect safe and effective nursing practice.

Tactic 1. Monitor and provide information and analyses of the trends and issues related to the regulation of nursing practice in multiple settings. (Staff)

Goal II.B. (continued)

Tactic 2. Identify and articulate Board of Nursing strategies in promoting professional accountability in licensed nurses. (NP&E)

Tactic 3. Identify need for and facilitate development of content for communication activities. (Staff)

Objective C. Conduct research on regulatory issues related to disciplinary activities.

Tactic 1. Implement two-year research project to compare and evaluate the effectiveness of regulatory approaches for the management of chemically impaired nurses. (Task Force on Chemical Dependency Issues)

Tactic 2. Monitor Member Boards' regulatory approaches for management of chemically impaired nurses. (Staff)

Tactic 3. Conduct research project to compare and contrast disciplinary remedies used by Member Boards (HRSA funded). (Staff)

Objective D. Provide for Member Board needs related to disciplinary activities.

Tactic 1. Promote and maintain 100% Member Board participation for reporting to the Disciplinary Data Bank. (Staff)

Tactic 2. Promote electronic access to the Disciplinary Data Bank. (Staff)

Tactic 3. Develop and implement electronic reporting by Member Boards compatible with the National Practitioner Data Bank. (Staff)

Tactic 4. Collect, analyze data and distribute reports periodically regarding types of violations and actions. (Staff)

Goal II.D. (continued)

Tactic 5. Implement and evaluate "add-on" session to CLEAR's NCIT course which focuses on nursing/health professions investigations. (Task Force to Implement Educational Programs for Disciplinary Investigators)

Tactic 6. Identify needs for and facilitate development of content for communications activities including discipline resources addressing quality of care cases, Disciplinary Process Flow Sheet and Criteria, expert witnessing. (Staff)

Tactic 7. Study the issue of sexual misconduct as it relates to nurses' practice and develop model(s) to assist Member Boards in making decisions regarding disciplinary action. (Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group)

Tactic 8. Conduct a survey on Member Board actions, decisions, positions and opinions on the six common issues identified by the Literature Review Focus Group and request information on the common practice issues which bring nurses to their boards for disciplinary action. (Staff)

Objective E. Review and analyze actions of government and other entities that affect the regulation of nursing practice.

Tactic 1. Monitor and provide analysis regarding the regulatory implications for nursing practice posed by current or proposed federal laws, as well as case law, including but not limited to the Americans with Disabilities Act. (Staff)

Tactic 2. Monitor and provide analyses regarding the regulatory implications for nursing practice posed by current or proposed state laws. (Staff)

Tactic 3. Monitor and provide analyses of major nursing research which may affect the regulation of nursing practice. (Staff)

Tactic 4. Identify need for and facilitate development of content for communication activities. (Staff)

Tactic 5. Determine advocacy role of National Council on federal/ national level. (BOD)

Goal II.E. (continued)

Tactic 6. Monitor and provide information and analyses of the effects of health care reform on the regulation of nursing practice. (Staff)

Goal III. **Nursing Education**

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

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

Tactic 1. Based on a review of Member Board role in the regulation of nursing education, identify needs and plan strategies for assisting Member Boards. (Member Board Education Needs Subcommittee)

Tactic 2. Identify needs for and facilitate development of content for communication activities. (Staff)

Objective B. Develop documents regarding issues that affect the regulation of nursing education.

Tactic 1. Monitor and provide information and analyses of the effects of health care reform on the regulation of nursing education. (Staff)

Objective C. Provide for Member Board needs related to the approval process of nursing education programs.

Tactic 1. Implement educational program for Member Board nursing education program surveyors. (Task Force to Implement Educational Programs for Nursing Education Program Surveyors)

Objective D. Review and analyze the actions of government and other entities that affect the regulation of nursing education.

Tactic 1. Monitor and provide analyses regarding regulatory implications for nursing education posed by current or proposed federal laws, as well as case law, including but not limited to the Americans with Disabilities Act. (Staff)

Goal III.D. (continued)

Tactic 2. Investigate and provide analysis regarding the regulatory implications for nursing education posed by current or proposed state laws, proposed state legislation and state initiatives. (Staff)

Tactic 3. Monitor and provide analyses of major nursing research which may affect the regulation of nursing education. (Staff)

Tactic 4. Identify need for and facilitate development of content for communication activities. (Staff)

Tactic 5. Monitor and provide information and analyses of the trends and issues related to the regulation of nursing education. (Staff)

Goal IV. Information

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

Objective A. Implement a comprehensive repository of information.

Tactic 1. Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions. (Staff)

Tactic 2. Compile and disseminate abstracts of completed, ongoing and projected studies by Member Boards and the National Council. (Staff)

Tactic 3. Develop and launch the highest priority information services, including: master database, electronic document retrieval system (EDRS), DDB report submission, incorporate SNLQ into EDRS, and forms & templates; as well as services already in process: EIRs, NCLEX candidate data, telecommunications capability. (Staff and focus groups)

Tactic 4. Plan for appropriate maintenance of all information services. (Staff)

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

Tactic 1. Develop a licensee database. (Staff)

Tactic 2. Continue development of policies for management and use of NIS database. (NIS)

Tactic 3. Develop a marketing plan for the NIS. (Staff with consultant)

Tactic 4. Initiate pre-marketing of NIS data as indicated by market analysis outcomes. (Staff)

Goal IV (continued)

Objective C. Provide consultative services for Member Boards.

Tactic 1. Provide or identify resources to meet individual information needs of Member Boards. (Staff)

Tactic 2. Facilitate individual Member Boards' research activities. (Staff)

Tactic 3. Identify current services provided by National Council staff and facilities; organize, package and promote these as "Resource Network". (Staff)

Objective D. Facilitate communication between National Council, Member Boards and related entities.

