Wyoming Nurse Reporter
Vol. 5 Number 3
Fall 2009

RNs Working in Specialty Areas

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Wyoming Nurse Reporter

Fall 2009 • Vol. 5 Number 3

On the Cover: Artwork by Amy Ostlind, Junior nursing student at FW Whitney School of Nursing, University of Wyoming

"Serving and safeguarding the people of Wyoming through the regulation of nursing education and practice"

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Agency Mission: The Wyoming State Board of Nursing is responsible for the protection of the public's health, welfare, and safety through the regulation of nursing, nursing education, nursing practice, and disciplinary standards. The responsibility of the Board of Nursing is to implement a cost-effective and efficient system of regulation, which meets the consumer demand for safe, competent, ethical practitioners of nursing which includes advanced practice nurses, registered professional nurses, licensed practical nurses, and certified nursing assistants.

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Greetings

From Mary Kay Goetter
Executive Director

To Air the Dirty Laundry or Not

Immediately after the last issue of the *Wyoming Nurse Reporter* (*WNR*) was mailed to our readership, an anonymous caller contacted the Wyoming State Board of Nursing (WSBN) and expressed great displeasure to a staff member about the content of the discipline report; namely, that it was too explicit in outlining the offenses committed by the disciplined nursing personnel. The caller was encouraged to contact me directly or put her concerns in writing so that we could publish it here for our entire readership; however, no further contact was made.

This past April, the WSBN held a public hearing upon request from 25 signatories who opposed the WSBN's proposed fee hike. On behalf of the nurses who requested the hearing, Geneva Schueler testified, "The board of nursing cited an increase in the number of disciplinary actions and fees associated with investigating as a reason to increase the licensure fees. There were only two reported disciplinary actions in the last quarter of 2008, and there were five in spring of '09. According to regulations, all actions must be reported. This number does not seem to justify an increase in the nursing fees" (*Public hearing on chapters 1-9 of the Wyoming State Board of Nursing proposed rules, 2009, p. 12*). Both the caller and Ms. Schueler raise legitimate questions about matters of discipline and compliance and how they are reported to the public. The highlight of this issue of WNR is the regulatory function of discipline and compliance that the WSBN is charged to fulfill. I will address these questions in this column.

The WSBN is an agency of state government and is bound to follow all applicable federal and state laws and statutes, as well as our own Nurse

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Practice Act (NPA) ("Nurse Practice Act ", 2005) and Administrative Rules and Regulations (ARR) (Wyoming State Board of Nursing, 2009). The NPA and the ARR provide the foundation for day-to-day board operations. Chapter 8, "Practice and Procedure" of the ARR was just revised and outlines the process for discipline. The NPA and ARR are available in full text on our website http://nursing.state.wy.us. All nurses are legally accountable for actions taken in the course of professional nursing practice; this accountability is formalized through legal regulatory mechanisms of licensure, and criminal and civil laws (American Nurses Association, 2003). As such, all nurses are required to be familiar and compliant with the applicable statutes, rules and regulations relevant to their State of licensure and practice. I strongly encourage all of our readers to visit the website and read through these documents. You may print them off for reference, or if you prefer, for a charge of $12, WSBN staff will mail you a bound hard copy.

As reported previously, the WSBN has experienced a significant increase in *the number of complaints* received; it is critical to differentiate that complaints received is not the same as *formal, reportable actions on complaints*. From 2004-2008, WSBN saw an average of a 300% increase in complaints. In the last year alone, the number of complaints received by the board doubled. This increase is due to a number of reasons. First of all, the number of Wyoming nurse licensees and nursing assistant certificate holders continues to steadily increase, at a rate of approximately 9% per year. Secondly, employers have become more aware of their obligation to initiate a complaint and more members of the public are aware of their ability to initiate a complaint. With the advent of more sophisticated national databases and increased communication between other state boards and amongst Wyoming state agencies (i.e., Office of Healthcare Licensing and Surveys [OHLS], Medicare/Medicaid Fraud Control Unit [MFCU], etc) WSBN staff have become aware of complaints and discipline generated by these other entities against our Wyoming licensees. This then gave us the information needed to initiate a complaint and investigation.

However, none of this is specifically reported to the public until and unless the board takes disciplinary action against the licensee/certificate holder (i.e., letter of reprimand, conditional license, surrender or revocation of the license, etc. See Chapter 8 ARR for a much more detailed explanation of the process and possible disciplinary actions). Applicants who are denied licensure/certification also must be reported.

Until the board members (not the board staff) make a final decision, the case is under investigation and is not publicly reported. The W.S. Public Records § 16-4-201 provides the specific direction that guides the WSBN in matters of confidentiality of investigative records. We must balance our mission of public protection with the nurse's (the person whom the complaint is made against) right to privacy and due process. Once disciplinary action is finalized, WSBN must report these individuals to the public through national databases and our official publication, which is the WNR. Complaints that do not satisfy the legal requirement of "clear and convincing evidence" are dismissed. This accounts for the large discrepancy between what is investigated and what is reported to the public. Yet, each and every complaint receives a thorough and comprehensive investigation by WSBN staff. That is why the WSBN increased our discipline and compliance department from one staff member in 2007 to four staff members today. Two of those staff positions are *At Will Employee Contracts (AWEC)* which means they are susceptible to budget cuts; converting these to permanent positions was a significant part of the justification for the WSBN's proposed licensure fee increase.

The next question is, what gets reported? And, why do we provide details of the violation and disciplinary action? Once formal discipline is taken against a licensee/certificate holder, the case is no longer under investigation and it then becomes public record (Wyoming State Board of Nursing, 2009). As a regulatory agency, our mission is to protect the public from fraudulent and unsafe practitioners of nursing. We have a duty to report these individuals, the discipline imposed, and the offenses for which they were disciplined (Wyoming State Board of Nursing, 2009). The reporting venues are NURSYS (a national database of nurses maintained by the National Council State Boards of Nursing), the Healthcare Integrity and Protection Data Bank (HIPDB), the CNA Registry maintained by OHLS, and the usual publication of the agency, which is WNR. Providing our readers the names of the respondents, the discipline imposed and the specific violations of the NPA and ARR serves several purposes. First and foremost, our mission is to protect the public; many of our readers know the individuals named or have worked with them in the past. Knowing their present licensure and disciplinary status allows other nursing professionals and employers to be cognizant that these same individuals may be attempting to illegally procure employment or violate a settlement agreement. WSBN receives reports from nurses and other healthcare workers who are only contacting us because they became aware of disciplinary action through the *WNR*.

Another powerful reason to publish the specific violations is that all of us in the nursing profession must be aware of the magnitude of the problem. Every time a nurse is impaired by drugs, alcohol or other chemical substances; practices under fraudulent conditions; steals a patient's pain medication, money or property; is negligent, abusive or practices outside the accepted standard of care—each and every time this happens—it diminishes our profession. Our image is tarnished. Our ability to develop trusting and therapeutic relationships with our patients and their families is hampered. Our credibility with other members of the healthcare team is weakened. Most important of all, our ability to provide the highest standard of care to our patients is threatened.

No, none of these reports of disciplinary action is enjoyable to read. Yes, graphic details of your colleague's criminal behavior are disturbing. It should be disturbing. Because it has to spur us out of ignorance and complacency toward purposeful action. The board of nursing is not a Neighborhood Watch founded on collective goodwill! We are a legal agency within the Wyoming state government and our mission is to protect the public. The Wyoming State Board of Nursing staff and members cannot do it alone. I implore each of you to be vigilant in your own professional practice and to be watchful and alert to the practice of others. Trust is earned, not given freely; the WSBN needs the cooperation and collaboration of every single nurse and employer of nurses to assist us in assuring our public that we are still deserving of their trust.

We are proud to feature original artwork as the cover for this issue of the WNR. Janet Somlyay, Assistant Lecturer from the Fay W. Whitney School of Nursing at the University of Wyoming submitted this excellent drawing from one of her Junior students, Amy Ostlind, in response to an assignment, "Draw a picture of a drug addict". Thank you, Ms. Ostlind, and best wishes in your nursing studies! The WNR would be very interested in publishing other original works of art or poetry from our readers. Please send your submissions to the WSBN.

In keeping with the theme of this issue, I want to notify all of our readers of an exciting partnership the WSBN has joined with other state regulatory agencies, the Department of Criminal Investigations, and the United States Attorney. The group is named Rx Drug Abuse Stakeholders (RAS) and its mission is to educate Wyoming healthcare providers and citizens about the hazards of prescription drug abuse. Our first annual conference will be held at the TA HEC Ranch in Buffalo, Wyoming, on October 6-9; please see the ad on the next page.

Finally, I wish to thank all of our readers and the staff and members of the WSBN. I celebrated my first anniversary in the position as your Executive Director and it has been an amazing first year. Please accept my gratitude for your professional service to the people of Wyoming.

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Letters To the Editor

Dear Mary Beth and the great folks at WSBN,

I recently transported a woman in labor, from a home birth to the Riverton Hospital. Everyone was so nice and the transport went very smoothly for all involved. Later, when I asked one of the nurses if she had seen the article about homebirth in "Wyoming Nurse Reporter," she said she had and they had talked about it at their nurses meeting.

I can't help but think that this article has done much to help a confusing midwifery situation be more understandable and to help ease the way for those of us Certified Nurse Midwives who are attending homebirths. Smooth transports, when necessary, produce ideal care.

Thank you,
Heidi Stearns, RN, MS
Certified Nurse Midwife-Board Certified,
Advanced Practice Registered Nurse

"Life is short, and we do not have too much time to gladden the hearts of those who walk the way with us. So be swift to love and make haste to be kind, and peace will be always with you." Unknown

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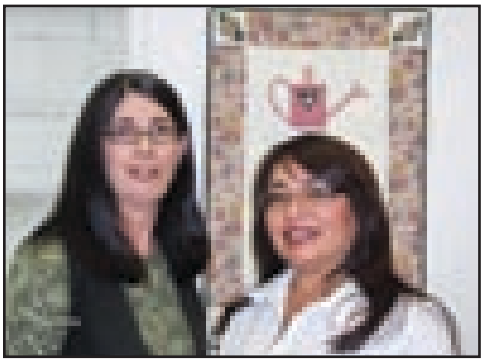
QUESTION:

A nurse administrator contacted the board inquiring why it takes so long to get new nurses licensed and wondered if there is anything nursing administrators and employers can do to expedite the process.



LaVelle Ojeda and Maxine Hernandez, Licensing/Examination Coordinators

RESPONSE:

I am responding to the email you sent to the Wyoming State Board of Nursing regarding the perceived delay in time it takes for applicants to receive their nursing license. It takes longer to obtain a nursing license than most of our customers expect. There are a number of reasons for this. Many times the applicant is not entirely truthful or accurate with employers on when the application was actually sent in, the fact that they did not complete the application correctly or were asked to provide more information, the start date indicated for the temporary permit, and most commonly, the fact that they have provided information to us that requires further investigation or review.

New graduate nurses/new employees don't necessarily want to start as early as they indicated to the employer and will put a requested start date on the temporary permit that allows extra time, sometimes as much as weeks.

We frequently receive fingerprint cards that have not been notarized or correctly sealed into the envelope we provide (and signed on the seal by Law Enforcement); we cannot accept fingerprint cards that have not followed the "chain of custody" starting with the signature of the law enforcement agent and the sealed and signed envelope. This is a requirement of the FBI and part of a complete background check which we perform in accordance with the law.

When the applicant answers "Yes" to any of the questions regarding criminal background or mental health history, further information is required. Few applicants provide the supporting documentation initially, so we have to request that information and then wait for it to be sent in. Or, the applicant will respond "No" to these questions and, then, when the Department of Criminal Investigations (DCI) background report is received, it will indicate that the applicant failed to disclose the true history. Then, we request the supporting documentation and wait for it be gathered and sent in to us. The application then goes to our Application Review Committee, a two person committee of the board members (not staff) who review the application, supporting documentation and personal statement and make a decision. These board members are volunteers with full time jobs who meet via teleconference once a week. This is a time-consuming and painstaking process that takes an extended amount of time when the applicant doesn't provide a truthful or complete application in the first place. Obviously, we will not discuss these issues with anyone other than the applicant.

