Effective June 1, 2010, the State of Missouri will Implement the Nurse Licensure Compact

Charlotte York, LPN, President

When Missouri implements the Nurse Licensure Compact (NLC), it will join its bordering compact states of Nebraska, Iowa, Arkansas, Tennessee and Kentucky in allowing nurses to have multistate licenses. With the addition of Missouri, a total of 24 states have joined the NLC since it was established in 2000. For a complete list of NLC participating states, visit [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc).

The NLC follows the mutual recognition model of nurse licensure. This model allows a nurse to have one multistate license in the nurse’s primary state of residence and practice in other NLC states, being subject to each state’s practice laws and discipline. Under a multistate license, practice across state lines is allowed, physically or electronically, unless the nurse is under discipline or a monitoring agreement that restricts practice to a single state.

A nurse must declare a primary state of residency in an NLC state in order to have multistate license privileges. The NLC only applies to registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs), not advanced practice registered nurses (APRNs).

How will this impact you?

- If you are a nurse declaring Missouri as your primary state of residency and you hold an unencumbered Missouri license, you will be given privileges to practice in any of the other NLC states. If you have an active license in any of the other NLC states, any such license will be made inactive on June 1, 2010. You must, however, hold a license in every non-NLC state in which you wish to practice.
- If you move from Missouri to another NLC state and declare that state as your primary state of residence, you can practice in that state with your Missouri license for a period of up to 30 days. By law, you can only hold one multistate license and will need to obtain a license in this new primary state of residence and inactivate your Missouri license.
- If you are a nurse licensed in Missouri, but have primary residency in a non-NLC state (such as Kansas, Oklahoma or Illinois) you must continue to hold a Missouri license in order to practice in Missouri. You will not have multistate licensure privilege to practice in other compact states.
- If you move from Missouri to a non-NLC state (such as Kansas, Oklahoma or Illinois) your Missouri license will become a single state license that is valid only in Missouri. You will need to apply for a new license in your new state of residence.

For more information, visit [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc) or email our executive director Lori Scheidt at [lori.scheidt@pr.mo.gov](mailto:lori.scheidt@pr.mo.gov).

Executive Director Report

**Legislative Update**

*Authorised by Lori Scheidt, Executive Director*

Our newsletter articles are due approximately two months before the newsletter is actually published. By the time you receive this newsletter the legislative session will have ended. In order to determine if bills actually passed, you can check the final disposition of bills at [http://www.moga.mo.gov](http://www.moga.mo.gov/)

**Executive Director continued on page 4**
Important Telephone Numbers

- Department of Health & Senior Services (nurse aide verifications and general questions) 573-526-5686
- Missouri State Association for Licensed Practical Nurses (MoSALPN) 573-636-5659
- Missouri Nurses Association (MONA) 573-636-4623
- Missouri League for Nursing (MLN) 573-635-5355
- Missouri Hospital Association (MHA) 573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of April 29, 2010

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Practical Nurse</td>
<td>25,259</td>
</tr>
<tr>
<td>Registered Professional Nurse</td>
<td>92,564</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117,823</strong></td>
</tr>
</tbody>
</table>

Schedule of Board Meeting Dates Through 2011

- June 2-4, 2010
- September 8-10, 2010
- December 1-3, 2010
- March 2-4, 2011
- June 1-3, 2011
- September 7-9, 2011
- December 7-9, 2011

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 web site at http://pr.mo.gov

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May, June, July 2010

Missouri State Board of Nursing
Licensure Committee Members:
Deborah Wagner, RN, Chairperson
Charlotte York, LPN
Adrienne Anderson Fly, Public Member
Lisa Green, PhD (c), RN
Rhonda Shimmens, RN, BSN, C
Roxanne McDaniel, PhD, RN

Licensed Practical Nurse renewals

LPN licenses expire May 31, 2010. The fee to renew your LPN license is $52.00. Nurses frequently call the office to inquire about license renewal procedures. Some of these calls occur because renewal notices were not received. Renewal notices are mailed three months prior to the expiration date to the address we have on file. Please notify the board of nursing office in writing of all address changes.

You must either renew online or with a paper renewal form. You cannot renew by sending only a fee. If you need a paper renewal, you may either detach the request from the renewal notification and mail or fax the request to our office or fax a written request with your name, license number, address and your signature. A paper renewal form will then be printed and mailed to you.

Approximately 25,000 renewal notices were sent to LPNs in early March. Unfortunately, not all are delivered. Many are returned because the post office determined the licensee has moved.

The State Board of Nursing will no longer issue a paper renewal form. You cannot send only a fee. If you need a paper renewal, you may either detach the request from the renewal notification and mail or fax the request to our office or fax a written request with your name, license number, address and your signature. A paper renewal form will then be printed and mailed to you.

If your current license expires prior to receipt of your new license, you may only continue working if your license status can be verified online as current. Nurses and employers are directed to www.nursys.com to verify multistate or single-state license status, discipline and expiration date. The actual license you receive will not indicate an expiration date or multistate or single-state license status. Licensure verification is available free 24/7 at www.nursys.com.

Licenses for military and federal employees

If a person is employed exclusively in the military or for a US government facility, he or she only needs A LICENSE IN ANY STATE. See 335.081 (8), RSMo. http://www.mega.mo.gov/statutes/C300-399/3350000081.HTM

So for purposes of the Compact, if you are employed exclusively in the military or for a US government facility, you may pick which state you want to have your license in, regardless of your primary state of residence. When we implement the Compact on June 1, 2010, we will not change your license to a multistate license. You will be considered to have a federal single-state license.

You need to complete the form found on our website at http://pr.mo.gov/boards/nursing/Change-Form.pdf. Check the box at the bottom so we can exempt you for the Compact due to your military status.

Criminal history background check for renewal of expired or inactive licenses

If your license has expired or has been placed on inactive status, you are required to complete a criminal history background check prior to being reinstated. You must contact L-1 Enrollment Services at 866-522-7067 or www.l1enrollment.com to schedule an appointment and then submit a receipt from L-1 Enrollment Services substantiating proof of fingerprinting with your application. You will need to provide L-1 Enrollment Services with the Missouri ORI number MO920100Z. You will pay a fee directly to L-1 Enrollment Services for this service.

324.010 No Delinquent Taxes, Condition for Renewal of Certain Professional Licenses

All persons and business entities renewing a license with the Division of Professional Registration are required to have paid all state income taxes and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your tax returns, your license will be subject to immediate suspension with 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. If you have any questions, you may contact the Department of Revenue at 573-751-7200.

Name and address changes

Please notify our office of any name and/or address changes immediately in writing. The request must include your name, license number, your name and/or address change and your signature. An address/name change form can be found at http://pr.mo.gov, the form may be downloaded from our website and submitted. Methods of submitting name and/or address changes are as follows:

- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, Missouri 65102.

