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Discovering Evidence for Effective Regulation

Joey Ridenour Inducted into the American Academy of Nursing

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Discovering Evidence for Effective Regulation

The journey to adopt "*Evidenced Based Regulation*: A *Regulatory Performance Measurement System*" was begun approximately ten years ago. National Council State Boards of Nursing (NCSBN) Board of Directors appointed a project advisory group in 1998 to partner with the Urban Institute to provide the oversight and guide development of a performance measurement system entitled *Commitment to Ongoing Regulatory Excellence* (CORE). The research and analysis of quantitative and empirical data has assisted boards in carrying out their mission to protect the public by isolating weaknesses and identifying strengths. The "evidence" or data has also assisted the 42 participating boards of nursing to make connections between performance differences and best practices.

The metrics deemed essential to understand the "operational health" of the board of nursing in fulfilling its public protection mission are:

1. Staff productivity (i.e. number of applicants licensed/investigative cases processed/educational programs approved)
2. Cost effectiveness (i.e. expense calculations per licensee)
3. Cycle times (i.e. processing of licensure applications and investigations)

Stakeholder satisfaction and perceptions are also critical to understanding the "operational health" of the regulatory board. The ratings and opened ended questions provided information to direct efforts in gaps in service.

The CORE measurement categories reported in this quarter of the Arizona State Board of Nursing Regulatory Journal represent a "dashboard of measures" for the evidenced based regulation framework. Similar to a dashboard in an airplane, which provides the pilot an overview of the critical functions of the airplane, the board dashboard provides you with a high level of understanding of how we are performing.

Beyond the numbers, we ultimately want to know how to improve our outcomes in better protecting the public. The Arizona State Board of Nursing finds the connection between the numbers and regulatory practices that drive performance is a way to achieve this.

Dr. Kevin Kenward, Director of Research, National Council State Boards of Nursing, in conjunction with the Commitment to Ongoing Regulatory Excellence Committee, provides the connections between the performance differences and identified best practices. "Discipline, Licensure, Educational Program Approval, Practice and Governance Best Practices" were based on interviews with those boards receiving the highest ratings in the CORE research and have been provided on page 12.

As Dr. Peggy Reiley, Senior Vice President & Chief Clinical Officer, Scottsdale Healthcare, recently stated about the status of becoming a "Magnet Hospital," the process of journeying to improve and be accountable for outcomes was the most important part of becoming a magnet facility.

Evidenced based regulation is also a journey of measuring outcomes and being accountable to you and the public.

Joey Ridenour RN MN FAAN

Joey Ridenour, RN, MN, FAAN

From the Board President
KAREN HARDY, RN MSN

What is Palliative Care?

During the course of the past three years, a number of family members have testified before the Board of Nursing that their loved ones did not receive the care needed at end of life. Many times, as licensed nurses have come before the Board and have described their interventions for control of patients' symptoms at their end of life, I have pondered, "How could the patients quality at the end of his life turned out differently?" "How could the nurse and system support more effective interventions?" Many times, I ask the nurse, "Does your hospital/institution have a Palliative Care Service?"

Some nurses respond: "What is Palliative Care and how do I find out more about it?" I encourage nurses to review the literature about Palliative Care and share the evidence with their colleagues. If they are in agreement with the evidence that palliative care improves the quality of life, they are encouraged to make the case for offering palliative care services at their institution.

The American Hospital Association reports that 22.2 percent of all U.S. hospitals have palliative care programs. (Center to Advance Palliative Care, 2007). At Yuma Regional Medical Center (YRMC), the Bio-Ethics committee took the lead and began to study ethical issues at end of life, which then led to a journal club for more study. Subsequently, a business proposal was submitted to the hospital operating board, medical executive committee and the administrative team. YRMC now has a Palliative Care cost center which funds a nurse and a physician medical director. These two professionals lead a multidisciplinary palliative care consult team and foresee this service evolving to an inpatient unit in the future.

Palliative care is an evidenced based, cutting edge movement which has emerged from hospice care. Hospice care provides palliative care but focuses on terminally ill patients who no longer seek treatments to cure their illness and are expected to live for six months or less (Center to Advance Palliative Care). Hospice is a program of care provided based on the understanding that dying is part of the normal life cycle. Hospice supports the patient through the dying process and the family through the dying and bereavement. (Ferrell & Coyle, 2001).

Palliative Care is the active total care of patients whose disease is not responsive to curative treatment… where control of pain, of other symptoms, and of psychological distress and spiritual distress is paramount (Ferrell and Coyle). The hallmark of palliative care is to ensure that patients do not suffer from uncontrolled symptoms by providing care through a multidisciplinary team in conjunction with medical and alternative/complementary treatments. The goal of palliative care is to relieve suffering and improve quality of life for patients with advanced disease.

Many patients access acute care facilities due to exacerbated symptoms of chronic or terminal disease processes that produce many symptoms. It has become paramount for these institutions to help the patient confront the reality of the illness and make decisions regarding care and transition in the continuum which may be hospice, nursing home or home health. Palliative care team members have become the experts at giving end of life information/news, coordinating family meetings, communicating with bedside care givers and including the patient and family in all decision making.

In turn, this care has provided patients with a higher level of quality of life as well as level of satisfaction. Their pain and symptoms are being treated vigorously. According to CAPC, over 90 percent of pain episodes can be treated with standard analgesic therapies closely monitored by a palliative care program. Patients appreciate having a voice in their care (Center to Advance Palliative Care). Palliative care follows a regime of setting realistic goals of care which include the patient and family. Patients feel as if their care is more coordinated and someone is helping them navigate the medical system. Furthermore, palliative care patients express a feeling of their care being closely monitored and well communicated, thus a feeling of increased safety.

Nursing staff express satisfaction with the added support of this team at the bedside. Communicated goal setting and proactive care planning expedite care and allow bedside caregivers to follow the agreed upon care, often reducing unnecessary tests and pharmaceuticals (Center to Advance Palliative Care).

The palliative care experience with impressive clinical outcomes has had an effect on the quality of end of life for patients by providing them with similar standards of better symptom control, relief of distress and help with difficult decision making. Palliative care is imperative to future healthcare and for the growing population living with advanced disease states. I believe that education on palliative care can improve the end of life outcomes.

For more information on palliative care, you can access the following Web sites:

Center to Advance Palliative Care
www.capc.org • www.getpallaitivecare.org
Hospice and Palliative Nurses Association
www.hpna.org
National Consensus Project for Quality Palliative Care
www.nationalconsensusproject.org
National Hospice and Palliative Care Organization (NHPCO)
www.nhpco.org

If you have questions about palliative care or starting a consult service in your institution, feel free to contact me at khardy@yumaregional.org.

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Commitment to Ongoing Regulatory Excellence (CORE)

Arizona Dashboard Report • Data Received June 2007 • Arizona State Board of Nursing Regulatory Journal
Joey Ridenour RN MN FAAN

Dashboard Average Licensees

	2002 n	Aggregate	Arizona	2005 n	Aggregate	Arizona n	Var.
RN	30	65,426	50,486	41	70,306	58,657	
LPN/ LVN	29	17,044	9,160		17,563	11.221	
Total	33	74,456	59,646	42	84,522	69,878	+17%

Arizona APRN/RN/LPN Licensees as of 10/16/07: 77,979 or approximately 30% more nurses licensed in last five years
Real time data available: www.azbn.gov

Dashboard Expense Calculations Per Licensee

	Aggregate	n	Arizona	Variance
2002	$42.59	22	$42.74	
2005	$37.91	26	$33.34	<12%> Below Aggregate

Arizona expenses are $4.67 less per licensee than similar Boards.
Percentage expenditures by functional area are: Investigations/discipline- 61%; Licensure – 9%; Educational Programs – 5%; Other Indirect Expenses – 25%

Dashboard Estimated Days to Resolve Cases FY 2005

2005	n	Aggregate Average	Arizona	Variance
Number of Days	31	274 7.3 month	218 9.13 months	<1.87 months> Below Aggregate

FY 2008 data to resolve cases is ranging 6.8 – 7.2 months.

Dashboard Cases Opened for Investigation

2004 n	n	Aggregate Average	Arizona	2005 n	Aggregate Average	Arizona	Variance
Cases Opened	30	388	459	31	401	404	+.007%

In 2005 Arizona opened approximately the same number of APRN/RN/LPN Cases as other similar boards. Perception has been that perhaps Arizona opened more cases than other boards.

Dashboard FY 2005 APRN/RN/LPN New Cases Assigned Investigators

	n	Aggregate Average	Monthly Average	Arizona Average	AZ Monthly Average	Variance
Number New Cases Asssigned	33	826	69	758	63	<68> yr. <6> mo.
Number of Cases per Investigator				126 annually	10.5 month	

Arizona opens approximately 60 cases per month on APRN/RN/LPN's and approximately 70 investigative cases for certified nursing assistants.

