With the RN renewal period upon us, some of you may be wondering what your renewal fee pays for. As a licensee who pays fees, you have the right to know how the funds you pay are expended. Nursing regulation is the governmental oversight provided for nursing practice in each state. Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared or incompetent. The public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners. Through regulatory processes, the government permits only individuals who meet predetermined qualifications to practice nursing. The Board of Nursing is the authorized state entity with the legal authority to regulate nursing.

The Missouri State Board of Nursing approves individuals for licensure, approves educational programs for nurses, investigates complaints concerning licensees’ compliance with the law, and determines and administers disciplinary actions in the event of proven violations of the Nurse Practice Act.

Effective January, 2013, the renewal fee is $60 for Registered Nurses and $52 for Licensed Practical Nurses. $10 of the RN and $2 of the LPN fee is deposited in a fund with the Department of Health in order to administer the nursing student loan program. You can access more information about the nursing student loan program at http://health.mo.gov/living/families/primarycare/healthprofloans/index.php

The top three budget items for our office are professional services to investigate complaints, supplies and salaries. Supplies include postage. This year, we will mail approximately 97,000 renewal notices for a total of postage bill of approximately $31,000. One of the ways costs can be decreased is to keep your address current with our office and renew online EARLY.

The Board of Nursing’s fund is also assessed costs from the Division of Professional Registration, Department of Insurance, Financial Institutions and Professional Registration and Office of Administration. These costs include services such as computers, information technology support, purchasing staff, accounting staff, web site maintenance, and licensing renewal processing staff. In addition, our office utilizes the Office of the Attorney General for some of our legal counsel work. Transfers total approximately 33% of our annual budget, while direct costs spent by our Board account for approximately 67% of our annual budget.

RN’s renew every two years in odd-numbered years and LPNs renew every two years in even-numbered years. Since there are more RN’s than LPNs, the Board receives more revenue in odd-numbered years than in even-numbered years. The RN renewal cycle is February to April. The LPN renewal cycle is March to May. When determining revenue and expenses, the Board has to plan to have enough reserve in the fund to pay expenses until the revenue from renewal fees is received. State statute 355.036-4, RSMo, indicates that the Board of Nursing funds “shall not be transferred and placed to the credit of general revenue” unless the amount in the fund at the end of the year exceeds two times our appropriation. This prevents the Board from charging excessive fees and also explains why renewal fees may fluctuate from year to year.

During the Board’s quarterly face-to-face meetings, the Board diligently reviews financial statements. We are very cognizant of the fact that nurses pay for the operation of the Board and continually look for ways to cut costs. Most of the State budget cuts are to state agencies that operate from tax dollars, commonly referred to as general revenue. The Missouri State Board of Nursing operates on fees collected from licensees. This does not mean that we are not affected by budget cuts. Since we are assessed fees through cost allocation plans, as other agencies suffer budget cuts, our cost allocation may increase. We review changes to projections and cost allocation plans at our quarterly Board meetings and make necessary adjustments.

As Board members, we are responsible for ensuring that monies are managed in a legal manner that is consistent with the mission of the Board. Additionally, the Board ensures the financial stability of the organization by making sure we have sufficient funds to carry out the activities required of the mission. These fiscal responsibilities are carried out in accordance with state and federal laws.
We need your input! Help Us Plan for the Future!

Authoried by Mary C. Becker
Senior Vice-President of Strategic Initiatives and Communications Missouri Hospital Association

WE NEED YOUR HELP! Make your mark and help Missouri nurses plan the future of nursing. We know that 80 percent of Missouri is designated as a health professional shortage area. We also know that 14 percent of Missouri’s nurses are 65 and older. These two facts would indicate that Missouri will need more nurses in the future. But, we don’t know how many actually work in the state!

Tell us more about your nursing background by visiting the Missouri Health Professionals Registry website at www.missourihealthprofessionalsregistry.org. It takes less than five minutes to complete. You’ll answer simple questions like the languages you speak, where you went to school and what you are doing now. The more you provide, the more important and here’s why:

• Missouri needs to plan to care for an aging population and we already have a shortage of health professionals.
• We don’t know much about our nursing workforce, and that makes it difficult to plan the future of nursing. Where do Missouri’s nurses work? What setting do you work in? What are your specialties and educational background?
• Knowing this basic information about the nursing workforce will help nursing advocates plan. It will help allocate future resources including scholarships, educational facilities and faculty.

Missouri’s nursing workforce needs to be understood and YOU are part of this story!

The Missouri Health Professionals Registry was created by the Missouri Department of Health and Senior Services with help from the Missouri State Board of Nursing. Your information is private. The data you enter will only be used to help us direct resources and understand the nursing workforce in Missouri.

This important initiative is endorsed by the Missouri State Board of Nursing, Missouri Nurses Association, Missouri Department of Health and Senior Services, Health Care Foundation of Greater Kansas City, Missouri Action Coalition, Missouri Alliance for Home Care, Missouri Foundation for Health, Missouri Health Care Association, Missouri Hospital Association, Missouri League for Nursing, Missouri State Association of Licensed Practical Nurses and Missouri Organization of Nurse Leaders.

We are located in Jefferson City, with convenient access to the Lake of the Ozarks, Columbia, St. Louis, and Kansas City. We offer an excellent salary and benefits program!

 televised every day through the Missouri State Board of Nursing.

We are located in central Missouri, with convenience access to the Lake of the Ozarks, Columbia, St. Louis, and Kansas City. We offer an excellent salary and benefits program!

Visit our website at www.crmc.org or call/e-mail Antonio Sykes at (573) 362-5043 or avsykes@mail.crmc.org to learn more about the excellent opportunities we have available for you with our organization.

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Executive Director’s Report continued from page 1

February, March, April 2013 Missouri State Board of Nursing  •  Page 3

information of nurses in their employ; that information
nurse can utilize this system to track licensure and
email reminders, as well as text messages, to nurses
and/or cell phone number. Institutions can send automatic
have the option of including the nurse’s email address
entries being entered into the system for the same person.
updated in e-Notify, decreasing the likelihood of multiple
with the BON, that information will automatically be
download the data at anytime.

Ease of Use
Institutions can enroll nurses into e-Notify easily either as
an individual or through bulk upload; all that is needed
is the nurse’s license number, license type and the state
as an individual or through bulk upload; all that is needed
is the nurse’s license number, license type and the state
information in e-Notify is pulled directly
from Nursys, the only national database for licensure
verification, discipline and practice privileges for
registered nurses (RNs) and licensed practical/vocational
nurses (LPNs/VNs). Nursys data is compiled from
information directly inputted from BONs (in participating
jurisdictions; visit nursys.com for current participation list).
The system provides real-time automatic notification
of status and discipline changes delivered directly to
institutions.

Customizable Features
It’s entirely up to the institution to determine how often
they want to receive notifications about nurses. They
have the option of receiving email notifications daily,
weekly or monthly. For licensure renewal notifications,
institutions can choose to receive alerts 30, 60 or 90 days
prior to a nurse’s license expiring.

Another unique feature of e-Notify is the ability for
institutions to turn a nurse’s notification setting on or off,
whether or not to receive notices about nurses that are
specific nurse’s licensure or discipline status. Only nurses
who have their notifications turned on are charged against
one of the employer’s 100 free credits.

Cost
All institutions are given 100 credits free of charge.
These credits cover the first 100 nurses enrolled into the
system are free. After that, the cost is $1 per nurse, per
year. A facility that employs 25 nurses would pay nothing
to utilize e-Notify; a facility with 150 nurses would only
pay $150 per year.

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Associations and the Board of Nursing share the
good of providing safe care to the citizens of Missouri; however,
the ways of accomplishing this goal are significantly different.

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rules regulating practice. The Board has authority to
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I'm not just a nurse.
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Registered Nurse licenses expire April 30, 2013

Registered Nurse licenses will expire on April 30, 2013. The fee to renew your RN license is $60.00. Nurses frequently call to inquire about license renewal procedures. Some of the calls occur because renewal notices are 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. 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 will then be printed and mailed to you. You can request a duplicate renewal form by visiting our website at www.pr.mo.gov/nursing and clicking on the link under RNs Now Renewing.

Approximately 97,000 renewal notifications were sent to RNs in early February. Unfortunately not all are delivered. Many are returned undeliverable because the post office determined the licensee has moved. We are not able to verify renewals mailed in late, at the last minute, or in person. It can take up to five business days to renew a license.

The State Board of Nursing will notify you if a verification of record with the Division of Professional Licensing is necessary. If the verification resulted in a need for further information, you will be notified in writing. Your renewal will then be processed. You will be mailed a new wallet-sized card with this renewal.