Contacting the Board

In order to assist you with any questions and save both yourself and our office valuable time, please have the following available when contacting the Board:

- License number
- Pen and paper
That section states, “The board may refuse to issue... any... license required pursuant to chapter 335 for one or any combination of causes stated in subsection 2...” As I’m sure you all know, subsection 2 of §335.066 contains the sixteen causes that the Board can use to pursue discipline against a licensee. Therefore, any reason that the Board can use to discipline a license can also be used as grounds to deny a license. As has been previously discussed in this space, §§335.066.2(2) and (4) RSMo are the provisions that apply to criminal charges. Here is the text of §335.066.2(2): “The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution pursuant to the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a nurse. The key phrase in that statute is, “The applicant shall be of good moral character...” The Board does not give answers on licensure until you’ve graduated from school. That puts the student in a tough situation: do they take the time and spend the money to get the degree, knowing there is a chance they won’t be allowed to test or do they give up on nursing school and pursue another career path? Understandably, many students are not happy when I give them the standard non-answer. Let’s take a look at the applicable statutes. Initial licensure falls under two main statutes: §§335.046 and 335.066 RSMo. §335.046 outlines the basic educational requirements for licensure. The key phrase in that statute is, “The applicant shall be of good moral character...” The Board may use this phrase as justification to refuse a license to anyone they feel, based on a careful review of their history, may use this phrase as justification to refuse a license to an applicant shall be of good moral character...” The Board isn’t answering until you’ve graduated from school. A few years ago, I was arrested and pled guilty to violating the drug laws of the State of Missouri. Therefore, if the Board can prove that the offense prosecuted in another state or the federal government; any reason that the Board can use to pursue discipline against a licensee. During the application process, the applicant has the opportunity to give the Board their side of the events. Usually, the applicant’s side of the story involves some variation of the ‘young and stupid’ theme. In addition, the applicants can provide the Board with some perspective on what happened; not just with the criminal offense, but also what was going on in their lives at the time of the offense. Maybe most importantly, applicants can tell the Board what they have learned from the experience and what changes they have made in their lives to avoid making the same mistakes in the future. All of these factors will be considered by the Board in making the determination whether or not to allow an applicant to sit for the NCLEX. Unfortunately, I end this column with the same non-answer that I have to leave the telephone inquirer with; the Board does not give answers on licensure until you’ve completed all the licensure requirements.

Executive Director continued from page 1

Mandatory Reporting Rule
Senator Bill Stouffer (R-District 21) introduced Senate Bill 1022 which would require all employers of nurses to report reprimands, discipline or restrictions to the board of nursing if the grounds for discipline are also grounds for discipline according to the professional licensing law for that health care professional.

State Government Budget and Reform
Senator Tim Green (D-District 13) filed Senate Bill 1000, which would transfer certain funds to the state general revenue fund including 3.6 million dollars from the board of nursing fund. Representative Chris Kelly (D-District 24) filed the companion house bill as House Bill 2305.

Senator Charlie Shields (R-District 34) filed Senate Joint Resolution 44. This proposed constitutional amendment, if approved by the voters, would eliminate each of the current constitutionally mandated departments within the executive branch. Senator Shields also filed Senate Bill 1057, which would require the Commissioner of the Office of Administration to issue a report to the General Assembly by December 31, 2010, in consultation with the directors of each state department, analyzing programs within every department that should be eliminated, reduced or combined with another program or programs.

Your Role in the Legislative Process
We urge you to study all facets of the issue being considered and know your facts. Be able to tell your legislator what impact a bill will have on his or her constituents. 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 meet with, 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.mosa.state.mo.us.
Missouri State Board of Nursing (MSBN) approval of nursing programs is limited to programs providing pre-licensure education at Practical Nursing, Associate Degree in Nursing as well as Baccalaureate Degree levels. Approval status may vary from initial approval contingent on a site survey (prior to actual program initiation) to initial, full or conditional program approval. Initial program approval may be granted during initial year(s) of program existence, until the first class of students graduate and official NCLEX® program pass rates for that first class are available. Program compliance with the respective Missouri Minimum Standards for Programs of Practical or Professional Nursing is then ensured by conducting an initial-to-full site survey. The Board may decide to keep a program on initial approval should the program fail to meet requirements for full program approval at that time. Initial approval may be extended for one year at a time. The Board has authority to remove initial program approval, if current program conditions were to prescribe such action.

Once a nursing program meets the requirements for full MSBN program approval and such approval has been granted, a program survey is conducted on a five-year rotation schedule. Additional site visits may be conducted as deemed necessary. If a fully approved program does not consistently meet criteria set forth by Missouri Minimum Standards for Programs of Practical and Professional Nursing (Missouri Nursing Practice Act, accessible on the MSBN website under Rules and Statutes), conditional MSBN program approval may be applied. The Board has the authority to apply/remove conditional program approval or completely remove program approval, as appropriate.

While Minimum Standards for Programs of Practical as well as Professional Nursing provide rules addressing various aspects of nursing education, appropriate licensure exam (NCLEX®) pass rates are essential. Each program is required to maintain program pass rates of 80% or above. Official NCLEX® program pass rates are reported for each calendar year (January 1st to December 31st of each respective year). Tracking of official as well as unofficial program pass rates is ongoing. Information regarding NCLEX® program pass rates as well as MSBN program approval status for each MSBN approved nursing program in Missouri are accessible on the MSBN website under Schools of Nursing and Pass Rates. The MSBN web address is http://pr.mo.gov/nursing.asp.

Registered Nurses and Licensed Practical Nurses of Missouri, would you be willing to increase the education surcharge you pay when renewing your license? Every two years pursuant to the Nurse Practice Act, 335.221, RSMo, LPNs pay an additional $2.00 and RNs pay an additional $10.00. These funds go toward the nurse loan/loan repayment program for students enrolled at all levels of nursing education. In 2008 there were 190 applications for assistance but funding for only 70 loans. In 2009 there were 143 applications but funding for only 79 loans. Our federal government funnels money into our loan repayment fund but not into the fund for school loans. LPNs would you be willing to increase your education surcharge to $3.00? RNs would you be willing to increase your education surcharge to $13.00?

Health care providers are a major employer in this country. Let us join together in making additional money available for additional nurses for the additional anticipated patients who will require care from 2011 through 2045. Please send your response to gail.ponder@dhss.mo.gov by June 30, 2010.
Case of the Quarter

Authored by Quinn Lewis
Investigations Administrator

This month’s case of the quarter involves a situation that the Board deals with frequently. The situation I am referring to is diversion of controlled medications by an addicted nurse.

The Board receives numerous complaints each year that pertain to the theft and misappropriation of controlled medications. Unfortunately, theft of controlled medications and illegal drug use is a major problem in the healthcare field. Illegal drug use and stealing medications pose a significant threat to the public.

The case you are about to read will give a clear example of how drug addiction compromises a nurse’s ability to practice safely and provide the best care possible for his/her patients.

DETAILS OF INVESTIGATION:

This case came to the Board via a mandatory report from a hospital located in the state of Missouri. The perpetrator in this case, who will be referred to as Nurse AP, was terminated after she was caught diverting drugs.

The investigation revealed that Nurse AP was employed by the facility as a staff nurse in the Emergency Department until her termination. Nurse AP was observed exhibiting some odd behaviors by another registered nurse at the facility. The nurse stated that her attention was drawn to Nurse AP when she noticed that AP’s pupils were dilated and AP kept disappearing from the unit. AP’s supervisor was contacted and advised of the situation, but took no action at the time.

During a staff meeting a few days later, AP’s supervisor was still concerned about AP’s behavior two days earlier. A different registered nurse who worked with AP stated that she had observed the same behavior from AP on the day in question. She said that AP’s behavior was inappropriate. AP seemed out of it and kept disappearing from the unit. The RN stated that she had noticed a few Pyxis discrepancies over the past several days with AP’s usage. Also, when AP would waste a narcotic she would bring a clear-filled syringe for waste instead of the medication in a vial.

The Pyxis discrepancies were explained to AP and her initial response was that she didn’t know how to use the Pyxis correctly. It was explained to AP that just for that morning she had pulled Dilaudid for two patients who weren’t hers. AP stated that she had pulled it just in case she needed it. AP was told that not only were neither of the two patients assigned to her but that both had flu like symptoms and most likely would not have been given Dilaudid.

