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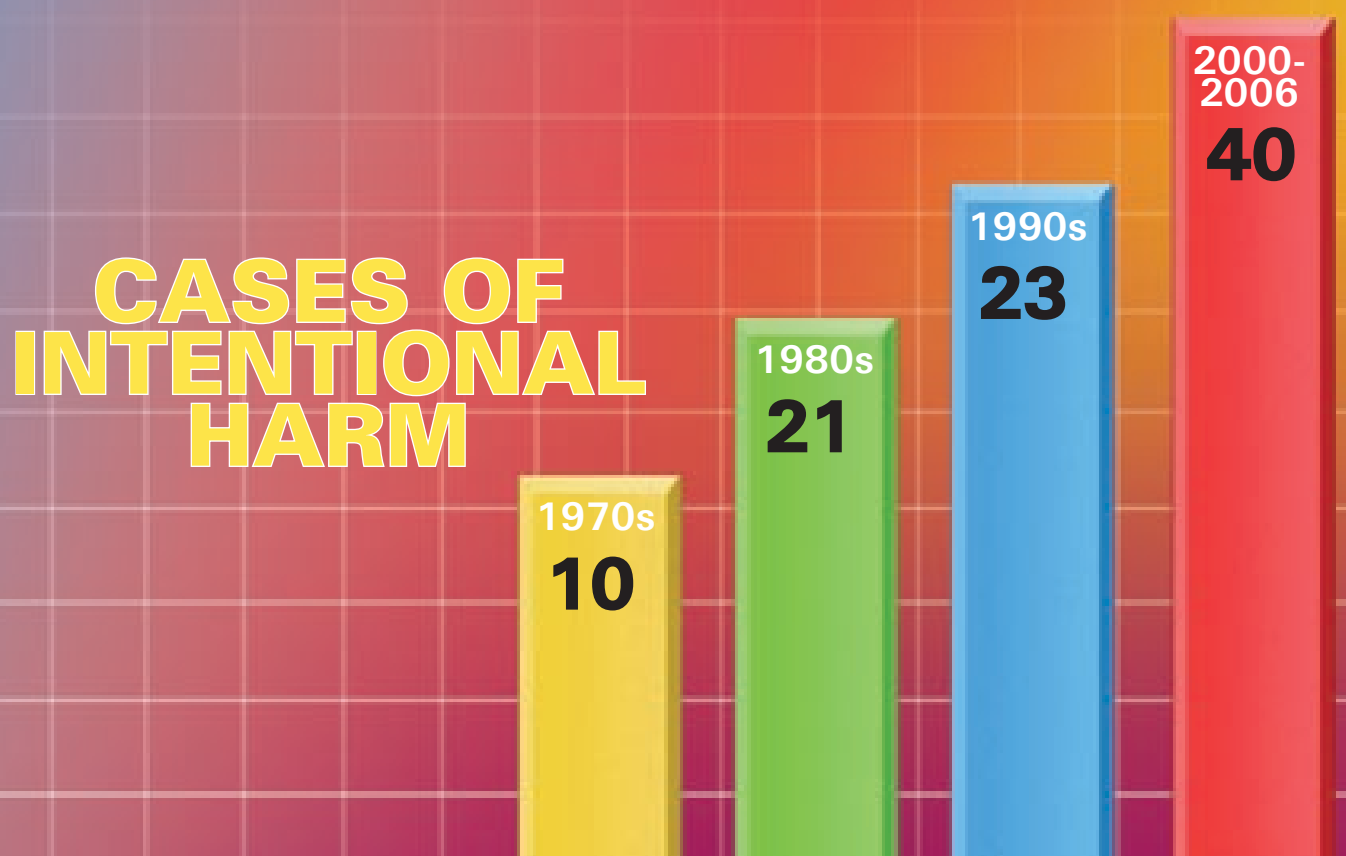
# Serial Harm of Patients Extends Beyond A Few Shocking Cases




INCREASED AWARENESS ON THIS DISTURBING SUBJECT IS THE WORK OF ALL HEALTHCARE PROFESSIONALS

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EDITION II

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This magazine is mailed quarterly to over 90,000 Arizona licensed nurses and reaches every nursing student, hospital administrator and nursing school administrator in the state

From the Executive Director & Staff
JOEY RIDENOUR, RN, MN, FAAN

# Violation of Trust *When Skills Designed to Provide Safety Are Used to Harm Patients*

"Serial murder by healthcare professionals is a poorly understood but increasingly identified phenomenon" as stated by Beatrice Crofts Yorker, JD, RN, MS, FAAN, and Dr. Kenneth W. Kizer, et al., *Serial Murder by Healthcare Professionals, Journal of Forensic Science, November* 2006, *Volume* 51, *Number* 6. The authors conducted a LexisNexis® search in which 90 criminal prosecutions of healthcare providers meet the criteria for serial murder of patients with the following findings:

1.) Between 1970 and 2006, 54 of the 90 were convicted for serial murder, four for attempted murder, five pled guilty to lesser charges and others are awaiting trial or outcomes have not been reported.
2.) Nursing personnel comprised 86% of healthcare workers prosecuted.
3.) The number of deaths resulting in murder convictions is 317, and the number of suspicious deaths by the convicted 54 healthcare workers is 2113.

The numbers are not only disturbing, but in the last two years additional nurses have been arrested as serial killers in long term care in Illinois and a nurse was arrested for sexually assaulting long-term care patients over a 20 year history in Ohio.

This edition of the Arizona State Board of Nursing Regulatory Journal is to heighten awareness that serial murder/harm of patients is a significant concern that "extends beyond a few shocking, isolated incidents. We all have a responsibility to promote strategies that promote early detection, prosecution and prevention of crimes that undermine the "public confidence in safety of healthcare" (Yorker et al., 2006).

Yorker et al. in the examination of the cases of serial healthcare killers describes healthcare worker characteristics, motives, methods, legal outcomes and suggestions for prevention:

**Cases per decade:** 1970's: **10**; 1980's: **21**; 1990's: **23**; 2000-2006: **40**

**Number of States Prosecuting Cases:** 22; with Texas, Michigan, California, Florida and Indiana having three or more

**Profession:** 60% RNs, or 54 of 90 prosecutions; 7 LPNs; 16 nurses' aides

**Gender/Ethnicity:** women comprise almost 49%; 44% male; 94% Caucasian

**Healthcare Setting:** 72% of majority of deaths occurred in hospitals in medical/surgical units or ICUs on the evening or night shifts. Killers were first suspected of killing in hospitals and after termination moved to another setting and continued to kill. 20% of the healthcare workers worked in long-term care.

**Victims:** almost always female; critically ill patients, very old, very young and "otherwise vulnerable"; some were ambulatory, showing no patient was immune.

**Method of Assault/Murder:** Injection was the main method; medications typically used are epinephrine, insulin, KCL, Anectine, Pavulon, Digoxin, Liodocaine, and air embolus. Nurse aides use alternate methods such as suffocation.

**Motives:** Some caregivers seemed to get sadistic satisfaction from killing certain types of patients, and colleagues could predict which patients may die under their care. Patients may have been demanding or whiny or required a lot of work.

**Toxicology:** Blood samples collected during a cardiac arrest revealed elevated levels of potassium; low blood glucose/high serum insulin for insulin overdose.

**Legal Outcomes:** An epidemiologist testified in Maryland that one nurse was 57 times more likely to have patients die under her care than all other evening shift nurses, resulting in a civil suit with $8 million in civil damages. Another case resulted in $27 million being awarded to families of nine infants who were injected.

Yorker et al. and Andrea Sattinger who wrote *Heinous Crimes: Though Rare, The Possibility of Serial Murders in Healthcare Settings Demands Vigilance, The Hospitalist, August* 2007 offers the following suggestions for prevention/intervention to decrease the likelihood the crimes will go undetected:

1. Current practices that allow easy access to otherwise therapeutic medications that become lethal when used by serial healthcare killers should be examined.
2. Very few of the serial healthcare killers have criminal records but many have a history of falsifying their credentials or other aspects of their background. "Their propensity to engage in fraud or fabrication of significant information is consistent with sociopathic traits and employers should consider any fraud or misrepresentation a serious risk factor."
3. Healthcare employers should be forthcoming with references that include information that a healthcare worker was fired or provide information regarding adverse patient outcomes associated with the healthcare worker.
4. Hospital/healthcare administration need to provide an atmosphere that facilitates staff reporting concerns about patient safety or criminal behavior and they also need to work effectively with law enforcement.
5. Administration also needs to ensure policies and procedures achieve a balance between protecting employee rights and ensuring patient safety.
6. Before looking at people, look at numbers. Stay aware if a disproportionate number of codes occur on the same shift and a higher than expected successful resuscitation rate arises. Track mortality on a monthly or per unit basis.

The violation of trust occurs when skills designed to prevent death cause death. Increased awareness on this disturbing subject is the work of all healthcare professionals.

Joey Ridenour RN MN FAAN

Joey Ridenour, RN, MN, FAAN



# THE WORK OF THE BOARD...

Serial healthcare workers who harm - the subject of this journal sounds foreign and harsh. The harsh reality - this is one of the categories of violation and discipline that the nine members of the Arizona State Board of Nursing must deal with. As a governor appointed board, we are responsible and tasked with upholding the statutes of the Nurse Practice Act.

Many nurses confuse the Board of Nursing with the Arizona Nurses Association and do not know that the mission of the Board of Nursing is "to protect the public." In doing this work and determining disciplinary action in relationship to violations of the Nurse Practice Act, we keep the mission in the forefront of any decision. Although the highly competent board staff fully investigates the complaint and presents an investigative report, the board decides on appropriate discipline in each case.

Discipline and violations seem counterintuitive to the art and science of nursing. As we read and review an average of 300 cases bi-monthly in preparation for each board meeting, we are reminded that those receiving disciplinary action are less than one percent of those licensed and certified in the state of Arizona. We debate the issue(s) presented based on "evidence" and on other aspects that always have a nexus to protect the public.

The board members highly regard their accountability to the public. With this accountability comes many demands, complex issues and well thought out decisions based on the law and practice standards. Whether at the bedside or as a nurse executive, you, as a nurse leader, hold the same accountability to our profession and the public.

