Executive Director’s Report

Know Your Nursing Practice Act

Roxanne McDaniel, PhD, RN, President

Every nurse should know the Nursing Practice Act (NPA) and be aware of other laws and rules that govern nursing practice. The NPA is the most important legislation affecting nursing. It defines the scope of practice for specific nursing roles and gives nurses the legal authority to practice within their scope. Licensing laws were created to protect the public, ensure safe practice and to establish the rules and regulations for the specific level of a nurse’s educational and licensure requirements.

On August 28, 2013, the Missouri Nursing Practice Act was revised. See the changes below. Please note that the bold text indicates additions and the text contained in brackets shows deletions.

The Nursing Practice Act

Know Your Nursing Practice Act continued on page 6

Executive Director’s Report

Licensed Practical Nurses Set to Renew in March 2014

Licensed Practical Nurse (LPN) renewal postcards with PIN numbers will be mailed to your address in early March 2014. They are mailed to the address on our records, so it is very important that you inform our office in writing whenever you change addresses. A change form can be found on the Board’s website and also in this publication.

It takes 3-5 business days for your license renewal to be processed. You can go to www.nursys.com to check the status of your license at any time.

Legislative Session

The 2014 Legislative session started January 8, 2014 and will go through May 16, 2014. Legislators began pre-filing bills on December 1, 2013. 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.

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Missouri State Board of Nursing Budget

Nursing regulation is the governmental oversight provided for nursing practice in each state. Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared or incompetent. The public may not have sufficient information and experience to identify an unqualified healthcare provider and is vulnerable to unsafe and incompetent practitioners. Through regulatory processes, the government permits only individuals who meet predetermined qualifications to practice nursing. The Board of Nursing is the authorized state entity with the legal authority to regulate nursing.

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

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

The Missouri State Board of Nursing also assesses costs from the Division of Professional Registration, Department of Insurance, Financial Institutions and Professional Registration and Office of Administration. These costs include services such as computers, information technology support, purchasing staff, accounting staff, web site maintenance, and licensing renewal processing staff. In addition, our office utilizes the Office of the Attorney General for some of our legal counsel work.

RNs renew every two years in odd-numbered years and LPNs renew every two years in even-numbered years. Since there are more RNs than LPNs, the Board receives more revenue in odd-numbered years than in even-numbered years. The RN renewal cycle is February to April. The LPN renewal cycle is March to May. When determining revenue and expenses, you have to plan to have enough reserve in the fund to pay expenses until the revenue from renewal fees is received. State statute 335.036.4, RSMo, indicates that the Board of Nursing funds cannot be placed to the credit of general revenue unless the amount in the fund at the end of the year exceeds two times our appropriation. This prevents the Board from charging excessive fees and also explains why renewal fees may fluctuate from year to year.

During the Board’s quarterly face-to-face meetings, the Board diligently reviews financial statements. We are very cognizant of the fact that nurses pay for the operation of the Board and continually look for ways to cut costs.

Within the next two years the Board will be transitioning to a new licensure system. We expect to see a decrease in operational expenses and increase in customer satisfaction and efficiencies when this system is fully implemented.

It is likely that we will see a steady decline in our revenue. It is often difficult to predict how many nurses will not renew. Of concern is that 17,479 (18%) of RNs and 4,524 (18%) of LPNs are over age 60. Even more alarming is the fact that 30,722 (32%) of RNs and 7,516 (30%) of LPNs are over age 55. We know that nurses come back into or stay in the workforce when the economy is down. The numbers show many nurses are older and will retire in the near future, just when the wave of baby boomers hit retirement age themselves and need more nursing care. When this large population of older nurses retires, our revenue will steeply decline. The Board will continue to monitor this trend.
Nursing Education - Responsibility, Trends, and Options

As the profession of nursing evolves, the need for transformation of how nursing students are taught and learn is very real. Transition to practice plays a huge role in patient safety as well as efforts to retain new nurses in clinical settings. Dr. Christine Tanner (2010) calls for creation of a system for nursing education through strong partnership between community colleges and universities that provides for common pre-requisites, utilizes competency-based nursing curricula and actively shares instructional resources to maximize opportunities for students and faculty. Dr. Patricia Benner (2010) identifies three major areas of apprenticeship in nursing education. Those areas include acquisition and utilization of nursing knowledge, development of clinical reasoning skills and ethical decision making. The need for standardization of pre-requisite scientific principles and clinical learning in nursing education. The need for standardization of pre-requisite course work, use of more effective teaching strategies, and direct linkage of patho-physiology and disease concepts to course work designed to bring about deliberate progression and graduate level clinical learning are education all essential links in meeting the magnitude of health care challenges that are faced in this country (AACN, 2012). As today’s complex health care environment continues to evolve, the impact of each nurse’s academic preparation on patient outcomes is reiterated throughout nursing literature (Tanner, 2010). The concept of life-long learning has never been more applicable. Academic progression in nursing is no longer an option, it is a necessity. Impact on patient outcomes, as paired with projections for opportunities in nursing employment, makes that clear. Reports of hiring trends reiterate the need for progression. Nationally, hospital preference to hire nurses prepared for BSN and higher levels is reflected. American Association of Colleges of Nursing (AACN, 2012) data indicates that nationwide, 59% of hospitals require BSN preparation for new hires; 77% of hospitals indicate strong preference to hire BSN prepared nurses. Metropolitan areas in Missouri reflect such trends as well. Historically, approximately 60% of the nursing workforce has been prepared at the ADN level. National Council of State Boards of Nursing (NCSBN, 2013) data shows that in 2011 57% of all first-time time testors taking the NCLEX-RN licensure exam were prepared at the ADN level. The Robert Wood Johnson Newsletter, published in September 2013, indicates that in 2012 53% of graduates from professional nursing programs were ADN prepared. Slight shift (approximately 4%) toward increase in BSN prepared graduates is indicated. Across the country significant increase in enrollment in RN to BSN completion programs is indicated. More nurses than ever are coming back to school to continue their education and gain desired degrees. AACN (2012) data indicates increase in RN to BSN enrollment from a little more than 30,000 in 2003 to nearly 90,000 students in 2011. The Robert Wood Johnson Newsletter (2013) indicates augmentation of enrollment to about 100,000 in 2012. While RN to BSN program enrollment is steadily growing, continued academic transformation of educational expectations, processes and experiences is necessary to progress toward the Institute of Medicine (IOM) goal for 80% of professional registered nurses to be prepared at BSN or higher levels by 2020. This goal was set by the IOM in 2010. While efforts should be concentrated to facilitate seamless progression, expand options and eliminate needless repetition of course work, rigorous academic standards must be upheld. Otherwise, the projected paradigmatic shift necessary to keep nurses prepared to optimally support positive patient outcomes is truly jeopardized. Nurses have lots of options to complete desired degrees. The number of BSN completion programs has dramatically increased in recent years. AACN (2012) data captures at least 646 programs; 400 or more offer on-line components, some are completely on-line. Many more programs are in development and data is unclear on just how many schools offer or are preparing to offer BSN completion programs at this time. It is of utmost importance for nurses to carefully evaluate BSN completion options prior to enrollment. With so many options available, finding a school that provides optimal opportunities for progression, fits well with the nurse’s schedule and offers course work that meets the nurse’s needs is not always easy.

It is important to remember that Missouri State Board of Nursing (Board) jurisdiction is limited to pre-licensure nursing education; therefore BSN completion and nursing education programs at the graduate/doctoral level are not approved by the Board. When choosing a BSN completion program, many factors come into play. Personal and professional responsibility to choose a nursing program rests with the nurse. Questions to ask may include inquiry about the school’s as well as the program’s accreditation status, extent of learning experiences in clinical settings and course work designed to bring about deliberate progression in nursing knowledge and clinical expertise.

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Exploration of Nursing Education continued on page 5
AGENDA
March 21, 2014
CROWNE PLAZA • ST. LOUIS AIRPORT • 11228 LONE EAGLE DRIVE • BRIDGETON, MO 63044

Conference Objectives
- Examine aspects of professionalism and compassion in the delivery and receipt of healthcare services in relation to individual health and well-being.
- Discuss a sociotechnical approach to improving healthcare quality and safety, addressing the social aspects of individuals within technical systems and processes.
- Discuss the impact of health information technology on the quality and safety of care delivery.
- Identify successful practices and processes for collaboration to improve healthcare quality and safety.
- Discuss the role of health literacy and clear understanding among healthcare professionals and patients for safety improvement.
- Examine how proven successful safety practices can be replicated.
- Discuss with industry leaders safety-of-care issues, applicable to any healthcare setting.

Recommended Audience
Healthcare consumers, executives, senior managers, physicians, nurses, pharmacists and other clinicians who lead or manage organizations or provide direct patient care in any healthcare setting and those who pay for care or establish healthcare policy. Leaders and caregivers from health system, hospital, home health, nursing home, pharmacy and other provider organizations and those from health plans, employers, insurers, and regulators will benefit from attending this conference.

Schedule of Events
7:30-9:00AM REGISTRATION & BOOK SIGNING: The Hidden Gifts of Helping STEPHEN G. POST, PHD
9:00-9:15AM CONFERENCE WELCOME
9:15-10:30AM KEYNOTE
10:30-11:00AM BREAK
11:00-Noon GENERAL SESSION FACILITATED PANEL DISCUSSION
Health Information Technology & Safety Improvement – True or False?
This session will discuss the challenges and benefits of health technology in delivering and receiving care and services from varying perspectives, including health information exchanges, academia, nursing, pharmacy and consumers.

Noon-1:00PM LUNCH VISIT VENDORS, POSTERS, THOUGHT LEADER PRESENTATIONS

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Nursing Education continued from page 3

opportunities for clinical application of advanced nursing concepts should be at the forefront of decision making processes when choosing the nursing program.

Institutional, regional and national nursing accreditation of a nursing program may become very important as someone begins to construct their nursing education. Transferability/acceptance of nursing course work often hinges on such accreditations; employment in select settings may be impacted as well. While national nursing accreditation does not guarantee that the nursing program is a great fit for the student/nurse, it does imply that certain academic standards are maintained. Newer nursing programs may not have national nursing accreditation, but candidacy status toward accreditation may be indicated. Overall, it is important to do the necessary research, ask questions, and consider all options while proactively choosing a nursing program that fosters solid academic progression, best meets individual needs and offers financially responsible options.

On a different note, many efforts are in progress to expand nursing education options for Missouri citizens. As discussed in last year’s Newsletters, funding established by the State of Missouri through legislative action and appropriation of funds continues to be utilized to foster nursing education. This year a third round of monies has been made available to Missouri nursing programs through the Nursing Education Incentive Program (NEIP). As many of you may know, this funding comes about through collaboration between the Missouri State Board of Nursing and the Missouri Department of Higher Education. Major grant focus on increase of physical and educational capacity of professional nursing programs is demonstrated. Seven (7) programs of professional nursing received funding in 2013. Since 2011 NEIP funding has contributed right at three (3) million dollars to foster nursing education in Missouri. Decisions related to grant awards have been made through collaboration between the Missouri State Board of Nursing and the Missouri Department of Higher Education. The Nursing Education Incentive Program (NEIP) grant awards can be reviewed at Missouri Department of Higher Education website: http://www.dhe.mo.gov/NursingGrant.php

References


Robert Wood Johnson Foundation Newsletter: Charting nursing’s future – The case for academic progression: Why nurses should advance their education and the strategies that make this feasible (September 2013. Issue Number 21). Washington, D.C.