Three of us from the board did a "tour of the state" this spring and visited seven of the nine Wyoming nursing programs to discuss professional licensure, compliance and discipline issues and how to protect the license by complying with the law and standards of nursing practice. Our hope was to alleviate the issues I discussed above. However, the number of applicants, either first-time through examination or by endorsement from another state, has steadily increased by ~9.5 percent/year and the number of applicants who need further review has increased from ~ 10 percent last year to 26 percent in the month of June.

And lastly, some of the delay just belongs to us. Despite the increase in activity and applications, our staff has not increased (although we did gain two temporary positions in Compliance & Discipline last year, but no increase in licensing staff). I am sure you are all aware of the economic compression state agencies are experiencing. I wish we had someone to just answer the phones, but the staff members who answer the phones are the same staff trying to process the applications. Nonetheless, we are continually seeking ways to improve our process and customer service. We also are in the process of revising the application to make it easier to read and understand. We absolutely can do better and we will keep trying.

In fact, we are planning a daylong educational seminar for nursing administrators to help them understand the regulatory process and learn how to partner with us and work together to provide a quality nursing workforce that meets your mission--patient safety--and our mission--public protection. We will notify you as soon as we have a date set and hope to see you then.

In the meantime, thank you for contacting us...please feel free to do so anytime.

Mary Kay Goetter, PhD, RNC, NEA-BC

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QUESTION:

To whom it may concern:

My name is JANE DOE. My biggest concern at this time is that I do not feel safe, for what I consider many valid reasons, not only because of my physical well being, but because of concerns about maintaining my nursing license. I have voiced my concerns to nursing supervisors which in turn have told me basically that they would try to do something, but there is not a whole lot they can do. I remember in school being told that if we did not feel comfortable taking the keys or going on to our on-coming shift that is our choice. I was wondering if that stands true and if so if I do refuse to take responsibility for the unit what the consequences may be? Also who would be a good agency or place to turn for concerns regarding not only patient safety, but staff safety also? I would greatly appreciate any answers that you may have. I am at a loss.

Thank you,
Jane Doe, RN

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ANSWER:

Dear Jane Doe,

Your email to the WSBN was forwarded to me. Thank you for sharing your concerns and questions about workplace environmental safety and implications for your licensure. I forwarded your email to Jean McLean, the Executive Director of the Office of Healthcare Licensure and Survey (OHLS) because the issue of your physical safety, and that of other staff who work there, is concerning. Jean shares that concern (we spoke on the phone about your situation). Since OHLS has oversight of your institution, she is the point of contact to address facility and administrative issues. I have copied her in this response.

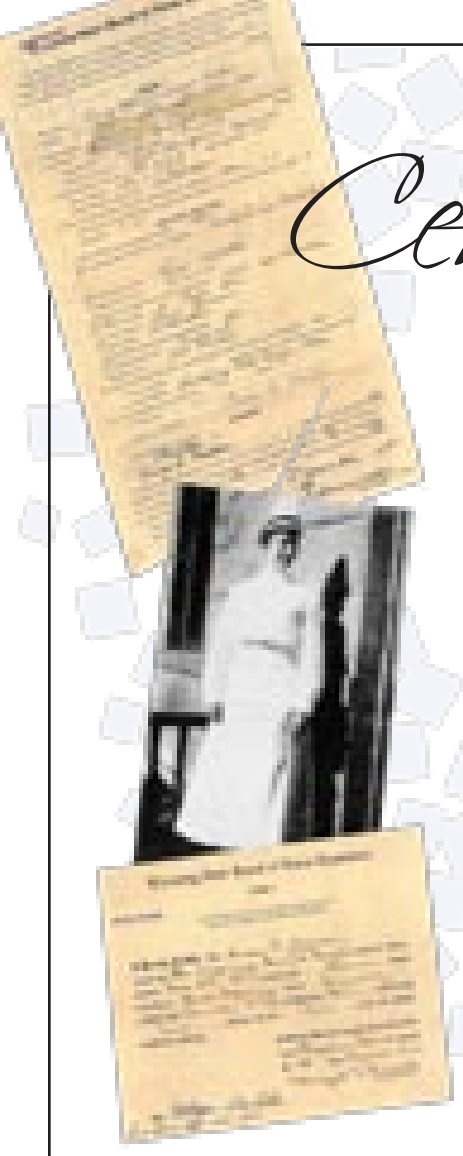
As to your questions about nursing licensure, I will address them here. The Scope and Standards of Nursing Practice, as well as Ethics for Nurses with Interpretive Statements are published by the American Nurses Association and available on its Web site; they provide general guidance to registered nurses on these issues. It is not a cut and dried assumption that accepting an assignment necessarily means you knew exactly what would be required of you to provide safe patient care. Nor does it mean that the facility has no obligation to provide you the necessary support to assure adequate and competent nursing care can be delivered to assure patient safety.

The one issue you indirectly bring up is patient abandonment. If a nurse "walks out" on his or her patients, or leaves them unattended (excessively long breaks, not giving report to another staff member when you are unavailable in the rest room or cafeteria) that could be interpreted to be a violation that could potentially receive disciplinary action from a board of nursing. A nurse who does not like the assignment, or does not want to float to another unit, or refuses an admission can rightfully be held accountable by the employer, and perhaps a board of nursing, as well (many circumstances need to be taken into account). When faced with a situation that the nurse finds absolutely unacceptable, the accepted alternative to abandonment is to initiate the chain of command. Notify your direct supervisor, preferably face-to face; if that is not possible, then by phone. If the response is unsatisfactory, speak to the next person above in the supervisory chain. It is a professional courtesy that will serve you well in the long run if you tell your supervisor (or the physician or administrator or whomever you are stating your grievance to) that you intend to go above them in the chain of command. Follow up with written documentation of your concerns after the immediate situation has passed. Always present a clear statement of what it is that you need to provide the care or some alternative to whatever it is that you are seeking recourse on. Many nurses thwart their cause by excessively emotional or indignant arguments. It is more likely that your supervisor or administrator will support you if you state something like this; "If I have to assess this patient and give him meds he doesn't want to take, I need someone from security present with me. I cannot go into his room without security personnel." Unfortunately many nurses choose a more emotion-laden statement like this; "If I don't get help right now, I am going to lose my license!"

Patient safety always comes first, so that even if there is no immediate relief (another nurse coming to assist) the professional nurse is obligated to provide the best nursing care possible in the situation. However, that being said, individual safety is also a priority. In these situations, the nurse must use his or her own professional judgment, critical thinking, and moral/ethical decision-making.

These situations are never easy and there are few clear-cut choices or simple answers. You are working in a very challenging environment. Please know that you are not alone and it is never a bad idea to seek more information to aid in making decisions. The information I have provided here is just general guidance. That being said, if you have a very specific troubling situation or you feel you need more direction, consulting with your own legal counsel may be needed. Please feel free to contact us anytime and best wishes,

Mary Kay Goetter, PhD, RNC, NEA-BC



Centennial Celebration!!

You are invited to an open house on December 7, 2009, hosted by the Wyoming State Board of Nursing (WSBN) to celebrate the 100-year anniversary of licensed nursing practice in Wyoming and to rededicate the board to the next 100 years of excellence in nursing education and practice! The event will be held at the WSBN office in Cheyenne at 1810 Pioneer Avenue. Come to the office to view a collage of pictures from a century of nursing and attend a "mock" board meeting which will be conducted according to the agenda from the first board meeting which occurred on December 7th and 8th, 1909:

Agenda for WSBN Meeting
(Taken from minutes of the first board meeting December 7 & 8, 1909)

Introduction of members present
Selection of chair
Call for nominations for president, vice-president, and secretary
New business:

1. Record keeping of future meetings of the board
   - Stationery- letter head and envelopes
   - Seal
   - Expense vouchers
   - Book for secretary's minutes

   Need a motion for purchase of these items
2. Standard size of training schools
   - Colorado Board of Nursing to be contacted for their recommendation
3. Curriculum for training schools to be at desired standard.
4. Grade to be determined successful in each required course of curriculum
5. Number of beds required of a hospital desiring to have a school
6. Course of study for male students.

The "mock" meeting will begin promptly at 2pm with afternoon tea to follow. Please join us to celebrate a 100 years of nursing regulation!

RNs Working in Specialty Areas

Is There Really a Difference? (Scenario)

Patti Hefflin, BSN, RN

Nurses are often placed in awkward situations when "pulled to another unit" to support specialty units that are short staffed due to position vacancies, call-offs, etc. In these situations, the nurse may struggle with feelings of loyalty to the facility and not wanting to upset administration by objecting to or refusing an assignment. Test your knowledge!! Ask yourself how you would handle the following situation. How would the Nurse Practice Act (NPA) and the Administrative Rules and Regulations guide your response?

Nancy Nurse has been an RN on the Medical-Surgical Unit at Good Care Hospital for 15 years on the night shift. When she arrived at work today, the hospital charge nurse, Cindy Staffer, informed her that the census was low on the Medical-Surgical Unit and that she would be assigned to work in the Intensive Care Unit (ICU) for the shift, since they were two people short.

Nancy Nurse informed the hospital charge nurse that she did not feel comfortable accepting the assignment since she has had no previous ICU experience. Cindy Staffer responded that the ICU had two call-offs and she was unable to get someone to come in. She informed Nancy Nurse that everything would be alright and the ICU charge nurse would assist her. Cindy Staffer informed Nancy Nurse that she would be given two "stable" patients, so there should be "no problem"; that she just needed an "RN" so they have proper staffing. Nancy Nurse continued to feel uncomfortable, but with coaxing from her manager, she decided to accept the assignment… after all, she could use the money and she would be given "stable" patients.

When Nancy Nurse arrived on the unit, the charge nurse, Chris Charger, oriented Nancy and gave her report on the two patients. Nancy was thankful that both patients did appear to be relatively stable. One patient was an 84 year old woman with rule out myocardial infarction (MI) on a nitroglycerin drip, no pain and vital signs stable. The other patient was a head trauma patient that had been in the unit for two days, was on a ventilator, ICP monitor and neuro checks every hour with pupils that were equal and reactive to light.

As the shift progressed, the situation became hectic. Nancy Nurse had the sinking feeling that she was "in over her head". Chris, the charge nurse, was occupied with a new admission of a patient who had been in a motorcycle accident. He was busy getting report from the OR nurses, taking off orders and dealing with family members.

About the same time, Nancy printed off an EKG strip for chart for the MI patient. She was comparing the strip with the previous one noted in the chart and realized something was wrong. The EKG had changed!! She became nervous, went to discuss the situation with the Chris, but

was informed she would have to wait because he was trying to stabilize his trauma patient. Nancy Nurse decided to contact the physician to have him come to the unit to evaluate the patient. After assessing the patient, the physician stated the patient was having a MI and decided the patient needed immediate transfer to a facility that could perform cardiac surgery. He ordered cardiac enzymes and Streptokinase to be started while preparing the patient for transfer to a facility with a higher level of care. Nancy Nurse didn't know what to do...she didn't know the protocol for Steptokinase administration! She contacted the pharmacy and (luckily) was able to get a copy of the policy. Nancy Nurse decided she would "wing it" and did a great job! Another ICU nurse helped Nancy through the process and the patient was transferred to the other facility. Nancy Nurse felt relieved. After the transfer was complete, she only had one patient and about four hours left for the shift. Nancy decided it was time for lunch!

When Nancy returned from lunch, she was informed that there was a rule out MI patient in the emergency room to be admitted since she had an "open bed" and her other patient was "stable". Two hours passed while she admitted the new patient and started the new orders. Nancy, now exhausted, was thankful she only had about 1 ½ hours to go!

While reassessing her patient with a head trauma, she noted that one of his pupils was now dilated and unresponsive to light. What do I do now, she thought to herself? Something else can't be going wrong!!

Discussion:

The following questions are important for nurses to resolve as we review the all too familiar scenario:

1. Was Nancy Nurse competent to work in the ICU since she had been a Registered Nurse for 15 years?
2. Were Cindy Staffer and Chris Charger correct in determining that Nancy was competent to care for the patients assigned to her?
3. How do the Wyoming Nurse Practice Act (NPA) and Administrative Rules and Regulations guide the nurses and administrators in this situation?