Dashboard Processing Licensure Applications From Receipt of Required Information

FY 2005	n	Aggregate Average	Arizona	Variance
APRN	19	9 days	3.31 days	<5.69> days less than aggregate
RN	27	18 days	0.78	<17.22> days less than aggregate
LPN	23	16	1.98	<14.02> days less than aggregate
Licensure Verification to Another Board of Nursing	15	8	14	+6 days greater than aggregate

Dashboard Stakeholders Data: Nurses

	2002 Agrregate n=2,622	2002 Arizona n=161	2005 Aggregate n=4,912	2005 Arizona n=178
Basic Education Current State of Residence	62%	37%	67%	53%
Another State	36%	58%	29%	40%
Outside US	2%	3.5%	4%	8%
Avg. Years	19.8	21.2	12.6	7.5
% Currently Employed	88%	90%	79%	88%

In 2002 & again in 2005, 88-90% of the nurses surveyed stated they are currently employed in nursing.

Dashboard Attending Board Meeting & Understanding Board Role

	2005 Aggregate n=4,921	2005 Arizona n=174	Variance
Attended Board Meeting	12.5%	17%	+4.5%
Fully/Somewhat Understand Difference between Professional Assoc. & Board	80.5%	83%	+2.5%
Differences Not Clear	19.5%	17%	1.5%

Approximately 17% of the nurses surveyed are not clear that the Arizona Nurse's Association is a professional/voluntary organization and the Arizona State Board of Nursing is a regulatory/mandatory state agency whose role is to protect the public from unsafe nurses/nursing assistants.

Dashboard First Contact Regarding Questions Nurse Practice Act

	AZ 2002	AZ 2005	Aggregate 2005
Board of Nursing	66%	51%	49%
Nurses Association	4%	3%	3%
Risk Management	11%	22%	19%
Nurse Practice Act	10%	14%	18%

Dashboard Public Perception Four Specific Areas

	2002 Aggregate	2002 Arizona	2005 Aggregate	2005 Arizona
Telephone System	2.25	2.55	2.4	2.54
Communication to Board	1.66	2.09	1.75	1.75
Complaint Resolution/Discipline Process	2.01	2.03	2.03	1.98
Licensure Requirements	2.02	2.09	2.00	1.95

1=excellent/very satisfied 2=good/satisfied; 3=fair/dissatisfied; 4=poor/very dissatisfieda

Dashboard Perception of Nurses Regarding Board Effectiveness in Protecting the Public

2002 Aggregate	2005 Arizona
N=4,855	N=169
1.79	1.78

1=excellent; 2=good; 3=fair; 4= poor

Dashboard Methods to Obtain Practice Information

	2002 Aggregate	2002 Arizona	2005 Aggregate	2005 Arizona
Nurse Practice Act	73.5%	76%	75%	85.5%
Web Site	21%	22.5%	37%	54%
Communication With Board Staff	25%	24%	16%	14%
Newsletter/Journal	53%	68%	41%	35%

The Nurse Practice Act on the web site and web site in general appears to be the two top methods to obtain practice information.

CORE

Discipline Best Practices

Dr. Kevin Kenward, Director Research NCSBN

- Boards with highest ratings on discipline outcomes
  - Delegated authority to board staff
  - Communicated well with stakeholders
  - Hired investigators & attorneys; actively managed the discipline process
  - Trained & mentored investigative staff
  - Applied discipline sanctions consistently

Licensure Best Practices

- Boards with highest ratings on licensure outcomes
  - Secured essential human and other resources
  - Made an aggressive commitment to customer service

Education Best Practices

- Boards with highest ratings on education outcomes
  - Provided consultative, as well as evaluative services to education programs
  - Took leadership role in establishing congruence between education & regulation

Nursing Practice Best Practices

- Boards with highest ratings on nursing practice outcomes
  - Facilitated understanding of legal scope of practice
  - Established high level of involvement with the statewide community
  - Delegated authority to staff
  - Made aggressive commitment to customer service

Governance Best Practices

- Boards with the highest ratings on governance outcomes
  - Promoted an understanding of the respective roles of board members and staff
  - Developed an effective working relationship & high level of trust between board & staff
  - Facilitated an effective working relationship among board members
  - Demonstrated a commitment to board member development

Education Corner

PAMELA RANDOLPH RN, MS
ASSOCIATE DIRECTOR/EDUCATION AND EVIDENCE BASED REGULATION

CORE REPORT — EDUCATION

The Commitment to Ongoing Regulatory Excellence (CORE) project under the direction of the National Council of State Boards of Nursing provides nursing regulatory boards with data from both internal and external stakeholders to identify best practices and benchmarking strategies for Boards of Nursing. The report is comprehensive, involving all Board functions including education and the approval of nursing programs. In 2005, 50 survey tools were sent to nursing programs in AZ, with 12 being returned (24 percent return rate). Ten of the responding programs reported having LPN programs and two reported ADN programs; one diploma program responded and one RN-BSN program responded. Not all programs responded to every survey question. Ninety percent of programs responding had fewer than 10 faculty members. One thousand survey tools were also mailed to nurses with 180 returned for an 18 percent return rate. In addition to other items regarding Board functions, nurses were asked to rate their basic nursing education and the current level of functioning. One hundred survey tools were mailed to employers with 31 returned for a response rate of 31 percent. Employers were asked to rate the preparedness of newly licensed nurses.

Perception of Basic Education

Practicing nurses were asked to rate how well their basic education prepared them to provide safe, effective nursing care. Ninety-two percent of AZ RNs thought their education prepared them "very well" or "well." Fewer AZ RNs rated their education as preparing them "very well" when compared to nurses nationally (47 percent vs. 41 percent) and compared to 2002 responses (57 percent vs. 41 percent). Similarly, fewer RNs rated their perception of their current abilities as "very well" (49 percent) than previously (61 percent) or nationally (59 percent). There were similar trends in the LPN data. This may be due to the limited experience in nursing of the sample. Average number of years licensed was 12.6 years nationally, 21.2 years in 2002, as opposed to 7.5 years for Arizona in 2005.

Employers were asked to rate the preparedness of newly licensed nurses to practice on a scale of one (adequate) to four (inadequate) and rated new grads as 2.11, finding them in the "somewhat adequate" category. This is less than the national average of 1.91 and ranks AZ grads 20 of 24 states surveyed. The best rankings for new graduates skills were for: administering medications by common routes, performing psychomotor skills, recognizing abnormal findings, and responding to emergency situations. The worst rankings were for: documenting a legally defensible account of care, teaching patients, creating a plan of care for patients, assessing the effectiveness of treatments, recognizing abnormal diagnostic lab findings, and supervising care provided by others.

Nurses were asked if there was content on the Nurse Practice Act within their curriculum, and 93 percent responded that there was, as compared to 87 percent nationally. Seventeen percent of AZ nurses attended a Board meeting

Perceptions of Board Functions by Nursing Programs

Nursing programs rated the effectiveness of Board functions as very effective in the area of public protection (ranking 1 of 23) and promotion of quality in nursing programs (6 of 23). In the areas of responsiveness to health care changes and responsiveness to innovation, the board ranked 8 of 23 respondents and in the very effective to somewhat effective categories. Ratings on the effectiveness of the review process remained in the very effective to somewhat effective range with high ratings for administration (5 of 23), clinical facilities (5 of 23), and curricula (7 of 23). Slightly lower ratings were related to faculty input into curricula (16 of 23) and employment input into curricula (11 of 23). Specific perceptions of the review process were measured on a 1-4 scale with 1 being highest. Areas of strength included comprehensiveness of feedback provided (1 of 23), fairness in monitoring compliance (8 of 23), and fairness/objectivity of board findings (8 of 23). Lower rankings were achieved for time spent on site during visit and communication with board staff (21 of 23). Nursing programs ranked the Board as "somewhat helpful" in addressing emerging issues with a ranking of 8 of 23. The Board was rated as fair in the sanction process and somewhat helpful regarding educational issues. Nursing programs rated assistance provided by Board staff as "somewhat helpful." Programs rated the Board as having adequate regulation in protection of the public (3 of 23) and practice standards and scope of practice with ratings falling slightly in the "too much regulation" category for the complaint resolution/discipline process and education program approval.

Programs consistently rated shortages of faculty and clinical sites as barriers to growth and their biggest challenge. They rated lack of competitive salaries and lack of qualified faculty equally as the major reasons why faculty positions were unfilled. Programs were also asked to break out the number of clinical hours. Arizona falls well below the national aggregate for LPN clinical hours at 260 as

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Joey Ridenour Inducted into American Academy of Nursing

Saturday, September 29, 2007, Joey Ridenour, Executive Director of the Board of Nursing, was recognized by the Maricopa Health Foundation with the "Joey Ridenour Nursing Excellence Award." Joey is the first recipient of this prestigious and soon to be annual nursing excellence award.