Tanner, C. (2010) Transforming pre-licensure nursing education: Preparing the new nurse to meet emerging health care needs. Nursing Education Perspectives, 31 (6), 347-353

The Department of Nursing at Webster University (St. Louis, MO) is conducting a faculty search seeking three individuals, one with nursing leadership/administration expertise. A master’s degree with a major in nursing, required, and an earned doctorate, strongly preferred. RN licensure in the State of Missouri is required.

These are nine (9) month academic positions. Faculty members have advising and practicum supervision responsibilities, are expected to teach core-nursing courses, engage in professional development, and other activities to support the nursing department. In addition, faculty members are expected to participate in department, college, university governance activities, and other university events.

Webster University is an Equal Opportunity/Affirmative Action educator and employer. We are committed to maintaining a culturally and academically diverse faculty of the highest caliber. We strongly encourage applications from those who identify as diverse in terms of gender, race, ethnicity, national origin, sexual orientation, disability, and/or veteran status.

To apply, send curriculum vitae and 3 letters of reference to Faculty Search, Dept. of Nursing, Webster University, 470 E. Lockwood Ave., St. Louis, MO 63119.
circumstances by the member of the applicant's or licensee's profession; 

(6) Misconduct, fraud, false statement, misrepresentation, dishonesty, unethical conduct, or unprofessional conduct in the performance of the functions or duties of a nurse so licensed or registered by this chapter, including, but not limited to, the following:

(a) Willfully and continually overcharging or overcharging for charging for visits which did not occur unless the services were contracted for in advance, or for services which were not rendered or documented in the patient's records;

(b) Attempting, directly or indirectly, by way of intimidation, coercion or deception, to obtain the use or enjoyment of or to discourage the use of a second opinion or consultation;

(c) Willfully and continually performing inappropriate, incompetent or negligent treatment, diagnostic tests, or nursing services;

(d) Delegating professional responsibilities to a person who is not qualified by training, skill, competence, experience, or experience or licensure to perform such responsibilities;

(e) Performing nursing services beyond the authorized scope of practice for which the individual is licensed in this state;

(f) Exercising influence within a nurse-patient relationship for the purpose of engaging a patient in sexual activity;

(g) Being listed on any state or federal sexual offender registry;

(h) Failure of any applicant or licensee to cooperate with the board during any investigation;

(i) Failure to comply with any subpoena or subpoena duces tecum from the board or an issuer of a certificate of registration or issuance of a license or allowing any person to use his or her certificate, license, registration, or authority, permit or license based upon a current residence;

(j) Failure to inform the board of the nurse's current residence;

(k) Failure to timely pay license renewal fees specified in this chapter;

(l) Violating a probation agreement, order, or other settlement agreement with the board pursuant to any licensing authority;

(m) Any other conduct that is unethical or unprofessional;

(n) Willfully and continually performing inappropriate, incompetent or negligent treatment, diagnostic tests, or nursing services; or delegating professional responsibilities to a person who is not qualified by training, skill, competence, experience, or licensure to perform such responsibilities;

(18) Knowingly making or causing to be made a false statement or misrepresentation of a material fact, with intent to defraud, for payment pursuant to the provisions of sections 335.011 to 335.096, or for payment from Title XVIII or Title XIX of the federal Medicare program;

(19) Failure of any nurse to properly guard against contagious, infectious, or communicable diseases or the spread thereof; maintaining an unsanitary office or performing professional services under unsanitary conditions; or failure to report the existence of an unsanitary condition in the office of a physician or in any health care facility to the board, in writing, within thirty days after the discovery thereof;

(20) A pattern of personal use or consumption of any controlled substance unless it is prescribed, dispensed, or administered by a provider who is authorized by law to do so;

(21) Habitual intoxication or dependence on alcohol, evidence of which is stronger than that of alcohol-related enforcement contact as defined by section 302.525;

(22) Failure to comply with a treatment program or an aftercare program entered into as part of a board order, settlement agreement, or licensee's professional health program.

3. After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 566. Upon receipt of the complaint by the hearing commission that the grounds, provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the named nurse on probation, for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit, for:

(1) Engaging in sexual conduct, as defined in section 566.010, with a patient in sexual activity;

(2) Engaging in sexual misconduct with a minor or someone the licensee believes to be a minor. "Sexual misconduct" means any conduct of a sexual nature which would be illegal under state or federal law;

(3) Possession of a controlled substance in violation of chapter 588 or Title XVIII or Title XIX of the federal Medicaid program;

(4) Failure of any nurse to properly guard against contagious, infectious, or communicable diseases or the spread thereof; maintaining an unsanitary office or performing professional services under unsanitary conditions; or failure to report the existence of an unsanitary condition in the office of a physician or in any health care facility to the board, in writing, within thirty days after the discovery thereof;

(5) Habitual intoxication or dependence on alcohol, evidence of which is stronger than that of alcohol-related enforcement contact as defined by section 302.525;

(6) Violation of the certificate or any affidavit or any other settlement agreement with the board pursuant to any licensing authority;

(7) Failure of any applicant or licensee to comply with any subpoena or subpoena duces tecum from the board or an issuer of a certificate of registration or issuance of a license or allowing any person to use his or her certificate, license, registration, or authority, permit, license or diploma from any school;

(8) Disciplinary action against the holder of a license or other right to practice any profession registered pursuant to sections 335.011 to 335.096 granted by another state, territory, federal agency or country upon grounds for which revocation or suspension is authorized in this state;

(9) A person is finally adjudged insane or not fit to practice. For purposes of this section, a licensee is deemed to have waived all objections to the admissibility of testimony from the provider of the evidence of unsanitary conditions or examination reports. The licensee shall sign all necessary releases for the board to obtain and use the examination during a hearing;

(10) Any cause for which the board may discipline that constitutes a serious danger to the health, safety, or welfare of a patient of the public.

9. The board shall submit existing affidavits and existing certified court records together with a complaint and request for an emergency suspension or restriction to the administrative hearing commission and shall supply the administrative hearing commission with the administrative hearing commissioner on call for the board for the licensee. Within one business day of the filing of the complaint, the administrative hearing commission may grant a request to suspend or restrict the board to the board. The service packet shall include the board's complaint and any affidavits or records the board intends to rely on that have been filed with the administrative hearing commission. The service packet may contain other information in the discretion of the administrative hearing commission. Within twenty-four hours after receipt of the request, the board shall either personally serve the licensee or leave a copy of the service packet at all of the licensee's current addresses on file with the board. Prior to the hearing, the licensee may file affidavits and certified court records for consideration by the administrative hearing commission.

10. While a licensee or the board of the licensee's files the complaint, the administrative hearing commission shall review the information submitted by the board and the licensee and shall determine based on that information if probable cause exists pursuant to subsection 8 of this section and shall issue its findings of fact and conclusions of law. If the administrative hearing commission determines that there is probable cause, the administrative hearing commission shall order the board to proceed with a hearing and shall either personally serve the licensee or leave a copy of the service packet at all of the licensee's current addresses on file with the board. The board shall be granted leave to amend its complaint if it is more than thirty days prior to the hearing. If less than thirty days, the board may be granted leave to amend pursuant to the provisions of chapter 208 or chapter 630, or federal Medicare program;

(3) Possession of a controlled substance in violation of chapter 588 or Title XVIII or Title XIX of the federal Medicaid program;

(4) Use of a controlled substance without a valid prescription;

(5) The licensee is adjudicated incapacitated or disabled by a court of competent jurisdiction;

(6) Habitual intoxication or dependence upon alcohol or controlled substances; or

(7) A report from a board-approved facility or a professional health program stating the licensee is not fit to practice. For purposes of this section, a licensee is deemed to have waived all objections to the admissibility of testimony from the provider of the evidence of unsanitary conditions or examination reports. The licensee shall sign all necessary releases for the board to obtain and use the examination during a hearing;

(8) Any cause for which the board may discipline that constitutes a serious danger to the health, safety, or welfare of a patient of the public.

11. The administrative hearing commission shall hold a hearing within forty-five days of the board's filing of the complaint to determine if cause for discipline exists. The administrative hearing commission may grant a request for an emergency suspension or restriction, but shall in any event hold the hearing within one hundred twenty days of the board's filing. The board shall be granted leave to amend its complaint if it is more than thirty days prior to the hearing. If less than thirty days, the board may be granted leave to amend pursuant to the provisions of chapter 208 or chapter 630, or federal Medicare program;

(2) If no cause for discipline exists, the administrative hearing commission shall issue findings of fact and conclusions of law, and in order terminating the emergency suspension or restriction.

(3) If cause for discipline exists, the administrative hearing commission shall issue findings of fact and conclusions of law, and in order suspending or revoking the license or allowing any person to use his or her certificate, license, registration, or authority, permit, license or diploma from any school;

(4) Failure of any nurse to properly guard against contagious, infectious, or communicable diseases or the spread thereof; maintaining an unsanitary office or performing professional services under unsanitary conditions; or failure to report the existence of an unsanitary condition in the office of a physician or in any health care facility to the board, in writing, within thirty days after the discovery thereof;

(5) Habitual intoxication or dependence on alcohol, evidence of which is stronger than that of alcohol-related enforcement contact as defined by section 302.525;

(6) Failure to comply with a treatment program or an aftercare program entered into as part of a board order, settlement agreement, or licensee's professional health program.

12. Any action under this section shall be in addition to and not in lieu of any discipline otherwise in the board's power to impose and may be brought concurrently with other actions.
The Implications of Nurse Fatigue

By Susan A. Phillips MSN, RN, PMHCNS-BC and Carol Moffett, Ph.D., FNP-BC, CDE
August 16, 2013
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Nurse Fatigue

It is estimated that approximately 36% of the U.S. workforce is fatigued and more than 40 million Americans suffer from some type of sleep disorder. Over 85 sleep disorders have been identified and some of those include: acute or chronic insomnia; restless leg syndrome; narcolepsy; sleep apnea; and shift work syndrome. The fatigued worker is locked in a vicious cycle of self-awareness of the level of impairment they are experiencing. Workers who experience continuous wakefulness of 21 or more hours have functional scores that are similar to a blood alcohol concentration of 0.08% (Armedt, 2001). Nurses experience fatigue and physical exhaustion, which can be exacerbated by work factors such as night shifts and long hours. It is a normal cycle for nurses and other night shift workers to fall asleep while on the job (Rogers, 2008).

Definitions

Fatigue is a feeling of weariness, tiredness, or lack of energy (Lerman, Flower, Gerson, & Hursch, 2012). Sleepiness, a tendency to fall asleep, often coexists with fatigue (Rogers, 2008). Nurse fatigue must not be confused with compassion fatigue, which is defined as a feeling of profound empathy or grief over the suffering of patients and their families. Fatigue can be caused by many different factors and situations. Nurses and other health care providers must be educated on the hazards of working while fatigued and the benefits of coming to work well rested. Strategies can be established in the workplace to identify a fatigued nurse and provide for properly trained consequences for the organization and the nurse. Evidence from the nursing literature emphasizes the detrimental effect fatigue has on the well-being of nurses and patient outcomes. Nurse fatigue may lead to a variety of adverse medical problems, burnout, errors, and patient dissatisfaction. Worker fatigue studies are more prevalent in the aviation, trucking, manufacturing, military, medical, and nuclear power plant industries (Hursch, 2004; Lerman et al., 2012). The nursing profession can benefit from these research findings as each of these industries have 24/7 operations. There is a need for more nursing research to fully explore the implications of nurse fatigue.

