Message from the President

Roxanne McDaniel, PhD, RN, President

Licensed Practical Nurse (LPN) Licenses Expire
May 31, 2014

Nurses are required to renew their professional license every two years. It may surprise you to know that about 15% of nurses don’t renew prior to the expiration date of their license. It may be easy to forget but not renewing has serious repercussions.

It is a violation of the Nursing Practice Act to practice nursing or use the title “nurse” without a current license, and practicing nursing on an expired license subjects a nurse to disciplinary action by the board. In addition, the employer and/or nurse cannot submit claims for Medicare/Medicaid reimbursement. Payments made for services provided while a nurse’s license was expired will be considered an overpayment and recovery procedures will commence.

Approximately 25,000 renewal postcards were mailed to LPNs in early March. The postcard provides the nurse with online renewal instructions. An LPN must either renew online or with a paper renewal. If you are an LPN and did not receive your postcard or need a paper renewal, obtain renewal instructions at the board’s website at www.pr.mo.gov/nursing.

It takes up to five business days to renew a license. Nurses are not issued a new wallet-sized card when the license is renewed. To verify your renewal, click on Search QuickConfirm at www.nursys.com. Once you find a record in this system, you have the option of downloading a report that you can save or print. This report can be retained in your records and/or given to your employer as evidence of license renewal.

If you are an employer of nurses, the best way to protect yourself from having a nurse practice with an expired license is to enroll your nurses in e-Notify at www.nursys.com. e-Notify provides real-time automatic notification of status and discipline changes delivered directly to you. The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for RNs and LPNs. Nursys data is compiled from information inputted directly from boards of nursing and is primary source equivalent. With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or no charge (cost is dependent on the number of nurses uploaded into the system). It is economical and provides vital information saving you money and staff time.

Executive-Director’s Report

Executive Director
Lori Scheidt, MBA-HCM

Address/Telephone Number
Missouri State Board of Nursing
3665 Missouri Boulevard
Jefferson City, MO 65102-0656
573-751-0651 Main Line
573-751-0652 Fax
Web site: http://pr.mo.gov
E-mail: nursyr@pr.mo.gov

Governor
The Honorable Jeremiah W. (Jay) Nixon

Department Of Insurance, Financial Institutions And Professional Registration
John M. Huff, Director

Division Of Professional Registration
Jane A. Raekers, Director

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Mariea Snell, DNP, MSN, RN, FNP-BC
Member
Alyson C. Speed, LPN
Member

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

Social Security Numbers on License Renewals
Senator Wayne Wallingford (R-District 27) filed Senate Bill 528. Passage of this bill would change the Social Security number requirement. Under current law, every application for a renewal of a professional license, certificate, registration, or permit must contain the applicant’s Social Security number. This act states that an application for a professional license renewal only has to include a Social Security number in situations where the original application did not contain a Social Security number. After the initial application for license renewal, which includes a Social Security number, an applicant is no longer required to provide a Social Security number in subsequent renewal applications.

Advanced Practice Registered Nurse Practice Bills
Representative Lyle Rowland (R-District 155) filed House Bill 1481 and Senator David Sater (R-District 29) filed Senate Bill 700. Passage of either of these bills would modify the laws relating to advanced practice registered nurses and collaborative practice arrangements. It would remove the geographic proximity requirement and indicate that the collaborating physician and APRN would maintain effective electronic communication. It would indicate that the collaborating physician’s review of the APRN’s delivery of health care services may be done through review of electronic medical records. Finally, it would eliminate joint rulemaking authority between the board of nursing and board of registration for the healing arts except those related to prescribing controlled substances.

Representative Donna Lichtenneger (R-District 146) filed House Bill 1491 and Senator Wayne Wallingford (R-District 27) filed Senate Bill 659. Passage of either of these bills would modify the laws relating to advanced practice registered nurses and collaborative practice arrangements. It would also grant the board of nursing the authority to license Advanced Practice Registered Nurses (APRNs).

Representative Jeanie Riddle (R-District 49) filed House Bill 1779. Passage of this bill would allow advanced practice registered nurses in collaborative practice arrangements to make certain decisions regarding patient restraints.

Nursing Workforce Analysis
Representative Chris Kelly (D-District 45) filed House Bill 1641. Passage of this bill would allow the board of nursing to contract with a public institution of higher education or nonprofit corporation or association for the purpose of collecting and analyzing workforce data from its licensees. It would also require the contractor to...
Laura Noren, MBA, BSN, RN, NE-BC, is the Service Line Director of Women’s and Children’s Health at Boone Hospital Center in Columbia, Missouri. She is also the Magnet Program Director for the hospital which is one of only 7% of hospital nationally to earn the American Nurses Credentialing Center’s Magnet Recognition for Nursing Excellence. During her 22 years at Boone Hospital Center, she has also been responsible for inpatient and outpatient care areas, marketing, staff and organizational development, and human resource functions. Boone Hospital Center is a member of St. Louis based BJC HealthCare and Laura has been active at both the local and system level in all of her roles.

Laura has worked in hospitals in Columbia, Jefferson City, St. Louis, and Kansas City. In addition to maternal health, she is experienced in cardiac care, burn care, critical care, and general medical/surgical care. Laura earned her Bachelor of Science degree in nursing from the University of Central Missouri and a MBA from William Woods University. She is a Registered Professional Nurse in Missouri and a Board Certified Nurse Executive by the American Nurses Credentialing Center. Laura was born and raised in Jefferson City, Missouri as the fifth child of Carl Noren, former Director of the Missouri Department of Conservation, and Ann Noren, former supervisor of Obstetrics and Newborn services at St. Mary’s Hospital, Jefferson City. Laura has lived in Columbia, Missouri for the past 22 years. She is married to Scott Wilson and they have four children and two grandchildren.

Aly Speed is an LPN at CoMo Cubs Pediatrics in Columbia. She earned her Practical Nursing Diploma at the Columbia Area Career Center, where she still serves on their Advisory and Admissions Committees. Aly is also a clinical preceptor for current Career Center nursing students. Aly is currently enrolled at Columbia College where she is pursuing her Associate of Science Degree in Nursing. She is very honored and excited to serve on the Missouri State Board of Nursing.

Important Telephone Numbers

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health &amp; Senior Services</td>
<td>573-526-5686</td>
</tr>
<tr>
<td>Missouri State Association for Licensed Practical Nurses (MoALPN)</td>
<td>573-636-5689</td>
</tr>
<tr>
<td>Missouri Nurses Association (MONA)</td>
<td>573-636-4623</td>
</tr>
<tr>
<td>Missouri League for Nursing (MLN)</td>
<td>573-635-5355</td>
</tr>
<tr>
<td>Missouri Hospital Association (MHA)</td>
<td>573-893-3700</td>
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Number of Nurses Currently Licensed in the State of Missouri

As of April 24, 2014

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
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<tbody>
<tr>
<td>Licensed Practical Nurse</td>
<td>25,314</td>
</tr>
<tr>
<td>Registered Professional Nurse</td>
<td>98,329</td>
</tr>
<tr>
<td>Total</td>
<td>123,643</td>
</tr>
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Important Telephone Numbers

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You may submit your comments on legislation by filling out the form below. You can also reach your state legislator using thetoolkit.org.

http://pr.mo.gov

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LAW MAINTAINS THE PRIVILEGE OF NURSES TO BE INVOLVED IN DETERMINING 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 INTIMATE KNOWLEDGE THAT HELP 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://mons.moga.gov/

You are encouraged to share your thoughts on legislation with your friends and colleagues. You may also bring information about bills to your next staff meeting or to a civic association meeting in your area.

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Phone: (816) 584-6257
Fax: (816) 584-6259
Email: david.esselman@park.edu

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ATTENTION NURSE EMPLOYERS

There are two tools that employers need to have in their toolkits:

1) Enroll your nursing staff in e-Notify at www.nursys.com. By doing this, you will automatically receive publicly available discipline and license status updates of your nurses. Using this service will save your human resources or credentials staff valuable time.

2) Verify new hires using Quick Confirm at www.nursys.com. Once you locate a record in this system, you have the option of downloading a report that you can save to your system or print. This report can be retained in the nurse’s personnel file.

May, June, July 2014

ATTENTION NURSE EMPLOYERS

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All persons and business entities renewing a license with the Division of Professional Registration are required to have paid all state income taxes and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. If your license is suspended for state income tax, you must stop practicing as a nurse immediately and you cannot return to nursing practice until your license is active again. If you have any questions, you may contact the Department of Revenue at 753-751-7200.

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Navigating the Nurse Licensure Compact:
Initial Licensure by Examination for New Graduates

Is your primary/legal state of residence (PSOR) a compact state?
(This is the state in which you hold a driver’s license, are registered to vote, and/or file federal income tax)

No

Apply for licensure by examination in any one state of choice.

Single-state license

Apply for licensure with one Board of Nursing (BON)

Register with Pearson VUE (see candidate bulletin)

Receive results from BON

Your new single-state license grants privilege to practice in only the state of issuance (other single-state licenses may be acquired via licensure by endorsement)

Follow the NCLEX examination steps

Yes

Apply for licensure by examination in your primary state of residence (PSOR)

Multi-state license

Receive eligibility from Board of Nursing

Schedule an exam with Pearson VUE via website or telephone

Arrive for exam – present photo ID and ATT (see candidate bulletin)

Receive a Authorization to Test (ATT) via letter or email from Pearson VUE

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

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CoxHealth is currently seeking a Patient Care Manager for our North Emergency Department. We are a 20 room ED located in Springfield, Missouri. We have quick patient turnarounds times and average 40,000 visits per year. Three to five years of ER nursing experience preferred and one year of leadership experience is required and all certifications must be current. Excellent pay and benefits available.

