MISSOURI STATE BOARD OF NURSING NEWSLETTER

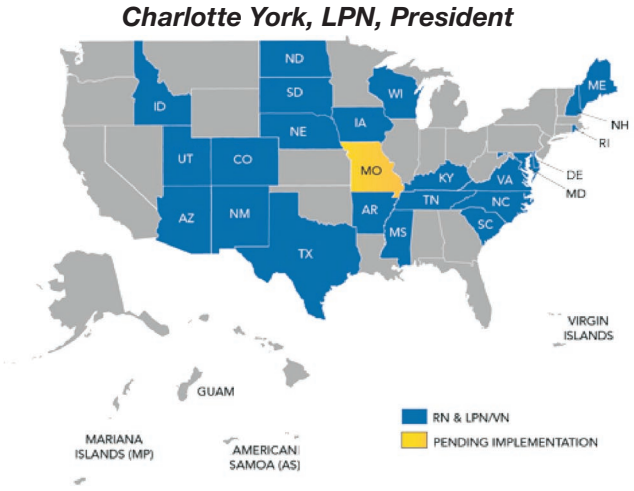
The Official Publication of the Missouri State Board of Nursing with a quarterly circulation of approximately 116,000 to all RNs and LPNs

Volume 12 • No. 2 **May, June, July 2010**

Message from the President

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

Charlotte York, LPN, President



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

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

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

How will this impact you?

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

For more information, visit www.ncsbn.org/nlc or email our executive director Lori Scheidt at lori.scheidt@pr.mo.gov.

ADDRESS/TELEPHONE NUMBER
Missouri State Board of Nursing
3605 Missouri Boulevard
PO Box 656
Jefferson City, MO 65102-0656
573-751-0681 Main Line
573-751-0075 Fax
Web site: http://pr.mo.gov
E-mail: nursing@pr.mo.gov

Visit us on the web anytime...
http://pr.mo.gov

Executive Director Report

Legislative Update

Authored by Lori Scheidt, Executive Director

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

Advanced Practice Registered Nurses

Representative Sue Allen (R-District 092) introduced *House Bill 1449*. This bill would add an advanced practice registered nurse to the list of approved health care providers who are authorized to write a prescription to refer a patient to a physical therapist.

A companion senate version of this bill was filed by Senator Frank Barnitz (D-District 16) as *Senate Bill 986*.

Mandatory Nurse License Verification

Representative Don Wells (R-District 147) introduced *House Bill 1990*, which would require a nurse's employer to verify the nurse's license before hire and at the time of each license renewal. This same language can also be found in *Senate Bill 1022*, filed by Senator Bill Stouffer.

Executive Director continued on page 4

Schedule of Board Meeting Dates Through 2011

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

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

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

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

Important Telephone Numbers

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

Number of Nurses Currently Licensed in the State of Missouri

As of April 29, 2010

Profession	Number
Licensed Practical Nurse	25,259
Registered Professional Nurse	92,564
Total	**117,823**

Nurses
CARING TODAY FOR A HEALTHIER TOMORROW

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Licensure Corner

Authored by Angie Morice
Licensing Administrator

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

Licensed Practical Nurse renewals

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

Please notify the board of nursing office in writing of all address changes.

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

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

The State Board of Nursing will no longer issue a paper verification to licensees who opt to come to the Board office to renew their licenses. **Renewals in person are NOT quicker.** If you have waited until the last minute to renew your license, you may come to the board of nursing office to renew your license, but you will **NOT** receive your license or verification that day. The license will be mailed to you. It can take up to five business days to renew a license.

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

Licensure for military and federal employees

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

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

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

Criminal history background check for renewal of expired or inactive licenses

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

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

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

Name and address changes

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

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

Contacting the Board

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

- License number
- Pen and paper

The Legal Perspective

Authored by Mikeal R. Louraine, BS, JD
Senior Legal Counsel for the
State Board of Nursing

At least once a week, I participate in the following telephone conversation, "This is (name). I am a student at (school). A few years ago, I was arrested and pled guilty to (offense). Am I going to be able to get a license?"

Unfortunately for the student involved, I'm unable to give them a definitive answer. The Board does not make decisions on eligibility to sit for the NCLEX until the student is fully qualified to take the test. In other words, the Board isn't answering until you've graduated from school. That puts the student in a tough situation: do they take the time and spend the money to get the degree, knowing there is a chance they won't be allowed to test or do they give up on nursing school and pursue another career path? Understandably, many students are not happy when I give them the standard non-answer.

Let's take a look at the applicable statutes. Initial licensure falls under two main statutes: §§335.046 and 335.066 RSMo.

§335.046 outlines the basic educational requirements for licensure. The key phrase in that statute is, "The applicant shall be of good moral character…" The Board may use this phrase as justification to refuse a license to anyone they feel, based on a careful review of their history, lacks the moral character to uphold the high standards expected of a nurse. Subsection 1 of the statute covers the educational requirements for a registered professional nurse, while subsection 2 refers to licensed practical nurses. Both, however, include the 'good moral character' requirement.

While a criminal conviction can fall under the 'good moral character' language, it more likely runs afoul of the language in §335.066.1 RSMo. That section states, "The board may refuse to issue… any… license required pursuant to chapter 335 for one or any combination of causes stated in subsection 2…" As I'm sure you all know, subsection 2 of §335.066 contains the sixteen causes that the Board can use to pursue discipline against a licensee. Therefore, any reason that the Board can use to discipline a license can also be used as grounds to deny a license. As has been previously discussed in this space, §§335.066.2(2) and (14) RSMo are the provisions that apply to criminal charges.

Here is the text of §335.066.2(2): "The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution pursuant to the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of any profession licensed or regulated pursuant to sections 335.011 to 335.096, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;"

There are several things worth noting about this section: first, there is no requirement that the person be convicted. If the individual has pled guilty or no contest or the Court entered a suspended imposition of sentence (SIS), the Board can still use that information to deny licensure. Second, the section applies to the laws of any state or the United States. In other words, a criminal offense prosecuted in another state or in Federal Court can be relied upon to deny licensure. Third, the offense must be reasonably related to the 'qualifications, functions or duties' of a nurse. The Administrative Hearing Commission and Courts have consistently held that any drug offense qualifies under this provision. If not reasonably related to nursing, the offense must have an 'essential element' of 'fraud, dishonesty or an act of violence.' Crimes which would fit under those provisions would include forgery, stealing and assaults. If neither of those categories fit, it could be an 'offense involving moral turpitude'. The Administrative Hearing Commission has written at length about what qualifies as an offense involving moral turpitude. It's worth noting that not all criminal offenses would qualify under this section.

Here is the text of §335.066.2(14): "Violation of the drug laws or rules and regulations of this state, any other state or the federal government;"

Again, a couple of things worth noting: first, not only is a conviction not required, there does not even have to be a charge filed in any court. If the Board can prove that an individual's conduct violates a drug law, that individual can have their license disciplined or denied. This circumstance usually arises in cases involving diversion. The facility that caught a licensee diverting controlled substances rarely reports the diverter to law enforcement. However, possessing a controlled substance without a valid prescription is a clear violation of the drug laws of the State of Missouri. Therefore, if the Board can prove that the person diverted the drugs, it can seek discipline against or deny a license. Second, again, the violation can be against the drug laws of any state or the federal government.

I don't want to give the impression that the process is cut and dry. A criminal conviction is not an automatic disqualifier for licensure. During the application process, the applicant has the opportunity to give the Board their side of the events. Usually, the applicant's side of the story involves some variation of the 'young and stupid' theme. In addition, the applicants can provide the Board with some perspective on what happened; not just with the criminal offense, but also what was going on in their lives at the time of the offense. Maybe most importantly, applicants can tell the Board what they have learned from the experience and what changes they have made in their lives to avoid making the same mistakes in the future. All of these factors will be considered by the Board in making a decision on whether or not to allow an applicant to sit for the NCLEX.

Unfortunately, I end this column with the same non-answer that I have to leave the telephone inquirer with; the Board does not give answers on licensure until you've completed all the licensure requirements.