Tactic 1. Maintain and enhance communications between and among the National Council and Member Boards. (Staff)

Tactic 2. Maintain and enhance meeting opportunities between the National Council and Member Boards. (Staff and Continuing Education Offerings Task Force)

Tactic 3. Create communications among National Council groups, consultants and contractors. (Staff)

Tactic 4. Enhance the public image and importance of nursing regulation via a variety of communications vehicles, liaison relationships and meeting opportunities, i.e., a public image campaign. (role of boards of nursing and board members, models, papers: Delegation, School Nurse). (Staff, BOD)

Tactic 5. Plan and select National Council sponsored continuing education programs. (Educational Programs Task Force)

Tactic 6. Create communications and dialogue opportunities that support and enhance the Executive Officers' Network. (Executive Officers' Network)

Tactic 7. Create a program for orientation of Member Board executive officers aimed to develop leaders in nursing regulation and administration. (Executive Officers' Network Orientation Task Force)

Goal IV (continued)

Objective E. Conduct and disseminate research pertinent to the mission of the National Council.

Tactic 1. Identify research proposals which merit funding. (Staff)

Tactic 2. Facilitate research activities of National Council committees, task forces, staff groups, etc. (Staff)

Tactic 3. Disseminate conclusions of role delineation study. (Staff)

Tactic 4. Identify needs for and facilitate development of content for communication activities. (Staff)

Tactic 5. Identify core competencies of nurse practitioners. (Task Force to Identify Core Competencies for Nurse Practitioners)

Goal V. **Organization**

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

Objective A. Implement a planning system to guide the National Council.

Tactic 1. Reach organizational consensus on future direction. (BOD)

Tactic 2. Review goals and objectives in light of identified future direction and propose modifications, additions and deletions to the Delegate Assembly. (LRP)

Tactic 3. Implement a process for long range planning which will ensure focused movement toward attaining the vision over the next five years. (BOD)

Tactic 4. Assess goals and objectives for alignment with future direction. (LRP)

Tactic 5. Facilitate intraorganizational coordination and effectiveness. (Staff)

Tactic 6. Create workplan for FY96 with linkage to Organization Plan and budget. (Staff)

Objective B. Implement a fiscal resource management system.

Tactic 1. Review and revise financial forecast assumptions to maintain a current forecasting model. (FC)

Tactic 2. Oversee use of the organization's assets to assure prudence and integrity of fiscal management and responsiveness to Member Boards' needs. (FC)

Tactic 3. Implement a program budgeting system, including the financial reporting changes mandated by the Financial Accounting Standards Board. (Staff)

Tactic 4. Assure that a proposed annual budget is presented to the Board of Directors prior to the beginning of the fiscal year. (FC)

Goal V.B. (continued)

Tactic 5. Maintain financial policies which provide guidelines for fiscal management. (FC)

Tactic 6. Develop non-dues, non-NCLEX revenue sources for the organization. (Staff)

Tactic 7. Implement plan for comparisons of National Council financial operation ratios to benchmark ratios in selected areas over the next four years. (Staff)

Tactic 8. "Fine-tune" the program budgeting process (by charging more elements of expense directly to the Organization Plan objectives and allocating remaining overhead to objectives.) (Staff)

Tactic 9. Decide and implement decision regarding equity investments and use of an investment manager. (FC)

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

Tactic 1. Identify needs for and create task forces and other committees to address specific topics important to the National Council's mission. (BOD)

Tactic 2. Manage National Council resources to effect the goals of the organization. (Staff)

Tactic 3. Review and evaluate articles of incorporation, bylaws, and policies to promote an appropriate organizational framework. (BOD)

Tactic 4. Assure a slate of qualified candidates. (CON)

Tactic 5. Assess organizational coordination and effectiveness. (BOD)

FY95 Budget - 10/1/94 - 9/30/95
By Program

UNRESTRICTED/UNDESIGNATED FUNDS:

Licensure Examinations		
NCLEX Exam Revenue	(17,952,000)	
NCLEX Processing Costs	12,036,000	
Review Fees	(30,000)	
Review Costs	26,325	
Other NCLEX Related Expense	1,800	
Exam Committee	204,272	
Subcommittee for Exam Administration	36,251	
CAT Evaluation Task Force	31,220	
NCLEX Panel of Judges	21,425	
Joint Research Committee	33,350	
NCLEX Program Reports Focus Group	16,745	
PN Test Plan Retreat	21,716	
Task Force to Study Feasibility of a Core Competency Examination for Nurse Practitioners	40,600	
NCLEX Support Costs	96,900	
NCLEX Income Subtotal		(5,415,396)
NACEP		
Royalty Income	(375,000)	
Marketing/Staff Travel	11,050	
Other NACEP Expense	12,755	
NACEP Income Subtotal		(351,195)
Investments		
Investment Income	(385,000)	(385,000)
Member Boards		
Member Board Contract Income	(183,000)	
Associated Exp. (Legal and Other)	4,000	
Member Board Income Subtotal		(179,000)
Delegate Assembly		
Delegate Assembly Income	(57,975)	
Delegate Assembly Expense	134,506	
Delegate Assembly Subtotal		76,531
Area Meetings		
Area Meetings Board Travel	21,200	
Area Meetings Staff Travel	21,200	
Area Meetings Expense Subtotal		42,400
Communications		
Honoraria	(3,500)	
Communications Projects Revenue	(162,265)	
Communications Projects Expense	419,975	
Continuing Education Offerings Task Force	13,106	

Executive Officers' Network Orientation Task Force	18,200	
Communications Expense Subtotal		285,516
Research		
Validation of Essential Competencies Study	59,367	
Job Analysis Monitoring Panel	20,606	
Task Force to Identify Core Competencies for Nurse Practitioners	44,768	
Task Force on Chemical Dependency Issues	21,636	
Revision of Job Analysis Methodology	10,000	
Supplemental Fund	9,240	
RN Job Analysis	11,300	
Nurse Aide Job Analysis Study	109,325	
Other	32,115	
Research Expense Subtotal		318,357
Practice and Education		
Public Policy Expense	17,450	
Unlicensed Personnel Subcommittee	14,148	
Nursing Regulation Subcommittee	13,610	
Nursing Practice and Education Committee	14,440	
Disciplinary System	(2,560)	
Task Force to Implement Educational Programs for Disciplinary Investigators	15,333	
Disciplinary Guidelines for Managing Sexual Misconduct Cases Focus Group	11,195	
Task Force to Study Advanced Practice Nurse Mobility	14,200	
Member Board Education Needs Subcommittee	5,316	
Task Force to Implement Educational Programs for Nursing Education Program Surveyors	6,439	
Essential & Continued Competence Subcommittee	35,771	
Practice and Education Expense Subtotal		145,342
Organizational		
Board of Directors	105,550	
Committee on Nominations	14,785	
Finance Committee	29,700	
Bylaws Task Force	4,190	
Long Range Planning Task Force	18,926	
Resolutions Committee	8,250	
Organizational Expense Subtotal		181,401
Administration		
Personnel Costs		
Salary and Benefits	2,550,003	
Staff Travel	5,500	
Staff Development	55,500	
Temporary Help	40,000	
Professional Fees		
Legal	29,000	
Accounting	22,000	
Data Processing Consultants	65,000	
Computer Training	16,000	