In-Patient & Critical Care Registered Nurses!

We are actively accepting applications for RNs & LPNs for various departments. We are expanding and have full and part-time RN positions available in these units:

- • Orthopaedic Medicine
- • Neurology Medicine
- • Cardiac Intensive Care
- • Neonatal Intensive Care
- • Medicine/Neuro Intensive Care

Please note: You will not be issued a new wallet-sized card with this renewal. On January 1, 2010, Missouri eliminated the issuance of license cards for regular license renewals. New licensees will be issued one initial license card which will contain the nurse’s name, profession and license number. There will be no expiration date on these licensure cards. Go to www.mures.com to verify multistate or single state license status, discipline and expiration date.

License Suspension Due to Tax Compliance Law

Pursuant to 324.010, RSMo, 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 within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. The Board has no discretion in this matter. The license is suspended by operation of law.

If your license is suspended because of non compliance of state income taxes, you must stop practicing as a nurse immediately and you can not return to nursing practice until your license is active again. If you have any questions, you may contact the Department of Revenue at 573-751-7200.

Name and address changes

Please notify our office immediately of any name and/or address changes 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.

Changing your address with the post office will not ensure that important information such as renewals, newsletters, complaint information, etc. will be mailed to your new address. It is imperative that you complete the Name and Address Change form and submit it to the Missouri Nursing Board.

Contacting the Board

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

- • License number
- • Pen and paper

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Avoiding Unprofessional Behavior Allegations

by Angie Matthes, RN, MBA/MHA

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Have you ever been treated poorly or received poor customer service? What impression of the person or business did you have following the poor service you received? Do your patients have a positive or negative perception of the care they receive based on how you interact with them? The Board of Nursing has been receiving a growing number of public complaints about nurses who are perceived as unprofessional, rude, uncaring, condescending and impatient.

What do you consider rude and unprofessional behavior? We can all recognize these behaviors in someone else, but can we recognize this within our own behaviors? Have you ever heard or made comments like these? “That patient is such a pain.” “That patient is crazy.” “I am so sick of that patient calling me every 5 minutes.” Consider how this would make you feel if this were said about you or someone you loved. While most of the time comments like these are said out of frustration and not meant for the patient to hear, you never know when they may be overheard. Nurses seem to be under more pressure today due to higher patient acuity, fewer staff and resources, and increased demands. In response to these stressors, nurses may react abruptly and convey a negative attitude without meaning to. However, patients and their loved ones rightfully expect to receive appropriate quality nursing care in a timely manner by caring and professional nurses. It is important to remember that it is how nurses present themselves to patients that can frame how patients view their entire healthcare encounter.

Consider the following scenarios:

Scenario # 1
Shortly after coming on duty, a patient lashes out at the nurse because he had not received his medication when he requested it. The nurse responded, “I just got here. We are short of staff and you are not our only patient.” What kind of impression do you think this made on the patient? Did this demonstrate care and concern for his well being? What if instead, the nurse responded with, “I am sorry this occurred. Is the pain medication effective in relieving your pain or are you beginning to have pain before your next medication dose is allowed.” Would you expect the patient receiving this response might feel the nurse showed empathy and a desire to help?

Scenario # 2
A confused patient is yelling at the nurse telling her to stop hurting her. The nurse responds, “Shut up. I am tired of listening to you whine all the time.” A visitor overhears this interaction and reports that the nurse was disrespectful and abusive. Consider how you might feel if someone said this to your loved one. Do you think you would feel comfortable leaving your loved one with someone that demonstrated no concern?

Everyone wants to feel like they have been heard when they share concerns or needs. No matter how exceptional the nursing care is, a nurse that has been perceived as rude or uncaring may end up being the nurse that the patient or family remembers the most. Most nurses report that when they became a nurse they did so because they wanted to help people. In order to do this well, nurses have to consider how they react and respond in stressful situations. The time it takes to respond positively and professionally is much less than the time it will take to respond to complaints down the road.

There will always be a difficult day or a challenging situation, but it is worth the effort when a nurse remains professional and carries out his/her role to the best of his/her ability in the most caring and compassionate manner. Remember, when patients experience anxiety and fear, these feelings can often be displayed as frustration and anger. Nurses must recognize this and display compassion and understanding.

When all is said and done, patients and their loved ones will not likely remember every health care provider involved in their care, but they usually will remember their best and worst experiences. Only you can control with which group you will be placed. A simple please, thank you and sincere compassion will leave your patients with a positive experience and perception of their nursing care. Attitudes are contagious: let yours be positive!
Substance Abuse: Risks Factors and Protective Factors

Nancy Darbro, PhD, APRN, CNS, LPCC, LADAC, Kansas State Board of Nursing
Kate Driscoll Mallaridakis, MS, RN, CNP, MAC, National Council of State Boards of Nursing

Addressing substance use disorders among nurses presents a complex challenge requiring an understanding of the many risk factors that make nurses vulnerable. This article analyzes the specific risk factors that affect nurses, including nursing specialty, gender, and workplace, as well as the protective factors for everyone. The article also discusses protective factors that help nurses avoid destructive substance abuse disorders and recover from them.

The prevalence of substance abuse and addiction among nurses and other health care professionals is no higher than the prevalence in the general population (Storr, Trinkoff, & Hughes, 2000). However, the prevalence of prescription drug misuse is 6.9% among nurses compared to 3.2% in the general population (Storr, 1998). Nurses with substance abuse disorders not only struggle with their own drug abuse issues, they also divert their patients’ prescribed medications, risking patient harm. Despite this, the lack of identification and the underreporting of nurses and other health care professionals in the workplace remain an issue (Baldissini, 2007).

Because nurses are the largest group of health care professionals, those who have abuse and addiction issues are more visible, more stigmatized, and more severely punished (Shaw, McGovern, Angres, & Rawal, 2004). To address substance use disorders among nurses proactively and compassionately, we need to consider the many risk factors that make them vulnerable.

The Effects of Specialty

The likelihood that nurses will use substances varies across specialties. The prevalence is higher among emergency department and psychiatric nurses (Anderson, 2004), Collins, Gollnisch, and Morsheimer (1999) also found higher rates of smoking in psychiatric nurses and significantly higher cocaine use in critical care nurses compared with other specialties. Oncology nurses and nurses listing their specialty as administration were more likely to consume five or more alcoholic drinks per occasion (Mkrtchian, 2006).

Specialties least likely to report substance use were general pediatric, women’s health, school, and occupational health nurses. The American Association of Nurse Anesthetists reported that the addiction rate among anesthesiologists and nurse anesthetists exceeds 15% (Howard & Chung, 2000a, 2000b). An anonymous survey of drug misuse among certified registered nurse anesthetists (McCullough, 1997) found that the reported misuse of controlled substances used in their practice (Bell, McDonough, Ellison, & Fitzhugh, 1999). Similar patterns have been found among physicians, psychiatrists and addictions counselors (Hughes et al., 1999), suggesting common causes among health professionals with substance use issues.

The Effects of Gender

Because women make up 91.1% of registered nurses (United States Department of Labor, 2010), it is crucial noting how addiction affects women. Women get sicker faster and have a more virulent course of addiction, perhaps because of their typically lower body weight and more intense reactions. Women tend to start substance abuse later in life and abuse fewer substances, yet they have more severe physical symptoms when they enter treatment (Dittman, 2008).

Women tend to seek medical help for signs and symptoms associated with substance abuse, such as insomnia, nervousness, and depression, but the cause goes undetected by medical professionals because screening for substance abuse in primary care settings is uncommon. Women are more likely to associate the onset of substance abuse with a stressful life event or loss and they have higher rates of comorbid psychiatric disorders, most commonly depression and anxiety (Blume, 1998; Goldberg, 2006). Typically, women enter treatment for substance abuse because of physical, mental health, or family problems; men tend to enter treatment because of a referral from an employer or the legal system (Blume, 1998). Men, who account for only about 9% of the nursing population, are overrepresented in the population of nurses in alternative programs and disciplinary cases (Distman, 2008; National Council of State Boards of Nursing [NCSBN], 2009).

Other people, including family members, fail to recognize nurses with abuse issues as long as the nurses’ behavior does not resemble the prototype of an addict or alcoholic. Women with higher incomes or educations are even less likely to be identified and referred for treatment until they reach an advanced state of addiction (Blume, 1998).

Women who abuse drugs or alcohol experience a societal stigma for substance abuse as well as a moral stigma because women are held to a higher moral standard than men. For nurses, both men and women, the stigma of substance use is powerful, and addicted women and nurses remain hidden populations (Blume, 1998) and are less likely to seek treatment for substance abuse disorders than men (Greenfield et al., 2007).