Executive Director continued from page 1

Mandatory Reporting Rule

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

State Government Budget and Reform

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

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

Your Role in the Legislative Process

We urge you to study all facets of the issue being considered and know your facts. Be able to tell your legislator what impact a bill will have on his or her constituents. Know the opposing viewpoint. Every issue has two sides.

As a licensed professional, you do have a voice in shaping the future of health care. You can meet with, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at http://www.moga.state.mo.us.

Education Report

Authored by Bibi Schultz, RN MSN, Education Administrator

Missouri State Board of Nursing Education Committee Members:

- Lisa Green, RN, PhD(c), Chair
- Charlotte York, LPN
- Ann Shelton, RN, PhD
- Roxanne McDaniel, RN, PhD
- Debra Wagner, RN

Missouri State Board of Nursing (MSBN) approval of nursing programs is limited to programs providing pre-licensure education at Practical Nursing, Associate Degree in Nursing as well as Baccalaureate Degree levels. Approval status may vary from initial approval contingent on a site survey (prior to actual program initiation) to initial, full or conditional program approval. Initial program approval may be granted during initial year(s) of program existence, until the first class of students graduate and official NCLEX® program pass rates for that first class are available. Program compliance with the respective Missouri Minimum Standards for Programs of Practical or Professional Nursing is then ensured by conducting an initial-to-full site survey. The Board may decide to keep a program on initial approval should the program fail to meet requirements for full program approval at that time. Initial approval may be extended for one year at a time. The Board has authority to remove initial program approval, if current program conditions were to prescribe such action.

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

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

Letter to the Editor

Respectfully submitted,
Lucy Brenner, BSN, MEd, RN

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

LPNs would you be willing to increase your education surcharge to $3.00? RNs would you be willing to increase your education surcharge to $13.00?

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

Investigations Corner

Case of the Quarter

Authored by Quinn Lewis
Investigations Administrator

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

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

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

DETAILS OF INVESTIGATION:

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

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

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

The Clinical Supervisor went to the Pyxis Machine and pulled the reports for the previous seven days. She correlated each narcotic pulled by AP with each patient's chart. She found 16 discrepancies from just that one week. It was discovered that AP had taken medications from the Pyxis for patients not assigned to her. Also, the patients had not been seen by the doctor or they did not have orders for those meds. The meds in question totaled 18 mg Dilaudid, 48 mg Morphine, 600 mg Demerol, 200 mg Vistaril, and 25 mg Phenergan.

There were other things discovered that were troubling as well. When AP wasted meds, they were wasted with zero medication being given to the patient. And AP always had an agency nurse witness her waste instead of a full time facility nurse.

On August 14, 2007, AP arrived at work at 11:00 am and she could not be found shortly after arriving. A Pyxis report was run at 11:08 am just for that day. The report revealed that 2 mg Dilaudid had already been taken out by AP for a patient who was not hers, who did not have orders, and who had not seen the doctor yet. At 11:55 am, another Pyxis report was pulled and it revealed that AP had pulled another 2 mg Dilaudid on another patient who was not assigned to her, who had no orders for Dilaudid, and who had not seen the doctor yet.

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

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

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

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

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

Discipline Corner

Authored by Janet Wolken, MBA, RN
Discipline Administrator

Missouri State Board of Nursing
Discipline Committee Members:

- Charlotte York, LPN, Chair
- Adrienne Anderson Fly, JD
- Robyn Chambers, LPN
- Aubrey Moncrief, CRNA, RN
- Deborah Wagner, RN

One of the reasons for publishing the narrative in the *Disciplinary Actions* section of this newsletter is so licensees can learn from the mistakes of others. As Discipline Administrator I become familiar with the licensee's actions that have placed them on discipline. It seems to me that a current trend is the making up of glucoscans, vital signs, and even physical assessments.

When I use the term "making up" it sounds friendlier, less like the reality that is the falsification of medical records. When a licensee falsifies a medical record she or he has violated the Nursing Practice Act. The licensee is then charged with incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096 (335.033.2.(5)), and could be disciplined.

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

Obviously, if the forgetting or getting too busy happens frequently, you will have your employer and the physician to answer to. If you determine that time is getting away from you then you need to ask for help. Delegate the task to an appropriate person, ask another licensee for help, page the house supervisor, or talk to the DON.

By documenting correctly and attempting to remedy the situation, you will not have violated the practice act and will be protecting your license.

Up to this point I have only discussed the licensee. Now I want to point out what may happen to the patient, the person that you are the advocate for.

If you make up the glucoscan, vital signs, or assessment, you may be putting the patient at great risk. The physician may write orders based on the false numbers you have recorded, the patient goes home and falls because you documented a normal range glucoscan at 1600 every evening when in fact the glucoscan was low. The patient has a hypoglycemic episode. The patient falls and they break a bone or get a head injury. Now you have "caused" the patient more hospital time or even death by making up a number.

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

Think how your actions as a nurse will affect your license and your patient's health.

Practice Corner

Authored by Debra Funk, RN
Practice Administrator

Missouri State Board of Nursing
Practice Committee Members:
- Aubrey Moncrief, RN, CRNA
- Deborah Wagner, RN
- Rhonda Shimmens, RN-C
- Roxanne McDaniel, PhD, RN,
- Robyn Chambers, LPN

Many nurses find themselves under discipline due to problems with medication administration. The Texas Board of Nursing published an article in one of their newsletters recently that described some best practices that have been found helpful in decreasing the number of medication errors.

Best Practices in Patient Safety: Minimizing Disruptions during Medication Administration
by Melinda Hester, MS, RN

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

Emrich (2010) reported that numerous forms of distractions interfere with nurses administering medications safely; from excessive work hours, to multitasking, interruptions and noise. Hicks, Sikirica, Nelson, Schein and Cousins (2008) identified in their study that distractions were the most common contributing factor for medication errors in patient-controlled analgesia (PCA). Hicks et al. (2008) defined contributing factors as those that influence an error from occurring, but do not directly cause it. Distraction is defined as "any interruption in the medication-use process" (Hicks et al., 2008, p. 431). Krechler et al. (2008) studied the types of interruptions that caused errors during the medication administration process. The sources of interruptions came from physicians, other nurses, telephone calls, patients' relatives or the nurses themselves. Interruptions from physicians accounted for 21 percent of the overall interruptions (Kreckler et al., 2008).

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

Pape et al. (2008) found, after just three weeks of study, the medication error rate declined and nurses were reporting greater work productivity. Interestingly, physicians and residents were still more likely to interrupt nurses after these interventions were instituted.

Other hospitals around the country and in Texas have reported impressive results in the reduction of medication administration errors when nurses wore brightly colored vests or sashes that alerted staff and others to the designated medication administration time. Another strategy shown to decrease the number of interruptions from colleagues has been to cover windows in medication rooms.

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

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

References

Emrich, L. (2010). Practice breakdown: Medication administration. In Benner, P.E., Malloch, K. & Sheets, V. (Eds.), Nursing pathways for patient safety. St Louis: Mosby Elsevier.

Hicks, R. W., Sikirica, V., Nelson, W., Schein, J. R., & Cousins, D. D. (2008). Medication errors involving patient-controlled analgesia. American Journal of Health-System Pharmacy, 65(5), 429-440.

Kreckler, S., Catchpole, K., Bottomley, M., Handa, A., & McCulloch, P. (2008). Interruptions during drug rounds: An observational study. British Journal of Nursing (BJN), 17(21), 1326.

Pape, T. M., Guerra, D. M., Muzquiz, M., Bryant, J. B., Ingram, M., Schranner, B., Alcala, A., Sharp, J., Bishop, D., Carreno, E., & Welker, J. (2005). Innovative approaches to reducing nurses' distractions during medication administration. Journal of Continuing Education in Nursing, 36(3), 108.

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APRNs and the Compact

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

1. APRN Document of Recognition card will no longer have an expiration date printed on it.
2. APRNs will receive only one (1) card with their initial application for recognition.
3. When doing a search on our website for an APRN, the Document of Recognition is considered "Active" as long as there is a result from the search. The expiration date will no longer appear in the search results. If a result does not appear, contact the advanced practice section at the Board office.
4. APRNs endorsing into the state from another compact state will be required to have a background check.
5. APRNs endorsing into the state from a non-compact state will be required to have a background check with their RN application.
6. APRN applicants who are already licensed as RNs in the State of Missouri will not be required to have a new background check.

