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REGULATORY JOURNAL

**HISTORY and
NEXT GENERATION
NCLEX (NGN)**

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REGULATORY JOURNAL



From the Executive Director

JOEY RIDENOUR, RN, MN, FAAN

History & Next Generation NCLEX (NGN)

Before NCLEX, there was what nurses called the “boards.” The “boards” was the unofficial term for the State Board Test Pool Examinations or SBTPE which was the national nurse licensure exam from 1941-1982. By 1950, nursing was the first profession where all Boards of Nursing in the U.S. used one uniform exam for domestic licensure. The SBTPE was first developed by the National League for Nursing (NLN) and later by the American Nurses Association (ANA). When NCSBN began in 1978, it took proprietorship of the SBTPE and renamed the exam National Council Licensure Exam (NCLEX).

The Arizona Veterans Memorial Coliseum is a 14,870-seat multi-purpose indoor arena in Phoenix, Arizona, located at the Arizona State Fairgrounds if you were a nurse who took the NCLEX before 1994, the Veterans Memorial Coliseum was your test center. Before computers changed the way we do most things, the NCLEX was a paper and pencil test, administered twice a year in locations that could house hundreds of students, proctors and #2 pencils. Everyone was tested on the same exact questions. Not only were you limited to two testing dates in February and July but the five part tests (surgical, medical, pediatric, maternity and psychiatric) took two days to complete. It was not uncommon for May nurse graduates to wait three to six months to test as well as usually waiting two to three months to get test results.

The first NCLEX administered by computer adapted testing (CAT) occurred on April 1, 1994. At the end of that year more than 155,000 nurses took NLCEX through

CAT and that number has risen every year for almost a quarter of a century. CAT selects test questions based on applicant responses and knows when to terminate the test once a pass or fail decision is reached. The average time to take the NCLEX is about two hours and typically includes approximately 75 questions.

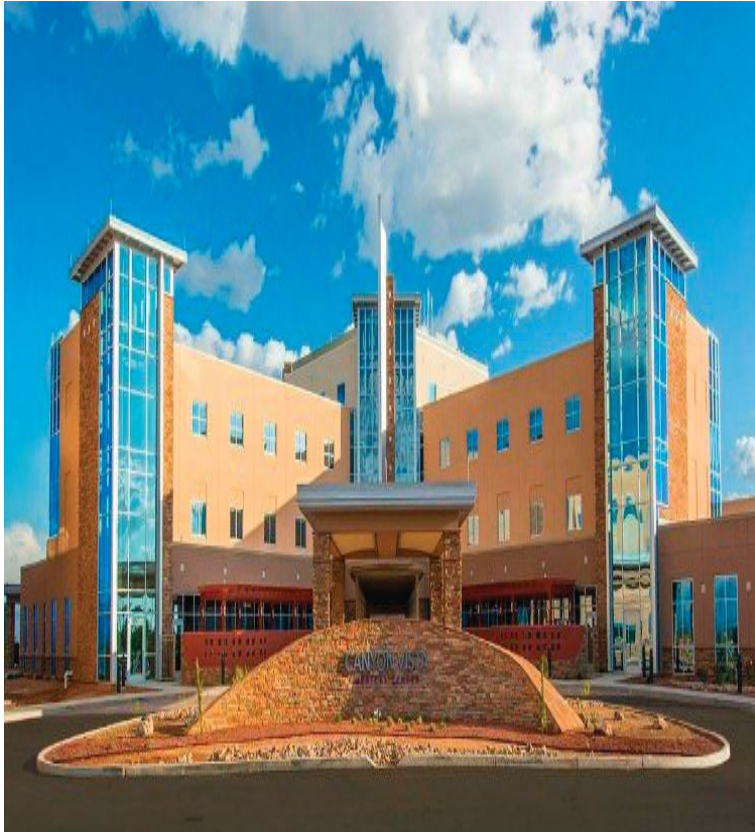
At the National Council of State Boards of Nursing (NCSBN) March 13-15, 2017 Midyear meeting the Examinations Department announced its Next Generation NCLEX (NGN) research project. (To view the presentation please visit: <https://www.ncsbn.org/9915.htm>). Over two years ago the NCSBN's NCLEX Examination Committee and examination staff began new research to ensure the NCLEX continued to measure the knowledge, skills, and abilities necessary for ensuring safe nurse practice in the evolving nursing practice environment. Philip Dickison, PhD, RN, Chief Officer, Examinations, stated the findings of the research indicated that: 1.) critical thinking and decision-making skills were an essential component of entry-level nursing education; 2.) the research moreover identified the need for measurement of competence in clinical judgment within high-stakes nursing licensure exams.

Dickison further stated that “clinical judgment is defined as the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and access presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care.”

Continued on page 6 >>>

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The following link provides a detailed discussion of the clinical judgement model: <http://www.jattjournal.com/index.php/atp/article/view/89187>).

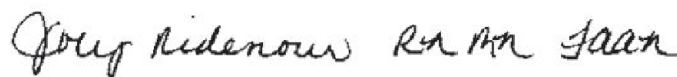
NCSBN research, literature review and pilot studies identified the following important elements of nursing clinical judgment:

- a. Cue recognition
- b. Hypotheses generation
- c. Hypotheses evaluation
- d. Taking actions
- e. Evaluating outcome

The Examinations Department is currently conducting the NGN research project to assess the ability of current and potential innovative items to assess clinical judgement. Beginning in July, 2017, NCSBN will present a Special Research Section as part of the NCLEX-RN administration. The Special Research Section will be given to select candidates taking the NCLEX-RN and will take

approximately 30 minutes to complete. This section will be administered following a candidate's regular NCLEX exam and will not count as part of their NCLEX score. Information about the Special Research Section will be made available to NCLEX candidates in early April via the NCSBN and Pearson VUE websites.

Included in this edition of Arizona Board of Nursing Regulatory Journal are two resources that have been developed specifically for the boards of nursing/regulatory bodies in regards to the NGN project. The first document is the NGN Project Summary and the second document is FAQs regarding the Special Research Section given at the Midyear meeting.



Joey Ridenour, RN, MN, FAAN



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Final candidates selected will be subject to a favorable adjudicated background investigation.

