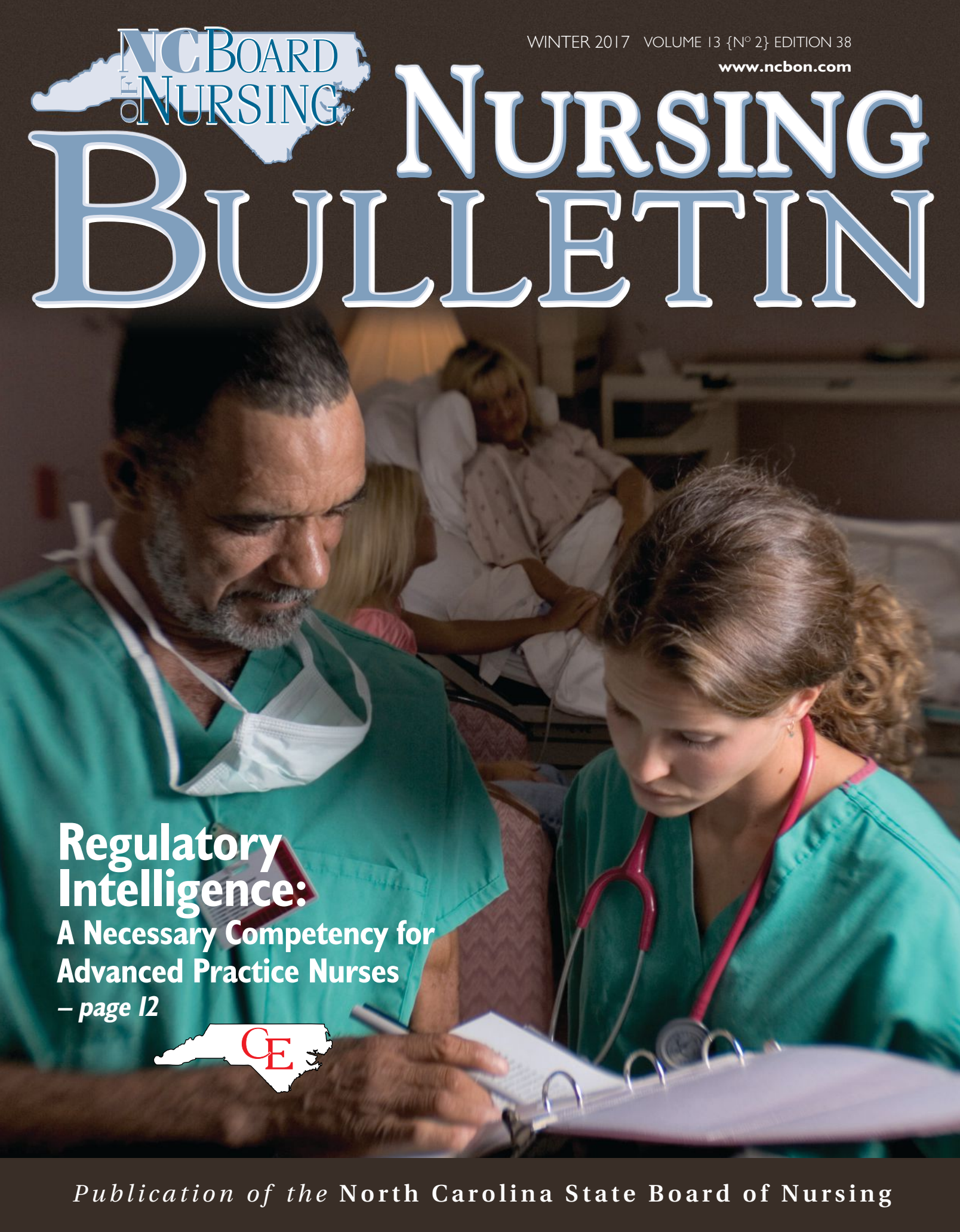


NURSING BULLETIN



**Regulatory
Intelligence:**
A Necessary Competency for
Advanced Practice Nurses
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4516 Lake Boone Trail
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Mailing Address

P.O. Box 2129
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Telephone

(919) 782-3211

Fax

(919) 781-9461

Website

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Board Chair

Pat Campbell

Executive Director

Julia L. George, RN, MSN, FRE

Editor

David Kalbacker

Managing Editor

Elizabeth Langdon

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from the **EXECUTIVE DIRECTOR**

With the new year, a new long session of the general assembly begins

The long session of the North Carolina General Assembly began in mid-January. This will be an exciting and busy year for nursing, as we watch the following bills:

H.B. 11 Handicap Parking Privilege Certification—This is an act to provide that medical certification and recertification requirements for handicapped parking privileges may be satisfied by a licensed physician, a licensed nurse practitioner or a licensed certified nurse midwife.

Sponsors of the bill are Representatives Adcock, Dobson, Hardister and Cunningham. Both Representatives Adcock and Cunningham are nurses.

Modernization of the Nursing Practice Act was introduced as Senate Bill 73 and House Bill 88 on February 13. In the Senate, the bill's initial sponsors are Senators Hise, Pate and Krawiec. On the House side, sponsors are Representatives Dobson, Lambeth, Stevens and Adcock.

The Modernization bill moves nursing regulation into the 21st Century. North Carolina is one of only three states in the country that continues to have “dual” regulation (boards of medicine and nursing) of nurse practitioners. This regulatory requirement is burdensome and adds no value to consumers. The Modernization bill would eliminate dual regulation and bring ALL four roles of APRNs under the Board of Nursing. It would also remove the requirement for a supervising physician for nurse practitioners and nurse midwives.

An update to the Nurse Licensure Compact, or the **Enhanced Nurse Licensure Compact (ENLC)** will be filed during this session. We do not have a bill number yet, but will notify all nurses when we do! North Carolina was an early adopter of the original Compact in 2000. The bill will merely be a technical change, tweaking the language with lessons learned over the past 17 years. The new ENLC could be implemented in states as early as the end of 2017! We will keep you informed of progress and impact for NC nurses.

Last, but not least—NCBON is in the process of strategic planning for 2018-2021. We are soliciting feedback from nurses, educators, employers, organizations, consumers and other stakeholders. Please let us hear from you as we embark on pertinent strategic planning for the future of nursing regulation! We will host all external stakeholders and interested parties on May 10, 2017. Please contact Elizabeth Langdon at elangdon@ncbon.com if interested in attending.

Julia L. (Julie) George, RN, MSN, FRE
Executive Director, NC Board of Nursing



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DEA Online Renewal APPLICATION UPDATE

Starting January 1, 2017, the DEA will only send out one renewal notification in accordance with Title 21, Code of Federal Regulations, Section 1301.13(e)(3). The renewal notification will be sent to the “mail to” address for each DEA registrant approximately 65 days prior to the expiration date. No other reminders to renew the DEA registration will be mailed.

This is to also advise you that the online capability to renew a DEA registration after the expiration date will no longer be available. You will

have to complete an application for a new DEA registration if you do not renew by midnight Eastern Time of the expiration date. The original DEA registration will not be reinstated.

Paper renewal applications will not be accepted the day after the expiration date. If DEA has not received the paper renewal application by the day of the expiration date, mailed in renewal applications will be returned and the registrant will have to apply for a new DEA registration.

- **DEA Form 224a** – Retail Pharmacy,

Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner

- **DEA Form 225a** – Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter
- **DEA Form 363a** – Narcotic Treatment Programs
- **DEA Form 510a** – Domestic Chemical

As a reminder, the NCBON provides information regarding the DEA @ <http://www.ncbon.com/dcp/i/nursing-practice-nurse-practitioner-prescribing>.