General Risk Factors

The following general risk factors make people more susceptible to substance use disorders:

- **Psychiatric factors.** Depression, anxiety, low self-esteem, low tolerance for stress, learning disabilities, feelings of desperation, feelings of loss control over one’s life, feelings of resentment, and early victimization, particularly verbal, physical, and sexual abuse
- **Behavioral factors.** Use of other substances, aggregates of childhood behavior, conduct disorder, antisocial personality disorder, avoidance of responsibilities, impulsivity and risk taking, alienation and rebelliousness, reckless behavior, schizoid personality disorder
- **Sociocultural factors.** Involvement with the criminal justice system, illegal behaviors, and poor interpersonal relationships
- **Social factors.** Early age (15 years or younger) at first use, alcohol-and drug-using peers, social or cultural norms condoning use, weak religious affiliation, expectations about the positive effects of drugs and alcohol, and access to and availability of drugs
- **Demographic factors.** Male gender, inner-city or rural rural residence, high-risk socioeconomic status, and lack of employment opportunities
- **Family factors.** Alcohol and drug use by parents, siblings, or spouse; family dysfunction, such as inconsistent discipline and lack of positive family rituals and routines; poor parenting skills; and family trauma, such as death or divorce
- **Genetic factors.** Inherited predisposition to alcohol or drug dependence, deficits in neurotransmitters such as serotonin, and absence of aversive reactions, such as flushing or palpitations Studies estimate that genetic influences account for 40% to 60% of the risk for substance abuse (National Institute on Drug Abuse, 2007; Schuckit, 2009).

Workplace Risk Factors

The top four risk factors for nurses in the workplace are access, stress, lack of education, and attitude.

**Access**

The ready availability of drugs is an occupational hazard, especially when combined with a poorly managed administration of controlled substances in health care facilities (Trinkoff, Storr, and Wall, 1999). Sullivan, Trinkoff, and Storr (1999), in a longitudinal study, found that in treatment programs and learned that one sixth changed work sites (usually by internal hospital transfer) to have easier access to drugs. On the other hand, Kenna and Wood (2004) found that reduced workplace access was related to a greater likelihood of using illicit substances among nursing students and that access is an psychosocial mediator affecting substance use among health professionals.

The ongoing lack of institutional controls and oversight in the storing and distribution of narcotics facilitates diversion and its concealment. Loos prescribing practices for one’s friends or family is another risk factor and reflects society’s tolerance for taking drugs and expectation of receiving prescriptions from office visits.

In one study, nurses did not seek appropriate medical care for self-diagnosed health problems; instead, they obtained prescription pads from friends without adequate workups (Solari-Twadell, 1988).

**Stress**

Nursing is a highly stressful occupation. In fact, nurses reported more on-the-job stress than any other group of health care professionals (Wolfgang, 1998). Long shifts, extra shifts, staffing shortages, and shift rotation contribute to increased stress. Trinkoff and Storr (1998) examined the relationship between work schedule characteristics and substance use and found that, in general, the more adverse the schedule characteristics, the greater the likelihood of substance abuse. The schedule characteristic most strongly associated with substance use was a combination of shift rotation and long shifts. Shift work and long work hours also lead to fatigue, sleep deprivation, circadian rhythm disruption, and other psychophysiological consequences (Geiger-Brown & Trinkoff, 2010). In a longitudinal study, adverse work schedules, including long work hours and limited time off to recover, were related to musculoskeletal injury, pain, and needlesticks (Trinkoff, Le, Geiger-Brown, Lipscomb, & Lang, 2006; Trinkoff, Le, Geiger-Brown, Lipscomb, 2007).

Self-medication for pain is always a concern among nurses. Bugle (1996) compared a group of nurses disciplined for substance abuse (n = 79) with a group of nurses not disciplined for substance use (n = 124). The findings: 40% of disciplined nurses used prescription drugs to control chronic pain compared with 20% of non disciplined nurses, and 42.5% of disciplined nurses used drugs for emotional problems compared with 6.5% of non disciplined nurses.

**Lack of Education**

The lack of education on the addictive process and its signs and symptoms remains one of the more profound-and overlooked-risk factors for nurses. This lack of education contributes to the negative stereotypes of those with substance use disorders, especially nurses and physicians (Chappel, 1992; Grover & Floyd, 1998). Commonly, other health care professionals hold the most negative views of colleagues with substance use disorders (Howard & Chang, 2000a, 2000b). Darbo (2005) interviewed many nurses who identified a lack of education and a culture of mistreatment in their workplace. Thus, as the adage goes, “Ignorance breeds...
contempt,” producing a work environment in which nurses with substance use disorders may take even greater pains to conceal their abuse, thereby increasing the risk of harm to all.

**Attitude**

For attitudes to increase the odds of substance use problems in nurses (Clark & Farnsworth, 2006). First, nurses may see substance use as an acceptable means of coping with life's problems and a way of promoting healing and obtaining drugs. The fourth attitude deals with the special status of health care providers as being invulnerable to the illnesses of their patients; health care providers see themselves as caregivers, not care receivers. Finally, professional training involving powerful drugs leads to an acceptance of self-diagnosis and self-prescribing for pain and stress.

**Risk Factors in the Epidemiologic Triad**

Figure 1 presents risk factors for substance abuse disorders based on the classic epidemiologic triad. Most risk factors in the field are easily understood, but two may require explanation.

**Western medical practices refer to Western medicine’s reliance on pharmacotherapy as first-line treatment and the resulting expectation by patients that drugs will be prescribed as a quick fix for pain and other conditions.**


Chevy Chase, MD: American Society of Addiction Medicine.


Nurses have specific risk factors for substance abuse disorders related to their professional specialties and their workplace. They also share risk factors with the general population. For example, 91% of nurses are women, most nurses are susceptible to gender-related risk factors as well. To address substance use disorders early in their progression with understanding and compassion, we need to know and carefully consider the many risk factors that make nurses vulnerable.

**References**


Nurse Practice Acts Guide and Govern Nursing Practice

Kathleen A. Russell, JD, MN, RN

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The practice of nursing is a right granted by a state to protect those who need nursing care, and safe, competent nursing practice is grounded in the guidelines of the state nurse practice act (NPA) and its rules. All nurses have a duty to promote the public's health and to keep up to date. Changes as dynamic this document evolves and the scope of practice expands. This article reviews the reasons for and the importance of state NPAs and associated rules.

Learning Objectives
- Recall the history of nurse practice acts (NPAs).
- Describe the eight elements of an NPA.
- Discuss disciplinary action, including grounds and possible actions.

Before we permit a new driver to get behind the wheel of a car, we must familiarize her with the laws governing it. But the laws don’t tell the whole story. For example, what is a driver to do when entering an unexpected intersection? What governs the driver’s movement into the intersection? How does the driver take into account other drivers and to keep an eye on the road? What is his or her level of knowledge and experience? The new driver needs guidance or rules to manage the interactions. In the same way, risks are certain in nursing. Patients are ill; medications and treatments have benefits and side effects; clinical situations are underdetermined, open-ended, and ambiguous. Of course, not all nurses provide the same services, and the laws are provided by designs to protect the public provide guidance in nursing practice.

Nursing acts specialized knowledge, skill, and independent decision making. “The practice of nursing involves behavior, attitude, judgment, and physical and sensory capabilities in the application of knowledge, skills, and abilities for the benefit of the client. Nursing careers take widely divergent paths—practice focus varies by setting, by types of clients, by different disease, therapy, and nursing areas. A nurse is not the only person who can provide this care, or regulation, or standards provided by laws designed to protect the public provide guidance in nursing practice.

The NPA gives authority to regulate the practice of nursing. The NPA does that by authorizing a board of nursing. Each NPA typically identifies basic standards that are commonly understood. However, definitions are often included in laws to avoid uncertainty about the meaning of words. For example, encumbered, rules and regulations have the full force and effect of law. Although the specificity of NPAs varies among states, all NPAs include:
- definitions
- authority, power, and composition of a BON
- educational program standards
- standards and scope of practice for nursing
- boards of titles and licenses
- protection of titles
- requirements for licensure
- grounds for disciplinary action, other violations, and possible remedies.

Definitions
For the intent of a law to be useful to legislators and citizens, terms or phrases used in statutes must be clear and unambiguous. Of course, a law does not need to define every term and situation that can arise. Generally, definitions are used to clarify what is and is not within the act. Often, definitions are included in laws to avoid uncertainty about the meaning of words. For example, encumbered, rules and regulations have the full force and effect of law. Although the specificity of NPAs varies among states, all NPAs include:
- definitions
- authority, power, and composition of a BON
- educational program standards
- standards and scope of practice for nursing
- boards of titles and licenses
- protection of titles
- requirements for licensure
- grounds for disciplinary action, other violations, and possible remedies.

