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SUBSTANCE USE DISORDER IN NURSING

A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs

Featured Articles

SUBSTANCE USE DISORDER

Signs and Symptons DRUG DIVERSION

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From the Executive Director

JOEY RIDENOUR, RN, MN, FAAN

This edition of the Arizona State Board of Nursing Regulatory Journal is must read "primer" for all nurse leaders, licensed nurses and certified nursing assistants regarding the number one issue that causes licensees and certified persons to be reported to the Board in the past ten years: Substance Use Disorders (SUD). Recent scientific advances, including those supported by the National Institute on Drug Abuse (NIDA), have led to a better understanding of SUD over the past decade, SUD is "now recognized as a chronic relapsing brain disease expressed in the form of compulsive behaviors.", says NIDA Director Nora D. Volkow, M.D. She further states that "nearly one in 11 Americans over the age of 12 is classified with substance abuse or dependence."

The best information and evidence based guidelines addressing SUD for all Nurses is: 1. the downloadable SUD manual from National Council of State Boards of Nursing and 2. articles by Val Smith, RN MS FRE found on pages 6 and 12.

For questions or comments regarding SUD, please contact CANDO Nurse Practice Consultant – Jan Kerrigan at 602 771 7864 or Nikki Austin, JD, RN, Associate Director/Investigations at 602 771 7819.

https://www.ncsbn.org/2106.htm (Free to Download) Substance Use Disorder in Nursing Manual: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs

The purpose of the Substance Use Disorder in Nursing manual is to provide practical and evidence-based guidelines for evaluating, treating and managing nurses with a substance use disorder.

An extensive body of scientific evidence shows that approaching addictions as a treatable illness is extremely effective financially and across the broader societal impacts. When treatments for nurses are individually tailored to meet their needs and an appropriate supportive monitoring system is in place, then recovering nurses are not impaired and can practice safely. NCSBN hopes that this manual will be a helpful tool that can be used to implement better practices in helping the healers to heal themselves and at the same time helping to protect the public.

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SUBSTANCE USE DISORDERS:
A Nursing Regulatory and Humanistic Perspective

My first nursing job as a new graduate in the late 1970's was on a medical surgical unit in a large acute care hospital.

Following the advice of my nursing instructors, I identified an experienced nurse to be my "mentor." "Lydia" was the charge nurse and often picked up additional shifts. Every other weekend, on her days off, Lydia worked for an air ambulance company. On our unit, staff all knew that whatever knowledge and skills we may lack or, as in my situation, still developing, Lydia not only possessed the knowledge and skills but did so at the expert level. In selecting Lydia as my mentor, I knew that when I "grew up" I wanted to be the nurse that Lydia was.

Several months into my employment I arrived on duty after a few days off and heard from other coworkers what I thought to be a horrible mistake. Our manager had suspected Lydia of diverting drugs and had been auditing Lydia's controlled drug removals. After Lydia signed out Demerol and entered a patient's room, the nurse manager followed. Lydia was found in the patient's bathroom injecting herself with the Demerol. She was taken to the nurse manager's office where other persons from administration were waiting and given the option to resign or be terminated. Lydia opted to resign. I remember to this day my shock and disbelief. "They" must have made a mistake. A nurse as capable as Lydia could not be using drugs. To me, at that time in my professional development, Lydia did not "look" like someone who not only used drugs but used patients and the hospital to steal drugs and use those drugs while on duty. My disbelief extended beyond Lydia. I could not fathom that any nurse could or would have a substance use disorder that resulted in them diverting drugs and using while on duty. Within a short period of time we heard that Lydia was hired by another hospital. After all, she was a well regarded nurse but one with a tremendous and deadly secret. While there is much to the story that I do not know, it is likely Lydia was not referred for treatment and likely Lydia was not reported to the Board of Nursing. It was the 1970's and for many of us, our knowledge of the Board of Nursing was limited to the granting of new graduates like myself our nursing licenses. It is my hope that if that same scenario occurred today with the same people, it would be done so with more confidentiality safeguards in place. Whether she remained employed at the hospital or not, it is my hope that Lydia would be referred for an evaluation for the purposes of obtaining appropriate treatment for a chronic, progressive and potentially fatal disease. Additionally, to assure patient and public safety, Lydia would be encouraged to report and be reported to the Board of Nursing. The Board of Nursing has programs in place that when appropriate, allow the nurse to maintain licensure contingent in part upon abstaining from unauthorized use of alcohol and drugs, compliance with treatment and other recovery requirements. Not only is their compliance with treatment monitored but their nursing practice is supervised and monitored.

What is Addiction/Substance Use Dependence?

Addiction, also referred to as substance use dependence, is a chronic and complex disease that often includes physical, cognitive, emotional, spiritual, financial and/or legal consequences. Addiction is a disease of the brain. The excessive use of alcohol and other drugs alter the normal function of the brain and changes the way the brain responds to issues of self-control, judgment, emotion, motivation, memory and learning. The course of the disease follows a predictable and progressive course and not uncommon, may result in death if left untreated. The disease of addiction is characterized by a maladaptive pattern of substance use manifested by at least 3 of the following:

- Persistent desire or unsuccessful attempts to "cut down" or control one's use
- Excessive time spent seeking and/or using alcohol and/or drugs
- Reduction of important activities as the substance use becomes more pervasive
- Changes in tolerance
- Continued use despite adverse consequences or high potential for adverse consequences
- Withdrawal

While individuals may have initially chosen to misuse substances, the disease of addiction is not intentional. Individuals who struggle with alcohol and/or drug addiction do not set out to destroy themselves, everyone & everything in their path. These disastrous and often deadly consequences are the result of the vicious cycle of a defined medical condition. The National Council on Alcoholism and Drug Dependence (www.ncadd.org) sites the following statistics:

- Alcohol is the most commonly used addictive substance in the United States- 17.6 million people, or one in every 12 adults, suffer from alcohol abuse or dependence along with several million more who engage in risky, binge drinking patterns that

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could lead to alcohol problems.

- Over 1.4 million arrests for DWI each year (less than 1% of 159 million self-reported episodes of alcohol-impaired driving)
- Almost half of all traffic fatalities are alcohol-related
- Over 86.5% of all alcohol-related deaths are pedestrian accidents, falls, fires, homicides, alcohol overdose, suicides and health-related deaths, e.g., cirrhosis, etc.
- One-quarter of all emergency room admissions, one-third of all suicides, and more than half of all homicides and incidents of domestic violence are alcohol-related
- Approximately 5 to 6 million Americans have drug problems
- Approximately 20 million Americans aged 12 or older used an illegal drug in the past 30 days representing 8% of the population aged 12 years old or older.
- There are more deaths and disabilities each year in the United States from substance abuse than from any other cause
- Untreated addiction is more expensive than heart disease, diabetes and cancer combined

Second to alcohol, the most commonly used and abused drug by the general population is marijuana. Other common drugs of abuse include cocaine, heroin, inhalants, LSD (acid), MDMA (ecstasy), methamphetamine, phencyclidine (PCP), steroids (anabolic), Vicodin, OxyContin and other prescription drugs.

Substance Use Disorders in Nursing

Substance use disorders in nursing is not a modern day phenomenon. O. M. Church, in a 1985 Nursing Administration Quarterly article, provided a historical review of substance abuse in nursing literature. Church reviewed the literary character Mrs. Sarah Gamp in Charles Dickens' novel Martin Chuzzlewit, published in the 1840's. Mrs. Sarah Gamp, otherwise known as Sairey, is a nurse who "sought work that provided accessibility to alcohol and food at the patient's expense." Nightingale reportedly addressed in her writings the need to dismiss nurses for being "dead drunk." In a 1900 Nursing Ethics book, a nursing author wrote, "Among my saddest experiences are the instances, fortunately very rare, in which I have encountered members of our own profession who have lost their power of self control and have become victims to the abuse of some powerful drug or alcoholic stimulant with all of it attending evils." Nurses are no more immune from developing substance use disorders and addiction than the general population. The risk of prescription drug misuse is higher among nurses than the general population. Prescription drug use is defined as drugs available by prescription whether or not the nurse obtains the drug by legitimate prescription or other means. Factors associated with nurses having a higher risk of misuse and abuse of prescription drugs include the easy access of medications/drugs, belief that medications/drugs can and will alleviate unwanted feelings and the belief that with the nurse's knowledge of pharmacology, they can control their substance use. Although the actual rate of addiction in nurses is unknown with estimates ranging from 6% to 20% of all nurses suffer from a substance use disorder, what is known is that one of the most common complaints received by Boards of Nursing and forms the basis for licensure disciplinary action is substance misuse, abuse or dependence related.

