Agenda Item #1.1
Prepared by: Katherine Thomas
Meeting Date: January 19-20, 2012

REPORT OF THE EXECUTIVE DIRECTOR

NATIONAL ISSUES

Future of Nursing Update: AARP and the Robert Wood Johnson Foundation announced 21 new state regional action coalitions: Arkansas, Delaware, Georgia, Hawaii, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, West Virginia, Wisconsin and Wyoming. These 21 new states are in addition to the 15 states already participating. A recently released report by RWJF breaks down the specific initiatives in seven of these participating states.
http://news.nurse.com/article/20111107/MW02/311070035
http://www.rwjf.org/humancapital/product.jsp?id=72889
Alexia Green, PhD, RN will present on activities of the Texas RAC on Friday morning of the Board meeting.

Federal Workforce Initiatives: In October, U.S. Department of Health and Human Services along with the Health Resources and Services Administration announced $82 million in awards for nursing scholarship programs and nursing education loan repayment programs to address nursing workforce shortages. The awards will be granted to those students who will provide services in provider shortage areas.
http://uspolitics.einnews.com/pr_news/61258336/hhs-awards-82-million-to-strengthen-nursing-workforce

HRSA Announces National Survey of Nurse Practitioners: Information on this survey was included in the October E.D. Report. The Health Resources and Services Administration (HRSA) provided this additional information in the November Federal Register when the agency announced a proposed project to conduct a sample survey of NPs. "The primary purpose of the Bureau of Health Profession's National Sample Survey of Nurse Practitioners data collection is to: (1) improve estimates of NPs providing services; (2) describe the settings where NPs are working; (3) identify the positions/roles in which NPs are working; (4) describe the activities and services NPs are providing in the healthcare workforce; (5) determine the specialties in which NPs are working; (6) explore NPs' satisfaction with and perception of the extent to which they are working to their full scope of practice; and (7) assess variations in practice settings, positions, and practice patterns by demographic and educational characteristics." The Texas Board of Nursing agreed to participate and furnished the data requested.
http://www.gpo.gov/fdsys/pkg/FR-2011-11-23/html/2011-30214.htm

Military Veterans Health Care Training: The President announced a new initiative to promote the educating and hiring of veterans in health care fields. He also introduced the Returning Heroes Tax Credit, which would incentivize hiring of unemployed veterans. As a result, federally funded "community health centers have pledged to hire at least 8,000 veterans approximately one for each health center in the U.S. – in clinical, administrative and other positions."
http://www.bloomberg.com/news/2011-10-25/obama-seeks-to-create-8-000-jobs-for-veterans-at-health-centers.html

Health IT: The Institute of Medicine (IOM) has published a report, *Health IT and Patient Safety: Building Safer Systems for Better Care*. The report outlines whether health technology improves the overall quality of health care. The report began after HHS requested IOM "evaluate safety concerns and to identify actions that both government and the private sector can take to alleviate those actions." Some of the research has shown that some types of health IT can lead to a lower quality of care due to "dosing errors, failure to detect life-threatening illnesses, and delaying treatment due to poor human-computer interactions or loss of data." They note that health IT products "are part of a larger socio-technical system that also includes people – such as clinicians and patients – organizations, processes, and the external environment." http://www.iom.edu/Reports/2011/Health-IT-and-Patient-Safety-Building-Safer-Systems-for-Better-Care/Report-Brief.aspx

3-D Virtual Simulation in Nursing Education: The Johns Hopkins University School of Nursing and Johns Hopkins Hospital have partnered together to provide students with virtual 3-D simulation that will allow nursing students to virtually treat patients in a variety of scenarios. To prepare for its launch, the university and hospital are currently developing preceptor orientation modules. "These modules will examine preceptor foundations, communications, clinical reasoning, educator challenges and creation of a caring culture. Between June 2012 and June 2014, the modules will be implemented, tested, evaluated and eventually incorporated into the orientation schedules of nursing schools and hospitals across the country." http://gazette.jhu.edu/2011/11/07/virtual-technology-prepares-johns-hopkins-university-nurses-for-reality/

New Graduate Survey Data: This article reports on the National Student Nurses Association's annual survey of new graduates and claims there is an oversupply of new graduate RNs. Mancino, Diane, "Inaction is Not an Option," *Dean's Notes*, Vol. 33: 2. November/December 2011, A J Jannetti, Publisher. Link: http://bit.ly/wiyPLL

California Board of Nursing Sunset Bill: In October 2011, California's Governor vetoed a sunset bill that would have extended the California Board of Registered Nursing (BRN). This resulted in "sunsetting" the BRN. The Governor vetoed the bill because it included a provision for board investigators to be classified as peace officers and be entitled to state pension benefits. The governor saw the inclusion of investigators as a fiscally inappropriate addition. The BON's powers have been redirected to the Department of Consumer Affairs. As of January 1, 2012, the California Board of Registered Nursing (CA-BRN) is now known as the Registered Nursing Program until the CA-BRN has been reconstituted at a future date by the Legislature.

2011 Environmental Scan: NCSBN has prepared an annual report on emerging issues and trends that impact nursing regulation. ***(See Attachment A).***

STATE ISSUES

Fraudulent Schools of Nursing: Board staff have not received any new complaints of fraudulent nursing education programs operating in Texas. Staff continue to serve as a resource to other state agencies and remain in frequent contact with staff of the Texas Workforce Commission (TWC) to share questions and concerns about nursing programs.
Staff has had regular contact with the Texas Workforce Commission (TWC) regarding complaints about programs or new programs applying to the TWC.

Meetings with TWC and THEBC: Education staff of the BON met recently with staff of the Texas Workforce Commission (TWC) and the Texas Higher Education Coordinating Board (THECB) to discuss each agency's requirements for new and existing nursing programs to ensure we do not unnecessarily duplicate each other's requirements and unduly burden schools. A follow up meeting will be scheduled. The two agencies will be invited to meet with the Board when we complete this process.

Health Professions Council: The Health Professions Council (HPC) met on December 12, 2011 for its regular quarterly meeting. Prior to this meeting, elections took place. The Executive Director of the Nursing Board encouraged other members to serve in leadership position after her 11 years as the Chair of the HPC. Gay Dodson of the Pharmacy Board and Hemant Makan of the Podiatry Board agreed and were elected as the Chair and Vice-Chair of the Council.

BOARD ISSUES

BON Bulletin Articles : The January issue of the *Board of Nursing Bulletin* contains articles on Demonstrating Continuing Competency through Nursing Certification; Expansion of Approved Certifications for Continuing Competency; A Question and Answer on recommendations for newly licensed LVNs or RNs as they begin their nursing practice; and a Profile on Board Member Mary LeBeck.

Board Development: At each board meeting, a board development session is held. Pursuant to discussions with the Board in July and with Richard Gibbs, Board Development Liaison, this meeting's development will be a presentation on drug testing required by the Texas Peer Assistance Program for Nurses (TPAPN) and the Board's disciplinary orders.

AGENCY ISSUES

Nursing Jurisprudence Examination: The Jurisprudence examination required for initial licensure by Texas Occupations Code Section 301.252, License Application, was implemented in September 2008. Access to the Board's examination is available through the website, http://www.bon.state.tx.us/olv/je.html. Those applying for initial licensure by exam or endorsement **after** September 1, 2008 must pass the Jurisprudence Exam in order to be eligible for licensure. Attached are statistics for Jurisprudence exam takers for past 3 fiscal years and through the first quarter of Fiscal Year 2012. ***(See Attachment B).*** Please note we have an additional section, Refresher Course/Renewal Requirements in the report.

Staff continue to study the issue of an online posting of questions from our jurisprudence examination which occurred in mid June. Staff is exploring adding security validation questions to the exam and will evaluate associated costs with the vendor.

Military Exceptions Licensed: Staff reported a new policy and procedure to grant licenses to active duty military personnel in Texas for temporary training assignments in civilian facilities at the January 2011 meeting. Since we implemented this policy, we have issued only five licenses due to the Military Exception policy; one by reactivation and four by endorsement.

KSTAR: Staff have met with representatives of KSTAR, a program at Texas A&M University that is currently designed to measure physician competency and remediate any practice

deficiencies. KSTAR stands for "Knowledge," "Skills," "Training," "Assessment," and "Research". The Texas Medical Board uses KSTAR in disciplinary matters. It is also designed to train physicians who wish to re-enter practice after a period of time out of practice. KSTAR is interested in developing a re-entry program for nurses and possibly a competency assessment and individualized remediation plan for nurses under discipline.

BON Assumes New Contract: The Texas Board of Nursing has agreed to perform the accounting duties for the Texas Low-Level Radioactive Waste Disposal Compact Commission. This is a new, very small agency that has no staff at this time. The Comptroller recommended they ask us for assistance. Staff met with Commission members and their Assistant Attorney General on December 30th and the contract has been signed.

Website: The following are changes that have been made to the website since your last Board Report.

- Posted adopted amendments to §223.1 (relating to Fees).
- Posted proposed amendments to §217.19 (relating to Incident-Based Nursing Peer Review and Whistleblower Protections) and §217.20 (relating to Safe Harbor Peer Review for Nurses and Whistleblower Protections).
- Posted proposed new §217.22 (relating to Special Accommodations) with proposed Special Accommodations form.
- Posted Disciplinary Action Files and Board Order Links for action reported in the October 2011 newsletter.
- Posted new FAQ's regarding Position Statements 15.27, The LVN Scope of Practice and 15.28, The RN Scope of Practice.
- Posted new FAQ's regarding Continuing Competency
- Posted Operating Budget for FY 2012.
- Posted PowerPoint slides from Nursing Education Consultants DECs Webinar, November 17, 2011.
- Posted Nursing Practice Webinar and Hosted Workshop FY 2012 Schedule and updated general registration information.
- Posted the NCLEX-RN Pass Rate for Last 5 years by Program (2011)
- Removed the information on our website about TWC's intent to revoke certificates of approval for all ATI owned schools. TWC has since reversed its decision to revoke DNI's approval.
- Updated all links to new domain bon.texas.gov

Agency Workforce Data: The purpose of the Board of Nursing Recruitment Plan is to achieve equal employment opportunity for all qualified persons. The plan calls for the Executive Director to submit a statistical report to the Board on personnel transactions. The Recruitment Plan and the EEO Data for 2011 are attached. ***(Attachment C)***.

Key Meetings and Presentations: attended/presented by the Executive Director and Staff since the last Board meeting. (Does not include internal meetings with staff) .

Executive Director meetings, conference calls, and presentations

Conference Call: Texas Nurses Association, Texas Hospital Association, Texas Organization of Nurse Executives to discuss quarterly conference calls with the Board, November 3, 2011, Austin.

Meeting: Health Professions Council, November 9, 2011, Austin.

Meeting: with Texas Nurse Practitioners and Coalition for Nurses in Advanced Practice regarding Health and Human Services rules on supervision, November 16, 2011, Austin.

Conference Call: Nurse Licensure Compact Administrators Executive Committee, November 28, 2011.

Webinar: National Council State Boards of Nursing, Navigating the New Website, November 30, 2011.

Meeting: with Representative of Cisco Jr. College to Discuss Recommendations to the Board of Nursing, December 2, 2011, Austin.

Meeting: National Council of State Boards of Nursing Board of Directors, December 5-7, 2011, Chicago.

Meeting: with new Legislative Budget Board Analyst, Eduardo Rodriguez, December 9, 2011, Austin.

Meeting: Health Professions Council Quarterly Meeting, December 12, 2011, Austin.

Conference Call: Nurse Licensure Compact Administrators, December 12, 2011.

Meeting: Becky Dean, Office of the Governor to Discuss Board Rules for Educational Programs, December 14, 2011, Austin

Conference Call: APRN Compact Implementation Group, Changes to the Model Statute, December 16, 2011.

Conference Call: National Council of State Boards of Nursing, Executive Officer Meeting, December 19, 2011

Conference Call: Leadership Development Network with guest speaker, Senator Cathy Giessel (Alaska), January 4, 2011.

Conference Call: National Council of State Boards of Nursing Board of Directors Subcommittee on Board Job Description, January 4, 2011.

Conference Call: National Council of State Boards of Nursing Policy Network, January 5. 2011.

Meeting: with SOAH Staff to Discuss New SOAH rule on Defaults and Summary Dispositions, January 6, 2011.

Conference Call: Nurse Licensure Compact Administrators Executive Committee, January 9, 2011.

Director of Operations Meetings and Presentations:

Presentations: BON Update, Texas Association of Vocational Nurse Educators, October 28, 2011, Austin.

Meeting: NCSBN Leadership Succession Committee, November 9-10, 2011, Chicago.

Presentation: BON Updates, Texas Association of Healthcare Recruiters, November 11, 2011, San Antonio.