If patients in a specialty unit are improperly assigned to an RN who is not competent in the specialty area, the lives of the patients as well as the nurse's license are in jeopardy!

In this scenario, although Nancy Nurse has been an RN for 15 years, she did not have the necessary skills and experience to care for these patients. Furthermore, in an ICU, patients who appear stable can suddenly change (the reason that they are in the ICU!!).The nurse must have the education and skills to address the situation quickly to ensure the patient will have the best outcome possible.

It is important to familiarize yourself with the laws that govern your license. You can easily access the Nurse Practice Act and the Administrative Rules and Regulations at the Wyoming State Board of Wyoming's website: http://nursing.state.wy.us. The portions of the NPA that guide nurses in these situations can be found in the "Definitions" and "Disciplining Licensees" sections:

"Competency" means the application of knowledge and the interpersonal, critical thinking, decision-making and psychomotor skills expected for the practice role within the context of public health, safety and welfare [NPA 33-21-120 Definitions (a)(vi)].

The board of nursing may refuse to issue to renew, or may suspend or revoke the license, certificate or temporary permit of any person, or to otherwise discipline a licensee, upon proof that the person:

(i) Has engaged in any act inconsistent with uniform and reasonable standards of nursing practice as defined by board rules and regulations;

(iv) Is unfit or incompetent to practice nursing by reason of negligence, habits or other causes including but not limited to:

(B) "Performance of unsafe nursing practice or failure to conform to the essential standards of acceptable and prevailing nursing practice, in which case actual injury need not be established."

(x) Has knowingly engaged in an act which the licensee knew was beyond the scope of the individual's nursing practice prior to committing the act, or performed acts without sufficient education, knowledge, or ability to apply nursing principles and skills [NPA 33-21-146 Disciplining licensees; grounds, (a)].

The Administrative Rules and Regulations also provide guidance:

(a) The purpose of the board in adopting rules and regulations in this chapter is to:

(iv) Identify behaviors which may impair the licensee's ability to practice with reasonable skill and safety, which include, but are not limited to:

(B) Unsafe practice;

(F) Neglect. [Administrative Rules and Regulations, Chapter 3 Standards of Nursing Practice, Section 1(a)]

(a) Accountability

(i) the Registered Nurse shall:

(D) Base professional decisions on nursing knowledge and skills, the needs of clients and the expectations delineated in professional standards.

(K) Obtains orientation/training for competence when encountering new equipment, technologies or unfamiliar care situations.

iii) Organizes, manages, and supervises the practice of nursing.

(A) Assigns to another only those nursing measures that fall within that nurse's scope of practice, education, experience and competence;

(B) Delegates to another only those nursing measure s that the person has the necessary education, skills, and competency to accomplish safely ..;

(C) matches client needs with personnel qualifications, available resources and appropriate supervision;

(I) Retains professional accountability for nursing care. [Administrative Rules and Regulations, Chapter 3 Standards of Nursing Practice, Section 2 (a)].

(a) Grounds for Discipline

(i) Engaging in any act inconsistent with uniform and reasonable standards of nursing practice, including but not limited to:

(B) Performance of unsafe client care;

(F) Neglect, including substandard care.

(ii) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established [Administrative Rules and Regulations, Chapter 3 Standards of Nursing Practice, Section 4 (a)]

Chapter 9 of the Administrative Rules and Regulations titled Delegation and Assignment includes a Decision Tree for Delegation to Certified Nursing Assistants. The decision tree can be used for making assignments for licensed personnel as well. One area of importance is the question: "Does the nursing assistant (or RN) personnel have the appropriate knowledge, skills and abilities to accept the delegation?" If the answer is no, "do not delegate until evidence of education and validation of competency is available" (Administrative Rules and Regulations, Chapter 9, Section 8, p. 9-6). "The bottom line is that professional nurses are ultimately accountable for maintaining competence to care for their patients prior to accepting a patient assignment" (Ricks, 2009, p. 9).

Patti Hefflin is a Compliance Consultant for the Wyoming State Board of Nursing.

Reference

Ricks, A. (2009). Are All RNs Created Equal? Mississippi Board of Nursing, Winter 1, (2), 6-9.

THE IMPAIRED HEALTHCARE WORKER

Mary Kay Goetter, PhD, RNC NEA-BC & Brenda Burnett, RN, MSN

The incidence of healthcare employees in the workplace who are impaired from chemical dependency/substance abuse is rising. Approximately 30 percent of the complaints received at the Wyoming State Board of Nursing (WSBN) are from employers and co-workers who suspect employees of chemical

dependency/substance abuse. This includes the use of alcohol, prescription drugs and diversion of medication from the work site. The Colorado State Board of Nursing estimates that, "approximately 20% of the total number of complaints … (are) related to drug/alcohol use or diversion of drugs in the workplace" (Colorado Board of Nursing, 2003). In 2002, the American Nurses Association reported that approximately 6 percent to 8 percent of nurses are impaired from chemical dependency/substance abuse (Ricks & Hudspeth, 2004).

The WSBN is very concerned about the problem of the impaired healthcare worker. The nurse who struggles with chemical dependency/substance abuse poses a direct threat to the patient safety. We urgently request your help to collaborate with the WSBN and ameliorate this grave problem. Below are excerpts from the Wyoming Nurse Practice Act (July 2005) that speak to the nurse's duty to report and steps we can take to address this issue:

The Wyoming Nurse Practice Act at W.S. 33-21-146(a) states that the board:

"may refuse to issue or renew, or may suspend or revoke the license, certificate or temporary permit of any person, or to otherwise discipline a licensee, upon proof that the person:

(i) Has engaged in any act inconsistent with uniform and reasonable standards of nursing practice as defined by board rules and regulations;

(iv) Is unfit or incompetent to practice nursing with reasonable skill and safety to patients by reason of physical or mental disability, or use of drugs, narcotics, chemicals or any other mind-altering material; or

(v) Has engaged in any unauthorized possession or unauthorized use of a controlled substance as defined in the Wyoming controlled Substances Act [§§ 35-7-1001 through 35-7-1057];

The Nurse Practice Act also provides in W.S. 33-21-153(a) that "hospitals, nursing homes and other employers of registered nurses, licensed practical nurses, and advanced practice registered nurses shall report to the board the names of those licensees whose employment has been terminated voluntarily or involuntarily for any reasons stipulated in W.S. 33-21-146."

So, remember to:

- Review the policies and procedures of your workplace;
- Adopt a zero tolerance for behaviors that put patients at risk from impaired healthcare workers;
- Expect facility leaders to adhere to these polices;
- Access the many resources available to assist in the creation of safe and healthy working environments. (See below for a list of suggested resources)

Mary Kay Goetter is the Executive Director for the WSBN & Brenda Burnett is a Compliance Consultant for the WSBN

References/Resources

ANA- The Impaired Nurse Resources Center, located at http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/workplace/ImpairedNurse.aspx

Colorado Board of Nursing, Resource Manual for the Impaired Nurse, located at: http://www.dora.state.co.us/nursing/complaints/DiversionResourceManual.pdf

The Council of State Governments – Drug Abuse in America-Prescription Drug Diversion, located at: http://www.csg.org/pubs/Documents/TA0404DrugDiversion.pdfNational Council of State Boards of Nursing. https://www.ncsbn.org/about.htm

Wyoming State Board of Nursing, Compliance Department (307) 777 – 7974.

Wyoming Professional Assistance Program, (307) 472-1222

U.S. Department of Justice Drug Enforcement Administration – Drug Addiction in Health Care Professionals, located at: http://www.deadiversion.usdoj.gov/pubs/brochures/drug_hc.htm

Re-written from Education for Worksite Monitors of Impaired Nurses by Linda J. Young

Worksite Monitors of Impaired Nurses

by Marcia Dale, RN, EdD, FAAN

This last month the media featured two cases involving health care providers, one a surgical technician and one a registered nurse. The surgical technician was accused of exposing patients to hepatitis C when she allegedly stole medications for her own use (Lopez, July 23, 2009). "She switched used, potentially infected syringes for clean ones with a powerful painkiller so she could get high" (http://cbs4denver.com/crime/Colorado.nurse.accused.2.1077534.html). It is uncertain how many people's health was adversely affected, but at this time 19 were infected with hepatitis C. The registered nurse who used drugs for several months before being fired, was obviously functioning under the perception that the workplace provided easy access (Associated Press, July 8, 2009). "Police say the 29-year-old former nurse at Hospice and

Palliative Care of Northern Colorado wrote forged prescriptions to get more than 4,000 tablets of Vicodin or Hydrocodone over the past eight months" (http://cbs4denver.com/crime/Colorado.nurse.accused.2.1077534.html). How can this happen when others obviously are working around the person taking the medications?

Being able to recognize an impaired practitioner and practicing the responsibility of reporting that person is essential to protect the public and to get the impaired person in a rehabilitation program. Professional assistance programs have become one means of assisting nurses back into the work force. Wyoming's program, Wyoming Professional Assistance Program, was featured in the Spring 2009 issue of The Wyoming Nurse Reporter. A monitor agreement is signed by the professional seeking rehabilitation. The

Continued on page 10

"agreement provides an individual treatment plan and structure" (Vandel, 2009, p. 18). Oversight for a professional's recovery is provided by the following: "a site mentor, random drug screening, attendance and participation in Caduceus meetings, and daily contact with the Wyoming Professional Assistance Program staff," who serves as the monitor (Vandel, 2009. p.18).

State boards are implementing recovery programs to aid nurses to re-enter the workforce. A literature review conducted by Young (2008) showed that substance abuse problems were predicted in 6.4 percent of nurses. There was an association between nursing specialty and use of marijuana, cocaine, and prescription drugs; cigarette smoking, and binge drinking. Emergency department nurses were 3.5 times as likely to use marijuana and cocaine compared with nurses in pediatrics, women's health, and general practice. Binge drinking was found to be more likely in oncology nurses and

administrators.

Two of the largest problems as found in the literature are recognizing the impaired practitioner and relapse once treatment has begun (Young, 2008). It is the employer's responsibility to educate nurses to recognize the impaired nurse, but it is also necessary to know that the new employee does not have a history of abuse or has been fired by another agency for abuse. One of the most important aspects of identifying abusers is to prevent harm to patients. In the case of the surgical technician who filled syringes with saline solution after using the Fentanyl, hepatitis C was spread to many unknowing patients and thousands had to be tested.

Management support is necessary to make recovery more likely, and policies should be written which spell out the process for the rehabilitation program. In Wyoming, the monitor is an employee of the Wyoming Professional Assistance Program, and nurse mentors are assigned to oversee the employee. The monitor is the person who oversees drug testing, attendance in the Caduceus meetings, and daily contact with the impaired person.

When an impaired person seeks help for a substance abuse problem, there is a 70% success rate in their returning to practice as cited in Domino, K.B., Hornbein, T.F., Olissar, N.I., et at 2005 (Young, 2008). Long term support is essential for the recovery to be permanent. The mentors in the workplace need to have an "overview of the developmental stages of addiction including initiation, escalation, maintenance, discontinuation, relapse, and recovery." This information can be found in The Chemical Dependency Handbook for Nurse Managers (Sheets, 2001) which can be obtained from the National Council State Boards of Nursing.

To address the education of monitoring nurses in the workplace, South Dakota developed a program that was offered in a timely manner, easily accessible and available when needed, and that could be completed in a reasonable period of time. Dr. Rosemarie Rizzo Parse's theory of Human Becoming was used as the foundation for Regulatory Decision Model that guided the South Dakota program. "Parse's theory demonstrates a fundamental belief that quality of life is defined from a person or community perspective" (Young, 2008, p. 334). The utmost imperative of the model was that the public be protected when the impaired nurse returned to the workforce. Four areas of content were emphasized in the program:

1. Understanding the role of the worksite monitor;
2. Recognizing signs of chemical dependency and relapse;
3. Creating a supportive environment for recovering nurses and
4. Providing sources of support for the monitor (Young, 2008, p. 335).

The methods of delivery that proved the most acceptable were a self-paced online course and short workshops. The short workshop format proved to be problematic because of confidentiality issues for monitors and impaired employees. The online presentations also solved the problem of getting small groups together in rural areas.