Next Generation NCLEX **Project Summary**

1. At the request of NCSBN's NCLEX Examination Committee, the examination staff began research to ensure the NCLEX continued to measure the knowledge, skills, and abilities necessary for ensuring safe nurse practice in the evolving nursing practice environment. This research identified the need for a high-stakes nursing licensure exam with a focus on clinical judgment. The findings of the research were substantiated by the inclusion of critical thinking and decision-making skills as an essential component of entry-level nursing education and the findings of the 2013-2014 NCSBN practice analysis confirming the importance of sound clinical judgment skills to a significant number of tasks performed by entry-level nurses.
2. Based on these initial findings, additional research has been conducted and presented at scientific meetings (NCME, AERA, Scientific Symposium, Sigma Theta Tau International). A comprehensive clinical judgment assessment model has also been published in the *Journal Applied Testing Technology*, 2016.
3. Clinical judgment is defined as the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care.
4. NCSBN research identified a list of contextual factors that play a role in the quality of nursing clinical judgment (Dickison et al, 2016). These factors may be divided into conditions that are internal (education, experience, knowledge, communication, consequences/risk, emotions/perceptions, professional orientation) or external (task complexity, time pressures, distractions, interruptions, professional autonomy) to the nurse.
5. NCSBN research, literature review and pilot studies identified the following important elements of nursing clinical judgment:
 - a. Cue recognition
 - b. Hypotheses generation
 - c. Hypotheses evaluation
 - d. Taking actions
 - e. Evaluating outcome
6. A pilot study was conducted in 2016 (cite Muntean et al. 2016 AERA presentation) to ascertain whether clinical judgment is more than just possessing nursing knowledge. The results of the pilot study indicated that while knowledge is necessary for safe nursing practice it is not sufficient to confirm the clinical judgment essential to safe nursing practice. The same study also suggested that the average ability of a nurse to demonstrate the different steps in the clinical judgment process (cue recognition, hypothesis generation, hypothesis evaluation, taking actions, and evaluating outcomes) is progressive. This finding indicates that simply recognizing cues and developing hypotheses does not guarantee the nurse's ability to evaluate a hypothesis nor does having appropriate ability to take actions guarantee the ability to evaluate the outcomes of the action taken. No single element of clinical judgement adequately predicts a nurse's clinical judgment ability, rather it is the combination of all the elements that add validity and reliability to the measurement of a nurse's clinical judgment ability.
7. Based on the assessment model presented by Dickison et al (2016), task models may be constructed to generate items and clinical scenarios

for use in nursing educational curricula and nursing high stakes licensure examinations that reflect real-life nursing clinical judgement situations.

8. An internal analysis of current NCLEX items indicated that while nursing clinical judgment is measured in the current NCLEX, items with higher fidelity that directly assess this construct are needed to keep up with the evolving nursing profession and nursing's role in protecting the public.
9. NCSBN examinations is currently conducting a research project to assess the ability of current and potential innovative items to assess clinical judgement. The research project consists of the following steps:
 - a. Develop item prototypes to assess clinical judgment tasks
 - b. Research the usability of the prototypes
 - c. Collect data on the prototypes
 - d. Determine which items accurately measure clinical judgement, are usable and provide useful data that can help measure a candidate's nursing competence.
 - e. Conduct a pilot using selected items.
10. A project communication plan is in development. The project team intends on providing regular updates to the NCSBN Board of Directors and the NCLEX Examination Committee as well as an update at each midyear and annual meeting. In addition, the plan includes communication to external audiences throughout various phases of the project.

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Highlights of the 2017 ENVIRONMENTAL SCAN

As 2017 begins, researchers, governments, and international organizations are examining how technological developments may have far-reaching consequences for the future of various professions. As the White House explores the future of artificial intelligence and the United Nations focuses on sustainable development, boards of nursing may see the profession of nursing itself transformed by technological innovation.

The Nursing Workforce

As of September 2016, a total of 3,880,565 registered nurses (RNs) and 913,453 licensed practical nurses and licensed vocational nurses (LPN/VNs) in the United States (NCSBN, 2016). The most recent Occupational Employment Statistics data indicate that 2,687,310 RNs and 695,610 LPN/VNs were employed in the United States as of May 2015 (U.S. Bureau of Labor Statistics, 2016). These statistics show that 2015 had the largest number of employed nurses in more than a decade; however, the LPN/VN population has actually seen a decrease (See Figure 1).

More than 250,000 advanced practice registered nurses (APRNs) are in the United States, categorized into four distinct roles: the certified nurse practitioner, the certified registered nurse anesthetist (CRNA), the certified nurse midwife (CNM), and the clinical nurse specialist. Certified nurse practitioners constitute nearly 70% of the total number of APRNs, with nurse practitioners reportedly numbered at 222,000 in 2014 (American Association of Nurse Practitioners, 2016). The CRNA accounts for approximately 20% of total APRNs. The American Midwifery Certification Board reported a total of 11,210 CNMs in 2015, approximately 3% to 4% of the total APRNs (AMCB, 2015).

Clinical nurse specialist numbers are a bit more difficult to estimate, as they have not been recognized in some states until fairly recently and still are not recognized in a few (Newland, 2016).

The trend for new graduates finding employment has improved each year since 2012 (See Table 1). In 2012, only 51% of new graduates had a job in less than 1 month after graduation. In 2016, 75% did. After 6 months, 97% had jobs compared with 86% in 2012 (National Student Nurses' Association [NSNA], 2016). The employment rate upon graduation did vary across regions, with the South having the highest number of employment opportunities (77% of new graduates were employed), and the West having the lowest (66% of new graduates employed) (American Association of Colleges of Nursing, 2016). Graduates of Bachelor of Science in nursing (BSN) programs continue to be employed as RNs at a greater percentage (92.73%) than those of associate degree in nursing, or ADN, programs (89.59%) or accelerated BSN programs (86.08%) (NSNA, 2016). Deans of baccalaureate programs (n = 576) reported that 54% of hospitals and other health care settings require new hires to have a BSN degree, a 6.6% increase from 2015.

The full article may be accessed at
[www.journalofnursingregulation.com/article/S2155-8256\(17\)30042-X/pdf](http://www.journalofnursingregulation.com/article/S2155-8256(17)30042-X/pdf)



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Next Generation NCLEX Special Research Section **Questions and Answers**

1. What is the special research section for?

The special research section is intended to collect data on new item types that could expand or enhance the measurement of entry-level nursing competence including clinical judgment.

2. What are the new item types that students can expect to see?

NCSBN is researching several item types, including: extended multiple response items, extended drag and drop items, CLOZE items, enhanced hot-spot items, dynamic exhibit items, and constructed response items.

3. What kind of information will be collected in the special research section?

The special research section will collect data on developing scoring rules, provide evidence of item characteristics and determine how much time candidates spend on each item.

4. How long will this research be conducted?

The first phase of the special research section is slated to occur between July and September 2017. Further special research sections may be included in future testing quarters depending on research needs.