Telecommunications Consultants	23,000	
Other	10,000	
Library/Memberships	9,900	
Printing/Supplies	104,300	
Insurance	35,000	
Computer Related Costs	21,200	
Information Master Plan Focus Group	23,000	
Miscellaneous Expense	6,600	
Rent/Utilities	251,000	
Telecommunication Charge - NCNET	47,500	
Telephone	45,000	
Telecommunications - Other	5,800	
Postage	70,000	
Equipment Maintenance/Rental	33,500	
Computer Maintenance/Rental	135,100	
Depreciation	337,662	
Administration Expense Subtotal		3,941,565

Summary

Unrestricted/Undesignated Funds:		
Total Revenue	(19,174,700)	
Total Expense	17,835,221	
Revenue Over Expense		(1,339,479)
Designated Funds:		
Role Delineation	15,000	
Computerized Clinical Simulation Testing	702,603	
Nurse Information System	45,792	
Chemically Impaired Nurses Research Study	121,349	
Special Services Division	100,000	
Designated Funds Subtotal		982,744
Restricted Funds:		
Robert Wood Johnson Grant Revenue	(277,182)	
Nurse Information System Expense	277,182	
HRSA Grant Revenue	(25,000)	
HRSA Expense	25,000	
Restricted Subtotal		0

Summary

All Funds		
Revenue	(19,476,882)	
Expense	19,120,147	
Revenue Over Expense		(356,735)

14 ORIENTATION MANUAL

National Council of State Boards of Nursing, Inc.

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the functions and operations of the National Council. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as Board of Directors and committee members.

Following a brief discussion of the National Council's history, this manual will describe the organization's structure, functions, policies, and procedures. More descriptive information on the National Council is available in a published orientation portfolio, available through the communications department.

History

The concept of an organization such as the National Council had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses' Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for persons involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of Nursing also worked with the National League for Nursing Education (NLNE) which, in 1932, became the ANA's Department of Education. In 1933, by agreement with the ANA, the NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, the NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published A Curriculum Guide for Schools of Nursing. Two years later, the NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine scorable form. In 1943, the NLNE Board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the "State Board Test Pool Examination" or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA Board appointed the Committee for the Bureau of State Boards of Nurse Examiners which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that it be replaced by a council. Although council status was achieved, many persons continued to be concerned about potential conflicts of interest and recognized the often heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body.

At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of the ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from the ANA to form the National Council of State Boards of Nursing.

Today, the National Council's membership consists of 61 boards of nursing, including those of the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands. An organizational chart depicting the relationship between the National Council and its Member Boards is attached (Appendix A).

Organizational Mission, Objectives, and Goals

The mission of the National Council of State Boards of Nursing is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. It strives to accomplish this mission by acting in accordance with the decisions of its Member Boards of nursing on matters of common interest and concern affecting public health, safety and welfare. To accomplish its aims, the National Council provides services and guidance to its members in performing their functions which regulate entry to nursing practice, continuing safe nursing practice and nursing education programs.

The National Council has several objectives, one of which is to develop and establish policy and procedure regarding the use of licensure examinations in nursing. Another is to identify and promote desirable uniformity in standards and expected outcomes in nursing education and practice as they relate to the public interest. The National Council also seeks to assess trends and issues that affect nursing, disseminate data relating to nurse licensure, and promote continued competence in nursing. To achieve these objectives, it plans and promotes educational programs; it provides consultative services for Member Boards and others; and conducts research that addresses education, practice, and policy-related issues. Strategies for achieving these goals are developed in accordance with organizational objectives and reflect the National Council's mission. The National Council's organization plan adds short-term activities and resources designed to accomplish the long-range goals, objectives and tactics. Activities to implement goals 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 and committees participate in evaluating the accomplishment of goals and objectives and the directives of the Delegate Assembly.

Organizational Structure and Function

Membership

Membership in the National Council is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by the National Council. At the present time, there are 61 Member Boards including those from the District of Columbia, the Virgin Islands, Puerto Rico, 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™ and/or NCLEX-PN™.

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 the National Council's licensure examinations. Member Boards also receive information services, public policy analyses, and research services. Member Boards who fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

Areas

The National Council's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues, and provide diversity of board and committee representation. Area directors are elected by delegates from their respective Areas through a majority vote of the Delegate Assembly. In addition, there are two directors-at-large who are elected by all delegates voting at the annual meeting. (See Glossary for list of jurisdictions by Area.)

Delegate Assembly

The Delegate Assembly is the major policy-making body of the National Council and comprises delegates designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates.

The Delegate Assembly meets at the National Council's annual meeting, traditionally held in August. Special sessions can be called under certain circumstances. Regularly scheduled sessions take place in Chicago every third year. In the years between, sessions are held in other cities on a rotation basis among Areas.

At the annual meeting, delegates elect officers and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and approve the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly approves most test-related decisions, including changes in examination fees and test plans.

Officers

Officers of the National Council include the president, vice-president, treasurer, four Area directors, and two directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate or 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 a term 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 a term of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term.

Officers are elected by ballot during the annual session of the Delegate Assembly. Area directors are elected by delegates from their respective Areas.

Election is by a majority vote. When a majority is not established by an initial ballot, re-balloting takes place between the two nominees with the highest number of votes. In case of a tie on the re-balloting, the choice is determined by lot.

Officers assume their duties at the close of the session at which they were elected. A vacancy in the office of president is filled by the vice-president. Other officer vacancies are filled by Board appointees until the term expires.

Board of Directors

The Board of Directors, the administrative body of the National Council, consists of the nine elected officers. Its primary function is to conduct the business of the National Council between sessions of the Delegate Assembly. The Board authorizes the signing of contracts including those between the National Council and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards, and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to the National Council's purpose, and provision for the establishment and maintenance of the administrative offices.