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DURHAM, NC, January 18, 2017—Duke University School of Nursing (DUSON) and the Duke University Health System (DUHS) launched the Duke Advancement of Nursing, Center of Excellence (DANCE) in a unique collaboration to promote personal professional advancement and lifelong learning for all nurses and nursing students.

The program hopes to advance the health of the communities and demonstrate Duke's commitment to excellence in patient-centered care. "Academic-practice partnerships like this one leverage the tremendous intellectual and social talents nurses across both settings have to improve the health of individuals, families and communities," said Marion E. Broome, PhD, RN, FAAN, dean and Ruby Wilson Professor of Nursing for DUSON, vice chancellor for Nursing Affairs for Duke University and associate vice president for Academic Affairs for Nursing for Duke University Health System.

"The design of the DANCE collaboration is intentional," said Mary Ann Fuchs, DNP, RN, NEA-BC, FAAN, vice president of Patient Care and system chief nurse executive for Duke University Health System and associate dean of Clinical Affairs for DUSON. "The DANCE Pillars build on the organizational strengths of DUHS nursing and DUSON, and purposely support



mutual goals which we believe advances clinical care, supports students and promotes internal and external influence of Duke Nursing."

Comprised of senior nursing leaders from DUHS and nursing faculty from DUSON, DANCE is built upon the commitments of two major pillars of growth. The vision of Pillar 1 is to build and nurture a learning environ-

ment for students and nurses to promote professional practice, both now and in the future. The vision of Pillar 2 is to generate and implement knowledge to support evidence-based practice, and integrate collaborative scholarship and research in the academic setting and practice environment.

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A Peek Inside NC Health News

Your Periscope for Health Care Issues around North Carolina

By Rose Hoban



When North Carolina's lawmakers returned to Raleigh in January, Medicaid was top of mind for people from both sides of the aisle who work on health care issues.

"There are so many moving wheels right now," said Rep. Greg Murphy (R-Greenville), a urological surgeon who sits on the Joint Legislative Oversight Committee on Health and Human Services.

When asked about the prospect of expanding the state's Medicaid program, a move allowed under the Affordable Care Act, he said, "As a physician, I take care of people and I want everyone to have access to care because I want everyone to lead healthy lives. So that's really my first thought. But in general, Medicaid expansion is one piece of the Affordable Care Act and the new incoming federal president has said as part of his agenda that he wants to repeal the ACA."

Murphy said he liked the ability for children to stay on their parents' insurance plans until they're 26 years old. He also liked Obamacare's mandate that insurers cover people with pre-existing conditions.

"It's through no fault of people's own, the bodies into which they're born and some of the difficulties that they face," he said.

But Murphy complained about some of the burdens put on his practice by the ACA and bemoaned increased costs to states.

Sen. Ralph Hise (R-Spruce Pine) said the state's Medicaid system needs

adjustments to ensure that it's consistent with any new federal policies. Mostly, though, he said he wanted to see the steady progress on North Carolina's Medicaid reform plan that will replace the current fee-for-service system with managed care. Beyond that, he said much depends on what happens in Washington.

That uncertainty has been the thread running through most of the conversations with people involved in state health policy for the past three months.

Mental Health Priorities

Once they got done shrugging their shoulders about larger forces, lawmakers talked about their desire to improve North Carolina's mental health system.

"I'd like to see the behavioral health urgent care and facility-based crisis (centers) continue to roll out, make sure that we're meeting people where their needs are," said Rep. Susan Martin (R-Wilson).

She said she hoped to build on work done last year by the Governor's Task Force on Mental Health and Substance Use to create, "better, earlier interventions and screenings and getting people services earlier."

She and other Republicans noted that hospital emergency departments are jammed with behavioral health patients, many of whom sit, on average, more than 90 hours to get a bed in a psychiatric hospital.

Murphy called emergency department wait times a "massive problem."

Drugs and Providers

The steady drumbeat of deaths from opiate overdose was also a cause for concern with lawmakers. In the past year, more than 1,200 people in North Carolina overdosed on opiates such as heroin and prescription drugs, with heroin claiming an increasing number of lives as pills become harder to get.

"Law enforcement is starting to tell me that we are seeing a shift from prescription drugs being replaced by heroin," Hise said. "Two years ago they would tell you that they saw nothing but prescription drugs... at least in western North Carolina."

Hise said he'd like to see more integration of the computerized controlled substances reporting system into the state's health information exchange system. The CSRS tracks how many opiate prescriptions a person might receive, allowing for pharmacists and doctors to see if a patient has been shopping for prescriptions. The health information exchange is the nascent system linking medical records among hospitals.

Lawmakers have said they're ready to mandate that providers use the CSRS each time they write prescriptions for painkillers, something physicians' groups have resisted to date.

Murphy, the doctor, said he's working with the state pharmacy, medical and dental boards to create the ability to e-prescribe narcotics because, currently, paper prescriptions are too easy to forge.

He also said providers need education about the risks of writing prescriptions for too many pills at once. But he also called for balance.

"You have patients who don't take a narcotic [at first], but when they get home, they need one and now because you cannot e-scribe it, they have to physically come to the office," said Murphy, who has an extensive rural practice.

Lambeth also said he'd like to see more talk of revising licensure rules for nurse practitioners, nurse-midwives and physician assistants.

He pointed to something the "rural-urban divide" in resources and economic development that's getting attention from lawmakers this year.

Lambeth said that allowing advanced practice nurses, such as psychiatric nurse practitioners, more leeway in their practice could relieve some of the health care access shortages in rural areas.

"Rural North Carolina is a priority and I think we need to figure out what to do, because living without adequate health care is a problem in many of those places."

Author:

Rose Hoban is the founder and reporting editor of North Carolina Health News, www.northcarolinahealthnews.org.

Hoban has been a registered nurse for 25 years. She practiced full-time for 12 years in several settings: an inner city emergency department, in drug treatment and in home health and hospice.

In 2003, she received a masters' degree in public health policy and journalism. Since moving to North Carolina in 2005, she's reported on science, health, policy and research throughout the state. Her work has earned numerous local, state and national awards. Contact Rose Hoban at editor@northcarolinahealthnews.org.

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Regulatory Intelligence: A Necessary Competency for Advanced Practice Nurses

Bobby Lowery, Ph.D, FNP-BC, FAANP, Education and Advanced Practice Nursing Consultant, North Carolina Board of Nursing

Author Note:

Correspondence concerning this article should be addressed to:

Dr. Bobby Lowery, Education and Advanced Practice Nursing Consultant
North Carolina Board of Nursing - PO Box 2129,
Raleigh, NC 27602
Contact: Blowery@ncbon.com

The Tenth Amendment of the U.S. Constitution maintains that each state has a right to protect their citizens through the regulation of health care providers (Hudspeth, 2009, Russell, 2012). The mission of the North Carolina Board of Nursing (NCBON) is to protect the public by regulating the practice of nursing (NCBON (c), 2016). While there is national consistency in the regulation of entry-level nurses, wide variation exists in how and by whom advanced practice registered nurses (APRNs) are regulated. This regulatory incongruence creates onerous and confusing regulation of APRN practice. There has been a plethora of discussion regarding the national standardization of APRN regulation, yet consistent APRN regulation has yet to be realized (Stanley, 2012). This lack of uniform regulation creates uncertainty and gaps in evolving regulatory knowledge for APRNs.

Despite a patchwork of inconsistent regulation, APRNs must have a working knowledge and correct application of regulation to ensure public protection through compliance with regulation governing APRN practice; all building on the foundation of the APRN graduate education. As noted in Exhibit 1, the purpose of this article is to assist APRNs in understanding regulation governing APRN practice in North Carolina (NC). This article will discuss the concept of regulatory intelligence using the acronym KACE, Knowledge, Application, Compliance, Education, as defined in Exhibit 2.