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Christy – Bethesda Southgate – Oakville, 200 Singleton Rd., 63129
Charlotte – Bethesda Meadow – Ellisville, 522 Old State Rd., 63021
Cordia – Bethesda Dilworth – Kirkwood, 2009 Big Bend Blvd., 63122

CoxHealth is currently seeking a Patient Care Manager for our North Emergency Department. We are a 20 room ED located in Springfield, Missouri. We have quick patient turnarounds times and average 40,000 visits per year. Three to five years of ER nursing experience preferred and one year of leadership experience is required and all certifications must be current. Excellent pay and benefits available.

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Understanding NCLEX Program Codes and Reports

NCLEX licensure exam pass rates are made available online by the Missouri State Board of Nursing (MSBN) to determine official NCLEX program pass rates for the prior year. Quarterly reports capture program graduates that took the NCLEX exam in any location. NCLEX reports indicate overall licensure exam pass rates for all pre-licensure nursing programs are provided on a quarterly basis as well.

Newly revised program codes have gone into effect as of April 1, 2014. The first two (2) digits of each new program code is a unique identifier for each pre-licensure nursing program. While some decrease in overall nursing practice, minimal change to the NCLEX-RN Test Plan was initiated on April 1, 2013. Test plan changes for the NCLEX-RN test plan are anticipated for 2014. While adjustments are made to best reflect current nursing practice, minimal change to the NCLEX-RN Test Plan structure is reported. While some decrease in overall NCLEX-RN pass rates are anticipated, minimal changes in Test Plan categories favor comparability of current examination to those of recent years. As indicated earlier, NCLEX Program Reports are packaged as subscriptions and released each May and November. Report information can be accessed at https://www.ncsbn.org/NCLEX_Program_Report.htm. (Bontempo, 2014).

NCLEX Program Reports cover graduate data from April 1, to March 31 of the next year. This becomes especially important when NCLEX Test Plans change, since changes in Test Plans are annually initiated on April 1st for respective years. NCLEX Test Plans usually change every three (3) years. Most recent change to the NCLEX-RN Test Plan was initiated on April 1, 2013. Test plan changes for the NCLEX-RN test plan are anticipated for 2014. While adjustments are made to best reflect current nursing practice, minimal change to the NCLEX-RN Test Plan structure is reported. While some decrease in overall NCLEX-RN pass rates are anticipated, minimal changes in Test Plan categories favor comparability of current examination to those of recent years. As indicated earlier, NCLEX Program Reports are packaged as subscriptions and released each May and November. Report information can be accessed at https://www.ncsbn.org/NCLEX_Program_Report.htm. (Bontempo, 2014).

NCLEX Program Reports are set up in sections, to include Summary & Overview, NCLEX Test Plan Report, Content Dimension Reports and Test Duration & Performance Reports. All data provided is specific to the respective nursing program, but does not include information specific to performance of individual program graduates.

Program data is compared to similar programs in the same licensing jurisdiction, other programs of similar degree type and all similar programs in the U.S. and its territories. The NCLEX Test Plan Report offers data on how well a “typical” program graduate performed on each sub-category of client needs represented on the NCLEX Test Plan. Test plan changes for the NCLEX-RN test plan are anticipated for 2014. Test plan changes for the NCLEX-RN test plan are anticipated for 2014. While adjustments are made to best reflect current nursing practice, minimal change to the NCLEX-RN Test Plan structure is reported. While some decrease in overall NCLEX-RN pass rates are anticipated, minimal changes in Test Plan categories favor comparability of current examination to those of recent years. As indicated earlier, NCLEX Program Reports are packaged as subscriptions and released each May and November. Report information can be accessed at https://www.ncsbn.org/NCLEX_Program_Report.htm. (Bontempo, 2014).

The Content Dimension Report section provides data on how well the “typical” program graduate performed on each item within content dimensions represented on the exam. Test Duration & Performance Report sections provide information about graduates’ testing experience. Test Duration Reports show average number of questions taken and time spent taking the exam. Data is separated by graduates who passed and failed the exam. Correlation between number of questions taken and position in relation to the passing standard is reflected. Performance Report data indicates how many questions within each category of the NCLEX Test Plan were answered correctly. Data related to each category distinguishes between the graduate performing right at the passing score are included (Mountain Measurement, Inc., 2014).

Overall, electronic NCLEX Quarterly and Program Reports provide wealth of statistical information. If utilized appropriately, program strengths and weaknesses related to the curriculum as well as clinical learning may be identified. Comparisons with similar programs and graduates in Missouri as well as across the country may provide valuable insight. Careful analysis of data may enhance and sustain instructional integrity, provide necessary data to initiate change in theory as well as clinical learning, foster transition to nursing practice and optimize patient safety for citizens in Missouri and across state lines.

References


Authors

Bibi Schultz, RN MSN, CNE
Education Administrator
Missouri State Board of Nursing (MSBN) Education Committee Members:
• Roxanne McDaniel, RN, PhD (Chair)
• Lisa Green, RN, PhD(c)
• Mariona Seat, DNSP, MSN, RN, FNP-BC

The College of Nursing seeks:
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• Associate Dean for Academic Programs
• Tenure Track Faculty
• Non-tenure Track Faculty

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College of Nursing
Innovation in Education, Research and Practice
The College of Nursing is seeking:

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• Tenure Track Faculty
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Access to safe health care when a nurse is not present is a public health issue facing many boards of nursing. This is especially true in schools where a nurse is not present to provide care for children with diabetes. This study examined the safety and effectiveness of a model of care that linked trained unlicensed school personnel to registered nurses (RNs) via telehealth technology to delegate and supervise diabetes care tasks, including insulin administration. The study took place from December 2010 to May 2013, and 5,568 doses of insulin were administered safely by unlicensed personnel. Surveys taken before and after implementation measured the perceptions of parents and school personnel regarding the safety and efficacy of the model of care. Statistical results showed large degrees of effectiveness. This study provides preliminary evidence supporting regulatory changes for the delegation of insulin administration and other diabetes care tasks by RNs.

The Virtual Nursing Care for Children with Diabetes in the School Setting project is a model for having a virtual nurse when a nurse is not present or needs help to meet the health care needs of the population. The Virtual Nurse project was inspired by three major concerns for the citizens of South Dakota: access to care for individuals with diabetes in settings where a nurse is not always present, legal barriers to the delegation and supervision of unlicensed personnel, and the cost of sustaining the current model of care. The model was based on the nursing principles of delegation and supervision of trained unlicensed personnel. By linking these nursing personnel with nurses, the model of care can be modified to meet the individual and community needs of the state. The literature shows several critical factors that influence the effectiveness of nursing delegation. Boards of nursing (BONs) have jurisdiction over licensed nurses and the nursing care they provide, including the care they delegate (Mueller & Vogelsmeier, 2013). Nurse practice acts (NPAs) define the legal limits of nursing practice and, in most jurisdictions, NPAs or administrative rules refer to delegation, though not all NPAs authorize delegation by registered nurses (RNs) (Corazzini et al., 2011).

The RN’s obligation to provide safe, quality care creates distinct challenges when delegating care to unlicensed personnel. These challenges include the lack of experience for school nurses by budgetary constraints, the lack of qualified nurses, and the increased use of unlicensed personnel (Gordon & Barry, 2009). Compounding the issue are federal and state requirements of the Individuals with Disabilities Education Act that mandate school service for complex student health needs as well as state regulation of school nursing care by requiring school nurses to delegate to unlicensed personnel (Resha, 2010). Thus, delegation to unlicensed personnel in schools has been an emerging challenge for school nurses who struggle to meet the expectations of their role, maintain their standards, and comply with their NPAs and other regulatory statutes.

School Children with Diabetes

South Dakota, like many other states, has been experiencing an increase in the number of children with diabetes in schools. Numerous concerns regarding less-than-adequate care have been cited by parents of children with diabetes attending schools where a nurse is not present. Parents reported that some school children have been transported to nursing homes for insulin administration during the school day. Other reports included that some school children were required to come to the school to administer insulin. Given the rural nature of South Dakota, this requirement presented several concerns for the state BON, including the ability of unlicensed personnel to administer insulin to children, citing their authority as an exemption to the NPA for gratuitous care of family and friends. These concerns as well as proposed legislation allowed the unlicensed personnel to delegate and supervise diabetes care tasks. Board of Nursing (BON) regulations were the basis for the South Dakota BON to examine the delegation of diabetes care in schools.

In 2009, the South Dakota Department of Health Institutional Review Board approved the study examining the delegation of diabetes tasks to unlicensed personnel with a virtual RN by means of telehealth technology. The goal of the study was to implement a model linking trained diabetes personnel could administer insulin and perform other diabetes care. The School Nurses Association in South Dakota strongly opposed allowing unlicensed personnel to perform any tasks that a nurse could do. At the same time, the South Dakota Diabetes Educators Association strongly supported the proposed legislation and formally requested that the BON support the project. The South Dakota BON supported the project because of the lack of consensus in the nursing community. The BON agreed the issue would be studied and methods for meeting the needs of children with diabetes in the schools would be examined.

At the same time, assisted living centers and residential care facilities were seeking ways to help those with diabetes receive care where they lived. The model was to allow someone who could not administer their own insulin had to be admitted to a skilled nursing facility. One client was taken to the emergency department of a local hospital to receive insulin because a virtual RN was not available. Clients indicated they were neither desirable nor economically sustainable. As a result, the BON was challenged to find ways to overcome barriers to the provision of diabetes care in settings where a nurse is not always present.

In response to these challenges, the BON and the South Dakota Department of Health engaged key stakeholders in conversations on diabetes care in two locations. Key stakeholders participating in the conversations were school administrators, policy makers, physicians, diabetes clinical nurse specialists, and concerned parents. The overall question was: “What possibilities exist to enhance diabetes management when a nurse is not present?” The findings of these two conversations were used to convene a task force to begin planning a pilot project. What emerged was a model linking trained unlicensed personnel with a virtual RN by means of technology to manage the care of school children with diabetes.