Meetings of the Board of Directors

Meeting dates for the year are finalized by the Board of Directors during its post-annual meeting Board meeting. All Board meetings are held in Chicago with the exception of the pre- and post-annual meeting Board meetings in those years when the annual meeting is conducted outside of Chicago.

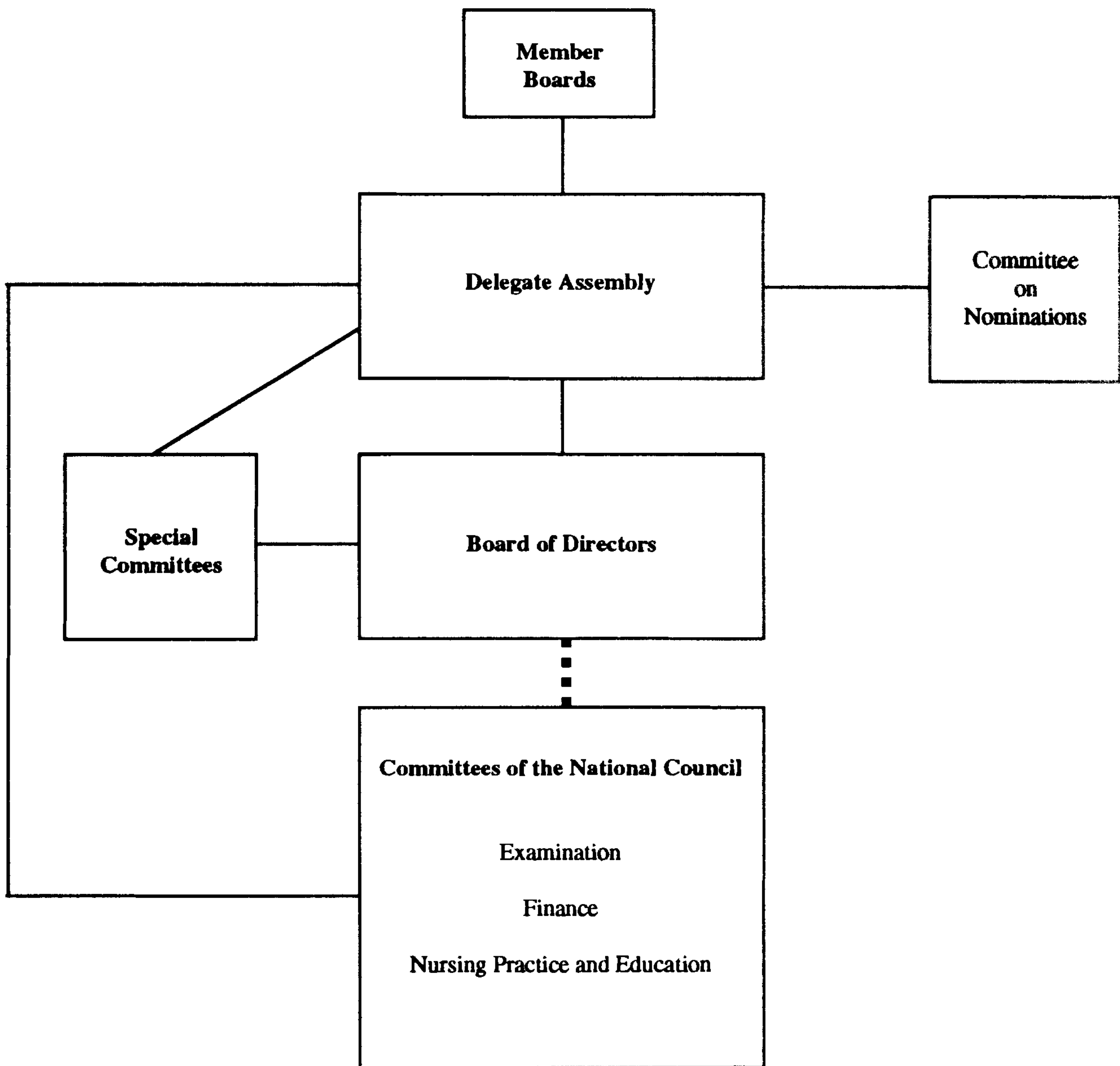
Board officers are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials

Appendix A

National Council of State Boards of Nursing, Inc.

Organization

As of June 1, 1995



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Board officers are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials

are mailed to Board officers two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the biweekly *Newsletter*.

Activities and materials generated during the two-week interval before the meeting are reported or distributed at the next meeting. This limits the flood of last-minute information to be distributed, read and considered during the Board meeting.

The agenda is generally organized around committee and staff reports in the various program areas. Items for Board discussion and action are accompanied by a memo or report which describes the item's background and indicates the Board action needed. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting. A summary of the Board's major decisions is also prepared and mailed to Member Boards for their information prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board officer for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the National Council office and include copies of the articles of incorporation and bylaws, policies and procedures, contracts, organization, budget, test plan, committee rosters, minutes, and personnel manual.

Communications with the Board of Directors

Communication between Board meetings takes place in several different ways. The executive director communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. The executive director and treasurer also discuss the budget on a quarterly basis after the accountant has had the opportunity to compile the necessary financial data. Quarterly reports of major activities are prepared by the executive director and provided to Board officers.

In most instances, the executive director is the person responsible for communicating with National Council consultants about legal, financial, and accounting concerns. This practice was adopted primarily as a way to monitor and control the costs of consultant services.

Conference calls can be scheduled, if so desired by the president. Written materials are generally forwarded to Board officers in advance of the call. These materials include staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board officers use the National Council letterhead when communicating as representatives of the National Council.

Committee on Nominations

National Council delegates elect representatives to the Committee on Nominations. The committee consists of four persons, one from each Area, who may be either board members or staff of Member Boards. Committee members are elected to one-year terms. They are elected by ballot with a plurality vote. The chair is that person who receives the highest number of votes.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director office and for the committee itself. The committee then prepares a slate for each position to be filled. During the Delegate Assembly, additional nominations may be made from the floor.

Committees

Most of the National Council's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Delegate Assembly or Board of Directors. At the present time, the National Council has three standing committees: Examination, Finance, and Nursing Practice and Education.