Director of Nursing Meetings and Presentations:

Meeting: Texas Nurses Association Education Committee Meeting, November 2, 2011, Austin.

Meeting: Texas Nurses Association, Texas Hospital Association, Texas Organization of Nurse Executives to discuss quarterly conference calls with the Board, November 3, 2011, Austin.

Conference Attendance: NCSBN World Café for Education, December 8, 9, Chicago.

Presentation: Victoria College, School of Nursing Pining Ceremony, December 15, 2011, Victoria.

Practice Consultants

Presentation: *Understanding Your Scope of Practice, Texas School Nurse Organization - Annual Conference, November 12, 2011, Austin.*

Presentation: Implementing Nursing Services Related to SB 1857 in HCS/TxHmL/ICF Services:
October 5 & 6, 2011, Lubbock
October 13 & 14, 2011, Houston
October 19 & 20, 2011, San Antonio
October 25 & 26, 2011, Fort Worth
November 10 & 11, 2011, Houston
November 29 & 30, 2011, Austin
December 1 & 2, 2011, Fort Worth

Educational Consultants

Presentation: Board Update to Texas Association of Vocational Nurse Educators Fall 2011

Meeting, October 28, 2011, Austin.

Meeting: Perkins Leadership Grant Meeting, November 8-9, 2011, Austin January 5-6, 2012, Austin

Webinar: Differentiated Essential Competencies, November 17, 2011, Austin.

Meeting: with Cisco College representatives, December 2, 2011, Austin.

Meeting: with Texas Workforce Commission and Texas Higher Education Coordinating Board staff, December 5, 2011, Austin.

Quarterly Statistics Where Executive Director Closed Cases in Compliance with Board Policy:

Case Resolution Report
September 1, 2011 through November 30, 2011

Type of Action	**Total**
No Jurisdiction	9
No Violation	7
No Action	934
Insufficient Evidence	228
Admonish	63
Without Prejudice	817
TPAPN Referrals	78
EEP Referrals	22
Corrective Actions	55
Totals	**2213**

Cases Where Executive Director Offered and Entered Ordered Orders in Compliance with Board Policy:

LVN DISCIPLINARY ORDERS

Time frame: September 1, 2011, through November 30, 2011

	DISCIPLINARY
51	**FINE WITH REMEDIAL EDUCATION** 39 Submitted an Application/Renewal Document in which false, deceptive, and/or misleading information was given by failing to disclose a criminal history 1 Inaccurately documented the time she left her private duty care assignment 1 Documented additional discharge instructions after the patient was discharged 1 Failed to document daily skilled nursing for several patients 1 Documented care not provided 1 Approved a refill of Xanax sixty (60) tablets without a physician's authorization 1 Lacked fitness to practice in that she was found sleeping while on duty 4 Practice nursing without a valid license 1 Failed to ensure that aide supervisory visits were performed and/or documented 1 Altered the physician's order to change the status of a patient
7	**REMEDIAL EDUCATION** 1 Failed to assess and/or document the assessment 1 Convicted of Secure Execution of Document by Deception a Third Degree felony offense 1 Failed to use aseptic technique while performing wound care 1 Administered Ritalin to a student without a physician's order 1 Failed to completely and accurately document physician's orders for medication changes 1 Withdrew Morhpine for patients but failed to document the administration 1 Convicted of the misdemeanor offenses of Public Intoxication and five counts of Criminal Trespass
11	**TPAPN BOARD ORDER** 1 Deferred judgment for Fraud a Second Degree felony offense 1 Convicted of Driving While Intoxicated 1 Intemperate use of Methamphetamine, Opiates and Tramadol 1 Diagnosed with Bipolar disorder 1 Engaged in unprofessional conduct in that she was observed by the facility staff to be in Possession of Marijuana 1 Convicted of Possession of Methamphetamine with Intent to Deliver 1 Intemperate use of Opiates 1 Submitted unauthorized, fraudulent prescription for Hydrocodone; intemperate use of Morphine and Dilaudid 1 Intemperate use of Amphetamines, Hydrocodone and Methamphetamines 1 Intemperate use of Fentanyl 1 Unlawful use of Cocaine resulting in a positive drug screen

49	**VOLUNTARY SURRENDER**	
	8	Non compliance with previous Board Order
	1	Administered Morphine without a physician's Order; failed to transcribe a mediation order for Protonix and Levaquin; failed to notify physician of a change in the condition of a patient
	1	Passed fraudulent, unauthorized prescriptions for Narcotics
	1	Intemperate use of Oxymorphone resulting in a positive drug screen
	1	Deferred judgement for Burglary of Habitation, Second Degree felony offense and Execution of Document by Deception, a State Jail felony offense
	1	Deferred judgment for Aggravated Assault, a Second Degree felony offense
	1	Falsified documents related to absences from employment
	1	Deferred judgment for Possession of Methamphetamine, a State Jail felony offense
	1	Deferred judgment for Tampering with Government Record, a State Jail felony offense
	1	Deferred judgment for Possession of Marijuana Over Four Ounces Under Five Pounds, a State Jail felony
	1	Pre-Trial Diversion for Theft of Property >=$1500<$20K, a State Jail felony offense
	1	Convicted of Conspiracy to Commit Mail Fraud and three counts of Mail Fraud
	2	Convicted of Driving While Intoxicated - 3rd or more, a Third Degree felony offense
	1	Falsely documented the administration of Morphine; misappropriation and intemperate use of Morphine
	1	Convicted of Attempted Possession of Phencyclidine 1-4 Grams and Endangering a Child both State Jail felony offenses
	1	Deferred judgment for Unauthorized Use of a Motor Vehicle, A State Jail felony offense
	1	Disciplinary action taken by another licensing authority
	1	Passed a fraudulent and unauthorized telephonically communicated prescription for Norco
	1	Convicted of Driving While Intoxicated with Child < 15, a State Jail felony offense
	1	Deferred judgment for Evading Arrest, a State Jail felony offense
	1	Diverted Hydrocodone Elixir and Diazepam belonging to the facility; produced a positive drug screen
	1	Deferred judgment for Fraud to Obtain Controlled Substance, a Third Degree felony offense
	19	Submitted a statement of Voluntary Surrender

LVN ENDORSEMENT/PETITIONER DISCIPLINARY ORDERS

Time frame: September 1, 2011, through November 30, 2011

44	**ENDORSEMENTS**	
	2	Disciplinary action taken by another licensing authority
	3	Denial of Licensure
	1	Convicted of four counts of Second Degree felony Burglary
	1	Convicted of two counts of Public Intoxication
	1	Non disclosure of Criminal History or Disciplinary Action on Application for Licensure by Endorsement
	36	No Grounds for Denial

444	**APPLICANTS/ PETITIONERS**	
	1	Non-disclosure of Criminal History
	1	Evaluation results indicated a substance abuse and possibly substance dependence condition
	1	Deferred judgment for State Jail felony Forgery and Class A misdemeanor Public Lewdness
	1	Convicted of State Jail felony Delivery by Actual Transfer of Cocaine and misdemeanor Assault Causing Bodily Injury, Criminal Mischief, Theft, Assault and Forgery
	1	Convicted of Driving While Intoxicated and pending Driving While Intoxicated charge
	1	Deferred judgment for State Jail felony Welfare Fraud
	1	Deferred judgment for Third Degree felony Tampering with Government Record
	1	Convicted of Second Degree felony Possession of a Controlled Substance - Cocaine, First Degree felony Possession of a Controlled Substance - Cocaine, and State Jail felony False Statement for Credit
	2	Deferred judgment for Class A misdemeanor Possession of Marijuana in Drug Free Zone
	1	Convicted of felony Delivery of Cocaine and two counts of felony Possession of Cocaine
	1	Convicted of felony Caretaker Theft from Elderly/Dependant Adult
	3	Convicted of two counts of misdemeanor Driving While Intoxicated
	1	Deferred judgment for felony Aggravated Assault with a Deadly Weapon and felony Credit Card Abuse
	1	Convicted of Possession of Marijuana and three counts of Theft
	1	Deferred judgment for Class A misdemeanor Resisting Arrest
	1	Deferred judgment for misdemeanor Engaging in Organized Criminal Activity and Racing on Highway
	1	Deferred judgment for Class A misdemeanor Burglary of a Vehicle
	2	Convicted of three counts of Theft
	1	Convicted of Third degree felony Tampering/Fabricating Physical Evidence
	2	Received an Article 15 Violation
	2	Convicted of felony Possession of a Controlled Substance
	1	Convicted of felony Fraud by Wire
	1	Deferred judgment for felony Possession of Controlled Substance and misd. Marijuana Possession
	4	Deferred judgment for State Jail felony Theft
	1	Deferred judgment for Third Degree felony Escape
	1	Convicted of misdemeanor Grand Theft of Personal Property
	2	Convicted of False Police Report
	1	Convicted of Hit and Run Attended Vehicle and Hit and Run Unattended Vehicle
	2	Deferred judgment for Second Degree felony Intoxication Manslaughter with Vehicle
	2	Pre-Trial Diversion for State Jail felony Credit Card or Debit Card Abuse
	1	Convicted of State Jail felony Forgery and Class A misdemeanor Possession of Marijuana
	1	Deferred judgment for State Jail felony Forgery and misdemeanor Theft
	1	Convicted of felony False Statement to Firearms Dealer in Acquisition of Firearms < $10K
	1	Convicted of Tampering w/ Government Record and 3 counts of Possession of a Controlled Substance
	1	Convicted of Class A misdemeanor Assault Causes Bodily Injury - Family Violence
	1	Deferred judgment for Class A misdemeanor Assault
	1	Disciplinary action taken by another licensing authority
	1	Convicted of Third Degree felony Unlawful Carrying Weapon on School Premises
	1	Entered a rehabilitation facility for substance use
	1	Convicted of misdemeanor Evading Arrest and Failure to Identify Fugitive
	1	Completed treatment for substance abuse; deferred judgment for Possession of a Controlled Substance
	1	Hospitalized for Detox followed by Residential recovery
	8	Denial of Licensure
	382	No Grounds for Denial/Youthful Indiscretion

LVN CORRECTIVE ACTION

Time frame: September 1, 2011, through November 30, 2011

31	**CORRECTIVE ACTION** 2 Non disclosure of misdemeanor Unlawfully Carrying a Weapon 1 Non disclosure of misdemeanor Receiving Stolen Property 4 Non disclosure of misdemeanor Theft 1 Failed to provide evidence of completion of twenty (20) hours of Continuing Education 1 Non disclosure of misdemeanor Harassment 9 Non disclosure of misdemeanor Driving While Intoxicated 1 Non disclosure of misdemeanor Reckless Conduct 1 Non disclosure of misdemeanor Resisting Arrest, Search or Transport 1 Non disclosure of misdemeanor Fail to ID Fugitive Intent to Give False Information 1 Non disclosure of misdemeanor Reckless Driving 1 Non disclosure of arrest for Aggravated Assault with Deadly Weapon - no charges filed 1 Non disclosure of misdemeanor Furnishing Alcohol to a Minor 1 Non disclosure of misdemeanor Criminal Mischief 1 Non disclosure of misdemeanor Possession of Marijuana 2 Non disclosure of misdemeanor Issuance of a Bad Check 3 Practiced Nursing without a valid license
3	**ENDORSEMENTS** 1 Non disclosure of misdemeanor Criminal Trespassing 1 Non disclosure of misdemeanor Partner/Family Member Assault 1 Non disclosure of misdemeanor Operating a Motor Vehicle Under the Influence of Alcohol
7	**APPLICANTS/ PETITIONERS** 1 Non disclosure of misdemeanor False Report to Police Officer 2 Non disclosure of misdemeanor Theft of Property 1 Non disclosure of misdemeanor Deadly Conduct 1 Non disclosure of misdemeanor Illegal Dumping >5 lbs <500 lbs 1 Non disclosure of misdemeanor Driving While License Suspended 1 Non disclosure of misdemeanor Consumption of Alcohol by a Minor

LVN DEFERRED DISCIPLINE

Time frame: September 1, 2011, through November 30, 2011

8	**REMEDIAL EDUCATION - DEFERRED DISCIPLINE** 1 Failed to appropriately and/or document the administration of Morphine , Norco and Xanax 1 Inappropriately accepted assignment to provide care without the knowledge and skills to provide the care 2 Failed to transcribed an order to the Medical Administration Record 1 Failed to submit documentation for visits made to multiple patients 1 Administered incorrect medication 1 Failed to monitor and supervise the nursing care of a Certified Nurse Aide 1 Failed to intervene or document the intervention

Cases Where Executive Director Offered and Entered Ordered Orders in Compliance with Board Policy:

