It Takes All of Us to Protect the Public

The Board of Nursing’s executive director, Lori Scheidt, was fortunate to attend the first Tri-Regulator Symposium held Oct. 17-18th in Washington, D.C. The theme of the symposium was “Protecting Patients and the Public: A Heritage of Excellence,” and was hosted by the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN). The meeting reinforced the fact that regulatory issues among medicine, pharmacy, and nursing licensing boards are more similar than not. More importantly it became very clear how important it is for health care licensing boards to collaborate. The Keynote Speaker Donna Shalala, former Secretary of Health and Human Services under President Clinton, made this very point. Dr. Shalala’s primary message was that state licensing boards must collaborate because of the impact that licensing boards have in promoting and advancing the health of the nation.

Interprofessional education panels presented current regulatory challenges on issues regarding opioid prescription abuse, the future of state-based regulation, assessment of professional competency, and health care workforce data needs of the country. All three health care licensing boards shared common challenges with the Missouri Board of Pharmacy, National Board of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN). The goal of their initiative is to encourage and promote a culture of patient safety in pharmacy practice throughout Missouri. Pharmacists are trusted and valuable members of the healthcare team and play a vital role in providing safe patient care. By utilizing effective patient safety tools and strategies, we can help ensure “Safe Practice, Safe Patients and a Safe Missouri.”

The Missouri Board of Pharmacy announced the launch of its 2013 patient safety initiative “MoSafeRx.” The goal of their initiative is to encourage and promote a culture of patient safety in pharmacy practice throughout Missouri. Pharmacists are trusted and valuable members of the healthcare team and play a vital role in providing safe patient care. By utilizing effective patient safety tools and strategies, we can help ensure “Safe Practice, Safe Patients and a Safe Missouri.”

Missouri Board of Pharmacy MoSafeRx Initiative

For Missouri board members and the public, the Missouri Board of Pharmacy announced its “MoSafeRx” initiative. The Missouri Board of Pharmacy, Missouri Pharmacists Association, and the American Pharmacists Association partnered to launch the initiative. The initiative is designed to raise awareness among the public and pharmacists about the importance of patient safety in pharmacy practice. The Missouri Board of Pharmacy is committed to ensuring that pharmacists provide safe and effective care to patients.

Executive-Director’s Report

Authored by Lori Scheidt, Executive Director

Legislative Update

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://pr.mo.gov/

Missouri Nursing Practice Act

Senator Jay Wasson (R-District 20) filed Senate Bill 370. Passage of this bill would add additional causes for which the Board of Nursing may file a complaint and allows the Board to request an emergency suspension of a license.

Advanced Practice Registered Nurse Practice Acts

Senator David Sater (R-District 20) filed Senate Bill 167. Representative Lyle Rowland (R-District 155) filed House Bill 314. Passage of either of these bills would modify the laws relating to advanced practice registered nurses and collaborative practice arrangements.

APRN Waiver of Collaborative Practice Mileage Requirement for Rural Health Clinics Only

Senator Jay Wasson (R-District 20) filed Senate Bill 330 and Representative Eric Burlison (R-District 133) filed House Bill 625. Passage of either of these bills would allow the geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics as long as the collaborative practice arrangement includes alternative plans for coverage.

Social Security Numbers on License Renewals

Senator Scott Sifton (D-District 1) filed Senate Bill 289 and Representative Wayne Wallingford (R-District 27) filed Senate Bill 314. Passage of either of these bills would change the Social Security number requirement. Under current law, every application for a renewal of a professional license, certificate, registration, or permit must contain the applicant’s Social Security number. This act states that an application for a professional license renewal only has to include a Social Security number in subsequent renewal applications.

Military Credit

Senator Dan Brown (R-District 16) filed Senate Bill 106 and Representative Charlie Davis (R-District 162) filed Senate Bill 389 and Representative Matt Clark (R-District 27) filed Senate Bill 314. Passage of either of these bills would change the Social Security number requirement. Under current law, every application for a renewal of a professional license, certificate, registration, or permit must contain the applicant’s Social Security number. This act states that an application for a professional license renewal only has to include a Social Security number in situations where the original application did not contain a Social Security number. After the initial application for license renewal which includes a Social Security number, an applicant is no longer required to provide a Social Security number in subsequent renewal applications.
filed House Bill 114. Passage of either of these bills would require all boards within the Division of Professional Registration to promulgate rules by January 1, 2014. Upon presentation of satisfactory evidence by an applicant for certification or licensure, the appropriate board shall accept education, training, or service completed by an individual who is a member of the United States armed forces or reserves, the national guard of any state, the military reserves of any state, or the naval militia of any state toward the qualifications to receive the license or certification.

Malpractice Insurance Proof for Homebirth Services
Representative Caleb Jones (R-District 50) filed House Bill 308. Passage of this bill would require that any person certifying and providing home birth services shall, prior to the provision of such services, furnish to all individuals for whom such services will be provided satisfactory evidence that such person has obtained and maintains a midwifery malpractice insurance policy with coverage of at least one million dollars. Any person who fails, prior to the provision of such services, to present proof of such malpractice insurance coverage is guilty of a class C misdemeanor.

Board of Professional Midwives
Representative Kurt Bahr (R-District 102) filed House Bill 792. Passage of this bill would require every employee and volunteer of a health care facility inspected by the department of health and senior services to receive an influenza vaccination each year.

Influenza Vaccination Requirement
Representative Jill Schupp (D-District 088) filed House Bill 792. Passage of this bill would require every employee and volunteer of a health care facility inspected by the department of health and senior services to receive an influenza vaccination each year.

Your Role in the Legislative Process
Legislation impacts nursing careers, shapes health care policy and influences the care delivered to patients. Your education, expertise, and well earned public respect as a nurse can allow you to exert considerable influence on health care policy. Nurses have been somewhat reluctant to do this in the past but you are in an excellent position to advocate for patients. Never underestimate the importance of what you have to say. As a professional, you bring a unique perspective to health care issues and often have intricate knowledge that helps provide insight for our legislators.

You should make your thoughts known to your legislative representatives. 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://moga.mo.gov/
Official NCLEX nursing licensure exam data is released in January of each year. Pursuant to Missouri State Board of Nursing rules for nursing programs, a minimum annual first-time tester pass rate of 80% is required. It is significant to note how well Missouri nursing programs prepare their graduates for the licensure exam. When compared and reflect strong focus on patient safety and transition to nursing practice. Ongoing educators across the state continue to develop and utilize innovative ways to teach their Missouri nursing programs prepare their graduates for the licensure exam. While nurse annual first-time tester pass rate of 80% is required. It is significant to note how well Pursuant to Missouri State Board of Nursing rules for nursing programs, a minimum

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of Program</th>
<th>Missouri Average Pass Rate</th>
<th>National Average Pass Rate</th>
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</thead>
<tbody>
<tr>
<td>2008</td>
<td>Registered Nursing</td>
<td>87.85%</td>
<td>86.73%</td>
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<tr>
<td>2009</td>
<td>Practical Nursing</td>
<td>80.2%</td>
<td>83.07%</td>
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<tr>
<td>2010</td>
<td>Practical Nursing</td>
<td>82.3%</td>
<td>82.7%</td>
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<tr>
<td>2011</td>
<td>Registered Nursing</td>
<td>90.16%</td>
<td>87.96%</td>
</tr>
<tr>
<td>2012</td>
<td>Registered Nursing</td>
<td>93.43%</td>
<td>90.34%</td>
</tr>
</tbody>
</table>

**National NCLEX statistics indicate that in 2012 a total of 4,977 Missouri graduates took their nursing licensure exam for the first time; of those 4,638 passed the exam on the first attempt. Within this data, out of 3,608 first-time testers for RN licensure, 3,371 passed the exam on the first attempt. For LPN licensure, out of 1,369 first-time testers, 1,267 passed the exam on the first attempt. It should be noted that each year the number of Missouri graduates sitting for the RN licensure exam has increased (3,416 in 2011 to 3,608 in 2012); whereas data reflects a slight decrease in Practical Nurse graduates sitting for the licensure exam for the first time (1,454 in 2011 to 1,369 in 2012). While local statistics regarding Missouri nursing programs are collected in a number of ways, annual reporting provides a rather comprehensive look at pre-licensure program data. Annual reporting for 2011 indicates that Missouri pre-licensure nursing programs have turned away 3,780 (BSN programs = 1,369, ADN programs = 1,585, PN programs = 826) applicants deemed eligible for admission but who could not be accommodated at that time. It is important to note that report data may be somewhat skewed since applicants often simultaneously apply to more than one nursing program/site. An applicant may also be deemed eligible for admission, even though he or she may not completely meet admission requirements at the time of application and therefore would not be eligible to enter the program as planned. With that said, when compared with the number of first-time testers in 2012, the number of applicants that were reported to have been turned away in 2011 becomes even more significant. A variety of factors impacts the number of admissions to nursing programs. Ongoing struggles to secure qualified faculty and availability of appropriate clinical placements are among major challenges. Annual reporting data indicates that in 2011 programs would have needed 290 additional faculty members to accommodate all prelicensure applicants who were deemed qualified for admission. While Associate Degree in Nursing programs report the highest number of applicants that could not be admitted (1,585), Baccalaureate Degree in Nursing programs report the greatest need for additional faculty (141) to accommodate all applicants. As mentioned in an earlier article, data collection from 2010 annual reporting predicts additional impact on faculty resources within the next couple of years. In 2010 nursing programs indicated that at least 142 nursing faculty were planning to retire by 2015. Significant change in the approach to nursing education is essential. A committee charged by the Missouri Action Coalition – Future of Nursing has been working for the

<table>
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<th>Benefits Include:</th>
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<tr>
<td>Flexibility</td>
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<th>RN’s</th>
<th>$42.00/hr</th>
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<td>LPN’s</td>
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**Rosario, RN**

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- Retirement benefits
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- Paid education and certification
- Tuition reimbursement
- Paid time off
- Paid sick time

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**Missouri State Board of Nursing Education Committee Members:**

- Roxanne McDaniell, RN, PhD (Chair)
- Lisa Green, RN, PhD(Ed)
- Irene Coco-Bell, LPN

**Statistics on Pre-licensure Nursing Education in Missouri continued on page 4**
Missouri Nursing Education Resource Committee – Call to Action

In October 2012 the Missouri State Board of Nursing accepted development of a set of nursing education resources to be made available to nurse educators across the state. The committee was one of the Board’s initiatives for 2013. To facilitate development of this set of resources, forming of the Missouri Nursing Education Resource Committee (MNERC) has been initiated. Several nurse educators have expressed interest in serving on this committee. The MNERC committee will convene to determine/apply best practices for nursing education and to provide expert examples/templates to guide educational as well as self-evaluation processes for nursing programs in Missouri. Utilization of sample resources will be voluntary and in no way mandated by the Board.

Resources will be made available to nurse educators as examples to assist with often tedious design of program documents and templates. Potential resources may include sample meeting minutes, sample faculty orientation plans, sample faculty mentoring records, generic library policies, a sample plan for acquisition and maintenance for skills lab equipment and supplies, and a sample plan for systematic program evaluation, just to name a few.

Nurse educators from all levels of nursing education across the state are encouraged to take part in this committee. Meetings will take place about every other month; some meetings will be conducted on a face-to-face basis, and some by conference call to facilitate committee processes.

Projecting beginning of the committee’s work is spring 2013; please express your interest to serve on this committee to Bibi Schulz at bibi.schultz@pr.mo.gov.

U.S. RNs Encouraged to Contribute to National Workforce Research

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Chicago – The National Council of State Boards of Nursing (NCSBN) and the Forum of State Nursing Workforce Centers will conduct a national survey of registered nurses (RNs) beginning in January 2013. All RNs in the U.S. active RN licenses are eligible candidates for survey participation. A random sample of this population will be chosen to participate.

Nurses who receive the survey are strongly encouraged to provide information such as basic demographic and professional data (e.g., age, year licensed, etc.) even if they are now employed in another profession or are retired. All responses will be kept confidential and data will only be reported as aggregate.