Authority, Power, and Composition of a BON
The NPA gives authority to regulate the practice of nursing and the enforcement of law to an administrative agency or BON. What is charged with maintaining the balance between the rights of the nurse to practice nursing and the responsibility to protect the public health, safety, and welfare is known as the NPA. The NPA is recognized as the legal basis of the profession, and the board is the legal representative of the public. By law, the NPA requires the board to develop the standards of practice for nursing. The NPA is the legal basis upon which the Board of Nursing (BON) acts to ensure the public's health, safety, and welfare. The BON is responsible for the scope of practice for nurses and the enforcement of nursing practice.

History of Nurse Practice Acts
Prior to the Industrial Revolution, individuals could evaluate the quality of services they received. Many communities hired the local doctor or an apothecary. Basic needs were met mostly by each family, and when people turned to others, they knew the reputations of those who provided health care. If that person could not call herself a nurse. However, as technology and knowledge advanced, a variety of people and groups began to provide services (NCSBN, 1996, p. 5). Individuals were no longer family. As with other health team members, nurses also require collaboration with the health care team; patient-centered health care plans, including goals and nursing interventions, can all be language within the NPA. Further standards include decision making and critical thinking in the execution of independent nursing strategies, provision of care as ordered or prescribed by authorized health care providers, evaluation of intended outcomes or changes; response or lack of response to interventions; and significant changes in patient condition (NCSBN, 2012a, 2012b).

The NPA typically identifies delegating and assigning nursing interventions to implement the plan of care as within an RN’s scope of practice (NCSBN, 2012a). The rules, however, specify the RN’s responsibility to manage, organize, and supervise the practice of nursing. Indeed, the rules delineate the specific steps for effective delegation by an RN as an "evergreen".

- unlicensed assistive personnel (UAP) have the education, legal authority, and demonstrated competence to perform the delegated task
- task is consistent with UAP’s job description
- task can be safely performed according to clear, written, and approved delegation and consent
- results of the task are reasonably predictable
- task does not affect patient care, including patient outcomes, or patient’s condition
- patient and circumstances are such that delegation of the task poses minimal risk to the patient and those consequences of performing the task appropriately are not detrimental
- RN provides clear directions and guidelines regarding the task (NCSBN, 2012b).

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programs—they are monitoring programs. The possibility of avoiding the public notoriety of discipline can be an important factor in breaking through the nurse’s denial of such use disorder (Brent, 2012). In order to make a program that will assist the nurse in retaining her or his license. These programs are designed to refer nurses for evaluation and treatment if the nurse obtained licensure by examination (NCSBN, 2012f). For all other grounds, the final decision reached by the board of nursing is based on the findings of an investigation and the results of the complaint process. The language used to describe the types of actions available to BONs varies according to state statute.

Figure 1
Board of Nursing Complaint Process

Investigation

Board proceedings

Reporting and enforcement

Although terminology may differ, board action affects the nurse’s licensure status and ability to practice nursing in the state taking action. BON actions may include the following:

• Fines or civil penalty
• Referral to an alternative-to-discipline program for practice monitoring and recovery support for those with drug- or alcohol-dependence or some other mental or physical health problems
• Public reprimand or censure for minor violation of the NPA, often with no restrictions on license
• Suspension or revocation requirements (monitoring, remediation, education, or other provision tailored to the particular situation
• Limitation or restriction of one or more aspects of practice, such as probation with limits on role, setting, activities, or hours worked
• Separation from practice for a period of time (suspension) or loss of license (revocation or voluntary surrender)
• Other state-specific requirements (NCSBN, 2012g)

BON actions are considered public information, and many BONs have determined that it is in the public interest to publicize their actions against nurses’ licenses and actions that reinstate licenses. BONs use a variety of methods to communicate this information, including newsletters and websites. Also, federal law requires that adverse actions taken against health care professional’s license be reported to federal databanks. The National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank are two federal databanks created to serve as resources of information to health care providers in the United States (NCSBN, 2012b).

Being Informed About Your NPA

Ignorance of the law is never an excuse! The NPA is not something one can study in a prelicensure nursing education program and then put aside. The act is a dynamic document that evolves and is updated or amended as changes in scope of practice occur. “Inherent in our current healthcare system is change which relates to society and the aging of the ‘baby boomers’; advances in technology; decreasing healthcare dollars; advances in evidence-based healthcare practices, techniques, and many other societal and environmental factors” (NCSBN, 2012i).

Your state BON is a resource for the NPA. Links to NPAs are available on most state BON websites. Some BONs attempt to provide new information to nurses via their website or newsletter (Tedford, 2011). For example, the Virginia BON posts a list of frequently asked questions to help nurses navigate the various aspects of licensure and posts announcements regarding practice or licensing changes on their homepage (Satterlund, 2012). The practice of nursing is a right granted by a state to protect patients, the public, and those with whom nurses interact. The NPA and its rules provide safe parameters within which to work and protect patients from unprofessional and unsafe practitioners. The last 100 years ago, state governments established BONs to protect the public’s health and welfare by overseeing and ensuring the safe practice of nursing. Today, BONs continue their duty, and the last few years have seen no one knows about it. “To maintain one’s license in good standing and continue practicing, nurses must understand their responsibilities” (Brent, 2012, p. 506). Make sure you know your state’s NPA and rules before you enter into that unprotected intersection of nursing care.

References


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Title and Licensure

The title nurse by unlicensed individuals misleads and endangers the public. “This poses a serious threat to patient care and safety. Reserving the title nurse for one who is unlicensed and to practice nursing allows the public to consult with professionals required to adhere to professional codes of practice and ethics” (Pennsylvania State Nurses Association, 2011).

NPA language generally includes a statement regarding the title of RN and LPN/VN. By specifying that the title of RN is “given to an individual intended to practice nursing” and LPN/VN is “given to an individual licensed to practice nursing,” the NPA protects these titles from being used by unauthorized persons and therefore protects the public (NCSBN, 2012a).

Each state’s BON may offer the nurse a nondisciplinary alternative-to-discipline program. These programs are not treatment

If a substance use disorder is suspected from the evidence and there is no diversion of medication, BONs may offer the nurse a nondisciplinary alternative-to-discipline program. These programs are not treatment

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6. Some newly licensed RNs are discussing their NPA during orientation. Which statement is incorrect and needs to be corrected by their preceptor?
   a. The NPA requires certification and a master’s degree for all APRNs.
   b. The standards and scope of practice for nurses are aligned with the nursing process.
   c. The use of the title registered nurse is protected by the NPA.
   d. The NPA sets standards for prelicensure nursing education.

7. What is the relationship between an NPA and rules or regulations?
   a. A BON can enact a rule without input from the public.
   b. A BON can change a regulation anytime.
   c. Rules can supersede the requirements of an NPA.
   d. Rules are often more specific than the NPA.

8. Which of the following is an example of unacceptable delegation?
   a. The RN asks the unlicensed assistive person to help a client walk to the bathroom.
   b. The RN asks the unlicensed assistive person to measure and then record a client’s vital signs.
   c. The RN assigns the LPN to care for a client who is ready for discharge.
   d. The RN delegates medication administration to the LPN.

9. Which of the following is a requirement for initial licensure as a nurse in every state?
   a. Confirmation of being drug free for at least 1 year.
   b. Passing a licensure examination.
   c. Criminal background check verifying no arrest record
   d. Endorsement by the state of permanent residence.

10. A complaint is filed against a nurse. What can the nurse expect to happen next?
    a. The complaint will be investigated.
    b. The nurse’s license will be temporarily suspended.
    c. The nurse will have a mandatory reduction in work hours.
    d. The nurse will be monitored on the job.

11. After agreeing to participate in an alternative-discipline program, a nurse can expect:
    a. an announcement of her or his participation in the discipline program
    b. an official letter of censure in her or his workplace records.
    c. to return to work with no restrictions.
    d. regular monitoring to ensure compliance with treatment.

12. Which type of discipline case involves accepting gifts and money from a client while caring for him or her?
    a. Abuse
    b. Fraud
    c. Boundary violation
    d. Practice-related

13. The nurse is renting a house from a former client and, after several months, refuses to pay rent. The former client files a complaint. This is an example of which type of discipline case?
    a. Fraud
    b. Abuse
    c. Boundary violation
    d. Practice-related

14. A nurse leaves the long-term care facility building for several hours without telling anyone and without authorization. It is later discovered that the nurse documented providing care and giving medications to residents while she was out of the building. This is an example of which type of discipline case?
    a. Fraud
    b. Abuse
    c. Sexual misconduct
    d. Practice-related

15. The National Practitioner Data Bank is:
    a. a repository of information about health care providers.
    b. used to keep track of nurses assigned to alternative-discipline programs.
    c. a method of tracking licensure renewal.
    d. available to the general public for finding information about health care providers.