RN DISCIPLINARY ORDERS

Time frame: September 1, 2011, through November 30, 2011

	DISCIPLINARY
23	**FINE WITH REMEDIAL EDUCATION** 12 Submitted an Application/Renewal Document in which false, deceptive, and/or misleading information was given by failing to disclose a criminal history 1 Inaccurately documented the time she left her private duty care assignment 3 Practiced nursing without a valid license 1 Failed to ensure that aide supervisory visits were performed and/or documented 1 Was unfit for duty due to dehydration related to taking prescribed Lasix and diet pills 1 Failed to follow physician's orders 1 Documented additional discharge instructions after the patient was discharged 1 Allowed and/or instructed an unlicensed person to administer insulin 1 Failed to ensure adequate coordination of services 1 Altered the physician's order to change the status of a patient
15	**REMEDIAL EDUCATION** 1 Failed to assess a patient and intervene when significant change in status 1 Failed to document assessments or interventions provided 1 Disciplinary action taken by another licensing authority 1 Inappropriately delegated to a student nurse the task of administering an injection of Toradol 1 Failed to properly secure medications 1 Shared personal information regarding a patient to staff 1 Inappropriately used whiteout to alter a medical record 1 Verbally abused a resident 1 Failed to document and submit documentation for nursing care rendered on nine (9) home visits 1 Erroneously documented blood pressure data 1 Forcibly pushed a patient down while the patient was in restraints 1 Attempted to remove IV's from two patients resulting in the catheters breaking in the vein and surgery being required for removal 1 Discharged a patient without completing all required x-ray series and without physician's approval 1 Violated personal boundaries in that she gave a patient her phone number and subsequently allowed him to move into her home 1 Removed a colostomy bridge without a physician's order

43	**VOLUNTARY SURRENDER** 11 Disciplinary action taken by another licensing authority 1 Convicted of Abandon/Endanger a Child Criminal Negligence, a State Jail felony offense 1 Administered Morphine without a physician's Order; failed to transcribe a mediation order for Protonix and Levaquin; failed to notify physician of a change in the condition of a patient 1 Falsified medical records in order to obtain compensation for nursing visits not performed 1 Intemperate use of Hydromorphone resulting in a positive drug screen 1 Passed fraudulent, unauthorized prescriptions for Narcotics 1 Diverted Hydrocodone Elixir and Diazepam belonging to the facility; produced a positive drug screen 1 Convicted of Driving While Intoxicated with Child Passenger, a State Jail felony offense 1 Deferred judgment for Fraud to Obtain Controlled Substance, a Third Degree felony offense 1 Intemperate use of Marijuana resulting in a positive drug screen 1 Prescribed narcotic medications for patient without benefit or written authority 1 Exhibited signs of impaired behavior and was prohibited from returning to work due to impaired condition 1 Falsified signatures on the Controlled Substance Administration Record for nurses off duty and deferred judgement for Obrtaining a Controlled Substance by Fraud, a Second Degree felony offense 13 Non compliance with previous Board Order 7 Submitted a statement of Voluntary Surrender
24	**TPAPN BOARD ORDER** 1 Misappropriation of Intravenous fluids 1 Convicted of Driving While Intoxicated 1 Misappropriated Versed and Propofol and intemperate use of Fentanyl and Propoxyphene 1 Deferred judgment for Fraud a Second Degree felony offense 1 Unlawful use of Cocaine resulting in a positive drug screen 1 Misappropriation of Ambien 1 Intemperate use of Alcohol 1 Found unfit for duty with the United States Navy due to an alcohol related incident 2 Entered into Nursing Assistance Program in another State 1 Disciplinary action taken by another licensing authority due to intemperate use 1 Entered treatment for alcohol abuse and depression 1 Misappropriated Demerol and Morphine; intemperate use of Alcohol 1 Lacked fitness to practice in that she took her husband's pain medication the night before her scheduled shift; intemperate use of narcotics 2 Intemperate use of Fentanyl 1 Intemperate use of Amphetamines, Hydrocodone and Methamphetamines 1 Intemperate use of Marijuana 1 Misappropriation of Ativan, Dilaudid and Sublimaze; intemperate use of Fentanyl 1 Misappropriation and intemperate use of Morphine 1 Voluntarily entered treatment for substance abuse 1 Disclosed use of Cocaine 1 Convicted of Driving While Intoxicated; practiced nursing without a valid license 1 Lacked fitness to practice in that she admitted to a substance abuse problem

RN ENDORSEMENT/PETITIONER DISCIPLINARY ORDERS

Time frame: September 1, 2011, through November 30, 2011

86	**ENDORSEMENTS** 1 Denial of Licensure 11 Disciplinary action taken by another licensing authority 1 Completed inpatient treatment 1 Deferred judgment for Third Degree felony Possession of a Controlled Substance - Cocaine 1 Convicted of Attempted Breaking and Entering w/ Intent, Stalking and Theft 1 Convicted of felony Embezzlement 1 Convicted of two counts of Driving a Vehicle Under the Influence and Criminal Damage 3 Non disclosure of Criminal History or Disciplinary Action on Application for Licensure by Endorsement 66 No Grounds for Denial
530	**APPLICANTS/ PETITIONERS** 5 Non disclosure of Criminal History or Disciplinary Action on Application for Licensure by Examination 4 Denial of Licensure 2 Entered Residential Treatment to address problems with chemical dependency 1 Entered treatment to work on a resolution to her substance use disorder; diagnosed with Bipolar Disorder 1 Completed Intensive Residential Treatment for alcohol recovery 1 Pre-Trial Diversion for Possession of Marijuana - Class B misdemeanor 1 Deferred judgment for felony Credit Card Abuse and Tampering with Government Record 1 Deferred judgment for Tamper with Government Records and convicted of Driving While Intoxicated 3 Convicted of two counts misdemeanor Driving While Intoxicated 2 Diagnosed with Bipolar Disorder 1 Convicted of felony Burglary of a Building and Possession of a Controlled Substance - Cocaine 1 Deferred judgment for Possession of Marijuana; convicted of three counts of Driving While Intoxicated 1 Deferred judgment for Third Degree felony Assault and First Degree misdemeanor Battery 2 Deferred judgment for State Jail felony Forgery 1 Deferred judgment for Aggravated Assault w/ a Deadly Weapon and convicted of Public Intoxication 1 Convicted of Theft, Sale of Alcohol to Minors and Illegal Operation of Sexually Oriented Business 1 Convicted of three counts of misdemeanor Petty Theft 1 Deferred judgment for Third Degree felony Involuntary Manslaughter - Reckless Driving 1 Deferred judgment for State Jail felony Driving While Intoxicated with Child Passenger 1 Convicted of misdemeanor Embezzlement and Theft 1 Convicted of three counts of Driving While Intoxicated 1 Deferred judgment for misdemeanor and State Jail felony Possession of Marijuana 3 Disciplinary action taken by another licensing authority 1 Deferred judgment for Second Degree felony Aggregate Theft 1 Convicted of Class E felony Possession of a Controlled Substance by Fraud and Battery of Law Officer 1 Failed to administer medication in a responsible manner while practicing as a Vocational Nurse 1 Deferred judgment for State Jail felony Credit/Debit Card Abuse 1 Deferred judgment for felony Criminal Mischief, Possession of a Controlled Substance, Possession of Marijuana and misdemeanor Possession of Marijuana and Harboring Runaway Child 1 Deferred judgment for four counts of misdemeanor Theft 2 Deferred judgment for felony Possession of a Controlled Substance 2 Entered a Substance Abuse Rehabilitation program 1 Deferred judgment for Third Degree felony Tampering with Government Record 1 Deferred judgment for State Jail felony Possession of a Controlled Substance 1 Deferred judgment for Possession of Marijuana and convicted of Possession of a Controlled Substance, Driving While Intoxicated and Possession of Marijuana 1 Hospitalized and diagnosed with Schizoaffective Disorder, Bipolar Type 1 Treated for Bulimia Nervosa, Dysthymia, and Alcohol Abuse 1 Convicted of Possession of Marijuana - 3 counts, Possession of a Driving While Intoxicated, Possession of Amphetamine and Methamphetamine and Man/Del/Sell/Possess a Controlled Substance 1 Deferred Judgment for Possession of a Controlled Substance and Driving While Intoxicated 476 No Grounds for Denial/Youthful Indiscretion

RN CORRECTIVE ACTION

Time frame: September 1, 2011, through November 30, 2011

32	**CORRECTIVE ACTION** 1 Non disclosure of misdemeanor Driving and/or Being in Actual Physical Control While Under the Influence of Intoxicating Liquor 1 Non disclosure of criminal history 1 Non disclosure of misdemeanor Obtaining a Dangerous Drug by Fraud 1 Non disclosure of misdemeanor Operate Motor Vehicle While Impaired by Alcohol 1 Non disclosure of misdemeanor Unlawfully Carrying a Weapon 2 Non disclosure of misdemeanor Assault Causing Bodily Injury 1 Non disclosure of misdemeanor Using Auto without Owners Consent 5 Non disclosure of misdemeanor Theft 1 Non disclosure of misdemeanor Obstructing a Highway or Other Passageway 1 Non disclosure of misdemeanor Retail Theft 10 Non disclosure of misdemeanor Driving While Intoxicated 1 Non disclosure of misdemeanor Reckless Conduct 1 Non disclosure of misdemeanor Resisting Arrest, Search or Transport 1 Non disclosure of misdemeanor Driving While License Suspended 2 Non disclosure of misdemeanor Issuance of a Bad Check 1 Non disclosure of misdemeanor Receiving Stolen Property 1 Practiced Nursing without a valid license
6	**ENDORSEMENT** 1 Non disclosure of misdemeanor Domestic Violence 1 Non disclosure of misdemeanor Theft 1 Non disclosure of misdemeanor Sodomy Solicitation 1 Non disclosure of misdemeanor Disorderly Conduct 1 Non disclosure of misdemeanor Driving Under the Influence of Alcohol 1 Non disclosure of misdemeanor Assault
2	**APPLICANTS/ PETITIONERS** 1 Non disclosure of misdemeanor Theft 1 Non disclosure of misdemeanor Possession of Marijuana

RN DEFERRED DISCIPLINE

Time frame: September 1, 2011, through November 30, 2011

1	**FINE WITH REMEDIAL EDUCATION - DEFERRED DISCIPLINE** 1 Demonstrated a temporary lapse of professional judgment when she stated to an officer “you better hope I don’t see or treat you in the emergency room” after being stopped for speeding
17	**REMEDIAL EDUCATION - DEFERRED DISCIPLINE** 1 Administered medications to the incorrect patient 1 Failed to identify a patient prior to starting dialysis treatment 1 Failed to appropriately and/or document the administration of Morphine , Norco and Xanax 1 Withdrew Hydrocodone but failed to document the administration 1 Improperly documented Fentanyl that was administered and/or wasted by other nurses 1 Failed to administer the anti-hypertensive Labetalol as ordered 1 Received incorrect dosage information from a patient’s wife then documented the information as if given by the physician in charge 1 Failed to administer intravenous Vancomycin and instead administered Desferal 1 Accepted an assignment while physically unfit to perform duties that were required 1 Failed to accurately and completely document the surgical procedure for a patient 1 Exceeded scope of practice when an order was written to discontinue an intravenous infusion 1 Failed to intervene or document the intervention 1 Delegated administration of an intramuscular injection to a non-licensed Certified Nurses Aide 1 Failed to maintain safe practice standards 1 Attempted to establish an IV site on a co-worker to infuse IV liquids, without a physicians’ order 1 Failed to ensure the documentation of care was correctly saved in the patient’s electronic medical record 1 Failed to follow physician’s orders for administering Heparin and failed to document the administration

Environmental Scan 2011

Annual review of emerging issues and trends that impact nursing regulation

National Council of State Boards of Nursing

The 2011 NCSBN Environmental Scan

Introduction

The following report provides a synthesis of the regulatory environment for 2011. It combines data from the political and economic landscape with information and events related to nursing and healthcare. The report addresses key issues related to the nursing workforce and education and summarizes the data, events and changes occurring around and within boards of nursing throughout this year. Ultimately, the goal of this report is to help regulators understand the context of the environment in which they work, keep regulators informed of the constantly changing healthcare milieu, and to provide data and information for strategic planning and decision-making.

Much of the data released during this year is from 2010. The publication of these data officially marks the completion of the first decade of the new millennium. For this reason, it was decided to enhance the annual environmental scan with a review of the past ten years. This is meant to provide comparison data, assist in the identification of trends and emerging issues, summarize the achievements or the lack of progress during the last ten years and serve as a backdrop for meeting the challenges of the future.