Overview of the Nurse Staffing Requirements that Resulted from the Work of the Technical Advisory Committee & the Missouri Nurses Association

Authored by Lisa DeSha, MONA

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

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

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

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

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

There are several key elements of the new regulations that apply to units organized as part of the hospital's nursing service. The units shall:

- Maintain a list of nursing staff who may be called when additional staff is needed per the hospital's developed policy.
- Develop a hospital-wide staffing plan and submit a copy of the plan to the DHSS annually at the beginning of the hospital's fiscal year.
- Document actual staffing levels by unit on a per-shift basis.
- Monitor staffing plan effectiveness with a minimum of three nursing sensitive indicators.
- Make the staffing plan available to patients or their authorized representatives.
- Seek input from direct care nursing staff in developing the staffing plan.

For your convenience, the entire nursing service regulation is reprinted here. New language is in bold-face type.

19 CSR 30-20.096 Nursing Services in Hospitals

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

(1) The nursing service shall be integrated and identified within the total hospital organizational structure.

(2) The nursing service shall have a written organizational structure that indicates lines of authority, accountability and communication.

(3) The organization of the nursing service shall conform to the variety of patient care services offered and the range of nursing care activities.

(4) Nursing policies and standards of practice describing patient care shall be in writing and be kept current.

(5) Policies shall provide for the collaboration of nursing personnel with members of the medical staff and other health care disciplines regarding patient care issues.

(6) Nursing service policies shall establish an appropriate committee structure to oversee and assist in the provision of quality nursing care. The purpose and function of each committee shall be defined and a record of its activities shall be maintained.

(7) Policies shall make provision for nursing personnel to be participants of hospital committees concerned with patient care activities.

(8) Policies shall be developed regarding the use of overtime. The policies shall be based on the following standards:

(A) Overtime shall not be mandated for any licensed nursing personnel except when an unexpected nurse staffing shortage arises that involves a substantial risk to patient safety, in which case a reasonable effort must be applied to secure safe staffing before requiring the on-duty licensed nursing personnel to work overtime. Reasonable efforts undertaken shall be verified by the hospital. Reasonable efforts shall include pursuing all of the following:

1. Reassigning on-duty staff;
2. Seeking volunteers to work extra time from all available qualified nursing staff who are presently working;
3. Contacting qualified off-duty employees who have made themselves available to work extra time, per diem staff, float pool and flex team nurses; and
4. Seeking personnel from a contracted temporary agency or agencies when such staffing is permitted by law or an applicable collective bargaining agreement and when the employer regularly uses the contracted temporary agency or agencies;

(B) In the absence of nurse volunteers, float pool nurses, flex team nurses or contracted temporary agency staff secured by the reasonable efforts as described in subsection (8)(A) and if qualified reassignments cannot be made, the hospital may require the nurse currently providing the patient care to fulfill his or her obligations based on the Missouri Nurse Practice Act by performing the patient care which is required;

(C) The prohibition of mandatory overtime does not apply to overtime work that occurs because of an unforeseeable emergency or when a hospital and a subsection of nurses commit, in writing, to a set, predetermined staffing schedule or prescheduled on-call time. An unforeseeable emergency is defined as a period of unusual, unpredictable or unforeseeable circumstances such as, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions, or natural disasters which impact patient care and which prevent replacement staff from reporting for duty;

(D) The facility is prohibited from requiring a nurse to work additional consecutive hours and from taking action against a nurse on the grounds that a nurse failed to work the additional hours or when a nurse declines to work additional consecutive hours beyond the nurse's predetermined schedule of hours because doing so may, in the nurse's judgment, jeopardize patient safety;

(E) Subsection (8)(D) is not applicable if overtime is permitted under subsections (8)(A), (B), and (C);

(F) Nurses required to work more than twelve (12) consecutive hours under subsections (8)(A), (B), or (C) shall be provided the option to have at least ten (10) consecutive hours of uninterrupted off-duty time immediately following the worked time; **and**

(G) The nursing service shall maintain and make available upon request to the department a list of qualified nurses,

Overview continued on page 10

Overview continued from page 9

nurse registries, and per diem nurses that may be called upon to provide replacement staff in the event of sickness, vacations, vacancies, disasters, and other absences of direct care nursing staff.

(9) The nursing service shall be administered and directed by a qualified registered professional nurse with appropriate education, experience and demonstrated ability in nursing practice and management.

(10) The nursing service administrator shall be responsible to the chief executive officer or chief operating officer.

(11) The nursing service administrator shall be a full-time employee and shall have the authority and be accountable for assuring the provision of quality nursing care for those patient areas delineated in the organizational structure.

(12) The nursing service administrator shall participate in the formulation of hospital policies and the development of long-range plans relating to patient care.

(13) The nursing service administrator, or designee, shall represent nursing at all appropriate meetings of the medical staff and governing board of the hospital.

(14) The nursing service administrator shall be accountable for the selection, promotion and termination of all nursing personnel under the authority of nursing service.

(15) The nursing service administrator shall have sufficient time to perform the necessary managerial duties and functions of the position.

(16) A qualified registered professional nurse shall be designated and authorized to act in the absence of the nursing service administrator.

(17) Nursing personnel shall hold a valid and current license in accordance with sections 335.011–335.096, RSMo.

(18) There shall be a job description for each classification of nursing personnel which delineates the specific qualifications, licensure, certification, authority, responsibilities, functions and performance standards for that classification. Job descriptions shall be reviewed annually and revised as necessary to reflect current job requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Validated patient complaints related to staffing levels.

(26) The hospital shall, in consultation with its direct care nursing staff, monitor and evaluate the hospital-wide staffing plan and nursing sensitive outcomes for effectiveness on a continual basis and revise the plan annually and as necessary.

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

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

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

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

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

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

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

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

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

Former Board Members

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

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

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

Childhood Immunization Requirements for School and Daycare Attendance Revised

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

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

Beginning July 2010,

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

Beginning with the 2010-11 school year,

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

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

New Member Welcomed to the Board!

Roxanne McDaniel, PhD, RN

Roxanne McDaniel, PhD, RN

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

Disciplinary Actions**

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

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

CENSURE

Auzat, Tonia Marie
Union, MO
Licensed Practical Nurse 2009015535
Respondent was required to abstain completely from the use or consumption of alcohol. On July 22, 2009, Respondent submitted a urine sample for random drug and alcohol screening. The sample tested positive for the presence of ethyl glucuronide, a metabolite of alcohol. Respondent was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Respondent has a bona fide relationship as a patient. On September 18, 2009, Respondent submitted a urine sample for random drug and alcohol screening. That sample tested positive for the presence of tramadol. Respondent does not have a valid prescription for tramadol.
Censure 12/8/2009 to 12/9/2009

Berry, Carol J.
St Joseph, MO
Licensed Practical Nurse 037580
Patient had a physician order for Percocet post-op for pain and a written prescription for Percocet at discharge. Upon discharge, patient requested two more Percocet tablets to take home because her pharmacy was closed and she could not get them until the next morning. Licensee removed four Percocet tablets, administered two to patient and sent two home with the patient. In an effort to cover her withdrawal of two additional Percocet tablets, Licensee falsely documented in the patient's electronic medical record that she administered two Percocet pills to the patient on another date. Licensee altered records in an effort to hide her actions.
Censure 2/11/2010 to 2/12/2010

Caola, Jeanne M.
Saint Louis, MO
Registered Nurse 076606
In October of 2008, a family member of Licensee was admitted to the hospital. Licensee got access to the family member's medical chart and made changes to the chart. Licensee was not employed at the hospital and was not assigned to provide care for the family member. Licensee did not have authority to make changes or add information to the family member's chart and did not seek authority or permission prior to making the changes. Licensee stated that when she made the changes and additions she was advocating for her family member.
Censure 2/18/2010 to 2/19/2010

Chandler, Rhonda Renee
Carterville, IL
Licensed Practical Nurse 2006001061
Licensee was employed as a licensed practical nurse by a nursing home. Licensee was asked by the home to submit to a urine drug screen. The urine sample tested positive for marijuana.
Censure 2/11/2010 to 2/12/2010

Crenshaw, LaKeisha Marie
Saint Louis, MO
Registered Nurse 2003024748
A PN employed at the nursing home reported to Licensee that she had observed bruising on one of the residents. Licensee did not initiate an investigation into the cause of the bruising. Licensee did not document in the resident's chart that the bruising had been reported to her. Licensee did not notify the resident's doctor or the administrator of the home about the incident, which resulted in delayed treatment of the resident. Licensee did not report the injuries to the family of the resident. Licensee took no action of any kind to facilitate the reporting or treatment of the resident's injuries.
Censure 2/5/2010 to 2/6/2010

CENSURE Continued...

