2010 Role Delineation Study: Medical-Surgical Nurse

National Survey Results

December 2010

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About this Report

This report pertaining to the practice of medical-surgical nurses was based on the results of American Nurses Credentialing Center's 2010 Role Delineation Study of Five Nursing Specialties: Cardiac Vascular, Gerontological, Medical-Surgical, Pediatric, and Psychiatric and Mental Health.

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Background

The American Nurses Credentialing Center (ANCC), which was incorporated in 1991 as a subsidiary of the American Nurses Association, is the largest nursing credentialing organization in the United States. Its vision is to be a galvanizing force for quality healthcare through credentialing excellence. Currently, ANCC offers 25 examinations at various levels including diploma and associate degree, baccalaureate, and advanced practice for nurses, clinical nurse specialists, and other disciplines. Approximately 10,000 – 12,000 candidates take an ANCC certification examination each year. In addition to certification, ANCC provides services such as the Magnet and Pathways to Excellence Recognition Programs for hospitals and other facilities that demonstrate excellence in nursing services, accreditation of continuing education programs, education and consultation services, and outreach to nursing organizations around the globe.

Role Delineation Study Overview

Role delineation or job analysis studies are typically carried out at the national level with the goal of describing current practice expectations, performance requirements, and environments. ANCC has a current goal of conducting a role delineation study of nurses approximately every three years in order to capture changes in work activities (referred to as "tasks" in this report) and the knowledge and skill areas required to perform those tasks. The findings are used to update the content of its respective certification examinations. This 2010 role delineation study (performed concurrently for five nursing specialties—cardiac vascular, gerontological, medical-surgical, pediatric, and psychiatric and mental health) involved two sets of processes or activities that ran more or less concurrently: a national Web-based survey and a linking activity. The national survey was designed to collect information on the tasks that nurses working in these specialties actually perform in practice, while the linking activity identifies the major knowledge and skill areas required to perform the tasks listed in the survey. The results of both of these processes were used in the updating of the test content outlines for each examination contained within the study.

Updated Test Content Outlines

The results of this role delineation study were used to update the test content outlines for each of the five specialty examinations contained within the study. Examination forms based on this updated test content outline for medical-surgical nursing are scheduled to go into effect May 6, 2012. A copy of the test content outline is available on the American Nurses Credentialing Center website.

Role of the Content Expert Panels

For this study, ANCC invited content experts to develop a list of tasks and demographic items for the survey, link knowledge and skill areas to the tasks list, and finalize the test content outlines for the respective certification examinations. All of the content experts serving on the panels were certified by ANCC in the nursing specialty they represented and were invited to serve on the panels based upon expertise in their specialties.

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Survey Methodology

The purpose of the development and administration of the national survey was to collect information on the tasks nurses actually perform in practice. Since the survey instrument used in this study was designed to be used across five nursing specialties, representatives from each of these five nursing specialties were asked to serve as members of a 10-member initial study workgroup (see *Joint Role Delineation Panel*) that acted as a sort of steering committee for the specialty-specific role delineation panels. The members of the joint panel met for three days (February 10-12, 2010) to construct a comprehensive list of tasks to be included in the survey. The list of tasks were organized and grouped into domains. Furthermore, the joint panel also constructed a generic map of knowledge and skill areas relevant to the tasks included in the survey.

Survey Chronology

The survey development and administration timeline was as follows:

February - May 2010

- The joint role delineation panel along with staff from ANCC and Castle drafted the survey, including demographic questions and the list of tasks to be rated.
- The survey was pilot tested.

June - August 2010

- The survey was revised based on pilot study results and feedback from a few selected specialty organizations.
- The final survey was approved and administered to the national sample on the Web.

September - November 2010

- The survey task results were analyzed, and task weights were determined.
- Each specialty-specific panel met to review the survey results and task weights.

Sample Selection

In January 2010, there were a total of 8,384 active ANCC-certified medical-surgical nurses who had received their certification as a medical-surgical nurse within the previous 10 years. A random sample of 1,533 medical-surgical nurses was selected from the ANCC certification database, with the constraint that the participants were to have received their ANCC certification within the previous 10 years.

Survey Development and Measures

On February 10-12, 2010, the joint role delineation panel, along with members of ANCC and Castle, met in Silver Spring, Maryland, to construct the list of tasks to be included in the 2010 Role Delineation Study of five nursing specialties—Cardiac Vascular, Gerontological, Medical-Surgical, Pediatric, and Psychiatric and Mental Health Nursing. The panel members first reviewed and updated the target population statements for each of the five nursing specialty areas. They used the scope and standards of practice for each of these specialties, which the panelists reviewed and discussed during the meeting. From the scope and standards, the panelists identified the performance domains and tasks potentially performed by nurses working within these specialties. The goal of this process was to create a comprehensive list of relevant tasks that were potentially performed by nurses in any one of the specialty areas, regardless of whether it was performed in the others.

As a result of this meeting, the panel reached consensus on a list of 51 tasks to be used in the 2010 survey. These tasks were divided into seven domains: (1) Assessment and Diagnosis, (2) Planning and Outcomes Identification, (3) Implementation, (4) Evaluation, (5) Nurse-Patient Relationship, (6)

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Patient, Family, Significant Other, and Caregiver Education, and (7) Management and Leadership. The complete text of the task list is presented in **Appendix A**, including two tasks that were added to that list at a later date. The joint panel also initially identified a set of 19 demographic items for inclusion in the survey; one was later removed based on a review of the pilot survey results. (See **Appendix B** for the final set of demographic items).

During the same meeting in February, the joint panel reviewed and approved three scales that respondents would use to rate the tasks listed in the survey — frequency (the frequency with which a task is performed), performance expectation (how soon on the job the performance of a task is expected), and consequence (the consequence of performing a task incorrectly). These three scales and their corresponding rating descriptions are illustrated in Table 1.