Many call the board members and staff to ask questions about the guidelines, parameters or duty to report a violation of the Nurse Practice Act. In today's culture with emphasis on patient safety, a concept that seems to apply is that of a Just Culture written by David Marx. He has also written Patient Safety and the "Just Culture": A Primer For Health Care Executives Medical Event Reporting Process. He describes a "just culture" as one that balances the need to have a non-punitive learning environment with the need to hold persons accountable for their actions. Maintaining such a culture requires a duty to report any operational errors immediately (within the system) with openness and non blame in the spirit of creating a learning environment and processes that limit failure. This culture suggests disciplinary action when there are bad outcomes created through intentional violations or intentional risk taking (reckless behavior). This might include intent to do harm, impairment, knowingly deviating from the standard or violating a rule or procedure. Most systems have set their threshold at this point, allowing disciplinary action when an employee should've been aware of the risk they were taking and the subsequent potential for harm. All of us in nursing have to make these hard decisions in order to create the safest environment possible for our patients.

The nine members of the Arizona Board of Nursing take their jobs on the board seriously and are accountable for utilizing their collective wisdom and experience nursing or public domain to make the best decisions possible with the information presented, to protect the public.

As always, please feel free to contact me or any board member with questions or concerns regarding "the work of the board."

Karen Hardy, RN, MSN

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# HEALTHCARE SERIAL OFFENDERS

BY VALERIE SMITH, MS, RN, FRE, *ASSOCIATE DIRECTOR INVESTIGATIONS/COMPLIANCE*

Media headlines over the past four years reflect the alarming concern about healthcare serial offenders. In December 2004, Charles Cullen, a nurse licensed in both New Jersey and Pennsylvania, was arrested and charged with the serial murders of patients over his 16-year nursing career. In March of 2006, Cullen pled guilty to the murder of 29 patients and the attempted murder of several others. Cullen, although portrayed as cooperative with authorities in attempting to identify his victims, is believed to have murdered over 40 patients, many of whom he could not recall and for whom sufficient evidence of murder could not be established after the fact. Co-workers and patients had reported concerns to management.

In October 2006, Vicky Dawn Jackson, a former nurse in Texas, pled guilty to killing 10 patients by injecting them with a drug used as a neuromuscular blocking agent that inhibits respirations. Authorities believe she may be responsible for 25 deaths in a small town Texas hospital where she worked and whom several of her victims were friends or acquaintances.

Headlines from an Ohio newspaper in January 2008 reported "Ohio Nurse is Confessed Serial Rapist." John Riems was arrested and charged with rape and gross sexual imposition after a partially paralyzed nursing home patient was able to communicate to family members that Riems had sexually assaulted him. During questioning, Riems reportedly told police that he had sexually abused approximately 100 patients under his care during his 23-year nursing career and employment in 10 different facilities. His alleged victims included men and women, mostly elderly or disabled and unable to report the sexual abuse. According to media reports, police have verified at least 14 cases of sexual abuse perpetrated by Riems. His co-workers report that he was known for his temper and for spending long periods of time in patients' rooms with the door closed. They further report that several patients did not want him to care for them and would refuse their medications "just to keep him out of their room." Co-workers assert that they informed management about their concerns.

In June 2008, headlines in a Pennsylvania newspaper reported "Male Nurse Charged with Raping Boy." According to media reports, in June 2008, Fred Magondu, a Pennsylvania licensed practical nurse who had been providing homecare to a 14-year-old boy, was arrested and charged with rape after semen found on linens and DNA results positively linked him to the sexual assault of the child under his care. The boy reportedly is both mentally and physically impaired, unable to speak and is blind. Another nurse alerted authorities after she noted when changing the boy's diapers that he was bleeding and bruised. Magondu was arraigned on multiple charges of rape, involuntary deviate sexual intercourse, indecent assault, corruption of minors and unlawful contact with minors. Magondu had been "caring" for the boy for several months and was employed by a pediatric agency and a nursing home, settings containing some of the most vulnerable patients. He has been a practical nurse since June 2006 and had no prior licensure disciplinary action, no prior known criminal history, is married and the father of three children.

According to the FBI and others who have extensively studied serial criminal offenders, serial offenders are often motivated by ritual and repetition. They may need to satisfy some form of fantasy, one that may not be common in the general population, through rituals. Beatrice Yorker, RN, MS, JD, has studied and published extensively about healthcare serial killers. She suggests the healthcare serial killer is motivated by power and control or excitement and attention. Law enforcement individuals maintain that the only way to stop a serial offender, whether it is killer or rapist, is to catch them. Charles Cullen told authorities that patients were being treated as nonhumans and as a result, they were suffering. His acts were not acts of mercy, as many of his victims were not dying or in pain. The medications that he used to end the life of innocent victims were drugs that cause a painful death. He is quoted as having told authorities, "I couldn't stop myself. I just couldn't stop."

The FBI has extensively studied serial offenders and has profiled behaviors common to the serial criminal. Most of their work and studies involve a known crime scene that may be ripe with evidence of wrongdoing. Unfortunately, this same type of crime scene is often not evident in a hospital or other healthcare setting. Most commonly, by the time the authorities suspect that there has been a crime committed, in the healthcare setting "evidence" has been compromised. Perhaps it has been compromised because the deceased has been embalmed and buried; the hospital room sanitized in preparation for the next patient(s); the short half life of many of the medications used to intentionally end a patient's life; the patient is unable to communicate what occurred or when communicating what occurred, has other history that may impact their perceived credibility.

Serial healthcare offenders are likely not much different from other criminal serial offenders. The difference though is that they have access to a vulnerable and unsuspecting population. Nursing is regularly rated as the most trusted profession. Who would think that amongst us are those who prey upon vulnerable individuals (patients), taking advantage of them, harming and some-

times, intentionally killing individuals under their "care"?

### BEHAVIORS COMMON TO SERIAL CRIMINALS

- They commit the same crime repeatedly.
- Their choice of housing, neighborhoods, cars, and clothing does not bring attention to them. Their family and neighbors are often "shocked" when they learn of the crimes committed.
- They select victims based upon availability, vulnerability, and desirability.
- Rarely is their criminal behavior impulsive but rather well thought out.
- They may have an obsession with publicity, particularly when media and others begin to report their findings.
- When they admit their actions, they often attempt to rationalize and justify their behavior by shifting blame on the victims or blaming the system.

### RED FLAGS COMMON TO INDIVIDUALS WHO SEXUALLY ABUSE PATIENTS

- Prior to coming to the attention of law enforcement or the regulatory board, there have been other complaints of sexual misconduct, inappropriate touching, inappropriate sexual language, or inappropriate contact with patients or co-workers that may have been investigated by the supervisor/employer but without any identified significant findings.
- The perpetrator selects:
  - Patients who are unable to defend themselves from the sexual attack.
  - Patients who are unable to tell others.
  - Patients who are not believable or may not be heard or perceived as credible.
- Patients under the influence of sedating medications.

### RED FLAGS COMMON TO SERIAL HEALTHCARE MURDERERS

- Prior employment records show questionable incidents.
- They often fail to provide full disclosure of prior employment history on application.
- A higher percentage of deaths occur while they are on duty.
- They are given nicknames by the staff before a concern is overtly identified or reported. Nicknames may include angel of death, angel of mercy, Dr. Kevorkian, magic syringe.
- They are uncommonly accurate in predicting patients' demise.
- Patient deaths are unexpected by staff or family, and they die alone.
- Witnesses report seeing them with the patient shortly before the patient unexpectedly died.
- Death is caused by substances readily available, not easily detectable and not routinely checked at autopsy, including insulin, digoxin, lidocaine, epinephrine and other respiratory paralysis agents. Syringes, IV lines and feeding tubes are likely portals of entry.
- If a code is called, ECG strips are often missing from the chart.
- They participate in and perform well during a code.
- The nurse insists patient(s) died of natural causes.
- The nurse fails to show remorse for victims and justifies his or her actions.
- Other patients or families complain about the nurse, but their comments often are ignored.

**The responsibility to recognize intentional harm and speak up lies at all levels in healthcare organizations and in the profession. The following is a list of suggestions for coworkers, employers and boards of nursing:**

- Supervisors should educate staff about the red flags of intentional harm and work to create an atmosphere where staff can appropriately relay concerns and insights.
- Staff who identify an unusual trend in deaths or bad outcomes must bring the information to a supervisor. They must be prepared to report concerns to the appropriate law enforcement and regulatory agencies.
- Patients or families who complain that a healthcare employee or nurse intentionally caused harm must be heard. Regardless of the outcome of the complaint, these allegations should be tracked and easily referenced if future complaints are received.
- To prevent further harm, investigations of alleged wrongdoing must be conducted quickly and timely by individuals who have the expertise to conduct the investigation. Information that supports possible intentional harm to patients must be reported immediately to the appropriate legal authorities, including state licensing boards.
- Individuals should not be allowed to resign in lieu of an investigation into wrongdoing.
- Individuals whose resignation interferes with the employer's ability to fully understand if harm was done or intended must be reported to the state licensing board. State licensing boards exist to protect patients, and they have trained, skilled investigators who review the facts of each case and can compel information.
- Law enforcement agencies and state licensing boards must work together on investigations and work quickly to take the appropriate licensure action upon receipt of information that a licensee has intentionally attempted to or succeeded in harming a patient.
- Facilities should institute tracking and accountability for all potentially lethal drugs similar to the measures employed with controlled substances. Unexplained missing drugs should be investigated and accounted.

Although nursing supervisors, employers and boards of nursing have become skilled in recognizing and investigating inadvertent errors, to protect the safety of lives of patients, we must also become skilled in recognizing and taking appropriate action when there is a suspicion or evidence of intentional harm. To minimize the harm caused by intentional acts directed at patients, nurses and employers have a responsibility to patients and the public to understand and recognize the red flags, to take quick action, and to report to the appropriate authorities.

# ARIZONA PILOT STUDY MEDICATION TECHNICIAN - FINAL REPORT

SUBMITTED BY D&S DIVERSIFIED TECHNOLOGIES, LLP DBA HEADMASTER, LLP

6/13/08

EXECUTIVE SUMMARY

Providing safe nursing home care is both a clinical and fiscal challenge that has resulted in the addition of medication technicians to nursing home health care teams in many states. The state of Arizona also faces many of these clinical and fiscal challenges; therefore, the State Board of Nursing was authorized by the Arizona Legislature (HB 2256) to conduct a pilot study to explore the impact to patient health and safety if trained and certified medication technicians were added to selected Arizona nursing home care teams. To complete the study, medication administrators across various credentialing levels (LPN, RN, and Medication Technician) were observed for four types of medication error rates (wrong drug, wrong dose, wrong route, wrong time). The Pilot Study Medication Technician (PSMT) project included baseline naïve observation of medication administration in six nursing homes, identification and training of medication technicians, naïve observation six months after the role of the medication technicians was integrated into the medication administration team in five nursing homes, and interviews with selected stakeholders to determine the impact of the addition of medication technicians through the perceptions of the team members.

