STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

BOARD OF NURSING

Exh. No. 9

File No.

Date

In the Matter of the Proposed Repeal of Current Rules (7 MCAR §§ 5.1050-5.1101 and 5.2040-5.2091) and Adoption of New Rules (7 MCAR §§ 5.3000-5.3021) Regarding Practical and Professional Nursing Program Approval

STATEMENT OF NEED AND REASONABLENESS

The Minnesota Board of Nursing (hereinafter "Board"), pursuant to Minn. Stat. § 15.0412, subd. 4, hereby affirmatively presents facts establishing need for and reasonableness of the above-captioned repeal of current rules and adopting new rules governing Board approval of practical and professional nursing programs. Words, terms and phrases used herein which are defined in 7 MCAR § 5.3000 shall have the same meaning as given in the rule unless the language or context clearly shows that a different meaning is indicated.

I

NEED FOR THE PROPOSED AMENDMENTS

The repeal of current rules and the promulgation of new rules are needed to reflect new legislation, changes in the nature and proportion of types of nursing programs existing in the state, development of refined educational theories and to incorporate the Board's perception of its roles to protect the public in light of these changes.

The current rules for program approval which pertain to curricular content were last amended in 1967 for practical nursing programs and in 1968 for professional nursing programs. Since that time, the legal definition of practical nursing found in Minn. Stat. § 148.29 was totally revised in

Minn. Laws 1971, ch. 418, §§ 2 and 3. The definition of professional nursing found in Minn. Stat. § 148.171 was totally revised in Minn. Laws 1974, ch. 554, § 1. Thus, nursing education and the rules concerning nursing education need to be revised to incorporate these legislative changes.

Furthermore, Minn. Stat. § 148.251, subd. 4 (Supp. 1981) requires the Board to adopt rules requiring some programs to grant practical nurses advanced standing in recognition of their nursing education and experience.

Furthermore, these rules recognize that the nature of programs offering nursing education have changed since the 1960's. In 1967, 5 of the 27 practical programs were conducted entirely by hospitals. In 1968, 16 of the 28 professional programs were conducted by hospitals. In 1982, of the 53 currently approved practical and professional nursing programs, all but 5 are conducted entirely by educational institutions and not hospitals.

In view of the developments addressed above, and in recognition of the fact that educational concepts are not static, the Board designated a committee in 1977 to study the influence of educational processes on nursing education. In 1979, the Board designated an advisory task force on nursing education which recommended to the Board that the approval rules regarding curriculum be repealed, that new rules should concentrate on the new legal definitions of practice referred to above, and that new rules should focus on the graduate outcomes. The work was completed with the January, 1981, final report of a third group, the program rule replacement taskforce. That report was sent to all nursing programs.

As a result of all the factors addressed above, the Board recognizes that there is a need to base program approval more on the nursing abilities expected in graduating students (outcomes) rather than on standards specified in curricular content (process). The proposed rules establish that the emphasis for program approval should rest with the ability of a program to graduate a

person with the knowledge, skills, and abilities required to safely practice nursing as legally defined. This can be accomplished by rewriting the rules so as to focus on the evaluation of the student's nursing abilities. In view of the shift of emphasis in approval requirements, total replacement of the current rules is proposed. In light of the Board's view that the abilities required of a practical nurse are incorporated into those of a professional nurse, the rules for practical and professional nursing programs have been merged.

Proposed rules which do not relate to the evaluation of nursing abilities have been kept to a minimum. Nonetheless, additional proposals are needed to:

1. Inform the public of the processes for obtaining and retaining approval;

2. Insure that graduating students will have a useful credential which will verify successful program completion and that they will have access to their academic records;

3. Implement Minn. Stat. § 148.251, subd. 4 insuring that professional programs leading to an associate degree provide for recognition of the practical nurses' previous nursing education and experience;

4. Insure that professional nurses are responsible for teaching and evaluating student learning that is nursing related;

5. Insure that all students are provided with clinical activities necessary to practice as a generalist, as required in the legal definitions of nursing;

6. Insure that specific standards will be met in the event of a clinical affiliation.

Some of the requirements in current rules are incorporated into the proposed rules since they are basic to implementing the approval process. For example, in any set of rules relating to approval, there must be requirements

which specify which institutions can conduct a program, the basic education needed by faculty members, the adequacy of learning materials and written authorizations to use clinical settings. Under 9 MCAR § 2.104, the Board need not again demonstrate the need for and reasonableness of existing requirements not affected by these rules. Nonetheless, in the interests of further informing the public, the Board will address in § IV of this document the need for and reasonableness of current requirements incorporated into the proposed rules. Essentially, these criteria are needed to enable the Board to predict whether the applying program will be able to graduate students who can safely practice within the parameters set forth in law.

II

THE DRAFTING OF THE PROPOSED REPEAL OR AMENDMENTS

As stated above, and as included as a part of the record for promulgation of these rules, the Board has gone through a long and detailed process to develop these rules. Indeed, since 1977 the Board has established a committee to review current rules in light of legal, educational and factual developments, an advisory task force on nursing education to recommend rule revision and has accepted a final report of the program rule replacement task force. As is evident in these reports, the Board has held extensive consultations with nursing educators and nursing service administrators in the development of these proposals.

III

STATUTORY AUTHORITY

The statutory authority for the proposed amendments is provided. Minn. Stat. § 148.191, subd. 2 (1980) states in relevant part as follows:

> The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.299. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.299. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.299 and board rules. (Emphasis added.)

Minn. Stat. § 148.292, subd. 1 states in relevant part as follows:

> The board shall by rule set minimum standards for schools and courses preparing persons for licensing pursuant to sections 148.29 to 148.297 and 148.299, and cause the same to be written and filed with the executive director of the board. It may by rule amend said requirements pursuant to sections 148.29 to 148.297 and 148.299 from time to time and any such amendment shall also be written and filed with the executive director of the board.

Subdivision 2 of this statute and Minn. Stat. § 148.251 subd. 1 require applying schools to submit evidence that they are prepared to meet the standards established by the Board.

Minn. Stat. § 148.251, subd. 4 (Supp. 1981) states in relevant part as follows:

> The associate degree nursing programs approved or seeking to be approved by the board shall provide for advanced standing for licensed practical nurses in recognition of their nursing education and experience. The board shall adopt rules by July 1, 1982, to implement this section.

IV

REASONABLENESS OF THE PROPOSED AMENDMENTS

The following facts and explanations are presented to establish the reasonableness of the proposed rules, 7 MCAR §§ 5.3000-5.3021 and the repeal of rules, 7 MCAR §§ 5.1050-5.1101 and 7 MCAR §§ 5.2040-5.2091.

7 MCAR § 5.3000 Definitions.

A. Scope.

The definitions are needed to provide a clear common reference for the rules being promulgated. Only the words which are crucial to understanding these rules and which could have more than one common meaning have been defined. The meanings have been ascribed solely for the purpose of these rules.

B. Advanced standing.

The term is needed to implement Minn. Stat. § 148.251 Subd. 4. and provide understanding of rule 7 MCAR § 5.3011. The meaning was adapted from the definition

for "advanced placement" found in Good's Dictionary of Education[1] and is commonly understood by educators and registrars.

Defining advanced standing as academic credit facilitates graduation by recognizing the previous nursing education and experience of licensed practical nurses. This definition permits faculty discretion in determining whether the licensed practical nurse may be exempted from whole nursing courses or parts of nursing courses.

C. Affiliation.

Although no practical or professional program now has an arrangment such as is described in this definition, the term is needed to enable the board to implement Minn. Stat. § 148.251 Subd. 2 and 148.292 Subd. 1 in the event a program makes such an arrangement. The definition has been limited in two ways so that rules 7 MCAR § 5.3016 C. and D. will only apply when a program's faculty turns its responsibility for students' clinical learning activities or the evaluations specified in rules 7 MCAR §§ 5.3014-5.3021 over to representatives of a clinical setting.

This definition enables the board to see that students are protected should a faculty surrender to others its responsibility for teaching and evaluating. It also allows a faculty without an affiliation discretion in selecting and using clinical settings without seeking prior board approval as is required by the current rules.

D. Approval.

The term is needed to implement Minn. Stat. §§ 148.191 Subd. 2., 148.211 Subd. 1. (4), 148.251, 148.281 Subd. 1. (7), 148.29 Subd. 1 (4), 148.292, and 148.293 Subd. 1 (1). The meaning is limited to the currently and commonly understood definition.

E. Board.

The term is needed for brevity.

F. Board review panel.

The term is needed to provide for uniform understanding of proposed rule 7 MCAR § 5.3007 C. The concept of the panel affords both parties an alternative to a contested case hearing. The meaning will accommodate the board's appointment of a group qualified to conduct the investigation necessitated by the particular alleged noncompliance with rules.

G. Controlling body.

The term is needed to clearly delineate the various types of schools and organizations which may conduct a program or apply to conduct a program. This term has been used in previous and current rules. The type of institution which may operate a program is now addressed in the rule 7 MCAR § 5.3004. B. and deleted from this definition.

H. Counseling.

This term is used in the professional practice definition in Minn. Stat. § 148.171 (3) and needs to be defined to provide a uniform meaning for the nursing category and related nursing abilities in rule 7 MCAR § 5.3018 D. The definition is also needed to differentiate "counseling" from the term "applying counsel" in the practical nursing definition in Minn. Stat. 148.29 Subd. 4. "Applying counsel" in that definition is reflected in the nursing ability of "giving, translating and transmitting information" (7 MCAR § 5.3017 E. 7.).

This definition for counseling requires faculties of professional programs to clearly distinguish between the nursing abilities of "giving information," "health teaching" and "counseling." This definition is supported by the fact that newly graduated registered nurses do counseling in the manner defined, that is by involving the patient or family in the process. This meaning is limited to clarify that students do not have the abilities of a psychiatric nurse with a master's degree, psychiatric social worker, psychologist, or psychiatrist.

I. Director.

The term is needed so the board may use the same title in reference to each person responsible for a program . This definition will permit the controlling body to use whatever title is preferred while allowing the board to simplify its record keeping. The meaning is essentially the same as that in past and current rules. The Advisory Task Force on Nursing Education and Program Rule Replacement Advisory Task Force have both advised that a professional nurse should continue to be responsible for implementation of both practical and professional programs.

J. Faculty.

The meaning is needed to clarify that the term includes the director and excludes individuals who are not responsible for teaching or evaluating student learning in the program. The meaning is limited in that those whose responsibility for teaching or evaluation is not ongoing, such as a guest lecturer or a adjunct appointee, are also excluded. The distinction from current rules is that only teaching and evaluation responsibilities are identified, and extraneous matters, such as guidance and research as in current rule 7 MCAR § 5.1050 G., are excluded.

The definition identifies the persons who will have to comply with the faculty requirements stated in rule 7 MCAR § 5.3012. This limited definition will not restrict the controlling body from defining faculty as it wishes for purposes other than complying these these rules.

K. Family.

The meaning is needed to clarify the nursing abilities required under the nursing category 7 MCAR § 5.3018 K. which stems from the professional practice definition in Minn. Stat. § 148.171 (3). The meaning will accommodate many groups of people who would not fit a classic definition thereby making it easier to evaluate the specified abilities. Since people living in the same household who are not related by blood may be of direct assistance in achieving a health goal, they are included. The meaning will also accommodate families of two members thereby clarifying that students do not need to have the ability to assess a large family. This definition

only explains family membership in terms of those who may be involved when students are being evaluated for the abilities specified in 7 MCAR § 5.3018 K.

L. Nursing ability.

The term is needed to implement the rules 7 MCAR §§ 5.3017-5.3021 regarding student evaluation. The judgment that these rules require faculties to make is clarified by this term in that each student, upon evaluation, will either have or not have the specified nursing ability. The meaning accommodates the many ways in which nurses perform. It is a term that to date has not been commonly used and therefore has not been contaminated with multiple interpretations nor does it have any previous connotations for nursing educators.

M. Nursing care.

The term is needed to refer to the nursing categories in rule 7 MCAR § 5.3017 D. and E. and in many of the other nursing categories and nursing abilities in these rules. The meaning is both simple and broad and will accommodate all present and, hopefully, future definitions used by the faculties. Due to its simplicity, the definition will encompass the practice of nursing being taught in both practical and professional nursing programs. This definition, particularly in its reference to personal services, is in keeping with the practical and professional practice definitions in Minn. Stat. §§ 148.29 Subd. 4. and 148.171 (3).

N. Nursing care plan.

The term is needed for reference in many nursing care abilities, primarily those in 7 MCAR § 5.3018 B. and J. The definition is needed to assure a common understanding of the components of the plan. The components included are among those commonly taught in professional nursing programs. The plan is defined as a pattern so that the components may either be written down or outlined in the student's mind. The meaning does not limit the patient goals to those set by nurses, so nursing actions may be developed to assist the patient in meeting non-nursing goals, such as those for medical care.

O. Nursing personnel.

The term is needed for reference to the nursing abilities in rule 7 MCAR § 5.3018 F., G., and H. The meaning clarifies which persons make up this group. Since licensed nurses and nursing assistants are commonly involved in administering nursing care, they are all accommodated by this definition. Nursing students are excluded so it is clear that evaluation of the students for the possession of these nursing abilities, when being done for compliance with 7 MCAR §§ 5.3020 and 5.3021, should not use a student's peer group to represent nursing personnel.

P. Observation.

The term is needed to refer to the nursing category in rule 7 MCAR § 5.3017 C. which stems in part from the practical nursing definition Minn. Stat. § 148.29 Subd. 4. The meaning has been broadened to incorporate all of the senses which nurses can use in determining patients' conditions. The senses in addition to seeing that are accommodated are hearing, touch and palpitation, smelling, and, if nececessary, tasting.

Q. Patient.

The term is needed for consistent reference throughout rules 7 MCAR §§ 5.3014-5.3021. This single term was chosen for simplicity and familiarity. The term is not meant to suggest that the person cared for by a student is necessarily ill or in a health care institution. The meaning is needed to clarify that all persons, including those not yet born, may be a nurse's patient. Since the person's need for nursing care, not health status, is the deciding factor, the definition cannot conceivably exclude anyone a faculty wishes to involve in student learning. An exception to the definition is permitted in order to accommodate the use of mannequins and actors to represent patients during the evaluation of students for possession of the nursing abilities. The exception does not extend to the evaluation of students for the ability to combine nursing categories as that would defeat the intent of the rule 7 MCAR § 5.3021.

R. Practical program, and S. Professional program.

These terms are needed for reference throughout these rules to distinguish, where necessary, between the requirements for approval of each type of program by the board. In the event a controlling body wishes to offer both types of programs,these definitions will accommodate the board making separate approval decisions. These terms as defined are clearly supported by the nursing practice definitions in Minn. Stat. §§ 148.171 (3) and 148.29 Subd. 4 and in the licensure requirements stated in Minn. Stat. §§ 148.211 Subd. 1 (4) and 148.291 Subd. 1 (4).

T. Program.

The term is needed to refer to the object of approval. The definition in the current rule is being repealed as it addresses the school or educational unit which may offer more than one course of study. Minn. Stat. § 148.191 Subd. 2 authorizes the board to approve schools and courses. If an educational unit chooses to offer both a practical and a professional program,the proposed definition will assure that each program will be subject to approval.

U. Safety.

The term is needed to provide understanding of the requirements for the predetermination of evaluation criteria in rules 7 MCAR §§ 5.3019 A. 3. and 5.3021 B. 3. The term is needed to provide a common understanding of the nursing abilities in rule 7 MCAR § 5.3017 D. 1. and E. 5. The comprehensive meaning is needed to reinforce the ways faculties guard against any and all aspects of endangering patients while evaluating the nursing abilities of students. The meaning will accommodate all evaluative situations and stimuli that a faculty may wish to use.

V. Survey.

The term is needed to implement Minn. Stat. §§ 148.191 Subd. 2., 148.251 Subd. 3. and 148.292 Subd. 1. The term is also needed for reference in rule 7 MCAR § 5.3007 which concerns the approval process. Examples that reflect current practice have been used to illustrate the meaning. The definition will accommodate suitable new methods of collecting and analyzing data which may be developed later.

W. Treatment.

The term is needed for the reference to the delegated medical functions which are carried out by nurses. The term was selected because it reflects the practical nursing definition in Minn. Stat. § 148.29 Subd.4. The term also serves to refer to the delegation of medical functions authorized in the practice definition for professional nursing in Minn. Stat. § 148.171 (3). The meaning is needed for understanding of the nursing categories and nursing abilities in rules 7 MCAR §§ 5.3017 F. and 5.3018 B. The meaning accommodates therapy prescribed by other health professionals including all medical functions now commonly delegated. The administration of medications prescribed by those legally authorized to write such prescriptions is also included. This definition will accommodate future functions that may be delegated to nurses by licensed health professionals.

7 MCAR § 5.3001 Purpose.

This rule is needed to inform readers, and those regulated, of the statutory authority for these rules. Minn. Stat. § 148.251 governs the approval of professional nursing programs and Minn. Stat. § 148.292 governs the approval of practical nursing programs. Minn. Stat. § 148.191 Subd. 2. mandates that:

> The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.299. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.299 and board rules.

These rules have been designed to carry out the board's responsibility to the public by assuring that both practical and professional programs evaluate students' abilities to practice safely in the categories of nursing defined in the Minnesota Statutes. Evidence of compliance with these rules will give the board an indication that the educational preparation of graduating students meets the nursing education requirement for Minnesota practical or professional nurse licensure. These rules will enable the board to prevent the opening of a proposed program that is not in compliance with one or more rules, and to prevent the continued operation of an approved program that is consistently unable to meet one or more of the rules.

7 MCAR § 5.3002 Scope of rules and temporary exemptions.

A. Scope.

This rule is needed to identify those bodies subject to these rules, to delineate the extent of the rules, and to clarify that these rules do not set maximum requirements. The requirements in rules 7 MCAR § 5.3000 to 5.3021 are proposed to provide the board with the information needed to determine whether students will be prepared to practice practical or professional nursing as defined by law. The limited purpose of these rules permits minimum requirements which should not be misinterpreted as either restrictions or maximums, as that is not the intent.

B. Continuing approval.

These rules have been designed so there is only one approval status, that of approval. If approval is granted to a proposed program and continued compliance with rules is evident, this approval will continue until that program is removed from the list of approved programs. This rule is needed to ensure that the approval of existing programs will continue and that existing programs will not have to re-submit applications for approval under these rules. Without this rule it would be necessary to treat on-going programs as proposed programs.

C. Temporary exemption.

This rule is needed to permit program representatives to elect to have a two-year period in which to prepare to meet these rules. The Program Rule Replacement Advisory Task Force advised the board to allow the temporary exemption as programs in the state are in various stages of readiness to comply with these rules. This exemption will permit faculties to choose immediate application of these rules and release from current rules, or to choose continued compliance with current rules while working toward compliance with these rules. Limiting the temporary exemption to two years was recommended by the Task Force after discussing with various program directors the time needed for compliance.

The July 1, 1983 deadline for applying for the exemption will provide ample time for faculty members to assess their situation in light of these rules, make a decision and, if necessary, submit the application for exemption. The scheme of the proposed rules is not in conflict with current rules, so continued compliance with the current rules will not hinder work toward compliance with the proposed rules. It will be possible for a faculty to end the exemption before July 1, 1985.

Because the scheme of the current rules is so different in emphasis from these proposed rules, it is necessary to have the director make a commitment to compliance with one set or the other. To permit a director to selectively choose some current rules and some proposed rules for compliance would not accomplish the purpose of approval.

D. Limited temporary exemption.

This rule is needed to implement Minn. Stat. § 148. 251 Subd. 4, which became law in 1981. Proposed rule 7 MCAR § 5.3011 requires the professional programs addressed in that statute to comply with the requirements for granting advanced standing to qualified licensed practical nurses by September 1, 1983. Without this rule it could be 1985 before licensed practical nurses would be assured recognition of previous nursing education and experience in all professional programs leading to an associate degree. See the statements regarding 7 MCAR § 5.3011 for further information.

This rule permits professional programs leading to an associate degree to have the exemption from immediate implementation of all of these rules except 7 MCAR § 5.3011. This limitation of the exemption is reasonable as the programs affected have known the content of 7 MCAR § 5.3011 since December 1981 when the board delayed scheduling a hearing on this rule due to budgetary implications for both the board and the nursing programs.

7 MCAR § 5.3003 Restrictions before approval.

This rule is needed to enforce Minn. Stat. §§ 148.281 Subd. 1 (7) and 148.293 Subd. 1 (1) which indicates that conducting a program to prepare students for practical or professional nurse licensure without prior approval by the board is unlawful. The rule is needed to ensure that the controlling body which does not have an approved program does not mislead students into thinking that it is offering nursing courses that will prepare the student for licensure.

The use of the term "proposed program" in printed references will mean that the controlling body can publicize its plans. References to the proposed program fairly inform potential students as to the developmental status of the controlling body's plan. This rule clarifies that it is possible for a controlling body, without an approved program, to conduct the supporting courses which are often taken by students prior to enrollment in a program, and to conduct continuing education activities for nurses and their assistants.

7 MCAR § 5.3004 Conditions for program approval.

A. Minimum conditions.

This rule is needed to alert representatives of controlling bodies, prior to the submission of an application, of the basic requirements which must be fulfilled before approval is considered.

B. Controlling body.

This rule is necessary to assure that a controlling body, which by its very nature could never be approved, not mislead students, nor waste its time and that of the board. This rule is reasonable as it maintains essentially the same standards as were set in 1976 regarding the type of controlling body that may apply for approval of a practical or professional program.

The rule is also needed to assure that nursing education for practical nurse licensure takes place in postsecondary educational institutions. No comprehensive high school has applied to operate a practical nursing program since that

was made possible by rule 7 MCAR § 5.2050 A. in 1976. It is, therefore, reasonable to repeal that provision.

It is necessary to specify that the educational institution be in Minnesota to implement Minn. Stat. §§ 148.281 Subd. 1 (7) and 148.293 Subd. 1 (1). The distinction regarding location is a necessary limitation as the Board neither seeks nor intends to survey and approve programs conducted by institutions located in other states.

Limiting the controlling bodies that may conduct a program to educational institutions and general hospitals that had existing programs as of July 1, 1976 was justified when current rules 7 MCAR §§ 5.1060 and 5.2050 A. were filed with the Secretary of State on November 24, 1975. The board need not rejustify these requirements which are not affected by the proposed amendments, according to 9 MCAR § 2.104.

C. Director.

This rule is needed to ensure that there will be one responsible person to whom students, other faculty members, the board and others can turn regarding the program. The director needs to be a professional nurse because this person sets nursing standards, imparts nursing knowledge and directs the evaluation of nursing abilities of all students. It is imperative this person, who is the faculty member most instrumental in preparing students for licensure, be a member of the discipline in which the graduating students will practice. It is, therefore, necessary to require representatives of a controlling body to name a professional nurse to develop the proposed program and implement it. This rule is reasonable as it permits full control over when this person is employed. All structuring of the position of the director is also left to the controlling body.

7 MCAR § 5.3005 Application for program approval.

A. Content.

This rule is needed to inform representatives of a controlling body of the content required in an application for approval. The requirements are needed to:

1. Assure that the information needed to document compliance with the rules is supplied. It is necessary to require the use of a board-supplied form to ensure uniform treatment of all applicants and to assure that approval is not granted solely because of cleverness or excellence of exposition. A board-supplied form is also necessary to ease review and speed processing. This subpart of the rule is necessary to prevent the submission of inaccurate information to be used in determining rule compliance.

2. Assure that applicants know the application process includes a survey and that all information submitted should be able to be confirmed by on-site observations, in-person conferences or other methods. This subpart of the rule is necessary to prevent the submission of falsified information and to give the board a means of verifying the information submitted.

3. Assure that representatives of the controlling body know the information is being submitted and that they are willing to be identified with the submitted information.

4. Assure that the proposed program has successfully passed the steps necessary for the Minnesota Higher Education Coordinating Board to determine its suitability with regard to statewide educational coordination including need and cost/benefit to citizens. If it is a public institution, this rule will provide the board with assurance that the public educational system has agreed to start and support the program. The board can confirm favorable review by the Minnesota Higher Education Coordinating Board and authorization from the public educational system. Those reviews require less detailed information than do the board requirements. Given the

nature of the board's requirements for approval, it is reasonable to assume that controlling bodies that are not evading other state agency requirements will be able to supply evidence of favorable review and, where applicable, authorization before the board acts upon the application for approval. This rule does not prohibit initiation of the application before these required steps have been completed.

5. Obtain the information necessary to predict if a proposed practical or professional program will be able to prepare graduates capable of practicing safely as defined by law. Because the application may be for a program which may take students one year (practical program) or two, three or four years (professional programs) to complete, documentation of compliance with the requirements has been staggered. It would be unfair and unreasonable to expect those beginning a program to comply with all requirements before the first student is admitted. However, it is reasonable and necessary that the following subpart of this rule assures full compliance with all rules by the time the first student has completed the program. The information requested to evidence readiness to comply with the selected rules in this subpart is reasonable in light of the commitment being made to potential students. The reasons why compliance with these requirements is necessary follow.

As a protection for potential students, it is necessary for the board to know that the controlling body has made arrangements for storage and dispensing of students' academic records in the event that the program is closed (7 MCAR § 5.3009). This information must be obtained during the application process in order to ensure that students would not be left without access to their records.

It would be impossible to know if the program could attract a qualified faculty unless it is able to fill the positions necessary to operate the first year (7 MCAR § 5.3012). In all fairness to students, a program cannot be implemented without a faculty. It is only in an emergency that a new program should have to encounter the difficulty of locating qualified teachers and orienting them in mid-year.

Again, it would be impossible to know if a controlling body would furnish the learning materials necessary to enable students to acquire and demonstrate nursing abilities unless that had been done for at least the first year. Even if the materials were on order, there would be no assurance that they would arrive in time to facilitate learning and evaluation. One new program's faculty and students were handicapped when the delivery of the ordered learning materials was delayed until near the end of the first school year (7 MCAR § 5.3013).

To predict that the program will be able to provide the required clinical learning activities to students, it is necessary to know that those clinical learning activities are planned for at least the first term (7 MCAR § 5.3014) and that the faculty has devised a way to evidence compliance with that requirement (7 MCAR § 5.3015). Without preplanning of clinical learning activities and establishment of how those activities will be documented, students could reach the time for graduation only to find that they have not had all of the preparation necessary for licensure. This preplanning is also necessary for development of the nursing courses and student evaluation tools.

A crucial factor in predicting whether a program can be implemented is the controlling body's ability to obtain authorization to use clinical settings for all of the necessary clinical learning activities (7 MCAR § 5.3016). Without the necessary clinical activities students cannot learn a practice discipline. Highly populated areas have a particularly high educational demand for clinical learning experiences. Once clinical settings are located, much planning and coordination are needed to ensure that students will have adequate learning opportunities. It would be unfair to potential students to approve a program knowing that the controlling body has not already obtained authorization for all the clinical settings necessary to implement the program. Also, it would be imprudent for the board to grant approval based on a prediction that clinical settings would become available at some future date.

Since the major thrust of these rules is on evaluating students' nursing abilities, the prediction of readiness for approval rests on evidence that the first evaluations to be used meet the rules (7 MCAR §§ 5.3017-5.3021). A new faculty will find many demands on its time as it begins to implement the program, so it is essential to have the evaluation tools and system for documenting compliance with the rules ready for at least the first term during which they will be used.

It is reasonable to expect a controlling body applying to conduct a program to be prepared to teach students what they are expected to learn. These rules do not differentiate from the current rules and practices in this regard.

Prior to submitting the application, representatives of the controlling body and the director should be able to judge for themselves if these rules are being met or what is needed to demonstrate compliance with the rules. The controlling body may submit the application when it is ready to comply with these rules.

6. Obtain descriptions of how all rules in which compliance was not actually evidenced in 5., will be met once the program is operational. This information is needed in order to predict if the program will be able to meet the rules and therefore the purpose of approval. It is necessary to require that the description be detailed in order to convey to applicants that claims must be substantiated, and to assure that the applicant has given careful consideration as to how the program will be implemented.

Describing the way in which the graduation of students will be verified is a straight forward matter that should not be difficult (7 MCAR § 5.3010). For community and junior colleges, the preplanning for awarding advanced standing to licensed practical nurses must occur before such students can be admitted, so the plan will be ready to be described (7 MCAR § 5.3011). The very act of obtaining learning materials for the first year will make it possible for the applicant to describe the plans for complying with that rule for any other years that may be

involved (7 MCAR § 5.3015). Again, the initial development of the clinical activities and evaluations for nursing abilities and the systems for documentation will set a pattern for describing the provisions for completing compliance with those rules (7 MCAR §§ 5.3014-5.3021). Without this degree of planning for complete program development, it would be uncertain that a program could be completely implemented.

7. Give the board the discretion to waive the sequencing of requirements which have been established to permit staggered development of programs. A waiver is necessary in the event that a controlling body wishes to complete program development before initiation. It would be unreasonable to hold to the entire sequence specified in the rules if almost complete compliance was evident on application.

B. Processing.

This rule is needed to inform applicants of the steps that will be followed in reviewing an application for approval. This rule leaves the timing of the application to the applicant. Whenever the application is satisfactory, approval will be granted. The process is reasonable because applicants will be notified if any deficiencies are found and have up to 24 months to supply additional information to support the application. If a controlling body does not want an unfavorable review, this rule clarifies that it is possible to withdraw an application at any point.

It is necessary that, in the case where approval has not been granted nor the application withdrawn, the board deny approval after 24 months in order to have closure of that application. Without such a provision it is possible that the board would be obligated to process outdated applications.

C. Reapplication.

This rule is needed because it is more work for everybody involved to confirm that the original information is still current and to get it up-dated, than it would be to submit and process a new application. It will be possible for an applicant to use relevant material from the rejected application. While it may

seem obvious to state that an application may be submitted at any time, clarification of that point is reasonable.

7 MCAR § 5.3006 Director's responsibilities.

A. Initial evidence of compliance.

This rule is needed to assure the new program's complete compliance with each rule. This monitoring of compliance is necessary since the ability to comply can best be predicted before implementation of each year the program begins. In the event that complete compliance is evidenced before the program begins, this monitoring may be waived under 7 MCAR § 5.3005 A. 7.

It will not be difficult for the director to submit written evidence of compliance because copies of written materials prepared for faculty and student use will suffice to document compliance with most rules. Written evidence of compliance with each rule is only required during the period of time it takes to implement the entire program. The director of a nursing program would be required to submit an annual report for each year of the program. Therefore, directors of practical nursing programs would submit one report only. Directors of professional nursing programs would submit a maximum of four reports. Annual submission of evidence of compliance from directors of programs that take two or more years to implement will enable the board's representatives to identify any potential deficiencies while there is time to achieve compliance. Total implementation of the program is needed to determine compliance with all rules. Such implementation will have taken place by the time the first student completes the program, even if that student was granted advanced standing.

B. Evidence of compliance upon request.

This rule is needed to inform directors that continued compliance with all applicable rules is expected at all times, and that evidence of that compliance may be requested at any time. This rule simply allows the common practice in this area to continue. The rule is necessary if the board is to carry out its responsibility

to the public and if approval of programs is to have meaning. Such a request for evidence may be made if the board has cause to suspect a lack of compliance with a rule, or to suspect program personnel of submitting false or misleading information or having used fraudulent practices to maintain or obtain approval. By informing the director of this responsibility, plans can be made for complying with such a request in the event a request is ever made.

C. Annual evidence of compliance.

This rule is needed to assure that the director of an on-going program consciously, at least once a year, review and attest to the program's compliance with all applicable rules. It is necessary to institute this annual affidavit since actual surveys for compliance with rules may be conducted less often than has been the case in the past. Having the affidavit on file will give the board some assurance that the person responsible for implementing the program has stated that the rules have been met. Use of a board-supplied form will assure uniform attention to this rule and simplify compliance. It is reasonable to require at least annual verification as to whether the program, wherever it was being presented, was conducted in compliance with the rules. Submitting the affidavit before October 1 means that the director will have last year's compliance in mind as the new school year begins. This practice will afford the director the opportunity to orient faculty members, some of whom may be new, to what the applicable rules require and the faculty's responsibility in complying with those rules.

Signing and dating an affidavit in front of a notary public and mailing it to the board will be a simple matter for the director. This rule should not be misinterpreted as involving a lengthy annual report because that is not stated in the rule.

D. Notice of change.

This rule is needed to inform directors which information needs to be reported to the board. It is necessary that the board be aware of who is responsible for implementation of the program, which bodies control the program, and the address of

of each, so the board can, if a need arises, immediately contact the director or controlling body. The information is also used whenever information regarding programs approved by the board is supplied to individuals or published. Other boards of nursing use such publications to verify that the program from which a licensure applicant has graduated was approved by this board at the time of graduation. If the name of the program and controlling bodies or addresses supplied by the licensure applicant do not correspond to that published by the board, problems result for the graduate. Presently, the board contacts each program each fall to verify names and addresses. This rule should eliminate the need to request that information annually.

The requirement is reasonable in that 30 days are allowed for supplying notice. The board will not approve nor in any way act upon these changes.

7 MCAR § 5.3007 Rule compliance survey.

A. Timing.

This rule is needed to implement Minn. Stat. §§ 148.291 Subd. 2, 148.251 Subd. 3 and 149.292 Subd. 1. This rule is also needed to inform regulatees of the times when surveys may be expected. The board is obligated to conduct the minimal number of surveys needed to assure the board and the public that all applicable rules are being met by programs that are approved.

The broad language of this rule is needed to empower the board to use its judgment as to when a survey is needed and to reinforce the concept that compliance with all applicable rules is expected at all times. While this rule will permit surveys as frequently as the board finds necessary, it allows minimal surveillance.

This rule makes some current practices explicit. Under both the current rules and these proposed rules, a program is presumed to be in compliance unless there is evidence to the contrary. The current rules permit surveys when the board deems necessary. Programs are currently being surveyed for compliance with all rules every four to six years. The proposed rule requires at least one survey every ten years. Resources permitting, a program may be surveyed more than outlined in the proposed rules. During the period between surveys, the director's annual affidavit will attest to rule compliance. The proposed system for survey is reasonable given the precise focus of these rules, the explicit nature of the evidence of compliance with these rules.