AP was told that she needed to do a drug screen. AP then started to cry and said that she knew that her screen would come back positive. AP said that she had a problem and she needed help.

AP was asked if she had ever used drugs while on duty in the Emergency Department, and AP stated that she had. AP admitted that she had already injected herself with the Dilaudid she had pulled earlier that day. AP was asked to empty her pockets. It was discovered she had empty Dilaudid vials, empty Phenergan vials, butterfly needles and bandages. AP’s drug screen resulted in a positive reading for opiates. During an interview with the Board’s investigator, AP admitted to the conduct cited in the investigative report. Needless to say, AP’s license was disciplined by the Board.

After reading this article it would be fair to conclude that, if a caregiver is addicted to a substance, he or she, at times, will neglect patient care in order to obtain that drug. This was demonstrated in this case by looking at AP’s behaviors, such as disappearing frequently from her assigned work area, and diverting drugs only minutes after arriving for her shift. Due to her frequent absences from her assigned work area and injecting herself with the drugs she stole, an argument could be made that patient care was compromised.

I am not qualified to speak intelligently about addiction, so I will not attempt to. But, what I am qualified to do is recognize facts. And those facts are that drug addiction is common in the nursing profession. I reached that conclusion from the many complaints I have reviewed and assigned for investigation during my seven years of employment with the Board of Nursing. I think that we all would agree that addiction is something that needs to be addressed, and that being impaired on duty is not acceptable behavior in any profession.

On August 14, 2007, AP arrived at work at 11:00 am and she could not be found shortly after arriving. A Pyxis report was run at 11:08 am just for that day. The report revealed that 2 mg Dilaudid had already been taken out by AP for a patient who was not hers, who did not have orders, and who had not seen the doctor yet. At 11:55 am, another Pyxis report was pulled and it revealed that AP had pulled another 2 mg Dilaudid on another patient who was not assigned to her, and who had not seen the doctor yet.

When AP was finally located she was summoned to the office. The Pyxis discrepancies were explained to AP and her initial response was that she didn’t know how to use the Pyxis correctly. It was explained to AP that just for that morning she had pulled Dilaudid for two patients who weren’t hers. AP stated that she had pulled it just in case she needed it. AP was told that not only were neither of the two patients assigned to her but that both had flu like symptoms and most likely would not have been given Dilaudid.

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One of the reasons for publishing the narrative in the Disciplinary Actions section of this newsletter is so licensees can learn from the mistakes of others. As Discipline Administrator I become familiar with the licensee’s actions that have placed them on discipline. It seems to me that a current trend is the making up of glucoscans, vital signs, and even physical assessments. When I use the term “making up” it sounds friendlier, less like the reality that is the falsification of medical records. When a licensee falsifies a medical record she or he has violated the Nursing Practice Act. The licensee is then charged with incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096 (335.033.2.(5)), and could be disciplined.

Do I think a lot of the licensees start out planning on “making up” their charting? No, I think they get caught up in working with their other patients, doing their other tasks, and then forget to do a glucoscan. Then the patient eats, and they wonder what should I do now? The best answer I can come up with is to be honest. Do the glucoscan and chart that it was after the meal. Do not do the glucoscan, circle the glucoscan on the MAR, and chart that it was not done. Let the physician know that you didn’t get the scan done prior to the meal and wait for further orders.

Obviously, if the forgetting or getting too busy happens frequently, you will have your employer and the physician to answer to. If you determine that time is getting away from you then you need to ask for help. Delegate the task to an appropriate person, ask another licensee for help, page the house supervisor, or talk to the DON. By documenting correctly and attempting to remedy the situation, you will not have violated the practice act and will be protecting your license.

Up to this point I have only discussed the licensee. Now I want to point out what may happen to the patient, the person that you are the advocate for. If you make up the glucoscan, vital signs, or assessment, you may be putting the patient at great risk. The physician may write orders based on the false numbers you have recorded, the patient goes home and falls because you documented a normal range glucoscan at 1600 every evening when in fact the glucoscan was low. The patient has a hypoglycemic episode. The patient falls and they break a bone or get a head injury. Now you have “caused” the patient more hospital time or even death by making up a number.

Maybe you skipped listening to the patient’s lungs, charted (falsified) they were clear in your assessment. Now it is two hours later, the patient has wheezes audible from the door because they are in congestive heart failure. You have to call a Code Blue. If the nurse had listened to the lungs at the beginning of the shift then called the physician and received an order for a diuretic, the next two hours would have had a very different ending.

Think how your actions as a nurse will affect your license and your patient’s health.
Drug errors rank third in the causes for patient harm (Kreckler, Catchpole, Bottomley, Handa, & McCulloch, 2008). Nurses are on the frontline in today’s healthcare system and one of their primary responsibilities is the administration of medications. Emrich (2010) discussed the current complexity of the healthcare system and that nurses must pay particular close attention to the medication administration process in fulfillment of their responsibility to patient safety. Because nurses are the last stop before medications are administered, they are positioned to catch errors that may have originated from physician orders, the pharmacy, or in packaging and labeling. This critical last stop in the process of administering medications must be protected, in order for nurses to fully devote their concentration and focus on carrying out the process of safe medication administration. Nurses, who are attentive throughout the medication administration process, are more likely to deliver safe and effective nursing care.

Emrich (2010) reported that numerous forms of distractions interfere with nurses administering medications safely; from excessive work hours, to multitasking, interruptions and noise. Hicks, Sikirica, Nelson, Schein and Cousins (2008) identified in their study that distractions were the most common contributing factor for medication errors in patient-controlled analgesia (PCAs). Hicks et al. (2008) defined contributing factors as those that influence an error from occurring, but do not directly cause it. Distraction is defined as “any interruption in the medication-use process” (Hicks et al., 2008, p. 431).

Kreckler et al. (2008) studied the types of interruptions that caused errors during the medication administration process. The sources of interruptions came from physicians, other nurses, telephone calls, patients’ relatives or the nurses themselves. Interruptions from physicians accounted for 21 percent of the overall interruptions (Kreckler et al., 2008).

In a study conducted by Pape et al. (2005), education on the medication administration process or the “Five Rights plus one” combined with written standardized protocols and the use of visual signage were effective in reducing the number of errors associated with medication administration. The education consisted of the medication administration basic elements: the right medication, the right dose, the right route, the right patient, the right time and the right documentation. Next, standardized protocol checklists were developed. These protocols were “safety checklists” based on the “Five Rights plus one” (Pape et al., 2008, p. 108). The use of safety checklists was a borrowed concept from the aviation safety research that found when pilots used checklists, worked as a team, and avoided extraneous conversations, fewer errors occurred (Pape et al., 2008, p. 108). The last intervention was the development of signs. Essentially, these were “Do Not Disturb” signs that were posted in strategic areas over medication administration carts and automated medication dispensing machines (Pape et al., 2008, p. 112).

Pape et al. (2008) found, after just three weeks of study, the medication error rate declined and nurses were reporting greater work productivity. Interestingly, physicians and residents were still more likely to interrupt nurses after these interventions were instituted. Other hospitals around the country and in Texas have reported impressive results in the reduction of medication administration errors when nurses wore brightly colored vests or badges that alerted staff and others to the designated medication administration time. Another strategy shown to decrease the number of interruptions from colleagues has been to cover windows in medication rooms.

The importance of decreasing distractions cannot be overstated. An important recommendation for the future is the need for additional education of all staff on the importance of decreasing distractions during nurses’ medication administration times. Healthcare providers have a duty to find ways to decrease the volume of medication errors that are occurring everyday in our healthcare system so that patients are safer. Nurses play an important role in the evaluation of systems to determine how distractions can be eliminated.

