

**Kentucky Board of Nursing Programs of Nursing Update
December 2005**

Questions? Contact: Patty Spurr, Education Consultant @ 502-429-3333; Patricia.Spurr@ky.gov

KENTUCKY NURSE EDUCATOR CONFERENCE: LOCATION HAS BEEN SET

At the November Education Committee meeting, it was decided that General Butler would be the location for the 1st Kentucky Nurse Educator Conference. The date remains May 19—mark your calendars now. Remind faculty to submit an abstract to present at the conference! More information will be distributed early in the New Year.

NURSING STUDENT'S LEGISLATIVE DAY

Hopefully you have already received information about the Nursing and Allied Health Professional Student's Legislative Day being planned for January 26, 2006. The program is co-sponsored by the KHA Center for Health Care Professions and the Kentucky Association of Nursing Students. The cost is only \$5- a bargain! A copy of the flyer is attached for your reference.

NURSE/PHYSICIAN COLLABORATION

Attached are two items of interest. The first one is a copy of an article written by Dr. Barry for the Jefferson County Medical Society newsletter. In this article she describes a situation where a nurse in the middle of the night called her. I am interested in your thoughts in response to this editorial.

Secondly, there is a handout made available to me from the Kentucky Hospital Association-Center for Career Professions. This handout provides a series of questions that a nurse should pose to himself/herself prior to calling a physician. You might find this helpful to share with faculty and then students.

AONE ENDORSES BSN AS ENTRY INTO PRACTICE

If you have not heard, AONE (American Association of Nurse Executives) released a statement in April 2005 advocating the baccalaureate degree as the appropriate preparation for nurses and calls for working collaboratively with educators to prepare nurses. Their statement titled "Practice and Education Partnership for the Future" calls for registered nurses to be educated in baccalaureate programs in an effort to adequately prepare clinicians for their challenging and complex roles. "These clinicians receive an additional layer of education, which enhances their professional development, prepares them for a broader scope of practice, and leads to a better understanding of the cultural, political, economic, and social issues that affect patients and influence care delivery." Currently 43% of the national RN workforce possesses baccalaureate or graduate degrees. To access the AONE statement:

CALCULATION OF NCLEX PASS RATES FOR 2005-2006 ACADEMIC YEAR

Presently Kentucky calculates program of nursing NCLEX pass rates as first time testers who graduate from July 1 to June 30 and test by September 30. Those students who test after September 30, are lost and never included in calculations

With the advent of the Clinical Internship January 1, the question is should an adjustment be made in the time period utilized for calculation?

Estimate of time frames:

- | | |
|---|-------|
| o Certified List Received at KBN: | 5/15 |
| (Credentials Branch has 14 days to process the provisional license) | |
| o Provisional License & Internship Start | 6/1 |
| o Internship Completed | 7/1 |
| (Credentials Branch sends information to Pearson Vue & then processing ~ 14 days) | |
| o Receives the ATT | 7/15 |
| 90 Day Timetable for ATT | 10/15 |
| Six month Timetable for Provisional License | 12/1 |

For the next calculation period (2005-2006):

- o Maintain the graduation dates as presently used: July 1 through June 30
- o Calculate the pass rate at the normal September 30 date and again at December 31.
- o December 31 will be utilized as the cut-off date for the 2005-2006 calculation cycle.
- o Provide a report and analysis by school of the impact of the September 30 cut-off on the calculation of the pass rate.
- o Following this analysis, determine the need to alter the calculation dates for the future.

FREE CE COURSE ON PAIN MANAGEMENT PROGRAM

A free CE course titled "The Last Chance of Comfort: An Update on Pain Management at the End of Life" is available online. The course provides an overview of pain management, dispels some pain myths, reviews ethical issues tied to pain management, provides suggestions on holistic approaches to pain, and illustrates effective pain management strategies across different settings of care. Free registration is available at <http://www.VistaCare.com/paincme>.

CCNE MOVES TO CONSIDER FOR ACCREDITATION ONLY PRACTICE DOCTORATES WITH THE DNP DEGREE TITLE

In a move consistent with other health professions, the Commission on Collegiate Nursing Education (CCNE), the autonomous accrediting body of the American Association of Colleges of Nursing (AACN), has decided that only practice doctoral degrees with the Doctor of Nursing Practice (DNP) title will be eligible for CCNE accreditation. The CCNE Board of Commissioners reached this unanimous decision on September 29, 2005 as part of its continuing work to develop a process for accrediting clinically-focused nursing doctorates. For more information: <http://www.aacn.nche.edu/Media/NewsReleases/2005/CCNEDNP.htm>

DANGEROUS MEDICAL ABBREVIATIONS

Hopefully by now most nursing faculty have gotten the word on the list of abbreviations that both the ISMP and JCAHO have determined to be dangerous. One of the major causes of medication errors is the ongoing use of potentially dangerous abbreviations and dose expressions. Just in case faculty do not have this information, the 2-page list of abbreviations is provided for your distribution to faculty.

POSITIVE DRUG SCREENS ON NURSING STUDENTS

Board staff have received questions from Programs of Nursing on how to handle situations where a student has a positive drug screen with the primary question as to the need to report the student to the Board like you would a licensed professional with a positive drug screen. The issue presented is as follows: A student enrolled in a prelicensure program of nursing is required by a clinical facility to undergo a drug screen. The results indicate that the student tests positive for an illegal drug. The nurse administrator of the program is made aware of the positive drug screen. What should the nurse administrator do?

In the opinion of the Board's General Counsel: The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. §1232g, cover students enrolled in prelicensure programs of nursing. FERPA prohibits schools from releasing educational records to third parties without consent, with certain exceptions. There is nothing in FERPA that would allow the school to make such a report to the Board. This would apply to nursing students who are LPNs or nurse aides as well, since they are entitled to the protection of FERPA. The healthcare facility that conducted the drug test, however, would have an obligation to report a positive drug screen on an LPN, pursuant to KRS 314.031. This is a legal opinion rendered to the Board of Nursing and programs of nursing should consult their own legal counsel in particular cases.