Profile of The Nurse With A Substance Use Disorder

Despite the prevalence of substance use disorders both within society and within the nursing profession, and despite increased media and attention within the nursing profession, many co-workers, supervisors, employers and others have difficulty recognizing or assisting a nurse colleague with an apparent substance use disorder. This is alarming considering the inherent responsibilities nurses have for patient care and safety and the potential fatal nature of the disease if left untreated.

Nurses and other healthcare professionals take great effort to protect their professional reputation, identity and nursing licensure. As with "Lydia," it is not uncommon that the nurse with a substance use disorder continues to be perceived by colleagues and themselves as high functioning well into the disease. Thus, signs and symptoms of the disease on the job usually indicates a late stage disease process and is characteristic of the inability to control one's use and the continued use despite potential for negative consequences (compromised patient care, patient harm, loss of job, licensure sanctions, ect). Late into their disease, many nurses will continue to rationalize their use and want to believe they can control their substance misuse. Their denial, intense shame and fear of consequences should others learn of their "secret" prevents them from proactively seeking treatment. Managers and co-workers may unintentionally enable the disease to progress by ignoring or excusing poor performance, incomplete work, attendance issues and other symptoms of a substance use disorder. Another way in which the disease is enabled is when an employer recognizing symptoms consistent with a possible substance use disorder opts to allow the nurse to resign or terminates the nurse without addressing the concerns of a possible substance use disorder and/or reporting the nurse to the Board. When this happens, the nurse is allowed to continue with a potentially fatal disease and patient care with the next employer is potentially negatively impacted.

Recognizing Workplace Indicators of Substance Use Disorder

As the substance use disorder progresses, signs and symptoms of the disease begin to manifest in the workplace. Workplace indicators of a substance use disorder may include and is not limited to the following:

Attendance: As the disease progresses,an individual's world becomes smaller as activities are selected that provide access and opportunity to use. If the substance of abuse is obtained outside of the workplace (alcohol, illegal drugs …) the individual may begin to demonstrate progressive absences from work, difficulty adhering to their work schedule, unusual or implausible reasons for absences. When at work, they may also demonstrate on the job absences (unexplained frequent or prolonged absences from the unit). When the workplace has become a source of supply of the drug (drug diversion) as it did with Lydia, it is not uncommon for the nurse to seek employment opportunities that provide access to the drug. This may be through work setting, patient selection, additional work hours, including overtime and they may have unexplained presence in the workplace during scheduled times off.

Interpersonal: Indicators include complaints from co-workers or patients or others; increased isolation from others;

unpredictability; changes in mood and/or energy level (alert to appearing sedated); increased conflict with others; legal problems; family or social problems.

Job Performance: Indicators include difficulty in organizing and prioritizing duties and responsibilities; difficulty meeting deadlines; deterioration in quality of work; poor judgment; forgetfulness; below standard practice; odor of alcohol on person or breath; inappropriate, inadequate or missing documentation; discrepancies with controlled drugs or the amount removed as compared to co-workers without a corresponding change in the patient condition that would explain the need for additional medications; high volume of controlled drug "waste," discrepancies in the accounting for controlled medications signed out; unauthorized removal of controlled substances or other medications of abuse; missing medications; selecting patients or assignments that provide them with access to drugs; altered provider orders for controlled substances, prescription fraud… In another section of this journal is listed some common indicators of drug diversion from the workplace.

What Not To Do

Do not ignore your observations and intuitive concerns. Often by the time a colleague begins to consider the possibility that a nurse has a substance use disorder, there is merit to the concerns. Do not allow the nurse who is demonstrating active signs and symptoms of impairment to continue to provide patient care or make decisions impacting patient care until further expert assessment can be completed and evidence of ability to safely perform. Do not allow the nurse to resign or be terminated without addressing identified concerns, providing resources for further evaluation and treatment and without notifying or causing the Board to be notified. Do not encourage the nurse to hide information from the Board. At times, and perhaps well meaning friends, colleagues, and others advising the nurse in how or what to share with the Board or assigned investigative staff, have encouraged the nurse to not disclose their substance abuse history or substance use disorder with the Board. Not disclosing can put patients at risk and can have deadly consequences for the nurse. It is a barrier to the nurse obtaining appropriate intervention and treatment. Addiction is a chronic progressive disease that may and often does result in death if left untreated.

What To Do

One of the first steps is having the knowledge and understanding that nurses are not immune from developing a substance use disorder. It is an equal opportunity disease that is often misunderstood by those with or impacted by the disease, including employers and co-workers. Nurses with an active substance use disorder have potential to not only harm patients but also cause harm or death to themselves. Be aware and observant for indicators of substance abuse. Colleagues who work closely with a nurse struggling with a substance use disorder often recognize that something is wrong before the supervisor who may not have as frequent encounters. If you are a colleague, do not assume the supervisor is aware. Share your concerns with the supervisor. Understand that simply asking the nurse whether or not they have a substance use disorder will not likely result in an admission. The barriers for those with a substance use disorder being truthful results from their intense shame and fear. You must be prepared to present objective information and ask questions until you understand what did or did not happen. Do not accept implausible answers. Anytime that there is reasonable concern that a nurse, for whatever reason, is currently unable to safely practice, they should immediately be removed from patient care until further assessment can be completed. If employer policies permit, and there is reasonable suspicion that the nurse may be under the influence of a substance, a drug test should be obtained and the panel of drugs tested should include the drug(s) that are of suspect. A nurse with a suspected substance use disorder should be referred for further evaluation for possible treatment and a report submitted to the Board for further review and investigation by the Board to determine safeness to practice. If the nurse acknowledges substance abuse, they may be eligible for the Board's non-public and non-disciplinary monitoring program for nurses with substance abuse disorders, CANDO. Information about CANDO can be found on the Board's website at www.azbn.gov. Although the Board's mission is patient protection, patient protection can often be accomplished by nurses who have a recent or active substance use disorder entering into CANDO or entering into a Consent Agreement with the Board that mandates treatment, abstaining from unauthorized substance use, practice limitations and practice supervision.

Summary

As nurses, we have shared responsibilities for patient safety and when we recognize that one of our colleagues may be struggling with a substance use disorder, we have a responsibility to do the right thing and bring it to the attention of someone who can intervene in behalf of both the patients and the nurse. While there is much to still learn about substance use disorders, the evidence shows that a combination of treatment, involvement in 12-step meetings and licensure/practice monitoring requirements established by healthcare regulatory boards can have positive impact on facilitating remission of the disease and returning nurses, when appropriate, to patient care and/or practice.

I often think back to my first known experience with a colleague who had an apparent substance use disorder. I hope somehow, someway she was able to seek and obtain appropriate treatment. I share the story of Lydia when providing education to nursing and healthcare employers as we need to see this disease with eyes wide open. To be effective in identifying and appropriately responding to colleagues with possible substance use disorders we need to shed our stereotype view of what a person with an addiction looks or acts like and timely respond with compassion, understanding and firmness. It is not if, but rather, when you suspect a nurse has a substance abuse disorder, dare to do the right thing and make your concerns known to those who have the ability to intervene in behalf of the nurse and patients.

Written by Valerie Smith, MS, RN, FRE, Consultant to the Executive Director, Arizona State Board of Nursing

Val has over 25 years experience with substance use disorders in nursing. She has been active both within the state and nationally in assisting others with developing guidelines and policies for recognition, intervention and regulatory management of nurses with substance use disorders.

e-Notify for RN/LPN

BY JUDY BONTRAGER, RN, MS
ASSOCIATE DIRECTOR OPERATIONS/LICENSING

Every year, boards of nursing (BONs) across the U.S. contact thousands of their nurses to remind them to renew their nursing license. Some BONs send emails; others send postcards and letters. It is then the responsibility of the nurse to renew their license. Left out of this equation, however, are the employers who rely on nurses to have current licenses to practice. Previously, the only way for employers to know if a nurse's license was about to expire was to look it up, one nurse at a time. And when it came to learning about discipline status, employers were left out of the loop again, having to seek this information on their own.

