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Q: What is the difference between the BON and the NCNA?

That's a good question because many people, including nurses, are not really clear about that. The Nurses' Association is a professional organization. It's a volunteer organization created, and I'm speaking from a regulatory perspective, but created to enhance the profession of nursing. The BON is a governmental organization and it has legal responsibilities to assure that we meet the requirements for minimum competency, that we deal with scopes of practice for the levels of nursing that we regulate in NC. So, we're really governmental whereas the professional organization is voluntary and professionally focused.

Q: Why do the BON, NCNA and Center for Nursing collaborate?

I think we are all interested in assuring that the public is well served in NC from the perspective of nursing care. And we all have different roles in that. As already referenced, the regulatory role that we have. The Center for Nursing's charge is really to look at the workforce and the future needs of NC. One of the reasons we work so well with the Center is that we can provide the baseline data of the current workforce because we gather that with all of our renewal process. Nurses have to renew their license every two years. So at least every two years, we are gathering data, demographic data, where people work, what types of specialty areas, etc. And that then is used by the Center to be the basis of where we are, excuse me, where we are now and where we need to be to meet the needs of the future.

Q: Let's do that again.

And the Center then uses the data in terms of knowing what our workforce is now, projecting, for instance, retirement of nurses, looking at areas of practice and education, where our biggest needs will be in terms of the future, for instance, the nurse educators will retire out earlier than the practice, people in practice. So that has big implications for how we educate our future nurses in NC. So we really serve a baseline purpose for the information that the Center then uses to develop their projections for the future. We work

carefully with the Nurses' Association because anything that we do from a regulatory standpoint needs to be professionally acceptable. If we don't work together then we find ourselves at odds when we go into public forums to change laws, in the legislature, so it's really important that we collaborate and are all in agreement about how we need to move forward with all the changes in the health care environment. How we as a profession of nursing, and a regulated profession, need to move forward.

Q: Is this type of collaboration rare?

I would like to think that NC is exemplary in that regard. I do know that states depending on how their labor laws are, some states work better with their nurses' associations than others. But we have had a long history, from the very beginning of how we got our first practice act, of these organizations working well together. I think currently it's a commitment of those of us that are in the executive director positions that we want to work together because we recognize that we all bring our own strengths and values to what we want to do for the future.

Q: What does it mean for NC to be the first state in the nation to pass a nurse registration law?

Well, a lot of thoughts roll through my head in terms of responding to that. Certainly I think women's position in society in the, at the turn of the century was not strong, and the fact that in the South, we had the first practice act was rather amazing in the sense that there that they brought the recognition through the General Assembly, and my guess is that there were no women in the General Assembly, I don't know for sure, but I would make that guess, and in a culture where women were really to be in the background, to get that recognition that the educated nurses were getting with that Practice Act was just pretty incredible in those days. So something to say there was a lot of strength in the women that pushed for this, and that they went against what was the norm for behaviors for women in that, at that period of time.

Today, looking back at that, I think it's a really strong legacy for us in NC to say that we have always pushed forward to be proactive in terms of being sure that people understand that there need to be requirements for practice, and that was what the law said, there will be requirements in order for you to be recognized as a licensed nurse in NC. You can't just come through having learned it at the bedside, which was the tradition at that point. So, I think that following along with that we have the sort of legacy of remaining proactive and being on that cutting edge of where do we need to be and are we positioning ourselves to be there in the future?

Q: How did NC become the first state in the nation to elect members of its BON?

The first thing I would say is that NC is the only state in the country where the nurses elect the board members, the nurse members of the BON. No other state does that. However, there are other occupational boards in NC where the members are elected, for example, the Board of Pharmacy members are elected so there was a culture inside our

state in terms of regulatory boards where some were elected rather than just being appointed, and primarily appointed by the governor. I think that it's an area that we're very proud of because it allows nurses in any area of practice to have the opportunity to become a candidate for the BON. We don't have the layer of the political framework that overrides political appointments by the governor. So anyone has the potential opportunity whether they are connected or not connected with professional organizations or political groups, etc. We believe that give the people who are board members the opportunity to really look at nursing without the additional lens of political position in the state or anything like that.