KENTUCKY PROGRAM OF NURSING NCLEX PASS RATES ANNOUNCED

At the December Board of Nursing meeting, the NCLEX Pass Rates by nursing program were accepted. A copy of the rates as they will be posted on the KBN website are attached for your information.

CLINICAL INTERNSHIP VERIFICATION FORM

Attached is the latest version of the form that new graduates will be able to use to verify completion of the Clinical Internship (remember that the content is required—not the form). The only change to this form from the one previously distributed is in the area for the Supervising Nurse. Healthcare facilities asked that there be a place added for the License Number for the Supervising Nurse, along with their position, and unit/area. This will allow the Board to contact the nurse should there be any questions about the internship.

NCLEX REPORTS ARE ENCLOSED ONLY IF YOU HAVE HAD STUDENTS GRADUATE SINCE JULY 1, 2005 AND TAKE THE NCLEX.

Nursing and Allied Health Professional Students' Legislative Day

January 26, 2006 at the Kentucky History Center

Program Objectives:

- Define the role of the Kentucky House of Representatives and Senate
- Describe how proposed legislation is submitted to legislators
- Identify the steps legislators undertake to have proposed legislation reviewed and approved
- Describe the enactment process once legislation has been approved
- Understand the difference between a statute and a regulation
- Describe the process of obtaining enactment of a regulation

Agenda:

9:00 a.m. – 9:30 a.m.

Registration at Kentucky History Center
(map enclosed)

9:30 a.m. – 9:35 a.m.

Introductions & Opening Remarks

9:35 a.m. – 10:15 a.m.

Welcome from the General Assembly

10:15 a.m. – 11:00 p.m.

Understanding the Legislative Process & How it Impacts Nurses and Allied Health Professionals in Kentucky

11:00 p.m. – 11:30 a.m. **Lunch**

(Provided at the Kentucky History Center)

11:30 a.m.

Participants meeting with their Legislators. To schedule appointments with your legislators following lunch, go to <http://www.lrc.ky.gov/whoswho/whoswho.htm> for contact information.

Allow 10 minutes to travel from Kentucky History Center to Capitol. Transportation to the Capitol will be the responsibility of the attendee.

Contact Hour Information:

Approval by the Kentucky Physical Therapy Association is pending. The Kentucky Board of Nursing through the providership of Coverage Options Associates approves the program for 1.8 contact hours. Program offering number: 5-0023-07-07-029. Expiration date – July 2007. The Kentucky Board of Nursing approval of individual nursing education provider does not constitute endorsement of program content. Participants must attend the entire session and complete the evaluation. Those who desire continuing education credit must have nursing license or social security number at registration.

For additional information about this event, contact Dana Boucher at (800) 945-4542.

Registration Form (please print neatly):

Name: _____ Phone #: _____

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

College/University: _____ College Major: _____

Current Status: Freshman Sophomore Junior Senior

Registration Fee: \$5 (includes lunch)

Make check payable to: *Kentucky Hospital Research & Education Foundation*

Mail completed registration form and check to: **Center for Health Care Professions**

P.O. Box 436629

Louisville, KY 40253-6629

Registration deadline is January 19. There is no refund if unable to attend; however, substitutions are allowed.

Close Calls

In my dream I'm paddling down the Rio Grande, searching for the green kingfisher, a fancy, speedy, pretty bird who darts from branch to branch out over the water. There! — a glimpse of his little crest, and then an owl zooms past my ear, waking me up. I wouldn't see what kind of owl the hospital was calling. It was all of two a.m.

"Dr. Barry?"

"Yes."

"This is the service, I have Norton's for you, put them through?"

"Yes."

[What if I said no, I was dreaming?]

Hi, this is 5B ICU, is this Dr. Barry?"

"This is Dr. Barry." *[No, it's Dr. Who.]*

"Please hold for Esmeralda."

[Great. I try to remember the owl's wing . . . and that had to have been the kingfisher, his bill was as long as his tail. If only I'd heard him calling.]

"Dr. Barry?"

"Yes."

"This is Esmeralda, in 5B ICU?"

"Yes, what's going on?" *[Yeah, yeah.]*

"You know Mrs. Bennifer?"

"Dr. Shaw's patient? Yeah, what's up?"

"Her urine output is low."

"How low?"

"Only two hundred cc's this shift."

[Oh, for heaven's sake. It's only two hours into the shift.]

"What's her total I and O for the day?"

"Uhh . . . I don't have that. Hold on."

[Damn. Why doesn't she have that?]

My cat wakes up and sits on my shoulder. I move the phone to the other hand.

"Dr. Barry?" *[Who else?]*

"What?"

"She's three thousand in and 4600 out."

"And she's on Lasix every twelve, right? At eight and eight?"

"Yes."

"Is she breathing worse? Are her stats lower?"

"She's congested."

[The dreaded word, congested: It can mean anything from florid CHF to the common cold, from somebody just not being suctioned enough to some poor old lady aspirating herself to death. I cut to the chase.]

"Is she in trouble?"

"What do you mean?"

"What's her heart rate?" *[Is she dying, you dodo.]*

"Umm . . . AMBER!" she shouts.

I flinch. My cat flinches.

"AMBER, can you see the monitor?"

She puts me on hold.

[I grit my teeth.]

"Dr. Barry?"

"What?"

"It's 80."

[I choose my words carefully.] "Is that up, or down, from when you came on?"

"Ummmm . . . I think it's down. The aide took it. CHARLOTTE!"

Jeez! My cat leaps off my shoulder.

"Dr. Barry?"

What? *[If I yell, it will wake my husband.]*

"Charlotte's off the floor. But I think it's the same."

[She thinks. It's so reassuring when ICU nurses leave the vital signs to the aides.]

"Do you think you can tell me her blood pressure, or do you have to holler at somebody else?"

She sounds wounded. "No, I can tell you."

"AND??"

"You mean now, or when I came on?"

[I grind my teeth.] "Esmeralda! I would like to know her pulse NOW as opposed to then, and her B/P NOW as opposed to then" — my husband turns over, noisily—"and I would like to know WHY you are upset about her urine output when nothing you have told me indicates that she's in trouble from it."