South Dakota Demographics

The geography of South Dakota lends itself to a model of care using virtual RNs. South Dakota is a large state with an estimated population of 833,354 (U.S. Census Bureau, 2012). Of the 38 counties in western South Dakota, 33 are considered frontier (having fewer than 7 people per square mile). South Dakota is one of the least urbanized states in the United States, with 91% of its residents living in rural areas. Only four counties have more than 30,000 people. Though South Dakota has the highest RN-to-resident ratio in the country, 1,247 RNs per 100,000 residents (U.S. Department of Health and Human Services [HHS], 2013b), most of the state’s rural and frontier counties are experiencing shortages of nurses and other health care professionals. According to the Health Resources and Services Administration (HRSA), 55 of South Dakota’s 66 counties (83%) are listed as primary care health professional shortage areas. Furthermore, 47 entire counties are considered by HRSA to be medically underserved, meaning these areas cannot support sufficient numbers of health care providers to meet their needs. Effective care in these counties (HHS, 2013a). Because of South Dakota’s rural nature, nurses cannot be present 24 hours a day in all settings where people with diabetes need assistance.

Testing the Model

The current study was intended to determine whether diabetes care tasks including insulin administration could be safely delegated to trained unlicensed personnel by a virtual RN. The study received approval from the Avera Health Institutional Review Board. RNs certified in diabetes education were linked with unlicensed personnel via telehealth technology to implement the diabetes management plan. The virtual RNs could clearly see and speak to the unlicensed personnel and the school children by means of the technology.

The main purpose of the study was to answer the following question: “To what extent is a model of nursing care utilizing a virtual RN linked to a trained unlicensed provider through telehealth technology safe and effective in the care of school children with diabetes, including insulin administration?” The study objectives were as follows:

- Implement and test a model of virtual nursing delegation that allows RNs to delegate and supervise diabetes care tasks to unlicensed personnel with a virtual RN, including insulin administration.
- Develop evidence-based quality indicators of safety for diabetes care delivered by unlicensed personnel with diabetes through the evaluation of clinical case management records.
- Measure change in perceptions of diabetes patients and family members.

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- Measure change in perceptions of diabetes patients and family members.

Method

An exploratory pilot project was performed in which clinical data were collected and a survey was conducted before and after model implementation. The project was implemented from December 1, 2010, through June 30, 2011. Data were collected during school times during the course of the project: initially, at the mid-point, and at the conclusion. The project consisted of the core consultants of the project; parents or guardians of children with diabetes, virtual RNs, and trained unlicensed personnel.

Survey tools were designed to measure multiple variables, including satisfaction, timeliness, communication patterns, responsiveness, and use of technology in the care of school children with diabetes before and after model implementation.

- Formulate a resource guide for school nurses, administrators, and unlicensed providers who deliver care to school children with diabetes.
- Discover the implications of virtual nursing care delivery for regulatory infrastructure expansion through analysis of research data.

Advisory Council

A core consultant panel, including the principal investigators, a clinical nurse specialist certified diabetes educator, technology experts, school nurses, and a research consultant provided the expertise for project implementation. This core panel, made up of the principal investigators, an advisory stakeholder council was appointed by the investigators. The advisory council met face-to-face three times during the course of the project; initially, at the mid-point, and at the conclusion. The council consisted of the core consultants of the project; parents or guardians of children with diabetes, virtual RNs, and trained unlicensed personnel.

Survey tools were designed to measure multiple variables, including satisfaction, timeliness, communication patterns, responsiveness, and technological proficiency. Clinical diabetes outcome measures were collected by the virtual RNs and analyzed by the primary investigators.

Virtual Nursing Care for School Children with Diabetes

Virtual Nursing continued on page 7
Administrators interested in participating contacted the principal investigators, and face-to-face meetings were conducted. A second method of recruiting participants was used for the remainder of the study. The certified diabetes educators invited parents of children who were their clients and who met study inclusion criteria to participate.

At the start of the study, the principal investigators were contacted by other parents and school administrators to request participation. In some cases, administrators were willing to participate, and the parents were not interested. In other cases, parents wanted their children to participate, but the schools declined to participate.

A total of 31 students participated: 20 males and 11 females. (See Figure 1.) Six students were ages 5 to 7; 21 were ages 8 to 12; and 4 were ages 13 to 18.

**Inclusion Criteria**

The following criteria were established for inclusion in the study:

- The school in South Dakota must have students diagnosed with type 1 or type 2 insulin-dependent diabetes.
- The student must require insulin administration by injection or pump on a regularly scheduled sliding-scale basis during the school day.
- The school must be able to identify an unlicensed personnel present every day to assist children with diabetes during lunch time.
- The school must have the appropriate technology to connect to the virtual RN.
- The school must be able to identify an unlicensed personnel who can partner with the virtual RN for the management of students with diabetes during the school day.
- Informed consent must be obtained from the student and his or her parents or guardian before participation in the project.

Parents and guardians of children meeting the inclusion criteria received the consent form, and the children received an age-appropriate assent form. By signing the document, the parents or guardians voluntarily consented to their children's participation.

**Measures**

The measures used to evaluate the safety and effectiveness of the nursing model of care were insulin administration, blood glucose monitoring, carbohydrate counting, activity monitoring, and the survey before and after implementation. The trained unlicensed personnel documented the care provided in a weekly diabetes care log. The logs were submitted to the virtual RNs at the end of each week and were the basis for clinical data collection for the study.

Virtual RNs calculated the total number of insulin dose administrations, blood glucose monitoring tests, and the number of urine glucose monitoring tests. These records were evaluated by the virtual RNs to determine if the times and results of the routine tests were recorded. The survey also evaluated the extra blood glucose monitoring tests performed and the actions taken in response to the results.

**Diabetes Education for Unlicensed Personnel**

Each school in the project selected one or more unlicensed persons to participate. Personnel included teachers, school administrators, and administrative assistants who agreed to be responsible for assisting with the management of children with diabetes. The American Diabetes Association’s (ADA) standardized curriculum in Diabetes Care at School: What Key Personnel Need to Know (ADA, 2008) was provided for the education of the unlicensed personnel. The curriculum was developed and reviewed by a team of ADA expert volunteers and staff.

The didactic portion was 10 hours and taught by the clinical nurse specialist, certified diabetes educator who served as the clinical expert for the project. The entire 10-hour program was video and audio recorded, and unlicensed personnel received a DVD copy and a training manual. Additionally, each unlicensed person received a kit of diabetes supplies to use in developing competence in carbohydrate counting and insulin administration by vial and syringe and by insulin pen. Before implementation, one-to-one competency evaluations and return demonstrations were conducted with each unlicensed person on carbohydrate counting, preparing and injecting insulin via syringes, and injecting insulin via an insulin pen, and assisting with entering data and delivering insulin via an insulin pump. Virtual RNs conducted the competence evaluations either in person or through the virtual technology units. In addition, each unlicensed person received a resource manual entitled Helping the Student with Diabetes Succeed: A Guide for School Personnel (Potter & Perry, 2005) developed by the National Diabetes Education Program (2011).

**Clinical Interventions**

A DMMP was completed for each student participating in the project. The DMMP detailed the specific needs of the child and formed an agreement among the student’s health care team, parent or guardian, and school personnel to meet the child’s needs. All schools that received federal funds were required to have a written plan for children with special health needs according to Section 504 of the Rehabilitation Act of 1973 (ADA, 2003). The DMMP form for this project was similar to the example provided by the ADA. The unlicensed personnel were responsible for implementing diabetes care tasks based on the DMMP in consultation with the virtual RN. Virtual consultation dates and times were arranged by the virtual RNs and the unlicensed personnel, and consultations took place once a week or more frequently if necessary.
amount of consultation and supervision needed for each unlicensed person was determined by the virtual RN. The virtual RN determined the amount of supervision based on an assessment of the child’s health status, diabetes management needs, and the unlicensed person’s level of comfort and proficiency in providing care. The virtual RN was available during school days by phone and virtual meeting if an unanticipated consultation was needed. Calls made to the virtual RNs outside the routine consultations were recorded in the clinical care record, which was submitted to the virtual RNs weekly. The trained unlicensed personnel also recorded the number of calls made to parents. These calls were made in compliance with elements of the DMMP.

Diabetes care tasks implemented and recorded by the unlicensed personnel included insulin administration, blood glucose monitoring, carbohydrate counting, activity monitoring, hypoglycemic recognition and treatment, emergency glucagon administration, and hyperglycemic recognition. The unlicensed personnel documented each of the clinical elements and provided the information to the virtual RNs weekly. Data were analyzed to determine the safety and efficacy of the care provided. Of particular concern to the primary investigators was the safety of delegating insulin administration to unlicensed personnel.

Survey of Parents and School Personnel
Parents were mailed a survey and consent form before their children participated in the project. When the project was completed or a child withdrew from the study, parents received a second survey. Nonresponding parents received a second mailing. School personnel received the survey before the study at their school address. Because the investigators then obtained the e-mail addresses of school personnel, the survey following the study was e-mailed. A second request was made to nonresponders.

Clinical Data Results
Clinical data and the survey were analyzed to evaluate the effectiveness of the models. The clinical data included insulin administration, blood glucose monitoring, carbohydrate counting, and activity monitoring.

Insulin Administration
Over the course of the project, 5,569 doses of insulin were administered subcutaneously by trained unlicensed personnel to children enrolled in the project. (See Figures 2 and 3.) The insulin was administered by pen, syringe, and vial, or pump and was based on the child’s DMMP. The unlicensed personnel administered the programmed doses of insulin consumed into the pumps, and the pumps calculated and administered the programmed doses of insulin. Unlicensed personnel also administered insulin by dialing the dose on an insulin pen and by drawing up insulin from vials into syringes. The virtual RNs monitored the vast majority of patients using either an insulin pump or insulin pen, according to age and vial method. Of the 5,569 insulin doses administered, 3,428 (61.6%) were administered to children ages 8 to 12 (Figure 3). Of these 3,428 doses, 1,968 (57.4%) were administered by insulin pump, and 1,460 (42.6%) were administered by insulin pen. Children ages 5 to 7 received 1,677 (30.6%) of the doses in the study. Of these doses, 972 (58%) were administered by insulin pump, and 707 (42.2%) were administered by insulin pen or syringe. Only 464 (8.3%) of the total doses were administered to children ages 13 to 18. All were administered by insulin pump.

