

NURSING BULLETIN

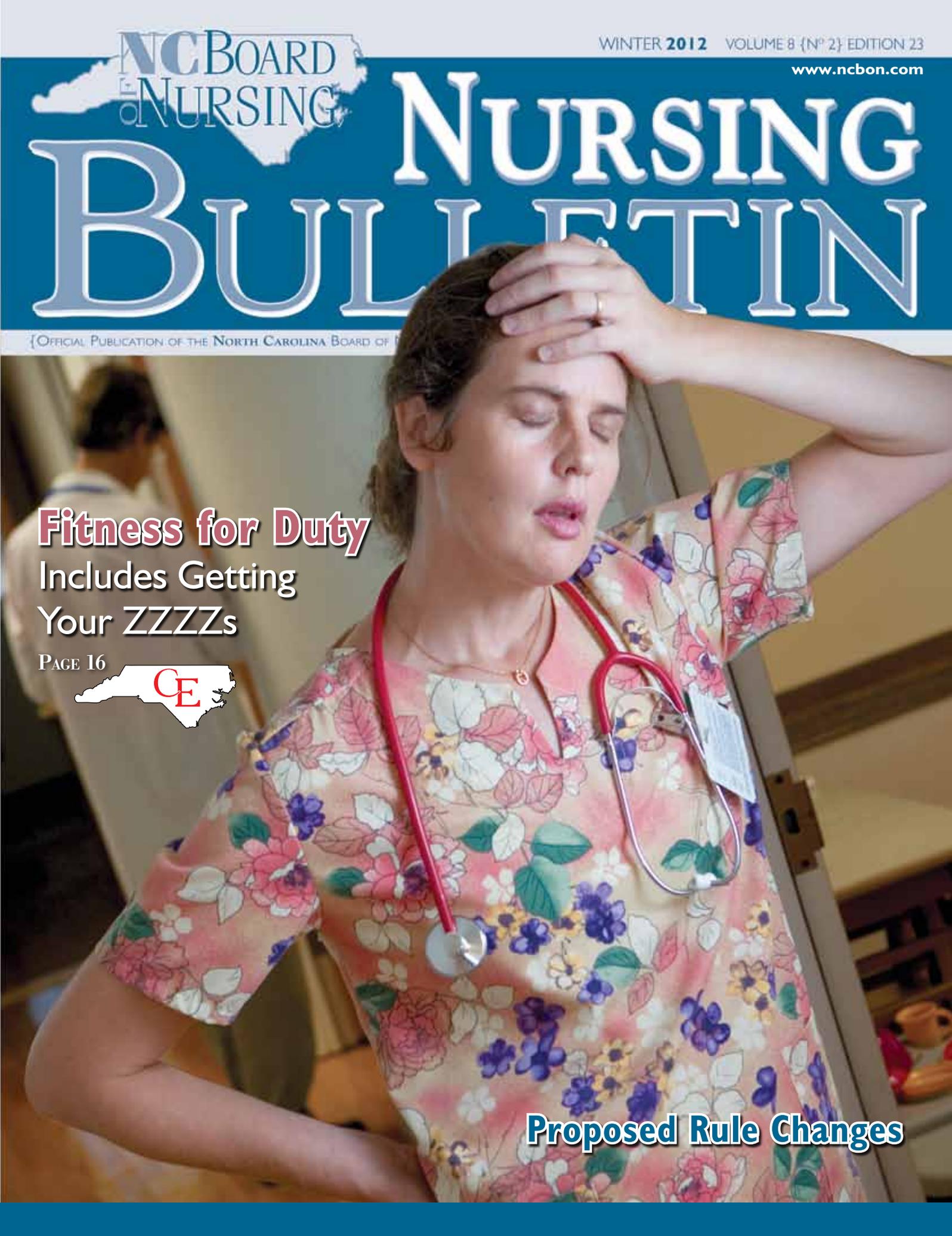
{OFFICIAL PUBLICATION OF THE NORTH CAROLINA BOARD OF NURSING}

Fitness for Duty
Includes Getting
Your ZZZZs

PAGE 16



Proposed Rule Changes



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NC BOARD
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**NURSING
BULLETIN**

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from the
Executive Director

A LOOK AHEAD AT 2012...



As we move into 2012, it is a time of reflection and also a time to look to our future.

In reflection, 2011 was a year for incremental changes in nursing regulation. Throughout the country, states began to respond to the Institute of Medicine report “The Future of Nursing: Leading Change, Advancing Health.” In North Carolina, the Board of Nursing is involved in the Future of Nursing Action Coalition and other initiatives to support nurses practicing to the full scope of their education and licensure.

Our Education and Practice Committee is actively exploring the RN scope of practice. This process looks at whether barriers exist for the RN; if so-are these barriers imposed through lack of understanding by licensees or employers or as a result of regulation?

One very exciting regulatory change in 2012 is our initiative to implement “Just Culture” in our complaint investigation and resolution processes statewide. “Just Culture” clearly makes a distinction between honest human error, risk-taking behavior, and outright reckless behavior. It holds individuals accountable for their behavioral choices, but does not punish individuals for isolated, inadvertent human error.

For the past several years, the Board has been a part of a pilot project with several hospitals and long-term care facilities to incorporate the “Just Culture” philosophy into our complaint resolution process.

Our work in this area has demonstrated that part of effective public protection is learning from mistakes. Board staff developed a Complaint Evaluation Tool (CET) to assist employers in determining whether or not an incident needs to be reported to the Board.

“Just Culture” has been a passion of mine for more than a decade, so I am particularly pleased that we have made such progress in North Carolina. I am also pleased that our work has been published in the January 2012 edition of the Journal of Nursing Regulation.

In addition to “Just Culture,” we are moving forward in exploring gaps in our regulation of advanced practice registered nurses, in exploring further efficiencies in our processes for licensure and regulation, re-vamping our website and moving to a new and improved licensure system. We have a busy year ahead!

Julia L. George, RN, MSN, FRE
Executive Director

NORTH CAROLINA BOARD of Nursing Calendar

LICENSURE REVIEW PANELS

- March 8
- April 12

ADMINISTRATIVE HEARING

- May 18
- July 20

EDUCATION/PRACTICE COMMITTEE

- April 4

BOARD MEETING

- May 17-18



from the **Board Chair**

EXPECTATION AND EVALUATION CREATING SUCCESSFUL BOARD MEMBERS

To be Chairperson for the North Carolina Board of Nursing is a tremendous honor. I am looking forward to doing the best job possible meeting my responsibilities not only as Chair but also as a board member. I have truly been impressed with the dedication and integrity of my fellow board members.

So what is the “job description” of a N. C. Nursing Board member and how can someone serving on this board be aware of whether he/she is meeting the expectations of the position? The North Carolina Board of Nursing has a Board Member Code of Conduct – Job Description that outlines the principles for assuring public trust in professional regulation. It is a set of behavioral expectations intended to assure the public that the Board and its individual members uphold the highest level of integrity and ethical standards.

Without quoting verbatim from this Code, a summary of expectations for each board member is first and foremost ensuring the public access to competent, safe and ethical practitioners in the profession of nursing. Additionally, members must be familiar with the laws, rules, regulations, policies and procedures that govern their service on the board. The work of a regulatory board, such as the Board of Nursing, is public service and not private interest or group advocacy. Board members do not represent the nursing profession, or any private group. Members of the Board of Nursing must avoid any actual or perceived conflict of interest that could compromise the integrity of the Board, and must strive to avoid any relationship, activity or position that may influence, directly or indirectly, the performance of his/her official duties as a Board member.

How does one serving on the N. C. Board of Nursing ensure that he/she is achieving these daunting behavioral expectations? Your Board of Nursing has an evaluation system in place that goes beyond anyone’s expectations. During the last three years that I have served on the board, I have been amazed at the number of evaluations and surveys that are completed by Board members and staff. Also during the September Board meeting another evaluation process was approved, that although it is voluntary, really gets to the heart of whether board members are indeed meeting the “job description.” This evaluation is called a 360 evaluation which, when used, will allow members of the Board to receive input about their strengths, weaknesses, meeting participation and meeting preparation. This evaluation has the potential to increase the growth of each Board member by giving collegial feedback with appropriate recommendations for improvement.

It is through education and assessment that all of us succeed in positions that we assume. I am proud to work with the members of the 2012 N. C. Board of Nursing. They not only know their role, but they seriously consider every issue that impacts the safety of nursing care for the citizens of North Carolina as well as promote nursing practice to the fullest extent of its scope of practice.