Committees and special committees are appointed by the Board of Directors to address special issues and concerns. Examples of special committees include the Nurse Aide Competency Evaluation Program Task Force, the Nurse Information System Task Force and the Licensure Verification Task Force.

Committees are governed by specific policies and procedures which may be found in National Council's policy manual. Committee membership is extended to all current members and staff of Member Boards. An effort is made to achieve balanced representation whenever possible, including Area, staff and Board members, registered and practical/ vocational nurses, and consumers. Consultants provide outside expertise to committees as needed, on a one-time or ongoing basis.

A National Council staff member is assigned to serve each committee. Staff work closely with the committee chairs to facilitate committee work and provide support and expertise to committee members, but they have no formal decision-making role. Agendas for the committee meetings are established by the chair. With staff assistance, the chair prepares the agenda, the call to meeting, and any other documents that must be reviewed prior to committee meetings. Staff supervises the mailing of these materials, which are sent to committee members no less than two weeks before the committee meeting.

At the request of committee members, staff will analyze issues and make recommendations in accordance with committee objectives and assumptions.

Examination Committee

The Examination Committee consists of at least six persons, including one representative from each Area. One of these persons must be a licensed practical/vocational nurse. The committee chair must have served on the committee prior to being appointed chair. Alternates to the Examination Committee are generally individuals with prior experience on a testing-related committee. Alternates to the Examination Committee may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member.

The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests research important to the development of licensure examinations.

The Examination Committee provides general oversight of the NCLEX™ process, including examination item development, security, administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, 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 the National Council's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is key to this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation. There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills, and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a cut score to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected for this process. They are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a cut score. Taking this outcome along with other data relevant to identification of the level of minimum competence, the Board of Directors sets a passing standard which distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes is the best legal defense available for licensing examinations. For most of the possible challenges that candidates might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

Finance Committee

The Finance Committee is comprised of one representative from each Area and the treasurer, who serves as the chair. The committee's primary purpose is to supervise National Council finances, subject to the Board of Directors' approval. It also reviews financial status on a quarterly basis and provides the Board with a proposed annual budget prior to each new fiscal year.

Nursing Practice and Education Committee

The Nursing Practice and Education Committee consists of at least one representative from each Area. The committee's purpose is to provide general oversight of nursing practice and education regulatory issues. It periodically reviews and revises the *Model Nursing Practice Act* and the *Model Nursing Administrative Rules,* and prepares other position statements and guidelines occasionally for presentation to the Delegate Assembly. It also prepares written information about the legal definitions and standards of nursing practice and education which it disseminates to Member Boards and other interested parties. In the recent past, the committee has had a number of subcommittees to study various issues, e.g., continued competence, advanced practice and changing trends in nursing education.

National Council Staff

National Council staff members are hired by the executive director, to whom they report. Their primary role is to implement the Delegate Assembly's policy directives and provide assistance to the Board of Directors and committees.

The National Council staff is organized into departments for the purpose of meeting the organizational objectives. The Testing Services Department exists to accomplish the National Council's primary objective, which is to develop and establish examination-related policy and procedure. Other staff members are assigned to the Departments of: Research Services; Communications; Nursing Practice and Education; Public Policy; Operations and Administration Services to assist the National Council to meet its other objectives. A list of staff and their respective titles can be found behind Tab 5.

General Delegate Assembly Information

Agendas for each session are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days before the annual meeting, Member Boards are sent copies of the *Book of Reports.* This document contains annual reports and recommendations from the standing committees, Board of Directors, officers, and executive director, as well as new business submitted by any member or the Board. It also contains the agenda and operating budget, as well as proposed rules for the conduct of Delegate Assembly business.

Prior to the annual session of the Delegate Assembly, the president appoints the Rules, Credentials, Elections, and Resolutions Committees as well as the Committee to Approve Minutes. Prior to any special session, the president appoints at least the Rules and Credentials Committees. In either case, the president must also appoint a timekeeper, a parliamentarian, and pages.

The purpose of the Rules Committee is to draft, in consultation with the parliamentarian, rules for the conduct of the specific Delegate Assembly. The Credentials Committee's function is to provide delegates and alternates with identification bearing the number of votes to which the individual is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to National Council's goals and fiscal impact to the organization. At a time designated by the president, it reports its recommendations to the Delegate Assembly.

Minutes of the Delegate Assembly are kept by the executive director, who serves as secretary (beginning with the 1996 Annual Meeting). These minutes are then reviewed, corrected as necessary, and approved by the Committee to Approve Minutes.

The duties of the Delegate Assembly, as specified in the bylaws, are to:

- approve new National Council memberships;
- elect officers and members of the Committee on Nominations;
- receive reports of officers and committees and take action as appropriate;
- approve any examination fee to be charged by the National Council;
- approve the auditor's report;
- approve policy and position statements;
- adopt the mission, goals and objectives of the National Council;
- approve the substance of all contracts between the National Council and Member Boards and the National Council and test services;
- establish the criteria for and select the test service(s) to be utilized by the National Council unless the National Council provides such services itself;
- adopt test plans to be used for the development of licensing examinations in nursing; and
- transact any other business as may come before it.

General Committee Information

Committee Appointments

The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and to ensure a wide representation of Member Boards, board staff and board members, the following procedure is used.

Individuals who wish to be considered for appointment or reappointment to a National Council committee/special committee submit a Committee Volunteer Information Form. All information from this form, along with information about the number of positions available on each committee, is forwarded to the respective Area director for recommendations for appointment or reappointment. Concurrently, committee chairs are asked to provide input as to whether individuals currently serving on committees should be reappointed. The Area directors recommend the appointment/reappointment of individuals to vacant positions. The Area directors' decisions are based on input received from committee chairs, as well as information obtained from the individuals' volunteer information form.

Prior to the Annual Meeting, the Board of Directors evaluates the qualifications of existing and potential committee chairs, makes the appropriate appointments for committee chairs, and reviews and approves the committee/special committee appointments that were recommended by Area directors. During the Board's post-Delegate Assembly meeting, appointments are made to any additional special committees required to accomplish the directives of the Delegate Assembly.

Committee Minutes

Minutes are taken at every committee meeting including telephone conference calls. Minute-taking is an extremely important responsibility because minutes serve as records of what took place at the meeting. Although minutes can be opposed by oral testimony, they are, in the vast majority of cases, legally binding once they have been adopted and certified. Thus, it is crucial that they accurately reflect the committee's process and outcomes.