Goodall, Dana S.
Kansas City, MO
Licensed Practical Nurse 049061
On January 14, 2008, Licensee entered a guilty plea to receiving stolen property in Circuit Court of Vernon County, Missouri.
Censure 1/21/2010 to 1/22/2010

Mills, Phyllis M.
Joplin, MO
Registered Nurse 096212
Licensee was in orientation for the duration of her employment with a hospital, and was terminated because Licensee could not perform essential functions. Licensee had not worked as a nurse for several years, and was not aware of some of the changes to practicing that had occurred while she was absent from nursing. After her termination, Licensee, upon her own initiative, completed twenty-five continuing education hours.
Censure 12/29/2009 to 12/30/2009

Simpson, Jon T.
Saint Peters, MO
Registered Nurse 2001019186
On August 22, 2008, in the Circuit Court of St. Charles County, Missouri, Licensee pled guilty to the Class D Felony of Possess/Discharge Loaded Firearm/Projectile Weapon While Intoxicated.
Censure 1/1/2010 to 1/2/2010

Suday-Handrahan, Carmelita
Saint Louis, MO
Registered Nurse 126263
On April 22, 2008, Licensee pled guilty in the Eastern District of the United States District Court to conspiracy to commit marriage fraud. The Court placed Licensee on probation for a period of twelve months. On May 27, 2009, Licensee was successfully released from probation.
Censure 12/31/2009 to 1/1/2010

PROBATION

Banks, Jill K.
Blackburn, MO
Licensed Practical Nurse 046540
On December 11, 2007, Licensee pled guilty to two counts of the Class C Felony of Passing Bad Checks in the Circuit Court of Carroll County, Missouri.
Probation 12/25/2009 to 12/25/2013

Boyle, Susan Lea
Columbia, MO
Registered Nurse 2010002144
On or about December 14, 1999 licensee was asked to submit to a pre-employment drug screen. Licensee tested positive for cocaine. Licensee's nursing license was placed on probation. Licensee had a relapse and violated the terms of her probationary license by using cocaine. Licensee voluntarily surrendered her nursing license on or about June 18, 2003. On or about October 16, 2008 the Board received Licensee's application. Licensee admits she was found guilty of unlawful possession of drug paraphernalia. Licensee admits she was found guilty of driving while intoxicated. Licensee admits to a sobriety date of August 24, 2007.
Probation 1/19/2010 to 1/19/2013

Cooper, Glen E.
Cameron, MO
Licensed Practical Nurse 058755
On August 20, 2009, Licensee was placed on the Department of Health and Senior Services' Employee Disqualification List for a period of eighteen (18) months.
Probation 2/26/2010 to 2/26/2012

Cruz, Tammy Lou
Marshall, MO
Licensed Practical Nurse 2002027911
On January 13, 2008, Licensee asked the CMT to remind her to do her accu-checks since she had forgotten to do them on Saturday. Licensee admitted to the CMT, that when she missed her accu-checks the previous day, she just "made them up". On January 18, 2008 the Director of Nursing retrieved the Treatment Administration Records for January 12, 2008. After going through the reading on the glucometer it was noted that on January 12, 2008, there were no readings in the memory of the glucometer that matched Licensee's charting for January 12th. Licensee admitted making a bad decision and that she should have called the RN on call to ask for advice in the matter.
Probation 1/21/2010 to 1/21/2011

PROBATION Continued...

Dennis, Gina C.
Wentzville, MO
Registered Nurse 151139
On January 9, 2009, Licensee and a second nurse started an IV on a third nurse. The third nurse was pregnant and the IV was started after the third nurse became light-headed and began having false labor pains. The third nurse received saline solution for hydration only. No other medications were administered. The saline and the supplies were pulled from the pyxis and the supply cart. No patient was charged for the saline or supplies, however, the saline and supplies were used without being paid for. Licensee and the second nurse did not have a doctor's order to start an IV or administer fluids to the third nurse.
Probation 2/26/2010 to 2/27/2010

Dutton, Jessica M.
De Soto, MO
Registered Nurse 148015
On January 9, 2009, Licensee and a second nurse started an IV on a third nurse. The third nurse was pregnant and the IV was started after the third nurse became light-headed and began having false labor pains. The third nurse received saline solution for hydration only. No other medications were administered. The saline and the supplies were pulled from the pyxis and the supply cart. No patient was charged for the saline or supplies, however, the saline and supplies were used without being paid for. Licensee and the second nurse did not have a doctor's order to start an IV or administer fluids to the third nurse.
Probation 2/26/2010 to 2/26/2010

Fields, Violet Antoinette
Saint Louis, MO
Licensed Practical Nurse 2010007240
On September 11, 2009, Licensee pled guilty of the Class C Felony of Stealing over $500.
Probation 2/26/2010 to 2/26/2014

Hannon, Christina Gayle
Kansas City, KS
Licensed Practical Nurse 2003001600
Licensee pled guilty to felony conspiracy to distribute and possession with intent to distribute a controlled substance on February 21, 2006 and was sentenced on May 8, 2006.
Probation 2/17/2010 to 2/17/2013

Hoffman, Tiffany Lynn
Lake Saint Louis, MO
Registered Nurse 2006006553
On January 8, 2009, Licensee was thirty-three weeks pregnant and was working a twelve hour shift. Licensee explained to two other nurses currently working that she was having contractions. Licensee consented to having IV fluids administered. The other nurses went to the Pyxis and removed the bags of IV fluids from another patient's account and started the IV fluids.
Probation 12/1/2009 to 12/2/2009

Killian, Dana Marie
Shawnee Mission, KS
Registered Nurse 2010001855
On or about June 15, 2005, Killian pled guilty to driving under the influence, her fourth offense, making her offense a felony.
Probation 1/20/2010 to 1/20/2012

Meng, Lynette Dawn
Springfield, MO
Registered Nurse 2009036284
Licensee is currently licensed in Idaho without restriction. The Board received Licensee's Application for a License by Endorsement. Licensee disclosed that she had previously voluntarily surrendered a professional license. Licensee disclosed that she had previously pled guilty, on April 20, 2007, to Misdemeanor Possession of a Legend Drug Without a Prescription. Licensee unlawfully obtained and used Norco, a prescription drug.
Probation 12/15/2009 to 12/15/2011

Prettyman, Mary L.
Lockwood, MO
Registered Nurse 135521
On September 1, 2008, Licensee placed numerous narcotic medications, in pill cups, in front of a resident. The resident was seated at a table in the facility's dining area. Licensee asked the resident to "keep an eye on" the medications. There were other residents sitting at the table with the med cups. A human resources employee removed the pills from the table and kept them in her office until Licensee came to her office looking for the med cups.
Probation 2/16/2010 to 2/16/2011

Probation continued on page 13

Probation continued from page 12

Roberts, Vicky M.
Brighton, IL
Registered Nurse 109513
On January 28, 2008, Licensee pled guilty to the Class A misdemeanor of possession of cannabis (marijuana).
Probation 2/10/2010 to 2/10/2011