The study sought to determine if the pattern of medication error was different with the addition of medication technicians to the medication administration team at the five nursing homes that completed the study. While the sample size precluded statistically significant inferences, the findings do indicate that the pattern of medication error remained stable with no clinically or statistically significant differences noted among the medication administrators' mean error rates both pre-implementation (LPN, 10.12 percent; RN, 11.54 percent) and post-implementation (Medication Technicians, 6.08 percent; LPN, 7.25 percent; and RN, 2.75 percent). These findings are similar to a national study funded by the Agency for Healthcare Research and Quality and conducted by Scott-Cawiezell and colleagues (2007a; 2007b). The study also found that members of the medication team were positively impacted by the presence of the medication technician over time.

Based upon the study's findings and the results of larger scale studies in other states, the research team recommends to the Arizona State Board of Nursing that they consider the integration of the medication technician role into the nursing home healthcare provider team within the scope of practice and supervision dictated during this project.

OVERVIEW OF THE PILOT STUDY OF MEDICATION TECHNICIANS

Nursing homes have many challenges in the midst of very fiscally constrained budgets to provide safe care. Innovation and evidence must be a critical part of how care is delivered to this ever growing and very frail population. In an ideal world, the frail and vulnerable residents would have RNs providing all aspects of their care. However, in a fiscally constrained world, staff representing many levels of credentialing must be maximized to assure that care can be given (Scott-Cawiezell et al., 2007a; 2007b). Therefore, to meet the needs of the frail and elderly in the state of Arizona, the following pilot study was completed in order to systematically assess the impact of adding medication technicians in the state of Arizona.

## BOARD ACTIONS

To implement the provisions of HB 2256, the Board completed the following activities:

- Formed a steering committee that included stakeholders from long-term care, education, Board of Pharmacy, and nursing associations;
- Adopted protocols for the administration of medications by pilot study medication technicians;
- Developed selection criteria for pilot facilities and selected six facilities: Good Shepherd (Peoria), Shadow Mountain (Scottsdale), Mountain View (Tucson), Silver Ridge Village (Bullhead City), Copper Mountain Inn (Globe), Heritage Health Care (Globe);
- Developed educational criteria for students and instructors and curriculum;
- Developed research guidelines and, through the efforts of Kathleen Pagels and the Arizona Health Care Association, raised $60,000 to help fund the research;
- Issued an RFP for a research team through the Arizona Health Care Association;
- Selected D&S Diversified Technologies to conduct the research with the collaboration of Dr. Jill Scott-Cawiezell;
- Assisted D&S Diversified Technologies to develop and implement a legally defensible and psychometrically sound written and manual skills competency exam;
- Conducted instructor training and delegation training at each facility;
- Visited each facility during training;
- Twenty one medication technicians trained and passed the competency exam to date.

## RESEARCH DESIGN AND METHODOLOGY

Nursing homes from across Arizona applied, and six were selected to participate in the pilot study to determine if the pattern of medication error changed with the addition of medication technicians to the medication administration teams. A seventh nursing home was designated the alternate for the study. Research nurses observed medication delivery pre-implementation and post-implementation (six months after the introduction of medication technicians) using "naive observation" methods initially described by Barker and colleagues. The naïve observation methods assured that data collectors recorded precisely what was observed. This method has been used in several federally

funded studies in medication safety (Barker, Flynn, & Pepper, 2002; Scott-Cawiezell et al., 2007a; 2007b).

Prior to observing any pre-implementation medication passes, the research team completed nurse observer training and established inter-observer reliability as the first step of the study. D&S DT hired consultant Barbara Sutherlin, RN, to observe and certify four Arizona RN observers using guidelines that were reviewed by the research consultant; the classroom portion of the nurse observer training was conducted March 8, 2006. Subject matter for the training included the method of observation, procedures to follow, using the observation form, categorizing errors by type, resident confidentiality, and using the drug reconciliation method to determine possible scheduled drug diversions. Then, two live medication pass observations were conducted during the morning shift and two during the evening shift the afternoon/evening of March 8th, all day March 9th, and the afternoon/evening of March 10th. Each nurse observer was trained (performed their base line observations) individually, and their observations were correlated to the trainer who was the constant in all the base line observations. Observations were conducted on separate units; observed subjects were four licensed practical nurses (LPNs). (The facility used only LPNs to pass medications.) The trainer (Barbara Sutherlin, RN) and each nurse observer trainee individually recorded findings gathered during the base line observations on separate medication pass worksheets. The findings of the nurse observer and trainer were not divulged (shared with each other) during the medication pass. Agreements versus disagreements were documented after the observations concluded. The inter-observer reliability coefficient was calculated using the formula described by Alberto and Troutman (1982), which considers agreements divided by agreements plus disagreements. The resulting calculated range of 95 percent to 99 percent is recognized as high inter-rater reliability and acceptable for the purposes of this study.

During the second round of data collection for the actual study (post-implementa-

tion phase), all observations were completed by the same trained nurse observer, and thus inter-observer reliability considerations became a non variable.

DATA ANALYSIS

Data was analyzed using tests of group differences including ANOVA, and appropriate post hocs analyses. Limitations related to the nested nature of the observations (pre-implementation, n=3039 medications observed in six facilities; and post-implementation n=2,521 medications observed in five facilities) was considered.

## RESULTS

SUMMARY OF THE NAÏVE OBSERVATION OF MEDICATION ERROR RATES

During the pre-implementation naive observations at the six pilot nursing homes, 31 LPNs and seven RNs were observed while delivering 3039 medications. The LPNs and RNs were sampled and observed in proportion to the actual medications delivered in the study facilities by credentialed level. The initial observations resulted in a mean medication error rate of 10.4 percent (LPN, 10.12 percent; RN, 11.54 percent). There were no statistical or clinical differences noted among the medication error rates observed.

A second observation was conducted post-implementation at the five remaining study facilities, observing 16 LPNs, two RNs and seven medication technicians delivering 2521 medications; again, sampling was completed in proportion to the actual distribution of credentialed level. The post-implementation observation resulted in a mean medication error rate of 6.6 percent (LPN, 7.25 percent; RN, 2.75 percent; Medication Technician, 6.06 percent). Again, there were no statistical or clinically significant differences noted among the medication administrators regardless of the credentialed level.

SUMMARY OF KEY INFORMANT OPINIONS ON THE IMPACT OF THE ADDITION OF THE MEDICATION TECHNICIAN ROLE

A total of 22 staff members and leaders from the five nursing homes were interviewed after the post pilot study intervention data collection period. The interviews were conducted in two phases as facilities completed the data collection process after the intervention. The sample included Directors of Nursing (DONs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Pilot Study Medication Technician (PSMTs). The majority of respondents worked a minimum of 35 hours per week. The range of experience was 1 to 23 years in their roles. Those interviewed work a variety of shifts. However, all interviews (with the exception of the DONs) had medication administration as a part of their current role. Of the informants that were routinely involved in passing medications, the current percentage of time that they passed medications ranged from 10 percent to 90 percent.


All informants were asked to discuss the changes in their roles with the addition of the medication technicians to the care team. Despite some early misgivings about the new medication technician role, all licensed personnel (RNs and LPNs) reported that when they were able to partner with a PSMT, they did have more time to work directly with the residents. They reported feeling better about their treatments and more complete assessments.

*"The concept is fabulous; I now have more time to assess my residents and work with other staff. In the past, I felt stuck behind the med cart."*

*"…nurses are now more available."*

*"…it is hard when the techs aren't here; they are good partners."*

The PSMTs also reported that it was their perception that their LPN and RN partners were spending more time with the residents. However, they also indicated that the success of the role was also impacted by their licensed partner.

*"I had a very difficult time in my new role at first. My nurse was constantly looking over my shoulder and making me very nervous. I could not get the pass done. Now, I have a new partner, and I love what I am doing. We work really well together. "*

A noteworthy finding was that one facility has had a great deal of difficulty in securing adequate staffing to fully and consistently implement the PSMT role. Although those staff could see benefit from the addition of the role, they also reported frustration in the inconsistencies of having the PSMT as their partner.

The sample of informants shared various additional roles along with their medication administration responsibilities. Some PSMTs reported tailored shifts to maximize the medication administrations that they could be involved in, and often they were also involved in related procedures. All reported that they routinely assisted other staff and residents when they were not passing medications.

The informants were consistent in what medications were being passed by the

PSMTs and the licensed staff. Licensed staff reported that, at times, the sharing of medication responsibilities was a challenge. However, they were learning systems to keep track of such things as needed (prn) narcotics and inhalers.

All but one informant reported the residents were very happy with the addition of the PSMT role.

*"They miss her when she is gone; the resident keeps asking me where [she] is today."*

*"Residents are glad for the change; they don't have to wait for their meds."*

The exception was a licensed person who felt that she had spoiled the residents and they were getting inconsistent time with the PSMT so they had not yet gotten used to the change.

Informants reported minimal changes to the medication administration procedure. They also reported minimal changes to the error reporting. No informants reported any perceptions of more medication errors, and many reported they believed there were actually fewer medication errors and they were sure that there was a significant improvement in on-time delivery of medications.

Finally, informants shared recommendations and lessons learned during the pilot medication technician project.

The recommendations include:

- The timeframe for the training was too condensed. The training needs to be more spread out to allow time to study the critical concepts.
- We need more PSMTs, and they need to be consistently assigned to the role to improve and build systems.
- Licensed staff would like to review the training so there can be consistent reinforcements for the PSMTs.

The lessons learned include:

- Speed comes with time; the key is being very careful.
- I now understand why blood pressures are so important for the medication pass, and I always double check them myself. Now I know why my nurse was always asking me what my blood pressure was.
- PSMTs add flexibility to staffing.

## DISCUSSION AND CONCLUSIONS

While the sample size and limited scope of the pilot study preclude large scale generalization of the findings, it can be noted that medication error rates did appear to remain stably distributed among the various levels of credentialing in the medication administration team. These findings would suggest that the introduction of the medication technician did not alter the rate of medication error. Additionally, the findings are in line with both the early and final reports from the AHRQ funded medication safety study (Scott-Cawiezell et al., 2007a; 2007b), again providing further support that the introduction of medication technicians did not negatively impact the provision of care to nursing home residents. In addition to the analysis of medication error rates, key informants consistently reported positive results with the addition of the medication technician to the healthcare team.

While the Arizona pilot study confirms earlier studies which indicate that medication technicians can provide safe medication delivery, many factors remain to be addressed. Nursing home residents have many illnesses; they take many medications, and they are very vulnerable to subtle alterations in their medication regimens. Many of the medications delivered in a routine medication administration do require assessment for potential adverse effects, and Medication Technicians lack the assessment skills and knowledge to make adjustments or watch for many potential adverse drug effects. Therefore, it is imperative as the Arizona State Board of Nursing moves forward that the role of the RN remain critical and clear in the management of resident's medication.