Committee minutes are taken by committee members or staff. If no one volunteers to take the minutes, the committee chair may appoint someone to serve as secretary. Whomever takes the minutes should remember to:

- record the date, place, and time of the meeting
- include a statement that the meeting was duly called
- indicate the presiding officer, chair, or committee member
- indicate who served as secretary
- record names of persons present and quorum statistics
- record the reading, correction, and adoption of minutes from the previous meeting
- record the adjournment time
- keep them clear and concise
- not include every routine document
- make amendments to the minutes only with the committee's approval
- initial any amendments

Minutes from National Council Board and committee meetings follow a specific format. With rare exception, they should reflect the topic discussed and the comments and/or actions that followed.

On the advice of legal counsel, the minutes of the discussion should not be laden with unnecessary detail or use a "he said/she said" approach. In other words, it is not desirable for the secretary to transcribe verbatim statements. Only in special circumstances is it necessary to identify individual speakers since the minutes should reflect committee discussion as well as committee action.

Whenever possible, the secretary should leave a handwritten copy of the minutes with the staff person assigned to the committee meeting. The staff person will then have the minutes typed and forwarded to the committee members with the next meeting's agenda. This procedure not only relieves the committee member of an additional burden; it also safeguards the minutes from loss. It also provides the committee chair with information to prepare the next meeting's agenda. In the event that the minutes cannot be left with the staff person, they should be forwarded to the National Council office within two weeks.

Committee Reports

Committee reports are sent to the National Council office no later than three weeks prior to each Board of Directors' meeting. The reports are written by the committee chair who is assisted by the committee staff person. Staff processes the reports and supervises their mailing.

The first page of the report contains committee recommendation(s). Subsequent pages document the committee's activities in either narrative or outline format. Background and rationale for the committee's recommendation(s) should be clearly stated. The report concludes with a reiteration of the committee's recommendation(s), and fiscal impact and legal comments are indicated.

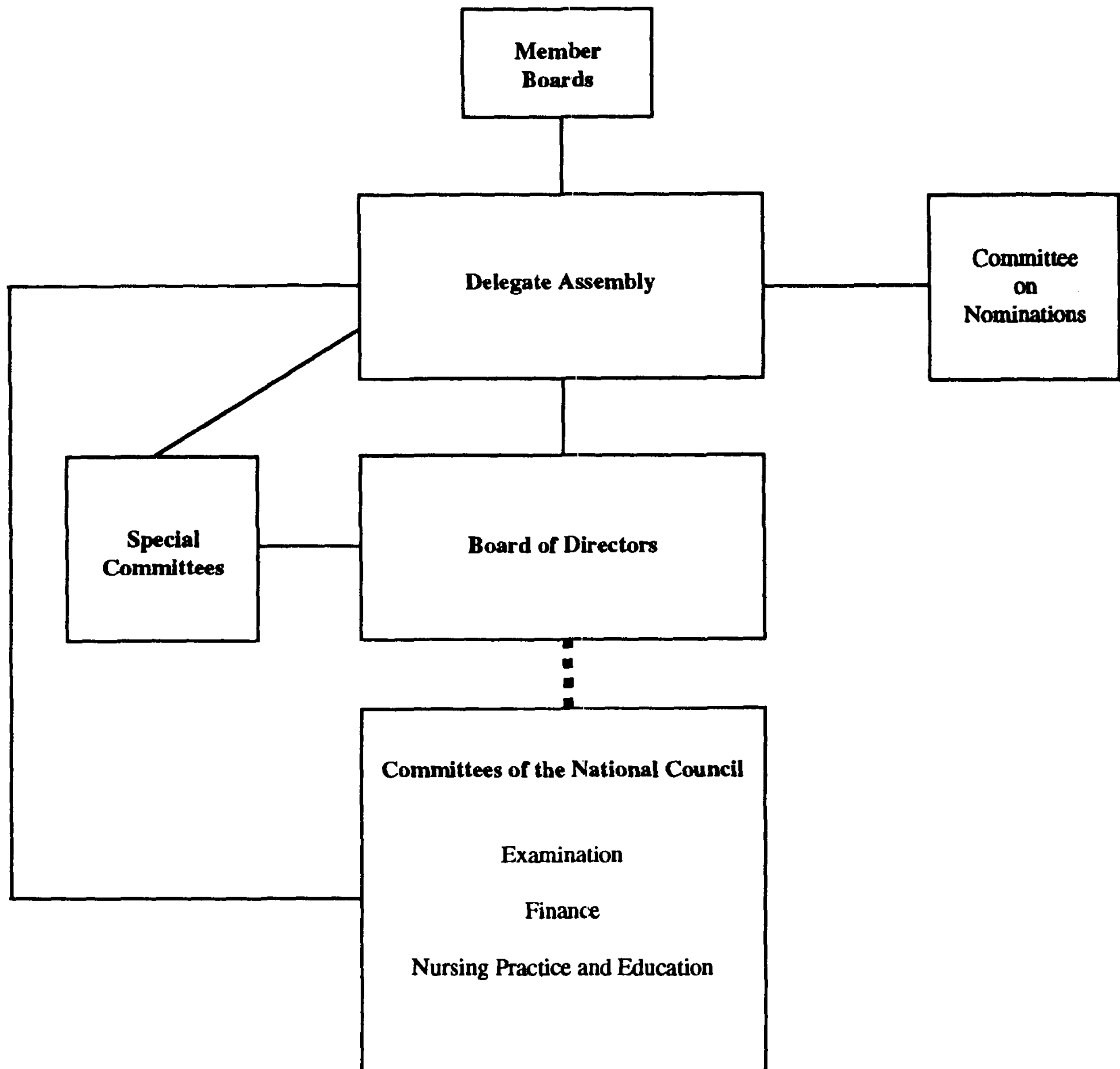
A summary of every committee meeting is reported to the membership via the *Newsletter* that follows the close of the individual meeting.

Appendix A

National Council of State Boards of Nursing, Inc.

Organization

As of June 1, 1995



15

GLOSSARY

Glossary

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American Association of Colleges of Nursing.

AANP
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ACNM
ACNM Certification Council, Inc.