Silence.

"Well . . . It's just lower."

"I see."

Silence.

I say, dangerously, "So you call me about

a patient whose vital signs you don't know, whose O2 stats you don't know, and whose I & O you don't know, simply because six hours after her last Lasix her urine output quits pouring out."

Silence.

"And you put me on hold twice and yell in my ear, to boot."

"Now, Dr. Barry, I'm sorry, I don't know what you're upset about. Her urine output was just — LOWER, and I thought I ought to notify you."

"You did. I am notified. Listen, Esmeralda, how long is a dose of Lasix supposed to last?"

Silence.

[At least she didn't yell for help.]

"Lasix lasts six hours. See? La-six, lasts six hours?"

"Oh!"

"So her last dose would be wearing off about now. But she's negative overall, she is not tachycardic, so I am not going to do anything till one of us makes rounds in the morning. You got it?"

"OK."

[I do not say, for God's sake, get your act together before you call the doctor. I do not say, for heaven's sake, examine the patient first! Know what they're allergic to. Know what meds they got recently. Know why, exactly, you are worried enough to call the doctor. If the only close call is whether we'll lose it, and wake our spouses, we can manage. But if the patient survives a close one

because you, the nurse, failed to know and I, the doctor, failed to ask, it's due to luck. Patients should not have to depend on luck.]

"Bye." I hang up. The kingfisher is long gone. **I**



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COMMENTARY

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SBAR Technique for Communication: A Situational Briefing Model

*Kaiser Permanente of Colorado
Evergreen, Colorado, USA*

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician's immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety.

When you download this tool, you will find two documents. The document, "SBAR report to physician about a critical situation," is a worksheet/script that a provider can use to organize information in preparation for communicating with a physician about a critically ill patient. The document, "Guidelines for Communicating with Physicians Using the SBAR Process," explains how to carry out the SBAR technique in detail. You will notice that both the worksheet/script and the guidelines use the physician team member as the example; however, they can be adapted for use with all other health professionals.

Background

Michael Leonard, MD, Physician Coordinator of Clinical Informatics, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado (Evergreen, Colorado, USA) developed this technique. The SBAR technique has been implemented widely at health systems such as Kaiser Permanente.

Directions

When you download this tool, you will find two documents. The document, "SBAR report to physician about a critical situation," is a worksheet that helps you perform the SBAR technique. The one titled, "Guidelines for Communicating with Physicians Using the SBAR Process," explains how to implement the SBAR technique in detail. You will notice that both the worksheet and the guidelines use the physician team member as the example; however, they can be adapted for use with all other health professionals.

***Please note that the file is in ZIP format, and contains two PDF files. Windows XP will automatically open the ZIP file; for other operating systems a tool like WinZip (or other free alternatives) should be used.*

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SBAR report to physician about a critical situation

<h1>S</h1>	<p>Situation I am calling about <patient name and location>. The patient's code status is <code status> The problem I am calling about is _____ I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally:</p> <p>Vital signs are: Blood pressure ____/____, Pulse _____, Respiration _____ and temperature _____</p> <p>I am concerned about the: Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual Pulse because it is over 140 or less than 50 Respiration because it is less than 5 or over 40. Temperature because it is less than 96 or over 104.</p>
<h1>B</h1>	<p>Background The patient's mental status is: Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>The patient is not or is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p>
<h1>A</h1>	<p>Assessment This is what I think the problem is: <say what you think is the problem> The problem seems to be cardiac infection neurologic respiratory ____ I am not sure what the problem is but the patient is deteriorating. The patient seems to be unstable and may get worse, we need to do something.</p>
<h1>R</h1>	<p>Recommendation I suggest or request that you <say what you would like to see done>. transfer the patient to critical care come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then ask: How often do you want vital signs? How long to you expect this problem will last? If the patient does not get better when would you want us to call again?</p>

Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
 1. Direct page (if known)
 2. Physician's Call Service
 3. During weekdays, the physician's office directly
 4. On weekends and after hours during the week, physician's home phone
 5. Cell phone

Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

2. Prior to calling the physician, follow these steps:
 - Have I seen and assessed the patient myself before calling?
 - Has the situation been discussed with resource nurse or preceptor?
 - Review the chart for appropriate physician to call.
 - Know the admitting diagnosis and date of admission.
 - Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
 - Have available the following when speaking with the physician:
 - Patient's chart
 - List of current medications, allergies, IV fluids, and labs
 - Most recent vital signs
 - Reporting lab results: provide the date and time test was done and results of previous tests for comparison
 - Code status
3. When calling the physician, follow the SBAR process:

(S) Situation: What is the situation you are calling about?

 - Identify self, unit, patient, room number.
 - Briefly state the problem, what is it, when it happened or started, and how severe.

(B) Background: Pertinent background information related to the situation could include the following:

 - The admitting diagnosis and date of admission
 - List of current medications, allergies, IV fluids, and labs
 - Most recent vital signs
 - Lab results: provide the date and time test was done and results of previous tests for comparison
 - Other clinical information
 - Code status

(A) Assessment: What is the nurse's assessment of the situation?

(R) Recommendation: What is the nurse's recommendation or what does he/she want?

Examples:

- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

4. Document the change in the patient's condition and physician notification.

CRITICAL THINKING STEPS PRIOR TO CALLING THE PHYSICIAN

**Developed by Rita Venhaus, Tomasewski, RN, MSN, ARNP, CCRN
and
Sally Pierce RN, BSN, CCRN**

This tool was developed to initiate critical thinking skills enhancing information delivery when communicating with physicians and other medical professionals. It is not a comprehensive list of medical problems or supportive data.

The BIG four questions

1. Why are you calling the doctor?
2. What is your supporting data?
3. What have you done?
4. What do you want?

Why are you calling the doctor?