Q: Do you feel that nurses are uniquely capable of providing good representation on the BON?

Well, prior to 1981, which is when we became an elected board, we did have representation, representatives on the board from the medical profession and hospital administrators. The belief for professional boards is that they may be regulated by members of their own profession and by members of the public whom they serve. And we believe that we have a strength there to be able to have both professional nurses and public members on the board. The other thing that is important in reviewing, particularly in disciplinary areas, having a board of nurses allows the board to have its internal expertise, so to speak, in terms of understanding practice. When you have boards that are mixed with other health professions, everyone comes to that board from their own profession and it's sometimes very difficult for them to make decisions related to nursing practice because again they see it through their own lenses.

Q: What is involved in the approval of educational programs in terms of initial licensure?

Well, in general, there needs to be an identified need for the program and programs need to be able to say we have the following resources both in terms of faculty, in terms of clinical areas that can be used and in terms of the educational setting itself. There then has to be a recognition of the educational program within the state system, that's outside of the board, in other words, it's an agency that's licensed or recognized as an academic institution.

Noise.

Q: What is involved in the approval of educational programs in terms of initial licensure?

It's the Board's responsibility to both approve initial programs wishing to become educational programs in the state and then to provide ongoing approval of those programs. We currently have about 92 programs approved in this state. And the board through rules has established what the standards are for those programs. And the standards look at not just curriculums, they look at faculty requirements, they look at student requirements. They have requirements in terms of access to clinical learning opportunities and they look at what are the requirements for the student to achieve in order for them to be eligible to take the licensure exam after they've completed the

program. One of the things we look at very regularly are what the pass rates are of the educational programs because that's an indicator of the strengths of programs, the strengths of the students, as well as the strengths of the faculty and curriculum.

Q: How is the BON changing its approach to disciplinary action?

For years, the focus of discipline has been on individual nurses to evaluate whether an individual is competent in their practice or whether they have either personal behaviors or lack of knowledge, skills and abilities in their practice, they have such a lack of those that they are not meeting minimum competency to practice. So the focus has been to investigate complaints about individuals and really to keep the focus on the individual.. We all recognize, I think everyone of us, that no one individual practices entirely independently most of the time. And that we all live in systems and some of those systems are healthy systems and some of those systems where care is delivered are not as healthy as they could be. That impinges on the practice of all of the health care providers within it. I think we are, with the report of the Institute of Medicine, the one that came out in late '99 in terms of 'to err is human,' their focus on patient safety and the medical errors that occur in systems, regulatory boards are really being forced to re-look at how we do discipline. And to be sure that we recognize that in many situations the system may be as much involved in creating a set-up, so to speak, for errors to occur as it may be an individual making a mistake. So we are actually being asked not necessarily to refocus, but to expand our focus from the individual, and there certainly are times when it is an individual issues, especially when it's driven by personal behavior, in terms of their not being able to practice safely. But we also need to be sure that we are carefully assessing those situations in the practice arena to look at what we may call the root cause of the problem. Is the root cause the individual and either their personal behaviors or their lack of knowledge, skills and ability in terms of their practice of nursing? Or is it a systems issue? So, that's where we are in the year 2001, is really expanding our focus. The other thing that we are wanting to do, which is a re-framing, I hope of discipline, is to try to move away from punishment and much more toward remediation. In other words, these are individuals who achieved at one minimum competency to practice given all of the issues that we know that are facing us in the future, it is far more important for us to try to remediate individuals than to take them out of practice and punish. So that really is a re-framing of the disciplinary process that we are required to carry out to be sure that we are appropriately protecting the people of NC.

Q: What specific programs has the Board put in place in this effort?