Arizona Nurses Association Action Proposal

Nurse Fatigue was identified by the membership of the Arizona Nurses Association (AzNA) in 2011 as an issue for concern and was developed into an action proposal. According to the findings at the time the proposal was written:

1. The likelihood of malpractice is higher with >24.5 consecutive hours of nursing practice (Rogers, 2008).
2. Errors are increased with overtime or working over 40 hours per week (ANA Policy Manual on Nursing, 2010).
3. Less than 50% of work breaks are away from patient care (AHRO, 2005).
4. Night shift workers may have difficulty staying awake due to disturbance in circadian rhythms (Dagan, 2002).
5. The majority of errors from fatigue are medication errors (Rogers, 2008).
6. Sleep deprivation is linked to increased deviation from standard practice and unintentional sleep at work (Scott, 2006).
7. Drowsiness while driving is related to inadequate sleep, night shift work, and difficulty with wakefulness at work (Rogers, 2008).
8. The Professional Issues Steering Committee (PISC), a task force of elected AzNA membership, was assigned to address the action proposal. The committee decided to administer an electronic survey to assess members' fatigue-related concerns and the survey was distributed via email in December 2012.

Nurse Fatigue Survey

The Nurse Fatigue Survey was administered as a confidential, electronic survey that included a demographics section and 17 items for response. The survey was active for three weeks and closed on January 15, 2013. There were 1,004 Arizona registered nurses (RNs) who responded. The targeted audience was RNs whose primary responsibility was direct patient care.

The majority of respondents were Baby Boomers (47%) and 42% were BSN prepared. The majority of nurses worked on the day shift (71%), 37% had greater than 20 years of nursing experience, and 69% worked 12-hour shifts. Eighty percent (80%) of respondents recognized their inability to concentrate at work and driving on the road was difficult with fatigue. They recognized that when fatigue increases, they have failure making mistakes and acknowledge drowsiness while driving; 28% experienced drowsiness behind the wheel at all times. The number of hours of sleep varied and 52% were concerned or seriously concerned about the number of hours they slept; 62% slept 6-7 hours and 33% reported sleeping 4-5 hours between shifts. In addition to quantity of sleep, the quality of sleep was also problematic; 33% of nurses reported sleep quality as poor or very poor and 33% used some form of prescription medication or over-the-counter preparation as a sleep aid most days of the week. Additional survey results are detailed in Table 1 and Table 2:

Table 1. 2012 AzNA Nurse Fatigue Survey Responses Related to Sleep

<table>
<thead>
<tr>
<th>Hours of sleep between shifts</th>
<th>4-5 hours % (#)</th>
<th>6-7 hours % (#)</th>
<th>8-9 hours % (#)</th>
<th>&gt;10 hours % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.1% (260)</td>
<td>62% (649)</td>
<td>11.3% (113)</td>
<td>0.6% (6)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of concern about adequacy of sleep</th>
<th>Very Poor % (#)</th>
<th>Poor % (#)</th>
<th>Fairly Good % (#)</th>
<th>Good % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.5% (144)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.6% (374)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.3% (321)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.5% (156)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of Sleep</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5% (35)</td>
<td>39% (391)</td>
<td>53.7% (538)</td>
</tr>
</tbody>
</table>

| Use of Meds to Sleep | 36.6% (364) | 63.4% (630) |

<table>
<thead>
<tr>
<th>Daily % (#)</th>
<th>2-3 times a week % (#)</th>
<th>Few times a month % (#)</th>
<th>Rare % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.4% (102)</td>
<td>32.6% (126)</td>
<td>27.4% (106)</td>
<td>13.7% (53)</td>
</tr>
</tbody>
</table>

Table 2. 2012 AzNA Nurse Fatigue Survey Responses Related to Fatigue Impact

<table>
<thead>
<tr>
<th>Frequency of feeling sleepy when driving after work</th>
<th>All of the Time % (#)</th>
<th>Most of the Time % (#)</th>
<th>Sometimes % (#)</th>
<th>Never % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0% (70)</td>
<td>21.2% (210)</td>
<td>55.6% (533)</td>
<td>18.3% (182)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of concern about error due to fatigue</th>
<th>All of the Time % (#)</th>
<th>Most of the Time % (#)</th>
<th>Sometimes % (#)</th>
<th>Never % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1% (139)</td>
<td>26.6% (263)</td>
<td>39.2% (387)</td>
<td>20.1% (199)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concern about ability to concentrate at work being compromised due to fatigue</th>
<th>All of the Time % (#)</th>
<th>Most of the Time % (#)</th>
<th>Sometimes % (#)</th>
<th>Never % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.3% (3)</td>
<td>3.0% (50)</td>
<td>75.5% (752)</td>
<td>19.2% (191)</td>
<td></td>
</tr>
</tbody>
</table>

Fatigue Risk Model

The Moore-Ede fatigue risk model was used as a framework to analyze the potential of a fatigue risk management system. According to Moore-Ede (2009), there are five defenses that need to be managed:

1. Workload-staffing balance
2. Shift scheduling
3. Employee fatigue training and sleep disorder management
4. Work place environment design
5. Fatigue monitoring and alertness for duty

The model features a feedback loop to help analyze fatigue-related errors and strengthen defenses to ensure continuous improvement. Use of a fatigue risk management system is considered a best practice (Lerman et al., 2012).

Symptoms of Fatigue and Performance Impairment

Fatigue can produce a variety of physiological, cognitive, and emotional symptoms that may be detrimental to quality of life, well-being, and performance on the job. Fatigue can be considered a public health issue, and failure to recognize and address fatigue-related problems in healthcare settings may have considerable economic implications. Fatigue reduces physical and mental performance and can also increase the likelihood of medical errors. Fatigue can affect patients' health and wellness and also lead to adverse outcomes for healthcare providers (Lerman et al., 2012).

Symptoms of fatigue may include:

- Difficulty concentrating
- Slower reaction time
- Memory impairment
- Increased irritability
- Reduced appetite
- Decreased physical activity

Fatigue can be caused by a variety of factors, including sleep deprivation, shift work, and chronic stress. It is important for healthcare providers to recognize fatigue as a potential issue and to take steps to address it. This includes providing adequate rest periods, improving work schedules, and ensuring that healthcare providers have access to resources to support their well-being.
Implications of Nurse Fatigue continued from page 8

Emotional symptoms. Emotional symptoms may be manifested by an unusually quiet or withdrawn demeanor, or a lack of energy or motivation to perform tasks. Mood may be significantly changed from the previous day, chronic fatigue can be so consuming that it interferes with familial relationships, professional careers, and social activities. The nurse may be more irritable, or may lose interest in activities they used to enjoy. Cognitive symptoms may range from being less able to concentrate to more forgetfulness. Fatigue can be so profound that the nurse is unable to perform physical tasks and/or cognitive tasks.

Long-term disorders. Chronic conditions associated with fatigue are: chronic fatigue syndrome; fibromyalgia; sleep disorders; depression; obesity; metabolic syndrome; diabetes; and cancer.

Countermeasures

A number of countermeasures or interventions have been implemented to mitigate worker fatigue and could be considered as having potential benefit for nurses in the health care industry. These include: sleep hygiene, being well hydrated, maintaining a cool temperature; social interactions; physical activity; and strategic use of caffeine. When possible, a short nap break can significantly improve function. A prophylactic nap lasting 2-8 hours taken during the day prior to working at night combined with strategic use of caffeine 200 mg, at crucial times of 1:30 a.m. and 7:30 a.m. further enhances performance, according to Buysse (1994).

Screening for sleep disorders. Sleep disorders are common among shift workers. Mechanisms to manage sleeplessness are numerous and can include a questionnaire such as the Epworth Sleepiness Scale (Johns, 1991) or the use of a device such as an actigraph worn on the wrist with computer-based analysis support for purposes of monitoring and identifying sleep patterns for a specific work. One such tool was developed with the Department of Defense and is known as the Fatigue Avoidance Screening Toolbox (FAST). This device measures alertness, sleep debt, 2 recent sleep in the past 24 hours; 3 time since awakening; 4 time of day; and 5 circadian rhythm disorders. The algorithm of questions that control and determine the predicted performance score. The tool also provides a scale that gives an equivalent to blood alcohol levels of 0.05%-0.08% (Hursh, 2004).

Sleep disorders generally require assessment and treatment by a health care provider. If a disorder is detected, it is deemed to be problematic; a sleep study is warranted. A sleep disorder is either a sleep syndrome, and sleep apnea as well as other sleep-related problems. With the sleep problem identified, interventions can be targeted to improve the quantity and quality of sleep. For the medical profession the experience is disordered sleep, adhering to the use of intervention modalities sometimes requires support and monitoring. Sleep apnea treatment with Continuous Positive Airway Pressure (CPAP) machines can be monitored by periodically downloading information collected from the device (Lerman et al., 2012). The wrist-worn actigraph with FAST software is another tool for determining fatigue management and other health care issues.

Sleep hygiene. One of the best ways to prevent fatigue is by practicing good sleep hygiene measures. Most people recognize the importance of sleep; yet, certain nighttime behaviors such as reading, watching television, eating late, smoking, drinking, using the computer, and engaging in other evening activities that keep people awake interfere with the natural sleep cycle. Research has shown that sleep usually improves if the individual is made to fall asleep easily. The sleep environment should be very dark, comfortable, quiet, and cool to facilitate falling asleep quickly and staying asleep. A daily exercise routine that promotes physical activity will improve sleep, help with stress management, and promote general health.

Insomnia applications for smartphones. Advanced technology now offers a number of insomnia applications available for purchase for smartphones that may be helpful for individuals having difficulty falling asleep or staying asleep. Sleep proceeds through stages from light sleep to deep sleep in a 90-200 minutes cycles. These cycles repeat approximately five times lasting 90-120 minutes. The phase of sleep an individual is in when their alarm goes off significantly impacts how tired he or she feels when awakening. Individuals move differently through the stages of one cycle. One application tracks movement during sleep. This application can be used by the individual is to determine the best time to wake the individual during a 30-minute time frame that ends at the end of the alarm time. This application also saves sleep data and offers a detailed sleep graph. By comparing statistics to analyze sleep issues with a sleep specialist. Another application plays relaxing sounds of nature or ambient music and can combine them all in different volumes. This application also offers a customizable option to combine personal music with existing sounds or interactive photographs to enhance the experience on sleepless nights. Other applications provide audio content consisting of relaxation sleep sessions or comforting words and relaxing, guided meditations by hypnotherapists designed to de-stress and discover an inner calm that is conducive to sleep.

Lighting. Workplace lighting needs are different during the day and night shifts because of the sensitivity of the human circadian system to nocturnal light. The need for bright light exposure during the day is more than during the night. Recent research has demonstrated that many of the adverse effects are due to the narrow band of light spectrum between 470 and 500 nanometers. The human visual spectrum ranges from violet (380 nm) to red (700 nm). There is mounting evidence that exposure to light at night when combined with frequent circadian rhythm disruption and sleep interruptions can cause sleep disturbances as well as cancer, heart disease, and metabolic disturbances (Lerman et al., 2012). Special eyeglasses were found to have beneficial effects in nurses when the sub-480 nm. light wavelength was filtered out improving alertness, sleep, and mood (Lerman et al., 2012).