Nancy Bruton-Maree, RN, MS, CRNA
Chair

NCBON JUST CULTURE COMPLAINT EVALUATION TOOL STATEWIDE ROLLOUT

The North Carolina Board of Nursing (NCBON) began its journey to Just Culture over six years ago. At that time, the NCBON committed to a Just Culture philosophy, shifting its focus from the traditional regulatory culture of blame and punishment to a culture that supports effective nursing practice, quality improvement, and patient safety. The guiding principles of a Just Culture focus practice event assessment and intervention on an individual nurse's behavioral choices and the potential risk to patient safety posed by these behavioral choices. Event resolution is not based upon the severity of the outcome of the practice issue or event. A Just Culture recognizes that punitive discipline in response to a human error fails to promote patient safety and learning from mistakes. However, at risk or reckless choices pose a risk to patient safety and individuals must be held accountable for those choices. A Just Culture also assesses organizational system designs that may have contributed to an event and addresses these accordingly.

As part of this journey, the Board developed and tested a Just Culture Complaint Evaluation Tool (CET). The CET provides a consistent evaluation of practice issues and events which holds the nurse accountable for behavioral choices, while at the same time treating the nurse fairly and respectfully. The CET provides a standard by which the employer and NCBON can work collaboratively to review practice errors or

issues and achieve a balance between learning from mistakes and maintaining individual accountability effectively. The CET serves to assist nursing leaders, employers, and the NCBON to identify and clarify when clinical practice events require a formal complaint to the NCBON; when consultation with NCBON staff is required, or when employer remediation, counseling, or consoling of the nurse would be appropriate.

When an untoward practice event or issue occurs, the first step for the nursing leader or employer is to investigate the event thoroughly and to then complete the CET assessment. The CET is submitted to the NCBON along with the complaint report and a copy is retained in the employee file. The CET scoring directs the employer as follows:

- Human Error – does not require a report to the NCBON
- At Risk Behavior – requires consultation with NCBON Practice Consultant
- Reckless Behavior – requires submission of a formal NCBON complaint/report.

The NCBON COMPLAINT EVALUATION TOOL (CET) IS NOW AVAILABLE FOR USE BY ALL NURSING LEADERS AND EMPLOYERS AS PRACTICE EVENTS ARE BEING INVESTIGATED AND DECISIONS ARE BEING MADE REGARDING FILING A BOARD COMPLAINT.

The CET is designed for use only for evaluation of clinical practice events or issues

involving Registered Nurses and Licensed Practical Nurses. It is important to note that confidentiality, fraud, theft, drug abuse, impairment on duty, drug diversion, boundary issues, sexual misconduct, and mental/physical impairment are not appropriate for evaluation using the CET. These events/issues MUST be reported to the NCBON.

The NCBON looks forward to continuing the Just Culture journey through collaboration with nursing leaders and employers to promote a culture that analyzes practice issues and errors using a fair and consistent framework. NCBON Practice Consultants are available to assist with questions, use of the CET, and most importantly, to provide consultation regarding the reportability of events.

The NCBON CET and supporting resource materials are located on the NCBON website at www.ncbon.com under "Complaints/Consumer Protection." Practice Consultant contact information is also provided on this site. In addition, the website will offer the following on-line learning opportunities:

- Just Culture and CET via podcast (coming soon), and
- continuing education contact hours (pending) for the *Just Culture in Nursing Regulation Complaint Evaluation Tool (CET) Instruction Booklet*.

2012 NCBON 9TH ANNUAL NURSING EDUCATION SUMMIT MARCH 26, 2012

This year the Education Summit will be held at the William and Ida Friday Center in Chapel Hill, NC. There will be a NCBON Update given by Julia L. George, RN, MSN, FRE, Executive Director.

Presenters and topics include:

Nell Ard, PhD, RN, CNE, ANEF
(Keynote Speaker)

Director of Nursing, Collin College
in McKinney, TX

Student Success: How to Predict and Facilitate Retention

Kim Larson, PhD, RN
Assistant Professor, East Carolina University
Team Based Learning

Elizabeth Van Horn, PhD, RN, CNE
Assistant Professor, UNC-Greensboro
Podcasting: How to implement in a Nursing Program/Social
Networking Issues

We are encouraging nursing program directors and faculty to invite their clinical practice partners and allied healthcare program faculty to participate. Registration information is available on the NCBON website.

NOMINATION FORM FOR 2012 ELECTION

Although we just completed a successful Board of Nursing election, we are already getting ready for the next election. In 2012, the Board will have three openings: one for an RN who is an advanced practice nurse; one for an RN who is a practical nurse educator; and one for an RN staff nurse. This nomination form is for you to tear out and use. The form must be completed and postmarked on or before April 1, 2012. Read the nomination instructions and make sure the candidate(s) meet all the requirements. Because all Board members serve four year terms, no LPN position is open during the 2012 election.

Instructions

Nominations for RN positions shall be made by submitting a completed petition signed by no fewer than 10 RNs (for an RN nominee) eligible to vote in the election.

The minimum requirements for an RN 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, except for the RN at-large position.

Minimum ongoing-employment requirements for the RN member 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, 2012.

Guidelines for Nomination

1. RNs can petition only for RN 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. (The certificate number appears on the upper right-hand corner of the license.)
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, 2012, for the nominee to be considered for candidacy. Petitions received before the April 1, 2012, deadline will be processed on receipt.
9. Elections will be held between July 1 and August 15, 2012. Those elected will begin their terms of office in January 2013.

Please complete and return nomination forms to 2012 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 2012

We, the undersigned currently licensed nurses, do hereby petition for the name of _____, RN, 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 - Advanced Practice Nurse
 RN - Practical Nurse Educator
 RN, Staff Nurse

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, 2012

NAME	SIGNATURE	CERTIFICATE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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TERCAP

IMPROVING NURSING PRACTICE AND PATIENT SAFETY

What is TERCAP? It stands for Taxonomy of Error, Root Cause Analysis and Practice Responsibility and is a study sponsored by the National Council State Boards of Nursing (NCSBN).

Nurses have typically been held solely responsible when errors in practice are made. This study was designed to collect a wide array of information to examine trends across the nation leading to practice breakdowns and to identify common risk factors and systems issues that contribute to errors so they may be corrected and prevented in the future.

North Carolina is one of 22 states participating in this study to identify the root causes influencing or impacting a nurse at the time of a practice breakdown. The findings from this study will be used both nationally and in NC. In NC the findings will be used by the Board to facilitate the development of strategic initiatives to support high safety

standards regarding nursing practice.

Statistically to date, there have not been enough cases entered into the study nationally for meaningful recommendations to be developed. The hope is as more states enter data this goal will be reached in the near future.

Preliminary analysis of data collected involving the practice breakdown of nurses in NC (2008 – 2010) is consistent with the preliminary results reported by NCSBN and found:

Nurse Characteristics:

- RNs with Associate Degree
- Female
- Average age - 46
- Experienced nurses working less than 2 years in the setting where the practice event occurred.

Patient Characteristics:

- Over age 65

- Diagnosed with dementia or Alzheimer's disease
 - Rarely resulting in patient harm.

Systems issues most commonly identified as contributing factors:

- Breakdown in healthcare team communication
- Frequent interruptions/distractions
- Conflict with other healthcare team members
- Unclear scope.

Most common types of practice breakdown identified:

- Lack of professional responsibility
- Clinical reasoning
- Failure to intervene
- Failure to accurately interpret signs/symptoms, orders
- Failure to assess
- Failure to implement preventative measures.

Are you new to nursing administration or management?

Joyce Winstead, MSN, RN

OR, are you a nurse administrator or manager that would benefit from attending an update on nursing regulation?

The NC Board of Nursing (NCBON) offers an orientation workshop for nurse administrators and managers, especially newly appointed, that provides information about nursing law and regulation pertinent to the responsibilities of the nurse administrator and manager. The workshop entitled *Orientation Sessions for Administrators of Nursing Services and Mid-level Nurse Managers* promotes the NCBON's mission to protect the public through

the regulation of nursing practice by providing regulatory education and information to enhance the knowledge and understanding of the nurse administrator and manager. The topics presented at the workshop include regulatory trends and issues, nursing scope of practice, filing Board complaints and the investigation process, programs for the impaired nurse, delegation to unlicensed assistive personnel, validation of competence, nurse licensure compact, Just Culture, the Practitioner Remediation Enhancement Program, and the Employer Notification System.

The 2012 workshop dates are February 15, May 8, September 25, and November 7. The workshop provides an in-person format on the NCBON campus in Raleigh, and awards 4.6 contact hours of continuing education. This is an excellent opportunity to interface with NCBON staff and to network with other nurse administrators and managers.