Nursing homes have many challenges in the midst of very fiscally constrained budgets to provide safe care. Innovation and evidence must be a critical part of how care is delivered to this ever growing and very frail population. In an ideal world, the frail and vulnerable residents would have RNs providing all aspects of their care. However, in a fiscally constrained world, staff representing many levels of credentialing must be maximized to assure that care can be given. This study provides some initial evidence to suggest that medication technicians can be effectively used for routine medication administration. Understanding the limitations of the medication technician and creating medication systems that include the RN and the medication technicians as partners could provide a safe medication administration where residents get the right medication, at the right time, in the right dose, through the right route, and prepared in the right method to assure the most therapeutic result (Scott-Cawiezell, 2007a).

Based upon the PSMT results and interviews, the research team can report the following:

1) There appears to be no reduction in the quality of care for Arizona nursing home residents due to the inclusion of medication technicians on the health care team. Therefore, their addition to the health care team could be implemented statewide.
2) The time frame for any future medication technician training should be extended to allow the students to pace their learning.
3) The role of any future medication technician should be consistently implemented to allow for medication processes to be constant from day to day.
4) The role of the RN in medication management should be explicitly clarified to complement the role of the medication technician in any system implemented for the routine administration of medications.

### REFERENCES


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# EDUCATION CORNER:

## NCLEX-RN® RESULTS AND ANALYSIS

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

The Education Department reviewed NCLEX-RN second quarter results for nursing programs, noting that, for the first time in several years, Arizona RN programs posted a passing rate lower than the national rate. A disturbing aspect of this trend is that second quarter results are usually the highest of the calendar year. For the quarter, 89.3 percent of U.S. educated nurses passed the exam on the first attempt, while 87.87 percent of Arizona educated students passed on the first attempt. While this difference is just slightly more than 1.4 percent, several Arizona programs are below the Board minimum standard of 75 percent for this quarter. The good news is that several programs, some quite large, posted pass rates above 90 percent for both the quarter and "year to date." These programs include Arizona State University, MCCDNP, Pima Community College, Northland Pioneer College, Central AZ College, Yavapai College and University of Arizona. Five Arizona programs are below 75 percent for the quarter, with four of those below 75 percent "year to date." Two programs are between 75 percent and 80 percent for both the quarter and "year to date." Two Arizona programs are under a "notice of deficiency" for posting pass rates below 75 percent for two consecutive calendar years. Quarterly, NCLEX results may be accessed at www.azbn.gov under resources/NCLEX.

Lowered NCLEX pass rates are not

a new phenomenon to the Board. The Board noted decreasing annual NCLEX-RN pass rates in 2002 and invited all nursing programs to attend a meeting exploring the reasons for the trend and possible remedies. It may be instructive to review what was learned from the dialogue in 2002.

## IDENTIFIED REASONS FOR NCLEX FAILURE

*Academic Preparation of Students*

Many programs noted that students are not academically prepared for the rigors of a nursing program. Some programs noted that passing prerequisite courses is not an adequate measure of student competence in the subject area. Other programs noted that many students passing college level English courses had very low reading comprehension skills. Some programs were able to correlate poor reading comprehension skills to NCLEX failure.

**Solution:** Require standardized admissions testing such as the NET with appropriate cut-off scores.

*Curriculum*

Several programs that experienced curricular change noted that they lost sight of NCLEX in the change and did not map the curricular content to the NCLEX test plan. Faculty involved in constant curricular changes and revisions were noted to have little attention to give to students. Content on the test plan was deleted in some of these programs.

**Solution:** Map curriculum to NCLEX; ensure curriculum is taught as planned; stabilize the curriculum to allow for the ability to "fine tune" but not completely overhaul the total program.

*Student Support*

Nearly all programs cited student stress and lack of support as a factor. Many students work long hours during the program. Interestingly, many programs did not cite the working itself as a significant factor, but the amount of support the student received from family and friends as crucial. Stressors for students include financial, relationship issues, and multiple roles they were expected to fulfill.

**Solution:** Early identification of students at risk for failure; provide services to students in the form of scholarships, externships, tutoring, and counseling services; support to the unsuccessful NCLEX candidate.

*Unprepared Faculty*

All programs reported difficulty recruiting and retaining qualified faculty. Many programs hire faculty prepared as practitioners who lack curricular and teaching theory and practice. The quality and experience of the faculty was cited as crucial to program success. Many programs also reported that faculty members were reluctant to fail a student clinically due to a multiplicity of factors which may include lack of knowledge of legal issues, lack of support of administration, "too much hassle," and insecurity.

**Solution:** Orient new faculty to clini-

cal teaching and curriculum; send faculty to test construction and curriculum workshops; allow faculty more time to prepare for classes and institute innovative teaching; mentor new instructors; and develop methods where clinical instructors can connect clinical experience to didactic content.

*Academic Rigor*

Many programs noted that lack of academic rigor contributed to lower pass rates. The tendency to offer extra credit for projects, rounding up of grades, few objective tests, test questions at an inappropriate level and not expecting students to read the materials were a few examples cited. A few programs also reported that overly detailed study guides to teacher-made tests might have encouraged students to study only for the test. Grade inflation, both within the nursing program and across campuses was also identified as a factor that contributed to over-confidence of the student and undermined reliance on pre-requisite courses to ensure a knowledge base.

**Solution:** Eliminate extra credit assignments, points for attendance, grading of clinical performance, and other measures thought to inflate grades. Do not "round up" grades—74.8 is still below the minimum 75.

*Teacher-made Tests*

Testing of students may not have been at the appropriate level for some programs. Several programs reported that when they examined course tests, many questions were at the knowledge and comprehension level rather than the application and analysis level, which is the level of the majority of NCLEX RN questions.

**Solution:** Construct test questions and exam plans consistent with the structure of NCLEX; utilize comprehensive end-of-course exams; require passing of all tests to pass course; utilize standardized tests of nursing content (HESI, ERI) and NCLEX predictor exams.

*Student Attitude*

Student attitude was also reported to affect pass rates. All programs agreed that many students major in nursing because it is a relatively high paying job in an uncertain economy. Some students are motivated to study only what will be on the test and are not active participants in learning. Some programs reported that students are over-confident regarding NCLEX.

**Solution:** Prepare students for the rigors of the program and the profession so that they understand that they will need to read and comprehend complex material, and that the foundation of nursing originates in a person's desire to help others and put another's need before one's own.

*Timing of NCLEX*

Time elapsed from graduation to testing was cited as a factor for several programs, although one large program did not find it significant. National data has long suggested that passing rates are higher for candidates who test closer to graduation.

**Solution:** Advise students to take NCLEX within five months of program completion.

In a follow-up meeting in 2004, all programs reported success using at least some of these methods. Arizona nursing programs consistently sustained overall annual pass rates above the national passing rate in the subsequent years. The Board publicly stated that programs should strive for and maintain a 90 percent annual NCLEX first-time pass rate.

There have been many changes in the educational environment in Arizona since 2002. In 2002, all nursing programs reporting NCLEX results were part of a regionally accredited educational institution, had been in existence for at least five years, and all were not-for-profit. Today, Arizona hosts several new programs, including those at private institutions that hold national accreditation (four programs) as specialized career schools and several for-profit programs. While growth in student numbers started between 2001 and 2002, it was not occurring at the unprecedented rate of today's programs. Clinical placements were relatively abundant in 2002, and faculty shortages were just beginning to be experienced. Several of the programs posting lower passing rates did not attend the NCLEX dialogue or follow-up meeting as they were not in existence at that time. The full reports of both meetings are available on our Web site www.azbn.gov under resources/NCLEX.

## LEARNING OPPORTUNITY FOR FACULTY

The Nurse Educator Chapter of the Arizona Nurses Association is presenting a conference entitled "Teaching IOM: Implications of the Institute of Medicine Reports for Nursing Education" with featured speakers/authors Anita Finkelman, MSN, RN, and Carole Kenner, DNS, RNC, FAAN. The conference will be held on October 17, 2008, at Grand Canyon University, Ethington Theatre, 3300 W. Camelback, Phoenix. A brochure and registration form can be downloaded from the following site: htpp://www.aznurse.org/files/75/documents/IOM%20Brochure_2.pdf.

## BOARD ACTIONS ON EDUCATION MATTERS

MAY 2008

- Board received information of change of administrator for Chamberlain College, Central Arizona College, and International Institute of the Americas
- Received information that the Psych-Mental Health Nurse Practitioner program at ASU would be divided into Adult and Family/Child specialties consistent with national guidelines
- Granted continuing approval with a report in six months for Cochise College and Arizona Western College
- Approved program change in program length at MCCDNP
- Dismissed complaints against: Grand Canyon University FNP program, SouthWest Skill Center High School NA program, and SouthWest Skill Center at EMCC NA program
- Issued Notice of Deficiency to Emmanuel School of Nursing

- Approved proposal for an associate degree RN program at Pima Medical Institute—Tucson
- Received for information "2007 Annual Reports from Arizona Nursing Programs"

JULY 2008

- Reviewed Program Site Visit Policy and ADA Accommodation for NCLEX Policy
- Reviewed Draft Agenda for Statewide Educators Meeting
- Reviewed Education Committee Evaluation
- Approved Requests for Program Change from Grand Canyon University and International Institute of the Americas
- Dismissed complaint against International Institute of the Americas
- Reviewed Analysis of Board Involvement with programs having low NCLEX pass rates and first quarter NCLEX results
- Approved University of Phoenix request to extend time to comply with notice of deficiency
- Reviewed notices of changes in administration of the following programs: University of Phoenix, University of Arizona, East Valley Institute of Technology, Pima Medical Institute, Grand Canyon University, Northern ARIZONA University and Arizona State University.

**SHAWN SHREEVE SCHOLARSHIP FUND**

Shawn Shreeve, RN, a flight nurse, was tragically killed when two medical helicopters crashed together in Flagstaff on June 29th, 2008. The Shreeve family, Flagstaff Medical Center and the community of Flagstaff have set up a foundation in Shawn's name to provide scholarships to nursing students, as that was Shawn's passion. To send a donation in Shawn's memory, please send a check or money orders to: Shawn Shreeve Scholarship Fund, c/o Foundation Office, Flagstaff Medical Center, 1200 N. Beaver, Flagstaff, Arizona 86001. The family thanks all donors for their assistance in funding this effort.