Regulatory Intelligence

Decades of research has demonstrated that APRNs provide safe, effective health-care comparable to or better than that of Interprofessional colleagues with similar focus (Lowery, B., Scott, E. & Swanson, M., 2015). However, while APRNs have demonstrable clinical expertise, there is often a gap in knowledge regarding regulation, its correct application and

compliance with regulation governing APRN practice in disparate states or jurisdictions. Regulatory intelligence is a new and important concept for APRNs to understand the evidence-based, safe parameters that guide APRN practice. APRNs have a professional responsibility to maintain current knowledge of all laws and rules governing their practice, understand the provisions of their Nurse Practice Act, and comply with its regulations. Furthermore, APRNs must be able to educate the public and Interprofessional team members regarding the laws and rules governing their practice.

APRN History in NC

The North Carolina Board of Nursing (NCBON) has a rich history of innovative leadership in protecting the public through the regulation of nursing practice. As the first state to establish a Board of Nursing in 1903, NC was also the first state to require licensure and registration of nurses, implement the first Nursing Practice Act (NPA), the only state to elect its

EXHIBIT I: Objective

Purpose

To assist APRNs in understanding regulations governing APRN practice

Outcome

1. Understand the purpose of regulation
2. Develop an understanding of the history of APRN practice in NC.
3. Demonstrate regulatory intelligence
4. Understand opportunities to develop regulatory intelligence

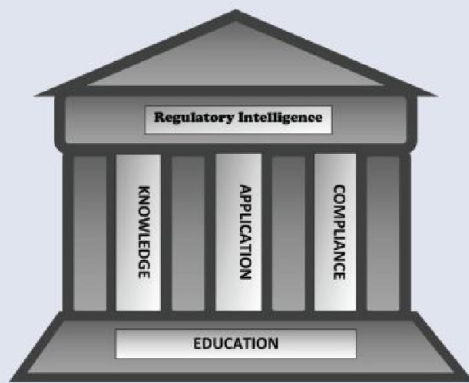


EXHIBIT 2: Regulatory Intelligence

Knowledge: Knowledge of laws and regulation governing practice

Application: Correct application of regulation to APRN practice in clinical practice

Compliance: Compliance with regulations governing practice to protect public

Education: Synthesis of regulatory knowledge from graduate education and evolving regulatory Board resources

nurse board members and the first state to provide prescriptive authority for nurse practitioners (NPs) (Russell, K., 2012; Toney, S. 2013).

Nurses are the largest segment of the healthcare workforce in NC with more than 150,000 licensees. The NC Administrative Code, 21 NCAC 36 .0120 (5), defines APRN as an umbrella title for RNs who meet the education and certification requirements of one of four roles; Nurse Practitioner, Nurse Anesthetist, Nurse-Midwife or Clinical Nurse Specialist. (NCBON (a), 2016). Exhibit 3 reflects six requirements to qualify for one of the four APRN roles. NC has a strong and growing cadre of nurses who are educated at the advanced

practice level, accounting for 6.1% of the total nursing workforce.

Regulatory Knowledge

Each of the four APRN roles make unique contributions to safe, effective healthcare for the citizens of NC. Likewise, each of the four APRN roles have differing regulations. Specific regulatory rules for each APRN role can be found in Table 1. The APRN role is an expansion of the basic nursing role through accredited graduate education and certification. An understanding of the regulation of all APRN roles and their contributions to healthcare is essential in optimizing the APRN's regulatory intelligence and for functioning

as a leader on Interprofessional teams (NCSBN, 2012).

The APRN role is an expanded nursing role. Therefore, it is essential to understand how APRN regulation builds on the nursing practice act which governs all nursing practice. The most current, consolidated administrative codes governing all nursing practice can be found in chapter 36 of the NC administrative code (NC Office of Administrative Hearings, 2016).

Nurse Practitioner

Nurse practitioners comprise the largest segment of the APRN workforce in NC, comprising 64.3% of the total APRN workforce (Lowery, 2016). The

EXHIBIT 3: APRN Definition

An Advanced Practice Registered Nurse (APRN) is a nurse:

1. Who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. Who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. Who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;
4. Whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. Who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. Who has clinical experience of sufficient depth and breadth to reflect the advanced practice role. (NCBON. (2016).

first NP educational program was piloted at the University of Colorado in 1965 by a physician, Dr. Henry Silver, and a nurse, Dr. Loretta Ford to meet the primary health care needs of vulnerable pediatric populations. NPs provide a broad range of primary and specialty care in diverse practice settings consistent with their education from a nationally accredited NP program, license, certification and maintained competence. NC was a leader in the inception and regulation of the NP role. The current joint regulatory process wherein nurse practitioners are regulated by both the NC Board of Nursing and the NC Medical board was implemented in the spring of 1970 (Johnson, 2011; Toney, S, 2013). The dual regulation is carried out via the NP Joint Subcommittee which is composed of members of the Board of Nursing and members of

the Medical Board to whom responsibility is given by G.S. 90-8.2 and G.S. 90-171.23(b)(14) to develop rules to govern the practice of nurse practitioners in North Carolina. Although the rule codification is maintained separately by the NCBON and NCMB, the NP practice requirements and scope are exactly the same in each set of rules (NCBON, 2017).

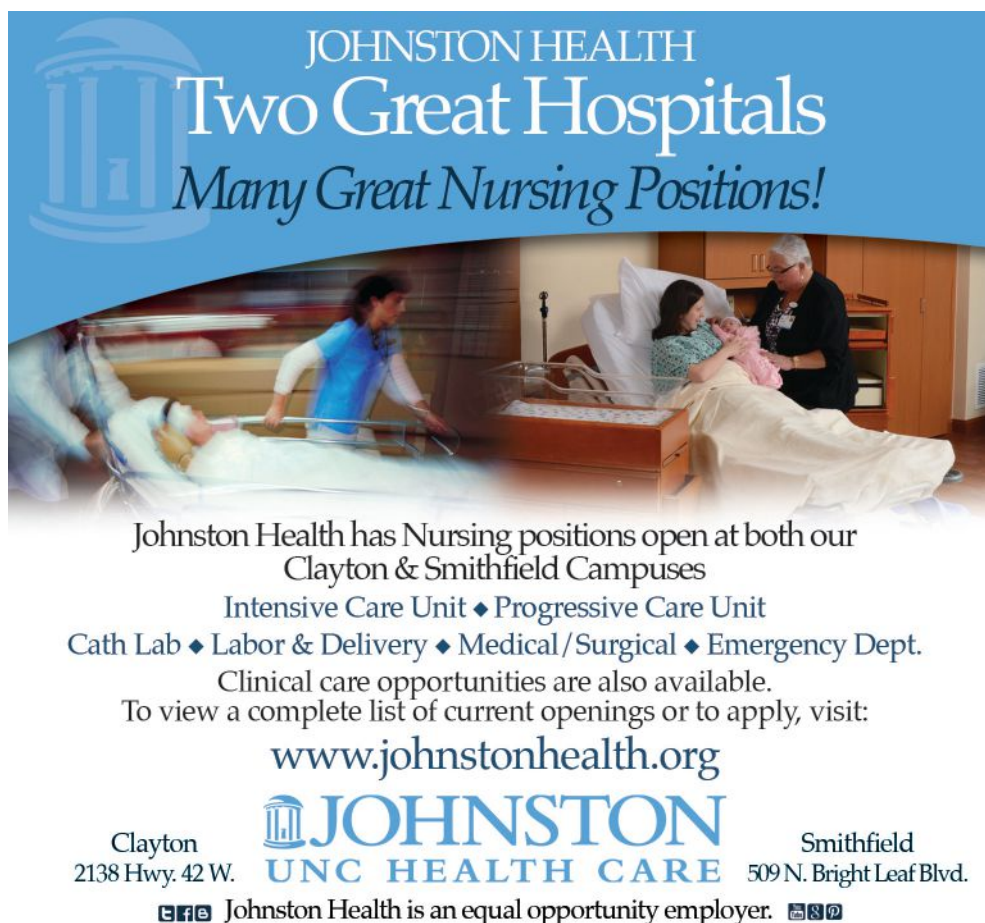
Nurse Anesthetist

Certified nurse anesthetists (CRNAs) comprise the second largest segment of the APRN workforce in NC, comprising 31.4% of the total APRN workforce (Lowery, 2016). Nurses led the way as the first official group of professionals to deliver anesthesia (Toney, S. 2013). The first nurse anesthesia educational program was established in 1909 in Portland, Oregon. Duke University established