Registration and additional information is located at www.ncbon.com, select "Workshops and Conferences," select "Board Sponsored Workshops," and scroll to "On-site Workshop".

COMING SOON!!!

Criminal Background Checks (CBC) LIVESCAN Available for NCLEX Applicants ONLY

Effective April 1, 2012, the North Carolina Board of Nursing will release web-based CBC documents that can be completed online, printed and taken to local law enforcement (Sheriff and Police Department) for Live Scan. Live Scan is digital fingerprinting and transmission of the impression directly to the State Bureau of Investigation and Federal Bureau of Investigation for processing. Live Scan will eliminate the need for manual fingerprinting by law enforcement officers and reduce the amount of processing time for the Board to receive CBC results.

Please visit the Board's website at www.ncbon.com for additional information or contact Barbara Nelson, Criminal Background Check Coordinator at (919) 782-3211 ext. 258 or bnelson@ncbon.com.

RULES CHANGES PROPOSED

21 NCAC 36 .0120 — DEFINITIONS

The following definitions shall apply throughout this chapter unless the context indicates otherwise:

1. "Academic term" means one semester of a school year.
2. "Accountability/Responsibility" means being answerable for action or inaction of self, and of others in the context of delegation or assignment.
3. "Accredited institution" means an institution accredited by a United States Department of Education approved institutional accrediting body.
4. "Active Practice" means activities that are performed, either for compensation or without compensation, consistent with the scope of practice for each level of licensee as defined in G.S. 90-171.20(4), (7) and (8).
5. "Advanced Practice Registered Nurse (APRN)" means nurse practitioner, nurse anesthetist, nurse-midwife or clinical nurse specialist, for the purposes of Board qualification a nurse who meets the criteria specified in G.S. 90-171.21(d)(4).
6. "Assigning" means designating responsibility for implementation of a specific activity or set of activities to a person licensed and competent to perform such activities.
7. "Clinical experience" means application of nursing knowledge in demonstrating clinical judgment.
8. "Clinical judgment" means the application of the nursing student's knowledge, skills, abilities and experience in making decisions about client care.
9. "Competent" means having the knowledge, skills and ability to safely perform an activity or role.
10. "Continuing Competence" means the ongoing acquisition and application of knowledge and the decision-making, psychomotor, and interpersonal skills expected of the licensed nurse resulting in nursing care that contributes to the health and welfare of clients served.
11. "Contact Hour" means 60 minutes of an organized learning experience.
12. "Continuing Education Activity" means a planned, organized learning experience that is related to the practice of nursing or contributes to the competency of the nurse as defined in 21 NCAC 36 .0223 Subparagraph (a)(2).
13. "Controlling institution" means the degree-granting organization or hospital under which the nursing education program is operating.
14. "Curriculum" means an organized system of teaching and learning activities directed toward the achievement of specified learning objectives/outcomes.
15. "Delegation" means transferring to a competent individual the authority to perform a selected nursing activity in a selected situation. The nurse retains accountability for the delegation.
16. "Dimensions of Practice" means those aspects of nursing practice that include professional responsibility, knowledge-based practice, legal/ethical practice and collaborating with others, consistent with G.S. 90-171.20(4), (7) and (8).
17. "Distance education" means the teaching/learning strategies used to meet the learning needs of students, when the students and faculty are separate from each other.
18. "Faculty directed clinical practice" means the responsibility of nursing program faculty in overseeing student clinical learning including the utilization of preceptors.
19. "Focused client care experience" means a clinical experience that simulates an entry-level work experience. The intent is to assist the student to transition to an entry-level practice. There is no specific setting requirement. Supervision may be by faculty/preceptor dyad or direct faculty supervision.
20. "Interdisciplinary faculty" means faculty from professions other than nursing.
21. "Interdisciplinary team" means all individuals involved in providing a client's care, who cooperate, collaborate, communicate and integrate care to ensure that care is continuous and reliable.
22. "Level of Licensure" means practice of nursing by either a Licensed Practice Nurse or a Registered Nurse as defined in G.S. 90-171.20(7) and (8).
23. "Level of student" means the point in the program to which the student has progressed.
24. "Maximum enrollment" means the total number of pre-licensure students that can be enrolled in the nursing program at any one time. The number reflects the capacity of the nursing program based on demonstrated resources sufficient to implement the curriculum.
25. "Methods of Instruction" means the planned process through which teacher and student interact with selected environment and content so that the response of the student gives evidence that learning has taken place. It is based upon stated course objectives/outcomes for learning experiences in classroom, laboratory and clinical settings.
26. "National Credentialing Body" means a credentialing body that offers certification or re-certification in the licensed nurse's or Advanced Practice Registered Nurse's specialty area of practice.
27. "NCLEX-PN™" means the National Council Licensure Examinations for Practical Nurses.
28. "NCLEX-RN™" means the National Council Licensure Examinations for Registered Nurses.
29. "Nursing Accreditation body" means a national nursing accrediting body, recognized by the United States Department of Education.
30. "Nursing program faculty" means individuals employed full or part time by academic institution responsible for developing, implementing, evaluation and updating nursing curricula.
31. "Nursing project" means a project or research study of a topic related to nursing practice that includes a problem statement, objectives, methodology and summary of findings.
32. "Participating in" means to have a part in or contribute to the elements of the nursing process.
33. "Pattern of noncompliance" means episodes of recurring non-compliance with one or more Rules in Section .0300.
34. "Preceptor" means a registered nurse at or above the level of licensure that an assigned student is seeking, who may serve as a teacher, mentor, role model and supervisor for a faculty directed clinical experience.
35. "Prescribing Authority" means the legal permission granted by the Board of Nursing and Medical Board for the nurse practitioner and nurse midwife to procure and prescribe legend and controlled pharmacological agents and devices to a client in compliance with Board of Nursing rules and other applicable federal and state law and regulations.
36. "Program Closure" means to cease operation of a nursing program.
37. "Program Type" means a course of study that prepares an individual to function as an entry-level practitioner of nursing. The three program types are:
 - (a) BSN - Curriculum components for Bachelor of Science in Nursing provides for the attainment of knowledge and skill sets in the current practice in nursing, nursing theory, nursing research, community and public health, health care policy, health care delivery and finance, communications, therapeutic interventions and current trends in health care. For this program type, the client is the individual, family, group, and community.
 - (b) Associate Degree in Nursing (ADN)/Diploma in Registered Nursing - Curriculum components for the ADN/Diploma in Registered Nursing provides for the attainment of knowledge and skill sets in the current practice in nursing, community concepts, health care delivery, communications, therapeutic interven-

tions and current trends in health care. For this program type, client is the individual, group of individuals, and family.

(c) Practical Nurse Diploma - Curriculum prepares for functioning in a dependent role in providing direct nursing care under the direction of a registered nurse or other health care provider as defined by the Nursing Practice Act. Curriculum components provide for the attainment of knowledge and skill sets in the current practice of practical nursing, communications, therapeutic interventions, including pharmacology, growth and development and current trends in health care. For this program type client is the individual, or group of individuals.

38. "Review" means collecting and analyzing information to assess compliance with Section .0300 of this Chapter. Information may be collected by multiple methods including review of written reports and materials, on-site observations and review of documents or in person or telephone interview(s) and conference(s).

39. "Rescind Approval" means a Board action that removes the approval status previously granted.

40. "Self Assessment" means the process whereby the individual reviews her/his own nursing practice and identifies the knowledge and skills possessed, as well as those skills to be strengthened.

41. "Specialty" means a broad, population-based focus of study encompassing the common health-related problems of that group of patients and the likely co-morbidities, interventions and responses to those problems.

42. "Supervision" means the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of an assigned or delegated nursing activity or set of activities.

43. "Survey" means an on-site visit for the purpose of gathering data in relation to reviewing nursing programs compliance with Section .0300 of this Chapter.

History Note: Authority G.S. 90-171.23; 90-171.38; Eff. April 1, 2003; Amended Eff. _____; November 1, 2008; May 1, 2006; December 1, 2005; August 1, 2005.

21 NCAC 36 .0702 — ISSUANCE OF A LICENSE BY A COMPACT PARTY STATE

For the purpose of the Compact:

1. A nurse applying for a license in a home state shall produce evidence of the nurses' primary state of residence. Such evidence shall include a declaration signed by the licensee attesting to the licensee's primary state of residence. Further evidence that may be requested includes, but is not limited to:

- (a) Driver's license with a home address;
- (b) Voter registration card displaying a home address; or
- (c) Federal income tax return declaring the primary state of residence; residence:

(d) Military Form No. 2058 — state of legal residence certificate; or

(e) W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

2. A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 30 days.

3. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance. The 30-day period in Item (2) of this Rule shall be stayed until resolution of the pending investigation.