Table 1. Rating Scales for Rating Task Statements

Frequency: Frequency refers to how often the <specialty> nurse performs the task, considering a one-year period. The following scale was used to record frequency:

0 = Never
1 = Rarely
2 = Sometimes
3 = Often
4 = Repeatedly

Performance Expectation: Performance expectation refers to the point in the <specialty> nurse's career at which he or she is expected to perform the task. The following scale was used to record performance expectation:

0 = Not at all
1 = Within the first six months (including exactly 6 months) of working as a <Specialty> nurse
2 = After the first six months (excluding exactly 6 months) of working as a <Specialty> nurse

Consequence: Consequence refers to the degree to which the inability of the <specialty> nurse to perform the task would be seen as causing harm to stakeholders. (Harm may be seen as physical, psychological, emotional, legal, financial, etc.) The following scale was used to record consequence:

0 = No harm
1 = Minimal harm
2 = Moderate harm
3 = Substantial harm
4 = Extreme harm

Members from ANCC and Castle discussed the methodology that would be used to rank the overall importance of the tasks listed in the survey. A series of analyses was used to determine the relative importance of the task statements. A more detailed description of these analyses is provided below (see the Data Analysis section), but the primary purpose was to use the consequence and frequency ratings to compute the relative importance of each task. Tasks with large relative importance scores can be interpreted as activities that are performed frequently or in which failure to perform them can result in serious harm, or both. These tasks were viewed as more critical to the certification process and were therefore weighted more heavily during the development of the updated test content outline.

In addition to computing the relative importance values for the task statements, the medical-surgical role delineation panel (see page 4) reviewed the performance expectation ratings and identified tasks that were either not expected of a medical-surgical nurse (i.e., rating of "0") or that were expected to be performed, but not within the first six months (i.e., rating of "2") of working in the specialty. The panel discussed each identified task to determine whether it should be removed from testing consideration and

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not included in the development of the updated test content outline. Final determinations for excluding a task were made based on panel consensus consistent with supporting survey data.

Data Collection

Pilot Testing. Using the same procedures for administering the national data collection, the survey was piloted in May 2010. Fifty (50) ANCC certified nurses from each specialty who had received their certification within the previous 10 years were randomly selected to take the pilot survey (250 invitations total). Overall, 84 (34 percent) of the nurses invited to take the pilot survey responded, and 15 (30 percent) of the 50 medical-surgical nurses responded. Also during this time, a few selected specialty organizations were asked to review the list of tasks.

Survey Revision. Two small revisions were made to the survey before it was finalized and administered to the national sample. First, after reviewing the results from the pilot survey, members from the joint panel agreed to remove one demographic question due to inconstancy of response data and low applicability to the overall purpose of the study. Second, based on feedback from the specialty organizations' reviews of the survey, two task statements were added to the survey (in Domain 1: Assessment and Diagnosis):

- Obtain a home medication list
- Perform a medication reconciliation

National Survey. On July 12, 2010, the 1,533 medical-surgical nurses selected to take the national Web-based survey were sent an alert letter via the United States Postal Service. On July 13, 2010, each nurse was also sent an e-mail containing the same information. The alert letter and e-mail explained the purpose and importance of the study, the eligibility criteria of the study, and stated how to access the survey via the Internet. Both indicated that the participant's responses would be kept confidential and also notified that respondents completing the survey would receive a five-hour reduction of their continuing education requirement for their recertification.

A follow-up postcard and two follow-up e-mails were sent out in the ensuing weeks. The follow-up correspondence thanked recipients if they had already submitted their completed survey and encouraged them to do so if they had not already. The follow-up postcard and first follow-up e-mails were sent to all selected nurses, and the final follow-up e-mail was sent out only to those who had not yet responded to the survey. The survey was closed on August 5, 2010.

Data Analysis

The analysis of survey data consisted of two separate processes that were performed more or less concurrently. The first process consisted of the medical-surgical role delineation panel's review of the performance expectation ratings and the identification of tasks that are either not expected of a medical-surgical nurse (i.e., rating of "0") or that are expected to be performed, but not within the first six months (i.e., rating of "2"). Discussions ensued regarding the tasks with the goal of removing those that were not seen as being expected of a medical-surgical nurse. Tasks designated for removal were not included in the development of the test content outline.

The second process—the analysis of the consequence and frequency ratings—was used to determine the relative importance of the each of the tasks. The details of those analyses are summarized below.

Factor analysis. First, a factor analysis was performed on the consequence and frequency ratings to ensure that the data were sufficiently unidimensional for conducting an Item Response Theory (IRT) analysis. The factor analysis revealed that over 37 percent of the total variance was explained by the first unrotated factor, easily surpassing Reckase's (1979) recommendation that the first unrotated

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principal factor of the item responses should account for over 20% of the total variance if the items are to be rescaled using the one-parameter logistic IRT model.

Reliability analysis. The rating scales were also highly reliable. Cronbach's coefficient alpha estimates for the performance expectation, consequence, and frequency scales when applied to all the data were 0.872, 0.983, and 0.942, respectively. Cronbach's coefficient alpha, a measure of internal stability, ranges in value between 0 and 1.

IRT analysis. The factor analysis showed the survey data to be sufficiently unidimensional, which led to the subsequent IRT analysis. To put the measures of consequence and frequency on the same interval scale, the consequence and frequency ratings were rescaled using Andrich's Rating Scale model (Andrich, 1978). The Rating Scale model belongs to a family of mathematical models known collectively as Item Response Theory (IRT). The IRT analysis was implemented using *Winsteps 3.70.0.5* (Linacre, 2010). These rescaled values are referred to as *item endorsements*.