The results of this survey are especially valuable in light of several factors. One is that no national source of current, complete and consistent information for nursing workforce data exists and this survey has the potential to fill that void. Also, the implementation of the Patient Protection and Affordable Care Act will insure more than 30 million U.S. residents who will seek health care in the years ahead. Additionally, the aging U.S. population means there will be an increased demand for nursing services in coming years. It is possible that the predicted shortfall of qualified nurses to care for this population will occur and will have a major impact on health care delivery in the future.

An adequate supply of RNs in the workforce is one of the essential components of a safe and effective health care system. Information from RNs selected to respond to this survey has the unique chance to contribute to this invaluable study, the results of which can be used to predict possible shortages and assist in the allocation of resources, program development decisions, and recruitment efforts in both the health care system and education sectors.

About NCSBN

The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories – American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also 12 associate members. Mission: NCSBN provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. The statements and opinions expressed are those of NCSBN and not the individual member state or territorial boards of nursing.

About Forum of State Nursing Workforce Centers

The Forum of State Nursing Workforce Centers is a national group of nurse workforce entities that focus on addressing the nursing shortage within each state and contributes to the national effort to assure a adequate supply of qualified nurses to meet the health needs of the U.S. population. The Forum supports the advancement of new as well as existing nurse workforce initiatives and shares best practices in workforce research, workforce planning, workforce development, and formulation of workforce-related policies and regulations in three major ways: through publications, via annual conferences, and by way of a virtual network.
Every year, boards of nursing (BONs) across the U.S. contact thousands of their nurses to remind them to renew their nursing license. Some BONs send emails; others send postcards and letters. It is then the responsibility of the nurse to renew their license. Left out of this equation, however, are the employers who rely on nurses to have current licenses to practice. Previously, the only way for employers to know if a nurse’s license was about to expire was to look it up, one nurse at a time. And when it came to learning about discipline status, employers were left out of the loop again, having to seek this information on their own.

Not anymore.

Institutions that employ nurses can now receive automatic licensure and discipline notifications about their nurses quickly, easily and securely with NCSBN’s new Nursys® e-Notify system. e-Notify is an innovative nurse licensure notification system that automatically provides employers employers and publicly available discipline data as it is entered into Nursys by BONs. Employers will no longer have to proactively seek licensure or discipline information of nurses in their employ, that information will automatically be sent to them.

The e-Notify system alerts subscribers when changes are made to a nurse’s record, including changes to license status, license expirations, license renewal, and public disciplinary action/resolutions and alerts. This means that if a nurse’s license is about to expire, the system will send a notification to the employer about the expiration date. Employers can also immediately learn about new disciplinary actions issued by a BON for their employed nurse, including receiving access to available public discipline documents.

Benefits
The 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 (LPN/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.

Cost
All institutions are given 100 credits free of charge. This means that the first 100 nurses enrolled into the system are free. After that, each nurse 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 $50 per year.

A unique feature of e-Notify is the ability for institutions to turn a nurse’s notification setting on or off, choosing whether or not to receive notifications about a 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.

Customizable Features
It’s entirely up to the institution to determine how often they want to receive notifications about their 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.

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 that issued their license. This information is used to locate the nurse directly from the Nursys database. Once nurses are enrolled, institutions can access their nurse list and download the data at anytime.

Another unique feature of e-Notify is its search functionality. Rather than searching for a nurse by his or her name, e-Notify only allows institutions to search by license number. This way, if a nurse changes their name with the BON, that information will automatically be updated in e-Notify, decreasing the likelihood of multiple entries being entered into the system for the same person.

When enrolling a nurse in e-Notify, institutions also have the option of including the nurse’s email address and/or cell phone number. Institutions can send automatic e-mail reminders, as well as text messages, to nurses securely.

With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or no charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

To subscribe to Nursys e-Notify go to nursys.com.
Navigating the Nurse Licensure Compact: Initial Licensure by Examination for New Graduates

Determine your primary state of residence (PSOR): Answer the following questions,
1) In which state do you hold a driver’s license?
2) In which state are you registered to vote?
3) In which state do you file your federal income tax?

Multi-State License
Apply for initial licensure by examination in your primary state of residence (PSOR).

单 State License
You may apply for an initial license by examination in any one state of choice.

Is your primary state a member of the NLC?

YES

NO

Follow the eight steps of the NCLEX

1. Apply for licensure with ONE board of nursing (BON).
2. Register and pay $200 with Pearson VUE (see candidate bulletin).
3. Receive receipt of registration from Pearson VUE.
4. Receive eligibility from the BON.
5. Receive an authorization to test (ATT) via letter or email from Pearson VUE.
6. Schedule an exam with Pearson VUE via the internet or phone.
7. Arrive for exam, present ATT letter and ID (see candidate bulletin).
8. Receive results from the BON.

Navigating the Nurse Licensure Compact: Licensure by Endorsement

Declaring a New Primary State of Residence (PSOR) / Obtaining a License when Moving from One State to Another

Is your new primary state of residence part of the Nurse Licensure Compact?

YES

NO

Apply for a RN or LPN license in your new primary state of residence.

You may continue to practice for up to 30 days from the time you establish residency, on your privilege to practice from your former home state / PSOR.

You can only hold one multi-state RN or LPN license but may hold multiple non-compact state licenses.

Your former license will be inactivated upon receipt of new home state license.

Your new multi-state license grants a privilege to practice in all NLC states contingent upon remaining a resident of the issuing state.

Apply for licensure in that state.

You may not practice in a non-compact state until you have a temporary permit or permanent license.

You may hold multiple licenses from non compact states.

Each single-state license is valid for practice only in the state of issuance.
Innovations in Nursing Education: The State of the Art

Teri A. Murray, PhD, APHN-BC, RN, FAAN
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Dr. Murray was a member of the Missouri State Board of Nursing from 2001 to 2009. She served as Secretary, President and on several national committees during her term on the Board.

This article provides an overview of the innovative pedagogic practices in nursing education published between 2009 and 2012. Four distinct categories emerged from the literature review: calls to action for reform or educational redesign, the use of technology; partnerships; and innovative curricular, clinical, and classroom teaching strategies. The publications provide clear evidence of the high capacity for creativity and innovation in nursing education.

The continuing current and future demand for nurses translates into the need for education programs that can produce needed numbers of professional nurses, have prompted many educational institutions to develop programs that meet education needs in new ways. The purpose of this article is to review innovations that have occurred from 2009 to 2012.

Effect of Nursing Demand on Education

The demand for registered nurses (RNs) remains at an all-time high despite the worst economic era since the Great Depression. Throughout the next decade, the nursing community is expected to experience shortages (AACN, 2012) with an anticipated need for 250,000 to 1 million new or replacement nurses (U.S. Department of Labor, Bureau of Labor Statistics, 2012b). This demand can be attributed to advances in medical and health care technology; a greater emphasis on preventive care, which increases longevity; aging population that requires more health care services; and an aging and retiring RN workforce (U.S. Department of Labor, Bureau of Labor Statistics, 2012b). Despite this projected need, more than 75,000 qualified applicants into nursing programs because of institutional, clinical environment, human resource, and budgetary constraints. Limitations included:

- classroom space for large numbers of students
- clinical placements
- clinical practice
- clinical preceptors for student nurses
- fiscal resources to hire more nurse educators

Less than 4% of the nearly 3 million RNs seek the graduate education required to work as a nurse educator, indicating that the current resources are constrained which reduces the profession’s ability to produce more RNs, thereby reinforcing the existing shortage and intensifying future shortages (AACN, 2012).

Need for Innovation

The concerns about limited capacity in nursing education have spurred questions about the sustainability of the current educational model and served as a catalyst for calls, position statements, and consensus documents from nursing organizations, foundations, and government agencies for reform and innovation. Innovation is defined as a process for inventing something new or improving on existing practices or methods (Melnyk & Fineout-Overholt, 2009; Christensen, Bohmer, & Kenagy, 2000). Research is needed to determine the best practices in nursing education, so the risks of innovation are reduced while ensuring educational innovations are consistent with public protection, and ensure the proposed innovative approaches work culminated in the development of the Innovation in Education Regulation Committee, which had three primary purposes: foster innovative models of nursing education, ensure the educational environment with educational integrity, and to develop strategies to improve the quality of patient care. A database address a U.S. prelicensure program; and the innovation had to focus on classroom or clinical activity. A database was created to store data and search by the author the reader had 106 articles that met the inclusion criteria. The following major categories emerged from the literature:

- Calls to action for reform or educational redesign
- Use of technology
- Innovative curricular, clinical, and classroom teaching strategies

Calls to Action

Several articles reinforce, validate, and further substantiate earlier calls for reformation of prelicensure nursing education. The calls center on the need to reexamine nursing education through the lens of innovative possibilities and consider alternatives to the traditional model (Grady, 2011; MacIntyre & Garner, 2012; Murray, Teel, & Murray, 2010). Some suggest the need to implement cutting-edge strategies to expand educational capacity (Molloch & Porter-O’Grady, 2011), to develop institutional cultures that support innovation (Melniky & Davidson, 2010), and to reevaluate the current practices and develop new models of teaching and clinical care (Kreienkamp, Loyd, & Buck, 2010; Kreienkamp, Loyd, & Buck, 2009).

Use of Technology

The use of various technologies as innovative pedagogic approaches has become increasingly popular in nursing education. These technologies are believed to help educators to enhance student learning, to balance the challenges associated with the faculty shortage and limited classroom and clinical space.

Since 2009, simulation has been a primary method for prelicensure nursing. This approach has incorporated a variety of techniques, including the role of use play, standardized patients, interactive media, and low- and high-fidelity mannequins (Ironsiiide, Jeffries, & Martin, 2009), though the majority of the studies focused on technology and mannequins. Descriptions for using simulation included teaching specific content, such as patient safety, pediatric care, and advanced life support, as well as teaching competencies associated with interprofessional and collaborative practice using a variety of techniques (Bok, 2009; Ferguson & Day, 2005; Ironside et al., 2009; Kaplan, Holmes, Mott, & Atallah, 2011; Robertson et al., 2010).

Virtual reality simulations (VRS) is used to allow students to engage in real-life experiences in low-risk environments.” VRS is a computer-assisted program that enables images and objects to appear as real. The projective and immersive elements of VRS, and the use of stereo images provided a sense of presence thus creating the sense of being in the simulated environment” (Jensen & Forsyth, 2012, p. 313). This innovative approach had been used to offset the challenges associated with increased patient acuity, high-student-to-faculty instructional ratios, and limited class and clinical space (Jensen & Forsyth, 2012). Second Life multiuser virtual environment (MUVE) is described as an Internet-based simulated environment in which the participant is represented by an avatar that can move freely through the environment manipulating objects (Schmidt & Stewart, 2009). Participants in the study described Second Life as a MUVE that uses a three-dimensional modeling feature to replicate real world environments and learning scenarios and allow learners to travel to different countries as providing the student with experiential learning and construction of knowledge in a low-risk, safe simulated environment (Skiba, 2007). The MUVE allows multiple users to create their own virtual world and interact with one another in a virtual world (Schmidt & Stewart, 2009).

Another innovative use of technology-mediated instructional partnerships (Bok, 2011) and Virtual Clinical Partnerships (VCP). This technology enables students to interact in real time with patients and preceptors in a geographically distant clinical environment. The VCP is a telehealth clinical practicum whereby students observe all activity in the patient’s room virtually while receiving clinical instruction from the nurse preceptor at the bedside; the student’s instruction is reinforced by the course faculty at the college (Grady, 2011). The major drawback described is the VCP is not a substitute for person-to-person experience with the patient (Grady, 2011).

Other technology in the literature includes the use of podcasts and other online technologies for classroom and clinical activities (Cublak & Crandie, 2011; George, Davidson, Serapiglia, Barla, & Thotakura, 2010). The students use the mobile device to access and manage clinically relevant information. The PDA provides point-of-care access to information and just-in-time learning. This immediate access to information is believed to improve student’s ability to provide sound, effective, quality patient care.