Sadler, Wilma J.
Sikeston, MO
Registered Nurse 113882
License No. 113882
Licensee documented the administration of several bolus doses of Morphine although there was no physician's order for the bolus doses. Licensee diverted Morphine from the patient for her personal use and she also diverted Morphine and Fentanyl on other occasions. Licensee diverted at least 25 micrograms of Fentanyl near the end of September 2007 and she consumed a bolus dose of Morphine from a PCA pump on October 16 and October 17, 2007 while on duty. On October 17, 2007, Licensee injected 2 milligrams of Morphine while on duty.
Probation 1/16/2010 to 1/16/2015

Schaller, Lawrence R.
Tipton, MO
Registered Nurse 2010004454
On September 28, 1999, Licensee pled guilty to the Class A Misdemeanor of 'Driving While Intoxicated-Prior Offender' in the Associate Circuit Court of Boone County, Missouri. Licensee was sentenced to six (6) months in the county jail. That sentence was suspended and Licensee was placed on two (2) years of unsupervised probation. Licensee successfully completed the period of probation. On April 12, 2004, Licensee pled guilty to the Class D Felony of 'Driving While Intoxicated-Persistent Offender' in the Circuit Court of Cole County, Missouri. The Court suspended imposition of sentence and placed Licensee on five (5) years of supervised probation. Licensee successfully completed the period of probation. On April 1, 2008, Licensee pled guilty to the Class A Misdemeanor of 'Passing a Bad Check' in the Associate Circuit Court of Morgan County. The Court suspended imposition of sentence and placed Licensee on two (2) years of unsupervised probation.
Probation 2/9/2010 to 2/9/2011

Snyder, Paige Renee
Carl Junction, MO
Registered Nurse 2002021789
In September and October 2006, Licensee misappropriated Morphine for her personal consumption. Licensee accomplished the misappropriation by leaving a small amount of Morphine in the vial, rather than waste all of the medication. Licensee then pocketed the vial and consumed the morphine at home.
Probation 1/19/2010 to 1/19/2013

Thiede, Melissa Mary
East Lyme, CT
Registered Nurse 2000167167
A review of patients under Licensee's care revealed that between January 15, 2007 and February 12, 2007 Licensee failed to document the administration or wastage of several doses of Oxycodone/APAP.
Probation 1/30/2010 to 1/30/2015

Tucker, Julie F.
Springfield, MO
Registered Nurse 092455
On November 17, 2008, Licensee pled guilty to Driving While Intoxicated. The Court placed Licensee on two (2) years of supervised probation. The offense was treated as a second offense as Licensee had previously pled guilty to Driving While Intoxicated in 2002. Licensee entered treatment for alcohol dependency on July 21, 2008 and was successfully discharged from primary treatment on August 27, 2008. Licensee then completed a six month aftercare program in March, 2009.
Probation 2/16/2010 to 2/16/2013

Vittetoe, Jennifer Michelle
Jefferson City, MO
Licensed Practical Nurse 2009039692
On March 18, 2005, Licensee pled guilty to the Class A Misdemeanor of Possession of Drug Paraphernalia in the Associate Circuit Court of Callaway County, Missouri. Licensee successfully completed that period of probation and was, therefore, not formally convicted of the offense. On January 3, 2006, Licensee pled guilty to the Class C Felonies of Burglary in the Second Degree and Theft/Stealing in the Circuit Court of Callaway County, Missouri. Licensee was discharged from probation early; in October of 2008, and was, therefore, not formally convicted of either offense.
Probation 12/30/2009 to 12/30/2010

Weber, Jennifer Linn
Saint Charles, MO
Registered Nurse 2003014511
On May 11, 2008, Licensee was arrested for Driving While Intoxicated. Following the arrest, while Licensee was in the back seat of the deputy's vehicle, Licensee stated, "I hope you never fucking have a baby at my hospital." The deputy interpreted that statement as a threat against himself and his family should they ever seek care at the hospital which employed Licensee.
Suspension 2/12/2010 to 2/13/2010; Probation 2/14/2010 to 2/14/2012

Wohldmann, Becky B.
Saint Louis, MO
Registered Nurse 096536
On June 24, 2003, Licensee pled guilty to the Class A Misdemeanor of Driving While Intoxicated . On December 18, 2006, Licensee pled guilty to the Class D Felony of Driving While Intoxicated. On July 23, 2007, Licensee pled guilty to the Class D Felony of Driving While Intoxicated and the Class D Felony of Resisting Arrest.
Probation 12/10/2009 to 12/10/2012

Young, Andrea
Jefferson City, MO
Registered Nurse 135143
On or about September 19, 2007, a search of an inmate's cell revealed a letter written by Licensee and addressed to inmate. Licensee wrote letters to inmate and discussed details of her personal life with him.
Probation 1/19/2010 to 1/20/2010

REVOKED

Burch, Tina L.
Springfield, MO
Registered Nurse 123400
Respondent was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Respondent has a bona fide relationship as a patient. The Board received a letter from a hospital advising that Respondent had been suspended from employment due to diverting Depakote on two to three occasions and Seroquel on two to three occasions. Respondent was interviewed and admitted to diverting Depakote, Seoquel and Cogentin from her former employer.
Revoked 12/8/2009

Revoked continued on page 14

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

Colleen Brady–PN024390
Tracy Bynog–PN058788
Clifford Cecil–RN087397
Brandy Hamblin–PN2007030944
Jamie L. Henke–RN110458
Pamela Johnston–RN115628
Cheryl Landry–RN2004025556
Susanne Langston–PN050275
Misty Murray–PN054744
Jeannie Renee Owens–PN2001025370
Wanda Ragsdale–Bland–PN053764
Linda Rowell–PN039938
Germaine Verrett–PN2004018393
Tammy Wilcox–RN111848
Paul Wolford–RN149889

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

Revoked continued from page 13

Cisco, Jennifer Dawn
Oak Grove, AR
Registered Nurse 2004001800
On July 16, 2008, Cisco pled guilty to first degree sexual assault, a felony, in the Circuit Court of Carroll County, Arkansas. Cisco was placed on probation for six years, was ordered to register as a sex offender and was ordered to pay restitution and court costs. Cisco's Arkansas registered professional nursing license was revoked on September 19, 2008.
Revoked 1/1/2010

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

Hamilton, Joseph P.
Fulton, MO
Registered Nurse 2007013124
Respondent was required to submit employer evaluations from every employer. If Respondent was unemployed, a statement indicating the dates of unemployment was to be submitted in lieu of an employer evaluation. The Board did not receive an employer evaluation or statement of unemployment by the May 19, 2009 or the August 19, 2009 documentation due date. Respondent was required to renew his nursing license immediately. Respondent's license expired April 30, 2009 and remains lapsed at this time. Respondent was required to contract with the Board's approved third party administrator (TPA) to schedule random drug and alcohol screenings. Respondent was required to call a toll free number every day to determine if he was required to submit a sample for testing that day. Respondent failed to call in to the TPA on seventy-four (74) days. Respondent was required to abstain completely from the use or consumption of alcohol. On July 17, 2009, Respondent submitted a urine sample for random drug and alcohol screening. The sample tested positive for the presence of ethyl glucuronide, a metabolite of alcohol.
Revoked 12/8/2009

Higgins, Cynthia L.
Jefferson City, MO
Licensed Practical Nurse 046551
Respondent was required to contract with the Board's approved third party administrator to schedule random drug and alcohol screenings. Respondent was required to call a toll free number every day to determine if she was required to submit a sample for testing that day. Respondent failed to call in to the TPA on 44 days. Further, on June 17, 2009 and July 23, 2009, Respondent called the TPA 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 required sample.
Revoked 12/8/2009

Hogue, Evonne
Saint Louis, MO
Licensed Practical Nurse 058811
In 2006, Licensee was employed as an LPN at a long term care center in St Louis, Missouri. Licensee was employed as a charge nurse at the center. On June 3, 2006, Licensee entered resident M.M.'s room and stripped her and all of her blankets, making her lay on the bed naked for a period of time. On June 4, 2006, Licensee upset M.M. by speaking to her in a derogatory manner. Licensee called M.M. a "nasty, stinky woman." M.M. became agitated with Licensee, and went behind the nurses station where Licensee was sitting. Licensee continued to make derogatory remarks to M.M. and she became more agitated.