We have had for some time an alternative program for nurses with chemical dependency problems which is a non-public program for individuals who agree to a very specialized monitoring system, for them to go through rehab, to not practice for a period of time, and then to go back into practice with careful monitoring. It's been in place, and again, that's individually focused on the individual rather than on the system. We are now involved in the pilot project, it has a rather long name, it's called Practitioner Remediation and Enhancement and Partnership, or for short, PREP. And it is a pilot to show collaboration between hospitals, the nursing board and individuals within systems who have deficits in

their knowledge, skills and abilities. The pilot project is to look at how we can enhance the skills of individuals within hospital settings so that they remain in practice and they get their skills back up to a level where they are safe practitioners. This is a non-public program. It's strictly a pilot at this time, but we think the exciting piece of this is two things, the board would be seen as less punishing, we would be far more proactive in terms of remediation, we would be far more proactive in working with the systems who really are the experts on what are the clinical requirements for nurses delivering care in that system, and we would be focusing on helping nurses in this program. We are just starting this, we'll be working with 7 hospitals over the next year and then reevaluating this as a real baseline potential for a broader-based program that would be non-public, but would be binding in terms of contractual arrangements for nurses who do have identified areas that they need to, in which they need to improve their skills. And we would require certain kinds of remediation to take place, whether that be education, whether it be closer mentoring or supervision within a specified time period.

Q: How do you distinguish between appropriate and inappropriate barriers to nursing practice?

We have been very challenged in the last 5 to 8 years by some national programs, particularly the Pew Commission, in terms of looking at what barriers that have been created over time that are no longer necessary in order to facilitate nurses practicing in the individual states or other health care professionals practicing in particular states. And so we've been challenged to look at what things do we no longer need to be doing that we used to do. And how can we facilitate the practice of nursing so that we are providing the public access to competent nursing care in a very timely manner. The history in this country, starting in 1903, is that state by state, you set your own practice laws, your own practice requirements, and that no one can step foot on your soil with, and to practice unless they've gone through the approval process in that state. At the same time, particularly for the last 35 to 40 years, we have gone toward uniform entry requirements for nursing that they graduate from an approved program, that they pass the national licensure exam, so we have made a lot of movement toward uniformity across the states. And now the challenge for states is to get rid of those things that are no longer necessary. Why does a nurse have to give us her entire history in terms of her education and the places she has practiced in before to see whether she meets minimum competency in NC? One of the things that we've done in the last couple of years to be ready for the fact that physical boundaries in states don't mean what they used to, we have a very mobile society. We are into the information age where boundaries, physical boundaries, don't mean anything. We are at the tip of really exciting health care technology where we are not only able to gather data but able to do distance intervention with clients, so we are in a period of what we have been calling tele-medicine, tele-nursing. We are just on the cusp of a whole new area of practice that borders are not important from state to state, so how do we, as the regulatory board, get rid of some of these unnecessary things and yet assure the public that people have met minimum competency? That's a big question.

Q: What is the Nurse Licensure Compact?

The Nurse Licensure Compact is an agreement that actually has to be passed by law in each of the states that wish to enter a compact which is an agreement about how we practice between states. And the National Council of State Boards of Nursing to which all boards of nursing belong, started the process in 1995, '96, to look at how we could be prepared for this new age of practice, both in terms of mobility of nurses, and in terms of tele-medicine. So they worked, and we all belonged to it, so it was really our product, those of us who are part who are members of boards of nursing. Our product was to create a model compact and then take it state by state for adoption or enactment by the General Assembly and as each state has joined, then those states have agreements that among the compact states you only have one license. It's like a driver's license model. So that you have a license in the state in which you reside and the compact gives you the multi-state practice privilege which means that if we are a compact state and Texas, which is also a compact state, if I live in NC and I wish to go to Texas for 3 months for instance, and practice in an area, then I do not need to go through that board of nursing and through all the initial licensure in that state to endorse there. but that they will recognize my license and I will practice in that state. I'm held, similar to driver's license laws, to practice according to the laws in that state, just as you and I are held to practice, to driving within the speed limits, etc. of Virginia when we go there, but we don't have to get a license there. So that's the model, in fact, we've used to develop this. When you're trying to build uniformity among states and yet the individual state still has the power and authority to establish what the practice requirements are.