At least one survey every ten years is necessary to assure that, even though there are not complaints and 75 percent or more of the graduates achieve licensure upon first writing of the licensure examination, the public and students are served through a thorough affirmative investigation. The maximum interval possible between surveys is reasonable given these rules which specify the nursing abilities expected of graduates. More frequent surveys are needed under current rules which require the board to monitor what a faculty puts into the curriculum, given the broad content topics in those rules.

The remainder of this rule is needed to empower the board to determine that rules are being complied with whenever any of the following specified situations occurs.

1. If the success rate of graduates writing the licensing examination drops so that one quarter do not get licensed, it is only prudent to determine whether the program is meeting all of the rules. The board recognizes that it would be unfair to hold a program responsible for the performance of its graduates on the licensure examination since the success of individual students is beyond the control of the faculty. However, if 25 percent of the graduates are unable to achieve licensure, which is the primary goal of the program, the board must take notice. The need for such surveys is expected to be minimal as the success rate of most programs is between 80 to 100 percent. Only two practical and two professional programs have had success rates below 75 percent in the last four years.

2. Whenever a rule for approval is added or changed the board will need to determine that compliance occurs in order to make its rule-making activities meaningful and worthwhile. It is reasonable that the board be given the capability to assure compliance with new requirements if the board is to fulfill its duty to protect the public in the practice of nursing.

3. Suspicion of lack of compliance. The board has a responsibility to assure the public that program approval has meaning. Approval can only be meaningful if a determination can be made about compliance whenever there is reason to suspect lack of compliance. The rule is reasonable as conducting an investigation will give the faculty an opportunity to document compliance with the rules in question.

4. Suspicion of fraud.

This rule is needed to empower the board to investigate cases where information comes to the board's attention that causes suspicion that false or misleading information was submitted or fraudulent practices were used to obtain or maintain approval. While such a case has not yet come to the attention of the board, it is reasonable and necessary for the board to have this power in the event it is needed. This rule will serve to let faculties know that an investigation would be made in such a case.

B. Survey notice.

This rule is reasonable and assures directors that they will always have notice before being expected to supply information to the board regarding compliance with rules. No minimum notice time is stated as the type of information requested and the route by which it is to be supplied will cause the time allowed to vary. Currently, at least two weeks and, more usually, two months are allowed for supplying information by mail.

This rule is needed to empower the board to make onsite observations without prior notice. This rule is necessary to assure the board can see the program as it is actually being implemented. It is recognized that notice of an on-site visit would need to be given whenever the board's representative wishes to confer with the faculty.

Even though it is usually necessary for the site visit to be prearranged, it would be prudent for the board's representative to be able to make an unannounced visit to determine if certain rules are actually being implemented. For example: to determine if a new program has the learning materials required in 7 MCAR § 5.3013, it may be necessary to visit at a time when the learning materials are being used by students, rather than when all of the materials have been assembled for a visit. To determine if registered nurse faculty members are responsible for guiding students in clinical settings as required in 7 MCAR § 5.3106 A., it may be necessary to observe faculty and students in a clinical setting at an unannounced time.

C. Board action.

This rule is needed to implement Minn. Stat. §§ 148.251 Subd. 3 and 148.292 Subd. 1. This rule will inform regulatees and other interested parties of the procedure that will be followed by the board following a rule compliance survey. This is necessary to clearly establish that there will only be one approval status. Having one form of approval eliminates the need that now exists within the current rules to grant interim approval, terminate interim approval, and grant and renew approval. This rule is also necessary to clarify the board's authority to specify what must be done when there is a lack of compliance. Since the factors involved in such cases will vary from program to program, the board needs to be able to deal individually with each deficiency.

The rule is reasonable in that directors will be informed of all board meetings when action is taken on program approval and informed in writing of the board's findings. In the case of apparent lack of compliance, the program's rights are protected under the Administrative Procedure Act. For example, program representatives will be notified 30 days prior to any board review panel or hearing. The notice will inform them that they may bring their legal counsel and any defense witnesses to the review panel or hearing. In a case where a lack of compliance is determined, it is not possible for the board to remove the program from the list of approved programs without first issuing a correction order, giving the program time to comply and, if that does not occur, holding another board review panel or hearing.

The board review panel may be used in place of a hearing. Following the panel review, no action will be taken by the board without the consent of representatives of the program. The rules of the office of Administrative Hearings are referenced to clarify to the public and faculties that in contested case matters where the representatives of the program disagree with the board review panel's recommendation, their rights to a hearing continue throughout the proceedings.

In cases where compliance is reached, the board can end the correction order early. If compliance is reached after the correction order expires but by the time the review panel is convened, only a reprimand may result. This rule eliminates the onus of provisional approval which exists in the current rules. The public is still protected since the knowledge of a program's approval status, including correction orders, would be public information.

7 MCAR § 5.3008 Program closure.

A. Notice.

This rule is needed so the board will be informed of a program's plans to close. This information is necessary so the board will be aware of the number of approved programs expected in the immediate future. In as much as compliance with these rules might be neglected when the number of students and faculty decreases, the board should be apprised of plans to close so as to be alert to possible noncompliance.

This rule is also necessary to assure that the board is informed of the actual date of closure. Since approval is terminated upon that date, that information is needed for record keeping purposes. The rule is reasonable in that the information requested is simple, and, in both cases, 30 days are allowed for supplying the information.

B. Ending approval.

This rule is needed to inform regulatees about the ending of approval when a program closes voluntarily. The date chosen for ending approval is reasonable since the need for approval ceases once students are no longer being graduated.

7 MCAR § 5.3009 Academic records.

This rule is needed to be sure the program assumes responsibility for storing and supplying records to students and graduates. Graduating students may need verification of their completion of an approved program to obtain licensure. While 50 years is an extensive period of time, that period was chosen in view of the emphasis in society today on life-long learning and working.

Graduates of closed programs often contact the board office to find out where to get copies of their records. The rule will enable the board to answer such inquiries without the need to provide record storage. Although private schools in this state are subject to similar rules by the Higher Education Coordinating Board (5 MCAR § 2.0908) and public schools have to meet similar requirements within their systems (Minn. Laws 1982, ch. 573, § 1, Subd. 1.). It is not necessary that the board have physical possession of the records, but it is reasonable that the board know the location of the records in order to answer graduates' inquiries.

It is necessary for the director to report the storage arrangements as a program could close without fulfilling this responsibility. The rule is reasonable as the responsibility for student records is an inherent responsibility in operating an educational program. Documentation will not be a burden as it will simply consist of reporting the arrangements when evidence of compliance is requested.

7 MCAR § 5.3010 Verification of completion.

This rule is needed to assure students of an official credential which will assure this board and the licensure authorities of other jurisdictions that the student has completed an approved program. Requiring programs to give students such a credential is reasonable in view of the fact that a goal of programs is to prepare students for licensure. There is no such requirement at present and although all students are given transcripts, many students encounter problems such as:

- The program is in a consortium and the transcript carries only the name of a controlling body which is not approved to conduct a program so there is no proof of completing an approved program.
- The name of the program is given but does not correspond to that by which the program is approved so there is no proof of the completion of an approved program.
- The final transcript may not include any date indicating completion of program requirements or conferral of degree, diploma or certificate so the credential does not establish completion of an approved program.
- The student with a degree in another field meets all program requirements within a degree granting educational institution, and is not considered eligible for a second degree so has no recognizable proof of program completion. The language of the rule will accommodate the program of such a controlling body, as the date of completing all program requirements is permitted and, if that date is provided, the date of degree conferral is not required.

This rule is reasonable because most of the information required is currently being given on transcripts. Therefore, registrars of programs without such complete transcripts should be able to bring their transcripts up to this simple standard without difficulty.

7 MCAR § 5.3011 Advanced standing.

Minn. Stat. § 148.251 Subd. 4 obligates the board to require each proposed program or currently approved program that leads to an associate degree in nursing to provide for advanced standing for licensed practical nurses. To implement the law, the board studied practical nurses' needs and current educational mobility practices to arrive at these requirements. Such background information follows.

In 1947, as an outgrowth of the shortage of professional nurses during World War II, the board began to license practical nurses. The legal practice definition indicates that practical nurses may only perform services that do not require the specialized education, knowledge and skill of a registered nurse. The number of Minnesota licensed practical nurses holding active registration each year has grown gradually, going from 1,361 in 1950 to 18,888 in 1982.

In 1964 the board began to approve nursing programs in junior and community colleges. These programs lead to an associate degree and the graduates can apply for a professional nursing license. The number of programs in Minnesota leading to an associate degree in nursing (ADN) has grown rapidly, going from 2 in 1964 to 12 in 1982.

In addition to the ADN programs, there are two other types of programs approved by the board to prepare students for professional nurse licensure; these programs lead to a diploma from a hospital and baccalaureate degree from a senior college or university. Completion of the typical curriculum in each of the four types of programs takes, on the average, the following length of time:

TYPE OF PROGRAM	TIME FOR COMPLETION
practical nursing	9-12 months
associate degree	2 academic years
hospital diploma	3 academic years
baccalaureate degree	4 academic years

Becoming a professional nurse is a natural career development path chosen by many licensed practical nurses. Most of the licensed practical nurses who want to become registered nurses choose to do so by the associate degree route which takes

less time than the other professional programs. The percentage of Minnesota ADN program graduates who are licensed practical nurses has risen markedly, from 8 percent in 1976 to 30 percent in 1981. See Table 1. for the percentage of licensed practical nurses graduating in FY 1981 from professional programs.

These rules are needed to implement Minn. Stat. § 148.251 Subd. 4. All practical nurses are not always able to enter a program where the curriculum capitalizes upon their previous nursing education and nursing experience. Five (42 percent) of the 12 programs leading to an ADN in 1981 did not have special provisions for recognizing the previous nursing education and nursing experience of practical nurses.

In 1981 fifty-eight percent of the programs leading to an ADN did have special provisions for recognizing licensed practical nurses. Three programs leading to an ADN accepted only licensed practical nurses and based the curriculum entirely upon these students' previous education and experience. Three other programs leading to an ADN admitted students to a typical ADN curriculum while offering a separate or modified track for a limited number of licensed practical nurses. One additional program leading to an ADN began to grant credit to licensed practical nurses which exempted them from the first nursing course.

Because of current rule 7 MCAR § 5.1081 A., all of the professional programs approved by the board have policies regarding opportunities for student placement in, and/or progression through, the curriculum based on satisfactory establishment of knowledge and skill, however acquired. The five programs leading to an ADN that did not have special provisions for licensed practical nurses in 1981 have challenge examinations in at least one-third of the nursing courses which are available to all students. These examinations relate to content in discrete courses. Upon entering a program leading to an ADN where the only option for recognition is challenge examinations, most licensed practical nurses elect to take the entire curriculum rather than challenging any of the courses. For those who do challenge

Table 1. Number and Percentage of Graduates
From Professional Nursing Programs
Who Were LPNs, FY 1981

NAME OF PROGRAM	NUMBER	PERCENTAGE
Anoka-Ramsey Community College	31	33
Austin Community College	8	21
Brainerd Community College	25	100
Hibbing Community College	7	22
Inver Hills-Lakewood Community Colleges	61	46
Minneapolis Community College	12	24
Normandale Community College	28	29
North Hennepin Community College	16	24
Northland Community College	32	100
Rochester Community College	32	15
St. Mary's Junior College	6	4
Willmar Community College	25	100
TYPE OF PROGRAMS		
All MN. ADN Programs	283	30
All MN. Hospital Diploma Programs	10	1
All MN. Baccalaureate Degree Programs	8	5

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and are successfully exempted from one or more courses, no formal assistance appears to be available to help the licensed practical nurse make the transition from practical to professional nurse.

These rules are needed to better assure that licensed practical nurses have at least a minimally equal opportunity to receive recognition for their previous nursing education and nursing experience in any one of the state's programs leading to an associate degree. Receiving such recognition will mean that the licensed practical nurse who chooses to do so may advance in his or her nursing career by acquiring the knowledge and skills he or she lacks to become a professional nurse. The advanced standing will eliminate repeated studying of core skills.

A. Advanced standing.

This rule is needed to implement Minn. Stat. § 148.251 Subd. 4. The need for the requirement in this rule is demonstrated in Table 2. which shows the variations that existed in the ways the programs leading to an ADN recognized licensed practical nurses' previous education and experiences in 1981.

Curriculum development projects, such as those conducted by the Agassiz Region Nursing Education Consortium and the Metropolitan Area Nursing Education Consortium have established that there is a core of nursing skills common to both the practical and associate degree nursing programs. It is reasonable and more efficient that programs leading to an ADN not re-teach these core skills.

It is necessary to specify that a minimum portion of nursing credits required for graduation be available to qualified licensed practical nurses to assure that each licensed practical nurse applying to a program leading to an associate degree has an equal opportunity for at least minimal recognition of previous nursing education and nursing experience. Past performance shows, see Table 2., that not all programs have voluntarily provided such recognition to licensed practical nurses.

*The ADN programs that are members of these consortia are respectively those conducted by Northland Community College and Inver Hills-Lakewood Community Colleges.

TABLE 2 Comparison of Proposed Requirements to Present Methods of Determining Advanced Standing in Minnesota ADN Programs

NAME OF PROGRAM	Proposed 1/3 of Total Nsg. Credits	Challenge exam credit*/percent**	Transcript review	Tests for LPNs credit*/percent**	Previously determined credit*/percent**	Review of Curriculum credit*/percent**
Anoka-Ramsey C.C.	15	37 cr./82%	Nonnursing	28 cr./62%		28 cr./62%
Austin C. C.	16	14 cr./29%				
Brainerd C.C.	17			22 cr./44%		
Hibbing C.C.	19	18 cr./32%				
Inver Hills-Lakewood C.C.	17	21 cr./44%	Nonnursing	21 cr./40%		21 cr./40%
Minneapolis C.C.	14	15 cr./35%				
Normandale C.C.	15	14 cr./30%	Nonnursing		15 cr./33%	
North Hennepin C.C.	16	15 cr./31%				
Northland C.C.	16		Nonnursing		23 cr./49%	23 cr./49%
Rochester C.C.	14	12 cr./29%			6 cr./15%	
St. Mary's J.C.	17	36 cr./71%				
Willmar C.C.	16			20 cr./41%		

*All credits are quarter credits in nursing.

**Percent of total nursing credits required for graduation.

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Given the statutory authority for this rule, it is reasonable to expect programs leading to an ADN make it possible for the licensed practical nurses who wish to become registered nurses to gain advanced standing which would fulfill at least one third of the nursing credits required for graduation. One third of the nursing credits is reasonable as that portion of credit or more is now available to licensed practical nurses in six of the programs leading to an ADN. This was the fraction for advanced credit selected in 1982 by the Governor's Task Force on Articulation of Nursing Education. Practical nurses receiving one third of the total nursing credits as advanced standing have been successful in achieving an associate degree and professional license.

Requiring a higher proportion of credit for all programs would be an unreasonable minimum that might result in inadequate time for the licensed practical nurse to successfully learn to be a professional nurse, or necessitate extensive and expensive program revision. Three of the 12 programs leading to an ADN have less than one third of the total nursing credits available for advanced placement through challenge examinations in 1981, and few practical nurses were utilizing those options. Requiring less than one third of the nursing credits would be meaningless in assisting the practical nurse toward graduation and not warrant rule promulgation.

It is reasonable to require that the advanced standing be given as credit which will fulfill graduation requirements. This requirement will prevent the possibility of a licensed practical nurse being given credit only to find it would not be useful in meeting his/her goal.

It is necessary to require that any advanced standing be granted before the licensed practical nurse begins the first course so he or she and the faculty will know how much credit will be needed to graduate. It is only with information about the common core of knowledge and skills held by the applicant that the faculty can help him or her plan to acquire what is needed. At present, licensed practical nurses may

not know if they will in fact get advanced standing until the first nursing course has been completed or until they have a satisfactory grade point average at the end of the program. In the five programs where only challenge examinations are available, the licensed practical nurse may have to take each challenge examination quarter by quarter.

Programs can control when the first nursing course is offered to the licensed practical nurse, making it reasonable to require that the credit for the advanced standing be granted before that course is started. Any increased cost that may be incurrred by making these determinations regarding advanced standing can be passed on to the licensed practical nurse. Verbal assurance has been received from some ADN program directors that it would be possible to administer tests for determining advanced standing and grant the credit before the licensed practical nurse begins the first nursing course.

This practice will make it possible for the licensed practical nurse to return to school knowing what he or she will have to do to graduate. With this information, the licensed practical nurse can make an informed decision about how to pace himself or herself in this endeavor while fulfilling any family and job responsibilities.

This rule is reasonable in that it does not address admission or selection criteria for the licensed practical nurses who apply for admission. The language of the rule clarifies that, as with any student, not all of the licensed practical nurses who are admitted may qualify for allor part of the available advanced standing. Determinations regarding admission and selection are internal matters best decided by the faculties and administration of the junior and community colleges.

B. Determining advanced standing.

This rule is needed to assure that the methods used in determining advanced standing are fair to all licensed practical nurses who wish to apply. The use of at least one of the methods specified in this rule is needed to be sure that the determinations of advanced standing in all of the programs addressed in Minn. Stat.

§ 148.251 Subd. 4 will be reasonable, realistic and nonrestrictive. Without the prohibitions inherent in this rule, it would be possible for a program to:

- Make the granting of advanced standing dependent on knowledge and skills that a licensed practical nurse should not be expected to have; and
- Only accept applications for advanced standing from licensed practical nurses who have graduated from specific practical nursing programs during certain years.

This rule is reasonable since each of the twelve programs leading to an associate degree are already using one or more of the required methods in determining advanced standing of students. The rule does not restrict the use of additional methods, such as curriculum review for consortia members. The preceeding Table 2. shows the various methods of determining advanced standing that were being utilized in 1981. The reasons the methods are specified in the rule follow.

1. Transcript review, which most programs have only done when evaluating applications from students wishing to transfer from one professional program to another, can be used. Use of this method of determination has been facilitated for licensed practical nurses by the practice of the community colleges providing a composite of credit for previous vocational learnings. This method is being used in some community colleges to grant advanced standing for nonnursing courses. It is reasonable to permit use of this method of making individual determinations regarding nursing credit between practical and professional programs.

2. Granting credit previously determined to be appropriate to the backgrounds of a certain class of applicants has been re-initiated by some nursing educators. Awarding a previously determined number of credits worked in the forties and fifties

and is working now. It is possible to make such determinations again as the various practical and professional programs have curricula which can now be easily understood and compared. As the faculties of the different types of nursing programs become more familiar with each other's curricula, trust is developing and this can facilitate prior determination.

Prior determination of academic credits for licensed practical nurses who graduated from any approved practical program is now utilized by three Minnesota programs leading to an ADN. One faculty engaged in analysis of other practical nursing programs as part of its development of an articulated curriculum; the previously determined credit is granted to the licensed practical nurse applicants who graduated from programs other than the interinstitutional nursing programs. The other two programs tested licensed practical nurses to establish the number of credits. It is reasonable to assume that other associate degree nursing programs may also wish to utilize this method in determining advanced standing.

3. Testing is a common method of determining advanced standing. Testing the licensed practical nurse for advanced placement was done in 1981 in four of the seven programs with special provisions for licensed practical nurses. Five of these programs only had challenge examinations for specific nursing courses.

Passing the tests and challenge examinations now in use may require some knowledge and skills unique to the professional nurse as the tests are designed to challenge courses, not to determine credit. These same tests and challenge examinations could continue to be utilized as long as the passing score is clearly not dependent upon possessing the specialized knowledge and skill of the professional nurse. If the required passing score needs to be adjusted, this could be done in at least two ways:

- Analyzing the test content and excluding that portion unique to professional nursing from the required passing score.
- Administering the test to a class of practical nursing students prior to graduation or to a group of licensed practical nurses to establish the minimum score achieved by the majority of practical nurses.

The legal practice definition of practical nursing prohibits the performance of services requiring the specialized education, knowledge and skill of a registered nurse. Clearly, licensed practical nurses should not be expected to have mastered content that they have no cause to know and that is only taught and evaluated in professional nursing programs. The legal practice definition and the rule specifying professional nursing abilities are the references available for making the distinctions between the content differences for practical and professional programs.

It is reasonable to permit inclusion of content unique to professional nursing in the test as long as passing the test is not dependent upon that knowledge or skill. This rule is not restrictive as to other uses of any test questions. The retention of the professional content will permit faculties to use the tests for multiple purposes such as determining the type of transitional learning activities needed by an individual.

C. Transition.

This rule is needed to assure that the licensed practical nurse receiving advanced standing has an opportunity to engage in learning activities that will help him or her to successfully make the transition from practical to professional nursing. Licensed practical nurses enrolled in programs without transitional learning activities, and where only challenge examinations are available,have reported to the board representative during a survey that the entire program must be taken or they will "miss something". Transitional learning activities are needed to bridge the gap between practical and professional nursing. This is a workable and reasonable approach, as shown by the fact that six of the programs leading to an associate degree that have special provisions for licensed practical nurses were providing transitional learning activities in 1981.

One of the options considered in developing these rules involved curriculum organization to ensure that advanced placement of licensed practical nurses could occur without loss of essential professional content. Since no one can predict how many, or if any, licensed practical nurses will enroll, it would be unreasonable to require that the program's resources be reallocated in this way. This rule is reasonable as it permits faculty flexibility in meeting students needs with a minimal amount of interference to on-going teaching-learning activities.

The content of the transitional learning activities can be geared to assist the licensed practical nurse upon entry to the program,or to meet any needs remaining before completing the program. To state the obvious, if no qualified licensed practical nurses are enrolled, the transitional learning opportunities will not need to be implemented.

This transition requirement is flexible and reasonable. The ways in which the learning activities are provided to the licensed practical nurse may be as varied as the faculty desires. The methods of delivery are unlimited. If prepared materials, such as learning packets, are utilized some may already be suitable for individual study by licensed practical nurses and others may be tailored to individual needs. The needs of individual qualified licensed practical nurses may range from understanding the role of the professional nurse to performing professional nursing assessments and developing nursing care plans.

D. Completion.

To ensure that licensed practical nurses with advanced standing do not have to spend more time completing the program than it takes students without advanced standing, it is necessary to set this requirement. While this rule cannot regulate the required subjects outside of nursing, it will at least determine that the nursing courses, which involve the biggest investment of time due to clinical experiences, can be completed in the usual amount of time. Without this rule, the licensed practical nurse might have to study longer and therefore be away from the work force and family responsibilities longer than other students.

This rule is reasonable for all programs as it applies only to:

- Nursing courses and not the supporting nonnursing courses,
- The licensed practical nurse who has obtained advanced standing equivalent to at least one third of the total nursing course credit and not to those who obtained less credit.
- Licensed practical nurses going to school full-time and not to those who are part-time students.

In 1981 six of the programs with special provisions for licensed practical nurses presented all of the nursing content necessary for an ADN in 9-13 months. These faculties control when the first nursing course is begun and this rule accommodates such control.

E. Reporting.

This rule is needed so the board can monitor compliance with the requirements of these rules. This rule will also provide the board with data needed to determine if these rules and the statute should be amended or repealed. The need for this rule in the future may be changed by any number of factors. For example, in July 1982 an examination of the meaning of academic credit in public and private post-secondary educational institutions was begun by the Minnesota Higher Education Coordinating Board. The study is being done by the staff to determine ways accountability can be reinforced and to determine the implications for inter-institutional cooperation.

Directors have long been accustomed to reporting the number of graduates with licenses to the board each year. Fall has been found to be the best time for the collection of such reports as the last academic year has been completed and the data tabulated. The number of licensed practical nurses admitted to the program will be known and easily reported. Reporting the number of licensed practical nurses admitted with advanced standing and the number of credits granted will be simple since those data will be a matter of record. While recording the number of licensed practical nurses applying for advanced standing may be a new practice for some programs,

reporting that number should not be burdensome. Explaining the absence of licensed practical nurses with advanced standing should be neither time consuming nor costly.

F. Compliance deadline.

The effective date is reasonable given that when the law passed in 1981 the board began to discuss the matter with the professional programs involved. At that time almost half of the 12 programs involved appeared to already be in compliance with these rules. All faculties of programs leading to an associate degree were aware in December 1981 that the board granted authority to staff to promulgate these rules, but agreed the staff would not schedule a hearing at that time because of budgetary implications for both the board and the nursing programs. Due to that action the programs have already had one more year than originally proposed to prepare to comply with these rules. It is doubtful that there is even one of the programs that will be affected which has not begun working toward compliance. However, if there is such a program, it should be able to meet this entire rule after one summer of work.

7 MCAR § 5.3012 Faculty.

A. Responsibility.

This rule is needed to assure that the unique nursing aspects of the education of nurses is conducted by professional nurses. Only professional nurses have the knowledge and skill needed to teach nursing theory and practice and to make accurate evaluative judgments regarding students' nursing abilities. The teaching and evaluation of both theory and practice components of nursing must be the responsibility of professional nurses since nursing is a practice discipline. Because nursing is a practice discipline, not an exact science, and because the board is responsible to the public for licensing nurses who can practice as defined by law, this rule is necessary. This requirement was recommended by the Advisory Task Force on Nursing Education and the Program Rule Replacement Advisory Task Force.

This rule is reasonable as society has generally become accustomed to members of a practice discipline teaching that discipline to its students. For example, no one expects nurses to teach physicians medicine even though some nurses are involved in teaching interdisciplinary courses that are offered to medical students as well as other health occupation students.

This rule will accommodate people from other disciplines teaching and evaluating theory that is supportive to nursing practice, such as therapeutic dietitians teaching nutritional theory. Interdisciplinary courses will be accommodated by this rule. The rule also permits the registered nurses involved in teaching and evaluating nursing theory and practice to have assistants. No qualifications are stated for those assistants. The director may give individual consideration to that matter. This rule clarifies that anyone may be selected by the director to be an assistant. For example, either people from other disciplines and people within the nursing discipline may act as assistants.

The rule is reasonable in that the responsibilities restricted to registered nurse faculty members have been limited only to those faculty functions known to have a very direct relationship to graduating students who can practice as defined by law. The rule is nonrestrictive in all other aspects.

B. Qualifications.

This rule is needed to inform the director of the requirements for each nurse faculty member and the means for demonstrating compliance with those requirements. It is reasonable to require the director to be able to supply evidence of compliance since the director is the manager of the appointed faculty members and the person with whom the board deals regarding the program's approval. This rule will accommodate reporting faculty members' qualifications without onsite retention of documents. The documents will not have to be kept on hand as long as the director is able to obtain and supply substantiating documentation should questions arise.

1. This rule is needed to continue assuring that registered nurse faculty members have a professional nursing license and are able to practice in Minnesota. With the exception of the allowance of permit, this requirement is the same as that in current rules 7 MCAR §§ 5.1071 A. and 5.2062 C. Although, in accordance with 9 MCAR § 2.104, this requirement does not have to be re-justified, the following information is provided for clarification.

It is only through the preparation for the professional nursing license that a faculty member will have obtained the basic background knowledge and skill that will enable her or him to make the decisions regarding nursing care to patients. Teaching and evaluating nursing often involve the unpredictable human element, patients. Faculty members are often called upon to make many on-the-spot decisions quickly and independently to protect the safety of patients while furthering the education of the student.

Professional nursing is a necessary background for the responsibility of guiding, teaching and evaluating the learning of nursing. Without one of the required cred-

entials it would be illegal for the faculty member to administer nursing care to patients in Minnesota. While teaching nursing students is not defined in Minnesota law as a component of professional nursing practice, it is inconceivable to think of a nurse teaching nursing without being legally able to administer care to patients.

Requiring that a permit to practice be based on licensure in another state, rather than being based on graduation and application to take the licensure examination, establishes that such a faculty member has had some time to adjust from the role of student to the role of professional nurse.

2. This requirement is needed to ensure that all faculty members who may be involved in evaluating students for possession of nursing abilities have at least basic preparation in evaluation. This requirement is necessary and reasonable given the scheme of these proposed rules which require student evaluation. Faculty preparation will be a key factor in achieving the intent of these rules.

Ten hours for preparation in the principles and methods of evaluation is minimal. Many nurse faculty members in the state already meet that requirement. Some may be able to document the required amount of content in their basic baccalaureate nursing education. It is reasonable to require faculty members who have not had that minimal preparation to strengthen their evaluative abilities. Each faculty member will find it useful to develop skill in evaluating. The examples given in the rule of the skills to be developed may be used not only to evaluate students' performance but also to evaluate the effectiveness of any of the following: the program, patient teaching, any nursing actions taken, nursing care plans, and teaching nursing personnel.

All faculty members should be able to meet the requirement regardless of their location in the state. If they are not located near an educational institution which offers such a course, the rule permits that preparation be acquired through planned faculty inservice learning activities or continuing education activities which may include completion of programmed materials, extension or correspondence study that can be documented. This requirement is not related to the requirement

for continuing education necessary to retain professional nurse registration. However, nothing prevents using educational activities for that purpose if the activity also meets those requirements.

It is necessary to specify how the preparation be acquired in order to assure it is documentable. While faculty members may learn from informal on-the-job experiences or from independent self-study, it would be impossible for the director to document that the preparation had taken place. It is necessary to specify the number of hours of educational preparation in order to have a standard for judging compliance with the rules. While a college course of 30 hours might well be necessary to develop the skill described, 10 hours was selected as a minimum since concentrated presentation and a specially designed in-service or continuing education activity could conceivably present the theory necessary to development of the skill.

It is necessary to specify the time within which the preparation must have taken place in order to be sure that faculty members will be able to implement these rules when they become effective. Faculty members of proposed programs will need the evaluation skills in order to develop the proposed program to meet these rules. Requiring proposed program faculty members to have met this requirement before opening is also reasonable since implementation of student evaluation will need to begin with program implementation.

All faculty members of currently approved programs will have at least two years to acquire this preparation. That amount of time is reasonable in light of the minimal number of hours required. Lest it seem negligent to require that faculty members have this preparation only once during their lifetime, the intent of this rule is simply to see that faculty members can implement these rules. It is true that knowledge of evaluation can be greatly expanded and continuing preparation would be advisable, but requiring that could result in over-regulation.

C. Basic education.

This rule is needed so the board can predict whether a proposed program will be able to meet these rules. While it is the responsibility and prerogative of the controlling body to specify the educational preparation of employees, the board is responsible to the public for judging whether or not the proposed program will be able to prepare graduates who will be able to practice safely.

The abilities of the faculty and the strengths of the controlling body without a program are unknown. To serve the public and potential students it is necessary for the board to specify basic educational requirements for the faculty. These minimal requirements will at least assure that faculty members have had the basic education currently being demonstrated by the successful operation of new and existing programs as minimally adequate.

It is no longer necessary for the board to have such requirements for currently approved programs as those faculty members had to meet the basic education requirements which existed when those programs were started. The controlling body of an on-going program is in the best position to determine the educational needs of the faculty. All of these programs will be held accountable by these rules for the evaluation of students for possession of the specified nursing abilities. If 25 percent or more of the graduating students do not achieve licensure on the first try, the board will survey the program to determine compliance with the rules. If a correction order is issued the deficiencies will have to be met or the program removed from the list of approved programs.

The board cannot determine that all of the proposed rules are met by proposed and new programs until the first students have graduated. Therefore, until that time occurs the board must at least set a minimal level of education for the faculty.

1. Requiring that the director of a proposed practical program have at least a bachelor's degree is in keeping with current rules for practical programs. The proposed rule requires graduation from an accredited institution so as to ensure that an objective outside body has reviewed the institution for quality of education. The last new practical nursing program to open could have met this new requirement. The requirement in B. 1. will assure that the director has preparation as a nurse so it is not necessary that the degree be in nursing. It is reasonable to not specify requirements for other faculty members of new practical programs as the professional licensure requirement will assure the basic preparation beyond that sought by the students.

2. This rule is needed to strengthen the permissive requirements for professional programs in the current rules. The director should have a credential greater than that conferred. A master's degree will provide the director with a knowledge of conceptual models and theories and research which is essential to the development and implementation of a new program. In 1973, the Council of State Boards of Nursing recommended to boards that by 1980 all faculty members be required to have master's degrees. The minimums set by this requirement are in keeping with, or less than, those required for program approval by most boards in other jurisdictions. At the national convention of the National Student Nurses Association held April 28-May 2, 1982 the house of delegates resolved in part that nursing educators (in professional programs) ought to be masters prepared. Given the geographic distribution problems in the state, the high demand for masters prepared nurses and the fact that there is only one Minnesota institution offering master's degrees in nursing, it is reasonable to permit the master's degree of the director to be in fields other than nursing and to not require other faculty members to have a master's degree. This requirement is reasonable in that it would permit employment of faculty members, other than the director, who do not have a master's degree. The last professional program to obtain approval could have met this rule.

As with practical programs, the requirement in B. 1. will assure nursing preparation, thereby permitting the required bachelor's degree to be in any field. This broadening of the degree that will meet the minimal requirement will lessen the difficulty in securing faculty members in the regions where it is not possible to readily obtain bachelor's degrees in nursing.

It is true that the requirement will keep proposed and new programs from employing registered nurses with an associate degree or a hospital diploma who do not have a bachelor's degree. This is necessary to ensure that the faculty planning the program have as much basic education as can reasonably be expected. Once the program is graduating students and evidencing compliance with all rules, and 75 percent or more of graduates achieve licensure on first attempt, the qualifications of the faculty need no longer concern the board.

7 MCAR § 5.3013 Learning materials.

This rule is needed to enable the board to predict whether the controlling body will be able to implement the program and evaluate students' nursing abilities. If the faculty develops a program which uses modern technological developments for teaching and evaluating learning, the board must be assured that the technical hardware and software are in place. Without this rule and 7 MCAR § 5.3005 A. 4. it would be possible for the controlling body to try to operate the program with little or none of the instructional and evaluative materials needed for teaching, learning and evaluating. Requiring that the learning materials for all first year nursing courses be on hand before the board acts upon the application is necessary to prevent the situation that occurred with one new program. Due to the lack of specificity in the current rules, the learning materials did not arrive until the year was almost over and it was very difficult for faculty and students to function using other libraries and learning laboratories.

This rule is reasonable as planning for the implementation of the program rests on the learning materials faculty and students will have to use. For example, faculty should not plan to evaluate students' abilities in a classroom laboratory with nursing care equipment and with mannequins, without fully knowing the capability of the

equipment and mannequins. Obtaining the materials before implementation begins is also good in that the faculty will be able to determine how to arrange the materials in laboratory to best accommodate demonstrations by students and how many students and evaluators can be accommodated.