For more information on how to decrease medication errors through minimizing distractions in the workplace, please visit the Institute for Safe Medication Practices (ISMP) website at www.ismp.org. ISMP offers the ISMP Medication Safety Alert! Nurse Advise-ERR free, electronically, to nurses. This newsletter is designed specifically for nurses who are administering medications in acute care settings and are looking for best practices to reduce the number of nursing errors associated with medication administration. Newsletters are also available for nurses in the community or ambulatory settings.

References


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APRNs and the Compact

APRNs will see some changes as a result of the implementation of the Nurse Licensure Compact.

1. APRN Document of Recognition card will no longer have an expiration date printed on it.

2. APRNs will receive only one (1) card with their initial application for recognition.

3. When doing a search on our website for an APRN, the Document of Recognition is considered “Active” as long as there is a result from the search. The expiration date will no longer appear in the search results. If a result does not appear, contact the advanced practice section at the Board office.

4. APRNs endorsing into the state from another compact state will be required to have a background check.

5. APRNs endorsing into the state from a non-compact state will be required to have a background check with their RN application.

6. APRN applicants who are already licensed as RNs in the State of Missouri must be required to have a new background check.
Overview of the Nurse Staffing Requirements that Resulted from the Work of the Technical Advisory Committee & the Missouri Nurses Association

Authored by Lisa DeSha, MONA

The Technical Advisory Committee on the Quality of Patient Care and Nursing Practices (TAC) was established during the 2000 legislative session as Senate Bill 788 was passed and signed into law effective August 28, 2000. Members were appointed by the director of the Department of Health and Senior Services (DHSS), and include:

a. One representative from the Department of Health and Senior Services;
b. Three registered nurses from nominations made by the Missouri Nurses Association;
c. One physician nominated by the Missouri State Medical Association;
d. Two members nominated by the Missouri Hospital Association;
e. One member representing licensed practical nurses; and
f. One public member.

The committee was begun to work with hospitals, nurses, physicians, state agencies, community groups and academic researchers to develop recommendations for improving the quality of patient care and ensuring the safe, efficient, and professional employment of nurses in hospitals and ambulatory surgical centers. Originally, the committee was to sunset in December of 2006, but the committee members requested an extension because several key patient safety issues had not been finalized. The extension was granted for an additional five years. The committee is now scheduled to sunset on December 31, 2011.

One major accomplishment recently was the development and finalization of safe staffing regulations. The TAC on the Quality of Nursing Care and Patient Safety co-authored rule changes to bridge a gap between mandated staffing ratios and staff participation in determining nurse staffing models and workload. These regulations provide guidelines for hospitals related to developing safe staffing patterns on nursing units. The committee developed a collaborative model which involves staff nurses in decision making.

In December 2008, the DHSS published amendments to the hospital nursing services rule that outlined new requirements for nurse staffing in hospitals. The rule, found in portions of 19 CSR 30-20.096, became effective Tuesday, June 30, 2009, and applies to hospitals licensed by the DHSS, including critical access hospitals. Effective Tuesday, June 30, 2009, and applies to hospitals licensed by the DHSS, including critical access hospitals.

PURPOSE: This rule establishes the requirements for nursing services in a hospital.

(1) The nursing service shall be integrated and identified within the total hospital organizational structure.
(2) The nursing service shall have a written organizational structure that indicates lines of authority, accountability and communication.
(3) The organization of the nursing service shall conform to the variety of patient care services offered and the range of nursing care activities.
(4) Nursing policies and standards of practice describing patient care shall be in writing and be kept current.
(5) Policies shall provide for the collaboration of nursing personnel with members of the medical staff and other health care disciplines regarding patient care issues.
(6) Nursing service policies shall establish an appropriate committee structure to oversee and assist in the provision of quality nursing care. The purpose and function of each committee shall be defined and a record of its activities shall be maintained.
(7) Policies shall make provision for nursing personnel to be participants of hospital committees concerned with patient care activities.
(8) Policies shall be developed regarding the use of overtime. The policies shall be based on the following standards:
(A) Overtime shall not be mandated for any licensed nursing personnel except when an unexpected nurse staffing shortage arises that involves a substantial risk to patient safety, in which case a reasonable effort must be made to secure safe staffing before requiring the on-duty licensed nursing personnel to work overtime. Reasonable efforts undertaken shall be verified by the hospital. Reasonable efforts shall include, but not be limited to:
1. Reassigning on-duty staff;
2. Seeking volunteers to work extra time from all available qualified nursing staff who are presently working;
3. Contacting qualified off-duty employees who have made themselves available to work extra time, per diem staff, float pool and flex team nurses; and
4. Seeking personnel from a contracted temporary agency or agencies when such staffing is permitted by law or an applicable collective bargaining agreement and when the employer regularly uses the contracted temporary agency or agencies;
(B) In the absence of nurse volunteers, float pool nurses, flex team nurses or contracted temporary agency staff secured by the reasonably efforts as described in subsection (8)(A) and if qualified reassignments cannot be made, the hospital may require the nurse currently providing the patient care to fulfill his or her obligations based on the Missouri Nurse Practice Act by performing the patient care which is required;
(C) The prohibition of mandatory overtime does not apply to overtime work that occurs because of an unforeseeable emergency or when a hospital and a subsection of nurses commit, in writing, to a set, predetermined staffing schedule or prescheduled on-call time. An unforeseeable emergency is defined as a period of unusual, unpredictable or unforeseeable circumstances such as, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions, or natural disasters which impact patient care and which prevent replacement staff from reporting for duty;
(D) The facility is prohibited from requiring a nurse to work additional consecutive hours and from taking action against a nurse on the grounds that a nurse failed to work the additional hours or when a nurse declines to work additional consecutive hours beyond the nurse's predetermined schedule of hours because of an unforeseeable emergency or because of an unforeseeable event or unforeseeable circumstances such as, but not limited to:
(E) Subsection (8)(D) is not applicable if overtime is permitted under subsections (8)(A), (B), and (C);
(F) Nurses required to work more than twelve (12) consecutive hours under subsections (8)(A), (B), or (C) shall be provided the option to have at least ten (10) consecutive hours of uninterrupted off-duty time immediately following the worked time; and
(G) The nursing service shall maintain and make available upon request to the department a list of qualified nurses.
and performance standards for that classification. Job descriptions shall be reviewed annually and revised as necessary to reflect current job requirements.

(19) There shall be scheduled annual evaluations of job performance for all classifications of nursing personnel.

(20) All nursing personnel shall be oriented to the hospital, nursing services, their position classification, the use of overtime, and the nursing service regulation 19 CSR 30-20.096. The orientation shall be of sufficient length and content to prepare nursing personnel for their specified duties and responsibilities. Competency shall be validated prior to assuming independent performance in actual patient situation.

(21) For specialized nursing units and those units providing specific services, unit policies and procedures, including standards of practice, shall be available and current.

(22) Nursing personnel meetings shall be conducted at intervals necessary for leadership and to communicate management information. Separate meetings for the various job classifications of personnel may be conducted. Minutes of all meetings shall be maintained and reflect attendance, scope of discussion and action(s) taken. The minutes shall be filed according to hospital policy.

(23) Every hospital shall develop, implement, and submit to the department by April 1, 2009, and annually thereafter at the start of the hospital’s fiscal year, a written hospital-wide staffing plan for nursing services. Every hospital shall have a process that ensures the consideration of input from direct care nursing staff from each unit within the hospital.