Computation of Relative Importance. The consequence and frequency item endorsements that resulted from the IRT analysis were then used to determine the relative importance of each task. The consequence and frequency item endorsements were first transformed to the N(5,1) scale to eliminate negative values. Subsequently, the transformed consequence and frequency item endorsements were multiplied together, and the magnitude of those values were treated as indicators of the relative importance of each task. The relative importance of the tasks, including tasks that were eventually removed from testing consideration, is reported in **Appendix D**.

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Survey Results

The total sample size of the national survey included 1,533 ANCC certified medical-surgical nurses who had received their certification within the previous 10 years. A total of 556 valid medical-surgical nurse surveys were returned for an overall response rate of 36 percent.

Demographic Information

Appendix B details the medical-surgical nurses' responses to the final survey's 18 demographic questions that included inquiry on the nurses' backgrounds and practice settings.

Demographic Background

Approximately 94 percent of the respondents were female. Sixty-eight (68) percent reported to be white, 16 percent Asian/Pacific Islander, and 10 percent African American. The majority of respondents (84 percent) fell into three age groups fairly evenly: 30-39, 40-49, 50-59.

Approximately 52 percent of the medical-surgical respondents indicated that a Bachelor's in Nursing was their highest degree in nursing, with another 27 and 13 percent indicating Associate in Nursing and Master's in Nursing as their highest degree, respectively. Less than one percent indicated they held a Doctorate in Nursing (Practice or Research).

The average number of years of experience the medical-surgical nurse respondents had as an RN was nearly 16 years. The respondents also reported on average nearly 14 years of experience working as a medical-surgical nurse.

Practice Settings

Approximately 44 percent of the medical-surgical nurse respondents indicated that they practiced in cities with populations between 50,000 and 249,999. Town areas with a population between 2,500 to 49,999 had the second highest percent of respondents (20 percent) and metropolitan areas with populations between 250,000 – 999,999 were a close third (19 percent). Only a little over two percent of the respondents indicated working in a rural (population less than 2,500) practice location.

In terms of practice setting, the majority (71 percent) of medical-surgical nurse respondents indicated that they practice in medical-surgical (48.5 percent), medical units (14 percent), or surgical units (8.5 percent).

Approximately 62 percent of medical-surgical nurses reported that "staff nurse" best described their work. Another 16 percent listed "charge nurse" as best describing their work. Nearly 74 and 66 percent of respondents described their patients as dealing with acute and chronic illnesses, respectively. The medical-surgical nurses also indicated that approximately 96 percent of their time was spent in caring for adults (18 to 65 years—49.3%) or aging adults (ages over 65 years—46.9%). When asked how many hours per week on average they spent working as a medical-surgical nurse, the average response was 34.8 hours with a standard deviation of 11.2 hours.

Task Descriptions

Task Summary Statistics. Descriptive statistics (means, standard deviations, and medians) for the consequence and frequency ratings and frequency statistics for the performance expectation ratings are reported in **Appendix C** for all 53 tasks.

The mode of the performance expectation ratings, the mean for the frequency and consequence ratings, and relative importance (based on the multiplied item endorsements from the IRT analysis) is reported for all 53 tasks in **Appendix D**, presented in rank order or relative importance. It should be

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noted that **Appendices C** and **D** contain statistics for the entire set of tasks before the medical-surgical panel reached a decision to remove a few of the tasks from consideration due to a variety of reasons (e.g., performance expectation ratings that were either too high or too low).

Performance Expectation. One task (1.12: Identify nursing diagnoses using a different system. [Specify the system]) had a performance expectation rating mode of zero (i.e., not at all). Three tasks had a performance expectation rating mode of 2 (i.e., performed after 6 months of working as a medical-surgical nurse) — 7.4: Serve as a clinical content expert for the design and enhancement of policies, procedures, processes, and systems that affect nursing care, 7.1: Serve as a preceptor, 6.4: Develop educational programs for groups.

Consequence. The highest rated task with respect to consequence was 3.5: Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques. Two of the top five rated tasks were from the Management and Leadership domain (domain 7) and included 7.7: Follow legal and regulatory requirements in nursing care delivery and management, and 7.2: Coordinate patient safety measures. Another two were from Assessment and Diagnosis (domain 1): 1.7: Obtain diagnostic test results, and 1.3: Perform a medication reconciliation. The lowest rated task was again 1.12: Identify nursing diagnoses using a different system.

Frequency. The top rated task with respect to frequency was also Task 3.5: Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques. The lowest rated task was again found to be task 1.12.

Task Relative Importance. The task with the highest relative importance value was 3.5: Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques. Task 7.7: Follow legal and regulatory requirements in nursing care delivery and management, was the second highest rated task. Task 1.12: Identify nursing diagnoses using a different system was the lowest rated task with respect to relative importance.

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Appendix A
Task Statements

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Domain 1: Assessment and Diagnosis

Tasks:

1.1 Obtain patient history using age-appropriate, system-specific, evidence-based tools.
1.2 Obtain a home medication list.
1.3 Perform a medication reconciliation
1.4 Perform physical examination using age-appropriate, system-specific, evidence-based assessment techniques.
1.5 Complete psychosocial assessment using age-appropriate, system-specific, evidence-based tools and assessment techniques.
1.6 Collect data on psychoses.
1.7 Obtain diagnostic test results.
1.8 Review findings provided by others.
1.9 Synthesize available data and knowledge to identify patterns and variances.
1.10 Identify nursing diagnoses using the North American Nursing Diagnosis Association-International (NANDA-I) taxonomy.
1.11 Identify nursing diagnoses using clinical pathways.
1.12 Identify nursing diagnoses using a different system. [Specify the system]
1.13 Create a problem list based on assessment data.
1.14 Document assessment findings in patient records.

Domain 2: Planning and Outcomes Identification

Tasks:

2.1 Prioritize nursing diagnoses and/or problems.
2.2 Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using Nursing Outcomes Classification (NOC).
2.3 Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using clinical pathways or a different system. [Specify other]
2.4 Develop an individualized, developmentally appropriate plan of care.
2.5 Document plan of care and expected outcomes in patient records.