Not anymore

Institutions that employ nurses can now have the ability to receive automatic licensure and discipline notifications about their nurses quickly, easily and securely with NCSBN's new Nursys e-Notify system. Launch Dec, 2012, e-Notify is an innovative nurse licensure notification system that automatically provides employers licensure and publicly available discipline information of nurses in their employ; that information will automatically be sent to them.

The e-Notify system alerts subscribers when changes are made to a nurse's record, including changes to license status, license expirations, license renewal, and public disciplinary action/resolutions and alerts. This means that if a nurse's license is about to expire, the system will send a notification to the employer about the expiration date. Employers can also immediately learn about new disciplinary actions issued by a BON for their employed nurse, including receiving access to available public discipline documents.

Benefits

The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for registered nurses (RNs) and licensed practical/vocational nurses (LPN/LVNs). Nursys data is compiled from information directly inputted from BONs (in participating jurisdictions; visit nursys.com for current participation list). The system provides real-time automatic notification of status and discipline changes delivered directly to institutions.

Cost

All institutions are given 100 credits free of charge. This means that the first 100 nurses enrolled into the system are free. After that, each nurse is $1 per nurse, per year. A facility that employs 25 nurses would pay nothing to utilize e-Notify; a facility with 150 nurses only pay $50

With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or not charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

per year. A unique feature of e-notify is the ability for institutions to turn a nurse's notification setting on or off, choosing whether or not to receive notifications about a specific nurse's licensure or discipline status. Only nurses who have their notifications turned on are charged against one of the employer's 100 free credits.

Customizable Features

It's entirely up to the institution to determine how often they want to receive notifications about their nurses. They have the option of receiving email notifications daily, weekly or monthly. For licensure renewal notification, institutions can choose to receive alerts 30, 60 or 90 days prior to a nurse's license expiring.

Ease of Use

Institutions can enroll nurses into e-Notify easily either as an individual or through bulk uploads; all that is needed is the nurse's license number, license type and the state that issued their license. This information is used to locate the nurse directly from the Nursys database. Once nurses are enrolled, institutions can access their nurse list and download the data at anytime. Another unique feature of e-Notify is its search functionality. Rather than searching for a nurse by his or her name, e-Notify only allows institutions to search by licensure number. This way if a nurse changes their name with the BON, that information will automatically be updated in e-Notify, decreasing the likelihood of multiple entries being entered into the system for the same person.

When enrolling a nurse in e-Notify, institutions also have the option of including the nurse's email address and/or cell phone number, Institutions can send automatic e-mails reminders, as well as text messages, to a nurse securely.

With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or not charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

To subscribe to Nursys e-Notify go to nursys.com

Signs and Symptoms of DRUG DIVERSION

BY VALERIE SMITH, RN, MS, FRE,
CONSULTANT TO THE EXECUTIVE DIRECTOR

When a nurse misappropriates drugs from the workplace and patients it is symptomatic of the disease of addiction. Drug diversion is indicative of compulsion to use, loss of control, and continued substance use (intense and intrusive craving) despite potential for negative consequences. Diversion of drugs is not uncommon in nurses and other healthcare professionals with an active substance use dependence disorder.

In hospitals and similar settings, drug diversion is commonly identified following a "discrepancy" or a routine controlled drug audit. Listed below are common patterns associated with a nurse who is diverting drugs:

- Higher volume of controlled drug removals than other nurses working similar hours and with similar patient assignments
- Intervals between removed doses are less than expected or ordered for the patient
- Amount removed exceeds the provider's ordered dose despite the correct dose being available
- Patients pain needs assessed and managed are often different on shift before and/or following
- May have a higher incidence of medication "waste"
- May fail to account for "wastage"
- May fail to obtain a witness for "wastage"
- May fail to adhere to established waste policies and procedures for accounting for controlled drugs
- Controlled drugs and/or corresponding controlled drug record "lost" or missing
- May select patient assignments that provide access to the controlled drug(s) or patients who can not accurately communicate to others whether or not they needed or received medications
- May have multiple removals of control drugs that don't make clinical sense
- Documentation of removed controlled drugs may be inadequate or nonexistent
- May remove controlled drugs at times the nurse is not assigned to unit
- May sign-out controlled drugs to patients not assigned to the nurse or no longer on unit
- Inconsistencies between patient's signed-out by the nurse report of pain & medication
- May seek additional or increased provider orders for controlled drugs
- Pattern to medication removals that is inconsistent with clinical status
- May sign-out under coworkers password
- May sign-out medications to counter withdrawal symptoms
- May obtain access to patient's discharge prescription and may alter the prescription to fill for self use
- May claim or have received personal prescriptions for drugs that are also being obtained by diversion
- In homecare settings, in addition to some of the above indicators, listed below are common patterns associated with a nurse who is diverting drugs:
- May seek early refills of a patient's controlled drugs without clinical need
- May call-in a "prescription" to the pharmacy using false credentials or identity
- May obtain controlled drugs from the patient's pharmacy without request and/or need from the patient
- Controlled drugs, partial or all, missing from the patient's home after the nurse has been to the home
- May "visit" the patient on off hours and without clinical need or necessity
- May obtain access to patient's written prescriptions and alter the prescription for self use.

It is important to remember that diversion of drugs is evidence of the progression of a serious and potentially fatal substance use disorder. To protect patients from unsafe practice, timely intervention and removal of the nurse from practice pending further evaluation and determination of safeness to practice is important. Timely and appropriate intervention may also prevent further compromise to the health and safety of the nurse with a substance use disorder.

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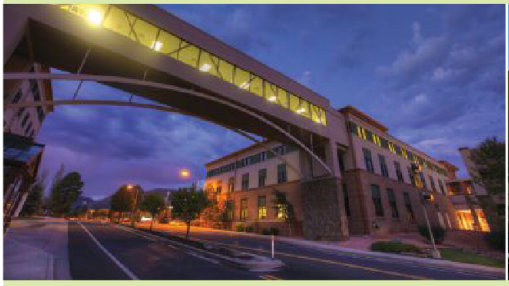

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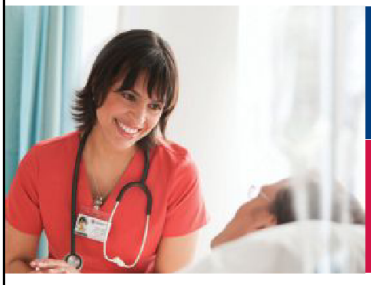
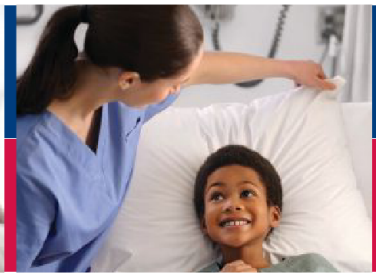
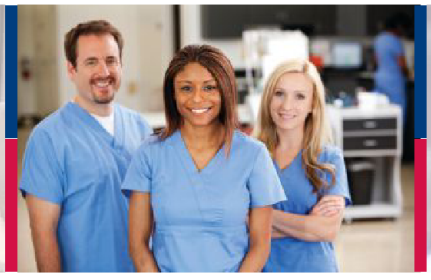
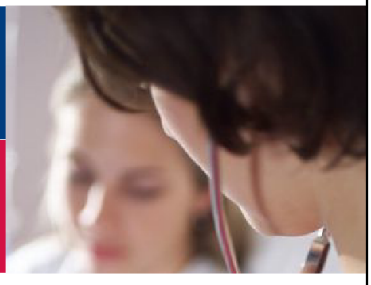

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8:00 am - 8:30 pm	**Knowing the Rules: Board Updates** by Pamela Randolph, RN, MS
8:30 am - 9:15 am	**Getting the Permit: CNA Exam Update** by Teresa Whitney & Vicky Castillo, RN, BS
9:15am - 10:00 am	**Establishing a Foundation: Curriculum Development** by Debra McGinty, RN, PhD.
10:00 am - 10:30 am	**Break & Vendors**
10:30 am - 11:15 am	**Building a Framework: Teaching Method (Didactic)** By Debra Hagler, PhD, RN, ACNS-
11:15 am - 12:00 pm	**Filling the Gaps: Teaching Method (Clinical Skills)** by Beatrice Kastenbaum, RN, MSN, CNE & Janine Hinton, PhD, RN, MN
12:00 pm - 1:00 pm	**Lunch & Vendors**
1:00 pm - 2:00 pm	**Nailing it Down: Clinical Supervision & Assessment** by Janina C. Johnson, MSN, RN
2:00 pm - 2:45 pm	**Building Structural Integrity: Test Banks & Test Security** by LeighAnn Remmert, BSN, RN, MS
2:45 pm - 3:00 pm	**Break & Vendors**
3:00 pm - 3:45 pm	**Passing Inspection: Preparing for AZBN Site Visits** by Opal Wagner, RN, BNS
3:45 pm - 3:50 pm	**Evaluations & Closing Remarks**

"This activity has been submitted to the Arizona Nurses' Association for approval to award contact hours. The Arizona Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation."

