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NCSBN 2014 Nurse Licensure Compact Survey Results:

What did Arizona nurses and employers recommend to improve the compact?

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VOL 11 • N°1 • APRIL 2015

4 From the Executive Director

6 Telehealth The Future is Now

8 Staff Directory

12 To Question, To Learn To Discover

16 NCLEX Information

18 Competency From NCLEX to Performance Report from the Deans and Directors Annual Meeting 2014

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22 CNA Disciplinary

25 RN/LPN Disciplinary

From the Executive Director

JOEY RIDENOUR, RN, MN, FAAN
& GUEST EDITOR – CINDY MAND RN BSN/GRADUATE STUDENT GCU

Arizona and 25 other states have joined the Nurse Licensure Compact (NLC). The NLC allows a nurse to have one multistate license in their primary state of residence and to practice in other compact states on a "privilege to practice" or PTP. This privilege applies to nursing practice both physically and electronically.

The NLC is a legal contract between member states that facilitates the movement of nurses between states. The National Council of State Boards of Nursing (NCSBN), along with the Federation of State Medical Boards (FSMB) and the National Association of Boards of Pharmacy (NABP) have all determined that health care practice occurs at the point where the recipient of the service is geographically located (NCSBN, 2015).

In 1997 NCSBN developed the NLC partially in response to the Telecommunications Act of 1996 to begin addressing the issue of telehealth (Tompkins, 2010). Fifteen years after it was first enacted in 2000, a total of 25 states have enacted legislation to become members of the NLC. In 2014, the NCSBN surveyed more than 152,000 licensed nurses to evaluate the impact of the NLC from their viewpoint, as well as the perspective of more than 26,000 nurse employers and all State Boards of Nursing (BONs). In this issue of the Arizona State Board of Nursing Regulatory Journal, the survey results will be provided to inform the public of the perceptions of the NLC and recommendations from nurses, employers and board's of nursing to advance the Nurse Licensure Compact.

National Council of State Boards of Nursing (2014). Nurse Licensure Compact Evaluation: All States Aggregate Findings:

1. 69% nurses with single state licenses aware of the NLC want their state to join the NLC. Those in favor stated the NLC benefits traveling nurses, offers increased employment opportunities beyond the state's borders and made finding a new job easier/quicker/flexible.
2. 62% of employers believe that the NLC makes it easier to hire a nurse.
3. Those who oppose their state joining the NLC – 2% of those surveyed – offered four reasons for their opposition: employment concerns, regulatory issues, concern over standards and cost.
4. 18% of compact nurses and 17% of single license nurses reported that they had provided services or communicated with a patient or client located in a different state/jurisdiction from where they were located during past 24 months (i.e., telehealth).
5. For those nurses who reported practicing in more than one state, nurses from compact states had a slightly higher average number of states practiced through telehealth: 4.15 in compact states and 4.06 in single license states.
6. Of employers who were familiar with NLC, the average number of nurses practicing on a compact license issued by another state was 2.38, or 4% of their nurses. Of those nurses, 47% were due to the nurse newly relocated, a close second were nurses living across state/jurisdiction border (46%), and third was traveling nurses.
7. Approximately 10% of nurses in single license states reporting have engaged in telehealth without a license in the past 24 months
8. 63% of Boards of Nursing (BON) responding indicated there was no financial impact of the NLC on the BON, while 37% indicated there was a financial impact.
9. All BON's reported advantages of being a member of the NLC, with 32% reporting some disadvantages. The advantages cited by BON's included the ability for licensees to practice in a number of states, the establishment of a consistent framework to regulate telehealth and distance education issues, and the ability to share investigative information. Disadvantages included anticipated confusion among employers and nurses about the compact, perceived increased workload for board staff and investigators, nurses aren't always timely licensed when they are supposed to be, and the lack of criminal background checks in all states.
10. 6% of compact employers and 20% of single license state employers indicated nurses in their organization require multiple nursing licenses from other states/jurisdictions to perform their job.
11. Of those positions requiring multiple licenses, the top 4 were: home health/hospice, case management, post-discharge follow up, and telehealth.
12. Employer's two most common recommendations to improve the NLC were to expand to more or all of the states and to provide more education and information about the NLC.
13. 5% of employers indicated there have been disadvantages of the NLC for their organization. The most common complaints: dealing with states that have not joined the compact and nurses not understanding their responsibilities related to the NLC.

National Council of State Boards of Nursing (2014). Nurse Licensure Compact Evaluation: Arizona Data

1. 468 Arizona nurses responded with 86% indicating they were employed in an urban-type area and 14% in a rural-type area.
2. 78% were at least somewhat aware of NLC.
3. 34% held an active license in another state or jurisdiction, with the average number of licenses held by compact licensees being 1 and the average number held by single state licensees being 3.
4. 23% nurses in AZ who were aware of the NLC and held a compact license did not know if their home state belongs to the NLC.
5. 27% with a compact license indicated they provide nursing services or communicate with patients or clients outside of their home state at least some of the time.
6. Average number of states a nurse in AZ with a compact license practiced through telehealth was 6 and 80% of those indicated they held only 1 license.
7. Average number of states a nurse in AZ with a single state license practiced was 7 and 11% of those indicated they held only 1 license.
8. 3% nurses indicated something had prevented them from applying for a nursing license in another state/jurisdiction. The top reasons indicated for not applying for another license were: no need for license outside of AZ, hassle/lengthy process, participating in board confidential program for Chemically Addicted Nurse Diversion Option (CANDO) or have discipline against their license and therefore are a single state license and cost.
9. 16% nurses practiced in another state/jurisdiction. The largest percentage of these (26%) said the type of position held was: a travel nurse, 22% indicated telehealth/case manager by phone or electronic, and 16% work for an employer/facility across the state border. Other practice environments included camp nurse, home health/hospice, and nurse educator.
10. Forty AZ nursing employers responded to the survey; 38% nursing home/long-term care, 20% hospital, 18% ambulatory surgery center (not hospital owned), and 25% "other."
11. 93% of the employers were at least somewhat familiar with NLC; of those 83% said the NLC helps expedite nurse hiring.
12. AZ employers familiar with the NLC responded that the average number of nurses practicing on a compact license issued by another state/jurisdiction in their organization was identified as 2.65 or 6%. Of those 2.65 nurses, 75% of the nurses live across state/jurisdiction border, 19% were travel nurses, and the rest were newly relocated nurses.
13. 14% of the employers require nurses to have multiple licenses from other states in order to perform their job.
14. 76% of employers said there was no disadvantage to the NLC, while 5% said there are disadvantages, such as after the nurse takes up residency as their primary state of residence, they do not timely apply for state license; sometimes nurses are unaware of what is expected of them and nurses are sometimes unfamiliar with regulations.
15. Top recommendations from AZ employers to improve the NLC were to add more/all states to NLC, educate nurses licensed in participating states, standardize continuing education requirements among states and educate nurses about their home state.

The NCSBN 2014 NLC survey findings clearly supports the insight that telehealth is a growing facet of healthcare in the 21st century. NCSBN has been the leader among healthcare regulators with the success of the NLC, with nurses, nursing employers and BONs, with all recognizing the positive impacts of the NLC. As healthcare delivery continues to evolve, it offers opportunities for innovative ways to address the challenges of balancing public protection and reducing regulatory barriers.

Joey Ridenour RN MN FAAN

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Just a decade ago, the idea that a health care provider could diagnose and treat a patient via teleconferencing technology was a concept more at home in the realm of Star Trek™ than what is now an increasingly commonplace event.

Whatever form it takes – patient consultations via video conference, e-health including patient portals, remote monitoring of vital signs, continuing medical education, consumer-focused wireless applications and nursing call centers, among other applications – "all are considered part of telemedicine and telehealth" (ATA, 2015) and are all part of a growing fabric of what it means to deliver health care services in the 21st century.