the first nurse anesthesia program in NC in 1931. The NCBON regulates CRNA practice. In July, 1993, the legal scope of practice for the CRNA was legally defined (Toney, S, 2013). CRNAs collaborate with anesthesiologists, physicians, dentists, and/or podiatrists to provide anesthesia care in a wide variety of ambulatory and surgical settings consistent with their education, license, certification and maintained competence. Moreover, CRNAs are the primary providers of anesthesia care in rural America, providing in nearly 100 percent of the rural hospitals in many areas of NC (AANA, 2016).

Nurse-Midwife

Certified nurse midwives (CNMs) comprise 2.9% of the APRN workforce in NC, (Lowery, 2016). The nurse midwifery practice act was ratified in 1983 in NC; limiting the lawful practice of mid-



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TABLE 1: APRN Roles

APRN Role	Nurse Practitioner	Nurse Anesthetist	Nurse-Midwife	Clinical Nurse Specialist
Regulated by	JSC	NCBON	MJC	NCBON
Regulatory Rules	21 NCAC 36 .0801– 21 NCAC 36 .0815	21 NCAC 36 .0226	21 NCAC 33 .0101– 21 NCAC 33 .0110	21 NCAC 36 .0228
Method of Recognition	Registration & Approval to Practice	Recognition	Registration & Approval to Practice	Recognition
Education	Nationally Accredited Graduate Education	Nationally Accredited Graduate Education	Nationally Accredited Graduate Education	Nationally Accredited Graduate Education
Requirement for National Certification?	Yes	Yes	Yes	Yes
Requirement for Physician Supervision?	Yes	No	Yes	No
Required Collaboration?	Yes—Collaborative Practice Agreement (21 NCAC 36 .0810 (2))	Yes—Collaboration with a physician, dentist, podiatrist, or lawfully qualified other health care provider (21 NCAC 36 .0226 (2))	Yes—Clinical practice guidelines (21 NCAC 3.0104 (1))	No
Prescriptive Authority?	Yes	No	Yes	No
Employment	Salaried or self-employed	Salaried or self-employed	Salaried or self-employed	Salaried or self-employed

wifery to the CNM. The CNM is regulated by an independent Midwifery Joint Committee comprised of two CNMs, two obstetricians who have had working experience with midwives and representatives from the NCBON and the NC Medical Board. The CNM provides well-woman and gynecological care for women of all ages, obstetrical care including prenatal, postpartum, intra-partum, and newborn care (NCBON, 2017). The only midwifery educational program in NC was established in 1991 at East Carolina University (Toney, S, 2013).

Application

A historical overview of the evolution of APRN practice and regulation is a

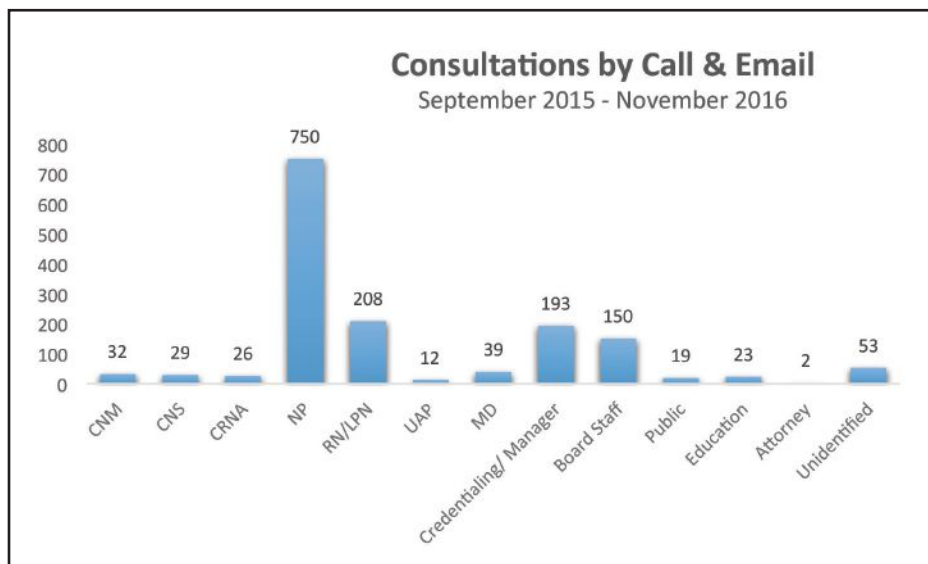
necessary foundation for correct application of regulation governing APRN practice. Increasing complexities in healthcare delivery require APRN leadership in evolving clinical scenarios. In addition to having a working knowledge of regulation, APRNs must demonstrate correct application of regulation in practice settings.

The APRN scope of practice (SOP) is established by formal graduate education in a nationally accredited nursing program, national certification and maintained competence (NCSBN, 2012 & Stanley, J., 2012). Furthermore, in NC the NP and CNM SOP is operationalized by the collaborative practice agreement between the primary supervising physician and

the NP or CNM, respectively.

Consistent with the distribution of the APRN workforce, NPs utilize NCBON consultation resources at a higher level than any other APRN group regarding application of regulation in clinical settings. As noted in Exhibit 4, NPs participated in 750 consultations by call and/or email from September 2015 until November 2016, constituting roughly 49% of all consultations conducted during that time period. Moreover, APRNs across all four roles frequently have application questions with 43% of application of regulation questions relating to clinical practice and compliance with scope of practice as noted in Exhibit 5. Correct applica-

EXHIBIT 4: APRN Consultations 9/2015-II/2016



tion of regulatory knowledge in diverse scenarios protects the public by ensuring that APRNs are practicing safely and within the parameters of their established scope of practice. The following examples reflect selected consultative application of APRN regulation for each of the four APRN roles. The examples were selected based on frequency of occurrence.

Nurse Practitioner

Continuum of care, population focus age ranges, scope of practice and Collaborative Practice Agreement (CPA) for pediatric nurse practitioners (PNPs).