- 1) Abnormal Vital Signs (pages 2-4)
- 2) Abnormal Rhythm (page 5)
- 3) Abnormal Lab (page 6)
- 4) Abnormal Cardiac Enzymes (Page 7)
- 5) Abnormal Chest (chest pain) [Page 7]
- 6) Abnormal Chest (shortness of breath, change in lung sounds) [Page 8]
- 7) Abnormal Head (neuro changes) [Page 9]
- 8) Abnormal Belly (Page 10)
- 9) Abnormal Groin (Page 11)
- 10) Abnormal Legs (Page 11)
- 11) Abnormal Bleeding (Page 12)
- 12) Abnormal Attitude (behavior) [Page 12]
- 13) Abnormal Pain (uncontrolled/unrelieved) [Page 13]
- 14) Abnormal I&O (increased or decreased) [Page 14]
- 15) Abnormal Blood Sugar (Page 15)
- 16) Abnormal Incision (Page 16)

1. ABNORMAL VITAL SIGNS

LOW BLOOD PRESSURE

What data supports the patient's issue or problem?

- Are medications contributing?
 - Antihypertensive meds, IV, PO or patches
- What is the volume status?
 - Is the I&O up or down?
 - What is the weight in comparison with admission weight?
- What is their normal blood pressure?
- What is their heart rate?
 - Recall that $HR \times SV = CO$, so if HR is low so will be the cardiac output (CO).
- What is the ejection fraction (EF)
- What is their hemoglobin?
- Is the pressure the same in both arms?

What have you done to treat the problem?

What do you want?

- Stop aggravating medications
- Fluid/blood products
- Vasopressors
- Transfer to critical care
 - CVP, Swan Ganz Catheter, Arterial line

HIGH BLOOD PRESSURE

What data supports the patient's issue or problem?

- Is there a history of hypertension?
 - Has the home medication been restarted?
- Is there history of renal artery stenosis?
- Are they symptomatic – headache, dizziness?
- If the patient is on IV antihypertensives, has an oral form been added?
- Is pain or anxiety a contributing factor?
- Did the patient have a recent surgery that hypertension would have a negative impact?
 - CAB, carotid endarterectomy, AAA, recent bleed
- What do the orders and doctors progress notes state in regard to BP?
- What is the goal BP?
 - Are we attempting to keep the BP higher than normal for a reason?

What have you done to treat the problem?

What do you want?

- More medication – add PO to IV or increase dosages
- Pain relief
- Stress relief
- Transfer to critical care
 - Arterial line

HIGH TEMPERATURE

What data supports the patient's issue or problem?

- Have recent cultures been done?
- Are the cultures complete? i.e. urine, sputum, blood, oozy yucky sites
- How old is the central line, int. needles, foley catheter?
- Are there sites/wounds that look infected?
 - Swollen, redness, drainage
- Is there productive sputum? What color is it?
- Has there been a neurological injury that is causing the high temperature?
- Are they getting blood transfusions?
- What antibiotics are they are? Are they sensitive to the organisms growing?
- Do we need an ID consult? Now or in the am?
 - What are the doctors writing in the progress notes?

What have you done to treat the problem?

What do you want?

- Cultures
- CBC
- Medication
 - Antipyretics, antibiotics
- ID consult, now or in the am

INCREASED RESPIRATIONS

What data supports the patient's issue or problem?

- What were the last chest x-ray results? Are they worse from previous reports?
 - Pleural effusion, CHF, pneumonia, atelectasis
- What are the results of ABG's?
- What is the method of O2 delivery?
- What is the SpO2?
- Is there pain associated with breathing?
- Are rubs auscultated? (pleural/pericardial)
- What is the blood sugar?
- Is septicemia suspected?
- Do they have a PE?
- Are they hyperthermic?
- Are they in pain?

What have you done to treat the problem?

What do you want?

- CXR, ABG's, VQ Scan, Spiral CT
- Pain/anxiety control
- FiO2
- Pulse oximetry

DECREASED RESPIRATIONS

What data supports the patient's issue or problem?

- CO₂ narcosis, excessive O₂ with history of pulmonary disease, COPD, emphysema
- What are the ABG's
- Are narcotics, sedatives, or anesthesia a factor?
 - Epidural, PCA, conscious sedation
- Has there been a neurological injury?

What have you done to treat the problem?

What do you want?

- ABG's
- Narcan/Romazicon

2. ABNORMAL RHYTHM

What data supports the patient's issue or problem?

- Asses the three R's: Rate, Rhythm, R wave width to determine if it is SVT or VT
- Are the leads in the appropriate position?
- Is the lead selection appropriate for the suspected rhythm?
- What is the patient's blood pressure?
- Do they have chest pain?
- What is their SaO2?
- Are they diaphoretic, short of breath or dizzy?
- Have they had this rhythm before, if so, what comment did the doctor make in the progress notes, what did they treat it with?
- How long did it last?
- What meds are they on to treat this?
- What is their K+, Mg+, is it a recent value?
- Have they been diuresed without K+ supplement or value checked?
- Do they have cardiac enzymes?
- Are the cardiac enzymes elevated?
- Is it a class I, II, or III rhythm?
- Did you get a 12 lead EKG?
- Is their pulse too low for the medication?
 - Lanoxin, Cardizem, Beta Blockers, etc.
- Has lab been checked for therapeutic/toxic blood levels?
 - Digoxin, procainamide, Theophylline

What have you done to treat the problem?

What do you want?

- Consult cardiology – now or in the am
- Appropriate medication for rhythm
 - DC medication if that is the suspected cause
- Pacemaker/cardioversion
- Additional labs
- Get in here and do something!! 😊

3. ABNORMAL LAB

What data supports the patient's issue or problem?