**Evaluation Form (required)**

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).
   - Recall the history of nurse practice acts (NPAs).
     1 2 3 4 5
   - Describe the eight elements of an NPA.
     1 2 3 4 5
   - Discuss disciplinary action, including grounds and possible actions.
     1 2 3 4 5

2. Rate each of the following items from 5 (very effective) to 1 (ineffective).
   - Was the author knowledgeable about the subject?
     1 2 3 4 5

• Were the methods of presentation (text, tables, figures, etc.) effective?
  1 2 3 4 5

• Was the content relevant to the objectives?
  1 2 3 4 5

• Was the article useful to you in your work?
  1 2 3 4 5

• Was there enough time allotted for this activity?
  1 2 3 4 5

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Revised CMS Hospital Regulations Address Nursing Barriers

Revised CMS Hospital Regulations Address Nursing Barriers

How Regulations Are Revised

The Social Security Act gives the Secretary of Health and Human Services (HHS) the authority to revise regulations when a need is identified. The need for revisions can come to the Secretary’s attention when the public, the CMS administrator, Congress, or the president identifies an issue. Research is conducted and consultation is sought with interested stakeholders to identify evidence-based practices and relevant research. Consultation is conducted with other federal agencies and CMS offices to coordinate policy decisions. A proposed regulation is drafted and cleared through all agencies in HHS and the Office of Management and Budget. The proposed regulation is published in the Federal Register to allow for a 60-day public comment period. The Administrative Procedures Act requires that the public have an opportunity to opine on any regulation it will have to comply with. After the 60 days, CMS must respond to all comments and make relevant revisions to the proposed rule based on them before the final rule is published in the Federal Register. Responses to the comments received on the proposed rule are incorporated into the final rule. Final rules generally go into effect 60 days after publication.

Accrediting organizations must change their standards to reflect the changes in the CMS regulations to ensure that the organizations they accredit are meeting the CMS requirements.

The final regulations reflect the CMS’s commitment to the general principles of the president’s January 18, 2011, Executive Order 13563, “Improving Regulation and Regulatory Review,” to reduce regulatory burden and to reflect current industry standards of practice. The purpose of the Executive Order is to improve the quality of existing regulations consistent with the statute; streamline procedural solutions for businesses to enter and operate in the marketplace; maximize net benefits (including benefits that are difficult to quantify); and reduce costs and other burdens on businesses to comply with regulations.

Revising the CoPs

CMS solicited input from hospitals, health care practitioners, accreditation organizations, patient advocates, professional organizations, members of Congress, and other experts on which CoPs should be revised or eliminated. Using this stakeholder input, CMS published a proposed rule for revisions to the CoPs on October 24, 2011 (CMS, 2011), with the overall intent of increasing the time and resources hospitals and providers can devote to patient care by revising or eliminating outdated, burdensome, and unnecessary regulations. The agency received 1,729 public comments on the proposed rule before the public comment period closed on December 23, 2011. Most comments supported the proposed rule, and many reasonable suggestions for additional revisions and clarifications were offered. CMS revised the proposed regulations based on the public comments and published the final regulations in the Federal Register on May 16, 2012 (CMS, 2012). The regulations went into effect on July 16, 2012.

The comments incorporated into the final rule can be classified into three categories: those from hospitals, those from physicians and other practitioners, and those from the general public. The hospital industry and accrediting organizations expressed overwhelming support for the proposals and agreement with efforts to bring the CoPs in line with current practice, eliminate burdensome and obsolete regulations, and provide hospitals with operational flexibility. Physician groups mostly disagreed with the rule’s staffing proposals and with what they viewed as CMS’s endorsement of replacing physicians with advanced practice registered nurses (APRNs) and nonphysician practitioners. Though nonphysician practitioners supported most of the proposals, they urged further changes that they believe would allow them to practice to the full extent of their education and training under their state laws and regulations.

When revising regulations, CMS takes state laws regarding scope-of-practice issues into account. If, for example, a CMS hospital regulation would state that only physicians may write medical orders, state laws permitting APRNs to write orders in hospitals would be overridden. Because of this, the CoPs often defer to state laws regarding scope-of-practice issues. However, hospitals may establish rules and policies that are more restrictive than federal and state laws.
state laws and regulations as long as their rules and policies do not violate a law or regulation. This final rule allows hospitals more regulatory flexibility because CMS believes hospitals will be encouraged to explore ways to expand their medical staff membership and practice privileges to truly benefit patients. CMS has attempted to reduce barriers to practice in the CoPs, so nonphysician practitioners, such as APRNs and physician assistants (PAs), can practice to the full extent allowed by their state laws.

Key Revisions Affecting Nurses

Nurses and nursing care are essential components of hospital operations, so any change to the regulations governing the delivery of care affects APRNs and registered nurses (RNs) in the hospital environment. The regulations revisions that went into effect on July 16, 2012, will most directly impact the delivery of nursing care by:

• broadening the concept of “medical staff” by encouraging the use of nonphysician practitioners, such as APRNs and PAs, so they may operate to the full extent of their capabilities as defined in their scope of practice
• requiring that all eligible candidates, including APRNs and PAs, be reviewed by the medical staff for potential appointment to the hospital medical staff and allowing for the granting of all the privileges, rights, and responsibilities of appointed medical staff members
• eliminating the 48-hour requirement for renewal of a medical staff member’s appointment
• encouraging the use of evidence-based preprinted and electronic standing orders, order sets, and protocols to improve the quality of care provided to all patients, which allows nurses to implement orders that are timely and clear.

Medical Staff Membership

CMS believes that the changes to the medical staff requirements most directly address the CMS-specific recommendations in the report, The Future of Nursing: Leading Change, Advancing Health (Institute of Medicine, 2010). One of Institute of Medicine recommendation urges CMS to amend or clarify regulations to ensure that APRNs are eligible for clinical privileges, admitting privileges, and membership on a hospital’s medical staff. CMS believes that the interprofessional practice approach to patient care is the best model for hospital patients. Various practitioners such as APRNs have proven themselves to be valuable members of a team in providing efficient, high-quality health care. Patients benefit from this interprofessional collaboration because it allows APRNs, physicians, and other practitioners to learn from each other and improve their practices. The savings hospitals will realize from this approach will be dependent on the extent to which they take advantage of the regulatory flexibility the new requirements afford. Hospitals that view these changes as a means to be more inclusive of APRNs on their medical staffs will most likely reap the most benefits, as will their patients.

Additionally, CMS requires that all eligible candidates who apply for medical staff membership be reviewed by the medical staff for possible appointment. CMS became aware of situations in which APRNs submitted applications to hospitals and did not receive any communication on the status of their submissions. In essence, the application was ignored. CMS expects this revised requirement to eliminate such occurrences and allow APRNs and other practitioners to be considered in an unbiased manner for membership on a medical staff.

Single Interdisciplinary Care Plan

Many hospital care planning processes have evolved into interdisciplinary systems in which interprofessional team members document, provide, and/or direct patient care. Nurses, however, have been required to develop a separate nursing care plan for every patient and then identify the sections of each nursing care plan that needs to be integrated into the hospital’s interdisciplinary care plan (ICP) and transfer the information to the ICP. By allowing hospitals to include the nursing care plan in the ICP, CMS will allow nurses to use their judgment and to practice to the full extent of their education and training. Patients benefit from these changes because delays in receiving care and the possibility of medical errors decrease.

Included in the final regulations is a requirement that all standing orders, order sets, and protocols be reviewed periodically and approved by the medical staff, nursing, and pharmacy leadership and that they be consistent with nationally recognized guidelines. The inclusion of nurses in the review and approval process ensures that nursing has input into the orders that they will be implementing on a consistent basis. As with any orders, these orders must be dated, timed, and authenticated by a practitioner who is responsible for the care of the patient. In addition, CMS now allows drugs and biologics to be prepared and administered on the orders of nonphysician practitioners acting in consultation with their state’s laws, scope of practice, and hospital privileges. The use of the term practitioner throughout the final regulation is intended to facilitate the hospital’s use of APRNs and PAs in the delivery of efficient, interprofessional care.

Moving Forward

Although the final regulation has done much to eliminate barriers to the delivery of care by APRNs within the hospital environment, much work is still needed. CMS will continue to encourage the use of nonphysician nurses but also will allow states to practice to the full extent of their capabilities as defined in their scope of practice.