In addition to the references cited within the text of this report, the following resources were used to obtain information about boards of nursing:

- Annual state reports
- Web surveys
- Minutes from the EO Seminar, networking sessions and area meetings at the Midyear and Annual meetings
- Board of Nursing Websites
- Legislative reports

THE NURSING WORKFORCE

2000-2010

The 21st century began with a serious shortage of registered nurses. The four year period preceding the new millennium (1996 to 2000) marked the slowest rate of growth in the U.S. population of registered nurses since 1980. This was attributed to a decrease in the numbers entering the profession as well as an increase in attrition. Also during this era (1996-2000) the percentage of RNs employed in nursing dropped by 1% (HRSA, 2002). Hospital and other types of facilities employing nurses had high vacancy rates and there were predictions of a catastrophic shortfall of nurses to meet the needs of the U.S. population. Over a ten year period, employers added incentives, federal funding was directed towards increasing the nursing workforce and the prospect of a career with numerous job opportunities helped to substantially increase the number of nurses. From 2008-present, the severe economic crisis also contributed to the workforce expansion by forcing many inactive licensees to return to work in nursing. Figure 1 depicts the sequential growth in the profession over the last 10 years. As can be observed, the overall nursing workforce grew by 20.6% from 2000-2010.

2011

The current data indicate continued growth of the profession. As the decade drew to a close in 2010, there were 2,655,020 employed registered nurses reported to the U.S. Department of Labor (2011). From 2008-2010, the number of employed nurses increased by 2.26%. Due to the aging nature of the nursing population {median age of an RN: 46 years (HRSA, 2010)} a high level of attrition could have potentially occurred within this period as nurses reached the age of retirement. Even with this potential high attrition level and an economic environment that has experienced high unemployment rates, the profession has still managed to maintain a growing workforce. The Department of Health and Human Services Health Resources and Services Administration (HRSA) reported in 2010 that the number of employed nurses has risen to its highest level since 1980. Almost 85 percent of registered nurses with active licenses are currently employed (HRSA, 2010).

Figure 1:

Total number of employed RNs: 2000-2010

	2000	2004	2008	2010**
Number of Employed RNs	2,201,813	2,442,593	2,596,399	2,655,020

(HRSA,2006, 2010)

**The 2010 statistics depicted above were taken from the semiannual *Occupational Employment Statistics (OES) survey* published by the U.S. Department of Labor.

- U.S. jurisdictions with the fewest number of employed nurses: Wyoming (4,790); Alaska (5,150) and Vermont (5,980).*
- U.S. jurisdictions with the highest number of employed nurses: California (240,030), Texas (176,030) and New York (169,710).*

**These statistics have remained the same throughout the decade.*

Federal Funding for Workforce Development Programs

In 2011, HRSA disseminated Nursing Workforce Development grants totaling $71,294,557. Awards include Nurse Education, Practice, Quality and Retention ($10.9 million total); Nursing Workforce Diversity ($3.6 million total); Nurse Faculty Loan Program ($23.4 million total); Advanced Nursing Education Program ($16.1 million total); Advanced Education Nursing Traineeships ($16 million total); and Nurse Anesthetist Traineeships ($1.3 million total) (HRSA, 2011).

Workforce Issues

Boards of Nursing

The following state workforce issues were reported by boards of nursing for 2011:

- New graduates having difficulty finding jobs. Particularly, Arkansas and Nebraska reported that 2010 graduates had difficulty finding jobs in urban areas, while rural and frontier areas continue to experience shortages.
- Kansas reports a workforce partnership committee that is developing a strategic plan to increase primary health care professionals in the state by 10-25%.
- Arkansas has seen a shift away from the use of LPNs in the hospital settings. This brought one program to a closure in 2011.

Other workforce issues for 2011:

- Occupational health nurses are being laid off or cannot find jobs due to the current economic situation.
- Due to severe budget cuts in education, many schools are eliminating the role of the school nurse.
- There are not enough jobs for clinical nurse leaders (CNL). At a recent meeting of the American Board of Nursing Specialties, AACN reported that health care systems need to develop the CNL role. There are 100 nursing programs offering the CNL degree and only an estimated 500 CNLs are currently practicing in that role.

Workforce Initiatives

The Future of Nursing: Campaign for Action: 2011 update

In July of 2009, the Institute of Medicine and Robert Wood Johnson Foundation led a major initiative to develop recommendations to transform nursing and lead it into the future. The result was a report *Future of Nursing: Campaign for Action*. October of 2011 marked the one year anniversary of the reports' release. The campaign is coordinated through the Center to Champion Nursing in America, who is focusing on the establishment of state level coalitions to implement the recommendations included in the report. This year 36 State Action Coalitions have been formally convened and include a wide range of health care providers, consumer advocates, policy-makers and leaders from the business, academic and philanthropic communities.

States with established Action Coalitions are: Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. Year one accomplishments include:

- Connecticut: Has secured funding for simulation labs and is developing common curriculum agreements.
- Florida: Is promoting seamless transition from community colleges to state colleges; and fostering community college/state college partnerships.
- Vermont: The Governor is forming a state commission to implement select recommendations from the report. AARP Vermont is slated to join the commission.
- The California Action Coalition held a town hall meeting to discuss with leaders, health-care professionals and consumers the necessary actions to improve health in the state and the role nurses should take to advance this vision.
- As part of its fiscal 2012 funding for the federal Department of Health and Human Services, the Senate Appropriations Committee called on Secretary Kathleen Sebelius, working with HRSA and the Centers for Medicare and Medicaid Services, to develop a plan to implement the recommendations and to report back to the committee early next year.
- The American Association of Colleges of Nursing announced collaboration with the Jonas Center for Nursing Excellence to enhance efforts to increase the number of doctoral prepared faculty available to teach in nursing schools.
- States have hosted more than 156 events related to the Campaign for Action, including statewide strategic planning sessions, stakeholder presentations, launch events and Action Coalition webinars.

CMS Funding

The Center for Medicare and Medicaid Center for Innovation announced on November 14, 2011 that the White House was allocating $1 billion in funding for grants that would demonstrate innovative ways to increase the health-care workforce while decreasing the cost of delivering

care. New programs are expected to be established and begin running within six months of funding (Kliff, 2011).

Workforce Legislation 2011

- Illinois established the State Healthcare Workforce Council to assess health care workforce trends, training issues and financing policies. The Council's objectives include a review of workforce supply, competence, diversity and primary care training.
- Nebraska amended the Nebraska Workforce Investment Act to include the study of health care workers and reducing provider shortages.

Future Workforce Issues

Despite the current stabilization of the workforce, it is predicted that the health care workforce shortage will re-emerge and exceed past proportions when the Affordable Care Act is fully implemented and 32 million more Americans are insured. This is anticipated between the years of 2014 and 2019 (Kliff, 2011).

NURSING EDUCATION

Faculty 2000-2010

While there have been significant improvements in the nursing workforce over the last decade, there have been few advancements in the number of faculty teaching in nursing education programs across the U.S. In the year 2002, Berlin and Sechrist referred to the shortage in numbers of nursing faculty as a "dire situation." An examination of data in figure 2 demonstrates some improvement from 2000-2010. However, data available for 2011 shows some increasing cause for concern as the numbers rise beyond the levels published in 2000.

Faculty 2011

Figure 2

The National Picture (2000-2011) of Nursing Program Faculty

	2000	2010	2011
Percentage of positions filled	92.6%	92.3%	92.3%
National vacancy rate	7.4%	6.9%	7.7%
Mean no of vacancies per school	1.7	1.6	1.8
Range of vacancies	0-17	1-16	1-16

In September 2011, Fang and Li (2011) published a *Special Survey on the Vacant Faculty Positions for Academic Year 2011-2012,* which reports on the current status and trends related to nursing faculty in baccalaureate or higher nursing education. The survey had a response rate of 603, of which 534 (or 88.6%) were from the AACN membership. Data are reported in Figure 3.

Figure 3

Nursing Program Faculty: Recent Trends (2009-2011)

	2009	**2010**	**2011**
Total budgeted positions	12,184	12,783	14,166
Total number of full-time vacancies (National Vacancy Rate)	803 (6.6%)	880 (6.9)%	1,088 (7.7%)
Total number of filled positions	11,385 (93.4%)	11,909 (92.3%)	13,078 (92.3%)
Mean number of vacancies per school	1.4	1.6	1.8
Range of Vacancies	1-13	1-16	1-16
The number of schools with no faculty vacancies, but that need additional faculty	117	112 (20.1%)	104 (17%)
The number of schools with no faculty vacancies, and that do not need additional faculty	127	141 (25.4%)	145 (24%)

Faculty statistics for 2011:

- The full-time faculty vacancy rate is the greatest in the West (11.7%) and lowest in the North Atlantic (9.3%). The Midwest has a vacancy rate of 11.3%, while the South has a vacancy rate of 9.5%.

- The degree requirements for vacant faculty positions are:
  - Earned Doctorate: 58%; this compares with 64.2% in 2000
  - Master's degree, Doctorate preferred: 34%; compares with 30.7% in 2000
  - Master's degree: 8.1% (2000 data not available).

- The major reasons reported in 2011 for not hiring new faculty include (n=104 schools that do not have vacant positions, but need more):
  - Insufficient funds to hire new faculty (72.1%)
  - Unwillingness of administration to commit to additional full-time positions (50.0%)
  - Inability to recruit qualified faculty because of competition for jobs with other marketplaces (33.7%)
  - Qualified applicants for faculty positions are unavailable in our geographic area (24.0%)

- Most critical issues faced by schools related to faculty recruitment and retention (n=603) in 2011:
  - Limited pool of doctorally prepared faculty (31.3%)
  - Noncompetitive salaries (26.7%)
  - Finding faculty with the right specialty mix (18.4%)
  - Finding faculty willing/able to teach clinical courses (5.3%)
  - Finding faculty willing/able to conduct Research (4.6%)
  - High faculty workload (3.2%)

Nursing Graduates and NCLEX: 2000-2010

As seen below in Figure 4, the number of candidates taking the NCLEX exam has doubled over the last decade. Figure 5 shows that there were almost twice as many candidates taking the NCLEX in 2010, when compared to 2000 for both associate degree and baccalaureate programs. The number of candidates from diploma programs also increased. Given the initiative to phase out diploma programs, one might have expected fewer graduates (candidates) in 2010. The converse is true and as the data indicate there were over 30% more diploma graduates taking the NCLEX in 2010 than in 2000.

Figure 4

Graduates from U.S. Nursing Programs 2000-2010

	January-December 2000	January-December 2010
Number of first time U.S. educated students taking the NCLEX-RN	71,475	140,889
Number of first time U.S. educated students taking the NCLEX-PN	35,666	66,831
NCLEX pass-rates first time RN test takers	83.8%	87,41%
NCLEX pass-rates first time PN test takers	85.0%	87.05%

Figure 5

Number of U.S. NCLEX Exam Takers by Program Type

	2000 Number of U.S. first time test takers taking NCLEX according to type of educational program	2010 Number of U.S. first time test takers taking NCLEX according to type of educational program
Diploma	2,679	3,753
Associate Degree	42,665	81,618
Baccalaureate	26,048	55,414
Unclassified or special codes	83	104
Total	71,475	140,889

Online and Proprietary Programs

The 2000-2010 decade was marked by a rapid increase in online and proprietary RN and PN programs. During 2011, state boards continue to report an increase in the number of proprietary programs applying for board approval.

A meta-analysis of teaching strategies finds that hybrid strategies (face-to-face and online learning) were the most effective in promoting positive learning outcomes (Means, Toyama, Murphy, Bakia & Jones, 2010).

Education Issues: Boards of Nursing

U.S. Member Boards

- Connecticut reinstated six vocational technical school LPN programs that were eliminated last year due to budget cuts.
- Georgia reports that clinical sites are limiting placements for ADN students.
- Hawaii is developing rules to approve distance learning education providers.
- Oklahoma implemented new rules in 2011 fostering innovation in nursing education; no programs have come forward yet.

Associate Member Boards

- College of Registered Nurses of Manitoba: All entry-level nursing programs will be at the baccalaureate level. While there are some students in the final terms of their diploma programs, there will be no further intake of diploma students.
- College of Nurses of Ontario: One of the first regulatory bodies in Canada to require the nursing jurisprudence exam

Education Legislation: 2011

Federal Regulation: Program Integrity Rules: State Authorization and Distance Education

On October 29, 2010, the U.S. Department of Education published the final Program Integrity regulations, which amend the eligibility requirements for institutions to receive funding under Title IV of the Higher Education Act (HEA) of 1965. Section 600.9 of these regulations relates to state authorization of education programs, including distance education. Under this section, for an institution to qualify to offer postsecondary education in a state, the institution must be named in state statute, constitution or other formal means. To clarify these requirements, the Department of Education offered the following example, "If, for example, in order to offer a diploma in nursing, State law requires a nursing school to be licensed by a State education agency as well as by the State's board of nursing, [the school must] document both licenses to be eligible for the Title IV, HEA student financial assistance programs." Additionally, the state must establish a complaints process for all authorized institutions.