The conclusions reached in the trials in South Dakota were that "organized education for professionals who serve as worksite monitors is important for consistent reporting to boards and for effective monitoring of impaired nurses who return to practice. Most professionals lack education and experience with chemical abuse recovery monitoring skills and benefit from programs that support effective skill building. Successful development and implementation of these programs is of benefit to patients, nurses, worksite monitors, and boards" (Young, 2008, p. 337).

When an impaired person seeks help for a substance abuse problem, there is a 70 percent success rate in their returning to practice as cited in Domino, K.B., Hornbein, T.F., Olissar, N.I., et at 2005 (Young, 2008). Long term support is essential for the recovery to be permanent.

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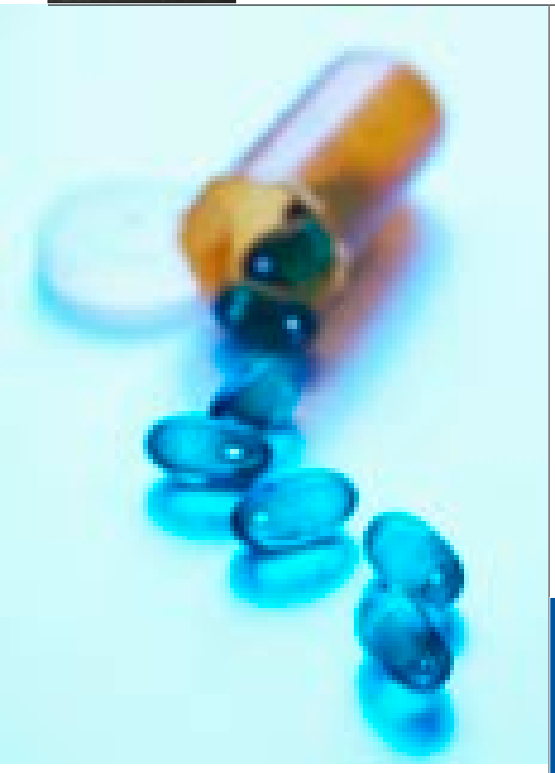
Gaurdia Banister PhD, RN

Committee on Impaired Nurses



Ms. S has been a registered nurse for over twenty-five years. She loves being a nurse, in fact she remembers wanting to be a nurse since she was a little girl. Lately, she has begun feeling stressed and overwhelmed by personal and professional problems. Ms. S is preoccupied by marital difficulties and seeing her aging parent's health decline. She is also plagued by chronic leg pain after a fall several years ago. She feels that her patients are becoming more demanding and after work she is exhausted. Ms. S lost her temper with a co-worker but later apologized. To alleviate her leg pain and reduce her anxiety she started taking prescription analgesics. When she runs out of medication and is unable to get her prescription filled, she begins diverting it from her patients. She is ashamed and embarrassed but she doesn't know what to do. This compilation suggests behaviors consistent with a chemical impairment.

Substance abuse and mental illness are serious concerns for any profession and certainly for nurses. If these medical problems are not addressed and treated, a threat to patient safety exists. The "Nurses Rehabilitation Program Act of 2000" established the Committee on Impaired Nurses (COIN) to supervise the operation of a rehabilitation program for nurses licensed in District of Columbia. The purpose of the committee was to provide an alternative to the Board of Nursing's disciplinary process for nurses who are impaired due to drug or alcohol dependence or mental illness.

Prior to the establishment of COIN, nurses were referred to the Board of Nursing for disciplinary actions, which ranged from probation and suspension to revocation of licensure. A group of psychiatric mental health nurses lobbied the government of District of Columbia for several years to enact legislation. They suggested a non-punitive approach that focused on treatment and on-going support as a foundational element of the program and emphasized a commitment to public safety. The COIN program offers comprehensive education to the nurse and the nursing community, referrals to treatment and on-going monitoring.

The program is designed to encourage nurses to seek assistance before their impairment harms a patient or damages their career through disciplinary action. Participation in the COIN program is voluntary. Impaired nurses may be referred to the COIN program through self-reporting, recommendations from colleagues, employers or the Board of Nursing. Nurses sign a contract of conditions and a release of information prior to entering the program. This allows the treatment provider to provide the COIN with information about the nurse's treatment regimen, treatment compliance and readiness to return to employment. An addiction specialist evaluates nurses with substance abuse issues; nurses with mental health issues must be evaluated by a mental health professional. Additionally, a nurse being monitored for substance abuse would be required to submit to random urine testing and is usually required to attend support group meetings.

Some key factors that promote success are the nurse's motivation to seek help and adhere to treatment recommendations, the nurse's desire to return to work and the support of family, friends and co-workers. COIN monitors the progress and compliance of the nurse who participates in the program for three years. If a nurse moves to another jurisdiction, similar programs are operated throughout the country and it is expected that the nurse participate in the program in that state.

Nurses understand the conditions of the program and the consequences if they violate the contract, i.e., dismissal from the program and being reported to the board for disciplinary action.

Embracing the concept that addiction and mental illness as treatable medical problems is imperative. The nurses in the COIN program are extremely motivated and want to get help. Generally, all they want to do is get back to caring for patients and becoming a productive member of society.

The program is designed to encourage nurses to seek assistance before their impairment harms a patient or damages their career through disciplinary action. Participation in the COIN program is voluntary. Impaired nurses may be referred to the COIN program through self-reporting, recommendations from colleagues, employers or the Board of Nursing.

Dr. Banister is the Executive Director at the Institute for Patient Care Massachusetts General Hospital, Boston, Massachusetts. A graduate of the University of Wyoming 1980 and Distinguished Alumna of School of Nursing, University of Wyoming 2008, she served as Chairperson of the Committee on Impaired Nurses in Washington, DC.

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http://www.peeradvocacyforimpairednurses.com

Impaired Nurse Resource Center -- http://www.nursingworld.org

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Brenda Burnett, RN, MSN

PRACTICING WITHOUT A LICENSE – DON'T BE CAUGHT OFF GUARD

Every renewal period there are a number of certificate and license holders who fail to renew their certificates or licenses before the expiration date. Most of these healthcare workers continue to work, unaware that they are now "practicing without a license," a situation that puts them at risk for board discipline but more importantly jeopardizes patient safety. Is your certificate or license current indicating an expiration date of 12/31/2010? It is easy to check! Log on to our website located at http://nursing.state.wy.us/ . Use the Verification link and search by name or license number.

Did you know:

1. The Board:

"may refuse to issue or renew, or may suspend or revoke the license, certificate or temporary permit of any person, or to otherwise discipline a licensee, upon proof that the person:

(iii) Has practiced fraud or deceit:

(A)In signing any report or record as a registered nurse or as a licensed practical nurse;

(D) In representing authority to practice nursing: or

. . . .

(vii) Has practiced nursing within this state without a valid current license or temporary or as otherwise restricted [Nurse Practice Act at W.S. 33-21-146(a)].

2. That "hospitals, nursing homes and other employers of registered nurses, licensed practical nurses, and advanced practice registered nurses shall report to the board the names of those licensees whose employment has been terminated voluntarily or involuntarily for any reasons stipulated in W.S. 33-21-146"[The Nurse Practice Act W.S. 33-21-153(a)].

Remember that practicing without a valid, current certificate or license is a reportable offense to the Wyoming State Board of Nursing. Protect this valuable property right and make sure you renew on time every time. Our next renewal period begins October 1, 2010.

Mary Kay Goetter is the Executive Director of the WSBN & Brenda Burnett is a Compliance Consultant for the WSBN.

Ever Wonder How To File A Complaint?

Patti Hefflin, BSN, RN

Did You Know??
It is EVERYONE's responsibility to report known or suspected violations of the board rules and regulations !! It is the law!
Nurse Practice Act 33-21-150 Immunity of board members and persons reporting information to the board states: a person "is not subject to a civil action for damages as a result of reporting information in good faith, without fraud or malice, relating to alleged violations of this act or board rules and regulations."
The Process
The complaint form is located on the Wyoming State Board of Nursing website: http://nursing.state.wy.us. On the left hand side of the page, click "Forms"; then choose "Complaint Form."

Fast Facts About Filing a Complaint

- Anonymous complaints are not accepted. A licensee has a property right to their license under Wyoming law and therefore is afforded the right of due process.
- All complaints must be signed and notarized.
- The following must be provided:
  - o Name of the person you are reporting.
  - o Detailed information. Be as specific as possible with dates and event details.
  - o When applicable, provide copies of medical records with patient identifying information shielded, PYXIS printout, staffing assignment sheets, etc.

Overview of the Disciplinary Process
1. The Compliance Consultant investigates the allegation and acts as an impartial, fact finding third party. All information during the investigation stage is confidential. Once a complaint is received, the Compliance Consultant sends a notice of the allegations and requests a response from the licensee/certificate holder being investigated. The individual being investigated is presumed innocent until clear and convincing evidence indicates otherwise.
2. When the investigation is complete, the complaint with all evidence and supporting documentation is presented to the Disciplinary Committee. The Disciplinary Committee is made up of two board members. Committee appointments are made on a rotating basis by the president of the board. Committee members review all the evidence and if necessary, request further investigation by the Compliance Consultant.
3. The Disciplinary Committee makes a recommendation to the entire board. The committee may recommend any of the following:
   a. Dismiss the case for lack of clear and convincing evidence;
   b. Issue an Advisory Letter;
   c. Issue a Letter of Reprimand;
   d. Settlement by conditional licensure with stipulations;
   e. Revoke; or
   f. Suspension.
4. If the Assistant Attorney General concurs with the Disciplinary Committee's recommendation, the case file will be placed on the agenda for the next Board meeting. The Board, then, votes to accept or deny the recommendation. After the Board action, the licensee and the complainant will be notified in writing of the outcome.

Questions??
There is valuable information on the Wyoming State Board of Nursing website: http://nursing.state.wy.us to include:
▶The Nurse Practice Act;
▶ Board Rules and Regulations;
▶Information regarding the complaint procedures and disciplinary process;
▶Complaint form;
▶Compliance Department contact information;
▶Information regarding the Impaired Nurse Program and the Wyoming Professional Assistance Program.
Patti Hefflin is a Compliance Consultant for the Wyoming State Board of Nursing.

TERCAP - Taxonomy of Error, Root Cause Analysis & Practice Responsibility A Pilot Program for WSBN

Brenda Burnett, RN, MSN

At April's 2009 Board meeting the Wyoming State Board of Nursing (WSBN) members approved a pilot use of the Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP) data collection tool and requested incorporation of this tool into the WSBN complaint process. (Revised complaint form and TERCAP data Collection Tool are located at: http://nursing.state.wy.us). Positive experiences have been reported by other boards of nursing and it is the goal of the WSBN that TERCAP will streamline and enhance the consistency of the complaint process and quality of practice breakdown investigations.

Safe Medication Administration	Documentation
Attentiveness/Surveillance	Clinical Reasoning
Prevention	Intervention
Interpretation of Authorized Provider's Orders	Professional Responsibility/Patient Advocacy

What is TERCAP?
The National Council of State Boards of Nursing (NCSBN) appointed a task force in 1999 to look at the causes of nursing breakdown and in 2004 the Institutes of Medicine tasked NCSBN to "undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their applicability by state boards of nursing and other state regulatory bodies" (IOM, 2004, p. 15). As a result of this effort the NCSBN Research project was formed and the TERCAP data collection tool developed. According to NCSBN "this tool creates an opportunity for consistent, comprehensive data collection and future analysis in the aggregate of the submitted data" (NCSBN, 2009).

National Council of State Boards of Nursing provides numerous resources for use of the TERCAP data collection tool located at: (https://www.ncsbn.org/887.htm?search-text=TERCAP). We are excited to launch this pilot and the WSBN's complaint form provides instructions on the purpose of TERCAP and the data collection tool. Wyoming data will be submitted to the national data base where it becomes part of the aggregate for future analysis. Additionally this information or data is retrievable. For example, we may determine that we are experiencing a greater percentage of medication administration errors than the national norm. This information should be helpful to a health care administrator in directing valuable resources to the most critical issues effecting patient safety.