Domain 3: Implementation

Tasks:

3.1 Use Nursing Interventions Classification (NIC) as the basis for interventions specific to the plan of care.
3.2 Use other evidence-based practice guidelines as the basis for interventions specific to the plan of care.
3.3 Create a safe, developmentally appropriate, therapeutic environment conducive to care.
3.4 Coordinate patient care.
3.5 Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques.
3.6 Document nursing interventions in patient records.

Domain 4: Evaluation

Tasks:

4.1 Collect data related to the patient's response to interventions.
4.2 Collect data on factors that impact the patient's care.
4.3 Evaluate the patient's response to interventions and the effectiveness of the plan of care.
4.4 Update the plan of care.
4.5 Communicate changes to the patient, family, significant other, and interdisciplinary team.
4.6 Document the patient's response to interventions and changes to the plan of care

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in patient records.

Domain 5: Nurse-Patient Relationship

Tasks:

5.1 Approach the patient in a developmentally appropriate manner.
5.2 Establish trust.
5.3 Develop rapport.
5.4 Maintain a developmentally appropriate therapeutic relationship.
5.5 Support the patient's parents, family, significant others, and caregivers.
5.6 Maintain appropriate physical and emotional boundaries.
5.7 Serve as patient advocate.
5.8 Document pertinent aspects of the nurse-patient relationship in patient records.

Domain 6: Patient, Family, Significant Other, and Caregiver Education

Tasks:

6.1 Identify learning needs.
6.2 Identify barriers to learning.
6.3 Develop an individualized education plan with the involvement of the patient, family, significant other, and caregiver.
6.4 Develop educational programs for groups.
6.5 Implement the education plan.
6.6 Evaluate the education plan's effectiveness.
6.7 Document the education provided and its effectiveness in patient records.

Domain 7: Management and Leadership

Tasks:

7.1 Serve as a preceptor.
7.2 Coordinate patient safety measures.
7.3 Improve quality of nursing care delivery.
7.4 Serve as a clinical content expert for the design and enhancement of policies, procedures, processes, and systems that affect nursing care.
7.5 Use electronic information systems in nursing care delivery.
7.6 Follow ethical standards in nursing care delivery and management.
7.7 Follow legal and regulatory requirements in nursing care delivery and management.

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Appendix B
Demographic Data Summary

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1: What is your gender?

	Count	Percent
Female	524	94.4
Male	31	5.6
Total	555	100.0

2: What is your age?

	Count	Percent
Under 20 years old	1	0.2
20 to 29 years old	45	8.1
30 to 39 years old	169	30.4
40 to 49 years old	147	26.4
50 to 59 years old	153	27.5
60 years old and over	41	7.4
Total	556	100.0

3: What is your ethnicity?

	Count	Percent
African-American	56	10.1
White, non-Hispanic	376	67.9
Asian/Pacific Islander	88	15.9
American Indian/ Alaskan Native	2	0.4
Hispanic/Latino	17	3.1
Other	15	2.7
Total	554	100.0

4: Which of the following describes your entry-level (basic) education in nursing?

	Count	Percent
Diploma in Nursing	60	10.8
Associate Degree in Nursing	240	43.3
Bachelor's in Nursing	246	44.4
Other	8	1.4
Total	554	100.0

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5: What is the highest degree you have earned in nursing?

	Count	Percent
Diploma in Nursing	29	5.2
Associate Degree in Nursing	150	27.1
Bachelor's in Nursing	293	52.9
Master's in Nursing	74	13.4
Doctorate in Nursing Practice (DNP)	1	0.2
Doctorate in Nursing Research (e.g., Ph.D., DNS, DSN)	0	0.0
Other	7	1.3
Total	554	100.0

6: Do you hold any degrees outside of nursing?

	Count	Percent
Yes	127	23.0
No	425	77.0
Total	552	100.0

7: Are you certified as a medical-surgical nurse?

	Count	Percent
Yes	553	99.6
No	2	0.4
Total	555	100.0

8a: How many years have you been certified as a medical-surgical nurse?

	Count	Percent
0-5	415	75.7
6-10	104	19.0
11-15	18	3.3
Over 15	11	2.0
Total	548	100.0

8b: How many years have you been certified as a medical-surgical nurse?

N	548
Min	0
Max	28
Mean	4.48
SD	4.11

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9: Do you hold other nursing certifications?

	Count	Percent
Yes	95	17.2
No	456	82.8
Total	551	100.0

10a: How many years have you been in practice as an RN?

	Count	Percent
0-5	73	13.2
6-10	129	23.4
11-15	117	21.2
16-20	92	16.7
21-25	46	8.3
26-30	40	7.2
31-35	33	6.0
36-40	17	3.1
Over 40	5	0.9
Total	552	100.0

10b: How many years have you been in practice as an RN?

N	552
Min	2
Max	43
Mean	15.69
SD	9.45

11a: How many years have you worked as a medical-surgical nurse?

Years	Count	Percent
0-5	114	20.7
6-10	144	26.2
11-15	104	18.9
16-20	75	13.6
21-25	48	8.7
26-30	26	4.7
31-35	21	3.8
36-40	15	2.7
Over 40	3	0.5
Total	550	100.0

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11b: How many years have you worked as a medical-surgical nurse?

N	550
Min	0
Max	42
Mean	13.72
SD	9.17

12: How many hours per week do you work as a medical-surgical nurse?

Hours	Count	Percent
0-20	63	11.5
21-35	94	17.1
36-40	355	64.7
Over 40	37	6.7
Total	549	100.0

13: What percent of time do you spend with each type of patient?