References


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CPR on the couch, rather than moving the patient to the nurse did not end the infusion immediately when her response to her daughter’s distress. She also testified that anaphylaxis. During depositions, the nurse said that regarding the nature of the emergency, and failed to resuscitation (CPR), failed to advise the 911 operator about the need for the administration of epinephrine. This expert testified that the defendant was responsible for handling and storing all reasonably foreseeable problems could be addressed the drug without epinephrine on hand, knowing that anaphylactic shock was a possible reaction, a known adverse effect. The monograph described anaphylaxis as an adverse effect and advised anyone administering the drug to have epinephrine immediately available. This expert stated that the defendant failed to meet the national standard of care for infusion therapy by failing to have the requisite knowledge about the drug and failing to regularly review medication orders and protocols and, if necessary, to expand the duty of nurses to evaluate and question the prudent administration of epinephrine in the home setting without having epinephrine available. The court held that the defendant owed a duty to the patient to withhold the medication because epinephrine was not provided by the home care agency or ordered by the physician, and the nurse was not authorized to prescribe it. This article discusses the law in depth and presents new challenges and implications for regulators regarding ensuring that regulations governing nursing practice are consistent with the court’s definition of a nurse’s duty and safe nursing practice.

Registered nurses (RNs) soon may find that the courts are placing an increased emphasis on patient safety by expanding the duty of nurses to evaluate and question medication orders and protocols and, if necessary, to refuse to administer prescribed drugs. In Applewhite v. AceHealth Inc. (2010), the Appellate Division, First Department, rejected the RN’s claim that she should not have administered an intravenous (IV) steroid in the home setting without having epinephrine available. The court held that the RN had a duty to her patient to withhold medication because epinephrine was not provided by the home care agency or ordered by the physician, and the nurse was not authorized to prescribe it. The term “practitioner” is defined by law and presents new challenges and implications for regulators regarding ensuring that regulations governing nursing practice are consistent with the court’s definition of a nurse’s duty and safe nursing practice.

The Incident

AceHealth, a home infusion agency in New York City, was directed by an ophthalmologist to provide methylprednisolone (Solu-Medrol) IV to a child suffering from rheumatoid arthritis. The agency followed its usual IV infusion protocol and sent the medication and necessary administration equipment to the patient’s home by mail. The ophthalmologist’s prescription specified three doses on 3 consecutive days for 3 months. The first month, the home infusion nurse administered the three doses without incident. The patient showed no signs of systemic reaction and the nurse administered the first of three doses for the second month, however, the patient had an anaphylactic reaction. The incident was the result of the patient’s doctor’s error. The doctor had prescribed methylprednisolone, and the devices needed to administer it.

The majority opinion of the appellate court held that the nurse committed malpractice when she administered the drug without epinephrine on hand, knowing that anaphylactic shock was a possible reaction. The court denied the request for dismissal and ruled the case should go to trial.

The Appeal

The defendant appealed the decision. Before the appeals court, the central issue argued by the plaintiff was that the nurse had a duty to her patient to withhold medication because epinephrine was not available and therefore was unprepared to treat the reaction, a known adverse effect. The appeals court, in a three-to-two opinion, held that the nurse committed malpractice when she administered the drug without epinephrine on hand, knowing that anaphylactic shock was a possible reaction. The majority held that a nurse in the home setting with no readily available epinephrine was required to ensure that all reasonably foreseeable problems could be addressed to minimize patient harm. According to the majority, theContemporary Court’s view of pharmacists as proactive participants with “reasonable directives of doctors they work with” (Applewhite v. AceHealth Inc., 2010, p. 104) required the nurse to withhold the drug without epinephrine available. Thus, the nurse could be held liable for malpractice, even without evidence that the prescribing physician or the home infusion industry required epinephrine. The nurse’s duty to inquire about the availability of epinephrine before proceeding with the infusion “simply recognizes the critical role of nurses as a check against medical error” (Applewhite v. AceHealth Inc., 2010).

The dissent reviewed the conclusion that the plaintiff was not authorized to carry epinephrine without a physician’s prescription. The dissent stated that the proximate cause of the anaphylactic reaction was the physician’s failure to provide epinephrine. The dissent reviewed the conclusion that the plaintiff was not authorized to carry epinephrine without a physician’s prescription. The dissent stated that the proximate cause of the anaphylactic reaction was the physician’s failure to provide epinephrine. The majority argued that a new duty for RNs or require RNs to have the same sense of responsibility as physicians. However, the dissent reviewed the conclusion that the patient was not authorized to carry epinephrine without a physician’s prescription. The dissent stated that the proximate cause of the anaphylactic reaction was the physician’s failure to provide epinephrine.

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The dissent also held that the RN defendant's expert could not prove indifference to the risk of injury or shock because, even though she was not a home infusion specialist, "any registered nurse with hospital experience would be aware of the potential risk on the issue of the standard of care relevant to an anaphylactic patient" (Appelwhite v. Acuhealth Inc., 2010, p. 113). The two dissenting judges noted that no court in New York ever addressed the element of proof for which New York does not issue advanced certification.

The dissent concluded that the home infusion therapist's mischaracterization of the evidence was to inquire about the standard of care (Appelwhite v. Acuhealth Inc., 2010, p. 114), but that even under that higher standard, allowing the claim to go forward against the nurse for failing to arrange for epinephrine, even named a defendant in the case would be unfair. The dissent added a cautionary note:

"The use of home infusion therapy to administer powerful medications, rather than administering them in a hospital setting where crash carts and antidotes are at hand, certainly has many cost benefits and personal advantages, but the outcomes are correct, and such powerful medications are accompanied by a substantial possibility of a life-threatening adverse reaction. (Appelwhite v. Acuhealth Inc., 2010, p. 115)"

Case Law: Duty to Inquire

More than two decades earlier, New York's highest court held that "the role of the registered nurse" has changed "from an employee of hospital to a member of a new professional provider [of] aggressive decisive healthcare provider" (Bleiler v. Bodnar, 1985). In Appelwhite v. Acuhealth Inc., the court decided that the nurse, who had a chance to inquire about the standard of care, was a "critical backstop" to preventing a serious injury.

In 1968, the Court of Appeals recognized that when an RN is called upon to act as an expert witness, "the community holds the RN to a higher standard of care" (Berry v. Peterman, 2010). An RN is not merely required to consult with the physician but also to inquire about the infusion with at least an EpiPen to combat such a reaction. (Appelwhite v. Acuhealth Inc., 2010, p. 115)

Legal Duty to Anticipate Harm

Nurses are legally responsible for inquiring and checking physician orders. If the RN reads the epinephrine prescription for the patient. She was not authorized to carry any form of epinephrine, including an EpiPen, to use on an as-needed basis. The court held that the expanded legal duty for RNs are not to be interpreted as the conditions of use of the standard of care to anaphylactic patient (Appelwhite v. Acuhealth Inc., 2010, p. 113). The two dissenting judges noted that no court in New York ever addressed the issue of the standard of care for which New York does not issue advanced certification.

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In 1968, the Court of Appeals recognized that when an RN is called upon to act as an expert witness, "the community holds the RN to a higher standard of care" (Berry v. Peterman, 2010). An RN is not merely required to consult with the physician but also to inquire about the infusion with at least an EpiPen to combat such a reaction. (Appelwhite v. Acuhealth Inc., 2010, p. 115)

Legal Duty to Anticipate Harm

Nurses are legally responsible for inquiring and checking physician orders. If the RN reads the epinephrine prescription for the patient. She was not authorized to carry any form of epinephrine, including an EpiPen, to use on an as-needed basis. The court held that the expanded legal duty for RNs are not to be interpreted as the conditions of use of the standard of care to anaphylactic patient (Appelwhite v. Acuhealth Inc., 2010, p. 113). The two dissenting judges noted that no court in New York ever addressed the issue of the standard of care for which New York does not issue advanced certification.

The dissent concluded that the home infusion therapist's mischaracterization of the evidence was to inquire about the standard of care (Appelwhite v. Acuhealth Inc., 2010, p. 114), but that even under that higher standard, allowing the claim to go forward against the nurse for failing to arrange for epinephrine, even named a defendant in the case would be unfair. The dissent added a cautionary note:

"The use of home infusion therapy to administer powerful medications, rather than administering them in a hospital setting where crash carts and antidotes are at hand, certainly has many cost benefits and personal advantages, but the outcomes are correct, and such powerful medications are accompanied by a substantial possibility of a life-threatening adverse reaction. (Appelwhite v. Acuhealth Inc., 2010, p. 115)"

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Pursuant to Section 335.066 RSMo, the Board “may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 62L, RSMo, against any holder of any certificate of registration or authority, permit, or license, or required by law or rule to be licensed, or who 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. The Board has identified by sex in all cases. Please check the license number. Each discipline case is different. Each case is considered separately by the Board. Each case contains factors, together with the outcome, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any case should not be viewed as Board policy and do not bind the Board in future cases. To view the Board’s Order or Settlement Agreement for a particular Licensee, please go to NURSYS.