Q: What is unique about NC and the compact?

In 1997, we went to the legislature and got the power and authority to enter into an interstate compact because we knew it was coming. And we really did not have any opposition to that at all. But as we worked at the national level, we felt that our position would be strengthened if we in fact had the entire compact enacted by the General Assembly. So in 1999, we went back to the General Assembly, with the support, again, of all the key nursing organizations – the Center for Nursing the NC Nurses' Association, the NC LPN Association, we also had the support of the Hospital Association and a lot of support from individual hospital systems in this state to enact that compact in law. And that was done in 1999. It became effective July 1, 2000. So we became, on July 1, 2000, one of 7 states enacting the compact. One year later, July 1 of 2001, there will be 13 states in that compact. So it's very exciting what's happening in terms of broadening regulation, decreasing unnecessary barriers so nurses don't have to go through the hoops of one more application system, getting information from all the other states that they've ever practiced in, paying an additional fee, and waiting for whatever the time period is that takes us to administratively enact that licensure. So that if they are traveling nurses for example and they have a contract that will take them to Utah tomorrow, they can go because that is a compact state as well.

Q:?

I think another thing about the Interstate Compact is that it clarifies, it will help the nurse recognize that she or he is responsible for practicing according to her practice

requirements of other states when they are doing tele-nursing for example, and knowing that they don't have to quote get licensed in that state. Right now it's a very confusing thing for nurses. When we first started doing transport, helicopter transport of patients from one place to another, we had to make decisions about, in the air in essence, over when you're passing through another state are you required to be licensed in that state? So those are the kinds of things that just, we don't have to deal with in that regulatory manner once we have these compacts in place. But it does not, we actually believe that this will enhance public safety because one of the things about the compact is that it allows us to share information about people who are being investigated about for potentially inappropriate practice, or not achieving their minimum competencies. We can share investigative information which we have not been able to do state to state outside the compact. So some states may have a person practicing there and not even know that there's been a major problem in terms of their practice until there's formal action taken in the state, in another state.

Q: Why is NC so consistently out in front in issues of nursing?

There's also another first that you should mention and that was nurses, first state where nurses were approved to prescribe medications which is the nurse practitioner piece.

Nursing is highly valued by the public. It's highly valued, therefore, in the legislature. There's not, there are progressive people in the profession that have kept those issues out in front.

The other thing that I think is very special about NC in terms of our regulatory board is that we are a very autonomous board. We are not umbrellaed under any other state agency, so when we decide that we really need to make some changes in our law, we can go to the legislature, directly to legislators to ask them to sponsor our bills and support that process. Other states who are umbrellaed are very, have many hoops that they have to jump through whether it's approval within their umbrella department, it may be that it has to be part of the governor's package of legislation. So it's a much slower process in other states. So, I think that's a very big reason for our being able to move. Many states want to be where we happen to be, but the machinery in the state is different.

Q: What is meant by bringing all of nursing under the BON?

In 1975, NC set forth, what I believe is hallmark legislation, in that we approved in the state nurses to be able to perform medical acts and to prescribe medications. That law which we now call the Nurse Practitioner Law was jointly formed under the BON and the Board of Medicine. In other words, the regulation of this advanced practice registered nurse was to be handled by two boards, the medical board and the nursing board.

In 1983, there was a Midwifery Practice Act that was passed. And there was established a midwifery joint committee composed of physicians and nurses, some of whom were members of both the Board of Medicine and the Board of Nursing and then others practicing in NC to regulate the practice of midwifery.