FACULTY DEVELOPMENT
A Deliberate Process

BY DEBRA MCGINTY, RN, PhD
Education Program Administrator 2010-2012

My position at the Board required me to visit nursing programs for a variety of reasons, from verifying information within applications for approval to conducting investigations. The very best programs are amazing. During one recent visit, after observing students in a clinical simulation exercise, they told me they were "grateful to fail" when they didn't quite reach the mark. The students said the program had high standards and they had to work very hard to meet faculty's expectations. They explained that when they failed, they knew the faculty's assessment was fair because the safety and health of patients were at risk if they continued to perform below standard. They thought themselves blessed to have faculty who were frequently available, easily accessible and always approachable. Students knew that the faculty had thoughtfully assessed their level of performance and would provide additional learning opportunities and sufficient support until they attained mastery.

Nursing programs with positive outcomes are staffed with faculty who are dedicated and committed to the success of their students. Supportive faculty are most often supported by deans and directors who share in their pursuit of excellence. A conspicuous culture of learning proliferates in which faculty seek opportunities to acquire new knowledge and skills to achieve successful student outcomes. These programs evidence a deliberate process of faculty development as illustrated by the following scenario:

The Dean at Watson College hired Ms. Brown in October 2012 to teach health assessment and fundamentals to baccalaureate students. Ms. Brown has 8 years experience in home health and long term care and no prior teaching experience. The Dean paired Ms Brown with an experienced and highly successful faculty mentor to assist her to learn program policies and teaching practices and to foster role development. Ms. Brown will co-teach with her mentor until the semester ends in December. In January 2013 she will teach these same courses independently but with consistent support from her mentor. Ms. Brown will complete a professional needs assessment to identify professional goals and will be encouraged to participate in faculty development workshops that address instructional methods, assessment of student learning, and advances in nursing science. Ms. Brown appreciates the Dean's evident support as she consistently responds with sensitivity, encouragement and recognition of achievement. Ms. Brown soon discovers that students positively respond to her instruction, exceed her expectations, and are successful in completing her course.

Mentorships for new faculty can ensure that they understand curriculum objectives, develop effective classroom activities, and implement fair and valid methods for evaluation of student performance. A process of reflective

self-assessment can assist new faculty to identify factors or actions that limit their instructional effectiveness and need improvement. By providing mentors, allocating resources for continuing education, and acknowledging the trials and triumphs of being a nurse educator, the program administrators foster successful transitions into the faculty role. Ms. Brown's early sense of competence and effectiveness is more likely to result in a positive teaching experience for her, a positive learning environment for her students and a long, satisfying career at Watson College.

Unfortunately, another all too common scenario in nursing education often results from the massive shortage of nursing faculty. The following fictitious case study describes the problem:

Faculty member Ms. Green was recently hired by the Henderson School of Nursing that offers an Associate Degree. She received her assignment to teach NUR 142 Nursing II, a course that builds on basic foundational skills and introduces students to nursing in acute medical-surgical settings. Ms. Green worked in ambulatory care settings for 17 years and has no experience in teaching. She was given class/clinical schedule, two text books, a syllabus, three unit exams and a final by the Dean. The concentrated course is 6 weeks in length and starts in two weeks.

When bad things happen to good programs, deans and directors do their best to assign the most qualified candidate available to instructional positions sometimes with little notice. However in this scenario, students are less likely to acquire a valued experience due to the learning curve of the new faculty. The faculty member must grasp the structure of course objectives and create a teaching plan with meaningful activities that will encourage and challenge students while teaching course content in an area outside her expertise. Further compromising the teaching-learning situation is the short a period of time available to adequately prepare for a course of critical importance. There will also be little time for students to assimilate, process, and apply their newly acquired knowledge. Their performance in clinical settings to assess and recognize contextual responses to care may be affected. If a student experiences a setback in learning or doesn't keep up with the pace, there is little time for review or remediation to get back on track.

The abbreviated duration of the course combined with her inexperience in instruction will challenge Green's abilities to adequately engage and evaluate students' learning. Green is particularly vulnerable to burnout if the difficult realities of her situation begin to erode her capacity for caring and personal satisfaction with her teaching position. Certainly once Green has taught this course initially, she will be better prepared in the future. She may be able to persevere and overcome these difficulties and with time develop a sense of salience of the content within the curriculum.

There is plentiful evidence in nursing education to support the implementation of mentorships and benefits of professional development for nursing faculty. The recruitment and retention of nursing faculty is a critical issue currently. Nursing programs that are struggling to attract and retain faculty and students can learn a great deal by examining the practices of nursing programs that have become "destination institutions" for nursing faculty rather than short "flight connection" stops.

Related Reading:

1. Dunham-Taylor, J., Lynn, C. W., Moore, P., McDaniel, S., & Walker, J. K. (2008). What goes around comes around: Improving faculty retention through more effective mentoring. *Journal of Professional Nursing*, 24(5), 337-346. http://dx.doi.org/10.1016/j.profnurs.2007.10.013
1. Krause-Parello, C. A., Sarcone, A., Samms, K., & Boyd, Z. N. (2012). Developing a center for nursing research: An influence on nursing education and research through mentorship. *Nurse Education in Practice*. In press, corrected proof available online 6 September 2012. http://dx.doi.org/10.1016/j.nepr.2012.08.004
1. Heinrich, K. T., & Oberleitner, M. G. (2012). How a faculty group's peer mentoring of each other's scholarship can enhance retention and recruitment. *Journal of Professional Nursing*, 28(1), 5-12. http://dx.doi.org/10.1016/j.profnurs.2011.06.002
1. Sawatzky, J. V., & Enn, C. L. (2009). A mentoring needs assessment: validating mentorship in nursing education. *Journal of Professional Nursing*, 25(3), 145-150. http://dx.doi.org/10.1016/j.profnurs.2009.01.003

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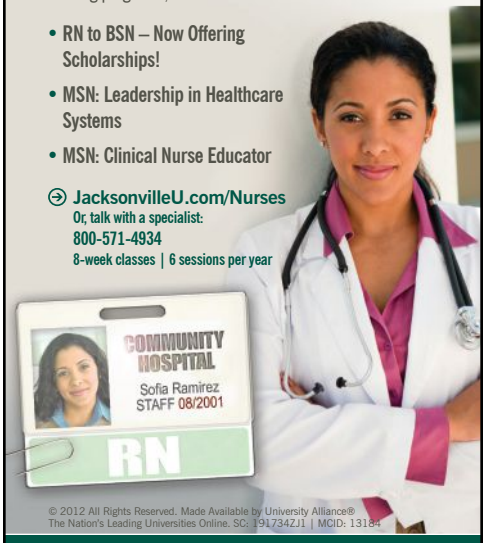

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CNA CORNER

BY PAMELA K. RANDOLPH, RN, MS,
ASSOCIATE DIRECTOR EDUCATION/EVIDENCE BASED REGULATION

CNA COMPETENCY EXAM CHANGES

The annual review of the CNA Manual Skills and Written Tests and testing procedures was conducted on September 27, 2012, at the meeting of the ad hoc Test Advisory Panel (TAP) at the Arizona Board of Nursing.