4. The former home state license shall no longer be valid upon the issuance of a new home state license.

5. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within 10 business days and the former home state may take action in accordance with that state's laws and rules.

6. As of July 1, 2005, no individual shall be issued a multistate licensure privilege unless the applicant provides evidence of successful completion of the licensing examination developed by the National Council of State Boards of Nursing, Inc.

7. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state.

8. A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license.

History Note: Authority G.S. 90-171.82(6); 90-171.83(a)(b); 90-171.85(b); 90-171.87(4); Eff. July 1, 2000; Amended Eff. _____; July 1, 2005.

21 NCAC 36 .0703 — LIMITATIONS ON MULTISTATE LICENSURE PRIVILEGE

(A) Home state Boards shall include in all licensure disciplinary orders or agreements that limit practice or require monitoring the requirement that the licensee subject to said order or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state Boards.

(B) An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) or adverse action. Once eligible for licensure in the prior state(s); a multistate license may be issued.
History Note: Authority G.S. 90-171.37; 90-171.85(f); 90-171.87(4); Eff. _____; July 1, 2000.

21 NCAC 36 .0801 AND 21 NCAC 32M.0101 — DEFINITIONS

The following definitions apply to this Section:

1. "Medical Board" means the North Carolina Medical Board.
2. "Board of Nursing" means the North Carolina Board of Nursing.
3. "Joint Subcommittee" means the subcommittee 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 performance of medical acts by nurse practitioners in North Carolina.
4. "Nurse Practitioner" or "NP" means a currently licensed registered nurse approved to perform medical acts consistent with the nurse's area of nurse practitioner academic educational preparation and national certification under an agreement with a licensed physician for ongoing supervision, consultation, collaboration and evaluation of the medical acts performed. Such medical acts are in addition to those nursing acts performed by virtue of registered nurse (RN) licensure. The NP is held accountable under the RN license for those nursing acts that he or she may perform.
5. "Registration" means authorization by the Medical Board and the Board of Nursing for a registered nurse to use the title nurse practitioner in accordance with this Section.
6. "Approval to Practice" means authorization by the Medical Board and the Board of Nursing for a nurse practitioner to perform medical acts within her or his area of educational preparation and certification under a collaborative practice agreement (CPA) with a licensed physician in accordance with this Section.
7. "Supervision" means the physician's function of overseeing medical acts performed by the nurse practitioner.
8. "Collaborative practice agreement" means the arrangement for nurse practitioner-physician continuous availability to each other for ongoing supervision, consultation, collaboration, referral and evaluation of care provided by the nurse practitioner.
9. "Primary Supervising Physician" means the licensed physician who, by signing the nurse-practitioner application; who shall provide ongoing supervision, collaboration, consultation and

Proposed Rule changes for Nurse Practitioners

By Eileen C. Kugler, RN, MSN, MPH, FNP Manager – Practice

In North Carolina nurse practitioner practice is regulated jointly by the North Carolina Board of Nursing and the North Carolina Medical Board. This is accomplished through the action of the Joint Subcommittee which is made up of three members from each board. Joint Subcommittee decisions become recommendations that are then forwarded to each board for approval. Recently the Joint Subcommittee and both boards approved proposed rule changes affecting NP practice requirements. The proposed rule changes, described below, will not become final until after public

hearings are held and any further changes receive final approval by the boards and the NC Rules Review Commission. A public hearing is scheduled on May 17, 2012 at 1:00 PM at the offices of the Board of Nursing in Raleigh.

If final approval is received, the following changes affecting rules 21 NCAC 36 .0801, .0803, .0804 and .0808 would become effective later on this year: the physician's signature will not be necessary on the approval to practice identification document thereby eliminating the need for this document further

streamlining the application process; the American Association of Critical Care Nurses Certification Corporation (AACN) would be added to the list of board approved certifying bodies; and, the length of time out of practice before a nurse practitioner refresher course is required to reenter practice would decrease from five to two years.

Stay tuned for the progress of these proposed rule changes. In addition to rule changes being published in the magazine, they also can be viewed on the Board's website www.ncbon.com.

- evaluation of the medical acts performed by the nurse practitioner as defined in the collaborative practice agreement. Supervision shall be in compliance with the following:
- (a) The primary supervising physician shall assure both Boards that the nurse practitioner is qualified to perform those medical acts described in the collaborative practice agreement.
 - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training license, shall not be named as a primary supervising physician.
 - (c) A fully licensed physician in a graduate medical education program who is also practicing in a non-training situation may supervise a nurse practitioner in the non-training situation.
10. "Back-up Supervising Physician" means the licensed physician who, by signing an agreement with the nurse practitioner and the primary supervising physician(s) shall provide supervision, collaboration, consultation and evaluation of medical acts by the nurse practitioner in accordance with the collaborative practice agreement when the Primary Supervising Physician is not available. Back-up supervision shall be in compliance with the following:
- (a) The signed and dated agreements for each back-up supervising physician(s) shall be maintained at each practice site.
 - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training license, shall not be named as a back-up supervising physician.
 - (c) A fully licensed physician in a graduate medical education program who is also practicing in a non-training situation and has a signed collaborative practice agreement with the nurse practitioner and the primary supervising physician may be a back-up supervising physician for a nurse practitioner in the non-training situation.
11. "Volunteer Approval" means approval to

- practice consistent with this rule except without expectation of direct or indirect compensation or payment (monetary, in kind or otherwise) to the nurse practitioner:
- 12. Disaster" means a state of disaster as defined in G.S. 166A-4(1a) and proclaimed by the Governor, or by the General Assembly pursuant to G.S. 166A-6.
 - 13. "National Credentialing Body" means one of the following credentialing bodies that offers certification and re-certification in the nurse practitioner's specialty area of practice: American Nurses Credentialing Center (ANCC); American Academy of Nurse Practitioners (AANP); American Association of Critical Care Nurses Certification Corporation (AACN); National Certification Corporation of the Obstetric Gynecologic and Neonatal Nursing Specialties (NCC); and the Pediatric Nursing Certification Board (PNCB).
- History Note: Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-18.2; 90-171.20(4); 90-171.20(7); 90-171.23(b); 90-171.83; Recodified from 21 NCAC 36 .0227(a) Eff. August 1, 2004; Amended Eff. _____; December 1, 2009; December 1, 2006; August 1, 2004.*

21 NCAC 36 .0803 AND 21 NCAC 32M .0103 — NURSE PRACTITIONER REGISTRATION

- (A) The Board of Nursing shall register an applicant who:
- 1. has an unrestricted license to practice as a registered nurse in North Carolina and, when applicable, an unrestricted approval, registration or license as a nurse practitioner in another state, territory, or possession of the United States;
 - 2. has successfully completed a nurse practitioner education program as outlined in Rule .0805 of this Section;
 - 3. is certified as a nurse practitioner by a national credentialing body consistent with 21 NCAC

- 36.0801(13); 36-0120(7) and (9); and
 - 4. has supplied additional information necessary to evaluate the application as requested.
- (B) Beginning January 1, 2005, new graduates of a nurse practitioner program, who are seeking first-time nurse practitioner registration in North Carolina shall:
- 1. hold a Master's or higher degree in Nursing or related field with primary focus on Nursing;
 - 2. have successfully completed a graduate level nurse practitioner education program accredited by a national accrediting body; and
 - 3. provide documentation of certification by a national credentialing body.
- History Note: Authority G.S. 90-18(c)(13); 90-18.2; 90-171.20(7); 90-171.23(b); 90-171.83; Eff. August 1, 2004; Amended Eff. _____; November 1, 2008; December 1, 2006.*

21 NCAC 36 .0804 AND 21 NCAC 32M .0104 — PROCESS FOR APPROVAL TO PRACTICE

- (A) Prior to the performance of any medical acts, a nurse practitioner shall:
- 1. meet registration requirements as specified in 21 NCAC 36 .0803 of this Section;
 - 2. submit an application for approval to practice;
 - 3. submit any additional information necessary to evaluate the application as requested; and
 - 4. have a collaborative practice agreement with a primary supervising physician.
- (B) A nurse practitioner seeking approval to practice who has not practiced as a nurse practitioner in more than five two years shall complete a nurse practitioner refresher course approved by the Board of Nursing in accordance with Paragraphs (o) and (p) of 21 NCAC 36 .0220 and consisting of common conditions and their management directly related to the nurse practitioner's area of education and certification.
- (C) The nurse practitioner shall not practice until

