Message from the President

Charlotte York, LPN, President

RN Renewal Notices to be Mailed February 1, 2009

The RN renewal season officially began on February 1, 2009 and ends April 30, 2009. Renewal notices were mailed out starting February 1, 2009. The ability to renew online at the Board of Nursing’s web site opened at midnight on February 1, 2009. RN licensure renewal is for a two-year period, expiring April 30th of each odd-numbered year. Missouri law requires that a nurse have an active license in order to practice nursing within the State. RN nursing licenses may be renewed via the Missouri Board of Nursing’s website by selecting Online Services and then Renew a License. A PIN number is required for online renewal. This number can be obtained from the renewal application that was mailed February 1, 2009. If a renewal application has not been received, please contact the Board office at 573-751-0681.

Failure to receive the renewal application does not relieve the licensee of the responsibility to maintain a current license. Per statute, licensees are responsible for keeping the Board of Nursing informed of their current mailing address. If a license expires, the nurse must stop working immediately and cannot begin working again as a nurse until current licensure status can be verified and confirmed. Updated licensure information can be accessed through the Missouri State Board of Nursing’s website at http://pr.mo.gov/nursing.asp by selecting Online Services and then License Search.

The Nursing Shortage—A Call to Action

The United States is in the midst of a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows. Compounding the problem is the fact that nursing colleges and universities across the country are struggling to expand enrollment levels to meet the rising demand for nursing care.

The Missouri State Board of Nursing worked with the Nursing Coalition and the Missouri Department of Health and Senior Services developing a survey in order to gather current statistics related to the shortage. There is an abundance of nursing shortage studies statistics on a national level but not any that are Missouri-specific. Data from this survey will be used to inform state and local decision makers regarding the recruitment, education, and employment of nurses in Missouri.

This survey is included with your renewal notice. Should the online renewal option be chosen, an online version of this survey is available. The information provided in the survey is kept confidential; the identity of individual respondents will not be shared. Completion of the questions is voluntary and does not affect licensure or license renewal but we strongly urge completion of the survey. This data is vital for Missouri lawmakers and confirmed.

Executive Director Report

The 2009 legislative session started on January 7, 2009 and goes through May 15, 2009. The Board of Nursing is not seeking any legislative changes this year. I can think of two laws that passed recently where nurses did not feel fully informed of the law before it became effective. The Board of Nursing did not introduce either of these laws and as a government agency is charged with enforcing the law as written.

One was the bill that requires all persons and business entities applying for or renewing licenses with the Division of Professional Registration to have paid all state income tax returns for the preceding three years. If a licensee failed to pay taxes or failed to file tax returns their license is subject to suspension for 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. This requirement was enacted in House Bill 600 of the 92nd General Assembly (2003), and was signed into law by the Governor on July 1, 2003.

The other bill was Senate Bill 724 of the 94th General Assembly (2008) and became effective August 28, 2008. This bill pertains to controlled substance prescriptive authority for advanced practice registered nurses. The legislative process is lengthy and changes to bill language are frequently made after bills are fully heard in committee hearings. An important phase of the legislative process is the action taken by committees. It is during committee action that the most intense consideration is given to proposed bills; this is also the time when the people are given their opportunity to be heard. The two most important committees related to professional licensees are the Senate Financial, Governmental Organizations and Elections Committee and the House Special Committee on Professional Registration and Licensing.

How a Bill Becomes a Law

No law is passed except by bill. Bills may originate in either house and are designated as Senate Bills or House Bills, depending on the house in which they originate. No bill (except general appropriations bills) may contain more than one subject, which is to be expressed clearly in its title. No bill can be amended in its passage through either house so as to change its original purpose. No bill can be introduced in either house after the 60th legislative day of a session unless consented to by a majority of the elected members of each house. The governor may request consideration of proposed legislation by a special message. No appropriation bill shall be taken up for consideration after 6:00 p.m. on the first Friday following the first Monday in May of each year.

Introduction of a Bill

Legislation approved by the 1971 General Assembly (H.B. 156) provides for pre-introduction of bills beginning December 1 preceding the opening of the assembly session and continuing up to, but not including, the first day of the legislative session at which the assembly is to hold its organizational meeting. How a bill becomes a law

The Missouri State Board of Nursing worked with the Nursing Coalition and the Missouri Department of Health and Senior Services developing a survey in order to gather current statistics related to the shortage. This survey is included with your renewal notice. Should the online renewal option be chosen, an online version of this survey is available. The information provided in the survey is kept confidential; the identity of individual respondents will not be shared. Completion of the questions is voluntary and does not affect licensure or license renewal but we strongly urge completion of the survey. This data is vital for Missouri lawmakers and confirmed.

Executive Director Report continued on page 4

GOVERNOR
The Honorable Jeremiah W. (Jay) Nixon

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Kip Stetzer, Acting Director

DIVISION OF PROFESSIONAL REGISTRATION
Jane Rackers, Director

BOARD MEMBERS
Charlotte York, LPN, President
Autumn Hooper, RN, Vice-President
Teri Murray, PhD, RN, Secretary

EXECUTIVE DIRECTOR
Lori Scheidt, BS

ADDRESS/TOLLFREE NUMBER
Missouri State Board of Nursing 3605 Missouri Boulevard PO Box 656 Jefferson City, MO 65102-0656 573-751-0681 Main Line 573-751-0075 Fax Web site: http://pr.mo.gov E-mail: nursing@pr.mo.gov
DISCLAIMER CLAUSE

The Nursing Newsletter is published quarterly by the Missouri State Board of Nursing of the Division of Professional Registration of the Department of Insurance, Financial Institutions & Professional Registration. Providers offering educational programs advertised in the Newsletter should be contacted directly and not the Missouri State Board of Nursing.

Advertising is not solicited nor endorsed by the Missouri State Board of Nursing.

For advertising rates and information, contact Arthur L. Davis Agency, 517 Washington St., P.O. Box 216, Cedar Falls, IA 50613, Ph. 1-800-626-4081. Responsibilities for errors in advertising is limited to corrections in the next issue or refund of price of advertisement. Publisher is not responsible for errors in printing of schedule. The State Board of Nursing and the Arthur L. Davis Agency reserve the right to reject advertising. The Missouri State Board of Nursing and the Arthur L. Davis Publishing Agency, Inc. shall not be liable for any consequences resulting from purchase or use of advertisers’ products from the advertisers’ opinions, expressed or reported, or the claims made herein.