	Infant (pre-birth to 2 yrs)		Child (ages 3 to 12)		Adolescents (ages 13 to 17)		Adults (ages 18 to 65)		Aging Adult (over 65 yrs)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
0 - 20%	551	99.1	552	99.3	550	98.9	43	7.7	79	14.2
21 - 40%	2	0.4	2	0.4	5	0.9	161	29.0	109	19.6
41 - 60%	3	0.5	2	0.4	0	0.0	248	44.6	266	47.8
61 - 80%	0	0.0	0	0.0	0	0.0	65	11.7	90	16.2
81 - 100%	0	0.0	0	0.0	1	0.2	39	7.0	12	2.2
Total	556	100.0	556	100.0	556	100.0	556	100.0	556	100.0
Average (percent)	0.9		0.9		2.0		49.3		46.9	

14: Which of the following best describes your work?

	Count	Percent
Staff Nurse (including community, clinic, in-patient/client, or other setting)	342	62.3
Clinical Nurse Specialist	7	1.3
Nurse Practitioner	6	1.1
Case Manager	3	0.5
Education	31	5.6
Management	40	7.3
Research	2	0.4
Charge Nurse	88	16.0
Clinical Nurse	1	0.2
Other	29	5.3
Total	549	100.0

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15: Which of the following best describes your primary practice setting?

	Count	Percent
Medical Unit	77	14.0
Surgical Unit	47	8.5
Medical/Surgical	267	48.5
Intensive Care Unit	20	3.6
Cardiac Surgery Intensive Care Unit	4	0.7
Correctional care Unit	2	0.4
Same Day Surgery	9	1.6
Same Day Medical	1	0.2
Recovery Room	4	0.7
Labor and Delivery/Post Partum	1	0.2
Emergency Department	7	1.3
Outpatient Clinic	13	2.4
Home care or Home Health	10	1.8
Hospice	2	0.4
Long Term Care	8	1.5
Psychiatric/Mental Health Facility	2	0.4
Pediatrics	3	0.5
Rehabilitation	10	1.8
School (Elementary. Middle, or High)	0	0.0
College or Post-Secondary Education Facility	4	0.7
Pediatric Intensive Care Unit	0	0.0
Neonatal Intensive Care Unit	0	0.0
Other	59	10.7
Total	550	100.0

16: Which of the following describes your patients (more than one could be selected)

	n	number selecting	percent
Well (minor illness)	637	117	18.8
Maternity	637	23	3.7
Acute	637	458	73.6
Chronic	637	412	66.2
Terminally Ill	637	245	39.4
Psychiatric	637	192	30.9
Other	637	35	5.6

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17: In which state is your primary practice setting located?

	Count	Percent
Alabama (AL)	1	0.2
Alaska (AK)	1	0.2
Arizona (AZ)	5	0.9
Arkansas (AR)	3	0.5
California (CA)	27	4.9
Colorado (CO)	10	1.8
Connecticut (CT)	7	1.3
Delaware	6	1.1
District of Columbia (DC)	1	0.2
Florida (FL)	38	6.8
Georgia (GA)	14	2.5
Guam (GU)	0	0.0
Hawaii	0	0.0
Idaho	3	0.5
Illinois (IL)	24	4.3
Indiana (IN)	4	0.7
Iowa (IA)	7	1.3
Kansas (KS)	0	0.0
Kentucky (KY)	6	1.1
Louisiana (LA)	5	0.9
Maine (ME)	2	0.4
Maryland (MD)	5	0.9
Massachusetts (MA)	5	0.9
Michigan (MI)	8	1.4
Minnesota (MN)	18	3.2
Mississippi (MS)	1	0.2
Missouri (MO)	5	0.9
Montana (MT)	3	0.5
Nebraska (NE)	2	0.4
Nevada (NV)	0	0.0
New Hampshire (NH)	7	1.3
New Jersey (NJ)	60	10.8
New Mexico (NM)	5	0.9
New York (NY)	69	12.4
North Carolina (NC)	16	2.9
North Dakota (ND)	0	0.0
Ohio (OH)	19	3.4
Oklahoma (OK)	4	0.7
Oregon (OR)	11	2.0
Pennsylvania (PA)	27	4.9
Rhode Island (RI)	4	0.7
South Carolina (SC)	8	1.4
South Dakota (SD)	4	0.7
Tennessee (TN)	7	1.3
Texas (TX)	32	5.8
Utah (UT)	0	0.0
Vermont (VT)	3	0.5

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17: In which state is your primary practice setting located?

	Count	Percent
Virginia (VA)	6	1.1
Washington (WA)	12	2.2
West Virginia (WV)	4	0.7
Wisconsin (WI)	5	0.9
Wyoming (WY)	3	0.5
Missing	39	7.0
Total	556	100.0

18: What is the geographical location of your practice setting?

	Count	Percent
Rural (population less than 2,500)	12	2.2
Town (population 2,500 to 49,999)	111	20.3
City (population 50,000 to 249,999)	242	44.2
Metropolitan (population 25,000 to 999,999)	104	19.0
Greater Metropolitan (population greater than 999,999)	63	11.5
Regionally (population across a designated area such as several states)	9	1.6
Nationally (population across the United States)	3	0.5
Internationally (population across multiple nations)	4	0.7
Total	548	100.0

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Appendix C
Summary Statistics: Consequence, Frequency, and Performance Expectation Ratings

Note: For each of the tables in Appendix C, recall the following descriptions for each of the three rating scales:

Consequence: Consequence refers to the degree to which the inability of the <specialty> nurse to perform duties in each performance domain or task would be seen as causing harm to stakeholders. (Harm may be seen as physical, psychological, emotional, legal, financial, etc.) The following scale was used to record consequence:

0 = No harm
1 = Minimal harm
2 = Moderate harm
3 = Substantial harm
4 = Extreme harm

Frequency: Frequency refers to how often the <specialty> nurse performs duties in each of the performance domains or tasks considering a one-year period. The following scale was used to record frequency:

0 = Never
1 = Rarely
2 = Sometimes
3 = Often
4 = Repeatedly

Performance Expectation: Performance expectation refers to the point in the certified nurse's career at which he or she is expected to perform the work activity. The following scale was used to record performance expectation:

0 = Not at all
1 = Within the first six months (including exactly 6 months) of working as a <Specialty> nurse
2 = After the first six months (excluding exactly 6 months) of working as a <Specialty> nurse

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Domain 1 Ratings: Assessment and Diagnosis

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
1.1: Obtain patient history using age-appropriate, system-specific, evidence-based tools.	552	2.0	1.7	1.2	553	4.0	3.6	4.0	0	1	0.2
									1	542	97.8
									2	11	2.0
1.2: Obtain a home medication list.	552	2.0	2.2	1.3	553	4.0	3.6	4.0	0	2	0.4
									1	544	98.6
									2	6	1.1
1.3: Perform a medication reconciliation	552	2.0	2.2	1.3	553	4.0	3.5	4.0	0	21	3.8
									1	519	93.9
									2	13	2.4
1.4: Perform physical examination using age-appropriate, system-specific, evidence-based assessment techniques.	552	2.0	2.1	1.2	553	4.0	3.8	4.0	0	5	0.9
									1	526	95.1
									2	22	4.0
1.5: Complete psychosocial assessment using age-appropriate, system-specific, evidence-based tools and assessment techniques.	551	2.0	1.6	1.1	552	4.0	3.5	4.0	0	11	2.0
									1	500	90.4
									2	42	7.6
1.6: Collect data on psychoses.	552	2.0	1.5	1.1	553	2.0	2.1	2.0	0	86	15.6
									1	363	65.6
									2	104	18.8
1.7: Obtain diagnostic test results.	552	2.0	2.2	1.3	553	4.0	3.5	4.0	0	4	0.7
									1	533	96.6
									2	15	2.7
1.8: Review findings provided by others.	551	2.0	1.7	1.2	552	4.0	3.3	4.0	0	9	1.6
									1	496	89.9
									2	47	8.5
1.9: Synthesize available data and knowledge to identify patterns and variances.	551	2.0	1.6	1.1	552	3.0	2.8	3.0	0	35	6.3
									1	299	54.2
									2	218	39.5
1.10: Identify nursing diagnoses using the North American Nursing Diagnosis Association-	551	1.0	1.1	1.1	553	3.0	2.9	3.0	0	52	9.4
									1	453	81.9

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[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
International (NANDA-I) taxonomy.									2	48	8.7
1.11: Identify nursing diagnoses using clinical pathways.	551	1.0	1.2	1.0	552	3.0	3.0	3.0	0	29	5.3
									1	463	83.9
									2	60	10.9
1.12: Identify nursing diagnoses using a different system. [Specify the system]	550	0.0	0.6	0.9	551	0.0	1.4	0.0	0	285	51.6
									1	224	40.6
									2	43	7.8
1.13: Create a problem list based on assessment data.	552	1.0	1.4	1.1	553	4.0	3.1	4.0	0	27	4.9
									1	479	86.6
									2	47	8.5
1.14: Document assessment findings in patient records.	551	2.0	2.0	1.3	552	4.0	3.8	4.0	0	2	0.4
									1	540	97.8
									2	10	1.8

Domain 2 Ratings: Planning and Outcomes Identification

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
2.1: Prioritize nursing diagnoses and/or problems.	552	2.0	1.8	1.1	554	4.0	3.6	4.0	0	5	0.9
									1	487	88.1
									2	61	11.0
2.2: Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using Nursing Outcomes Classification (NOC).	552	1.0	1.2	1.0	554	3.0	2.9	3.0	0	61	11.0
									1	383	69.3
									2	109	19.7
2.3: Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using clinical pathways or a different system.	551	1.0	1.2	1.0	553	3.0	2.7	3.0	0	71	12.9
									1	374	67.8
									2	107	19.4
2.4: Develop an individualized, developmentally appropriate plan of care.	551	1.0	1.5	1.1	553	4.0	3.4	4.0	0	15	2.7
									1	476	86.1

[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
									2	62	11.2
2.5: Document plan of care and expected outcomes in patient records.	551	1.0	1.4	1.1	553	4.0	3.5	4.0	0	12	2.2
									1	506	91.7
									2	34	6.2

Domain 3 Ratings: Implementation

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
3.1: Use Nursing Interventions Classification (NIC) as the basis for interventions specific to the plan of care.	551	1.0	1.2	1.1	552	3.0	2.7	3.0	0	101	18.3
									1	392	70.9
									2	60	10.8
3.2: Use other evidence-based practice guidelines as the basis for interventions specific to the plan of care.	552	1.5	1.5	1.1	553	3.0	3.1	3.0	0	31	5.6
									1	416	75.2
									2	106	19.2
3.3: Create a safe, developmentally appropriate, therapeutic environment conducive to care.	552	2.0	2.1	1.3	553	4.0	3.6	4.0	0	3	0.5
									1	510	92.2
									2	40	7.2
3.4: Coordinate patient care.	552	2.0	1.9	1.2	553	4.0	3.7	4.0	0	3	0.5
									1	482	87.3
									2	67	12.1
3.5: Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques.	552	3.0	2.9	1.3	553	4.0	3.8	4.0	0	1	0.2
									1	542	98.0
									2	10	1.8
3.6: Document nursing interventions in patient records.	552	2.0	1.8	1.3	553	4.0	3.7	4.0	0	5	0.9
									1	537	97.1
									2	11	2.0

[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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Domain 4 Ratings: Evaluation