Will 2015 be the year when all the challenges involving reimbursement, regulation, infrastructure and access as well as provider and patient adoption fall into place? Has telehealth's time to be a viable alternative to face-to-face health care provider visits arrived? What barriers need to be overcome for telehealth to have complete parity with inpatient visits?

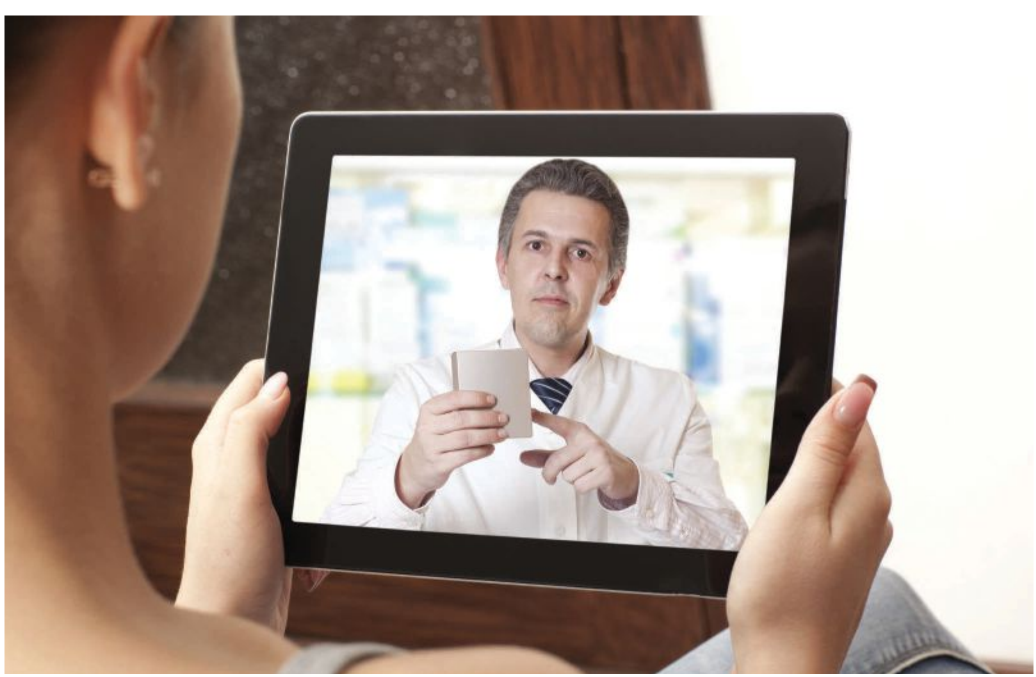
Congressional and media attention over the past year has heated up because it appears as though telehealth might address many ongoing access issues, including the shortage of health care providers; particularly in primary care. A Georgia Public Policy Foundation study concluded that without telehealth, patient access might be delayed, denied or otherwise not available. Telehealth provides the patient savings in time and money and can reduce the stress from delayed or denied face-to-face medical care (Bachman, 2015).

With the Affordable Care Act bringing millions of people into the health care system, no less than 44 states have current telehealth legislation pending. On the national level, bills are being debated in committees for eventual introduction in Congress.

While trade articles have touted the virtues of telehealth for years, in the past 12 months it has captured the attention of the mainstream media. The subject has been covered extensively in Forbes, highlighted on network TV and radio news shows and debated in blogs and within the online community of health care providers and patients alike.

Used on a wide scale, telehealth has the potential to lower costs and provide improved patient outcomes. So why hasn't there been widespread adoption of telehealth?

In Focus, **Spring 2015**



The concern over whether or not patients will readily accept telehealth alternatives to inpatient visits is somewhat unfounded. As the population has grown more comfortable and adept at using online technology, the technology itself has become both more sophisticated in scope and more user-friendly and reliable in practice. Although some of the most elderly of senior citizens may face challenges in using digital tools, a Pew Research Study (Smith, 2013) found that, "Six in ten seniors—59%—report using the Internet. This is a six percentage point year-over-year increase from the 53% of older adults who went online at a similar point in 2012." In fact, the rate of adoption of social media among those age 60 and over is the fastest growing segment of the marketplace.

Another argument questions the reliability and ability of providing the necessary data to inform the provider. This concern is mitigated by ongoing advances in the industry that have made telehealth technology the cutting-edge of innovation. These advances include higher video and image resolution, more efficient use of bandwidth that has made connectivity more reliable, and electronic health record systems facilitating increased data exchange (iHealthBeat, 2013). Additionally, telehealth technology can provide "sophisticated synchronous and asynchronous video communications, IT-enabled real-time data-transfer capabilities and advances in wireless patient monitoring that have all evolved sufficiently to support telemedicine platforms." (Darves,2014)

So does telehealth provide similar or better patient outcomes to an in-office visit? A 2013 American Telemedicine Report, Telemedicine's Impact on Healthcare Cost and Quality, noted that scientific studies in the area of telemedicine and quality of care "indicate that the use of telemedicine for such applications as monitoring of chronic care patients or allowing specialists to provide care to patients over a large region have resulted in significantly improved care. For most telemedicine applications, studies have shown that there is no difference in the ability of the provider to obtain clinical information, make an accurate diagnosis, and develop a treatment plan that produces the same desired clinical outcomes as compared to in-person care when used appropriately."

This same report also found that the vast majority of the peer-reviewed research studies about the cost effectiveness of telemedicine (based on large sample sizes and following sound scientific rigor) are relatively new but are consistently concluding that telemedicine saves the patients, providers and payers money when compared with more traditional approaches to

Continued on page 9

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providing care. An August 2014 study by global professional services company Towers Watson estimated telemedicine could potentially deliver more than $6 billion a year in health care savings to U.S. companies (Towers Watson, 2014).

If all of these factors point to a win-win scenario for all of the parties involved, why isn't telehealth more mainstream? The fact remains that the sticking points to telehealth lie in administration and policy, i.e., the regulation of health care providers and reimbursement for services.

Reimbursement has been a thorny issue in telehealth. Providers have lobbied for parity in providing telehealth services with traditional in-office visits, while payers/insurers have been reluctant to value the services in the same way. That may be changing. The Centers for Medicare and Medicaid Services (CMS) (U.S. Department of Health and Human Services Health Information Technology, 2014) have issued new rules on payments to physicians providing telehealth services, an indication that the agency is expanding reimbursement for telemedicine. CMS also added seven new procedure codes for telehealth, including annual wellness visits and psychotherapy services. Among private-payers, there is no accepted standard in place because there is still a wide discrepancy between whether they will pay for telehealth services, and for what type of services they will cover and under what conditions. Some insurers see the value and cost effectiveness of telehealth and will reimburse for services while others will not.

All of the allied health professions regulatory groups are grappling with the issue of telehealth.

The Tri-Regulator Collaborative is comprised of the "big three" organizations representing the state and territorial licensing boards in the U.S. that regulate the practice of medicine, pharmacy and nursing; they include the Federation of State Medical Boards (FSMB), National Association of Boards of Pharmacy (NABP), and NCSBN. Last year they affirmed that in a consumer protection model, health care practice occurs where the recipient of health care services is located.

Continued on page 10

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This affirmation highlights the need for portability of licenses. While other health care provider regulatory bodies are just getting started in this process of interstate practice, NCSBN's Nurse Licensure Compact (NLC) has been ahead of the curve since its implementation in 2000.

The NLC allows for registered nurses (RN) and licensed practical/vocational nurses (LPN/VN) to have one multistate license, with the ability to practice in both their home state and other NLC states. The APRN Compact allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other compact states. There are currently 24 states in the NLC. Influenced by the growing need for nurse mobility and clarification of the authority to practice for many nurses currently engaged in telenursing or interstate practice, boards of nursing (BONs) have worked over the past several years to revise the NLC to ensure it reflects best practices and provides for continued high standards of public protection.