On November 10, 2007, Joey was inducted as a Fellow, in Washington, D.C., into the American Academy of Nursing. Induction into the Academy represents an esteemed honor and recognition of outstanding achievement. To become a Fellow, nominees must exemplify extraordinary commitment and contributions to nursing, as well as demonstrate the potential for sustained contributions to the profession in the future. The selection criterion include evidence of significant national and/or international contributions to nursing and health care and is based on evidence of the nominee's work to improve nursing practice and health policy. The Academy is comprised of the country's top nursing executives, policy makers, scholars, researchers and practitioners.

Congratulations Joey! We are proud of you and grateful for your wisdom, leadership and your work to improve nursing practice, patient outcomes, and health policy.

Board Members and Board Staff of the Arizona State Board of Nursing

Evidence and Regulation

by By Kathy Malloch PhD, MBA, RN, FAAN
Arizona State Board of Nursing Board Member; National Council State Boards of Nursing, Area I Director

Historically, evidence-based practice or evidence based medicine has focused on seeking evidence for clinical practice. In the work of evidence-based researchers, seven levels of evidence have been identified as benchmarks for the strength of the evidence (Table 1.).

Evidence-based practice is defined as the conscientious use of current best evidence in making decisions about patient care (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). According to Melnyk & Fineout-Overholt, evidence-based practice is a problem solving approach to clinical practice that integrates:

- A systematic search for and critical appraisal of the most relevant evidence to answer a burning clinical question
- One's own clinical expertise
- Patient preferences and values.

To be sure, there are applications in nursing regulation. In nursing regulation, evidence is needed for decision making to assure the public is protected. For example, evidence is needed to determine the ideal number of board members, turn-around time for issuance of licenses, turn-around time for discipline and hearing cases, boundaries for scope of practice, types of discipline, length of probation etc. Overall, evidence for the infrastructure of a

TABLE 1. LEVELS OF EVIDENCE

Seven levels of evidence have been identified by Guyatt and Renie, 2002 and Harris et al, 2001 around which professionals examine available evidence.

- Level I. Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs), or evidence-based clinical practice guidelines based on systematic reviews or RCTs.
- Level II. Evidence obtained from at least one well-designed RCT.
- Level III. Evidence obtained from well-designed controlled trials without randomization.
- Level IV. Evidence from well-designed case-control and cohort studies.
- Level V. Evidence from systematic reviews of descriptive and qualitative studies.
- Level VI. Evidence from a single descriptive or qualitative study.
- Level VII. Evidence from the opinion of authorities and / or reports of expert committees.

TABLE 2. OBSERVED LEVELS OF EVIDENCE BY MALLOCH

Level VIII.	Personal biased opinion
Level IX.	Hearsay from others not readily remembered
Level X.	One time suggestion from unidentified and unreliable source that sounded good.

board of nursing, processes for licensing and discipline, and templates for evaluation are needed. Patient care quality and the nurse license as a property right require the dedication, diligence, and commitment of nursing professionals to assure that decisions are made on the best available evidence. Further, when additional evidence is needed, efforts to begin to develop the evidence should then be initiated.

The goal for nursing regulators is to develop a body of evidence that mirrors the efforts of clinical practice; the best evidence that is applied by nurse regulators in the jurisdiction and community in which nursing is practiced. To continue our work at the Arizona State Board of Nursing, the following recommendations are offered.

Recommendations to advance nursing regulation:

1. Understand the basic principles of evidence based practice
2. Challenge assumptions regularly
3. Always consider the context, or setting in which regulation occurs
4. Work to minimize Malloch's Levels 8 – 10 evidence. (Table 2)

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THE POSITIVES AND NEGATIVES OF URINE DRUG SCREENING

By Connie Linck, RN, MN, *Nurse Practice Consultant, CANDO*

State Boards of Nursing are accountable for the protection of the public from nurses who may be unsafe including those impaired due to substance abuse or chemical dependency. The Arizona State Board of Nursing (AZBN) uses a multifaceted approach to monitoring nurses with identified substance abuse/chemical dependency issues. This multifaceted approach includes monitoring compliance with treatment recommendations, employer performance evaluations, attendance at required 12-step and nurse support group meetings, and random urine drug screening. While there are both positives and negatives associated with random urine drug screening, it is the method most commonly used to monitor the abstinence of nurses who demonstrate a pattern of substance abuse or chemical dependency in Board ordered monitoring programs, as well as in voluntary peer assistance programs. In addition to monitoring abstinence, urine drug screening facilitates early identification and intervention for nurses who experience relapse. This article will discuss the benefits of urine drug screening, the limitations of urine drug screening, data obtained from an audit of 182 Chemically Addicted Nurses Diversion Option (CANDO) participants and recent decisions by the Arizona State Board of Nurses related to drug screening for nurses in the monitoring and CANDO programs.

Urine Drug Screening

Urine drug screening involves the testing of an individual's urine to identify the presence of unauthorized or illegal substances. Based on an evaluation of a nurse's substance abuse history and risk for relapse, AZBN requires a minimum designated number of urine drug screens each month for nurses in the monitoring program and the CANDO program. These drug screens are completed on a random basis. Additionally, for cause, testing may be required if relapse is suspected, or based upon other non-compliance. Most commonly, a 12-panel drug screen is required which includes most commonly abused drugs and alcohol. Expanded testing may be required for substances that are not included in the 12-panel screen on a case by case basis. In order to ensure the accuracy of urine drug screen results, attention is paid to specimen identification, chain of custody, specimen validity testing and confirmation of results.

Chain of custody procedures are followed to ensure that the results of testing on the specimen actually belong to the person indicated on the specimen label. The nurse submitting the specimen witnesses the sealing and labeling of the specimen and signs a chain of custody form. The chain of custody form remains with the specimen and identifies which individuals handled the specimen and that the specimen was handled in a secure manner. Adherence to chain of custody procedures is important when disputes occur over positive test results.

All positive urine drug results are confirmed with gas chromatograph-mass spectrometry (GC-MS). GC-MS confirmation methods are used to rule out false positive or negative findings, identify metabolites, and determine drug concentrations in the urine. Validity testing is another method used to ensure the reliability of specimens (SAMHSA, 2004).

Despite the checks and balances, individuals may tamper with urine specimens in an attempt to avoid detection of unauthorized substance use. Thus, urine specimens are screened for temperature, pH, specific gravity and creatinine. Techniques used to avoid detection of unauthorized substance use can include: avoidance, substitution, dilution and adulteration (Drug Testing Quarterly, 2000).

In addition to monitoring abstinence, urine drug screening facilitates early identification and intervention for nurses who experience relapse.

Methods to Avoid Detection

Individuals who are using unauthorized or illegal substances may attempt to avoid detection by failing to submit drug screens when required. Delaying submission of a drug screen, in some cases, can allow sufficient time for substances to clear the individual's system. Testing below the normal drug testing thresholds may be used to identify low levels of substances in a specimen.

Another method to avoid detection is to substitute a clean sample stored for the purpose of substitution. The "clean sam-

ple" may be another individual's urine, or synthetic urine that is chemically designed to resemble human urine. Temperatures out of normal range are indicative of a substituted specimen.

A dilute specimen, one with a specific gravity <1.003 or a creatinine <20mg/dl, is not a valid indicator of drug or alcohol abstinence. A dilute specimen can occur by excessive consumption of liquids, the use of diuretics, or the use of commercially made products designed to dilute the amount of drug in the urine.

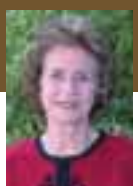
In addition to avoidance, substitution and dilution, adulterants may be added to a urine specimen to mask unauthorized substances. These additives may include common household products, or commercially prepared products (Drug Testing Quarterly, 2000).

Review of Data

A review of 182 current CANDO participant files was completed. Preliminary data was gathered to compare the number of missed urine drug screens and dilute drug screens submitted prior to an identified relapse, meaning the actual use of an unauthorized substance. Some of the nurses in the sample experienced both missed and dilute specimens. For the purpose of the following summary, those nurses were counted in both groups.

Of the 182 files reviewed, 111 nurses never failed to submit a drug screen. Of those 111 nurses, 21 nurses (18.9 percent) did experience an identified relapse. A total of 58 nurses failed to submit a drug screen on at least one or two occasions. Of those nurses, 15 nurses (25.9 percent) experienced an identified relapse. Of concern, is that of the 13 nurses who failed to submit more than two drug screens, 76.9 percent experienced an identified relapse.

One hundred twenty-five of the files reviewed revealed that the nurses never submitted a dilute drug specimen; twenty of the 125 nurses (16 percent) did experience an identified relapse. Of the forty-two nurses that submitted one or two dilute specimens, 18 (42 percent) experienced an identified relapse. Of the fifteen nurses who cont >>>



Commitment to Ongoing Regulatory Excellence (CORE)

Judy Bontrager, RN, MN, *Associate Director of Operations*

Some additional CORE findings received June 2007

REGARDING LICENSURE:	AZ	AGGREGATE
• Nurses satisfaction with licensure & renewal process	1.77	1.64
(1 = very satisfied 2 = satisfied 3 = dissatisfied 4 = very dissatisfied)		
• Adequacy of requirements for licensure	1.95	2.0
(1 = too much regulation 2 = adequate requirement 3 = too little regulation)		
REGARDING PRACTICE		
• Nurses perception about how nurses understand their scope of practice as defined by the Nurse Practice Act.	1.53	1.68
(1 = completely understand 2 = understand 3 = misunderstand 4 = completely understand)		
• Helpfulness of the Board on questions about practice	1.54	1.68
(1 = very helpful 2 = helpful 3 = unhelpful 4 = very helpful)		
• Responsiveness of the Board to changes in practice	1.88	2.06
(1 = very responsive 2 = responsive 3 = somewhat responsive 4 = not responsive)		

Our goal is to provide the nurses of Arizona efficient and complete service. Your continued input is valued and appreciated.