- What has been the trend for this lab?
- Has the doctor made a note about this?
- What may be the cause?
 - Low K+
 - Excessive diuresis, vomiting, excessive NG drainage, diarrhea, alkalosis
 - Are they on insulin?
 - High K+
 - Too much supplemental K+, renal insufficiency, salt substitutes, TPN, tube feeding, blood transfusions, rhabdomyolysis, acidosis, ACE inhibitors, Aldactone, Cyclosporins, NSAIDS, heparin, lovenox, lab error
 - Low Calcium
 - Medications
 - lasix, phenytoin, certain antibiotics, rifampin, pentamidine, ketoconazole – consult with pharmacy
 - Banked blood, rhabdomyolysis, renal disease, sepsis
 - High Calcium
 - Antacids, TPN, renal failure, malignancy, lithium, immobilization
 - Low Magnesium
 - Diuretics, some antimicrobials, ETOH, hypokalemia, hypercalcemia, NG suction, diarrhea, digoxin, insulin
 - High Magnesium
 - Renal failure, Mg containing antacids, lithium intoxication, lab error
 - CBC
 - WBC – high could indicate an infection. Low could indicate poor immune system
 - Hg and Hct – High could indicate dehydration, low could indicate bleeding.
 - Low Platelets
 - Certain antibiotics, massive blood infusions, heparin induced thrombocytopenia, lovenox, IABP, long heart/lung machine time
 - Platelet Inhibitors
 - Plavix, Integrilin, Persantine, Ticlid, ASA
 - Creatinine
 - High
 - Dehydration, renal failure, IV contrast dye, rhabdomyolysis, excessive blood transfusions

What have you done to treat the problem?

What do you want?

- Dependant upon the result of the lab in question; do you need to stop, start or adjust medications?
- Are blood products indicated

4. ABNORMAL CARDIAC ENZYMES

What data supports the patient's issue or problem?

- Is the patient having chest pain?
- Has the doctor been notified of abnormal result?
- If nuclear studies or GXT treadmill was scheduled, the doctor needs to determine if the test should be cancelled

What have you done to treat the problem?

What do you want?

- Other diagnostics, i.e. more cardiac enzymes, EKG's, schedule heart cath instead of treadmill if applicable

5. ABNORMAL CHEST – CHEST PAIN

What data supports the patient's issue or problem?

- Was the patient admitted with chest pain?
- What have the diagnostics shown? i.e. cardiac enzymes, positive V/Q
- Does this chest pain feel like what they had on admission?
- How long have they had it?
- How do they describe it?
 - Heavy, tight, sharp
- What relieved the pain or made it worse?
- What did the EKG show?
- What meds are they on?
- What did the CXR indicate?
- What is their cardiac rhythm?
- What are their vital signs?
- Did your intervention relieve the pain?

What have you done to treat the problem?

What do you want?

- Consult cardiology, now or in am
- 12 lead EKG
- Cardiac enzymes, ABG's
- Medications
 - NTG, MS, ASA, heparin, lovenox
- Cath lab
- CXR

6. ABNORMAL CHEST - SHORTNESS OF BREATH

What data supports the patient's issue or problem?

- Is this new?
 - History of COPD, Emphysema, heavy smoker, CHF
- What diagnostics have been done for this, i.e. CXR, echo, CT scan, ABG's
- What are their vital signs – how fast are they breathing?
- Are they diaphoretic?
- What is their SaO₂?
- What are the lung/heart sounds? (Rubs?)
- Do they have pain that is not relieved?
- What is the method of O₂ delivery?
- Serum Na⁺ (low may indicate fluid overload?)
- What is the I&O and weight trends since admission?
- Does the patient have an Inferior Vena Cava (IVC) filter in place?

What have you done to treat the problem?

What do you want?

- Consult pulmonology/cardiology now or in the am
- Increase oxygen delivery
- ABG's
- CT scan or V/Q scan
- CXR
- Lasix

7. ABNORMAL HEAD - NEURO CHANGES

What data supports the patient's issue or problem?

- What is the neuro change?
 - Alert and oriented? Follow commands? Appropriate conversation?
- Prior diagnostic results?
- What was their baseline neuro status prior to admission and prior to your shift? (prior CVA etc)
- Are they on anticoagulants?
 - Are they forgetful, restless, pupil changes, motor changes, are they suddenly quiet?
 - What meds may be contributing to this?
 - Narcotics, sedatives, sleepers, lidocaine, digoxin?
 - Reglan can cause confusion in the elderly
 - Are there changes in vital signs?
 - When did it begin?
 - What is the blood sugar?

What have you done to treat the problem?

What do you want?

- Consider medications
- Consult Neurologist/Neurosurgeon now or in the am
- CT/MRI of head now or in the am
- Transfer to critical care

8. ABNORMAL BELLY

What data supports the patient's issue or problem?

- Is the abdomen distended?
- Abdominal girth?
- Are bowel sounds present?
- What is the quality of bowel sounds?
 - Hyper or hypoactive
 - Are they passing flatus?
- Localized tenderness or rebound tenderness?
- When was the last BM?
 - What was the quality?
- Are nausea/vomiting present?
- Do they complain of heartburn/indigestion?
- What are the progress notes stating?
- Diagnostics
 - KUB, CT scan, NG decompression
 - Elevated WBC's?
 - Is the patient NPO or eating?

What have you done to treat the problem?

What do you want?

- Consult now or in the am
- Flat plate (KUB)
- CT of abdomen
- NG to suction
- Liver function studies, CBC
- Promote evacuation of the rectal vault
 - Stool softener or fleets
 - PT consult to get the patient up and moving!

9. ABNORMAL GROIN

What data supports the patient's issue or problem?

- Is there a hematoma present?
- Is there a bruit present?
- What is the platelet count? Is it recent?
- When were the lines pulled?
- What was the procedure?
- Is there history of a inguinal hernia?
- Are medications contributing to the situation?
 - Integrilin, heparin, ASA, plavix

What have you done to treat the problem?

What do you want?

- Hg/Hct
- Ultrasound of groin to r/o pseudoaneurysm
- D/C medication if appropriate

10. ABNORMAL LEGS

What data supports the patient's issue or problem?

- Do they have a palpable DP, PT, popliteal pulse? If not is it auscultated via Doppler?
- Is this a new finding?
- When did it start?
- What is the color, temperature, sensation, capillary refill time of the leg? Is there pain?
- Is there edema present?
- If DVT is suspected are sequential stockings/TEDS on?
 - They should be off until DVT is ruled out
- What is their diagnosis?
- What diagnostic have been done? Angiogram, cath

What have you done to treat the problem?