ADA
Americans with Disabilities Act.

ANA
American Nurses' Association.

ANCC
American Nurses' Credentialing Center.

AONE
American Organization of Nurse Executives.

APN/APRN/ARNP
Advanced Practice Nurse/Advanced Practice Registered Nurse/Advanced Registered Nurse Practitioner. This level of nursing practice is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care.

Area
Designated geographic regions of National Council Member Boards.

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

Blueprint
The organizing framework for an examination which includes the percentage of items allocated to various categories.

Board Member
An individual who serves on a board of directors (national level) or a board of nursing (state level).

BOD
Board of Directors of the National Council of State Boards of Nursing.

Bylaws
The laws which govern the internal affairs of an organization.

CAC
Citizen Advocacy Center.

CAT
Computerized Adaptive Testing.

CCNA
Council on Certification of Nurse Anesthetists.

CDC
Case Development Committee. A committee of clinical experts which has the responsibility of developing cases for the Computerized Clinical Simulation Testing (CST®) project.

CGFNS
The Commission on Graduates of Foreign Nursing Schools. (An agency providing credentialing services for foreign educated nurses, as well as a certification program designed to predict success on NCLEX-RN™)

CLEAR
Council on Licensure, Enforcement and Regulation. (An organization of regulatory boards and agencies)

CNATS
Canadian Nurses Association Testing Service.

CNM
Certified Nurse Midwife.

CNS
Clinical Nurse Specialist.

CON
Committee on Nominations. The elected committee of the National Council responsible for preparing a slate of qualified candidates for each year's elections. The Committee on Nominations' members serve one-year terms.

CRNA
Certified Registered Nurse Anesthetist.

CST®
Computerized Clinical Simulation Testing.

CTB/McGraw-Hill
National Council's test service for the NCLEX™ paper-and-pencil development and administration, 1981-1994.

Decision Consistency
A test statistic that indicates the expected consistency of pass or fail classification decisions across different administrations of the examination. It is concerned only with classification accuracy, not with the precision of the numerical test scores, as is the reliability statistic used with paper-and-pencil examinations.

Delegate Assembly
The policy-making body of the National Council which comprises 61 Member Boards. Each Member Board is entitled to two votes.

Diagnostic Profile
The document sent to failing candidates reflecting their performance on various aspects of the NCLEX test plan.

DIF
Differential item functioning, or a measure of potential item bias.

Direct Registration
A method of submitting candidate registrations for NCLEX. Registrations are submitted by candidates, with the $88 fee, directly to ETS. The option for telephone registration is available for $97.25.

Disciplinary Data Bank (DDB)
A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards.

EC
Examination Committee.

Education Program Reports
See *NCLEX™ Program Reports.*

EDWARD
Electronic Document Warehousing And Retrieval Database. System to provide guided electronic access to all National Council documents and publications. Nurse practice acts and administrative rules will be made available first, followed by position papers and other frequently requested documents. Part of the Information Master Plan (IMP).

EIRs
Electronic Irregularity Reports. Reports written by the test center staff on the day of testing regarding any irregularities occurring during NCLEX testing. These reports are forwarded overnight to ETS, the National Council and the Member Board where the candidate is seeking licensure.

Electronic Access
Member Boards' direct inquiry of the National Council Disciplinary Data Bank via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

ETS
Educational Testing Service. National Council's test service for NCLEX using computerized adaptive testing, located in Princeton, New Jersey. ETS also engages in educational and certification testing services.

Experimental Items
Newly written test questions placed into examinations for the purpose of gathering statistics. Experimental items or "tryouts" are not used in determining the pass/fail result.

FARB
Federation of Associations of Regulatory Boards.

Fiscal Year (FY)
October 1 to September 30 at the National Council.

HCFA
Health Care Financing Administration. (A unit of the federal government under the Department of Health and Human Services)

HRSA
Health Resources and Services Administration. (A unit of the federal government under the Department of Health and Human Services)

ICN
International Council of Nurses.

ICONS
The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing; the American Association of Critical Care Nurses; the American Organization of Nurse Executives; the American Nurses' Association; the Bureau of Labor Statistics, the Division of Nursing (BHPR, HRSA); the National Center for Health Statistics; the National Council of State Boards of Nursing; the National League for Nursing; and the American Association for Nurse Anesthetists.

IMP
Information Master Plan. Strategy to fulfill the Organization Plan's tactic, "Implement a comprehensive repository of information." The IMP will include electronic submission of information to the Disciplinary Data Bank; the Nurse Information System; electronic archives (see EDWARD); databases of organization-related information (see SAHVI); and other on-line resources for the National Council's Member Boards, staff and other appropriate audiences.

Insight
A triannual newsletter discussing issues related to nurse aides and assistive personnel, delegation to UAPs, and the NACEP.

Issues
A quarterly newsletter published and nationally distributed by the National Council.

Item
A test question.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses. Their use enables many measurement benefits (see Rasch Model).

Item Reviewers
Individuals who review newly written items developed for the NCLEX-RN™ and NCLEX-PN™.

Item Writers
Individuals who write test questions for the NCLEX-RN, NCLEX-PN and NACEP.

JRC
Joint Research Committee. This committee consists of three National Council and three ETS staff members, and two external researchers. The committee is the vehicle through which research is funded for the NCLEX program. Funding is provided jointly by the National Council and ETS.

KSA
Knowledge, Skill and Ability statements.

Logit
A unit of measurement used in IRT models. The log transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

LRP
Long Range Planning. (A task force of the National Council)

MNAR
Model Nursing Administrative Rules. (A publication of the National Council)

Mantel-Haenszel
A well-accepted statistical procedure used to estimate the differential item functioning or potential bias of test items.

MBOS
Member Board Office System. The software used in many Member Board offices to communicate electronically with ETS regarding NCLEX candidates.

Member Board
A jurisdiction having a contract with the National Council to administer NCLEX-RN and/or NCLEX-PN.

MNPA
Model Nursing Practice Act. (A publication of the National Council)

NACEP™
Nurse Aide Competency Evaluation Program. (Also a task force of the National Council)

NAPNES
The National Association for Practical Nurse Education and Service.

National Council Organization Plan
Mission, goals and objectives of the National Council as adopted by the Delegate Assembly.