"If an institution is offering postsecondary education through distance or correspondence education to students in a State in which it is not physically located or in which it is otherwise subject to State jurisdiction as determined by the State, the institution must meet any State requirements for it to be legally offering postsecondary distance or correspondence education in that State."

Due to a number of complaints and questions, on May 6, 2011, the Assistant Secretary for Postsecondary Education issued a letter to clarify the requirements and effective date of the distance education component. "Under the State authorization regulations, a student that is enrolled in an educational program offered by an institution cannot use Title IV, HEA program funds for that program if the institution the student is attending does not have State authorization *in the State in which the student is located* while receiving instruction" (emphasis added). The effective date for the regulation was pushed back to July 1, 2014, in order to give institutions time to comply with the new rule. In the meantime, each institution must show that it is making a good faith effort toward obtaining state authorization.

In response to the regulation, the Association of Private Sector Colleges and Universities filed suit against Department of Education Secretary Arne Duncan. In the July 12, 2011, district court ruling, Justice Rosemary M. Collyer found that "as to the one aspect of the new regulations that would require distance educators to obtain authorization from every State in which they have students, the Secretary gave no prior notice and its adoption in the final regulations violated the [Administrative Procedure Act]" since the regulation details were not included in the proposed rule and, therefore, no notice and opportunity for comment was granted. On September 8, 2011, the Department of Education filed a notice of appeal.

Federal Regulation: Program Integrity Rules: Gainful Employment

As a part of the Program Integrity Rules, the final rules for the US Department of Education's Gainful Employment Rule were published in June. Under the final rules, "career programs offered by schools, such as the University of Phoenix – the nation's largest for profit-school—will no longer be eligible for federal student aid if they do not hit certain benchmarks indicating they are not leveraging students into unsustainable debt. The career programs must prove that at least 35 percent of their former students are repaying their student loans; that the annual loan payment of the average graduate is less than 30 percent his or her discretionary income; or that the graduate's annual loan payment is not more than 12 percent of his or her total salary." The Department estimates that five percent of proprietary schools will not be able to reach those benchmarks and will be closed as a result.

STATE BUDGETS

2000-2010

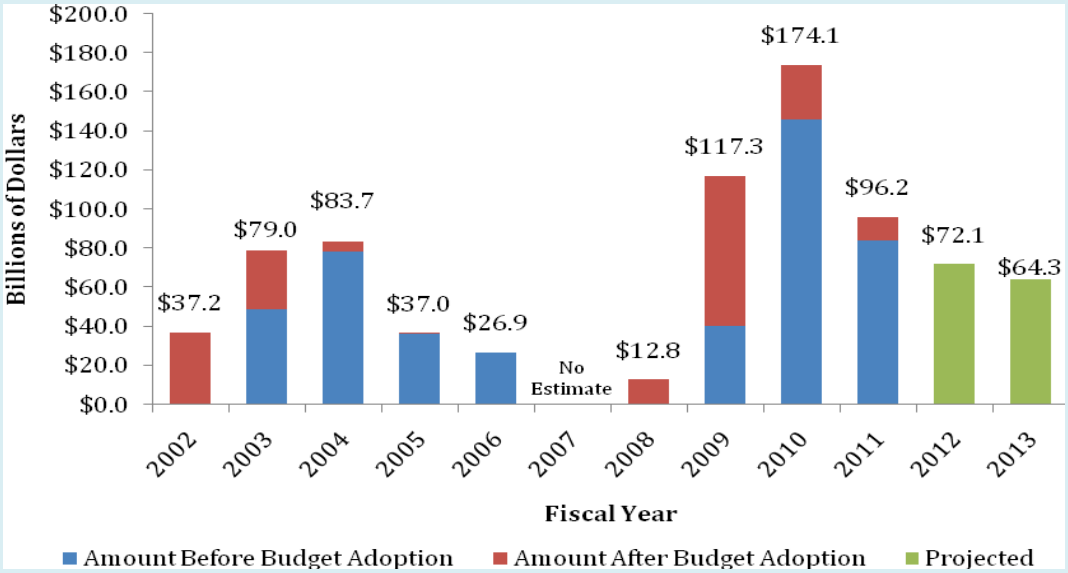
The beginning and end of the first decade of the 21st Century were contrasting bookends in terms of the U.S. and individual state economies. The economy of early 2000 was influenced by the technological boon of the 90's and soaring housing market. State spending, however, exceeded inflation and population growth in the early part of the decade. Each year state budgets grew with an increasing number of expenditures on programs, operations and welfare benefits. (Leonard, 2011). In 2007, states such as Arizona, California, Florida and Nevada began to experience budget problems. The real estate market took an abrupt turn and was on the verge of collapse. By December of that year, states were in the midst of one of the worst financial crises since the Great Depression of 1929. (Center on Budget and Policy Priorities, 2010)

All of the major tax sources within the states were impacted. Unemployment rose and the personal income tax revenue (a large source of revenue for 41 states) was significantly impacted.

Spending by the consumer decreased and the state sales tax revenue (45 states) plunged. Additional revenue sources including real estate taxes, and business taxes also dropped dramatically. As a result, every state with the exception of North Dakota experienced severe budget shortfalls (Pattison, 2011).

Figure 6

State Budget Gaps: 2002-2013 (projected)



Source: NCSL survey of state legislative fiscal offices, various years

2011

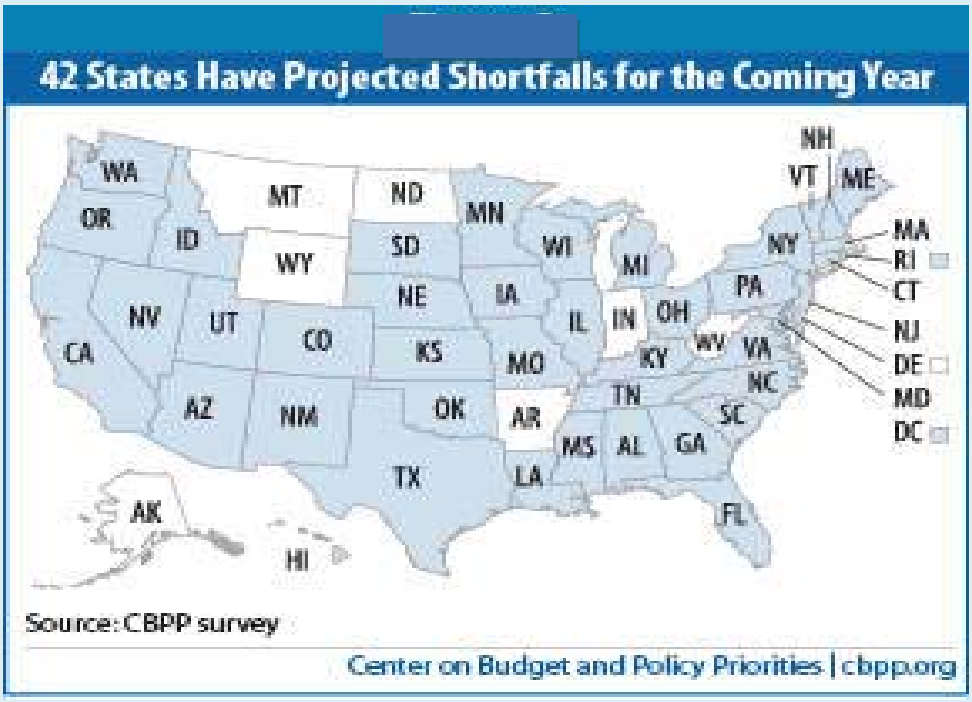
The current financial situation for most states remains serious after another year of severe budget shortfalls. At the beginning of FY2012[1], 42 states had projected shortfalls. During the 2012 fiscal year, these states and the District of Columbia will be working to close $103 billion dollars in budget gaps. At least 46 states have had to cut back on services; 30 states have had tax increases. These gaps have greater implications than in past years because the federal aid provided to the states beginning in 2009 as part of the Federal Recovery Act came to a close in 2011. (Center for Budget and Policy Priorities, 2011)

In addition to this, the temporary increase in the federal share of Medicaid spending under the American Recovery and Reinvestment Act expired in June 2011. States' Medicaid expenditures are projected to increase 28.7 percent. States will be required to increase spending to replace the federal funds (Kaiser Commission on Medicaid and the Uninsured, 2011).

[1] *Most state fiscal years run from July 1 through June 30 of the following year. Four states have exceptions to this: New York (April 1), Texas (September 1), and Michigan and Alabama (October 1) (Center on Budget and Policy Priorities, 2010).*

Eight states do not have shortfalls in FY2012. These are Alaska, Arkansas, Delaware, Indiana, Montana, North Dakota, West Virginia, and Wyoming. Two of these states, North Dakota and Montana, have not experienced any budget shortfalls from 2009-2012. Alaska, reported shortfalls in fiscal year 2010 but not for subsequent years. California remains the state with the greatest budget gap of 23 billion.

Figure 7



Despite the dismal forecast, there some signs of recovery on the horizon. In June of this year the Center on Budget and Policy Priorities reported stronger-than-expected revenue growth. Also encouraging is the fact that while 42 states have reported shortfalls, this is far fewer than in the past two years.

Looking ahead, approximately 24 states are predicting shortfalls for FY 2013 equaling $46 billion; however, as more states prepare their budgets for the upcoming year this total is likely to grow. Overall, the nation's economy is weak, unemployment rates remain at unprecedented highs and state economies lag behind the federal in terms of recovery. The FY 2012 shortfall, as well as the FY 2013 shortfalls that states are predicting, are in addition to over $430 billion in shortfalls that states have already closed for fiscal years 2009, 2010, and 2011 combined.

Budget Issues: Boards of Nursing

Boards of Nursing continue to report travel restrictions and furlough days due to state budget deficits. Boards are also reporting that staff have to take salary cuts by contributing 3% of their income to their retirement fund.

HEALTHCARE IN THE UNITED STATES

Healthcare Advancements: 2000-2011

One of the most remarkable scientific achievements of modern times occurred in 2003 when it was announced that the human genome project, begun 13 years prior, was brought to completion and scientists had identified all of the human genes and sequenced the 3 billion DNA subunits. This was just a start for a decade of accomplishments in healthcare and science.

For ten years, beginning in 1999 through 2009, the age-adjusted death rate in the United States declined from 881.9 per 100,000 population to 741.0. This historical achievement is the lowest U.S. age-adjusted death rate on record. The following advances over the last decade contributed significantly to this decline:

- Decrease in vaccine preventable illnesses
- Improvements in the control and prevention of infectious diseases
- Decline in smoking
- Improvements in maternal child health, namely the decrease in neural tube effects due to the increase intake of folic acid supplements
- Early screening and detection for cancer
- Reduction in deaths from heart disease
  (Centers for Disease Control and Prevention, 2011)

Despite the advancements in technology, diagnostics and treatment, the events of the past decade also revealed gaps in the nation's ability to respond to crises. The terrorist acts of September 11, 2001, as well as Hurricane Katrina illustrated a severe lack of domestic readiness to respond to emergencies. Much of this was attributable to inadequate communication networks and poor training of early responders. There was also a need for real-time surveillance and epidemiological systems as bioterrorism also became a threat to the well being of U.S. citizens.

Efforts to improve the U.S. emergency response system were initially focused on extending the capacity of the public health system (e.g., purchasing supplies and equipment). In the second half of the decade, the focus shifted to improving the laboratory, epidemiology, surveillance and response capabilities of the public health system (Board on Health Promotion and Disease Prevention (HPDP), 2002).

During this decade, several boards of nursing experienced disasters and emergencies in their states. Much has been learned about disaster preparedness through the sharing of these experiences. NCSBN addressed this need by convening a committee of experts to develop emergency preparedness guidelines for boards of nursing. In addition, the Nursys Emergency Responder service was developed to provide approved emergency response organizations the ability to verify nurse licenses in bulk free of charge during a declared all hazards event.

Access to Care: 2000-2011

Despite improvements in public health and a decline in mortality rates over the last decade, many Americans did not seek health care over the last decade due to a lack of access. This can be due to living in a health professional shortage area or not having health insurance to pay for services.

Figure 8 shows a significant increase in the numbers of uninsured Americans over the last decade.

Figure 8

Uninsured Americans: 2001-2010

	2001	2010
Number of Americans uninsured	41.2 million	50.7 million
Percentage of Americans uninsured	14.2%	16.7%

(The Number of Uninsured Americans Continued To Rise In 2004, 2005).
Census Bureau's Current Population Survey

Healthy People 2010, published in 2000, designated the elimination of health disparities as a national goal. Ten years later, there is little evidence of improvement. In fact, as poignantly depicted in Figure 9, the increase in the number of uninsured Americans occurred in ethnic groups while the number of Non-Hispanic White uninsured remained stable.