What do you want?

- Non-invasive studies
- Arteriogram

11. ABNORMAL BLEEDING

What data supports the patient's issue or problem?

- Where is the bleeding and when did it begin?
- What is the H/H?
- What meds are they on?
 - Integrilin, ASA, plavix, heparin, coumadin, lovenox, Vioxx, NSAIDS.
- What are their vitals?
- Are they symptomatic, i.e. dizzy, diaphoretic, chest pain, nauseated.
- Have they had this before?
- What is the amount of bleeding?
- What is the character of bleeding?
 - Bright red, serous sanguineous, dark

What have you done to treat the problem?

What do you want?

- Chem. Comp., CBC, and Coagulations studies
- DC anticoagulants
- Blood products
- Consult

12. ABNORMAL ATTITUDE - BEHAVIOR

What data supports the patient's issue or problem?

- Is the patient combative, crawling out of bed, pulling out lines?
- Is this new or does the patient have a history of sundowners?
- Can medication be a contributing factor?
- What are the vital signs, including SpO2?
- Any neuro changes associated with this?
- Is the pain controlled?

What have you done to treat the problem?

What do you want?

- Pysch consult
- Change environment
- Restraints
- Haldol – get baseline QTC
- Ativan
-

13. ABNORMAL PAIN - UNCONTROLLED/UNRELIEVED PAIN

What data supports the patient's issue or problem?

- What is the current pain rating?
- What is the patient's pain rating when they are comfortable?
- What is the patient's goal for pain rating?
- Is the patient on a pain medicine regimen at home?
- Is the patient requesting pain medicine more frequently than the medication is ordered?
- Is the pain medication ordered adequate to cover the pain?
- Is the patient able to participate in activities/ADL's as ordered or as the patient would typically do?
- Has there been consistency in treating pain, or is there variance among caregivers? (Hit and miss pain med delivery)
- How is pain adversely affecting the patient?
 - Sleep, eating, nauseated, VS elevated, pulmonary toiletry, activity

What have you done to treat the problem?

What do you want?

- Change in pain medication
- Amount, frequency, route
- Diagnostics
 - CT scan, ultrasound, CXR –is patient receiving adequate pain med for condition/situation?
- Change in activity level if patient is limited
 - Out of bed, PT consult
- Consideration of pharmacist's recommendations
- Application heat or cold, elevation
- Is this a situation where the pain clinic should be consulted?

14. ABNORMAL INTAKE AND OUTPUT – INCREASED AND DECREASED

What data supports the patient's issue or problem?

- What are their current vital signs?
- Do they have a prostate history?
 - a) What does their blood pressure normally run?
 - b) Is their blood pressure too low to perfuse the kidneys?
- What are their weight trends and/or I &O?
 - c) Are they over or under diuresed?
 - d) Are they loosing fluids from other sources, i.e. vomiting, bleeding, diarrhea, massive NG drainage
- What is their creatinine?
- Is their foley patent - do they need one?
- What does the bladder scanner show?
- e) How much total hourly intake is the patient receiving?
- f) What does their UA show – do they need one?
- g) What is their recent Na⁺ and K⁺ levels?

What have you done to treat the problem?

- Bladder scanner
- Irrigated the foley
- Encourage fluid intake if hypovolemia is suspected
- Treated nausea/diarrhea if order present

What do you want?

- Fluids started or decreased
- Antiemetic or antidiarrheal
- Directic if indicates
- Urology consult
- Foley catheter if indicated
- IV fluids if indicated

15. ABNORMAL BLOOD SUGAR

What data supports the patient's issue or problem?

- Low
 - What is their insulin dose?
 - Are they on oral hypoglycemic medications?
 - When does the insulin peak?
 - Is the patient NPO?
 - What is their neuro status?
 - What are the glucose trends?
- High
 - Steroids, TPN, tube feeding
 - Stress
 - Sepsis
 - Hg A1C
 - What are the glucose trends?

What have you done to treat the problem?

What do you want?

- Increase or decrease in medication
- Endocrine consult – now or in am?
- Change to an insulin drip
- Increase frequency of accuchecks

16. ABNORMAL INCISION

What data supports the patient's issue or problem?

- Has the dressing been changed daily? Date the dressing changes on the dressing!
- Is there drainage?
 - Color, amount
 - Has it been cultured – if so what is the result?
 - Are they on antibiotics?
 - Is the organism sensitive to the antibiotic?
- Is there odor?
- What is the appearance of the incision?
 - Staples or sutures present?
 - Open
 - Red, pale
 - Edema
- Is the incision more painful now than the past 24 hours?
- Is the doctor aware of this? (progress notes)
- What is their temperature, white blood count?

What have you done to treat the problem?

What do you want?

- Consult, now or in the am
- Culture
- Antibiotics

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

It's been over 2 years since we published a list of abbreviations, symbols, and dose designations that have contributed to medication errors. Now, with the 2004 JCAHO National Patient Safety Goals calling for organizational compliance with a list of prohibited "dangerous" abbreviations, acronyms and symbols, we thought an updated list would be useful. Since JCAHO has specified that certain abbreviations must appear on

the organization's list, we've highlighted these items with a double asterisk (**). Also, effective April 1, 2004, each organization must include at least three additional items on their list. However, we hope that you will consider others beyond the minimum JCAHO requirement. Selections can be made from the attached list. These items should be considered for handwritten, preprinted, and electronic forms of communication.