Chemical Sleep Aid Use Requires Caution

Chemical sleep aids may include over the counter preparations such as diphenhydramine, melatonin, or cold remedies that may be perceived as harmless and benign; however, they have adverse effects and some can be especially dangerous when combined with alcohol or other CNS depressants due to their sedative or antihistaminic effect. Others may have abuse potential. Prescription medications for sleep may include sleeping pills, some of which are associated with serious reactions such as hallucinations and abnormal dreams. Other prescription medications such as benzodiazepines, antistimulants, and tricyclic antidepressants may produce sedation but they also have other side effects that are not always considered before initiating certain medications.

Employer Role in Promoting Healthy Nursing Work Hours

The responsibility for fatigue risk management is shared by employers and the individual employee (Lerman et al., 2012). The nurse promotes, advocates for, and strives to protect nurses from the overload of responsibility for decisions that could place themselves and others at risk. Nurses need to have each other’s back.

Nurse Responsibility and Role in Avoiding Fatigue

According to the ANA Code of Ethics for Nurses (2001), the nurse’s primary responsibility is to the patient whether it is an individual, a family, a group, or the community. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. The nurse’s obligation extends to his or her own decision-making and could place themselves and others at risk. Nurses need to have each other’s back.

Pervasive among nurses who work on all shifts resulting in serious consequences for the safety of patients and the well-being of nurses. There is mounting evidence to suggest that 12-hour shifts and working over 40 hours per week contributes to fatigue and drowsiness. This has a direct impact on nurse performance and patient safety (Rogers, 2008). As a result, it is strongly recommended that nurses protect their sleep time between shifts and strive to achieve a minimum of seven to eight hours per 24 hours. Nurses must also be vigilant of their co-workers who demonstrate signs of fatigue and intervene when necessary. An organizational culture of safety that supports the physiological needs for rest among health care providers will enhance performance and improve patient safety. One responsibility of the healthcare facility is to plan, implement, and evaluate opportunities for rest breaks in a quiet space for nurses. Education and awareness about the dangers of nurse fatigue for nurses is an important role in hospital organizations will contribute to a healthier work environment and a safer environment for care of patients.

Regulatory Statements on Health Care Worker Fatigue

The Joint Commission issued Sentinel Event Alert 48 in 2011 and brought recognition to the dangers of extended work hours among nurses in the health care industry. The work hours have been slow to adopt changes, particularly with regard to nursing. The Joint Commission (2011) recommends the creation and implementation of a fatigue management plan work hours might include:

1. Actively engaging in conversations with others
2. Doing something that involves physical action (e.g. Housekeeping)
3. Consuming caffeine
4. Taking short naps less than 45 minutes in length
5. Maximizing success by trying different combinations of strategies
6. Counteracting severe consequences by obtaining adequate sleep

Summary

As a result of the 2011 Nurse Fatigue Action Proposal, A2ENA generated a nurse fatigue survey and disseminated the findings through presentations, publication of articles, and a continuing education module for contact hours that will be posted on the A2ENA website this year. Fatigue is a pervasive among nurses who work on all shifts resulting in serious consequences for the safety of patients and the well-being of nurses. There is mounting evidence to suggest that 12-hour shifts and working over 40 hours per week contributes to fatigue and drowsiness. This has a direct impact on nurse performance and patient safety (Rogers, 2008). As a result, it is strongly recommended that nurses protect their sleep time between shifts and strive to achieve a minimum of seven to eight hours per 24 hours. Nurses must also be vigilant of their co-workers who demonstrate signs of fatigue and intervene when necessary. An organizational culture of safety that supports the physiological needs for rest among health care providers will enhance performance and improve patient safety. One responsibility of the healthcare facility is to plan, implement, and evaluate opportunities for rest breaks in a quiet space for nurses. Education and awareness about the dangers of nurse fatigue for nurses is an important role in hospital organizations will contribute to a healthier work environment and a safer environment for care of patients.
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Nurse Imposter Alert

Employers in the Metro St Louis area please beware of an individual identified as Dana R Reinhardt, Caucasian female, DOB 06-04-76, attempting to obtain employment as a nurse by falsely using the credentials of a licensed nurse by the same name. Dana Reinhardt possesses a valid Illinois driver’s license and her last known address is 401 Mockingbird Lane, Waterloo, Ill. Dana R. Reinhardt, DOB 06-04-76, is not a licensed nurse in the State of Missouri.


The Board of Nursing is requesting contact from the following individuals:

April Hasenzahl–RN20009008893
Ashley Hurley–PN2003016522
Larry Lavender–RN2012004237
Gaille Maddux-Wolfguts–RN109555
Melinda Novak–PN055876
Sherry Pelecanos–RN069541
Keisha Stone–RN2004066343
Candie Wilkins–PN2004026358

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov.
Disciplinary Actions

Pursuant to Section 335.066 RSMo, the Board “may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo., against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew an active or expired nursing license. To file the complaint, the applicant must be an active or expired nurse. Any holder of any certificate of registration or authority, 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 be positively or negatively affecting 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

Bender, Corinne S.
Nevada, MO
Licensed Practical Nurse 040280
On February 19, 2012, Licensee arrived at the facility and began her shift as a registered nurse in the Alzheimer's unit, and had many residents assigned to her care. During her shift, licensee approached male resident J in the dining room who had been diagnosed with Alzheimer’s and began to tell him he needed to take a shower. When J voiced his unwillingness to take a shower, licensee began to argue with him. Then, licensee left J at his table who was seated in a dining room chair (at his table) still refused to go, licensee then proceeded to remove J’s shoes, socks, pants, watch and eyeglasses in full view of other residents in the dining room. J tried to push away licensee as she did so. J then remained in full view of other residents and CNAs with only a pull-up diaper and shirt on. Licensee then dragged the dining room chair with J in it out of the dining room into the hall to a set of doors that go into an area of the unit. As licensee was dragging the chair through the door with J in it, J grabbed the door edge. Licensee pried J’s hands loose in order to further pull the chair through the doors. Shortly after this occurred, licensee was confronted by facility officials who instructed her to clock out and leave the facility. Licensee was initially permitted to leave the facility. Shortly after this, licensee was discovered to have removed J’s pants in the dining room and that it was “not common” to do that. Censure 10/18/2013 to 10/19/2013

Heck, Thomas Jacob
Lexi Summitt, MO
Registered Nurse 200205630
Pharmacy reports were run from April 1, 2011 through April 22, 2011. Licensee was discovered to have removed Hydromorphone on seven patients that did not have orders for Hydromorphone. Licensee documented the administration of Hydromorphone to the seven patients that did not have an order for Hydromorphone. Administering Hydromorphone to the seven patients that did not have an order for Hydromorphone is outside the scope of practice of a registered nurse.
Censure 09/04/2013 to 09/05/2013

Johnson, Sharon Sue
Jefferson City, MO
Licensed Practical Nurse 012642
On February 19, 2012, Licensee arrived at the facility and began her shift as a charge nurse in the Alzheimer’s unit, and had many residents assigned to her care. During her shift, licensee approached male resident J in the dining room who had been diagnosed with Alzheimer’s and began to tell him he needed to take a shower. When J voiced his unwillingness to take a shower, licensee began to argue with him. Then, licensee left J at his table who was seated in a dining room chair (at his table) still refused to go, licensee then proceeded to remove J’s shoes, socks, pants, watch and eyeglasses in full view of other residents in the dining room. J tried to push away licensee as she did so. J then remained in full view of other residents and CNAs with only a pull-up diaper and shirt on. Licensee then dragged the dining room chair with J in it out of the dining room into the hall to a set of doors that go into an area of the unit. As licensee was dragging the chair through the door with J in it, J grabbed the door edge. Licensee pried J’s hands loose in order to further pull the chair through the doors. Shortly after this occurred, licensee was confronted by facility officials who instructed her to clock out and leave the facility. Licensee was initially suspended from employment from the facility and later terminated from employment as a result of the above conduct. Licensee’s conduct violated the facility’s policies. Licensee admitted to the Board’s investigator that she had removed J’s pants in the dining room and that it was “not common” to do that. Censure 10/18/2013 to 10/19/2013

Gokenbach, Virginia H.
Cedot, MO
Registered Nurse 082873
On April 6, 2012, Licensee charted that she performed an assessment on a patient which she did not actually perform. On April 22, 2011. Licensee was discovered to have removed a soiled dressing in a sink.
Censure 11/05/2013 to 11/06/2013

CENSURE continued...

Harrison, Paula Jo
Jefferson City, MO
Registered Nurse 2008024149
Respondent failed to submit a chemical dependency evaluation by the documentation due date and submitted a sample for testing with a low creatinine level, which is considered dilute and a failed urine test.
Censure 09/24/2013 to 09/25/2013

Randall, Laura M.
Joplin, MO
Registered Nurse 137105
Resident SM lived at the facility, and licensee developed a relationship of professional trust and confidence with SM, other patients, her colleagues and other staff. Licensee drove SM to a bank wherein SM withdrew $800.00 and licensee accepted $800.00 from SM in order to repair her car.
Censure 11/19/2013 to 11/20/2013

Gilliland, Gina R.
Atlanta, MO
Registered Nurse 128073
Respondent failed to call in to NTS on five separate (5) days. On two separate occasions Respondent did not report to work as requested and submitted the required samples which showed low creatinine readings.
Censure 11/05/2013 to 11/06/2013

Bullard, Bradford L.
Ashland, MO
Licensed Practical Nurse 058867
On January 7, 2013, Licensee was on duty and was aware that patient DG was in seclusion at the hospital. Licensee was asked to assist a co-worker with an assessment of DG. Licensee then proceeded to stand in the doorway of DG’s seclusion room. Licensee began a conversation with DG in which staff and other patients were present in which Licensee stated to DG: “I bet you’re ready for a shower, I can smell you through the door, can’t I?” “Well, I think you need to wash your body because it smells”, and “If you were a dog, I’d shoo you.” Licensee’s comments demeaned and belittled DG. DG cried after hearing licensee’s comments. Licensee admitted to hospital officials and to the Board’s investigator that he made the comments to DG. Licensee’s conduct violated the hospital’s policies. Licensee’s employment ended when he resigned in lieu of termination by the hospital as a result of these events, on April 17, 2013.
Censure 10/23/2013 to 10/24/2013

Parker, Deborah A.
Kansas City, MO
Registered Nurse 065965
Respondent worked on a lasped license in Missouri from 05- 01-2011 - 04-22-2011.
Censure 11/05/2013 to 11/06/2013

CENSURE continued...