Background:

The ad hoc Test Advisory Panel (TAP) is made up of volunteer CNA instructors. Attendees at the CNA Retreat are asked if they would like to serve on this panel and selection is made based upon past attendance, past or potential contributions to the process and representation of rural/urban areas and program types. Most volunteers are offered at least one opportunity to participate on a TAP. The changes proposed by the TAP were approved by the Board on November 9, 2012 and will be effective February 1, 2013.

Changes
Effective February 1, 2013
Testing Processes/Evaluation

- To emphasize safety yet retain the efficiency of the test on items such as bedpan and occupied bed making, the candidates will be able to use the test observer (TO) to ensure against resident falls if they need to leave the immediate bedside.
- One evaluation question will be changed to ask which current testing practices help lessen anxiety.
- All sites will be required to have a wheelchair with removable footrests
- Test sites will be asked to remove or cover posters or displays that may cue students on skill performance.
- All test sites will be asked to sign an agreement that they will not videotape testing events.
- Test confirmation and candidate handbook changes will be made to better inform candidates of ID requirements and wait times.
- Testing candidates with proof of allergy to hand sanitizer will be allowed to bring their own inert substance to simulate hand sanitizer.
- D and S will provide data on skill test time to see if there is a relationship between time to complete skills and passing.

Written Exam

- TAP members reviewed 163 new test items and retained 111 for use on AZ candidates—total items 1216.
- There was one minor change to the written exam plan: an item was added to the category of "Safety" and deleted from "Basic Nursing Skills." This increases the items in "Safety" from 6 to 7 and decreases the items in "Basic Nursing Skills" from 10 to 9. The total number of items on written test remains at 75.
- D and S will explore writing more items on essential skills that are not tested in the manual skills exam, such as weighing, peri-care male, and catheter care.

Manual Skills Exam

- Mouthcare Comatose Patient: Delete "Rinses and dries equipment and returns to storage." Rationale: a "toothette" is used which can be discarded in the trash, no other equipment is needed—currently candidates would fail if they did not use equipment
- Pericare Female: Add "Maintains respectful, courteous interpersonal interactions and all times." Rationale: Consistent with other skills and resident rights.
- Pericare Female: Specify that 3 strokes (each stroke a separate step) must be used to clean and rinse outer and middle perineal area and must clean and rinse the rectal area from front to back all

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with a clean portion of the wash cloth. Rationale: consistent with textbook instructions and principles of personal hygiene

- Range of Motion: All range of motion tasks will have as key step, "places resident supine (leg)" or "places resident on back (arm)." Rationale: ROM cannot be effectively done in other positions
- Ambulation with Walker and Ambulation with Weight Belt: Add step "places resident (in wheelchair) in easy reach of call light" and remove "places call light within reach of resident." Rationale: removes "trickiness" from this item which calls for the student to place the call light near the resident, yet the call light does not reach the resident in the wheel chair without unplugging. Some students are able to critically think and move the resident to the call light, others are very nervous and do not think to do this resulting in missing the step or providing an inoperable call light.
- Anti-embolic Hose: Add key step that stocking must be properly placed without restriction. Rationale: Some candidates are placing the heel and toe of the stocking in the wrong position resulting in constriction and potential harm to patients by cutting off circulation.
- Blood Pressure: Change step to "inflates BP cuff to no more than 30 mmHg above loss of pulse." The test observer (TO) will be given a narrow range to count as correct. Rationale: step was misleading by instructing candidates to inflate no more than 30 mmHg above loss of pulse—may be scored as correct by a TO if inflated less than 10 mmHg above even if the candidate was unable to detect the systolic BP.
- Bed Bath-Face, Arm, Hand and Underarm: Change test scenario to instruct students to wash the whole face and the one side (R or L) arm, hand and underarm. Rationale: current instructions just state wash one side of the body and some students are confused as to whether to wash half or whole face (both are correct). Revising this instruction will eliminate confusion on the part of candidates and be more consistent with teaching in programs.
- Change title of "Transferring a Weight bearing Non-ambulatory Resident from Bed to Wheelchair (and wheelchair to bed) Using a Gait Belt" to "PIVOT Transfer a Weight- bearing …." Rationale: decrease confusion and lets candidate know the type of transfer better—candidates have been asking the actor to ambulate thereby failing the skill.
- Positioning Resident on Side: Specify in the instructions and candidate handbook that resident does not need to be under the covers for the positioning. Rationale: allows candidate to better visualize position of resident and ensure correct alignment.
- Positioning Resident on Side: Add a step that the resident must be positioned on the correct side. Rationale: the TO specifies L or R side but occasionally the candidate places on the wrong side—without this step, the candidate would pass.
- Positioning Resident on Side and Making an Occupied: Better clarify the separate steps in the Candidate Bulletin based on whether the candidate uses the TO for fall prevention or not. Rationale: To better prepare students and decrease confusion for both scenarios.
- For any skill involving a wheelchair: Include in candidate instructions of the scenario that the physician has ordered "no footrests" on the wheelchair. TO will remove footrests from wheelchair before testing. All sites will be required to have wheelchairs with removable foot rests. Rationale: Much time is lost manipulating footrests that may be unfamiliar to candidates. Many nursing home residents have orders for no footrests so they can self propel with feet.
- Denture Care: Add "rinses cup" after step #4—and that denture cream does not need to be labeled "non-abrasive." Rationale: currently the item is "places dentures in rinsed cup" which measures 2 behaviors—placing the dentures in the cup and rinsing the cup—separating these increases the reliability and validity of the test—denture cream by definition is non-abrasive.
- Bedpan and Output/Bed Bath/Perineal Care: moving step of lowering bed in candidate handbook to prior to equipment being cleaned so patient is not left with bed in high position—candidate also has the option to ask the T.O. to monitor the patient for safety. Rationale: consistent with safety standards although doing this would necessitate removing gloves and washing hands prior to lowering the bed and then re-donning gloves to take care of equipment. Instructors may want to encourage students to use the TO as a safety person to prevent falls.

TAP Panel Members 2012

Delores Brindle, CareGiver Training Institute
Mary Edwards, Hospice of the Valley
Teresa Hagen-Hale, Cochise College @ Sierra Vista Campus
Stacy Hatton, Rio Rico High School
Marie Rozell, East Valley Institute of Technology (EVIT)
Shirley Soden, Cactus Wren Training Program, LLC.
Jacqueline Cushard, Paradise Valley Community College
Linda Niemeyer, Central Arizona College
Karen A. Hansen, Northland Pioneer College
Don Johnson, Coconino Community College - Flagstaff
Diane Christoffer, The Gardens Rehab & Care Center
Patricia Hickey, Life Care Center of Sierra Vista