Distance education (online or Web-delivered) course work was another technology that can be used for prelicensure education used to increase student access to higher education, particularly in rural areas, and to extend the length of the program. The use of distance education for graduate nursing education has been in place for more than a decade, its use in prelicensure education is relatively new. Other noteworthy innovations involving technology for classroom or clinical learning include the use of the social media networks, podcasting, and interactive audience participation systems such as clickers (Joiner, Volk, & Ramberg, 2010; Schlaefer, 2010; Sharoff, 2011).

Partnerships

Strategic partnerships are defined as relationships between two or more entities that involve the sharing of resources and activities for a common purpose (Bok, 2011; Gulati, 1995). Although several types of innovative partnerships were found in the literature, the majority were between an academic institution and a health care organization. The strategic intent of many partnerships focused on one or more of the following initiatives:

- Advance educational progression-achieving the next level of education, for example, from an associate degree to a bachelor’s degree.
- Expand faculty, student, or clinical site capacity
- Facilitate transition to practice
- Create community partnerships

Improve patient care for specific populations

Fetsch and DeBiasi (2011) and Murray, Chappe, Krein Kamp, Loyd, and Bock (2010) described a collaborative academic-service partnership that

Innovations in Nursing continued on page 8

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active learning strategies that foster student engagement. This new approach involves the use of strategies that incorporate technology and distance education. (Wong, & Vincent, 2010; Debourgh, 2012; McCann, 2010; & Egues, 2010) or to improve patient care and foster innovations (Bowman et al., 2011).

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Innovative Curricular, Classroom, and Clinical Strategies

Many of the innovative curricular and classroom strategies incorporate technology and distance education. Some of these strategies were developed as a result of a cultural shift from the traditional teacher-directed, content-focused curriculum to a student-centered, concept-based approach. This model emphasizes the role of the student as a self-directed learner and the comfort zone of having the faculty provide content that the student absorbs. This new approach involves the use of active learning strategies that foster student engagement (Schreier, Peery, & McLean, 2009).

Table 1 Features of a Dedicated Education Unit

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Innovations in Nursing continued on page 9

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The most commonly described innovation in clinical settings was the dedicated education unit, an innovative clinical teaching method designed to integrate the expertise of the staff nurse into the clinical learning of the student, facilitate the transition to practice, and improve the learning outcomes. (Katel, Bannister, & Mylott, 2009; Murray, Crain, Meyer, McDonough, & Schweiss, 2010). (See Table 1). This new approach involves the use of strategies that incorporate technology and distance education. (Wong, & Vincent, 2010; Debourgh, 2012; McCann, 2010; & Egues, 2010) or to improve patient care and foster innovations (Bowman et al., 2011).

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Innovations in Nursing continued from page 8


Volume 3/Issue 4


Woebber, K. (2012). Jumbled data cases provide context for teaching quality and safety principles to new accelerated BSN students. Journal of Nursing Education, 51(2), 120. doi:10.3912/OJIN.Vol-16No03PPT03

Tori Murray, PhD, APHN-BC, RN, FAAN, is dean and associate professor at Saint Louis University School of Nursing, St. Louis, Missouri.
A study analyzing closed professional liability claims against nurses over a 5-year period was completed by CNA HealthPro and Nurses Service Organization. Of the 516 closed claims, the average total incurred payment per claim was $204,594. The study identifies current liability patterns and trends and provides risk-control recommendations to enhance patient safety and minimize liability exposure. Study results indicate that nurses need to be held strictly accountable for acting within their scope of practice as well as within the policies and procedures of their place of employment. The data also show a need for all spoken and written communication to be documented fully in the patient’s health information record. The claims demonstrate that nurses are expected to serve as the patient’s advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient’s medical needs.

A good way for nurses to prevent exposure to legal liability is to understand-and-avoid-the-behaviors that have led to liability allegations in the past, and a recent comprehensive study of closed professional claims provides important information that can assist nurses as well as other healthcare providers, administrators, and regulators. Conducted by CNA HealthPro and Nurses Service Organization (NSO), Understanding Nurse Liability, 2006–2010: A Three-Part Analytical Report assesses closed professional liability claims against nurses over a 5-year period and identifies current liability patterns and trends, including the most common types of allegations filed (CNA HealthPro and Nurses Service Organization, 2011b). The study also provides risk-control recommendations to enhance patient safety and minimize liability exposure. Thus, the study can help nurses understand their vulnerabilities and take appropriate actions to help ensure patient safety and minimize liability exposures.

Scope of the Study

The report analyzes claims involving registered nurses (RNs), licensed practical nurses (LPNs), and licensed vocational nurses (LVNs) that were closed between January 1, 2006, and December 31, 2010, and resulted in an indemnity payment of $10,000 or more. The complete report on the study has three parts: 1) statistical charts and analyses on 20 topics relating to nurses’ professional liability claims, including risk-management recommendations to nurses involved in aesthetic services (CNA HealthPro and Nurses Service Organization, 2011a); 2) data on eight topics relating to license-defense claims; and 3) 19 highlights from the NSO 2011 nurse work profile surveys.

The database for the report was derived by applying specific exclusion criteria to the 3,222 closed claims attributed to CNA-insured nurses through the NSO program during this time period, narrowing the number of claims from 3,222 to 516.

The exclusion criteria were as follows:

- The closed claim was before January 1, 2006, or after December 31, 2010.
- The claim closed as an incident, never rose to the level of a legal action, and did not result in a payment by CNA.
- The claim closed with an indemnity payment of less than $10,000 on behalf of the insured nurse. (Closed claims with indemnity payments of less than $10,000 were excluded for many reasons, including the fact that they typically reflected less severe claims and were closed without extensive discovery actions, such as obtaining and assessing clinical records, expert opinions, and sworn depositions).
- The closed claim involved an advanced practice nurse (a nurse practitioner, clinical nurse specialist, certified nurse midwife, or certified registered nurse anesthetist).
- The closed claim involved a nursing assistant, nurse aide, or nursing student.
- The closed claim involved only legal representation for deposition assistance.

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Professional Liability Claims

Of the 516 claims, 26% were involved in RN claims, and 8.1% involved LPNs and LVNs. For purposes of the study, the term incurred payment represents the costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim. The average total incurred payment per claim was $204,594. The average for RNs was $221,489, and the average for LPNs and LVNs was $126,784. These data suggest that LPNs and LVNs tend to have fewer and less severe claims than RNs, possibly due to RNs’ higher level of responsibility and the greater probability of work in an acute-care setting.

The study found that an indemnity payment of $10,000 or more was made in 56.2% of the 516 claims, a payment of $100,000 or more was made in 24.8%, and a payment of $1,000,000 was made in 3.5%.

The specialties with the highest average indemnity payments were obstetrics, neurology/neurosurgery, and plastic/reconstructive surgery. A possible emerging trend involved aesthetic services, which are most often provided by nurses under the direction of a licensed independent practitioner in the practitioner’s office or clinic or in a spa. The scope of aesthetic services provided by nurses varies based on the state nurse practice act (NPA). The highest percentage of closed claims occurred in the medical/surgical, gynecology, and obstetrics specialties. (See Table 1).

Claims involving scope of practice had the highest average indemnity payment, perhaps because practicing outside the scope is perceived as egregious misconduct. Claims with an allegation relating to scope of practice are thus difficult to defend successfully. Allegations related to patient assessment and monitoring were relatively common and resulted in high average paid indemnity. Allegations related to treatment/care accounted for the highest percentage of closed claims.

Allegations related to patients’ rights, patient abuse, and professional conduct were reviewed as well. Patients have the right to receive care from a nurse who is properly trained, experienced, and competent to provide patient care. The costliest single claim in this category involved the death of a patient under the care of a nurse who was abusing illegal substances. The highest percentage of closed claims in this category involved violations of the patient’s right to receive care in a safe environment. Allegations related to abuse included patient-to-patient abuse and physical, sexual, and verbal abuse of the patient by the nurse. (See Table 1).

LPNs and LVNs Compared With RNs

To help better understand risk exposure, the study compared the 43 closed claims in which the defendant was an LPN or LVN with the 473 RN closed claims. The study revealed these claim characteristics:

- LPNs and LVNs were defendants in 81% of the claims. The distribution of CNA/NSO-insured to have more claims involving scope of practice.
- The average indemnity payment for LPNs and LVNs of $83,213 was about half the average of $168,418 for RNs.
- The specialty with the highest average paid indemnity for LPNs and LVNs was surgery; for RNs, it was neurology/neurosurgery.

Nurse License-Defense Paid Claims

An action taken against a nurse’s license differs from a professional liability claim in that the disciplinary action may or may not involve allegations related to patient care and treatment. Also, the amounts paid in response to license-defense claims differ from those paid in response to liability claims. Disciplinary actions represent the cost of providing legal representation to the nurse, rather than indemnity or settlement payments to a plaintiff.

During the study period, there were 1,127 license-defense paid claims in which legal counsel defended nurses against allegations that could have led to license revocation. License-defense paid claims involved both medical and nonmedical regulatory board complaints against nurses. Claim characteristics analyzed included licensure type, location, allegation, and licensing board outcome.
• Claims by Licensure Type: The percentage of license-defense paid claims by licensure type was 84.5% for RNs and 15.5% for LPNs and LVNs, which correlates with the proportion of RNs and LPNs/LVNs in the overall CNA/NSO-insured nurse population.

• Claims by Practice Location: RNs with a license-defense paid claim worked most often in a hospital setting (57.3%), followed by aging services facilities (19.6%) and home health services (16.6%).

• Claims by Allegation Type: The four allegation classes with the highest percentages of license-defense paid claims were the same for RNs and LPNs/LVNs, although the order of prevalence differed. For RNs, the most common allegation was related to professional conduct (23.9%), followed by improper treatment/care (21.1%), medication administration errors (19.7%), and abuse/patient’s rights (13.7%). For LPNs and LVNs, the most common allegation was related to medication administration errors (25.4%), followed by abuse/patient’s rights (22.4%), improper treatment/care (19.4%), and professional conduct (15.2%; see Table 2).

• Any complaint filed against a nursing license can result in career-altering consequences, such as suspension, probation, license surrender, or license revocation. With regard to board complaint outcomes for paid license-defense claims, half of the board’s final decisions resulted in no action, and 45.2% involved mentoring the nurse’s practice, requiring further education, or issuing a caution. Only 4.8% of the decisions involved license surrender or revocation, terminating the nurses’ careers. A detailed view of the allegations related to professional conduct shows that drug diversion or substance abuse was the top allegation for RNs and LPNs/LVNs. Drug diversion or substance abuse allegations included diversion of medication for self or others, failure to document proper disposal of narcotics, inaccurate medication counts not reported/detected, and apparent intoxication from alcohol or drugs while on duty. Nursing professionals must recognize the stress factors that may lead to unprofessional conduct and be proactive in seeking support to manage challenging situations or circumstances. Allegations related to patients’ rights and patient abuse represented 13.7% of the total allegations for RNs and 22.4% for LPNs and LVNs. Physical abuse allegations ranked highest for both RNs at 4.7% and LPNs/LVNs at 12.1%. The ability to manage difficult patient situations is a core nursing competency. Developing communication and relationship skills for a diverse patient population qualifies as an essential risk-control tool for nurses, minimizing exposure to allegations of abuse and violation of patients’ rights.