5. What kind of candidates will be selected for the special research section?

Only NCLEX-RN candidates may be selected to participate in the special research section. A number of

factors determine whether or not a candidate will be given the special research section (e.g., the time remaining in their NCLEX appointment).

6. Will my performance on the special research section effect my NCLEX result?

No. Data derived from the research section will not be used to determine the candidate's result.

7. Will more information about the special research section come out soon?

Yes. Language informing candidates about the special research section is included in the regular correspondence to NCLEX candidates, on the NCSBN and Pearson VUE websites and provided via the NCSBN social media sites.

8. How long will the special research section take?

The special research section should take approximately 30 minutes to complete.

9. Is there a place that I can make comments regarding the new item type?

Please contact nclexinfo@ncsbn.org or 1.866.293.9600 for comments regarding the special research section.

10. How will the items be scored (e.g., partial credit, full credit, etc.)?

The special research section items will not be scored. One of the purposes of the special research section

is to gather the data needed to determine scoring methods for the new item types.

11. What resources/who created the new type of questions?

Expert nurses and psychometricians at NCSBN and Pearson VUE created the new item types based on the steps of the clinical judgement model. The content was validated with approved nursing references and by NCSBN subject matter expert reviewers.

12. What research has been conducted to validate the new item types?

Focus group studies, usability studies, and cognitive labs studies are either well underway or planned for future portions of this research project. The data from the special research section will be another step to collect important empirical evidence to validate new item types.

13. How can nursing schools incorporate the clinical judgement model into their curriculum?

The communication plan for this research project will include early communication between NCSBN and the nursing education community to ensure effective integration of the clinical judgement model into nursing education programs.

14. When will the new item types go into effect on the exam?

The new item types are still in the research and development phase and

the data gathered from the special research section will inform which item types are able to go through to further research steps.

15. Is the NCLEX going to change?

The new item types are still in

the research and development phase, the results of which will inform whether the items are appropriate for the measurement of entry-level nursing competence. More research data is required before it can be determined whether or not the NCLEX will change.



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CASE STUDIES

Case Study Number 1

Background: According to the Board's Advisory Opinion on Abandonment, the following requirements define patient abandonment: (1) The nurse must have first accepted the patient assignment, thus establishing a nurse-patient relationship. Accepting a patient assignment varies from setting to setting and requires a clear understanding of workload and agreement to provide care, and then (2) disengaged from the nurse-patient relationship without giving reasonable notice and report to the qualified person (e.g. supervisor, nurse) so that arrangements can be made for continuation of nursing care. Transfer of patient care requires reporting the condition, circumstances, and needs of all patients under the nurses' care, in oral or written form, to another nurse who acknowledges receipt and understanding of the report.

Case Facts: The Board received a complaint from a staffing supervisor at a skilled nursing facility, alleging a nurse accepted a 12-hour night shift through the nurse's employer, a local staffing agency. When the nurse arrived at the facility for the shift, the nurse told staff that he did not have his computer login information and did not feel comfortable working at this facility. Respondent stated he was going to leave the facility. Respondent left the facility and the staffing supervisor reported the behavior to the Board as possible abandonment.

According to the Complainant, the nurse had "accepted" the shift through the nurse's employer, the staffing agency, and then refused to work, which therefore constituted abandonment. Respondent said that he did not have his login information, and even when the login information was provided, Respondent refused to accept report and never began the shift. Further, according to the complaint, Respondent left the facility before the night supervisor could find a replacement for RN coverage.

The nurse stated that the staffing agency notified him that the skilled nursing facility was looking for a nurse for a night shift, where Respondent had worked shifts during the previous summer.

Respondent said that he would accept that shift since he worked there previously. Two hours prior to the start of the shift, the agency called the nurse again and notified him that there had been a change, and the nurse would be working in a different area within the facility. Respondent notified his employer that he had not worked in this area and at the very least would require an orientation to the unit. The employer informed him that everything had been taken care of and confirmed the nurse would receive an orientation on the unit. When the nurse arrived at the facility, he was informed that he would receive report, and would be the only nurse on duty that shift. Respondent informed the day shift nurse that he would not take report and requested to speak to a supervisor. The nurse informed the staffing office that he had not been there for at least two months, and they had changed their computer system since he had last been there. The nurse informed the supervisor that he was assured by his employer that he would be oriented to the unit prior to taking the shift. The nurse also told the supervisor that he had not yet taken report, and would not do so until he received a proper orientation.

Board Decision/Outcome: Respondent did not accept the patient assignment and there was RN personnel already within the facility. The Board dismissed the case.

Case Study Number 2

Background: According to the Arizona Nurse Practice Act, all certified or licensed personnel are to maintain confidentiality of the patient health record. The confidentiality of the record cannot be breached for personal reasons, or reasons other than involving the direct care of the patient. Patient confidentiality is regulated in the Arizona Nurse Practice Act and also in the Health Insurance Portability and Accountability Act (HIPAA).

Case Facts: The Board received a complaint from the nurses former family member alleging the nurse, while on duty as a LPN in a hospital, saw and confronted a relative from a family member's previous relationship ("Patient A"), who was visiting a relative recovering from surgery." The nurse allegedly used her employment

status to access the hospital's computerized medical records system. The family filed a complaint with the hospital, and following the facility investigation, the nurse's employment was terminated for misuse of company property, and violating patient confidentiality.

The nurse repeatedly denied that she accessed Patient As record. Investigators presented the screen shots of the nurse accessing this particular record, using her login.

Board Outcome: The Board voted to offer a Civil Penalty (a form of a disciplinary action with a monetary fee) for violating facility/employer policy, accessing patient information.

Case Study Number 3

Background: The Arizona Nurse Practice act allows discipline of a nursing license if the licensee is unfit or incompetent due to the use of alcohol, or is addicted to the use of habit-forming drugs and exhibits a pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location.

Case Facts: The Board received a complaint from hospital personnel alleging that the nurse was possibly under the influence of substances while on-duty and taking care of patients. Complainant said that the nurse came to work looking disheveled, odor of alcohol, evasive, shivering, at times would be hostile and argumentative, would disappear for extended amounts of time, and had dark marks on her upper arms. Complainant stated when she started working on the unit she was a "good nurse" and as time progressed, her appearance changed. The nurse was frequently tardy (up to several hours) and on one occasion left work before her shift ended. Complainant asserted that the nurse created an "unsafe hostile work environment," such as raising her voice when questioned and

had demonstrated frequent mood changes.