# CNA CORNER:

## FREQUENTLY ASKED QUESTIONS REGARDING CERTIFIED NURSING ASSISTANT PROGRAMS

By Lila Van Cuyk, RN, BSN
*NURSE PRACTICE CONSULTANT/CNA PROGRAMS*

The most frequently asked questions regarding the C.N.A. Education Programs are:

1. **WHAT ARE THE NEW/CHANGED REQUIREMENTS?**
   *NEW REQUIREMENTS:* "Notification of Board Requirements for Nursing Assistant Certification prior to start of program" has an added item. In addition to the five-year felony bar and the AZBN fingerprints, as of 1/1/08, you should notify prospective students of the requirement of proof of citizenship/nationality status. These requirements and appropriate documents can be found on the Board Web site at www.azbn.gov.

2. **WHAT INFORMATION IS TYPICALLY OMITTED BUT SHOULD BE PROVIDED ON THE CERTIFICATE OF COMPLETION?**
   - Address of the program is to be placed on the certificate; this helps in those cases where a program changes the name or has a similar name to another program.
   - Total program hours (minimum 120 hours) AND how many of hours were classroom/laboratory (minimum 60 hours), clinical (minimum 40 hours, with at least 20 of those hours in long-term care) and traineeship hours, if any. (No more than 20 hours and must be supervised/documented by a REGISTERED nurse.)

**3. HOW ARE HOURS CALCULATED IN THE PROGRAM?**

Hours are calculated as follows:

- o Actual clock hours with the student and instructor present.
- o If program uses Carnegie hours (50 minute hours), these need to be converted to clock hours.
- o Hours not relevant to developing competences and therefore should not be counted are: travel time to/from classroom to clinical; time on lunch break, even if you are discussing relevant materials; time doing home work assignments or watching "feature" movies (even if the movie is about a health topic).

**4. WHAT INFORMATION IS TO BE SUBMITTED TO THE BOARD REGARDING THE INSTRUCTOR QUALIFICATIONS?**

In reviewing instructor qualifications, programs or individuals should submit documentation that the instructor is a REGISTERED NURSE who has one year of experience supervising CNAs or teaching adults or has taken a course in how to teach adults. (This needs to be on a resume or explained in writing.) Please note that the instructor must be in the classroom at all times, even if the program utilizes a supplemental teacher, e.g. physical therapist or LPN.

## TESTING UPDATE

D&S Technologies will be presenting an instructor workshop to increase instructor's knowledge of the NA Certification testing process and skill demonstrations in

November 2008. D&S will send a mailing to all NA Training programs in September/October to give information on dates and locations. If you are interested in hosting one of the workshops, please contact D&S Technologies at: 877-851-2355.

- Revised April 1, 2008, Candidate Handbook available at D&S Web site: *www.hdmaster.com.*
- Top five frequently missed manual skills in 2008:
  - o Weighing an ambulatory resident – 85 percent pass rate
  - o Fluid intake – 86 percent pass rate
  - o Peri-care - 86 percent pass rate
  - o Blood Pressure - 86 percent pass rate
  - o TPR oral digital – 88 percent pass rate
- Top three frequently missed test categories as listed in the candidate handbook for the written test on page 4.
  - o Care impaired (resident)
  - o Personal care
  - o Data collections

**New information on the AZBN Web site www.azbn.gov:**

See Resources/Educational Resources/Other Documents and Downloads/CNA Programs Annual Pass Rate. This posting gives the First Time Pass Rates for NA Training Programs. In 2007, there were 3390 candidates who took the Certification test for the first time. The average Written score was 91 percent, and the average Skills score was 78 percent. Congratulations to all the students and programs!!

See Resources/Educational Resources/Other Documents and Downloads for a sample document for Notification of Board Requirements for Certification.

See Home Page for info on the new Proof of Citizenship/Nationality Requirement.

**SAVE THE DATE**

**6th Annual CNA Educator Retreat**
**Friday January 9, 2009**
**Black Canyon Conference Center in Phoenix, AZ.**
**Theme for 2009 will be**
**CARING: THE HEART OF CNA PRACTICE**

# Regulation RUNDOWN

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

## 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 (NPA) to determine what changes are needed to best position the Board to respond to future health care needs. The Board is expected to approve a comprehensive overhaul of the NPA for the 2009 legislative session. Potential changes include an increase in the number of Board members ncluding a CNA representative, the authority to engage in innovative programs and projects, recognition of retirement status for licensed nurses, and increasing the authority of the Executive Director to approve CNA programs and expedite other matters that do not require Board deliberation. The Board is continuing to work with Certified Registered Nurse Anesthetists, the Arizona Nurses Association and other stakeholders to draft statutes that best protect the public and reflect the Board's mission. A draft of proposed changes will be posted at a future date on the Board's Web site for public comment and information following acceptance by the Board.

## R4-19-206, Articles 1 and 4, R4-19-509, R4-19-814

An open public hearing regarding this rulemaking package was held on July 9, 2008, with seven members of the public attending. Written and verbal testimony was provided by Stephanie Stewart from the University of Wisconsin-Oshkosh opposing amendments to R4-19-206. The proposed amendments to this rule would have required nursing programs to limit precepted clinical experiences to the last semester of an RN program. Based on evidence provided by Dr. Stewart and reports from other states using preceptors in innovative roles throughout the program, Board staff recommended withdrawing R4-19-206 from the rulemaking package. Communication from Education Committee members and the Arizona Nurses Association was sought to determine if key stakeholders would be negatively affected by the withdrawal. Both groups agreed that the Board should withdraw this rule from the rulemaking packet so that the effects could be more fully debated and understood. The Board also received written testimony from the Arizona Nurses Association in support of the other amendments contained in this rulemaking package. On July 28, 2008, the Board adopted the Notice of Withdrawal for R4-19-206. The Board also adopted the Notice of Final Rulemaking for the rest of the rulemaking package and directed Board staff to submit the package to the Governor's Regulatory Review Council for their approval. Amendments to Article 1 add and change some definitions and timeframes. Article 4 contains updated practice standards for RNs and LPNs. The Board made technical changes to R4-19-509 and R4-19-814 to reduce redundancy and to update reference rule numberings. The Notice of Final Rulemaking can be obtained by accessing the Board's Web site: www.azbn.gov under resources/proposed rules.The person to contact at the Board regarding regulation is:

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

# Case Study:

BY VALERIE SMITH, RN, MS, FRE, ASSOCIATE DIRECTOR

## SEXUAL MISCONDUCT INVOLVING SEVERAL EMPLOYERS AND SEVERAL PATIENTS

A complaint was received by the Board alleging that a CNA displayed inappropriate sexual behavior towards a patient while hospitalized. According to documentation received with the complaint, the patient reported an incident postoperatively. He reported that during the night shift, he woke when he felt the CNA rubbing his nipples and then touching his groin area and stating to him, "Some guys like to fool around, do you?" Although the patient was groggy from his recent surgery, he knew something wasn't right and rebuffed the sexual advances. When interviewed by the Board investigator, the patient explained that he was 10 hours post surgery, and although groggy, he clearly remembered the incident. He stated that he waited several weeks to report the incident because he was too embarrassed.

During the Board's investigation, the following was identified:

- The CNA had been employed at seven different healthcare facilities over a three year period of time and had been terminated from at least three prior healthcare employers for misconduct and was not eligible for rehire.
- There were at least three prior complaints alleging inappropriate touching or behavior involving patients at three different facilities, none of which had been reported to the Board or other legal authorities. Two of the complaints involved patients recovering postoperatively.
- Two months prior to the complaint being received by the Board, the CNA had allegedly sexually abused a patient at another Arizona hospital. According to the patient/victim in this case, he too did not report the incident to anyone at the hospital because he was shocked, scared and didn't know what to do. He contacted the police only after he began getting phone calls at home from the CNA, one of which was monitored by the police. The CNA reportedly admitted to the officer that he sexually touched the patient and claimed that this was the first time and that he felt bad about what he did. However, despite knowing that charges were being pursued, two months later, he attempted to assault a patient at another hospital, the incident that initiated the complaint to the Board.

The CNA plead guilt to attempted sexual abuse, an undesignated class six felony offense. His CNA certificate was revoked.

LESSONS LEARNED:

1. Patient's complaints that a healthcare worker engaged in sexually inappropriate behavior with them must be taken seriously.
2. For every patient who comes forward to report they were the victim of sexual misconduct, there may be others who we will never know or hear from.
3. Victims of sexual misconduct are often embarrassed and may not report the incident. When the incident is reported, it may be after the patient has been discharged. A delayed report must be taken as seriously as a contemporaneous report.
4. Healthcare workers who engage in sexual misconduct with patients are considered predators and select victims who may not be able to defend themselves, who may be unable able to report what occurred or confused by what occurred.
5. Investigating allegations of sexual misconduct must be done by individuals who have expertise in sexual misconduct and who have the ability to obtain collateral information. The information obtained from multiple sources and prior employment settings is critical to understanding potential patient harm.
6. Allegations of sexual misconduct of a RN, LPN or CNA must be reported to the Board of Nursing as soon as possible.
7. Allegations of sexual misconduct involving allegations of sexual assault must be reported immediately to the appropriate law enforcement officials.