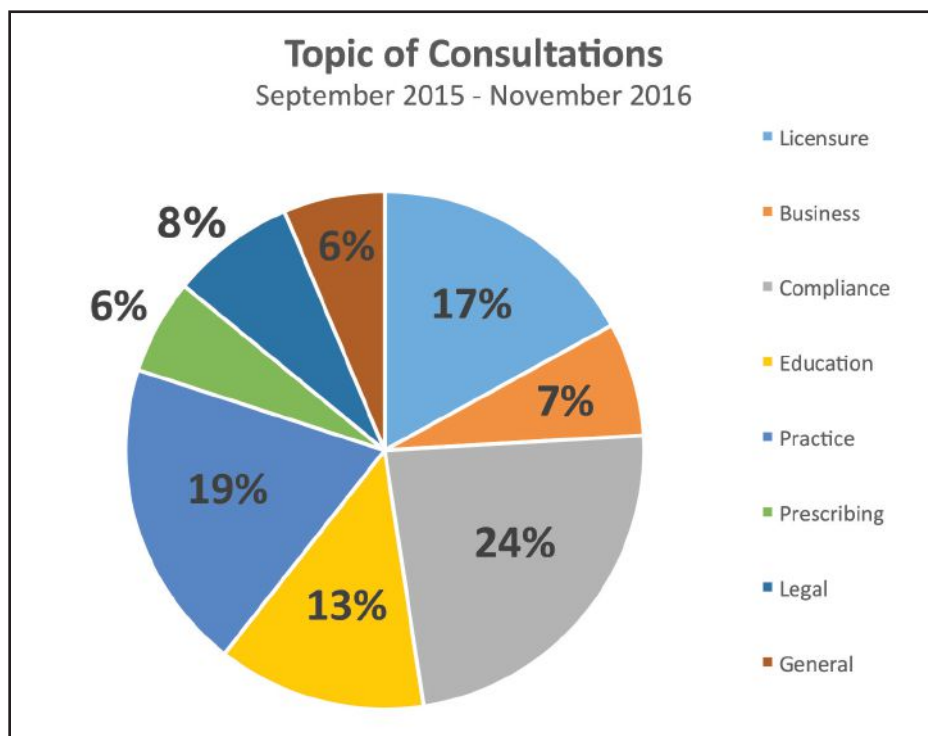
Based on 21 NCAC 36 .0803 NURSE PRACTITIONER REGISTRATION and 21 NCAC 36 .0804 PROCESS FOR APPROVAL TO PRACTICE a Pediatric Primary Care NP is credentialed to provide primary care for children from infancy to age 21 in primary care settings, the Certified Pediatric Nurse Practitioner in Acute Care (CPNP-AC) is qualified to provide family-centered and culturally respectful care for pediatric patients from birth to age 21 with acute, complex, critical, and chronic illness across a variety of care settings. There may be rare occasions for which it would be appropriate for a CPNP to provide care beyond the

age of 21 for a limited/specified period of time. For example, a PNP may choose to continue to provide care to an aging pediatric client with chronic, congenital conditions including but not limited to cystic fibrosis or congenital heart disease to ensure transitions in care to a clinician appropriately credentialed in the adult health population focus. This is within the scope of practice for

the PNP as long as there is no violation of institutional policy or other laws, and this activity is documented in the Collaborative Practice Agreement (CPA).

The NP Scope of Practice are set forth and defined by the NP rules (21 NCAC 36 .0802 SCOPE OF PRACTICE) & operationalized by the Collaborative Practice Agreement (CPA). The CPA must clearly identify what drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered and performed, would be appropriate for the diagnosis and treatment of the common medical problems seen in a NP practice sites. As long as the CPA includes transitional care activities and this is documented as part of the scope of care for the NP, there is documentation of education, and maintained competence for this activity AND this is not in violation of institutional policy, it would be within the scope of practice as established in the CPA. The continuum of care does not limit location of the NP care; rather, the care is within the normal scope and competence of the PNP.

EXHIBIT 5: Trends in application of APRN regulation



The NP Survival Guide to NCBON Compliance Review Audits provides additional information that is useful to practicing clinicians and administrators to ensure safe delivery of NP care. This document amplifies the regulatory requirements for the CPA as stipulated in 21 NCAC 36 .0804(4) and describes quality improvement processes and continuing education requirements for NP practice.

Nurse Anesthetist **Requirements for a Certified Nurse Anesthetist (CRNA) to administer anesthesia in a dental setting.**

CRNAs are regulated under the authority of the NC Board of Nursing (NCBON). The NCBON interpretation of 21 NCAC 36 .0226 NURSE ANESTHESIA PRACTICE is that there are no statutory requirements for supervision of CRNA practice. When a CRNA chooses and implements a plan of care throughout the spectrum of anesthesia care as noted in 21 NCAC 36 .0226 (c) NURSE ANESTHESIA PRACTICE, this is the practice of advanced practice nursing.

CRNA practice includes ONLY the choice and implementation of a plan of care throughout the spectrum of anesthesia care as detailed in 21 NCAC 36 .0226 (c) NURSE ANESTHESIA PRACTICE. CRNAs may perform nurse anesthesia activities in COLLABORATION with a physician, dentist, podiatrist, or other lawfully qualified health care provider as noted in 21 NCAC 36 .0226 (b)(1) NURSE ANESTHESIA PRACTICE. CRNA practice does NOT include prescribing a medical treatment regimen or making a medical diagnosis as also noted in 21 NCAC 36 .0226 (b)(1) NURSE ANESTHESIA PRACTICE. For that reason, the supervision required in this part of the rule is not required for CRNA practice.

There are no rules addressing supervision as this is not a requirement for CRNA practice. Two issues, institutional policy and third party payer requirements

may create scenarios that are not regulatory issues.

The NC Dental Board does have requirements for dentists to certify a dental practice for the administration of anesthesia as noted in § 90-30.1. Standards for general anesthesia and enteral and parenteral sedation; fees authorized.

A particular institution may choose a more stringent/restrictive requirement than is required by NC rules and regulation, however. If a particular institution requires additional physician supervision per their institutional policies, this may be defined as a designated professional accepting responsibility and oversight of practice. The means of oversight and method of accessibility must be defined regarding how the supervisor and supervisee will be continuously accessible to each other either electronically or face-to-face, if dictated by institutional

policy. Furthermore, certain payers may require supervision based on their operational definitions as a requirement for reimbursement.

Nurse Midwife **Physician supervision requirements for certified nurse midwives (CNM) in NC.**

Midwifery practice falls under the jurisdiction of the Midwifery Joint Committee (MJC). While the MJC pays for administrative support from the NCBON, the MJC is a discrete regulatory board empowered to promulgate the rules governing midwifery practice (Article 10A § 90-178.4.). Neither the laws nor the administrative rules require with specific interval for consultation, quality improvement meetings between the CNM and the supervising physician other than identified in 21 NCAC 33 .0104 (3).



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The supervisory requirements of CNM practice are stipulated in 21 NCAC 33 .0104 PHYSICIAN SUPERVISION. The supervising physician must be actively engaged in the practice of obstetrics in North Carolina. The CNM's practice parameters are operationalized through mutually agreed upon written clinical practice guidelines which define the individual and shared responsibilities of the midwife and the supervising physician(s) in the delivery of health care services and must include a plan for ongoing communication between the CNM and the supervising physician. Periodic and joint evaluation of services rendered, e.g. chart review, case review, patient evaluation, and review of outcome statistics; and periodic and joint review and updating of the written medical clinical practice guidelines are required.

Clinical Nurse Specialist Voluntary Clinical Nurse Specialist (CNS) recognition requirements.

Effective July 1, 2015, the new CNS Rules (21 NCAC 36.0228) require all Clinical Nurse Specialists to be recognized by the North Carolina Board of Nursing in order to practice as a CNS in North Carolina. Recognition as a CNS in NC requires you to meet the requirements for CNS practice as defined in 21 NCAC 36 .0228 CLINICAL NURSE SPECIALIST PRACTICE. The educational and certification requirements in law and rule protect the public. NC law and rule does not allow for CNS practice outside of these requirements. Please see the information for CNS recognition listed on the NCBON website at Clinical Nurse Specialist Documentation Requirements. An employer may choose to continue to allow a licensee to use the

CNS title until such time that there is title protection for the CNS title.

Compliance

Regulation of professional practice is a dynamic process that is influenced by evolving healthcare delivery systems, increasing complexities in health care, professional advocacy groups, political will; all of which impact promulgation of revised or new regulation to ensure public protection. The dynamic nature of regulation can create challenges in the acquisition of regulatory knowledge, correct application of regulation in evolving healthcare delivery systems and compliance with the regulations governing APRN practice.