Interviews with other witness's revealed coworkers had become concerned that the nurse may have a substance use disorder. The coworkers' concerns related to the nurses attendance issues and also noticed needle "tracks" on one or both arms. The nurse would frequently ask coworkers if they needed help administering medications, including controlled substances, and would sign the drugs out under other nurse's names. Management received intermittent complaints from staff that Respondent would sleep while on duty and leave the unit for extended periods. Over the following months, it was reported that the nurse's absenteeism increased and during a meeting with management, disclosed that she used an illegal substance. It was not until after the nurse received a suspension notice that the nurse subsequently resigned in lieu of termination from the hospital.

Board Outcome: The Board issued an order to summarily suspend Respondent's nursing licensure, which ultimately led to revocation of the nurse's license.

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TOP 10 PATIENT SAFETY CONCERNS for Healthcare Organizations 2017

Why We Create This List

ECRI Institute creates this annual list of Top 10 patient safety concerns to support healthcare organizations in their efforts to achieve the following:

- Proactively identify potential threats to patient safety
- Improve patient safety by addressing concerns

This report offers perspectives from some of our many experts, as well as links to further guidance on addressing these issues.

How the Concerns Were Identified

In selecting this year's list, ECRI Institute relied both on data regarding events and concerns and on expert judgment. Since 2009, when our patient safety organization (PSO), ECRI Institute PSO, began collecting patient safety events, we and our partner PSOs have received more than 1.5 million event reports. That means that the 10 patient safety concerns on this list are very real. They are causing harm — often serious harm — to real people.

The process synthesized data from these varied sources:

- Routine review of events in the PSO database
- PSO members' root-cause analyses and research requests
- A survey of Healthcare Risk Control (HRC) members regarding their top patient safety concerns
- Topics reflected in weekly HRC Alerts
- Voting by a panel of experts from inside and outside ECRI Institute

But this is not an exercise in simple tabulation. The list does not necessarily represent the issues that occur most frequently or are most severe. Most organizations already know what their high-frequency, high severity challenges are. Rather, this list identifies concerns that might be high priorities for other reasons, such as new risks, existing concerns that are changing because of new technology or care delivery models, and persistent issues that need focused attention or pose new opportunities for intervention.

How to Use This List

Use this list as a starting point for conducting patient safety discussions and setting priorities. This list is not meant to dictate which issues an organization should address. Rather, it's intended to serve as a catalyst for discussion about the top patient safety issues faced by the organization.

Determine whether your organization faces similar issues that should be targeted for improvement. Organizations can investigate whether they are experiencing problems with these or related concerns — and whether they have processes and systems in place to address them.

Develop strategies to address concerns. The full report on the top 10 patient safety concerns discusses key strategies for each issue, and other ECRI Institute resources provide more in-depth guidance on individual topics. See page 14 for more information.

Consider applications across care settings. Although not all patient safety concerns on this list apply to all healthcare organizations, many are relevant to a range of settings across the continuum of care.



1 Information Management in EHRs

Healthcare providers have troves of information to manage, and the advent of electronic health records (EHRs) has brought this challenge to the forefront. **“But the object is still for people to have the information that they need to make the best clinical decision,”** says Lorraine B. Possanza, DPM, JD, MBE, senior patient

safety, risk, and quality analyst and health information technology (IT) patient safety liaison, ECRI Institute.

Healthcare organizations must approach health IT safety holistically. One key step is integrating health information management professionals, IT professionals, and clinical engineers into patient safety, quality, and

risk management programs. Other strategies include ensuring that users understand the system’s capabilities and potential problems, encouraging users to report concerns and investigating those concerns, engaging patients in information management, and harnessing the power of EHRs to enhance patient safety.

Unrecognized Patient Deterioration 2

Over the past few decades, concerted efforts have enabled speedier recognition of and response to stroke and heart attack. Certain other conditions—including sepsis, some maternal conditions, and serious postsurgical complications — **“need the same type of prompt recognition and attention in order for the patient to have a**

good outcome,” says Patricia N. Neumann, RN, MS, senior patient safety analyst and consultant, ECRI Institute.

Organizations must cultivate staff competencies in rapidly identifying conditions of concern. Practice (e.g., in simulations) and the use of tools (e.g., early-warning criteria) may aid speedy recognition.

Clinicians can proactively assess patients’ risk, plan for appropriate care and monitoring, educate at-risk patients, and supplement with technological monitoring. Organizations can develop condition specific protocols for an organized and speedy response and analyze work systems and processes to identify and address barriers.

3 Implementation and Use of Clinical Decision Support

Clinical decision support (CDS) encompasses **“tools that we use to ensure that the right information is presented at the right time within the workflow,”** explains Robert C. Giannini, NHA, CHTS-IM/CP, patient safety analyst and consultant, ECRI Institute. But if use is suboptimal, opportunities may be missed. Patient harm—as

well as disruption of clinical workflows and provider frustration—could result.

Healthcare organizations must design CDS systems judiciously; resources are available from HealthIT.gov, ECRI Institute, and others. A multidisciplinary team should have oversight. End users must be trained in the proper use of CDS, as well as their

roles and responsibilities, and have access to support structures.

On an ongoing basis, organizations should monitor the effectiveness and appropriateness of CDS alerts, evaluate the impact on workflow, and review staff response to alerts. The tool should be redesigned as necessary.



4 Test Result Reporting and Follow-Up

Testing is a complex process. When inadequately managed, this complexity can contribute to fragmentation. **“Sometimes as clinicians we become very task oriented—labs ordered, blood drawn and sent; imaging ordered, x-ray completed—and we lose sight of the big picture,”** says Kelly C. Graham, RN, patient safety analyst

and consultant, ECRI Institute. **“Critical thinking and teamwork get lost when you’re focusing just on your assigned task.”**

Organizations should analyze their test result reporting systems and monitor their effectiveness in triggering appropriate follow-up. Policies and procedures should clearly designate accountability for acting on test

results. To help close the loop, organizations can facilitate two-way conversations among healthcare professionals involved in treatment and those involved in diagnostic testing.

Patient engagement and health literacy strategies can be used to teach patients what to do—and why it is important.

Antimicrobial Stewardship 5

Today, drug choices for treating many bacterial infections are becoming increasingly limited and expensive—and in some cases, nonexistent. Inappropriate prescribing is a key factor. **“If prescribing habits do not change, more people will die from infections for which there is no treatment,”** says Sharon Bradley, RN, CIC, senior

infection prevention analyst, ECRI Institute.

Healthcare organizations may decide to hold prescribers accountable for adherence to treatment guidelines. A physician advocate can lead the effort and talk to other physicians as a peer.