Figure 9

Uninsured Americans by Ethnicity: 2001-2010

	2001	2010
Non-Hispanic White	12.5%	12%
Non-Hispanic Black	15.2%	21%
Hispanic	29.1%	32.4%

(Pleis JR, Benson V, Schiller JS, National Center for Health Statistics, 2003).
(Robert Wood Johnson Foundation, 2010).

Health care disparities have been on the national agenda for over the last ten year. The *National Healthcare Quality Report*, released in 2010 (the year the Healthy People goals were to be met), reported significant health care disparities related to race, ethnicity and socioeconomic status. Although there are differences related to condition and population, disparities were noted in almost all aspects of health care and in both urban and rural areas. The report outlined significant disparities related to the following:

- Health care quality: effectiveness, patient safety, timeliness and patient centeredness,
- Access to care
- Levels and types of care: preventive care, treatment of acute conditions and management of chronic diseases.

It has been 35 years since Congress passed the Health Professions Educational Assistance Act of 1976 to address the shortage of primary care providers in rural and urban areas of the United States. This legislation mandated the development of Primary Care Health Professional Service Areas (HPSAs). These designated regions are eligible for loan repayment, technical assistance, increased reimbursement through Medicare, Federally Qualified Health Center (FQHC) and Rural Health Clinic designations, and assistance for communities to increase their supply of primary care providers (Doescher, 2009)**.**

- Estimated Underserved Population in 2011: 11.8%. There are 6,033 Primary Care Health Professional Shortage Areas (HPSA), which encompass a population of 64 million. In order to meet the primary care needs of the people living in these deprived areas, 16,336 practitioners are needed to meet the need for primary care providers (a population to practitioner ratio of 2,000:1) (Kaiser Commission on Medicaid and the Uninsured, 2011).

- Jurisdictions with the highest underserved populations: Louisiana (34.4%); New Mexico (32%); Mississippi (31.9%). New Jersey has the lowest (1.7%) (Kaiser Foundation, 2008).

Quality of care: 2000-2011

In 2006, the first *National Scorecard on U.S. Health System Performance* was developed and was the first instrument to measure and monitor the performance of the health care system in the U.S. Key indicators include health care outcomes, quality, access, efficiency and equity of care. Since its institution, the U.S. has had predictably poor ratings marked by inconsistency and routinely demonstrating numerous missed opportunities to prevent disability, disease, hospitalization and mortality (Schoen, 2011).

The National Scorecard on U.S. Health System Performance (2011) concluded that the "quality of care remains uneven." The report found two measures that negatively impacted the overall score, one being the increasing number of uninsured or underinsured and the other the deaths that might be prevented by timely and effective care. On a 100 point scale, the U.S. healthcare system scored a 64, down from 67 in 2006 (see figure 10) (The National Journal, 2011).

Figure 10

The National Scorecard on U.S. Health System Performance
(out of a possible 100 points)

Year	Score
2006	67
2008	65
2011	64

(The Commonwealth Fund, 2008)

Another report measuring the outcomes of U.S. healthcare is the *National Healthcare Quality Report (NHQR).* Annually, AHRQ is mandated to provide Congress with an update on the quality of health care delivery in the U.S. The following are key findings from the report:

- Health care quality and access in the U.S. is suboptimal, especially in minority and low-income groups.
- Quality is improving slowly; however, access and disparities are not.
- Necessary improvements in quality and reductions in disparities have been identified for certain services, geographic areas and populations, including:
  - Cancer screening;
  - Management of chronic diseases, especially diabetes;
  - Preventative services; and
  - Individuals living in central states and/or inner-city and rural areas

- In addition, the following results were also noted:
  - Quality is improving for palliative and end-of-life care, as well as patient and family engagement,
  - Quality is not improving for population health, patient safety and access,
  - More data are required to assess care coordination, overuse and health system infrastructure,
  - Disparities persist in health care quality and access.

(U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, 2011b).

Section 3011 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (DHHS) to present to Congress a National Strategy for Quality Improvement in Health Care (the *National Quality Strategy*). The purpose of this is for DHHS to determine priorities/goals for healthcare improvement and a strategic plan for how to achieve the goals. The initial strategy and plan for implementation was presented to Congress in March 2011, with contribution from the National Priorities Partnership (part of the National Quality Forum, which provides consultation services to DHHS). There are three categories of strategic opportunity in making progress toward the National Quality Strategy aims:

- There must be a national strategy for data collection, measurement, and reporting that supports measurement improvement efforts of public-and private-sector stakeholders at the national and community level.

- There must be an infrastructure at the community level that assumes responsibility for improvement efforts, resources for communities to benchmark and compare performance, and mechanisms to identify, share, and evaluate progress.

- There must be ongoing payment and delivery system reform – emphasizing primary care that rewards value over volume; promotes patient-centered outcomes, efficiency, and appropriate care; and seeks to improve quality while reducing or eliminating wastes from the system.

The overall aims of the strategy focus on better quality of care, healthier people and communities and affordable care. (Report to Congress: the National Strategy for Quality Improvement in Healthcare, 2011).

Legislative Update: The Affordable Care Act

During 2011, 26 states filed a federal lawsuit in response to the Affordable Care Act. Recently, the State of Ohio voted in favor of a non-binding referendum that would bar mandated health insurance. On November 14, 2011, the United States Supreme Court agreed to hear and make a ruling on the constitutionality of the Affordable Care Act. This is potentially a landmark decision that will establish a precedent for the future scope of federal power.

Patient Safety: 2000-2010

In the year 2000, people in the U.S. were stunned after learning of the scope of preventable medical harm occurring in the U.S. health care system following the publication of the Institute of Medicine (IOM) report, *To Err is Human*, 1999. The IOM report concluded that as many as 98,000 people die needlessly each year as a result of preventable harm. The report also suggested that the U.S. was not doing enough to prevent these mistakes. A Kaiser Family Foundation report revealed that more than half of all Americans had heard of the IOM report. It was the most closely followed health policy story of 1999. The IOM called for measureable improvement in patient safety saying, "it would be irresponsible to expect anything less than a 50% reduction in error over five years." (Institute of Medicine, 1999) and (Kohn, Corrigan, Donaldson, 1999)

Within days of the report, President Clinton's administration asked for the formation of a federal task force to address the recommendations. Seven hearings occurred on Capitol Hill and at least five federal bills were filed that pertained to medical error (Consumers Union, 2009)

In addition, other studies released during the same time period, confirmed the IOM findings across populations. Miller and Zhan (2004) analyzed the 2000 Healthcare Cost and Utilization Project data for patient safety indicators and estimated the patient safety risks for hospitalized children. Data indicated that adverse events in children occurred in high numbers and at considerable expense and mortality risk.

Within a year of the IOM's report's release, further study by AHRQ and others suggested the actual rates of error and harm were much higher than the IOM reported (Romano, Geppert, Davies, 2003). Congress responded by increasing appropriations to DHHS and specifically allocating funds for patient safety.

In a poignant article following the IOM report, Lucien Leape and Don Berwick warned that there were no quick fixes. They suggested that the problem of medical error was not due to a lack of knowledge, but unsafe systems. Blame and guilt would not change the paradigm. Instead they believed that multidisciplinary champions, learning from safe industries and leadership could lead to effective change (Leape and Berwick, 2000 and 2005).

These landmark reports, and those subsequent to it, generated a decade of research and initiatives to improve patient safety across the U.S. health care system. Included in this was a new way of addressing error in terms of systems. Hospitals and other institutions began encouraging the reporting of errors by not punishing the practitioner, but by seeking to understand the cause. The Just Culture initiative, adopted from the aviation industry, emerged from this new way of thinking about error.

As part of the *5 Million Lives Campaign* that was initiated in response to the IOM report, The Institute for Healthcare Improvement (IHI) launched the *Boards on Board* program in 2007. This was a new program to focus hospital boards on improving quality and reducing harm within their institutions. The program recommended that boards devote at least 25% of their time discussing safety issues. Despite this, a follow up survey of 1000 U.S. hospital board chairs, three years later in 2010, found that fewer than half of the non-profit hospital boards rated quality of care and patient safety as one of their top two priorities (Jha & Epstein, 2010).

In 2003, Aiken and her colleagues reported the results of a study of surgical patients hospitalized in 168 Pennsylvania hospitals. Death rates were almost two times higher in institutions that employed less than 10% of nurses holding bachelor's degrees when compared with hospitals where more than70% of the nurses had BSN degrees. The researchers concluded that employing nurses from bachelor's degree programs could save lives and lead to better outcomes (Aiken, 2003)

One of the most significant strides in the last decade was the decrease in bloodstream infections. This progress is attributed to the development of collaborative protocols such as those developed by the Keystone project. These strides were the result of over ten years of research conducted by the National Health Safety Network and the Central Line Associated with Bloodstream Infections (CLABSI) groups (Provonost, Marsteller & Goeschel, 2011; Heiser-Rosenberg 2011). The Centers for Disease Control and Prevention, reviewing data from the National Healthcare Safety Network, found that central line infections, overall, dropped by 33 percent in 2010. Surgical site infections dropped as well, as did infections associated with catheters inserted in the urinary tract. The number of people who contracted methicillin-resistant Staphylococcus aureus (MRSA) infections from health care facilities dropped an impressive 18 percent (Fox, 2011).

Based on the premise that a culture of safety begins with the institution’s willingness to participate in patient safety initiates and measure patient safety outcomes, AHRQ has been conducting the *Hospital Survey on Patient Safety Culture* since 2006. The purpose is to provide comparative data so hospitals can benchmark themselves against other hospitals in terms of patient safety and the development of a culture of safety within the institution. In 2011, the survey had 472,397 responses from hospital staff representing 1,032 hospitals and health systems. Results reported by the survey respondents indicate that teamwork within hospital units/work areas is improving; and that supervisors and managers are becoming more mindful of patient safety issues, collaborating with staff and implementing staff suggestions on improving patient safety. In addition, the majority of the staff responding gave their unit/work area high overall ratings (excellent to very good) in regards to patient safety.

The top three patient safety actions implemented by hospitals between the previous and most recent survey administration were:

- Improved fall prevention program (56 percent)
- Implementation of a root cause analysis program (52 percent)
- Use of the SBAR (situation-background-assessment-recommendation) technique to improve communication (51 percent) (AHRQ, 2011).

Hospital readmission rates have increased in many U.S. hospitals. One in six Medicare patients returns to the hospital within 30 days of discharge for a medical condition and half of Medicare patients do not see a primary care clinician within two weeks of leaving the hospital (Dallas, 2011).

Staffing ratios have been a persistent theme in nursing since the advent of the patient safety movement. Below target levels of nursing staff can be associated with increased patient mortality. A New England Journal of Medicine special article in March 2011 revealed that higher patient mortality was associated with lower staffing levels at a single large academic medical center. However, the association between increased mortality and high patient turnover rates was also significant (Needleman, et al., 2011).

Despite some improvements there is still serious cause for concern. As part of the National Quality Strategy report to Congress this year, the following was noted:

- Serious preventable medication errors occur in 3.8 million inpatients and 3.3 million outpatients each year
- 37% of preventable medication errors result from dosing errors
- 11% of preventable medication errors result from drug allergies or harmful drug interactions (National Priorities Partnership, 2010)

2011 has seen the emergence of a new patient safety issue: epidemic drug shortages. Fifteen patients have died in the past 15 months because they could not receive needed drugs or because of complications of substituted agents. Drug shortages are not new, but this year they have reached crisis proportions and a "grey market" has emerged (PRESSTV, 2011).

Medicare has added online safety ratings to the CMS Hospital Compare website (http://www.hospitalcompare.hhs.gov) allowing patients to see how hospitals in their area are performing against others in rates of specific complications. The patient safety data compare hospital rates on:

- Surgical complications
- Infections
- Medical errors
- Potentially avoidable deaths (HHS, 2011)

Planned disclosure in response to serious and sentinel events is a best practice in the Innovation Series IHI white paper on the *Respectful Management of Serious Clinical Events*. They advocate for clinical crisis planning, full disclosure, expression of compassion for the family and for caregivers, possible compensation, and extensive family and team support. The white paper makes use of checklists and tools to advise hospital leaders and boards in following best practices after clinical crisis events (Conway, Federico, Stewart, & Campbell, 2011).

The creation of national Patient Safety Organizations (PSOs) creates a rich informational resource to help institutions uncover and correct the systemic factors that undermine patient safety. It is within this framework that providers can share stories and events without reprisals. PSOs were initiated in 2009 and it is too early to quantify the contribution of PSOs toward positive outcomes. While nearly 100 enrolled within the first year, 17 delisted because they could not perform the basic functions of a PSO (Terry, Daughenbaugh, & Martin, 2011).