Two current trends make this rule particularly necessary. This is a time when many questions are being raised about the ethics of "using" patients unnecessarily for student learning and evaluation. Some nursing schools are using heavily equipped nursing skills laboratories for the student learning and demonstrations that do not need to be carried out with actual patients. At the same time, educational institutions are undergoing drastic budget cuts and the cost of learning materials is rapidly increasing due to inflation. In view of these conflicting trends the board must determine how the faculty intends to implement the program and determine if it has the necessary materials to do so.

The rule is reasonable as it allows for staggered compliance (7 MCAR § 5.3005 A. 5.) so that the entire inventory of learning materials does not have to be on hand before the program opens, except in the case of a practical program where the entire program will be implemented in the first year. It is necessary to continue the implementation of this rule through the graduation of the first student in order to determine that the learning materials are adequate for the implementation of the entire program. The intent of the rule is simply to assure that those controlling bodies starting new programs cannot neglect to supply learning materials.

Such a rule is not necessary for currently approved programs each one has learning materials in place that are known to be adequate at this time. The faculty of an existing program will need to maintain and renew those learning materials in order toprepare students to possess the expected nursing abilities listed in 7 MCAR §§ 5.3017 and 5.3018. If non-compliance with those rules is found, it will be up to the controlling body and faculty to remedy the matter, by up-dating of learning materials or whatever, if approval is to be continued.

7 MCAR § 5.3014 Clinical learning activities.

This rule is needed to ensure that a single focus program, such as a program preparing only entry level gerontology nurses, could not be conducted. Programs are approved to prepare graduates to meet the nursing education requirement for Minnesota licensure. Because the legal practice definitions do not speak to the age, sex or condition of patients, nor to patients' settings, both the practical and professional nursing licenses authorize entry level nurses to practice as generalists. The generalist in nursing must have been adequately prepared to minister to commonly encountered patients. A program which would focus on caring for only one age group of patients or patients in the same stage of health or illness would not be in accordance with these definitions.

This rule is sufficient for the board to determine that each student is prepared as a generalist. This rule will assure the public that each student has had exposure through either learning experiences or evaluation experiences with patients in various categories. The content of this rule was designed to supplement the list of nursing abilities specified in succeeding rules.

The rule is reasonable since faculties may elect to comply either through learning activities involving student application of nursing abilities with patients in one or more of the categories, or through evaluation of students' application of nursing abilities with patients in one or more of the categories. The rule will thereby accommodate the exemption of students from clinical learning activities with patients in any of the categories, provided the student's application of nursing abilities has been evaluated while caring for patients in those categories. To require that generalist preparation be assured entirely through evaluation of ability to care for all of the necessary categories of patients could be extremely costly and perhaps not possible.

A. Notice of option change.

How a faculty organizes student contacts with the various patients commonly encountered by practical and professional nurses differs from program to program. Patients may be classified differently by faculties, depending on their philosophical view of nursing, health and learning. This rule is needed to offer faculties the opportunity to select one of two options. The faculty may elect the option which best fits the way the program is organized or seems least intrusive.

While either option will meet the intent of the rule, it is necessary that the director go on record as to which option will be implemented during the coming school year. Choosing options in the midst of the year or operating without any awareness of the need to comply with one of the two options could lead to the very problem the rule is designed to prevent, that is, the preparation of students without generalist preparation.

The turnover in directors and other faculty members warrants yearly reporting. Reporting this commitment annually is reasonable, since it will be possible for the director to indicate the option chosen with a checkmark when completing the annual evidence of compliance form.

Since the director will be able to choose between two options, these proposed requirements should not add new complications to the problems involved in providing students with clinical activities. Both options permit the occurrence of clinical activities in "clinical settings" which are not defined in these proposed rules. The original working definition for the term, "any place where patients or nursing personnel are available" was so broad that the Revisor's Office advised that a definition was not necessary. The absence of a restrictive definition should make it possible for faculties to find places suitable for students to apply nursing abilities with patients in each of the categories stated in the options.

As shown by the attached article some authorities have recognized that there is no clear cut absolute for the amount or mix of theory and clinical learning activities needed by each student.[2] Given the diverse pool of students and their learning capacities, the varied teaching-learning methods available, and varied opinions as to what is a "good nurse", the lack of agreement as to the clinical activities that should be required should not be surprising.

There is common agreement today that what matters is whether the student has learned, not how, where or when the student learned.[3] Most nurses recognize that, although the board specified the number of weeks for certain types of clinical experience prior to 1967, such requirements are no longer necessary to ensure that students are prepared as generalists. It is more fair to students, who learn at different rates and come with different backgrounds, to assure that learning and evaluation activities are provided with patients in each of the categories, than it would be to specify amounts of clinical learning.

This rule is reasonable as it neither requires excessive clinical learnings, nor limits clinical learning. Concern has been expressed that educational budget cuts may reduce the amount of clinical activities usually provided. The alternative for learning is use of classroom laboratories. Equipping such a laboratory is becoming increasingly expensive. Whichever route is chosen these rules will assure that preparation for the identified nursing abilities will occur and that students will have been prepared as generalists.

This rule is designed to assure that the student has applied nursing abilities while caring for patients in essential categories. The major thrust of all of these rules is to require that faculties evaluate students for possession of essential nursing abilities. In other words, the requiring of such evaluations, rather than specifying amounts of learning time, has been chosen as the most important part of the teaching-learning process for the board to focus on. To prepare students to pass the evaluations, a reasonable amount of clinical learning will have to be provided.

B. First program opti

This rule is needed to provide an option in assuring generalist preparation for each student. This option will assure that students have had either clinical learning activities or have been evaluated for possession of nursing abilities while caring for patients in various stages of health and physical or mental illness, and in all major age groups except adolescents. Administering nursing care to adolescents is a matter of adapting to the adolescent who is physically like either children or adults, both of which are required categories of patients. This rule, in combination with the nursing abilities in 7 MCAR §§ 5.3017 and 5.3018, will assure adequate generalist preparation of both practical and professional students.

The categories of patients are broad enough to enable faculties to plan learning activities and/or evaluations with patients in each category. These categories will mesh well with programs which have integrated nursing courses, courses organized around chronological life span, and/or courses promoting the care of healthy as well as the ill persons. The faculties that do not find it easy to relate their programs to these categories can be accommodated through the second program option in C.

C. Second program option.

This rule is needed to provide an option in assuring that each student will have been prepared as a generalist. This option will assure that students have had either clinical learning activities or have been evaluated for possession of nursing abilities while caring for patients in the categories specified for practical and professional programs. The board's experience has demonstrated that these categories are broad enough to enable faculties to select clinical activities in each category. These categories will mesh well with programs which have courses integrated around a medical model. Faculties that no longer wish to continue documenting compliance with these categories may utilize the first program option in B.

1. The patient categories specified for practical nursing programs are the same as in the current rules.

2. The patient categories specified for professional programs are the same as in the current rules with the exception of removing the phrase "all age groups" and specifying adults over 65 years of age. The latter change is necessary in view of the general societal concern for care of the aged and the fact that the care of other age groups (children and newborn infants) are also specified.

The categories in this option were justified when current rules 7 MCAR §§ 5.1091 B. and 5.2084 B. were promulgated. In accordance with 9 MCAR § 2.104, a re-justification is not needed.

7 MCAR § 5.3015 Evidence of student clinical activities.

This rule is needed to clarify the two ways directors may document compliance with the rule 7 MCAR § 5.3014. Such documentation is needed to assure that the intent of that rule is accomplished. The focus on each student and all students in 7 MCAR §§ 5.3014 and 5.3015 is necessary in order to prevent some students inadvertently having most of their learning experiences occur with one category of patient while having no exposure to other categories of patients.

The two methods of compliance are outlined in order to provide ease of documentation. If a faculty is philosophically opposed to check lists and does not want to keep, or have students keep, student activities records it will be able to document compliance through course materials. The rule is also reasonable in that it clarifies that compliance need only be proved for current students and the last graduating class. This will eliminate the need to keep materials and records for all classes to prove compliance.

7 MCAR § 5.3016 Clinical settings.

A. Use of clinical settings absent affiliation.

This rule is necessary to assure that the learning and evaluation of nursing practice is overseen by faculty members who are registered nurses. It is necessary that the responsibility rests with faculty members of the program approved by the board as the board only has jurisdiction over the program. The board cannot and does not regulate clinical settings. The faculty members are the ones who know the program and can relate the activities in the clinical setting to the theory that is taught. These faculty members need to be registered nurses for the reasons given for 7 MCAR § 5.3012.

This requirement is in the current rules 7 MCAR §§ 5.1100 G. 1. and 5.2090 G.1. All programs are in compliance with those rules. This requirement is reasonable as it does not exceed that in the current rules. The faculty members responsible may have assistants as clarified in 7 MCAR § 5.3012 A. If it is impossible for faculty members to arrange for student activities in clinical settings where the faculty can be responsible, compliance with C. and D. is an alternative.

B. Clinical use authorizations.

This rule is needed in order to predict that the controlling body will be able to implement the proposed program. Without authorization for educational use of clinical settings it would not be possible for students to learn the practice of nursing, much less to be evaluated to determine if they have the ability to combine nursing categories in a clinical setting.

The following quote illustrates the difficulty in locating clinical settings which will authorize use by a new program and the reason why clinical activities are essential in nursing education and, therefore, why these authorizations are needed.

> ... the school must compete for use of clinical facilities... clinical experiences are viewed as complementary to classroom learning and as essential in preparing qualified professional practitioners. They provide opportunity for the student to integrate learning, apply theory to practice, acquire psychomotor skills, and make the transition from nursing student to professional person.[4]

Past experience has proved that this rule, which is similar to a current rule, prevents the inanguration of a program that cannot obtain authorization for implementation in clinical settings. This rule protects potential students from entering a program which cannot provide clinical experience. The rule is reasonable in view of the fact that nursing is a practice discipline. It is possible for a controlling body to meet this requirement as is shown by the fact a new baccalaureate program opened this fall after meeting similar requirements in the current rules. The number of students to be enrolled at any time will be known prior to application for approval because that number will be needed in budgeting for the proposed program.

C. Beginning affiliation.

This rule is needed to assure implementation of Minn. Stat. §§ 148.251 Subd. 2 and 148.292 Subd. 1. These statutes are implemented in the current rules through requirements that the board approve all plans for educational use of clinical facilities prior to implementation. With the repeal of the current rules, this rule is necessary to minimally safeguard student clinical learning activities and evaluations related to rules 7 MCAR §§ 5.3014-5.3021, in the event it is planned that students will not be guided and learning not evaluated by the faculty.

This rule is reasonable as it assures the protection of student education in the event a program's faculty is not responsible for teaching and evaluating students' abilities in clinical settings. At the present time none of the approved programs in the state have an arrangement with a clinical setting which meets the definition of affiliation. However, if a program proposes to start the practice of "farming students out" for essential learning or evaluation this rule will allow the board to:

1. Evaluate the purpose of the affiliation to determine if it will satisfy one or more of the rules for approval.

2. Require plans that will assure that one faculty member will be observing students at least once a week thereby assuring faculty awareness of student progress. This requirement will also provide students with at least weekly access to a faculty member. This requirement will also give representatives of a clinical setting and one faculty member an opportunity for weekly face-to face interchange

regarding the program and student clinical activities.

3. Require that the affiliation not be longer than one half of a term. If the period of time for the affiliation were permitted to be longer, the student could be led far afield from the planned program. It would be preferable that all student learning and evaluation continue to be conducted by the faculty in order to assure integration and synthesis of learnings. One of the difficulties for the faculty without direct control of student learning would be determining whether students have the necessary nursing abilities. In the event that the current practice of providing faculty guidance does not continue to be possible, the time during which student clinical activities are not the responsibility of the faculty must be limited.

4. Limit the number of times students are exposed to different groups of teachers with different goals and values. Even in the longest nursing program, that is,a program leading to a baccalaureate degree, most students probably have a maximum of seven terms in which to learn to practice professional nursing. If more than one-seventh of the time for completion is spent learning under the direction of those who are not faculty members,it would be unfair to students. The problem is more acute for students in practical programs where one term equates to one third of the program. Without this subpart of the rule it would be possible for a controlling body to enroll students without adequate provision of qualified faculty members to guide or evaluate student activities.

It is reasonable to have the faculty document the need for an affiliation so students are not subjected to a fragmented education for capricious reasons. The once-a-week faculty member contact is reasonable in that it could serve many purposes and would be the common practice of a conscientious faculty in any case. Limiting the length of time for a student to participate in an affiliation is reasonable as any such arrangements which are needed will most likely address a speciality which is not readily available to the faculty. For example, if students are to care for ill children and there is not a large enough group of such patients

within the immediate vicinity of the program, the arrangement could be of short duration as students would be able to have theory and practice supplemented with well children in the vicinity of the program. If a longer period of time is needed for an affiliation, one would question if the practice experiences sought are too advanced for an entry level program. If more than two affiliations are necessary to implement the program one would question why the program originated in its geographic area.

D. Continuing affiliation.

This rule is necessary in order to assure that the implementation of any affiliations are carried out in keeping with the requirements established for beginning an affiliation. Without this rule there would be no way to know that the standards established for beginning the affiliation are maintained. If a program is going to operate an affiliation, it is reasonable to expect that the board will monitor the situation to assure that students are obtaining the education needed for licensure.

7 MCAR § 5.3017 Nursing abilities to be evaluated.

This rule will enable the board to implement the legislative mandate to "prescribe by rule curricula and standards for schools and courses preparing persons for licensure under section 148.171 to 149.299" (Minn. Stat. § 148.191 Subd. 2). This rule is fundamental to accomplishing the intent of approval which is to assure the public that new programs and existing programs are able to prepare students to practice as defined by law.

These proposed rules represent a sharp departure from previously used program approval rules. The board will no longer examine a curriculum for inclusion of specific areas of content; the development of curriculum content is strictly a faculty responsibility. Instead of concentrating on the educational process used by a program, the board will focus on the product of the educational process.

The reasons for this new approach to approval are described in the first section of this Statement. The proposed approach is reasonable because nursing is an applied art and science. Nursing is a practice discipline, nursing is done with one's hands. The patients cared for by licensed nurses expect nurses to be accountable for their actions. These rules will require faculties to evaluate students' ability to apply nursing knowledge. The public will be assured the students who will be seeking licensure are already accustomed to being held accountable for their actions.

It is reasonable to assure the public that nurses can do nursing. This is possible because outcomes of the educational process are visible. A student's ability to practice can be measured. The current rules set requirements before the fact and those requirements pertaining to educational process give no assurance that the graduate will be able to practice as defined by law.

These new rules identify broad categories of nursing functions drawn from the legal practice definition found in Minn. Stat. §§ 148.29 Subd. 4 and 148.171 (3). Below each category heading there is a group of nursing abilities which

represent steps in or ways of performing these functions. In this rule the board has identified the common core of nursing abilities which it expects students to possess on graduation from approved practical and professional programs. By identifying these nursing abilities, the board, for the first time, has provided program faculty with direction about the behaviors expected of graduating students. Both the categories and abilities stated in this rule form the basis for succeeding rules regarding evaluation of students' nursing abilities and their ability to combine nursing categories.

A. Listing for evaluation.

The categories of nursing are needed for organization. The categories ensure that the abilities are inclusive of all aspects stated or implied in the legal definitions. It is reasonable to have drawn the categories from the practice definition as these have been a part of the law since 1971 in the case of practical nursing and since 1974 for professional nursing. The categories and nursing abilities are broad enough that they will not become immediately obsolete.

It is reasonable for the board to prescribe curriculum through rules which require faculties to evaluate student performance of required nursing abilities. Good's comprehensive definition of building a curriculum includes the plan (sequence of subjects/courses and the content), implementation (means employed to provide students with opportunity for desired learnings) and evaluation (means used to make judgments regarding students' attainment of designated behaviors).[5]

Rather than continuing to specify areas of content for curriculum, these rules leave the curriculum content determination to faculties, focus on the categories of nursing drawn from the legal practice definitions and specify the nursing abilities necessary to perform the functions of those categories. The proposed approach is reasonable as it may be looked at as a preventive measure. Licensees who are incompetent can be disciplined. Rather than the board prescribing a remedy for incompetence when it is identified, the public is better served by

faculties having freedom in preparing students as necessary to determine competence before graduation. As long as the essential categories of nursing are evaluated, it is not necessary for the board to examine how the categories are taught. These rules concentrate on the nursing abilities of graduates however acquired, and not on procedure that may or may not relate to outcome. However, it is safe to assume that faculties will plan and implement the curriculum needed for students to acquire the board-identified nursing abilities.

The categories of nursing and nursing abilities were developed by the Program Rule Replacement Advisory Task Force based on work by the previous Curriculum Approval Task Force and the Advisory Task Force on Nursing Education. The nursing abilities are the result of input received since the board published the Notice of Intent to Collect Information from Non-agency Sources on December 19, 1977.

Faculties for each of the three types of professional programs (associate degree, baccalaureate degree and diploma) and the practical programs have each formed their own statewide organizations. Each of those statewide faculty organizations have prepared, for each type of program, a list of the competencies which the students of those programs typically possess upon graduation. These four lists of competencies were used by the Curriculum Approval Task Force in drawing up a fairly exhaustive list of nursing skills. The skills compiled by the Curriculum Approval Task Force were used by the Program Rule Replacement Advisory Task Force in developing the lists of essential nursing abilities in this rule and 7 MCAR § 5.3018. Since the competency lists constructed by these four faculty organizations formed the base for identifying the nursing abilities in these rules, one must assume that faculties have already developed some process for evaluating students' performance of most, if not all, of the required nursing abilities.

Each category of nursing practice has been made mutually exclusive to eliminate confusion in use. Basing the nursing categories on the practice definitions provided an organizational scheme which does not follow any one curriculum

model. It should be equally easy for each faculty to relate its program to these rules. This also means that complying with these rules should not be unduly disruptive to the curriculum plan of any program. These rules, with the categories of nursing and nursing abilities to be evaluated, will reinforce the assessment activities of faculties and, in some instances, could lead to more structured judgments about students' nursing abilities.

The nursing abilities are goal oriented and general in nature. The abilities are reasonable as they will cause nurses to focus in on promotion of health rather than waiting for patients to evidence needs or problems. The list of nursing abilities is not exhaustive. Only those abilities thought to be essential to the provision of minimally complete and safe nursing care are included. It should be clearly understood that these rules define the minimal behaviors expected at the time the student graduates from a program and is ready to enter practice.

These nursing abilities do not define nursing practice for licensed nurses and should not be seen as limiting the functions of either practical or professional nurses in employment or independent practice. Neither should these rules be seen as restricting what will be expected of students.

It is reasonable to put into one list the nursing abilities that form a common core for both practical and professional nursing. The common core approach is supported by the movement toward interinstitutional nursing programs. Two consortia have developed articulating curricula which can produce graduates with credentials ranging from a nursing assistant certificate to a bachelor's degree with a nursing major, There are also two additional programs leading to an associate degree that base an accelerated curriculum on the acceptance of only students who are already licensed practical nurses. The faculty of practical and professional programs will evaluate students for the same nursing abilities. However, the scope and variety of acceptable nursing actions will be defined and measured by each faculty. More complex categories of nursing and nursing abilities are

specified for professional programs in the rule 7 MCAR § 5.3018.

All of the following nursing abilities are needed due to the commonalities in nursing practice. These core abilities form the base of nursing care. These abilities are those that patients are entitled to expect from licensed nurses. The composite of abilities are needed for the composite of patients cared for by nurses.

The fact that employers anticipate that graduating students will possess these abilities was borne out by nursing service representatives that served on the Program Rule Replacement Task Force's reaction panel. The panel, which also included educators, clarified that these abilities are basic to safe nursing care and, therefore, expected of all licensed nurses including those entering practice.

The following categories of nursing practice are reasonable because they do not exceed the legal practice definitions. Each of the nursing abilities within each category is reasonable in view of patient and employer expectations. Any commonly taught nursing skill which benefits patients will be a way of demonstrating one of the following abilities.

B. Interaction with patients.

This category is needed as an entity separate from all other listed categories of nursing practice. The abilities in this category enable a nurse to relate to patients and to individualize their care. This function is needed every time a patient has a contact with a nurse.

1. Patients are entitled to care from graduating students who possess ability in verbal and nonverbal communication. All patients need to understand what is expected of them, and what is going to happen around them or to them. They can only gain this understanding if the nurse can communicate in an understandable manner. The need for this ability is crucial to the comfort of all patients, and particularly for patients with communication problems such as those due to sensory losses, respiratory and neuromuscular conditions, cultural background, or intellectual impairment.

2. Each patient's situation will vary in one way or another, and yet each patient is entitled to receive care from a nurse who has the ability to form a relationship which will be helpful to that patient. It is through such a relationship that the patient comes to trust the nurse and is, therefore, better able to participate in achieving optimal function.

C. Nursing observation and assessment of patients.

This category is needed as any nursing care plan must be based on the existing situation. Observation and assessment will acquaint the nurse with the patient's existing situation. This category is also needed to assure that graduating students will have the ability to organize their nursing actions and establish priorities for administering care to a group of patients.

1. The human body is complex in structure and function. The planning and implementing of a patient's nursing care must be based on accurate data regarding the current status of his body's physical structure and function. Therefore, the ability to collect these data is crucial to the quality of care the patient will receive. For example: It is only if data are collected regarding a patient's problem with locomotion that the problem can be recognized and safe care ensured. If a patient has a problem with oxygenating tissues, that must be recognized immediately to safeguard the patient's life.

2. The plan for, and implementation of, a patient's nursing care must also be based upon accurate data regarding non-physical functions. For example, it is only if data are collected regarding a patient's confusion as to orientation of time and location, that the problem can be recognized and these factors addressed. Only if a patient's lack of self-respect is identified, can plans be made to assist in increasing self-esteem. Only if a patient's lack of participation in groups is recognized can the patient be helped to meet his belonging needs.

3. As the examples for the first two abilities clearly show, it is only when meaning is attached to the collected data that the patient is served. The ability

to compare the data to established norms and standards and draw implications therefrom is a crucial step in assessing the patient's situation.

4. A patient's satisfaction with his nursing care, not to mention his safety and progress in maintaining or regaining health, will rest with the sequence with which nursing actions are carried out. For example, the nurse must be able to organize her activities to provide the cardiac patient with both care and rest.

5. Once a plan of care is developed by the professional nurse, all nurses must be able to establish priorities in administering the nursing care. Since nurses in health care facilities usually care for groups of patients, it is important, from each individual patient's point of view, that the nurse is able to exercise proper judgment in determining priorities for care. One of the problem areas identified in the practice of new graduates, according to Habgood is that:

> they lack organization skills in caring for groups of patients.[6]

This ability of setting priorities is fundamental to the organization of care for groups of patients.

D. Physical nursing care.

This category is the center of practice for both practical and professional nurses. Patients rely on nurses for this function as the steps which carry it out protect or preserve the patient's physical welfare and safety.

1. The patients' physical safety must be protected and assured at all times. Many patients are completely vulnerable and must be able to rely on the nurse to protect them. Other patients may simply not be aware of the hazards in their environment. For example, the nurse needs to be able to take the actions in any situation that will prevent the patient being burned or falling.

2. All patients need to be protected from the spread of infections. For patients with diminished immunity this protection is essential to safeguarding life. Since nurses often care for groups of patients, it is critical that all graduating

students use appropriate hand washing technic and are able to carry out isolation technic which will prevent the spread of pathogens to a patient, and from one patient to another.

3. The care of almost every patient may demand that a judgment be made as to whether clean or sterile technic should be used in administering care. A patient's life can be threatened if he has a break in skin or mucous membranes and is not protected by sterile technic from the spread of pathogens which can cause an infection. However, applying sterile technic when a clean technic would suffice may subject the patient to some inconvenience and certainly increased cost.

4. The patient has to rely completely upon nurses to maintain the sterility of equipment and supplies. For example, if the nurse is changing a patient's sterile dressing, the patient may not be aware of a break in technic that could result in the introduction of a pathogen which can cause an infection. Without this ability, the nurse may, like the patient, not notice when the sterility of equipment and supplies has been compromised. Absence of this ability is then doubly dangerous for the patient.

5. The skin and mucous membranes are the patient's shield against the spread of pathogens and loss of heat and fluids. Patients must be able to rely on the nurse to assist them in maintaining this vital line of defense. The ability to maintain the integrity of these external coverings may involve many nursing actions. For examples, protection through appropriate cleansing; protection from irritants, friction, and pressure; and replacement of lost moisture.

6. Nursing measures which promote respiratory function can assist the patient in achieving many goals, ranging from increased physical comfort to prevention of death. It is, therefore, crucial that the nurse know how to promote the expansion of a patient's lungs or other measures to increase oxygenation.

7. It is self-evident that the promotion of circulation of life sustaining blood is important to the patient. Nursing actions which demonstrate this vital

ability include appropriately positioning and moving extremities, and applying devices such as special hosiery that promotes venous return.

8. The promotion of nutrition and fluid balance is again crucial to a patient's physical well-being. This ability is one that calls for ingenuity in helping individual patients in light of their age, cultural background, personal preferences and physical condition.

9. Promoting a patient's elimination of body wastes is elemental in the patient's physical care. The nursing actions needed may range from monitoring and assisting with toileting, to training for bowel and bladder control and evacuation.

10. Patients often need the promotion of physical activity in order to compensate for enforced inactivity. Graduating students would be remiss if they were unable to prevent disabilities from occurring in bed-ridden patients. Other patients may need assistance in regaining or maintaining ambulatory status. Yet other patients will benefit from this ability because of motor development problems.

11. Patients who have lost physical independence have every right to expect nurses to consciously promote independence. If a patient is not encouraged to do as much as he can for himself, he will not be likely to regain independence. Consciously helping a patient to maintain physical independence is necessary to continued physical well-being.

12. Patients have a right to have their bodies made as comfortable as possible without medication. There are many nursing actions that may be taken to relieve discomfort. For examples, positioning, supportive binders and massage.

13. Again, patients have a right to expect that nurses will try to promote their rest and sleep without medication. Careful attention to the patient's rest pattern, environment, and activities are some of the ways the patient could be assisted.

14. Of course, patients are also entitled to provision for personal hygiene. Attention to appearance as well as assistance, when needed, with cleansing and

grooming is necessary not only for the patient's sense of physical well-being but also for safety reasons such as protection from pathogens.

E. Psychosocial nursing care.

This category is deemed to be as important as the preceding one. A patient's intellectual, emotional and social (spiritual) status are crucial to his health. This nursing function is essential as it incorporates the steps nurses take to assist the patient during times of emotional stress.

1. Many illnesses can adversely affect intellectual development, or decrease use of or impair intellectual function. The fact that a patient's intellectual function is important to his welfare needs no explanation. Some of the ways in which the nurse can promote intellectual development and maintenance of intellectual function range from assisting the patient to establish or maintain his own identity and orientation to reality, to increasing acceptable stimuli and reinforcing appropriate responses to stimuli.

2. Emotional development is a process that continues, if development is normal, throughout life. It should go without saying that a patient's emotional development is important to his well-being. During a patient's contact with nurses, he is entitled to care which will promote his emotional development. Nurses can carry out this step through such actions as reinforcing healthy expression of feelings, and assisting a patient to handle or control emotions in a constructive way.

3. Since humans do not live in isolation, social development is a life-long process that is important to the well-being of patients. Nurses may promote this type of development by, for example, assisting a patient to fulfill interest through activities and to participate in groups, and providing opportunities for him to carry out spiritual practices.

4. A patient's self-esteem will have a bearing on his ability to achieve optimal function. Nurses have many opportunities to assist a patient by promoting

his self-esteem. Some of the ways this can be done include giving a patient choices, helping him find ways to feel useful, and pointing out his progress toward achievement of goals.

5. A feeling of psychological comfort and safety is necessary to a patient's welfare. Patients are as entitled to nursing which promotes this feeling as they are to nursing which provides for physical safety and comfort. Psychological comfort and safety can be promoted by nursing actions which reduce the unfamiliar and reduce anxiety, such as by providing for personal privacy, providing information about the current situation, and providing opportunity for a family to form an attachment to a newborn child.

6. The need to adapt to a stressful change or loss may occur at any time in a person's life. Change, such as those due to a death or loss of independence, may overwhelm a patient, or at least interfere with his sense of well-being. Nurses are often in a position where they can help promote a patient's re-adjustment to a change or loss. In addition, a dying patient and his family should be able to rely on the nurse for comfort. Immediately after the death of a patient the nurse can also provide the family with comfort through measures such as the provision for privacy and the provision of a person who can be of assistance.

7. Provisions which satisfy a patient's need to know can increase his well-being. A patient should be able to rely on nurses providing him with information he needs. The nurse is in a position to translate the information he needs into terms he can readily understand.

F. Delegated medical treatment.

This category is needed to assure the implementation of a patient's medical regimen. The function of safely administering treatments commonly prescribed by physicians has long been delegated to nurses. Inability to perform the steps in this function puts a patient at risk of harm.

1. For patients who need oxygen, its safe administration can be life-saving.

Such a patient has a right to expect that if his physician orders oxygen, any nurse could administer it.

2. Another life-saving measure is maintaining patency of a patient's airway. If fact, if a nurse could not clear a patient's obstructed airway of secretions, the administration of oxygen would not be effective.

3. Patients often need to be re-hydrated by intravenous fluids. The nurse must be able to assist in the administration of this treatment. The fluid must be kept flowing at the prescribed rate to ensure the patient is treated without being subjected to circulatory overload. The patient is also dependent on the nurse to see that the fluid is going into the vein, rather than infiltrating and damaging surrounding tissues.

4. There are many conditions which could interfere with a patient's gastrointestinal function. The patient with such a condition should be able to receive the care prescribed by his physician. Prescribed treatments which are commonly implemented by nurses include nasogastric feedings by gravity, emptying and re-applying an ostomy bag, and administering an enema.

5. Proper implementation of treatments related to genito-urinary function can be important to the patient's physical comfort and safety. Such treatments commonly involve catheterization and maintenance of a closed urinary drainage system. It is essential that sterile technic be maintained during these treatments.

6. The function of the patient's skin is often treated by application of cold or hot packs, and the latter may need to be moist and sterile. Another common treatment is administration of light treatments. In such cases, the assurance that the patient receives a beneficial treatment, rather than suffer further damage to the integument, rests with the nurse.

7. The treatments which may be prescribed for a patient with a musculoskeletal dysfunction will vary with the dysfunction. The most common treatments encountered will require the nurse to be able to provide care to a patient in a cast and to

a patient in traction.

8. In view of the large number of new medications introduced each year it is mandatory the nurse be able to locate the information necessary to administer a prescribed medication. The nurse must be familiar with authoritative resources to determine, for example, the medication's usual action, dosage and side-effects. Without such information the nurse can neither safeguard the patient during administration nor recognize the possible effects of the administration.

9. Since medications may not come in the dosage prescribed, the ability to calculate the dosage of a medication is crucial to a patient's safety. Nurses may not always practice in settings where prescribed medication is dispensed in units which correspond to the correct individual dose. Therefore, nurses must be able to determine metric and apothecary equivalents, convert metric weight and volume from one unit of measure to another, and solve equations containing common fractions and decimal fractions to determine the amount of medication to be given.

10. The ability to prepare a medication for administration is necessary for the patient to benefit from his prescription. Nurses may not always practice in settings where medications are administered by other levels of nursing personnel. Therefore, nurses must be able to prepare the prescribed medication for administration. The actions involved are those of verifying accuracy of the prescription as to the name of the drug, dosage, time, route and patient; and making adjustments for age and condition of the patient and frequency of administration. In the case of injections it is necessary that the nurse is able to mix two medicationsin one syringe.

11. and 12. It is necessary for the treatment of patients that nurses have the ability to give medications by the two most commonly used routes. By far the most medications are administered by mouth. Although many routes are used for injection, the intramuscular route is the one most likely to result in permanent injury to the patient if an incorrect site is selected for administration.

13. The patient must depend on a nurse to notice both the beneficial and adverse effects of a medication. The nurse is in a position to observe and record a patient's signs, symptoms, behaviors and comments related to the administration of medications.

14. Nurses are often delegated the responsibility of administering a controlled substance. It is necessary the nurse be able to follow procedure to maintain the security of controlled substances to assure a medication for pain will not be ineffective due to dilution, replacement or other tampering. Following procedure for accounting for the use, waste, or other disposal of controlled substances protects all involved as it provides a way to ascertain any misuse or abuse of these substances.

G. Reporting and recording.

This category is essential if patients are to be assured continuity of care that is safe and aimed at assisting them to achieve optimal function. This function is particularly important in settings where many nursing personnel, and perhaps other health professionals, are involved in caring for patients around the clock.

1. The ability to give oral reports is commonly needed by nurses to inform nursing personnel, the physician and others involved in a patient's care of the data collected about the patient, of the plan for the patient's care and of the patient's response to, or results of, care. The effectiveness of a patient's continued care is dependent on the pertinence and accuracy of these oral reports.

2. The nurse must be able to record in the patient's record the nursing actions taken, the patient's reactions to the care, and the resulting patient outcomes. The patient's record is significant in different ways to the patient, others caring for him, institutional administrators and members of the legal profession who have reason to examine it. Nurses must be able to comply with all record-keeping requirements which may be imposed by law, and institutional licensing and accrediting bodies.[7]

H. Evaluating nursing actions.

This category is essential to the improvement of patient care. This function is important to individual patients in terms of assisting them to achieve optimal function. Nurses need the ability to evaluate the effects of their own actions to determine whether or not the desired outcomes were achieved. For the patient's sake, the nurse must be able to also judge whether or not the effects of his or her actions were beneficial to the patient.

7 MCAR § 5.3018 Additional professional nursing abilities to be evaluated.

A. Listing for evaluation.

This rule is needed to ensure that students graduating from professional nursing programs have the nursing abilities to practice as defined in Minn. Stat. § 148.171 (3). This rule is necessary to specify, in addition to the common core of nursing abilities in 7 MCAR § 5.3017, those abilities unique to professional nursing. The need for these additional abilities is clearly shown by comparing the practice definition for practical nurses in Minn. Stat. § 148.29 Subd. 4 to that for professional nurses in Minn. Stat. § 148.171 (3).

As with the list of categories and abilities in 7 MCAR § 5.3017, the list in this rule was developed with broad input, for the same reasons, resulting in the same overall characteristics. Indeed, these abilities are as essential for students graduating from professional programs as the core abilities are for the students graduating from both practical and professional programs. This rule is reasonable given there are three kinds of professional programs, leading to an associate degree, a baccalaureate degree or a diploma. All three prepare students for the same license.