Organizations can also educate patients, family members, and the

general public about antimicrobial stewardship and the reasons behind it.

The Centers for Disease Control and Prevention has outlined core elements for antibiotic stewardship for hospitals, nursing homes, and outpatient settings. To identify gaps, organizations can use the checklists included in each set of core elements.

6 Patient Identification

Although the majority of the 7,613 events analyzed for ECRI Institute PSO’s Deep Dive: Patient Identification were caught before they caused patient harm, about 9% resulted in patient injury, including two deaths. **“The report brought national attention to an issue that most healthcare providers recognize as a significant problem,”**

says William M. Marella, MBA, MMI, executive director, PSO operations and analytics, ECRI Institute.

Leaders can start by fully supporting patient identification initiatives—by prioritizing the issue, engaging clinical and nonclinical staff, and asking staff to identify barriers to safe identification practices, for example.

Redundant processes for patient identification can increase the likelihood of preventing patient mix-ups. Elements such as electronic displays and patient identification bands may be standardized. When used as intended, bar-code systems and other technologies can also support safe patient identification.

7 *Opioid Administration and Monitoring in Acute Care*

In analyzing events for its upcoming Deep Dive on opioid safety, ECRI Institute PSO noted problems with opioid administration and patient monitoring. **“We’re seeing the same issues with administration that you see with other medications,”** says Gail Horvath, MSN, RN, CNOR, CRCST, patient safety analyst and consultant, ECRI Institute. However, **“unlike with some of these**

other medications, opioids can have catastrophic consequences.”

The organization may wish to evaluate and address work system and process factors that may contribute to opioid administration errors, such as organizational culture and workload. Best practices can be implemented for processes including patient identification, medication purchasing, labeling,

dispensing, use of bar-code medication administration systems, and independent double checks.

Staff must carefully assess patients before and after administration—using an opioid-induced sedation scale, for example. For certain patients, capnography or minute ventilation monitoring can supplement nurse monitoring.

Behavioral Health Issues in Non-Behavioral-Health Settings 8

Healthcare organizations do not always recognize when a patient has behavioral health needs—and the patient’s needs may therefore go unmet. Some unmet behavioral health needs can cause hostile or aggressive behavior, which can frighten or frustrate staff, especially if they lack training or support. Patients and staff can be injured,

sometimes seriously. **“We’re very reactive, and that’s part of the problem,”** says Nancy Napolitano, patient safety analyst and consultant, ECRI Institute.

Comprehensively assessing all patients can help providers proactively determine patients’ behavioral health needs. All staff should be trained to recognize early signs

or cues of behavioral health needs, use nonoffensive techniques, and de-escalate a situation and participate in frequent drills.

Behavioral emergency response teams, which staff can call when a patient’s behavior becomes agitated or threatening, can be implemented to support early assessment and response.

9 *Management of New Oral Anticoagulants*

Since 2010, four new oral anticoagulant medications have been approved. In an analysis of ECRI Institute PSO events involving these agents, almost 34% of events for which a harm score was provided resulted in patient harm, ranging from temporary injuries to death. **“We need more awareness of the proper use**

of the agents; it’s not ‘one size fits all’ and you’re done,” says Stephanie Uses, PharmD, MJ, JD, patient safety analyst and consultant, ECRI Institute.

Standardized order sets should specify doses for the different medications based on indication. Organizations can use CDS to alert practitioners to duplication

of therapy and track response to alerts. A multidisciplinary team should develop plans for reversal of anticoagulant therapy, and reversal agents should be readily accessible. Collection and analysis of events involving new oral anticoagulants can help organizations identify further prevention strategies.



10 *Inadequate Organization Systems or Processes to Improve Safety and Quality*

Numerous studies show a link between error prevention and a culture of safety. Nevertheless, healthcare organizations have been slow to adopt all the necessary features of a high-reliability organization. Root-cause analyses are vital, but Elizabeth Drozd, MS, MT(ASCP), CPPS, patient safety analyst and consultant, ECRI Institute, also recommends

that organizations **“be proactive rather than waiting until a patient is harmed.”** Proactive strategies can be used to examine processes, identify what can go wrong, and make the process less vulnerable to error before mistakes can occur. Strong preventive strategies, such as standardization and automation, should be explored.

Leaders should support a “just culture” that emphasizes learning rather than blaming. Individual accountability must be balanced with organizational responsibility to design and improve systems to ensure safe care. Finally, all organizations should have an actionable quality and patient safety plan with high-level approval.



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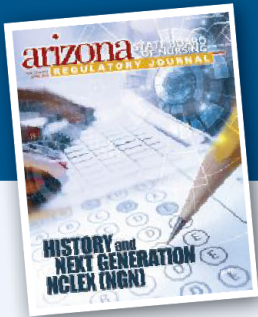
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3/31/2017	Aguiniga Cervantes, Maria G.	CNA999989241	Decree of Censure
12/29/2016	Alari, Jennifer M.	CNA999996207	Revoked
3/8/2017	Anderly, Jessica J.	CNA1000031558	Revoked
3/21/2017	Anderson, Brendon J.	CNA Applicant	Certificate Denied
10/24/2016	Barlow, Oskar	CNA Applicant	Certificate Denied
3/14/2017	Berg, Tina A.	CNA Applicant	Certificate Denied
3/8/2017	Burns, Todd D.	CNA1000021667	Revoked
2/10/2017	Campos, Guadalupe K.	CNA1000028389	Voluntary Surrender
1/27/2017	Cheeseman, John K.	CNA Applicant	Certificate Denied
10/26/2016	Clayton, Ronald J.	CNA1000034224	Revoked
*2/8/2016	Cota, Michelle A.	CNA1000009139	Decree of Censure
11/21/2016	Curd, Nicholas D.	CNA Applicant	Certificate Denied
1/4/2017	Eakin, Susan L.	CNA157193803	Revoked
1/30/2017	Eggen, Tara L.	CNA1000012368	Voluntary Surrender
2/14/2017	Erwin, Audrey J.	CNA1000039373	Voluntary Surrender
3/6/2017	Estrada, Socorro	CNA1000008487	Revoked
1/26/2017	Fenner, Shina D.	LNA1000017357	Revoked
1/23/2017	Fredericks, Tiffani A.	CNA1000009988	Stayed Suspension
3/8/2017	Fuller, Paula L.	CNA239233103	Revoked
3/6/2017	Gamboa, Amanda D.	CNA1000028183	Revoked
1/4/2017	Geer, Tracy S.	CNA1000005163	Revoked
1/19/2017	Gupta, Rebekah L.	CNA Applicant	Certificate Denied
3/7/2017	Hayes, Genevieve M.	CNA1000026578	Revoked
3/14/2017	Heacox, Julie D.	CNA Applicant	Certificate Denied
10/3/2016	Hendrix, Tiffany R.	CNA Applicant	Certificate Denied
12/2/2016	Hill, Carlisa M.	CNA Applicant	Certificate Denied
10/26/2016	Ijams, Ben T.	CNA999996590	Revoked
11/28/2016	Jackson, Erika E.	CNA Applicant	Certificate Denied
2/16/2017	Johnson, Kimberly R.	CNA563102641	Reinstatement Denied
12/20/2016	Johnson, Matilda A.	CNA461686803	Decree of Censure
2/23/2017	Julian, Brian A.	CNA1000042419	Decree of Censure
10/11/2016	Kaisand, Kimberly A.	CNA1000053063	Decree of Censure
1/20/2017	Kamara, Mamayan	CNA Applicant	Certificate Denied
1/4/2017	Keams, Marguerite M.	CNA805562803	Revoked
11/21/2016	Kormos, Kevin J.	CNA Applicant	Certificate Denied
12/27/2016	Kuyateh, Mickey M.	CNA1000000495	Revoked
1/19/2017	Larussa, Karen L.	CNA Applicant	Certificate Denied
11/21/2016	Lee, Gilmore	CNA Applicant	Certificate Denied
11/3/2016	Lee, Yvette C.	CNA Applicant	Certificate Denied
10/24/2016	Lenoir, Lakisha A.	CNA Applicant	Certificate Denied
12/14/2016	Levene, Adrianna M.	CNA1000045813	Voluntary Surrender