Surface, Carrie Layne
Jackson, MO
Licensed Practical Nurse 2010036651
On October 25, 2011, licensee was counseled for ordering an MRI on the wrong patient as a result of misinterpreting a physician’s orders. This same patient’s order also contained an order from the physician for the prescription of Valium to be called in and licensee did not do so. On November 9, 2011, licensee was counseled for telling a patient that had called in with rectal bleeding that the patient would have to address it in a physical scheduled to occur in one month. Licensee was counseled on the need to triage urgent problems and schedule them appropriately. On November 11, 2011, licensee was counseled for telling a patient’s father which patient had a knot on his arm and a history of cancer that he would have an appointment in January, 2012, a time frame of approximately two months later. Licensee was counseled again on the need to triage urgent problems and schedule them appropriately. On December 30, 2011, licensee was counseled for failing to label specimen containers, resulting in an inability for the lab to conduct the required tests on a pap smear, resulting in a patient having to return to have another pap smear. On January 9, 2012, licensee received a written warning that she had continually not identified patients with a date of birth in violation of policies. On June 12, 2012, licensee was counseled when a patient under the care of an oncologist exhibited wheezing symptoms and licensee did not timely bring the matter to a physician’s attention resulting in the patient not getting an immediate appointment. On July 9, 2012, licensee was counseled for putting the wrong patient name and date of birth on a patient message resulting in the physician ordering the incorrect medication for the patient. On July 10, 2012, licensee was suspended from employment for violating policies by placing a soiled dressing in a sink.
Censure continued on page 12

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CENSURE continued...

CENSURE continued on page 12

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Funding for this project was provided in part by the Missouri Foundation for Health, a philanthropic organization whose mission is to improve the health of the people in communities it serves.

Southeast Missouri State University
Cape Girardeau
Probation 10/08/2013 to 09/26/2015.

Goodman, Crystal Dawn
Kennett, MO
Registered Nurse 2007016993

On December 13, 2010, the floor was staffed by Licensee and a nurse aide. Licensee repeatedly volunteered to leave the floor to give a patient, her brother-in-law, on a different floor, Demerol, a controlled substance pain medication. On December 13, 2010, while on duty, Licensee called her manager, asking to go home because she was sick with a stomach virus. Licensee’s speech at the time of the telephone call was slurred and unintelligible. Licensee’s manager contacted the house supervisor on duty. The on duty house supervisor observed Licensee with her head on the desk. Licensee’s eyes were closed. Licensee’s movements were lethargic, and her speech was slurred. Licensee struggled to answer simple questions and had to be continually aroused by hospital staff to complete her work. Three registered professional nurses on staff observed Licensee’s conduct on December 13, 2010 and all three believed her to be under the influence of some drug. Despite claiming a stomach virus, Licensee was not observed vomiting or running to the restroom. Licensee agreed to the drug test but asked to complete her charting first. Staff observed that Licensee could not stay on task and continued to put her head down. Licensee could not focus and had to be aroused to finish her work. Accordingly, the facility decided to proceed with the drug screen. Licensee then refused to submit to the drug test. Licensee was informed that she would be terminated if she refused. Licensee continued to refuse the drug test.

Censure 11/05/2013 to 11/06/2013

Morris, Cheri Lynn
Mountain Grove, MO
Registered Nurse 2005006900

Respondent was required to cause letters or statements of ongoing treatment evaluations from a mental health professional to be submitted to the Board by specified quarterly due dates. The Board did not receive an updated treatment evaluation form submitted on Respondent’s behalf by either March 26, 2013 or June 26, 2013. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 26, 2013. However, the Board received a statement of unemployment on July 3, 2013.

Probation 10/08/2013 to 09/26/2015

Probation continued...

Beaty, Kathy E.
West Plains, MO
Licensed Practical Nurse 0240463

On May 10, 2013, Licensee began working in Missouri. Licensee worked from May 10, 2013 through June 11, 2013. Licensee was working using her Texas nursing license while she applied to renew her Missouri nursing license. On June 11, 2013, Licensee reported that she discovered that her Texas nursing license was expired. Licensee practiced nursing in Missouri without a license from May 10, 2013 through June 11, 2013. On August 23, 2013, Licensee pled guilty to the class A misdemeanor of assault of a family member.

Probation 10/09/2013 to 10/09/2018

Gibson, Mary Elizabeth
Carryville, MO
Licensed Practical Nurse 2004025902

Respondent pled guilty to Possession of Up to 35 Grams Marijuana, a class A misdemeanor and Unlawful Use of Drug Paraphernalia, a class A misdemeanor.

Probation 10/08/2013 to 10/08/2018

Turner, Roger Allen
Olean, MO
Licensed Practical Nurse 2013042857


Probation 11/15/2013 to 11/15/2014

Lyttom, Ashley Nicole
Holts Summit, MO
Registered Nurse 2006022276

Respondent could not produce a prescription for Tramadol or Valium. Licensee's behavior while at work in wasting a narcotic the previous day was concerning. An inquiry into licensee’s medication administration activity revealed that licensee was administering more Tramadol to her patients than her peers.

Probation 10/24/2013 to 10/24/2016

Alexander, Sheri Lynn
Saint Charles, MO
Registered Nurse 2012001385

Respondent testified and stipulated that she did not call into NTS as required on July 16, 2013. Respondent also stipulated to this fact at the hearing. As part of the terms of her disciplinary period and probation, Respondent was required to completely abstain from the use or consumption of alcohol in any form regardless of whether treatment was recommended. At the hearing, Respondent testified and stipulated that she last consumed alcohol on September 20, 2012. She further testified that since that date she has participated in a seven month “rehab” for alcohol abuse and has seen multiple counselors. At the hearing, Respondent testified and stipulated that she did not call into NTS as required on July 16, 2013. Probation 10/08/2013 to 10/08/2018

Fulk, Corinna L.
Winona, MO
Registered Nurse 2003002686

Licensee was hired in approximately January, 2012 and terminated on November 5, 2012. On October 12, 2012, staff received a report from another staff member that Licensee’s behavior while at work in wasting a narcotic the previous day was concerning. An inquiry into licensee’s medication administration activity revealed that licensee was administering more Tramadol to her patients than her peers.

Probation 11/08/2013 to 11/08/2018

Besand, Dawn M.
Hillsboro, MO
Registered Nurse 2000418423

In accordance with the terms of the Agreement, Respondent was required to contract with the Board approved third party contained alcohol, but consumed it over the course of two (2) days because she was ill with bronchitis and wanted to sleep. Probation 09/20/2013 to 01/11/2015

Menard, Aymilee Michelle
Eldon, MO
Registered Nurse 2005021682

From June 7, 2013 through August 19, 2013, Respondent failed to call in to NTS on one (1) day, to wit, July 16, 2013. As part of the terms of her disciplinary period and probation, Respondent was required to obey all federal, state, and local laws; and all rules and regulations governing the practice of nursing in this state. On June 26, 2013, Respondent pled guilty to Driving While Intoxicated, in the Circuit Court of Miller County as a result of her actions in which she drove while intoxicated, which occurred on September 20, 2012. Respondent also stipulated to this fact at the hearing. As part of the terms of her disciplinary period and probation, Respondent was required to completely abstain from the use or consumption of alcohol in any form regardless of whether treatment was recommended. At the hearing, Respondent testified and stipulated that she last consumed alcohol on September 20, 2012. She further testified that since that date she has participated in a seven month “rehab” for alcohol abuse and has seen multiple counselors. At the hearing, Respondent testified and stipulated that she did not call into NTS as required on July 16, 2013. Probation 10/08/2013 to 10/08/2018

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U.S. Department of Veterans Affairs
Veterans Health Administration
Marrs, Jennifer Renea
Mound City, KS
Registered Nurse 2011041705
Licensee was discovered sleeping several times while on duty at the home of client J on January 16, 2013; January 22, 2013, and January 23, 2013. J's family members witnessed her sleeping and took photographs of the different positions of her while she slept. Licensee falsified nursing notes by going to J's home at 0700 on January 21, 2013 and leaving at 0709 but then charting as if she had stayed from 0700 until 1600 and charted nursing notes at 0700, 0800, 0830, 0900, 1000, 1100, 1200, 1300, 1400, 1500, and 1600. Licensee also charted that she had a conversation with J's mother who was out of town at the time, an impossibility. Licensee falsified nursing notes on January 7, 2013, January 8, 2013, and January 9, 2013 by charting that she worked at J's home from 0700 to 1900 when in fact she only worked 0700 to 1600. Licensee falsified nursing notes on December 24, 2013 by charting that she worked at J's home from 0700 to 1700 when she only worked from 0700 to approximately 1200. Licensee made false entries of nursing notes at 1230, 1330, 1430, 1530, 1630 and 1730. Licensee falsified nursing notes on January 7, 2013 by charting that she worked at J's home from 0700 to 1800 when she had stopped working there at 1700. Licensee falsified nursing notes on January 28, 2013 by charting that she had falsified the nursing notes of her working hours on December 24, 2012 and January 31, 2013. Prohibition 10/09/2013 to 10/09/2016

Perkins, Erin LeAnn
Saint Charles, MO
Registered Nurse 2011016467
While employed at the hospital, on February 16, 2012, Licensee stole and diverted to herself by injecting into herself Propofol from the hospital's supply. Licensee was found by staff members lying on the floor next to her. Licensee was treated from a puncture site and a syringe containing Propofol and found by staff members lying on the floor with blood coming from a puncture site and a syringe containing Propofol. Licensee was allowed to enter into the Hospital's and to the Board's investigator to injecting herself with Propofol. Licensee was treated from a puncture site and a syringe containing Propofol. Licensee was allowed to enter into the Hospital's and to the Board's investigator to injecting herself with Propofol. Licensee was treated from a puncture site and a syringe containing Propofol. Licensee was allowed to enter into the Hospital's and to the Board's investigator to injecting herself with Propofol. 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Licensee was treated from a puncture site and a syringe containing Propof0
Benadryl drawer of the Pyxis machine under the name of Patient A and removed vials of Benadryl. Patient A did not have an order for Benadryl. At 0900, a physician wrote an order for Fentanyl 50 mcg IV. Licensee removed 100 mcg of Fentanyl at 0930 and 1010. At 1906 and 1918, Licensee and another nurse wasted 150 mcg of Fentanyl. At 1912, a third nurse documented the administration of 50 mcg of Fentanyl.

Prohibition 09/09/2013 to 10/09/2015

Burke, Kelly Nicole
Sacoch, TX
Registered Nurse 2004020662

On January 27, 2012, Registered pupil guilty to two (2) class C felony counts of stealing of a credit card. On January 27, 2012, Registered pupil guilty to the class C felony of stealing over $500 but less than $2,500 and to the class C felony of theft of a credit card. On January 27, 2012, Registered pupil guilty to the class C felony of burglary in the second degree. Respondent admitted that she became addicted to heroin and was involved with three other individuals in breaking into vehicles to steal various items, including credit cards and cash, among other items, in order to obtain heroin for personal consumption.

Prohibition 10/31/2013 to 10/31/2018

Kaufman, Laura J.
Saint Louis, MO
Registered Nurse 086016

Licensee pled guilty to the offense of driving while intoxicated on June 24, 2009. Licensee pled guilty to driving with excessive blood alcohol content and was convicted of this offense on December 28, 2010. Licensee was found guilty of the offense of Driving While Intoxicated on February 17, 2012. Licensee received treatment at the St. Anthony's Medical Center substance abuse treatment program from May 5, 2010 to June 30, 2010 and was diagnosed with alcohol dependence. She was discharged from the facility as non-compliant. She re-entered the program on August 8, 2010 and was discharged on August 13, 2010. Licensee entered the "Choices" substance abuse treatment program as ordered by the Circuit Court of St. Louis County, Municipal Division, on August 18, 2010 and completed the program on November 16, 2010. Licensee entered the Queen of Peace substance abuse treatment program on February 22, 2012 and completed the program on March 1, 2013. Licensee has not been participating in random drug or alcohol screenings. Licensee lists her date of sobriety and the date she last drank alcohol as May 4, 2012.