Practice drift is a common occurrence documented through behavioral research (Chastain & Burhans, 2016). Each of the four APRN roles have regulatory requirements for periodic quality-improvement evaluations and evaluation of compliance with current regulations. The public is protected by the standardized approach to NP Compliance Reviews by ensuring that the nurse practitioner is meeting the requirements of the Boards' rules and regulations, for example. Compliance and quality improvement processes for each role can be found in the rules governing each of the four APRN roles listed in Exhibit 2.

The NCBON offers multiple resources under the Nursing Practice link on the NCBON website to assist APRNs, administrators and the public when uncertainty exists regarding compliance with APRN regulation.

Education

An essential component of graduate nursing education includes knowledge of the effect of legal and regulatory processes on nursing practice, healthcare delivery, and outcomes (AACN, 2011). The NCBON recognizes the importance of regulatory content in nursing education,

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however, post-licensure nursing education is not regulated by the NCBON. Post-licensure nursing curricula are approved by national accreditation bodies (ANCC, 2011; Rounds, 2010).

While foundational knowledge of APRN regulation must be included in APRN curricula, the NCBON strives to ensure opportunities for licensees to update knowledge, application and compliance with APRN regulation. The NCBON offers multiple opportunities for APRNs to enhance regulatory intelligence through publications, posting of open meetings records, Board presentations, continuing education, service opportunities, posting regulatory news and announcements on the NCBON website and through direct communication with licensees. Timely communication is ensured when licensees maintain an updated email address, email and phone numbers with the NCBON. Per 21 NCAC 36 .0201 it shall be the duty of each registrant to keep the Board informed of a current mailing address. Name, address, phone number or email updates can be completed through the nursing gateway on the NCBON website.

Opportunities to Enhance Regulatory Intelligence

Every APRN must demonstrate basic legal and regulatory knowledge to meet the requirements of graduate nursing education; creating foundational regulatory knowledge. Building on the seminal 2010 report, Nursing Leadership from the Bedside to the Boardroom, (Robert Wood Johnson, 2010), APRNs may enhance regulatory intelligence through service and leadership on regulatory boards, professional advocacy groups and other board service related to the regulation of healthcare.

NC is the only state that elects the nurse majority of its Board. The Board is comprised of 11 nursing members; 3 public members. Regulatory intelligence

can be enhanced by exercising your right to vote and consider applying your nursing leadership skills by running to serve as a board member with the NCBON. Moreover, numerous regulatory resources to enhance regulatory intelligence are available on the websites of the NCBON and the National Council of State Boards of Nursing. Information regarding Board membership, responsibilities and committee meetings can be found on the NCBON website under the governance link (NC BON (b) 2016).

Conclusion

Regulatory intelligence is an important concept for nurses to understand the evidence-based, safe parameters that guide nursing practice. The acronym K.A.C.E. is a simple acrostic for remembering the necessary components of regulatory intelligence. Graduate nursing

education provides a foundational knowledge regarding APRN regulation. Regulatory knowledge of all APRN roles amplifies the leadership of each APRN in intra- and Interprofessional nursing leadership. Correct application of APRN regulation must be evaluated periodically to ensure safe delivery of APRN care and compliance with APRN regulation. The NCBON offers innovative leadership and resources to partner with APRNs, administrators and the public in optimizing regulatory intelligence. Utilization of Board resources and serving on the NCBON is an opportunity for APRNs to enhance regulatory intelligence while impacting current and evolving healthcare delivery systems.

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“Regulatory Intelligence: A Necessary Competency for Advanced Practice Nursing” (2.0 CH)

INSTRUCTIONS

Read the article. There is not a test requirement, although reading for comprehension and self-assessment of knowledge is encouraged.

RECEIVE CONTACT HOUR CERTIFICATE

Read the article and the Chapter 36 (consolidated) Administrative Code Rules which guide the work of the NCBON and reflect on the following five questions. Chapter 36 (consolidated) is located at <http://reports.oah.state.nc.us/ncac/title 21 - occupational licensing boards and commissions/chapter 36 - nursing/chapter 36 rules.pdf>.

1. What is the purpose of regulation?
2. Describe the history of APRN practice in NC.
3. What are the overlapping points of regulation between entry-level nursing and the four APRN roles?
4. How is regulatory compliance assessed among the four APRN roles?
5. Describe opportunities to develop regulatory intelligence.

There is not a test requirement, although reading for comprehension and self-assessment of knowledge is encouraged.

RECEIVE CONTACT HOUR CERTIFICATE

Go to www.ncbon.com and scroll over “Nursing Education;” under “Continuing Education” select “Board Sponsored Bulletin Offerings,” scroll down to the link, “Regulatory Intelligence: A Necessary Competency for Advanced Practice Nursing.”

Register, be sure to write down your confirmation number, complete and submit the evaluation, and print your certificate immediately.

If you experience issues with printing your CE certificate, please email practice@ncbon.com. In the email, please provide your full name and the name of the CE offering (Regulatory Intelligence: A Necessary Competency for Advanced Practice Nursing).

Registration deadline is 11-01-2018.

PROVIDER ACCREDITATION

The North Carolina Board of Nursing will award 2 contact hours for this continuing nursing education activity.

The North Carolina Board of Nursing is an approved provider of continuing nursing education by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

NCBON CNE CONTACT HOUR ACTIVITY DISCLOSURE STATEMENT

The following disclosure applies to the NCBON continuing nursing education article entitled “Regulatory Intelligence: A Necessary Competency for Advanced Practice Nursing.”


Participants must read the CE article and additional reading(s) listed (if applicable) in order to be awarded CNE contact hours. Verification of participation will be noted by online registration. No financial relationships or commercial support have been disclosed by planners or writers which would influence the planning of learning outcomes and content of the article. There is no endorsement of any product by NCNA or ANCC associated with the article. No article information relates to products governed by the Food and Drug Administration.

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Celebrating the Accomplishments of the FOUNDATION FOR NURSING EXCELLENCE (FFNE)

Since its creation by NCBON in 2002, the Foundation has been focused on improving health outcomes for all North Carolinians by enhancing the practice of nursing. It is a great pleasure to share with all licensees our Foundation for Nursing Excellence Report 2002-2016 which provides an overview of our nursing workforce-related accomplishments over the past 15 years. Although FFNE took the lead in these initiatives, including preceptor role development, creating new pathways for educational progression toward a BSN through the RIBN project, and establishing the NC Future of Nursing Action Coalition, none of this could have been done without the support and involvement of many organizations and individuals across the state. As we complete our current grant work, it is time to review our accomplishments, celebrate the outcomes of our efforts, and thank each of you for your interest and support for this important work! You may access our report at <http://www.ffne.org/library/library/documents/ffne-final-report-2016-final-web.pdf>. Please share this report with your colleagues.



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2016 *Nursing Bulletin* Readership SURVEY RESULTS

The North Carolina Board of Nursing would like to thank those that participated in the 2016 *Nursing Bulletin* Readership Survey! The survey was available on the NCBON website for 30 days and randomly distributed by email to a selection of nurses throughout the state. The NCBON received over 550 responses and below is an overview of the results.

First and foremost, do nurses read the *Nursing Bulletin*? Eighty-four percent of respondents do read the magazine. Of the 16% that indicated they do not read the magazine, 34% do not receive it.

DID YOU KNOW: The *Nursing Bulletin* is sent to the address on file for every nurse in North Carolina. Log on to your Nurse Gateway profile to ensure your mailing address is correct. The *Bulletin* is also available in an E-reader version on the NCBON website.