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
10/3/2016	Limon, Eliza Y.	CNA Applicant	Certificate Denied
3/6/2017	Lino, Joan M.	CNA999988803	Revoked
3/7/2017	Listo, Colleen G.	CNA999948305	Revoked
*9/6/2016	Lobina, Whitney T.	CNA Applicant	Certificate Denied
3/24/2017	Lucien, Felix G.	CNA1000027847	Revoked
12/8/2016	Matthews, Chanae C.	CNA1000053723	Decree of Censure
3/7/2017	Mcbeth, Latonia A.	CNA1000002630	Reinstatement Denied
10/26/2016	Mchardy, Shannon L.	CNA Applicant	Certificate Denied
11/25/2016	Medlin, Marcella A.	CNA Applicant	Certificate Denied
11/25/2016	Mickey, Ciera N.	CNA Applicant	Certificate Denied
3/16/2017	Monroe, Amanda K.	CNA999993257	Decree of Censure
1/20/2017	Montijo, Brian J.	CNA1000054246	Revoked
3/14/2017	Moreno, Rosa O.	CNA Applicant	Certificate Denied
2/6/2017	Murphey, Scott J.	CNA Applicant	Certificate Denied
12/2/2016	Nez, Ranae M.	CNA Applicant	Certificate Denied
1/3/2017	Ojeda, Elizabeth H.	CNA1000034885	Revoked
3/8/2017	Owens, Cecilia E.	CNA1000016896	Revoked
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11/9/2016	Porter, Latrice N.	CNA Applicant	Certificate Denied
3/21/2017	Price, Marquerita N.	CNA Applicant	Certificate Denied
10/26/2016	Quintero, Brian A.	CNA1000036831	Revoked
2/24/2017	Reed, Nathania J.	CNA1000009965	Voluntary Surrender
10/20/2016	Riggs, Candace C.	CNA Applicant	Certificate Denied
11/28/2016	Rincon, Robert M.	CNA1000041010	Decree of Censure
12/7/2016	Roberts, Sylvan N.	CNA1000053645	Civil Penalty
10/3/2016	Salazar-Rojas, Joel I.	CNA Applicant	Certificate Denied
10/21/2016	Sanchez, Gloria	CNA193620213	Renewal Denied
1/23/2017	Sartin, Amanda J.	CNA1000044173	Voluntary Surrender
3/20/2017	Sepulveda, Mary Helen	CNA Applicant	Certificate Denied
11/18/2016	Silver, Chelsey A.	CNA Applicant	Certificate Denied
10/27/2016	Sterling, Latricia V.	CNA Applicant	Certificate Denied
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10/26/2016	Thompson, Charles S.	CNA1000041782	Revoked
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3/7/2017	Vyamungu, Venant	CNA1000034782	Revoked
10/3/2016	Walden Celaya, Enedina D.	CNA Applicant	Certificate Denied
3/6/2017	Willess, Jordan M.	CNA1000049611	Voluntary Surrender
2/23/2017	Williams, Delores M.	CNA999998039	Voluntary Surrender
*9/16/2016	Woody, Delphina	CNA1000013225	Stayed Suspension

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
10/3/2016	Ajeakwa, Comfort A.	RN Exam	License Denied
2/8/2017	Alexander, Robert T.	RN159971/AP3870/AP10014	Decree of Censure
10/26/2016	Allen, Roger G.	RN169677/CNA1000017600	Revocation
12/6/2016	Amick, Kelsie R.	RN186922	Voluntary Surrender
1/3/2017	Anchondo, Brandy N.	LP049817	Decree of Censure
3/20/2017	Anderson, Debra L.	RN041529	Voluntary Surrender
1/20/2017	Anderson-Cole, Dawn M.	LP043396	Voluntary Surrender
11/17/2016	Anderson-Cole, Dawn M.	LP043396	Summary Suspension
11/17/2016	Armstrong, Carrie S.	TRN204637	Stayed Revocation with Probation
3/21/2017	Arnett, Aaron	RN171155	Voluntary Surrender
10/26/2016	Arnold, Jacqueline	LP045182	Revocation
12/20/2016	Ayoub, Sultan Y.	RN138359/AP3529	Summary Suspension
12/20/2016	Baty, Joshua J.	LP051774/CNA1000030505	Summary Suspension
3/6/2017	Baty, Joshua J.	LP051774/CNA1000030505	Voluntary Surrender
2/15/2017	Beck, Mindy L.	TRN206229	Limited Licensure
10/7/2016	Bennett, Carrie A.	Compact - IA RN115934	Voluntary Surrender-Privilege to Practice
2/27/2017	Bianco, Megan M.	RN157099	Stayed Revocation with Suspension
12/30/2016	Bishop, Melissa R.	RN142926	Voluntary Surrender
10/13/2016	Bonvillain, Rita S.	LP044275	Reissuance Denied
10/3/2016	Bowen, Kristy A.	RN162464	Voluntary Surrender
10/25/2016	Boyle, Rebecca L.	RN114982	Revocation
12/21/2016	Bracamonte, Elisa R.	RN038748	Stayed Revocation with Probation
10/26/2016	Brenner, Jeanne	RN096503	Revocation
1/27/2017	Burtman, Svetlana	RN133876/AP4511	Decree of Censure
3/14/2017	Campos Salinas, Jessica Y.	LP049077	Decree of Censure
3/20/2017	Cline, Kelli D.	LP040707	Decree of Censure
10/24/2016	Coenen, Amy L.	RN170880	Voluntary Surrender
2/22/2017	Coleman, Tana L.	RN102493	Voluntary Surrender
12/7/2016	Datingaling, Josefina G.	RN063058	Probation
1/3/2017	Delaney, Kathryn L.	LP021963	Voluntary Surrender
1/3/2017	Delashmit, Sarah A.	RN182674	Revocation
11/30/2016	Disner, Paul M.	RN094413	Voluntary Surrender
2/2/2017	Donley, Patricia J.	RN184407	Voluntary Surrender
1/19/2017	Dooley, Jenna A.	RN174038	Voluntary Surrender
1/3/2017	Dovgan, Lori S.	RN066495	Revocation
10/26/2016	Dumas, David G.	RN179325	Revocation
3/25/2017	Ebereonwu, Laura C.	RN170503	Stayed Revocation with Suspension
10/14/2016	Egnash, Brandi M.	RN183854	Revocation