## CNA DISCIPLINARY ACTION

*Not reported in previous Newsletter

APRIL-MAY-JUNE 2008

| EFFECTIVE DATE | NAME | CERTIFICATE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 6/4/2008 | Aldridge, Kennie A. | CNA1000001294 | Suspension | Negligence; Unprofessional Conduct; Patient Abuse |
| 6/3/2008 | Alvarez, Ana | CNA524899103 | Stayed Revocation | Patient Abuse |
| 3/30/2008* | Anderson, Corey J. | CNA705404869 | Civil Penalty | Criminal Conviction |
| 5/5/2008 | Ayala, Jesus | CNA996701641 | Revoked | Unable to Practice Safely; Patient Abuse; Negligence |
| 5/5/2008 | Banks, Eleisa D. | CNA1000010824 | Revoked | Misappropriation of Property; Unprofessional Conduct |
| 6/17/2008 | Barisano, Franchesca M. | CNA1000016304 | Civil Penalty | Criminal Conviction; Fraud/Deceit |
| 4/15/2008 | Barker, Kristina A. | CNA999952755 | Civil Penalty | False Reports/Falsifying Records |
| 6/12/2008 | Bonito, Lorna K. | CNA Applicant | Certificate Denied | Criminal Conviction; Failure to Cooperate |
| 6/30/2008 | Buccieri, Cheri A. | CNA508599103 | Revoked | Substandard or Inadequate Care |
| 5/17/2008 | Coll, Melody L. | CNA488729103 | Civil Penalty | Practicing Beyond Scope |
| 3/28/2008* | Cruz, Amanda G. | CNA Applicant | Certificate Denied | Criminal Conviction; Fraud/Deceit; Failure to Cooperate |
| 4/4/2008 | Cubias, Martha D. | CNA903597583 | Civil Penalty | Fraud/Deceit |
| 5/6/2008 | Davis, Daniel L. | CNA1000015818 | Civil Penalty | Criminal Conviction |
| 6/30/2008 | Felix, Guillermina | CNA498869803 | Stayed Revocation | Patient Neglect; Patient Abuse; Dual Relationship/Boundaries |
| 6/30/2008 | Flores, Frank | CNA125125103 | Revoked | Unable to Practice Safely - Substance Abuse; Criminal Conviction; Misappropriation of Property |
| 5/5/2008 | Gray, Antoinette M. | CNA005607379 | Revoked | Patient Abuse; Patient Neglect; Unprofessional Conduct |
| 5/2/2008 | Grundy, Jennifer M. | CNA1000015785 | Stayed Revocation | Criminal Conviction |
| 5/27/2008 | Guy, Pamela K. | CNA Applicant | Certificate Denied | Criminal Conviction; Unable to Practice Safely - Substance Abuse; Failure to Cooperate |
| 2/28/2008* | Harmes, Nancy D. | CNA Applicant | Certificate Denied | Criminal Conviction; Fraud/Deceit; Failure to Cooperate |
| 6/30/2008 | Harris, Jerry L. | CNA999998015 | Revoked | Patient Abandonment; Patient Neglect; Fraud |
| 6/16/2008 | Harris, Ret M. | CNA999947939 | Civil Penalty | Patient Abuse; Substandard or Inadequate Care |
| 5/5/2008 | Hicks, Marilyn M. | CNA999950275 | Revoked | Patient Abuse; Unable to Practice Safely - Substance Abuse; Failure to Comply Board Order |
| 6/30/2008 | Holder, Shawn R. | CNA999999511 | Revoked | Unprofessional Conduct; Unable to Practice Safely - Substance Abuse |
| 5/5/2008 | Jackson, Sasha J. | CNA1000001796 | Revoked | Unable to Practice Safely - Substance Abuse; Fraud; Unprofessional Conduct |
| 4/4/2008 | Jensen, Leslie M. | CNA843878441 | Voluntary Surrender | Violation of Fed/State Statutes/Rules; Criminal Conviction; Unable to Practice Safely - Substance Abuse |
| 4/19/2008 | Karima, Chisaka | CNA Applicant | Certificate Denied | Unable to Practice Safely - Substance Abuse |
| 5/5/2008 | Layton, Tristan L. | CNA1000008575 | Revoked | Unable to Practice Safely; Unprofessional Conduct |
| 4/22/2008 | Lehti, Nancy L. | CNA1000003724 | Voluntary Surrender | Patient Abuse |
| 6/1/2008 | Luopa, Mary E. | CNA1000002182 | Civil Penalty | Practicing Beyond Scope |
| 6/30/2008 | Lynn, Bianca P. | CNA999996407 | Revoked | Unable to Practice Safely - Substance Abuse; Fraud; Narcotics Violation or Other Violation of Drug Statutes |
| 5/23/2008 | Mabb, Jason B. | CNA1000000283 | Voluntary Surrender | Sexual Misconduct; Patient Abuse; Unprofessional Conduct |
| 4/21/2008 | Manhertz, Joan E. | CNA425448566 | Civil Penalty | Negligence; Substandard or Inadequate Care |
| 2/4/2008* | Mendoza, Marie A. | CNA442397833 | Voluntary Surrender | Failure to Comply Board Order |
| 4/1/2008 | Meyer, Lydia E. | CNA323875973 | Stayed Revocation | Unable to Practice Safely - Substance Abuse |
| 5/5/2008 | Mierzejewski, Sheryl K. | CNA999947689 | Revoked | Unable to Practice Safely - Substance Abuse; Failure to Comply Board Order |
| 4/28/2008 | Mosher, Peter L. | CNA818947666 | Revoked | Patient Abuse; Sexual Misconduct; Patient Neglect |
| 5/5/2008 | Moulton, Andrea J. | CNA999996695 | Revoked | Misappropriation of Property; Exploiting a Patient for Financial Gain; Dual Relationship/Boundaries |
| 5/23/2008 | Naivalututalia, Tarusila D. | CNA1000016051 | Civil Penalty | Fraud/Deceit; Failure to Cooperate |
| 3/14/2008* | Navarro Jr., Victor M. | CNA999989146 | Stayed Revocation | Criminal Conviction; Unable to Practice Safely - Substance Abuse |
| 6/30/2008 | Neal, Rachel L. | CNA1000007985 | Revoked | Patient Abandonment; Violation of Fed/State Statutes/Rules; Unprofessional Conduct |
| 6/30/2008 | Nesselroad, Nicole V. | CNA999998011 | Revoked | Criminal Conviction; Failure to Comply Board Order; Failure to Cooperate |
| 6/10/2008 | Nobriga, John B. | CNA281147504 | Voluntary Surrender | Patient Abuse; Practicing Beyond Scope |
| 6/30/2008 | Oakes, Virginia L. | CNA943598103 | Revoked | Unable to Practice Safely - Substance Abuse; Patient Abuse; Failure to Comply Board Order |
| 6/23/2008 | Ojo, Oyenike E. | CNA Applicant | Certificate Denied | Breach of Confidentiality; Substandard or Inadequate Care; Misrepresentation of Credentials |
| 5/30/2008 | Okamura, Stephanie L. | CNA1000005875 | Revoked | Failure to Comply Board Order |
| 4/24/2008 | Olague, Rudy C. | CNA999997473 | Suspension | Failure to Comply Board Order |

## CNA DISCIPLINARY ACTION CONTINUED

*Not reported in previous Newsletter

APRIL-MAY-JUNE 2008

| EFFECTIVE DATE | NAME | CERTIFICATE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 6/30/2008 | Palacios, Jose | CNA338176441 | Revoked | Unable to Practice Safely - Substance Abuse; Sexual Misconduct; Patient Neglect |
| 5/5/2008 | Pineira, Teela B. | CNA1000012179 | Revoked | Unable to Practice Safely - Substance Abuse; Failure to Cooperate |
| 5/30/2008 | Ramos, Gilbert R. | CNA1000015257 | Revoked | Failure to Comply Board Order |
| 5/5/2008 | Reid, Veronica B. | CNA139336983 | Revoked | Criminal Conviction; Failure to Comply Board Order |
| 5/5/2008 | Rhodes, Phyllis | CNA195930803 | Revoked | Criminal Conviction; Failure to Cooperate; Violation of Fed/State Statutes/Rules |
| 6/2/2008 | Rivera, Iran R | CNA1000008757 | Stayed Revocation | Failure to Provide Services; Patient Abuse; Patient Neglect |
| 5/5/2008 | Romero, Rayna L. | CNA1000008097 | Revoked | Unable to Practice Safely - Substance Abuse; Failure to Comply Board Order |
| 5/5/2008 | Sawyer, Evelyn J. | CNA1000012654 | Stayed Revocation | Patient Abuse |
| 6/30/2008 | Sayler, Bridgette C. | CNA1000011547 | Revoked | Patient Abuse; Patient Neglect; Unprofessional Conduct |
| 4/24/2008 | Sutherland, Gina L. | CNA Applicant | Certificate Denied | Criminal Conviction; Unprofessional Conduct; Failure to Cooperate |
| 6/12/2008 | Thompson, Cindy M. | CNA Applicant | Certificate Denied | Nolo Contendere Plea; Unable to Practice Safely - Substance Abuse; Failure to Cooperate |
| 5/12/2008 | Treat, Ryan M. | CNA1000015896 | Stayed Revocation | Criminal Conviction |
| 6/30/2008 | Twiss, Tammy S. | CNA1000005877 | Revoked | Exploiting a Patient for Financial Gain; Misappropriation of Property |
| 6/22/2008 | Vielma, Martha Y. | CNA Applicant | Certificate Denied | Criminal Conviction; Failure to Cooperate; Violation of Fed/State Statutes/Rules |
| 6/12/2008 | Vines, Gene A. | CNA Applicant | Certificate Denied | Criminal Conviction; Failure to Cooperate |
| 4/1/2008 | Wakefield, Shane | CNA999995215 | Stayed Revocation | Patient Abuse |
| 5/9/2008 | Warren, Kathleen J. | CNA1000011719 | Voluntary Surrender | Patient Abuse |
| 4/28/2008 | Whitman, Claudia A. | CNA Applicant | Certificate Denied | Unable to Practice Safely - Substance Abuse; Criminal Conviction; Unprofessional Conduct |
| 6/30/2008 | Wing, Patricia D. | CNA1000011529 | Revoked | Unable to Practice Safely - Substance Abuse |
| 6/12/2008 | Woida, Amanda N. | CNA Applicant | Certificate Denied | Criminal Conviction; Failure to Cooperate |
| 6/18/2008 | Young, Rhea M. | CNA999999282 | Civil Penalty | Patient Abuse; Substandard or Inadequate Care |

## CNA Discipline ACTION CLEARED

APRIL-MAY-JUNE 2008

| EFFECTIVE DATE | NAME | LICENSE |
|---|---|---|
| 5/16/2008 | Lee, Christi M. | CNA999990533 |
| 4/24/2008 | Felkins, Penny R. | CNA1000012192 |
| 4/11/2008 | Farley, Nicole M. | CNA1000012137 |
| 4/11/2008 | Villarreal, Sergio | CNA1000012044 |
| 4/14/2008 | Kennon, Amanda M. | CNA1000011264 |