- notification of approval to practice is received from the Board of Nursing after both Boards have approved the application.
- (D) The nurse practitioner's approval to practice is terminated when the nurse practitioner discontinues working within the approved nurse practitioner collaborative practice agreement, or experiences an interruption in her/his registered nurse licensure status, and the nurse practitioner shall notify the Board of Nursing in writing. The Boards may extend the nurse practitioner's approval to practice in cases of emergency such as injury, sudden illness or death of the primary supervising physician.
- (E) Applications for approval to practice in North Carolina shall be submitted to the Board of Nursing and then approved by both Boards as follows:
1. the Board of Nursing shall verify compliance with Rule .0803 and Paragraph (a) of this Rule; and
 2. the Medical Board shall verify that the designated primary supervising physician holds a valid license to practice medicine in North Carolina and compliance with Paragraph (a) of this Rule.
- (F) Applications for approval of changes in practice arrangements for a nurse practitioner currently approved to practice in North Carolina:
1. addition or change of primary supervising physician shall be submitted to the Board of Nursing and processed pursuant to protocols developed

- by both Boards; and
2. request for change(s) in the scope of practice shall be submitted to the Joint Subcommittee.
- (G) A registered nurse who was previously approved to practice as a nurse practitioner in this state who reapplies for approval to practice shall:
1. meet the nurse practitioner approval requirements as stipulated in Rule .0808(c) of this Section; and
 2. complete the appropriate application.
- (H) Volunteer Approval to Practice. The North Carolina Board of Nursing shall grant approval to practice in a volunteer capacity to a nurse practitioner who has met the qualifications to practice as a nurse practitioner in North Carolina.
- (I) The nurse practitioner shall pay the appropriate fee as outlined in Rule .0813 of this Section.
- (J) A Nurse Practitioner approved under this Section shall keep proof of current licensure, registration and approval available for inspection at each practice site upon request by agents of either Board.

History Note: Authority G. S. 90-18(13), (14); 90-18.2; 90-171.20(7); 90-171.23(b); Recodified from 21 NCAC 36.0227(c) Eff. August 1, 2004; Amended Eff. _____; December 1, 2009; November 1, 2008; January 1, 2007; August 1, 2004.

21 NCAC 36 .0808 — INACTIVE STATUS

- (A) Any nurse practitioner who wishes to place her or his approval to practice on an inactive status shall notify the Board of Nursing.
- (B) A nurse practitioner with an inactive approval to practice status shall not practice as a nurse practitioner.
- (C) A nurse practitioner with an inactive approval to practice status who reapplies for approval to practice shall meet the qualifications for approval to practice in Rules .0803(a)(1), .0804(a) and (b), .0804(a); .0806(b); .0807, and .0810 of this Section and receive notification from the Board of Nursing of approval prior to beginning practice after the application is approved by both Boards.
- (D) ~~A nurse practitioner with an inactive approval to practice status of greater than who has not practiced as a nurse practitioner in more than two~~ five years shall complete a nurse practitioner refresher course approved by the Board of Nursing in accordance with Paragraphs (o) and (p) of 21 NCAC 36 .0220 and consisting of common conditions and their management directly related to the nurse practitioner's area of education and certification in order to be eligible to apply for approval to practice. ~~certification.~~
- History Note: Authority G.S. 90-18(13); 90-18.2; 90-171.36; 90-171.83; Recodified from 21 NCAC 36 .0227(g) Eff. August 1, 2004; Amended Eff. _____; December 1, 2009; December 1, 2006; August 1, 2004.*

Fitness for Duty Includes Getting Your ZZZZs



Permission was granted to the North Carolina Board of Nursing by the Texas Nurses Association to reprint this article with authorized edits, and to award 1.0 contact hour.

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Introduction

In 2006, Wisconsin registered nurse Julie Thao faced criminal prosecution for “neglect of a patient causing great bodily harm” following a medication error that resulted in a patient’s death. Nurse Thao had slept at the hospital the night before after a 16-hour shift. It was the July 4th holiday, and she had agreed to work a double shift (7:00 a.m. to midnight) in order to help provide adequate staff coverage for the Labor and Delivery unit in which she was employed. Nurse Thao mistakenly infused an epidural anesthetic intravenously, thinking the drug was an antibiotic prescribed for a strep infection the patient had. Both infusion bags had been placed next to each other on a counter in the patient’s room. The

patient died within the hour, although her newborn son survived (Error, 2006).

Was nurse Thao guilty as charged? Or was nurse Thao, who had an impeccable record prior to this incident, a good nurse who made a mistake with disastrous consequences? Most nurses will make medication errors at some point in their careers, and most of their patients will be “lucky” enough not to suffer serious consequences from their mistakes. How does the fact that nurse Thao had worked a double shift the day before and slept at the hospital play into the error equation?

Nurses are frequently asked to “work over” to cover an unexpected absence of a co-worker or to cover a chronically short-staffed area. Despite the availability of extra hours and the temptation of additional income, the professional accountability of nursing carries a responsibility to be in a safe condition to care for patients. “Fitness for duty” is used to describe this condition. Nurses may not be aware of what factors influence fitness for duty and how easily human performance limitations- emotional, cognitive, and physical components- can contribute to errors. This article reviews the limitations of human performance as it influences fitness for duty and impacts the nurse’s ability to practice safely.

Anatomy of an Error

Anatomy is the science of structure. We all completed an anatomy course early in our nursing education to learn about the structure of the human body, but most of us have probably not considered the anatomy of an error until we are faced with the consequences of an error. It is at that point that we can ask, “How did this happen? I was so careful!” The obvious answer is that we are human and ‘to err is human.’ But, there is more....

Error is defined as those occasions when a planned activity fails to achieve the intended outcome. (Reason, 1990). Errors can be broken down into two types. Active errors occur by the person doing the activity, for example when a nurse gives the patient a wrong medication. Latent errors occur farther away from the action, that is, away from the bedside. An example might be look-alike medications stored in adjacent bins in the medication cart or new equipment to which staff have not been oriented. Essentially, these are errors waiting to happen.

Because human error is inevitable, prevention is directed at the design of systems that can prevent errors – mechanisms that don’t allow you to make a mistake. “We cannot change the human condition, but we can change the conditions under which humans work.” (James Reason). For instance, you cannot fill your car’s unleaded gas tank with leaded gasoline because the gas receptacle for no-lead gasoline tanks has been designed smaller than a leaded nozzle. The two don’t fit, thus preventing an error.

There are many examples of this approach in health care as well: pre-filled syringes prevent dosage errors, programmed infusion pumps prevent certain infusion errors, and bar coding has prevented some identification errors. However, health care is extremely complex and it is impossible to design potential errors out of all processes. Consider the design of the work environment, staffing and scheduling practices, and communication processes – has any health care system perfected these designs to eliminate error? Though improvements have been made, nurses continue to be left at the “sharp end” where latent errors become active. Therefore, the nurse often represents the final opportunity to prevent a *latent error*



from becoming an *active error* – the last safety net so to speak.

Human Performance Factors

Humans are imperfect. Human factors confound performance and risk for errors. Some human factors affecting performance include distraction, fatigue, pressure/stress, norms, lack of communication, lack of knowledge/skills, lack of teamwork, and lack of resources. Many of these factors involve our interaction with the environment, for example, when we're faced with unfamiliar equipment, poor lighting in a patient's room, a noisy nurses' station, or a difficult physician. Environmental distractions are a well documented factor in medical errors. When reduced, performance improves. Recently, several San Francisco hospitals were successful in reducing their medication errors by 88 percent by reducing the interruptions (distractions) nurses experienced when administering medications (*San Francisco Chronicle*, 10/28/09).

Other human factors are internal. Fatigue is an internal human factor that crosses both our emotional state and physical abilities. Performance ability considers the relationship of the nurse's work capacity to workplace demands and can be referred to as "fitness for duty." We often think of impaired practice due to alcohol or other substance use when we hear the term "fitness for duty," but fitness for duty is actually a broader concept that encompasses any factor that may affect the nurse's ability to perform competently and safely. Fatigue is one such factor that has been studied thoroughly in other industries, but only recently applied to healthcare.

Fatigue as a Factor in Fitness for Duty

Any factors affecting the nurse's ability to perform competently and safely influence the nurse's fitness for duty. Fatigue is defined as "an overwhelming sense of tiredness, lack of energy, and a feeling of exhaustion associated with impaired physical and/or cognitive

functioning, sleepiness, and fatigue often co-exist as a consequence of sleep deprivation." (Rogers, 2008, p.2-509). Fatigue may result from circadian rhythm effects, sleep deprivation and continuous fatigue effects, and "time-on-task" effects.