Important Telephone Numbers

<table>
<thead>
<tr>
<th>Professional Organization</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health &amp; Senior Services</td>
<td>573-526-5686</td>
</tr>
<tr>
<td>Missouri State Association for Licensed Practical Nurses (MoSALPN)</td>
<td>573-636-5659</td>
</tr>
<tr>
<td>Missouri Nurses Association (MONA)</td>
<td>573-636-4623</td>
</tr>
<tr>
<td>Missouri League for Nursing (MLN)</td>
<td>573-635-5355</td>
</tr>
<tr>
<td>Missouri Hospital Association (MHA)</td>
<td>573-893-3700</td>
</tr>
</tbody>
</table>

Number of Nurses Currently Licensed in the State of Missouri

As of January 29, 2009

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Practical Nurse</td>
<td>23,646</td>
</tr>
<tr>
<td>Registered Professional Nurse</td>
<td>91,634</td>
</tr>
<tr>
<td>Total</td>
<td>115,280</td>
</tr>
</tbody>
</table>

Schedule of Board Meeting Dates Through 2010

<table>
<thead>
<tr>
<th>Date</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 11-13, 2009</td>
<td>2009</td>
</tr>
<tr>
<td>June 3-5, 2009</td>
<td>2009</td>
</tr>
<tr>
<td>September 9-11, 2009</td>
<td>2009</td>
</tr>
<tr>
<td>December 2-4, 2009</td>
<td>2009</td>
</tr>
<tr>
<td>March 3-5, 2010</td>
<td>2010</td>
</tr>
<tr>
<td>June 2-4, 2010</td>
<td>2010</td>
</tr>
<tr>
<td>September 8-10, 2010</td>
<td>2010</td>
</tr>
<tr>
<td>December 1-3, 2010</td>
<td>2010</td>
</tr>
</tbody>
</table>

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our website at http://pr.mo.gov
other decision makers as they work to effectively identify and resolve issues associated with the nursing shortage and develop comprehensive short and long range state workforce planning strategies to turn the shortage around.

Show Me Response—Online Registration System for Volunteer Health Professionals

Nurses have an opportunity to lend aid following a large scale disaster or other public health emergency by pre-registering, as a health care professional willing to provide services, at www.showmesresponse.org. Health professionals that pre-register as volunteers can be deployed rapidly and effectively in the event of a disaster. This disaster volunteer registration site is operated by the Missouri Department of Health and Senior Services and allows registration as a volunteer during a disaster or emergency situation. The registration system will collect basic information about the volunteer and the volunteer’s professional information such as license number, expiration date, certifications, and specific contact information.

To qualify as a volunteer, the nurse must be a Missouri resident and/or have an active, undisciplined license with the Missouri State Board of Nursing. Upon registration, credentials are checked. All reasonable efforts, in accordance with the federal guidelines for Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), will be made to ascertain the credentials of individuals interested in becoming a volunteer.

During a state or national disaster, this system may receive requests for potential volunteers. If a decision is made to request the services of a volunteer, the selected individual will be contacted through an automated system and asked about availability. An individual can choose to accept or decline any request for activation.

Board of Nursing Nearing 100 Year Anniversary

In March 1909, nearly 100 years ago, the Nursing Practice Act became effective in Missouri. The first Missouri State Board of Nursing was composed of 5 members appointed by Governor Herbert S. Hadley. These 5 nurses, Elizabeth Tooker, RN; Ida Gerding, RN; Maude Landis, RN; Charlotte Forrester, RN; and Fanny E. S. Smith, RN held the first meeting of the Board in December 1909 to adopt the rules and regulations to govern themselves.

The mission of the Board then, as it is today, was to protect the public by development and enforcement of state laws governing the safe practice of nursing.

Legislative Authority

The Nursing Practice Act (NPA) exists to govern and regulate the profession of licensed nurses, set standards for the approval of nursing schools in Missouri, determine the scope of practice of licensed nurses, and define who may use the title of registered nurse (R.N.) and licensed practical nurse (L.P.N.) within the State of Missouri. Rules are promulgated to provide guidance for the Board to carry out the mandate of the NPA. The Board of Nursing has no authority to change the law; changes can only be made by the legislators.

Number of Licensees

The State of Missouri has approximately 91,000 licensed RNs and 24,000 LPNs functioning in a variety of health care settings. About 6,450 of the RNs are also Advanced Practice Registered Nurses (APRNs).

Board Members

Board members are appointed to the Board by the Governor with advice and consent of the Senate when a vacancy occurs either by expiration of a term or resignation of a Board member. There are nine Board member slots; five of whom must be registered professional nurses, two must be licensed practical nurses, one an undesignated member, and one member a voting public member. Every appointment except to fulfill an unexpired term shall be for a term of four years, but no person may be appointed for more than two consecutive terms. The board is entrusted with the duty of ensuring that the RNs and LPNs licensed in Missouri comply with Chapter 335 thus creating an atmosphere of safe and effective nursing care in the interest of public protection. The members of the Board, along with its staff and general counsel are entrusted with the legal responsibility to see that the provisions of the law are carried out effectively, in addition to serving as a policy making and planning group. When administering the NPA and establishing policy, the Board considers the needs, the patient, the community, the State of Missouri and programs of professional and practical nursing. The Board’s primary role is governance while the staff’s primary role is management.

Board Member Changes

In the last issue of our newsletter, it was noted that Amanda Skaggs, RNC, WHNP, accepted the position of President of the Missouri State Board of Nursing. Ms. Skaggs’ term expired 8/13/2008 and was serving until reappointed or replaced. On November 13, 2008, Kelly Scott, MSN, RN, BC, FNP, was appointed to the Board in the slot formally held by Amanda Skaggs.

There will undoubtedly be more changes to the Board. We currently have a vacant RN board member position and a vacant public member position. We are thankful for the commitment and dedication of all Board members (past and present) that have willing served in these roles. In the 100 years of existence of the Board there has been 149 such individuals.
Perfection of a Bill
If a bill is reported favorably out of committee or a substitute is recommended, it is placed on the "perfection calendar" and when its turn comes up for consideration it is debated on the floor of the originating house. If a substitute is recommended by the committee or if committee amendments are attached to the bill, they are first presented, debated and voted upon. Further amendments can then be proposed by other members with their changes designated as House or Senate amendments to differentiate from the committee amendments. When all amendments have been considered, a motion is made to declare the bill perfected. Perfection is usually voted on a voice vote but on the request of five members, a roll call shall be taken. If a majority of members vote to perfect, the bill is reprinted in its original or amended form.

Signing of the Bill
Bills truly agreed to and finally passed in their typed form are then signed in open session by the House speaker and Senate president or president pro tem. At the time of signing, any member may file written objections which are sent with the bill to the governor.