Table 3

<table>
<thead>
<tr>
<th>Credits</th>
<th>Nonclaims</th>
<th>Claims</th>
<th>Average Paid Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>28.0%</td>
<td>21.4%</td>
<td>$24,851</td>
</tr>
<tr>
<td>Less than 30</td>
<td>41.9%</td>
<td>40.2%</td>
<td>$17,491</td>
</tr>
<tr>
<td>30 to 60</td>
<td>30.1%</td>
<td>38.2%</td>
<td>$15,623</td>
</tr>
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</table>

Qualitative Nurse Work Profile Survey

Part III of the report presents selected highlights from the NSO’s 2011 Qualitative Nurse Work Profile Survey, which was conducted to compile data from nurses about issues that are not addressed by the analysis of closed claims (Nurses Service Organization, 2011). The purpose of the survey was to examine the relationship between professional liability exposure and a variety of demographic and workplace factors. The survey participants included RNs, LPNs, and LVNs who participated in the NSO insurance program between January 1, 2006, and December 31, 2010. The responding nurses were divided into two groups: those who had experienced a professional liability claim resulting in a loss and those who had never experienced a claim.

Here is a summary of the findings:

• The majority of respondents with claims (69.2%) had been in nursing practice for 16 years or more at the time of the incident that resulted in a claim. The longest respondents worked as nurses, the greater the number of claims. The highest percentage of closed claims involved nurses who had worked more than 21 years. Also, a correlation existed between the average paid indemnity and the number of years in the profession.

• The highest proportion of respondents with claims had bachelor’s degrees, followed by those with associate’s degrees, those from diploma programs, those with master’s degrees, and those with doctorate degrees. Indemnity payments were higher for claims from respondents who had completed a nursing diploma program than from respondents with a bachelor’s or associate’s degree.

• Respondents who did not have a mentor or preceptor during their first 2 years as a nurse had a lower average paid indemnity. Respondents with a mentor during their first 2 years as a nurse had a higher average paid indemnity than those who did. Most respondents with a mentor or preceptor indicated that the mentor or preceptor was a role model and a support system. Respondents who had a nurse manager or director as a mentor had the highest average indemnity payments. Respondents mentored by a nurse practitioner, clinical nurse specialist, or physician had the lowest average indemnity payments.

• Continuing education was associated with decreased average indemnity payments. As the number of required credits for such programs increased, the average paid indemnity decreased. (See Table 3).

• The existence of an organization/facility policy for disclosing mistakes resulted in a 50% decrease in the average paid indemnity. One-fourth of the respondents stated their facility did not have a policy for disclosing mistakes, and a third stated they did not know if such a policy existed.

• Although the use of electronic medical records is increasing, 64.6% of respondents who experienced claims used handwritten records at the time of the incident. Average paid indemnity decreased when electronic medical records were used exclusively.

• Interaction with management was associated with decreased average paid indemnity. Respondents who noted they felt comfortable turning to management for help had a lower average paid indemnity than those who did not. Those who said they were afraid to contact management concerning the incident had the highest average paid indemnity.

Identifying and Minimizing continued on page 12

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Kindred Hospital Kansas City
St. Luke’s Rehab Hospital
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Kindred Hospital St. Louis
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Risk-Control Recommendations

Develop, maintain, and practice professional working relationships and effective communication—which involves the exchange of accurate, written and spoken communication skills. The following additional strategies can help reduce the likelihood of scope-of-practice allegations:

- If a job description, contract, or set of policies and procedures appears to violate the legal scope of practice, bring the discrepancy to the organization’s attention.
- State clearly that you are unwilling to risk license revocation and legal action by failing to comply with the scope of practice or NPA.
- Know the organization’s policies and procedures related to clinical practices, documentation, and steps required if given an assignment beyond the legal scope of practice or personal nursing experience.

Maintain clinical competencies relevant to the patient population and health care specialty. Nurses have a duty to provide care in their legal scope of practice, and patients have a right to care that is a common contributing factor to delays and errors. Be sure to convey key information related to acute and chronic conditions, nursing interventions and any special needs. Ensure that critical information has been shared whenever the patient is transferred to another caregiver or environment.

Involving the chain of command when necessary to focus attention on the patient’s status or any change in condition. Nurses are the patient’s advocate, ensuring that the patient receives appropriate care when needed. Advocacy includes the duty of invoking the necessary interventions by the nursing and medical staffs of command to ensure timely attention to the needs of every patient and persisting in the adequacy of satisfactory nursing care. Nurses must be comfortable with utilizing the medical chain of command when a practitioner does not respond to calls for assistance, fails to appreciate the seriousness of a situation, or neglects to initiate appropriate intervention. The following strategies can help reduce apprehension regarding chain of command issues:

- Always consider which information to share, when to share it, how to share it (for example, in writing, in person, or via telephone), and with whom to share it.
- Ensure that communication among caregivers and between caregivers and the patient is professional, is respectful, and inclusive. As the caregiver with the most access to the patient, the nurse is often the one who ascertains the patient’s needs and wishes and conveys them to others. Include family members or significant others in discussions only if the patient or designated legal representative has given authorization.
- Determine the patient’s primary language, follow organizational procedures to obtain translation/interpreter services, and ensure that the patient receives information regarding condition and treatment in his or her primary language.
- Carefully communicate patient assessments and observations to other health care team members to develop and modify the plan of care as necessary.
- Utilize sound handoff methods. Failure to adequately communicate among shift-to-shift practitioners appears to violate the legal scope of practice or NPA.

The claims demonstrate that nurses are expected to serve as the patient’s advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient’s medical needs. Another lesson reinforced by the data is the need for all communication, spoken and written, to be documented in the patient’s health information record.

Risk-Control Recommendations

The closed claims data suggest that many errors are predictable and preventable. Therefore, ongoing attention to regulatory requirements and development and enhancement of core competencies can increase patient safety while minimizing nurses’ liability exposure. Compliance with critical processes, such as performing careful documentation and understanding and invoking the chain of command, is essential in every nursing setting. Regulatory requirements and organizational scope of practice or policies differ, comply with the most stringent of the applicable regulations or policies. The following additional strategies can help reduce the likelihood of:

- Address communication issues between nursing and medical staffs and identify instances of intimidation, bullying, retaliation, or other detriments to the patient and provider.
- Notify leadership of individuals or areas that prevent nursing staff members from invoking the chain of command or that punish them for doing so.
- If the organization’s current culture does not support invoking the chain of command, explain the risks posed to patients, staff, practitioners, and the organization, and invite discussions regarding the need for a cultural shift with administration, risk management, and/or legal counsel.

Conclusion

This analysis of professional liability claims reveals that nurses continue to be held strictly accountable for acting within their scope of practice as well as within the policies and procedures of their place of employment. Many claims develop from a failure involving core competencies, such as patient assessment, monitoring, treatment and care, practitioner and patient communication, timely and complete documentation, and invocation of the chain of command.

The claims demonstrate that nurses are expected to serve as the patient’s advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient’s medical needs. Another lesson reinforced by the data is the need for all communication, spoken and written, to be documented in the patient’s health information record.

We anticipate that the data, analysis, risk-control recommendations, and self-assessment checklist contained in the full report will inspire nurses nationwide to examine their practices carefully and focus their risk-control efforts on the areas of statistically demonstrated error and loss.

The information, examples, and suggestions contained herein have been developed from our ongoing experience of seeing and listening to practitioners, and from our qualitative data analysis. We believe our findings to be reliable, but they should not be construed as legal or other professional advice. For the full report and complete 2011 nurse survey, visit www.cna.com and www. nso.com/nurseclaimsreport2011.

References


Joyce H. Benton, MSA, RN, ARM, DFASHRM, CPHRM, LHRM, is the Risk Control Director at CNA HealthPro. Ms. Benton is an author and frequent speaker on health care risk management at the local, state, and national level. Jennifer Flynn, BA, is a Program Manager in the health care risk management division at Aon Affinity Insurance Services.
Table 1

Expectations of the Code of Ethics

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<td>5.1 Moral self-respect</td>
<td>Moral respect accords moral worth and dignity to all human beings irrespective of their personal attributes or life situation. Such respect extends to oneself as well; the same duties that we owe to others we owe to ourselves. Self-regarding duties refer to a realm of duties that primarily concern oneself and include professional growth and maintenance of competence, preservation of wholeness of character, and personal integrity (American Nurses Association, 2011).</td>
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Table 2

California Nursing Practice Act: Alcohol Use and Convictions

- On the subject of drug-related – including alcohol-related – transgressions, the California Nursing Practice Act states:
  - (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, any furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
  - (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022.

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Professionalism continued from page 13

(Sulla v. Board of Registered Nursing, 2010, p. 5; see Table 2). The second provision defines unprofessional conduct as including ‘‘any offense involving the consumption . . . or self-administration of alcohol’’ (Sulla v. Board of Registered Nursing, 2010, p. 4; see Table 2). The ALJ in this case, the ALJ ordered the revocation of the nurse’s license as a result of the DUI conviction (although the judge stayed the revocation subject to 3 years’ probation). Under the authority of these two provisions, the ALJ found, as in this case, that the nurse’s conduct did not violate the statute (Sulla v. Board of Registered Nursing, 2010, p. 5).

Two Appeals

The nurse appealed the ALJ’s finding and the BON’s decision to the Superior Court, which overturned the BON’s decision, finding that the nurse’s conduct had a substantial relationship between the conviction and the professional qualification before the BON may impose professional discipline. The board argued that the ALJ’s decision was in error because it violated the pre-eminence of the California Nursing Practice Act (Sulla v. Board of Registered Nursing, 2012, pp. 1203–1204, citing Watson v. Superior Court, 2009). However, the Superior Court did not find a legal connection exists if the conduct of the licensee demonstrates a lack of medical knowledge of the effects of alcohol and legal prohibitions against drinking and driving (Sulla v. Board of Registered Nursing, 2012, p. 1203, citing Griffiths v. Superior Court, 2002). In other words, an implicit nexus exists between alcohol-related misconduct and professional fitness, even if the transgression does not occur during the actual practice of medicine.

Finally, the court referred to a case upholding the discipline of a physician with several DUI arrests, but no convictions. In this case, the court required a nexus between the type of misconduct underlying the discipline and the ability of the physician to practice medicine (Sulla v. Board of Registered Nursing, 2012, pp. 1203–1204, citing Watson v. Superior Court, 2009). However, a logical connection exists if the conduct of the licensee endangers himself, another person, or the public generally (Sulla v. Board of Registered Nursing, 2012). Three DUI arrests, even without a conviction, represented sufficiently dangerous misconduct logically connected to an inability to professionally practice medicine (Sulla v. Board of Registered Nursing, 2012).

Drawing from these cases, the Court of Appeals maintained that a nexus or logical relationship existed between the professional fitness of a registered nurse and the alcohol-related misconduct because the nursing practice act specified the nexus by including in the definition of unprofessional conduct a conviction related to alcohol misuse. Therefore, the statute did not violate due process by conclusively determining that misconduct with a conviction and the ability of the physician to practice medicine (Sulla v. Board of Registered Nursing, 2012, p. 1206).

Also, the Court of Appeals quickly disposed of the nurse’s claim that the statute governing the regulation of nurses violated equal protection. The nurse argued that imposing discipline on nurses for a single alcohol-related conduct conviction after a single alcohol-related conviction, while the Medical Board requires two alcohol-related convictions prior to disciplining a physician. The Court of Appeals overturned the Superior Court and reinstated the original ruling of the ALJ imposing discipline on the nurse’s license (Sulla v. Board of Registered Nursing, 2012).

Rationale of the Appellate Court

The appellate court maintained that the nursing practice act did not explicitly require the BON to establish a nexus between the conduct described and the licensee’s professional fitness (Sulla v. Board of Registered Nursing, 2012, p. 1201). In addition to the explicit language of the pertinent statute (Table 2), the court extrapolated case law from three analogous instances of physician discipline by medical boards because the court had not previously considered similar actions by the BON.

First, the court cited a case clearly noting that a medical board may discipline physicians for personal drug use without showing that the drug use impinged on the physician’s professional conduct. The BON then appealed the decision, and in response, the nurse made two general arguments. First, the nurse asserted that due process requires a finding of a nexus, or logical relationship, between misconduct and the professional qualification before the BON may impose professional discipline. Second, the nurse argued that the BON violated the due process right of the individual after a single alcohol-related conviction, while the Medical Board requires two alcohol-related convictions prior to disciplining a physician. The Court of Appeals overturned the Superior Court and reinstated the original ruling of the ALJ imposing discipline on the nurse’s license (Sulla v. Board of Registered Nursing, 2012).