The World Health Organization (WHO) launched the new resource on patient safety, The *Multi-professional Patient Safety Curriculum Guide* in October 2011. This comprehensive guide is useful for universities and schools as well as facilities to use for training and to promote patient safety education across the disciplines of dentistry, medicine, midwifery, nursing and pharmacy (WHO, 2011).

Patient Safety: Boards of Nursing

NCSBN analyzed 861 practice breakdown cases submitted to its TERCAP (Taxonomy of Error, Root Cause Analysis and Practice-responsibility) Nursing Adverse Event Reporting System by 20 boards of nursing during 2008 and 2010. The 2011 TERCAP committee reported the findings of the study at the 2011 NCSBN Annual Meeting held on August 4, in Indianapolis, Indiana. Current data reveal that a nurse's negative job history (discipline or termination by employer) may serve as a useful index to identify a small group of nurses with potential risk of committing practice breakdowns.

The purpose of the TERCAP project is to improve nursing practice by systematically analyzing practice errors and their root causes. Twenty three Boards of nursing voluntarily submitted their cases to the NCSBN TERCAP database.

Boards of nursing report continued interest in the Just Culture model as more boards learn about and implement these principles in their state.

EMERGING ISSUES AND TRENDS: BOARDS OF NURSING 2011

The following section summarizes the changes and innovations in boards of nursing that have taken place throughout the last year.

Practice

The following position statements, advisory rulings/opinions and interpretive guidelines were issued or revised by boards of nursing during 2011:

Arizona

- Application of fluoride varnish under the supervision of an RN
- Role of the LPN in intravenous infusion therapy/venipuncture
- Use of fractionated laser by the LPN (if supervision on site)
- Role of the LPN in providing ventilator care under direct or indirect supervision and delegation of an RN

- Role of the LPN in wound care in collaboration with the RN or Licensed Independent Practitioner (LIP)

Arkansas

- Provision of care to patients receiving analgesia by a specialized catheter (epidural, intrathecal, intrapleural)

Illinois

- LPNs who possess the proper education, training and experience may administer intravenous medication

Iowa

- LPNs allowed to practice in a licensed hospital, nursing facility, or end stage renal dialysis unit to perform selected procedures related to the expanded scope of practice of intravenous therapy including peripheral catheters, midline catheter and practice, and peripherally inserted central catheters (PICC).

Kentucky

- LPN who has received appropriate training and demonstrated competency can provide Basic Life Support activities during a cardio-respiratory arrest
- Reaffirmed advisory opinion issued in June 2004 that states administration of local anesthesia in a dental setting is not within the scope of the LPN
- Revised "Components of LPN Practice"
- Revised "Roles of Nurses in Maintaining Confidentiality of Patient Information"

Massachusetts

- Revised advisory ruling on *Foot Care* which guides LPNs (within their scope of practice) who incorporate foot care to meet patient goals (unsure exactly what was revised)
- Revised advisory ruling on *Holistic Nursing and Complementary/Alternative Modalities(CAM)* which guides LPNs (within their scope of practice) who incorporate CAM to meet patient goals; these modalities include increased comfort , relief of pain, relaxation, improved coping mechanisms, reduction of stress, etc. (unsure exactly what was revised)
- Revised advisory ruling on *Pain Management* (revision includes addition of a section related to APRN prescriptive authority; revision does not affect LPNs)

Ohio

- Reaffirmed interpretive guideline that addresses licensed nurses' role in care of patients receiving intramuscular, subdermal or subcutaneous injected medications for cosmetic/aesthetic treatments

South Dakota

- Licensed nurse may delegate to trained medication assistant the task of dialing a dose on an insulin pen

Texas

- Interpretive Guideline for LVN Scope of Practice was retired and replaced with Position Statement 15.27. *The LVN Scope of Practice*

Discipline

- Alaska established a discipline database to summarize licensing actions taken by the Board. The link to this database can be found on the Board's website at www.nursing.alaska.gov.
- California approved a statutory proposal to amend their mandatory reporting law. Prior to this amendment, many licensees were permitted to submit resignations in lieu of suspension or termination. This amendment would require employers of LVNs to report to the Board any resignation submitted by an LVN in lieu of suspension or termination for cause. Additionally, the employer would be required to report any LVN who was "rejected" for cause as well as suspended, terminated or resigned in lieu of suspension or termination for cause.
- Delaware implemented a new process for discipline using a hearing officer for uncomplicated disciplinary cases. In order to facilitate this new process, they hired two attorneys and one paralegal.
- Two boards implemented procedural changes to streamline the disciplinary process: District of Columbia and Florida.
- The Massachusetts BON recently reviewed cases involving misuse of patient-related information or images so they have published information in its annual newsletter to remind nurses of their accountability and responsibilities in dealing with patient health information.
- Virginia experienced an increase in the number of cases related to social networking and boundary violations.
- Several boards expressed a continued interest in Just Culture and have implemented or will consider integrating Just Culture principles into the disciplinary process.

Licensure

- Alaska adopted legal prohibitions for sexual misconduct affecting patients. (Any RN, LPN, or CNA committing sexual misconduct shall be subject to discipline up to and including revocation of licensure or certification.).
- American Samoa initiated discussions of CE requirements for license renewal but has not yet implemented this because of difficulty in acquiring a provider number.
- Idaho is considering strategies for determining continued competence/lifelong learning for LPNs as a condition of licensure renewal.
- Iowa adopted rules that require foreign educated nurses to complete the CGFNS Professional Report when applying for license by endorsement.
- Kentucky stopped issuing one time permanent wallet size license cards as of May 1, 2011. Instead, notifications including license number, expiration date, and the web address of Kentucky's Nursing Laws are sent via email. .
- Massachusetts BON has approved the Board's Licensure Policy, "Determination of Good Moral Character Compliance" in the event that a candidate for nurse licensure is found to have violated the NCLEX Examination Candidate Rules. If this situation occurs, the candidate will be excluded from licensure by exam or reciprocity for a five year period.

- Montana implemented CE requirements of 24 contact hours for the renewal period beginning January 1, 2011 through December 12, 2012.
- Oklahoma passed rule changes that require continuing qualifications for practice for currently licensed nurses.
- More boards are continuing to use online technology for licensure renewal and licensure application by endorsement and by examination. Additionally, more boards are becoming paperless and some are becoming cardless.

BOARDS OF NURSING: 2011 LEGISLATION

Scope of Practice Legislation

Louisiana enacted a law that allows RNs to delegate to LPNs components of the training and supervision of the direct service worker, but the RN retains the responsibility and accountability for all acts of delegation

APRN Legislation

Seven states were successful in passing legislation that better aligns their state with the APRN Consensus Model:

- Changed title to APRN – two states (KS and OK)
- Graduate level education as a minimum standard – two states (KS and VT)
- National certification required – two states (NV and VT)
- Dual licensure required (RN and APRN) – two states (KS and OK)
- Independent prescribing permitted – two states (HI and ND)
- Independent practice – three states: North Dakota removed the requirement for a written collaborative practice agreement; Illinois further removed it for APRNs in hospital affiliate practice; and Vermont removed it after a "transition to practice" requirement has been met.

Additionally, Oregon law now requires that any individual who uses the title "doctor" must designate the health care profession in which the individual's doctoral degree was earned.

Alaska instituted new regulations that allow advanced practice nurses to delegate injections of certain medications and vaccines to certified medical assistants. Certified medical assistants are not regulated in Alaska.

Arkansas began requiring advanced practice nurses to submit the collaborative practice agreement as a prerequisite for license renewal. (This was in rules, but not previously enforced.)

Connecticut revised regulations to recognize the Doctor of Nursing Practice Degree. Formerly, the regulations required a Master's Degree for advanced practice nurse licensure.

Georgia will begin recognizing clinical nurse specialists as advanced practice nurses January 1, 2012.

In Massachusetts, all prescribers, including APRNs who engage in prescriptive practice must complete new statutory education requirements which include pain management, identification of patients at risk for substance use and counseling patients about side effects, the addictive nature of a drug, and proper storage and disposal of medications.

Seven states are still in session and have pending APRN related bills (IL, MA, MI, NJ, NY, OH and PA). Four states have APRN bills that will be carried over into the 2012 legislative session (HI, OK, TN and VT).

Discipline Legislation

- Delaware and Illinois both passed legislation that prevents sexual offenders from being eligible for nurse licensure and revokes licensure for any sexual offenses committed.
- Missouri enacted a law that requires the BON to notify an employer of any change in a nurse's licensure status.
- Maryland and Wyoming passed laws that permit the BON to discipline for failure to comply with certain types of orders. In Maryland a licensee can be disciplined for failing to comply with an order from the Governor relating to catastrophic health emergencies. In Wyoming a licensee can be disciplined for violating a previously entered board order.
- Texas enacted legislation that authorizes the BON's evaluation of nurses with license suspensions for drug or alcohol use to be disclosed to a peer assistance program.
- Ohio passed House Bill 93 which provides the Board with enhanced investigative access to the drug database and the ability to share confidential investigatory information more freely with law enforcement and state agencies.
- Georgia passed legislation that prohibits the use of the title nurse by anyone other than a licensed RN or LPN.

Licensing Legislation

- Kentucky law now requires applicants for RN licensure to pass a jurisprudence exam.
- A West Virginia law provides an exemption to licensure for individuals who render health care service in the state in connection with any event or program offered by a nonprofit youth organization.
- Several states (FL, KY, TN, UT and VA) passed laws that provide temporary licensing, exceptions to licensing or expedited licensing for military personnel or their spouses.
- Illinois law now prevents any health care professional who is or has been a sex offender from holding a health care professional license in the state.
- Criminal Background Checks:
    - Georgia passed a bill that requires fingerprint CBCs for applicants for LPN licensure.
    - Indiana enacted a law that provides for CBCs for health care professional licensing, which includes nursing.
    - A new Rhode Island law now requires that all who apply for a license to practice nursing, and those already licensed, but seeking employment, must first undergo federal and state CBCs.
    - In Oklahoma, beginning in 2013, CBCs must include fingerprints and a state and federal records search.

- Kentucky has expanded their criminal background check requirements. Beginning January 10, 2011, fingerprinting is required not only for Kentucky RN and LPN applicants but also for APRN and SANE applicants for initial licensure.

CONCLUSIONS AND POLICY IMPLICATIONS FOR THE FUTURE

The first decade of the new millennium presented many challenges to boards of nursing: an increasing number of proprietary and online programs seeking board approval, state budgetary constraints, demands for increased use of assistive personnel, expanding scope of practice for RNs, state disasters and emergencies, licensure issues including uniformity of APRNs and patient safety concerns.

Despite all this, boards have managed to be innovative, cost effective and keep public protection at the forefront. They have adopted new legislation that ranged from encouraging innovation in nursing education to taking on the medical establishment and adopting critical components of the Consensus Model for APRN regulation. They have embraced new technology, gone from paper to paperless, become full participants in Nursys and are beginning to share investigative data with one another beyond that of the nurse licensure compact.

The future promises more challenges and changes. If the Affordable Care Act is deemed constitutional by the Supreme Court, it may have more impact on regulation than any other law in history. As larger numbers of nurses are needed to accommodate the predicted 32 million more Americans that will be insured, the number of nursing programs will continue to rise and approval of programs will continue to present challenges as possible pressure mounts to reduce regulations.

Health insurance does not provide access to care. Individuals living in health professional shortage areas will continue to suffer from a deprivation of services unless there are more health professionals able to serve those areas. This has implications for APRNs and the need for uniformity and fewer barriers to providing care in remote rural as well as inner city areas.

Patient safety will continue to be an issue throughout the next decade. As boards begin to adopt new models such as *Just Culture* and think differently about discipline, collaboration is needed with health care institutions. The future focus must be on remediation and prevention of error as well as identification of it.

While many of the challenges of 2012 and beyond are yet unforeseen, there is one thing for certain-- there will be many opportunities for collaboration, to learn new ways of doing things, to defy tradition and find more cost-effective and efficient ways of regulating nurses and keeping the public safe.