There has been a coalition of advanced practice registered nurses for several years in our state working on the premise that all of nursing should be regulated by the nursing board. And so the movement has been there to try to pull these other groups, the nurse practitioners and the nurse midwives, under the sole authority of the BON rather than working with 2 regulatory authorities and to say to the public that it is an area of advanced practice nursing that we're dealing with. In 1973 it was hallmark to believe that we could get this legislation passed for nurses to prescribe and perform medical acts, and that was wonderful. Again, real progressive in NC. But in the year 2001, we have a very clearly developed curriculum for advanced practice nurses, all done under nursing education programs. So it would be consistent to bring the practice of that area under the regulation of the Board.

Q: What are ways the public can verify licensure?

It's there, it is a difficult thing for the public to know how to access that information, but we do have both an internet-based verification system as well as a telephone-based verification system used primarily by employers, and particularly bigger employers than the individual who wants to hire someone in the home may not know this as readily,, but you can access through our website verification information. You have to know the nurse's name, and you have to have either the nurse's social security number or their license certificate number. With that information, then, you will be given the information about the nurse that he or she is licensed until such and such a date in the future and that they have the interstate, multistate practice privilege, if the are residents of NC. There are nurses who reside in Virginia and work in NC. They do not have the multistate privilege to practice because VA is not a compact state. So that would not be shown on that verification, but you get the basic information of the individual being licensed. And if the individual has any discipline, active discipline action on their license, for instance, they may have a restricted license, then what that internet-based program will say is we cannot verify this, you need to contact the BON. Then that tells the caller to contact us. We pull the information up and can give them further information about yes, they are licensed but they may carry a restricted license and these are the restrictions.

Well, I think it will, it is becoming more and more important to the public that they know who their practitioners are, not just their physicians or their dentists, but their nurses, and we have to be able to provide that information because number one, we serve the public.

Q: What is the major challenge the Board must handle in dealing with a smaller workforce?

We aren't sure that we know what all our challenges are going to be. We do recognize that with the future of nursing shortage that isn't going to go away. This nursing shortage is not going to go away, unlike many of the previous ones. And so we recognize that there will be fewer people to perform more activities. In other words, more will be put on the shoulders of the nurse. The nurse will be asked to accept more responsibility and accountability. The real tough issue is how much can one safely accept? The other tough

issue is how can we utilize assistance personnel to support the practice of nursing in a safe manner, but to probably delegate activities that we have believed for the last 50 years only a nurse can perform. (Noise)

Some of the other challenges in terms of the predicted nursing shortage will be pressure for instance in communities for perhaps decreasing the admission criteria in the education programs because there's such a push, a need for people. So it's going to be a real challenge to those educational programs to be really clear about what the minimum standards have to be. Boards will be looking at that too in terms of is there any area where we need to change our standards that would still appropriately protect the public. So I think there are going to be some rough times ahead. And the other thing that I truly believe is that healthcare will change. Because we aren't going to have the bodies in the future. So one of the more recent studies, I think sort of crystallized the future of health care is that hospitals will be intensive care units, nursing homes will be what we really know as hospitals and nursing home care will be delivered in the home and families will be far more involved in the care of their loved ones. There won't be enough care providers out in the workforce. It's going to be a challenge for us all, not just regulatory bodies, but all of us in terms of the care that's going to be needed.

Q: What is meant by the term scope of practice?

The law in NC in terms of the practice of nursing defines what we call components of practice. And that's, those are parameters of practice, what's legally yours to do as either a registered nurse or a licensed practical nurse that ranges from the assessment of clients in terms of their health care needs, nursing interventions, the responsibility for evaluating clients' response to care, responsibility for informing other health care providers of changes in status and things that you know someone else has the legal authority and expertise to evaluate. It's your responsibility to communicate with them. Those are all issues related to scope of practice. As an example of what's outside of scope of practice for a registered nurse is they do not have the authority to prescribe legend drugs, or controlled substances, that's a part of their scope of practice for advanced practice nurses and for physicians and other health care providers. So the scope of practice is what is legally defined as being within your domain.