Table 2

<table>
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<tr>
<th>Professional Qualification</th>
<th>Definition</th>
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Arkansas provides specific acts in its legislative definition of unprofessional conduct:

- Failing to assess and evaluate a patient’s status
- Unduly approving or recommending medications
- Providing inaccurate or misleading information regarding employment history to an employer
- Cure by using a drug screen
- Failure to repay loans to the nursing student loan fund (Arkansas Administrative Procedures Act, 2008).

In addition, Arkansas law gives the BON great discretion by further defining unprofessional conduct as including “conduct of a character likely to defraud, deprive, injure, or impair the public by an act, practice, or omission that fails to conform to the accepted standards of the nursing profession” (Arkansas Administrative Procedures Act, 2008).

Conclusion

Nurses must never lose sight of the fact that they are licensed professionals, and the nursing license brings broad responsibilities (Tecltham, 2013). There is a duty to be informed about the laws that govern and the nursing profession (Russell, 2012). Nurses also have the responsibility of ensuring that the people they serve in the nursing profession, one is considered a professional at all times. As the court in this case noted, “driving under the influence reflects a lack of professional conduct that meets the accepted standards of the nursing profession, and demonstrates both a disregard of the medical knowledge of the effects of alcohol and the legal prohibitions against drinking and driving” (Sulla v. Board of Registered Nursing, 2012, p. 1203 citing Griffiths v. Superior Court, 2002).

Quite simply, nurses do not leave their nursing license and professionalism at the workplace door.

References


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Pursuant to Section 335.066.2, RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of a certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

**CENSURE

Brown, Mary S.
Eldersville, MO
Registered Nurse 131188

Licensee practiced as a nurse on a lapsed license from April 30, 2009, through August 21, 2012.
Censure 01/23/2013 to 01/24/2013

CENSURE Continued...

Smith, Anthony W.
La Monte, MO
Registered Nurse 2001003241

The Board did not receive proof of employer evaluation or statement of unemployment by the documentation due date of October 20, 2012. The Board did not receive proof of any completed hours for any of the continuing education classes required by the October 15, 2012 due date.
Censure 01/09/2013 to 01/10/2013

Jackson, Patricia Ann
Sikeston, MO
Licensed Practical Nurse 2007024454

Licensee was an in-home nurse. Licensee worked for the patient on December 5, 2011. On December 5, 2011, Licensee plugged her personal phone into the patient's home computer to charge the phone's battery. Licensee's phone automatically downloaded Licensee's pictures to the patient's home computer. On December 6, 2011, the patient's mother discovered the photographs on her computer. The patient's mother saw a photograph of her daughter (the patient) that Licensee had taken. The computer also had a video that Licensee had recorded of the patient cleaning the feeding tube button of the patient. Neither the patient nor her mother signed any release or consent to allow Licensee to take the pictures or video.
Censure 01/03/2013 to 01/04/2013

Martinez, Maggie Mae
Sedalia, MO
Licensed Practical Nurse 2005011435

Respondent failed to timely complete required continuing education classes.
Censure 12/27/2012 to 12/28/2012

Rosenkoetter, Marcia G.
Springfield, MO
Registered Nurse 056569

Licensee worked from May 1, 2011 through September 20, 2012, on a lapsed license.
Censure 12/27/2012 to 12/28/2012

Bagato, Judy A.
Greenville, IL
Registered Nurse 082092

Licensee worked in a treatment center. During the time she worked at the Center, Licensee regularly signed orders for prescription narcotics in the handwriting style of the physician. The narcotics included Oxycodone, Fentanyl, Endocet and Percocet. When the physician prescribed medication, Licensee would not write the physician's name, but would imitate the handwriting of the physician and sign his name. Licensee did this for two different physicians at the Center. Licensee also signed the physicians' names on the 540 B forms, a form mandated by the United States Department of Health Human Services to track changes in participation and medication related to the center's participation in the 340B Drug Pricing Program. The physicians had knowledge of this practice.
Censure 12/25/2012 to 12/26/2012

Person, Juanita A.
Saint Louis, MO
Registered Nurse 2012026954

Respondent failed to call in to NTS on eight (8) different days. The Board did not receive a thorough chemical dependency ongoing treatment evaluation submitted on Respondent's behalf by the documentation due date.
Censure 01/09/2013 to 01/10/2013

Herman, Sarah Elizabeth
Excelsior Springs, MO
Licensed Practical Nurse 201210824

Respondent failed to timely submit employer evaluations, proof of completion of required continuing education courses, and a signed summary of her meeting with the discipline administrator.
Censure 12/27/2012 to 12/28/2012

Bot-Baron, Marcy A.
Springfield, MO
Registered Nurse 135489

Licensee is a registered nurse. Licensee lost her nursing license due to a test result from the continuing education class which the Board was unable to locate.
Censure 01/24/2013 to 01/25/2013

Censure continued on page 16
Censure continued from page 15

King, John Frederick
Olive, Missouri
Registered Nurse 2009004411
Licensee was subject to discipline for failure to follow a policy regarding her inappropriate behavior at a “skills fair” at Golden.

Registered Nurse 2007000466
Respondent failed to submit to a drug and alcohol screen on a date when required to do so with a Board-approved third-party administration, and for testing positive for alcohol on another date.

Clark, Karen Sue
Columbia, Missouri
Registered Nurse 2007000466
Respondent was counseled on using profanity on the job only a few days after being counseled not to have a diagnosis or documentation to support such a diagnosis of his poor ability in starting I. V.s and that he was not in the computer, but “timed” the order as 1025 in the action taking place on the order. Licensee then put the telephone down, got back to the computer, and put it into the computer, which is a prerequisite to any documentation generally and why it was important and critical to document accurately.

Short, Jill Ann
Deepwater, Missouri
Licensed Practical Nurse 20030322401
Licensee received a call from a patient who also worked there. On December 10, 2007, Licensee attempted to assist staff in pushing a patient who was close to the patient’s face and started to speak aggressively to the patient. However, staff was able to calm the patient down and the patient was not in the computer, but “timed” the order as 1025 in the action taking place on the order. Licensee then put the telephone down, got back to the computer, and put it into the computer, which is a prerequisite to any documentation generally and why it was important and critical to document accurately.

Garrett, Sharon Renee
Doniphan, Missouri
Registered Nurse 20070022404
Licensee was subject to discipline for failure to follow a physician’s orders on two different occasions.

Love, Venita Nadine
Saint Joseph, Missouri
Licensed Practical Nurse 2005007978
On December 10, 2007, Licensee attempted to assist staff in pushing a patient who was close to the patient’s face and started to speak aggressively to the patient. However, staff was able to calm the patient down and the patient was not in the computer, but “timed” the order as 1025 in the action taking place on the order. Licensee then put the telephone down, got back to the computer, and put it into the computer, which is a prerequisite to any documentation generally and why it was important and critical to document accurately.

Censure ended on page 16

Claraebout, Tammy K.
Independence, Missouri
Licensed Practical Nurse 056770
Respondent pled guilty to the class D felony of attempted theft/stealing (value of property or services is $500.00 or more but less than $25,000.00). In her renewal application, Licensee admitted to smoking methamphetamine and marijuana in the past.

Probation 12/18/2012 to 12/18/2017

Cooper, Yvonna Faye
Farmington, Missouri
Licensed Practical Nurse 20000172305
On June 2, 2011, Respondent’s drug screen was positive for benzodiazepine metabolites, and admitted that he had diverted Fentanyl he obtained at the hospital over the previous few months at various times.

Probation 01/23/2013 to 02/19/2016

McWilliams, Melinda L.
Olathe, KS
Registered Nurse 2007018854
On February 18, 2011, a patient complained that Licensee had taken one of her Ativan. A Pyxis review revealed that Licensee had removed three Ativan doses for the patient. Licensee only documented the administration of two Ativan doses to the patient and failed to document the administration or waste of the third Ativan dose.

Probation 01/09/2013 to 01/09/2018

McWilliams, Melinda L.
Independence, Missouri
Registered Nurse 20000172305
On June 2, 2011, Respondent’s drug screen was positive for benzodiazepine metabolites, and admitted that he had diverted Fentanyl he obtained at the hospital over the previous few months at various times.

Probation 01/23/2013 to 02/19/2016

May, June, July 2013

PROBATION

ward, Clyde Edward, II
Hannibal, Missouri
Registered Nurse 2010036566
On December 9, 2011, Licensee entered into a Consent Order with Stipulations with the State of Illinois Board of Nursing, stipulating that his nursing license was subject to discipline as a result of diverting Demerol from his employer for personal consumption.

Probation 01/24/2013 to 02/14/2017

Brandon, Elizabeth Ann
Harrisburg, MO
Registered Nurse 081065
Licensee submitted to random urine drug screening test given by her employer. The test was positive for marijuana.

Probation 12/24/2012 to 12/14/2017

Henry, Jerry N.
Saint Louis, Missouri
Registered Nurse 095804
Licensee failed to contact NTS on two occasions, failed to inform his employer about his probation, failed to turn in two employer evaluations or statements of unemployment by the due date, and failed to complete continuing education classes by the due date.

Probation 01/15/2013 to 09/03/2015

Coon, Rosemary Marie
Trenton, Missouri
Registered Nurse 2013005547
On December 5, 1996, Applicant pled guilty to excessive alcohol content. On September 6, 2001, Applicant pled guilty to the class D felony of passing a bad check. On September 6, 2001, Applicant pled guilty to the class D felony of passing a bad check in the Circuit Court of Grundy County, Missouri. On March 13, 2002, Applicant pled guilty to the class D felony of passing a bad check. On July 29, 2004, Applicant pled guilty to driving while intoxicated. She was referred to drug court, post plea, on September 16, 2004 and successfully completed the program. On September 11, 2003, Applicant pled guilty to the class D felony of driving while intoxicated.

Probation 02/09/2013 to 02/19/2016

Brunnert, Patrick Norman
Belton, Missouri
Registered Nurse 2005021020
On March 12, 2010, Licensee was observed by a security camera entering a restroom and later leaving the same restroom with his arm in a position as if “he had just given blood.” A surly syringe labeled “Fentanyl” - an alcohol wipe, a bloody cotton ball and a used syringe labeled “Fentanyl,” an alcohol wipe, a bloody cotton ball and a used syringe had been found in the restroom. Licensee admitted to withdrawing Fentanyl and injecting it into himself. Licensee admitted to adverse effects of and dependence on Fentanyl.

Probation 02/13/2013 to 02/13/2018

PROBATION
the medications at the scheduled times, but documented the patient to try to sleep without the medication. On October 22, 2010, Licensee again recorded that a card of 15 Vicodin was completed, but failed to fill out a CSL or document the administration or waste of the Fentanyl. The facility recorded a drug screen of Licensee. The drug screen was positive for Fentanyl and Marijuana. A review of the medical records revealed that Licensee had removed approximately forty vials of Fentanyl from a Pyxis at the Hospital from December 31, 2010 through January 30, 2012, for which there was no documentation of administration or waste. A review of medical records revealed that Licensee had removed 142 Fentanyl vials from a Pyxis from October 1, 2011 through January 30, 2012, for which there was no documentation of administration or waste. Probation 12/25/2012 to 12/25/2017.

Probation continued on page 18

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Probation continued from page 16

Kesler, Mary Beth
Peculiar, MO
Licensed Nurse 2009017898
On July 2, 2010, Licensee submitted to a urine drug screen. The drug screen revealed positive for cocaine and hydromorphone. Probation 01/02/2013 to 01/02/2016.

Hawkins, Richard H.
Saint Louis, MO
Licensed Practical Nurse 2001558900
According to his official time card, Licensee did not work on July 17, 24, and 27, 2011. However, Licensee signed resident P15 Treatment Administration Records (TARs) for 27, 24, and 27, 2011, stating that he had performed the prescribed treatments including wound care for resident P15. Probation 01/01/2013 to 03/01/2015.