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
2/28/2017	Ekereuke, Catherine O.	RN112447	Decree of Censure
10/16/2016	Esparza, Rachel M.	RN159484/LP044593	Voluntary Surrender
3/13/2017	Fairchild, Tabitha A.	LP046733	Voluntary Surrender
3/24/2017	Fisher, Elliott E.	LP035306/CNA280101339	Revocation
1/19/2017	Flores, Tania M.	LP049386	Stayed Suspension with Probation
10/21/2016	Francis-Lindsay, Christina	Reissuance Applicant	Reissuance Denied
3/2/2017	Garcia, Davina B.	RN166106	Decree of Censure
1/3/2017	Garman, Montsho	RN159778	Revocation
11/15/2016	Gay, Loretta M.	RN160976	Voluntary Surrender
1/26/2017	Gorsuch, Jasmine E.	LP045725	Summary Suspension
12/19/2016	Graven, Mara J.	RN204458	Decree of Censure
11/15/2016	Grizer, Bruce E.	RN Endorsement	License Denied
11/18/2016	Gyles, Thomas S.	RN180698	Stayed Revocation with Probation
3/10/2017	Hackl, Rachel E.	RN094663/AP1413	Decree of Censure
11/17/2016	Hackman, Felix	RN145614	Decree of Censure
3/8/2017	Hall, Joseph D.	RN165503	Revocation
12/19/2016	Hamilton, Jennifer L.	RN162294	Stayed Revocation with Probation
12/27/2016	Harlan, Sherry A.	RN102537	Reissuance Denied
1/27/2017	Harmer, Brian J.	RN152301	Probation
3/6/2017	Hasson, Michelle L.	LP045510	Decree of Censure
1/3/2017	Headlee, Stacey L.	RN155349	Revocation
10/25/2016	Heard, Lee A.	RN094404	Revocation
3/1/2017	Henao, Dario E.	RN164718	Probation
10/26/2016	Henley, Nicole L.	RN164826	Probation
10/26/2016	Hensley, Melissa E.	RN152796	Revocation
12/15/2016	Hernandez, Annelle M.	RN145607	Civil Penalty
10/25/2016	Hiller, Jill M.	RN085361	Voluntary Surrender
3/20/2017	Hines, Andrea L.	LP048200/CNA1000013278	Voluntary Surrender
12/14/2016	Hoefl, Cassandra A.	LP053407	Probation
10/11/2016	Holliday, Lee	RN039226/AP0099	Decree of Censure
10/26/2016	Hollingsworth, Mary G.	RN090421/LP029017	Revocation
3/8/2017	Honaker, Erin K.	LP044685	Revocation
1/19/2017	Hoy, Ann V.	RN079222	Voluntary Surrender
12/27/2016	Hughes, Sukanlaya	RN151776/AP4387/SN1019/LP042913	Revocation
12/2/2016	Iannoli, Gina E.	RN147241	Decree of Censure
12/20/2016	Johnson, Cora M.	RN124360	Probation
3/21/2017	Johnson, Jenny L.	RN Endorsement	License Denied
10/31/2016	Johnson, Matthew	RN150245/CNA1000008748	Stayed Revocation with Suspension
1/4/2017	Jones, Jennifer L.	RN131539	Revocation
10/21/2016	Jones, Linette M.	RN Endorsement	License Denied

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
11/23/2016	Kaymen, John C.	RN156179/LP044073	Voluntary Surrender
3/24/2017	Kearney, Robert A.	RN161218	Decree of Censure
11/21/2016	Knapp, Michelle M.	RN Endorsement	License Denied
3/7/2017	Kochheiser, Dana E.	RN076433	Revocation
10/26/2016	Lange, Karen C.	LP020675	Revocation
3/16/2017	Lawlyes, Tyler J.	RN199340	Stayed Revocation with Suspension
1/4/2017	Lawson, Marilyn L.	RN140278	Revocation
10/26/2016	Lewis, Jonathan M.	RN132908	Probation
11/7/2016	Liu, Qing	RN178970	Voluntary Surrender
12/14/2016	Llacuna, Kira L.	TRN095176	Reissuance Stayed Revocation with Probation
2/16/2017	Lonergan, Sophia E.	RN157092/AP3346	Decree of Censure
10/21/2016	Long, Sandra K.	RN079849//AP2928	Revocation
11/1/2016	Lopez, Tamara R.	LP037918/CNA999990763	Probation
12/30/2016	Lott, Paige E.	RN169981/SN1088	Decree of Censure
12/27/2016	Ludwig, David E.	RN153178	Revocation
10/26/2016	Lynn, Paula W.	RN154886	Revocation
03/21/2017	Martin, Betty	LP966304	Voluntary Surrender
3/23/2017	Marzley, Michael A.	RN147571	Stayed Revocation with Suspension
2/23/2017	Mayes, Jocelyn R.	RN141319	Decree of Censure
1/27/2017	Mazur, Dennis P.	RN122325	Probation
12/6/2016	McCarthy, Mary J.	LP022531	Voluntary Surrender
2/17/2017	McConnell, Matthew J.	RN118329/AP3837	Probation
11/17/2016	McEntire, Paula A.	RN165738/LP041680	Decree of Censure
11/3/2016	Mendoza, Emilia F.	LP044153	Probation
12/27/2016	Menendez, Miguel	RN184986	Revocation
10/3/2016	Meyer, Jean H.	RN042915	Stayed Revocation with Probation
3/3/2017	Miller, Cindy J.	RN Exam	License Denied
10/26/2016	Miller, Judy E.	RN175254	Revocation
1/3/2017	Mills, Leonard C.	RN140911	Revocation
1/3/2017	Mims, Raphael I.	LP049984	Revocation
1/25/2017	Moctezuma, Christine L.	LP042684	Voluntary Surrender
11/17/2016	Mohammed, Camille Angeli V.	RN189942	Stayed Suspension with Probation
10/25/2016	Mollenhauer, Sarah A.	LPN Endorsement	License Denied
3/7/2017	Momon, Debra	LP024121	Revocation
11/17/2016	Moran, Jaime	RN204408	Decree of Censure
12/12/2016	Morgan, Kim L.	RN167965/LP041400	Decree of Censure
3/9/2017	Mortensen, Laurie J.	RN098399	Voluntary Surrender
1/6/2017	Mueller, Brita L.	RN171349	Voluntary Surrender
11/7/2016	Nelson, Brandee M.	LP041405	Voluntary Surrender
2/9/2017	O'Brien, Robert W.	RN125649	Stayed Revocation with Probation