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submitted more than two dilute specimens, 60 percent experienced a relapse.

The length of time from entry into CANDO and an identified relapse was also reviewed. Of the 189 current participants in CANDO, 39 nurses or 20.6 percent experienced one relapse. Of those nurses who relapsed, 87 percent relapsed within the first 18 months after entry into CANDO.

While the above data is preliminary, it identifies some opportunities to improve urine drug screen surveillance for nurses in both the monitoring program and the CANDO program.

AZBN Modifications for Urine Drug Screening Requirements

Following a recent review of drug screening recommendations from the National Council of State Boards of Nursing (NCSBN, 2006) and the data collected from the files of 182 participants in CANDO, the Arizona State Board of Nursing made the decision to modify requirements for the urine drug screening of nurses in the monitoring program and the CANDO program. Modifications include the frequency of testing and guidelines for non-compliance.

The frequency of urine drug testing for nurses entering CANDO and monitoring will be increased during the first 18 months. The frequency of testing following relapse will also increase. While the Board took into consideration the financial impact of this change on nurses, the increase allows for improved surveillance during the time when nurses are most vulnerable to relapse.

More stringent non-compliance guidelines were adopted for missed drug screens, and the submission of dilute specimens, adulterated or substituted specimens.

Conclusion

Even though there are challenges associated with random urine drug testing, it remains a valuable tool for monitoring abstinence, thus promoting patient safety when a nurse with chemical dependency returns to nursing practice. With treatment, many nurses are able to successfully remain abstinent. Nurses who are unable to remain abstinent may attempt to conceal their use of unauthorized substances, putting patients and themselves at risk of harm. Ongoing diligence is required in the monitoring process for the early identification and intervention when relapse occurs, thus assuring the ongoing protection of the public.

REFERENCES

Drug Testing Quarterly (Summer, 2000) *Adulteration of Urine Specimens*. Retrieved August 9, 2007 from www.norchemlab.com/reference/dtq/0007dtq01.htm

SAMHSA, Mandatory Guidelines and Proposed Revisions to Mandatory Guidelines for Federal Workplace Drug Testing Programs. [Federal Register: April 13, 2004 (Volume 69, Number 71)]. Retrieved October 15, 2007 from: http://www.workplace.samhsa.gov/DrugTesting/Files_Drug_Testing/Notices_Docs_Resources/FR_Proposed/Notice%20of%20Proposed%20Revisions%20to%20the%20Mandatory%20Guidelines%20(FR%20DOC04-7984).pdf

National Council of State Board of Nursing (2006). Business Book of Reports: *Drug Screening as a Regulatory Tool*.

Arizona State Board of Nursing Job Opening

NURSE PRACTICE CONSULTANT POSITION

There is an opening at the Arizona State Board of Nursing for a full-time nurse practice consultant. The primary duties of this position are to investigate allegations of nurse practice act violations by licensed nurses and advanced practice nurses. This position requires a Master's Degree in nursing or related field. The successful candidates will have excellent written and oral communication skills, the ability to objectively obtain and analyze information, knowledge and applicability of the nurse practice act including scope of practice and standards of care, and effective time management skills. For more information, please contact Valerie Smith, RN, MS, FRE, Associate Director, Investigations and Compliance at 602-889-5206 or vsmith@azbn.gov.

Education Corner continued from Page 14

opposed to 771 nationally. Associate degree hours were slightly above the national average with 725 as opposed to 620.

Summary

The Board was rated favorably in most categories by education programs responding to the survey. Areas for improvement include communication with nursing programs, improving the site visit process, and responsiveness to emerging issues and changes in nursing practice. Nursing program graduates were rated lower than average when compared to graduates from other participating states.

Board Actions on Education Matters

July 2007

- Approved increase in enrollment for East Valley Institute of Technology
- Approved change in mission and goals for Mohave Community College
- Approved new policy on changes in mission and goals for nursing programs
- Approved revisions to the "Facility Availability Form"
- Removed deficiency from Coconino Community College
- Dismissed complaint regarding Phoenix Shanti CNA program
- Dismissed complaint regarding Northland Pioneer College Refresher Program

September 2007

- Granted proposal approval to Kaplan College to establish an associate degree RN program
- Dismissed complaint against Direct Caregivers CNA Program
- Approved increase in admissions for Coconino Community College
- Granted proposal approval to Chamberlain College to establish a BSN nursing program
- Approved policy on program expansion during provisional approval

I/O: Size:

Regulation

by Pamela Randolph RN, MS
ASSOCIATE DIRECTOR/EDUCATION AND EVIDENCE BASED REGULATION

RUNDOWN

Nurse Practice Act Changes

Every five years, the Board considers what changes may need to be made to the statutes governing the Board of Nursing. The Board is currently reviewing the Nurse Practice Act to determine what changes are needed to best position the Board to respond to future health care needs. A draft of proposed changes will be posted for public comment and information following acceptance by the Board.

Articles 1 and 4

Extensive revisions of Articles 4 (Regulation) and 1 (Definitions and Time-frames) are underway. A preliminary review was conducted by Board staff, Board members, Education Committee, and Scope of Practice Committee. After reviewing additional changes at the August 3, 2007, Education Committee meeting, the Committee asked that staff add a rule regarding preceptorships in pre-licensure nursing programs. The committee will review the draft at their October 26 meeting. Following review by the committee and the Board, a preliminary draft will be posted on the Board Web site for general public review and comment. A docket opening has been filed with the Secretary of State.

The person to contact at the Board regarding regulation is:

Pamela Randolph
Associate Director Education and Evidence-based Regulation
602-889-5209
E-mail: prandolph@azbn.gov
Fax: 602-889-5155

EXPERIENCE OF BEING PLACED ON PROBATION

By Jane Luscumb, RN, BSN

Staff Note:Probation of a nursing license is one of the actions that the Board may consider following the completion of an investigation in which there has been an identified violation of the nurse practice act and there is reasonable concern about the licensee's ability to practice safely. It is a "disciplinary" action that is intended to both remediate the identified issues and provide evidence that the licensee is safe to practice thereafter.

The staff and Board members often hear about the concerns nurses have as they enter into a probationary agreement with the Board. Common feelings that nurses express include anger, fear and shame. Anger that they are subject of a complaint and disciplinary action; fear that they will not be able to find employment or be employable; and shame related to having others (employer, supervisor, colleagues and providers) know about their licensure probation.

On July 26, 2007, Jane Luscomb completed the terms of her probation and shared with the Board, her experience with the process from the time of the report/complaint to the Board through her probation. The Board members asked Jane if she would be willing to share her story in writing. It is being published with the hope that others can benefit from Jane's experiences. – Valerie Smith, MS, RN, FRE; Associate Director Investigations/Compliance

Prior to a few years ago, my contact with of the State Board of Nursing consisted of renewing my RN license every two years and reading the nurse practice act for updates. I assume that there are many nurses that have had similar limited experiences. I would never have expected that I would be called before the Arizona State Board or that I would be placed on probation. I would like to share my experience on this journey and how it affected me.

MY INTRODUCTION TO THE STATE BOARD

Three years ago, I experienced an unusual reaction to a prescribed medication which caused me to suffer three weeks of short term memory loss. Before I realized my memory was affected, I worked three days for a home care agency. The moment I noticed I could not remember what I did for the past few days, I immediately called my supervisor and went to my doctor. A few days later, I was requested to resign my position and told I needed to self-report the incident to the Arizona State Board of Nursing.

EMOTIONAL COSTS

I felt terrified that something was seriously wrong with my brain. I questioned if I would ever be able to practice nursing again. I was angry at my supervisor for losing my job and suggesting I self-report. After that, I moved into feelings of worthlessness. I had been in nursing for 25 years. If I am not a nurse, what am I?

A few weeks later, still unable to work, I was contacted by the State Board. I thought they would not pursue it, but instead, they assigned an investigator to me who explained the process and what I needed to do to prepare to be heard by the board. She was very helpful and kind, but to me, she represented the institution that could end my way of life.

Several months later, I received a letter with an option to appear before the State Board. While accumulating all the reports from the battery of medical and psychiatric tests that I had completed, I obtained legal representation from an attorney. I felt as ready as I could be.