The Wyoming State Board of Nursing compliance staff: Brenda Burnett at (307) 777-7616 or Patti Hefflin at (307) 777 8504 are available to answer questions or assist with the completion of the data collection tool.

Brenda Burnett is a Compliance Consultant for the WSBN.

References:
Institute of Medicine. (2004). Keeping Patients Safe, Transforming the Work Environments of Nurses. Ann Page (Ed).
National Council of State Boards of Nursing, located at: https://www.ncsbn.org/about.htm.

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NCSBN Focus

Discipline of Nurses: A Review of Disciplinary Data 1996–2006

Kevin Kenward, PhD

Although nurses are viewed as being the most trusted and ethical of all professionals, a small but growing minority are subjects each year of disciplinary actions by boards of nursing. The trends of disciplinary actions and the characteristics of disciplined nurses were the focus of a study using 11 years' worth of data from National Council of State Boards of Nursing's Nursys databank of license and discipline information.

Descriptive statistics were generated to determine what factors and characteristics (eg, type of nurse, criminal history, educational background, repeat offenders, etc) are related to disciplinary actions taken by boards of nursing. The most frequent types of violations and most common actions taken by boards of nursing as well as recidivism rates and much more information are provided.

Background

Although nurses top the list of most trusted professions on an annual basis,[1] a small percentage of them have to be sanctioned each year for their conduct. The disciplinary process used by boards of nursing is a means of enforcing the provisions of state administrative laws and rules and regulations. State statutes and rules provide the framework for a state's discipline process, along with board policies, procedures, and customs. The process begins with the receipt of a complaint and goes through investigation (either formal or informal administrative proceedings) resulting in an action taken by the board of nursing. The possible actions, sanctions, and remedies that the board can take are also set forth in statutes and rules.

A rise in disciplinary actions throughout the 1990s led researchers to examine factors associated with the discipline of physicians,[2–6] as well as gender differences,[7] consequences of discipline,[8] and the effectiveness of discipline among nurses.[9] Researchers have also studied disciplinary actions as they apply to the incidence of medication errors[10] or drug use among nurses.[11] However, there has been little descriptive information at a national level about disciplinary actions taken by state boards of nursing.

This report is based on data provided by boards of nursing to Nursys between January 1996 and December 2006. Nursys is a comprehensive electronic information system that includes nurse licensing and disciplinary information and is maintained by the National Council of State Boards of Nursing. Fifty-one out of a possible 59 boards reported data to Nursys at the end of 2006, and 44 (86%) of these boards gave permission to use their disciplinary data for this study. Nurses who entered alternative programs for discipline or diversion programs were not identified and are not included in this study.

Characteristics of Disciplined Nurses

Number Disciplined

There were 52,297 nurses reported by 44 boards of nursing for a disciplinary action between January 1996 and the end of December 2006. During this period, the statistics for disciplined nurses increased from a low number of 3,193 in 1996 to a high of 8,131 in 2006. This represents an increase of 155% in 11 years. However, the population of nurses also increased during this period. Nevertheless, the percentage of the nurse population that has been disciplined during this 11-year period increased by almost 90%, from 0.10% to 0.19% (Figure 1).

Type of License

Of the 52,297 nurses included in this study, 1% held an advanced practice (AP) license, 63% were registered nurses (RN), and 36% were licensed practical nurses (PN). Approximately 3.5% (1,876) held more than 1 type of nursing license. A little more than 3% held both RN and PN licenses, and one-third of 1% held an AP license, along with either an RN or PN license or both.

For analyses involving type of license, unless otherwise specified,

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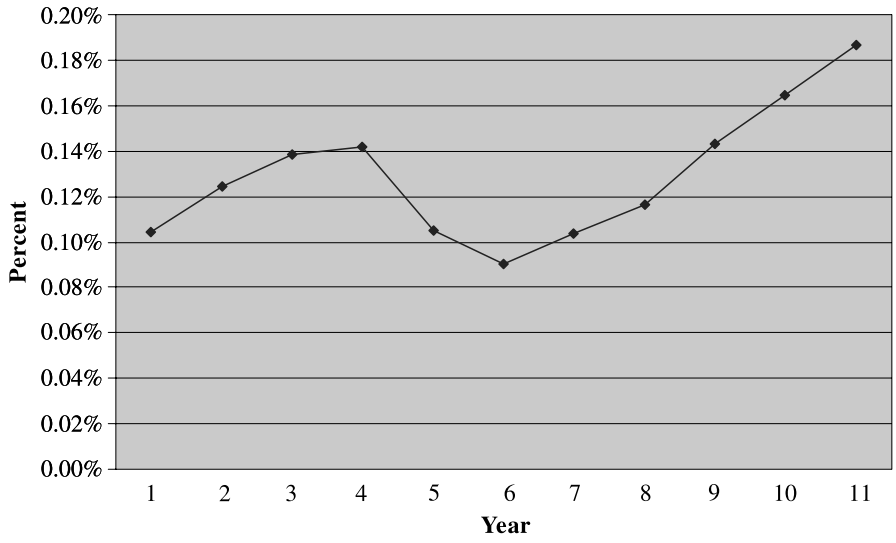

Figure 1 • Percentage of disciplined nurses by year.

nurses were categorized according to the highest level of license obtained. For example, if a nurse was licensed as both an AP nurse and an RN, they were considered an AP nurse. There were also 1,456 nurses who had the same action taken against both their RN and PN licenses. For example, if a nurse's RN license was suspended for drug abuse, the board would also suspend the PN license so that the nurse could not have one of the licenses suspended and practice on the other one. When counting violations, actions, and incidents, these duplicate sanctions were excluded, and only sanctions against the higher level license were counted. There were 186 AP nurses who, in addition, had either an RN or a PN license. Yet, when discipline was taken against an AP license, the same actions were never applied to either the associated PN or RN license.

There were statistically significant differences ($p < .05$) between nurses with different types of licenses. Although these differences are very small, they do indicate that PNs are more likely to be disciplined than either AP nurses or RNs. Until further studies are conducted, the reason for this will remain speculative. One possible reason is because more PNs work in long-term care facilities, which may adhere to stricter reporting criteria compared to hospitals.

Race/Ethnicity

Among disciplined nurses, there was a slightly higher percentage of African Americans, native Americans, and Hispanics compared to the general nurse population and slightly lower percentages of Asian/Pacific Islanders and whites.

Sex

Among RNs, males represented 18% of the disciplined population. This indicates a markedly higher proportion of males when compared to the National Sample Survey of Registered Nurses (2004), which estimates that males make up approximately 6% of the RN population.

Age and Experience

The average age at first licensure was 31.5 years. The average number of years a nurse had practiced at the time of the disciplinary action was almost 12 years. Seven percent had worked for 1 year or less. Approximately one-fifth of disciplined nurses had worked between 2 and 5 years. Another 26% had been nurses for 6 to 10 years. Nurses who had worked between 11 and 24 years represented 37% of disciplined nurses, and 8% had worked for more than 25 years.

Violations

The number of violations went up approximately 65% in 11 years, from 7,737 in 1996 to a high rate of 12,780 in 2006. Approximately 8% of all violations were for a criminal act, and approximately 3% involved a medication error. Those with drug-related violations (ie, drug abuse, drug diversion, alcohol abuse, drug use only, drug-related conviction, other drug-related violations, writing illegal prescriptions, presenting illegal prescriptions, wastage errors, and sale of drugs) represented 24% of all violations. Eighteen percent of the nurses disciplined for drug-related violations were male nurses. Again, this is

approximately 3 times as many males as you would expect to find in the population of nurses.

Actions

The average age at the time of disciplinary action was 43 years. Almost 14% of the actions taken against nurses provided probation. Thirteen percent resulted in suspended licenses, approximately 12% imposed payment of fines, 10% were reprimands, and 8% resulted in revocation of the license.

An analysis was undertaken to determine if the same actions are taken for the same violation across jurisdictions. Table 1 indicates that the state boards issued similar actions for certain violations. The table indicates the most commonly imposed disciplinary actions for drug abuse and false documentation violations and the number of jurisdictions that use those actions.

Recidivism

More than three-fourths of the disciplined nurses had only one incident. An incident was defined as the number of different action dates that occurred in a nurse's record. For example, if there was a board action taken against a nurse on January 2, 2003; February 4, 2004; and March 30, 2005, the nurse was deemed to have had 3 separate incidents.

The average percentage of recidivism of nurses in a given state was 24%, with a low rate of 9% and a high rate of 40%. Recidivism in this case is defined as a nurse with more than 1 incident.

Because most of the disciplined nurses did not recidivate, it is not surprising that 96% of the disciplined nurses were disciplined in only 1 state. A little less than 4% were sanctioned in 2 states, whereas 3 nurses were sanctioned in 6 different states.

Study Limitations

There are several limitations to this study. One limitation is that not all jurisdictions participated in the sharing of information. Another limitation is the significant amount of missing data. Forty-five percent of the cases had missing race/ethnicity information, and 41% had missing education program data.

Conclusions

This report analyzed disciplinary data reported by 44 boards of nursing from 1996 through 2006.

Some of the major findings of the study are as follows:

- A very small percentage (less than 1%) of nurses are disciplined in a given year.
- PNs are more likely to be disciplined than RNs or APRNs.
- Drug-related violations represent 24% of all violations.
- Males are disproportionately disciplined especially among nurses with a chemical dependency problem.
- Almost 96% of disciplined nurses have been disciplined in only 1 state.
- Discipline occurs less frequently among nurses with 1 year or less of experience, and 39% of disciplined nurses have been licensed between 10 and 24 years.
- One-fifth (21%) of disciplined nurses recidivate.
- Missing data make it difficult to draw any conclusions about the relationship between discipline and educational program.

Further studies are needed to evaluate the general findings of this study. Addressing the factors that are associated with PNs and male nurses, for example, being more prone to discipline, will be useful in determining effective disciplinary remedies imposed by boards of nursing. Nurse executives and nurse managers may find these data useful in providing focus to staff development activities. It may be that educating staff nurses about what conduct will likely result in board discipline and how to avoid that conduct not only can help reduce the individual nurse's likelihood of experiencing discipline but also can improve patient care.

TABLE 1
Common Actions for Selected Violations

Violation	Action	No. of Jurisdictions
Drug abuse	Suspension	43
Drug abuse	Probation/conditions	41
Drug abuse	Revocation	37
False documentation	Suspension	42
False documentation	Reprimand/censure	40
False documentation	Probation/conditions	39

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Disciplinary Actions

Bill Corson, CNA #15155
July 9, 2009
Revocation of Certificate

Bill Corson, CNA, was employed at Wyoming Retirement Center in Basin, Wyoming. For his conduct in forcefully feeding a resident with a metal spoon, which led to injuries to the resident, Corson was found to have violated the nurse practice act for (1) engaging in an act inconsistent with uniform reasonable standards of nursing practice, and (2) being unfit or incompetent to practice nursing by reason of negligence in the performance of unsafe nursing practice or the failure to conform to the essential standards of acceptable and prevailing nursing practice. Corson's CNA certificate was revoked by the Board following hearing.

Grounds for Discipline: Chapter VII, section 11(b) of the Board's Administrative Rules and Regulations: (i) inability to function with reasonable skill and safety for the following reasons, including but not limited to: (D) Client abuse, including sexual abuse; (F) Client neglect; (H) Performance of unsafe client care; (iv) Failure to conform to the standards of prevailing nursing and nursing assistant/nurse aid practice, in which case actual injury need not be established.

Denials of Applicants Seeking Licensure or Certification

The Nurse Practice Act, 33-21-146 identifies the following reasons that an application may be denied:

"(a) The board of nursing may refuse to issue or renew, or may suspend or revoke the license, certificate or temporary permit of any person, or to otherwise discipline a licensee, upon proof that the person:

(i) Has engaged in any act inconsistent with uniform and reasonable standards of nursing practice as defined by board rules and regulations;

(ii) Has been found guilty by a court, has entered an Alford plea or has entered a plea of nolo contendere to a misdemeanor or felony that relates adversely to the practice of nursing or to the ability to practice nursing;

(iii) Has practiced fraud or deceit:

(A) In procuring or attempting to procure a license to practice nursing;

(B) In filing or reporting any health care information, including but not limited to client documentation, agency records or other essential health documents;

(C) In signing any report or record as a registered nurse or as a licensed practical nurse;

(D) In representing authority to practice nursing; or

(E) In submitting any information or record to the board.