(24) The hospital-wide staffing plan for nursing services shall:

(A) Include the number, skill mix, and qualifications of direct care nursing staff needed for each unit of the hospital;

(B) Be based on the expected nursing care required by the unit population and individual needs of each patient. The expected unit population and individual nursing care needs of each patient shall be the major criteria used in determining the number and skill mix of direct care nursing staff needed;

(C) Identify relevant factors in each hospital unit including, but not limited to, the number of patients in a unit; intensity of care required; skill and experience of care givers including registered nurses, licensed practical nurses, ancillary personnel, and other members of the patient care team consistent with the level of authority and responsibility delegated under state licensure; admission, discharge, and transfers; nonpatient care duties; geography of a unit; and the availability of technological support; and

(D) Provide for documentation of the actual staffing plan.

(25) Every hospital shall establish nursing sensitive indicators and monitor outcomes of these indicators to evaluate the adequacy of the hospital-wide staffing plan for nursing services. At least one (1) of each of the following three (3) types of outcomes shall be used to evaluate the adequacy of the staffing plan:

(A) Patient outcomes such as patient falls, adverse drug events, injuries to patients, skin breakdown, infection rates, length of stay, or patient readmissions;

(B) Indicators of work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on-call use, or overtime rates; and

(C) Validated patient complaints related to staffing levels.

(26) The hospital shall, in consultation with its nursing practice committee, determine and publish a hospital-wide staffing plan and nursing sensitive outcomes for effectiveness on a continual basis and revise the plan annually and as necessary.

(27) Each facility shall develop and utilize a methodology which ensures it is staffed with appropriately qualified direct care nursing staff in each unit to meet the unit population and individual care needs of the patients. Each unit shall document actual staffing and patient census during every shift.

(28) At a minimum, there shall be a sufficient number of registered professional nurses on duty at all times to provide patient care requiring the judgment and skills of a registered professional nurse and to supervise the activities of all nursing personnel.

(29) There shall be sufficient licensed and ancillary nursing personnel on duty on each nursing unit to meet the needs of each patient in accordance with accepted standards of nursing practice.

(30) Each nursing unit shall post in a visible location on the nursing unit or make available to the patient(s) or patient’s authorized representative a copy of the unit’s hospital-wide staffing plan for nursing services and documentation of actual daily staffing levels.

(31) Patient care assignments shall be consistent with the qualifications of the nursing personnel and the identified patient needs. Nurses included in the count of direct care nursing staff in a unit of a hospital for purposes of compliance with the hospital-wide staffing plan shall have appropriate licensing, training, and orientation to ensure that the nurses are capable of providing competent nursing care to the patients in the unit. Hospitals shall also verify that nurses included in the count are capable of providing competent nursing care to the patients in the unit. Nurses included in the count shall spend a minimum of seventy-five percent (75%) of their time providing direct patient care.

(32) Documentation in the patient’s medical record shall reflect use of the nursing process in the delivery of care throughout the patient’s hospitalization.

(33) A registered professional nurse shall assess the patient’s needs for nursing care in all settings where nursing care is provided. A nursing assessment shall be completed within twenty-four (24) hours of admission as an inpatient. The registered professional nurse may be assisted in the process by other qualified nursing staff members.

(34) Patient education and discharge needs shall be addressed and appropriately documented in the medical record.

(35) The necessary types and quantities of supplies and equipment shall be available to meet the current needs of each patient. Reference materials pertinent to patient care shall be readily accessible.
**New Member Welcomed to the Board!**

**Roxanne McDaniel, PhD, RN**

Roxanne McDaniel is the Associate Dean for the baccalaureate and graduate programs at the MU Sinclair School of Nursing. She earned her BSN and MS(N) at Creighton University in Omaha, Nebraska, and her PhD at the University of Texas at Austin. Roxanne has practiced in various clinical and academic settings including adult health, oncology, surgery and community health. Prior to joining the faculty at MU, she taught in Nebraska and Louisiana. At MU, Roxanne taught adult health courses in the undergraduate and graduate programs and supervised masters and doctoral student research. She currently teaches an honors course for freshmen on career explorations in nursing. She has conducted research in symptom management in adults with cancer, focusing on nausea, vomiting, and retching. She has numerous publications in peer-reviewed journals. She is honored to serve on the Missouri State Board of Nursing. Join us in welcoming Dr. McDaniel to the Board!

**Childhood Immunization Requirements for School and Daycare Attendance Revised**

Nurses play an integral role in the success of Missouri’s public health by ensuring our children receive protection from vaccine-preventable diseases. The Missouri Department of Health and Senior Services (DHSS) immunization mandates for schools and daycare centers caring for more than ten children have been revised to include additional vaccines.

As a brief review, the new vaccine mandates provide that:

**Beginning July 2010,**
- all children in daycare settings caring for ten or more children will be required to show evidence of age-appropriate immunizations for pneumococcal disease.

**Beginning with the 2010-11 school year,**
- all children entering kindergarten will be required to show evidence of the second dose of Varicella (chickenpox)
- 8th grade students will be required to show evidence of one booster dose of Tdap, a pertussis containing tetanus booster. Td will no longer be sufficient for the school age booster. The booster must contain the pertussis component. All students beyond the 9th grade are strongly encouraged to be fully immunized against pertussis.

For more information go to [http://www.dhss.mo.gov/Immunizations/WhatsNew.html](http://www.dhss.mo.gov/Immunizations/WhatsNew.html)

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**Former Board Members**

It is with sadness that we report the deaths of two former Board members. **Clare B. Eisenbach, RN,** from Sikeston, Missouri, died February 3, 2010. Ms. Eisenbach was appointed to the Board in January 1968 and served until June 1970.

**K’Alice (Kay) Breinig, RN,** formerly of Joplin, Missouri, died February 18, 2010, in Arkansas. K’Alice was appointed to the Board on April 29, 2005 and served until her resignation on September 30, 2008.

Their leadership had a great impact on the quality of the nursing profession in this state. Generations of nurses and the public will benefit by the contributions they made to the nursing profession. They will be missed.
Censure 2/5/2010 to 2/6/2010

Action of any kind to facilitate the reporting or treatment of the doctor or the administrator of the home about the incident, which had observed bruising on one of the residents. Licensee did not seek authority or permission prior to making the changes. Licensee was not permitted to make such drug and with whom Respondent has a bona fide relationship as a patient. On September 18, 2009, Respondent submitted a urine sample for random drug and alcohol screening. That sample tested positive for the presence of ethyl glucuronide, a metabolite of alcohol. Respondent 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 Respondent has a bona fide relationship as a patient. On September 18, 2009, Respondent submitted a urine sample for random drug and alcohol screening. That sample tested positive for the presence of tramadol. Respondent does not have a valid prescription for tramadol. Censure 12/8/2009 to 12/9/2009

Censure 2/11/2010 to 2/12/2010

In an effort to cover her withdrawal of two additional Percocet tablets, Licensee falsely documented in the patient’s electronic medical record that she administered two Percocet pills to the patient on another date. Licensee altered records in an effort to cover her withdrawal of the two additional Percocet tablets. Censure 2/11/2010 to 2/12/2010

Censure 2/18/2010 to 2/19/2010

Licensee stated that when she made the changes and additions to the medical chart and made changes to the chart. Licensee was not permitted to make such drug and with whom Respondent has a bona fide relationship as a patient. On September 18, 2009, Respondent submitted a urine sample for random drug and alcohol screening. That sample tested positive for the presence of tramadol. Respondent does not have a valid prescription for tramadol. Censure 12/8/2009 to 12/9/2009

Censure 12/31/2009 to 1/1/2010

PROBATION Continued...