*Not reported in previous Newsletter

## RN/LPN DISCIPLINARY ACTION

APRIL-MAY-JUNE 2008

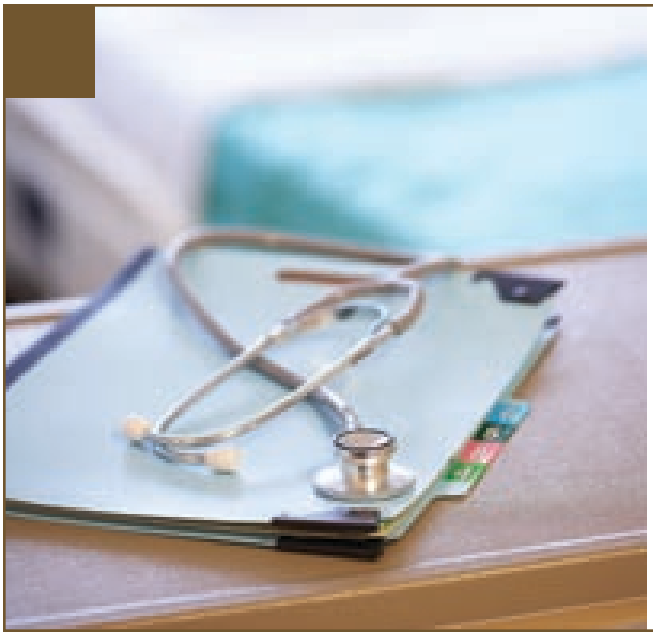
| EFFECTIVE DATE | NAME | LICENSE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 4/7/2008 | Abrams, Linda K. | RN030111 | Decree of Censure | Substance Abuse |
| 4/8/2008 | Acosta, Pablo C. | RN110209 | Decree of Censure | Practicing Beyond Scope |
| 3/5/2008* | Adams, Amy M. | LP038565 | Probation | Substandard or Inadequate Care |
| 3/19/2008* | Allen, Heather M. | LP044106 | Civil Penalty | Practicing Without Valid License |
| 5/29/2008 | Banuelos, Emilia | LP040527 | Probation | Substandard or Inadequate Care, Failure to Maintain Records |
| 6/3/2008 | Barnes, Lindsay | RN152367 | Civil Penalty | Criminal Conviction |
| 5/1/2008 | Barnett, Robert L. | LP044372 | Probation | Disciplinary Action Taken by any Licensing Authority |
| 4/28/2008 | Barry, Laurie A. | RN Endorsement | License Denied | Criminal Conviction, Unable to Practice - Substance Abuse, Failure to Cooperate with Board |
| 3/20/2008* | Behnke, Audrey L. | RN148250 | Probation | Practicing Beyond Scope, Unprofessional Conduct, Substandard or Inadequate Care |
| 5/1/2008 | Benkelman, Floy T. | RN125440 | Probation | Dual Relationship/Boundaries |

| EFFECTIVE DATE | NAME | LICENSE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 4/2/2008 | Bennett, Roseanna C. | RN026399 | Probation | Unable to Practice Safely, Substandard or Inadequate Care, Failure to Maintain Records |
| 5/28/2008 | Bennett, Sheila A. | RN137215 | Voluntary Surrender | Unable to Practice Safely, Substandard or Inadequate Care, Failure to Maintain Records |
| 4/21/2008 | Blodgett, Aaron K. | LP041705 | Decree of Censure | Patient Abandonment |
| 6/9/2008 | Bocchicchio, Cynthia L. | RN089150 | Stayed Revocation w/ Suspension | Failure to Comply Board Order, Unprofessional Conduct |
| 4/1/2008 | Brandon, Mary D. | RN063521/AP1747 | Revocation | Failure to Comply Board Order |
| 5/28/2008 | Bray, April D. | LP044417 | Probation | Criminal Conviction |
| 5/15/2008 | Bredow, Deanna S. | LP041389 | Decree of Censure | Misappropriation of Property |
| 3/23/2008* | Brent, Catherine | LP037622 | Probation | Substance Abuse, Substandard or Inadequate Care, Failure to Provide Services |
| 5/1/2008 | Brown Jr., Garry L. | LP000032935 | Probation | Criminal Conviction, Failure to Cooperate with Board |
| 5/15/2008 | Calzada, Maria G. | RN107811 | Revocation | Failure to Comply Board Order |
| 4/22/2008 | Caval, Terri | LP023161 | Probation | Unprofessional Conduct, Substance Abuse |
| 4/25/2008 | Collicott, Nancy L. | RN124272 | Probation | Substandard or Inadequate Care, Unauthorized Administration of Medication |
| 6/11/2008 | Conner, Pamela L. | RN118960 | Revocation | Failure to Comply Board Order |
| 3/19/2008* | De Vries, Darlene R. | RN063590 | Suspension | Unable to Practice Safely, Failure to Maintain Records, Error in Administering Medication |
| 1/28/2008* | Dean, Jennifer A. | RN127746 | Suspension | Failure to Comply Board Order, Unable to Practice Safely - Substance Abuse |
| 4/24/2008 | Demar, Shawna N. | LP036455 | Revocation | Failure to Comply Board Order |
| 5/23/2008 | Erkfitz, Karen R. | LP035842/CNA189349194 | Revocation | Failure to Comply Board Order |
| 4/29/2008 | Ewing, Deana | RN106682 | Probation | Substance Abuse |
| 6/16/2008 | Fisher, Andrea L. | RN086939 | Voluntary Surrender | Failure to Comply Board Order |
| 3/20/2008* | Flynn, Laura M. | RN115903 | Civil Penalty | Practicing Without Valid License |

| EFFECTIVE DATE | NAME | LICENSE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 3/31/2008* | Forsley-Plata, Elizabeth A. | RN151823 | Probation | Disciplinary Action Taken by any Licensing Authority |
| 4/24/2008 | Foster, Paul | Compact - RN, TN | Revocation-Privilege to Practice | Unable to Practice - Substance Abuse, Diversion of Controlled Substance |
| 5/4/2008 | Frankley, Alison E. | RN150331 | Stayed Revocation w/ Probation | Failure to Comply Board Order |
| 5/23/2008 | Gore, Joni M. | LP Examination | License Denied | Criminal Conviction, Unauthorized Administration of Medication |
| 5/14/2008 | Gorski, Carl J. | RN085409 | Stayed Revocation w/ Suspension | Failure to Comply Board Order |
| 5/16/2008 | Grayson, Alison M. | LP Endorsement | License Denied | Criminal Conviction, Fraud, Unable to Practice - Substance Abuse |
| 6/12/2008 | Greer, Jillian L. | RN152545 | Probation | Criminal Conviction |
| 5/8/2008 | Haglund, Cheryl | RN Endorsement | License Denied | Violation of Fed/State Statutes/Rules, Criminal Conviction, Unprofessional Conduct |
| 5/14/2008 | Haney, Robin R. | RN110519 | Stayed Revocation w/ Suspension | Failure to Comply Board Order |
| 4/4/2008 | Hanks, Millicent L. | RN118958 | Voluntary Surrender | Failure to Comply Board Order |
| 5/14/2008 | Hare, Bonnie L. | RN067325/AP0200 | Civil Penalty | Substandard or Inadequate Care, Failure to Provide Services |
| 5/12/2008 | Harvey, Deborah L. | RN085425 | Voluntary Surrender | Violation of Fed/State Statutes/Rules, Criminal Conviction, Unable to Practice - Substance Abuse |
| 5/2/2008 | Hastings, Foy L. | RN101835 | Revocation | Failure to Comply Board Order, Violation of Fed/State Statutes/ Rules, Patient Abuse |
| 3/20/2008 | Hinojosa, Melba R. | RN152210 | Civil Penalty | Practicing Without Valid License |
| 4/2/2008 | Hinske, Linda J. | RN059168 | Suspension/Indefinite | Unable to Practice Safely, Incompetence, Failure to Maintain Records |
| 4/24/2008 | Holmes, Edward | Compact - LP, WI | Revocation-Privilege to Practice | Criminal Conviction, Fraud, Failure to Cooperate with Board |
| 5/7/2008 | Howard, Amy | RN143340 | Probation | Misappropriation of Property, Unprofessional Conduct |
| 4/14/2008 | Hubbell, Diane E. | RN078968 | Stayed Revocation w/ Suspension | Unable to Practice - Substance Abuse |
| 6/18/2008 | Hubbell, Diane E. | RN078968 | Revocation | Failure to Comply Board Order |
| 4/2/2008 | Hutto, Robin | LP044267 | Civil Penalty | Criminal Conviction, Narcotics Violation or Other Violation of Drug Statutes |
| 4/17/2008 | Isambert, Connie F. | RN090746/LP022596 | Probation | Substance Abuse |
| 4/29/2008 | James, Barbara L. | RN054909 | Stayed Revocation w/ Suspension | Substance Abuse, Diversion of Controlled Substance |
| 6/1/2008 | Jauert, Leonore J. | LP037888 | Decree of Censure | Patient Neglect, Failure to Maintain Records |
| 4/16/2008 | Johnson-Belisle, Jennifer L. | RN086576 | Probation | Substance Abuse, Narcotics Violation or Other Violation of Drug Statutes |
| 5/2/2008 | Jonas, Susan R. | RN092432/AP0500 | Revocation | Practicing Beyond Scope, Substandard or Inadequate Care, Unauthorized Prescribing Medicine |
| 4/24/2008 | Kagan, Marc S. | RN112375 | Probation | Misappropriation of Property |
| 4/4/2008 | Kazmaier, Pamela A. | RN047628 | Voluntary Surrender | Violation of Fed/State Statutes/Rules, Criminal Conviction |
| 4/16/2008 | Kramer Jr., Mike | RN094894 | Stayed Revocation /Probation | Completed terms of Suspension, Converted License to Stayed Revocation/Probation |
| 5/2/2008 | Krom, Sandra J. | LP014716 | Revocation | Unprofessional Conduct, Unable to Practice - Substance Abuse |
| 3/20/2008* | Kuznecova, Natalija | RN Endorsement | Civil Penalty | Practicing Without Valid License |
| 4/25/2008 | Lehne, Jamie R. | RN135957 | Probation | Substance Abuse |
| 3/19/2008* | Lobres, Leilanee B. | RN Endorsement | Civil Penalty | Practicing Without Valid License |
| 5/2/2008 | Malcutt, Joan F. | RN136742 | Revocation | Unable to Practice - Substance Abuse |
| 4/28/2008 | Mancuso, Diane B. | RN075229 | Probation | Substance Abuse |
| 6/10/2008 | Manuel, Phyllis A. | RN138610 | Voluntary Surrender | Failure to Comply Board Order |
| 4/1/2008 | Marquart, Travis L. | LP042995 | Civil Penalty | Practicing Without Valid License |
| 4/10/2008 | Martin, Stacy L. | LP034335 | Probation | Substandard or Inadequate Care, Failure to Maintain Records |
| 6/27/2008 | Martinez, Janet | LP034177 | Revocation | Failure to Comply Board Order |
| 4/28/2008 | Mason, Priscilla | RN085502/LP027667 | Probation | Substance Abuse |
| 5/14/2008 | Massa, Joyce A. | RN151999 | Civil Penalty | Practicing Without Valid License |
| 4/18/2008 | Maurice, Shirley A. | RN026259 | Decree of Censure | Practicing Beyond Scope |
| 5/21/2008 | Mays, Lynette L. | LP042299 | Decree of Censure | Failure to Maintain Records |
| 6/17/2008 | McCoy, Elizabeth | LP038465 | Decree of Censure | Criminal Conviction |
| 5/6/2008 | McDonald, Melissa A. | RN124948 | Decree of Censure | Practicing Beyond Scope |
| 6/27/2008 | Miller, Evelyn E. | RN127076 | Revocation | Unable to Practice - Substance Abuse, Narcotics Violation or Other Violation of Drug Statutes, Diversion of Controlled Substance |
| 5/14/2008 | Mora, Claudine A. | RN123991 | Probation | Practicing Beyond Scope, Unprofessional Conduct, Unauthorized Administration of Medication |