We interpret the scope of practice. I think one of the wonderful things about nursing and health care in general, is it's an evolving area with our new technologies and research and capabilities, things are always changing and how we deliver care changes. So we want to be sure that our scope of practice are broadly enough stated so that we can change and gain the additional knowledge and skill that we need in order to provide safe care. But at the same time, we have to be really clear where the lines are in terms of we do not go beyond this because it's outside our scope of practice, it's outside what we're prepared to do and what we're licensed to do. And if there's a need to change the limits of scope of practice, then we'd have to go back through a legislative process to do that. So

the Board has a very large responsibility in interpreting the practice act and one of the major activities that we do is consultation with individuals as well as with health care

systems for helping them understand what is the scope of practice. The thing that I've always been impressed with in working with the board is that we do have a very broad scope of practice and there are very few things we can't do. There are many, many things that are within our scope of practice.

Q: What is the distinction between diploma and baccalaureate nursing programs?

When the Practice Act was enacted in 1903, the major driver behind that were the diploma education programs. Nurses who were educated really believed that the public needed to know that there was a difference between the nurse educated in formal education programs and the nurse who learned it as an apprentice, so to speak, at the bedside. So the strength of diploma programs grew out of the Civil War era and into the mid-1900s and only beginning really and probably around 1960, did we begin to have some rather significant shifts. Baccalaureate programs came into NC in the 1950s. In the 1960s, we began to have community college-based programs. Hospitals were and had slowly moved away from their primary role as the educators of nurses. So that today we have only 5 hospital-based programs in the state. I believe we have 3 diploma-granting programs in the state and that's been a major shift in the last 50 years. Diploma programs we have, I'm sorry, baccalaureate programs, we have 12 baccalaureate programs in the state of NC. We have 48 ADN programs for RNs. So there's been a growth in both the baccalaureate although a slower growth there than in the community college program. From a regulatory standpoint, the entry to practice is the same whether your a graduate from a ADN program, a diploma program, or a baccalaureate program, they all lead to licensure at the RN level. In the community college system, we also have the practical nurse education programs which lead to a license as a licensed practical nurse. So, regulatorily, we do not recognize a difference.

Q: Who are your NC nursing heroines?

First of all, I'd like to say that I am not a historian, so I have not spent a lot of time really understanding some of the individuals. You've got many other people that know those folks in depth. But the Mary Lewis Wyche folks, the Lydia Holmans, the individuals who knew where they wanted nursing to be and moved it in the face of someone saying 'You're crazy' or trying to shut you up, so to speak.

Lydia Holman and her stories of practice in the mountains and being pulled up in front of the medical board at one point in time because of the concerns about what she was doing did not deter her from taking the care to the people who were really in need of that care. They're real pioneers. In today's age, we've got so much regulation surrounding us that probably they would have been in deeper problems with their own regulatory boards, but that wasn't the story in the early development of nursing and I'm glad it wasn't because it allowed people to recognize where the needs were and to supply the resources as best they could. So, I don't have a heroine as such, but I do admire the fortitude, the clarity or goals and moving towards that in the face of much deterrence.

Q: How does this legacy effect you?

I think one of the inspirations is needing to be clear about where we are, where we need to be, realistically, in terms of health care, in terms of the needs of our changing population. And being committed to focus on that and not to focus on what personally I may believe is the right thing to do or allowing turf battles to, to keep us from moving forward. Turf battles are there, they're louder these days than they used to be in terms of overlapping scopes of practice and we need to help people understand that as various disciplines involved in health care, we overlap in many areas and that no one has ownership to a specific area to any great extent and you can't hang on to those things. So, I think the real challenge is being sure that you focus on why nursing practice needs to be moving forward in our state as well as in the country rather than what are we here to protect.

Q: Why has legislative activity been important for nursing?