REVOKED Continued...

M.M. walked toward Licensee. Licensee pushed M.M. against a window with her forearm, pushing against M.M.'s neck. Two co-workers placed themselves between Licensee and M.M. to prevent them from fighting. After the confrontation, Licensee continued to antagonize M.M. On June 6, 2005, the center terminated Licensee for violating M.M.'s right to be free from abuse. Licensee was referred for placement on the EDL.

Later in 2006, Licensee was employed as an LPN at a different long term facility in St Louis, Missouri. Licensee served as the night shift charge nurse on the dementia unit. On August 9, 2006, a resident in a wheelchair, H.M., referred to Licensee in a derogatory manner. Licensee walked over to H.M. and tilted her wheelchair back until the handles of the wheelchair touched the floor. Licensee left H.M. in this position for approximately five to ten minutes before returning the wheelchair to an upright position. Another resident, G.D., witnessed the incident and questioned Licensee's actions. Licensee walked behind G.D. and wrapped her arms around the resident and proceeded to lower G.D. to the floor. H.M. and G.D. both have severe dementia. On January 30, 2008, DHSS placed Licensee's name on the EDL for a period of three years.
Revoked 12/8/2009

Oxenreider, Ashley Nicole
Brighton, MO
Licensed Practical Nurse 2007006512
Respondent was prohibited from violating the Nursing Practice Act. On or about October 27, 2008, a co-worker of Respondent noted a discrepancy in the med count. A chart audit was conducted which revealed numerous instances where Respondent had charted the administration of medications when she had, in fact, not administered the medications. Respondent admitted to pre-charting on at least two patients. Pre-charting in a patients medical records constitutes falsification of a patients records and is a violation of the Nursing Practice Act.
Revoked 12/8/2009

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

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

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

Respondent advised the Board that she is working as an in-home caregiver for an elderly patient. The job involves taking vital

REVOKED Continued...

signs, administering multiple medications, including insulin, and providing site care for the patient's feeding tube. Respondent's job constitutes the practice of nursing. Respondent's nursing license was suspended from January 15, 2009 until January 15, 2010. Therefore, Respondent has been practicing nursing in violation of the Agreement.
Revoked 12/8/2009

SUSPENSION

Mullins, Aspen Leigh
Kingsville, MO
Licensed Practical Nurse 2004029026
On September 17, 2007 Licensee documented that she had given a resident their nebulizer treatment, which was ordered by a physician. However the night shift charge nurse discovered that there was no nebulizer machine in the resident's room. On September 18, 2007 Licensee admitted that Licensee had not given the resident his nebulizer treatment because he was not wheezing. On September 17, 2007 at approximately 10:30 p.m. during the change of shift Licensee reported she had given a resident I.V. Vancomycin at approximately 4:30 p.m. The night shift charge nurse informed Licensee it was not due to be administered until 10:30 p.m. At that point Licensee changed her story and Licensee stated that she had not administered the medication rather she had only flushed the resident's PICC line. However in the Nursing Progress Notes Licensee charted that she did indeed give the resident his I.V. Vancomycin at 4:30 p.m. On September 18, 2007 Licensee admitted that she in fact had administered the I.V. Vancomycin at 4:30 to the resident and then discovered by looking at the Medication Administration Report that it was not suppose to be administered until 10:30 p.m. therefore Licensee went back to the resident's room disconnected the I.V. Vancomycin and destroyed the rest of the medication. Licensee did not notify the House Supervisor or the Physician of the error. The patient was not observed to have suffered any adverse consequences as a result of the medication error. The patient was not observed to have suffered any adverse consequences for not having received the ordered nebulizer treatment.
Suspension 12/8/2009 to 3/8/2010

VOLUNTARY SURRENDER

Cheshire, Helen A.
Columbia, MO
Licensed Practical Nurse 035145
Licensee voluntarily surrendered her Missouri Nursing License on February 11, 2010.
Voluntary Surrender 2/11/2010

Corzine, Meredith Carmen
O' Fallon, MO
Registered Nurse 2006021315
From May, 2006 to December, 2008, Licensee was employed as a registered nurse at a hospital. On December 15, 2008, Licensee was found to have stolen medications and narcotic paraphernalia from the hospital. As a part of the ensuing investigation, Licensee admitted that she had diverted controlled substances from the hospital in the past. Licensee admitted that she had been diverting controlled substances for approximately three months.
Voluntary Surrender 1/21/2010

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

Pullin, Michael Dean
El Dorado Springs, MO
Registered Nurse 2001004413
On June 24, 2009, Licensee entered a plea of guilty to the Class B Felony of Child Molestation in the First Degree in the Circuit Court of Henry County, Missouri. The Court sentenced Licensee to five (5) years in the Missouri Department of Corrections.
Voluntary Surrender 12/29/2009

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

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Nearly all of us are aware of nurses with back pain–or we may suffer from it ourselves. What we may not realize is how enormous the problem is. This issue of the UNA Newsletter is dedicated to educating Utah nurses about the risks they and their co-workers face in performing routine patient care. We'll also give you information about what you can do to help: you *and* your co-workers.

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

Last year, over 71,000 nurses suffered a back injury–but these are only the injuries that can be directly traced to work. 48% of nurses complain of chronic back pain, but only 35% have reported a work related injury.[i] Many of the injuries will simply be endured by nurses and health care givers, with no recourse to any compensation. The cumulative weight lifted by a health caregiver in one typical eight hour shift is 1.8 TONS.[ii] *Back injuries are incremental and pain often presents in unrelated circumstances.*

Cost of the problem

Nurses back injuries cost an estimated $16 Billion annually in workers compensation benefits. Medical treatment, lost workdays, "light duty" and employee turnover cost the industry an additional $10 billion.[iii]

Bureau of Labor Statistics show an inexcusable situation. Fig. 1 is a 2007 Bureau of Labor Statistics chart of the industries with the highest numbers of worker injuries.[iv] The top category: hospitals. In addition, the fourth and fifth categories are also of health care workers. In total, over 505,000 health care workers were injured. We know that a large percentage of these injuries are due to patient handling.

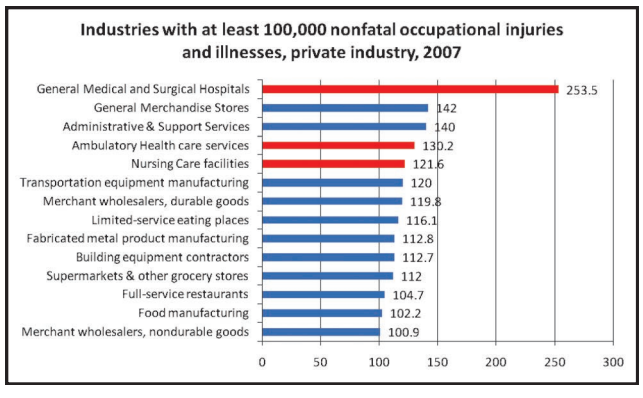


Fig. 1[v]

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

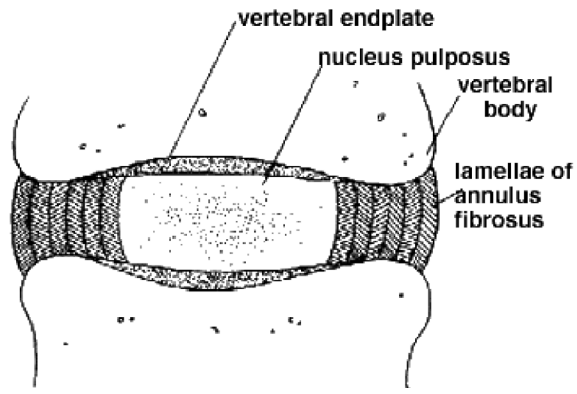
Fig. 2

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

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

Hospitals and nursing homes are well aware of the risks of back injury resulting from patient care. Virtually all of us have had numerous "back injury prevention" classes over our work life. Why then, are the injuries so high? Is it because we just don't listen? Or, is it because *there is no safe way to manually lift and care for patients?* Just look at the diagram below for a comparison between the NIOSH lifting standards and everyday patient care reality.