Our sleep-wake cycle is regulated biologically by two factors and their interactions: a homeostatic system and circadian rhythm. Circadian rhythm is a "biological clock" which regulates our periods of sleepiness and wakefulness during the day. It functions in response to light signals which stimulate the release of hormones such as cortisol in the morning light and melatonin in evening. We respond with fluctuations in attentiveness during the day. Most of us experience our greatest sleepiness in the early morning hours (2:00 a.m. – 4:00 a.m.) and a lesser period in the early afternoon (1:00 p.m. – 3:00 p.m.). Circadian rhythms can only be shifted one to two hours in either direction and can be influenced by our sleeping and waking behaviors. For example, if we normally wake early in the morning, but stay up late and sleep over on the weekends, we experience greater than usual sleepiness on Monday morning as our body adjusts to the change in sleep pattern. Disturbances in circadian rhythm, such as when traveling across time zones, also interrupt our normal sleep patterns and force our body to adjust – we experience this as "jet lag." Night shift workers are especially challenged to manage disruptions to circadian rhythms.

Sleep deprivation may result in:

- Lapses in attention and inability to stay focused
- Reduced motivation
- Compromised problem-solving
- Confusion or bewilderment
- Irritability or hostility
- Unusual tenseness or anxiety
- Memory lapses (particularly in short term memory)
- Impaired communication
- Faulty information processing and judgment
- Diminished ability to detect and

recognize the significance of subtle changes in patient's health

- Diminished reaction time
- Slowed information processing
- Inability to deal with unexpected indifference and loss of empathy

Sleep/wake homeostasis is a second biological component that interacts with our circadian rhythm to help us maintain adequate sleep. While circadian rhythm regulates the timing of sleepiness, sleep-wake homeostasis is concerned with the duration and intensity of sleep. While awake, we accumulate a need for sleep. When we get adequate quality sleep, we are able to replenish this sleep deficit. When we don't, our homeostasis or balance is upset and we become sleep deprived.

Most adults require seven to eight hours of sleep per day. Sleep deprivation occurs when we don't get required sleep or when we are awake longer than 16 hours. Lack of uninterrupted sleep intervals, such as when breaking up sleep into several naps, can also contribute to sleep deprivation (as any mother of an infant can attest!). A sleep deficit is cumulative over time and may require more than one replenishing normal sleep cycle to remedy.

Time-on-task is an industrial concept that refers to fatigue that accumulates during the work period. Prolonged concentration while reviewing and noting physician orders may be an example of time-on-task that may result in fatigue. Generally, fatigue increases and performance diminishes with sustained task effort.

How Fatigue Affects Fitness for Duty

Imagine...you are on your way to Hawaii to begin your dream vacation. As you board your airplane you are greeted by a red-eyed pilot carrying a large "energy drink" and overhear her comments to the flight attendant that she only had time for a four-hour nap between flights so was feeling a bit tired. Sound frightening? Would you board the plane?

What if you knew that in a safety

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study conducted by the National Transportation Safety Board (NTSB) of U.S. major carrier accidents from 1978 to 1990, it was concluded:

Half the captains for whom data were available had been awake for more than 12 hours prior to their accidents. Half of the first officers had been awake for more than 11 hours. Crews comprising captains and first officers whose time since awake was above the other made more errors overall and significantly more procedural and tactical decision errors (1994).

How confident are you of the pilot's fitness for duty?

Insufficient sleep is associated with cognitive problems, mood alteration, reduced job performance, reduced motivation, increased safety risks, and psychological changes (Rogers, 2008). Federal regulators recognize the adverse effects of fatigue on safety and require the airline industry (along with trucking and nuclear industries) to directly manage fitness for duty of airline crew members – specifically the number of consecutive hours that can be worked and the number of hours required between work periods for adequate rest. In 2004, the Institute of Medicine (IOM) report recommended Regulatory Boards should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime or voluntary overtime in excess of 12 hours in any given 24 hour period and in excess of 60 hours per 7-day period.

Patients in hospital beds are more likely to be greeted by a sleepy nurse than airline passengers are a sleepy pilot. Knowing that this sleepy nurse has a significantly greater risk of making an error that will affect your care, and perhaps your recovery, how safe do you feel now?

Despite recommendations from the Institute of Medicine in 2004, (*To reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in a combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24-hour period and in excess of 60 hours per 7-day period*), and recent attention to hours worked by

medical residents, hours worked by nurses remain, for the most part, unchallenged. In a survey conducted by the Texas Nurses Association, 60 percent of hospital chief nursing officers reported having a fitness for duty policy, yet only 4 percent of those reported considering fatigue as a component of this policy.

Nurses are not immune to fatigue or related effects on performance. A landmark study of 393 staff nurses over 5317 work shifts documented the significant effects of work duration, overtime, and number of hours worked on errors:

- *The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more.*
- *Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.*
- *There (was) a trend for increasing risks when nurses work overtime after longer shifts, with the risks being significantly elevated for overtime following a 12-hour shift.*
- *Working more than 40 hours per week and more than fifty hours per week significantly increased the risk of making an error.*
- *Results were somewhat similar for near errors (Rogers et al., 2004, p.207).*

Why are nurses at risk for fatigue?

There are a number of professional and personal factors that contribute to nurse fatigue. The unpredictable nature of the health care environment – emergencies, fluctuating census patterns, changes in patient conditions, physician practice patterns-contributes to changing needs for nursing staff. Although organizations have strategies for anticipating patient care needs and scheduling staff appropriately to meet those needs, it is often a “best guess” and must be adjusted. This creates gaps in staffing needs – some days more nurses than those scheduled will be needed, requiring additional work hours and possible overtime. An organization that has vacancies faces even greater challenges

in meeting its staffing needs without requiring additional hours from nurses.

Professional Factors Related to Nurse Fatigue:

- On-call hour
- Required overtime hours
- Total # hours worked per week
- Length and sequencing of shifts
- Rotating shifts
- Chronic short staffing
- Working when sick

Personal Factors Related to Nurse Fatigue:

- Working extra jobs
 - Voluntary overtime
 - Additional home/family responsibilities
 - Overall physical/mental health
- (Nursing Organizations Alliance, 2006)

Characteristics of a 24-hour, 7 day-a-week operation also contribute to a nurse's risk for fatigue. Night shift hours predispose individuals to sleep deprivation due to their circadian rhythm and likely interruption in sleeping schedule on days off. Twelve-hour shifts are popular with nurses, but they easily lead to fatigue at the end of the work day, or at the completion of a few shifts in a row. On-call often interrupts sleep as well as requires nurses to work hours exceeding the recommended daily limit.

As human beings, nurses will have personal factors affecting risk for fatigue. Nurses who report social duties and caretaking roles outside of work often report higher levels of stress both at work and at home. A nurse may be the caretaker for elderly family, young children, or ill partners. Concerns about one setting (e.g., the home) are frequently reported to interfere with performance in the second arena (work) (Scott et al., 2006) Our physical and mental health – aging, dehydration, depression, anxiety and stress – also affects our experience of fatigue and related performance.

Nurse's responsibility for fitness for duty

Just as you wouldn't go in to work under the influence of alcohol, you shouldn't go to work under the influence of fatigue – whatever the reason (personal or professional factors). Vigilance is not enough. Individuals are poor

Sleep Hygiene	
Do	Don't
Establish a regular schedule: wake up & go to bed at the same time every day	Go to bed if you aren't sleepy
Practice a relaxing bedtime routine	Consume alcohol, caffeine, heavy/spicy/sugary food 4-6 hours before bed
Create a sleep friendly environment	Go to bed hungry
Exercise! But not right before bed	Read, write, eat, watch TV, etc in bed

- Do not consume caffeine outside of work hours
- Only consume caffeine at the beginning of the shift or between 3:00 a.m. and 5:00 a.m.
- If you work nights, take a nap prior to your shift
Rogers, 2008

A primary preventative countermeasure is to minimize sleep loss by using days off to “catch up” or “stock up” in anticipation of sleep debt. Good sleep habits, or sleep hygiene can improve sleep quality. However, despite the quality of sleep, several sleep cycles are required to fully recover from a sleep deficit and sleep cannot be effectively “stored” to accommodate for a future lack of sleep.

Operational strategies include those things you can do while on the job to mitigate fatigue. Social interaction and conversation can assist in maintaining alertness, physical exercise combats sleepiness, however may leave one more fatigued later. Strategic use of caffeine can improve alertness. Nutritional snacks and planned breaks can assist the nurse in maintaining energy.

The nurse has a primary duty to the patient. Nurses who believe that this duty may be violated by accepting an assignment when too tired to work safely must refuse the assignment. The decision to refuse the assignment must be based upon the belief that no reasonable nurse would accept the assignment.