In very brief terms, if it's not in the law, then nobody really has to comply with it. So that if you know professional standards hold up in some places, but when there are crunches and crises then you go to the minimum legal standards. So if we did not have clear definition of scopes of practice, when we get into, for instance, the nursing shortages that we've periodically had, people may put, for instance, licensed practical nurses into administrative positions. They're not authorized within their scope of practice to function at that level. But it's the law that helps protect those things. The law helps protect the public in saying that if you're not adequately prepared for it, we haven't assured minimum competency for it, then it's outside your scope of practice.

Q: Why does nursing need public advocacy?

In terms of all health care providers, it's the nurse that's there through the ups and downs of the care that's needed. The physicians and other people who are involved in focusing much more on what's the problem and how does it need to be treated, are providers who are much more in and out. If I am in a hospital, the only reason I have to stay overnight, is that I need nursing care. Same with a nursing home, the reason I would stay is that I would need nursing care. Physicians are not there, they come periodically. But the nurse is there around the clock. In the community-based ambulatory settings, nurses are really there to help families incorporate the health care needs into the rest of their life's needs. Nursing is much more holistically-focused profession within all of the areas of health care than any other. They can be seen as the generalists. The ones who try to put it all together, what their needs are in terms of medical treatment, what their needs are, for instance, in terms of physical therapy and rehabilitation, occupational therapy, pulling all of those things together is really the role of the nurse. The public needs to advocate for it and at the same time I think they do. I think that nurses are seen as very credible, important people in the lives of the public. But they need to advocate for it in the sense that it is an important profession, that it's going to be stressed because of the shortage and it will change what the public expects of nursing. We won't be there in the same numbers to provide care. So, it's sort of a hard question for me to get my hand around,

but the advocacy is there, the need is to be sure that nursing maintains a presence in the health care arena that is directly available to the public.

Q: Why are LPNs so valuable in the health care system?

LPNs are extremely valuable in terms of providing care to clients who need nursing care but are not so critically ill and unstable that they are changing their status minute by minute, hour by hour. LPNs are well-prepared to take care of the basic nursing needs of the public. And so we find, for instance, that the majority of LPNs work in settings such as nursing homes. Nursing homes are primarily staffed by LPNs. Yes, there are RNs, but not to the percentage of LPNs. LPNs practice in hospitals but that practice has changed quite a bit because and there are fewer LPNs percentage-wise now than there were even 8 years ago because of the critical status of clients. LPNs don't have as broad an education, they're not prepared to make immediate nursing judgements about really complex issues as RNs are. So the person at the bedside needs to be able to have to authority to make decisions appropriately and in ICUs for instance you won't find very many LPNs because they simply don't have that level of preparation. But the majority of people who have chronic conditions and ongoing nursing care needs outside of that real acute, unstable area, can be very well served when LPNs are part of that nursing framework. You would have to have RNs as well, but they work collaboratively and the RN has the responsibility of deciding when it is appropriate for the LPN to care for the patient and when it's more appropriate to see the client.

Q: Why is there a need for prevention and primary care?

Well, you've probably heard me use 2 words sort of back and forth and that's the client and the patient. We have traditionally had in health care, the traditional focus has been sick care. And most of the resources have gone in the direction of hospitals and those areas where we're providing care to the sick. But certainly research is there to say if you provide the education and prevention on the front end, you decrease the expenses of the sick care. And the frequency of that.

Nursing as a discipline is a holistic, has a holistic approach to care of clients. So the holistic approach says that prevention, education on the front end are as important, if not more so, than caring for the client when we or she is sick. So it's a piece of our culture in nursing and I believe it needs to become a greater piece of our culture in health care, that we need to look at the health of individuals and support health and we have spent far too much time supporting the sick care. Not that it's not needed, but we would need it less if we did a better job on prevention and education.

Q: What is the board's future composition and evaluation of itself?