The NCBON uses the *Nursing Bulletin* to keep the nurses of North Carolina informed, safe and competent in their practice. More than 80% of respondents agree or strongly agree that the

magazine content provides current information on the Board's offerings and programs, explains new nursing directives and generates a clearer understanding of NC Board of Nursing's mission to protect the public.

When asked about topics of interest, respondents indicated articles on patient safety, continuing competency offerings and interpretation of practice were among the most requested. Other areas of interest included examples of practice breakdown, practice settings and legislative issues. The NC Board of Nursing makes every effort to address the above topics from a regulatory perspective and will continue to provide more articles of the above stated interests in future issues.

Thank you for your continued readership of the NCBON *Nursing Bulletin*. We hope to continue to be your key resource for nursing regulation information in the state. If you have any questions or comments, please email Elizabeth Langdon at elangdon@ncbon.com or call 919-782-3211.



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Proposed Rule Amendments

21 NCAC 36 .0806 is proposed for amendment as follows:

21 NCAC 36 .0806 ANNUAL RENEWAL

(a) Each registered nurse who is approved to practice as a nurse practitioner in this state shall annually renew each approval to practice with the Board of Nursing no later than the last day of the nurse practitioner's birth month by:

- (1) Maintaining current RN licensure;
- (2) Maintaining certification as a nurse practitioner by a national credentialing body identified in 21 NCAC 36 .0801(8);
- ~~(2)~~(3) Submitting the fee required in Rule .0813 of this Section; and
- ~~(3)~~(4) Completing the renewal application.

(b) If the nurse practitioner has not renewed by the last day of her or his birth month, the approval to practice as a nurse practitioner shall lapse.

History Note: Authority G.S. 90-8.1; 90-8.2; 90-18(14) 90-171.23(b); 90-171.83;
Recodified from 21 NCAC 36.0227(e) Eff. August 1, 2004;
Amended Eff. February 1, 2017; December 1, 2009; November 1, 2008; August 1, 2004.

21 NCAC 36 .0807 is proposed for amendment as follows:

21 NCAC 36 .0807 CONTINUING EDUCATION (CE)

In order to maintain nurse practitioner approval to practice, the nurse practitioner shall earn 50 contact hours of continuing education each year beginning with the first renewal after initial approval to practice has been granted. At least 20 hours of the required 50 hours must be those hours for which approval has been granted by the American Nurses Credentialing Center (ANCC) or Accreditation Council on Continuing Medical Education (ACCME), other national credentialing bodies or practice relevant courses in an institution of higher learning. Every nurse practitioner who prescribes controlled substances shall complete at least one hour of the total required continuing education (CE) hours annually consisting of CE designed specifically to address controlled substance prescribing practices, signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management. Documentation shall be maintained by the nurse practitioner for the previous five calendar years and made available upon request to either Board.

History Note: Authority G.S. 90-5.1; 90-8.1; 90-8.2; 90-14(a)(15); 90-18(14); 90-171.23(b)(14); 90-171.42;
2015 Session Law 12F;
Recodified from 21 NCAC 36 .0227(f) Eff. August 1, 2004;
Amended Eff. February 1, 2017; December 1, 2009; April 1, 2008; August 1, 2004.

21 NCAC 36 .0809 is proposed for amendment as follows:

21 NCAC 36 .0809 PRESCRIBING AUTHORITY

(a) The prescribing stipulations contained in this Rule apply to writing prescriptions and ordering the administration of medications.

(b) Prescribing and dispensing stipulations are as follows:

- (1) Drugs and devices that may be prescribed by the nurse practitioner in each practice site shall be included in the collaborative practice agreement as outlined in Rule .0810(b) of this Section.
- (2) Controlled Substances (Schedules II, IIN, III, IIIN, IV, V) defined by the State and Federal Controlled Substances Acts may be procured, prescribed or ordered as established in the collaborative practice agreement, providing all of the following requirements are met:

- (A) the nurse practitioner has an assigned DEA number which is entered on each prescription for a controlled substance;
 - (B) ~~dosage units for schedules II, IIN, III, and IIN are limited to a 30-day supply;~~
Refills may be issued consistent with Controlled Substance Law and Regulation; and
 - (C) the supervising physician(s) must possess the same schedule(s) of controlled substances as the nurse practitioner's DEA registration.
- (3) The nurse practitioner may prescribe a drug or device not included in the collaborative practice agreement only as follows:
- (A) upon a specific written or verbal order obtained from a primary or back-up supervising physician before the prescription or order is issued by the nurse practitioner; and
 - (B) the written or verbal order as described in Part (b)(3)(A) of this Rule shall be entered into the patient record with a notation that it is issued on the specific order of a primary or back-up supervising physician and signed by the nurse practitioner and the physician.
- ~~(4) — Refills may be issued for a period not to exceed one year:~~
- ~~(5)~~(4) Each prescription shall be noted on the patient's chart and include the following information:
- (A) medication and dosage;
 - (B) amount prescribed;
 - (C) directions for use;
 - (D) number of refills; and
 - (E) signature of nurse practitioner.
- ~~(6)~~(5) Prescription Format:
- (A) all prescriptions issued by the nurse practitioner shall contain the supervising physician(s) name, the name of the patient, and the nurse practitioner's name, telephone number, and approval number;
 - (B) the nurse practitioner's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed as defined in Subparagraph (b)(2) of this Rule.
- ~~(7)~~(6) A nurse practitioner shall not prescribe controlled substances, as defined by the State and Federal Controlled Substances Acts, for the nurse practitioner's own use or that of a nurse practitioner's supervising physician; or that of a member of the nurse practitioner's immediate family, which shall mean a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-siblings, or any other person living in the same residence as the licensee; or anyone with whom the nurse practitioner is having a sexual relationship or has a significant emotional relationship.
- (c) The nurse practitioner may obtain approval to dispense the drugs and devices other than samples included in the collaborative practice agreement for each practice site from the Board of Pharmacy, and dispense in accordance with 21 NCAC 46 .1703 that is hereby incorporated by reference including subsequent amendments of the referenced materials.

History Note: Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-18.2; 90-171.23(b)(14); Recodified from 21 NCAC 36 .0227(h) Eff. August 1, 2004; Amended Eff. February 1, 2017; December 1, 2012; April 1, 2011; November 1, 2008; August 1, 2004.

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SUMMARY of ACTIVITIES

Administrative Matters:

- Approved 2017 Strategic Plan Roadmap
- Approved proposed amendments to the following Rules and directed staff to proceed with rulemaking (Amendments on pages 24–25).
 - 21 NCAC 36 .0806 Annual Renewal
 - 21 NCAC 36 .0807 Continuing Education (CE)
 - 21 NCAC 36 .0809 Prescribing Authority

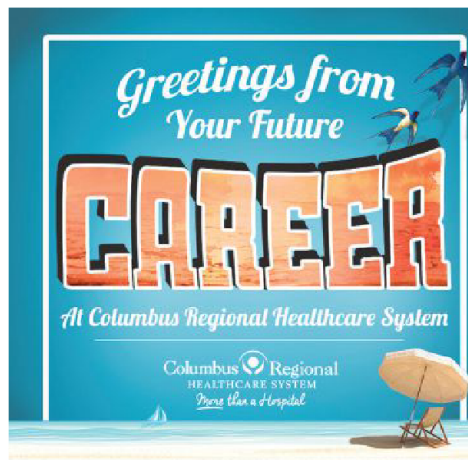
Regulatory Compliance Matters:

- Removed probation from the license of 14 RNs and 4 LPNs.
- Accepted the Voluntary Surrender from 2 RNs and 1 LPNs.
- Suspended the license of 13 RNs and 1 LPNs.
- Reinstated the license of 5 RNs and 0 LPNs.
- Number of Participants in the Alternative Program for Chemical Dependency: 153 RNs and 8 LPNs (Total = 161)
- Number of Participants in the Chemical Dependency Program (CDDP): 89 RNs, 10 LPNs (Total = 99)
- Number of Participants in Illicit Drug and Alcohol/Intervention Program: 20 RNs, 10 LPNs (Total = 30)

Education Matters:

Ratification of Full Approval Status:

- Craven Community College – ADN and PN
- ECPI Raleigh – PN
- Isothermal Community College – PN
- Region A Nursing Consortium – ADN
- South University – BSN
- Southeastern Community College – ADN and PN



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NOMINATION FORM FOR 2017 ELECTION

Although we just completed a successful Board of Nursing election, we are already getting ready for our next election. In 2017, the Board will have two openings: RN – At Large, LPN. This form is for you to tear out and use. This nomination form must be completed on or before April 1, 2017. Read the nomination instructions and make sure the candidate(s) meet all the requirements.