Dennis, Gina C.
Wentzville, MO
Registered Nurse 151319
On January 9, 2007 a first and a second nurse started an IV on a third nurse. The third nurse was pregnant and the IV was started after the third nurse became light-headed and began having false labor pains. The third nurse received saline solution for hydration only. No other medications were administered. The saline and the supplies were pulled from the pyxis and the supply自我。No patient was charged for the saline or supplies, however, the saline and supplies were used without being paid for. Licensee and the second nurse did not have a doctor’s order to start an IV of administer fluids to the third nurse. Probation 2/26/2010 to 2/22/2010

Dutton, Jessica M.
De Soto, MO
Registered Nurse 148015
On January 9, 2007, Licensee and a second nurse started an IV on a third nurse. The third nurse was pregnant and the IV was started after the third nurse became light-headed and began having false labor pains. The third nurse received saline solution for hydration only. No other medications were administered. The saline and the supplies were pulled from the pyxis and the supply自我。No patient was charged for the saline or supplies, however, the saline and supplies were used without being paid for. Licensee and the second nurse did not have a doctor’s order to start an IV of administer fluids to the third nurse. Probation 2/26/2010 to 2/22/2010

Fields, Violet Antoinette
Saint Louis, MO
Licensed Practical Nurse 2003000600
On January 8, 2009, Licensee was thirty-three weeks pregnant and was working a twelve hour shift. Licensee explained to two other nurses currently working that she was having contractions. Licensee consented to having IV fluids administered. The other nurses went to the Pyxis and removed the bags of IV fluids from another patient’s account and started the IV fluids. Probation 12/21/2009 to 12/22/2009

Hannah, Christina Gayle
Kansas City, KS
Licensed Practical Nurse 2003000600

Hoffman, Tiffany Lynn
Lake Saint Louis, MO
Registered Nurse 2006006553

Killian, Dana Marie
Shawnee Mission, KS
Registered Nurse 2010000235
On or about June 15, 2005, Killian pled guilty to driving under the influence, her fourth offense, making her offense a felony. Probation 1/10/2010 to 1/10/2012

Meng, Lynette Dawn
Springfield, MO
Registered Nurse 20090034284
Licensee is currently licensed in Idaho without restriction. The Board received Licensee’s Application for a License by Endorsement. Licensee disclosed that she had previously voluntarily surrendered a professional license. Licensee disclosed that she had previously pled guilty, on April 20, 2009 to Felony Possession of a Legend Drug Without a Prescription. Licensee unlawfully obtained and used Norco, a prescription drug. Probation 12/19/2009 to 12/15/2011

Pretmann, Mary L.
Lockwood, MO
Registered Nurse 135521
On September 1, 2008, Licensee placed numerous narcotic medications, in pill cups, in front of a resident. The resident was seated at a table in the facility’s dining area. Licensee asked the resident to “keep an eye on” the medications. There were other residents sitting at the table with the med cups. A human resources employee removed the pills from the table and kept them in her office until Licensee came to her office looking for the med cups. Probation 2/16/2010 to 2/16/2011
Offense as Licensee had previously pled guilty to Driving While Intoxicated. The Court placed Licensee on two (2) years of suspended probation. Licensee successfully completed that period of probation and was therefore not formally convicted of the offense. On January 3, 2006, Licensee pled guilty to the Class C Felonies of Burglary in the Second Degree and Theft/Stealing in the Circuit Court of Callaway County, Missouri. Licensee was discharged from probation early, in October of 2008, and was, therefore, not formally convicted of either offense.

Probation 12/20/2009 to 12/30/2010

Vittetoe, Jennifer Michelle
Jefferson City, MO
Licensed Practical Nurse 2009039692
On March 18, 2005, Licensee was arrested for Driving While Intoxicated. Following the arrest, while Licensee was in the back seat of the deputy’s vehicle, Licensee stated, “I hope you never have a baby at my hospital.” The deputy interpreted that statement as a threat against himself and his family should they ever seek care at the hospital which employed Licensee.
Suspension 2/12/2010 to 2/13/2010; Probation 2/14/2010 to 2/14/2012

Wohldmann, Becky B.
Saint Louis, MO
Registered Nurse 0966536
On June 24, 2003, Licensee pled guilty to the Class A Misdemeanor of Driving While Intoxicated. Following the arrest, while Licensee was in the back seat of the deputy’s vehicle, Licensee stated, “I hope you never have a baby at my hospital.” The deputy interpreted that statement as a threat against himself and his family should they ever seek care at the hospital which employed Licensee.
Probation 12/10/2009 to 12/10/2012

Young, Andrea
Jefferson City, MO
Registered Nurse 135143
On or about September 19, 2007, a search of an inmate’s cell in the Second Degree and Theft/Stealing in the Circuit Court of Callaway County, Missouri. Licensee was discharged from probation early, in October of 2008, and was, therefore, not formally convicted of either offense. On January 3, 2006, Licensee pled guilty to the Class C Felonies of Burglary in the Second Degree and Theft/Stealing in the Circuit Court of Callaway County, Missouri. Licensee was discharged from probation early, in October of 2008, and was, therefore, not formally convicted of either offense.
Probation 12/20/2009 to 12/30/2010

REVOKEDE

Burch, Tina L.
Springfield, MO
Registered Nurse 123400
Respondent 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 Respondent has a bona fide relationship as a patient. The Board received a letter from a hospital advising that Respondent had been suspended from employment due to diverting Depakote to two on three occasions and Xanax on one to two occasions. Respondent was interviewed and admitted to diverting Depakote, Xanax and Zopiclone from her former employer.
Revised 12/8/2009

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@peg.mo.gov.
Cisco, Jennifer Dawn
Oak Grove, AR
Registered Nurse 2004038100
On July 16, 2008, Cisco pleaded guilty to first degree sexual assault, a felony, in the Circuit Court of Carroll County, Arkansas. Cisco was placed on probation for six years, was ordered to register as a sex offender and was ordered to pay restitution and court costs. Cisco's Arkansas registered professional nursing license was revoked effective September 19, 2008.
Revoked 1/1/2010

Ferguson, Joshua Davis
Kansas City, KS
Licensed Practical Nurse 2004009581
On April 30, 2007, in the District Court of Johnson County, Kansas, Ferguson pled guilty to attempted criminal sodomy. He was sentenced to 13 months' incarceration followed by 24 months' supervised probation.
Revoked 12/8/2009

Hamilton, Joseph P.
Fulton, MO
Registered Nurse 2007071324
Respondent was required to submit employer evaluations from every employer. If Respondent was unemployied, a statement indicating the dates of unemployment was to be submitted in lieu of an employer evaluation. The Board did not receive an employer evaluation or statement of unemployment by the May 19, 2009 or the August 19, 2009 documentation due date. Respondent was required to renew his nursing license immediately. Respondent's license expired April 30, 2009 and remains lapsed at this time. Respondent was required to contract with the Board's approved third party administrator (TPA) to schedule random drug and alcohol screenings. Respondent was required to call a toll free number every day to determine if he was required to submit a sample for testing that day. Respondent failed to call in to the TPA on twenty-four (24) days. Respondent was required to abstain completely from the use or consumption of alcohol. On July 17, 2009, Respondent submitted a urine sample for random drug and alcohol screening. The sample tested positive for the presence of ethyl glucuronide, a metabolite of alcohol.
Revoked 12/8/2009

Higgins, Cynthia L.
Jefferson City, MO
Licensed Practical Nurse 046551
Registered Nurse 2000170580
Revoked 12/8/2009

Voluntary Surrender 1/21/2010

Rawlings, Susan C.
Dearborn, MO
Registered Nurse 153588
On March 16, 2006, in the Circuit Court of Platte County, Licensee pled guilty to possession of a controlled substance (marijuana) and possession of drug paraphernalia with intent to use.
Revoked 12/8/2009

Rhines, Gregory Franklin
Pleasant Hill, MO
Licensed Practical Nurse 2005027306
Respondent was required to contract with NCPS, Inc. (n/k/a FirstLab) to schedule random drug and alcohol screenings. Pursuant to that contract, Respondent was required to call a toll free number every day to determine if he was required to submit a sample for testing that day. During the disciplinary period until the filing date of the complaint, Respondent failed to call in to FirstLab on nineteen (19) days. Respondent has not called in to FirstLab since October 16, 2009
Revoked 12/8/2009

Sadler, Wilma J.
Sikeston, MO
Registered Nurse 113882
Respondent was required to contract with the Board's approved third party administrator to schedule random drug and alcohol screenings. Respondent was required to call a toll free number every day to determine if she was required to submit a sample for testing that day. Respondent failed to call in to NTS on seventeen (17) days. Further, on September 15, 2009, Respondent called and was advised that she had been selected to provide a sample for screening. Respondent failed to report to a laboratory to provide the sample.