In some ways, however, nursing lags behind other allied health care regulators in that most BONs lack a formal policy for telehealth nursing practice. In a recent survey conducted by NCSBN, only 14 jurisdictions indicated they had a policy in place addressing these issues. Additionally, nurse employers and policymakers often make requests of NCSBN for compiled state-by-state telehealth nursing licensure requirements similar to what is readily available from FSMB about physician requirements, but no such compilation is possible at this time.

A model policy for telehealth nursing practice will be reviewed by the NCSBN Board of Directors for potential adoption. Offering key elements defining telehealth nursing practice, this model provides a jumping-off point for NCSBN Member Boards to develop their own policies.

Telehealth is a proven concept; it is just waiting for all of the factors influencing its complete acceptance as part of the health care delivery system to align.

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In Focus, **Spring 2015**

Consent Agreement and Order Training

For people who have signed an agreement or who are considering signing an agreement with the Board of Nursing, please attend a Consent Agreement/Order training class on Wednesday June 17, 2015 from 3:00 p.m. to 4:30 p.m. at the Board office located at 4747 N. 7th St. Phoenix, AZ Suite 200.

The facilitator will be Tamara Greabell, RN. Please call 602-771-7862 to RSVP by June 16, 2015.

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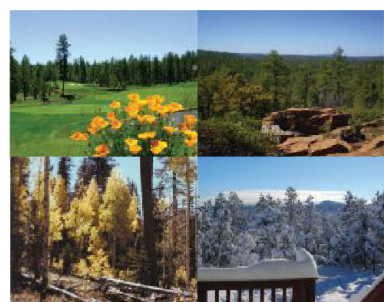

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An in-depth look at two NCSBN studies and their potential impact on the future of nursing

Walk the halls of the NCSBN Nursing Regulation department and there's a good chance you'll hear the words "simulation study" and "TTP" (that's short hand for transition to practice). That's because after three years of research, the National Simulation Study and the Transition to Practice Study are finally coming to a close. Final data are still being collected and analyzed, which means outcomes are not far behind. But before we look forward, let's take a look back to see how it all started. Maybe the researchers will even give us an early peek at their findings.

In the Beginning

Boards of nursing (BONs) utilize research data to inform regulatory decisions. Where do the BONs get that data from? A variety of sources, including peer-reviewed journals and industry studies. Sometimes though, the literature is lacking and more information is needed to make regulatory decisions.

Every three years, the NCSBN Board of Directors selects new areas of scientific study that will build on the body of knowledge and provide vital data to the BONs. "The goal of NCSBN research is to turn data into evidence-based policy BONs can use as they continue their mission of public protection," said NCSBN Chief Nursing Officer Maryann Alexander. Based on feedback from the BONs and recommendations from NCSBN

staff, the BOD chooses a variety of topics that need further study. These projects are outlined in the NCSBN Research Agenda, which serves as the blueprint for the NCSBN Research department for a three year-period.

In 2010, the BOD approved the 2011-2013 NCSBN Research Agenda. Included in the agenda were several topics of interest to BONs, among them, simulation and transition to practice. The need for data on these subjects led to the development of two multi-site, multi-year studies: the National Simulation Study and the Transition to Practice Study, both of which report their final outcomes and conclusions later this year.

National Simulation Study

Back in the late 1990s/early 2000s, high fidelity simulators started to appear in nursing. These simulation manikins had the ability to standardize the nursing education experience. With these manikins, a school could ensure that every student would experience a cardiac arrest and learn how to handle it. As schools of nursing began to invest in these simulators, BONs were inundated with requests to allow the simulators to be used in lieu of traditional clinical sites. “Competition for clinical sites was on the rise,” said Jennifer Hayden, associate, Research, NCSBN. “There were more nursing students and less clinical sites available. Simulation looked like a good solution.” But did simulation really provide the same educational experience as a clinical site did? “Boards of nursing needed answers, but the literature was lacking,” Hayden explained. “So, the BONs turned to NCSBN and asked us to conduct a study that would provide them with the evidence they needed to make regulatory decisions on simulation in nursing education.”

The National Simulation Study was divided into three phases. Phase I consisted of a survey that was sent to all prelicensure nursing programs in the U.S. to determine the prevalence of simulation use—types of equipment used and the courses in which simulation is used; faculty training and development to use simulation; and if simulation is used as a substitute for clinical hours. Phase II involved randomizing nursing students to receive varying amounts of simulation in place of traditional clinical hours. Hayden and her research team set out to find nursing schools willing to participate. “We wanted to include associate degree and baccalaureate programs so the study could

be generalizable. We also needed schools that were large enough to have three groups of participants that would each have various amounts simulation,” Hayden said. 23 schools applied, 10 were chosen. In August 2011, 847 new nursing students were randomized into one of three study groups: traditional clinical (the control group), 25 percent simulation or 50 percent simulation. Each semester and in each of the core clinical courses, students were assessed on their nursing knowledge, clinical competency and how well they perceived their learning needs were met in both the clinical and simulation environments.

In May 2013, 667 of the study cohort graduated (several students dropped out of the study or left the nursing program all together). To determine their readiness to practice, 587 nurses agreed to participate in a longitudinal follow-up study (Phase III). To date, 62 percent of follow-up study participants have been hired as registered nurses (RNs).

The data collected from the study, in addition to NCLEX pass rates, end-of-program competency assessments, end-of-program nursing knowledge, how students rated simulation environment and how simulation works on a course-by-course basis will all be explored when Hayden reports her outcomes in a supplement that will be published with the Journal of Nursing Regulation (JNR) later this year. “The results of this research will be so valuable to nurse regulators and educators. What we learn from this study

Continued on page 14

and future studies that build on our work will be used for years to come to guide and shape clinical education," Hayden explained.

Transition to Practice Study

The transition from nursing student to newly licensed nurse can be exciting, yet overwhelming. Newly licensed nurses are expected to take the knowledge and skills they acquired in an educational setting and apply them seamlessly into clinical practice. For some, this transition is easy, but for many new nurses, the transition can be stressful and difficult. Studies suggest that when newly licensed nurses don't properly transition into new practice, nurse retention, competency and patient safety are affected.

NCSBN began studying transition to practice back in 2002. In 2008, the first evidence-based model was introduced. "Transition to practice is just as relevant today as it was when I started at NCSBN in 2002," Nancy Spector, director, Regulatory Innovations, NCSBN, said. "We can't hire a new nurse and expect them to hit the ground running. Too much is at stake." The Transition to Practice Study investigated whether NCSBN's Transition to Practice Model improved quality and safety outcomes, and whether it could be generalized into diverse settings. To study this, two phases were developed. Phase I focused on RNs in hospital settings; Phase II studied RNs and licensed practical/vocational nurses (LPN/VNs) in long term care, home health, ambulatory and public health settings. "The Transition to Practice Study is one of the first to randomize sites to an intervention and control group. This is important because the control group, which used its traditional orientation procedures, served as a comparison to the intervention group's use of a standardized transition to practice model. Therefore, if there are significant differences in the outcomes between the two groups, they are likely because of the use of the use of the transition to practice model being used in the intervention group."

A large sample size was needed in order for the study to be successful, so Spector and her research team started looking for sites. Ten states showed interest; three were selected. In the end, 108 hospitals and 42 nonhospital settings in Illinois, North Carolina and Ohio participated in Phase I, which had 1,437 newly licensed RNs participating. Phase I ended in March 2013; Phase II ended in January 2014. Because of this, outcomes are still being collected and analyzed, so it's too soon to even give us a glimpse at the results. Guess we're going to have to wait until later this year when they're officially published. But if Hayden and Spector's excitement about their studies are any indication, we have much to look forward to!

Want to read the outcomes from the National Simulation Study and Transition to Practice Study as soon as they are published? Then make sure you subscribe to JNR by visiting http://jnr.metapress.com.