Governor’s Part in Lawmaking
The governor has 15 days to act on a bill if it is sent to him during the legislative session; and 45 days if the legislature has adjourned or has recessed for a 30-day period.
If he signs a bill, it is returned to its house of origin with his message of approval, then delivered to the Office of Secretary of State. If the legislature is not in session, it is delivered directly to the Office of Secretary of State.

Final Passage of a Bill
After perfection and reprinting, the bill goes on the calendar for third reading and final passage. When the bill is reached in the order of business any member may speak for or against its passage but no further amendments of a substantive nature can be offered. At the conclusion of debate, a recorded vote is taken. Approval of a constitutional majority of the elected members (18 in the Senate and 82 in the House) is required for final passage. Passage of the bill is then reported to the other house where it is again read a second time; referred to committee for hearing; reported by committee; and third read and offered for final approval. If further amendments are approved, these are reported to the originating house with a request that the changes be approved. If the originating house does not approve, a conference may be requested and members from each house are designated as a conference committee. Upon agreement by the conference committee (usually a compromise of differences), each reports to its own house on the committee’s recommendation. The originating house acts first on the conference committee version of the bill. If it is approved it goes to the other house and upon approval there, the bill is declared "truly agreed to and finally passed." If either house rejects the conference committee report, it may be returned to the same or a newly appointed committee for further conferences. Upon final passage, a bill is ordered enrolled. It is typed in its finally approved form, printed and the bills are closely compared and proofed for errors.

Effective Date of Laws
The 1945 Constitution provides that no law passed by the General Assembly shall take effect until ninety days after the end of the session in which it was enacted; except an appropriation act or in case of an emergency, which must be expressed in the preamble or in the body of the act. Some bills specify the exact date when they are to take effect.

Your Role in the Legislative Process
Nurses represent over 28% of professionals licensed within the Missouri Division of Professional Registration. The Fall 2003 issue of John Hopkins Nursing indicated that “by some estimates, 1 of every 45 potential voters is a nurse. But in the legislative arena, the nursing profession has two sides. Know the opposing viewpoint. Every issue has two sides. As a licensed professional, you do have a voice in shaping the future of health care. You can have a face to face meeting, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at http://www.moga.mo.gov/
Information gathered during the investigation:

INTERVIEW OF THE PATIENT:
The patient had a good night. The patient then called Nurse B to tell her that the patient had an attack and needed the epinephrine. Nurse A said that she usually taped the vial to the syringe, but for some reason, did not do it this time. Nurse A stated that she was going to throw the syringe away, but there was no additional epinephrine readily available in case the patient needed it, so she just left it on the patient’s bedside table. Nurse A stated that she told oncoming Nurse B about the syringe containing epinephrine on the patient’s bedside table because it was the last one in the patient’s drawer. Nurse A said that she told Nurse B that if she wasted the epinephrine syringe, she would have to go to pharmacy to get more. Nurse A stated that she was very sorry and she never intended to hurt the patient. If there was a way to go back and change things, she would. She said that she would never make that mistake again.

INTERVIEW WITH NURSE A:
The patient came in with an unknown etiology but it was made known that when the patient was having a reaction there was not much time to react, so you had to get the epinephrine to the patient immediately.

The patient had a good night. The patient then called Nurse A into the room and said she was starting to have difficulty. Nurse A went to get the epinephrine and the Benadryl. When she got back to the room the patient said that she would rather wait before taking the epinephrine, because it was not that bad. Nurse A decided to give the patient Benadryl IV, and keep the epinephrine in her pocket since that was the only epinephrine the patient had in their drawer. Any other epinephrine would have to be obtained from the pharmacy. Nurse A then decided to put the syringe with the epinephrine on the bedside table so it would be readily available in case the patient worsened and needed the epinephrine. Nurse A said that she usually taped the vial to the syringe, but for some reason, did not do it this time. Nurse A stated that she was going to throw the syringe away, but there was no additional epinephrine readily available in case the patient needed it, so she just left it on the patient’s bedside table. Nurse A stated that she told oncoming Nurse B about the syringe containing epinephrine on the patient’s bedside table because it was the last one in the patient’s drawer. Nurse A said that she told Nurse B that if she wasted the epinephrine syringe, she would have to go to pharmacy to get more. Nurse A stated that she was very sorry and she never intended to hurt the patient. If there was a way to go back and change things, she would. She said that she would never make that mistake again.

INTERVIEW WITH NURSE B:
Nurse B stated that she was advised by Nurse A that she left a syringe of epinephrine on the patient’s bedside table, but she was not told the syringe was not labeled, or how much medication was in the syringe.

Nurse B said that she did an initial flush and hung the piggy back. When she went back into the room to do a flush, she took the syringe with the saline flush with her and laid it on the bedside table beside the epinephrine. Nurse B stated that neither syringe was labeled.

Nurse B said that she laid the syringe on the bedside table so she could disconnect the IV medication. Nurse B stated that when she went to pick up the syringe to do the flush, she noticed that there were two syringes on the bedside table. She said since neither of the syringes was labeled and that the order was for 0.3cc of epinephrine and since the flush syringe had been used and it had less left, she thought that the flush syringe should have the most in it. Nurse B threw away the flush syringe that had the least amount of clear liquid in it. Nurse B said that she began to do the flush by injecting the entire amount into the IV and then left the room. Nurse B said that the patient immediately called her back into the room, at which time the patient started having convulsions.

Nurse B said that she was very sorry about what happened and wishes that she would have done things differently.

INTERVIEW OF THE PATIENT:
The patient said that she would like to emphasize that Nurse B looked at both syringes and stated “I have a 50/50 chance.” Nurse B then picked up one syringe, threw it away, and used the other one. The patient stated that when Nurse B injected the epinephrine in her IV, she immediately had an effect, and was in a great deal of pain.

The patient verbalized that she could not understand why someone would take a 50/50 chance of giving a patient the wrong medication, especially when the wrong one could, and in most cases would, kill the patient. The patient said that she continues to have numerous health problems because of this incident.

After reading the above case, I’m sure most of you have identified several preventative measures that could have been taken to avoid this tragic accident. I hope those of you who are nurses take the time to discipline yourselves to use safe medication administration practices; someone’s life could depend on it.
Clinical Preceptors

Nurse Educators across the state are dedicated to providing nursing students with most valuable clinical experiences. While planning educational experiences which provide students with realistic patient assignments, educators often call on clinical nurses to serve as clinical preceptors. Careful preceptor/student selection is essential to student learning and invaluable to patient safety. While students, patients and nurses may greatly benefit from such precepted clinical experiences, Missouri State Board of Nursing (MSBN) regulation guidelines should be followed.