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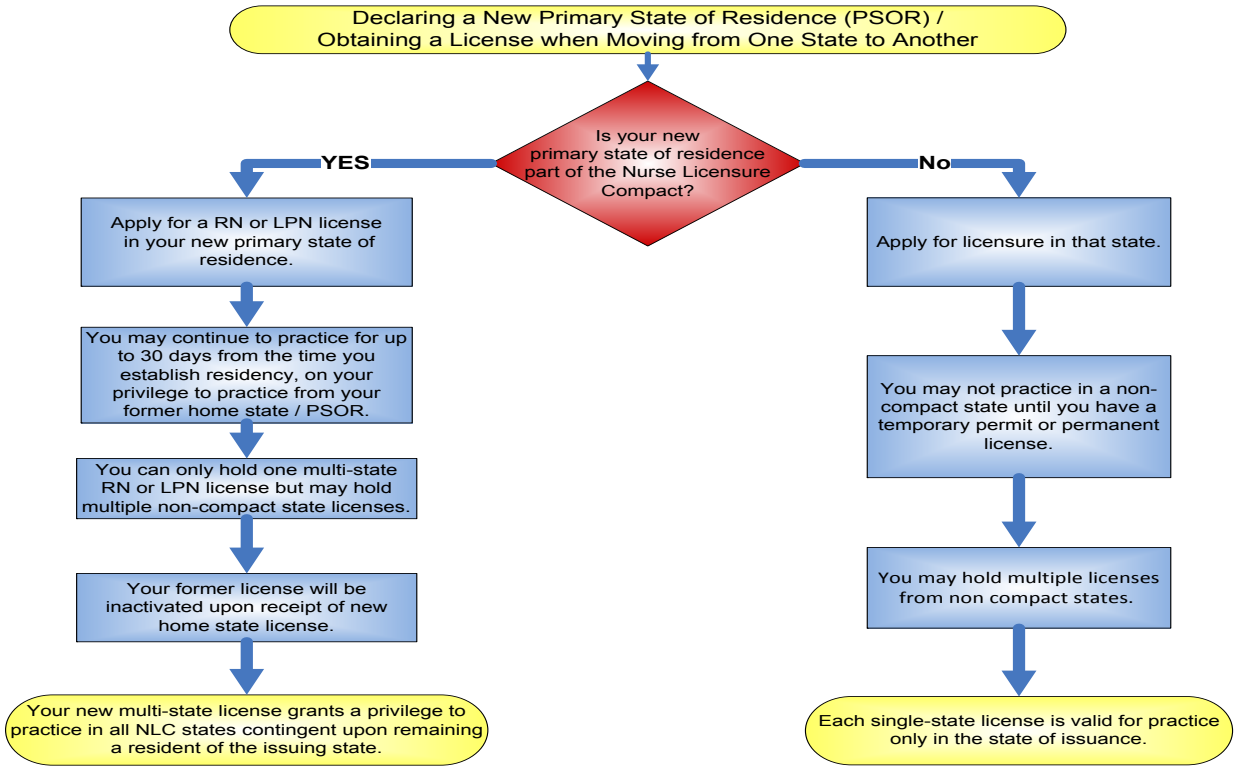
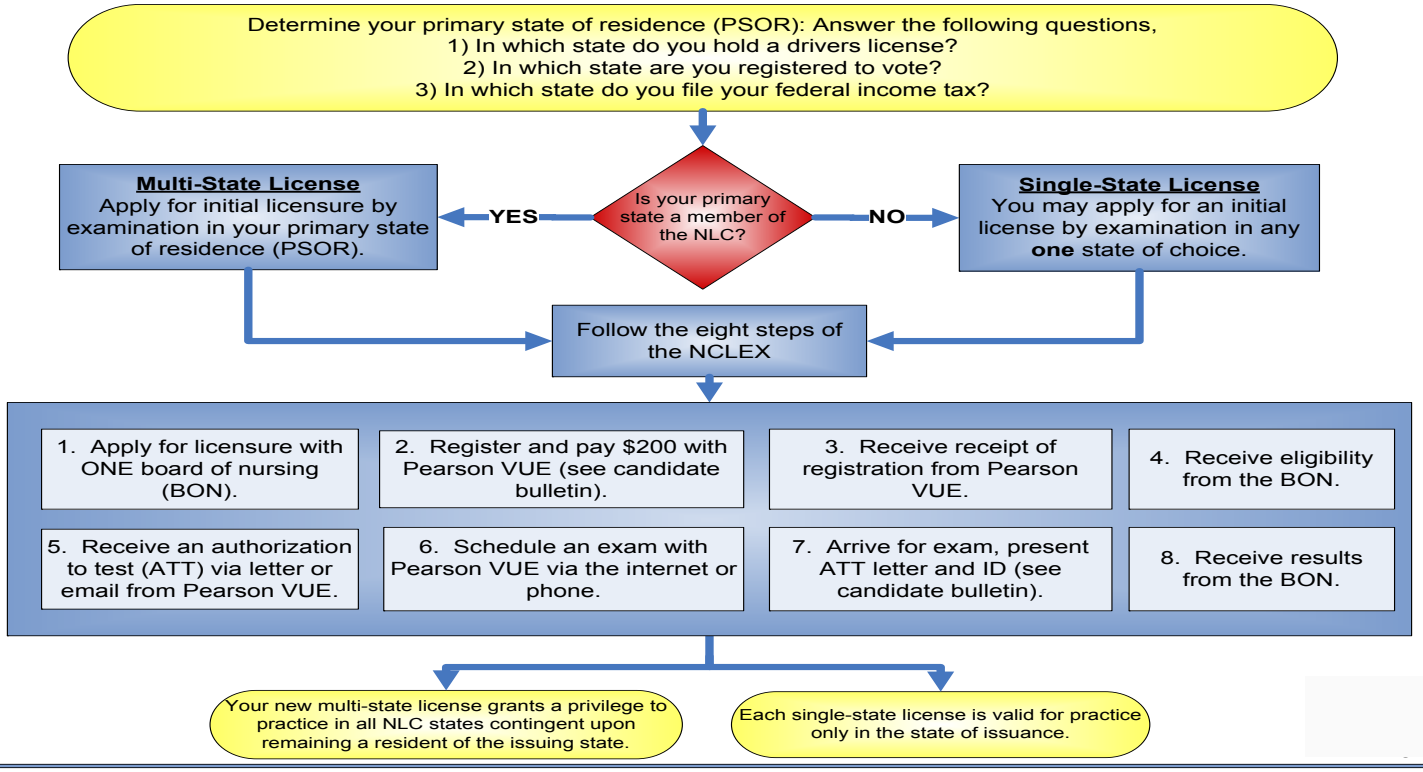


INITIAL LICENSURE BY EXAMINATION FOR NEW GRADUATES



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Once you enter your nurses into the Nursys e-Notify system you will receive notification about changes in licensure status as soon as they are made by a board of nursing. If a nurse's license is about to expire, the system will alert you and then you can choose to use the system option to send the nurse a reminder. You will also immediately find out if there has been new disciplinary action or a publicly available nurse alert issued by a board of nursing for your employed nurse.

CNA DISCIPLINARY ACTION

JUNE, JULY, AUGUST & SEPTEMBER 2012

*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
7/18/2012	Anderson, Ashley N.	CNA1000019626	Voluntary Surrender
9/20/2012	Anderson, Raven N.	CNA1000026182	Stayed Suspension
9/12/2012	Auer, Katherine J.	CNA Applicant	Denial of Initial Certificate
7/17/2012	Baez, Christina R.	CNA Applicant	Denial of Initial Certificate
9/7/2012	Banuelos, Jorge L.	CNA1000008931	Revocation
8/10/2012	Barron, Ubaldo A.	CNA1000013725	Voluntary Surrender
8/15/2012	Berg, Kristin L.	CNA1000034087	Voluntary Surrender
8/1/2012	Berger, Theresa M.	CNA1000034536	Decree of Censure
7/20/2012	Blackgoat, Dorothy A.	CNA999998551	Stayed Revocation
9/7/2012	Butcher, Shawn E.	CNA913727103	Revocation
8/1/2012	Carmical, Kathy J.	CNA1000034695	Decree of Censure
7/6/2012	Castro, Conrad S.	CNA1000022142	Revocation
7/6/2012	Claunch, Shaylin B.	CNA Applicant	Denial of Initial Certificate
6/8/2012	Coelho, Jenna M.	CNA Applicant	Denial of Initial Certificate
6/14/2012	Cook, April A.	CNA386348627	Voluntary Surrender
9/20/2012	Cowan, Emily R.	CNA1000004128	Voluntary Surrender
6/26/2012	Cunningham, Ashley R.	CNA1000015358	Decree of Censure
9/4/2012	Davis, Kristin S.	CNA Applicant	Denial of Initial Certificate
7/6/2012	Davis, Margo L.	CNA338975593	Denial of Certificate Renewal
7/1/2012	Delvalle, Natalie R.	CNA1000009645	Stayed Revocation
9/4/2012	Doten, Steven A.	CNA Applicant	Denial of Initial Certificate
9/7/2012	Eldredge, Emma A.	CNA999950782	Revocation
7/6/2012	Espinosa, Michael P.	CNA999950102	Revocation
7/6/2012	Felix, Esperanza	CNA128361103	Revocation
9/18/2012	Foster, William H.	CNA Applicant	Civil Penalty
6/12/2012	Franklin, Laura L.	CNA1000016252	Decree of Censure
7/6/2012	Furr, Jason P.	CNA1000014283	Revocation