We have, we've not really changed our Practice Act since 1981. Health care has changed tremendously. The high-tech issues that just were beginning to be introduced in the mid-'80s are now common practice in the turn of the century. So, it's important that the Board look at the composition of its board members and do they reflect the workforce in

NC, are they open because we are an elected board to every nurse who practices in NC and actually they aren't. There are certain nurses who don't have access to board positions. There is not a position for them. So we have had a task force in NC looking at what the future board composition and tenure would be like. And they have in fact presented a recommendation to the board, the board is considering that and making some adjustments to that in terms of size, looking at trending in terms of the sizes of regulatory bodies. We look at all the other boards in the country, we recognize that in NC we have 15 members, 2 public members and 13 licensed nurse members. There's been a big push nationally to make sure we have adequate public input on our boards. So one of the things we are looking at is expanding the size of the public membership and reframing the positions for particularly RNs, so that we open up opportunities for instance a nurse administrator from any type of health care system, not just hospitals currently it's hospitals and that was the big provider in the '80s, but we've got home care and hospice and the growth of nursing homes and new ideas coming out all the time. So we want to be able to expand that position. We wanted to have position for staff nurses irregardless of where they practice. We use the word staff and that takes us back into primarily the hospital mode, but the nurse who provides direct care to clients, not the nurse who manages the overall nursing care delivery system. So we're looking at that, we're looking at size, we currently elect members for a 3 year term and they may run for an additional 3 year contiguous term. They can then be off the board and run any number of times in the future, there's no limitation on tenure. There's no limitation on it. We've looked at what would make the board function better in terms of length of service. Is 3 years as good as what 4 years would do for the board where the membership isn't changing as frequently and where people are reaching their maximum potential and practicing as a board member for a longer period of time. So those are some of the things we are looking at. The other thing that I think appropriately so board's are being challenged to do is to basically report their evaluation of themselves. Are they doing their regulatory functions in a manner that is publically credible. So, we've expected health care systems for years to have in place a quality assurance program, a quality improvement program and now it's time for regulatory boards to be developing that. In fact, NC is one of the, a pilot states for a program that's sponsored by the National Council of State Board's of Nursing looking at developing templates for regulatory activities, best practices, and a mechanism for each board evaluating itself in term of those issues. So, that's a new area for us. There's no, we can't take a model and put it right on regulation because we are sufficiently different that we have to create it ourselves using information from other systems, and we're developing that. But I think it will be very important that we give a report card reading, so to speak, to the public on a very regular basis about what we are doing and how efficient and effective we are in what we do. Until we look at ourselves, we really don't know what we do is effective.

Q: Could you tell us why NC should be proud of its history of nursing?

Well, I think in terms of our centennial celebration, NC has a tremendous number of things to be proud of and to celebrate. Certainly, the fact that we were the first state to have a Practice Act signed into law and the first state, if not the first country, to have a nurse license issued which occurred in June of 1903. We have a really proud history in

terms of all the other things from a regulatory standpoint that we've done – the Nurse Practitioner movement, and not just the movement, but the authority for nurses to do things that heretofore had only been the turf of medicine which was to prescribe drugs, that's a big area, and to make diagnoses that are consistent with the medical framework for diagnosing. That was a huge step forward. The movements of, in the 1980s, early '80s, of

creating a board that was elected and took out that sort of political overlay of who are you and whom have you supported in the past in order for me to appoint you to a board. We don't have that. I think that makes it a healthier board that can focus very clearly on its public mandate. I believe that we continue to do things that say we're not just willing to stay with the status quo we want to be sure that NC is well positioned for the changes in health care that are coming along. So that has allowed us to move forward with the interstate compact and it's certainly important in the fact that we're looking at continued competence of nurses. We've done a really good job about the entry level but what we haven't done in NC is to really look at what should be the Board's role in terms of continued competence. So those are other areas we are moving toward. But we do have a rich history, and I think it's that rich history that supports our continuing to be really proactive. I think that you know we all know that NC was first in flight, well we were actually first in nursing before we were first in flight. So.