Instructions

Nominations for both RN and LPN positions shall be made by submitting a completed petition signed by no fewer than 10 RNs (for an RN nominee) or 10 LPNs (for an LPN nominee) eligible to vote in the election. The minimum requirements for an RN or an LPN to seek election to the Board and to maintain membership on it are as follows:

1. Hold a current unencumbered license to practice in North Carolina
2. Be a resident of North Carolina
3. Have a minimum of five years experience in nursing
4. Have been engaged continuously in a position that meets the criteria for the specified Board position, for at least three years immediately preceding the election.

Minimum ongoing-employment requirements for **both RNs and LPNs** shall include continuous employment equal to or greater than 50% of a full-time position that meets the criteria for the specified Board member position, except for the RN at-large position.

If you are interested in being a candidate for one of the positions, visit our website at www.ncbon.com for additional information, including a Board Member Job Description and

other Board-related information. You also may contact Chandra, Administrative Coordinator, at chandra@ncbon.com or (919) 782-3211, ext. 232. After careful review of the information packet, you must complete the nomination form and submit it to the Board office by April 1, 2017.

Guidelines for Nomination

1. RNs can petition only for RN nominations and LPNs can petition only for LPN nominations.
2. Only petitions submitted on the nomination form will be considered. Photocopies or faxes are not acceptable
3. The certificate number of the nominee and each petitioner must be listed on the form.
4. Names and certificate numbers (for each petitioner) must be legible and accurate.
5. Each petition shall be verified with the records of the Board to validate that each nominee and petitioner holds appropriate North Carolina licensure.
6. If the license of the nominee is not current, the petition shall be declared invalid.
7. If the license of any petitioner listed on the nomination form is not current, and that finding decreases the number of petitioners to fewer than ten, the petition shall be declared invalid.
8. The envelope containing the petition must be postmarked on or before April 1, 2017, for the nominee to be considered for candidacy. Petitions received before the April 1, 2017, deadline will be processed on receipt.
9. Elections will be held between July 1 and August 15, 2017. Those elected will begin their terms of office in January 2018.

Please complete and return nomination forms to 2017 Board Election, North Carolina Board of Nursing, P.O. Box 2129, Raleigh NC 27602-2129.

Nomination of Candidate for Membership on the North Carolina Board of Nursing for 2017

We, the undersigned currently licensed nurses, do hereby petition for the name of _____, RN / LPN (circle one), whose Certificated Number is _____, to be placed in nomination as a Member of the N.C. Board of Nursing in the category of (check one):

☐ RN – At Large ☐ LPN

Address of Nominee: _____

Telephone Number: (Home) _____ (Work) _____

E-mail Address: _____

PETITIONER - (At least 10 petitioners per candidate required. Only RNs may petition for RN nominations).

TO BE POSTMARKED ON OR BEFORE APRIL 1, 2017

NAME	SIGNATURE	CERTIFICATE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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Please complete and return nomination forms to 2017 Board Election, North Carolina Board of Nursing, P.O. Box 2129, Raleigh, NC 27602-2129.



CE Opportunities 2017

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Standard presentations offered are as follows:

- **Continuing Competence** (1 CH) – 1 hour – Presentation is for all nurses with an active license in NC and is an overview of continuing competency requirements.
- **Legal Scope of Practice** (2.0 CHs) – 2 hours – Defines and contrasts each scope, explains delegation and accountability of nurse with unlicensed assistive personnel, and provides examples of exceeding scope. Also available as webcast.
- **Delegation: Responsibility of the Nurse** - 1 CH – 1 hour
Provides information about delegation that would enhance the nurse's knowledge, skills, and application of delegation principles to ensure the provision of safe competent nursing care.
- **Understanding the Scope of Practice and Role of the LPN** (1 CH) – 1 hour – Assists RNs, LPNs, and employers of nurses in understanding the LPN scope of practice. Also available as webcast.
- **Nursing Regulation in NC** (1 CH) – 1 hour – Describes Board authority, composition, vision, function, activities, strategic initiatives, and resources.
- **Introduction to Just Culture and NCBON Complaint Evaluation Tool** (1.5 CHs) – 1 hour and 30 minutes
Provides information about Just Culture concepts, role of nursing regulation in practice errors, instructions in use of NCBON CET, consultation with NCBON about practice errors, and mandatory reporting. Suggested for audience NOT familiar with Just Culture.
- **Introduction to the NCBON Complaint Evaluation Tool** (1 CH) 1 hour – Provides brief information about Just Culture concepts and instructions for use of the NC Board of Nursing's Complaint Evaluation Tool, consultation with NCBON about practice errors, and mandatory reporting. Suggested for audience already familiar with Just Culture.

To access online CE articles, webcasts, session registration, and the presentation request form, go to www.ncbon.com - Nursing Education - Continuing Education

ONLINE BULLETIN ARTICLES

- **Regulatory Intelligence: A Necessary Competency for Advanced Practice Nurses** (2 CHs). No fee.
- **What Could Happen: The consequences of "practice drift" ...Is It Worth the Risk?** (1.5 CHs). No fee.
- **Development of Sanctioning Guidelines for Public Discipline in Nursing Regulation: The North Carolina Board of Nursing Journey** (1 CH). No fee.
- **Who's Your Supervisor or Manager? Nursing Practice: The Management and Supervision of Nursing Services** (1 CH). No fee.

More offerings on www.ncbon.com

ORIENTATION SESSION FOR ADMINISTRATORS OF NURSING SERVICES AND MID-LEVEL NURSE MANAGERS

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Session Dates

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\$40.00 fee (non-refundable unless session is canceled)

Register online at www.ncbon.com. Registration at least two weeks in advance of a scheduled session is required. Seating is limited. If you are unable to attend and do not have a substitute to go in your place, please inform the NCBON so someone on the waiting list can attend.

WEBCASTS

- **Understanding the Scope of Practice and Role of the LPN** (1 CH)
Provides information clarifying the LPN scope of practice. An important course for RNs, LPNs, and employers of LPNs. No fee.
- **Legal Scope of Practice** (2.3 CHs) ~ Provides information and clarification regarding the legal scope of practice parameters for licensed nurses in North Carolina. \$40.00 Fee

PODCASTS

- Just Culture Podcast & Resources
 - Continuing Competence Requirements
 - Internationally Educated Nurses
- <http://www.ncbon.com/dcp/i/news-resources-podcasts> (No CH provided)

NORTH CAROLINA BOARD OF NURSING **CALENDAR**

Board Meeting:
May 12, 2017

Administrative Hearings:
February 23, 2017
May 11, 2017

Education/Practice Committee:
April 6, 2017

Hearing Committee:
March 30, 2017
April 27, 2017

Licensure Review Panel:
March 9, 2017
April 13, 2017
May 18, 2017
June 8, 2017

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