MEETING THE STATE BOARD

My meeting before the State Board was intimidating. I sat in the back and watched as nurse after nurse addressed a half circle of men and women who would collectively be deciding their fate. I was surprised at the issues and accusations I heard. It was very eye-opening.

Then it was my turn. I told my story and answered their questions. I was given two years of probation in order to monitor my mental capabilities and ability to work. I had many stipulations, but was offered to approach the State Board after one year to end the probation early.

ATTITUDE IS EVERYTHING.

I realized at that time that I had it within me to make this year the best year of my life or the worst year. The choice was mine. I decided to do everything in my power to assure that I would be able to finish my probation in just one year. If the State Board was concerned about my memory, I needed to prove to them I could think. I began to look for graduate nursing programs in which I could enroll. Most would not accept me because of my probation, but after looking at five programs, I found one. I am currently enrolled in a MSN program.

HOW HAS BEING ON A STATE BOARD ORDER AFFECTED MY LIFE?

One of my probation requirements was to do monthly random drug screens. To

accomplish this, I was given a color and every morning, Monday through Friday, I had to call the lab and listen to an automated voice announce the color of the day. If my color was called, I had until 5 p.m. to provide a urine specimen.

Another requirement that affected me was that I had to work under direct supervision of another RN. In my present position as a home care nurse, I did not have anyone providing direct supervision, so I had to quit my home care job. At this point, my self-esteem was at an all time low. I applied for a position as infection control nurse in a small hospital, and with the great references written by my last employers, I was hired right away. The Director of Nursing was wonderful. She was very supportive and helped me to believe in myself again. I came to understand that I was not being punished by the Board. They needed to monitor my ability to function to assure I was safe to practice. I knew I was OK but I needed to prove it to the State Board.

WHAT WAS THE FINANCIAL COST OF THE INVESTIGATION AND COMPLIANCE WITH THE BOARD ORDER?

My financial cost was about $3,500 to $4,000. Costs included gas to and from Phoenix five times, attorney costs, mandatory counseling, medical co-payments, and drug testing.

WHAT CAN YOU DO TO PROTECT YOUR LICENSE?

The focus must be on prevention. Here are a few suggestions.

- Stay current regarding understanding the Nurse Practice Act
- Assure you are working within your scope of practice
- Document thoroughly
- Read and stay competent and current in your field.

If you are placed on a board order, what should you do?

- Be proactive. Get medical, psychological studies done early if required.
- Stay organized.
- Keep files of everything.
- Stay in contact with your person doing the board monitoring by e-mail or phone calls.
- Be open and honest with your investigator and monitor.
- Keep a positive attitude and ask for help.
- Keep a calendar of when reports are due and make sure they are not late.
- Attend a support group

ONE LAST BOARD VISIT

I am pleased to report that I have made my last trip to Phoenix for a board review. I have been released from probation after one year due to my total compliance. I am very thankful to have had the support of my monitor and supervisor at work. They have helped me tremendously this past year. I have come to realize that the State Board is here to help support nurses and to protect the public. Nurses need to know that this is a fair system with many checks and balances. There are many people working together to assure nurses are providing safe care. This experience has allowed me to better understand the Board process and because of it, I am a better nurse.

CNA DISCIPLINARY ACTION

*Not reported in previous Newsletter

JULY-AUGUST-SEPTEMBER 2007

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE	VIOLATION(S)
9/10/2007	Ali, Linda J.	CNA073141539	Revoked	Criminal Conviction
9/10/2007	Aragon, Sonja M.	CNA999994828	Revoked	Patient Abuse; Misappropriation of Property; Unprofessional Conduct
7/2/2007	Avelar, Brytni A.	CNA1000003050	Revoked	Failure to Follow Orders; Unprofessional Conduct; Misconduct-Theft - Client
11/21/2006*	Baca, Averill R.	CNA1000010985	Civil Penalty	Criminal Conviction-Against Person - Alcohol Related
8/10/2007	Bahe, Carol L.	CNA1000002879	Suspension	Violating Board Order
9/5/2007	Baylor, Lisa M.	CNA Applicant	Certificate Denied	Patient Abuse
7/2/2007	Beaver, Leann	CNA704611599	Revoked	Failure to Follow Orders; Drug Abuse
7/25/2007	Bigler, Linda K.	CNA233089103	Stayed Suspension	Drug Abuse; Violating Board Order
7/2/2007	Billie, Lee Ann	CNA515397803	Revoked	Violating Board Order
9/9/2007	Blue, Debra D.	CNA948304837	Stayed Suspension	Unable to Practice Safely - Substance Abuse
7/2/2007	Bocanegra, Fernando	CNA999953566	Revoked	Misconduct-Mental Abuse; Fraud, Deceit-Obtaining License
9/7/2007	Burns, Deidre C.	CNA1000001777	Stayed Revocation	Narcotics Violation or Other Violation of Drug Statutes
9/10/2007	Casias, Tamela J.	CNA404210441	Revoked	Failure to Comply Board Order; Criminal Conviction; Narcotics Violation or Other Violation of Drug Statutes
6/25/2007*	Castro, Josie I.	CNA Applicant	Certificate Denied	Criminal Conviction-Misdemeanor
7/18/2007	Chavez, Tresha L.	CNA Applicant	Certificate Denied	Criminal Conviction-Misdemeanor; Alcohol Abuse
9/10/2007	Clawson, Tricia L.	CNA086921803	Revoked	Criminal Conviction; Exploiting a Patient for Financial Gain
9/28/2007	Clemens, Kathy L.	CNA623699803	Voluntary Surrender	Unable to Practice - Substance Abuse
9/10/2007	Crossett, Maria H.	CNA1000002233	Revoked	Patient Abuse; Substandard or Inadequate Care
9/12/2007	Curley, Janicia E.	CNA999951935	Stayed Revocation	Criminal Conviction
8/3/2007	Dabalo, Wakgari M.	CNA1000000790	Revoked	Misconduct-Physical Abuse; Fraud, Deceit
6/29/2007*	David, Melissa M.	CNA Applicant	Certificate Denied	Drug Abuse; Criminal Conviction
8/13/2007	Decore, Sandra M.	CNA1000013354	Stayed Revocation	Alcohol Abuse; Substandard or Inadequate Care
8/13/2007	Durfield, Eric C.	CNA1000003511	Voluntary Surrender	Criminal Conviction-Drug Related; Violating State/Federal Statutes/Rules
9/5/2007	Effiong, Edidiong E.	CNA999997703	Stayed Revocation	Unprofessional Conduct; Substandard or Inadequate Care
8/9/2007	Encarnacion, Marianne R.	CNA1000010314	Civil Penalty	Misconduct-Physical Abuse
7/18/2007	Estes, Kyra D.	CNA Applicant	Certificate Denied	Criminal Conviction-Misdemeanor; Drug Abuse
8/3/2007	Evans, Francine	CNA1000013369	Civil Penalty	Criminal Conviction-Felony
7/2/2007	Freand, Melissa A.	CNA999993669	Revoked	Criminal Conviction-Felony; Violating State/Federal Statutes/Rules
8/14/2007	Fuentes, Sara M.	CNA1000013381	Civil Penalty	Criminal Conviction
6/27/2007*	Gallegos, Daniel V.	CNA Applicant	Certificate Denied	Failure to Cooperate with Board
4/9/2007*	Gerson, Eva L.	CNA1000003716	Civil Penalty	Criminal Conviction-Misdemeanor
7/17/2007	Gibbons, Jay W.	CNA1000011243	Revoked	Violating Board Order
6/27/2007*	Graham, Cassandra L.	CNA Applicant	Certificate Denied	Criminal Conviction-Felony
6/27/2007*	Harding, Latasha T.	CNA Applicant	Certificate Denied	Criminal Conviction
7/2/2007	Hargis, Kay F.	CNA999947647	Stayed Revocation	Failure to Follow Orders; Misconduct-Physical Abuse; Verbal Abuse; Violating Board Order
6/19/2007*	Harrelson, Irene	CNA1000012747	Stayed Revocation	Criminal Conviction-Misdemeanor; Alcohol Abuse
9/10/2007	Harris, Zonya M.	CNA1000008550	Revoked	Criminal Conviction; Unprofessional Conduct; Patient Abandonment
9/10/2007	Hernandez, Danny	CNA1000000678	Revoked	Violation/Failure to Comply Board Order; Fraud - Unspecified; Unable to Practice Safely
9/5/2007	Hernandez, Wanda L.	CNA Applicant	Certificate Denied	Fraud
6/29/2007*	Hyten, Delana R.	CNA Applicant	Certificate Denied	Criminal Conviction-Drug Related; Misdemeanor
8/30/2007	Irvine-Jaman, Caroline	CNA999989969	Stayed Suspension	Dual Relationship/Boundaries; Unprofessional Conduct
6/29/2007*	Kelley, Tiffany V.	CNA Applicant	Certificate Denied	Criminal Conviction-Misdemeanor
3/22/2007*	Kull, Jeanette R.	CNA999997220	Voluntary Surrender	Sexual Misconduct-Boundaries; Failure to Maintain Minimal Standards
9/17/2007	Lemon, Angela C.	CNA999948721	Stayed Revocation	Patient Abuse
9/15/2007	MacDonald, Elizabeth A.	CNA1000003581	Stayed Suspension	Criminal Conviction-Misdemeanor
9/18/2007	Mann, Adrienne M.	CNA Applicant	Certificate Denied	Criminal Conviction; Unable to Practice Safely- Substance Abuse
8/1/2007	Marroquin, Lesly A.	CNA999993022	Civil Penalty	Misconduct-Physical Abuse; Misconduct-Verbal Abuse
9/10/2007	Martin, Ray D.	CNA548854813	Revoked	Submitting False Claims; Fraud/Deceit
8/20/2007	May, Christy A.	CNA Applicant	Certificate Denied	Criminal Conviction
3/1/2006*	Montague, Rebecca E.	CNA Applicant	Civil Penalty	Criminal Conviction-Misdemeanor - Alcohol Related; Misconduct