The public must be confident that each person holding a professional nursing license has the same essential abilities. The abilities listed in this rule are required for all students graduating from all professional programs. It is recognized that programs leading to an associate degree have not traditionally addressed the nursing categories of case finding, or the categories of nursing assessment of actual or potential physiological and psychological health needs of families and communities. Recently, many associate degree programs have begun to address the categories of delegation to nursing personnel, supervision of nursing personnel and teaching nursing personnel. It may be necessary for faculties to make some curriculum content additions in order to assure that students have all of the listed abilities. However, it will not be necessary for the additions to be extensive or elaborate.

It is reasonable to assume that every nurse should have the following abilities because the law authorizes licensed nurses to perform all of these services. Since the board has a statutory duty to see that licensees can perform functions specified in these categories it is necessary to ensure that the students who may apply for a license have been so prepared.

The following categories of nursing practice and the abilities within them are reasonable because they do not exceed the legal practice definition for professional nursing. For example, the category of assessing communities includes abilities of collecting and interpreting data and planning, not implementation or evaluation.

The Program Rule Replacement Task Force convened a reaction panel which included professional nurse educators to review the categories of nursing and abilities. The educators on the panel indicated that these nursing abilities can be taught and can be evaluated. The nursing care providers consulted by the Program Rule Replacement Advisory Task Force indicated thatthese nursing abilities, in combination with those specified in 7 MCAR § 5.3017, are inclusive of those reasonably expected of newly licensed professional nurses.

B. Nursing care planning.

This category is essential to nursing practice today. The professional nurse needs to be able to formulate a nursing care plan to care for a patient safely and to assist him toward optimal function.

Patients must be able to rely on professional nurses to develop nursing care plans for them. It is the professional nurse who has the knowledge from physical and behavioral sciences to use in interpreting data collected pertaining to the patient's physical, physiological, intellectual, emotional and social functions, and his medical regimen. The professional nurse is in a position to involve the patient and/or his family in arriving at realistic attainable goals and identifying the outcomes which will signify that those goals have been met. It is the professional nurse who can specify the nursing actions to achieve these desired patient outcomes and goals. This ability is essential to assure coordination among all levels of nursing personnel assisting the patient toward optimum function.

C. Case finding.

This category is needed to assure that students graduating from programs can practice as defined by law. Case finding is a function specified in the legal professional practice definition. This ability focuses on identifying persons not currently receiving nursing care who could benefit from that care. Another category, that of "nursing observation and assessment of patients", includes identifying patients needing additional nursing care.

It would be unreasonable to require the ability be "recognizing the need for medical care", as nursing programs should not be held responsible for evaluating students for their ability to identify persons who need care from others. Healthy individuals and those not receiving nursing care must be assured that, on assessment, if nursing care is needed that will be identified. The nurse must be able to recognize if an individual's signs, symptoms, and behaviors are consistent with a need for the independent services of a nurse. If individuals are to know the options available to them, the professional nurse must have the ability to recognize an individual who could benefit from nursing care. The ability to administer the independent nursing care needed is assured through all other categories of nursing practice except those of "delegated medical treatment" in 7 MCAR § 5.3017 and this rule.

D. Health teaching and counseling.

This category is essential as nurses are in an ideal position to assist patients toward an understanding of their health status and how to maintain or improve that status. This function is vital to a patient's independent function.

1. More emphasis is being placed on health maintenance and on caring for illnesses in the home. Such self-care makes it necessary for patients to rely on professional nurses to assist them in understanding health practices and how to administer their own care. The nurse must have the ability to teach patients regarding health practices and the needs for care which have been identified by nurses and other licensed health professionals. This teaching may involve assisting the patient to recognize negative health practices, to understand the implications of alternative health practices and to understand how to meet his own care needs in his situation.

2. Patients must be assured that the professional nurse is able to deliberate with them, mutually assessing the patient's strengths, needs and how optimal function and independence can be promoted given these strengths and needs. The need for such counseling may occur with any patient, and is increasingly evident as more patients are being cared for at home following strokes, heart disease, other illnesses, cancer therapy and other treatments. The nurse must be able to assist such patients to solve their own problems. It is important that the nurse refrain from making decisions for the patient so the patient has the opportunity to adapt and become as independent as possible.

E. Referral to other health resources.

This category is needed to assure patients of assistance in locating and contacting a suitable health resource. This function is essential to the continuation of care which is effective for the patient.

1. Patients must be able to rely on the professional nurse to review their needs, including those which health professionals other than nurses are qualified to meet, and their personal wishes regarding health care. Based on this review, the nurse must have the ability to identify health resources which match the patient's needs and desires. The resources identified must be appropriate to the patient if the patient is to be willing to consider further care.

2. For professional nurses to be able to carry out the legally mandated function of "referral," patients must be assured the necessary information is provided to them and to the health resource. The ability to provide the patient with the information he needs about the resource is fundamental to a satisfactory referral. The ability to provide the resource with the information needed about the patient is necessary for continuity in meeting the patient's needs.

F. Delegation to nursing personnel.

This category is essential to the safety and welfare of patients in a group care setting. This function will assure that the patient receives responsible care from appropriate personnel members.

1. The patient must be able to rely on the professional nurse matching his needs for care to the skills of personnel available to care for him. The patient has a right to care by nursing personnel who can safely provide that care. The nurse must have the ability to determine which nursing actions needed by the patient can be delegated and the level of personnel to whom those actions should be delegated. Determinations to delegate nursing care must be based upon knowledge of the patient's situation, condition, and nursing care plan. This knowledge must be matched by knowledge of the legal scope, abilities and other responsibilities, the various levels of nursing personnel,as well as the degree of supervision available to them. This ability is particularly important to the patient in this time of health care cost containment. Care from appropriate levels of nursing personnel may reduce the cost of care to the patient.

2. For the patient's care to be accomplished, the nursing personnel to whom actions are delegated must be clear at to how the responsibilities for the care are being shared and for how long. The ability to clarify the responsibilities for delegated actions protects the patient by assuring all nursing personnel involved can be held accountable for the actions delegated.

G. Supervision of nursing personnel.

This category is necessary to the well being of patients in group care settings. This function enables the nurse to improve the care administered by nursing personnel.

1. The professional nurse, with knowledge of the legal scope and abilities of the various levels of nursing personnel, must be able to assess nursing personnel in terms of degree or amount and type of supervision needed. Patients must rely on the supervising nurse's ability to observe the activities of nursing personnel to determine which personnel need direction or assistance to meet the goals specified for each patient.

2. To assure quality nursing care is provided to each patient in a group setting, the professional nurse must be able to provide direction and assistance to the nursing personnel administering care. The nurse must know how to make herself available to others and how to work with them in constructive ways. Since all levels of nurse personnel need,at sometime, direction and assistance, it is reasonable that professional nurses have this ability.

3. Fundamental to supervision is determining if the work of others has been completed and the quality of that work. Patients rely on the professional nurse who is responsible for supervision to evaluate the care given by nursing personnel. It is through the comparison of the care given to the goals and outcomes set in the nursing care plan that the patient will be assured of effective care. This ability is also important as providing personnel with both positive and negative feedback regarding their work should improve the quality of care they give in the future.

H. Teaching nursing personnel.

This category will safeguard patient care by ensuring that all professional programs evaluate students for the ability to meet a learning need of nursing personnel. This function enables the professional nurse to improve the practice of other nursing personnel.

1. To teach, the nurse first must have the ability to assess learning needs. Professional nurses must be able to fulfill this initial step in accomplishing the legal responsibility of teaching nursing personnel. The nurse must be able to recognize negative practice or gaps in knowledge to provide a remedy through completing all steps of this function.

2. The ability to develop a teaching plan for meeting an assessed learning need is necessary to efficiently and effectively perform this function. This ability is needed to assure that a specific learning need will be met; a pre-packaged lesson may not relate to the needs of a specific group of nursing personnel. While an unplanned teaching session may meet a learning need, the professional nurse must have this ability so this important activity is not left to chance.

3. The fulfillment of this function can only be done by actually implementing a teaching plan. The assessment and planning steps are meaningless unless the professional nurse has the ability to carry out the plan.

4. For patient safety, it is important that the professional nurse have the ability to determine if a learning need of nursing personnel has been met. The learning needs of nursing personnel will have a bearing on the care provided patients. A nurse who assumes what was taught was learned will be placing patients at risk of harm. The professional nurse must, therefore, have the ability to evaluate if nursing personnel have in fact learned what has been taught. If learning has not taken place and further teaching is needed, it is better to determine that through planned evaluation than through randomly collected evidence of inadequate or imcompetent nursing care.

I. Delegated medical treatment.

This category is needed to assure patients of the safe administration of intravenous medication. The fact that this treatment is commonly delegated to professional nurses, not practical nurses, makes specification of this function necessary. The step of doing the venapuncture is not required for a variety of reasons, the most important being the recognition that infrequent performance of the procedure places the patient's comfort and safety in jeopardy and does not guarantee continued safe performance of the skill.

This ability is increasingly needed today as the population of more intensely ill patients increases in health care facilities. For example, more premature infants and burn patients are surviving and needing this treatment. Also, an increasing number of patients with cancer are receiving chemotherapy through an intravenous route. The prescribing physician and patients must rely on professional nurses to be able to administer intravenous medication safely and accurately.

J. Evaluation of nursing care plans.

This category is necessary to assure patients that the nurse can judge the value of their nursing care plans and can modify a nursing care plan as needed. This

evaluative function is crucial to providing nursing personnel with the direction needed to assure patients receive effective nursing care.

1. Patients must rely on the professional nurse to determine effectiveness of their care plans which are used by various levels of nursing personnel. It is the professional nurse who can analyze the data collected about the patient to see if the goals, actions and desired patient outcomes specified in the care are reasonable. The professional nurse is in a position to also compare the desired patient outcomes with the actual outcomes to judge if the plan is effective and current.

2. The patient has a right to expect that if changes are needed in the plan, based on reassessment of the patient's current status and the effectiveness of nursing care plan for him, changes will be made. The professional nurse must have the ability to modify a nursing care plan so the patient will be able to achieve optimal functioning. This ability is needed to assure the patient, who needs continued care, that the nursing care plan will result in safe, effective care.

K. Nursing assessment of actual or potential physiological or psychological health needs of families.

This category is needed as most individuals are members of families. People living together are defined as a family as they are in a position to work together in meeting health goals. The function of assessing the health needs of a family provides a service inducive to the well being of individual members as well as the family itself.

1. The public has a right to expect that a professional nurse can fulfill this function. The professional nurse is able to use theory and knowledge of families in collecting data pertaining to a family's structure and function and in interpreting these data in terms of health needs. The family will benefit from the professional nurse's ability to collect and interpret data about family functions such as making decisions, providing for the health of its members and using a crisis experience as a means of growth.

2. The family must be assured the professional nurse has the ability to develop a plan to assist the family to achieve its health goal. It is the professional nurse, who collected and interpreted data pertaining to the family and its health needs, who can assist the family in finding ways to achieve its health goal.

L. Nursing assessment of actual or potential physiological or psychological health needs of communities.

This category is needed as every individual is a member of a community. All individuals are accommodated because a community is defined only to the extent that it have a population and an environment. The function of assessing factors in the community which can influence an individual's health is beneficial to individuals.

1. The public has a right to expect that a professional nurse can fulfill this function. The professional nurse is able to use theory and knowledge of communities in collecting data on factors which impinge on an individual's health and in interpreting those data in terms of health needs. The individual will benefit from the professional nurse's ability to collect and interpret data about community factors such as air, water and noise pollution, population density, and accident, morbidity and mortality rates.

2. The individual must be assured the professional nurse has the ability to develop a plan to modify conditions in the community which affect his health. It is the professional nurse,who collected and interpreted data pertaining to the community's effects on an individual's health,who can assist him in finding ways to modify the conditions within the community.

7 MCAR § 5.3019 Preparation for evaluation.

A. Predetermination.

This rule is needed to ensure that each faculty makes at least these essential preparations before starting to evaluate students. Such preparations are necessary if the rule 7 MCAR § 5.3020 is to be successfully implemented. It should be recognized that this rule does not require measures of validity or reliability because it would be too costly to require faculties to implement such requirements. However, these rules will not prevent any faculty which wishes to address those issues from doing so.

The reasons this rule is reasonable are the same as those for the proposed focus on evaluation; see the discussion for 7 MCAR § 5.3017. All required preparations are common to standard practice in evaluation and in accord with the basic principles of evaluation. All of the predeterminations are needed to provide the faculty with comparable data on which to base evaluative decisions about students' possession of the nursing abilities.

The academic freedom of faculty members is protected as there are no specifications regarding whether the nursing abilities should be evaluated singly or in combination, what types of evaluation methods should be used, where, when, or in what sequence the evaluations for 7 MCAR § 5.3020 must be done. It is necessary to require that specific predeterminations be written so each faculty member and each student will be aware of what is expected. It would be unreasonable to condone evaluation in which the student was not informed in writing of what is expected or in which individual faculty members could change the expectations at will. Having these determinations in writing and dated will also make it easy for the faculty to document compliance with the rule.

The specific predeterminations are needed because:

1. The faculty members need to agree upon which of the many possible nursing actions that would illustrate possession of the nursing ability will be acceptable and/or required. With this predetermination, students will be clear as to what they

learn and what is expected of them. As may be seen in the preceeding discussion of the nursing abilities in 7 MCAR §§ 5.3017 and 5.3018, the abilities are so broadly stated as to permit the variations of practice that may be common in the program's setting. Examples of nursing actions which would demonstrate the nursing abilities are available in the Final Report of the Program Rule Replacement Advisory Task Force which was sent to all faculties in 1981. Faculties have total freedom in determining which actions and the number of actions required to demonstrate each nursing ability.

2. The evaluation situation or stimulus must be structured before the evaluation can take place. This requirement is reasonable since students can be expected to demonstrate possession of an ability only if the evaluation situation or stimulus elicits, or at least permits, that demonstration. It is necessary that the demonstration to be brought about by the evaluation situation or stimulus be measurable for quality for the evaluator to judge if the student possesses the ability. This requirement is reasonable as the evaluation situation or stimuli may be used for succeeding groups of students.

This subpart of the rule is needed because without it a faculty might construct an evaluation situation or stimulus that brings out nursing actions which would not illustrate the ability to be evaluated. For example, if a faculty were to predetermine that the evaluation situation for determining possession of the nursing ability "administer a prescribed medication by mouth" (7 MCAR § 5.3017 E. 11.) were to involve a mannequin, the situation would make it impossible for the student to demonstrate the ability. Nor could the evaluator determine that the student could assist a "patient" to swallow the medication without choking, or that the medication was in fact administered.

It is recognized that not all faculties will have already developed evaluation situations or stimuli for each of the nursing abilities and to do that will take thought. Some of the nursing educators contacted by the Program Rule Replacement Advisory Task Force reported that students are already being evaluated for possession of most of the nursing abilities. Those directors indicated it might take their faculties a quarter to review the curriculum, locate the evaluation items and

make any necessary changes. The faculties that have more work to do can take, in accordance with 7 MCAR § 5.3002 C., over two years to prepare for these evaluations.

3. The judging of each nursing ability must be based on predetermined criteria. To provide consistency for both faculty and students, the criteria must be written. The requirement is reasonable because students will know the criteria by which they will be judged. In order to be useful, it is necessary that the criteria be measurable. For example, if a criterion for evaluating the ability to "promote social development" (7 MCAR § 5.3017 D. 3.) was "uses all opportunities to reinforce patient's social interests" it would be impossible to determine if the student really did that in an evaluation situation. Even with a written evaluation stimulus, there would be little likelihood of getting two evaluators to agree on what all the opportunities for reinforcement were.

It is necessary to require that the criteria be appropriate to the nursing ability in order to ensure that the criteria do indeed relate to the ability. The following example exemplifies how a faculty could, without this requirement, include the following criteria inappropriate to judging possession of a nursing ability.

EXAMPLE OF RELATIONSHIP OF CRITERIA TO NURSING ABILITY

Nursing Ability	Criteria	Relationship
- prevent spread of pathogens. (7 MCAR § 5.3017 C.2.)	- Provision selected for patient's disposal of soiled tissues reduced exposure of patient and roommate to contaminates.	- Related to the nursing ability.
	- Administered antibiotic at time ordered.	- Not related to independent aspect of the nursing ability.
	- Clear and accurate statement of how the nursing activity will improve the patient's immunity.	- Not related to the nursing ability.

Looking at the preceeding example one can see how a faculty could develop two out of three criteria inappropriate to making a judgment regarding possession of a specific ability. Administering medications on time would be dependent upon a physician's order and could serve as a criterion for administering a medication, but the second criterion will not provide the faculty with information regarding the student's ability to independently prevent the spread of pathogens. While the third criterion would provide information about the student's understanding of a patient's response to spread of pathogens, that criterion will not assist the faculty to judge if the student has the ability to prevent spread of pathogens.

Requiring that the criteria address the safety of the patient is reasonable, given the board's charge to protect the public. Safety is a factor that is,or should be, automatically addressed by faculties and should not be seen as unreasonable. The matter of patient safety needs to be addressed even if paper and pencil test items are used for the evaluation stimulus. The criteria or correct answers should determine whether or not the student would safeguard the patient in a real situation. Although one or two of the nursing abilities may on the surface not seem to directly relate to a patient, there really are patient safety factors that should be addressed with each ability. For example: for professional programs evaluating the ability to "make a plan to assist a family to achieve a health goal" (7 MCAR § 5.3018 J. 2.), a safety criterion could be, "includes an action which will reduce the risk of harm to the member or members needing or receiving nursing care."

Although it may seem redundant to require that the criteria for evaluation ascertain the accuracy of the performance, it would be a grave omission to not specify this component. Without such criteria the whole evaluation would be a waste of everyone's time and energy. For example, if there is no criterion which sets the standard for conformity, defines the quality of correctness, or requires that the demonstration be free of error,it will be impossible for the faculty to judge if the student possesses the nursing ability.

Although the rules do not address how to carry out the evaluations,or require training evaluators to obtain inter-rater reliability, the initial step of requiring the faculty to write evaluative criteria to accomplish the purpose of the evaluation is both necessary and reasonable. While the faculty has the prerogative of determining the characteristics of satisfactory and unsatisfactory performance, this rule will ensure that the faculty will set standards.

4. The faculty must predetermine the basis for deciding whether the student possesses the nursing ability to inform the student of the acceptable level of performance and what he or she is aiming to achieve. It is necessary for the faculty to predetermine the bases for decisions so individual faculty members will be consistent in making final decisions regarding students' abilities.

Someone must set the standard for determining if a student has or does not have the expected abilities. This rule will accommodate faculties choosing the standard of performance that is agreeable to them and is seen as necessary given the various factors in that setting which may influence the evaluation. Only the faculty members can determine what they are willing to accept as evidence of minimal ability. It is recognized that it is not yet possible to scientifically determine how much proficiency should be required. Therefore, it is best to leave this decision to faculties so the decision can be changed by them when that seems necessary. For most faculties this component of evaluation may seem the most familiar and their customary grading or rating system may be what they use.

B. Evidence of preparation.

This rule is necessary to ensure completion of the predeterminations necessary for the evaluation of the nursing abilities. This rule will inform directors of approved programs of the evidence needed to document compliance with A. The predeterminations will have to be completed for each nursing ability. However, the evidence of the predeterminations for only a sample of the nursing abilities will have to be submitted to document compliance with the rule. Since the sample of nursing abilities will not be announced until a survey commences, or is underway, the predeterminations will have to have been completed for each nursing ability.

The rule is reasonable in that the predeterminations will be used by students and faculty. Documentation will not be burdensome as a copy of these predeterminations will serve. Requiring that the predeterminations be dated will enable the faculty to show that the materials were developed before evaluation commenced.

Compliance may be demonstrated easily by the director through copies of the predeterminations for the announced sample of abilities. Compliance can be determined by mail or during on-site conferences.

C. New program compliance.

This rule is needed to predict that a proposed program will be able to implement the rules regarding evaluation of the student's nursing abilities. It is necessary to require the director of a proposed program to demonstrate, in a staggered sequence (7 MCAR § 5.3005 A. 5.), that predeterminations for the evaluations are done. If predeterminations are satisfactorily completed for the first term in which evaluations will be done, the board will know that the faculty is able to write the predeterminations needed for evaluation. Prior completion will also assure that the evaluations for one term are ready to be implemented.

It is reasonable for the faculty of a new program to meet these rules since the completion of the work can be done in natural phases. If the evaluations are completed prior to the first term in which they will be used, the new faculty members should feel less stress as they develop evaluation tools for succeeding terms while implementing the on-going program. If the faculty of a proposed program wishes to complete all the predeterminations for all the nursing abilities prior to approval, that may be done. The board may waive the sequencing requirements in accordance with 7 MCAR § 5.3005 A. 7.

This rule is also necessary in order to require that the director of a new program submit, in accord with 7 MCAR § 5.3006 A., written and dated predeterminations for all of the nursing abilities by the time that the first student completes the program. It is reasonable to require a new program to document compliance for all

of the nursing abilities rather than for a sample of abilities as the evaluation of these abilities is crucial to determining whether or not a new program has fulfilled its obligations to prepare graduates to practice as defined by law.

Existing programs are also required to have predeterminations for all nursing abilities. The reason existing programs are required to document those predeterminations for only a sample of the abilities is that such programs have been regularly graduating students whose abilities are readily evident. If complaints about the abilities of the graduates are received, or if less than 75 percent of the students pass upon the first writing of the licensure examination, a thorough investigation of rule compliance can be made. The new program, having once documented predeterminations for all abilities, can evidence future compliance for a sample of abilities since it,too,will be regularly graduating students whose abilities will be evident to all.

7 MCAR § 5.3020 Evaluation of nursing abilities.

A. Practical program evaluation requirement, and B. Professional program evaluation requirement.

This rule is needed to enable the board to determine that faculties evaluate students for possession of essential nursing abilities. The rule is also necessary to inform directors of practical and professional programs of the requirement. The requirement of evaluating students for possession of nursing abilities is crucial to this new approach to approval which will enable the board to judge the value or quality of the program by stated goals for the outcomes of educational processes.

This rule is basic to changing the focus of approval from inputs and process to outcomes. As Dr. Connant has indicated, the ultimate beneficiaries of evaluations of a practitioner's abilities or competence are the patients and consumers.[8] The basic goal of assuring the public is served by competent graduating students will be achieved by the process outlined in these rules.

As has already been stated, the nursing abilities for programs have been drawn from the practical and professional practice definitions in the law. In order to distinguish between the functions outlined in these definitions, the requirements are stated separately. For further information about the common core of nursing abilities for both practical and professional programs and the additional nursing abilities specified for professional programs only, see the statements related to rules 7 MCAR §§ 5.3017 and 5.3018.

The evaluation of each student is specified, even though it is the program that is the subject of approval, since the goal of the program and the board's approval process is the preparation of graduating students who can meet the requirements for licensure, and once licensed, practice as defined by law. The abilities are those essential to practice as defined by law, therefore, it is important that each student be evaluated for possession of each nursing ability.

This rule, along with 7 MCAR § 5.3017 and, for professional programs 7 MCAR § 5.3018, will assure that faculties know the nursing abilities the board expects students completing the program to possess. This rule will also assure that faculties have collected evaluative data about each student's possession of those nursing abilities. Consistent with the current rules, the board does not now intend to interfere with the faculties' right to determine standards for passing nursing courses or graduating. The board is not in a position to judge the standards for passing within a program. For further reasons why the faculty is best able to set academic standards,see the statements related to 7 MCAR § 5.3019 A. 4. The board does set the standard for passing the licensure examination which all graduating students will have to pass before they may practice as defined by law.

This rule will assure that each student has been evaluated for the capacity to safely and accurately perform each of the nursing abilities identified as essential. It is recognized that there is no way to absolutely assure the quality of practice students will exhibit after graduation and licensure. However, the rule will require that faculties have made a determination about students' abilities before graduation.

The word evaluation is not defined in these rules. The working definition utilized during the development of these rules was "evaluation shall mean a systematic process of judging worth,value or quality of an entity." That broad definition was eliminated as unnecessary upon advice of the Revisor's Office.

This rule will permit faculties to continue to develop and utilize their own philosophy of evaluation,as various philosophies of evaluation are accommodated. A faculty's philosophy of evaluation will dictate how these evaluations are approached.

The faculty has discretion in establishing the nursing actions to demonstrate the nursing ability, in setting the evaluation situation or stimulus, in determining the methods of evaluation, in setting the criteria and in setting the basis for the decision regarding possession of the abilities.

Maximum flexibility is permitted as no time period has been designated for the evaluation of students. To determing if the student possesses the nursing ability as required by rule, it will be necessary for the faculty to make a final judgment. Prior to the the final judgment, the faculty would have opportunity to guide students' development as needed. It is recognized that learning and practice must take place before evaluation and the timing of that will vary from program to program. The evaluations may be started early and spread out over the entire time the student is enrolled if the faculty finds that appropriate.

To make the rule as flexible as possible for all concerned, the number of times a faculty may permit students to repeat the evaluations is not limited. Faculties that wish to require passing examinations as a prerequisite for graduation may administer the examinations in time for students to remediate and repeat needed evaluations before the expected graduation date.

In recognition of the flexibility needed to administer the evaluations, no setting has been specified for these evaluations. The number of nursing abilities which could be tested at one time may also be determined by the faculty. The broad nature of the nursing ability statements is such that faculties will be able to develop appropriate evaluation situations and stimuli and find settings where the evaluations can be conducted.

The unprohibitive nature of this rule and rules 7 MCAR §§ 5.3017-5.3019 will accommodate future changes in evaluative technics. As was indicated before, the nature of the nursing abilities is broad enough to accommodate future changes in nursing practice and nursing settings.

Current evaluative technics will also be accommodated by these rules. The fact that no setting has been required for the evaluations specified in this rule frees faculties to be creative. Some of the settings in which we now know the nursing abilities could be evaluated are:

- Clinical setting with a patient.
- Laboratory with a peer or actor simulating a patient.
- Laboratory with a mannequin or model simulating a patient.
- Laboratory with nursing care equipment and supplies.
- Classroom with and without multimedia equipment.

Since this rule does not specify any methods of evaluation that must be used, faculties may again be creative. The only requirements to be kept in mind are that the evaluation situation or stimulus must permit a demonstration of each identified nursing ability and demonstration of the ability can be observed or measured for quality. Some of the ways in which we now know data regarding student performance can be analyzed are:

- Observation of student performance in clinical or laboratory setting.
- Verbal or written response to situation presented verbally, in writing or via multimedia.
- Computer programs.
- Nursing record/report.
- Written report, audio or video tape of student's interaction with patient/personnel.
- Written nursing care plan.
- Paper and pencil examinations.
- Oral examinations.

The Program Rule Replacement Advisory Task Force struggled with the fact that faculties may feel too many evaluations are required even though many nursing abilities may be evaluated simultaneously. The only possible solution seriously considered for that problem was to place the abilities in a hierarchy and then require evaluations

of only the most important nursing abilities. It was soon discovered that the nursing abilities most important in one patient situation had to be replaced with different nursing abilities when another patient situation was considered.

Since no one, when given various commonly encountered individual patient situations, was willing to say which nursing abilities were the most important, the conclusion was that all the nursing abilities are essential and students must be evaluated for the possession of each one. It will be possible for students to demonstrate many nursing abilities at one time as patients are human beings who cannot be fragmented.

The number of nursing abilities to be evaluated may be of special concern to the faculties in professional programs which grant students with practical nurse licenses an associate degree after one year of study. In as much as there is no specific in the rule that the evaluation be conducted by the program, the director may waive specific evaluation requirements for students who can document that they were evaluated for those specific nursing abilities in another program. The director may also elect to repeat evaluations of student performance as deemed necessary.

The required evaluations may be used for other purposes than compliance with this rule. For example, the program, irrespective of the rule, may collect information regarding other characteristics demonstrated by students during these evaluations, as long as that additional information is not used to make judgments about a required nursing ability.

As is shown in the attached article, the process of student performance evaluation has long been a problem of nursing faculties.[9] It should reassure a faculty which is worried about implementing these rules to know that allowance has been made for the current state of the art of evaluation in Minnesota nursing programs. The requirement regarding faculty preparation in evaluation in 7 MCAR § 5.3012 B. 2. will facilitate faculty implementation of these rules.

The Program Rule Replacement Advisory Task Force worked out actual evaluation situations for a representative sample of the nursing abilities to be sure that they were measurable. These examples are included in the final report of the task force which has been made available since 1981. The examples are not included as a part of this Statement due to the volume of detail.

The current rules for approval require each faculty to have its own list of graduate competencies (7 MCAR §§ 5.1090 D. and 5.2080 D.) and to have identified the essential requirements in the nursing courses (7 MCAR §§ 5.1082 B. and 5.2072 B.). Through these graduate competencies, each faculty has identified the knowledge and skills achieved on graduation and the course requirements for student demonstration of attainment of the knowledge and skills. Since those demonstrations of knowledge and skills incorporate most of the proposed nursing abilities, this rule, which requires faculties to formally evaluate each student for each of the proposed nursing abilities,should be easily met.

C. Evidence of evaluation of nursing abilities.

This rule is needed to inform directors of the ways in which compliance with this rule may be demonstrated. The three options are necessary to permit faculties to choose the method of documentation which best suits their situation. Each of the options will permit the board to determine whether each student has been evaluated for each nursing ability.

Evidence of compliance for a sample of nursing abilities will suffice as the sample will be announced by the board's representative at the time of the survey, usually during the onsite visit. Since the faculty will not know which nursing abilities will be sampled, the faculty will need to have evidence of evaluating all nursing abilities. If all nursing abilities have not been evaluated, this should be evident in the sample.

There are three possible ways to document compliance. Faculties are not restricted to just one method of documenting compliance; more than one method may be used. The ways that will be easiest for the faculty may be elected.

1. Faculties that are accustomed to incorporating skill evaluations in the nursing course requirements may elect this method.

2. Faculties that are accustomed to evaluating students for level objectives may elect this method. Method 2 may be elected more in the future as new evaluation systems are developed.

3. Faculties that are accustomed to utilizing individual student checklists or records may elect this method. If the faculty elects to use method 3 in documenting compliance, a sample of student records will be selected and reviewed during an onsite conference. Since the faculty will not know which student records will be reviewed, any evidence that some students were not evaluated should be found in the sample.

Some faculties may elect to use more than one method. Faculty members may find one or more of the specified methods useful in assuring they record evaluations of students and, if they choose to do so, incorporate those evaluative findings into course and graduation requirements.

D. New program compliance.

This rule is needed to inform faculties of proposed programs and new programs that compliance with the rule must be demonstrated by the time the first student has completed the program. In the case of new programs, the board will not use sampling technics for nursing abilities, thereby ensuring that the new program fully implements this rule.

As with proposed rule 5.3019, sampling the nursing abilities would not give the board, the public and students adequate assurance that each student in a new program was evaluated for all of the nursing abilities. Using sampling technics during a survey of a program which is continuously graduating students is possible because the board will be able to investigate in the event of a complaint about the

graduates' abilities or if 75 percent or less of the graduates pass the licensing examination upon first writing. New programs will not have had previous graduating classes so the board would not be able to assume that the absence of complaints meant the sampling technics were adequate.

The rule is reasonable in that new programs will be able to comply in the natural developmental phases specified in 7 MCAR §§ 5.3005 A. 5. and A. 6.

7 MCAR § 5.3021 Evaluation of combining nursing abilities.

A. Evaluation requirement.

This rule is needed to ensure that each program includes determination of students' ability to combine various parts of nursing practice. This rule is necessary to assure that faculties provide opportunity for each student to merge nursing abilities from several nursing categories to provide a coordinated, interrelated performance of nursing actions.

The practice of nursing itself requires that nurses combine the categories of nursing practice. The nature of nursing is such that nurses rarely exhibit a single ability exclusively when caring for patients. The nature of a patient-relationship is such that a nurse usually cannot use tunnel vision by observing and responding to a single aspect of the patient in isolation from other aspects. The ability to combine nursing categories indicates that the graduating student is able to maintain the integrity of the patient as a human being.

The requirement that the evaluation include a minimum of three categories of nursing practice is necessary to assure the student will have to establish sequence and coordinate a series of actions. Combining three or more categories will provide the student with the opportunity to obtain an internal harmony and consistency among the different actions required.

The context in which nurses practice has variables that cannot be replicated in a classroom laboratory. Therefore, each student must be evaluated while caring for actual patients in clinical settings. The components of this evaluation need to be structured to this extent to assure that the faculty will be able to judge the student's ability to coordinate and interrelate actions taken.

The requirement that there be at least one evaluation of combining categories of nursing, and that the evaluation be done in a clinical setting, is necessary to the implementation of these rules. While some faculties may elect to do most of the evaluations required in 7 MCAR § 5.3020 in clinical settings, other faculties will not. Although probably all faculties give their students clinical performance

grades, only a few faculties are known to be engaging in clinical evaluations of the type specified in this rule.

An evaluation of the student's abilities to combine categories of nursing in a clinical setting is seen by the board as the most feasible means currently available for holding programs accountable for the product produced. The Program Rule Replacement Advisory Task Force asked that the board require that all programs include at least three such evaluations, one of a simple nature and two more complex. After listening to some faculty members cite the cost that would be involved if they were to do three evaluations in keeping with their philosophy of evaluation, the board has selected to require only one evaluation of combining nursing categories in a clinical setting. This reduction in number of evaluations was made in order to ensure that all faculties could be successful in meeting this rule. Furthermore, for the purpose of these rules one evaluation will suffice. Having assured that one evaluation will meet the goal of these rules, additional evaluations are not proposed as, due to costs, that would be unduly burdensome.

Additional evaluations may be done. Some directors may elect to do more than one to assure that faculty members are skilled in clinical evaluation and that students are comfortable with such evaluations. These evaluations may also be conducted to meet the evaluations of nursing abilities required in 7 MCAR § 5.3020.

This rule utilizes components recommended by the Program Rule Replacement Advisory Task Force to ensure that the single required evaluation will be carried out in more complex clinical situations. These components, indicative of a complex situation, are multiple patients or, for professional programs, multiple nursing personnel, a severe or urgent patient condition, or an unpredictable patient or nursing personnel situation. Requiring the evaluation to focus on only the more complex situations should not be interpreted as devaluing simple situations for evaluation. Simple situations are a relevant part of nursing and may be particularly useful in familiarizing students with this type of evaluation.