Revoked 12/8/2009

Mulkins, Aspen Leigh
Kinegrove, MO
Licensed Practical Nurse 2004029926
On September 17, 2007 Licensee documented that she had given a resident their nebulizer treatment, which was ordered by a physician. However the night shift charge nurse discovered that there was no nebulizer machine in the resident's room. On September 18, 2007 Licensee admitted that Licensee had not given the resident his nebulizer treatment because he was not wheezing. On September 17, 2007 at approximately 10:30 p.m. during the change of shift Licensee reported she had given a resident IV. Vancomycin at approximately 4:30 p.m. The night shift charge nurse informed Licensee it was not due to be administered until 10:30 p.m. At that point Licensee changed her story and Licensee stated that she had not administered the medication rather she had only flushed the resident's PICC line. However in the Nursing Progress Notes Licensee charted that she did indeed give the resident his IV. Vancomycin at 4:30 p.m. on September 18, 2007 Licensee admitted that she in fact had administered the IV. Vancomycin at 4:30 to the resident and then discovered by looking at the Medication Administration Record that was not suppose to be administered until 10:30 p.m. Therefore Licensee went back to the resident's room disconnected the IV. Vancomycin and destroyed the rest of the medication. Licensee did not notify the House Supervisor or the Physician of the error. The patient was not observed to have suffered any adverse consequences as a result of the medication error. The patient was not observed to have suffered any adverse consequences for not having received the ordered nebulizer treatment.
Suspension 12/8/2009 to 3/8/2010

Voluntary Surrender 12/1/2010

Corzine, Meredith Carmen
O'Fallon, MO
Registered Nurse 2006021315
From May, 2006 to December, 2008, Licensee was employed as a registered nurse at a hospital. On December 15, 2008, Licensee was found to have stolen medications and narcotic paraphernalia from the hospital. As a part of the ensuing investigation, Licensee admitted that she had diverted controlled substances from the hospital in the past. Licensee admitted that she had been diverting controlled substances for approximately three months.
Voluntary Surrender 12/1/2010

Pritchett, Krista M.
Watertown, SD
Licensed Practical Nurse 2000170580
On December 14, 2009 Licensee Voluntarily Surrendered her Nursing License
Voluntary Surrender 12/14/2009

Pullin, Michael Dean
El Dorado Springs, MO
Registered Nurse 2001804413
On June 24, 2009, Licensee entered a plea of guilty to the Class D Felony of Child Molestation in the First Degree in the Circuit Court of Henry County, Missouri. The Court sentenced Licensee to five (5) years in the Missouri Department of Corrections.
Voluntary Surrender 12/29/2009
Nearly all of us are aware of nurses with back pain—or we may suffer from it ourselves. What we may not realize is how enormous the problem is. This issue of the UNA Newsletter is dedicated to educating Utah nurses about the risks they and their co-workers face in performing routine patient care. We'll also give you information about what you can do to help you and your co-workers.

“My name is Elizabeth White. I am an RN who graduated in 1976 from the BYU College of Nursing. In December, 2003, I was working in the Surgical ICU at Arrowhead Regional Medical Center, the San Bernardino, California county hospital. My assignment that night was a 374 lb patient who was on a ventilator and also on spinal precautions. I was able to get help to turn and bathe him only once that shift. However, because he was on spinal precautions his mattress was flat, but had to be in reverse Trendelenberg because of the vent. He slid down to the foot of the bed, of course. Only one other staff member was available to help pull him away from the foot of the bed. By the end of the shift, I was in so much pain I could hardly walk. I ended up leaving clinical nursing: nearly 6 six years later I still have pain on a daily basis.”

Last year, over 71,000 nurses suffered a back injury—but these are only the injuries that can be directly traced to work. 48% of nurses complain of chronic back pain, but only 35% have reported a work related injury. The cumulative weight lifted by a health caregiver in one typical eight hour shift is 1.8 TONS. Back injuries are incremental and pain often presents in unrelated circumstances.

Cost of the problem
Nurses back injuries cost an estimated $16 Billion annually in workers compensation benefits. Medical treatment, lost workdays, “light duty” and employee turnover cost the industry an additional $10 billion. Bureau of Labor Statistics show an inexusable situation. The top category: hospitals. In addition, the fourth and fifth categories are also of health care workers. In total, over 505,000 health care workers were injured. We know that a large percentage of these injuries are due to patient handling.

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It is interesting that the Bureau of Labor Statistics divided health care into three categories, when they are really of one industry. A more accurate chart would look like Fig. 2:

<table>
<thead>
<tr>
<th>Industry with at least 100,000 nonfatal occupational injuries and illnesses, private industry, 2007</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical and Surgical Hospitals</td>
<td>10,653</td>
<td>20,241</td>
</tr>
<tr>
<td>Ambulatory Health Care Services</td>
<td>1,416</td>
<td>1,432</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>1,131</td>
<td>1,151</td>
</tr>
<tr>
<td>Nursing Care Facilities</td>
<td>1,313</td>
<td>1,313</td>
</tr>
<tr>
<td>General Hospitals</td>
<td>1,275</td>
<td>1,294</td>
</tr>
<tr>
<td>Long Term Care Facilities</td>
<td>1,275</td>
<td>1,294</td>
</tr>
<tr>
<td>Total Health Care</td>
<td>31,033</td>
<td>33,578</td>
</tr>
</tbody>
</table>

Fig. 1

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<th>2003</th>
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<tbody>
<tr>
<td>All Health Care</td>
<td>525,3</td>
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</tr>
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<td>General Medical and Surgical Hospitals</td>
<td>10,653</td>
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<td>33,578</td>
</tr>
</tbody>
</table>

Fig. 2

Healthcare worker injuries were three times the number of any other industry. Also, the RATES of injury are six times the rates of construction workers and dock workers. Why are we not angry? Perhaps it is because we are used to it, and figure that it can’t be any other way. After all, patients must be cared for, right?

THE CAUSES OF NURSING BACK INJURY, or, YOU MUST NOT BE USING GOOD BODY MECHANICS

Hospitals and nursing homes are well aware of the risks of back injury resulting from patient care. Virtually all of us have had numerous “back injury prevention” classes over our work life. Why then, are the injuries so high? Is it because we just don’t listen? Or, is it because there is no safe way to manually lift and care for patients? Just look at the diagram below for a comparison between the NIOSH lifting standards and everyday patient care reality. There are physiological reasons for this. William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University has made extensive studies on what happens to the human back under stress.