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
12/19/2016	O'Brien, Terrence C.	LP024743	Decree of Censure
2/2/2017	Odongo, Joyce R.	RN170219	Decree of Censure
11/17/2016	Palmer, Mauda K.	RN094532	Summary Suspension
10/11/2016	Parsons, Elizabeth	RN157544	Voluntary Surrender
3/8/2017	Patterson, Rochelle A.	RN101879	Revocation
10/11/2016	Penne, Kay L.	RN203378	Probation
11/17/2016	Perez Canez, Felicia	LP047645	Civil Penalty
11/16/2016	Perotti, Shawn C.	RN167275	Civil Penalty
3/15/2017	Pius, Pfon T.	LP045093	Decree of Censure
10/3/2016	Poe-Ami, Delores	RN088587	Decree of Censure
2/2/2017	Ponwith, Vincent G.	RN075299	Voluntary Surrender
1/4/2017	Port, Kerin C.	RN129303	Revocation
3/7/2017	Pratt, Jillian M.	RN153478	Revocation
1/27/2017	Raichert, Jayme L.	RN140707	Probation
1/27/2017	Ramsey, Prudence A.	RN169503	Voluntary Surrender
1/12/2016	Randall, Jeffrey S.	LP044667	Voluntary Surrender
12/12/2016	Randhawa, Jasmine K.	RN165766	Civil Penalty
1/26/2017	Rangel, Shannon M.	LP041945	Summary Suspension
12/16/2016	Robinson, Dawn R.	RN174550	Stayed Suspension with Probation
10/12/2016	Rodriguez, Amy L.	RN134521	Revocation
10/20/2016	Rodriguez, Cheryl M.	LP038152	Decree of Censure
3/23/2017	Romo, Patricia G.	RN056655/AP2342	Decree of Censure
11/9/2016	Russell, Chauncy M.	RN159130/CNA1000008877	Stayed Revocation with Probation
1/4/2017	Sabala, Hillary A.	LP041714	Revocation
2/14/2017	Sanchez, Ryan M.	LP049668	Voluntary Surrender
11/29/2016	Santos, Judith	RN098132	Probation
11/3/2016	Scalmato, Rose	RN126372	Voluntary Surrender
1/3/2017	Schilt, Blanche K.	RN201369/CRNA1215	Voluntary Surrender
1/4/2017	Schmieg, Gerald L.	RN118265	Revocation
1/4/2017	Sedita, Allison J.	RN150879	Revocation
11/14/2016	Silva, Michelle A.	LPN Endorsement	License Denied
1/4/2017	Skinner, Kathy A.	RN163557	Revocation
10/14/2016	Smith, Mary K.	RN140579	Voluntary Surrender
10/21/2016	Sotelo, Rebecca	Reissuance	Reissuance Denied
3/15/2017	Spinuzzi, Jodi G.	LP043771	Decree of Censure
2/21/2017	Stanford, Mary B.	RN076792	Revocation
2/3/2016	Starkey, Alana M.	RN175676	Voluntary Surrender
1/6/2017	Talboy, Patricia J.	RN179821/LP048655	Civil Penalty
1/3/2017	Theut, Olivia J.	RN195373	Stayed Revocation with Probation
10/28/2016	Thomas, Kimberly A.	LP033839/CNA177805510	Voluntary Surrender

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
11/17/2016	Thompson, Jilaine	Compact Nurse-VA	Summary Suspension of Nurse Multi-State Licensure Privilege
3/2/2017	Thompson, Michael G.	RN085632	Voluntary Surrender
3/24/2017	Todd, Amber C.	LP044168/CNA1000008127	Stayed Revocation with Suspension
1/4/2017	Todd, Nicole T.	RN174751/LP047951	Revocation
1/19/2017	Torres, Teresa S.	RN035464	Voluntary Surrender
1/30/2017	Villa, Crystal M.	RN195179	Voluntary Surrender
2/14/2014	Villarreal, Kelly N.	RN205843	Probation
11/30/2016	Vlasic, Andrea T.	RN144982	Stayed Revocation with Suspension
3/9/2017	Weigand, Linda	RN128658	Stayed Revocation with Suspension
12/20/2016	Whiteaker, Brett A.	RN168273	Summary Suspension
3/1/2017	Williams, Debourne A.	RN206425	Probation
3/8/2017	Williams, Terri L.	LP Endorsement	License Denied
11/2/2016	Wright, Preston A.	RN191098	Probation
10/31/2016	Young, Angela D.	RN176855	Voluntary Surrender
12/23/2016	Young, Courtney L.	RN112461	Decree of Censure
10/6/2016	Zielsdorf, Lee M.	RN203380	Probation



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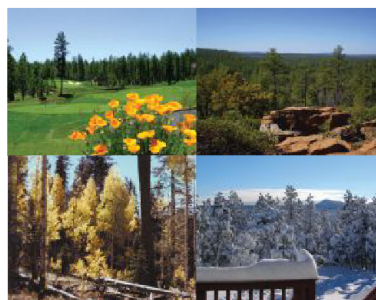
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