Rose, Karen Renee
Saint Peters, MO
Licensed Practical Nurse 2000167161
On July 22, 2010, the Director of Nursing made copies of a resident’s narcotic sheet. The resident’s narcotic sheet showed how much of each narcotic she was admitted. Licensee’s drug screen came back postive for amphetamine, methamphetamine, methadone, opiates and cannabinoids.

COUNT II
On August 21, 2010, Licensee was found “blue, drooling and lifeless” outside the main entrance. The Director of Nursing called 911 and paramedics took Licensee to the hospital where she was admitted. Licensee’s drug screen was positive for Fentanyl and Methamphetamine. A review of the medical records revealed that Licensee had removed 142 Fentanyl vials from a Pyxis from October 1, 2011 through January 30, 2012, for which there was no documentation of administration or waste. A review of medical records revealed that Licensee had removed 142 Fentanyl vials from a Pyxis from October 1, 2011 through January 30, 2012, for which there was no documentation of administration or waste. Probation 12/25/2012 to 12/25/2017.

Probation continued on page 18

Nolan, Jennifer A.
Florissant, MO
Registered Nurse 128691
On January 30, 2012 Licensee removed 12 vials of Fentanyl for a patient who was not assigned to her. Licensee did not document the administration or waste of the Fentanyl. The facility requested a drug screen of Licensee. The drug screen was positive for Fentanyl and Marijuana. A review of the medical records revealed that Licensee had removed 12 vials of Fentanyl from a Pyxis at the Hospital from December 31, 2011 through January 30, 2012, for which there was no documentation of administration or waste. Probation 12/25/2012 to 12/25/2017.

Probation continued on page 18

May, June, July 2013

Missouri State Board of Nursing • Page 17

Probation continued from page 16

Kesler, Mary Beth
Peculiar, MO
Registered Nurse 2009017898
On July 2, 2010, Licensee submitted to a urine drug screen. The drug screen revealed positive for cocaine and hydromorphone. Probation 01/02/2013 to 01/02/2016.

Hawkins, Richard H.
Saint Louis, MO
Licensed Practical Nurse 2001558900
According to his official time card, Licensee did not work on July 17, 24, and 27, 2011. However, Licensee signed resident P15 Treatment Administration Records (TARs) for 27, 24, and 27, 2011, stating that he had performed the prescribed treatments including wound care for resident P15. Probation 01/01/2013 to 03/01/2015.

Rose, Karen Renee
Saint Peters, MO
Licensed Practical Nurse 2000167161
On July 22, 2010, the Director of Nursing made copies of a resident’s narcotic sheet. The resident’s narcotic sheet showed how much of each narcotic she was admitted. Licensee’s drug screen came back positive for amphetamine, methamphetamine, methadone, opiates and cannabinoids.

COUNT II
On August 21, 2010, Licensee was found “blue, drooling and lifeless” outside the main entrance. The Director of Nursing called 911 and paramedics took Licensee to the hospital where she was admitted. Licensee’s drug screen came back positive for amphetamine, methamphetamine, methadone, opiates and cannabinoids.

COUNT III
On November 10, 2010, a card of 15 Vicodin was found missing. Licensee had recorded that the card was completed, but had failed to fill out a Controlled Substance Log (CSL) or document the administration of medication in the Medication Administration Record (MAR). On November 15, 2010, Licensee again recorded that a card of 15 Vicodin was completed, but failed to fill out a CSL or document the administration in a MAR. When confronted about the discrepancies in the administration and documentation of Vicodin, Licensee admitted that she had taken the Vicodin and that she had a substance abuse problem. Probation 12/18/2012 to 12/18/2017.

Hamilton, James Lee
Kirksville, MO
Licensed Nurse 2006026920
On May 7, 2011, Licensee took a red permanent marker and drew on a resident’s forehead. Licensee removed the red ink with an alcohol pad; however, residue remained during the next day.

Probation 02/07/2013 to 02/07/2014

Warren, Shannon
Carthage, MO
Registered Nurse 1389963
Effective on October 10, 2011, Licensee agreed to a voluntary surrender of her Tennessee RN license to the Tennessee Board of Nursing. The Agreed Order found that licensees had diverted narcotics from her workplace, was impaired at her workplace, and tested positive for Fentanyl.

Probation 01/18/2013 to 01/18/2018

Heberlie-Whitster, Jeannie M.
Perryville, MO
Registered Nurse 105559
On October 30, 2007, Licensee was counseled on the issue of behavior contributing to a non-therapeutic and tense work environment and inability to focus on and perform tasks. On December 11, 2008, Licensee received a counseling with the issues identified as documentation. On June 29, 2011, Licensee was placed on a performance improvement plan. The issues identified were behavior contributing to a non-therapeutic, disruptive, and potentially unsafe work environment and overall quality of work. Licensee wrote a letter to the Tennessee Board of Nursing indicating she had a substance abuse problem.

Probation 02/01/2012 to 02/01/2015

Davie, Jeffrey Scott
East Prairie, MO
Registered Nurse 2011001321
Respondent failed to call the Board’s third-party administrator on several dates when required to do so. He also tested positive for alcohol on another date. He also did not provide a sample on another date when so prompted to do so. He also did not timely file an employer evaluation as required by the terms of his probation.

Probation 12/27/2012 to 01/28/2015

McDonald, Kerry W.
Saint Charles, MO
Licensed Practical Nurse 058747
On April 19, 2011, Licensee pleaded guilty to the Class A misdemeanor of assault of a law enforcement officer.

Probation 01/01/2013 to 01/01/2014

Martin, Jason Wayne
Ozark, MO
Registered Nurse 2002002333
Respondent’s license is subject to discipline for testing positive for a controlled substance in a four-cause drug screen given by his employer. He is also subject to discipline for being disciplined by the state of New York for conduct that, had it occurred in Missouri, would have been subject to discipline.

Probation 12/27/2012 to 12/27/2017
Licensee documented that resident had a 2 cm split above his upper lip. Her chart documentation showed the following

A chart audit was conducted on Licensee’s charts at the Hospital. The audit revealed charting errors including discrepancies between medications withdrawn from the Pyxis and the medication documented as administered to patients. Licensee admitted to improperly dispensing narcotics.

Respondent’s license is subject to discipline for diversion of medications and medication administration. Probation continued on page 19.

Licensee did not document the administration or waste of the Oxycodone. On March 2, 2012 at 1945, Licensee removed two tablets of Valium. Licensee did not document the administration or waste of the Valium. On February 23, 2012, Licensee withdrew two tablets of Valium but was not at the patient’s home. Probation continued on page 19.

Licensee also failed to inform the physician that resident was on Nebivolol are to hold administration when the patient’s blood pressure is less than 110. On May 23, 2012, Licensee signed a consent for colonscopy form indicating that the patient’s son, who had power of attorney for the patient, had given consent for the procedure when Licensee had not spoken to the son about the procedure.

From January 26, 2012 through February 15, 2012 patient AR was in the hospital. Licensee turned in time sheets but was not at the patient’s home.

Licensee did not document the administration or waste of the Morphine. On January 1, 2012, Licensee removed a marked bottle of Morphine No. 2 from the pharmacy, which contained 40mg of Morphine. Licensee did not document the administration or waste of the Morphine. On February 23, 2012, at 2224, Licensee removed Morphine 4mg. Licensee documented the administration of this 4mg of Morphine at 2201, which is an impossibility. On February 23, 2012, at 2224, Licensee removed Sng of Valium. Licensee did not document the administration or waste of the Valium. On February 22, 2012, Licensee removed two tablets of Valium from the pharmacy and the administration of one tablet of Norco. Licensee did not document the administration of the Norco. Probation continued on page 19.

Licensee did not document the administration or waste of the Demerol. Probation continued on page 19.

Licensee did not document the administration or waste of the Tetrahydrocannabinol (”THC,” or Marijuana). On July 13, 2010, Licensee submitted to a pre-employment drug screen. The drug screen was positive for Marijuana. Licensee admitted that she smoked Marijuana with her daughter, who was fourteen years old at the time.

Licensee did not document the administration or waste of the Oxycodone. On March 2, 2012 at 1945, Licensee removed two tablets of Valium. Licensee did not document the administration or waste of the Valium. On February 23, 2012, Licensee withdrew two tablets of Valium but was not at the patient’s home.

Licensee did not document the administration or waste of the Morphine. On January 1, 2012, Licensee removed a marked bottle of Morphine No. 2 from the pharmacy, which contained 40mg of Morphine. Licensee did not document the administration or waste of the Morphine. On February 23, 2012, at 2224, Licensee removed Morphine 4mg. Licensee documented the administration of this 4mg of Morphine at 2201, which is an impossibility. On February 23, 2012, at 2224, Licensee removed Sng of Valium. Licensee did not document the administration or waste of the Valium. On February 22, 2012, Licensee removed two tablets of Valium from the pharmacy and the administration of one tablet of Norco. Licensee did not document the administration of the Norco. Probation continued on page 19.

Licensee did not document the administration or waste of the Demerol. Probation continued on page 19.

Licensee did not document either the administration or waste of the Marijuana she smoked. Licensee merely charted “right AKA” (right above the knee amputation), and did not document anything about Y’s dressing. Licensee was asked by the physician to change Y’s dressing more than once because patient Y was having multiple stools, which could contaminate patient X. Patient Y’s chart and the shift that included the pharmacy assistant did not list any dressings for patient Y’s beak and knee in whole or part. Licensee also did not record patient Y’s multiple stools or a description of the wound or dressing on the right stump at the end of the licensee’s shift, the next shift, or even after the patient had a new dressing on the right stump and Y’s bed was wet.

Licensee did not document either the administration or waste of the Marijuana she smoked. Licensee merely charted “right AKA” (right above the knee amputation), and did not document anything about Y’s dressing. Licensee was asked by the physician to change Y’s dressing more than once because patient Y was having multiple stools, which could contaminate patient X. Patient Y’s chart and the shift that included the pharmacy assistant did not list any dressings for patient Y’s beak and knee in whole or part. Licensee also did not record patient Y’s multiple stools or a description of the wound or dressing on the right stump at the end of the licensee’s shift, the next shift, or even after the patient had a new dressing on the right stump and Y’s bed was wet.

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Licensee admitted that she smoked Marijuana with her daughter, who was fourteen years old at the time.

Stewart, Tessa Layne
Kansas City, MO
Registered Nurse 20130404777
In January, 2012, Applicant consumed alcohol and then overdosed on Xanax and Hydrocodone that she found in a friend's closes. Probation 02/14/2013 to 02/14/2018

Timmerman, Scott
Villa Ridge, MO
Registered Nurse 110143
Patient had an order for Pantoprazole one daily for GERD. Pantoprazole medications were in a “bubble pack.” Licensee documented that he administered the medication to patient on January 27 and 28, 2012. The bubble pack did not change in appearance from one day to the next. Patient had a sliding scale insulin (SSI) order for HS at 2200. Patient had a sliding scale insulin order for with meals at 0700, 1130, and 1630. Licensee used the wrong SSI medication for the 2200 distribution on January 10, 2012 through January 12, 2012, January 14, 2012 through January 20, 2012; and, January 23, 2012 through January 26, 2012. Licensee received an order to change the time that Plavix was administered for a patient. The time was to be changed from evening administration to morning administration. Licensee discontinued the evening dose but did not transcribe the new time of administration to the morning.