As nurse educators plan such clinical experiences, selection of clinical preceptors should occur in concert with the clinical facility. Preceptors may be used as role models, mentors and supervisors of students. Preceptors should never replace faculty, but assist faculty to help students achieve designated clinical objectives. Preceptors should not be utilized in entry-level clinical experiences and precept no more than two students at a time. Nursing programs should provide clinical nurses with written policies describing duties, roles and responsibilities of faculty, students and preceptors. Clinical objectives for each experience should also be provided. Preceptors should provide feedback to faculty regarding student performance; yet final student evaluation should remain the responsibility of faculty. Faculty should be readily available to students and preceptors and all should meet periodically to assure optimal student and patient outcomes.

The Missouri Nursing Practice Act requires clinical preceptors for students enrolled in professional nursing programs to possess Missouri licensure as a registered professional nurse with at least one (1) year of experience in the area of clinical specialty for which the preceptor is used. Preceptors for students enrolled in programs of practical nursing may be licensed as a registered or licensed practical nurse in Missouri with similar levels of clinical experience.

Missouri nursing students, patients and nurses may greatly benefit from optimally managed, precepted clinical experiences. As preceptors assist nursing faculty to provide well-rounded realistic clinical experiences for future nurses, it is essential to assure clinical assignment models designed to optimize student preparation for practice as well as provision of safe and effective nurse/patient situations.

Missouri Nursing Practice regulations guiding precepted clinical experiences are accessible on the MSBN website at http://pr.mo.gov under rules. Chapter 2, Minimum Standards for Programs of Professional Nursing, section 20 CSR 2200-2.085, as well as Chapter 3, Minimum Standards for Programs of Practical Nursing, section 20 CSR 2200-3.085, provide regulatory guidelines for the different levels of nursing education.
Missouri State Board of Nursing

Discipline Committee Members:
- Charlotte York, LPN, Chair
- Autumn Hooper, RN

Prohibition Requirements

When a nurse is placed on probation the terms of the probation are defined in the Settlement Agreement or Board Order. For the purpose of this article the disciplinary document will be referred to as an agreement. Every disciplinary agreement is different based on the conduct of the licensee.

Each licensee that is placed on probation is required to meet with the Board or its professional staff at such times and places as required by the Board. If the Licensee does not receive notice of a meeting with the Board within one month after the effective date of the agreement then the licensee must contact the Board office. The discipline section mails out an appointment letter with the date, time and place of the meeting with the executed discipline agreement. Included in this mailing are the quarterly due dates and the forms required for use to fulfill portions of the agreement. If you would like to view the forms they may be found at http://pr.mo.gov/nursing-monitoring.asp.

The agreement is different based on the public.

To successfully complete the probationary period the licensee must comply with all of the requirements in the agreement. If they do not comply then a probation period of unemployment.

When licensees are employed in a nursing position the board may place employment restrictions on their nursing practice. The restrictions may include any of the following that the Board feels necessary to provide protection to the public:
- Licensee shall not carry narcotic keys, administer, possess, dispense, or otherwise have access to controlled substances.
- Licensee shall only work as a nurse at a facility where there is on-site supervision by another nurse or physician.
- Licensee shall not work for a temporary employment agency.
- Licensee shall not work home health.
- Licensee shall not work home health.

The Board members carefully review the conduct of the licensee and decide what restrictions they feel necessary; the licensee is responsible for following the restrictions.

Each licensee on probation shall not violate the Nursing Practice Act, shall renew their license immediately and shall not allow the license to lapse. They may place their license on inactive status but the conditions of discipline will continue to apply if the license is inactive.

The licensee shall inform the Board within ten days of any change of home address or home telephone number.

The licensee shall advise any employer or potential employer of the probationary status and shall provide a copy of the entire disciplinary agreement to any employer or potential employer. The licensee must also keep the Board informed of their current place of employment and of any changes of employment. This requirement also includes non nursing employers such as retail stores, restaurants, etc.

Employers must fill out an employer evaluation form on a quarterly basis. Two forms are available, one if the nurse is working in a nursing position (Nursing Employment Evaluation Form) and the other is a Non-

nursing Employment Evaluation Form. The forms must be sent to the Board Office by the supervisor. If the licensee ends employment with an employer through resignation or termination a final evaluation form must be submitted by the supervisor within six weeks following the last day of employment. If a licensee is not employed, they must submit a signed affidavit on a quarterly basis stating the period of unemployment.

When licensees are employed in a nursing position the board may place employment restrictions on their nursing practice. The restrictions may include any of the following that the Board feels necessary to provide protection to the public:
- Licensee shall not carry narcotic keys, administer, possess, dispense, or otherwise have access to controlled substances.
- Licensee shall only work as a nurse at a facility where there is on-site supervision by another nurse or physician.
- Licensee shall not work for a temporary employment agency.
- Licensee shall not work home health.

The Board may require drug screens. The Board contracts with a third party administrator for the drug screens. The licensee is required to call or check in by computer between 0500 and 1600 on a daily basis, 365 days of the year. At any time the licensee may be required to submit a specimen, they must report to a lab that same day to give the specimen.

The Board may require continuing education hours be completed in specific topic areas. The certificate of completion for the education hours and the course objectives must be submitted to the Board Office by a set due date.

The Board may require drug screens. The Board contracts with a third party administrator for the drug screens. The licensee is required to call or check in by computer between 0500 and 1600 on a daily basis, 365 days of the year. At any time the licensee may be required to submit a specimen, they must report to a lab that same day to give the specimen.

To successfully complete the probationary period the licensee must comply with all of the requirements in the agreement. If they do not comply then a probation violation hearing will be scheduled to allow the licensee the opportunity to inform the Board why they were unable to comply. At the conclusion of this hearing the Board will decide if further discipline is necessary for the protection of the public.

The terms listed in this article are general terms and they may be altered on an individual basis.
Transitions of care can be complex. A patient might receive care from a physician in an outpatient setting, and then be admitted as an inpatient to a hospital before moving to a skilled nursing facility. Because a patient’s journey in health care involves encounters with multiple disciplines and multiple persons within those disciplines, the ownership of this process can be dropped.

An example of this can be seen in patient care after discharge. Medicare patients express greater dissatisfaction with discharge-related care than any other aspect of medical care. Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized. Of these beneficiaries, 64% receive no post-acute care between discharge and readmission. The Medicare Payment Advisory Commission (MedPAC) estimated that up to 76 percent of these readmissions may be preventable.

Nationwide, most organizations, experts and stakeholders agree that three main principles must exist for the transition of care process to succeed: accurate communication, provider accountability and patient involvement.