Organizational Safety Practices

Health care has traditionally valued nurses who never call in, who pick up extra shifts when needed, and who never seem to need a break- yet, this valuing allows fatigue and its dangers to permeate the organizational culture. Current evidence and recommendations challenge organizations to shift their culture toward one respectful of the deleterious effect of fatigue on the patients, the nurse, and the organization. A number of organizational practices can be implemented to fight fatigue in the workplace. First, organizations can work to understand current practices that may contribute to fatigue by conducting an assessment of staffing

judges of their impairment from fatigue or sleep deprivation and alertness cannot be willed.

The nurse has a primary duty to his/her patient(s) that supersedes any facility policy or physician order. The Code of Ethics for Nurses (ANA, 2001) clearly outlines the nurses’ responsibility for safe patient care:

- “The nurse’s primary commitment to the patient ...” (Provision 2)
- “The nurse is responsible and accountable for individual nursing practice...” (Provision 4)

Further, in the North Carolina Board of Nursing statement on “Extended Work Hours and Patient Safety” (www.ncbon.com-Practice-Position Statements-Extended Work Hours and Patient Safety) nurses and managers are encouraged to avoid overtime hours if either has reason to believe that the licensee is sleep deprived or performance is otherwise compromised. Nurse must communicate safety concerns clearly to managers and those working in more than one job must exercise caution in self-regulating their total hours worked. It is the position of the Board of Nursing and Division of Health Service Regulation that work hours must be managed by all concerned with an emphasis on safe patient care.

The nurse has a duty to always act in the best interest of the patient. This duty to the patient includes being physically and emotionally “fit” to provide safe patient care. Therefore, nurses providing direct patient care have a professional responsibility to ensure they are adequately rested and not fatigued when accepting a patient assignment.

Likewise, a nurse making an assignment for staffing a unit must consider the physical and emotional ability of the person to whom the assignment is made and is therefore responsible for considering the nurse’s fatigue and patient’s safety in making an assignment, a work schedule, or setting policies (e.g. on-call hours).

Individual Safety Practices

Despite the evidence, nurses are frequently faced with either voluntary or required work schedules that may put them at risk for fatigue. How can nurses protect themselves and their patients when they may be at risk for fatigue? A number of countermeasures, preventative and operational strategies (Rosekind et al., 1996), can assist in maintaining alertness and on-the-job performance. However, these strategies should be applied with caution –they do not eliminate the safety risks of working when fatigued.

Evidence-Based Practice Recommendations

- Get 7-8 hours of sleep per 24 hour period
- Do not work > 48 hours in a 7-day period
- Do not schedule/work 12-hour shifts
- If you must work 12-hour shifts:
- Do not work more than 3 shifts without a day off
- Take breaks free from patient care responsibilities (10 minutes/2hours and a 30 minute meal break)
- Take 10-12 hours off between shifts to obtain adequate sleep
- Use caffeine therapeutically

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and scheduling, use of overtime and breaks, nurse satisfaction measures, and patient incident and employee accident reports. This information can help organizations in identifying their risks related to potential fatigue, prioritizing issues, and developing a fatigue management plan to incorporate evidence-based recommendations.

When duty to keep patients safe is threatened by fatigue.....

Jennie began her day of scheduled on-call at 3:30 p.m. when her 8-hour OR shift concluded. After arriving home at 4:30 p.m., she had something to eat and then took a 2-hour nap. At 10:30 p.m. she was called in for a trauma. She completed two emergency cases that night and was particularly disturbed by one patient, a young woman who died during surgery.

She returned home at 4:30 a.m., but had a difficulty falling asleep. Feeling exhausted, she called the charge nurse at 5:00 a.m. to let her know that she felt too tired to work after taking call that night. The charge nurse told her she was expected to come in to work and coming in on-call was no excuse for missing work. Despite grabbing a double Espresso on the way to work, Jennie found herself having difficulty staying awake while driving.

What should Jennie do? What responsibility does her Manager have in this situation?

Jennie is accountable for knowing if she is safe and competent to accept an assignment (21 NCAC 36.0217 (c) (7) –accepting or performing professional responsibilities which the licensee knows or has reason to know he or she is not competent to perform. Therefore, in this situation Jennie must refuse to accept an assignment.)

The Charge Nurse, likewise is accountable for her decision to make an assignment to Jennie, (21 NCAC 36.0217 (c) (5)–delegating responsibilities to a person when the licensee delegating knows or has reason to know that the competency of that person is impaired by physical or psychological ailments, or by alcohol or other pharmacological agents, prescribed or not.) Therefore, in this situation the CN should not give Jennie an assignment.

Conclusions

The fallibility of human beings, limitations of human performance, and importance of fitness for duty are well established. The health care industry has not yet incorporated this knowledge into its systems to effectively design out errors or “mistake proof” care. It is incumbent on the nurse to assume responsibility for safe patient care. That responsibility includes ensuring personal fitness for duty when accepting an assignment.

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EARN CE CREDIT

INSTRUCTIONS

Read the article and on-line reference documents (if applicable). There is not a test requirement, although reading for comprehension and self-assessment of knowledge is required.

RECEIVE CONTACT HOUR CERTIFICATE

Go to www.ncbon.com and select “Events, Workshops & Conferences;” then select “Board Sponsored Workshops;” under “Bulletin Articles,” scroll down to the link “Fitness for Duty Includes Getting Your ZZZZs.” Register, complete and submit the evaluation, and print your certificate immediately. **Registration deadline is March 1, 2014**

NCBON CNE CONTACT HOUR ACTIVITY DISCLOSURE STATEMENT

The North Carolina Board of Nursing will award **1.0 contact hour** 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.

CE Opportunities 2012



To access online CE articles, webcasts, session registration, and the presentation request form, go to:

www.ncbon.com Click on:



to the right of the homepage.

Questions:
Paulette Hampton
919-782-3211 ext. 244
Paulette@ncbon.com

Online Bulletin Articles

Competency Validation: What Does it Mean for You? (.75 CHs)

Assists nurses in understanding what validation of competence is and why it is necessary for patient safety and good nursing practice. No fee required.

Public Protection Through Safe Nurse Staffing Practice (.85 CHs)

Assists nurses in understanding safe staffing practice. No fee required.

Incivility in Nursing (1 CH)

Provides nurses with information about the impact of incivility and strategies to promote a culture of civility. No fee required.

NEW!

Fitness for Duty Includes Getting Your ZZZs (1CH)

Enhances the knowledge base and practice of the nurse by outlining the limitations of human performance as it influences fitness for duty and the nurse's ability to practice safely. No fee required.

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 required.

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.

Questions:
Pamela Trantham
919-782-3211 ext. 279
Pamela@ncbon.com

Orientation Session

Face-to-face workshop at NC Board of Nursing office.

Information session regarding the functions of the Board of Nursing and how these functions impact the roles of the **nurse administrator and the mid-level nurse manager** in all types of nursing services.

Session Dates

May 8, 2012
September 25, 2012
November 7, 2012

\$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. There is usually a waiting list for this workshop. 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.

PAPER REGISTRATION REQUEST, CONTACT PAULETTE HAMPTON 919-782-3211 EXT 244

PRACTICE CONSULTANT AVAILABLE TO PRESENT AT YOUR FACILITY!

An NCBON practice consultant is available to provide educational presentations upon request from agencies or organizations.

To request a practice consultant to speak at your facility, please complete the Presentation Request Form online and submit it per form instructions. The NCBON will contact you to arrange a presentation.

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 (2.3 CH)** – 2 hours and 18 minutes – Define and contrast each scope, explain delegation and accountability of nurse with unlicensed assistive personnel, and provide examples of exceeding scope. Also available as webcast.
- **Understanding the Scope of Practice and Role of the LPN (1 CH)** - 1 hour - Presentation will assist RNs, LPNs, and employers of nurses in understanding the LPN scope of practice. Also available as webcast.
- **Documentation and Medication Errors (1 CH)** – 1 hour – Explain purpose, importance, and desirable characteristics of documentation; describe relationship between nursing regulation and documentation; identify practices to avoid and those that may violate NPA; and identify most common medication errors and contributing factors.
- **Nursing Regulation in NC (1 CH)** – 1 hour – Describe Board authority, composition, vision, function, activities, strategic initiatives, and resources.

THE FOUNDATION FOR NURSING EXCELLENCE

Taking the lead in increasing the number of BSN-prepared nurses in North Carolina



The Foundation for Nursing Excellence (FFNE) has received major support from The Duke Endowment (TDE) to increase the number of BSN-prepared nurses in North Carolina by expanding the RIBN (Regionally Increasing Baccalaureate Nurses) project statewide. The Foundation has also received funding from the Jonas Center for Nursing Excellence, the Robert Wood Johnson Foundation and Northwest Health Foundation to support this major initiative through the Partners Investing in Nursing (PIN) initiative.