Dalton, Tammy Denise
Caryville, MO
Registered Nurse 20030125801
On May 11, 2012, Licensee was tasked with destroying medications. Licensee asked a charge nurse to assist in destroying the medications. The charge nurse was called away, and Licensee was witnessed pouring a sticky red liquid into an ashtray and placing it in her purse. Probation 01/24/2013 to 02/24/2018

Alt, Heather Renee
Saint Genevieve, MO
Registered Nurse 20120673765
On February 27, 2008, the father of a patient that Respondent was caring for requested a different nurse, as Respondent did not give report. On February 27, 2008, the father of a patient that Respondent was caring for requested a different nurse, as Respondent did not give report because she did not seem to know anything about her assigned patients and she was “walking in circles” while trying to give report. On February 27, 2008, the father of a patient that Respondent was caring for requested a different nurse, as Respondent appeared “drunk or on drugs” and had tripped over his wife. It was also stated that Respondent had fallen asleep several times while charting and repeatedly gave the same directions for discharge. Respondent was later assigned to care for a patient who had ankle surgery on that date. Respondent did not fully communicate the patient's status to the surgeon and left the nurse’s desk without any of the patient's charts. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine.

Collins, Gloria
Versailles, MO
Licensed Practical Nurse 2000163736
On September 21, 2010, Licensee removed narcotics at the time her shift was ending on four patients, causing suspicion and investigation. On September 22, 2010, Licensee dispensed narcotics to patients not assigned to her and without the knowledge of the nurses assigned to the patients. Licensee documented pain level in the flow sheet for the patients she dispensed as needed (PRN) narcotics to Licensee did not document the administration of the narcotics on the medication administration record for patients. Licensee removed narcotics for patients from the medDISPENSE without a witness. Probation 12/04/2010 to 12/04/2015

Driver, Gennifer Nicole
Cape Girardeau, MO
Licensed Practical Nurse 2000373247

Coy, Laura Michelle
Cameron, MO
Licensed Practical Nurse 2006030429
On September 21, 2010, Licensee removed narcotics at the time her shift was ending on four patients, causing suspicion and investigation. On September 22, 2010, Licensee dispensed narcotics to patients not assigned to her and without the knowledge of the nurses assigned to the patients. Licensee documented pain level in the flow sheet for the patients she dispensed as needed (PRN) narcotics to Licensee did not document the administration of the narcotics on the medication administration record for patients. Licensee removed narcotics for patients from the medDISPENSE without a witness. Probation 12/04/2010 to 12/04/2015

Johnston, Chelsea Marie
Springfield, MO
Registered Nurse 2013002075
Respondent was licensed as a Registered Professional Nurse in New Jersey and she voluntarily surrendered her nursing license in an Order of Voluntary Surrender as a result of diverting Percocet from her employer for personal consumption on November 16, 2009. Respondent then enrolled in the New Jersey Recovery and Monitoring Program (RAMP). Respondent’s license was then reinstated on July 30, 2010 under specified terms and conditions. Due to Respondent not being physically well, the peer counselor did not sign off for Respondent to return to work. Respondent ceased complying with the Order of Reinstatement; hence, New Jersey issued a Final Order of Discipline on August 22, 2011, suspending her license due to non-compliance with the terms and conditions of the Order of Reinstatement. Probation 01/23/2013 to 01/23/2018

Wright, Rosemary Marie
Saint Louis, MO
Licensed Practical Nurse 2006010201
Respondent was required to obtain specified continuing education hours and have the certificate of completion for all hours submitted to the Board by September 28, 2012. Respondent never submitted to the Board proof of any completed hours. Probation 12/20/2012

Spillman, Kirsten D.
Bonita Springs, FL
Registered Nurse 126140
On May 11, 2012, Respondent arrived for her shift at approximately 7:50 p.m. A review of Respondent’s use of the Diebold system showed multiple discrepancies in patients. In regards to the first patient, Respondent removed multiple doses of Zolozprim, Norvasc and Lipitor at times when only a single dose was ordered to be administered. In regards to the second patient, the patient was not assigned to Respondent; however, Respondent removed Valium, Lovenox, Cispaaz, Zocor, Betapacea and Flomax for the patient. It was also discovered that Lovenox had been discontinued for this patient. In regards to the third patient, Respondent was not assigned to the patient; however, Respondent removed Naxem for the patient even though the nurse assigned to care for the patient documented the administration of Naxem to the patient prior to Respondent’s removal of the medication. The three other patients assigned to Respondent on May 20, 2008, had no Diebold activity for her shift, indicating that Respondent did not remove any of the medications ordered for those patients. Respondent could not provide a reason for her actions in regards to anything about her assigned patients and she was “walking in circles” while trying to give report. On February 27, 2008, the father of a patient that Respondent was caring for requested a different nurse, as Respondent appeared “drunk or on drugs” and had tripped over his wife. It was also stated that Respondent had fallen asleep several times while charting and repeatedly gave the same directions for discharge. Respondent was later assigned to care for a patient who had ankle surgery on that date. Respondent did not fully communicate the patient's status to the surgeon and left the nurse’s desk without any of the patient's charts. The patient who received the dose of Morphine was a minor who could not have received more than one milligram of Morphine.

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Liz Turner, LSS Neighborhood Nurse Leader

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Schall, Christine A.  
Columbia, IL  
Licensed Practical Nurse 0434970  
Concern exists to discipline the nursing license of Christine Schall for failing asense while on duty as a licensed practical nurse and for discipline imposed against her nursing license in the State of Illinois.  
Revoked 12/18/2012

Jordan, Christopher J.  
Jefferson City, MO  
Registered Nurse 0820688  
The Missouri State Board of Nursing has found Christopher Jordan's nursing license is subject to discipline because he diverted controlled substances from his place of employment, and he did not plead guilty to a crime reasonably related to the nursing profession having an essential element of dishonesty and that is also a crime.  
Revoked 01/15/2013

Eastham, Janet L.  
El Dorado Springs, MO  
Registered Nurse 146834  
Concern exists to discipline the nursing license of Janet Eastham for failing to properly chart the administration of medications to patients, failing to follow established protocols for patient care, and testing positive for a controlled substance for which she did not have a prescription.  
Revoked 12/18/2012

Brady, Colleen C.  
Fulton, MO  
Licensed Practical Nurse 0243490  
Cause exists to discipline the nursing license of Colleen Brady for not assigning alcohol while at work.  
Revoked 12/18/2012

Holmes, Marta L.  
Columbia, MO  
Registered Nurse 1001010  
Respondent was responsible for patients in the Symptom Evaluation Unit (SEU), a walk-in urgent care unit for Oncology patients as well as other patients in the facility. On June 5, 2008, Respondent received a verbal warning for late documentation, breach of patient confidentiality, medication administration, delay in initiation of chemotherapy, commitment to co-workers and patients, and not taking vital signs on six of eight patients. Examples of delayed or incomplete documentation by the Respondent included not timely recording to record vital signs include patient records from May 24, 2008, May 25, 2008, May 31, 2008, and June 1, 2008. On June 5, 2008, Respondent was counseled regarding an incident where a patient of hers was seen in the SEU early in the day then returned to the emergency room (ER) with chest pain but could not be admitted into the ER for treatment because Respondent still had the patient in the system in SEU. On June 5, 2008, Respondent acknowledged and apologized for the issue that required her improvement. A plan was made to help her in the SEU and on the floor.  
On August 2, 2008, Respondent was assigned to a scheduled 17,000 dose of chemotherapy to a patient. The dose had not been administered at 1700, requiring another nurse to administer the dose. On August 5, 2008, Respondent was assigned to administer a scheduled 17,000 dose of chemotherapy. The dose had not been administered at 1800, requiring another nurse to administer the dose. On November 8, 2008, an order was written for 500 to transfuse two units of packed red blood cells and then discharge the patient to home. The order was noted by Respondent at 1145. The packed red blood cells were received, but Respondent did not administer the packed red blood cells until 1415. The first unit was completed at 1645 and the second unit was not hung until 1715. Failure to administer the packed red blood cells for the patient in a timely manner caused delay (discharge and treatment held up) resulting in the patient's oncology nurse to finish Respondent's work. On November 15, 2008, an order was written to type and cross and transfuse two units of packed red blood cells to patient. Respondent noted the order at 1015. Respondent did not hang the unit until 1330. The first unit was completed at 1630 and the second unit was not hung until 1715. Failure to administer the packed red blood cells in a timely manner caused delays for the patients, in a timely manner caused delays for the patients and resulted in the oncology nurse to finish Respondent's work. On December 24, 2008, Respondent was assigned to administer 515 before 1500. Respondent removed a controlled analgesic (Percocet) from a patient. Respondent then placed the PCA in the hallway where it remained until 1900. The PCA contained 39cc of Morphine. On December 27, 2008, a patient was admitted to the SEU for lab tests to determine if he would receive his scheduled chemotherapy that day. Respondent failed to assist the patient or have lab drawn for forty-five (45) minutes, responding that the laboratory would not be available to draw labs. On March 5, 2009, Respondent received a written warning for late documentation, breach of patient confidentiality, timely administration of blood products, not completing a medication chart, and not conducting a physical examination. On March 5, 2009, Respondent acknowledged and understood the areas that required her improvement. On July 28, 2009, Respondent received a written warning related to not documenting on the patient. The patient was also not noted in the system on January 17, 2009, a Pneumococcal Vaccine was scheduled per standing hospital protocol as a physician's order. It was to be administered at 0800 to a patient. The medication was not administered as given by Respondent.  
Revoked 12/17/2012

Feltrop, Sherry L.  
Jamestown, MO  
Registered Nurse 939729  
On January 14, 2009, Respondent was convicted of 'Driving While Intoxicated - Drug Intoxication.'  
Revoked 12/18/2012

Pribble, Shelley Ann  
Bonne Terre, MO  
Licensed Practical Nurse 2200536127  
Revoked 12/18/2012

Muse, Sheila Lynn  
Steele, MO  
Licensed Practical Nurse 2005032631  
On April 10, 13 and April 14, 2009, while on duty, Respondent diverted hydrocodone.  
Revoked 12/17/2012

Surber, Shannah Marie  
Benton, MO  
Licensed Practical Nurse 2005032933  
Cause exists to discipline the nursing license of Shannah Surber for pleaded guilty Fraudulently Attempting to Obtain a Controlled and for pleading guilty to Possession of a Controlled Substance.  
Revoked 01/22/2013

DeVore, Katya  
Sorento, IL  
Registered Nurse 2006019130  
Respondent was required to contract and enroll with the Board's third party administrator (TPA), currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screenings for all patients at risk of drug use within twenty (20) working days of the effective date of the Agreement, or by November 1, 2012. Respondent has not completed the contract or remained compliant with NTS. Respondent was required to submit a chemical dependence evaluation by the Board to November 15, 2012. The Board has not received an evaluation.  
Revoked 12/27/2012

Blanks, Iris B.  
Saint Louis, MO  
Registered Nurse 1552306  
On May 25, 2006, Respondent refused to administer Thorazine to a patient as required by physician's order. On November 15, 2006, Respondent was counseled regarding an incident where a patient of her's was seen in the SEU early in the day then returned to the emergency room (ER) with chest pain but could not be admitted into the ER for treatment because Respondent still had the patient in the system in SEU. On January 24, 2011, Respondent received counseling for diverting controlled substances at her place of employment.  
Revoked 12/17/2012

Akers, Lisa C.  
New Braunfels, TX  
Registered Nurse 1350879  
On January 3, 2009, a medication that was seen by Respondent was prescribed Augmentin and Tescalol Perles. Neither medication was listed in the patient's medication list. This patient had been seen by Respondent on February 2nd and was given antibiotics for a venous line infection. On February 4, 2011, staff gave Respondent a detailed note to create a work excuse on a certain patient and the note  
Revoked 01/17/2013

Weber, Pamela J.  
Blue Springs, MO  
Registered Nurse 2000014421  
On January 20, 2010, Respondent received counseling for failing to follow the admissions. On March 18, 2010, Respondent hung Vancomycin 1300 mg on a patient instead of the patient's ordered Vancomycin 1500 mg. The Vancomycin 1500 mg was a different patient's prescribed medication. On May 17, 2010, Respondent requested a certified nursing assistant to administer a morphine nebulizer treatment to a patient. Administering a controlled substance, in any form, is outside the scope of practice for a certified nursing assistant.  
Revoked 12/17/2012