It is necessary to require that the evaluation situation include two or more patients, or for professional programs, two or more nursing personnel, or a patient with a severe or urgent condition, or an unpredictable patient or nursing personnel situation so that faculties can determine if students possess the ability to combine nursing abilities. It is only in such real-world situations that the faculty will be able to determine if the student has learned and can act upon those learnings. It is necessary that the students' abilities be evaluated as they have to respond to a real patient whose behaviors and needs can never be totally predicted. A nurse needs discretionary judgment in practice as that is essential to a patient's safety and welfare. Requiring this evaluation will assure that faculties prepare students for some of the situations they will face after graduation.

It is not expected that the new graduate will have the competency that a nurse will have after practicing two or three years. At the same time, there is a minimal level of practice that patients are entitled to receive from a licensed nurse. The patient cannot be expected to distinguish between the nurse who has just graduated and the nurse who has had a license for several years. Schools must accept the responsibility for preparing students to be able to practice as defined by law.

Since all components of the deliberative process currently being used by nurses are listed as separate nursing categories, the categories must be reunited to provide comprehensive care to a patient. For example, in order to observe and assess a patient's needs, develop a nursing care plan (professional programs only), interact with a patient, implement physical and psychosocial nursing care, carry out delegated medical functions, record and evaluate those actions the student would have demonstrated nursing abilities from seven or, for professional programs, eight different nursing categories. Since a combination of a minimum of seven or eight categories comprise the nursing process, it is reasonable to expect an evaluative situation to include at least three categories.

Some faculties may be concerned about the logistics and cost of conducting an evaluation of combining nursing categories for the number of students enrolled. Dr. Carrie B. Lenburg's book, The Clinical Performance Evaluation, Appleton-Century-Crofts, New York, 1979 should be of assistance to these groups as it includes examples of how three clinical performance examinations may be conducted for 100 students.[10] While a few Minnesota programs may graduate more than 100 students in an entire year, it is doubtful that any programs have more than 100 students in a single class.

This rule should not be misinterpreted regarding the methods of evaluation, as none is specified. As was discussed in relation to 7 MCAR § 5.3020, the term evaluation is not defined and various philosophies of evaluation will be accommodated. The faculty has the prerogative of choosing evaluation methods as long as the requirements for the predeterminations in B. are met. Nor are there any stipulations as to the number of students an evaluator may evaluate at any one time.

If the faculty is concerned about time and cost of the evaluation, such concerns must be considered in light of the freedom the faculty has to be creative in the way in which the evaluation is conducted. Granted, a faculty's philosophy of evaluation may be constrained by the limits imposed by budget and school calendars. However, the board has imposed no constraints; it has permitted the faculty freedom of choice in designing the evaluation methods. There are many ways in which the evaluator may collect enough data about a student's performance in order to judge if the criteria are met and whether the standard set as the basis for decision is met or exceeded.

B. Preparation for evaluation.

This rule is needed and reasonable for the same reasons as were given for 7 MCAR § 5.3019. The only element that is different in this rule is that a clinical situation must be specified for the evaluation of a student's ability to combine nursing categories. Predetermining the factors in the clinical evaluation situation is necessary to be fair to the student and to assure comparability of evaluations between students. There will be many variables in the clinical situation which the faculty will not be able to control, so establishing which variables will be controlled

is essential. Even if a professional program faculty chooses to make the evaluation complex by specifying an unpredictable patient or personnel situation, there will be basic factors which must be predetermined in order to assure the situation will be unpredictable, will permit students to demonstrate the ability to combine the nursing categories selected, and will permit the demonstration to be measured.

The faculty will need to reach agreement on which nursing categories must be combined. Given the seven core categories in 7 MCAR § 5.3017, plus 11 categories for professional programs in 7 MCAR § 5.3018, many mixtures of three or more categories will be possible. A faculty may want to set-up several evaluation situations, so, in the event that the specifications of one cannot be met, due, for example, to changes in the patient population of a clinical setting, another evaluation situation may be used.

The predetermination of the criteria for combining nursing categories will be crucial to enabling the faculty to determine if the student has achieved a coordinated, interrelated performance of nursing actions. It will be necessary for the faculty members to come to agreement on the standards they hold for being sure a student can "put it all together". The criteria expected will focus entirely on the quality of combining the selected categories. The criteria for evaluation of the specific nursing abilities may also be used as needed.

The rationale for requiring the faculty to predetermine the basis upon which it will decide whether the student has the ability to combine nursing categories is the same as that given, under 7 MCAR § 5.3019 A. 4., for deciding if the student possesses the nursing abilities.

C. Evidence of preparation.

This rule is needed to clarify the evidence of the predeterminations for the evaluation that must be available. That evidence will actually be the written materials used by the faculty and students for the evaluation so no extra work will be entailed. Proposed and new programs may present this evidence in a natural developmental sequence in accordance with 7 MCAR §§ 5.3005 A. 5. and 6. and 5.3006 A.

D. Evidence of evaluation of combining nursing categories and E. New program compliance.

The need for and reasonableness of these two rules is the same as stated for 7 MCAR § 5.3020 C. and D. with one exception. Since only one evaluation is required, all of the evaluation situations developed will be reviewed for predeterminations. If the faculty chooses to document compliance of evaluation through individual student records, sampling of student records may be used.

Repealer.

In view of the complete shift of emphasis in approval requirements, total replacement of the current rules is proposed. Current rules, which focus on the educational process, are not consistent with the focus of the proposed rules, which is on the educational product, that is, the student's abilities. It is not the board's intent to add the proposed rules to the current rules. Such a combination would simply, and needlessly, add to the cost of implementation and compliance. Therefore, the current rules must be repealed.

The current rules, taken as a whole, are superfluous to the approach to approval taken in these proposed rules. Some of the individual requirements in the current rules have been utilized in the proposed rules. These requirements from the current rules have been retained because they have been found not only necessary to the preparation of students to meet the nursing education requirements for licensure, but crucial to assuring the public that a safe practitioner is prepared. The aspects of the current rules which are retained apply primarily to new programs. These aspects are described in the preceding sections of this Statement.

Many aspects of the current rules are replaced by new requirements in the proposed rules. A description of the interchange of requirements follows. Current rules regarding curriculum structure, content and instruction requirements are no longer needed as the proposed rules have requirements regarding the evaluative aspect of curriculum. In addition, the proposed rules specify clinical activities necessary to generalist preparation. The current rules which require faculties to state graduates' competencies and to document those competencies in course and graduation requirements have been replaced by the proposed rules which require evaluation of students for possession of board specified nursing abilities.

Current rules for prior board approval of clinical facilities have been replaced by proposed rules which empower the board to protect the education of students if a clinical affiliation occurs. The proposed rules also assure that professional nurse faculty members, in the absence of an affiliation, will continue to be responsible for student learning and evaluations in clinical settings.

The proposed rules are designed to be efficient as well as effective. In the matter of granting approval, the proposed rules are simpler and easier to implement than the current rules. The four approval statuses (interim, approval, renewal of approval and provisional approval) have been replaced by approval which will continue once granted unless a correction order is issued and expires before the deficiency is corrected.

Current rules that are neither incorporated nor replaced in the proposed rules are those which are not needed, given the proposed rules. Such current rules need to be repealed as they do not directly ensure the graduation of students who can practice as defined by law. The operational areas for which the board will no longer need to hold requirements are:

- non-discrimination policies for faculty;
- number of practical program faculty members;
- practical nursing curriculum arranged so nursing assistant content taught in first 12 weeks and total curriculum content equivalent to 25 percent of associate degree curriculum;
- 400 hrs. of theory & 9-12 months length for practical program of studies;
- student policies for educational progression opportunities;
- criteria for program philosophy; and
- criteria for faculty evaluation of the program.

Subparts C. and D. of 7 MCAR § 5.3002 may be repealed after the option for temporary exemption to the proposed rules may no longer be used. It is reasonable to repeal subparts C. and D., as well as current rules 7 MCAR §§ 5.1050 to 5.1101 and 5.2040 to 5.1091, on June 30, 1985 as, in accordance with 7 MCAR § 5.3002 C., all approved programs must comply with the new rules by that date.

In summary, the current rules were not designed to assure that graduates are able to practice as defined by law. The proposed rules are precisely focused to that end. Therefore, all of the current rules may be repealed on June 30, 1985.

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Dated: November 19, 1982

STATE OF MINNESOTA

BOARD OF NURSING

Joyce M. Schowalter, RN

The Long and Tortured History of Clinical Evaluation

ALMA S. WOOLLEY

From character appraisals to checklists and from anecdotal record to computer printout, every method has had its heyday and most have been found wanting.

ANY institution wanting an overflow audience for a symposium need only plan a program called "Evaluation of Nursing Students in the Clinical Area." Registration will be quickly filled with eager young clinical instructors, ever hopeful of hearing someone—anyone!—illumine this mysterious area of nursing education. There will not be very many seasoned instructors at the symposium, except perhaps on the podium or as huddle group leaders. After a few years of struggling with the problem, one usually develops a philosophy one can live with and accepts the fact that a real solution is still eluding us.

How did this state of affairs develop? A look at clinical evaluation over the years shows that educators have enthusiastically embraced various approaches to the problem—only to drop each one when a more promising alternative was developed. Since each time the method has been published but all too often the reasons for disillusionment with it have not been openly discussed, one can find support in the literature for almost any way of doing this task. Small wonder that educators so frequently work out their own solutions, and that their evaluations are so often subjective.

In a cleverly designed study, Hayter presents an instance of this problem. She showed 31 nurse educators three films of a student caring for a patient in shock. In one film, the student carried out all of the essential actions indicated for this situation with above average skill. In another, she gave a fair but satisfactory performance, while in the third, she made several mistakes. The instructors were asked to grade the student in each film on an A to F scale, and to give the reasons for the grade they chose.

There was only 44 percent agreement among the instructors or between them and the researcher; for example, the above-average student received sixteen Cs, three Ds, and one F, but only one A. Few of the reasons given for the grades were relevant to the care of a patient in shock; indeed, Hayter described 19 of them as "clearly subjective" and 25 as "global and meaningless."[1]

Replication of Hayter's study in some of our university schools of nursing is indicated, but highly unlikely to occur. Who, after all, would want to document our ineptness in setting standards and judging proficiency in this age of living from grant to grant?

THE CHANGING THEORY-PRACTICE MIX

Educators agree that students need a laboratory experience, but its purpose has been shifting constantly and is currently not clear. Much of the confusion is due to the evolving status of nursing and the changing concepts of nursing education.

The magic mix of theory and practice has not yet been found. In the early days of apprenticeship training, the ratio was heavily weighted toward practice. Today,

the clinical laboratory experience differs in each of the major kinds of educational programs for nurses. For baccalaureate students, for instance, the laboratory is no longer just the hospital, but extends into homes, schools, and every community agency even remotely connected to health care delivery. These programs chiefly focus on the assessment of health problems, case finding, prevention, and rehabilitation, and emphasize the sociocultural aspects of health and illness.

Moreover, some schools de-emphasize technical skills to the point that students may graduate without ever having learned or done many of the procedures they would be required to know as staff nurses in a general hospital. Consequently, many avoid taking this kind of position, and some hospitals avoid hiring them. These nurses, however, have learned to think, to use their own judgment, and to be accountable for their decisions; the nurse with this orientation is apt to be a nuisance in the hospital structure.

The baccalaureate graduate is also apt to be a victim of reality shock, which Kramer believes is largely created by the faculty members who were her role models when she was a student. Many of them have had very little working experience themselves, have been largely unsuccessful in adjusting to the world of work, and have gone back to school so that they can teach others to do things as they have been taught.

Kramer identifies clinical uncertainty and ambiguity as sources of another common conflict that may be related to the new graduate's experience as a student in the clinical laboratory. Student assignments are carefully selected, and there is one correct way to carry them out. As a clinician, on the other hand, the new graduate meets ambiguous situations because of the numerous unexplained variables involved in applying knowledge to clinical practice.[2]

Nurse educators need to decide whether the clinical laboratory should be very different from the work situation in order to emphasize its learning aspects, or whether it should stimulate the real situation so the students can test out their learning. The method of evaluation to be used should follow from the purpose of the laboratory experience.

In an extensive study of the use of the clinical laboratory in nursing education, Infante examined the use of the laboratory in the education of teachers, doctors, and social workers to see if those groups are doing any better with the problem than nurse educators are. Education for nursing chiefly differs from education for other professions in that the nursing student is usually given total patient care assignments, Infante says, commenting that the "idea that the student is not a nurse but is learning to be a nurse is often forgotten."[3]

Semantic support for this criticism lies in the common term used to describe what the student does in the laboratory--performance, as in "to exhibit one's feats." The student is graded on her "clinical performance"; tools are devised for "evaluation of clinical performance," and a "summary of performance" frequently appears on transcripts and recommendation. Perhaps just ceasing to use this word and finding a more appropriate descriptive term would result in a rethinking of the laboratory concept in nursing.

TOLERANCE FOR ERROR

Such rethinking will have to take place if Infante's ideas are to be generally adopted. In particular, nurse faculty members have traditionally not been able to accept her idea that they should tolerate students making errors in the clinical area. One mistake that could jeopardize the life of a patient is considered one too many. Low faculty student ratios are necessary for the accreditation of a nursing program, with the result that nursing education is exorbitantly expensive. Infante believes that the teacher's function is to allow for students' errors so that they can learn to correct themselves. Her permissive attitude toward error was not shared by the respondents in her study, nor would it be shared by the nursing service personnel who control access to patients and to the clinical laboratory.

The skills controversy has appeared as a constant thread in nursing education. In the beginning, skills were observed, learned, and practiced in the real situation, because there was no alternative. With the introduction of educational methodology, fully equipped classroom laboratories were developed in which students could learn skills and practice on lifelike manikins ("Mrs. Chase") and even on each other in a simulated hospital ward. As often as was practical, their ability to carry out procedures was tested before they were allowed to do them on patients.

The sixties brought a new approach to nursing education, as to many other disciplines, that can be summed up in this question: Why practice on dummies when we have all those real live patients out there? Mrs. Chase was packed away; out went the beds and simulated utility rooms. Instructors searched the census list for a patient who could serve as a demonstration model for ten intense students, who then practiced what their instructors hoped they had learned on other captive

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patients. Students expended considerable energy in trying to prevent the patient from knowing that it was a trial run. Those of us who preferred some rehearsal for action were outnumbered by the new thinkers; and who would want to be called rigid or inflexible for liking the old way better?

The seventies have brought a merciful reversal of this situation. The fact that so many schools are in competition for laboratory facilities has forced faculty to find better ways of using clinical time. Mrs. Chase is back, with many more simulated parts and functions. Students learn and practice skills in audiovisual labs until they are ready to use them in the clinical area. The patient's right to protection from the inexperienced student is recognized, as is the student's right to be awkward at first in private.[4]

There are, however, some educators who deprecate technical skill acquisition by baccalaureate students. They see the professional nurse as the thinker and the planner for health care, while the two- and three-year nurses carry out the technical details. Nursing educators in general place less emphasis on skill acquisition than nursing service personnel would like, with the result that the new graduate consumes a tremendous amount of energy in skill mastery on her first job. This absorbing concern impedes her efforts to learn how to function in the system.

It is essential that faculty who want to implement the essential elements of the laboratory concept arrive at some working consensus about how important it is for students to acquire skills and how competent they are expected to be while in the program. Another major decision to be made is whether to grade the student, and if so, how.

CHECKLISTS AND RATING SCALES

Some kind of judgment about competency has been evident since the earliest days of the nurse-training system. A look as far back as 1900 shows that Nutting described how students learned district (public health) nursing in a school for nurses in Waltham, Massachusetts, as follows:

> After the probationer has *satisfied her teachers of her ability to do well* [italics mine] the nursing service required at one place, she makes the visit by herself on the following days until the patient recovers or until another probationer is taken there to be taught, and she is transferred to a more difficult case.[5]

Later, Gilman introduced the "Students' Efficiency Record." It was designed to be an improvement over a "Nurse's Record Card" that was filled out by the head nurse after a student had been on her ward, and was sent to the training school office to be transferred to a master card. Its contents were never shared with the student, who often did not find out until her third year what her weak areas were. The new record consisted of two facing pages with a list of procedures (such as preparation of mustard pastes) that the student might do on one side, and on the other a list of personality traits and "professional fitness" characteristics with descriptive adjectives to be checked—for instance:
Industrious——very, moderately, indolent
Neatness of person——marked, moderate, slovenly.[6]

As nurses entered universities for advanced study in education and administration in the early thirties and were expected to write theses and do beginning research projects, the problem of "rating ward practice" was discovered and became the subject of many surveys and studies. One scale devised during this time for the most common daily procedures subdivided each procedure into steps, with point values for various actions.

For example, under "lifting naked babe when bathing," a student who lifted correctly received 20 points, but lifting the babe by the neck was worth only five points, and a student who lifted it "by one arm only" received none. To add statistical sophistication, three raters were to observe the same student "with consideration for the reaction of the student who did not know the purpose of the special attention," and a reliability coefficient of .89 was calculated for the tool.[7] In the late 30's attention shifted from such careful observation and weighting of scores to the student's "adjustment." Evaluation was seen as a way of giving the student more effective "educational, professional, and personal guidance toward increased adjustment."[3]

The problem of grading became less important during the war years, but when the two-and-a-half-year Cadet Nurse Corps Program turned out to be feasible, nursing educators began to think about how time in the clinical area could best be spent:

> Certainly the accelerated programs have brought to our attention the folly of continued performance of tasks beyond the point where they have educational value. No time should be wasted in needless repetition when there is so much material to be learned in such a short time.[9]

The de-emphasis on repetitiously learned skills and mechanically perfect performance originates with statements such as these. Anecdotal records, for instance, replaced the efficiency record rating at Duke University, but a follow-up study in 1950 reported considerable difficulty in their use. Head nurses and supervisors regarded writing them as a chore, so they were not written frequently enough. They were largely interpre-

tation of behavior rather than being an objective recording, and unsatisfactory behavior was more frequently reported than satisfactory progress. More was written about the amount of work students did than about their relationships with patients, understanding of problems, or ability to teach.[12]

The concept of normative rating was implicit in Jamison's rating scale, designed in 1950. Students were rated in six categories as unsatisfactory to superior "compared with others." The question, "In what ways do her manner and stability fit her to be a head nurse?" applied only to seniors.[11] Apparently this career choice still represented a pinnacle to which the best students were expected to aspire.

In the sixties, three widely publicized studies became the impetus for revision of evaluation procedures. The purpose of Palmer's study was "to determine whether a rating device based on the objectives of clinical practice would provide a reliable and valid method of determining a grade."[12] She reported a high degree of success and satisfaction with her tool, but still felt there were limitations—among them, instructor bias and subjectivity and the raters' variable experience with supervision. Nevertheless, the rating scale found wide acceptance and use.

Palmer therefore experimented further to determine the degree of accuracy with which students could use this device to determine their own grades. She hoped that increased self-understanding and self-assessment on the part of students would result in better perception of the needs of patients. Futhermore, students who were unsuited for nursing might come to this realization themselves and shift to another field voluntarily, and gifted students might recognize their talents early and feel obliged to nurture them. Self-evaluation would also contribute toward the development of emotional maturity in the student. Last, but hardly least, it would save faculty time—a necessary claim for any new method of doing anything.[13]

Correlation of instructor rating with student self-rating in two classes over a two year period ranged from .81 to .91; Palmer concluded that this method of determining grades was both valid and reliable. Student and instructor questionnaires indicated high satisfaction with this process. Even the poorer students were satisfied, and several recognized that they needed to make a different career choice. Unlike Infante, Palmer saw the doing aspects of care as the central activity of the clinical laboratory, and weighted these as 46 percent of the total grade.[14]

During the same period—the early sixties—that Palmer focused on baccalaureate education, Rines interviewed instructors in eight junior and community colleges in order to develop a program for evaluation that would be based upon the way in which students learn. Although the objectives of the clinical laboratory in the two-year program are necessarily different from those in the four-year program because of the different terminal behaviors expected of graduates, her findings were widely quoted and utilized in all types of programs.

Rines believed evaluation should be based upon objectives of the program and upon observed behavior, without mixing fact and opinion. She recommended that anecdotal records, checklists, rating scales, student self-evaluations, and patient observations all be used to give a complete picture of the student's behavior, as long as they were not used to compare the student's performance to that expected of a graduate nurse. Rines' emphasis upon the student as a learner rather than as a performer is consistent with Infante's attitude toward the laboratory as a place to learn rather than to perform. Rines introduced the idea that "the only justifiable units for measuring student behavior while learning the practice of nursing are the units "satisfactory" and "unsatisfactory."[15]

CRITICAL INCIDENTS

The critical incident technique developed by John Flanagan in the Aviation Psychology Program during World War II was adapted for nursing by Gosnell and Fivors, who collected over two thousand descriptions of effective and ineffective behavior and classified them into twelve areas. Clinical instructors were consciously to direct their observations toward these twelve categories and to record incidents observed on individual pieces of paper; supervisors, head nurses, and anyone else who happened to observe the student could also write reports. The authors attempted to develop a task taxonomy of nursing functions to "establish the kinds of components or skills involved in each task," and to describe levels of tasks from the simple to the complex. No task was excluded; if it existed, it could be described. The category entitled "Comforts patient," for instance, comprises eleven separate activities, including "Reassures patient that his choice of physician is a good one."[16]

A final evaluation form developed by these authors consisted of a large double spread folder printed in blue for recording effective incidents (Behaviors to be Encouraged) and in red for notations of ineffective incidents (Behaviors Needing Improvement). Twelve areas of behavior, some with five subdivisions, were described. Many examples of both kinds of behaviors

were given, but the problem of how or whether to grade this wealth of data was not discussed. Many people regarded the critical incident technique as the final solution to the evaluation dilemma, but many more considered it a time-consuming, laborious, and even ridiculous way to measure learning, and its popularity was short-lived.

My first experience in teaching nursing was in a school that had adopted the critical incident technique. In the orientation to my job as evening instructor for all students assigned to the 4-12 shift in a large university hospital, I was shown how to write nonjudgmental anecdotes or behavioral descriptions of what I observed students doing as I made my rounds. Incidents were to be recorded on cards and placed in a file box for that purpose on the head nurse's desk. Anyone who observed a student was welcome to contribute to the file.

I found this one of the more pleasurable aspects of my job, and dutifully filled the file box with vivid descriptions of various critical (and amusing) incidents of the sort that are bound to occur on busy floors with too many patients and too little help. After a few weeks I noticed that I was having increased difficulty in locating the students when I arrived on the floor; they seemed to be at supper no matter what time I came. I also noticed that almost all the incidents in the file boxes were mine, and that those few written by other instructors were bland, at best.

Finally, one of the daytime instructors, who had actually helped orient me to the procedure, made a point of complimenting me on what excellent anecdotes I was writing. When she mentioned how much everyone was enjoying reading them, the pieces fell into place and I realized that she was giving me the benefit of what Kramer calls "back-region socialization." I restrained my literary impulses for the duration of my employment, but my distaste for the critical incident method has never lessened.

Heslin described the necessity of having clear criteria for evaluation, but she was not clear about whether she was talking about evaluating graduates or students. Her references to both imply that the same procedure could be used for both, an excellent example of the confusion about this issue.[17]

Clissold and Metz followed Mager's lead by attempting to devise their own taxonomy of nursing actions. They believed that

> . . . it is time for the nurse to discard her attitude that professional tasks possess ethereal qualities and realize that her oft-repeated statement, "there are some intangible aspects of nursing that just cannot be evaluated," reveals only her inability to explain what she is doing.[18]

"The skills controversy has appeared as a constant thread in nursing education. . . . It is essential that faculty arrive at some working consensus about how important it is for students to acquire skills and how competent they are expected to be while in the program. Another major decision is whether to grade the student, and if so, how."

Anderson and Saxon further refined this process by devising check lists for recording observable behaviors, with the successful performance and the failing performance for each procedure described. For example, "moving the patient from supine to side-lying position" was described in 17 steps, including number 13: "Go to other side of bed."[19] The idea of breaking every nursing procedure into every possible observable step is mind-boggling.

Simulated clinical experiences for the purpose of evaluation have been used by several programs. Freilach and Corcoran described how they test skills in the college laboratory by using a multimedia approach: slides, films, tapes, manikins, and role playing. In the testing situation the student is given a card with written instructions for what she is to do and how much time she has—for example:

> While you are caring for Mrs. Abrams, she suddenly becomes dyspneic, restless, apprehensive, and cyanotic. You have decided to administer oxygen by mask immediately. Please do as you would do in the actual situation. You will also be evaluated on your communication skills. A timer will ring at the end of two minutes. Another student will play the role of Mrs. Abrams.[20]

As the student follows the instructions on the card, she is evaluated according to previously established criteria for the item. This seems to me to be an excellent method of testing skills. Variables can be controlled, and no patient's safety is at stake. With a large class this could be time consuming, but there would also be more faculty both to do the testing and, presumably, to supply the creativity to set up the situations.

Barritt and Irion developed Rines' earlier suggestion that only pass-fail grades be given for clinical laboratory experience; they were in favor of the honors-satisfactory-unsatisfactory grading system for all courses in the university. They believed that "even the best-defined behavioral objective is dependent on the perception of the interpreter," and that the nongrading system would

"destroy the myth that one can justify and differentiate between letter grades in terms of behavior."[21]

They admitted, however, that the lack of grades might pose a problem for students seeking admission to graduate school, since their poll of graduate programs resulted in a majority of unfavorable responses. One dean said, "Faculties who sit on admissions committees are about as grade-oriented as students." The authors suggested that an anecdotal record might accompany each student's transcript. They apparently did not regard the prospect of having an admissions committee read detailed descriptions of one's behavioral ups and downs as more threatening than having them see a simple letter grade or grade point average.

The question of normative- versus criterion-referenced evaluation has been explored by Bower and Krumme. Bower's faculty decided on normative grading for three theory and two skills courses so that they could measure their curriculum by correlating the results with the National League for Nursing achievement tests and the State Board examinations for licensure, which are all normed. The faculty used criterion methods for courses involving research, interpersonal relations, and group dynamics, and for the four clinical practicum courses. Pass-fail grading is used in evaluating students' performance in the practicum, and letter grades for all other courses. Bower feels that the criterion method of evaluation encourages the student to be responsible and accountable, removes competition and isolation, and promotes cooperative goal achievement.[22]

NORMS VS. CRITERIA

Krumme made a strong case for criterion-referenced measurement of nursing performance because "norm-referenced tools fail to provide adequate measurement of the quality of nursing care." She considers A,B,C grading to be normative measurement, which certainly need not be so. Krumme examines a number of evaluation tools, including the Slater Nursing Competencies Rating Scale and the Wandelt Quality Patient Care Scale, which require the rater to compare a nurse's performance with an ideal model "without defining the behaviors which constitute such an ideal or the deviations from it."

Krumme then discusses patient care audit methods devised by the Joint Commission on Accreditation of Hospitals, and further adds to the confusion about what we are evaluating students in the clinical area *for:* learning or worker activity.[23] Other writers have differed sharply from Krumme on the subject of criterion-referenced evaluation, maintaining that "criterion referenced measurement is a delusion, because all meaning comes from relative assessments: performance cannot be interpreted unless a person has some idea what the score values should be."[24]

Madden, a feminist, sees the clinical area (and, in fact, the whole nursing curriculum) as an opportunity for consciousness raising. Faculty can reinforce feminist concepts by treating students as colleagues rather than as subordinates. They "must let students make their own decisions in the clinical area to a point just barely short of disaster." If the course objectives reflect feminist concerns, evaluation will then include independent judgment, leadership skills, and self-confidence. Reinforcement of strengths rather than pointing out weaknesses should be emphasized. Self-evaluation in cooperation with faculty evaluation is preferred because "women generally have not had—and therefore need—the experience of evaluating and valuing their own work, rather than relying on the approval of others."[25]

The ultimate in evaluation efficiency has been suggested by Watkins, whose faculty compiled a master list of 933 nursing student behaviors, with accompanying prescriptions for improving performance. Each faculty member received a loose-leaf notebook with the behaviors, prescriptions, and their key numbers. Students received lists of expected behaviors for each term. After these had been digested by a computer, instructors only had to fill in the key numbers of the behaviors that they believed a student had displayed, plus the number of the appropriate remedial action, and send the form to data processing. The student received the printout, and the school saved an estimated $4500-6000 a year in faculty salary time.[26] What the faculty did with the time or the school with the money is not clear, but this is one place where folding, spindling, or mutilating could be disastrous.

The concept of evaluation has been examined extensively in nursing, as in other areas of education. Jane Kennedy, who later became an anti-war activist, saw evaluation used in nursing as a restrictive and punitive instrument rather than as part of a growth process in which the nurse or student can "set her own goals, in her own way, toward her utmost limits."[27]

Heinemann cautioned against allowing students to develop role conflicts by evaluating them according to practitioner expectations. She felt that they expend a tremendous amount of energy in trying to deal with unrealistic expectations that instructors have of them and which they set for themselves.[28]

Gilbert Sax defines evaluation as a "process through which a value judgment or decision is made from a variety of observations and from the background and training of evaluator."[29] Kelly makes this clear distinc-

tion between measurement, which entails using rating scales and other instruments, and evaluation, which always includes value judgments. She feels that we would all be less frustrated and more honest if we would admit that evaluation is both intuitive and subjective.[30]

A lively discussion of the serendipitous aspects of learning was touched off by Styles, who admitted that for some time she had a "nagging feeling" that education's intense pursuit of behavioral objectives in its efforts to "legitimize itself as a learned discipline" was causing us to neglect more important aspects of learning. She offered two alternatives to "precise goal-directed instruction": (1) the development of the learner's self-concept and (2) the fostering of the experimental way of life.[33]

Styles supports both these concepts with quotations from Combs and Snygg and from Randolph Bourne and, as she points out, David Harman translated them into televisionese when he explained his role as Lucas Tanner:

> The role of the teacher is to get a person excited about himself and what he can do. You've got to give the kid the enthusiasm to attack life, to dive in and try things, even if he blows it.[32]

The idea of allowing nursing students to blow anything in the clinical laboratory might be accepted by Madden and Infante, but by very few others in this age of litigation.

A recent editorial in *Nursing Outlook* strongly supports the idea that nursing is more than the sum of its parts. In a plea for recognition of the important intangibles of practice, it asks, "How can one measure 'to be there'? Quantify a presence? Calibrate compassion? Are any of these qualities less significant because they can't be broken down into discrete, sequential behaviors?"[33] Evaluation, then, is making a subjective judgment about the meaningfulness of the whole, both from the parts that are measurable, and from those that must be assessed intuitively.

CONCLUSION

My search for a definitive prescription for evaluation has come to an end, and I have not found it. It would be presumptuous to say that therefore it cannot be found. What I have gained from the search are the following conclusions, which I feel I can defend as parts of a workable framework for a solution to the evaluation problem.

- The clinical laboratory remains an important, indispensable aspect of the nursing curriculum. Nursing is a practice discipline, and the criterion for the validity of any nursing theory is its eventual applicability to that practice, which can only be determined in the real situation.
- Nursing has a unique function in health care and has sufficient respectability in academia to originate, test, and validate its own educational process. It is unnecessary and unwise to continually judge ourselves by, and attempt to emulate the practices of, other service professions.
- Demonstration and practice of skills and evaluation of their mastery should take place under the controlled conditions of the college laboratory. With all the technological aids that are available, there is no excuse or necessity for a professional nurse to be less adept at nursing skills than one who has had a fraction of her education.
- The student should be given less responsibility for actual patient care and more responsibility for finding and utilizing learning opportunities. Instructors should be aware of the laboratory versus the worker concept when accompanying students to the clinical area. The mere presence of an instructor does not assure a learning experience for the student; if she merely chooses the student's patient and then proceeds to evaluate the student's "performance" against a worker concept, her presence has been ineffective in guiding learning.
- Use of the word "performance" in describing what the student does in the laboratory should be discontinued. Laboratory practice, laboratory learning, or some more suitable term should be substituted while the student is mastering the "feat" that she will exhibit in the future.
- There is no valid or reliable method of grading students in the clinical area in baccalaureate education. With the laboratory or even the mixed learner-worker concept, pass-fail is adequate. Criteria for this distinction are fairly easily determined. Kolstoe is probably accurate in his conclusion that whatever grading scheme you choose, it is probably bad, and that the best course is "to select whatever grading system is least in line with what your colleagues use. That way, you emerge as creative, and that is a characteristic highly prized by students and faculty alike."[34]
- The clinical laboratory experience in a "second step" baccalaureate program must be different from that of basic programs. Second step, upper division, or "retread" programs for registered nurses who are already graduates of diploma or associate degree programs and who have been licensed to practice, often for many years, are designed to bridge the gap between the technical and the professional roles in nursing. The

essence of these programs is not an accumulation of credits or greater facility with more complicated machinery, but a widening of perspective, a synthesis of knowledge from many fields and its application to health care, and above all, a behavior change. The laboratory is the community, and the focus is on health and all its facets.

The anxiety generated by this change is tremendous; opportunity for the student to assume the new role, test new theoretical frameworks, and prove their value to herself must be provided in order for this energy to be channeled in a useful direction. As the complexity of the role increases, specific behavioral objectives become less important; the student has learned a new way of thinking, and behavior change follows.

The Carnegie Commission saw higher education in the United States as standing midway on the continuum from "faithful reproduction of society as it exists to the attempted production of a totally new form of society." They recommended that both faculty members and students share in evaluating society for the purpose of self-renewal.[35].

Nursing has a special part to play in that mission: evaluation of the quality of health care available to all people. Students in baccalaureate programs need to be socialized into the role of "Bicultural Troublemakers"—persons with high enough professional orientation to know what changes should be made, and high enough respect for the system to stay within it long enough to effect them.[36] The clinical laboratory is the ideal place for this synthesis to occur, but true evaluation of its effectiveness is a lifelong process. ■

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STATE OF MINNESOTA

COUNTY OF HENNEPIN

RECEIVED
JAN 5 1983
ADMINISTRATIVE HEARINGS

BEFORE THE MINNESOTA BOARD OF NURSING

In the Matter of Proposed Repeals of Current Rules (7 MCAR §§ 5.1050-5.1101 and 5.2040-5.2091) and Adoption of New Rules (7 MCAR §§ 5.3000-5.3021) Regarding Practical and Professional Nursing Program Approval

SUPPLEMENTAL STATEMENT OF EVIDENCE

Introduction

The purpose of this document is to supply evidence in response to the oral testimony presented at the hearing on the proposed rules and to the written comments received to date. Clarification is also offered wherever questions have been raised which indicate a need for further information about a rule.