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**CENSURE**

Kaleilac, Liane M.  
Registered Nurse 0095892  
Registered Nurse 2008095264  
On April 22, 2010, in the State of Michigan, 6th Judicial Circuit Court in the County of Oakland, Licensee entered a plea of guilty to the offense of obtaining a false identification to a criminally discontent person. Licensee was convicted of either or both charges.

Probation continued on page 17

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**PROBATION**

Ward, Lisa  
Registered Nurse 0009580  
Registered Nurse 2006023276  
Licensee had trouble staying awake during a staffing meeting and fell asleep. She explained that she had not had enough sleep. Licensee was convicted of reckless conduct.

Probation continued on page 17

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**CENSURE Continued...**

a resident from the medication cart and took them for pain. Licensee admitted this was improper. When the narcotic was off at the end of her shift, she remembered reaching into the drawer and retrieving the narcotic. She thought she was thinking of regular Tylenol and admitted that she had taken the Tylenol from the medication cart for personal use.

Censure 11/14/2012 to 11/15/2012

Butts, Wanda R.  
Registered Nurse 0095890  
On July 10, 2012, Licensee was called to report a request for the requested samples which showed a low creatinine reading. On June 4, 2012, the low creatinine reading was correct. Licensee’s shift ended. The security camera tape was reviewed by the pharmacist.

Censure 09/18/2012 to 09/19/2012

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**PROBATION Continued...**

The doctor’s name or DEA number. Licensee voluntarily entered a drug diversion program after the above incident.

Probation continued on page 17
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On August 26, 2011, Licensee entered into a Board Order with the Saint Louis, MO Probation 09/26/2012 to 09/26/2015.

c. Acting seductively in the presence of patients and co-workers; and

b. Speaking inappropriately and sexually about patients and their inappropriate and unprofessional manner in the following ways:

Licensee told C.K., Business Office Manager, that she diverted insulin for Vancomycin to be delivered intravenously. Licensee admitted that she diverted the controlled substances for Class A Felony of possession of a controlled substance from May 31, 2010 through June 13, 2011. Thirty-nine undocumented narcotics were

Licensee entered an inpatient substance abuse program on March 29, 2011 through May 12, 2011. Licensee was arrested for domestic battery, Respondent reported to the morning nurse that Patient, F.C., had to have three glucagon injections to get her blood sugar back up to a glucose reading of 100. On June 14, 2010, Patient gave a report to the morning nurse that Patient, F.C., had a glucose reading of 6, and Patient, F.C., was clammy and had symptoms of being hypoglycemic. On June 14, 2010, Patient, F.C.'s blood sugar, resulted in delayed care pursuant to the protocol requires insulin to be held and a physician to be notified if a patient's blood glucose level is below 60. On June 14, 2010, Patient gave a report to the morning nurse that Patient, F.C., had a glucose reading of 6, and Patient, F.C., was clammy and had symptoms of being hypoglycemic. On June 14, 2010, Patient, F.C.'s blood sugar, resulted in delayed care pursuant to the protocol requires insulin to be held and a physician to be notified if a patient's blood glucose level is below 60. On June 14, 2010, Patient gave a report to the morning nurse that Patient, F.C., had a glucose reading of 6, and Patient, F.C., was clammy and had symptoms of being hypoglycemic.

On April 20, 1999 Licensee pled guilty to the Class A Misdemeanor of possession of unlawful drug paraphernalia. On December 20, 2004, Licensee pled guilty to unlawful use of drug paraphernalia and driving while intoxicated (DUI). On December 29, 2011, Board staff again explained to Licensee how to forward 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.

You can then go to www.nursys.com to see the details of the discipline including the Board’s order.

To subscribe to the e-alerts, send your name and email address to Lori Scheid at lori.scheid@pr.mo.gov.
admitted to drinking a lot of beer and liquor together every night to get drunk, and was afraid that she was becoming dependent on alcohol prior to her suicide attempt.

Prohibition 10/30/2012 to 10/30/2014

Powell, Jessica Marie

Kansas City, MO

Registered Nurse 2009903893

Licensure was employed on February 5, 2010 until she was terminated on September 30, 2010. While working, Respondent was given a urinalysis in which Respondent tested positive for THC, a metabolite of marijuana. Respondent was asked to submit to a random urine screen. Respondent’s urine sample tested positive for THC.

Prohibition 09/28/2010 to 09/28/2015

Mayurals, Karen P.

Columbia, MO

Registered Nurse 2008537792

On April 3, 2010, Respondent was requested to submit to a drug screen after she was observed exhibiting strange behavior during her shift. Respondent initially agreed to take the drug test and signed a form agreeing to the test. Respondent then told her supervisor she did not want to take the test due to using cocaine within the past couple of days prior to April 3, 2010. Prohibition 04/28/2010 to 09/26/2017

Lewis, Jana E.

Springfield, MO

Registered Nurse 147777

On June 13, 2007, a prescription pill vial in a pharmacy bag for an employee of the facility was delivered to the Emergency Room triage desk by a pharmacy employee. The prescription vial contained thirty 20 mg tablets. Security camera footage revealed that the Licensee removed the prescription from the desk drawer. The employee notified security that the Licensee gave him the missing prescription vial. No pills were missing from the prescription. When interviewed by hospital security, Licensee admitted that she removed the Adderall from the triage desk. She further admitted that she had no valid reason to remove the Adderall from the desk or from the unit.

Prohibition 09/19/2012 to 09/19/2013

Clay, Janisse S.

Saint Louis, MO

Licensed Practical Nurse 053062

Licensure was employed on September 7, 2004, Licensee voluntarily surrendered her license in Missouri to practice as a registered nurse. The facts surrounding this voluntary surrender are as follows:

On March 20, 2003, Licensee diverted one tablet of Loritab. On about April 2, 2003, Licensee diverted one tablet of Loritab. On or about April 2, 2003, Licensee diverted one tablet of Percocet. On or about July 15, 2009, Licensee entered into an agreement with the Kansas State Board of Nursing, stipulating that she diverted Demerol on June 10, 2004. The Kansas State Board of Nursing issued disciplinary action, and Licensee was granted a license with limitations on her practice and participation in the Kansas Nurses Assistance Program.

Prohibition 09/17/2012 to 09/17/2014

Kohnz, Garrett Alan

Columbia, PA

Registered Nurse 2012031302

On March 21, 2007, Licensee pled guilty to the offenses of involuntary manslaughter while driving under the influence of alcohol or drugs and attempted voluntary manslaughter while driving under the influence of alcohol or drugs. Licensee was sentenced to serve a sentence of sixty (60) months in prison.

Prohibition 09/04/2009 to 09/04/2015

Norvell, William C.

Saint Louis, MO

Licensed Practical Nurse 033336

On June 18, 2012, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. On August 6, 2012, Respondent again was chosen to report to a collection site to provide a sample. Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. Prohibition 09/26/2012 to 07/06/2015

Chambers, Maria R.

Wheatland, MO

Licensed Practical Nurse 054085

On October 27, 2012, Licensee received an order on R.P. for Lisinopril 5 mg BID, which she noted and transcribed to the Medication Administration Record (MAR). The physician then called back the same day, October 27, 2012, and changed the Lisinopril order back to the original order of 5 mg daily, monitor the resident, and to notify physician of findings after a week of vital signs. Licensee did not notify the physician of the order change, she put a line through the first order she received, “errored” the original order of 5 mg daily, monitor the resident, and to notify physician of findings after a week of vital signs. Licensee did not notify the physician of the order change.

Suspension 10/18/2012 to 11/17/2012; Probation 11/18/2012 to 11/18/2017

NSAIDS/PROBATION

Fister, Samantha Rae

Missouri, MO

Licensed Practical Nurse 2003022279

Licensee admitted to committing the act of diversion of the Tamcard from her employer. Licensee stated that her Tamcard addiction to Tamcard started in December 2010 after she had surgery. Probation 11/13/2013 to 11/13/2017

Gann, Tunia Marie

Cahool, MO

Licensed Practical Nurse 2012399864

On May 4, 2009, Licensee pled guilty to possession of a controlled substance. She received a suspended imposition of sentence and was placed on probation. She was released early from probation on December 19, 2011. On June 5, 2009, Licensee pled guilty to leaving the scene of an accident in the State of Illinois. She received a suspended imposition of sentence and was placed on probation. Licensee self-reported that she previously abused methamphetamine.