The Future of NCSBN Research

As the two studies come to an end, several more are just beginning, as outlined by the 2014-2016 NCSBN Research Agenda (which is available at www.ncsbn.org/169.htm). Take the Continued Competency Study for example. The lack of evidence on the topic, coupled with the fact that each state has its own competency requirement, has made it difficult to determine whether there is any one thing that predicts nurse competency. Furthermore, competency is measured in a variety of ways, including the use of examinations, self-assessment, continued education and certifications. With so many measurement tools, which is the best? Which tool accurately measures competency? Several hospitals in Illinois are currently serving as study sites to help NCSBN answer these questions. The data collected in this study will help NCSBN determine whether a large scale, multi-site national study should be implemented. No problem though. NCSBN is used to successfully pioneering research studies.

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1. Apply for licensure/registration with one board of nursing/regulatory body (BON/RB).

2. Register and pay the exam fee to Pearson VUE via the Internet or telephone.
   - Payment via MasterCard, Visa or American Express will be accepted.
   - You must be made eligible by the BON/RB (see Step 4) within 365 days of your NCLEX registration and payment.

3. Receive Acknowledgement of Receipt of Registration from Pearson VUE by email.

4. BON/RB makes you eligible in the Pearson VUE system.

5. Receive Authorization to Test (ATT) email from Pearson VUE.
   - You must test within the validity dates (an average of 90 days) on the ATT. There are no extensions.

6. Schedule your exam appointment via the Internet (by accessing your online account) or by telephone.

7. Arrive for the exam appointment and present your acceptable identification.

8. Receive your official results from your BON/RB up to six weeks after your exam (this time period varies amongst BONs/RBs).

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There are no refunds of NCLEX fees for any reason.

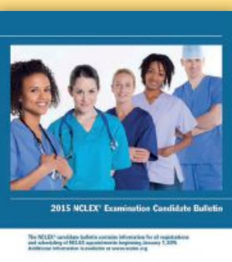
Acceptable Identification

- Use the exact name that is on your ID when registering for the NCLEX with Pearson VUE. At the test center, the name on the ID you present must match the name in the Pearson VUE system. If it does not match you will be required to reregister and pay another exam fee.
- All forms of identification listed below must be valid (non-expired) government-issued identification containing the following information:
  - Name (in Roman characters)
  - Recent photograph
  - Signature
- The **only** acceptable forms of identification for domestic test centers are:
  - Passport books and cards
  - Driver's license
  - Provincial/Territorial or state identification card
  - Permanent residence card
  - Military identification card
- The only identifications acceptable for international test centers are:
  - Passport books and cards
- The definitions of domestic and international test centers can be found on the Testing Locations page.
- IDs from a U.S. sanctioned (embargoed) country must follow the proof of residence policy.
- Temporary identification (examples include limited term IDs and any ID reading "temp" or "temporary") is only acceptable if it meets the required elements stated above.
- If you cannot provide an acceptable ID at your appointment, you will have to reregister and pay another exam fee for the NCLEX.

Rules for Scheduling/Rescheduling/Unscheduling

If you need to reschedule your appointment:

- Tuesday, Wednesday, Thursday or Friday appointments must be changed 24 hours in advance of the original date and time. For example, if your appointment is on Wednesday at 2:00 pm, then you must call to reschedule by Tuesday at 2:00 pm.
- Saturday, Sunday or Monday appointments must be changed no later than the Friday before the original date and time. For example, if your appointment is on Monday at 2:00 pm, then you must call to reschedule by Friday at 2:00 pm.



Know all the policies and rules before you start the NCLEX process by accessing the NCLEX Candidate Bulletin.

Don't Forget!

- You may not access or bring any educational, test preparation or study materials to the testing center at any time during your examination.
- Cell/mobile/smart phones, tablets, pagers or other electronic devices may not be accessed at all during your examination appointment (including breaks). Candidates will be required to store electronic devices in sealable, plastic bags at the test center. Candidates who refuse to store their electronic devices in the Pearson VUE provided plastic bag upon check-in will not be allowed to test and will be required to reregister and pay another exam fee.

FAQs

Have questions? Check out the Frequently Asked Questions page of ncsbn.org.

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Email pvamericascustomerservice@pearson.com

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Pearson Professional Testing
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Bloomington, MN 55437-1099

By Phone

U.S. and Canada: Call NCLEX Candidate Services (toll-free) 1.866.49NCLEX (1.866.496.2539), Monday – Friday, 7:00 am – 7:00 pm, Central Standard Time. For French support, call 1.866.288.8454.

Asia Pacific Region: Call NCLEX Candidate Services at (pay number) +852.3077.4923, Monday – Friday, 9:00 am to 6:00 pm, Hong Kong Time.

Europe, Middle East, Africa: Call NCLEX Candidate Services at (pay number) +44.161.855.7445, Monday – Friday, 9:00 am – 6:00 pm, Central European Time.

India: Call NCLEX Candidate Services at (pay number) 91.120.439.7837, Monday – Friday, 9:00 am – 6:00 pm, Indian Standard Time.

All other countries not listed above: Call (pay number) 1.952.905.7403, Monday – Friday, 7:00 am to 7:00 pm, Central Standard Time.

Candidates with hearing impairments who use a Telecommunications Device for the Deaf (TDD):
Call the U.S.A. Relay Service at (toll-free) 1.800.627.3529 or the Canada & International Inbound relay service at (pay number) 605.224.1837. These services are available 24 hours a day, seven days a week.

NCSBN

National Council of State Boards of Nursing

Contact NCSBN about NCLEX development, general NCLEX information and general questions/inquiries relating to exam administration:

Online www.ncsbn.org/nclex.htm

Email nclexinfo@ncsbn.org

Write National Council of State Boards of Nursing, Inc.
Examinations Department
111 E. Wacker Drive, Suite 2900
Chicago, Illinois 60601-4277

By Phone 866.293.9600

Contact your board of nursing/regulatory body about licensure/registration, name or address changes and endorsement. Contact information for most BONs/RBs is available a **www.ncsbn.org/contactbon.htm.**

Visit the Association of Registered Nurses of Prince Edward Island or the Registered Nurses Association of Northwest Territories and Nunavut websites for contact information for these RBs.

01/15

Competency: From NCLEX® to Performance

Report from the Deans and Directors Annual Meeting

October 10, 2014

Report prepared by:
Pamela K. Randolph RN, MS, FRE
Associate Director Education and
Evidence-based Education

Introduction

Every year the Arizona State Board of Nursing (Board) holds an annual meeting with nursing program administration to address areas of common interest. Meetings have ranged from informal sessions, where each program described their issues and asked for the collective wisdom of the group, to formal continuing education. Recently the Board has planned the meeting to facilitate problem exploration and solving in a group setting. The 2014 meeting was held to provide a forum for Arizona program directors and the Board Education Department to network, share information involving competency. The program was entitled Competency: From NCLEX to Performance. In 2013 the NCLEX-RN passing standard was raised, with a subsequent drop in pass rates for some programs. However other programs increased their NCLEX pass rates. Learning how programs increased or sustained their pass rates would promote discussion and innovation in all programs. Performance competency, the ability to interpret patient cues and execute sound nursing judgment, is always of concern to the Board and nursing programs. Advances in neuroscience, behavioral sciences and research supporting simulation to improve performance competency, made this a timely topic.

Planning

Board staff planned the day in conjunction with Northern Arizona University School of Nursing and appreciated the involvement of Sally Doshier, Assistant Dean of Nursing and Debera Thomas, Dean of Nursing in helping secure the venue and registering participants. The venue was in Flagstaff in October, just as the leaves were changing and the days getting cooler. Last year's participants requested a cooler climate for the meeting as in September and October temperatures in Phoenix frequently are close to or exceed 100 degrees.