The testimony has been helpful in identifying language in the rules that can be made clearer without substantive change. The proposed language changes are identified in the sections regarding proposed rules §§ 5.3000 Definitions and 5.3018 Additional professional nursing abilities. Three other modifications which are needed in the proposed rules are also described in the sections regarding proposed rules §§ 5.3007 Rule compliance survey, 5.3011 Advanced standing and 5.3012 Faculty.

The following summary is offered for better understanding before beginning the rule-by-rule discussion. There are only two main issues at dispute.

The first issue is the appropriate level of clinical expertise for graduates of all programs which the Board should require. The suggestions offered would cause the Board to go beyond the purpose of approval. The intent of these rules is to set a standard for judging whether a program

merits authorization to prepare students to meet the nursing education requirement for licensure in Minnesota. These proposed rules address the clinical abilities of graduates much more directly than do the current rules. For the first time, program approval rules will specify the behaviors expected of new graduates. To make the rules more complex or even more specific at this point would be counter-productive to the Board's aim of effective and yet not burdensome rules.

The second issue is the appropriateness of certain categories of professional nursing practice for graduates of associate degree and hospital diploma programs. There is agreement that all of the categories proposed are appropriate for baccalaureate programs. Despite others' charges, response from diploma program faculties has indicated support of all of the abilities for their graduating students. The only remaining dispute then is of the appropriateness of some of the professional categories and some of the abilities listed in proposed rule § 5.3018 for graduating students of associate degree programs.

The necessity of applying the same categories and abilities to all professional programs may be more easily understood if it is recalled that the Board issues only one professional license. While the Board recognizes three different kinds of professional programs exist, associate degree, diploma and baccalaureate degree, all three kinds prepare graduating students to achieve the same goal. That goal is professional licensure. This license is issued as an indication that the licensee is qualified to provide essential professional-level care to patients, regardless of the kind of professional program from which the licensee graduated.

From this background it should be more readily acknowledged that all professional nurses should have the same essential abilities in the same

categories of professional practice. There is no statutory authority for the Board to issue different professional licenses based on different educational backgrounds. There is no precedent for the Board to hold different approval requirements for various professional programs. The current rules, and all previous approval rules, have required the same curriculum topics and clinical experience for all professional programs.

Therefore, due to this unitary nature of the professional license, evidence is presented in this document regarding the appropriateness of the categories of professional practice in proposed rule 7 MCAR § 5.3018. This evidence shows that all of the categories and abilities are already being addressed in all professional programs. The proposed rules incorporate minimal requirements the Board deems essential to preparing a graduating student to practice professional nursing. These proposed rules do not preclude some professional programs from addressing the categories of professional practice more extensively than other programs. The Board is required to adopt rules which reflect the provisions of the law. On this issue, the provisions of the law are clear and unmistakeable.

Rule-by-Rule Discussion.

7 MCAR § 5.3000 Definitions.

New G. Clinical setting.

Struck (oral testimony) has brought to the Board's attention that a definition for "clinical setting" is needed to prevent clinical learning and evaluative activities taking place in classroom laboratories. The Program Rule Replacement Advisory Task Force's working definition, which was included in the Statement of Need and Reasonableness, should be inserted in the proposed rules after subsection F. as follows:

New G. Clinical setting. "Clinical setting" means any place where patients or nurses are available.

(Reletter subsequent definitions through L.)

No opposition to the inclusion of this definition was voiced during the hearing. The use of this definition was always the intent of the Board. The definition has been included in previous drafts and received no negative comments. Providing this familiar definition for uniform understanding does not appear to fall under the criteria found in 9 MCAR § 2.111.

Old H. Counseling.

Menikheim (oral testimony) suggested "or family" be stricken from this definition. The Board holds that the definition for "counseling" should continue to specify "patient or family", as this alternative will assure that students being evaluated for the nursing ability specified in proposed rule § 5,3018 D.2. will be able to demonstrate the ability of assisting a patient to independence. For example, if a patient's family is encouraging the dependence of the patient, the student may be able to assist that patient to be more independent by deliberating with the family. The definition does not

mean that the family must be included in evaluation of a student's counseling ability.

Since the professional practice definition in Minn. Stat. § 148.171 (3) specifies assessment of individuals, families or communities, it is reasonable to assume that professional nurses can provide care such as counseling, as defined for the purpose of these rules, to families as well as individuals. Students graduating from a professional program, whether the program leads to an associate degree, diploma or baccalaureate degree, will, once licensed as registered nurses, be authorized to do such counseling. This definition is needed to facilitate evaluation of a student's rudimentary counseling ability.

Mathiowetz (written testimony for Minneapolis Community College) suggested separate definitions for health teaching and counseling. The Board followed the Revisor's suggestion that the proposed definition for teaching be deleted, as a common dictionary definition of teaching was in keeping with the intent of proposed rule § 5.3018 D.1. The definition for counseling must be retained for the reasons just given, and for the reasons stated in the Statement of Need and Reasonableness.

M. Nursing care.

Hazzard (written testimony for North Hennepin Community College) and Menikheim (oral testimony) objected to the definition of nursing care. The substitute definition pertains to nursing, not nursing care and so would be inappropriate. The Board's study of the use of the term in proposed rules §§ 5.3017 D. and E. and 5.3018 C. indicates that what is meant is simply the care provided by nurses. Since that meaning is self evident, the Board wishes to strike this proposed definition as follows:

~~M. Nursing care. "Nursing care means responding to the needs of patients and performing personal~~

~~services for and with patients.~~

O. Nursing personnel.

Menikheim recommended "and assistants" be struck from this definition. The Board holds that the definition for "nursing personnel" must continue to mean "nurses and nursing assistants" in order to facilitate the evaluation of students for the abilities listed in proposed rule § 5.3018 F., G., and H. To accomplish the purpose of these rules, it is necessary to assure students will be able to demonstrate their ability to delegate, supervise and teach the assistants of nurses as well as nurses. Restricting the definition to only nurses would mean that students when evaluated for the ability, for example, to teach nursing personnel, would have to teach nurses whom it would be safe in assuming, know more than the student.

Henry (written testimony for Professional and Technical Health Care Union) questions the inclusion of nursing assistants in this definition. It is true that nursing assistants are sometimes called nurse aides and the Board has no jurisdiction with regard to this category of nursing personnel. Nevertheless, given the circumscribed purposes of these rules it is necessary to retain nursing assistants in this definition for the reasons cited above.

S. Professional program.

Menikheim (oral testimony) recommended striking or changing this definition. The Board holds that professional program and its definition are appropriate as stated in the proposed rules, given Minn. Stat. § 148.171 (2), (3), and § 148.211 subdivision 1. It is not legally possible for the Board to limit this term to only baccalaureate programs, when associate degree and hospital diploma programs also prepare graduates to be licensed as professional nurses. It is not possible to eliminate this definition given

that proposed rules §§ 5.3012, 5.3014, and 5.3020 include different requirements for practical and professional programs.

There simply is no legislative authorization for the Board to categorize nursing programs and establish different, and presumably discriminatory, statuses for educational programs. To do so would not only classify programs according to different statuses, but imply that registered nurses graduating from one type of program and licensed by the Board are somehow wider or narrower than that authorized in Minn. Stat. § 148.171 (3).

7 MCAR § 5.3002 Scope of rules and temporary exemptions.

C. Temporary exemption.

Morrison (written testimony for Rochester Community College), Hazzard (oral and written testimony of December 16, 1982 and January 3, 1983 for North Hennepin Community College), Tracy (written testimony for St. Mary's Junior College), and Bergstrom (written testimony for Minnesota Community College System) have requested that implementation of these proposed rules not be required for three to four years. Only associate degree program faculties have indicated a need for more than two years to prepare to implement these rules. The need for additional time is based on their interpretation of certain categories of professional practice in proposed rule § 5.3018. The discussion of those categories in this document shows that there is little additional work that will have to be done by associate degree faculties to meet the requirements regarding the professional categories. Therefore, a longer exemption is not warranted.

Two years is ample time to prepare the evaluation predeterminations that are not now in existence. This work could be done even more quickly, if done as a joint effort by groups of faculties. Any individual curriculum revision necessary would not have to be extensive; that fact is documented in subsequent sections regarding the professional nursing categories in proposed rule § 5.3018. This is not to say that a faculty could not use more than two years to prepare for implementation. However, such lengthy deliberations should not be countenanced in view of the data collected January 19, 1978 regarding what new graduates should know and be able to do. See documents submitted pursuant to 9 MCAR § 2.105.

Without an imminent deadline, such as that proposed, faculties may agonize needlessly over implementation. The following quote regarding the

development of performance examinations designed to determine the awarding of external associate degrees in nursing describes what the July 1, 1985 deadline is designed to prevent.

> The searching for perfection can be carried to extremes and can delay the actual implementation of the examination. Much will be learned from the first actual administration. A balance has to be achieved between moving ahead before the test and persons involved are ready, and resisting implementation because unanticipated problems might emerge.
>
> In actuality, this process may be symptomatic of the "avoidance phenomenon", reflecting to some degree the committee's resistance to putting their work on the line. Rather than concern with aspects of the test, such behavior could be an indication of anxiety regarding whether or not the test really works, and whether or not it will be well received by colleagues. The fear of failure may be conscious or unconscious, and may or may not be well founded; nonetheless, it is real and must be recognized and resolved in as logical a manner as possible.[1]

The proposed July 1, 1985 deadline is a logical way to get faculties started on full implementation of the legal practice definitions which were enacted in 1971 for practical nursing and in 1974 for professional nursing.

7 MCAR § 5.3007 Rule compliance survey.

B. Survey notice.

Toddie (written testimony for St. Mary's Hospital School of Nursing) and Sowell (oral and written testimony for all practical program directors) suggested that the notice of time allowed for supplying information regarding compliance with rules be mutually agreed upon with the program director. It should be understood that mutual agreement regarding the date of expiration of a correction order is provided for through the Board review panel in subsection C. entitled Board action. However, a survey is done to establish whether a correction order is warranted and notice of that survey must give each program the same length of time for supplying each particular type of evidence by each of the possible routes. Permitting each program director a voice in when to submit the evidence of compliance with rules could result in unequal treatment of programs. This practice could also result in a program having enough time to create evidence which would indicate compliance which did not in fact exist at the time of the survey began.

Concern that the director may not be available to supply information when notified by the Board to do so has been taken care of by proposed rule § 5.3006 B. This rule notifies directors that a request to demonstrate compliance with rules may be received at any time. § 5.3006 B. alerts directors to arrange for the handling of such a request in their absence.

C. Board action.

It has come to the Board's attention through the Hearing Examiner that the Minnesota Administrative Procedure Act is being reassigned to a different chapter of Minnesota Statutes. Therefore in the two places where the Minnesota Administrative Procedure Act is referenced in subpart 2., the citation in the specific Minnesota Statute will be struck.

7 MCAR § 5.3011 Advanced standing.

There is a correction on page 36 of the Statement of Need and Reasonableness which should be noted. At the bottom of Table 1 all Minnesota hospital diploma programs graduated ten licensed practical nurses which constituted five (not one) percent of the total graduates. All Minnesota baccalaureate degree programs graduated eight licensed practical nurses which constituted one (not five) percent of all baccalaureate graduates. The last two numbers in the percentage column were inadvertently transposed.

It was recommended by Rowe (oral and written testimony) and Churchill (written testimony for St. Luke's Hospital School of Nursing) that this rule be broadened to include all professional programs. It must be remembered that Minnesota Statute § 148.251 Subd. 4 only identifies the professional programs leading to an associate degree. The rule as proposed does not restrict other professional programs from providing advanced standing opportunities to licensed practical nurses or other students. Broadening the proposed rule would be a substantive change which cannot be done in this proceeding. This is an issue which can best be resolved by the Board in the future.

A. Advanced standing.

Bergstrom (written testimony for Minnesota Community College System) suggests that the language in proposed rule be changed from "The faculty... shall allow a qualified licensed practical nurse to gain advanced standing" to "shall maintain a program design which shall make it possible for..." This proposal must be denied for the following reasons.

First, the suggested language change would weaken the implementation of Minnesota Statute § 148.251 Subd. 4. The different connotations in "making obtaining of advanced standing possible" rather than "allowing advanced standing

to be gained" subtly shifts more of the burden from the program to the licensed practical nurse. The faculty's decision making power as to who is qualified to receive how much advanced standing is clearly protected by the Board's proposed rule.

Secondly, the language change suggested by Bergstrom would unnecssarily involve the Board in program design. The Board only wants to see the desired goal is reached and does not have to be involved in how it is reached. The proposed rule is written so the program does not necessarily have to be specially designed. The proposed rule is clear and will accomplish the same end in a cost effective manner. The proposed rule can be applied evenly to private and public programs.

Bergstrom (written testimony for Minnesota Community College System) is concerned that requiring the faculty to grant advanced standing before the first nursing course is begun will mean that the faculty will also be expected at that time to name specific nursing course exemption. The proposed rule clearly calls for granting advanced standing which is defined in § 5.3000 B. as credit and does not call for specifying nursing courses.

Flickinger (written testimony for Rochester Community College) asks that a program be permitted to allow a qualified licensed practical nurse to gain recognition for 1/3 of the nursing courses rather than 1/3 of the credits. Flickinger goes on to describe how the credits vary in number for the various nursing courses. It is precisely because of this variance in number and credit value of courses within each college, and between colleges that the Board has defined advanced standing in proposed rule § 5.3000 B. to mean credit. It is only through the focus on credits rather than courses that the Board can treat programs equally in this matter. It is also only through credits that the Board can assure that licensed practical nurses will be

equatably treated in each associate degree program.

The focus on credit gives faculties flexibility in curriculum design. The particular problem cited at Rochester Community College by Flickinger could be resolved in several ways without changing the proposed rule. For example, an auto-tutorial package could be prepared which would provide licensed practical nurses with learning content regarding some aspects of the role of the professional nurse. The content included and work required could be designed to be worth the amount of credit needed to move the licensed practical nurse with full advanced standing into the next appropriate nursing course. Such an auto-tutorial package would also meet the requirements in section C. entitled Transition.

B. Determining advanced standing.

The following is in response to the inquiry by Henry (oral and written testimony for Professional and Technical Health Care Union) regarding whether or not provision for evaluating a licensed practical nurse's knowledge and skill which is permitted under subpart 3 will enable faculties to evaluate a licensed practical nurse's experience. This method of determining advanced standing is in keeping with Minnesota Statutes § 148.251 Subd. 4 which requires that advanced standing shall be provided in recognition of "nursing education and experience" (emphasis added). Testing will provide the licensed practical nurse with a way of establishing both knowledge and skill gained by virtue of both nursing education and experience.

In view of this testimony, and since subpart 4 does not accommodate experimental learning, the following addition is proposed so subpart 1 reads as follows:

1. review of a licensed practical nurse's previous education as reported on a

transcript or similar document and, if desired, review of records of previous nursing experience.

Similiar language was a part of previous rule drafts which were reviewed by associate degree faculties and would not be a substantive change. The language was not included because no faculty was conducting such a review nor expressed an interest in the review of nursing experience. However, the Board did not intend to prevent such review from being possible. It appears, according to the criteria of 9 MCAR § 2.111, that this addition to the proposed rule would not be a substantial change.

D. Completion.

Henry (oral testimony) asked that this requirement accommodate completion in a reasonable length of time by licensed practical nurses who are part-time students. In dealing with the length of time needed to complete a program, faculties set provisions with the "regular or average student" in mind. Therefore, the Board is using full-time students as the standard in this rule. Provision will have to be made for full-time licensed practical nurses with full advanced standing to complete in a reasonable length of time (that for similar average students), and part-time licensed practical nurse students will also have access to those provisions.

C. Transition.

Hazzard (written testimony for North Hennepin Community College) commented that requirement means additional work for an already busy faculty. It is true that the provision of certain types of transitional learning activities may require additional work for the faculty. It should be noted that the examples given in the rule include transitional learning activities which would cause the faculty little or no additional work. For example, the

provision could be for licensed practical nurses to audit classes which include content regarding professional nursing. Auditing would meet this rule and would not require any additional work by the faculty.

E. Reporting.

Struck (oral testimony) has voiced concern about the director being required to provide only an explanation to the Board if no licensed practical nurse was admitted to the program with advanced standing. Requiring the submission of an explanation without provision for the Board to judge the suitability of the explanation is in keeping with the data gathering focus of this subsection of the rule. Since the rule is new, the Board must be kept apprised of all advanced standing granted to licensed practical nurses and if none is granted, why it was not granted. It is only through the gathering of this information that the Board will be able to make decisions in the future about the continued need for this rule.

7 MCAR § 5.3012 Faculty.

A. Responsibility.

Henry (written testimony for Professional and Health Care Union) disagrees that only registered nurses can teach practical nurses. It should be clearly understood that others, including licensed practical nurses with or without additional educational preparation, may assist registered nurse faculty members or teach related subjects.

Having licensed practical nurses as fully responsible faculty members in practical nursing programs has long been an issue. The Program Rule Replacement Task Force included practical nurses as faculty members for practical programs in one draft of rules and received much opposition from practical and professional program faculties. No support for the concept was received. In all subsequent drafts registered nurse licensure has been required and has received full support. This support has included that of the licensed practical nurses who were and are members of the Board.

The reasons why registered nurses must teach nursing are given in the Statement of Need and Reasonableness, see page 48. This need can be better understood by recalling that licensed practical nurses do not have the same educational or work background in decision making regarding the initiation of nursing care of patients as does the registered nurse.

B. Qualifications.

The appropriateness of proposing minimal faculty qualification requirements has been recognized for the most part. Morrison (written testimony for Rochester Community College) and Hazzard (oral and written testimony for North Hennepin Community College) expressed concern about the requirements being "dangerously low". If experience shows that faculties are not adequately qualified to meet the minimum standards in these other proposed rules, the faculty qualifications may be increased.

Manahan (written testimony for Normandale Community College) says that the ten hours required for educational principles and methods of evaluation are unreasonable. In addition to the arguments given on page 49 of the Statement of Need and Reasonableness, it must be understood that most continuing education offerings for nurses and educators include six to nine hours a day. Certainly, two days or less in a lifetime is not an unreasonable amount of preparation. In fact other testimony such as Hazzard (oral and written for North Hennepin Community College) has indicated the opposite.

Henry (written testimony for Professional and Technical Care Union) has asked the meaning of hours. The proposed rule was intended to say clock hours, not credit hours, and that should be added as follows:

> 2. Each registered nurse faculty member must successfully complete at least ten clock hours of educational preparation in principles and methods of evaluation....

Manahan (written testimony for Normandale Community College) suggests the continuing education requirement is not needed as the faculty's skill in evaluation can be determined through the evaluative tools it develops. While that is true, this rule is designed to assist faculties in preparing to develop and implement the evaluations. This requirement is needed to protect the student by preventing development and use of poor evaluation tools.

Consideration has been given to the recommendation from Struck (oral and written testimony for Anoka-Hennepin AVTI) that all faculty members evaluating students in clinical settings be required to have at least three prior years of full-time work experience. The proposed requirements do not restrict faculty members from engaging in activities which would increase

their clinical experience, nor will the proposed rules restrict clinical expertise in faculty members that need such skill. It must be understood that the proposed rules contain the minimum requirements now known to be adequate for the Board's purpose which is only to see that programs prepare graduates who meet the nursing education requirement for licensure.

The Board currently requires minimal work experience for faculty of practical nursing programs in 7 MCAR § 5.2062 A. and B. Now, in view of Struck's testimony, which was supported by Henry (written testimony for Professional and Technical Health Care Union) the Board agrees that this requirement should be retained, not repealed as proposed. Therefore, the following amendment is proposed, and subpart C. 1. would read:

C. ~~Basic education~~. New program requirements. Representatives of a controlling body applying for approval of a program or the director of a program that has not yet had a student complete the program must be able to supply documents showing that each of the registered nurse faculty members meets the additional ~~educational~~ qualification specified as follows:

1. For practical nursing programs, the director must have at least a bachelor's degree of science or arts in a regionally accredited college or university. In addition, the director and all other faculty members must have had one year of experience in direct relation to nursing care during the five years preceding appointment. This experience may include teaching nursing and nursing administration.

Pursuant to 9 MCAR § 2.104 the amendment does not have to be rejustified as it is taken from current rule § 5.2062 A. and B. The issue of similar work experience for faculty members of new professional

programs was not supported by professional programs, see Frank's written testimony(for Inver Hills Community College). In any case, there is no requirement for work experience in current rules for professional programs. This is an issue the Board may address later.

Elioff (written testimony for the Practical Nursing Program-Eveleth Area Vocational Technical Institute) recommends the Board require a 1:8 instructor student ratio for clinical activities. Again, it must be understood that the proposed rules contain the minimum requirements now known to be adequate for the purpose of approval. Many faculties vary the clinical ratio with level of student (for example, 1:6 for beginning students) and with content being applied (for example 1:16 when in caring for patients with emotional problems). It is unreasonable to ask the Board to set this single standard for all programs. This recommendation would be expensive to implement and was not supported by other practical programs.

7 MCAR § 5.3014 Student clinical activities.

B. First program option, and C. Second program option.

It is not necessary to both require, as suggested by Struck (öral and written testimony for Anoka-Hennepin Area Vocational Technical Institute), that students have clinical learnings with specific categories of patients and that students be evaluated for the ability to care for patients in the specific categories. It is true that at the information collection meeting on January 19, 1978 many nursing service administrators indicated that graduating students needed to be able to better perform nursing skills. Having identified that problem, some who testified claimed that the solution was that the Board should require students to have more clinical experience. Henry (current written testimony for Professional and Technical Care Union) supports that solution. However, it must be recognized that clinical experience per se, regardless of quantity, does not quarantee satisfactory performance desired by employers.

Information has been supplied in the Statement of Need and Reasonableness on pages 56 and 57 regarding the fact that students learn at different rates and that what matters is whether the student has learned, not how much time was spent in learning. The Board's goal is that programs graduate students who have the ability to care for various categories of patients, not that students have had a specified amount of experience caring for those patients.

In the same section in the Statement of Need and Reasonableness the Board has explained that while it may be preferable to require evaluations of the students' ability to care for all the necessary catetories of patients, this would prove to be very costly to schools and students. Likewise it could take much time and prolong the entire program. Given the numbers of students involved, the variety of clinical settings used and the current crowding of many settings, as well as the campus and clinical scheduling problems involved, such a requirement would work an undue hardship on programs. Permitting faculties to choose to meet this rule by documenting either that students had clinical learning activities or evaluations will serve the purpose of assuring that students have exposure as a generalist.

Faculties that choose to meet this rule through documentation of evaluations will not need to demonstrate to the Board that the student has had the clinical learning experiences. The evaluations which would meet this rule will have to include evaluative situations with real patients in real clinical settings and the student's performance will be of a "hands-on" nature. Faculties need to have the option of being able to prove evaluations for clinical experience when wanting to exempt educational mobility students from needlessly repeating clinical learnings. The ability to choose which facet of education to document to the Board was supported by Churchill (written testimony for St. Luke's Hospital School of Nursing).

Flickinger (written testimony for Rochester Community College) would like to be able to meet this rule through simulated settings as well as clinical settings. It must be remembered that this rule is merely to assure student exposure as a generalist and does not mean that all student learning and evaluation must occur in clinical settings. The faculty is at liberty to provide either the learning activities or evaluations required in this rule whenever wanted. Initial learning activities may be done in simulation and new learning technologies may be used as long as students have activities in or evaluations of caring for one of the optional categories of patients in clinical settings.

Menikhiem (oral testimony) charges that the categories of patients for generalist exposure are incongruent with the nursing abilities in succeeding rules. This rule and its categories of patients supplement the list of nursing abilities in §§ 5.3017 and 5.3018 to assure patients, employers and new graduates that graduating students have had exposure to caring for the essential categories of patients. As a supplement the categories may not be congruent, but that is not necessary as long as the categories of patients and categories of practice are not incongruent which they are not.

B. First program option.

It has been suggested by Davis, Darley, Wilke, Kern, Styshal (written testimony) that only baccalaureate programs should provide students with learning and evaluative experiences in the community with healthy patients. It should be noted that "healthy patients" is but one of seven categories in one of two options. If a program does elect this option in providing students with exposure as a generalist, healthy patients can be found in hospitals. In the context of this rule healthy simply means "absence of an acute or chronic illness". The example of healthy patients

given in the rule identifies patients in an uncomplicated maternity cycle. Healthy mothers have healthy newborn infants in acute hospital settings and are currently cared for by all students in all practical and professional programs. If a faculty elects to use this option it would not be necessary for the students to go out into the community to have exposure to "healthy patients".

The other example of healthy patients in the rule are those needing teaching. There are many additional categories of nursing practice which would be appropriately applied in the care of healthy patients. Interaction with patients, nursing observation and assessment, psychosocial care, delegated medical treatment, and referral to other health resources are some.

Nurses prepared in baccalaureate programs may work with healthy patients in a different way than do graduates of other programs preparing for licensure. However, this rule does not specify the activities needed to demonstrate the ability to care for this category of patient. The various practical and professional programs may require different levels of activities to meet this rule.

Students in all programs need exposure to healthy patients so students are able to assess when a person's health has deviated from normal. It is necessary for students to have been exposed to a healthy patient to know how to assist other patients to reach optimal function. In order to learn to help patients maintain their health, it is necessary that students be exposed to healthy persons. Such exposure is possible through the selection of this option. If a faculty elects the second program option, exposure to healthy patients will be assured for practical nursing program students by caring for mothers of newborn infants and newborn infants, and for professional program students by caring for mothers and newborn infants in the maternity cycle.

Churchill (written testimony for St. Luke's Hospital School of Nursing) notes the absence of adolescents from the categories of patients. This absence will not prevent faculties who view the adolescent as unique, from providing students with exposure to adolescents. The Board does not need to require that clinical activities or evaluations involving adolescents be provided for all students as long as such exposure is provided with children and adults.

C. Second program option..

The concern was expressed by Hazzard (written testimony for North Hennepin Community College) that practical nursing programs should not include exposure to caring for patients with mental and emotional problems. Experience in caring for patients with mental and emotional problems is required in current rule 7 MCAR § 5.2084 C. and does not have to be re-justified under 9 MCAR § 2.104.

The activities or evaluations in caring for patients with mental and emotional problems would be different from those of caring for patients with mental illnesses which is specified for professional programs only. Most practical nursing programs now provide experience in caring for patients with mental and emotional problems at the time when students are caring for adult medical-surgical patients including geriatric patients. If this option is not selected, practical nursing students will be assured of exposure to caring for patients with mental and emotional problems through the abilities in § 5.3017 E. Psychosocial nursing care.

7 MCAR § 5.3016 Clinical settings.

B. Clinical use authorizations.

Hussa (testimony for St. John's Hospital) recommends the insertion of specific new language which would say that the Board "supports clinical evaluation of faculty members' skillfulness in utilizing said setting for evaluation purposes." It is unclear if Hussa wants such evaluations done by representatives of the faculty or the clinical setting. If the later is the case, the addition of such language would not be advisable, because the Board has jurisdiction over programs, not clinical settings. It is the belief of the Board that it should not hold permissive requirements. Any clinical setting considering authorizing a new or an existing program's use of its resources could make such evaluations a stipulation of use without the Board's involvement.

Hussa (written testimony for St. John's Hospital) also recommends the Board require the program be able to relate activities in the clinical setting to the theory taught by demonstrating a working knowledge of the setting's policies, procedures and philosophy. While there is a somewhat similar provision in current rules 7 MCAR § 5.1101 B.4.b. and § 5.2091 B.4.b. those rules should be repealed for two reasons. Given these proposed rules, the clinical use authorization is of a concern to the Board only as needed to predict that a proposed program will be able to provide students with needed clinical experience. Secondly, the Board will no longer need to facilitate coordination between programs and clinical settings. Such matters can be readily resolved by the parties entering into or renewing clinical use authorization.

C. Beginning affiliation.

Clarification may be needed here due to the response given by a

panel member at the hearing to Hermann's question, "Does a program need prior approval to use a clinical facility for an affiliation?" The answer is simply, yes. The approval is needed when clinical setting representatives will be responsible as defined for affiliation in § 5.3000 B.

Concern has been expressed by Toddie (written testimony for St. Marys Hospital School of Nursing) that subpart 3 of this rule permits an affiliation to be as long as one-half of a two to fifteen week term. It is true that educational terms may vary in length in practical nursing programs from two to fifteen weeks. Having students in an affiliation for half a fifteen week term would be similar in length to half of a semester. While more than half a term could be too long to go without faculty supervision, half a term is reasonable and may be necessary to accomplish the educational goals.

It is inaccurate to conclude that if students had an affiliation twice, each for half of a fifteen week term, they would not be supervised by the faculty for over half of the program. The longest single affiliation permitted by this proposed rule would be seven weeks. Even if a student had the maximum of two affiliations which totaled fifteen weeks, that would not come to half of an entire program. Practical nursing programs in this state range from 36 to 50 weeks in length. It is expected that faculty will use decretion in the amount of time given to any affiliation. In any event, students will be protected by the rules as originally proposed.

Concern was expressed by Hazzard (written testimony for North Hennepin Community College) that this proposed rule may limit innovative teaching approaches such as "co-op education". It is not the intent of this rule to stifle faculty creativity or cooperation between education and nursing service. It is the Board's understanding that if the cooperative education

program offered in Boston were copied here, it would not meet the definition of affiliation and this rule would not apply. The definition of affiliation is such that this rule need only be met when nonfaculty members are going to be totally responsible for (1) determining and (2) guiding students in implementation of clinical learning activities and (3) evaluating nursing abilities of students assigned to the clinical setting in accordance with proposed rules §§ 5.3014 - 5.3021. In the event a faculty does relinquish all three of these responsibilities, it is appropriate and reasonable for the Board to review the arrangements for prior approval. Even though this proposed rule would have to be met, an innovative educational arrangement could take place; the arrangement would just have to meet the Board's requirements.

7 MCAR SS 5.3017 - 5.3021 Evaluation section.

Before addressing these rules individually, several points need to be made about this section of the proposed rules. It will simplify matters to address only once the concepts running throughout these five rules. Testimony related to only one rule will be addressed later in the relevant section.

Hazzard (written testimony for North Hennepin Community College) has expressed "concern over the heavy evaluation model" proposed in these rules. It must be clearly understood that if a faculty determines that the evaluation of a student's abilities require "a lot of 1:1 contact between faculty and student", that requirement has been established solely by the faculty, not the Board. Proposed rules SS 5.3017 - 5.3021 do not specify the method of evaluation, nor a specific ratio for evaluator to student. While a faculty may wish to use a 1:1 ratio of some evaluations this is not required by the proposed rules.

The idea that "the balance between learning and evaluation, present in all programs, will be upset" by the required evaluations in unwarranted. Programs are currently evaluating students' knowledge and skills. The fact that these rules will require the evaluation to become, in some cases, more formalized should not in and of itself cause less emphasis to be put on learning. The reverse would seem to be true. The need to establish possession of specified abilities should assure that learning remains a vital element in programs.

The concerns about cost and effort involved in evaluating students' abilities should be tempered by the freedom faculty

will have to carry out the evaluations. Although only one evaluation must be done in a clinical setting, all of the evaluations may be done there. Selective use of clinical settings for evaluations would reduce the cost of setting up simulations which was cited by Tracy (written testimony for St. Mary's Junior College). Although only one evaluation must involve a combination of categories of nursing practice, all of the evaluations may be done in combination, thereby reducing the cost of numerous evaluations. The faculty has complete control over the specification of the nursing actions that must be taken to demonstrate the required abilities, so the faculty can control cost by controlling the depth and the scope of the evaluations.

The method of evaluation is not stipulated, so cost can be reduced through the evaluative methods selected. The ways that have already been utilized in the evaluation of students' abilities are described in the article by Wooley entitled "The Long and Tortured History of Clinical Evaluation." There is every reason to believe that the evolution of nursing will continue and these rules will not restrict the development of new evaluative methods in any way.

The anxiety engendered in a faculty by evaluation of student performance is also alluded to in the Wooley article. Evaluator anxiety may certainly be responsible for some of the concerns being expressed regarding these rules. The following description makes this anxiety understandable:

> Almost every evaluator experiences some degree of tension and anxiety - before, during, and after a performance examination. This is natural....New evaluators wonder whether they are applying the test correctly, whether they are

> interpreting the critical elements appropriately, or whether they are being too lenient or too strict. They worry about their own potential for actual error in judgment. Early in the process most evaluators also worry about the tests' adequacy to measure the competence of students; hence they worry about the instrument itself as well as their ability to apply it properly...Does it test enough really to document competence in nursing care: If a student passes on this occasion can I be sure they are good nurses?[2]

The concern was expressed by Hazzard (written testimony for North Hennepin Community College) that students would be subjected to increased stress by the required evaluations. No one likes to be evaluated and yet we are all subject to evaluation and the negative stress it causes throughout our school and work life. Even if possible, it probably would not be advisable to eliminate stress from our lives. Reducing distress is, of course, a reasonable goal. The predeterminations required by the proposed rules SS 5.3019 and 5.3021 B. will help students by letting them know exactly what is expected of them. Student distress will also be reduced as these rules will result in formal evaluation and reduce the mixing of educational practice and informal evaluation now occurring in some programs.

Requiring the evaluations in proposed rule S 5.3020 be performed in a specific setting would be too restrictive and unnecessarily intrusive. Faculties are in the best position to determine the setting for and method of evaluating each ability and the amount of situational control needed to adequately evaluate the student's possession of an ability. Requiring that 50 percent of the evaluations occur in clinical settings as suggested by Struck (oral and written testimony for Anoka-Hennepin AVTI) would impose an unreasonable and an unnecessary

burden on faculties who, out of consideration for patients, only use clinical settings when absolutely needed. Faculties are in the best position to determine the setting for and method of evaluating each ability and the amount of situational control needed to evaluate adequately the student's possession of an ability.

While some faculties may choose to evaluate student possession of some abilities in clinical situations, establishing that 50 percent be in clinical settings would not be reasonable given the variety of sound methods available for evaluating. In many evaluations, situational controls, often lacking in a clinical setting, are needed to collect evaluative data adequately and fairly. Verbal support has been received from faculties for the flexibility the proposed rules allow in sites and methods to be used in evaluating the abilities.