Prohibition 10/11/2013 to 10/11/2018

Trimble, Jamie Kane
Cameron, MO
Registered Nurse 2013035608

On March 5, 2002, Applicant pled guilty to the class B misdemeanor of Driving while Intoxicated. On September 19, 2007, Applicant pled guilty to the class B misdemeanor of driving while intoxicated. On May 20, 2008, Applicant pled guilty to the class B misdemeanor of driving while intoxicated and endangering the welfare of a child.

Prohibition 09/23/2013 to 09/23/2016

Israel, Aaron Jeffrey
Ballwin, MO
Registered Nurse 2010025185

It was noted on July 12, 2011 that Licensee had 0% medication scanning scores and received his first counseling. Scanning the medications ensure the right medications are going to the right patient. Licensee was aware of the requirement of scanning medications, but stated it was “easier” to click on the medication in the patient record. On July 12, 2011, Licensee was placed on a Level I warning for failure to administer and close in the Administration Policy for failing to scan all patients and medications while administering the medications in the month of June 2011. The policy was discussed and reviewed with the Licensee. On July 29, 2011 a report was run to check the progress for scanning for Licensee. It was found that Licensee understood procedure and was able to demonstrate how to scan the medications but chose not to on particular orders. On June 21, 2011 a complaint was filed for failure to scan Fentanyl and on August 4, 2011 it was given a second counseling and placed on suspension pending investigation. On July 14, 15, 26, and 27 Licensee failed to follow the Medication Administration Policy by bypassing all safety scanning features. A report from the pharmacy was run for the time period of May 1, 2011 through August 4, 2011 and it was determined that:

• Licensee had removed nineteen Xanax 0.25 mg; documented 17; two Xanax were not documented as administered or wasted
• Licensee had removed sixteen Xanax 0.5 mg; documented 15; one Xanax was not documented as administered or wasted
• Licensee had removed 111 Norco; documented 67; forty-four Norco were not documented as administered or wasted
• Licensee had removed forty-five Oxycodone IR 5 mg; documented 31; fourteen Oxycodone IR were not documented as administered or wasted
• Licensee had removed thirty-two Percocet; documented 24; eight Percocet were not documented as administered or wasted

Patient W.P. had an order for Hydrocodone one tablet QID, PRN. On the July 14-15, 2011 shift Licensee withdrew one Hydrocodone for W.P. at 2026, 2124, 2335, 0226 and 0401. Licensee did not document the administration or waste of these medications. On July 7, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 0238 and 0433. These were withdrawn two hours apart. The 0433 dose was not documented as administered or wasted. On July 7, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 0433 and 2116. These doses were not documented as administered or wasted. On July 12, 2011 Licensee withdrew one Hydrocodone on patient D.C. at 0659 and 0410. These doses were not documented as administered or wasted. On July 16, 2011 Licensee withdrew two Hydrocodone on patient J.M. at 2001 and 2049. Licensee documented the administration of one Hydrocodone. Three Hydrocodone were not documented as administered or wasted. On July 29, 2011 Licensee withdrew one Hydrocodone on patient D.A. at 2049 and 2204. These doses were withdrawn two and a half hours apart. Licensee did not document the administration or waste. Prohibition 09/06/2013 to 09/06/2015

Marcum, Michael Leland
Independence, MO
Registered Nurse 2002019966

Licensee’s RN license was suspended by the North Dakota State Board of Nursing on November 9, 2010 and the North Dakota Board issued a Findings of Fact and Conclusions of Law in conjunction with the suspension of his nursing license. The Findings of Fact and Conclusions of Law included several findings in regard to licensee’s behavior as a nurse, including that he tested positive for the illegal drug of cannabis while at work; manufactured IV drops of Fentanyl in patient’s rooms; removed “sharps” containers from patients’ rooms when they were not full; had inappropriate conversations with nursing staff of a sexual nature; allegedly removed narcotics from IV infusions, and demonstrated “panicky” behaviors of flushed skin and pacing, while at work. Prohibition 11/19/2013 to 11/19/2016

McChre, Andrew Lindsey
Independence, MO
Registered Nurse 2003018585

On December 6, 2011, Licensee was caring for a patient along with a coworker, nurse JT. Licensee provided the patient with a tetanus shot. After giving the patient the shot, Licensee jabbed the used needle into nurse JT’s shoulder. Licensee admitted to his supervisor that he had poked nurse JT with the used needle. Licensee said that he believed that the needle had been capped. Prohibition 11/20/2013 to 11/20/2014
Respondent was removing more medication from the subject to discipline by the Board as a result of Respondent violated the Nursing Practice Act and that her license was

Registered Nurse 2000146059
Uptegrove, Jacinda Renee
Probation 10/08/2013 to 12/08/2018

However, a chemical dependency evaluation was received by the Board on August 9, 2013. On April 5, 2013, Respondent failed to call in to NTS on eight (8) different days. On March 11, 2013, Respondent reported to a lab and provided a drug screening. That sample tested positive for the presence of codeine that was not hers on August 11, 2011. Respondent called her director of nursing on August 12, 2011 and admitted that she had consumed cough syrup with codeine in it. Licensee signed the form, indicating she wasted or witnessed the waste of the medication. Licensee falsified a medical document by signing the disposal form when she in fact did not waste nor witness the waste of a controlled substance. In Licensee's written statement to the facility she admits to allowing a CNA access to a controlled substance. It was not in the CNA's job duties to destroy codeine or morphine. Licensee called her director of nursing on August 12, 2011 and admitted that she had consumed cough syrup with codeine that was not hers on August 11, 2011. Voluntary Surrender 09/20/2013

Simonton, Sherri Renee
Independence, MO
Licensed Practical Nurse 2009002063
On August 10, 2011 a Certified Nursing Assistant (CNA) was witnessed the waste of a controlled substance. In Licensee's written statement to the facility she admits to allowing a CNA access to a controlled substance. It was not in the CNA's job duties to destroy codeine or morphine. Licensee called her director of nursing on August 12, 2011 and admitted that she had consumed cough syrup with codeine that was not hers on August 11, 2011. Voluntary Surrender 09/20/2013

Clara, Tammy K.
Independence, MO
Licensed Practical Nurse 056770
Licensee voluntarily surrendered her Missouri nursing license on 11-04-2013. Voluntary Surrender 11/04/2013

Brummett, Patrick Norman
Belton, MO
Licensed Nurse 2005021020
Licensee voluntarily surrendered his license on October 21, 2013. Voluntary Surrender 10/21/2013

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Probation continued...

PROBATION continued...

administration, Licensee admitted to diverting Vicodin for her personal consumption. Probation 09/20/2013 to 09/20/2018

Whitaker, Michelle M.
Warrenton, MO
Licensed Nurse 116708
On September 10, 2011, Licensee pled guilty to the class C felony of Possession of Controlled Substance Except 35 Grams or Less of Marijuana. Licensee additionally pled guilty to the class A misdemeanor of possession of marijuana and the class A misdemeanor of unlawful use of drug paraphernalia. Probation 10/23/2013 to 10/23/2016

VOLUNTARY SURRENDER

Simonton, Sherri Renee
Independence, MO
Licensed Practical Nurse 2009002063
On August 10, 2011 a Certified Nursing Assistant (CNA) was pulled over in a traffic stop and a bottle of promethazine with codeine belonging to a resident was found in her car. The Disposal or Return of Medication form for that bottle of promethazine with codeine was dated July 27, 2011 and it indicated that 79 ml of the medication was destroyed at the facility. Licensee signed the form, indicating she wasted or witnessed the waste of the medication. Licensee falsified a medical document by signing the disposal form when she in fact did not waste nor witness the waste of a controlled substance. In Licensee's written statement to the facility she admits to allowing a CNA access to a controlled substance. It was not in the CNA's job duties to destroy codeine or morphine. Licensee called her director of nursing on August 12, 2011 and admitted that she had consumed cough syrup with codeine that was not hers on August 11, 2011. Voluntary Surrender 09/20/2013

Clara, Tammy K.
Independence, MO
Licensed Practical Nurse 056770
Licensee voluntarily surrendered her Missouri nursing license on 11-04-2013. Voluntary Surrender 11/04/2013

Brummett, Patrick Norman
Belton, MO
Licensed Nurse 2005021020
Licensee voluntarily surrendered his license on October 21, 2013. Voluntary Surrender 10/21/2013

VOLUNTARY SURRENDER continued...

Reece, Patricia D.
New Franklin, MO
Licensed Practical Nurse 050104
Licensee held a license to practice licensed practical nursing, License No. L0054392, issued by the Oklahoma Board of Nursing until it was voluntarily surrendered on July 24, 2012. The voluntary surrender was based on an agreed stipulation made by licensee and the Oklahoma Board of Nursing in an Order that stated that on or about March 12, 2012, while Licensee was working as an RN in Colcord, OK, that she failed to transcribe a physician order for Lovenox which resulted in resident GM failing to receive the Lovenox for four days, resulting in resident GM having to be transferred to a hospital for evaluation. Licensee stipulated in the Order that her Oklahoma license was to be placed on voluntary surrender status for a period of two years which barred her from reapplying for her license until two years has passed from the date of the Order, with various reinstatement requirements required should she so apply. The Stipulation, Settlement, and Order was approved in full on July 24, 2012. Voluntary Surrender 11/05/2013

Nolen, Mark Allen
Kennen, MO
Licensed Practical Nurse 2003019170
On November 3, 2012, licensee was in a motor vehicle accident and was initially charged with driving while under the influence of drugs. Licensee underwent a urine test as a result of the arrest, and the test was positive for Zolpidem, Paroxetine, Citalopram, Desmethylcitalopram, Promethazine and Diphenhydramine. Licensee had previously been warned by his physician not to take the Paroxetine and the Citalopram together at the same time. On November 8, 2012, a physician for OG contacted staff and requested that licensee no longer be allowed to see any of her patients. She said this because she had suspected licensee of stealing and diverting to himself OG's Ativan while at OG's home. An interview with OG later confirmed that OG had in fact witnessed licensee taking her Ativan when refilling her medication tray and licensee informed OG that “the pharmacy had shorted her on pills again. Licensee also on November 8, 2012, requested an increase in OG's Ativan from 5mg to 1 mg. Licensee did not tell OG he was doing this. OG's physician then notified OG's pharmacy she did not want licensee to ever pick up any medications from the pharmacy for any of her patients again. Licensee illegally and unlawfully took the Ativan to divert controlled substances to himself; and was dishonest and committed misrepresentation by requesting an increase in OG's Ativan without authority, and in doing so was practicing outside the scope of his nursing license. Voluntary Surrender 10/21/2013
From February 9, 2013 through July 29, 2013, Respondent Johnston, Stacy Nicole admitted to a relapse and diversion of narcotics. The Facility identified 5 Oxycodone 5/325 mg tablets. The Facility identified for patients not under her care. A total diversion report for a controlled substance audit based on apparent discrepancies of a registered professional nurse. On October 17, 2010, Respondent consumed Methamphetamine and Propoxyphene while on duty. On October 16, 2010, and October 17, 2010, Respondent was under the influence of controlled substances because she did not need blood sugar check or receive an IV medication. Respondent connected the patient to the system instead of actually taking the patient's blood pressure and based on his response she put that into the computer. Respondent left the facility. Respondent left without passing report on her duty. Respondent refused to submit to a drug screen and claimed she simply passed out due to diabetes. There was no evidence of diabetes in the bathroom. A urine screen revealed Respondent was positive for lidocaine and propofol.