Assignment

Each program was asked to prepare an abstract of one intervention that the program uses or used in the past to improve NCLEX. The abstract should describe the strategy, how/why it was chosen, outline the implementation including challenges, and describe the outcomes. Outcomes should address student satisfaction, attrition, cost-effectiveness and faculty satisfaction of the implemented strategy. Programs were asked to choose topics based on the quality of evidence related to the strategy. There was a word limit of 500 words or less.

Evaluation of Abstracts

Overall 15 abstracts were received with 11 being submitted by the October 1, 2014 deadline. The abstracts were evaluated by three persons: Pamela Randolph, Associate Director of Education and Evidence-based Regulation for the Board; Ronda Doolen, Nursing Program Administrator for the Board, and Sally Doshier, Assistant Dean and Associate Professor at Northern Arizona University.

Five of the persons/programs submitting abstracts were chosen for podium presentations. Presentations were selected based on their uniqueness, the quality of the data, and the holistic nature of the approach. All abstracts were supplied to meeting attendees.

Performance

Janine Hinton RN, Ph.D, simulation coordinator at Scottsdale Community College was asked to coordinate a presentation on performance competency with emphasis on the neurology of competency. Hinton is considered an expert in simulation and situational awareness. Co-presenters included Kristine Roberts and Carrie Kieras.

Proceedings

The meeting was attended by representatives of three of the seven approved

LPN programs, 16 of the 23 approved Associate Degree Programs and seven of the eight approved BSN programs for a total 26 of 38 Arizona approved programs (68%). Approximately 50 persons were in attendance including Board staff and speakers. Attendees were provided with copies of all abstracts, an agenda, a blank concept map to take notes and copies of Board staff slides.

Introduction

Board staff opened the meeting with an overview of competency, competency related to scope of practice and myths associated with measuring competence, including the myth of self-assessment.

NCLEX Competency

The first speaker to present an abstract was David Kutzler Director of the LPN program at Pima Community College, Center for Training and Development. Kutzler analyzed scores on standardized exams in relation to NCLEX passing and concluded that having a cut-score would have "held hostage" three of four students who scored below 730, the optimal cut-score, but passed NCLEX on the first attempt. Faculty decided not to implement a cut score, but to continue to use HESI because of its value as a practice "high stakes" test and for the remediation resources available to students.

The second speaker was Paula McNichols, Director of the RN program at Mohave Community College. McNichols described a situation at her college where nursing faculty had up to 78 students per instructor across three campuses with only interactive television connection (ITV), which was unreliable. Their NCLEX pass rate barely met the minimum Board requirement. Mohave worked with the Board, their accrediting body (NLNAC now ACEN), and their school administrators to improve instruction at the program. Class sizes were reduced to 25 students per instructor, nursing labs were upgraded, the curriculum was mapped to NCLEX, academic standards, admission requirements were raised and communication with students increased, faculty provided rubrics for all assignments and faculty improved test item writing skills. NCLEX passing rates increased from 81% in 2011 to 96% in 2012. Even with the increase in passing standard Mohave's pass rate was 85% in 2013, and is 91% for the first 2 quarters of 2014.

The third abstract was presented by Deborah McDonald Davis, Nursing Program Director and Rosemary Estoup, Assistant Program Director from Carrington College. Carrington College experienced a decline in NCLEX pass rates in 2013. Their plan to correct included an in-depth review and analysis of the issues. The plan focused on faculty training and standardization within the classroom. Mentoring and in-service opportunities for faculty were increased. Faculty reviewed all policies, duties were re-aligned to better suit faculty qualifications. In reviewing syllabi, curriculum "drift" was found and faculty were not teaching to the curriculum. Faculty re-mapped content to proceed from simple to complex. Faculty were provided additional guidance and support. In turn faculty were expected to increase tutoring and support to "at risk" students. Rubrics were standardized and faculty adopted Danielson's *Domains of Teaching* to provide the groundwork for faculty expectations and role. The program reported that their pass rates increased from 57% in 2013 to 87% in the first 3 quarters of 2014.

Sandy Ludwig, nursing faculty member from Eastern Arizona College (EAC) presented information on how her program increased student's pharmacology sub-scores on NCLEX. Nursing exams were re-designed to include 10 questions on pharmacology on each exam. Students were required to answer 80% of those questions correctly. Students who struggle with this content were identified early and provided remediation resources in the form of additional study resources and extra tutoring. Students who fall below the 80% standard at the end of the course have an additional opportunity to demonstrate mastery by attaining an 80% on a cumulative test consisting of 25 pharmacology questions. Students who cannot meet this threshold are deemed not to have mastered an essential course competency and are required to repeat the course. EAC reported that the sub-score for pharmacology, as reported from NCLEX test data by Mountain Measurements, went from two percentage points below average before the intervention, to two percentage points above average after the intervention. Additionally, the program reports that the extra help offered to students has increased student satisfaction.

The last speaker of the morning session was Sharon Caves, Program Director, Pima Medical Institute, Mesa. Caves inspired the audience by providing information on the "Passion Partnership Model." Caves attributed the success of her program and its students to her faculty's commitment to students. Faculty strive to understand each student as a unique individual. Faculty apply the concept of Human Flourishing (NLN) to their relationship with students. As nurses advocate for their patient, her faculty advocates for students to be the best they can be. This has led to curriculum revision and engagement of faculty and students. Every faculty member lives their passion, approaches students with encouragement and forms trusting partnerships with them. Caves provided support from the literature that passion and commitment leads to better outcomes. Caves currently uses Spur, Baily & Feruson's (2010) *Framework for Passion and Teaching* to anchor PMI's curriculum, philosophy, teaching methodologies and outcomes. PMI has done well in both NCLEX pass rates (86% in 2012; 84% in 2013) and on-time graduation rates (71% in 2012; 85% in 2013).

Performance Competency

Dr. Janine Hinton, Kristine Roberts and Carrie Kieras, from Scottsdale Community College, presented a lively session on performance competency. They sought to

Continued on page 20

teach us a skill, juggling with sharp objects, by watching a U-tube video and taking a multiple choice exam. After the exam we were declared competent, yet none of us could even juggle round soft objects, let alone sharp objects. This demonstration illustrated for the audience the complexity of skill acquisition. The presenters emphasized that to properly perform a skill, more areas of the brain were utilized than to answer a multiple choice question. Dr. Hinton spoke on components of nursing expertise including, skilled know-how and deliberative practice. Endsley's concept of situational awareness, attending to the right cues from the environment and patient to predict the future, was introduced. Most medical errors occur because individuals do not understand the situation they are in. Simulation was presented as modality for nursing students and practicing nurses to better understand patient cues and execute correct responses. Hinton presented results from the current research, "*Measuring Competency with Simulation, Phase II*" (a collaborative research project between the Board, Scottsdale Community College and Arizona State University) and her dissertation research on medication error trapping.

In the second section of the presentation, Kristine Roberts described a simulation-only elective course at Scottsdale Community College. The course titled, "*The Deteriorating Patient*," is limited to 10 students and conducted by 2-3 faculty members. The course presents the students with various high fidelity simulation scenarios of patients in need of rescue and provides them with opportunities to predict the consequences and intervene on the patient's behalf. The course is open to pre-licensure students and practicing RNs and LPNs.

Wrap-up

Board staff closed the meeting with a review of competency development and a comparative analysis of Board cases where simulation performance was compared with reported errors from practice. To wrap-up the day, each participant was asked what they learned new or re-learned from the day. All participants stated they enjoyed the day and expressed a desire to attend next year. Tucson programs agreed to host next year's event.