One of the conclusions in the Wooley article attached to the Statement of Need and Reasonableness was that evaluation of skills should take place in the classroom laboratory where the conditions can be controlled. Proposed rule S 5.3021 already requires one evaluation be done in a clinical setting and that is sufficient. In this case, more is not necessarily better. To change proposed rule S 5.3020 to make 50 percent of the evaluations occur in clinical settings would interfere with faculties' evaluative practices more than minimally necessary.

One of Struck's comments was that these rules could mean that a student would only have been known to have one day in a clinical setting. If a student is able to demonstrate the

ability to care for all of the categories of patients required in proposed rule S 5.3014 B. or C. and the ability to combine three categories of practice as required in proposed rule S 5.3021 A., there would be no need to require the student to "spend" more time in a clinical setting. While it is doubtful that all of these evaluations could be conducted in one day, the point is whether the student has the abilities, not the quantity of exposure needed to get the abilities.

To require more clinical experience for its own sake is only one possible solution to a problem that was not clearly identified in the testimony presented. Since the essay in the October 25, 1982 Newsweek has been introduced into the record with Struck's testimony, please see the attached response (Exhibit 1) published in the December, 1982 American Journal of Nursing. This editorial speaks of the need to differentiate between quantity and quality in educational practices.

7 MCAR S 5.3017 Nursing abilities to be evaluated.

A. Listing for evaluation

Tracy (written testimony for St. Mary's Junior College) recommends the 45 core abilities be reduced from 45 to 40. No suggestions were offered as to which abilities should be eliminated. As was explained in the Statement of Need and Reasonableness, pages 98-99, the Program Rule Replacement Task Force was unable to eliminate any of the core abilities given the various patient situations nurses commonly encounter. It is essential that all abilities be retained so the statutory practice definitions are implemented.

B. Interaction with patients

2. establish a relationship based on the patient's situation.

Menikheim (oral testimony) voiced the opinion that the level of acceptable performance, particularily as related to the "patient's situation", needs to be stated in this rule. No testimony has been presented that the proposed ability is inappropriate or should be deleted.

No level of performance against which students must be evaluated is indicated for any ability. Student possession of each of the core abilities must be evaluated regardless of the program, practical or professional, from which the student is to graduate. Not stipulating levels of performance is reasonable in that the Board's function is to establish minimal requirements. The proposed rules will assure that students in practical and professional programs are evaluated at least once and at a minimum level of acceptability as determined by a faculty on

possession of each listed ability. Faculties retain the flexibility to ascertain the level of performance and specific actions required to adequately evaluate students. The Board expects that faculties of practical and professional programs will establish differing levels of acceptable performance, which may be well above what is proposed as the minimum requirement.

The Board is aware that a "patient's situation" is a complex entity when all facets of the situation are viewed. Not specifying the complexity or totality of the patient's situation on which the student is to establish a relationship allows faculties of practical and professional programs flexibility in establishing the level of performance required. By not defining the patient's situation or stipulating any level of performance, the ability may be met, for example, by merely considering the age of the patient or the anxiety level of the patient when establishing a relationship. Both of these factors (age and anxiety level) are to be considered when relating to patients, according to the statement of practical nurse competencies for graduates of practical programs, developed by Minnesota practical nurse educators.

Faculties of all programs, practical and professional, have the flexibility to establish the level of performance required appropriate to the type of graduate being prepared. It is expected that faculties will determine the level of acceptable performance as required by proposed rule S 5.3019 A.

C.2. Collect data pertaining to a patient's intellectual, emotional and social function.

E.1. Promote development or maintenance of intellectual function.

Churchill (written testimony for St. Luke's Hospital School of Nursing) recommends changing the word "intellectual" to "cognitive" or "learning." It is true that one definition of intellectual is superior knowledge, however, since patients have various levels of intelligence this meaning would obviously not apply. The definitions for cognition and learning could lead one to expect the nurse to be able to assess a patient's learning function in ways which would only be appropriate to educational psychologists. The intent here is simply to distinguish between mind and emotion and the term intellect best serve that purpose.

7 MCAR S 5.3018 Additional professional nursing abilities to be evaluated.

A. Listing for evaluation

Menikheim, O'Grady, and Espelien (oral testimony) and Atkins (written testimony for College of St. Teresa), Bergstrom (written testimony from Minnesota Community College System), Hazzard (written testimony from North Hennepin Community College), Davis et al, and 12 students at Metropolitan State University (written testimony), Mathiowetz (written testimony for Minneapolis Community College), Tracy (written testimony for St. Mary's Junior College), Manahan (written testimony for Normandale Community College), and Franks (written testimony for Inver Hills Community College), assert that students in associate degree and diploma programs are not now evaluated for possession of some abilities in these proposed rules and such evaluation should not be required. These witnesses believe selected abilities are appropriate only to baccalaureate programs. It is the Board's position that since the legal definition of the practice of professional nursing authorizes professional nurses to perform the functions delineated in these rules, graduates from all professional programs must be prepared to function in that manner.

The categories of practice as indicated in headings B. through L. are derived from the legal definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3). This definition pertains to all professional nurses, regardless of the program from which one graduated. Also, the laws governing

approval of nursing programs do not differentiate between kinds of professional programs. While the Board recognizes that three kinds of professional programs exist (associate degree, diploma, and baccalaureate degree), the public must be assured that graduates from any professional program are prepared to practice professional nursing as legally defined.

The Board's response as to the necessity and reasonableness of these requirements is summarized as follows:

1. Pursuant to Minn. Stat. S 148.171 (3), the practice of professional nursing includes the assessment of the health needs of individuals, or of families, or of communities.

2. An individual who is granted a license to practice professional nursing may engage in the practice as defined by Minn. Stat. S 148.171 (3) without limitation. The Board does not have nor would it seek statutory authority to issue limited, restricted or conditional licenses to applicants based upon the degree or diploma conferred upon them by institutions preparing them to practice professional nursing. More specifically, the Board may not license one group of nurses as qualified to assist the needs of individuals, a separate group who may assess the needs of families, and a third category of nurses to assess the needs of communities, or any combination thereof.

3. Pursuant to Minn. Stat. S 148.191, subd. 2, the Board has a statutory mandate to prescribe standards for programs preparing students for licensure, without distinction as to the nature of the degree or diploma conferred to such students. It is necessary and reasonable for the Board to expect that all programs preparing a student for licensure as a professional

nurse provide elemental instruction in those areas in which any professional nurse is legally entitled to practice. Indeed, the Board might be abrogating its role were it to approve a program which fails to offer instruction or provide evaluation in an area of practice expressly included within the statute as constituting the practice of professional nursing. Further, to allow each regulated program to define what constitutes the practice of professional nursing according to its own curricula may constitute an unlawful delegation of authority to determine the practice of nursing and would result in a fragmented concept of the practice of professisonal nursing throughout the state.

The issue of assessing families and communities will be discussed under sections K. and L. of this rule. Bergstrom (written testimony for Minnesota Community College System) points out that not all of the categories of practice in the statutory definition need to be included in the proposed rules since Minn. Stat. S 148.171 (3) reads:

> such as...supervision and teaching nursing personnel, health teaching and counseling, case finding and referral to other health resources...

All of these categories of practice are part of the practice of professional nursing. See the last section of the memo dated April 3, 1981, from John Borman to Terry P. O'Brien, attached hereto and made a part hereof as Exhibit 2. The Board has heard no convincing grounds for the omission of any one of these categories and all have been included in these proposed rules and were included in all developmental drafts which have been circulated for review during the past five years.

There is another dimension of concern in the desire to limit selected professional categories of nursing practice to only baccalaurerate degree programs. According to McGarry (written testimony for Visiting Nurse Service of Minneapolis) community health agencies have difficulty in providing learning activities to baccalaureate and higher degree students. Suggestions have been made that associate degree and diploma students should not engage in clinical activities outside of hospitals and nursing homes. While these proposed rules do not limit student activities to certain settings, all of the disputed categories of practice except one can be demonstrated in those traditional in-patient settings. The demonstration of the one exception which is the ability specified in proposed rule S 5.3018 C. under the category of "case finding", can also be demonstrated without displacing baccalaureate students from community health care agencies.

Given these facts, it is not only reasonable but imperative for the Board to establish minimal requirements which all professional programs must meet relative to each legally authorized function of professional nursing. Such requirements will assure the public that graduates of any professional program have been evaluated at a minimal level of performance in each function of professional nursing as authorized by law.

Furthermore, the Board will establish that students in associate degree programs are now taught, at minimum, basic concepts relative to performing the abilities found in C. through H., K. and L. which are disputed as evidenced in the aforemen-

tioned testimonies. Since no setting for or method of evaluating or complexity of the situation for evaluation are specified, all faculties are allowed flexibility in determining these aspects. The Board expects faculties in different settings will necessarily establish differing situations, stimuli and methods for evaluating students.

Because, as will be demonstrated in subsequent sections, students in associate degree programs are now taught concepts relative to the abilities, the only added step to be performed by faculties of this kind of program is to develop a systematic, specific way in which to evaluate students on possession of the ability. There is no testimony from baccalaureate degree or diploma faculties which indicates that the implementation of these evaluations poses a problem to baccalaureate or diploma programs. Additionally, the Board will attempt to clarify the intent of the disputed categories of nursing functions and abilities in B. through L. and demonstrate how the abilities can be evaluated in simple, readily available situations.

C. Case finding

The definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3) includes "case finding" as an example of a function in providing nursing care supportive to or restorative of life. The testimony previously mentioned indicates this ability should be performed only by students in baccalaureate degree programs. Faculty of diploma programs (written testimony of Rowe and Churchill) indicated this is an ability for which students in diploma programs should be evaluated. The Board believes it is reasonable and imperative

that students in all professional programs be evaluated for this ability as well as all other functions in the definition.

While the Board recognizes that case finding may be interpreted to involve extensive community or public health nursing practices, the specified ability is minimal in its scope. It is not the intent of the Board to require programs to prepare public health nurses or to provide extensive learnings in and evaluation of students' ability to practice public health nursing. Since the meaning of the term "case finding" might be interpreted in a more complicated manner than intended by the Board, it is proposed that the heading "case finding" be replaced by a heading which more clearly summarizes the content of the rule as follows:

C. ~~Case finding~~ Identifying potential patients.

The minimal requirement specified in the ability is to remain unchanged.

As with all abilities, no setting for, method of, or depth of evaluation is specified, allowing all faculties flexibility in determining appropriate activities and criteria for student demonstration of the ability. It is expected that different levels of performance and methods of evaluation will be established for the various programs. Requiring students to be evaluated on this ability to a minimal degree will assure the public that graduates from all professional programs will have at least a basic ability to carry out this legal function.

Since the level of performance is not specified, the actions to be demonstrated to evaluate student possession of the ability

need not be complex. The proposed rule accommodates very simple evaluation which could even be done early in the program. Students in all professional programs are taught the "meaning," scope, and functions of nursing. The proposed rule only requires that faculties evaluate students on their ability to identify a person who could benefit from care that nurses can provide.

The stipulation that the individual is not currently receiving nursing care differentiates this ability from the abilities of assessing patients who are already receiving nursing care (7 MCAR S 5.3019 C.). Mathiowetz (written testimony for Minneapolis Community College) testifies that the situations from which associate degree programs could choose persons for student evaluations only include patients who are currently receiving nursing care. The Board believes this to be untrue.

The population and situations from which to choose for student evaluation are vast, as witnessed by the prevalence in our society of heart disease, cancer, accidents, hypertensive disorders, sexually transmitted diseases, and nutritional problems, to site a few examples. Given the numerous environmental, physical and social stresses to which individuals are subjected, or subject themselves, it is reasonable for each student in professional programs to demonstrate at least once and to a minimal degree that the student can identify a person who could benefit from nursing care. Identifying specific nursing care needs of the individual or nursing care actions to be taken is not required.

Furthermore, two competencies within the Statement of the Competencies of Minnesota Associate Degree Nursing Graduates,

developed by faculty members of associate degree nursing programs in 1977 (see attached Exhibit 3), imply that knowledge of even greater depth relevant to this ability is now taught in associate degree programs. These competencies are:

> Knows the components and principles of optimum health and the physical and emotional stressors in the environment which influence health.
>
> Knows theories of nursing and medical care; purposes and effects of the preventative, diagnostic, therapeutic, supportive and rehabilitative measures used. (emphasis added).

It is reasonable for faculties of associate degree nursing programs to evaluate students on application of this knowledge at least once and to a minimally acceptable degree, as determined by faculty, in a situation involving an individual not currently receiving nursing care.

The proposed rule does not require that nursing care be actually carried through, although that is not prohibited, and could serve as the actions for student demonstration of other abilities. An example of this would be identifying an individual who could benefit from health teaching regarding prevention of heart disease and proceeding to carry out the teaching. Evaluation of the actual teaching would satisfy the requirement for a different rule, S 5.3019 D.1.

Hazzard (written testimony of January 3, 1983, for North Hennepin Community College) recommends substituting "health" care for "nursing" care. Using the term health care instead of nursing care within the ability was an issue discussed by the Board. The Board retained the use of the term "nursing care." The Board continues to believe, since students are preparing to

be professional nurses, they must be able to identify persons who would benefit from the type of care that nurses, which they are aspiring to become, can provide. As described in previous paragraphs within this section, (1) the ability speaks only to identifying an individual, (2) knowledge of the functions and scope of nursing and the care that nurses can provide is taught in all professional programs, and (3) the population or situations from which to choose for evaluation are practically limitless.

D. Health teaching and counseling

Testimony, previously mentioned, indicated providing health teaching and counseling is not a function to be performed by graduates of associate degree or diploma programs. Faculty of diploma programs, however, have testified that this is a function for which diploma program students should be evaluated. The definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3) includes health teaching and counseling as an example of a function in providing care supportive to or restorative of life. Therefore, it is necessary and reasonable for the Board to require all professional programs to evaluate student possession of the abilities to perform the functions of health teaching and counseling. The intent of the rule is not to prepare graduates of professional programs to be psychiatric nurses or health counselors, but only to assure each student is evaluated at least to a minimal degree for possession of these abilities.

The specific objection to requiring students to perform this

function is with the requirement of the ability in D.2, which is promoting patient's independent functioning through counseling. A current rule, which all professional programs now meet, requires programs to include content in "application of knowledge in developing nursing skills in: ...developing effective interpersonal relationships with the patient and his family, helping him to assess his resources ...." The requirement of the proposed rule is to evaluate students for the ability to promote independent functioning of the patient, which may be merely "... helping him to assess his resources...." Another aspect of the proposed requirement is that this promotion of independent functioning be done through mutual deliberation in assisting the patient or family in decision making (see definition of counseling), which involves "...developing effective interpersonal relationships with the patient and his family." Since all professional programs are currently including essentially the same application of content as would be required by the proposed rule, the only added step for a program to take would be to identify this content and develop a specific way in which student application of such content would be evaluated. The situation for evaluating students may be as simple or complex as deemed appropriate by faculties. As with all other abilities, the level of performance required, the site and the method for evaluation are not specified.

Allowing this counseling to occur with individuals or families is reasonable in that flexibility in how faculties will evaluate student possession of this ability is further broadened, and, in fact, the individual's functioning may only be improved

with deliberating with the family rather than the individual singly.

E. Referral to other health resources

The previously cited testimony indicated that referral to other health resources is not a function to be performed by graduates of associate degree or diploma programs. Faculty of diploma programs, however, have supported this as a function for which diploma program students should be evaluated. The definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3) includes referral to other health resources as an example of a function in providing care supportive to or restorative of live. Therefore, it is necessary for all professional programs to evaluate students for possession of this legal function which may be performed by all professional nurses.

Two abilities are proposed for which faculties must evaluate students. The intent of the Board through these requirements is not to prepare a graduate with extensive ability for referring patients to appropriate health resources. The intent is to assure the public that students in professional programs have, at least to a minimal degree, been evaluated for these abilities and are prepared to function as described in the legal definition.

Since no level of performance is described in the rule, faculties retain the flexibility to determine student actions which will demonstrate the ability. The health resources used for referral may be those which are readily available to hospitalized patients, for example, dietitians and social workers; or those which are available to persons in a community,

for example, school health personnel or community groups for persons with long-term physical or emotional disabilities; or those to which a hospitalized patient is to be transferred, such as a nursing home. Given the wide variety of accessible health resources, it is reasonable to require that students, at least once, are evaluated on their ability to identify resources which match a patient's needs and desires (E.1) and to provide necessary information (E.2).

A competency within the Statement of Competencies of Minnesota Associate Degree Nursing Graduates, developed by faculty members of associate degree nursing programs in 1977 (see Exhibit 3), indicates that graduates are prepared with knowledge of referral-making and beginning steps in referral. This competency reads:

> Knows essentials of making referrals, recognizes the need for referrals...and initiates action toward referral through immediate supervisor.

Since graduates are currently prepared to refer patients to other resources, the only added step would be for faculties to identify a way in which students are specifically evaluated for possession abilities.

F. Delegation to nursing personnel

Delegation to nursing personnel has been singled out as a separate category due to its importance in carrying out the legal function of supervising nursing personnel. It is necessary and reasonable for the Board to require all professional programs to evaluate students on this category stemming from the legal definition.

Competencies taken from the Statement of Competencies of

Minnesota Associate Degree Nursing Graduates, developed by faculty members of associate degree nursing programs in 1977 (see Exhibit 3), indicate that students are taught basic concepts in delegation to carry out this supervisory nursing function. In addition to learning basic principles of management and supervision, each graduate knows as stated in one competency "...the roles and functions of members of the health team and applies this knowledge to professional team relationships." Another competency reads as follows:

> "Knows principles of management and can apply this knowledge in assessing, planning, organizing, and coordinating the nursing care for a group of three to six patients in simple nursing situations one to two patients in complex situations, and as a team member only in highly complex situations."

Specifying "as a team member only" for highly complex situations implies that, for simple and complex situations, management functions and delegation of some aspects of care are performed.

Given these competencies which are at this time included in the description of associate degree nursing program graduates, the added step for faculties to take would be to identify a way in which students are specifically evaluated for possession of the abilities of determining which actions are to be delegated and the level of nursing personnel to whom they should be delegated (F.1.) and specifying responsibility for delegated actions to these personnel (F.2.).

Hazzard (written testimony of January 3, 1983, for North Hennepin Community College) recommends deleting rule F.2. The need for the ability in F.2. was substantiated on page 83 of the

Statement of Need and Reasonableness on. The Board believes this aspect of delegation is necessary for safety of the patient in assuring all aspects of the patient's care are provided. Additionally, the function of delegation is only accomplished when responsibilities for carrying out the action are turned over to another. While the ability in F.1. requires student evaluation of possession of one aspect of delegation, the function cannnot be seen as complete without the follow-up step of specifying or delegating to nursing personnel the responsibilities. The ability in F.2. is necessary to assure graduates can fulfill both aspects of delegation as delineated in F.1. and F.2.

Furthermore, the second paragraph of Minn. Stat. S 148.171 (3) clearly authorizes all professional nurses to delegate nursing functitons to other nursing personnel. It is reasonable for the Board to rerquire that the ability to delegate be evaluated.

As with other abilities, no setting for or method of evaluation or level of performance is specified, allowing faculties to determine appropriate actions and evaluation methods for determining student possession of this ability which is crucial to carrying out this aspect of the legal definition of nursing. It is expected faculties of professional programs will,as necessitated by different settings, establish differing actions and evaluation situations and methods.

G. Supervision of nursing personnel

The previously cited testimony indicated that supervising nursing personnel is not a function to be performed by graduates

of associate degree or diploma programs. Faculty of diploma programs, however, have testified that this is a function for which diploma program students should be evaluated. The definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3) includes supervising of nursing personnel as an example of a function in providing care supportive to or restorative of life.

To establish that students in all professional programs are prepared, at least to a minimal degree, to perform this function, the Board has proposed three abilities for which students must be evaluated. Again, no setting for or method of evaluation or level of performance is specified, allowing faculties flexibility in determining these aspects. The intent of the rule is not for programs to prepare graduates who can immediately function in supervisory positions. The intent is to assure the public that graduates have, at minimum, rudimentary knowledge and skill to carry out this legal function.

The competencies within the Statement of Competencies of Minnesota Associate Degree Nursing Graduates which were referenced in the previous statements relative to subsection F. indicate that knowledge and application of simple supervisory functions are now included in associate degree nursing programs. Knowing "...roles and functions of members of the health team..." and applying this knowledge provides the basis for the proposed rule requirement of determining the need of nursing personnel for supervision (G.1.). Directing or assisting nursing personnel (G.2.) is inherent in the previously referenced competency which, in part, states:

"knows principles of management and can apply this knowledge in assessing, planning, organizing and coordinataing the nursing care..."

An added overall statement regarding the practice of the associate degree prepared nurse as developed by these faculty members reads:

"In simple nursing situations the A.D. nurse may function without supervision and/or may provide supervision for other nursing personnel."

Since faculties agree through these statements, that these abilities are at this time taught and applied, the only step for faculty to take is to identify a way in which students are specifically evaluated for possession of these abilities. Evaluating nursing care given by nursing personnel (G.3.) is a sine qua non to carrying out supervisory functions. With this evaluation aspect, the nurse, who retains accountability for actions performed by others, can assess whether the actions by other nursing personnel were done safely and completely.

Hazzard (written testimony of January 3, 1983, for North Hennepin Community College) recommends deleting abilities G.2. and G.3. The Board believes student evaluation for all three aspects of supervising nursing personnel is essential to assuring safe patient care as described herein and on page 84 of the Statement of Need and Reasonableness.

H. Teaching nursing personnel

Testimony, previously cited, has been received indicating that teaching nursing personnel is not a function to be performed by graduates of associate degree or diploma programs. Faculty of diploma programs, however, have testified that this is a function

for which diploma program students should be evaluated. The definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3) includes teaching of nursing personnel as an example of a function in providing care supportive to or restorative of life.

To assure the public that graduates from all professional programs are prepared to function as legally described, four abilities for which students are to be evaluataed are proposed by rule. The four abilities encompass commonly accepted steps in the teaching-learning process. Since no level of performance is specified, faculties of professional programs can establish the depth or complexity required in demonstrating possession of the abilities. This flexibility allows faculties to determine acceptable actions, which may be as simple as teaching proper procedure or technique to a nursing assistant. A competency taken from the Statement of Competencies of Minnesota Associate Degree Nursing Graduates, developed by faculty members of associate degree nursing programs in 1977 (see Exhibit 3) indicates rudimentary aspects of the four listed abilities are at this time taught and applied in associate degree programs. The competency reads:

> knows principles of teaching and learning and applies them, informally, in simple and complex nursing situations with patients and families and in teaching peers and non-professional nursing personnel. A.D. practitioners may teach clients and co-workers any content they have learned in their basic nursing program.... (emphsis added)

Since these concepts are currently taught and applied, the only added step is for faculties to identify a way in which students are specifically evaluated on possession of these

proposed abilities.

Hazzard (written testimony of January 3, 1983 for North Hennepin Community College) recommends deleting abilities H.3. and H.4. The Board believes the legally authorized function of teaching nursing personnel encompasses all four abilities and evaluating students on possession of all four abilities is essential as described herein and on pages 84 and 85 of the Statement of Need and Reasonableness.

I. Delegated medical care

A question was raised by Henry (oral and written testimony for Professional and Technical Health Care Union) regarding why practical nursing programs are not expected to evaluate students for the ability to administer intravenous medications. The committee whose work formed the basis for these rules surveyed 150 Minnesota employers of licensed practical nurses in 1979 and found that the skill of adding an intravenous solution that included medication to an intravenous infusion was performed in 51 of the facilities or agencies surveyed. Seventy-one percent of those responding to the survey indicated that the skill was done by personnel other than licensed practical nurses or by less than half of the employed licensed practical nurses, or by more than half of the licensed practical nurses but less often than an average of once each month.

The survey demonstrated that licensed practical nurses in Minnesota are not commonly performing this skill and therefore do not need to be evaluated for this ability. This ability is not commonly taught in practical nursing programs. In view of these

findings and the practical nursing definition in Minn. Stat. S 148.29, subd. 4, it is appropriate to require that only professional nursing students be evaluated for this ability.

K. Nursing assessment of actual or potential physiological or psychological health needs of families, and

L. Nursing assessment of actual or potential physiological or psychological health needs of communities

Providing a nursing assessment of the actual or potential health needs of families or communities is a function of professional nursing included in the definition of the practice of professional nursing found in Minn. Stat. S 148.171 (3). To implement this portion of the law the Board proposes to divide the function into two parts. Part K. relates to families, and part L. relates to communities. For each part or category, there are two proposed abilities for which students in professional programs must be evaluated.

The testimony cited at the beginning of the discussion of proposed rule S 5.3018 indicates these two categories should be performed only by students in baccalaureate degree programs. The appropriateness of ability L.2. is also disputed by Atkins (written testimony for the College of St. Teresa). Testimony has been submitted from faculty of diploma programs supporting the abilities in parts K. and L. as appropriate for evaluation in diploma programs. Hazzard (written testimony of January 3, 1983 for North Hennepin Community College) asserts that the abilities in K.2. and L.2. should be deleted. Associate degree faculties have submitted testimony that evaluation for all four abilities in both categories would be inappropriate in their programs.

At least one witness at the hearing, Espelien (oral testimony) sought a clarification of the meaning of the disjunctive "or" as used in the Nurse Practice Act. Minn. Laws 1974, Ch. 554, S 1, now codified as Minn. Stat. S 148.171 (3), amended the definition of nursing practice to clarify that assessment of health needs of families and communities constitutes an integral part of nursing practice. The law states in relevant part as follows:

> The practice of professional nursing means the performance...of the professional interpersonal service of: (a) providing a nursing assessment of the actual or potential health needs of individuals, families, or communities....

An issue raised at the hearing was whether the use of the disjunctive "or" within the nurse practice definition permits either the Board or nursing programs to selectively choose or exclude assessment of health needs of individuals, families or communities from the definition of nursing. It was stated that if the statute used the conjunctive "and," nursing practice would include all three of the health assessments, but that the disjunctive "or" permits an individual nurse or nursing program or the Board to exclude any category from the practice definition.

The Board is bound to give force and effect to all legislative provisions entrusted to it and in the course of its duties may not selectively discard or ignore elements found in the practice definition. To implicitly repeal sections of the definition of nursing contravenes the canons of construction found in Minn. Stat. S 645.08 (1980), case law and the concept of

generic licensure. Plainly stated, the Act mandates that nursing practice include the assessment of the health needs of families or of communities as well as individuals. Stated in another way, in order to be engaged in the practice of nursing one need not combine a simultaneous assessment of communities, families and individuals' health needs. To assess the needs of any one category constitutes the practice of nursing. The Board has regulatory authority over and a professional nurse is licensed to lawfully engage in the assessment of the health needs of a community, family or individual, or any combination thereof.

The preposition "or" must be construed in its common meaning as a disjunctive. Minn. Stat. S 645.08 (1) provides that "Words and phrases are construed according to rules of grammar and according to their common and approved uses...." "Or" has never been accorded a special, technical meaning by the Minnesota Supreme Court or the Minnesota Legislature. Thus, the word must be construed according to its common usage unless the statute plainly requires a different construction. Maytag v. Commissioner of Taxation, ____ Minn. ____, 17 N.W.2d 37, 39 (1944).

Webster's New Collegiate Dictionary (G. & C. Merriam Co., 1979) defines "or" as "a function word to indicate an alternative." Thus, any alternative referenced in the statute must be construed to constitute the practice of nursing in and of itself.

A somewhat similar statute was addressed in State v. Rolph, 140 Minn. 198, 167 N.W. 553 (1918). In that case, a chiropractor was charged with practicing medicine without a license. The contemporary medical practice act defined medical practice inter

alia as appending the letters M.D. or M.B. to one's name, or for a fee prescribes, or recommends any drug or medicine or other agency for relief or treatment of bodily injury, infirmity or disease. Although not a part of the holding, the court expressly recognized that:

> It requires no discussion or argument to demonstrate that the physician who thus applies his learning and energies a diagnostician limiting efforts to the discovery, character and location of a disease or ailment is performing a highly important duty of the profession, and is engaged in the practice thereof, though he prescribes no drug and administers no specific treatment.

Id. at ___, 554. Clearly, the Minnesota Supreme Court, in reviewing the disjunctive "or" in a similar practice act, has found that engaging in any one of several alternatives statutorily set forth constitutes the practice addressed. Similarly, the practice of nursing encompasses assessing needs for any one of the alternative categories set forth therein and not a totality of all three.

Whether any one of alternative criteria separated by "or" need be fulfilled to fall within a statutory classification has more recently been addressed in Michigan Employment Security Commission v. Arrow Plating Co., ____ Mich. ____, 159 N.W.2d 378 (1968). In defining what must be acquired by a successor employer as the "organization, trade or business, or 75 percent or more of the assets" within the employment securities act, the court held that:

> [B] y using the disjunctive "or," the legislature obviously intended that a successor employer need only meet one of the listed criteria to be so classified.

Id. at 380. Again, the assessment of health needs of either a community, of a family or of an individual, separately or in combination, constitutes the practice of nursing. An attempt to strike the disjunctive "or" from Minn. Stat. § 148.171(3) and substitute the conjunctive "and" would effectively repeal the clear meaning of the statutory language, and remove Board jurisdiction over nurses assessing only individuals. Such a strained interpretation would bring about the absurd result that a person who limits her practice solely to assessing health needs of individuals, a common function of a hospital primary nurse, would not be practicing nursing since she is not also assessing family and community needs. Further case authority recognizing that "or" is disjunctive, is usually so considered, and is its commonly accepted meaning for purposes of statutory construction is found in State ex rel. Fenigan v. Norfolk Livestock Sales Co., ____ Neb. ____, 132 N.W.2d 302 (1964) and

Heckathorne v. Heckathorne, ____ Mich. ____, 280 N.W.2d 79 (1978). See also memo dated April 3, 1981, from John Burman to Terry P. O'Brien, attached hereto and made a part hereof as Exhibit 2.

Minn. Stat. § 148.171(3) (1980) is clear and unambiguous in establishing that health assessments of individuals, or families, or communities constitutes the practice of nursing. Nevertheless, assuming, arguendo, that the language is ambiguous, the interpretation placed upon this statute by the agency charged with its enforcement is entitled great weight. See, e.g., Mattson v. Flynn, 216 Minn. 354, 13 N.W.2d 11 (1944); Mankato Citizen Telephone Co. v. Commissioner of Taxation, 275 Minn. 107, 145 N.W.2d 313 (1966); Knoppe v. Gutterman, 358 Minn. 33, 102 N.W.2d 689 (1960). Clearly, the Board views licensure as a professional nurse as a generic, as opposed to a specialty license. Inasmuch as every professional nurse is entitled to practice nursing as defined, every professional nurse may be presumed to have minimal competence to practice as a professional nurse. Since the Board does not issue limited professional licenses to practice in community nursing, family nursing or individual nursing, and does not have the authority to do so, each nurse is presumed to have a fundamental core of knowledge necessary to practice within all aspects of the legal definition. Otherwise, the Board is, in effect, purporting to license professional nurses whom it may not deem competent to provide all the essential elements of nursing as legally defined. Surely, the Board cannot be expected to confer a license to practice professional nursing upon an individual, while simultaneously recognizing that the individual is unqualified to practice a basic function of a professional nurse, for example, that of assessing the needs of a community.

Since the Board of Nursing is the agency established in the Nurse Practice Act by the legislature to enforce the entire Practice Act, the Board is

charged with the interpretation and enforcement of the definition of nursing contained in Minn. Stat. § 148.171(3). It is well-settled law that an express grant of authority to an administrative agency to make rules carries with it the implied authority to make necessary clarifications and definitions within the designated area of regulation. See, e.g., Welsand v. Minnesota Railroad and Warehouse Commission, 251 Minn. 504, 88 N.W.2d 834 (1958). The Board would unlawfully delegate its authority if it allowed school programs or separate agencies to define what constitutes the practice of nursing within Minn. Stat. § 148.171(3) by selecting which sections of the Practice Act apply to their programs. Legislatively granted authority to exercise discretion may not be fully delegated by the Board to whom it was initially delegated. See e.g., Muehring v. School District No. 31, 224 Minn. 432, 28 N.W.2d 655 (1947). This principle is particularly true when an agency purports to transfer its authority to the entities regulated. In Garces v. Department of Registration and Education, 118 Il. App.2d 100, 254 N.E.2d 622 (1969), the court held that the agency's use of standards set by nongovernmental educational authorities constituted an unlawful delegation of its statutory authority to define a reputable school as that term was used in the statute. Similarly, it would be an unlawful delegation of the Board's statutory duty to define what constitutes the practice of nursing should it permit each and every nursing program to define which part of the Nurse Practice Act it chooses as exemplifying an integral part of nursing. Should the Board allow one group of schools to determine nursing practice as confined to a nursing assessment to individuals, and not to families or communities, the Board would effectively delegate the authority to determine the practice of nursing to every school reviewing the Act. For example, the College of St. Theresa may determine that the practice of nursing encompasses a wider scope than North Hennepin Community College. Such a result would fragment the concept of

professional nursing within the state, and result in the legal scope of a nurse's practice being defined neither by statute nor Board interpretation of statute, but by the educational program which conferred the degree or diploma. Since the legislature established the Board to review and approve programs based upon their ability to prepare candidates to practice nursing, it could not have intended that each school may determine those standards based upon its interpretation of the practice of nursing.

O'Grady (oral testimony) and Cink (written testimony for Ramsey County Public Health Department) objected to including the categories of assessing families and communities as requirements for any professional program other than baccalaureate degree programs. It is noted in Cink's follow-up letter of December 25, 1982 that the objections are to the wording of the abilities K.2. and L.2. rather than to inclusion of the categories themselves. Rowe (oral and written testimony for St. Cloud Hospital School of Nursing) and Churchill (written testimony for St. Luke's Hospital School of Nursing) recommended different wording for the heading of category L. relating to assessment of communities. Neither Rowe nor Churchill objected to the abilities L.1. and L.2.

The objections to the requirements and wording which were posed in the referenced testimony may be summarized as follows: (1) the categories are inappropriate as functions to be performed by graduates of all professional programs, (2) the abilities are not currently taught or evaluated in associate degree programs, (3) abilities K.2 and L.2 should be deleted, (4) the heading of category L. should be reworded, (5) the wording of abilities K.1, K.2, L.1, and L.2 should be changed. The objections are dealt with sequentially.