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*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
9/4/2012	Garcia, Maria C.	CNA Applicant	Denial of Initial Certificate
8/28/2012	Garcia, Noemi	CNA1000017917	Stayed Revocation
8/27/2012	Gomes, Beverly J.	CNA Applicant	Denial of Initial Certificate
8/21/2012	Hall, Harrison L.	CNA1000034887	Decree of Censure
7/3/2012	Hawley, Alba L.	CNA999992827	Voluntary Surrender
9/17/2012	Hernandez, Adrianna J.	CNA Applicant	Denial of Initial Certificate
8/28/2012	Hooper, Pamela J.	CNA Applicant	Denial of Initial Certificate
7/20/2012	Howe, Dorthina	CNA Applicant	Denial of Initial Certificate
9/4/2012	Johnson, Danielle R.	CNA Applicant	Denial of Initial Certificate
8/13/2012	Juarez, Teresa D.	CNA1000034753	Civil Penalty
7/17/2012	Keeling, Tyler C.	CNA Applicant	Denial of Initial Certificate
7/6/2012	Koch, Jacqueline R.	CNA1000000669	Revocation
9/7/2012	Lawrence, Juan B.	CNA987615103	Revocation
9/7/2012	Luna, Jessica L.	CNA1000003999	Revocation
7/17/2012	Lupe, Kristy M.	CNA Applicant	Denial of Initial Certificate
7/6/2012	Marciniak, Heather M.	CNA1000017156	Revocation
9/19/2012	Martino, Ashley R.	CNA Applicant	Denial of Initial Certificate
9/5/2012	Mata, Maria D.	CNA Applicant	Denial of Initial Certificate
7/6/2012	Mcelroy, Alba D.	CNA999989078	Revocation
7/17/2012	Mcgee, Janet M.	CNA Applicant	Denial of Initial Certificate
7/17/2012	Moore, Gail Y.	CNA Applicant	Denial of Initial Certificate
7/17/2012	Moreno, Erica N.	CNA Applicant	Denial of Initial Certificate
9/10/2012	Moyes, Aleecia M.	CNA Applicant	Denial of Initial Certificate
7/6/2012	Murrin, Kirk D.	CNA1000022446	Revocation
9/7/2012	Nash, Natasha L.	CNA1000018447	Revocation
9/6/2012	Njai, Malick M.	CNA750763441	Civil Penalty
7/6/2012	Oller, Diana M.	CNA1000022440	Revocation
7/13/2012	Oporta, Ileana E.	CNA Applicant	Denial of Initial Certificate
6/22/2012	Ortega, David G.	CNA Applicant	Denial of Initial Certificate
9/12/2012	Ortega, Maria	CNA Applicant	Denial of Initial Certificate
9/7/2012	Parkersmith, Pamela	CNA401631103	Revocation
7/6/2012	Piper, Linda A.	CNA999989635	Revocation
9/7/2012	Pitman, Vichitra	CNA473111619	Decree of Censure
7/6/2012	Pizano, Tina M.	CNA1000005305	Revocation
9/6/2012	Quinn, William F.	CNA Applicant	Denial of Initial Certificate
9/10/2012	Renninger, Anne R.	CNA293279649	Voluntary Surrender
7/13/2012	Rexius, Kiley M.	CNA Applicant	Denial of Initial Certificate
6/5/2012	Reyes, Jessica J.	CNA999997496	Revocation
9/4/2012	Richey, John E.	CNA Applicant	Denial of Initial Certificate
9/3/2012	Ricks Jr, Ronald D.	CNA Applicant	Denial of Initial Certificate
8/8/2012	Robison, Terrie A.	CNA1000035050	Civil Penalty
8/8/2012	Rodriguez Fugger, Elizabeth M.	CNA1000019884	Decree of Censure
7/6/2012	Sampson, Richard L.	CNA1000008560	Revocation
9/7/2012	Scholz, Heather M.	CNA1000009400	Revocation
9/7/2012	Shestko, John A.	CNA625785803	Revocation
6/28/2012	Silas, Geneva	CNA012678353	Voluntary Surrender
8/13/2012	Smith, Jeanne-Jo	CNA1000034754	Decree of Censure
9/17/2012	Smith, Serena	CNA Applicant	Denial of Initial Certificate
9/7/2012	Sohl, Dena L.	CNA999993487	Decree of Censure
7/6/2012	Soto, Jessica M.	CNA1000006869	Revocation
6/11/2012	Stevens, Suzanne C.	CNA1000021011	Voluntary Surrender

*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
8/20/2012	Stuart, Shanna L.	CNA1000030764	Civil Penalty
7/19/2012	Sutton, Cristin L.	CNA1000034174	Decree of Censure
7/6/2012	Taylor, Heather J.	CNA1000023673	Revocation
9/21/2012	Taylor, Natalie N.	CNA1000035333	Stayed Revocation with Suspension
8/15/2012	Tucker-Villa, Cheryl A.	CNA109030103	Voluntary Surrender
7/6/2012	Turquoise, Caroline	CNA1000013078	Revocation
9/7/2012	Van Dyke, Alice K.	CNA999947768	Revocation
6/12/2012	Vierra, Ellen M.	CNA453815083	Decree of Censure
7/17/2012	Walker, Sharonda N.	CNA Applicant	Denial of Initial Certificate
6/2/2012	Wearne, Haiden	CNA1000025034	Decree of Censure
8/30/2012	Wils, Lynn D.	CNA1000011636	Decree of Censure
9/7/2012	Woods, Sheila A.	CNA108741669	Revocation
9/21/2012	Zamarripa, Erica M.	CNA1000027527	Civil Penalty
9/12/2012	Zambonini, Shann M.	CNA Applicant	Denial of Initial Certificate

RN/LPN DISCIPLINARY ACTION

JUNE, JULY, AUGUST & SEPTEMBER 2012

*Not reported in previous Journal

EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
8/13/2012	Althoff, Christine M.	RN033121/CNA216801360	Voluntary Surrender
8/8/2012	Andersen, Lisa M.	RN175566	Civil Penalty
7/13/2012	Arrington, Melissa M.	RN115663	Revocation
7/6/2012	Berg, Deborah A.	LP041858	Decree of Censure
6/26/2012	Beyerlein, Ellen J.	RN122412	Voluntary Surrender
9/18/2012	Bosseler, Jill D.	RN065435	Probation
7/30/2012	Bostic, Juny Y.	RN Endorsement Applicant	Denial of Initial License
7/11/2012	Branum, Robert W.	RN137052	Probation
6/18/2012	Braveman, Marc B.	RN151443	Decree of Censure
7/6/2012	Burke, Stacy J.	RN101708	Revocation
7/6/2012	Burns, Michelle B.	RN078233	Revocation
7/18/2012	Capotosti, Elizabeth D.	RN113576/AP3574	Stayed Revocation with Suspension; Voluntary Surrender of Advanced Practice Certificate
9/7/2012	Carlton, Tommy L.	RN127562	Revocation
8/16/2012	Chebbi, Souhaiel	RN157575	Stayed Suspension/Probation
7/6/2012	Cherry, Cynthia A.	RN147125	Revocation
7/6/2011	Christensen, Vanessa L.	RN128064/LP037896	Revocation
8/23/2012	Christian, Casey J.	RN129051/LP035864/CNA700728313	Suspension
9/21/2012	Christianson, Laura J.	RN076329	Revocation
7/6/2012	Clarke, Vicki L.	RN128844	Revocation
7/18/2012	Connerton, Amy R.	RN087578	Voluntary Surrender
7/10/2012	Coons, Connie M.	RN090703/LP030068	Voluntary Surrender
7/16/2012	Cooper, Gina C.	RN128425	Suspension
8/20/2012	Coursey, Victoria A.	RN112915	Voluntary Surrender
8/29/2012	Davis, Kayren L.	RN125761	Decree of Censure
7/6/2012	Delate, Marylee	RN152204	Revocation
7/6/2012	Do Carmo, Kathryn L.	LP037548	Revocation
7/6/2012	Dowdy, Brenda J.	LP037329	Revocation
9/21/2012	Drew, Elizabeth T.	RN117517	Civil Penalty