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
4.1: Collect data related to the patient's response to interventions.	552	2.0	1.8	1.2	553	4.0	3.5	4.0	0	9	1.6
									1	504	91.1
									2	40	7.2
4.2: Collect data on factors that impact the patient's care.	552	2.0	1.7	1.1	553	4.0	3.3	4.0	0	13	2.4
									1	478	86.4
									2	62	11.2
4.3: Evaluate the patient's response to interventions and the effectiveness of the plan of care.	552	2.0	1.8	1.2	553	4.0	3.6	4.0	0	4	0.7
									1	511	92.4
									2	38	6.9
4.4: Update the plan of care.	552	1.0	1.5	1.1	553	4.0	3.5	4.0	0	3	0.5
									1	519	93.9
									2	31	5.6
4.5: Communicate changes to the patient, family, significant other, and interdisciplinary team.	552	2.0	2.0	1.3	554	4.0	3.6	4.0	0	8	1.4
									1	518	93.7
									2	27	4.9
4.6: Document the patient's response to interventions and changes to the plan of care in patient records.	551	2.0	1.7	1.2	553	4.0	3.6	4.0	0	4	0.7
									1	522	94.6
									2	26	4.7

Domain 5 Ratings: Nurse-Patient Relationship

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
5.1: Approach the patient in a developmentally appropriate manner.	551	1.0	1.5	1.1	552	4.0	3.7	4.0	0	2	0.4
									1	524	94.9
									2	26	4.7
5.2: Establish trust.	551	2.0	1.7	1.2	552	4.0	3.8	4.0	0	3	0.5
									1	532	96.4
									2	17	3.1

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* Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
5.3: Develop rapport.	550	1.0	1.5	1.1	551	4.0	3.7	4.0	0	6	1.1
									1	524	95.1
									2	21	3.8
5.4: Maintain a developmentally appropriate therapeutic relationship.	551	2.0	2.0	1.3	552	4.0	3.8	4.0	0	1	0.2
									1	532	96.4
									2	19	3.4
5.5: Support the patient's parents, family, significant others, and caregivers.	550	1.0	1.4	1.1	550	4.0	3.6	4.0	0	5	0.9
									1	500	90.7
									2	46	8.3
5.6: Maintain appropriate physical and emotional boundaries.	550	2.0	1.8	1.3	551	4.0	3.6	4.0	0	4	0.7
									1	508	92.2
									2	39	7.1
5.7: Serve as patient advocate.	550	2.0	2.0	1.3	551	4.0	3.7	4.0	0	2	0.4
									1	499	90.6
									2	50	9.1
5.8: Document pertinent aspects of the nurse-patient relationship in patient records.	549	1.0	1.3	1.1	550	3.0	3.0	3.0	0	37	6.7
									1	473	85.8
									2	41	7.4

Domain 6 Ratings: Nurse-Patient Relationship

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
6.1: Identify learning needs.	550	2.0	1.7	1.1	551	4.0	3.6	4.0	0	0	0.0
									1	508	92.2
									2	43	7.8
6.2: Identify barriers to learning.	550	2.0	1.7	1.1	551	4.0	3.5	4.0	0	4	0.7
									1	510	92.6
									2	37	6.7
6.3: Develop an individualized education plan with	549	2.0	1.5	1.1	550	4.0	3.3	4.0	0	11	2.0

[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
the involvement of the patient, family, significant other, and caregiver.									1	445	80.8
									2	95	17.2
6.4: Develop educational programs for groups.	548	1.0	0.8	0.9	549	2.0	1.6	2.0	0	128	23.3
									1	138	25.1
									2	284	51.6
6.5: Implement the education plan.	550	1.0	1.4	1.1	551	3.0	2.9	3.0	0	23	4.2
									1	400	72.6
									2	128	23.2
6.6: Evaluate the education plan's effectiveness.	550	1.0	1.4	1.1	551	3.0	2.9	3.0	0	20	3.6
									1	387	70.4
									2	143	26.0
6.7: Document the education provided and its effectiveness in patient records.	550	1.0	1.3	1.1	551	4.0	3.2	4.0	0	12	2.2
									1	470	85.3
									2	69	12.5

Domain 7 Ratings: Management and Leadership

	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
7.1: Serve as a preceptor.	549	1.0	1.3	1.2	550	2.0	2.2	2.0	0	15	2.7
									1	48	8.7
									2	487	88.5
7.2: Coordinate patient safety measures.	549	2.0	2.3	1.3	550	4.0	3.2	4.0	0	12	2.2
									1	400	72.7
									2	138	25.1
7.3: Improve quality of nursing care delivery.	547	2.0	1.7	1.2	548	3.0	2.9	3.0	0	13	2.4
									1	284	51.7
									2	252	45.9
7.4: Serve as a clinical content expert for the design and enhancement of policies, procedures,	548	1.0	1.2	1.2	549	2.0	1.9	2.0	0	52	9.5
									1	67	12.2

[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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	Cons n	Cons Med	Cons Mean	Cons SD	Freq n	Freq Med	Freq Mean	Freq SD	PE Rating	PE Freq	PE Perc
processes, and systems that affect nursing care.									2	430	78.3
7.5: Use electronic information systems in nursing care delivery.	548	2.0	1.6	1.3	548	4.0	3.5	4.0	0	18	3.3
									1	499	90.7
									2	33	6.0
7.6: Follow ethical standards in nursing care delivery and management.	549	2.0	2.1	1.3	550	4.0	3.6	4.0	0	2	0.4
									1	531	96.5
									2	17	3.1
7.7: Follow legal and regulatory requirements in nursing care delivery and management.	549	2.0	2.3	1.4	550	4.0	3.7	4.0	0	5	0.9
									1	528	96.0
									2	17	3.1

[*] Consequence Ratings: 0 = No Harm, 1 = Minimal Harm, 2 = Moderate Harm, 3 = Substantial Harm, 4 = Extreme Harm. Frequency Ratings: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Repeatedly. Performance Expectation Ratings: 0 = Not at all; 1 = Within the first 6 months of working as a <specialty> nurse; 2 = After the first 6 months of working as a <specialty> nurse.