There are physiological reasons for this. William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University has made extensive studies on what happens to the human back under stress.[vi]

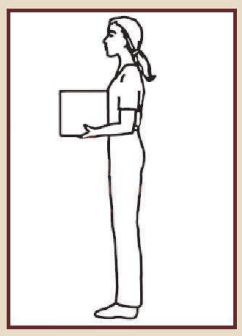


Basic anatomy lesson: the intervertebral disc is fibrous, dense tissue with a resilient gel filled center. The outer fibrous ring is called the annulus fibrosis, and the center the nucleus pulposus. It has no blood supply, and no nerve endings. It receives its fluid and nutrients by osmosis from the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

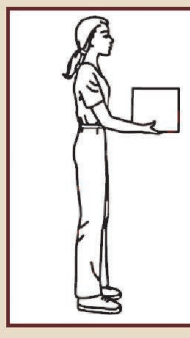
NIOSH, (National Institute of Occupational Safety and Health) a division of the Centers for Disease control, sets standards for safe lifting practices.

The Standards

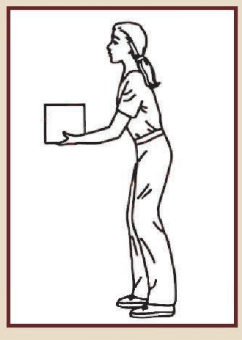
When a worker's hands are 10 inches from the ankles, 1/3 of the worker's body weight may be lifted, if a rest period follows. This is about 51 pounds for the average worker.



When the worker's hands are farther from the ankles, the weight must be reduced. When the hands are 16 inches from the ankles, the weight must be reduced by 40%. This would be about 30 lbs.



When a worker's hands are 25 inches from the ankles, the weight must be reduced by 60%. This would average 20 lbs. ***NO Weight should be lifted beyond that point.***

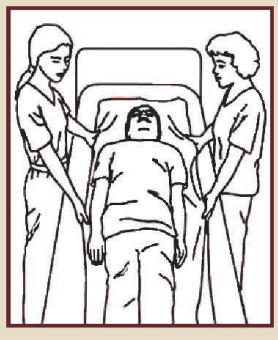


The Reality

When a nurse turns a patient from side-to-side the reach is 33 to 35 inches. The nurse must lift 35% of the patient's body weight, an average of 52.5 lbs. ***This is FAR beyond safe lifting limits!***

To transfer a patient, the nurses kneel on the bed, reach completely across, and pull. This requires even worse body mechanics.

Pulling a patient up in bed requires that the patient be lifted nearly off the mattress. Though the reach is not far, half of a normal patient's body weight (75 lbs.) is excessive lifting.

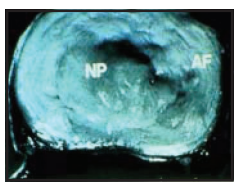


The Elephant in the Room continued on page 16

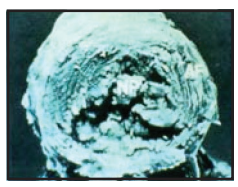
The Elephant in the Room continued from page 15

Pathophysiology, or, We all have our limits

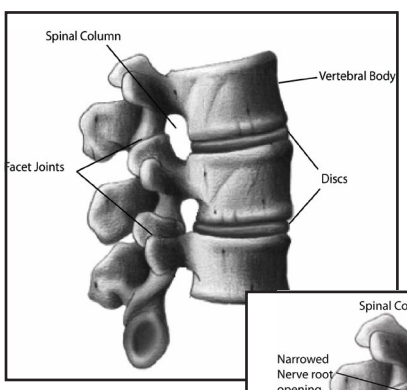
When lifting tolerances are exceeded, the end plate of the intervertebral disc is damaged with tiny tears called microfractures. No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein agglutinens and scar tissue which is thicker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



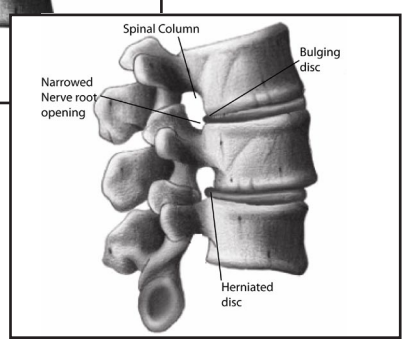
Normal disc



Degenerated disc



Normal spine anatomy, with healthy discs.

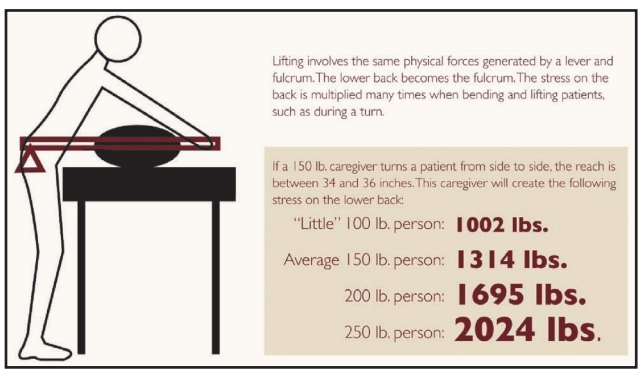


Disc degeneration causing bulging or herniated disc, resulting in back pain.

What are safe lifting pressures for the disc, or, Should you lift a "little 100 lb grandma"?

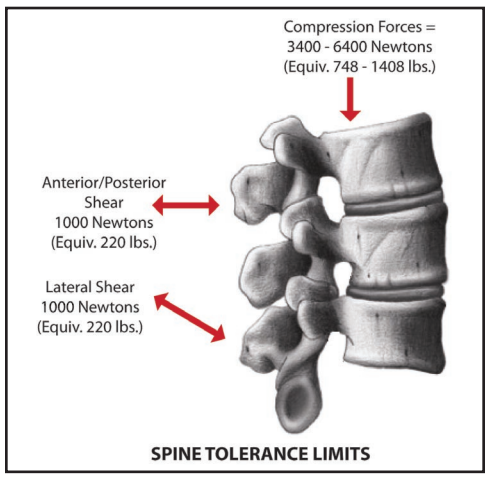
Downward pressure will cause damage to the disc end plate at pressures from 700 to 1100 lbs. Since many caregivers are physically small, the limits should be at the low end of this. However, most manual patient handling includes pushing and pulling elements. With pushing and pulling, damage occurs at about 1/3 the force. Nurses understand shearing: shearing damage to the disc occurs at lower forces than pressure.

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



vii

This illustration shows only the downward pressure, and doesn't take into account the pulling (shearing) required to turn a patient on to his side. Nurses are the ONLY people who call 100 lbs *light!* Since there is no way to keep the weight bearing close to the body, no "good body mechanics" will compensate for the forces that damage your back.



SPINE TOLERANCE LIMITS

THERE IS NO SAFE WAY TO MANUALLY MOVE A PATIENT!!! EVER. You WILL be injured *every single time* you manually move a patient. This includes not only transfers, but turning, linen changes, rolling a patient on to a sling, boosting the patient up in bed, and assisting the patient to stand.

WHAT IS THE SOLUTION to manual patient handling? Patients must be cared for. Every nurse knows it is not an option to simply refuse to care for their assigned patients.

Lifting Teams? These teams are very expensive, though they have been shown to reduce injuries. But, what about the lifting team? They will be injured as well, inevitably. Also, no lifting team can be everywhere at once, and patients may need repositioning at any time, not just on the lifting team schedule.

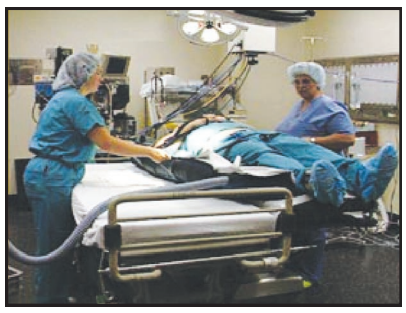
Patient Handling equipment is the only answer. There are multiple equipment solutions available on the market today. None does everything; but there is equipment available which will completely eliminate the manual lifting required for patient care.