(iv) Is unfit or incompetent to practice nursing by reason of negligence, habits or other causes including but not limited to:

(A) Being unable to practice nursing with reasonable skill and safety to patients by reason of physical or mental disability, or use of drugs, narcotics, chemicals or any other mind-altering material; or

(B) Performance of unsafe nursing practice or failure to conform to the essential standards of acceptable and prevailing nursing practice, in which case actual injury need not be established.

(v) Has engaged in any unauthorized possession or unauthorized use of a controlled substance as defined in the Wyoming Controlled Substances Act [§§ 35-7-1001 through 35-7-1057];

(vi) Has had a license to practice nursing or to practice in another health care discipline in another jurisdiction, territory or possession of the United States denied, revoked, suspended or otherwise restricted;

(vii) Has practiced nursing within this state without a valid current license or temporary permit or as otherwise permitted under this act;

(viii) Has knowingly and willfully failed to report to the board any violation of this act or of board rules and regulations;

(ix) Has been found by the board to have violated any of the provisions of this act or of board rules and regulations; or

(x) Has knowingly engaged in an act which the licensee knew was beyond the scope of the individual's nursing practice prior to committing the act, or performed acts without sufficient education, knowledge, or ability to apply nursing principles and skills; or

(xi) Has failed to submit to a mental, physical or medical competency examination following a proper request by the board made pursuant to board rules and regulations and the Wyoming Administrative Procedure Act.

(b) Upon receipt from the department of family services of a certified copy of an order from a court to withhold, suspend or otherwise restrict a license issued by the board, the board shall notify the party named in the court order of the withholding, suspension or restriction of the license in accordance with the terms of the court order. No appeal under the Wyoming Administrative Procedure Act shall be allowed for a license withheld, suspended or restricted under this subsection" (pg 12-13 of 18).

The following actions were taken on applications:

Judith A. Combs, CNA Applicant	**Denial**	**Drugs-Possession of a Controlled Substance, Felony Drugs-Possession with Intent to Sell within 1,000 Feet of School, Felony Resistance/Interference Felony Arrest**	**June 22, 2009**
Mary K. Fear, RN Applicant	**Denial**	**Worked as an RN from 1/2003 until 8/2007 without a License**	**June 9, 2009**
Charlotte A. Francisco, CNA Applicant	**Denial**	**Resisting Arrest & Obstruction without Violence Misdemeanor Fraudulent Activities Resisting Officer, Trespassing & Obstruction of Police**	**May 11, 2009**

Lee Allen Geis, RN Applicant	Denial	Failure to Meet Competency, Failure to Disclose Original State Of Licensure, Failure to Disclose Pending Florida Board of Nursing Discipline Action, Order of Emergency Suspension of License from State of Florida Department Of Health, Burglary 3/2001 & Criminal Conviction 5/2008	July 10, 2009
Veronica A. Hinds, CNA Applicant	Denial	2005, 2006 & 2007 Minor in Possession Possession of Marijuana DUI & Solicitation for Alcohol	July 10, 2009
Christina M. Hoover, CNA Applicant	Denial	Shoplifting & Interference with Police Officer	April 10, 2009
Keondra T. Jackson, CNA Applicant	Denial	Multiple DUI's & Failure to Report DUI to WSBN Failure to Complete Probationary Terms Worked 11.6 weeks past the 120 day period allowed as a CNA	June 5, 2009
Amber M. Malone, CNA Applicant	Denial	Assault, DUI, Leaving the Scene of Property Damage Disturbing the Peace, & Disorderly Conduct Voluntarily admitted to treatment for Methamphetamine Dependency	May 29, 2009
Kim M. Muniz, CNA Applicant	Denial	Larceny, Fraud by Check Drugs-Misdemeanor-Unlawful Possession Controlled Substance Drugs-Felony-Unlawful Possession of Schedule I or II Narcotics	June 21, 2009
Lindsey C. Urbin, CNA Applicant	Denial	Felony Fraud by Check	May 18, 2009

Patti Hefflin, BSN, RN

Wyoming State Board of Nursing (WSBN) Meets with Students and Faculty Members of Wyoming Nursing Education Programs

The Executive Director, Practice and Education Consultant, and Compliance Consultants visited the nursing programs throughout the state during April and May 2009.

Our goal was to increase the understanding of the relationship of regulation to professional nursing practice and education. We also emphasized the importance of protecting the property right that comes with being licensed as a nurse as it relates the mission of the WSBN. Lastly, we discussed common compliance and discipline issues that included graduate nurse regulations, differentiation between the roles of the LPN and RN and scope of practice issues.

The evaluations were overwhelmingly positive from students and faculty! The WSBN feels the tour of the state to the nursing education programs is a cost-effective means of meeting multiple objectives that promote the mission of WSBN.

The WSBN would like to take this opportunity to congratulate the new graduates and welcome them to the nursing profession!

Patti Hefflin is a Compliance Consultant for the Wyoming State Board fo Nursing.

Marguerite Herman

Revised Rules and Regulations Signed by Governor Freudenthal

The rule making and revision process has been successfully completed for four chapters of the Administrative Rules and Regulations: Chapters 3, 7, 8 and 9.

The Wyoming Board of Nursing approved all nine chapters and put them out for public comment in December of 2008. Subsequently, the Board withdrew five of the nine chapters because of the controversy stirred by proposed revisions, and work continues on those chapters.

The four remaining chapters were approved by Gov. Dave Freudenthal in June 2009.

Chapter 3: Standards of Nursing Practice

New language more accurately reflects current national standards related to nursing practice and continued competency. The Board determined that lack of standardization of Licensed Practical Nurse (LPN) roles made it necessary to add rules related to IV Therapy certification. Administrative costs associated with adding "IV certified" to the license may be considered when the Board of Nursing revises Chapter 5 rules concerning fees.

Be certain to review the content of these chapters to be found on the web site: http://nursing.state.wy.us

Chapter 7: Certified Nursing Assistants

Revisions to this chapter remove most of the language about "delegation," which now is contained in a new Chapter 9. The Board also removed language related to oversight of the CNA registry and educational programs, which now are the responsibility of the Office of Healthcare Licensing and Survey in the Wyoming Department of Health.

Board staff is meeting with nurses and administrators from long term care, assisted living and the state Division of Disabilities to draft possible rule language for medication administration by CNAs who get extra education and testing. As part of the drafting process, the Board is taking comments from nurses, administrators and the public.

Chapter 8: Practice and Procedure

This chapter implements the Board's authority to conduct investigations, hearings and proceedings on alleged violations of the Nurse Practice Act or the Board's rules and regulations. The revisions clarify processes used by the Board to investigate and decide the outcome of complaints filed against people who hold and who are seeking licenses or certification by the Board.

Chapter 9: Delegation and Assignment.

This new chapter consolidates information (from Chapters 3 and 7) about the concept and process of safe delegation of nursing duties. The licensed nurse delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcomes, ability of the staff to whom the task is delegated and the context of other patient needs. This chapter is based upon the Joint Statement on Delegation from the American Nurses Association and the National Council of State Boards of Nursing (2006). For more information on delegation from the American Nurses Association, check out this Web site: http://www.safestaffingsaveslives.org//WhatisSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx

Marguerite Herman is the consumer representative for the Wyoming State Board of Nursing.

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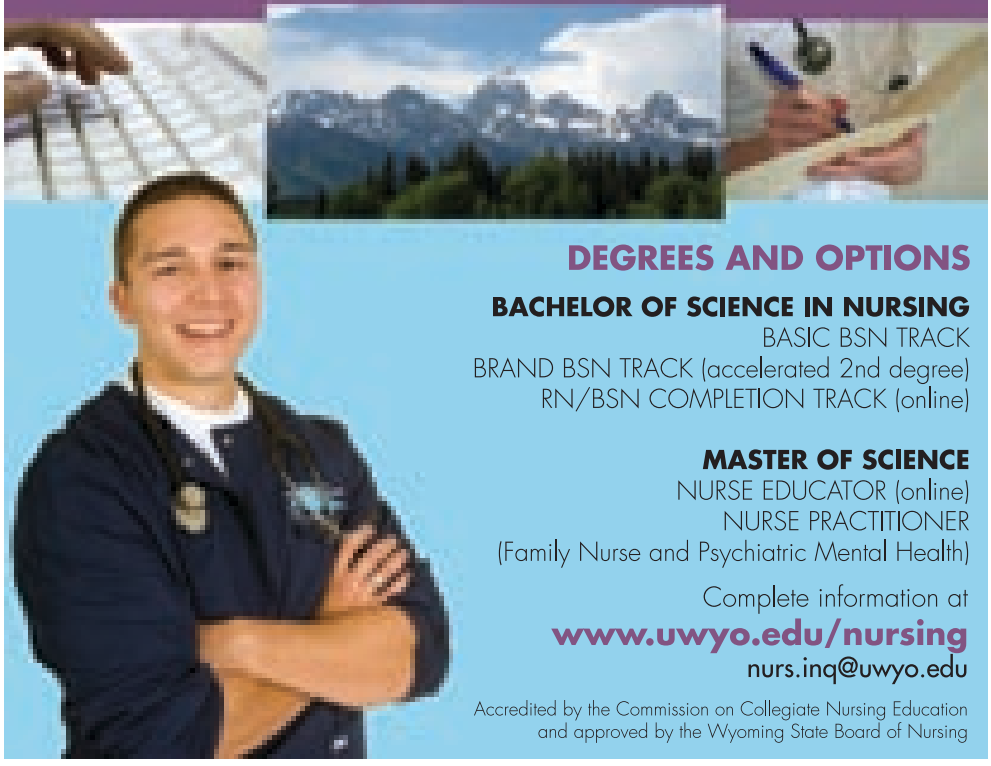

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Mary Beth Stepans, PhD, RN

PRACTICE QUESTIONS

Each day nurses ask important questions about issues that affect many nurses. The goal of the Practice Column is to share with our readers information related to these frequently asked questions.

Question: I am an LPN and wish to begin a private respite program modeled after the National Family Caregiver program. These are my questions:

1. Am I able as an LPN to direct CNAs to do personal care such as bathing and dressing along with the respite care if it is private pay?
2. If not, what exactly does being directed by an RN mean. Do they have to be on-site or can I contact them by phone?
3. In the past, I directed both RNs and CNAs. The only service the RN provided was the initial and yearly nursing assessments and delegations for clients who would be receiving personal care. Would this be appropriate in private care?
4. The nursing assessment forms used by the Aging Division allow an LPN to perform the assessments as long as an RN approves. Is this still the policy and can we use the same model for private care?
5. Would we be able to do foot care in the home if the protocol were approved by an RN and podiatrist. Last year when I worked on getting a foot care clinic started for the Senior Center this was the ruling I received from the Nursing Board.

Answer: According to the Nurse Practice Act, the " 'Practice of practical nursing' means the performance of technical services and nursing procedures which require basic knowledge of the biological, physical, behavioral, psychological and sociological sciences. These skills and services are performed under the direction of a licensed physician or dentist, advanced practice registered nurse or registered professional nurse" [NPA 33-21-120 (a)(x)].

- Applying these principles, as you have done for foot care, it is appropriate that the physician and RN are involved in directing the care through protocols.
- It is not appropriate for an LPN to "direct" RNs in the provision of nursing care although a RN could be hired by the owner of a business who also happens to be a LPN as long as the RN provides the direction for the provision of nursing care.
- RNs are responsible for initial assessments. LPNs are responsible for "collecting, reporting, and recording objective and subjective data ..... Data collection includes observations about the condition or change in condition of the client" [Chapter 3, Section 3(a)(i)(A)]. Therefore, for clients who require basic nursing care, the LPN does the follow-up and notifies the RN or primary care provider of changes.
- It is not appropriate for a RN to "sign off" on the assessment done by a LPN. Each professional is responsible for their own assessment. Revisions in Chapter 3 have just been approved (http://nursing.state.wy.us) so you might find it useful to review this chapter.

The definition of direction can be found in the Administrative Rules and Regulations.