(continued from page 7)
TABLE 1
Results of Paired-Samples t-test: Survey Responses of Parents and School Personnel Before and After the Study

<table>
<thead>
<tr>
<th>Item</th>
<th>Before M (SD)</th>
<th>After M (SD)</th>
<th>t(dff)</th>
<th>p</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide safe, quality care.</td>
<td>3.56 (1.13)</td>
<td>4.56 (1.73)</td>
<td>2.66 (8)</td>
<td>.028</td>
<td>1.05</td>
</tr>
<tr>
<td>Obtain immediate assistance if a child experiences complications or fast-paced conditions for instant decisions.</td>
<td>3.67 (1.22)</td>
<td>4.44 (1.73)</td>
<td>1.70 (8)</td>
<td>.111</td>
<td>77</td>
</tr>
<tr>
<td>Communicate with registered nurse (RN) to supervise medication administration.</td>
<td>2.70 (1.83)</td>
<td>4.30 (1.23)</td>
<td>2.85 (9)</td>
<td>.079</td>
<td>1.02</td>
</tr>
<tr>
<td>Respond appropriately to parents or teacher’s questions about diabetes care.</td>
<td>3.30 (1.70)</td>
<td>4.60 (1.70)</td>
<td>3.51 (9)</td>
<td>.033</td>
<td>1.50</td>
</tr>
<tr>
<td>Make sound evidence-based decisions in a timely fashion within in policies, procedures, and standards.</td>
<td>3.20 (1.64)</td>
<td>4.60 (1.70)</td>
<td>2.62 (9)</td>
<td>.028</td>
<td>1.03</td>
</tr>
<tr>
<td>Use technology to assist the care of children with diabetes.</td>
<td>3.33 (1.50)</td>
<td>4.65 (1.73)</td>
<td>2.06 (8)</td>
<td>.074</td>
<td>1.04</td>
</tr>
<tr>
<td>Experience a level of satisfaction that I am doing my best in caring for children with diabetes.</td>
<td>3.70 (1.16)</td>
<td>4.60 (1.70)</td>
<td>2.38 (9)</td>
<td>.041</td>
<td>1.94</td>
</tr>
<tr>
<td>Rate the extent to which this project met your expectations.</td>
<td>–</td>
<td>4.71 (1.49)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

School Personnel

<table>
<thead>
<tr>
<th>Item</th>
<th>Before M (SD)</th>
<th>After M (SD)</th>
<th>t(dff)</th>
<th>p</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide safe, quality care.</td>
<td>3.61 (1.13)</td>
<td>4.54 (1.59)</td>
<td>3.55 (7)</td>
<td>.002</td>
<td>1.04</td>
</tr>
<tr>
<td>Obtain immediate assistance if a child experiences complications or fast-paced conditions for instant decisions.</td>
<td>3.78 (1.25)</td>
<td>4.52 (1.80)</td>
<td>3.29 (8)</td>
<td>.024</td>
<td>1.71</td>
</tr>
<tr>
<td>Communicate with RN to supervise medication administration.</td>
<td>3.56 (1.47)</td>
<td>4.50 (1.52)</td>
<td>3.32 (7)</td>
<td>.003</td>
<td>1.03</td>
</tr>
<tr>
<td>Respond appropriately to parents or teacher’s questions about diabetes care.</td>
<td>3.32 (1.28)</td>
<td>4.39 (1.63)</td>
<td>3.81 (7)</td>
<td>.001</td>
<td>1.06</td>
</tr>
<tr>
<td>Make sound evidence-based decisions in a timely fashion within in policies, procedures, and standards.</td>
<td>3.50 (1.14)</td>
<td>4.29 (1.73)</td>
<td>2.63 (7)</td>
<td>.014</td>
<td>1.78</td>
</tr>
<tr>
<td>Use technology to assist the care of children with diabetes.</td>
<td>3.06 (1.41)</td>
<td>4.18 (1.90)</td>
<td>3.45 (7)</td>
<td>.002</td>
<td>1.00</td>
</tr>
<tr>
<td>Experience a level of satisfaction that I am doing my best in caring for children with diabetes.</td>
<td>3.56 (1.20)</td>
<td>4.64 (1.68)</td>
<td>3.03 (7)</td>
<td>.001</td>
<td>1.17</td>
</tr>
<tr>
<td>Rate the extent to which this project met your expectations.</td>
<td>–</td>
<td>4.21 (1.92)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

requests; the response rate was 32.3% (N = 10). Before the study, 50 surveys were sent to the school personnel group, which included administrators and trained unlicensed providers. Completion of this survey was required for inclusion in the study. After the study, 28 surveys were returned for a 56% response rate. Parents were asked to rate their perceived level of ability to trust the school with care of their children with diabetes before and after the study. School personnel were asked to rate their perceived level of ability to trust the school with care of a child with diabetes, in the school. The questions on the surveys were identical for both groups. A series of paired-samples t-tests were conducted to examine differences in responses before and after the study. Only participants who completed both surveys were included in the analyses. Effect sizes indicated large differences in responses before and after the study. (See Table 1.)

Despite a small sample size, results of the before and after surveys completed by parents indicated statistically significant differences for all items except the ability to use technology, n = 8, p = .074; and the ability to obtain immediate assistance if a child experiences complications, t (8) = 1.70, p = .111. However, these items had large (d = 1.04) and medium (d = .77) effect sizes. Regarding the technology item, the unlicensed personnel and vendors were the primary users of the technology. Regarding the immediate assistance item, the absence of a significant difference in parent responses before and after the study should be explored further, though it must be noted that no emergency situations arose during the study.

Results of the before and after surveys completed by school personnel indicated statistically significant differences for all survey items. Effect sizes were large (d >.80) for most survey items. Every measure for the parent group indicated a large effect size with the exception of mode of evidence-based decisions in a timely fashion, which had a medium effect size (d = .78). For the school personnel, obtaining immediate assistance if a child experiences complications also had a medium effect size (d = .71).

Overall, survey results showed large changes in parents’ perceptions of the school’s ability to provide safe care for their children and in unlicensed personnel’s perception of their ability to provide safe care for children with diabetes. The survey findings complement the clinical outcome data and lend support to the safety and efficacy of RNs delegating and supervising diabetes clinical care tasks, including insulin administration, to trained unlicensed personnel using the Virtual Nursing Care for Children with Diabetes in the School Setting model of care.

Limitations of the Study

One of the limitations of this study was the small sample size of students with diabetes. The investigators intended the sample size to be between 30 and 32 students to make the project feasible given the human and financial resources available. Safety was also a consideration in keeping the sample size small. A second limitation was the lack of survey data from the virtual RNs. Despite the limitations, the investigators believe that valuable information was obtained for evidence-based decision making by nursing regulators.

Implications for Nursing Regulation

The clinical outcome data and survey results support the Virtual RN model as safe and effective. The study also provides preliminary evidence for BONs to support policy changes regarding the delegation of insulin administration and diabetes care tasks in the school setting.

Additional investigation in the area of handling complications and conditions that call for immediate assistance is needed based on the responses of parents and school personnel. Carbohydrate counting also needs more attention based on the responses of parents and school personnel. Diabetes training programs may need changes regarding the delegation of insulin administration to ensure unlicensed personnel are competent in this task.

Access to care in the safest manner possible is a public protection issue for BONs. In this study, virtual nursing practice, including coordination of care, education and training, delegation and supervision, and evaluation of outcomes was safely and successfully implemented. The investigators believe RN involvement is necessary to assure that the public that safe diabetes care is being provided. Nursing regulators need to be open to the exploration of new models of care that maximize the knowledge, skills, and abilities of RNs and reduce the legal barriers to the delegation and supervision of nursing tasks.

References


Gloria Damgaard, MS, RN, FRN, is the Executive Director of the South Dakota Board of Nursing. Linda Young, MS, RN, FRN, BC, is the Nursing Practice Specialist for the South Dakota Nursing Workforce. The authors wish to recognize the following individuals for their participation and assistance with this study: Rhonda Jensen, CNS, MS, RN, CDE; Mary Lobb Oyos, CNS, MS, RN, CDE; Gayle Bates, RN; Sheila Freed, RN; Molly Sutter, RN; Marge Hegge, EdD, RN; Casey Bielac, Marilyn Pentecost; Dee Schlottbach; DaaneVroekel; and Erin Mathies.

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Pursuant to Section 355.062 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 355.001 to 355.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license” for violation of Chapter 335, the Nursing Practice Act.

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

CENSURED

**Disciplinary Actions**

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CENSURE Continued...

different days. In addition, on four separate occasions, Respondent reported to the lab and submitted the required urine sample which showed a low creatinine reading. Censure 12/20/2013 to 12/21/2013

Kromat, Janet Gail  Springfield, MO  Registered Nurse 2008036280  Failure to start IV drip in dehydrated ER patient.

On April 11, 2011, Licensee had a patient that was her responsibility and was admitted to the hospital through the emergency room at 1200 with the diagnosis of dehydration, nausea, and vomiting (“Patient X”). The physician ordered Patient X to receive intravenous fluids. Licensee conducted her shift at 8 p.m. and during that eight hour shift, never administered the intravenous fluids to Patient X that had been ordered at 1200.

Failure to isolate patient with C. diff.

During her shift on April 11, 2011, Licensee was assigned to care for “Patient Y” who had clostridium difficile (“C. diff”). Licensee knew the patient had C. diff, but took no steps to ensure isolation of the patient to protect from infection other hospital employees, other patients, or visitors to the hospital. The “hand-off” ticket given to licensee in reference to patient Y when she was assigned to care for the patient clearly showed the patient should be isolated.

Improper administration of bicarbonate.