| EFFECTIVE DATE | NAME | LICENSE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 4/3/2008 | Moraga, Cheryl L. | RN073549/LP023801 | Decree of Censure | Substance Abuse |
| 5/31/2008 | Nass, Kimberly | RN132115/LP039242 | Decree of Censure | Criminal Conviction |
| 5/14/2008 | Natividad, Olive C. | RN152128 | Civil Penalty | Practicing Without Valid License |
| 6/11/2008 | Neufeld, Martin S. | RN134049 | Voluntary Surrender | Unable to Practice - Substance Abuse, Diversion of Controlled Substance |
| 4/14/2008 | Nguyen, Thi Khoa | RN113810 | Decree of Censure | Substandard or Inadequate Care, Failure to Maintain Records |
| 5/8/2008 | Orender, Virginia A. | LP021180 | Voluntary Surrender | Failure to Comply Board Order, Fraud, Diversion of Controlled Substance |
| 5/15/2008 | Paccioni, Taryn W. | RN083610 | Suspension/Indefinite | Unable to Practice - Substance Abuse |
| 5/2/2008 | Pilon, Joanne | RN139873 | Revocation | Unable to Practice - Substance Abuse |
| 5/14/2008 | Preble, Michael C. | RN108165/LP028334 | Stayed Revocation /Probation | Failure to Comply Board Order ; Diversion of Controlled Substance; Substance Abuse |
| 5/2/2008 | Puhr, Rebecca J. | RN116584 | Revocation | Failure to Comply Board Order, Unable to Practice - Psych/Mental |
| 3/10/2008* | Raetz, Barbara J. | LP022736 | Probation | Substandard or Inadequate Care |
| 4/28/2008 | Randle, Amaryllis S. | LP030159 | Decree of Censure | False Reports/Falsifying Records |
| 5/30/2008 | Rodgers, Dianne E. | RN120630 | Revocation | Failure to Comply Board Order |
| 4/8/2008 | Roubideaux, Kara L. | RN149039 | Civil Penalty | Practicing Without Valid License, Criminal Conviction |
| 5/29/2008 | Ryan, Beth A. | RN056318 | Revocation | Failure to Comply Board Order |
| 6/16/2008 | Ryan, Brenda Jo | RN124189 | Revocation | Failure to Comply Board Order |
| 5/15/2008 | Sahadi, Barbara A. | RN121062 | Revocation | Failure to Comply Board Order |
| 4/1/2008 | Sanchez, Martin E. | LP036693 | Revocation | Failure to Comply Board Order |
| 3/22/2008* | Schoen, Martin S. | RN127190/AP1907 | Suspension/Indefinite | Fraud, Unauthorized Prescribing Medicine, Violation of Fed/State Statutes/Rules |
| 5/14/2008 | Sciandra, Debra A. | LP037818 | Probation | Unprofessional Conduct, False Reports/Falsifying Records |
| 5/30/2008 | Sharma, Manju | LP043697/CNA999997680 | Civil Penalty | False Reports/Falsifying Records, Substandard or Inadequate Care |
| 4/4/2008 | Shearer, Sandra D. | RN152005 | Stayed Suspension w/ Probation | Disciplinary Action Taken by any Licensing Authority, Substance Abuse |

| EFFECTIVE DATE | NAME | LICENSE | DISCIPLINE | VIOLATION(S) |
|---|---|---|---|---|
| 2/26/2008* | Shoemaker, Kimberly A. | LP036554 | Probation | Criminal Conviction |
| 6/10/2008 | Sosa, Clarissa N. | LP016014 | Decree of Censure | Error in Administering Medication |
| 6/27/2008 | Spence, Candy L. | RN116153 | Suspension/Indefinite | Fraud, Unable to Practice - Substance Abuse, Narcotics Violation or Other Violation of Drug Statutes |
| 6/18/2008 | Stearns, Gerald M. | RN129549/LP034413 | Voluntary Surrender | Unable to Practice Safely, Substandard or Inadequate Care |
| 4/2/2008 | Summers, Nancy S. | Compact - RN, VA | Civil Penalty | Substance Abuse, Substandard or Inadequate Care |
| 5/14/2008 | Tambi, Kennedy C. | RN129381 | Probation | Failure to Comply with Health & Safety Requirements, False Reports/ Falsifying Records, Substandard or Inadequate Care |
| 5/2/2008 | Taylor, Bette S. | RN123853 | Revocation | Disciplinary Action Taken by any Licensing Authority, Fraud, Unable to Practice - Substance Abuse |
| 6/4/2008 | Tenorio, Raquel R. | RN117144 | Decree of Censure | False Reports/Falsifying Records |
| 4/20/2008 | Townsend, Kelly P. | RN108755 | Decree of Censure | False Reports/Falsifying Records |
| 5/14/2008 | Tuballa, Leonardo A. | RN151975 | Civil Penalty | Practicing Without Valid License |
| 5/23/2008 | Twitchell, Carol F. | RN108325 | Revocation | Failure to Comply Board Order |
| 5/30/2008 | Velovich, Georgia | LP023641 | Decree of Censure | Negligence |
| 3/5/2008* | Vonada, Shane R. | LP042258 | Probation | Substance Abuse |
| 4/25/2008 | Wade, Lydeana L. | RN106685 | Revocation | Unable to Practice - Substance Abuse, Diversion of Controlled Substance |
| 4/1/2008 | Wadzeck, Stacey L. | RN102668 | Voluntary Surrender | Narcotics Violation or Other Violation of Drug Statutes, Diversion of Controlled Substance |
| 5/1/2008 | Wall, Jason E. | LP040360 | Stayed Suspension w/ Probation | Completed Terms of Indifinite Suspension; License Converted to Stayed Suspension/Probation |
| 5/20/2008 | Walls, Margaret M. | RN133940 | Decree of Censure | Unauthorized Dispensing of Medication, Unauthorized Administration of Medication |
| 5/6/2008 | Weber, Margie D. | RN Endorsement | License Denied | Disciplinary Action Taken by any Licensing Authority, Unable to Practice - Substance Abuse, Fraud |
| 5/23/2008 | Whitaker, Joyce M. | RN084343 | Revocation | Failure to Comply Board Order, Patient Neglect |
| 6/27/2008 | Willemsen, Patricia H. | RN106911 | Revocation | Unprofessional Conduct, Substandard or Inadequate Care, Error in Administering Medication |
| 5/8/2008 | Wisner, Pamela D. | RN102410 | Probation | Substance Abuse |
| 5/27/2008 | Wood, Bobbie K. | LP Endorsement | License Denied | Disciplinary Action Taken by any Licensing Authority, Failure to Meet the Initial Requirements of a License |
| 5/12/2008 | Wyant, Edward | RN149415 | Civil Penalty | Violation of Fed/State Statutes/Rules, Criminal Conviction, Fraud |
| 3/17/2008* | Yates, Yolanda | LPN Endorsement | License Denied | Failure to Meet Licensing Board Reporting Requirements, Violation of Fed/State Statutes/Rules, Failure to Cooperate with Board |
| 4/28/2008 | Young, Jacqueline A. | LP026926 | Decree of Censure | Patient Abandonment |
| 5/14/2008 | Zarate, Georgieanna P. | RN115206/LP035550 | Stayed Revocation w/ Suspension | False Reports/Falsifying Records, Unable to Practice - Substance Abuse |



# RN-LPN Discipline
## ACTION CLEARED

APRIL-MAY-JUNE 2008

| EFFECTIVE DATE | NAME | LICENSE |
|---|---|---|
| 35/14/2008 | Dusold, Margaret A. | LP040023 |
| 4/5/2008 | Eischen, Tricia M. | RN148615 |
| 5/7/2008 | Hagen, Robin L. | LP032674 |
| 5/14/2008 | Lee, Kathy H. | RN118565 |
| 5/16/2008 | McCann, Karen D. | RN118940 |
| 5/14/2008 | Nolte, Vicki S. | RN108240/LP033096 |
| 6/30/2008 | Reiss (Pottgen), Heather B. | RN107514 |
| 5/14/2008 | Stepp, David A. | RN127460 |
| 6/10/2008 | Tascione, Maryanne T. | RN047390 |
| 4/9/2008 | Whinery, Brenda | RN080021 |
| 4/15/2008 | Williams, Brenda S. | RN054527/SN0674 |

# ONE NURSE WHO SPOKE UP AND MADE A DIFFERENCE!

*GUEST COMMENTARY* BY REGINA G. COTTRELL, MN-ED, BS, RN

Approximately 30 months ago, I filed a complaint with the Ombudsman Office regarding duplicate regulatory efforts of Certified Nursing Assistant Training Programs by the AZ State Board of Nursing (AzBN) and the AZ State Board of Private Postsecondary Education (PPSE). Programs that are created, managed, and taught by entrepreneurial nurses were required to be approved by the AzBN and also gain licensure from the PPSE. After fourteen months of legal scrutiny, the Ombudsman concluded that the dual oversight of both boards was unnecessary. They also concluded that in most areas, the AzBN had greater attention to detail, higher standards and lower costs to programs. Arbitration between the two boards was unsuccessful, and it was determined that statutory change was necessary.

Senator Paula Aboud sponsored SB 1431 exempting free-standing CNA programs from Private Post Secondary oversight. I was called upon to provide testimony in support of the bill before the House Health Committee chaired by Representative Bob Stump. I also was privileged to meet Senator Aboud of the Senate Health Committee and Mr. Michael Shanahann from the Ombudsman Office. I informed the committee that I was the individual who filed the complaint with the Ombudsman and that I had spent almost $25,000.00 to meet PPSE requirements. My students, staff, and business received no benefit from the whole process. It truly was a waste of energy, time, manpower, and money. The committee voted unanimously in favor of the bill; it passed both houses and was signed by Governor Napolitano on May 15, 2008.

I learned several lessons from this experience: "Good things come to those who wait;" and one person can make a difference. As an individual, I have the responsibility to change the things I can change. As a nurse, I have the duty to advocate for change. I encourage every nurse in Arizona to speak up when an issue is unsafe, costly, or even unfair. The legislators will listen. Harvey Mackay has a moral: "If you don't speak up, prepare to put up." (AZ Republic, 4/2008).

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, AZ 85014-3653

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