Daniels, Kurt Kimberly  
Phillipston, MA  
Registered Nurse 2001000060  
Respondent was subject to discipline for not complying with the terms of her probation by not contracting with a Board-approved random drug and alcohol screening service as required by the terms of her probation by not contracting with a Board-approved random drug and alcohol screening service as required by the terms of her probation by not contracting with a Board-approved random drug and alcohol screening service as required by the terms of her probation.  
Revoked 12/17/2012

Robinson, Gregory J.  
Keller, TX  
Registered Nurse 137461  
Respondent's license is subject to discipline for not complying with the terms of her probation by not following the requirements of her probation.  
Revoked 12/17/2012

Evers, Elaine Ann  
Houston, TX  
Licensed Practical Nurse 2010027052  
Respondent was convicted of receiving stolen property of $500 or more.  
Revoked 12/17/2012

West, Meagan Eva  
Cree Court, MO  
Registered Nurse 2000808557  
The ABC found cause to discipline the nursing license of Meagan West for diverting controlled substances at her place of employment.  
Revoked 12/17/2012

Daughtrey, Jeanette R.  
Tecumseh, MO  
Licensed Practical Nurse 043433  
Respondent disclosed the nursing license of Jeanette Daughtrey for discipline imposed against her nursing license in the State of Arkansas and for failing to properly administer medications to patients as ordered and to properly document in patients' charts.  
Revoked 12/20/2012
Revocation continued from page 20

Holder, Joyce E.
Cairo, IL
Licensed Practical Nurse 052793
Respondent diverted the controlled substance of methadone for herself and pled guilty to theft/theft of the methadone. Reversed 12/17/2012

Hardesty, Luanna J.
New Bloomfield, MO
Licentified Practical Nurse 056026

Kuehn, Amanda Christine
Saint Louis, MO
Registered Nurse 20000151384
The Administrative Hearing Commission found that Amanda Kuehn failed to remit the discipline because she tested positive for amphetamine. Reversed 12/24/2012

Haynes, Amanda Michele
Hartville, MO
Registered Nurse 20070024059
Amanda Whitson-Haynes violated the terms of a Board Order by failing to contact National Toxicology Specialists on four occasions, by submitting a sample with a low creatinine level, by failing to meet with the Board Disciplinary Administrator as ordered, and by failing to complete continuing education units. Reversed 12/17/2012

Gunn, Shannon Marie
Belton, MO
Registered Nurse 20010033427
Respondent failed to call in to NTS on eleven different (11) days. On November 4, 2011, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading of 149. One of the missed calls was on November 5, 2011, the day after the low creatinine level was submitted as her sample. Reversed 12/24/2012

Langston, Susanne M.
Columbia, MO
Licensed Practical Nurse 085275
When called as a nurse, Respondent misappropriated Ativan (lorazepam) from two residents. Respondent changed a dosage amount on the pharmacy and stating it was per a doctor's order, which was false. Respondent also refused to take a drug test after an investigation into the matter, but admitted she would take a test for Ativan. On July 7, 2008, Respondent’s name was submitted to the required sample which showed a low creatinine level of 149. One of the missed calls was on November 5, 2011, the day after the low creatinine level was submitted as her sample. Reversed 12/24/2012

Hoffman, Margaret Ann
Columbia, MO
Registered Nurse 2006002669
Respondent failed to call in to NTS on five (5) occasions. On September 25, 2011, Respondent was required to report to NTS. That sample tested positive for the presence of amphetamine. Reversed 12/17/2012

Davidson, Sharon
Jackson, MO
Registered Nurse 0327537

Hinkle, Mark A.
Jackson, MO
Registered Nurse 153943
Commission discipline the nursing license of Mark Hinkle for pleading guilty to the class C felony of Voluntary Manslaughter on January 21, 2010 in Lawrence County, Tennessee and for discipline imposed against his nursing license in the States of Arizona and Tennessee. Reversed 12/18/2012

Mercurio, Rebecca S.
West Plains, MO
Registered Nurse 105045
Caused the licensee to discontinue the dispensing of medication withdrawal, administration, and wasting and reporting to work with a controlled substance in her system in an amount that would have impaired the licensee. Reversed 12/17/2012

Sanders, Andrea Ruth
Jefferson City, MO
Registered Nurse 2008007843
Respondent tested positive for EtG, a metabolite of alcohol. Respondent was required to completely abstain from the use or consumption of alcohol. Reversed 12/18/2012

Voluntary Surrender continued on page 22

Missouri State Board of Nursing • Page 21

May, June, July 2013

REVOCATION Continued...

Licensee was required to submit to a test and submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription for amphetamine. Reversed 12/20/2012

Harmon, Anita G.
Mineral Point, MO
Licensed Practical Nurse 004370

Gach, Misty Dawn
Saint Louis, MO
Registered Nurse 2000014609
Respondent failed to call in to NTS on thirteen different (13) days. On November 4, 2011, Respondent reported to a lab and submitted the required sample which showed a low creatinine level of 149. One of the missed calls was on November 5, 2011, the day after the low creatinine level was submitted as her sample. Reversed 12/24/2012

Kuehn, Amanda Christine
Saint Louis, MO
Registered Nurse 050275
Respondent’s two-year old son, E.K., opened a bag of mortar used for tiling and spread the mortar over the back deck of the home. While Respondent was cleaning E.K., Respondent left the baby with the child and slapped E.K. hard enough to leave bruises on the left side of E.K.’s face. E.K.’s bruises were observed to be dark red in color and appeared to be in the shape of a hand and fingers. On August 1, 2007, Respondent pled guilty to assault in the third degree. Reversed 12/17/2012

Cadwallader, Brandi Lynn
Saint Louis, MO
Licentified Practical Nurse 2003023943
Respondent documented giving medications to residents, but residents did not receive the medications as documented. Respondent was requested to submit to a urine drug screen. She provided a sample, but it was cold and did not register a temperature. She was asked to provide another sample, but said she could not and stated that she would test positive for marijuana. On February 19, 2010 and March 9, 2010, Respondent forged the signature of a physician on prescriptions for herself. On February 10, Respondent filled the February 19 prescription. When she presented the March 9 prescription at the same pharmacy, the pharmacist questioned the signature and called the police. Respondent was advised that she had to provide a photo ID in place of the pharmacy’s photo ID policy. Upon further investigation, it was discovered that the physician had not written the prescription. Reversed 12/17/2012

Duchon, Deborah K.
Saint Louis, MO
Registered Nurse 084772
Respondent was placed on the Department of Mental Health’s employee disqualification registry (registry). On March 27, 2009, Respondent transported a patient/client receiving services from the Department of Mental Health (DMH), and was assaulted by the patient/client. Respondent failed to inform her employer that the patient/client assaulted her until six (6) days after the event when confronted by her employer. This placed other employees at the facility in danger because they were unaware of the patient/client’s assultive nature. Respondent also gave inconsistent stories to the police about what happened. Reversed 12/19/2012

Rainsner, Spring E.
Windsor, MO
Registered Nurse 2001002250
Respondent was required to call a toll free number every day to determine if she was required to submit to a test for alcohol. Respondent failed to call in to NTS on two (2) separate days. On February 12, 2012, Respondent called NTS and was required to submit to a test for alcohol. Reversed 12/20/2012

Franz, Jeannie P.
Saint Louis, MO
Registered Nurse 081073
On March 11, 2010, Respondent refused to administer pain medication to a patient who was crying out in pain. Respondent failed to notify the patient’s physician and did nothing to address the patient’s situation. Respondent allowed the patient to cry all night. On March 16, 2010, Respondent refused to administer blood and prepare a patient for a blood transfusion as directed by a physician’s order. The 30 minute window to perform this task passed. The patient’s interactions were discovered by the charge nurse. On April 9, 2010, Respondent refused to place a patient on a telemetry monitor as directed by a physician’s order. Reversed 12/17/2012

Morrissey, Erin K.
O’Fallon, MO
Registered Nurse 123377
On October 9, 2012, Respondent was required to submit to a test and submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription for amphetamine. Reversed 12/20/2012

May, June, July 2013

REVOCATION Continued...

Licensee was required to submit to a test and submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription for amphetamine. Reversed 12/20/2012

Harmon, Anita G.
Mineral Point, MO
Licensed Practical Nurse 004370

Hinkle, Mark A.
Jackson, MO
Registered Nurse 153943
Commission discipline the nursing license of Mark Hinkle for pleading guilty to the Class C felony of Voluntary Manslaughte...
Voluntary Surrender continued from page 21

Licensee was employed at a facility in Missouri. Pursuant to the Facility's policy, Licensee did not have the authority to pick up medication at the pharmacy. On May 9, 2011, Licensee went to the pharmacy and picked up a 30ml bottle of Morphine 100 mg/5ml (the “Medication”). Licensee initiated that she picked up the Medication at the pharmacy. Licensee admitted to the Facility administrator that she went to the pharmacy and picked up the Medication. Licensee never delivered the Medication to the facility or to any of the Facility's patients. An investigation by the Facility discovered that eleven 50ml bottles of Morphine Sulfate distributed from the pharmacy were unaccounted for at the Facility.

Voluntary Surrender 12/10/2012

Sargent, Carolyn L.
Columbia, MO
Licensed Practical Nurse 2008020351
Registered Nurse 2008020351
Overland Park, KS
Registered Nurse 2008020351
Licensee's Kansas Registered Professional Nurse license was voluntarily surrendered to the Kansas State Board of Nursing on May 24, 2012. The reason(s) licensee's Kansas license was voluntarily surrendered was because licensee pled guilty in the state of Kansas to three felony counts of sexual exploitation of a child under the age of 18.

Voluntary Surrender 02/28/2013

Spiegel, Jay Barry
Overland Park, KS
Registered Nurse 2008020351
Licensee's Kansas Registered Professional Nurse license was voluntarily surrendered to the Kansas State Board of Nursing on May 24, 2012. The reason(s) licensee's Kansas license was voluntarily surrendered was because licensee pled guilty in the state of Kansas to three felony counts of sexual exploitation of a child under the age of 18.

Voluntary Surrender 02/13/2013

Braley, Cindy Joanne
Brookfield, MO
Registered Nurse 2008029483
On April 21, 2010, Licensee entered a guilty plea to Possession of Up to 35 Grams Marijuana. On January 21, 2011, Licensee entered a guilty plea to Possession Of Controlled Substance, a class C felony.

Voluntary Surrender 12/04/2012

Corso, Tracey L.
Cincinnati, OH
Registered Nurse 2010032008

Voluntary Surrender 02/28/2013

Mascher, Bellinda Lee
Kansas City, MO
Licensed Practical Nurse 2007027179
On May 15, 2012, Licensee telephoned a prescription order for Lortab and Clindamycin to a local pharmacy, utilizing a fictitious patient name and falsely using as authorization the name and BNDD/DEA number of a physician who was the medical director of a family health care clinic for the department. Licensee misrepresented herself by telling the pharmacy staff that she was “one of the clinic nurses” at the department. The pharmacy called the clinic in an attempt to clarify the order. Licensee attempted to pick up the prescription at the pharmacy and was denied. On May 16, 2012, licensee admitted to Department officials that she had falsely called in the prescription and had misrepresented herself to the pharmacy.

Voluntary Surrender 01/01/2013

Spiegel, Jay Barry
Overland Park, KS
Registered Nurse 2008020351
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Voluntary Surrender 02/13/2013

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Voluntary Surrender 01/01/2013

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Voluntary Surrender 02/13/2013

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Voluntary Surrender 01/01/2013

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Overland Park, KS
Registered Nurse 2008020351
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Voluntary Surrender 02/13/2013

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Brookfield, MO
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Voluntary Surrender 12/04/2012
NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

__________________________ ☐ RN ☐ APRN ☐ LPN
Missouri License Number ____________________________

☐ Social Security Number ____________________________

Signature (This form must be signed) ____________________________

DATE ____________________________

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed) ____________________________ First Name (Printed) ____________________________

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Last Name ____________________________ First Name ____________________________ Middle Name ____________________________

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