On November 25, 2010, Licensee had a patient for whom she was responsible with the diagnosis of metabolic acidosis (“Patient Z”). Patient Z’s lab work showed a pH of 7.29 to 7.32. The physician ordered Patient Z to receive bicarbonate to treat the acidosis. The physician ordered Patient Z to receive “DS w/ half an amp of HCO3 (bicarb) @ 100 per hour.”

The physician also ordered Patient Z to receive Flagyl, Cefepim, Vancomycin, and Calcium Gluconate IV. The HCO3 fluid is not compatible with many other substances and so must be administered by a separate intravenous line. Patient Z never had only one intravenous line, and licensee never started a second one. The Calcium Gluconate IV was “piggy backed” into the HCO3 line by licensee, and the HCO3 and the Calcium Gluconate IV are incompatible. Licensee did not run the HCO3 with the other medications in the IV, but rather Patient Z received no HCO3 while the other medications were being administered via the one intravenous line. Patient Z’s lab work showed a pH of 7.05 to 7.10 which is normal. Licensee did not run the HCO3 with the other medications in the IV, but rather Patient Z received no HCO3 while the other medications were being administered via the one intravenous line. Patient Z’s lab work showed a pH of 7.05 to 7.10 which is normal. Licensee did not run the HCO3 with the other medications in the IV, but rather Patient Z received no HCO3 while the other medications were being administered via the one intravenous line.

Failure to start IV’s.

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CENSURE continued from page 10

Licensee practicing nursing in Missouri without a current, valid license from June 1, 2012, through July 30, 2013.
Censure 12/27/2013 to 12/28/2013

Gresham, Shelly Yvonne
Poplar Bluff, MO
Registered Nurse 126637

On October 22, 2012, Licensee entered a guilty plea to one felony count of health care fraud as a result of billing errors. Licensee was placed on the Department of Health and Human Services, Office of the Inspector General’s, employee disqualification list.
Censure 12/27/2013 to 12/18/2013

Cleveland, Vicky C.
Joplin, MO
Licensed Practical Nurse 057929

On March 5, 2013, patient KB was scheduled per a physician’s order for an ultrasound. The physician changed the order to a CT and notified licensee to change the appointment. Licensee did not change the appointment, resulting in KB having an ultrasound, a useless procedure. On March 4, 2013, patient MW’s guardian called licensee and requested if it was possible to get an antibiotic prescription updated without bringing the child in. Licensee sent a message to MW’s physician, but did not attempt to follow up with him until March 8, 2013; and the physician did not see the message until March 11, 2013, a week later. When licensee finally responded to them, patient MW’s guardian had already taken MW to another doctor because they never got a response. Another of licensee’s responsibilities was to check various nursing stations for outdated materials including samples from drug representatives and vaccines to insure nothing has expired. On March 14, 2013, a supervisor discovered that lipidics which had expired on January 31, 2013, were still in nursing stations. Licensee had signed off as part of her responsibilities on a nursing station inspection sheet on February 28, 2013 that stated in pertinent part that “Expired medications are not present.”
Censure 12/25/2013 to 12/26/2013

Hinten, Marilyn M.
Centralia, MO
Licensed Practical Nurse 043537

The AHC found that Respondent is subject to discipline against her license for incompetency, and for violation of professional trust or confidence.
Censure 01/08/2014 to 01/09/2014

Shafer, Lisa A.
Kansas City, KS
Registered Nurse 134809

On January 27, 2013, Licensee was working in the Med/Surg Unit at the hospital as a charge nurse. Licensee assumed the care of patient LS who was in declining health. Licensee disconnected LS’s oxygen without a physician’s order allowing her to do so. Licensee disconnected LS’s feeding tube without a physician’s order allowing her to do so. Licensee informed a house supervisor of what she had done, licensee was told to call a physician for the proper orders. When licensee contacted a physician, the physician ordered the oxygen not be removed but the feeding tube could be removed. LS expired a few minutes after licensee received the physician’s latest orders. Licensee’s conduct violated hospital policies. Licensee had been previously counseled for violating physicians’ orders. Licensee’s employment was terminated for her conduct. Licensee has admitted to the Board’s investigator that she made a “mistake” by disconnecting the oxygen and the feeding tube and understands now she should have called a doctor when LS’s family agreed to have the oxygen disconnected and using computers in the PCU. Patient BC was not a patient in the PCU and Licensee had been instructed to work on patient BC in the PCU.
Censure 01/07/2014 to 01/08/2014

Smithher, Cicily Renea
West Plains, MO
Registered Nurse 2009924678

From May 20, 2011, Respondent has failed to call in to NTS on thirteen (13) different days. Respondent admitted that she had missed the phone calls to NTS. Respondent stated that she had been working the night shift which had messed up her sleeping patterns and led to the missed calls. Respondent offered a text result following she gave a hair sample to NTS with negative drug test results and a letter from her employer indicating Respondent is being transferred from night shift to day shift.
Censure 01/08/2014 to 01/09/2014

PROBATION continued on page 12

Macornic, Brittany Lynne
Jefferson City, MO
Registered Nurse 2012003670

Licensee worked in the Progressive Care Unit (PCU). On February 6, 2013, patient BC filed a complaint alleging that Licensee had accessed BC’s medical file without permission. The Clinical Information Services Manager, investigated the complaint and discovered that Licensee had accessed patient BC’s medical record on January 4, 2012, on January 9, 2012, and on March 8, 2012. Patient BC’s medical records were accessed using Licensee’s sign on and using computers in the PCU. Patient BC was not a patient in the PCU and Licensee had no medical reason for accessing BC’s medical records.
Probation 02/13/2014 to 02/13/2015

Claxton, Kelly Ann
Kansas City, KS
Registered Nurse 2008004706

On October 23, 2012, licensee documented administering 5 mg of Haldol through an IV to patient DM at 0330, but the dose was not scanned through the hospital’s computer system as required by policy. There were also no records of the Haldol being pulled from the Accudose machine by licensee or any other person. Licensee stated at the time that she must have made a mistake as to the time it was administered. Licensee’s “scan” rate for the month of September, 2012 was only 58% for medicine scanning and 88% for patient scanning. On October 23, 2012, the same patient DM had a dose of Meropenem, an intravenous antibiotic, due at 0500, but licensee entered a “hold” acknowledgement in the hospital’s system for the patient at 0547, and did not administer the Meropenem until 0740, nearly three hours late. On October 23, 2012 for patient ES whom licensee was also responsible for, licensee did not use the oral care kits specifically timed for the patient. The patient was ventilated and licensee used ordered “day shift” kits on the patient, resulting in a violation of hospital policy and an inaccurate count of when the specifically timed kits were used. The reason for the policy and why it is important to use the timed kits is because it is a part of policy and protocol to help prevent hospital-acquired infections in ventilated patients, which if not followed, could result in a higher incidence of ventilated patients acquiring such infections. Patient ES was also on an insulin drip and required bedside glucose checks to be performed every two hours. Hospital records showed 3 hour intervals between licensee’s glucose checks.
Probation continued on page 12

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The hospital’s Meditech system showed licensee recorded 3 glucose checks that licensee documented 2200 and 0200 glucose checks that licensee documented with our organization. If anyone has knowledge of their whereabouts, contact the following individuals:

Mary Gibson–RN2004006343
Tanya Hancock–PN2008005839
Shelel Peleanco–RN020065941
Nicolette Ramos–RN2010036091
Keisha Stone–RN2014006343
Candie Wilkins–PN2004026358

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0882 or send an email to nursing@pro.mo.gov.

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PROBATION continued from page 11

The hospital’s Meditech system showed licensee recorded 3 glucose checks for her entire shift, but a check of the ICU’s meter/scales (another monitoring system) showed that the 2200 and 0200 glucose checks that licensee documented were not actually performed. Licensee stated at the time that she did not know how to properly document the glucose checks in the Meditech. Licensee also did not calculate ES's inputs and outputs hourly as required by hospital policy. Licensee also did not do a pain reassessment on ES as required by hospital policy after pain medications were given to ES. In regard to her overall documentation of ES on this shift, licensee did not document ES every two hours per hospital policy, did not document ES’s weight daily per hospital policy, did not document a bath given on the shift which is required per hospital policy, and in fact had no patient notes on ES for the entire night of October 23, 2012. Licensee also placed patient DM in a “four-point” restraint during this shift when the physician’s orders only allowed restrained of the upper extremity. When confronted with this, licensee admitted she was not aware of the restraint protocol. When confronted about this restraint issue, licensee stated that DM was only tied for a short time and then she untied him. Licensee falsely made this statement as nurse D actually untied patient DM at approximately 0500 the morning of October 24, 2012. Licensee also failed to transcribe any admittance notes or patient notes on patient DM throughout the entirety of her shift in violation of hospital policy. Probation 12/26/2013 to 12/26/2015

Whitting, Shannine Antonette
Saint Louis, MO
Licensed Practical Nurse 2007034657
Licensee pled guilty to the class A misdemeanor of endangering the welfare of a child, second degree, on December 21, 2011. On June 23, 2010, Licensee left her three year old child in a car while she went into a store. The temperature was 91 degrees with a heat index of 99 degrees. When confronted with this, Licensee additionally failed to disclose that she had pleaded guilty to passing a bad check when she submitted her license renewal to the Board that was received by the Board on July 9, 2012. Licensee additionally failed to disclose that she had pleaded guilty to passing a bad check in Boone County, Missouri. On December 3, 2012, Kansas Board of Nursing revoked Licensee’s nursing license in a default order because she failed to respond to the Kansas Board of Nursing or to complete the requirements of her diversion agreement. On February 11, 2013, Licensee was placed on a drug screening test as part of the pre-employment hiring. The urine drug screen tested positive for marijuana. Probation 02/18/2014 to 02/18/2015