"Direction means the intermittent observation, guidance and evaluation of the nursing practice of another by a licensed physician, dentist or registered professional nurse who may only occasionally be physically present; or joint development of a plan of care in advance by those individuals involved which will be implemented by others without the physical presence of a licensed physician, dentist, or registered professional nurse. In the latter situation, a licensed physician, dentist or registered professional nurse shall be available for consultation in the event circumstances arise that cause consultation to be necessary. The degree of direction needed shall be determined by evaluation of the patient care situation, and the educational preparation and demonstrated proficiency of others" [Chapter 1, Section 6(a) (xxiii)].

Therefore, the RN need not be physically present, but must be available for consultation should the need arise. The RN's clinical judgment is vital in terms of how much direction is required in a specific situation.

Question: If a screening tool is used in the acute care setting, is it within the scope of practice of the nurse to administer pneumovax and influenza vaccine without an order from a healthcare provider with prescriptive authority.

Answer:

The directive that comes from the Department of Health & Human Services, Centers for Medicare & Medicaid Services indicates that in long term care facilities, home health agencies and hospitals, all orders for drugs and biologicals must be in writing and signed by the practitioner or practitioners responsible for the care of the patient as with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This is a strategy designed to increase influenza and pneumonia vaccination rates across the United States.

Consequently, long term care facilities, home health agencies and hospitals can be reimbursed for the influenza and pneumococcal vaccines even if the physician's order isn't signed for the individual patient. The issue for nursing lies in whether a physician-approved protocol or standing order is acceptable. IF the primary care providers in your agency are willing to approve such a protocol, it is certainly within the nurse's scope of practice to administer the pneumococcal and influenza vaccine once an assessment for contraindications has been completed.

Mary Beth Stepans, PhD, RN is the Practice and Education Consultant for the Wyoming State Board of Nursing.

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Continued on page 26

Marcia Dale, RN, EdD, FAAN

The Medical Assistant: Preparation and Their Scope of Practice

Medical assistants are a relatively new member of the health care team. Schools to train this new category of individuals have grown considerably and offer programs in a traditional or online format leading to a certificate or a diploma. The program is usually eight months to one year in length. The associate's degree medical assistant training programs last two years and provide other general education curriculum. Some schools are accredited by the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools. The American Association of Medical Assistants awards the Certified Medical Assistant (CMA) credential to medical assistants who have:

1. Successfully completed a medical assisting educational program accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES).

2. Passed the CMA (AAMA) Certification Examination (American Association of Medical Assistants, n. d.).

Training prepares the student to handle a wide variety of tasks in a hospital, clinic or private medical practice environment. Because the scope of practice varies so widely, medical assistants are expected to know something about pharmacology, accounting, office procedures, and patient- care procedures. Courses in a program of study include: clinical and diagnostic procedures, first aid, human anatomy, keyboarding and computer applications, laboratory techniques, medical billing and insurance coding, medical law and ethics, and medical terminology (Medical Assistant Training: Get the Details on Medical Assistant Training retrieved April 17, 2009).

The essential element of the scope of practice for a medical assistant is that the supervising licensed health care provider MUST be present on the floor, office, or in the building whenever the medical assistant provides any type of direct patient care or performs a procedure (Advanced Medical Assistant, n. d.). Laws that guide the practice of the medical assistant vary from state to state.

The scope of practice is confusing because of the differences in state laws. If a decision is made to employ MAs, the employer must become familiar with state laws on the topic in order to write appropriate policies. For example, in Alaska, an MA is allowed to insert urinary catheters and start IVs. They are also allowed to administer medications as ordered into an IVunder the direction of a physician. It is each health care provider's responsibility to understand their role in relationship to

the role of the MA. To make things even more complicated, skill levels are not the same for every medical assistant and the type and level of certifications differ. In many states, anyone performing phlebotomy, ultrasound procedures, EKGs or x-rays must have a specific license to do so (Advanced Medical Assistant, n. d.).

Connecticut has guidelines for licensed nurses delegating to unlicensed personnel, which includes MAs since there isn't licensure or certification of MAs in Connecticut. California requires all MAs that perform phlebotomy to have the California Department of Human Services approved phlebotomy technician certification (Advanced Medical Assistant, n. d.).

Only seven states: Arizona, California, Florida, New Jersey, Maryland, South Dakota, and Washington have specific regulations governing medical assistant's scope of practice (AAMA, April 21, 2009). In each of these states, except Washington, only the physician delegates tasks to the MA; in Washington, however, the nurse may delegate tasks to the MA.

In Wyoming, MAs are not regulated by either the Wyoming State Board of Nursing or the Wyoming Board of Medicine. This means that MAs working in Wyoming are not licensed or certified. According to the Nurse Practice Act 33-21-120, the nurse is responsible for "delegation to appropriate assistive personnel as provided by state law and board rules and regulations" [(a)(x)]. Therefore, nursing tasks may not be delegated to un-licensed personnel. In Maine, the Board of Licensure in Medicine has ruled that physicians are accountable for the actions of unlicensed assistants employed by the physician who do not fall under the Board's jurisdiction when they perform any invasive procedure, including the administration of injections. The terms "under the direct control" and "in the immediate presence," as stated in 32 M.R.S.A. §3270-A, shall mean the physician must be in reasonable proximity to lend medical assistance to a patient should something adverse happen. Also, physicians, pursuant to 32 M.R.S.A. §3270-A are accountable for the activities of unlicensed assistants employed by them (Advanced Medical Assistant, n. d.).

The bottom line is that, in Wyoming, there is no regulatory body responsible for Medical Assistants, and there are no established standards of care. Although some schools and training programs in Wyoming prepare this type of health care worker, and many MAs are employed in Wyoming, there is no role for nurses in this model, including advanced practice registered nurses. The MAs work directly for the medical provider who hires them. It is the burden of that employer to know exactly what the MA's educational and experience background is and to provide the required supervision.

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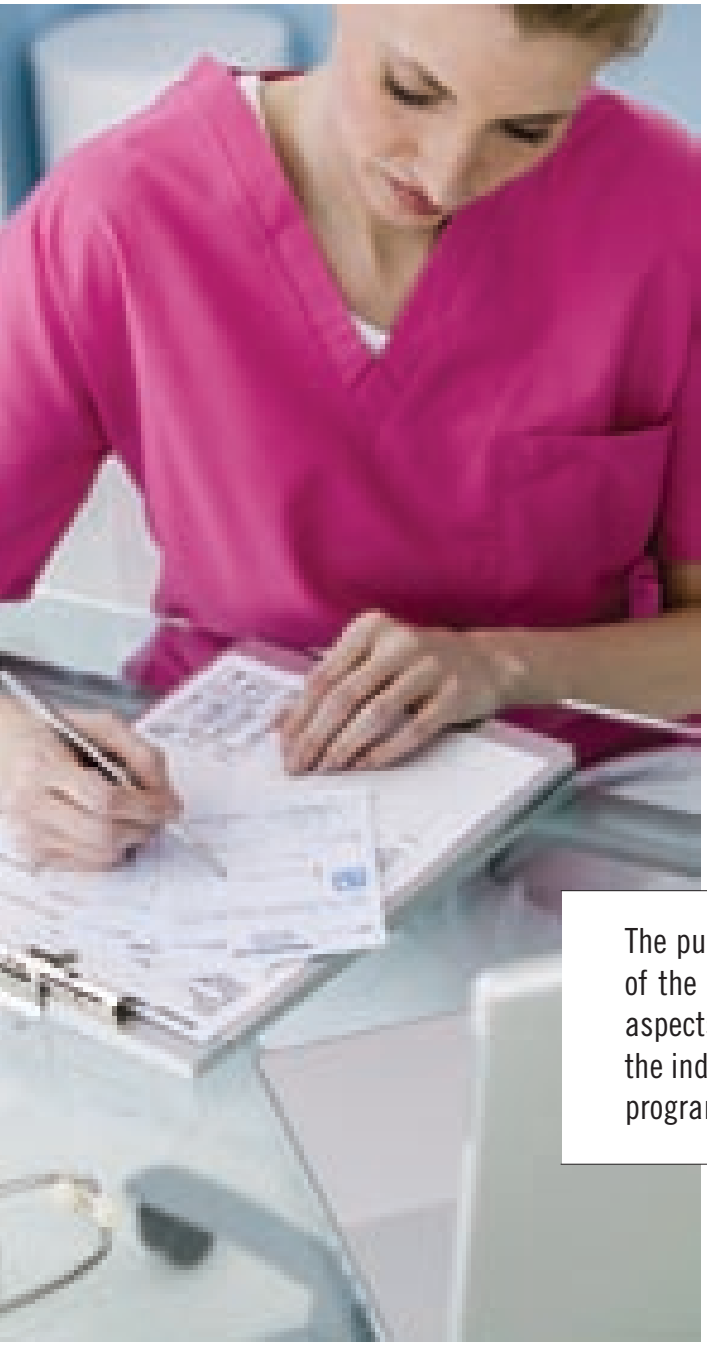
Brenda Burnett, RN, MSN

WHAT DOES REPORTING BOARD DISCIPLINARY ACTION MEAN TO YOU?



The Wyoming State Board of Nursing (WSBN) reports final disciplinary action taken against a licensee or certificate holder to various agencies and publishes this information in the Wyoming Nurse Reporter (WNR). Final disciplinary action includes denying an application to revoking a license or certificate. The purpose of reporting these actions is to protect and serve the interests of the public. Agencies maintain data bases and are tasked with knowing the status of individuals who may be excluded from receiving compensation or benefit from federally funded programs. Disciplinary action from the WSBN has multi state and national consequences.

Below are brief summaries and links of the agencies that the WSBN reports final disciplinary action based on level of licensure:

Nursys (https://www.nursys.com/Index.aspx):

Nursys® (Nurse System) is:

a computer system that contains nurse license and license discipline information that is provided by boards of nursing in the United States and its territories. Nursys® receives regular updates of nurse personal (name, address, etc.) and license information from Nursys® Licensure participating boards of nursing. All boards of nursing, including non-Nursys® Licensure participating boards, have access to information within Nursys®, and are able to enter and edit discipline information (Nursys, 2009).

The WSBN reports disciplinary action for Licensed Practical Nurses, Registered Nurses and Advanced Practice Registered Nurses to Nursys® as our reporting agent for NPDB-HIPDB.

National Practitioner Data Bank – Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) (http://www.npdb-hipdb.hrsa.gov/):

> The purpose of HIPDB is to:
> …combat fraud and abuse in health insurance and health care delivery. This is accomplished by collecting and disseminating final adverse actions taken against health care practitioners, providers, and suppliers. HIPDB is primarily a flagging system that may serve to alert users that a comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent (HIPDB, 2009).

Disciplinary action for Certified Nursing Assistants is reported directly to NPDB-HIPDB. Office of Healthcare Licensing & Survey (OHLS) (http://wdh.state.wy.us/ohls/index.html):

The Wyoming Office of Healthcare Licensing and Survey assures that patients and residents receive quality care from healthcare facilities which are required to be licensed by the State of Wyoming. The Office also promotes health and safety through on-site inspections and complaint investigations (OHLS, 2009).

Additionally, OHLS maintains a registry located at: http://health.wyo.gov/OHLS/CNA.html of all nurse aides who are certified to provide services in long term care facilities and swing beds licensed by the Wyoming Department of Health. If a CNA is not listed on the registry, that individual is not eligible to work as a CNA in a nursing care facility or swing bed in Wyoming (OHLS, 2009). CNAs wishing to become

The purpose of reporting these actions is to protect and serve the interests of the public. Agencies maintain data bases and are tasked with various aspects of notification of the current status of an individual to excluding the individual from receiving compensation or benefit from federally funded programs.

listed on the registry simply access the OHLS web site (http://www.health.wyo.gov/ohls/CNA.html), download and complete the form and send it to OHLS either by fax or mail.

Office of the Inspector General (OIG), located at http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG) as mandated by Public Law 95-452 is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs by excluding the individual from receiving benefits from federally funded programs (OIG, 2009).