Accurate communication: Poor communication is often found to be the root cause of patient safety and quality concerns within medical care organizations. Communication of information about a patient’s treatment plan and expectations of follow-up should be accurate, clear and timely. This will ensure that the patient’s needs are met across the continuum of care. Effective communication plays an essential role in assuring provider accountability and patient involvement during transitions of care.

Provider accountability: Accountability among providers will help ensure that all providers involved in a patient’s care have access to information at each phase of care, and are aware of when a transition occurs. Identifying and standardizing essential information will ensure improved transitions of care. Elements to include are:

- An accurate list of medications (utilize a “medication reconciliation” process).
- Name and contact information for the patient’s primary physician(s).
- Expectations for follow-up.
- A list of treatments or procedures the patient has received.
- Signs and symptoms to report.
- Discharging facility/unit/murse.

Patient involvement: The patient and his or her family should always be informed about the details of the transition process. Failure to do so can have a negative impact on patient self-management. A strong provider/patient relationship helps to ensure a patient’s involvement and understanding. The patient should:

- Have access to his/her Personal Health Record.
- Be familiar with the discharge preparation checklist.
- Receive a self-activation and management session with a transition coach.
- Receive follow-up visits from the transition coach at home or in a skilled nursing facility, along with accompanying phone calls designed to sustain the first three components and provide continuity.

Focusing on the critical transitions of patients and their caregivers across health care settings and among providers is a promising approach to enhancing transitions of care and improving health care quality.

Update on APRN Controlled Substance Prescriptive Authority

The Task Force that has been working on the rules that the Board of Nursing is responsible for promulgating has submitted a draft to the Board for review. This preliminary review was accomplished at the December 2008 Board meeting. Comments will be sent back to the Task Force. Bureau of Narcotics and Dangerous Drugs (BNDD) has been working on their rule changes as well. Work is also underway to clarify and revise the collaborative practice rules. Once completed, the draft will be sent to the Board of Healing Arts and the Board of Nursing and then to the Collaborative Practice Task Force for final approval.
Summary of Actions
December 2008
Board Meeting

Education Matters
Curriculum Changes
• Request to place some non-nursing courses on-line was received from Sanford Brown College, Associate Degree Program, #17-421 was acknowledged by the Board.
• Request to increase the program hours from 1334 total hours to 1384 total hours was approved for Kirksville Area Technical Center, PN Program #17-186.
• Request to change the curriculum hours from 1463 to 1356 hours was approved for Warrensburg Area Career Center, PN Program #17-172.

Enrollment Changes
• Request to increase enrollment from 25 to 30 students with 2 alternates was approved for Bolivar Technical College, PN Program #17-121.

New Programs
• The proposal to establish a new Practical Nursing Program from Carthage Technical Center was accepted.
• A Letter of Intent to establish a new Practical Nursing Program from Metro Business College was acknowledged.
• A Letter of Intent to establish a new LPN to RN Bridge Program from Pikes/Lincoln Technical Center, PN Program #17-168 was acknowledged.
• A Letter of Intent to establish a part-time LPN to RN Bridge Program from Bolivar Technical Center was acknowledged.
• A Letter of Intent to establish a new Practical Nursing Program from Clinton Technical School was acknowledged.

Surveys
• Numerous survey reports were reviewed and accepted.

Discipline Matters
The Board held 8 disciplinary hearings and 15 violation hearings.

Licensure Matters
The Licensure Committee reviewed 53 cases. Results of reviews as follows:
Applications Approved—3
Applications Approved with letters of concern—18
Applications Approved with probated licenses—12
Applications tabled for additional information—4
Applications Denied—12
Renewal Application Denied, License Revoked—2
Censures—2
Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act. **Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee’s identity, please check the license number.**

PROBATIONARY LICENSE

Listed below are individuals who were issued an initial probationary license or had their expired or inactive licenses renewed on a probationary status by the Board during the previous quarter with a brief description of their conduct.

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
<th>Effective Dates of Restricted License</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becky Sue Lankford</td>
<td>PN2008031815</td>
<td>On September 20, 2006, Licensee pled guilty to the Class A Misdemeanor of Possession of a Controlled Substance (Marijuana).</td>
<td>10/14/2008 to 10/14/2010</td>
</tr>
</tbody>
</table>

CENSURE

Listed below are the individuals who were given the discipline of censure. This is the least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer A Diaz</td>
<td>RN2005026731</td>
<td>Licensee failed to call NCPS on twenty-three (23) days. The Board did not receive an employee evaluation or statement of unemployment by the documentation due date of May 20, 2008. The Board did not receive proof of support group attendance by the first documentation due date of February 20, 2008 or the subsequent documentation date of May 20, 2008.</td>
</tr>
<tr>
<td>Thomas J Jacob</td>
<td>RN107619</td>
<td>On August 23, 2006, Licensee entered an Alford plea to one count of sexual misconduct in the second degree.</td>
</tr>
<tr>
<td>Tracy G Kaddouri</td>
<td>RN2008027933</td>
<td>Licensee practiced nursing in the State of Missouri from July 5, 2007 to August 6, 2008 without a current, valid license.</td>
</tr>
<tr>
<td>Mary Jo Seeley</td>
<td>PN026632</td>
<td>Licensee was hired on March 5, 2007 Licensee saw clients through May 3, 2007. Licensee did not return the client’s chart to the agency.</td>
</tr>
<tr>
<td>Sally M Tunison</td>
<td>RN096407</td>
<td>On September 20, 2007 Licensee transported two separate patients to the cardiology floor where Licensee failed to notify the accepting nurse of the patients' arrival to the floor. Licensee also failed to place either patient on the cardiac monitor. Both patients had written physician's orders for cardiac monitoring.</td>
</tr>
<tr>
<td>Pauline P Woolman</td>
<td>PN039852</td>
<td>From November 10, 2007 to November 13, 2007, a resident received six doses of Lovenox along with her scheduled Coumadin. The physician's orders stated that daily labs had to be drawn to monitor the effectiveness of the Coumadin. Licensee administered the Lovenox without drawing the daily labs.</td>
</tr>
</tbody>
</table>
### Missouri Moves Closer to Accurate Medical Error Data and Prevention

**Missouri Center for Patient Safety receives federal designation to help**

JEFFERSON CITY, Mo.—Effective Nov. 5, Missouri will be among the first ten organizations announced as using a new federal program to learn how, when and why medical errors happen across the state.

On Wednesday, Nov. 5, the Missouri Center for Patient Safety will be designated as an official Patient Safety Organization (PSO). This designation allows the Center to safely collect and report information about medical errors.

"Until now, there was no system to obtain reliable data that tells us how often medical errors occur in Missouri," said Becky Miller, executive director of MOCPS. "We are excited to be one of the first states to have a designated PSO. As a designated PSO, MOCPS will expand on its work to safely collect and report information about medical errors.