Basic anatomy lesson: the intervertebral disc is fibrous, dense tissue with a resilient gel filled center. The outer fibrous ring is called the annulus fibrosis, and the center the nucleus pulposus. It has no blood supply, and no nerve endings. It receives its fluid and nutrients by osmosis from the adjacent vertebrate bone through the end plate, which also attaches the disc to the vertebrae.

NIOSH, (National Institute of Occupational Safety and Health) a division of the Centers for Disease control, sets standards for safe lifting practices.

<table>
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<tr>
<th>The Standards</th>
<th>The Reality</th>
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<tr>
<td>When a worker’s hands are 10 inches from the ankles, 1/3 of the worker’s body weight may be lifted, if a rest period follows. This is about 51 pounds for the average worker.</td>
<td>When a nurse turns a patient from side-to-side the reach is 33 to 35 inches. The nurse must lift 35% of the patient’s body weight, an average of 52.5 lbs. This is FAR beyond safe lifting limits!</td>
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<tr>
<td>When the worker’s hands are farther from the ankles, the weight must be reduced by 40%. This would be about 30 lbs.</td>
<td>When the hands are 16 inches from the ankles, the weight must be reduced by 60%. This would average 20 lbs. NO WEIGHT should be lifted beyond that point.</td>
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<td>Putting a patient up in bed requires that the patient be lifted nearly off the mattress. Though the reach is not far, half of a normal patient’s body weight (75 lbs.) is excessive lifting.</td>
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THE ELEPHANT IN THE ROOM

The Elephant in the Room continued on page 16

The Elephant in the Room: Huge Rates of Nursing and Healthcare Worker Injury

times the rates of construction workers and dock workers. Why are we not angry? Perhaps it is because we are used to it, and figure that it can’t be any other way. After all, patients must be cared for, right?

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Pathophysiology, or, We all have our limits

When lifting tolerances are exceeded, the end plate of the intervertebral disc is damaged with tiny tears called microfractures. No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein aggregations and scar tissue which is thicker and less permeable than the normal tissue. Over time, with many microfractures occurring, most of the end plate of the vertebra converts to scar tissue. The disc can no longer absorb fluid and nutrients. It becomes weakened, porous, soft and dry, which is the condition we know as degenerated disc. The softer tissue then bulges into the spinal column causing pain and muscle spasm, or the gel in the center of the disc can even herniate through the soft porous outer tissue, causing much greater pain. With severe degeneration, the disc can collapse, which narrows the space available for the nerve root. This narrowed space puts pressure on the nerves, causing pain and muscle spasm.

ILLUSTRATION SHOWING PRESSURES (NOT SHEARING) GENERATED IN TURNING A PATIENT

Tasks which exceed safe spinal loading, requiring Safe Patient Handling Equipment:
- Transfers: bed to chair, chair to shower
- Bed repositioning: Side to side turn, and pull away from the side rail
- Bed repositioning: Boosting to the head of the bed
- Bed repositioning: Linen changes and bathing
- Sling placement: Bending and lifting to roll a patient on to a sling
- Assisting patient to stand
- Assisting a patient up from the floor

Bed to bed transfer

This is a mattress that uses a blower to inflate a mattress, which then slides on a cushion of air. The brand name is Hover Matt. It removes most of the friction so the force needed for transfer is minimal.

THE ELEPHANT IN THE ROOM continued on page 17
Bed Repositioning: Boosting

The ErgoNurse, designed for bed repositioning, boosts a patient using the sheets. It will also lift for side to side turns, linen changes and bathing.

Some specialty fabrics will allow boosting with minimal effort, then resist sliding again.

Linen changes and bathing of bedridden patients

Ceiling lifts can use repositioning slings to move the patient around for linen changes and bathing.

Companies offering Safe Patient Handling equipment:
ArjoHuntleigh/Diligent Services
aXtraHand, LLC
Barton Medical Corporation
Dane Technologies, Inc.
Ergolet
ErgoNurse
ERGObag, Division of NuStar, Inc.
EZ Way
Goldmann Inc.
Hill-Rom, Inc.
Horcher Lifting Systems, Inc.
HoverTech International
Jamar Health Products, Inc.
Joerns Healthcare, Inc.
LiftSeat
Medicare Products
Molift, Inc.
Optima Products, Inc.
Prism Medical
RecoverCare
Rehab Seating Systems
Rifton Equipment
Sizewise
Stryker
SureHands Lift & Care Systems
Technimotion Medical, a Division of Ergo-Asyst Technology
Vancare, Inc.

Help is on the horizon. Nationally, the Nurse and Health Care Worker Protection Act of 2009 has been introduced in both houses of Congress. In brief, these bills (identical at the present time) require OSHA to establish a safe patient handling standard, require health care facilities to establish safe patient handling programs, and allow health care workers to refuse to perform any lifting task which exceeds the standards or for which they have not been trained. The House bill is HR 2381, and the Senate bill is S 1788. It is certain that the wealthy and powerful hospital lobby will oppose the bill. However, we nurses have numbers on our side. Since there are about 2.5 million nurses, and about 1 million nursing aides, if we were all to contact our legislators, we could ensure the passage of these bills.

The HoverJack, from HoverTech, inflates to lift a patient from the floor.

Assisting the patient up from the floor

A Liko ceiling lift repositions a patient using a loop sling. Linen can be changed while the patient is suspended.

Placing the patient on a sling:

The ErgoNurse uses a sheet to suspend the patient, allowing sling placement without bending and lifting.

Assisting the patient to stand:

This is a Barton Sit-to-Stand device.

COST EFFECTIVE

Safe Patient Handling equipment is very cost effective. When associated factors such as lost work days, modified duty, worker retraining, employee turnover, and even bedsores are factored in, the hospital recoups its investment in less than two years!

Those who have instituted Safe Patient Handling programs have learned that not only is equipment needed, but training, education and surprisingly, enforcement. Though it may seem a paradox, many times caregivers resist change. They’ve been doing it one way for their entire working careers as caregivers, and feel that it takes too much time, or is inconvenient. Yet, they continue to incur injuries at high rates. However, when a no-lift policy is implemented (and if necessary, enforced), the staff will adopt the safe patient handling equipment especially as they realize their back pain and injuries diminish. Oregon SAIF, the State Worker Comp Company, instituted pilot Safe Patient Handling programs, and has seen injury rates and costs plummet. Harris Methodist Ft. Worth, in Ft. Worth Texas, also instituted a pilot program, and went to zero injuries. Their pilot unit has had no injuries in 2½ years. We know that these injuries are entirely preventable.

Let’s work together and solve this problem.

2 Tuohy-Main, Kate, “Why manual handling should be eliminated for resident and carer safety,” Geriauction, 1997, 15(10)
5 Bureau of Labor Statistics, 2008, op cite
6 Marras, W. “A Comprehensive Analysis of low-back disorder risk and spinal loading in patient handling”, Ergonomics, 1999, 42(7) 904-906
7 Blowsick, Donald, Professor of Ergonomics at the University of Utah, “Manual Material Handling”
8 Marras, 2009, op cite
10 Dougherty, M., “Handle With Care”, Strategies for Nurse Managers, April 2008

HOW TO CONTACT YOUR REPRESENTATIVES

IN CONGRESS:

Let’s work together and solve this problem.

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IN CONGRESS:

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### NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

- [ ] NAME CHANGE  
- [ ] ADDRESS CHANGE  
- [ ] PHONE CHANGE  

- [ ] RN  
- [ ] LPN

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**PRIMARY STATE OF RESIDENCE ADDRESS:** (where you vote, pay federal taxes, obtain a driver’s license)

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**MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)**

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- [ ] I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

Return completed form to: Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102  
Or  
Fax to 573-751-6745

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