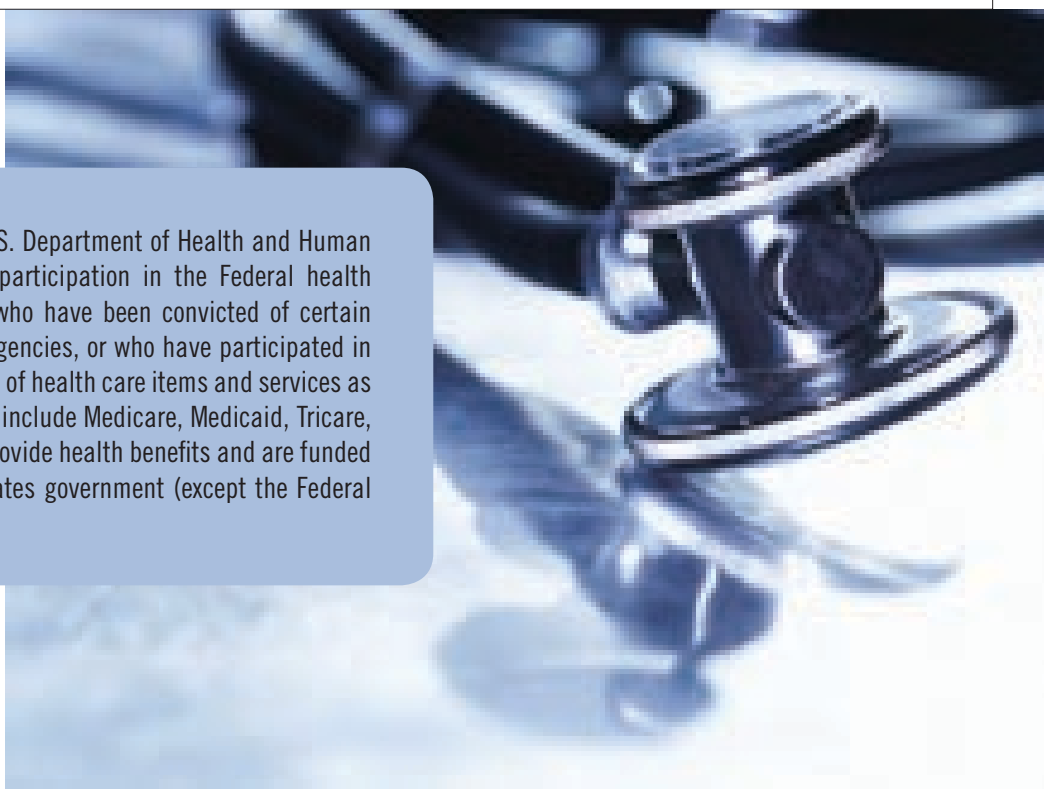
The OIG mandates that board action resulting in the loss of a certificate or license be reported. Action by the OIG may result in the exclusion of the individual from participation in any Federal health care program. Following this article is the Informational Bulletin From the Office of Inspector General, which provides additional relevant detail on circumstances that the OIG must exclude and those they may exclude.

Reporting final disciplinary action by the board is one mechanism which enables us to fulfill our mission: to serve and safeguard the people of Wyoming through the regulation of nursing education and practice.

Brenda Burnett is a Compliance Consultant for the WSBN

INFORMATIONAL BULLETIN FROM THE OFFICE OF INSPECTOR GENERAL

Facts You May Need To Know About Your Employment



The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has the authority to exclude from participation in the Federal health care programs any individuals and entities who have been convicted of certain offenses, sanctioned by other governmental agencies, or who have participated in inappropriate activities related to the provision of health care items and services as detailed below. Federal health care programs include Medicare, Medicaid, Tricare, Veterans Affairs and all other programs that provide health benefits and are funded directly, in whole or in part, by the United States government (except the Federal Employees Health Benefits Program).

The Social Security Act (Act) authorizes the OIG to exclude individuals and entities based on particular circumstances. The Act specifies when the OIG must exclude and when the OIG may exclude. The OIG must exclude an individual or entity who has been convicted of:

1. Medicare- or Medicaid-related crimes (misdemeanor or felony)
2. Patient abuse or neglect (misdemeanor or felony)
3. Felony health care fraud (not related to Medicare or Medicaid)
4. Felony controlled substance violations

The OIG may exclude in several other instances. For example, the OIG may impose exclusions based on:

1. Convictions for misdemeanor health care fraud (not related to Medicare or Medicaid)
2. Convictions for misdemeanor controlled substance violations
3. Disciplinary actions taken by licensing boards or other Federal or State health care programs
4. Quality of care issues related to denial of services, excessive/unnecessary services, or substandard care
5. Prohibited activities such as false claims, fraud, kickbacks (with or without a conviction)
6. Defaults on health education assistance loans

Once a person is excluded, Federal health care programs will not pay for anything that the person furnishes, orders, or prescribes, regardless of what that person's job is. The exclusion affects, among others, the excluded person, anyone who employs or contracts with the excluded person, or any hospital or other provider where the excluded person provides services. The exclusion applies regardless of who submits the claims or requests for reimbursement and applies to all items or services, including administrative and management services, furnished by the excluded person. An excluded person may not be employed by a provider to perform functions for which the provider is paid, in whole or in part, by any Federal health care program. As a result, an excluded person generally may not be employed by a hospital, nursing home, or other institutional provider which participates in Federal health care programs. The exclusion is nationwide in scope and applies to all health care professions and occupations.

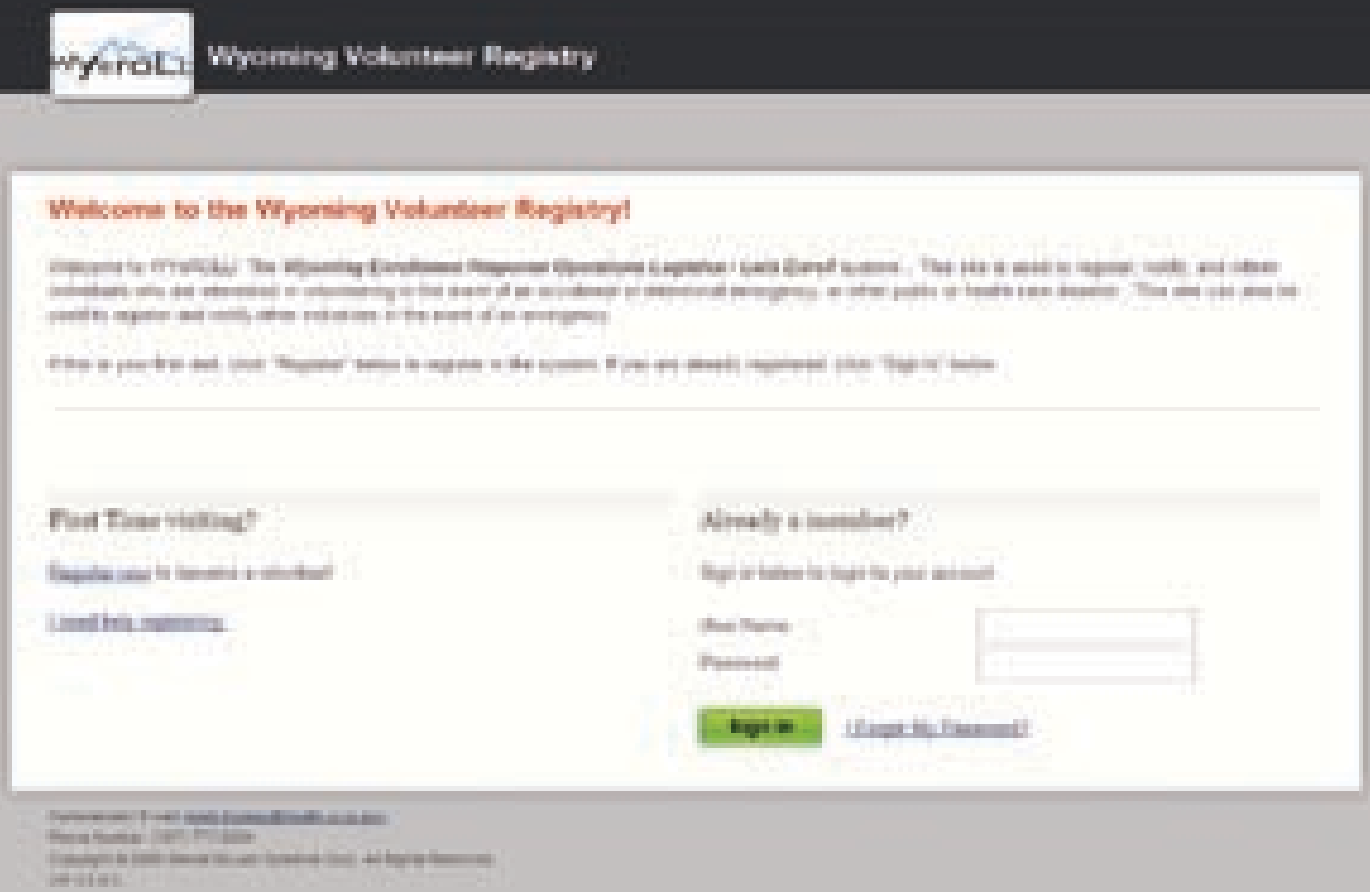
For example, if a nurse is excluded, he or she will be precluded from many types of employment in the health care field. Items or services furnished by the excluded nurse cannot be reimbursed, either directly or indirectly, by a Federal health care program. A nurse cannot work at a hospital, nursing home, or other institutional provider if the nurse's salary or fringe benefits are paid directly to the nurse or indirectly through the employer on a Federal health care program's cost report. These prohibitions apply regardless of whether the person excluded as a nurse now has a different license within the nursing field (e.g., LPN instead of RN), or changes fields and is now employed as a physician, secretary, administrator, information clerk, cafeteria worker, or any other position where the salary is reimbursed by Federal health care programs directly or on a cost report. Once excluded, an individual or entity is not able to participate in Federal procurement and non-procurement programs and activities. For example, an excluded person cannot be granted Federal student loans or housing loans, nor will any excluded party be able to enter into any contract with the Federal government.

An exclusion does not affect an excluded individual's, or his/her family's, rights to receive personal benefits as a beneficiary of Medicare, Medicaid, or any other Federal health care program.

More information about exclusions, Frequently Asked Questions, and a Special Advisory Bulletin about the Effect of Exclusions, may be found on the OIG's Website at http://oig.hhs.gov. Then click on EXCLUSIONS DATABASE, and choose the information you wish to access.

April 2003

Wyoming Volunteer Registry



Over the past several years the Wyoming Department of Health (WDH) and the Wyoming State Board of Nursing (WSBN) have partnered to develop a registry of nurses who are willing to volunteer during emergencies. We are very grateful to those nurses who have added their names to the list of volunteers that could be called to support health operations during an emergency.

We are excited to share with you the next stage in volunteer registration for healthcare providers within Wyoming. The Wyoming Volunteer Registry, "WyEROLL - WY Enrollmemt, Response, Operations, Logistics, Let's Volunteer", system was implemented by the WDH in 2007. WyEROLL provides for a statewide web/based volunteer registry system for both medical and non-medical volunteers. This registry is always a work in progress as volunteer groups and individuals register on the system on a daily basis. The intention of this system is to register, notify, and inform individuals who are interested in volunteering their time and skills in the event of an accidental or intentional emergency, or other public or health care disaster. The primary advantage of the WyEROLL is the fact that the system notifies potential volunteers when there is an event that requires volunteers rather than people manually making those calls.

The WDH and WSBN are continuing to partner with the registration of nurses. However, rather than a form that you fill out with your license renewal, you will see a link to WyEROLL from the WSBN registration and renewal website for those interested in volunteering.

The WyEROLL website is https://vol.wyoming.gov. This site can also be used to register and notify other partners, including private industry in the event of an emergency. Additional features of the site include volunteer group-specific web pages with news, announcements and information/resources available. Registering takes approximately 15 minutes. Remember, volunteering through this system is VOLUNTARY. Registering means you are willing to volunteer but it does not commit you. If a situation arises in which volunteers are needed, each registrant will have the opportunity to volunteer for the particular need or decline.

Again thank you for your past and continued support of the Wyoming volunteer registry efforts! If you have questions please contact Merit Thomas (307-777-6904 or merit.thomas@health.wyo.gov).

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