Post-Event Evaluations

Overall the evaluations were positive. Some of the comments are included below:

Great way of sharing ideas and success

Appreciated the schools who presented; excellent remedies of what is important

Analysis to student engagement was a great connection

Liked the different approaches

The neurology presentation was excellent

Great evidence-based data

Great conference this year

Very informative

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EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
11/21/2014	Abasta, Amanda G.	CNA1000044815	Decree of Censure
1/30/2015	Ager, Setimia D.	CNA1000045505	Stayed Suspension
12/31/2014	Amie, Zipporah R.	CNA1000011790	Revocation
10/22/2014	Averitt, Gregory R.	CNA1000022845	Decree of Censure
11/12/2014	Bledsoe, Jeffery R.	CNA Applicant	Certificate Denied
12/31/2014	Bojorquez, Karla M.	CNA999994240	Revocation
10/2/2014	Brady, Toni	CNA1000044367	Civil Penalty
12/31/2014	Brumfield, Avonna	CNA1000033122	Revocation
12/29/2014	Campa Alcarez, Alma A.	CNA1000045295	Decree of Censure
1/1/2015	Cannon, Bria J.	CNA Applicant	Certificate Denied
10/27/2014	Carrillo, Ivonne V.	CNA1000010175	Revocation
11/21/2014	Carroll, Shelly M.	CNA999995483	Voluntary Surrender
1/20/2015	Christensen, Katherine	CNA1000045294	Decree of Censure
10/9/2014	Cisneros, Jose N.	CNA1000044595	Decree of Censure
12/31/2014	Clark, Jamie F.	CNA1000024691	Revocation
10/28/2014	Clausen, Christopher L.	CNA Applicant	Certificate Denied
10/17/2014	Conant, Sharma S.	CNA1000036129	Decree of Censure
12/31/2014	Dale, Kelly D.	CNA1000020242	Revocation
12/30/2014	Dutton, Christopher G.	CNA1000031493	Decree of Censure
1/7/2015	Earl, Eric D.	CNA Applicant	Certificate Denied
1/30/2015	Engber, Aimee M.	CNA1000016740	Stayed Suspension
10/29/2014	Ferguson, Megan L.	CNA1000021911	Revocation
12/31/2014	Feuchster, Brandess K.	CNA1000041050	Revocation
11/14/2014	Flores, Sherri L.	CNA621743809	Revocation
10/29/2014	Ford, Laurie S.	CNA Applicant	Revocation
11/4/2014	Garner, Hunter R.	CNA Applicant	Certificate Denied
12/19/2014	Gillum, Taquila R.	CNA1000019218	Decree of Censure
10/28/2014	Gitonga, Anthony M.	CNA Applicant	Certificate Denied
12/31/2014	Go, Anna F.	CNA1000035186	Revocation
1/7/2015	Gregg, Michelle E.	CNA Applicant	Certificate Denied
10/23/2014	Harding, Nohemi S.	CNA1000011532	Decree of Censure
1/2/2015	Harris, Latoya N.	CNA Applicant	Certificate Denied
10/22/2014	Hart, Stephanie J.	CNA1000037196	Revocation
1/3/2015	Hatch, Kevin J.	CNA Applicant	Certificate Denied
11/19/2014	Hilkemeyer, Jacqueline D.	CNA999991580	Revocation
12/31/2014	Hindman, Michael S.	CNA1000037758	Revocation
11/3/2014	Holloman, Eric J.	CNA Applicant	Certificate Denied

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
1/23/2015	Hoxsie, Evan E.	CNA1000045372	Stayed Suspension
10/24/2014	Isibor, Osariemen	CNA1000044629	Decree of Censure
1/14/2015	J-harris, Jacqualynn J.	CNA Applicant	Certificate Denied
10/22/2014	Johnson, Coleen C.	CNA1000016454	Revocation
1/2/2015	Juarez, Tracy S.	CNA Applicant	Certificate Denied
10/22/2014	Kennedy, Cathy C.	CNA1000015231	Revocation
1/7/2015	Kent, Rachel A.	CNA Applicant	Certificate Denied
12/12/2014	Kline, Lyndsey D.	CNA1000045031	Decree of Censure
11/4/2014	Kowalski, Amy J.	CNA1000031025	Decree of Censure
1/15/2015	Kroff, Joleen A.	CNA Applicant	Certificate Denied
11/3/2014	Krznar, James P.	CNA Applicant	Certificate Denied
10/1/2014	Lape, Toni D.	CNA000028614	Revocation
1/13/2015	Laughner, David A.	CNA1000036656	Voluntary Surrender
1/7/2015	Lewis, Nina T.	CNA Applicant	Certificate Denied
11/11/2014	Lolley, Matthew J.	CNA Applicant	Certificate Denied
10/28/2014	Lopez, Samantha A.	CNA Applicant	Certificate Denied
12/12/2014	Lopez, Tara L.	CNA1000045015	Decree of Censure
12/30/2014	Lu, Bodong	CNA Applicant	Certificate Denied
10/23/2014	Macdonnell, Kendra J.	CNA Applicant	Certificate Denied
12/31/2014	Macey, Diana L.	CNA999994573	Revocation
10/29/2014	Maldonado, Imelda M.	CNA1000019018	Decree of Censure
1/9/2015	Martinez, Veronica	CNA Applicant	Revocation
1/16/2015	Martinez, Veronica	CNA1000039726	Revocation
12/30/2014	Matthes, Desiree E.	CNA1000045054	Decree of Censure
1/5/2015	Mcbride, Holly R.	CNA1000045141	Decree of Censure
1/1/2015	Mccann, Ashley C.	CNA Applicant	Certificate Denied
1/3/2015	Mejia Centeno, Melitza	CNA Applicant	Certificate Denied
11/3/2014	Melgoza, Sharlene L.	CNA866664641	Certificate Denied
10/28/2014	Melville, Jessica R.	CNA Applicant	Certificate Denied
11/4/2014	Mendez, Julio C.	CNA Applicant	Certificate Denied
10/22/2014	Mendietta, Jessica	CNA1000027567	Revocation
11/3/2014	Miller, Dawn S.	CNA Applicant	Certificate Denied
1/2/2015	Ned, Wakkuna R.	CNA Applicant	Certificate Denied
11/4/2014	Nelson, Maren P.	CNA Applicant	Certificate Denied
12/30/2014	Nelson, Sara J.	CNA1000017059	Decree of Censure
12/31/2014	Newman, Dawnemarie	CNA1000022316	Revocation
12/15/2014	Nissen, Crystal M.	CNA999999560	Stayed Suspension
1/12/2015	Notestine, Katherine K.	CNA1000030172	Decree of Censure

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
11/24/2014	Ochoa, Joseph C.	CNA1000044818	Decree of Censure
12/15/2014	Osborn, Naline L.	CNA999993514	Revocation
12/31/2014	Patera, Jeanne	CNA1000033559	Revocation
1/8/2015	Pearson, Rebecca C.	CNA Applicant	Certificate Denied
12/12/2014	Phillips, Briana D.	CNA1000045035	Decree of Censure
12/31/2014	Plante, Stephanie L.	CNA1000014989	Revocation
10/20/2014	Porter, Autumn L.	CNA1000044589	Civil Penalty
11/3/2014	Provost, Sarah M.	CNA Applicant	Certificate Denied
1/7/2015	Quinn, April N.	CNA Applicant	Certificate Denied
12/10/2014	Reed, Ryan K.	CNA1000028380	Decree of Censure
1/14/2015	Reynolds, Lori D.	CNA Applicant	Certificate Denied
1/16/2015	Rivera, Albert	CNA999987708	Revocation
10/15/2014	Rivera, Maria L.	CNA1000003155	Revocation
12/31/2014	Rodriguez, Maria	CNA1000042839	Revocation
12/31/2014	Rodriguez, Rita	CNA Applicant	Certificate Denied
12/31/2014	Roman Jr, Francisco	CNA1000028761	Revocation
12/1/2014	Ryan, Joyce L.	CNA Applicant	Certificate Denied
10/29/2014	Scheib, Kristina C.	CNA1000020834	Decree of Censure
11/19/2014	Scott-garrett, Yvette L.	CNA1000041434	Suspension
12/12/2014	Shack, Carolyn J.	CNA841401299	Decree of Censure
12/15/2014	Shuma, Paul A.	CNA1000039026	Revocation
10/1/2014	Sindayigaya, Victor	CNA1000014230	Suspension
10/28/2014	Spangler, Dina A.	CNA Applicant	Certificate Denied
10/17/2014	Sueing, Aleathea M.	CNA Applicant	Certificate Denied
10/8/2014	Summers, Debra M.	CNA1000044466	Civil Penalty
10/29/2014	Talbot, Daniel J.	CNA1000008171	Revocation
10/29/2014	Taylor, Tanya C.	CNA1000012859	Revocation
1/8/2015	Thompson, Chad A.	CNA Applicant	Certificate Denied
11/21/2014	Uy, Anecita P.	CNA1000020921	Revocation
10/28/2014	Vanderpool, Shannon J.	CNA Applicant	Certificate Denied
10/23/2014	Walsh, Kevin J.	CNA Applicant	Certificate Denied
10/27/2014	Wheeler, Nicole L.	CNA Applicant	Renewal Denied
10/23/2014	Williams, Margaret A.	CNA Applicant	Certificate Denied
12/26/2014	Wilson, Alexandra L.	CNA Applicant	Certificate Denied
12/31/2014	Yazzie, Kerome D.	CNA Applicant	Certificate Denied
12/18/2014	York-foltz, Judith H.	CNA1000045037	Decree of Censure
11/4/2014	Youngblood, Brittany G.	CNA Applicant	Certificate Denied