McClure, Scott Davis
Lees Summit, MO
Registered Nurse 2002012042
On August 2, 2012, Licensee was observed and reported for suspicious behavior. He was observed to be unsteady when walking, to be displaying suspicious behavior, and, having bloodshot eyes. Licensee was sent for a “for cause” drug and alcohol urinalysis test on August 2, 2012. The test was positive for Benzodiazepines, specifically, midazolam (brand name Versed), licenced in a controlled substance, that he had taken Versed and Fentanyl and had been diverting Versed and Fentanyl from his employer. Probation 02/18/2014 to 08/18/2017

Megeorge, Donata D.
Platteville, MO
Registered Nurse 104428
In October 2012, Licensee was part of a routine monthly audit which reviewed use and documentation of narcotics. As a result of the audit, the correctional facility indicted that there were 20 mg of Oxazepam and 20 mg of Oxazepam withdrawn doses of Ambien from the Pyxis, but had not documented the medication as given to patients, wasted, returned, or retained. Licensee additionally failed to document any of Licensees medication charting, finding further errors. On May 13, 2012 at 2316, Licensee withdrew 10 mg of Zolpidem for patient 410894661. Licensee failed to document the administration, waste, or return of the Zolpidem. Probation 05/19/2013 to 05/19/2014

Hubbard, Nathan
Platteville, MO
Registered Nurse 104428
In July 2012, Licensee was part of a routine monthly audit which reviewed use and documentation of narcotics. As a result of the audit, the correctional facility indicted that there were 20 mg of Oxazepam and 20 mg of Oxazepam withdrawn doses of Ambien from the Pyxis, but had not documented the medication as given to patients, wasted, returned, or retained. Licensee additionally failed to document any of Licensees medication charting, finding further errors. On May 13, 2012 at 2316, Licensee withdrew 10 mg of Zolpidem for patient 410894661. Licensee failed to document the administration, waste, or return of the Zolpidem. Probation 05/19/2013 to 05/19/2014

Page 12 • Missouri State Board of Nursing May, June, July 2014

PROBATION continued on page 13

PROBATION Continued...

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mistake. When initially told of this error in regard to Patient S by another staff member, licensee initially did not respond to attempt to remedy the situation, but continued with her lunch break. On November 7, 2011, licensee was assigned to take a total medication count for Patient P had a physician order for Hydroxyzine to be given orally. Licensee administered the Hydroxyzine to patient P through an IV in violation of the patient's orders. This route of medication administration could have put patient P in grave danger of vascular necrosis.

Proportion 02/26/2014 to 03/12/2014

Wiseman, Rhonda K.
Fulton, MO
Licensed Practical Nurse 052194
On July 21, 2011, licensee was assigned to work the morning charge nurse noted that the medication cart for Hydrocodone was not correct. Licensee, who had been the charge nurse for the day shift, was asked to provide an explanation for the incorrect count and related that she had given the last two Hydrocodone that day to patient DG and had removed the Hydrocodone drug card from the medication cart. Upon further review it was discovered that Hydrocodone had been ordered the patient DG five times in the last 5 weeks for 60 pills each, but patient DG had only received Hydrocodone 4 times during this period. Licensee submitted a sample for drug screening which returned positive for amphetamine. Licensee did not have a prescription for either hydrocodone or amphetamine.

Proportion 12/26/2013 to 12/26/2018

Bird, Suzan I.
Hopkins, MO
Registered Nurse 155688
On December 12, 2011, Licensee received an Employee Counseling for being discovered going through a coworker’s locker and purse without permission. Licensee indicated to her supervisor that she was only looking for a pen. On October 15, 2012, Licensee received an Employee Counseling for leaving work early when she still had patients to care for. On December 5, 2012, Licensee was working, as a health nurse. Licensee was observed accessing envelopes on a desk in the Human Resources Office. It was later discovered that one hundred and thirty (130) dollars was missing from several envelopes. When Licensee was confronted about this incident by her supervisor, Licensee admitted to taking twenty dollars from the envelopes.

Proportion 12/06/2013 to 12/06/2015

Adams, Krystal Renee
Odessa, MO
Licensed Practical Nurse 2001027268
On February 3, 2010, Respondent pled guilty to the class B misdemeanor of driving while intoxicated (DWI), combined alcohol/drug intoxication. Proportion 01/21/2014 to 08/21/2019

Wyatt, Vernalia Maria
Kansas City, MO
Licensed Practical Nurse 2003022288
A.I.
On December 6-7, 2007, Respondent was working the 11 pm to 7 am shift at the Facility. One of the residents whose care was registered nurse A.I. had symptoms of vomiting and nausea for several days prior to December 6, 2007. His doctor had ordered anti-nausea medication for his insulin for his diabetes. In the early morning hours of December 7, 2007, A.I.’s condition deteriorated. A.I.’s roommate, P.K., and a CNA on duty with Respondent were concerned with A.I.’s condition and asked Respondent if they could look at him. Respondent waited more than two hours before checking on A.I. She did not check on him regularly, and she failed to assess his deteriorating health condition. Respondent indicated that she did not have a nurse’s diagnosis of the medications ordered by the doctor, and she did not notify the doctor or send A.I. to a hospital for evaluation. Respondent was assigned to work on A.I.’s chart on December 7, 2007 that he was complaining of an upset stomach. Shortly after 7 am on December 7, 2007 A.I. was found in his room by the morning charge nurse. A.I. had face down, and was unresponsive. A.I. died short time later, before emergency personnel arrived and before he could be transported to a hospital.

Other Residents
At least 15 residents of the Facility reported that Respondent used abusive language toward them and refused to meet their needs in a timely manner, including administering their medications.

Investigation and Discipline by the Facility and DHSS
On January 4, 2008, Respondent was placed on immediate suspension from the Facility for at least five days pending the outcome of an investigation. The investigation was initiated in direct response to a complaint by a Missouri Department of Health and Senior Services (“DHSS”) survey team that happened to in the Facility conducting an audit, who were told about incidents involving Respondent by residents of the Facility. On January 8, 2008, Respondent’s employment at the Facility was terminated after the investigation substantiated allegations of neglect and abuse. On March 25, 2009, Respondent was placed on the EDU, for a period of three years after the investigation conducted by DHSS.

Proportion 01/15/2014 to 01/15/2016

Steffen-Hobs, Melissa Kay
Keokuk, IA
Registered Nurse 200401285
Licensee and the Iowa State Board of Nursing entered into a “Notice of Hearing, Statement of Charges, Settlement Agreement and Verdict Form (Combined)” (hereinafter Order) on August 20, 2013, wherein Licensee stipulated that she submitted to a pre-employment drug screen on April 11, 2013, that was positive for marijuana.

Proportion 12/01/2014 to 02/10/2014

Riden, Vickie Rose
Lebanon, MO
Licensed Practical Nurse 200228222
DL was not licensee’s patient and licensee had no legal reason to access or possess DL’s protected health information. An investigation revealed that licensee had access to DL’s protected health information inappropriately on July 18, 2012, August 6, 2012, and August 13, 2012. Licensee’s actions violated policies and the federal Health Insurance Portability Accountability Act (HIPAA).

Proportion 01/22/2014 to 01/22/2015

McCallister, Jessica Raye
Houston, MO
Licensed Practical Nurse 2013044682
Applicant pled guilty to the class C felony of Possession of a Controlled Substance.

Proportion 12/17/2013 to 12/17/2018

Jett, Tammy Michele
Saint Louis, MO
Registered Nurse 2001027203
Licensee documented six visits to client SH. It was reported to NFN that Licensee only made one visit. Licensee documented nine visits to client PW. It was reported to NFN that Licensee only made three visits. Licensee documented nine visits to client AM. It was reported to NFN that Licensee only made one visit. Licensee documented three visits to client JS. It was reported to NFN that Licensee only made one visit. Licensee documented six visits to client TG. It was reported to NFN that Licensee only made five visits. Licensee documented nine visits to client AG. It was reported to NFN that Licensee only made three visits.

Proportion 12/25/2013 to 12/25/2015

Cockrell, Hazel M.
O Fallon, MO
Registered Nurse 061422
On August 15, 2013, Licensee pled guilty to the misdemeanor of theft/embezzlement of U.S. property. Licensee was ordered to pay restitution in the amount of $44,395.40 and was placed on five (5) years of supervised probation.

Proportion 02/25/2014 to 02/25/2019

Walker, Alvin T.
St Peters, MO
Licensed Practical Nurse 044721
On February 5, 2012, Respondent reported to his place of employment as an LPN while under the influence of alcohol. Licensee was ordered to pay $100,000 in delinquency, and then was required to submit to an alcohol and drug screen by officials and was relieved from duty by officials at that time. Respondent became upset and left the building without submitting to the request for the drug screen. Licensee then went to his car in the parking lot and started the engine. Respondent was subsequently arrested by the local police department while still in possession of driving while intoxicated and was asked to submit to a chemical test of his breath by the police, which he also refused.

Proportion 01/14/2014 to 01/14/2019

Joseph, Nahdeen J.
Independence, MO
Licensed Practical Nurse 2005053418
On June 7, 2011, Respondent submitted to a urine drug screening test as part of the pre-employment hiring process. The urine sample provided by Respondent on June 7, 2011 tested positive for cocaine metabolites when tested.

Proportion 01/13/2014 to 01/13/2017

Missouri State Board of Nursing • Page 13

PROBATION continued from page 12

PROBATION...
of Oxycodone. The bags were also found to contain a large quantity of non-controlled and found to contain approximately 100 medication cards, including the controlled substance went home and returned with two large bags full of medications. The bags were examined, containing various medications. This incident was reported to Facility officials on February 5, 2013. Facility officials immediately contacted licensee and confronted her about the bags. 

Putman, Elizabeth Ann
Platte City, MO
Registered Nurse 2008005331
Respondent testified that she went to a bar with a girlfriend in October, 2010 and “did cocaine.” Respondent testified: “I don’t remember doing that, but I did do it and several days later I tested positive. My UA was positive for cocaine for a pre-employment drug screen. Respondent further testified: “I was so inebriated I just don’t remember very much of that night at all. I don’t remember a lot of it.”