CNA DISCIPLINARY ACTION CONTINUED

*Not reported in previous Newsletter

JULY-AUGUST-SEPTEMBER 2007

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE	VIOLATION(S)
9/24/2007	Mungal, Chanroutee	CNA058201524	Stayed Revocation	Patient Abuse
9/11/2007	Munguia, Elvira R.	CNA Applicant	Certificate Denied	Criminal Conviction; Unable to Practice - Substance Abuse
7/24/2007	Munguia, Manuel E.	CNA999997342	Voluntary Surrender	Unsafe Practice; Failure to Follow Orders; Sexual Abuse
9/10/2007	Norris, Sharon M.	CNA999992425	Revoked	Misappropriation of Property
8/30/2007	Okamura, Stephanie L.	CNA1000005875	Stayed Revocation	Dual Relationship/Boundaries; Unable to Practice - Substance Abuse
8/15/2007	Pietrzyk, Amanda E.	CNA999988598	Revoked	Violating Board Order
7/2/2007	Reed, Dallas C.	CNA999996278	Revoked	Criminal Conviction-Felony; Criminal Conviction-Misdemeanor; Violation of Fed/State Statutes/Rules
9/12/2007	Risvik, Maryann L.	CNA Applicant	Certificate Denied	Criminal Conviction
9/5/2007	Schroeder, Suzanne M.	CNA Applicant	Certificate Denied	Criminal Conviction; Unable to Practice - Substance Abuse
8/28/2007	Shah, Prince Rajin R.	CNA1000013587	Stayed Revocation	Criminal Conviction; Unable to Practice - Substance Abuse
7/2/2007	Stonechek, Jacob E.	CNA1000005893	Revoked	Criminal Conviction-Misdemeanor; Drug Related; Violating Board Order
7/31/2007	Tomsen, James K.	CNA Applicant	Certificate Denied	Criminal Conviction-Felony; Misdemeanor; Alcohol Abuse
8/20/2007	Vicari, Angela R.	CNA1000012797	Revoked	Violating Board Order
7/2/2007	Watson, Aleita F.	CNA999997763	Revoked	Criminal Conviction-Felony; Failure to Follow Orders; Misconduct-Verbal Abuse
8/18/2007	Widdison, David M.	CNA1000003612	Stayed Suspension w/Fine	Substandard or Inadequate Care; False Reports/Falsifying Records
9/5/2007	Williams, Carla M.	CNA1000009713	Civil Penalty	Patient Abuse; Patient Neglect
8/24/2007	Williams, Carmen L.	CNA1000013442	Stayed Revocation	Criminal Conviction
6/22/2007*	Williams, Comonique M.	CNA Applicant	Certificate Denied	Criminal Conviction; Fraud/Deceit - License/Credentials
7/3/2007	Winckel, Kurtis L.	CNA Applicant	Certificate Denied	Criminal Conviction-Drug Related; Drug Abuse; Fraud, Deceit-Obtaining License
8/31/2007	Zuniga, Elizabeth M.	CNA999991118	Stayed Revocation	Criminal Conviction; Patient Abuse

CNA Discipline ACTION CLEARED

JULY-AUGUST-SEPTEMBER 2007

EFFECTIVE DATE	NAME	LICENSE	ACTION
8/29/2007	Asaro, Josephine S.	CNA1000010307	Stayed Suspension Cleared
8/11/2007	Begishie, Sylvia A.	CNA1000006330	Stayed Suspension Cleared
9/19/2007	Collins, Brigette E.	CNA999994039	Stayed Revocation Cleared
8/9/2007	Hartsock, Patti S.	CNA1000009955	Stayed Suspension Cleared
8/21/2007	Wamsley, Jenny L.	CNA1000003697	Stayed Revocation Cleared

RN/LPN DISCIPLINARY ACTION

JULY-AUGUST-SEPTEMBER 2007

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE	VIOLATION(S)
8/10/2007	Alces, Jacqueline M.	RN044609	Decree Censure	Substandard or Inadequate Care; Practicing Beyond Scope
7/13/2007	Allen, Robert D.	RN112112	Voluntary Surrender	Criminal Conviction; Substandard or Inadequate Care
9/17/2007	Aurmani, Joelle M.	RN107545	Voluntary Surrender	Unable to Practice - Substance Abuse; Substandard or Inadequate Skill Level
7/2/2007	Balke, Sandra J.	RN128780	Revocation	Substandard or Inadequate Care; Unable to Practice Safely
9/19/2007	Barnes, Laura S.	RN065967	Stayed Revocation w/ Suspension	Violation/Failure to Comply Board Order; Narcotics Violation or Other Violation of Drug Statutes
7/17/2007	Behlers, Douglas D.	RN114544	Suspension	Violation/Failure to Comply Board Order
6/1/2007*	Benitez, Rodolfo E.	LP032280	Decree of Censure	Substandard or Inadequate Care; Patient Abuse
9/14/2007	Blumberg, Jacqueline M.	LP018736	Stayed Revocation w/ Suspension	Unable to Practice - Substance Abuse
8/31/2007	Cannon, Charles	Compact RN, TN	Revocation-Privilege to Practice	False Reports/Falsifying Records; Narcotics Violation or Other Violation of Drug Statutes; Diversion of Controlled Substance