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
10/8/2014	Abele, Susan J.	RN044623	Decree of Censure
12/31/2014	Age, Verna S.	RN171702/CRNA0811	Revocation
10/22/2014	Averitt, Gregory R.	RN188943	Decree of Censure
10/14/2014	Babb, Adam D.	RN142708	Voluntary Surrender
10/27/2014	Baltz, Karissa	RN132162/CNA999951361	Revocation
1/7/2015	Barnes, Kristie M.	RN120453	Reissuance with Stayed Revocation Probation
12/15/2014	Barnes, Trina V.	RN107113	Decree of Censure
10/27/2014	Bean, Sheila C.	RN180883	Revocation
11/25/2014	Benton, Cory M.	RN164598	Stayed Revocation with Suspension
10/10/2014	Brown, Peary A.	RN105646	Voluntary Surrender
11/21/2014	Bustos Jr., Alfredo	RN147266	Civil Penalty
1/7/2015	Castner, Heather A.	RN176052	Probation
12/30/2014	Ceron, Hilario	RN069045/LP015898	Revocation
12/16/2014	Cisler, John C.	RN109968	Voluntary Surrender
1/8/2015	Claudio, Beth L.	RN Endorsement	License Denied
1/26/2015	Cook, Robin L.	RN121951	Voluntary Surrender
11/17/2014	Cranswick, Vanessa L.	RN118559	Stayed Suspension with Probation
1/30/2015	Cwiklinski, Damien J.	RN Endorsement	License Denied
10/8/2014	Dale, Kelly D.	RN Exam	License Denied
10/10/2014	David, Sonny A.	RN145962	Decree of Censure
1/16/2015	Davis, Sheryl E.	RN Endorsement	License Denied
10/6/2014	Del Sol, Benjamin A.	RN188901/CNA1000015355	Decree of Censure
12/31/2014	Delos-Santos, Debrah A.	RN131245	Revocation
12/18/2014	Dimond, Devrie R.	RN177121	Voluntary Surrender
10/28/2014	Dinicola, Nicholas R.	RN Endorsement	License Denied
10/29/2014	Dorcis, Lori M.	RN158422	Revocation
10/1/2014	Faulx, Lori A.	RN153031	Revocation
1/8/2015	Fernandez, Brenda S.	LP018821	Revocation
10/29/2014	Fidler, Frederick L.	LP033544	Revocation
1/5/2015	Fox, Betsy L.	RN093255	Decree of Censure
1/5/2015	Fox, Cheryl D.	RN066877/LP021085	Decree of Censure
11/25/2014	Frame, Joann M.	RN114449	Voluntary Surrender
12/30/2014	Frank, Wanda L.	RN Endorsement	License Denied
11/18/2014	Frye, Mary C.	RN120381	Voluntary Surrender

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
11/12/2014	Gardner, Kristi A.	RN128783	Voluntary Surrender
11/12/2014	Gonzalez, Tiffany L.	RN Endorsement	License Denied
1/2/2014	Greenlief, Kayla A.	RN168730	Voluntary Surrender
10/7/2014	Gyuro, Margaret M.	LP005428	Decree of Censure
12/31/2014	Haeffelin, Kelly L.	LP037154	Revocation
10/29/2014	Hall, Mara L.	RN102731	Revocation
11/6/2014	Hanson, Dayton L.	LP049298	Decree of Censure
1/30/2015	Hardy, Kathrine M.	RN129539/AP2027	Civil Penalty
10/21/2014	Hartley, Michelle A.	RN148883/LP043058	Stayed Revocation with Suspension
1/30/2015	Heil, Trudy R.	RN056661/AP0213	Probation
11/11/2014	Hendrixon, Brian D.	RN Endorsement	License Denied
1/30/2015	Hohm, Abram J.	RN166423	Summary Suspension
11/21/2014	Huebner, Shane A.	LP047979	Stayed Revocation with Suspension
12/15/2014	Huebner, Shane A.	LP047979	Revocation
1/30/2015	Jackson, Courtney D.	RN161584	Probation
12/3/2014	Jones, Elaine G.	RN030122	Voluntary Surrender
1/30/2015	Joselane, Janet L.	LP043768	Decree of Censure
11/6/2014	King, Brandon L.	RN175638	Voluntary Surrender
12/8/2014	King, Karen M.	RN106795/AP2526	Stayed Suspension with Probation
11/21/2014	Knisely, Susan C	RN168669	Summary Suspension
1/30/2015	Koepfer, Dawn M.	LP038838	Stayed Suspension with Probation
12/3/2014	Kyer, Juliana H.	LP033724	Revocation
12/1/2014	Lamb, James R.	RN093041/AP2293	Stayed Revocation with Suspension
10/31/2014	Landreth, Sally A.	RN127294	Voluntary Surrender
11/10/2014	Lapierre, David G.	RN189221	Decree of Censure
12/31/2014	Lepage, Raymonde	RN031550	Revocation
1/30/2015	Lilly, Adrian W.	RN154892	Summary Suspension
11/19/2014	Lough, Tara M.	RN161733	Voluntary Surrender
12/26/2014	Martinez, Michelle M.	RN129204	Revocation
12/17/2014	Mayhew, Martha L.	RN054997/AP1663	Decree of Censure with Civil Penalty
12/3/2014	McGuinness, Sean E.	RN145175/CNA1000004701	Voluntary Surrender
12/31/2014	Mendiola, Lydia	RN126354/LP038339	Revocation
1/16/2015	Mendiola, Primitivo G.	RN128286/LP038442	Revocation
1/9/2015	Merrill, Shannil L.	RN120207/LP036178	Revocation