Count II

January 23, 2011, while on duty. Licensee withdrew narcotics for patients not under her care. A total diversion report for January 23, 2011, reported that Licensee withdrew and diverted: 5 Dilaudid 5mg/ml carpijects; six Morphine 2 mg/ml carpijects; 8 Hydrocodone 5/325 mg tablets and 5 Oxycodone 5/325 mg tablets. The Facility identified the alleged diversion and improper charting and Licensee admitted to a relapse and diversion of narcotics. The Facility terminated Licensee as a result. Voluntary Surrender 9/26/2013

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Revocation continued on page 17

Revocation continued on page 17

February, March, April 2014
Bond, Mary Jane  
Saint Louis, MO  
Licensed Practical Nurse 033490  
On February 4, 2011, at 11:00 p.m., T.R., CNA, reported to Respondent that Patient, E.S., was breathing heavily and sweating profusely. On February 4, 2011, at or around 11:00 p.m., Respondent did not check patient, E.S.'s, temperature or do an assessment. On February 5, 2011, at 1:00 a.m., T.R., CNA, reported to Respondent that Patient, E.S., did not look good and was panting. Respondent was aware that Patient, E.S., had a temperature over 104 degrees and his blood sugar was 404. Respondent indicated that at 1:00 a.m. on February 5, 2011, she administered Tylenol to patient, E.S. Respondent did not do an assessment of the patient at the time she administered the Tylenol nor did she notify the patient’s physician of his change in condition. On February 5, 2011, she administered Tylenol to patient, E.S. at 3:00 a.m. on February 5, 2011, but did not recall why, as the Tylenol was not documented in her nursing chart that “Tylenol was given, temperature was 104.1, and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent’s EtG level was 20,801 nanograms per milliliter (ng/ml) and her EtS level was 6,586 ng/ml. On December 17, 2012, Respondent again reported to a collection site to provide the required sample and the sample again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent’s EtG level was 1,209 ng/ml and her EtS level was 668 ng/ml. In addition, Respondent’s creatinine level on December 17, 2012, was 9.8, which is suspicious for a diluted sample. On January 10, 2013, Respondent again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent, when she reported to a collection site to provide a sample, which was once again positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent’s EtG level was 11,299 ng/ml and her EtS level was 4,530 ng/ml. On March 14, 2013, Respondent’s creatinine level was 14.2, which is suspicious for a diluted sample. On Friday, March 22, 2013, Respondent reported to a collection site to provide the required blood sample, which was positive for Phosphatidyl ethanol (PEth), a metabolite of alcohol. The PEth level was 321 ng/ml. On Wednesday, February 13, 2013, Respondent reported to a collection site to provide the required sample, which again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent’s EtG level was 1,039 ng/ml and her EtS level was 462 ng/ml. On Thursday, June 13, 2013, Respondent reported to a collection site to provide the required sample, which again tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Additionally, her creatinine level was 14.3 on that date. Respondent’s EtG level was 9,134 ng/ml and her EtS level was 3,562 ng/ml. On July 12, 2013, Respondent reported to a collection site to provide the required sample, which tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. Respondent’s EtG level was 11,588 ng/ml and her EtS level was 3,508 ng/ml. Since the beginning of Respondent’s probation, Respondent has failed to call in to NTS on four (4) occasions, to-wit: March 17, 2013; May 13, 2013; May 19, 2013; and, June 29, 2013. The Board did not receive an employer evaluation by the documentation due date of July 17, 2013. The Board did not receive an evaluation update or letter of final evaluation/summary by the documentation due date of July 17, 2013. The cutoff for EtG is 500 nanograms per milliliter. The cutoff for EtS is 100 nanograms per milliliter. The standard of care for monitoring professionals for alcohol abstinence is urine EtG/EtS testing followed with PETH tests after positive EtG results. Hand sanitizer exposure would only be significant if the EtG level was below 2,000 ng/ml, which is the highest level anyone has ever been able to produce using hand sanitizer and then measuring urine EtG. The highest level for EtS after hand sanitizer use was 25 ng/ml. Multiple positive urine EtG/EtS tests indicate ongoing ingestion of ethanol. Blood spot PETH test stands for phosphatidylethanolamine which is another metabolite of ethanol that is more reliable in terms of assessing how much someone may be drinking because the levels correlate more closely with the amount of alcohol consumed. PETH can detect binge drinking or regular, constant drinking over a period of time. The cutoff for PETH is 20 nanograms per milliliter. A PETH level of 321 ng/ml indicates ongoing, regular drinking that correlates to three standard drinks per day during the two to three-week time period prior to the test. It is more likely than not that she is ingesting ethanol on a regular basis. Respondent testified that she drank alcohol on one occasion during her probation. She stated that when she found out her case was going to be going in front of the Board she drank alcohol on one day at the beginning of March when she consumed six (6) beers. Respondent stated that she did not drink in any other occasion.  
Revoked 09/13/2013  
Knehans, Robin Rachelle  
Saint Louis, MO  
Licensed Practical Nurse 2012002713  
On April 12, 2013, Respondent reported to a lab and submitted the required sample which showed a low...  
Revocation continued on page 18
On June 24, 2013, July 9, 2013, and July 29, 2013, Respondent did not receive proof of completion of any of the required hours. The Board did not receive proof of completion of any of the required hours submitted to the Board by June 25, 2013. The Board did not receive proof of completion of any of the required hours. On June 24, 2013, July 9, 2013, and July 29, 2013, Respondent was required to obtain continuing education hours. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 25, 2013. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by June 25, 2013. The Board did not receive proof of completion of any of the required hours.

Revoked 09/11/2013

Branson, Carole L.
Overland Park, KS
Registered Nurse 093520

The Board received information that the Kansas State Board of Nursing had disciplined the Kansas nursing license of Respondent. The facts leading to the Kansas Board to discipline Respondent’s Kansas nursing license are as follows:

a. On or about April 20, 2009, Respondent was hospitalized with a diagnosis of poisoning by benzodiazepine-based tranquilizers.
b. Respondent told the triage nurse that she “just needed to sleep” and took Lorazepam she had taken from the hospice center where she worked.
c. At the time, Respondent was employed in a skilled nursing unit.
d. Nine different prescription medications belonging to six current or former residents were found in Respondent’s residence.
e. As a result of this incident, the Kansas Board of Nursing referred Respondent to the Kansas Nurses Assistance Program (KNAP).

On or about November 17, 2009, KNAP closed Respondent’s KNAP case due to noncompliance on the part of Respondent. KNAP reported that Respondent failed to complete a drug and alcohol assessment and return a signed release of information forms.

Revoked 09/12/2013

Roux, Monica A.
Edina, MO
Licensed Practical Nurse 057529

On or about April 20, 2009, Respondent was hospitalized with a diagnosis of poisoning by benzodiazepine-based tranquilizers.

On or about November 17, 2009, KNAP closed Respondent’s KNAP case due to noncompliance on the part of Respondent. KNAP reported that Respondent failed to complete a drug and alcohol assessment and return a signed release of information forms.

Revoked 09/12/2013

Woods, Melissa Kay
Farmington, MO
Registered Nurse 2012034842

During Respondent’s probation in accordance with the terms of the Amended Order, Respondent failed to call in to NTS on thirty-eight different (38) days. Respondent additionally failed to report to a collection site when selected for testing on June 25, 2013; July 9, 2013 and July 30, 2013. On May 28, 2013, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of Amphetamines and Methamphetamine. In addition, on June 7, 2013, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of Cocaine, Amphetamines and Methamphetamine.

Respondent testified that she “was guilty” and testified that she used cocaine “maybe a week or two before” May 28, 2013. She further testified that she had stopped calling into NTS because she “pretty much had given up.” Upon specific questioning by the Board, Respondent testified that she hadn’t been “using” in about a week, but prior to that had been “using” “maybe every other day.”

Revoked 09/12/2013

Call Stephanie Brink at 660-248-6639 or e-mail sbrink@centralmethodist.edu

Revocation continued on page 19
shaking, trembling, aggressive towards other staff, speaking loudly, speaking fast, fidgety, and with red eyes. Also on March 3, 2011, a resident under Respondent’s care fell, and Respondent did not follow the protocol for this emergency. Based on the aforementioned observances and behaviors exhibited by Respondent, she was asked to submit to a urine drug screen by the Nursing Home. The urine drug screen revealed that Respondent possessed and tested positive for Lorazepam, Hydrocodone and Marijuana. Revoked 09/12/2013

Roland, Sandra L.
Kansas City, KS
Registered Nurse 122217
On March 4, 2013, the Board entered an “Order of the State Board of Nursing” regarding Issuance of a Probated License to Sandra Roland (Order). Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not contact the Board after receiving this Order, nor did she attempt to reschedule the meeting or to inquire what she needed to do. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 4, 2013. Revoked 09/12/2013

Lahn, Candice Elizabeth
Kansas City, MO
Registered Nurse 2010034426
Licensee failed to contract with NTS within twenty (20) working days of the effective date of the Agreement, failed to contact NTS on fifty (50) days, failed to provide samples for testing on three (3) occasions, failed to submit a chemical dependency evaluation due by the date, failed to submit an employer evaluation or statement of unemployment by the due date, failed to submit proof of completion of continuing education courses, and failed to renew her nursing license. Revoked 09/12/2013

Shepard, Kenneth Edward
Bixby, OK
Registered Nurse 2007035974
The Oklahoma State Board of Nursing disciplined Respondent’s Oklahoma nursing license on September 23, 2009, pursuant to a consent order, signed and agreed to by Respondent, agreeing that his license in Oklahoma was subject to discipline, in part, as a result of: On or about May 28, 2008, the District Attorney for Tulsa County, Oklahoma, filed information in the District Court of Tulsa County, Oklahoma, Case No. CF-2008-2439, charging Respondent with: Count I: Lewd molestation, a felony; and Count II: Obscene Electronic Communication, a misdemeanor.
Respondent failed to appear on the scheduled date. Respondent was convicted of both counts and sentenced to two (2) years in the penitentiary. Respondent entered the Tulsa Community Correctional Center on July 21, 2008 and was released on April 30, 2010. On March 3, 2011, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent appeared for the drug screen and stated that she had brought someone else’s urine to use in the drug screen after being informed that her urine sample was required to be observed. Respondent further stated that she took a tramadol the night before the test for which she did not have a prescription for it. She was given the option of doing the test with her own urine. Respondent stated that she would do the test at all. Respondent left the office without providing a sample. Respondent failed to assure that lab personnel observe all urine specimen collections. In accordance with the recommendations of the chemical dependency professional, Respondent was required to work with a sponsor and submit evidence of weekly attendance at Narcotics Anonymous meetings. The Board received proof of attendance at Narcotics Anonymous meetings by the required documentation dates. On each of the required support meeting report forms Respondent stated that she was not required to have a sponsor. Revoked 09/24/2013