Abbreviations	Intended Meaning	Misinterpretation	Correction
μg	Microgram	Mistaken as "mg"	Use "mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use "right ear," "left ear," or "each ear"
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right eye," "left eye," or "each eye"
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	Use "mL"
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
IJ	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
IN	Intranasal	Mistaken as "IM" or "IV"	Use "intranasal" or "NAS"
HS	Half-strength	Mistaken as bedtime	Use "half-strength" or "bedtime"
hs	At bedtime, hours of sleep	Mistaken as half-strength	
IU**	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
o.d. or OD	Once daily	Mistaken as "right eye" (OD-oculus dexter), leading to oral liquid medications administered in the eye	Use "daily"
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use "orange juice"
Per os	By mouth, orally	The "os" can be mistaken as "left eye" (OS-oculus sinister)	Use "PO," "by mouth," or "orally"
q.d. or QD**	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"	Use "daily"
qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly"
qn	Nightly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly" or "at bedtime"
q.o.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written	Use "every other day"
q1d	Daily	Mistaken as q.i.d. (four times daily)	Use "daily"
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "6 PM nightly" or "6 PM daily"
SC, SQ, sub q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or 1/2 (apothecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half" or "1/2"
SSRI	Sliding scale regular insulin	Mistaken as selective-serotonin reuptake inhibitor	Spell out "sliding scale (insulin)"
SSI	Sliding scale insulin	Mistaken as Strong Solution of Iodine (Lugol's)	
i/d	One daily	Mistaken as "tid"	Use "1 daily"
TIW or tiw	3 times a week	Mistaken as "3 times a day" or "twice in a week"	Use "3 times weekly"
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unit"
Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
No leading zero before a decimal dose (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "l" such as Inderal40 mg; Tegretol300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100mL)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Abbreviations such as mg. or mL with a period following the abbreviation	mg. mL.	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	Intended Meaning	Misinterpretation	Correction
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug name
DTO	Diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCl	hydrochloric acid or hydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT	hydrocortisone	Mistaken as hydrochlorothiazide	Use complete drug name
HCTZ	hydrochlorothiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSD4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mitoxantrone	Use complete drug name
PCA	procainamide	Mistaken as Patient Controlled Analgesia	Use complete drug name
PTU	propylthiouracil	Mistaken as mercaptopurine	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Use complete drug name
TAC	triamcinolone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	TNKase	Mistaken as "TPA"	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed Drug Names	Intended Meaning	Misinterpretation	Correction
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name
"Norflox"	norfloxacin	Mistaken as Norflex	Use complete drug name
"IV Vanc"	intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Symbols	Intended Meaning	Misinterpretation	Correction
3	Dram	Symbol for dram mistaken as "3"	Use the metric system
m	Minim	Symbol for minim mistaken as "mL"	
x3d	For three days	Mistaken as "3 doses"	Use "for three days"
> and <	Greater than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "greater than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 10" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
o	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "hr," "h," or "hour"

** Identified abbreviations above are also included on the JCAHO's "minimum list" of dangerous abbreviations, acronyms and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. An updated list of frequently asked questions about this JCAHO requirement can be found on their website at www.jcaho.org.

KENTUCKY BOARD OF NURSING
312 Whittington Parkway, Suite 300
Louisville, KY 40222-5172

2004-2005
NCLEX Pass Rate* and Approval Status

	2000		2001		2002		2003		2004		2005		
	Pass Rate	# Tested	Approval Status										
Baccalaureate Degree Nursing													
Bellarmino University	98%	42	88%	43	100%	38	100%	47	100%	61	97%	90	Full
Berea College	73%	15	86%	14	94%	17	71%	7	93%	14	91%	11	Full
Eastern Kentucky University	95%	66	86%	71	96%	49	95%	38	100%	72	92%	107	Full
Kentucky Christian University	0%	0	0%	0	0%	0	0%	0	0%	0	75%	4	Full
Morehead State University	88%	16	86%	22	85%	27	87%	15	64%	14	95%	20	Full
Murray State University	93%	41	100%	33	92%	37	81%	27	100%	39	88%	41	Full
Northern Kentucky University	0%	0	0%	0	0%	0	0%	0	75%	16	90%	30	Full
Spalding University	90%	39	73%	37	93%	28	74%	23	97%	33	91%	74	Full
Thomas More College	100%	5	86%	14	86%	7	86%	7	88%	8	50%	8	Full
University of Kentucky	93%	49	96%	57	97%	65	95%	61	94%	62	98%	64	Full
University of Louisville	83%	88	85%	55	96%	70	88%	64	92%	87	89%	116	Full
Western Kentucky University	94%	32	89%	36	100%	24	78%	36	93%	44	90%	60	Full

	2000	2001	2002	2003	2004	2005
Graduates	411	396	371	329	456	633
Testing	393	382	362	323	451	625
Passing	353	336	344	288	425	571
Kentucky Pass Rate Average	90%	88%	95%	89%	94%	91%
National Pass Rate Average	82%	84%	85%	86%	85%	85%

* Pass rates are calculated considering individuals who: 1) graduated between July 1, 2004 and June 30, 2005; 2) tested between July 1, 2004 Sept. 30, 2005; and 3) are first time takers of NCLEX.