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EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
7/20/2012	Eades, Robert A.	TRN165958	Denial of Initial License
6/29/2012	Engelbretson, Nicole L.	RN Exam Applicant	Denial of Initial License
7/6/2012	Etzel-Elaqad, Jennifer L.	RN154226	Revocation
7/13/2012	Faraci, April D.	LP046426	Revocation
6/4/2012	Farnworth, Lindsay A.	RN174382	Probation
7/26/2012	Fawley, Kimberly A.	RN159187	Civil Penalty
7/6/2012	Gabbard, Linda E.	RN078051	Revocation
8/3/2012	Garris, Dwiana G.	RN064416	Voluntary Surrender
7/6/2012	Gentile, Phil J.	RN097452	Revocation
6/22/2012	George, Jennifer L.	RN153283	Probation
6/17/2012	Golden, Kristin M.	RN164181	Probation
9/21/2012	Goley, Melissa M.	TRN176897	Stayed Revocation with Probation
7/30/2012	Gorsuch, Jasmine E.	LP045725/CNA1000011542	Decree of Censure
6/4/2012	Hair, Edward L.	TRN164228	Denial of Initial License
9/7/2012	Hamilton, Courtney C.	RN154763/LP043840/CNA1000011676	Revocation
7/6/2012	Haney, Robin R.	RN110519	Revocation
9/7/2012	Harms, Debra J.	LP040621	Revocation
8/31/2012	Harrelson, Vicki L.	LP014894	Voluntary Surrender
9/19/2012	Harris, Danny N.	RN137186	Voluntary Surrender
6/22/2012	Hatcher, Delmar M.	LP043281	Voluntary Surrender
7/31/2012	Hayes, Aaron J.	RN165398	Probation
6/7/2012	Hernandez, Jerilynn	LP040769/CNA1000001146	Decree of Censure
7/6/2012	Hickman, Sharon R.	LP042726	Suspension
6/20/2012	Horn, Tiffany A.	RN150360	Stayed Suspension with Probation
7/6/2012	Hua, Chyi Jen	RN114042/LP033131/CNA573348499	Revocation
9/18/2012	Ivery, Susan	RN133137	Voluntary Surrender
7/25/2012	Jadlocki, Erin E.	RN120586	Voluntary Surrender
7/31/2012	Karaszewski, Kathleen A.	RN059186/AP3583	Suspension
6/26/2012	Kibler, Ramona M.	RN062310	Voluntary Surrender
8/14/2012	King, Brandon L.	RN175638	Suspension
8/15/2012	Knerr, Gail D.	RN070222	Voluntary Surrender
7/18/2012	Kropczynski, Raymond M.	RN169604	Stayed Suspension with Probation
8/6/2012	Lamis, Elizabeth A.	RN095229	Decree of Censure
7/6/2012	Landa, Stephanie L.	RN090090	Revocation
8/14/2012	Langevin, Debra A.	LP031383	Voluntary Surrender
7/6/2012	Laskowski, Judith A.	RN128606	Voluntary Surrender
6/1/2012	Leary, Phyllis A.	RN090326	Revocation
9/10/2012	Leonard, Linda L.	RN149056	Voluntary Surrender
7/6/2012	Leonardo, Nancy S.	RN056074/LP018360	Revocation
6/20/2012	Long, Roxanne L.	RN090529/LP029040	Voluntary Surrender
9/20/2012	Lopshire, Jennifer A.	RN098560	Suspension
6/30/2012	Mackey, Marlise A.	LP025149/CNA718121803	Decree of Censure
6/18/2012	Maley, Robert L.	LP042750	Probation
7/24/2012	Marson, Theresa J.	RN151909	Probation
7/6/2012	Mcconnell, Sherry M.	RN139247	Revocation
7/13/2012	Mccullough, Amy J.	RN049271	Voluntary Surrender
7/6/2012	Mclain, Sarah	RN113175	Stayed Suspension with Probation
8/14/2012	Mcmacken, Rhonda R.	RN037938	Voluntary Surrender
6/21/2012	Mcquinn, Ashley N.	RN155036	Probation
7/20/2012	Mercer, Meegan A.	LP024604	Voluntary Surrender
8/15/2012	Milacek, Cindy N.	RN069702	Voluntary Surrender

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EFFECTIVE DATE	NAME	LICENSE	DISCIPLINE
7/6/2012	Mills, Barbara A.	RN106182/LP032661	Revocation
7/3/2012	Mills, Katherine S.	RN078388/LP024218/CNA652660103	Voluntary Surrender
7/2/2012	Mineweaser, Kevin L.	RN164538	Probation
7/13/2012	Mitchell, Jennifer A.	LP045304	Revocation
9/7/2012	Moeser, Cynthia H.	RN070302/LP022965	Revocation
8/6/2012	Moody, Kimberly A.	RN152388/LP043199	Probation
7/6/2012	Moore, Rita	RN063898/LP021121	Revocation
9/7/2012	Morrill, Carole B.	RN043092	Revocation
7/6/2012	Mulhare, Kimberly R.	RN119228	Revocation
7/6/2012	Myrick, Margo F.	LP016807	Revocation
8/23/2012	Neal, William R.	RN097393	Revocation
9/20/2012	Nieblas, Madalene	RN119362/LP036960	Civil Penalty
7/6/2012	Noble, Cindy C.	RN090524/LP029109/CNA246878163	Revocation
9/28/2012	Ogrady, John J.	RN135233	Voluntary Surrender
7/6/2012	Oladiran, Tajudeen O.	LP000032877/CNA545045414	Revocation
9/20/2012	Olson, Rebecca	RN098724	Stayed Revocation with Probation
7/6/2012	Olstein, Cynthia K.	RN030305	Revocation
8/22/2012	Opfel, Ned J.	RN152503	Civil Penalty
6/11/2012	Osebold, Celine G.	RN113017	Decree of Censure
6/12/2012	Peterson, Astra V.	LP045242	Probation
9/7/2012	Phillips, Leslyann K.	RN142246	Revocation
8/3/2012	Porter, Rachael A.	RN160001	Probation
7/6/2012	Prawdzic-Witoslawski, Bozena A.	RN111477/LP034041	Revocation
7/12/2012	Purtill, Mary T.	RN Exam Applicant	Denial of Initial License
7/5/2012	Radcliffe, Leslie C.	RN121673/CNA999987590	Voluntary Surrender
7/6/2012	Rider, Jennifer D.	LP037135	Revocation
9/19/2012	Robertson, Inyanga	RN Endorsement Applicant	Denial of Initial License
7/5/2012	Russell, Sally A.	RN057561	Voluntary Surrender
9/7/2012	Sanabria, Cathy E.	RN094273	Revocation
8/29/2012	Scarce, Sandra S.	RN114468	Voluntary Surrender
7/3/2012	Schneider, Brandi L.	RN146151	Voluntary Surrender
8/31/2012	Sikes, Suzanne H.	RN145485	Voluntary Surrender
7/6/2012	Smith, Linda D.	RN079924	Revocation
9/7/2012	Smith, Lisa A.	LP020978	Revocation
9/7/2012	Smith, Rhoda C.	LP010557	Revocation
6/5/2012	Somerlik, Miloslava	LP031393/CNA024621433	Revocation
9/25/2012	Songer, Denise J.	RN107519	Voluntary Surrender
6/26/2012	Soto, Adrian	LP046950	Probation
8/17/2012	Thompson, Connie M.	RN080799	Voluntary Surrender
7/20/2012	Tolentino, Tracy A.	LP036193/CNA138706441	Probation
9/7/2012	Tuck, Debora L.	RN086567	Revocation
9/14/2012	Turner, Audrey L.	RN143271	Voluntary Surrender
7/6/2012	Vincent, Sheema T.	RN160863	Revocation
9/20/2012	Vucetic, Anne C.	RN155243	Stayed Revocation with Suspension
7/20/2012	Weinstein, Pamela A.	RN147720	Revocation
9/7/2012	Welch, Anne M.	LP040399/CNA1000001150	Revocation
9/20/2012	Welch, Heidi L.	LP040399	Stayed Revocation with Probation
9/7/2012	Willison, Keri R.	RN125492	Revocation
9/19/2012	Withey, Carrie A.	RN164112	Voluntary Surrender
6/20/2012	Woodrum, Diana M.	LP046578	Civil Penalty
6/4/2012	Wright, Sandra L.	RN056130	Decree of Censure
6/26/2012	Zerbel, Ashley M.	RN158213/LP044459/CNA1000007430	Revocation

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