We apologize to all makers of equipment which are not featured in this article. Care has been taken to present representative examples of equipment performing each task. Each facility should determine its own needs, and investigate each company and brand of equipment. We do not present the pros and cons of different types of equipment. A list of companies who manufacture and sell each type of equipment is provided, to give some place to start to those who might wish to begin. The list of companies is by no means exhaustive. No remuneration has been given by any company.

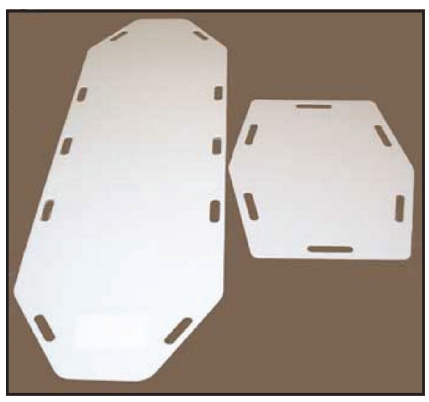
Tasks which exceed safe spinal loading, requiring Safe Patient Handling Equipment:

- **Transfers:** bed to bed, or gurney to bed
- **Transfers:** bed to chair, chair to shower
- **Bed repositioning:** Side to side turn, and pull away from the side rail
- **Bed repositioning:** Boosting to the head of the bed
- **Bed repositioning:** Linen changes and bathing
- Sling placement: Bending and lifting to roll a patient on to a sling
- **Assisting patient to stand**
- **Assisting a patient up from the floor**

Bed to bed transfer

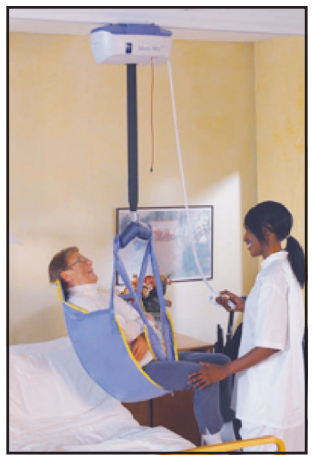


This is a mattress that uses a blower to inflate a mattress, which then slides on a cushion of air. The brand name is Hover Matt. It removes most of the friction so the force needed for transfer is minimal.

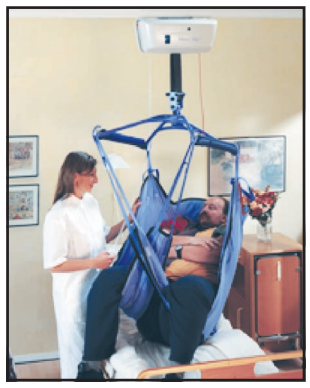


Slide Boards reduce friction; not entirely but they help. Some facilities use a slick fabric tube or even garbage bags to reduce the friction in a bed to bed transfer.

Bed to wheelchair transfer

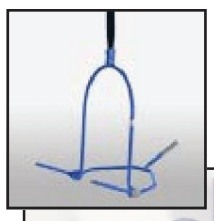


A ceiling lift can facilitate transfers, after placing the patient on a sling. This is an Arjo lift.



An Arjo bariatric lift accommodates heavy patients.

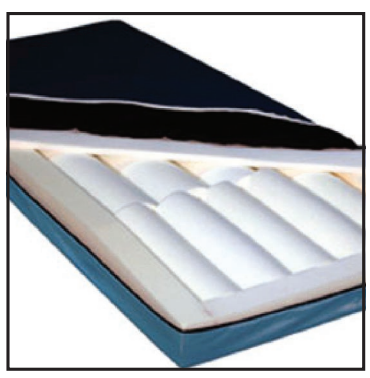
This Liko mobile lift will lift in sitting, standing or horizontal positions.



The Arjo 4-point spreader bar puts the patient in a comfortable semi-reclined position.
There are also vehicle transfer solutions. Liko has a video on its web site.

Bed Repositioning: Side to side turn

Advanced hospital beds have skin saving programs, and some abilities to reposition patients. This is the Hill-Rom Versa-Care bed. Some mattress overlays available will turn the patient by inflating the mattress on one side, then another.



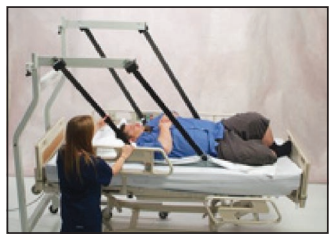
This is an advanced mattress by Joerne, for pressure reduction.

The Elephant in the Room continued on page 17

The Elephant in the Room continued from page 16

Bed Repositioning: Boosting patients up in bed

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



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

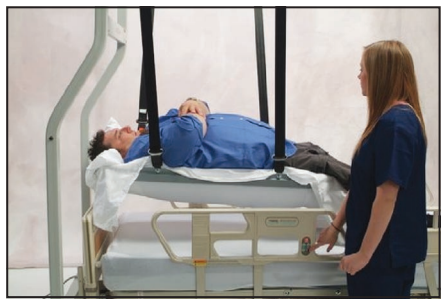
Some specialty fabrics will allow boosting with minimal effort, then resist sliding again.

Linen changes and bathing of bedridden patients

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

Placing the patient on a sling:

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



Assisting the patient to stand

This is a Barton Sit-to-Stand device.

Assisting a patient up from the floor

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

Companies offering Safe Patient Handling equipment:

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

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

HOW TO CONTACT YOUR REPRESENTATIVES IN CONGRESS:

For the House of Representatives: Go to: House.gov, and put in your zip code. The website will tell you who your representative is, and contact information for them. For your Senators, go to Senate.gov and your senators are listed there.

Note! The volume of emails is now so great that less attention is paid to them. They will get it, but it might take a while. It is better to send a hard copy of your letter.

COST EFFECTIVE

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

Those who have instituted Safe Patient Handling programs have learned that not only is equipment needed, but training, education and surprisingly, enforcement. Though it may seem a paradox, many times caregivers resist change. They've been doing it one way for their entire working careers as caregivers, and feel that it takes too much time, or is inconvenient. Yet, they continue to incur injuries at high rates. However, when a no-lift policy is implemented (and if necessary, enforced), the staff will adopt the safe patient handling equipment especially as they realize their back pain and injuries diminish. Oregon SAIF, the State Worker Comp Company, instituted pilot Safe Patient Handling programs, and has seen injury rates and costs plummet.[ix] Harris Methodist Ft. Worth, in Ft. Worth Texas, also instituted a pilot program, and went to zero injuries.[x] Their pilot unit has had no injuries in 2 ½ years. We know that these injuries are entirely preventable. Let's work together and solve this problem.

i "Safe Patient Handling: A Report", by Peter Hart & Associates, March 2006

ii Tuohy-Main, Kate, "Why manual handling should be eliminated for resident and carer safety," *Geriaction, 1997, 15(10)*

iii Eldlich, Richard F., Kathryne L. Winters, Mary Anne Hudson, L.D. Britt, William B. Long, "Prevention of disabling back injuries in nurses by the use of mechanical patient lift systems," *Journal of Long-Term Effects of Medical Implants,* 2004, 14(6)

iv Bureau of Labor Statistics, Department of Labor, *Nonfatal Occupational Injuries and Illnesses Requiring Days Away from Work, 2007*, Nov. 2008

v Bureau of Labor Statistics, 2008, op cit

vi Marras, W. "A Comprehensive Analysis of low-back disorder risk and spinal loading in patient handling", *Ergonomics,* 1999, 42(7) 904-906

vii Bloswick, Donald, Professor of Ergonomics at the University of Utah, "Manual Material Handling"

viii Marras, 2009 op cit

ix Oregon SAIF, report, http://www.saif.com/medical/medical_571.aspx

x Dougherty, M, "Handle With Care", *Strategies for Nurse Managers,* April 2008

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Missouri License Number Social Security Number

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(_____)_____ _____
Daytime Telephone Number E-mail Address

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_____
Physical address required, **PO boxes are not acceptable**

_____
CITY STATE ZIP

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

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STREET OR PO BOX

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CITY STATE ZIP

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