*Not reported in previous Newsletter

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE	VIOLATION(S)
9/4/2007	Carpenter, Brenda D.	RN Endorsement	License Denied	Disciplinary Action Taken by any Licensing Authority
8/22/2007	Carroll, Patricia A.	RN128137	Decree of Censure	Substandard or Inadequate Care
7/16/2007	Castillo, Raphael F.	RN Endorsement	License Denied	Practicing Without Valid License; Fraud/Deceit - License/Credentials; Misrepresentation of Credentials
7/25/2007	Caudill, Daryl C.	RN087274/LP026996	Stayed Suspension w/Probation	Substandard or Inadequate Care; Failure to Maintain Records
7/3/2007	Chacha, Imanuel W.	RN123302	Voluntary Surrender	Sexual Misconduct
7/2/2007	Chamberlin, Joyce E.	LP035441	Revocation	Substandard or Inadequate Care; Patient Abuse; Falure to cooperate with board
9/5/2007	Childers, Sarah D.	RN045339	Stayed Revocation w/Suspension	Unable to Practice - Substance Abuse; Diversion of Controlled Substance
5/31/2007*	Chong, Jose E.	RN134249	Decree of Censure	Substandard or Inadequate Care; Failure to Maintain Records; Practicing Beyond Scope
6/25/2007*	Chuck, Sandra E.	Compact LPN, NC	Revocation-Privilege to Practice	Substandard or Inadequate Care; Dual Relationship/Boundaries
7/18/2007	Cizek, Robert E.	LP Endorsement	License Denied	Criminal Conviction; Faiure to Cooperate with Board
6/29/2007*	Combs, Kathleen E.	LP038751	Voluntary Surrender	Violation/Failure to Comply Board Order
7/26/2007	Curry, Mary Ann	RN146936	Civil Penalty	Practicing Without Valid License
8/20/2007	Demattia, Arlene C.	LP037609	Stayed Revocation w/Suspension	Violation/Failure to Comply Board Order
8/22/2007	Depner, Kevin C.	RN111956	Decree of Censure	Unable to Practice - Substance Abuse
8/20/2007	Dixon, Debra S.	RN119800	Probation	Unable to Practice - Substance Abuse
6/27/2007	Dubose, Myron M.	RN Endorsement	License Denied	Failure to Cooperate with Board
8/15/2007	Dunsworth, Michele M.	RN148071	Probation	Unable to Practice - Substance Abuse
7/1/2007	Efaw, Lisa M.	LP037468	Decree of Censure	Unable to Practice Safely; Practicing Beyond Scope
8/27/2007	Elias, Evelyn A.	LP032000	Decree of Censure	Failure to Maintain Records
8/21/2007	Ellery-Williams, Sarah S.	RN041822	Voluntary Surrender	Unable to Practice - Substance Abuse
6/14/2007*	Farago, Katherine M.	RN109521	Decree of Censure with Fine	Dual Relationship/Boundaries
9/7/2007	Farnell, Elizabeth	RN082173	Suspension	Violation/Failure to Comply Board Order; Improper Delegation/ Supervision; Unauthorized Dispensing of Medication
6/27/2007*	Frank, Steven B.	RN147014	Probation	Substandard or Inadequate Care; Dual Relationship/Boundaries; Sexual Misconduct
7/26/2007	Gibson, Andrea J.	RN146165	Civil Penalty	Practicing Without Valid License
5/25/2007*	Gillcoatt, James P.	RN089620	Probation	Substandard or Inadequate Care; Sexual Misconduct
6/25/2007*	Grexa, Barbara M.	RN050756	Probation	Error in Administering Medications
7/31/2007	Hacker, John D.	RN142840	Civil Penalty	Criminal Conviction
6/25/2007*	Hahn, Rebecca Jo	RN087853	Revocation	Violation/Failure to Comply Board Order
8/9/2007	Hall, Asuncion G.	RN073406/LP020478	Probation	Substandard or Inadequate Care
8/21/2007	Harper, Kevin B.	RN102109	Decree of Censure	Misappropriation of Property; Improper Delegation/Supervision
6/11/2007*	Hatchell, Lisa L.	RN146679	Civil Penalty	Misappropriation of Property
6/21/2007*	Hill, Janet S.	RN098672	Voluntary Surrender	Unable to Practice - Substance Abuse
9/7/2007	Holloman, Sherri A.	RN110939	Revocation	Disciplinary Action Taken by any Licensing Authority; Failure to Cooperate with Board
7/25/2007	Hopper, Mary J.	RN091230	Probation	Unable to Practice - Substance Abuse; Narcotic Violation or other Violation of Drug Statutes
8/31/2007	Hoy, Patricia	RN102903	Decree of Censure	Substandard or Inadequate Care
8/27/2007	Humphrey, Marie	RN116821	Decree of Censure	Substandard or Inadequate Care; Failure to Maintain Records
8/20/2007	Inman, Darlene M.	RN079078	Decree of Censure	Practicing Beyond Scope
6/25/2007*	Jackson, Neal C.	RN110090/ CNA999976560	Revocation	Unable to Practice Safely; Unprofessional Conduct; Failure to Cooperate with Board
9/10/2007	Kappeler, Trudy K.	LP038910	Decree of Censure	Practicing Beyond Scope
8/17/2007	Kaufman, Thomas J.	TRN081617	Reinstatement w/ Probation	Violation/Failure to Comply Board Order
9/17/2007	Kelly, Bethany G.	RN032382	Voluntary Surrender	Unable to Practice - Psych/Mental; Failure to Maintain Records
6/15/2007*	Kidwell, Deborah R.	RN118739	Court Ordered Revocation	Criminal Conviction

*Not reported in previous Newsletter

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE	VIOLATION(S)
9/4/2007	Larson, Diane M.	LP Endorsement	License Denied	Substandard or Inadequate Care; Practicing Beyond Scope; Disciplinary Action Taken by any Licensing Authority
8/24/2007	Link, Sherryl L.	RN145582/AP2870	Civil Penalty	Practicing Without Valid License
8/23/2007	Lopez, Blaine C.	LP041505	Revocation	Violation/Failure to Comply Board Order
7/18/2007	Lorrin, Lara M.	RN Endorsement	License Denied	Criminal Conviction; Unprofessional Conduct; Unable to Practice - Substance Abuse
6/12/2007*	Martin, Gezzele R.	RN097422	Decree of Censure with Fine	Improper Delegation/Supervision
9/19/2007	McCullough, Lynn K.	RN079877	Voluntary Surrender	Violation/Failure to Comply Board Order; Narcotics Violation or Other Violation of Drug Statutes, Unable to Practice-Substance Abuse
8/26/2007	Medford, Wendy	RN115980	Stayed Suspension w/Probation	Violation/Failure to Comply Board Order; Unable to Practice Safely; Narcotics Violation or Other Violation of Drug Statutes
6/29/2007*	Mennen, Ivy Jo	Compact RN, IA	Voluntary Surrender - Privilege to Practice	Unable to Practice - Substance Abuse; Diversion of Controlled Substance
9/6/2007	Moran, William M.	RN Endorsement	License Denied	Criminal Conviction; Fraud/Deceit - License/Credentials; Failure to Cooperate with Board
8/20/2007	Moreno, Robert L.	LP026650	Revocation	Violation/Failure to Comply Board Order
7/2/2007	Mruskovich, Melissa A.	RN091432/AP1271	Revocation	Violation/Failure to Comply Board Order
6/19/2007*	Oetting, Christy R.	RN122381	Decree of Censure	Breach of Confidentiality
7/16/2007	Ohler, Allen M.	RN118488	Revocation	Violation/Failure to Comply Board Order
9/20/2007	Oliver, Debra D.	RN133700	Voluntary Surrender	Disciplinary Action Taken by any Licensing Authority; Failure to Cooperate with Board
6/13/2007*	Oliver, Natasha L.	RN097137/AP1526	Stayed Revocation w/Suspension	Unable to Practice - Substance Abuse; Unauthorized Prescribing Medicine
8/31/2007	Omereonye, Gold	Compact RN, WI	Revocation-Privilege to Practice	False Reports/Falsifying Records; Substandard or Inadequate Skill Level, Failure to Maintain Records
9/4/2007	Parnell, Deborah A.	RN Endorsement	License Denied	Disciplinary Action Taken by any Licensing Authority
8/22/2007	Pelzer, Daniel	RN085546/LP027677	Revocation	Violation/Failure to Comply Board Order
6/19/2007*	Petitti, Sharon A.	RN075224	Voluntary Surrender	Violation/Failure to Comply Board Order
7/12/2007	Pollicino, Sarah E.	RN Endorsement	License Denied	Criminal Conviction; Failure to Cooperate with Board
6/29/2007*	Pottgen, Heather B.	RN107514	Probation	Criminal Conviction; Unable to Practice - Substance Abuse
8/19/2007	Richardson, Dean C.	RN113024	Decree of Censure	False Reports/Falsifying Records
8/17/2007	Robb, Ryan P.	RN148123	Civil Penalty	Criminal Conviction, Unable to Practice - Substance Abuse
7/25/2007	Roberts, Rachael L.	RN147277/LP039076	Civil Penalty	Practicing Without Valid License
9/10/2007	Rodgers, Dianne E.	RN120630	Stayed Revocation w/Probation	Unable to Practice - Substance Abuse
7/25/2007	Rosset, Lorrie L.	RN114964	Stayed Suspension w/Probation	Failure to Maintain Records; Error in Administering Medication
9/13/2007	Ryan, Beth A.	RN056318	Stayed Revocation w/Probation	Unable to Practice - Substance Abuse; Diversion of Controlled Substance
6/19/2007*	Sanchez, Jeanette N.	RN126855	Suspension	Violation/Failure to Comply Board Order
7/5/2007	Schmidt, Sherill A.	RN098931	Suspension	Substandard or Inadequate Care; Diversion of Controlled Substance
6/28/2007*	Shaffer, Corie L.	RN Endorsement	License Denied	Unable to Practice - Substance Abuse; Diversion of Controlled Substance; Disciplinary Action Taken by any Licensing Authority
8/5/2007	Siefken, Sherry	RN089581	Decree of Censure	Substandard or Inadequate Care
9/7/2007	Smith, Shannon H.	LP039590	Revocation	Misappropriation of Property; Narcotics Violation or Other Violation of Drug Statutes; Failure to Cooperate with Board
8/22/2007	Sokolowski, Paul S.	RN135203	Probation	Sexual Misconduct; Dual Relationship/Boundaries
7/26/2020	Spradlin, Barbara A.	RN146399	Civil Penalty	Practicing Without Valid License
8/7/2007	Stepp, Gary W.	RN063970	Decree of Censure	Substandard or Inadequate Care; Practicing Beyond Scope
8/27/2007	Tarango, Lucy S.	LP008527	Stayed Revocation w/Probation	Unable to Practice - Substance Abuse
7/16/2007	Taras, Christopher J.	RN094548	Probation	Substandard or Inadequate Care; Failure to Maintain Records
6/22/2007*	Tate, Kelly L.	RN136595	Stayed Revocation w/Suspension	Unable to Practice - Substance Abuse
6/19/2007*	Thomas, Sandra C.	RN105564	Probation	Unable to Practice - Substance Abuse
6/15/2007*	Timis, Radu G.	RN105218	Decree of Censure	Substandard or Inadequate Care; Practicing Beyond Scope
6/8/2007*	Tober, Kathryn A.	RN084319	Voluntary Surrender	Unable to Practice - Substance Abuse