1. Since the function of providing a nursing assessment of actual or potential health needs of families or communities is included in the legal definition of the practice of professional nursing, it is reasonable and imperative that the Board assure the public that graduates of all professional programs have been evaluated, as students, for their ability to perform this legal function. The proposed abilities are limited to collecting and

interpreting data (K.1 and L.1) and making a plan (K.2 and L.2), restricting the requirement to only the assessment of families and communities as specified in law. Since neither the setting for or method of evaluation nor the level of performance is specified for the evaluation of any of the abilities, faculties from differing professional programs can determine the sites and conditions for evaluating the complexity of performance deemed acceptable. It is not the intent of the Board to require all professional programs to prepare public health nurses, but only to assure the public that graduates are prepared to function, to a minimal degree, as authorized in the legal definition of the practice of professional nursing.

2. It is untrue that all professional programs are not at this time including content about family structure and function and planning with families to achieve health goals. Board surveys for the last 10 years have revealed that every approved professional program includes at least the rudiments of this category. Very common and simple examples of this content are learnings related to assisting a family in the care of a newborn, and assisting a family with an ill child or a hospitalized family member with a long-term illness to deal with associated physical needs and emotional stresses. Further evidence that these concepts are already taught and applied in associate degree programs includes a competency within the Statement of Competencies of Minnesota Associate Degree Nursing Graduates, developed by faculty members of associate degree programs in 1977(see Exhibit 3). This competency reads:

> Knows physiological, psychological and sociocultural factors which influence the childbearing process and uses the nursing process to assist individuals and families during childbearing and the beginning phases of child rearing.

Still other competencies in this document include references to teaching families and using interpersonal and group interaction skills with families. In order for these graduates to be able to "...use the nursing process to assist individuals and families..." and to teach families, an assessment of the family's health needs must have been done. "Assessment" is a commonly accepted initial step in the nursing process and teaching-learning process.

Similarly, Board surveys show that content pertinent to assessment of communities is currently included in all professional programs. Content about, as examples, contaminated foods, water, and air, control of communicable diseases, and accident incidence and prevention, as evidenced in introductory nursing texts [3,4] is now presented to students in professional programs. Knowledge of community educational, health and welfare resources and of physical and emotional stressors in the environment which influence health are already taught in associate degree nursing programs as evidenced in the Statement of Competencies of Minnesota Associate Degree Nursing Graduates, prepared by faculty members of associate degree nursing programs in 1977(see Exhibit 3). Since content relevant to the effects of factors in a community on an individual's health is currently included in associate degree nursing programs, the only step to be taken is for faculties to identify ways in which students will

be specifically evaluated to determine possession of the two listed minimal abilities L.1. and L.2. Diploma programs can meet this requirement according to Rowe and Churchill. Baccalaureate degree programs currently provide public health nursing experiences and therefore can meet the requirement.

No method of or setting for evaluation of the abilities (L.1. or L.2.) or level of performance is described in the proposed rules. The rule allows the data to be collected and interpreted and plans to be as simple or complex as deemed appropriate by the faculty. For example, in preparing for discharge of a patient from an institutional setting, collecting and interpreting data about the community to which the patient is being returned and devising a plan for modifying these conditions would be acceptable. Since "community" is defined in this rule to require only a population and an environment, the community can be as small as a place of employment or group housing, or as large as a town.

3. The Board believes making a plan, as required in proposed abilities K.2. and L.2., is appropriate to assessment of families and communities and must be retained as an ability to be evaluated for each of these two categories of nursing. The working definition of "assessment" used by the Program Rule Replacement Task Force, was "the act of collecting data, interpreting data and planning nursing action." This definition, which includes planning, was in the task force's final report. This report was distributed to all nursing programs. No comments regarding the inappropriateness of "planning" in this definition of assessment were received from faculty of any nursing program.

This definition was also included in an earlier draft of proposed rules which was reviewed by the Revisor's Office. On advice of the Revisor's Office the definition of assessment was deleted. believes that the abilities should be retained.

Four commonly accepted steps in the nursing process are assessment including collecting and interpreting data, planning, implementation and evaluation. The legal definition of the practice of professional nursing in Minn. Stat. S 148.171 (3) clearly specifies three of these steps, assessment, implementing (providing nursing care), and evaluation. As a policy matter, the Board has determined that the planning step in the nursing process should be inorporated in the proposed rules with assessment and evaluation in order to deal with the entire process. There is no justification for omitting a vital and generally accepted part of the nursing process.

In relation to caring for individuals, nursing care planning is specified as a separate category of nursing in these proposed rules (S 5.3018 B.). In relation to families and communities, the Board has added this planning step as abilities to be evaluated within categories K. and L. The Board believes that requiring only collecting and interpreting data, is by itself too simplistic for professional-level nursing. Adding the planning step, i.e., requiring students to make a plan for a family (K.2.) and a community (L.2.) is a reasonable and appropriate requirement for professisonal programs.

Given that faculty expressed no objections to the definition of assessment found in the Program Rule Replacement Task Force's

final report nor to the inclusion of "nursing care planning" as a category of nursing in respect to caring for individuals, and Board policy regarding "planning," the Board believes that the abilities K.2. and L.2. should be retained.

4. The Board acknowledges Rowe's (oral and written testimony for St. Cloud Hospital School of Nursing) concern regarding the wording of the heading of the category pertaining to assessment of communities (L.).

Although the two listed abilities form the substance of the requirement and the heading of the category is only a label, the Board recognizes that confusion may exist between the label and the substance. As can be noted by the minimal requirements delineated in the two abilities (L.1. and L.2.), it is not the intent of the Board to require programs to produce public health nurses or to provide extensive community health learnings and activities. There is no intent to interfere with current public health nursing certification practices.

The wording of the headings of both categories K. and L. is directly related to that found in the legal definition of the practice of professional nursing. The Board does not believe the headings are inconsistent or inappropriate. However, because the headings may lead faculties, employers and public to believe students have received more experience in community health nursing than is intended or required by the two abilities, the Board proposes the current heading be amended as follows:

K. ~~Nursing assessmenet of actual or potential physiological or psychological health needs of families.~~ Health needs of families.

L. ~~Nursing assessment of actual or potential physiological or psychological health needs of communities.~~ Health needs of communities which effect individuals' health.

These headings are simpler to read and understand, and more accurately reflect the abilities for which students are to be evaluated. No changes are proposed in the abilities K.1., K.2., L.1. and L.2., as further explained in the following paragraphs.

5. Cink's thoughtful recommendations (written testimony for Ramsey County Public Health Department of December 25, 1982) regarding wording changes in the proposed abilities, K.1., K.2., L.1., and L.2 are appreciated. He believes the current wording describes the practice of public health nursing. However, the Board's position is that the wording of the abilities, with one minor concession, should remain unchanged. The Board submits that nowhere in the wording of categories K. and L. or the proposed abilities, K.1., K.2., L.1., and L.2. is it stated that a family on which the student is to perform the assessment must be in a community, the site for public health nursing, or that the assessment of a community needs to involve any actual student learning experiences in a community. In fact, as is shown in previous statements within this section, these abilities can be evaluated using situations commonly available and taught to students in all professional programs. It is further believed that wording changes in the headings of categories K. and L. as proposed in the previous paragraphs will clarify that community or public health nursing practice is not intended or required.

Specifically, Cink proposes replacing the words "collect and interpret data" in K.1. and L.1. with "identify strengths and problems...". The Board submits that "strengths and problems" cannot be identified without having data on which to base the identification and making some judgment about or interpretation of these data to get to the point of identifying strengths and problems. It is reasonable that students preparing to be professional nurses be able to collect the data about a family and a community as well as interpret those data in relation to health needs. Furthermore, the legal definition of the practice professional nursing specifies "assessment...of families or communities." The terms "collect and interpret data" are appropriate to the practice of all nurses, not only public health nurses. See proposed abilities S 5.3017 C.2. and 3. which require evaluations in practical and professional programs of the ability of collecting and interpreting data for the assessment of individuals. No objections have been received regarding these abilities. Specifying that the data pertain to a family's structure and function, as stated in the Board's rule, K.1., establishes the minimum types of data that must be collected and interpreted about a family.

Since no level of performance is specified, each faculty can establish a minimal level of acceptable performance deemed appropriate for its students to demonstrate they are able to collect and interpret data about a family's structure and function (K.1.) and about a community's population and environment (L.1.).

The Board does not agree with Cink's recommendation to

include "identify how the family can influence an individual's health" in K.1. or "identify how the environment can influence an individual's health" in L.1. First, the concept in these phrases, that of identifying "how-to's" is more appropriate to the "planning" abilities in K.2. and L.2.; the concept adds another dimension beyond the Board's wording of collecting and interpreting data, and certainly beyond the ability that would be involved in the first half of Cink's recommended wording of K.1. and L.1., that of identifying strengths and problems. Second, the Board's proposed rules L.2. and K.2., each of which relate to making a plan, do not exclude the concepts as proposed by Cink. In fact, these concepts of identifying strengths and weaknesses may each be elected by faculties of professional programs as a criterion for determining the student's ability to make a plan to assist a family and to make a plan for modifying conditions in a community. The wording of the abilities must remain broad to accommodate different sites, methods, and criteria for evaluating student possession of the abilities.

It is unclear what Cink's proposed insertion of the words "an identified" adds to abilities K.2. and L.2. The Board believes insertion of these words to either K.2. or L.2. would make the rules unnecessarily restrictive. His intent may be to tie evaluation of the abilities in K.1. to K.2. and L.1. to L.2. However, the Board's proposed abilities are intentionally written so as to be separate and distinct, one not necessarily dependent on achievement of another. Combining evaluations of abilities is not prohibited but neither is this required. In view of the

concerns expressed about these abilities there is no point in adding unwarranted restrictions to the flexibility now allowed.

Cink also proposed activity rule L.2. be revised by using the singular term "condition" instead of "conditions." The Board agrees the singular form of the term should be used and will not affect the intent of the rule. Therefore, it is proposed the rule read:

2. make a plan for modifying ~~conditions~~ a condition within the community which affects the health of an individual.

7 MCAR § 5.3019 Preparation for evaluation.

A. Predeterminations.

Struck's suggestion (oral and written testimony for Anoka-Hennepin AVTI and majority of other practical nursing program directors) that the Board should require that students must pass specified evaluations will be dealt with in relation to proposed rule § 5.3020. Whether or not the Board requires passing, Struck's proposed changes in the predeterminations are unnecessary. One either has an ability (shown by meeting the criteria) or one does not have it. Additional language about identifying a minimum passing score is not needed as setting a passing score is one of the possible ways of meeting subpart 4. The proposed rule clearly requires faculties to predetermine, in subpart 4, "the basis for deciding whether the student possesses each nursing ability". The basis can encompass any system of determining possession of abilities, including scoring.

Struck's suggestion that the Board require students to have demonstrated the abilities before being admitted to the licensing examination is a separate issue that is inappropriate to program approval rules. If such a requirement were to be considered, it would be for rules for licensure by examination. It is difficult to understand how the applicant for licensure could be asked to supply the necessary evidence, particularly applicants from programs outside of Minnesota. Even if the requirement were only for Minnesota graduates and they would be able to get the necessary evidence, there would be a logistic problem in the Board determining if each of almost 3000 licensure applicants per year had indeed passed the 45 core abilities and, for professional applicants, the 20 additional professional abilities. For these reasons, this suggestion is not being considered in this proceeding.

7 MCAR § 5.3020 Evaluation of nursing abilities.

Struck's concern (oral and written testimony for Anoka-Hennepin and a majority of practical nursing program directors) that the rule does not specify that each student has passed each evaluation is unwarranted. Rules for approval of programs have never required that curriculum content topics be passed, and yet no complaints have been received regarding students not "knowing" those required topics. Because the Board does not now propose to decree that the evaluations be passed is not reason to assume that students will cease being motivated to learn. Students have always attempted to meet the level of performance established by the faculty, and there is every reason to believe students will continue to do so. The current rules have established that the Board has not needed to require passing so, even if that were permissible, it is not necessary or advisable with these rules.

The intent of these proposed rules in not to certify graduates as skilled to perform specific nursing functions, but to assure that all students receive exposure as a generalist and are evaluated for the rudimentary abilities necessary to practice as defined by law. The licensure examination has been, and is now, utilized by the Board to determine if a graduating student is suitable for licensure. This separate system continues to be used by the Board to safeguard the public with regard to who is issued a nursing license. Further, if 25 percent or more of the graduates do not pass the licensing examination, the Board will survey the program for rule compliance. Therefore, it is unnecessary for the Board to intrude on the conduct of the program by specifying that the evaluations of students' abilities be passed.

Furthermore, if the Board did want to attempt to require passing, the implementation costs would be increased for both the Board and programs.

To illustrate, for a professional program to document and the Board to verify that each of 50 students had passed evaluations for possession of each of 65 abilities would be very complex. For example, if 10 of the abilities were evaluated through paper and pencil test items, spread out over two years in 10 different course examinations which included other test items as well, it would be necessary to review the 10 examinations written by the 50 students to see that the items related to each of the 10 required abilities were answered correctly. This example does not even consider repeat examinations and other methods of evaluation. Again, for the Board to require passing, even if permissible, would certainly not be advisable.

7 MCAR § 5.3021 Evaluation of combining nursing categories.

Flickinger (written testimony for Rochester Community College) cites the need to be able to evaluate students for the ability to combine categories of nursing in simulated settings as well as in clinical settings. Since the proposed rule does not stipulate when this evaluation must be done, it is expected that faculties will only implement the evaluation when the student can demonstrate this ability without putting patients at risk of harm. To permit this evaluation under a controlled laboratory condition would defeat the purpose of evaluating a student's application of nursing abilities while coping with unpredictable clinical situations.

Conclusion

The hearing process has been useful in determining that there is no dispute regarding the proposed approval process and that there is support for the approach of focusing on student outcomes. In view of the fact that 53 programs will be affected by these rules, the lack of negative comments regarding the proposed rules as a whole is a tribute to the committee and two task forces which collected and utilized information from interested parties throughout the five years spent developing these rules.

It is important that the proposed rules be promulgated with only the modifications described by the Board as needed in proposed rules §§ 5.3000 G. and M., 5.3007 C.2., 5.3011 B.1., 5.3012 B.2. and C.1., and 5.3018 C., K. and L. Such promulgation will permit the Board to continue implementing its statutory responsibility in approving programs.

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Dated: January 5, 1983

STATE OF MINNESOTA

BOARD OF NURSING

Joyce M. Schowalter

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EDITORIAL

Recalling the Not-So-Good Old Days

There was a legislator in Georgia who was the quintessential old time politician: paternalistic, outwardly pious, and foxy. Whenever nurses gave him irrefutable data that he didn't want to act on but couldn't ignore, he handled it by producing the opinions of one "Miss Addie"—an "old-timey nurse" who supposedly lived in his district.

Of course, no one could ever track down "Miss Addie," but when some real nurses in his district pointedly made his acquaintance, that particular foxhole got sealed off.

I felt I'd finally met Miss Addie when I read the October 25 *Newsweek* essay by a "retired nursing teacher," Alice Ream, who recalls the good old days (apparently before the 1950s) when "a nurse could walk into any hospital and be fully functional in a few days." Ms. Ream then attacked nursing education for failing to impart skills, and claimed that the "unskilled nurse" lay at the center of the hospitals' malpractice problems.

Actually, Ms. Ream has "discovered" some already-acknowledged problems in nursing education that have been worked on—with considerable progress—in the past few years. It hurts to be flogged in public for something you're already in the process of fixing. It's also puzzling. Whose interests are served by dredging up this issue in front of four million people?

Ms. Ream pointed to the incidence of hospital infections as evidence of nurses' lack of skills. To lead off her bitter attack, she cited an Associated Press report of "56,000 deaths in US hospitals each year from bladder catheter infections." Such an accusation has to be examined both scientifically and historically.

First, the press story was taken from a September 9 *New England Journal of Medicine* study in which, coincidentally, catheter insertion and errors in care actually *were* among the variables examined. The researchers found no significant correlation between errors in catheter insertion or care and infection or death. And, according to my own conversation with the principal researcher, there was certainly nothing in this study to suggest "bumbling nurses"—if anything, just the opposite.

Second, while any deaths from sepsis are too many, the estimates of death in the *NEJM* study are themselves questioned by the Centers for Disease Control. CDC sticks by previously published estimates, as follows: Nearly 40 million persons are hospitalized for acute care each year. Of those, 10 percent (four million) are catheterized. Of those, about 15 percent (600,000) acquire bacteriuria. Of those, one percent (6,000) develop bacteremia, and of those, about 30 percent (1,800) die of sepsis.

But the historical point is the most ironic. Prior to the era of closed sterile gravity drainage (that is, when Ms. Ream and the rest of us were so meticulously irrigating urinary catheters), infection control experts estimate that fully 85 to 100 percent of patients became bacteriuric during their period of catheterization. Infection rates due to urinary catheters have in fact been *reduced* from at least 85 percent to 15 percent since the "good old days."

It's too bad that Ms. Ream fired her broadside without stopping to look at the extreme variations in quality that exist among hospitals. Then, perhaps, she might have asked some quantity questions, as well. If RNs are such bunglers, what happens when a hospital increases its ratio of registered nurses to patients? Claire Fagin's article in this issue provides lavish documentation of exactly what happens: consistently, patient outcomes improve—and costs go down.

For a moment, let's envision quality of patient care as existing on a continuum, or spectrum. At the top of the quality spectrum are hospitals, agencies, or units whose patient care outcomes are better than the norm, so that they are able to concentrate on creating new ways to improve care, such as those Dr. Fagin's article describes. In the middle of the spectrum would be hospitals whose patients' outcomes resemble the current norms, such as those for hospital-acquired UTI. As individual hospitals or units are found toward the bottom end of the quality spectrum, however, issues of patient safety loom ever larger. Such places cannot retain professional staff, and a crisis atmosphere prevails. At the bottom end of the quality spectrum, the minimum standards of care are established by lawsuits.

Though it's hard to believe, there are people who would like to separate the issue of quality from the issue of quantity. They'd prefer to think that standards of care can be developed, and nurses asked to uphold them, without taking staffing or working conditions into account.

Seven emergency department nurses at a 92-bed hospital in Oregon have just successfully challenged that separation of quality from quantity (News, page 1809). When their night staffing was ordered cut from one RN and one LPN down to a lone RN, the seven RNs protested on grounds of safety, both for patients and for the nurse. All were fired for insubordination.

The nurses appealed to the National Labor Relations Board, which ruled that staffing can be considered a working condition, and is not solely an administrative prerogative. "To a health care professional, such as an RN," said the NLRB, "the handling of patient care is a condition of employment."

Yes, Ms. Ream, a lot has changed since the good old days. It used to be that nurses could be fired at will for attempting to uphold standards. But now, nurses like the Oregon Seven are refusing to let such practices continue. I, for one, am happy to be living in the present.

Mary B. Mallison, RN, Editor

SF-00926 01

Exhibit 2

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Terry P. O'Brien
Special Assistant
Attorney General

DATE: April 3, 1981

FROM John M. Burman
Law Clerk

PHONE: 341-7272

SUBJECT: Statutory Construction of Nursing Practice Act

You asked that I research the statutory construction questions raised by Margaret Baach.

Margaret Baach's first question is whether the Board of Nursing (hereinafter "Board") may construe the "or" in Minn. Stat. § 148.171(3)(a) (1980) as a conjunctive.1/ It may not.

Minn. Stat. § 645.08(1) provides that:

> Words and phrases are construed according to rules of grammar and according to their common and approved usage; but technical words and phrases and such others as have acquired a special meaning, or are defined in this chapter, are construed according to such special meaning or their definition.

(Emphasis added.) "Or" has never been accorded a special, technical meaning by the Minnesota Supreme Court; neither has the Legislature provided a statutory definition. "Or" must, therefore, be construed according to its common usage, unless "the sense of the statute plainly requires" a different construction. Maytag v. Commissioner of Taxation, 17 N.W.2d 37, 29 (Minn. 1944) ("And" may be construed as "or" if the sense of the statute "plainly" requires it.)

Webster's New Collegiate Dictionary defines "or" as "a function word to indicate an alternative." Applying this common meaning to Minn. Stat. § 141.171(3)(a) (1980) does not result in an ambiguous or patently inconsistent result. Nor does the sense of the statute "plainly" require that "or" be construed as "and." Accordingly, "or" must be interpreted as indicating alternatives, its common and accepted usage. Id. I believe, however, that interpreting "or" as a disjunctive does not prevent the Board from going ahead with their proposals.

1/ Minn. Stat. § 148.171(3)(a) (1980) states that:

> The practice of professional nursing means the performance for compensation or personal profit of the professional interpersonal service of: (a) providing a nursing assessment of the actual or potential health needs of individuals, families, or communities.... (Emphasis added.)

As I understand Margaret Baach's memo, the Board has proposed separate "categories and nursing abilities" for the assessment of individuals, the assessment of families, and the assessment of communities. The disjunctive language in Minn. Stat. § 148.171(3)(a) (1980) in no way precludes the proposal. On the contrary, if the "or" was an "and," the Board could not establish separate criteria for each of the services listed because performing any one or two of the services would not constitute the practice of nursing, and the Board could not regulate the conduct. Given the disjunctive language of the provision, however, one practices nursing who provides a nursing assessment of individuals, or families, or communities. The Board's proposal does not, therefore, founder on the final "or" in the statute.2/

Margaret Baach's second question is whether the "such as" language of Minn. Stat. § 148.171(3)(b) (1980) prevents the Board from establishing "categories and nursing abilities" for each of the functions listed therein.3/ It does not.

The functions listed after "such as" in the statute exemplify actions which constitute the practice of nursing. As such, the performance of any one of the specified functions would constitute the practice of nursing, which the Board may regulate as provided in the Nurse Practice Act. The importance of the inclusion of "such as" in the statute is to indicate that the providing of supportive or restorative functions not specified may also constitute the practice of nursing. See State v. End, 45 N.W.2d 378, 380 (Minn. 1950) ("Such" is construed in accordance with its common meaning, i.e., of the sort or degree otherwise indicated or implied.) Accordingly, the "such as" language of Minn. Stat. § 148.171(3)(b) (1980) does not prevent the Board from going ahead with its proposals.

If you have any questions or require additional information, please let me know.

JMB:sil

2/ This memo does not, of course, address the broader question of the general statutory authority of the Board to take its proposed actions.

3/ Minn. Stat. § 148.171(3)(b) (1980) states that:

> The practice of professional nursing means the performance for compensation or personal profit of the interpersonal service of: . . . (b) providing nursing care supportive to or restorative of life by functions such as skilled ministration of nursing care, supervising and teaching nursing personnel, health teaching and counseling, case finding and referral to other health resources . . . . (Emphasis added.)

STATEMENT OF THE COMPETENCIES

OF

MINNESOTA ASSOCIATE DEGREE NURSING GRADUATES

from: "Development of a Statement of the Competencies of Minnesota's Associate Degree Nursing Graduates" by Mary M. Mergens, July, 1975.

Revised and Edited by the following Associate Degree Nursing Program Directors/Faculty/Chairpersons:

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March, 1977

STATEMENT OF THE COMPETENCIES

OF

MINNESOTA'S ASSOCIATE DEGREE NURSING GRADUATES

I. Synthesis of Knowledge from Nursing and Supportive Disciplines.

I. Possesses sufficient knowledge from Nursing and from the supportive disciplines enumerated below to sustain the practice of Nursing at the Associate Degree "level".

A. Knows theories of basic human needs--physical and psychosocial--and their manifestations throughout the life cycle.

B. Knows the components and principles of optimum health and the physical and emotional stressors in the environment which influen health.

C. Knows theories of human growth and development; the physical, psychological, social and cultural dimensions affecting personality and behavior.

D. Knows theories of human social behavior derived from the behavioral sciences, the social,psychological and cultural influences on individuals and groups, the economic, political and religious factors which influence behavior and the roles individuals play in groups.

E. Knows theories of individual differences; the physical, psychological, social and cultural dimensions along which individuals and groups vary (i.e. contributions of minority cultures, understanding of youth cultures, senior citizens, physically handicapped, etc.)

F. Knows facts and principles of the natural and biological sciences (chemistry, physics, biology, anatomy and physiology, and microbiology applicable to nursing practice.

G. Knows facts and principles of pharmacology, mathematics and nutrition applicable to nursing practice.

H. Knows principles and techniques of written and spoken communications.

I. Knows content from the humanities (philosophy, theology, music, literature, art and theatre) which contribute to the understanding of human needs and problems.

J. Knows causes, predisposing factors, modes of transfer and incidence of disease and methods of control and/or prevention.

K. Knows major manifestations of common health disorders at differing age levels and the expected results of medical and nursing treatment.

L. Knows theories of nursing and medical care; purposes and effects of the preventative, diagnostic, therapeutic, supportive and rehabilitative measures used.

M. Knows basic principles of management and supervision.

N. Knows common educational, health and welfare resources in the community.

I. Nursing Process Skills

A. Assessment

B. Planning

C. Implementation

D. Evaluation

II. Knows principles and techniques of problem solving and applies this "Nursing Process" in an orderly systematic manner to determine clients' needs or problems, to make plans to solve them, to initiate nursing care plans or assign others to implement them, and to evaluate the extent to which nursing care plans are effective in resolving the problems identified.

A. Knows principles and techniques of systematic observation and data collection, interprets and analyzes data to assess implications for nursing care and applies these abilities in all nursing care situations according to their knowledge base and within the criteria for determining the complexity of the nursing situations.

B. During any 8-hour shift of duty, plans nursing actions for 3-6 patients in simple nursing situations (or 1-2 patients in complex nursing situations) after assessing and determining priority of needs; contribute to developing comprehensive plans of care for patients in highly complex nursing situations.

C. Knows preventive, diagnostic, therapeutic, supportive and rehabilitative nursing measures and implements these within the plans of care on a given shift for 3-6 patients in simple nursing situations or 1-2 patients in complex nursing situations.

D. Establishes measureable criteria for ongoing evaluation of nursing interventions, (based on desired patient outcomes) and uses these to ascertain the effectiveness of care in all nursing situations and to revise care plans accordingly.

III. Interpersonal and Group Process Skills

A. Communication Skills

B. Group Dynamics

C. Nurse-Patient Relationships

D. Role as Member of Health Team

III. Interpersonal and Group Process Skills

A. Knows theories and techniques of interpersonal communication and applies these in interactions with patients, families and co-workers; recognizes situations where a higher degree of interpersonal skill is required and seeks assistance.

B. Knows theories and processes of group dynamics and group interaction and applies this knowledge in selected group situations with patients, families, and co-workers.

C. Knows basic concepts and theories of the helping relationship and endeavors to apply these in all nursing situations in an effort to establish therapeutic relationships and preserve human dignity and self-respect.

D. Knows the roles and functions of members of the health team and applies this knowledge to professional team relationships.

Nursing Care Skills and Delegated Medical Functions	IV. Nursing Care Skills and Delegated Medical Functions	Clinical Competencies Common to all Minnesota A.D. Graduates	Additional Competencies Which May be Expected of A.D. Nursing Graduate Depending on Their Basic Nursing Program and/or Specific Clinical Experiences
A. Basic Human Needs - Physical	A. Basic Human Needs - Physical	A.	A.
1. Physical Safety	1. Knows principles governing safe patient care, applies standarized safety measures in giving direct Nursing care to patients of all ages, and removes hazards to safety in all nursing situations.	1. Physical Safety a. Administration of Medications 1. oral (liquid and pills) 2. sub-cutaneous 3. intermuscular b. Use of restraints, siderails c. Application of heat and cold d. Pre and post-operative care	1. Physical Safety a. Administration of Medications 1. ear, eye, nose drops 2. rectal suppositories
a. Asepsis	a. Understands principles of medical and surgical asepsis and applies these in simple and complex nursing situations and can transfer this knowledge and adapt techniques to some highly complex nursing situations.	Asepsis a. Handwashing for medical asepsis b. Sterile Technique (gloving, dressing change, handling transfer forceps)	Asepsis a. Isolation Technique b. Wound Irrigations
2. Rest and Comfort	2. Understands the principles and therapeutic effects of rest and comfort measures for patients; is skillful in the ministration of these techniques and applies them in all nursing care situations.	2. Rest and Comfort a. Bathing patient b. Making occupied and unoccupied beds c. Providing oral hygiene/nail and hair care d. Giving backrub e. Perineal care f. Diaper changing	2. Rest and Comfort a. Abdominal/breast binders b. Application of derm packs

	Functions	A.D. Graduates	May Be Expected of A.D. N Graduates Depending on Th Basic Nursing Program and, Specific Clinical Experie
A. (continued)			
3. Oxygen	3. Knows the principles of establishing and maintaining an adequate airway and oxygenation and applies this knowledge in simple and complex nursing situations.	3. Oxygen Application of Ace Bandages Application of Elastic stockings Turning-Coughing-Hyperventilating patients Assessing Vital Signs -Temperature (oral, rectal, axillary) -Pulse (apical,radial) -Respirations -Blood Pressure -Fetal Heart Tones Oxygen administration	3. Oxygen Use of Blow bottles Oxygen Administration -mask, cannula -hymidifiers -inhalation therapy Postural drainage Tracheostomy Care and suctioning Pharyngeal suction Cardio-Pulmonary Resusitation
4. Exercise	4. Knows principles and therapeutic effects of good body mechanics and utilizes this knowledge from self and patients in all nursing situations which require positioning, moving, lifting and transferring patients or maintenance of posture and body alignment.	4. Exercise Exercising the patient with active and passive range of motion. Positioning, moving and transfer of patient Ambulating patients Use of wheelchairs Maintaining patients in traction	4. Exercise Use of canes, crutches, wheelchairs, walkers Care of casts Use of Stryker frame an circo-electric bed
5. Nutrition and Fluids	5. Knows principles of adequate nutrition and manifestations of inadequate absorption, utilization and storage of nutrients and applies this knowledge in simple and complex nursing situations.	5. Nutrition & Fluids Feeding patients of all ages Weighing patients Measuring Intake & Output Maintaining Intravenous therapy -changing bottles/bags tubings & dressings -regulating rates of administration	5. Nutrition & Fluids Nasogastric intubation and suctioning Gavage/Lavage Discontinuing IV's

A. (continued)

6. Elimination	6. Knows principles of normal eliminations and nursing actions which will assist patients to attain, maintain or restore normal elimination function and applies these measures in simple and complex nursing situations.	6. Elimination Positioning the bedpan/urinal Testing the urine for sugar and acetone	6. Elimination Giving an enema Use of rectal tubes Collecting Urine and stool specimens Inserting a suppository Catheter irrigation Urinary catheterization Ostomy care & irrigation
7. Sexuality	7. Knows factors which influence the expression of human sexuality and applies this knowledge in attaining "self-awareness" in the realm of sexuality and in giving care to patients in any nursing situation.	7. Sexuality	7. Sexuality Vaginal irrigations
a. Childbearing	a. Knows physiological, psychological and sociocultural factors which influence the childbearing process and uses the nursing process to assist individuals and families during childbearing and the beginning phases of childrearing.	a. Childbearing Performing post-partum checks Assessment of normal newborn	a. Childbearing Timing contractions during labor Monitoring the fetus during labor
B. Basic Human Needs - Psycho-social	B. Basic Human Needs-Psychosocial 1. Knows approaches that foster emotional health and promote psycho-social well-being and utilizes these measures to help persons under stress or with patterns of behavior characteristic of common mental illnesses.	B. Basic Human Needs - Psycho-social (See Competency Statements for related skills in Communications, Teaching, etc.)	B. Basic Human Needs - Psycho-social

and Delegated Medical Functions	and Delegated Medical Functions	Common to All Minnesota A.D. Graduates	May be Expected of A.D. Nursing Graduates Depending on Their Basic Nursing Program and/or Specific Clinical Experiences
C. Delegated Medical Functions	C. Delegated Medical Functions	C. Delegated Medical Functions	C. Delegated Medical Functions
	1. Knows the principles, techniques and authority with which he/she receives, records, and carries out delegated medical functions and applies this knowledge in all nursing care situations.	Preparation of patients for diagnostic tests Charting, reporting, use of Kardex	Assisting with physical examinations Obtaining specimens for culture Performs neurological checks Admitting, transferring and discharging patients

Teaching Skills	V.	Knows principles of teaching and learning and applies them, informally, in simple and and complex nursing situations with patients and families and in teaching peers and non-professional nursing personnel. A. D. practitioners may teach clients and co-workers any content they have learned in their basic nursing programs or as a result of participating in continuing education experiences.
Leadership/Management Skills	VI.	Knows principles of management and can apply this knowledge in assessing, planning, organizing, and coordinating the nursing care for a group of 3-6 patients in simple nursing situations, 1-2 patients in complex situations and as a team member only in highly complex nursing situations.
Professional Growth	VII.	Knows the requirements and the process essential to professional growth, applies this knowledge striving for excellence in practice, and evaluates own progress in meeting professional goals.
A. Legal and Ethical Responsibilities	A.	Applies knowledge of legal and ethical responsibilities in all nursing situations and periodically evaluates own performance in these areas.
B. Continued Professional Growth	B.	Knows the necessity for increasing scope and depth of nursing knowledge and skills, accepts responsibility for continued professional growth and demonstrates interest and initiative in pursuing this and begins to evaluate own progress in this area.

VII. Professional Growth (continued)

C. Referral Agent

D. Personal Philosophy of Nursing

E. Professional Organization and Issues

F. A.D. Role and Limitations

VII. Professional Growth (continued)

C. Knows the essentials of making referrals, recognizes the need for referrals in simple and complex nursing situations and initiates action towards referral through immediate supervisor.

D. Clarifies own concept of the meaning of nursing and develops an individual philosophy which will enhance the practice of nursing and, therefore, the well-being of the community.

E. Knows significant history and literature of the profession, understands factors which influence change within the profession and applies this knowledge in responding to current professional issues.

F. Understands the responsibilities and limitations of technical nursing practice, function within the scope of own ability and seek the help of qualified practitioners when patient needs are beyond his/her scope; functions in clinical specialty areas with additional post-basic education and/or experience; begin to evaluate own strengths and weaknesses in relation to role as first-level A.D. practitioners.

VIII. Personal Growth

VIII. Knows own requirements and the process essential to personal growth, applies this knowledge to make life meaningful, and evaluates progress towards achieving personal goals.

(All of Minnesota's A.D. Nursing Programs have additional expected terminal objectives related to personal and professional growth. However, since achievement of these goals is heavily dependent on individual and personal variables, they are not stated here as competencies.)