NBME
National Board of Medical Examiners. NBME is currently modifying its computerized clinical simulation testing (CST) software for application to nursing.

NCBPNP/N
National Certification Board of Pediatric Nurse Practitioners and Nurses.

NCC
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialities.

NC or NCSBN
Abbreviated form of National Council of State Boards of Nursing, Inc.

NCLEX-RN™
National Council Licensure Examination-Registered Nurse.

NCLEX-PN™
National Council Licensure Examination-Practical Nurse.

NCLEX™ Program Reports
Published by the Educational Testing Service twice per year, the *NCLEX™ Program Reports* provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX. Included in the *NCLEX™ Program Reports* is information about a program's performance by the *NCLEX™ Test Plan* dimensions and by content areas. Data about a program's rank nationally and within the program's state are also included.

NCLEX™ Quarterly Reports
The NCLEX™ Quarterly Reports summarize the performance of all first-time candidates educated in a given jurisdiction who were tested in a given quarter.

NCNET
National Council's electronic network for Member Boards.

Newsletter
A biweekly publication produced by the National Council staff and distributed to each Member Board. Items included on a regular basis: committee reports; Board of Directors' agendas, major actions and minutes; health care reform updates; report and/or analyses of federal legislation; examination statistics; notice of upcoming events; updates to National Council manuals; solicitations for persons to serve in various capacities; information from the testing department related to the NCLEX; and information related to National Council activities.

NFLPN
National Federation of Licensed Practical Nurses.

NIRS
Nursing Information Retrieval System. A set of databases containing nursing and medical information which are being linked via a simple coding scheme that permits quick and efficient identification and capture of the numerous relationships which exist within and across databases. It is designed to expedite CST case and scoring key development, quality assurance, and the delivery of a CST examination.

NIS
Nurse Information System. A national database being developed by the National Council, containing demographic information on all licensed nurses. NIS will be an unduplicated count of nurse licensees that can serve as a resource on the characteristics of licensed nurses (e.g., employment status, educational preparation, clinical specialty, etc.). (Also a task force of the National Council)

NLN
National League for Nursing.

NNRR
National Nursing Research Roundtable.

NP
Nurse Practitioner.

NP&E
Nursing Practice and Education. (A standing committee of the National Council)

NPDB
National Practitioner Data Bank. A federally-mandated program for collecting disciplinary data regarding health-care practitioners. The NPDB began operation in September 1990, receiving required medical malpractice payment reports for all health care practitioners, and required reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by P.L. 100-93, section five. Implementation of section five is on hold until the NPDB has gained sufficient experience under Title IV to extend services.

OBRA 1987
Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

ONCC
Oncology Nursing Certification Corporation.

Ontario Model
Refers to the Regulated Health Professions Act (RHPA), which includes a general act and procedural code that applies to all regulated health professions, as well as 21 profession-specific acts. The legislation went into effect on December 31, 1993, and replaced the Health Disciplines Act and various others pieces of legislation.

Pew Charitable Trusts
A national and international philanthropy with a special commitment to Philadelphia, which supports not-for-profit activities in the areas of conservation and the environment, culture, education, health and human service, public policy and religion. The mission of the Pew Health Professions Commission is to assist the nation's health professional schools in understanding the changing nature of health care in the United States, what types of health care workers will be needed for the future and with what skills, and in designing and implementing programs that are capable of educating such professionals.

PIN
Provider Identification Number.

Psych Corp
The Psychological Corporation. The Psychological Corporation is the test service contracted by the National Council and guided by the Nurse Aide Competency Evaluation Program (NACEP) Task Force to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA).

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude, and mastery as measured by testing instruments.

RAP
Research Advisory Panel.

Rasch Measurement Model
The item response theory model used to create the NCLEX measurement scale. Its use allows person-free item calibration and item-free person measurement.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. That is, it assesses the degree to which a test score reflects the person's true standing on the trait being measured. The National Council uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the NACEP. For adaptively administered examinations, such as the NCLEX using CAT, the decision consistency statistic is the more appropriate statistic for assessing precision (see Decision Consistency).

RFP
Request for Proposals.

SAHVI
Storehouse of Administrative, Historical and Volunteer Information. Database to contain comprehensive National Council historical and volunteer information, as well as mailing list data. Part of the Information Master Plan (IMP).

SKDC
Scoring Key Development Committee. Committee of clinical experts which has the responsibility of developing scoring keys for the Computerized Clinical Simulation Testing (CST) project.

SNLQ
State Nursing Legislation Quarterly. A bimonthly journal publication reviewing nursing legislation throughout the country. The journal is published by the National Council and delivered electronically via NCNET to Member Boards as a benefit of membership.

SSD
Special Services Division. A unit of the National Council which develops services and products, the revenue from which will go to support core programs for Member Boards.

Standard Setting
The process used by the Board of Directors to determine the passing standard for an examination, above which examinees pass the examination and below which they fail. This standard denotes the minimum acceptable amount of entry-level nursing knowledge, skills and abilities. The National Council uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is conducted every three years for NCLEX and whenever the test plan or *NACEP Blueprint* changes.

Submission of Reports
A Member Board, upon taking disciplinary action, submits to the National Council Disciplinary Data Bank biographical data about the nurse and information regarding the grounds for and the disciplinary action taken by the board of nursing.

Summary Profiles
Summary profiles are no longer produced by CTB. They have been replaced by *NCLEX™ Program Reports* produced by ETS. See *NCLEX™ Program Reports.*

Sylvan Learning Systems
A subcontractor of ETS for delivering computerized tests. The NCLEX using CAT is administered at over 200 Sylvan Technology Centers across the United States and its territories.

Test Plan
The organizing framework for NCLEX-RN and NCLEX-PN which includes the percentage of items allocated to various categories.

Test Service
The organization which provides test services to the National Council, including test scoring and reporting. ETS is the test service for NCLEX using CAT, and The Psychological Corporation is the test service for the NACEP.

TPC
See Psych Corp.

Tri Council for Nursing
Members include the American Association of Colleges of Nursing, American Organization of Nurse Executives, American Nurses' Association, and National League for Nursing.

UAP/ULAP
Unlicensed Assistive Personnel.

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. The National Council assures the content validity of its examinations by basing each test strictly on the appropriate test plan (RN or PN) or blueprint (NACEP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.