Federal PSO requirements are defined in the Patient Safety and Quality Improvement Act of 2005. The PSOs will form a network of organizations across the nation that will encourage reporting of errors and increase knowledge about why errors occur and how they can be prevented. The federal government estimates PSOs will collectively reduce preventable adverse events by up to 3%, saving up to $435 million in health care costs within their first five years of operation.

As a designated PSO, MOCPS will expand on its work over the past three years to support and facilitate ongoing statewide patient safety improvement; increase provider and consumer knowledge about medical errors and decrease medical errors and health care costs.

Missouri is one of the first states to have a listed PSO. The designation is given through the Agency for Health Research and Quality and the U.S. Department of Health and Senior Services.

### About MOCPS

As a private, not-for-profit corporation, the Missouri Center for Patient Safety (MOCPS) is dedicated to fostering change throughout Missouri’s health care system. Based in Jefferson City, the mission of MOCPS is to improve health care quality and patient safety in collaboration with health care providers, physicians, purchasers, consumers and government. Online at [www.mocps.org](http://www.mocps.org).

### Missouri Moves Closer to Accurate Medical Error Data and Prevention

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
<th>Effective Dates of Probation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen M Ahkemeier</td>
<td>RN130554</td>
<td>On August 10, 2007, Licensee was requested to submit a drug and alcohol test which tested positive for THC, a metabolite of marijuana.</td>
<td>11/4/2008 to 11/4/2010</td>
</tr>
<tr>
<td>Shaunte Jenean Allen</td>
<td>RN2007004388</td>
<td>On September 18, 2007, Licensee submitted to a drug screen and the results were positive for marijuana.</td>
<td>9/24/2008 to 9/24/2010</td>
</tr>
<tr>
<td>Cheryl Rae Bell</td>
<td>RN2007013131</td>
<td>On August 10, 2007, Licensee submitted to a urine drug screening test as part of a pre-employment hiring process which tested positive for THC, a metabolite of marijuana.</td>
<td>11/4/2008 to 6/26/2009</td>
</tr>
<tr>
<td>Gregory W Evans</td>
<td>RN129504</td>
<td>Licensee violated the terms of the disciplinary agreement by not calling in to NCPS, inc on 28 days.</td>
<td>10/2/2008 to 10/2/2013</td>
</tr>
<tr>
<td>Linda L Golitday</td>
<td>RN2000168576</td>
<td>Licensee’s husband reported to the Missouri State Board of Nursing that Licensee had an inappropriate relationship with an inmate while Licensee was employed at the Department of Corrections. Licensee opened a P.O. Box so that she could receive letters from the inmate. Licensee gave cash to the inmate. Witnesses at Licensee’s employment stated they felt that Licensee and inmate were having an inappropriate relationship.</td>
<td>9/2/2008 to 9/2/2009</td>
</tr>
<tr>
<td>Tanya L Graczek</td>
<td>RN145671</td>
<td>Licensee’s supervisor noticed that Licensee’s documentation became sloppy and erroneous, creating inconsistencies in her narcotic counts and charting. A random chart assessment for two of Licensee’s shifts on or around February 2005 identified nine charting inconsistencies. These inconsistencies included the waste of morphine without a witness and data entry errors involving the failure to note on patient medication administration records the administration of morphine, Oxycodone, and Chlordiazepoxide taken from storage.</td>
<td>11/25/2008 to 11/25/2010</td>
</tr>
<tr>
<td>Carolyn E Harrington</td>
<td>RN2000164704</td>
<td>Licensee was required to contract with NCPS, Inc. Since the beginning of her disciplinary period to the filing of the probation violation complaint, Licensee failed to call in to NCPS on thirteen (13) days. On March 26, 2008, Licensee failed to report to a laboratory to provide the requested sample. Licensee is required to abstain completely from the use or consumption of alcohol. On May 14, 2008, Licensee submitted a urine sample the test was positive for the presence of ethyl glucuronide, a metabolite of alcohol.</td>
<td>9/18/2008 to 9/18/2013</td>
</tr>
<tr>
<td>Marie Elizabeth Lasater</td>
<td>RN2000302278</td>
<td>On September 23, 2005, Licensee submitted a to a cause drug screen, which tested positive for Fentanyl. Licensee misappropriated Fentanyl for her personal consumption.</td>
<td>9/19/2008 to 9/19/2013</td>
</tr>
<tr>
<td>Norma Monsivais</td>
<td>RN122376</td>
<td>On June 23, 2007 Licensee appeared to be intoxicated. Licensee asked her co-workers to supply the urine sample for testing. After it was discovered by staff that she had made attempts to falsify her requested samples a Breathalyzer test was done and was positive with a .153 blood alcohol content. Licensee was directed to enter into a contract and participate in the Employee Assistance Program. On September 11, 2007, two separate breathalyzer tests were performed on Licensee with results of .097 blood alcohol content and .094, respectively.</td>
<td>11/8/2008 to 11/8/2012</td>
</tr>
<tr>
<td>Krista M Pritchett</td>
<td>PN200170580</td>
<td>On June 21, 2005, Licensee withdrew 2 mg of Dilaudid using the name, password and initials of a registered professional nurse. Licensee falsely documented administering 1 mg of Dilaudid and falsely documented wasting the remaining 1 mg of Dilaudid. Licensee misappropriated the 2 mg of Dilaudid for her personal consumption. On June 21, 2005, Licensee withdrew 2 mg of Dilaudid using the name, password and initials of a registered professional nurse. Licensee falsely documented administering 2 mg of Dilaudid. Licensee misappropriated the 2 mg of Dilaudid for her personal consumption.</td>
<td>11/9/2008 to 11/9/2011</td>
</tr>
<tr>
<td>Charris Jonea Rathbone</td>
<td>PN2005089915</td>
<td>On January 1, 2008, Licensee left the facility without giving report to the incoming nurse and before Licensee shift was over Licensee told nurse she was leaving without giving a report.</td>
<td>11/8/2008 to 11/8/2009</td>
</tr>
<tr>
<td>Name</td>
<td>License Number</td>
<td>Violation</td>
<td>Effective Dates of Probation</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Tara C St James</td>
<td>PN040434</td>
<td>On March 5, 2006, at approximately 6:50 p.m., a CMT witnessed Licensee holding a resident with both arms and shaking her. The CMT observed Licensee shaking the resident in a back and forth motion while holding the resident’s wrists. The CMT heard Licensee say, “Yea take her away because I’m about to lose my license, because I’m getting mad.” Another witness stated that the resident wanted to go behind the nurse’s desk therefore Licensee got up from her chair to prevent the resident from going behind the nurse’s desk. After Licensee wheeled the resident away a couple of times the resident proceeded to get out her chair and grab on to Licensee’s clothes at which point Licensee grabbed the resident’s wrists and shaking her back and forth and deniers making the statement about her license. Due to this incident, Licensee was terminated on March 7, 2006.</td>
<td></td>
</tr>
<tr>
<td>Harriette L Stewart</td>
<td>PN032223</td>
<td>On June 2, 2007, Licensee documented a 90% oxygen saturation on a resident, when it would have been impossible to ascertain the resident’s oxygen saturation level because the Center's only pulse oximeter machine was broken and had been discarded in the trash.</td>
<td></td>
</tr>
</tbody>
</table>

**REVOCATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
<th>Effective Dates of Revocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joyce A Arrowood</td>
<td>RN112173</td>
<td>On December 20, 2004, Licensee’s name was placed on the U.S. Department of Health and Senior Services, Office of Inspector General’s Federal Exclusion List until December 20, 2014. In March 2004, Licensee began employment at Ashland as a registered professional nurse and was continuously employed until March 16, 2006, in violation of the OIG exclusion. On February 2, 2004, Licensee began employment at Fulton as a registered professional nurse and was continuously employed until March 14, 2006, in violation of the OIG exclusion.</td>
<td></td>
</tr>
<tr>
<td>Triisti R Carroll</td>
<td>PN053087</td>
<td>Pursuant to the decision of the Administrative Hearing Commission, Licensee’s license is subject to disciplinary action under Section 335.066.2(1), (5), (12) and (14) RSMo.</td>
<td></td>
</tr>
<tr>
<td>Melissa L Diomedes</td>
<td>RN120749</td>
<td>Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. During her disciplinary period, Licensee failed to call NCPS on twelve days. Licensee was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Licensee has a bona fide relationships as a patient. On July 15, 2008, Licensee submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana.</td>
<td></td>
</tr>
<tr>
<td>Carla J Paulson</td>
<td>RN144231</td>
<td>Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to undergo a thorough chemical dependency evaluation. The Board never received a thorough chemical dependency evaluation submitted on Licensee’s behalf. Licensee was required to undergo a thorough mental health evaluation. The Board never received a thorough mental health evaluation submitted on Licensee’s behalf. Licensee was required to renew her nursing license. Licensee has not renewed her license. Licensee is required to meet with representatives of the Board at regular intervals. Licensee was advised by certified mail to attend a meeting with the Board’s representative on July 16, 2008. Licensee did not attend the July 16, 2008 meeting.</td>
<td></td>
</tr>
<tr>
<td>Dawn R Schappe</td>
<td>RN120571</td>
<td>Licensee was the Director of Nursing at Leland, a skilled nursing facility in University City, Missouri. In April, 2001, two residents of the facility died as a result of hyperthermia. Two other residents with pre-existing medical conditions declined as a result of the excessive heat in the facility and they also died. On April 7, 2006, the Administrative Hearing Commission found that the Board had grounds to discipline Licensee pursuant to §§335.066.2(5) and (12) RSMo. “[s]he failed to adequately monitor residents and failed to adequately instruct her staff to monitor and take actions to protect the residents.” “We find that Schappe’s failure to adequately supervise her staff and monitor the residents at Leland evidences incompetence.”</td>
<td></td>
</tr>
</tbody>
</table>

Revocation continued on page 14
## Revocation

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
<th>Effective Dates of Revocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Danette Schnelle</td>
<td>PN1999138406</td>
<td>Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to undergo a thorough chemical dependency evaluation within six weeks of the effective date of the Agreement and have the results sent to the Board within ten days of its completion. The Board never received a thorough chemical dependency evaluation submitted on Licensee’s behalf. Licensee was required to keep her nursing license current. Licensee’s license expired on May 31, 2008 and has not been renewed.</td>
<td>9/18/2008</td>
</tr>
<tr>
<td>Edith M Young</td>
<td>PN037991</td>
<td>Licensee was required to meet with representatives of the Board at regular intervals. Licensee was advised by certified mail to attend a meeting with the Board’s representative on April 2, 2008. Licensee failed to attend the meeting or call to reschedule the meeting. Licensee was required to submit employer evaluations from each and every employer. If Licensee was unemployed, a notarized statement indicating the dates of unemployment was to be submitted in lieu of employer evaluations. The Board did not receive an employer evaluation or a statement of unemployment by the first documentation due date of July 2, 2008.</td>
<td>9/18/2008</td>
</tr>
</tbody>
</table>