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2004-2005 NCLEX Pass Rate* and Approval Status	2000		2001		2002		2003		2004		2005		Approval Status
	Pass Rate	# Tested											
Associate Degree Nursing													
Ashland Community & Technical College	90%	49	89%	45	87%	39	88%	56	92%	49	94%	54	Full
Big Sandy Community & Technical College	100%	13	95%	22	56%	9	87%	15	94%	16	90%	21	Full
Bluegrass Community & Technical College	87%	79	93%	54	98%	47	95%	59	91%	65	97%	78	Full
Eastern Kentucky University	84%	110	87%	94	98%	89	94%	85	91%	117	93%	107	Full
Elizabethtown Cmty. & Technical College	98%	53	90%	51	100%	35	98%	43	95%	44	94%	51	Full
Hazard Community & Technical College	80%	51	91%	64	77%	48	100%	55	82%	50	88%	59	Full
Henderson Community College	86%	36	97%	34	91%	33	97%	38	100%	55	88%	65	Full
Hopkinsville Community College	77%	47	97%	37	100%	34	93%	46	98%	44	93%	42	Full
Jefferson Community & Technical College	81%	101	92%	100	96%	68	100%	83	96%	85	97%	122	Full
Kentucky State University	84%	31	84%	19	81%	32	88%	25	100%	29	94%	36	Full
Lincoln Memorial University - Corbin Campus	100%	7	91%	11	93%	14	73%	22	94%	18	83%	23	Full
Madisonville Community College	81%	52	96%	49	94%	35	100%	38	91%	55	91%	74	Full
Maysville Community & Technical College	86%	14	94%	17	100%	14	91%	23	93%	15	92%	24	Full
Midway College	75%	60	96%	44	91%	47	87%	31	80%	45	89%	47	Full
Morehead State University	94%	17	100%	21	93%	14	86%	35	85%	20	92%	25	Full
Northern Kentucky University	92%	59	91%	58	94%	78	88%	80	89%	27	93%	76	Full
Owensboro Community & Technical College	95%	20	100%	12	95%	19	100%	10	100%	16	75%	52	Full
Pikeville College	94%	17	95%	19	100%	16	100%	22	91%	23	100%	22	Full
Somerset Community College	90%	31	92%	25	97%	32	100%	32	100%	32	100%	37	Full
Southeast KY Cmty. & Technical College	78%	40	93%	29	93%	30	94%	35	86%	36	95%	38	Full
Spencerian College	0%	0	0%	0	0%	0	80%	64	77%	122	76%	100	Conditional
St. Catharine College	84%	25	85%	20	0%	0	100%	10	100%	15	100%	10	Full
West KY Community & Technical College	88%	51	88%	41	93%	46	93%	46	93%	60	93%	72	Full
Western Kentucky University	89%	63	89%	75	86%	71	89%	76	86%	95	76%	122	Full

	2000	2001	2002	2003	2004	2005
Graduates	1053	960	864	1040	1149	1371
Testing	1026	941	850	1029	1132	1357
Passing	878	868	785	951	1021	1218
Kentucky Pass Rate Average	86%	92%	92%	92%	90%	90%
National Pass Rate Average	83%	83%	85%	86%	85%	85%

* Pass rates are calculated considering individuals who: 1) graduated between July 1, 2004 and June 30, 2005; 2) tested between July 1, 2004 Sept. 30, 2005; and 3) are first time takers of NCLEX.

KENTUCKY BOARD OF NURSING
312 Whittington Parkway, Suite 300
Louisville, KY 40222-5172

2004-2005
NCLEX Pass Rate* and Approval Status

	2000		2001		2002		2003		2004		2005		Approval Status
	Pass Rate	# Tested	Pass Rate	# Tested	Pas Rate	# Tested	Pass Rate	# Tested	Pass Rate	# Tested	Pass Rate	# Tested	
Practical Nursing													
Ashland Community & Technical College	0%	0	67%	24	90%	20	87%	15	93%	41	94%	34	Full
Big Sandy Community & Technical College	97%	36	100%	8	84%	32	90%	10	82%	28	94%	31	Full
Bluegrass Cmty. & Technical College - Danville	90%	51	92%	36	86%	22	90%	38	85%	47	91%	45	Full
Bluegrass Cmty. & Technical College-Leestown	91%	23	78%	32	100%	40	97%	32	95%	39	94%	49	Full
Bowling Green Technical College - Glasgow	98%	53	100%	21	96%	52	95%	21	84%	31	90%	42	Full
Elizabethtown Cmty. & Technical College	100%	14	90%	10	94%	18	100%	12	100%	10	100%	11	Full
Galen College of Nursing	84%	62	82%	57	96%	83	92%	78	98%	87	96%	106	Full
Gateway Community & Technical College	86%	58	91%	33	89%	28	81%	47	81%	53	88%	51	Conditional
Hazard Community & Technical College	95%	42	98%	40	94%	35	89%	27	88%	51	94%	35	Full
Hopkinsville Community College	0%	0	0%	0	100%	5	100%	16	100%	1	95%	21	Full
Jefferson Community & Technical College	95%	22	87%	31	97%	29	89%	19	100%	29	100%	32	Full
Laurel Technical College	0%	0	0%	0	92%	12	89%	18	0%	0	92%	12	Full
Madisonville Community College	86%	28	91%	32	88%	17	97%	36	84%	43	95%	42	Full
Maysville Community & Technical College	0%	0	0%	0	71%	17	94%	16	83%	18	100%	19	Full
Maysville Cmty. & Technical College - Rowan	0%	0	94%	34	100%	15	0%	0	93%	14	100%	14	Full
Owensboro Community & Technical College	78%	23	93%	15	92%	12	0%	0	100%	27	100%	15	Full
Somerset Technical College	73%	45	95%	41	86%	22	98%	45	100%	20	95%	20	Full
Southeast KY Cmty. & Technical College	97%	38	81%	32	75%	24	92%	65	97%	31	94%	47	Full
Spencerian College	93%	42	85%	86	80%	105	72%	151	82%	136	96%	91	Conditional
West KY Community & Technical College	96%	25	88%	17	100%	13	100%	13	100%	16	97%	36	Full

	2000	2001	2002	2003	2004	2005
Graduates	591	588	643	720	763	783
Testing	562	549	601	659	722	753
Passing	506	489	540	578	646	713
Kentucky Pass Rate Average	90%	89%	90%	88%	89%	95%
National Pass Rate Average	85%	86%	86%	88%	89%	90%

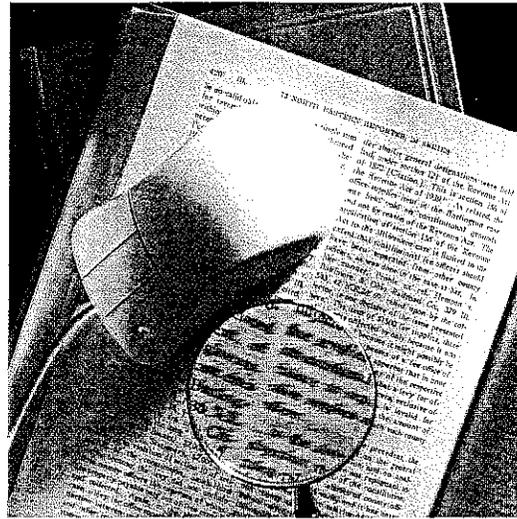
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