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
12/30/2014	Morales, Louie	LP041530	Revocation
12/29/2014	Morehead-Ruff, Latoya N.	RN Exam	License Denied
11/5/2014	Murphy, Robert A.	RN102316	Probation
12/31/2014	Nelson, Allene R.	RN029619	Revocation
11/3/2014	Newton, Mark A.	RN162648	Decree of Censure
10/20/2014	Nicholls, Amy T.	RN135542/LP039398	Voluntary Surrender
10/7/2014	Nooy, Catrina N.	LP037859	Decree of Censure
11/13/2014	Norlin, Glenna R.	RN150702	Revocation
11/5/2014	Olivarez, Priscilla M.	RN189045	Suspension
11/20/2014	Painter, Brenda L.	LP030765	Reissuance with Stayed Revocation Probation
1/22/2015	Palmer, Adrian R.	RN166711/CNA113355120	Stayed Suspension with Probation
11/21/2014	Parham, Jeanne M.	RN123105	Probation
10/4/2014	Patterson, Emily A.	LP045787	Decree of Censure
11/14/2014	Peaches, Geniece M.	RN162537	Probation
12/10/2014	Peasley, Nancy A.	LP034871	Decree of Censure
11/21/2014	Peck, Jeremiah R.	RN Reissuance	Reissuance Denied
11/13/2014	Peralta, Christina A.	LP036643	Voluntary Surrender
11/21/2014	Pieramici, Melissa C.	RN143264/CNA1000002485	Summary Suspension
12/10/2014	Pietraszewski, Angela L.	RN146638	Voluntary Surrender
1/16/2015	Pina, Jenny M.	RN166241	Probation
10/20/2014	Pio, Timothy L.	LP046104	Civil Penalty
12/31/2014	Popp, Kathleen J.	RN067894	Revocation
10/28/2014	Poray, Carrie A.	RN Endorsement	License Denied
1/7/2015	Provo, Jonica E.	RN Endorsement	License Denied
11/4/2014	Rajczyk, John A.	RN054584	Voluntary Surrender
12/31/2014	Rasmussen, Marilynn S.	RN040283	Revocation
12/12/2014	Reynolds, Brittany N.	RN189499	Decree of Censure
10/24/2014	Richards, Joshua D.	LP038793	Suspension
10/2/2014	Rivera, Maria L.	RN153792/CNA1000003155	Stayed Revocation with Suspension
10/15/2014	Rivera, Maria L.	RN153792/CNA1000003155	Revocation
11/14/2014	Rodriguez, Amy L.	RN134521	Stayed Revocation with Suspension
12/29/2014	Rood, Tristan L.	RN114875	Decree of Censure with Civil Penalty
11/18/2014	Rudders, Daniel L.	RN133647	Stayed Revocation with Probation
1/15/2015	Rusu, Vasile Cristian	RN120578	Voluntary Surrender

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
10/6/2014	Schmidt, Marlene R.	LP019747	Decree of Censure
11/19/2014	Schnorr, Amie L.	RN123257	Reissuance with Stayed Revocation Probation
12/31/2014	Schwartz, Paula S.	RN090867	Revocation
10/31/2014	Sedlacek, Joseph B.	RN170602	Voluntary Surrender
12/31/2014	Shaikh, Marie T.	RN088227/LP028572	Revocation
10/29/2014	Shrewsbury, Kathleen H.	RN063241	Revocation
10/31/2014	Sipin, Crystal L.	RN811472, TX	Voluntary Surrender of Nurse Multi-State Licensure Privilege
12/31/2014	Skinner, Lela E.	RN062452	Revocation
1/30/2015	Slade, Tamara C.	RN163348/CNA1000014975	Stayed Revocation with Suspension
1/22/2015	Smith, Shannon H.	LP039590	Stayed Suspension with Probation
1/30/2015	Smith, Stephanie J.	RN148284	Decree of Censure
10/28/2014	Snyder, Teresa L.	RN Endorsement	License Denied
12/31/2014	St Clair, Ursula A.	RN168476	Revocation
10/10/2014	Stanton, Maureen F.	RN188777	Decree of Censure
10/27/2014	Steel, Adryon L.	RN158449	Revocation
12/31/2014	Stevens, Stephanie L.	RN177901	Revocation
12/10/2014	Stocks, Penny	RN184964	Probation
10/31/2014	Supan, Baby Agatha	LP044060	Probation
11/19/2014	Surofchek, Mitzi S.	RN142423	Voluntary Surrender
12/31/2014	Swogger, Barbara J.	LP028395/CNA913062803	Revocation
12/3/2014	Tarleton, Marcia A.	RN134690	Voluntary Surrender
12/31/2014	Tauman, Joseph W.	RN081778/LP026281	Revocation
1/7/2015	Taylor, Staci L.	RN157820/CNA1000012575	Decree of Censure
10/15/2014	Thomas, Tina M.	RN107823	Decree of Censure
1/2/2015	Tolentino, Tracy A.	LP036193/CNA138706441	Voluntary Surrender
10/1/2014	Vanderwalker, Linda S.	RN071998/LP023408	Suspension
10/29/2014	Vastine, Keri	RN096000	Revocation
10/28/2014	Williams, Angela N.	LP038961	Voluntary Surrender
11/12/2014	Williams, Bryan E.	RN Endorsement	License Denied
10/14/2014	Young, Sherry L.	RN080046/AP1225/LP023192	Decree of Censure
12/11/2014	Zafke, Danielle N.	RN Exam	Probation
1/16/2015	Zmudka, James E.	RN098725	Revocation

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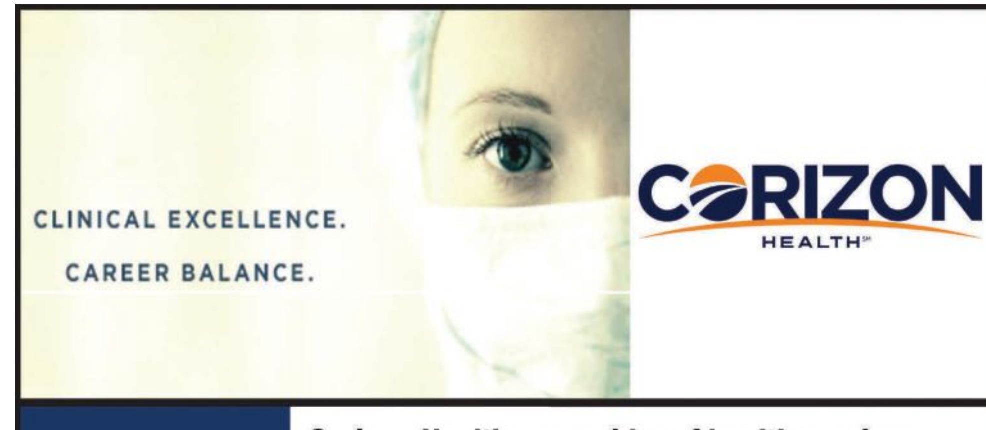

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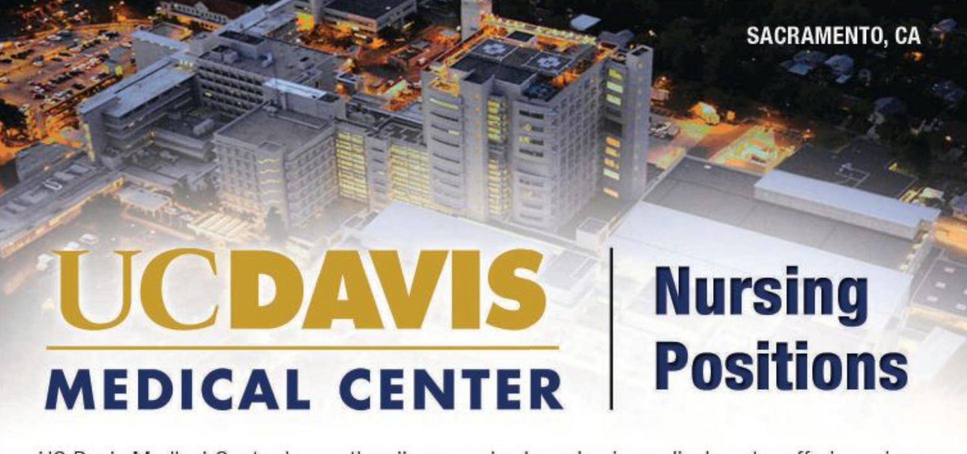

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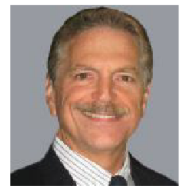
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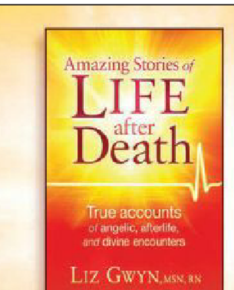

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