Chilton, Kristen Rachelle
Van Buren, MO
Registered Nurse 2005921021
On April 7, 2013, Licensee reported she had snorted a line of meth the previous night. Respondent testified: “I don’t remember doing that, but I did do it and several days later I tested positive. My UA was positive for cocaine for a pre-employment drug screen. Respondent further testified: “I was so inebriated I just don’t remember very much of that night at all. I don’t remember a lot of it.”

Combs, Lisa G.
Troy, MO
Licensed Practical Nurse 056703
On January 25, 2013, licensee was observed leaving the Facility with two large bags containing various medications. This incident was reported to Facility officials on February 5, 2013. Facility officials immediately contacted licensee and confronted her about the bags. Licensee initially denied removing any medications from the facility, but then admitted that she had taken the medications from the Facility with the intention of taking them home and destroying them. Licensee then verbally offered her resignation to the Facility officials, went home and returned with two large bags full of medications. The bags were examined, and found to contain approximately 100 medication cards, including the controlled substance Oxycodone. The bags were also found to contain a large quantity of non-controlled substances, including but not limited to, unlabeled bottles of Milk of Magnesia, Suppositories and Tylenol. Licensee was then escorted from the building and the facility changed her status from resignation to termination on February 7, 2013. Licensee did not have a prescription for Oxycodone. Licensee violated the Facility’s policies by her conduct. Probation 01/07/2014 to 01/07/2016

Michael, Sarah Jayne
Kansas City, MO
Registered Nurse 2014001333
On June 15, 2012, Licensee signed a “Notice of Hearing, Statement of Charges, Settlement and Final Order (Combined)” (Order) stipulating that her Iowa nursing license was subject to discipline based upon the following:

a. The Respondent was employed at retirement facility from September 29, 2005, until her termination on February 8, 2012.
b. On February 8, 2012, the Respondent exhibited behaviors consistent with impairment and was requested to submit to a reasonable suspicion drug screen, and she refused.
c. The Respondent admitted to using methamphetamine for approximately six months prior to her termination.

The Iowa Board of Nursing indefinitely suspended Licensee’s license “pending completion of treatment as recommended on February 20, 2012, completion of all additional treatment recommendations, and twelve (12) continuous months of sobriety.” The Order further stated that Licensee’s license “will be placed on probation for a period of twelve (12) months upon fulfillment of the provisions stated above.”
Probation 01/15/2014 to 01/15/2019

Smith, Angelina Jeanette
Arlington, TX
Licensed Practical Nurse 2009036587
Respondent was working in the State of Texas under the privilege to practice on her Missouri Nursing license. On August 14, 2012, the Texas State Board of Nursing and Respondent entered into an Agreed Order which suspended Respondent’s privilege to practice in the State of Texas. On October 27, 2010, while utilizing Respondent’s multistate licensure compact privilege associated with her license to practice practical nursing in the State of Missouri, in Texas, Respondent administered morphine to Patient Medical Record Number 1800000868, and inaccurately documented the administration in the patient’s medication administration record (MAR). On October 27, 2010, while utilizing Respondent’s multistate licensure compact privilege associated with her license to practice practical nursing in the State of Missouri, in Texas, Respondent administered morphine to Patient Medical Record Number 1800000868 in excess frequency and/or dosage of the physician’s order. Respondent’s conduct was likely to injure the patient in that the administration of Morphine in excess frequency and/or dosage of the physician’s order could result in the patient suffering from adverse reactions.
Revoked 09/09/2014

Bryant, Julie Elizabeth
Springfield, MO
Registered Nurse 1999137293
On March 26, 2012, Respondent pled guilty to the class A misdemeanor of hindering prosecution.
Revoked 09/09/2014

Brooks, Sarah Darlene
Kahoka, MO
Registered Nurse 2007025716
From June 5, 2013 through October 4, 2013, Respondent failed to call in to NTS on one (1) day in addition, on three separate occasions, Respondent reported to lab and submitted the required sample which showed a low creatinine readings. On August 15, 2013, Respondent reported to a collection site to provide a blood sample for testing using the PEth Blood Spot test, and the sample returned a positive result for PEth, a metabolite of alcohol.
Revoked 09/09/2014

Toosley, Michael Scott
Fulton, MO
Licensed Practical Nurse 2007005336
On September 20, 2012, Respondent’s Arizona nursing license LP045056 was revoked by the Arizona State Board of Nursing, and that Board barred him from reapplying for reinstatement of that license for a period of five years. The Arizona final Order also revoked Respondent’s Arizona licensed practical nurse (LPN) license.
Revoked 08/08/2014

Coleman, Brenda K.
Oak Grove, MO
Licensed Practical Nurse 047183
Respondent did not complete the contract process with NTS by July 23, 2013. Respondent did not attend the meeting or contact the Board to reschedule the meeting. The Board did not receive a chemical dependency evaluation by the due date of August 5, 2013. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of September 14, 2013.
Revoked 08/08/2014

Besand, Dawn M.
Hillsboro, MO
Registered Nurse 20090148452
Respondent did not complete the contract process with NTS by the required due date of October 22, 2013, and as of the filing of this probation violation complaint Respondent has not completed the contract process with NTS. Respondent allowed her license to lapse. Respondent admitted that she had contracted with NTS and had not renewed her nursing license.
Revoked 08/08/2014
Logston, Hadin Reed  
Independence, MO  
Licensed Practical Nurse 2009006611  

From August 24, 2013, Respondent has failed to call in to NTS on twenty-five (25) different days. In addition, on October 14, 2013, October 28, 2013, and November 5, 2013, Respondent failed to call NTS; however, those were also days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to give a sample for testing on three (3) different days. Respondent failed to submit an employer evaluation or statement of unemployment by the quarterly due date of October 28, 2013. Respondent failed to submit an update of quarterly attendance at support group meetings by the quarterly due date of October 28, 2013.  
Revoked 01/08/2014

Oswalt, Joanna Shea  
Kennett, MO  
Licensed Practical Nurse 2008028844  

On October 18, 2011, Respondent pled guilty to the Class A misdemeanor of passing a bad check. On October 22, 2012, Respondent pled guilty to the Class A misdemeanor of passing a bad check. In October 2011, Respondent was working at a center. The Center started a new policy in early October 2011 that stated two nurses must sign off on the delivery of narcotics from the pharmacy without a second nurse, when the policy requiring two nurses to sign for the delivery was in effect. When Respondent signed for the medication, a second nurse was present and able to sign for the delivery. On October 12, 2011, Respondent charted the administration of hydrocodone to patient BT at 1230. Respondent did not start working till 1500. On October 12, 2011, Respondent charted the administration of hydrocodone to patient BT at 1630. This is just four hours after the last charted dose and the medication is ordered for one tab every six hours. On October 12, 2011, Respondent charted the administration of hydrocodone to patient AW at 1230. Respondent did not start working until 1500. On October 12, 2011, Respondent charted the administration of hydrocodone to patient AW at 1700. This is four hours and fifteen minutes after the last charted dose and the medication is ordered for one tab every six hours. On October 12, 2011, Respondent charted the administration of hydrocodone to patient CS at 1600. On October 12, 2011, Respondent charted the administration of hydrocodone to patient CS at 1800. This is two hours after the last charted dose and the medication is ordered for one tab every four hours. In March of 2011, Respondent was employed at a facility. On March 18, 2011, Respondent forged a Certified Medical Technician's signature to place an order for hydrocodone for a patient.  
Revoked 12/20/2013

Thompson, Karen F.  
Kansas City, MO  
Licensed Practical Nurse 031248  

When Respondent filled out her application for renewal of her Missouri licensed practical nursing license in 1998, after letting her license lapse in 1993, she did not disclose that her Nevada nursing license had been revoked or that she had ever been convicted of a crime. Respondent's licensed practical nursing license was renewed by the Board at that time based on the fraudulent answers and misrepresentations contained within her 1998 renewal application. On February 3, 2011, the Board received a complaint via NURSYS from the Nevada Board of Nursing, indicating that Respondent's license was revoked on or about October 10, 1996, for her conviction of possession of a controlled substance with the intent to sell, and for carrying a concealed weapon in the state of Nevada.  
Revoked 12/20/2013

Miller, Ronda Gay  
Independence, MO  
Licensed Practical Nurse 2000163232  

While working in her capacity as a registered nurse from November 2011 through January, 2012, Respondent pulled medication including controlled substances more often than prescribed; pulled medication on a patient that had been discharged and did not document administration or waste of medication accurately. From January 15, 2012 to January 18, 2012 a total of 32 doses of Oxycodone were removed from the Pyxis by Respondent with the last charted dose and the medication is ordered for one tab every six hours. On October 12, 2011, Respondent charted the administration of hydrocodone to patient CS at 1600. On October 12, 2011, Respondent charted the administration of hydrocodone to patient CS at 1800. This is two hours after the last charted dose and the medication is ordered for one tab every four hours. In March of 2011, Respondent was employed at a facility. On March 18, 2011, Respondent forged a Certified Medical Technician's signature to place an order for hydrocodone for a patient.  
Revoked 12/20/2013

Drew, Candace N.  
Moberly, MO  
Licensed Practical Nurse 021174  

On June 15, 2011, while Respondent was at work, her pupils were dilated, her speech was slurred, her gait was unsteady, and she was unable to complete sentences. Respondent submitted to a drug test. She tested positive for THC, a marijuana metabolite. Respondent admitted to smoking marijuana. On September 16, 2011, in an interview with the Board's investigator, Respondent admitted that she had smoked marijuana several times a week, and continued to do so after her employment was terminated.  
Revoked 08/04/2014

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September 2-4, 2015
December 2-4, 2015