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Appendix D
Task Statements Sorted by Relative Importance

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Medical-Surgical	Perf Exp Mode	Avg Cons	Avg Freq	Relative Importance
3.5: Administer medications as prescribed using evidence-based, developmentally appropriate, age-appropriate techniques.	1.0	2.92	3.83	36.8
7.7: Follow legal and regulatory requirements in nursing care delivery and management.	1.0	2.30	3.69	30.6
1.4: Perform physical examination using age-appropriate, system-specific, evidence-based assessment techniques.	1.0	2.08	3.76	30.3
1.14: Document assessment findings in patient records.	1.0	2.03	3.76	30.1
5.4: Maintain a developmentally appropriate therapeutic relationship.	1.0	1.95	3.75	29.5
1.2: Obtain a home medication list.	1.0	2.19	3.61	29.0
5.7: Serve as patient advocate.	1.0	2.03	3.66	28.8
3.6: Document nursing interventions in patient records.	1.0	1.84	3.74	28.8
7.6: Follow ethical standards in nursing care delivery and management.	1.0	2.08	3.61	28.5
3.3: Create a safe, developmentally appropriate, therapeutic environment conducive to care.	1.0	2.06	3.62	28.5
1.7: Obtain diagnostic test results.	1.0	2.21	3.54	28.5
5.2: Establish trust.	1.0	1.67	3.75	28.0
1.3: Perform a medication reconciliation	1.0	2.21	3.47	27.8
3.4: Coordinate patient care.	1.0	1.88	3.65	27.8
4.5: Communicate changes to the patient, family, significant other, and interdisciplinary team.	1.0	1.95	3.61	27.8
5.6: Maintain appropriate physical and emotional boundaries.	1.0	1.80	3.64	27.3
4.3: Evaluate the patient's response to interventions and the effectiveness of the plan of care.	1.0	1.84	3.58	26.9
4.6: Document the patient's response to interventions and changes to the plan of care in patient records.	1.0	1.72	3.61	26.5
1.1: Obtain patient history using age-appropriate, system-specific, evidence-based tools.	1.0	1.66	3.61	26.3
5.3: Develop rapport.	1.0	1.45	3.72	26.3
7.2: Coordinate patient safety measures.	1.0	2.26	3.20	26.3
2.1: Prioritize nursing diagnoses and/or problems.	1.0	1.75	3.55	26.2
5.1: Approach the patient in a developmentally appropriate manner.	1.0	1.45	3.71	26.2
4.1: Collect data related to the patient's response to interventions.	1.0	1.79	3.52	26.1
6.1: Identify learning needs.	1.0	1.68	3.55	25.9
6.2: Identify barriers to learning.	1.0	1.71	3.53	25.9
7.5: Use electronic information systems in nursing care delivery.	1.0	1.60	3.54	25.3
5.5: Support the patient's parents, family, significant others, and caregivers.	1.0	1.41	3.63	25.2
1.5: Complete psychosocial assessment using age-appropriate, system-specific, evidence-based tools and assessment techniques.	1.0	1.62	3.45	24.8
4.2: Collect data on factors that impact the patient's care.	1.0	1.72	3.32	24.4
4.4: Update the plan of care.	1.0	1.47	3.50	24.3
1.8: Review findings provided by others.	1.0	1.72	3.30	24.3
2.5: Document plan of care and expected outcomes in patient records.	1.0	1.44	3.49	24.1

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Medical-Surgical	Perf Exp Mode	Avg Cons	Avg Freq	Relative Importance
6.3: Develop an individualized education plan with the involvement of the patient, family, significant other, and caregiver.	1.0	1.52	3.33	23.5
2.4: Develop an individualized, developmentally appropriate plan of care.	1.0	1.47	3.35	23.4
7.3: Improve quality of nursing care delivery.	1.0	1.65	2.93	22.1
1.13: Create a problem list based on assessment data.	1.0	1.44	3.14	22.1
3.2: Use other evidence-based practice guidelines as the basis for interventions specific to the plan of care.	1.0	1.48	3.06	21.9
6.7: Document the education provided and its effectiveness in patient records.	1.0	1.34	3.19	21.9
1.9: Synthesize available data and knowledge to identify patterns and variances.	1.0	1.55	2.78	21.0
5.8: Document pertinent aspects of the nurse-patient relationship in patient records.	1.0	1.32	3.03	21.0
6.5: Implement the education plan.	1.0	1.37	2.89	20.7
6.6: Evaluate the education plan’s effectiveness.	1.0	1.35	2.88	20.6
1.11: Identify nursing diagnoses using clinical pathways.	1.0	1.22	2.97	20.3
2.2: Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using Nursing Outcomes Classification (NOC).	1.0	1.23	2.86	19.9
1.10: Identify nursing diagnoses using the North American Nursing Diagnosis Association-International (NANDA-I) taxonomy.	1.0	1.10	2.92	19.5
3.1: Use Nursing Interventions Classification (NIC) as the basis for interventions specific to the plan of care.	1.0	1.22	2.66	19.1
2.3: Formulate expected outcomes with patient, family, significant other, and interdisciplinary team involvement using clinical pathways or a different system. [Specify other]	1.0	1.18	2.71	19.1
1.6: Collect data on psychoses.	1.0	1.49	2.11	18.4
7.1: Serve as a preceptor.	2.0	1.32	2.19	18.0
7.4: Serve as a clinical content expert for the design and enhancement of policies, procedures, processes, and systems that affect nursing care.	2.0	1.21	1.86	16.5
6.4: Develop educational programs for groups.	2.0	0.78	1.58	13.7
1.12: Identify nursing diagnoses using a different system. [Specify the system]	0.0	0.63	1.39	12.3

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