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE	VIOLATION(S)
6/23/2007*	Tobias, Kathleen A.	RN109753	Decree of Censure	Substandard or Inadequate Care; Failure to Maintain Records
7/7/2007	Twitchell, Carol F.	RN108325	Probation	Unable to Practice Safely; Substandard or Inadequate Care; Practicing Beyond Scope
8/31/2007	Via, Shannon M.	RN112721; Compact RN, NC	Voluntary Surrender	False Reports/Falsifying Records; Substandard or Inadequate Care; Narcotics Violation or Other Violation of Drug Statutes
9/19/2007	Walker, Judith A.	RN129503	Stayed Revocation w/Probation	Violation/Failure to Comply Board Order
7/31/2007	Walle, Deborah L.	RN125409	Probation	Unable to Practice - Substance Abuse
7/2/2007	Weaver, Rose M.	RN093868	Voluntary Surrender	Violation/Failure to Comply Board Order
7/2/2007	West, Michelle L.	RN108072/LP033416	Revocation	Violation/Failure to Comply Board Order; Practicing Without Valid License
7/2/2007	Whelton, Nancy J.	RN106268	Revocation	Violation/Failure to Comply Board Order
6/29/2007*	Williams, Kera L.	Compact RN, AR	Revocation - Privilege to Practice	Practicing Beyond Scope
7/25/2007	Wright, Paulette D.	RN124982/AP1846	Probation	Unable to Practice Safely; Substandard or Inadequate Care

RN-LPN Discipline
ACTION CLEARED
APRIL-MAY-JUNE 2007

EFFECTIVE DATE	NAME	LICENSE
7/25/2007	Albro, Jeffery S.	RN132007
7/25/2007	Alderson, Margaret A.	RN073411
7/21/2007	Colby-Nielsen, Judith M.	RN044665
8/19/2007	Dallman, Susan M.	LP040250
9/5/2007	Dutchover, Eric P.	RN076370
9/13/2007	Hershfield-Mayoral, Avis	RN141634
8/20/2007	Hodson, Jon S.	RN067738
6/28/2007*	Kane, Colleen K.	RN085203
7/26/2007	Luscumb, Jane M.	RN096938
6/16/2007*	Pate, Kelsie D.	RN128151
7/25/2007	Peric, Adrian J.	RN085548
7/25/2007	Sims, Sheila Y.	RN099043
9/13/2007	Ventrone, Jean R.	RN062807
8/9/2007	Warren, Gail W.	RN061982
8/10/2007	Watson, Christina D.	RN141003
7/24/2007	Wilson Dakin, Connie S.	RN136109

Arizona State Board of Nursing

The Fifth Annual CNA Educators Retreat: INSIDE THE CNA CLASSROOM

FRIDAY, JANUARY 11, 2008
8 a.m. – 4:30 p.m.

EXCITING NEW VENUE!!
THE BLACK CANYON CONFERENCE CENTER
9440 N. 25TH AVENUE, PHOENIX, AZ

The Fifth Annual CNA Educators Retreat: Inside the CNA Classroom will provide a unique opportunity to network with dedicated colleagues & learn innovative techniques that will inspire and motivate today's CNA.

The AZBN Executive Panel and Event Speakers will provide updates and information on:

- *The Nurse Practice Act*
- *CNA Certification*
- *CNA Misconduct*
- *The Med Tech Pilot Study*
- *Diversity in the Classroom*

And Much More!

"Excellent!" "SUPERB!!" "…enjoy networking & inspiration from others!" "I expected more and got more. Thank you!"
-2007 Retreat Attendees

Guest speaker, Janis McMillan, MSN, RN will discuss *Professionalism in the CNA Classroom*. Don't miss your opportunity to share an incredible learning experience with your colleagues! Submit your registration form *NOW!*

For more information visit our website or call ▸▸▸

Arizona State Board of Nursing

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Make No Mistake: *Human Errors Can Be Minimized*

***Andreas A. Theodorou, M.D.**, Professor of Clinical Pediatrics Chief, Pediatric Critical Care Medicine Associate Head, Department of Pediatrics, University of Arizona Health Sciences Center Co-Director, Center for Quality and Safety, University Medical Center*

Dr. Theodorou is a member of the Arizona Hospital and Healthcare Association's Patient Safety Steering Committee.

In a perfect world, medical professionals would never make mistakes. We live, however, in the real world where hospital professionals are human and therefore prone to errors. The first step to preventing medical errors and avoiding adverse patient outcomes is for hospital staff members to recognize why mistakes happen.

COMMUNICATION IS THE KEY

Most errors in the hospital setting can be traced to poor communication. A healthcare team is comprised of individuals from multiple professions, and individual members may not understand how they should communicate with their team. If a nurse recognizes that an order may be incorrect, may he or she bring it to the attention of the attending physician, or will the nurse feel uncomfortable doing this? It is critical to create an atmosphere that empowers all team members to communicate. All healthcare professionals must know that their input is not only valued, but essential to team well-being and, most important, to patient safety.

Patient handoff is an example of a time requiring good, clear communication, and yet, interruptions are so common as to be the norm. Distractions can mean the loss of important information, creating a potentially ripe setting for errors. In this case, staff need to take special care to ensure that important details regarding a patient's condition are not omitted.

CLOSING THE LOOP

Delivering pertinent information is only half of the equation. The other half is confirmation of receipt of the information. For example, if a physician says, "Please give one ml of 1:10,000 epinephrine," the nurse must confirm, "One ml 1:10,000 epinephrine given." Having procedures in place that require this confirmation "closes the loop," prevents misunderstanding, and ensures that instructions were understood and carried out.

EASY DOES IT

Experts find that if a safety measure is inconvenient, people will find a way to work around it. But workarounds can be very dangerous in a hospital setting. For example, the hospital may have invested in expensive, "safe" IV pumps that are programmable to prevent overdoses. But if using this safety feature is lengthy or complicated and if it can be bypassed, it often will. Safety procedures must be designed

to accommodate the way people work in a busy, time-pressured situation.

CHANGING THE CULTURE

One way hospitals can foster a culture of communication is to incorporate patient safety information into all new employee orientations. At University Medical Center (UMC) in Tucson, Arizona, the patient safety program is presented to new employees, emphasizing the responsibility to communicate clearly and including information on how to report an adverse event. The emphasis from day one is on building a safer system, not on punishment. The team at UMC Center for Quality and Safety want to hear about events, including near misses, because these learning experiences can change the status quo and ultimately improve patient safety.

With thoughtfully developed procedures and systems, the culture of medicine is slowly changing. Busy healthcare professionals have an increasing awareness of the importance of good communication and the value of input from different disciplines. This is being taught to nursing, medical, pharmacy and public health students at the University of Arizona's Arizona Health Sciences Center in exercises aimed at bringing all the students together to learn. Joint learning builds respect and understanding among the different disciplines.

A hectic and stressful clinical environment can foster poor communication and lead to errors. But, as with the closed loop technique, systems and procedures are available to improve critical communications. A technique called SBAR, an acronym that stands for Situation, Background, Assessment, Recommendation, serves as a simple reminder of the critical points to cover when communicating vital patient information. The Arizona Hospital and Healthcare Association (AzHHA) offers an SBAR Implementation Kit as part of its *Safe & Sound* patient safety initiative. (Visit www.azhha.org or call 602-445-4300 for more information.)

BUILDING A SAFETY NET

The good news is that hospitals can implement systems with enough layers in place to catch errors before they become adverse events. It all starts with a committed leadership, such as the board of directors, CEO, and administrators, and is sustained by a well-educated hospital staff whose members respect each and every other member of the health care team. Make no mistake; improving safety procedures and staff communication will lead to improved safety and better patient care.

Nursing Integral Part of ASU University as Entrepreneur Initiative

Center for Healthcare Innovation & Clinical Trials Launched

The College of Nursing & Healthcare Innovation has launched an interdisciplinary initiative with the formation of the Center for Healthcare Innovation & Clinical Trials (CHI&CT) to help bring innovative healthcare products to market. The center is in partnership with Innovation Space, an ASU entrepreneurial joint venture with the College of Design, the Ira A. Fulton College of Engineering, the W.P. Carey School of Business, and AZ technology.

CHI&CT is one of the key components of the ASU Entrepreneur Initiative and its purpose is to teach students how to develop products that create market value while serving real societal needs and minimizing impacts on the environment. The clinical trials initiative is funded by the Kaufman Foundation

"University as Entrepreneur" program as part of a five-year grant to Arizona State University.

Linda Mottle, clinical associate professor at the college, has been named director of the center. She has more than 30 years experience in the health and clinical research fields as an administrative manager, nursing clinician, and organizational leader, specializing in health program and clinical research development and intensive cardiac care.

The center also will have an educational component where interdisciplinary students can learn the process of translating innovative ideas into the design and testing of new healthcare products and approaches. Specifically, the CHI&CT has developed a new Graduate Certificate that has been submitted to the University for approval.

It is anticipated the 15 credit hour graduate certificate for clinical research management will be approved to be offered in January 2008. The center also will offer an interdisciplinary Master of Science for Clinical Trials Management and pre- and post-doctoral mentor programs for research scientists at a later date.