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

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Erickson, Wendi Michelle
Columbia, MO
Licensed Practical Nurse 2003022564
Respondent has failed to call in to NTS on seven (7) days. In addition, on September 19, 2013, Respondent reported to lab and submitted the required sample which showed a low creatinine reading of 16.7. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of September 30, 2013. Respondent was required to submit a chemical dependency evaluation to the Board within six (6) weeks of the effective date of the Agreement. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent’s behalf, by the August 9, 2013, documentation due date. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by September 28, 2013. The Board did not receive proof of completion of the continuing education hours by the September 28, 2013, documentation due date. Revoked 01/08/2014

Lawless, Shelly R.
Columbia, MO
Licensed Practical Nurse 048130
From the start of Respondent’s probation, through October 31, 2013, Respondent failed to call in to NTS on one hundred and seventy (170) days. Respondent has not called NTS to communicate. Respondent was required to submit a test since May 15, 2013. On May 3, 2013, Respondent called NTS and was notified that she had been selected for testing that day. She reported to a collection site; however, she left the site prior to providing a urine sample for testing. Further, on May 14, 2013, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on May 29, 2013; June 11, 2013; July 1, 2013; July 17, 2013; July 30, 2013; August 12, 2013; August 29, 2013; September 9, 2013; September 20, 2013; October 3, 2013; October 22, 2013; Respondent failed to call NTS; however, all were days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on all of those dates referenced above. Respondent was to submit an employer evaluation from every employer or, if Respondent was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of July 24, 2013 or October 24, 2013. Respondent was required to submit evidence of regular attendance at Alcoholics Anonymous, Narcotics Anonymous or other support group meetings to the Board at such times as required by the Board, but not less than quarterly. The Board did not receive evidence of any support group attendance by the July 24, 2013 or the October 24, 2013, documentation due dates. Revoked 01/08/2014

Churchill, Danella J.
Jefferson City, MO
Licensed Practical Nurse 0577096
Respondent was the home care nurse assigned for patient M.H. Patient M.H. has cerebral palsy and other coexisting conditions. He lives at home with his mother. Patient M.H. required much care as he needed a wheelchair for mobility and had very limited ability to communicate. Respondent had worked on numerous occasions for M.H. and was knowledgeable as to the level of care M.H. required and his daily medication schedule. Respondent was also aware that M.H. had attempted to leave his home on several occasions and this required that all external doors to the house be locked at all times. Respondent was working a shift on November 23, 2010, as M.H.’s nurse from 7:30 a.m. to 3:30 p.m. On November 23, 2010, M.H.’s mother noticed between 1:30 p.m. and 2:00 p.m. that the house became very quiet. She then noticed M.H. continue to drive his wheelchair back and forth in front of her office door and he did this for about 30 minutes. When M.H.’s mother was done with her shift at 3:00 p.m., she came out to check on M.H. and found him alone and Respondent sleeping in M.H.’s bedroom. M.H.’s mother stated that Respondent did not awake when her name was called, and M.H.’s mother had to physically shake Respondent to wake her up. M.H.’s mother discovered that the back door was unlocked while Respondent was sleeping. When Respondent was questioned by a Board investigator, she admitted that there were a number of times she did not document when she gave medication to patient M.H. on the day it was given. Respondent stated that she did not document to document the next time she worked with M.H. Respondent further stated she was careless with documentation and knew it was a “big no-no” because documentation is very important. Respondent entered a plea of guilty to driving while intoxicated. Revoked 12/20/2013

Brown, Whitney Lynn
Florissant, MO
Licensed Practical Nurse 2010006003
A family member of a deceased resident of a facility contacted the administrator of the facility on February 4, 2011. The family member informed the administrator that Respondent had opened a cell phone account in the name of the deceased resident. To open the cell phone account Respondent had to use the social security number of the deceased resident. Respondent admitted to taking social security numbers and identification information from the dead to open accounts. Respondent further stated she was careless with documentation and knew it was a “big no-no” because documentation is very important. Respondent entered a plea of guilty to identity theft for using the name and social security number of the resident that resulted in the theft of credit in excess of five hundred ($500.00) dollars. Revoked 01/08/2014

Fortner, Amanda Rae
Dexter, MO
Registered Nurse 2007009501
On July 11, 2013; August 13, 2013; August 29, 2013; October 3, 2013; October 22, 2013; and, November 7, 2013, Respondent submitted to a Blood Spot Test for random drug screening. That sample tested positive for the presence of phospatidyl ethanol (PEth), which is a metabolite of alcohol. Additionally, Respondent failed to call NTS on October 11, 2013. On
On June 25, 2010, Respondent submitted a notarized statement to the Texas Board in which she voluntarily surrendered the right to practice vocational nursing in the state of Texas. The Texas Board accepted the voluntary surrender of Respondent’s vocational nursing license. On March 29, 2012, Respondent applied for a practical nursing (“LPN”) license in Missouri. In Section III, “Licensure History,” Respondent reported that she held an active LPN license in Louisiana against which no disciplinary action had been taken. She did not mention that she had been licensed in Texas.

On October 27, 2008, Respondent pled guilty to the class C felony of possession of a controlled substance. Respondent subsequently violated her probation and on June 10, 2010, her probation was revoked and her probation was continued with the additional condition that she be supervised for ninety (90) days via TAD or SCRAM.

Gonzalez, Nicole Noe Kansas City, MO Licensed Practical Nurse 2004028333 On January 29, 2010, an automatic notice of discrepancy printed indicating a Xanax count discrepancy. The discrepancy was logged under Respondent’s name.


May, Jill A.
Registered Nurse 2014001285
Springfield, MO
________________________________________________
Voluntary Surrender 01/21/2014

Royer, Denise J.
Lathrop, MO
Registered Nurse 2009001533
________________________________________________
Voluntary Surrender 10/12/2013

Steffen-Hobs, Melissa Kay
Registered Nurse 2014001285
Licensee voluntarily surrendered her Missouri nursing license on February 11, 2014. Voluntary Surrender 03/11/2014

Smith, Bridget Susan
Independence, MO
Registered Nurse 2011005705
On 02-13-2014 Licensee Voluntarily Succeeded her Missouri Nursing License. Voluntary Surrender 02/13/2014

On May 6, 2012, Licensee was asked to submit to a “for-cause” drug test and tested positive for THC (a metabolite of marijuana). On October 15, 2012, Licensee tested positive for the class A Misdemeanor of Possession of Controlled Substance Except 35 Grams or Less in the Circuit Court of St. Louis County, Missouri. Voluntary Surrender 02/26/2014

Shewmake, Angela ReNae
Godfrey, IL
Registered Nurse 2010042906
On April 5, 2013, licensee, while at work, was unable to be found by her peers. Licensee was eventually found in the ICU bathroom, locked inside. Licensee had been unconscious in the bathroom and two syringes were later found that had fallen from her purse. Licensee was, as a result of her condition, asked to submit to a “for-cause” drug test. Licensee later admitted to taking both Midazolam and Fentanyl, which she tested positive for the for the-once drug test. The pharmacist also advised the pharmacist that she had diverted Fentanyl from the facility “heavily” in the past few weeks and had done it over the course of the last year, infrequently. Licensee also admitted to the Board’s investigation that she had in the past worked as a nurse while under the influence of Fentanyl. Licensee did not have a prescription for Midazolam or Fentanyl.

Scholtz, Jennifer L.
Chesterfield, MO
Registered Nurse 137057
On January 8, 2014, Licensee voluntarily surrendered her Missouri nursing license. Voluntary Surrender 01/08/2014

Ferguson, Rene L.
Sugar Creek, MO
Registered Nurse 122832
On May 29, 2013, Licensee tested positive for marijuana as part of a pre-employment hiring process. Voluntary Surrender 12/27/2013

Stack, Deborah J.
Granite City, IL
Registered Nurse 128298
On August 15, 2012, Licensee submitted to a urine drug screening test as part of the pre-employment hiring process. The urine drug screen tested positive for marijuana, benzodiazepines, oxazepam, and naldizepam. Licensee did not have a prescription for marijuana, oxazepam or naldizepam. Respondent admitted to self-medicating with Valium and THC (a metabolite of marijuana) for three (3) days. Voluntary Surrender 12/05/2013

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May, June, July 2014 Missouri State Board of Nursing • Page 19

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

NAME

ADDRESS

PHONE

ALTERNATE PHONE

EMAIL

Missouri License Number

RN

APRN

LPN

Social Security Number

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed)

First Name (Printed)

NEW INFORMATION

Last Name

First Name

Middle Name

Daytime Telephone Number

Alternate Phone Number

E-mail Address

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

Physical address required, PO boxes are not acceptable:

CITY

STATE

ZIP

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

CITY

STATE

ZIP

I declare ___________________________________ as my primary state of residence effective _______________.

(primary state of residence) (effective date)

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

Information on the Nurse License Compact can be found at www.ncsbn.org/lic.htm
In accordance with the Nurse License Compact “Primary State of Residence” is defined as the state of a person’s declared, permanent and principal home for legal purposes, domicile. Documentation of primary state of residence that may be requested (but not limited to) includes:

• Driver’s license with a home address
• Voter registration card displaying a home address
• Federal income tax return declaring the primary state of residence
• Military Form no. 2858 – state of legal residence certificate
• W-2 from US Government or any business, division or agency thereof indicating the declared state of residence

Proof of any of the above may be requested.

When your primary state of residence is a non-compact state, your license will be designated as a single-state license valid only in Missouri.

When your primary state of residence is a compact state other than Missouri, your Missouri license will be placed on inactive status and you can practice in Missouri based on your unrestricted multi-state license from another compact state.

I solemnly declare and affirm, that I am the person who is referred to in the foregoing declaration of primary state of residence; that the statements therein are strictly true in every respect, under the pains and penalties of perjury.

_______________________________
Signature (This form must be signed) ____________________________
Date

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The woman filed a lawsuit, claiming that the placement of the PICC line damaged her right median nerve. The damage caused paralysis of her right thumb and index finger, which had to be amputated with surgery. After the surgery, the patient continued to experience pain and numbness in her right hand and partial loss of use of her right arm.

A jury awarded the plaintiff $107,200 in damages.

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