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Board of Nursing Statistical Report

Measure	Tot. FY'09	Tot. FY'10	Tot. FY'11	1st Qrt	2nd Qrt	3rd Qrt	4th Qrt	FY '12 Tot.
Nursing Jurisprudence Exam	**32,320**	**27,177**	**27,821**	**6,327**	**0**	**0**	**0**	**6,327**
Exam Not Completed	485	1,845	1,216	558	0	0	0	558
Percentage Not Completed	1.50%	6.79%	4.37%	8.82%	??	??	??	8.82%
Did Not Passed	17,576	1,602	2,468	5,769	0	0	0	5,769
Percentage Did Not Pass	54.38%	5.89%	8.87%	91.18%	??	??	??	91.18%
Exam Passed	14,259	23,730	24,137	??	0	0	0	0
Percentage Exam Passed	44.12%	87.32%	86.76%	ERR	??	??	??	0.00%
NJE - Breakdown by Applicant Group								
LVN-Candidate	**4,627**	**7,266**	**7,472**	**1,647**	**0**	**0**	**0**	**1,647**
Exam Not Completed	282	835	399	86				86
Did Not Passed	177	723	991	191				191
Exam Passed	4,168	5,708	6,082	1,370				1,370
LVN-Endorsement	**938**	**1,384**	**1,716**	**407**	**0**	**0**	**0**	**407**
Exam Not Completed	57	94	105	16				16
Did Not Passed	90	193	387	98				98
Exam Passed	791	1,097	1,224	293				293
RN-Candidate	**8,104**	**10,929**	**11,057**	**2,531**	**0**	**0**	**0**	**2,531**
Exam Not Completed	265	569	361	95				95
Did Not Passed	35	250	387	101				101
Exam Passed	7,804	10,110	10,309	2,335				2,335
RN-Endorsement	**5,217**	**7,598**	**7,576**	**1,959**	**0**	**0**	**0**	**1,959**
Exam Not Completed	221	347	351	73				73
Did Not Passed	183	436	703	163				163
Exam Passed	4,813	6,815	6,522	1,723				1,723
Refresher Course/Renewal Requirements	**n/a**	**n/a**	**n/a**	**56**	**0**	**0**	**0**	**56**
Exam Not Completed				3				3
Did Not Passed				5				5
Exam Passed				48				48

Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, Texas 78701

Recruitment Plan

Reviewed and Revised: December, 2010

Introductory Statement

The Texas Board of Nursing (Board) is committed to the spirit and reality of Equal Employment Opportunity. This plan is designed to assure the implementation of human resource policies and practices to promote equal employment opportunities. The Board recognizes that full and equal participation of minorities, women and disabled persons in all employment opportunities is a necessary component of an effective Recruitment Plan.

The goal of the Board's Recruitment Plan is the achievement of genuine Equal Employment Opportunity for all qualified persons. Selection under such plans should be based upon the ability of the applicant(s) to do the essential functions of the job. Such plans should not require the selection of the unqualified nor should they require the selection of persons on the basis of race, color, sex, religion, national origin, age or disability status. The Board recognizes that under applicable authorities, State Agencies have flexibility to formulate Recruitment Plans that are best suited to their particular situations.

To carry out this plan, the Board shall analyze its workforce to determine whether percentages of sex, race, ethnic (age or disability) groups in individual job classifications are substantially similar to the percentages of those groups available in the relevant labor market or population who possess the basic job-related qualifications. Relevant data sources include the Texas Workforce Commission and the U.S. Census. When substantial disparities are found through such analysis, the Board shall establish affirmative steps to remedy the situation by:

a) establishing specific short-term or long-range goals and specific timetables;
b) establishing an enhanced recruitment program;
c) reviewing essential work duties; and
d) establishing career enhancement training.

Policy Statement

"It shall be the public policy of the Board not to discriminate against any employee or applicant for employment because of race, color, religion, national origin, sex, age or disability status. Further, the Board shall take all necessary affirmative steps to insure the employment and promotion of otherwise qualified minorities, women and disabled persons who may be under represented in the agency's workforce."

The Board is committed to the principles of Equal Employment Opportunity law. Therefore, this written plan has been prepared to ensure that the Board's Recruitment policy shall be properly implemented and no artificial barriers shall be intentionally or otherwise created to deny applicants for employment or employees of the Board equal employment opportunities.

The plan is available for review by Board employees, applicants for employment and the general public upon request.

Program Responsibilities

The Board's Recruitment Plan has the support of board members, Executive Director, agency management and supervisory personnel. Specific responsibilities shall be assigned and delegated to the Board and management personnel to ensure that the necessary authority and power is available to implement the provisions of the plan.

The Executive Director, assisted by the agency Operations Director, shall establish policies and monitor the implementation of the Recruitment Plan. Further, the Executive Director shall review annually for purposes of revision or modification, the Recruitment Plan, workforce analysis and personnel policies, procedures and practices including, but not limited to recruitment, selection, promotions, job descriptions, classifications, compensation, progressive discipline or other terms and conditions affecting the equal employment opportunities of applicants for employment or Board employees because or race, color, national origin, religion, sex, age or disability status.

The Director of Operations shall be designated as the Recruitment Officer for the Board with the authority for operationalizing the Recruitment Plan. It shall be the responsibility of the Director of Operations to ensure that the Board's Recruitment policies are implemented in an efficient and effective manner. The Executive Director shall provide annual progress reports to the Board outlining Recruitment Program accomplishments.

Program Goals

I. To ensure objectivity, consistency, uniformity and job relatedness through design and implementation of appropriate personnel policies, procedures and practices that affect the equal employment opportunities of the Board employees and applicants for employment.

II. To ensure a diverse workforce, the Board's Recruitment Program shall establish monitoring and reporting systems.

Action Programs to Achieve Goals

A number of specific result-oriented activities must be pursued to operationalize the general goals of the Board's Recruitment Program.

I. Policy Dissemination:

A. The Board shall utilize the Texas Workforce Commission Communication network and the Health Professions Council to distribute the Board's Recruitment policy. Also the Board shall provide its Recruitment policy to statewide minority and women's organizations for distribution to their respective members. Further, where practical, the Board shall distribute posters informing citizens about the Texas Commission on Human Rights Act and the Board's Recruitment policy. The Board shall include, in notifications posted for vacant positions, information that it is an equal employment opportunity employer.

B. As part of an orientation program, each new employee shall receive a copy of the Board's Recruitment policy. Further, performance evaluations of management and supervisory personnel shall include criteria measuring how effectively they implemented the objectives of the Board's Recruitment Program.

II. Recruitment

A. To the extent possible and within budgetary constraints, the Board shall utilize a wide range of recruiting sources to secure the maximum number of qualified minority applicants for available positions within all classifications. Such sources shall include statewide minority organizations and educational institutions, newspapers and the Texas Workforce Commission. The Board shall continue to expand and update its list of such recruiting sources including appropriate contact persons.

B. Notices of vacant positions shall be posted in accordance with the regular ten working day posting rule. Such notices shall be distributed to all recruitment sources previously identified, except when the vacancy is to be filled by promotion only. It is the policy of the Board to fill position vacancies by promoting its qualified employees when practicable. Where vacancies occur in classifications which have been identified as being underutilized, the Board shall place emphasis on recruiting from minority applicant sources.

C. An Applicant Flow Record shall be maintained to the extent possible, to determine the mix of candidates applying for vacant positions according to race, national origin, and sex.

III. Selection Procedures

The U.S. Equal Employment Opportunity Commission, the U.S. Civil Service Commission, the Department of Labor and the Department of Justice have issued Uniform Guidelines on Employee Selection Procedures. These guidelines address all phases of an employer's selection process and provide suggested requirements which, if adhered to, will greatly reduce an employer's susceptibility to charges of employment discrimination which involve the selection process.

A. Position audits shall be conducted on a continuing basis to ensure that current position descriptions accurately reflect the actual duties, tasks and responsibilities required to successfully perform the job. These audits shall also be utilized to determine the appropriateness of the minimum qualifications for the positions and to ensure that only valid, essential job-related qualifications are required.

B. All testing and screening procedures shall be reviewed on a continuing basis (within the resources available) to ensure their job-relatedness and validity. Information acquired from the position audits shall be used to construct valid, job-related tests and screening procedures.

C. All employment interviews shall be reviewed for job-relatedness. Non-job related questions and those items which may tend to screen out a particular ethnic or racial group shall be eliminated. Technical assistance in the construction of interview questions and interviewing procedures shall be given to hiring authorities.

D. All test scores and interview results shall be maintained in accordance with agency record retention requirements for each classification. This information is to assess the presence of artificial barriers to Equal Employment Opportunity.

IV. Upward Mobility

A. The Director of Operations shall compile required reports on promotional opportunities and selection of candidates promoted. The reports shall identify race, national origin, and sex of candidates promoted and reason selected.

B. The Director of Operations shall provide where needed and when requested, counseling and employee development activities to assist employees in preparing for promotional opportunities. Employees shall be encouraged to participated in training or educational opportunities (within resources available) that improve their promotability and competitiveness.

C. On-the-job training and in-service training programs shall be designed and made available to expose Board employees to a broad range of job duties and experiences.

Discipline Procedures

The Board has a progressive disciplinary system that is linked to specific policies and procedures with which personnel are expected to comply. Such a progressive disciplinary system will be designed in steps of severity ranging from written warnings to termination. Also, this disciplinary system shall be constructed in such a way as to ensure uniformity and consistency to conform with Board policies prohibiting discrimination. (See Human Resource Policies)

Appeal and Grievance Procedures

The Board voluntarily offers a grievance procedure to give an employee an opportunity for internal review of alleged unlawful retaliation, alleged unlawful discrimination, or adverse personnel actions. These procedures shall provide aggrieved employees the opportunity to discuss their problems at several levels. (See Human Resource Policies).

Monitoring the Recruitment Plan Achievement

The Director of Operations shall be responsible for administering the Board's Recruitment Plan and providing regular reports to the Executive Director. Utilizing such reports, the Executive Director shall monitor the implementation of the plan and identify any revisions necessary to assure effective application. Such reports may include:

A. Annual Recruitment Program Progress Report:

This narrative report shall include an itemized summary of the programs achievements, progress and shortcomings with accompanying recommendations.

B. Annual Workforce Analysis by race, national origin, sex and EEO category:

A racial, ethnic and sexual profile of Board Personnel by EEO category shall be prepared. EEO categories where minorities and females are under represented shall be identified. These workforce profiles shall be compared to the Board's Recruitment goals. Accomplishments and shortcomings shall be noted and corrective actions recommended to the Executive Director.

C. Annual Applicant Flow Report:

The Applicant Flow Report shall include, to the extent possible, a breakdown of all applicants by race, national origin, sex, and position vacancy. The report shall also indicate whether or not a job offer was made, reason not selected and the person(s) who made the employment decision.

D. Annual Personnel Transaction Report:

The Executive Director shall submit to the Board, through its internal Annual Report, as statistic report which shall include a record of the following personnel transactions: 1) number of vacancies; 2) persons referred for each vacancy; 3) persons hired; 4) employees promoted; and 5) employees terminated. All transactions shall include race, national origin, sex and EEO category. The information contained within these reports shall provide the data base in the preparation of the Recruitment Program Progress Report.

E. Annual Grievance Status Report:

This report shall be submitted to the Executive Director. It will provide an itemized statistical summary of the number, status and issues raised by employee grievances and discrimination complaints.

Time Frame for Implementation

The Board shall implement and review the action program previously identified annually.

Workforce Analysis

Board of Nursing Workforce as of November 30, 2010 is:

African-American	11.6%	Female	75%
Anglo	57.9%	Male	25%
Hispanic	29.5%		
Other	1.1%		

Discrimination Complaint Data

There are no employment discrimination charges pending with the Texas Workforce Commission - Civil Rights Division

EEO Data-2011

	Sex		Race/National Origin						Vet	Job Source					
Posting # and Title	M	F	White	Black	Hispanic	Asain / Pacific Islander	American Indian / Alaskan	Other	Vet	Work in Texas	Governors Job Bank	Austin American Statesman	BON Website	Other State Employee	Other
11-01-Admin Asst. III Enforcement	11	72	50	15	14	1	0	3	2	46	0	9	16	3	9
11-05-Admin Asst. III Enforcement	11	95	61	16	24	2	0	3	3	58	0	13	18	3	13
11-11-Admin Asst. IV Nursing	12	86	53	15	24	2	0	5	3	57	0	6	25	5	10
11-02-License Permit Specialist III	1	8	0	3	6	0	0	0	0	0	0	0	0	9	0
11-04-Investigator II	41	29	38	14	15	1	0	2	12	37	0	8	11	3	11
11-07-Accountant V	12	14	14	1	8	2	0	1	3	13	0	1	5	1	5
11-06 CS Rep II	16	118	64	34	30	1	0	3	6	79	0	15	17	6	16
11-08-Admin Asst IV ADP	8	98	61	16	26	2	0	2	2	65	0	4	24	5	11
11-09-Nurse Consultant-Edu	0	11	8	2	0	0	0	1	0	2	0	0	5	1	3

11-10-Nurse Consultant-APRN	0	8	6	2	0	0	0	0	2	2	0	0	6	0	0
Totals	112	539	355	118	147	11	0	20	33	359	0	56	127	36	78