Suspension 11/08/2012 to 11/08/2015

SUSPENSION/PROBATION

Smith, Brian William

Keene, MO

Registered Nurse 2003017238

Suspension 10/17/2012 to 11/20/2012

Probation 11/20/2012 to 11/20/2017

Voss, Elizabeth Maria

Ibrie, MO

Registered Nurse 2010010363

Suspension 10/11/2012 to 11/10/2012

Probation 11/11/2012 to 11/18/2017

Cox, Sharon Denise

Fiorissanti, MO

Licensed Practical Nurse 20098026379

Suspected October 30, 2012 to April 30, 2014

Probation May 1, 2014 to May 1, 2016

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February, March, April 2013
investigator that she forged PG’s name on her nurse visit reports. The DHSS investigation revealed that there were 24 nurse visits for which Licensee falsified signatures for clients she did not actually visit. 

Suspension 10/30/2010 to 04/30/2014; Probation 5/31/2012 to 5/1/2016

**Revised**

Ryan, Tammy M.
Doniphan, MO

Registered Nurse 2008032542

Respondent failed to call in to NTS on January 12, 2012, March 8, 2012, March 9, 2012, March 12, 2012, March 13, 2012, March 14, 2012, April 26, 2012, May 17, 2012, and from May 30, 2012 through July 9, 2012. Further, on February 21, 2012, April 19, 2012, and May 29, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on November 9, 2011, provided the required sample which had a creatinine reading of 20.0 is suspicious for a diluted sample. Respondent was required to submit updated treatment information from a chemical dependency professional by due dates provided to her. The Board did not receive updated treatment chemical dependency information submitted on Respondent’s behalf by the November 30, 2011 and February 29, 2012, documentation due dates. Respondent was required to attend a support group and submit the support group attendance reports to the Board by due dates provided to her. The Board did not receive proof of support group attendance by the November 30, 2011 and February 29, 2012, documentation due dates.

Revised 09/13/2012

Gotsch, Mary Lynn
Carrollton, MO

Licensed Practicial Nurse 042132

Between December 8, 2001 and July 26, 2012, Respondent failed to call in to NTS on two (2) days. 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 had been prescribed by a person licensed to prescribe such drug and with whom Respondent had a bona fide relationship as a patient. On June 5, 2012, Respondent submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of Methamphetamnine. Respondent was required to completely abstain from the use or consumption of alcohol in any form, regardless of whether the use or consumption of alcohol was permitted by the terms of KNAP. Respondent did not contract with NTS.

alcohol screenings as part of her Missouri probation as Respondent was no longer in KNAP. Respondent did not contract with NTS.

REVOKEKED continued on page 20

**Revised**

Gaddis, Merry Wayne
Prattville, KS

Registered Nurse 2011030943

On October 24, 2011, the Board issued a Modification Order, which required Respondent to submit compliance reports from the Kansas Nurses Assistance Program (KNAP), and stated that failure to comply with the terms of KNAP would be considered a violation of her probation. On July 30, 2012, the Board, received a letter from Regena M. Walter, KNAP Program Manager. The letter indicated that Respondent chose to leave the nursing profession and that the Respondent’s KNAP file was then closed as unsuccessful. On July 30, 2012, Respondent was instructed to contract with NTS and participate in random drug and alcohol screenings as part of her Missouri probation as Respondent was no longer in KNAP. Respondent did not contract with NTS.

Revoked 09/18/2012

Young, Lynnette Renee
Viburnum, MO

Registered Nurse 2003106418

The Administrative Hearing Commission found cause for the Board to discipline Respondent’s license for diverting controlled substances for her own use, maintaining inaccurate patient records and failing to properly dispense, administer and dispose of medications.

Revoked 09/18/2012

Shelfon, Brandi Rae
De Kalb, MO

Licensed Practicial Nurse 2008025205

An investigation into Respondent’s time sheets and flow sheets from January 5, 2012, and January 6, 2012, for patient 00311 revealed that Respondent had falsified her time sheets, taken confidential information from patient 00311’s home and forged the signature of patient 00311’s mother on patient 00311’s flow sheet, reflecting that Respondent worked those hours reflected on the flow sheet.

Revised 09/12/2012

Rittman, Sarah Christine
Lees Summit, MO

Registered Nurse 2008021528

On August 17, 2012, Respondent failed to call in to NTS on five (5) days. On October 20, 2011, Respondent submitted a sample which showed a creatinine reading of 15.7. On January 5, 2012, Respondent submitted a sample which showed a creatinine reading of 18.2. Creatinine readings below 20.0 are suspicious for diluted samples. On May 22, 2012, Respondent reported to a collection site to provide a sample, and the sample tested positive for marijuana. On June 26, 2012, Respondent reported to a collection site to provide a sample, and the sample tested positive for marijuana.

Revised continued on page 20
site to provide a sample and the sample tested positive for Marijuana. Respondent subsequently sought treatment for substance abuse and self-inflicted injuries. Since patient, R.B.'s discharge on May 15, 2007, Respondent began counseling sessions with a test-monitoring company. Patient, R.B. left his wife and moved in with Respondent within two weeks of her contact with him. Patient, R.B. stated that Respondent was trying to get him to buy a track for her and Respondent also asked him to purchase a gun. On July 3, 2007, Respondent was observed by staff leaving the hospital with patient, R.B. In addition, on August 16, 2007, a charge nurse observed R.B. of Respondent's locker revealed a 14-inch Bowie knife in her possession. This possession of such a knife inside the hospital was a violation of policy, due to the possibility of damage a knife could cause in any psychiatric or other setting. Patient, R.B. also stated that Respondent could go to jail for a car loan. Patient, R.B. was re-admitted on August 16, 2007, with complaints of anxiety and anger. Patient, R.B. was diagnosed with being harassed by a woman he had an affair with, and he was feeling hopeless, helpless, and having suicidal thoughts. Revised 10/01/2012

Adkison, Diana

Registered Nurse 076180

Registered Nurse 076180 continued on page 21
Voluntary Surrender continued from page 20

in the home of a client in March of 2011. Licensee was assigned to the client’s home after A.R.’s duties changed. While working in the client’s home, A.R. misplaced her watch and ring. The client found the watch and returned it to A.R., but did not find the ring. On August 17, 2011, Licensee met with A.R. for her yearly evaluation. When Licensee arrived for the evaluation, she was wearing A.R.’s ring. A.R. asked Licensee where she had gotten the ring. Licensee stated she had gotten it from the client’s house. A.R. told Licensee it was her ring and she had lost it at the client’s house. Licensee admitted to taking the ring from the client’s house and stated, “Oh I was just waiting for the client to say they had lost it.” Licensee returned the ring to A.R.

Voluntary Surrender 09/17/2012

Durt, Anita F.
East Winnetka, WA
Registered Nurse #18984
Voluntary Surrender 09/17/2012

Myers, Claudia J.
Mcdeery, MO
Registered Nurse #146421
On or about October 6, 2009, in The Circuit Court of Macon County, MO, Licensee entered a plea of guilty to the Class B Misdemeanor of “Driving While Intoxicated” in violation. She received 30 day suspended execution of sentence with two years of supervised probation and special conditions. Driving while intoxicated is a crime of moral turpitude.

Voluntary Surrender 09/04/2012

Holechuck, Chase Logan
Rogersville, MO
Registered Nurse #2099033780
On October 30, 2010, while on duty as a nurse, Licensee exposed her genitalia to a female co-worker. On June 6, 2011, Licensee pled guilty to the Class B Misdemeanor of “Sexual Misconduct in the Second Degree” in the Associate Circuit Court of Greene County, Missouri.

Voluntary Surrender 11/03/2012

Gunn, Michelle Renee
Lee’s Summit, MO
Registered Nurse #2005025829
Licensee voluntarily surrendered her Missouri nursing license on September 4, 2012

Voluntary Surrender 09/04/2012

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Voluntary Surrender 09/04/2012

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Voluntary Surrender Continued...

Voluntary Surrender 09/12/2012

Hatfield, bethany m.
Norfolk, NE
Registered Nurse #2005025829
Licensee voluntarily surrendered her Missouri nursing license on September 4, 2012.

Hilbert, Sarah Jeannine
Kansas City, MO
Registered Nurse #2099033780
Licensee voluntarily surrendered her Missouri nursing license on September 4, 2012.

Voluntary Surrender 07/20/2012

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Missouri State Board of Nursing • Page 21
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