Ward, Clyde Edward, II
Hannibal, MO
Registered Nurse 2010035665
Respondent was required to contract with the third-party administrator, currently National Toxicology Specialists, Inc. (NTS), and participate in random drug and alcohol screenings. During Respondent’s probation, Respondent failed to call in to NTS on one (1) day, July 8, 2013. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of April 24, 2013, and July 24, 2013. The Board did not receive an update of treatment evaluation from a chemical dependency professional submitted on Respondent’s behalf by the documentation due dates of April 24, 2013, and July 24, 2013. The Board did not receive proof of support group attendance by the documentation due dates of April 24, 2013, and the July 24, 2013, documentation due dates. The terms of the Agreement additionally required Respondent to renew his nursing license within five (5) working days of its expiration and not allow his license to lapse. Respondent’s registered professional nursing license lapsed on April 30, 2013, and was not renewed until July 17, 2013. Revoked 09/12/2013

Bollman, Stacie Dawn
Madison, MO
Licensed Practical Nurse 20080072760
On February 16, 2012, Respondent forced a resident to walk when the resident did not want to, causing the resident to fall several times. Because of her actions, Respondent’s name was placed on the Department of Health and Senior Services Employee Disqualification list. Revoked 09/01/2013

Sylla, Samantha Jean Marie
Saint Ann, MO
Registered Licensed Nurse 2011029814
During Respondent’s probation period, Respondent has failed to call in to NTS on three (3) days. Further, on June 5, 2013, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to call in to NTS on one (1) day. In February, March, April 2014 Missouri State Board of Nursing  •  Page 18
Crystall Tillman Harris, DNP, RN, CPNP
July 2013

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From the North Carolina Board of Nursing
Fall 2013, Volume 10 (No 1) Edition 28 of the Nursing Bulletin

Two highlights for the article:
The use of social networking can have numerous benefits but also unintended consequences for an individual nurse’s career, and
Remember that it pertains to provided nurses. As nurses, we educate our patients and can provide appropriate websites for patient and family education. Many nurses use it as a means of professional networking and communication; however, a lot of the content is electronic. Networking can also disseminate research and evidence-based practice findings to colleagues. Smart phones and tablets have entered the household and are our most trusted healthcare professionals. Nurses should not only understand the use of these technologies, but nurses should also consider where or to where use these technologies.

Benefits of Social Networking
It is wonderful to live in an age of social networking and see the变得 popular of these professionalism are the same online as in any other circumstance.
The use of social media, including Facebook, Twitter, LinkedIn, YouTube, blogs, chat rooms, MySpace and other similar sites are increasing exponentially. A 2010 Pew report stated that among adults, 73% use Facebook, and 53% of Internet users have a LinkedIn (Pew, 2011). The use of social media will continue to rise and is a common daily occurrence for most of us.

Nurses have an added responsibility of ethical use related to personal use of social networking. Once again this year, nurses were ranked highest on honesty and ethical standards according to the Gallup poll, as being more honest than any other profession in the United States (Jones, 2011). Nurses have held the number one spot every year since 1999, with the exception of 2001 when firefighters toppled the list. Nurses are held to higher standards. As nurses, it is important to uphold the public’s trust and respect in all areas of our lives, including the use of social networking. Because we are the most trusted healthcare professionals, nurses should not only understand the use of these technologies, but nurses should also consider when or where to use these technologies.

Concerns of Social Networking
With the increase in technology, also come some concerns. National organizations’ guidelines for personal or work information that reflects poorly on the nurse and professionalism in nursing is a concern for all of us. Many times breaches of patient confidentiality can occur, either intentionally or inadvertently. Examples include description of a patient with enough detail for identification, posting videos or pictures of patients, and referring to the patient in a demeaning manner (ANA, 2011). This can lead to a breach of patient confidentiality and privacy and damage to a nurse’s career.

Also of concern is the ability of the nurse to become distracted while using smart phones. Such distractions have the potential to be catastrophic. There are appropriate uses of technology at work during patient care… and checking one’s Facebook status is not one of them.

Students have been expelled from nursing school for posting online photos of themselves with a placenta and nurses have been fired for discussing patient cases on Facebook. In the Byrnes vs. Johnson County Community College litigation, a nursing student posted a photo of herself with a placenta on her Facebook page. The photo went viral within hours; the student was expelled one day later and was told that she could re-apply to enter the program the following year. The patient issue was that in the photo you could see the student’s I.D badge and the school’s patch on her uniform. By right-clicking on the photo the embedded date of the photo is retrievable. Social media will continue to rise and is a common daily occurrence for most of us.

The American Nurses’ Association (ANA) has developed a guideline for use of social media by nurses that elucidates principles for social networking that can lead to appropriate use of the technology (ANA, 2011). Simply removing a name or face does not necessarily protect the patient’s identification. The principles are:

• Nurses must not transmit or place online individually identifiable patient information.
• Nurses must observe ethically prescribed professional-patient boundaries.
• Nurses should understand that patients, colleagues, institutions, and employers may view postings.
• Nurses should take advantage of privacy settings and seek to separate personal and professional information online.

Nurses should bring content that could harm a patient’s privacy, rights, or welfare to the attention of appropriate authorities. Nurses should participate in developing institutional policies for social networking. The Health Insurance Portability and Accountability Act (HIPAA) protection includes information that can reasonably be used to identify the patient.

HIPA A’s Don’t of Social Networking:
• Do make a distinction between your personal life and professional online.
• Do use social media for educational and professional purposes.
• Be mindful of HIPAA.
• Don’t post your patient records as high as possible.
• Don’t be lulled by false security.
• Don’t discuss your patients or your colleagues.

The Code of Ethics for Nurses provides a framework for nurses in ethical decision-making and can provide guidance in the use of social media (ANA, 2001). The Code of Ethics for Nurses reminds us of our primary commitment to patients, to practice with compassion and respect for all individuals, and the requirement to communicate knowledge (ANA, 2001). According to the ANA:

The patient’s well-being could be jeopardized and the fundamental trust between patient and nurse be destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written, or electronic.

Consequences for Inappropriate Use of Social Networking
There are consequences to inappropriate use of social media. The potential consequences vary according to the specific breach of trust. Social networking is a common daily occurrence for most of us.

Social Networking and Nurses continued on page 21

The National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) have mutually endorsed each organization’s guidelines for upholding professional boundaries in a social networking environment and have created a joint webinar on Guidelines for Social Media (ANA and NCSBN, 2011). The webinar is open to the use of social media lists and actions nurses can take to minimize risk and provides scenarios of unprofessional behavior based on actual events reported to Boards of Nursing (NCSBN, 2011).

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Consequences for Inappropriate Use of Social Networking
There are consequences to inappropriate use of social media. The potential consequences vary according to the specific breach of trust. Social networking is a common daily occurrence for most of us.
If the Board finds the allegations to be true, the nurse can face disciplinary action ranging from a reprimand or sanctions to temporary loss of license. Thirty-three state BONS reported complaints last year against nurses who violated patient privacy using social media (NCSBN, 2011). In many cases, the nurse inadvertently breached confidentiality.

There may be other consequences also. The nurse may face complaints that a state or federal law to protect patient confidentiality was breached. This violation can result in civil or criminal charges. There is also the possibility the nurse could face a lawsuit for personal damages including defamation or invasion of privacy. If employment rules were broken, the nurse may face suspension or termination at work.

The line of speech protected by labor laws and the First Amendment and the ability of an employer to impose expectations on employees outside of work is still being determined (National Labor Relations Board, 2011). Nonetheless, inappropriate comments can be detrimental to a cohesive health care delivery team and may result in sanctions against the nurse (Cronquist and Spector, 2011).

Policies

Organizations are finding the need to develop policies and professional guidelines to aid nurses in negotiating responsibility and professionally the use of social networking. This is beginning to happen in some medical institutions but needs more widespread attention in order to avoid legal and ethical problems.

Managers need to be aware that, although sending a friend request to an employee might seem rather fun and friendly, it could have unintended consequences. Even if the manager is comfortable initiating the request, the employee may not feel the same way, creating a potentially negative undertone to their working relationship. It may lead to potential claims of fraternization, harassment, or stalking.

Inappropriate social networking should also be included in nursing education program curriculums. Discussions of professional conduct and ethical behavior in the health care workplace and clinical settings are necessary. The importance of social networking must be a priority with new students during orientation, and the potential pitfalls social media may create foreseen.

Most health care employers expect that the employee will follow the same behaviors online as they would in face-to-face contact. Be sure to know the policies of your employer or academic institution. Many institutions now have policies such as:

- Do not “friend” patients
- Do not accept “friend requests” from patients or their family members
- Never share any patient information via Facebook or other social media
- Never post pictures of patients or pose with patients for pictures.
- Never give medical advice via social media.

Summary

Our online conversation should reflect the same professionalism that is expected when working with the public. If you are about to post an item that you know would be embarrassing if seen by a colleague, employer, patient, or family member, then do not post it. It is essential to maintain professional integrity when incorporating networking, even when doing so only in your personal life.

Remember once you post something, there is a digital footprint forever. Just because you delete a post, photo or video, does not mean it is destroyed. Data can be retrievable from law enforcement or technology experts.

The golden rule in social networking is this: assume that there is no privacy. Pretend that what you are writing is appearing on a permanent billboard. If you would not want it to be printed for all to see, then think twice before posting to a social media site.

**Examples of Inappropriate Posts from Ethical Reasoning and Online Social Media:**

- My patient was the cutest little 70-year-old lady. And I found out she lives in my neighborhood. Awesome… a new friend.
- So far, my clinical sucks… when will I start doing the fun stuff?
- First day of orientation, and I feel completely overwhelmed! I seriously don’t know what I’m doing yet. I feel sorry if you were my patient today…. but I will get better.
- The new staffing policy here is awful… who thought it was OK to have each nurse have 6 patients. Looks like our NAs will have to do a lot more!
- Friday afternoon…. so glad the weekend is here. Time to get drunk. I need a vacation from responsibility.
- What’s up everyone? I’m on a break at clinical and had some time to post. Anybody out there have a minute to catch up?
- I’m going to make sure that I have a living will. I just don’t understand why the patient I cared for today wants “everything done” to hang on.
- My supervisor was bugging me today to join ANA. Why would I need to do that?

(Englund et al., 2012)

**References**


Jones, J. Record 64% Rate Honesty, Ethics of Members of Congress Low: Ratings of nurses, pharmacists, and medical doctors most positive. Dec. 12, 2011.


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### Schedule Of Board Meeting Dates Through 2015

**March 5-7, 2014**  
**June 11-13, 2014**  
**September 3-5, 2014**  
**November 19-21, 2014**  
**March 4-6, 2015**  
**June 3-5, 2015**  
**September 2-4, 2015**  
**December 2-4, 2015**

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

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 686, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at [http://pr.mo.gov](http://pr.mo.gov)

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Mariam Decker, RN JD, Attorney  
573-443-3134  
[mdedecker@owwlaw.com](mailto:mdedecker@owwlaw.com)

The choice of a lawyer is an important decision and should not be based solely on advertisements.

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- Bartlesville Clinic - Bartlesville
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