## SUSPENSION

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number</th>
<th>Violation</th>
<th>Effective Dates of Suspension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian J Vargo</td>
<td>PN055216</td>
<td>Licensee initially denied taking Percocet, but then admitted to taking Percocet for his personal use and acknowledged he had a problem with prescription medications.</td>
<td>10/22/2008 to 10/22/2009</td>
</tr>
<tr>
<td>Name</td>
<td>License Number</td>
<td>Violation</td>
<td>Effective Dates of Voluntary Surrender</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Kathleen M Bailey</td>
<td>PN058448</td>
<td>Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to meet with representatives of the Board. Licensee was advised by certified mail to attend a meeting with the Board's representative on June 11, 2008. Licensee failed to attend the meeting.</td>
<td>9/18/2008</td>
</tr>
<tr>
<td>Lucretia Kay Baucom</td>
<td>PS2007025644</td>
<td>In accordance with the terms of her probation, Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Pursuant to that contract, Licensee was required to call a toll free number every day to determine if she was required to submit to a test that day. Licensee failed to call NCPS, Inc. on fifteen (15) days. Further, on two dates, Licensee called and was advised that she had been selected to provide a urine sample for screening. Licensee failed to report to a laboratory to provide the requested sample. Licensee was required to cause a letter of ongoing treatment evaluation from a licensed mental health professional to be submitted to the Board. The Board did not receive a letter of ongoing treatment evaluation from a licensed mental health professional by the documentation due date.</td>
<td>10/30/2008</td>
</tr>
<tr>
<td>Sheri M Charlton</td>
<td>PN048734</td>
<td>A resident refused to get out of bed for dinner. The resident was forced out of bed and placed in a wheelchair. The resident threw himself out of the wheelchair. Licensee directed staff to put the resident back in the wheelchair. Licensee picked the resident up from behind and pulled him down into the wheelchair. Licensee restrained the resident by putting a sheet under one of the resident's legs and tying the sheet behind the chair. Licensee wrongfully and without physicians orders restrained the resident.</td>
<td>10/22/2008</td>
</tr>
<tr>
<td>Abby Lee Hess</td>
<td>RN2007018175</td>
<td>Licensee stated, “I originally requested licensure in Missouri in order to be able to attend a four week clinical rotation in Joplin. After receiving the license and noting that there was to be a five year probation period, my clinical instructor/dept chair at the school, advised that it would not be necessary to go to the Joplin clinical and pay for the extra monitoring fees required for the five year period for a brief clinical. My only action to be taking at this time is to voluntarily surrender my Missouri license. I do remain an active participant in KNAIP, and have been for over one year.” Licensee signed an agreement with the Missouri State Board of Nursing voluntarily surrendering her Missouri license.</td>
<td>11/18/2008</td>
</tr>
<tr>
<td>Rebecca A Pickle</td>
<td>RN127735</td>
<td>On January 17, 2006, Licensee misappropriated 2mg of Hydromorphone for her personal consumption. On the same day, Licensee misappropriated four syringes of Hydromorphone for her personal consumption. Again on the same day, Licensee misappropriated four syringes of Hydromorphone for her personal consumption. On January 30, 2006, Licensee misappropriated two tablets of Oxycodone/acetaminophen 5/325 for her personal consumption. On February 7, 2006, Licensee misappropriated two tablets of Oxycodone/acetaminophen 5/325 for her personal consumption. On the same day, Licensee misappropriated 1mg of Lorazepam for her personal consumption. Again on the same day, Licensee misappropriated 0.5mg of Hydromorphone for her personal consumption. On February 7, 2006, Licensee misappropriated 2mg of Hydromorphone for her personal consumption. On that day, Licensee exhibited impairment while on duty at the Hospital in that she had an unsteady gait, slurred speech, was lethargic, had difficulty gathering her thoughts and spoke in half sentences repeatedly that didn't make any sense. Licensee administered Lovenox to a patient despite a physician's order to hold the medication until after an LP was performed. This resulted in a delay in testing. Licensee failed to assess a post-operative patient and failed to administer insulin per sliding scale as ordered by the patient's physician. On February 9, 2006, Licensee submitted to a drug screen, the results of which were positive for Lorazapam, Hydromorphone, Morphine and Oxycodone. Licensee did not have valid prescriptions for any of the controlled substances.</td>
<td>9/19/2008</td>
</tr>
<tr>
<td>Kathy L Raniero</td>
<td>RN153827</td>
<td>On or about the week of August 11, 2005, licensee possessed and smoked marijuana.</td>
<td>10/22/2008</td>
</tr>
<tr>
<td>Kathleen A Vantrump</td>
<td>RN077618</td>
<td>A pharmacy tech received a prescription for licensee. The pharmacy tech noticed that the label, which typically bears the name of the patient, had been removed and licensee's name was handwritten where the label had been. The pharmacy tech called the prescribing doctor to ascertain the validity of the prescription. The doctor verified that he did not write the prescription for licensee. Licensee admitted to the Board's investigators that she altered the prescription for the purpose of obtaining Percocet. Following the above-referenced occurrence, licensee's employer audited licensee's pyxis activity for the previous thirty (30) days. The audit revealed nine (9) occasions when licensee removed two (2) Percocet tablets without a physician's order and without documenting the administration or waste of the Percocet. When licensee was questioned about the allegation of diverting Percocet, licensee admitted that she withdrew Percocet from the Pyxis for patients who did not have a physician's order and did not document that the medication had administered or wasted. Licensee admitted that she began diverting Percocet in March 2008 and continued to do so until her termination.</td>
<td>10/10/2008</td>
</tr>
</tbody>
</table>
Did you know you are required to notify the Board if you change your name or address?

A change form is available on our website at

http://pr.mo.gov
Joint Statement on Pain Management by the Missouri Board of Healing Arts, Board of Nursing and Board of Pharmacy

December 2008

Pain is one of the oldest medical problems and the most universal physical affliction. It also is one of the most common reasons for people to seek medical attention. Adequate pain management leads to enhanced functioning and increased quality of life. In contrast, inadequately controlled pain can have such profound consequences as disability, depression and despair. In addition, inadequately controlled pain can increase utilization of healthcare resources and expenditures.

The Missouri Boards of Healing Arts, Nursing and Pharmacy are in accord with the Joint Commission on Accreditation of Healthcare Organizations in recognizing that “Patients have the right to appropriate assessment and management of pain.” Inappropriate treatment of pain includes non-treatment, undertreatment, overtreatment, and the continued use of ineffective treatments. It is, therefore, incumbent upon Missouri physicians, nurses, pharmacists and other health professionals to work cooperatively and effectively to address the multiple dimensions of pain and to provide maximum pain relief with minimal side effects.

In the interest of the public's health, the Missouri Boards of Healing Arts, Nursing and Pharmacy issue this joint statement. This statement is not intended to define complete or best practice, but rather to communicate guidelines for professional practice. These guidelines are not intended to interfere with a healthcare provider's professional duty to exercise that degree of care, skill and knowledge required of a prudent practitioner under the circumstances. The guidelines are intended to assist in the management of pain by defining the roles and responsibilities of health care professionals to recognize and appropriately manage pain in their patients.

To effectively assist patients in the management of pain, health care professionals should, within their scope of practice:

- Use a multi-disciplinary approach, when available, to develop and implement an individualized, outcome-based, written treatment plan that incorporates appropriate pharmacologic and/or non-pharmacologic and psychological interventions;
- Regularly evaluate and document the effectiveness of the treatment plan, using a consistent, developmentally appropriate, standardized assessment tool;
- Adjust the treatment plan as necessary to optimize comfort, quality of life, and functionality as defined by the patient and the treatment team;
- Anticipate and effectively manage side effects of pain medications;
- Educate patients, family members, and caregivers with respect to their rights and responsibilities regarding pain and its management;
- Minimize risks of diversion and abuse of controlled substances through appropriate assessment, monitoring, and documentation;
- Recognize that individuals with the disease of addiction may also experience pain and may require the use of analgesics, including opioids. Specialized management and/or referral may be necessary;
- Consult and refer to other providers in cases where patients have pain that cannot be effectively managed;
- Utilize evidence-based policies and protocols for pain management when possible;
- Apply appropriate, up-to-date knowledge and treatment; and
- Comply with all state and federal laws and regulations regarding prescribing, dispensing, and administering prescription drugs, including controlled substances.

Pertinent terms relating to pain management are defined as follows:

**Acute Pain**
Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

**Addiction**
Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as “drug dependence” and “psychological dependence.” Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

**Analgesic Tolerance**
Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

**Chronic Pain**
A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

**Pseudoaddiction**
Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

**Substance Abuse**
Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

**Tolerance**
Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.