As recommended in both the 2004 NC Institute of Medicine Nursing Workforce Report and the 2010 Institute of Medicine Report: The Future of Nursing – Leading Change, Advancing Health, a higher educated nursing workforce is needed to address the increasingly complex healthcare needs of our citizens, and expand the pool for future faculty and advanced practice nurses. Currently more than 66% of our newly licensed nurses enter the workforce with associate degrees in nursing and less than 16% of these nurses achieve a BSN or higher degree in nursing during their careers. Given

the important role community colleges have in educating the majority of the NC nursing workforce, it is imperative that we create new pathways for qualified nursing students entering a community college to seamlessly progress to the completion of a baccalaureate degree at the beginning of their careers if we hope to increase the proportion of BSN prepared nurses and build the necessary faculty pipeline to avert a severe workforce crisis.

In 2008, the FFNE, in collaboration with Western Carolina University and Asheville Buncombe Technical Community College, began work toward the implementation of a four-year, dual admission, seamless progression educational track between the community college and the university. This is an economically feasible opportunity for students to remain in their home communities while working toward a baccalaureate degree in nursing. The first cohort of RIBN students was admitted to this track in 2010 with the goal of achieving their BSN in 2014.

Based on the success of the initial stage of this project in western NC and the broad interest in expanding this educational model statewide, we

are now expanding the RIBN model in five more regions across the state, to include 14 associate degree and five university nursing education programs. Several more community colleges and universities hope to join this initiative in the near future.

Please visit our website at www.ffne.org to learn more about this and other important Foundation initiatives, including our NC Future of Nursing Action Coalition activities. The Foundation for Nursing Excellence exists to positively impact health outcomes for North Carolinians by addressing nursing workforce issues and improving patient safety. *The Foundation for Nursing Excellence is a tax-deductible organization that welcomes your support. For more information visit the Foundations's website at www.ffne.org.*

ATTENTION: NURSE AIDE RN SUPERVISORS AND EMPLOYERS

The Board of Nursing has received information that some RN Supervisors are charging Nurse Aides a fee to verify employment. This verification is necessary to be eligible for renewal of listings at both the Nurse Aide I and Nurse Aide II levels.

The Board considers these charges levied against a Nurse Aide to be unethical, unprofessional and inappropriate.

ADMINISTRATIVE MATTERS

21 NCAC 36.0120 - Definitions - Reason for the proposed action is to clarify definition of APRN, expressly listing the four distinct roles; this is also consistent with national nomenclature for advanced practice registered nurses.

21 NCAC 36 .0702 and .0703 - Nurse Licensure Compact - Reason for the proposed action is to bring the licensure compact rules in compliance with the Nurse Licensure Compact Administration Model Rules for the Nurse Licensure Compact, consistent with Article 9G of Chapter 90.

21 NCAC 36.0801; .0803; .0804 and .0808 - Nurse Practitioner - Reason for the proposed actions - The Board of Nursing and the NC Medical Board recently reviewed the Nurse Practitioner rules to improve clarity and to be more in sync with the physician assistant process; correct references in rule and to change the years of inactive for the refresher course.

There will be a Public Hearing on these rules - May 17, 2012 at 1:00 p.m. at the Board of Nursing office.

Instructions for oral and written comments: Persons may submit objections to these rules by contacting Jean H. Stanley, APA Coordinator, NC Board of Nursing, P O Box 2129, Raleigh, NC 27602; Fax: 919-781-9461; E-mail: jeans@ncbon.com

APPROVED PROPOSED RULES REVISIONS AS FOLLOWS:

- 21 NCAC 36.0120 Definitions
- 21 NCAC 36.0702 Issuance of a License By a Compact Party State
- 21 NCAC 36.0703 Limitations on Multistate Licensure Privilege
- 21 NCAC 36.0801 Definitions
- 21 NCAC 36.0803 Nurse Practitioner Registration
- 21 NCAC 36.0804 Process for Approval to Practice
- 21 NCAC 36.0808 Inactive Status

see P. 12 for proposed rule changes or visit www.ncbon.com and on the left side click on law and rules, and proceed to Proposed Rules.

INVESTIGATION AND MONITORING ACTIONS

Received reports and Granted Absolutions to 4 RNs, 2 LPNs.
Removed probation from the license of 16 RNs and 3 LPNs.
Accepted the Voluntary Surrender from 11 RNs and 2 LPNs.
Suspended the license of 22 RNs and 6 LPNs.
Reinstated the license of 15 RNs, 1 LPN.

Number of Participants in the Alternative Program for Chemical Dependency: 132 RNs and 12 LPNs (Total = 144)
Number of Participants in the Chemical Dependency Program (CDDP): 74 RNs, 8 LPNs (Total = 82)
Number of Participants in Illicit Drug and Alcohol/Intervention Program: 28 RNs, 13 LPNs. (Total = 41)

PRACTICE MATTERS

Approved two additional charges to the Education & Practice Committee for 2012:

- Exploring the advisability of allowing an NCLEX-RN applicant who fails the NCLEX-RN examination to be licensed as a practical nurse in North Carolina upon passing the NCLEX-PN examination with no specific preparation related to the LPN legal scope of practice.
- Exploring the advisability of requiring validation of the ongoing clinical competence of NCLEX-PN and NCLEX-RN examination candidates over time, accompanied by mandatory clinical remediation as indicated; of requiring mandatory didactic remediation over time.

EDUCATION MATTERS:

Summary of Actions related to Education Programs

Ratification of Full Approval Status – 8 programs

Determination of Program Approval Status – 1 program

Approval of Status Changes Related to Annual NCLEX Results per Board Policy

2011 Pass Rate Met or Exceeded 3-year average Standard and returned to Full Approval – 1 program

Returned to or Maintained on Full Approval – 10 programs

Second Consecutive Year below Standard – 1 program

Third Consecutive Year below Standard – 1 program

Board's Education and Practice Committee EXAMINING RN SCOPE OF PRACTICE

The Board at its September 2011 meeting charged the Education and Practice Committee to review the Registered Nurse (RN) Scope of Practice to assure that RNs are able to practice to the full extent of their licensure in NC. The committee is to identify if the Board in any of its interpretations of the Nursing Practice Act and related Administrative Code Rules has created barriers that limit RNs' ability to fully practice in their various work settings. The Board is also interested in hearing new, generative ideas of how identified changes in the RN scope of practice could benefit care

delivery in those practice settings in the future.

Committee meetings are scheduled throughout 2012 at the Board's office in Raleigh. Meeting dates are Wednesdays April 4th, August 1st, and December 5th, from 9am to 3:30pm. The agenda and information regarding each meeting will be listed on the Board's website (www.ncbon.com) and will be updated throughout the year. Representatives from nursing administration, various practice settings, related organizations/associations and state agencies, as well as staff nurses and the public are being invited to present their

opinions and visions regarding the charge.

All meetings will provide an Open Comment period for any individual interested in presenting their perspective to the committee. Interested individuals are requested to register at least 4 weeks prior to the scheduled meeting (space is limited) by contacting Paulette Hampton at either 919-782-3211 ext. 244 or paulette@ncbon.com. Those unable to attend a scheduled meeting may enter their perspectives anonymously through an online survey offered on the Board's website.

PREP (PRACTITIONER REMEDIATION ENHANCEMENT PROGRAM) 2001 - 2012 AND STILL GOING STRONG!

Q What type of nurse was PREP designed to help?

A PREP was developed to assist those licensees who have had a minor practice breakdown and/or who may be demonstrating some “at risk” behaviors. The practice deficiencies identified must not involve drugs, abuse, or be criminal in nature, and the licensee must be motivated to improve his/her own practice through remediation. In addition, the licensee’s ongoing practice must not pose a risk to public safety.

Q Why should an employer consider referring a nurse to PREP?

A All nurses are susceptible to slips, lapses and mistakes, and may drift away from standards due to failing to perceive risks. Perfect performance is unrealistic. The goal of PREP is to help good nurses make better choices by providing an individualized remediation plan to help set them back on the right path.

Q At what point does an employer make a PREP Referral?

A Usually after an investigation is made into an event, at the point when it is determined that the licensee might benefit from partnering with the Board for remedial education. (More resources available than many facilities, HR requirements, etc.) This is normally not a program for the licensee who has been counseled numerous times in the past for the same behavior(s).

Q So, how does PREP work?

A After receiving a referral, a tailored PREP Remediation Plan is developed by Board staff for the licensee based on the input from the employer and the licensee. This is sent to the licensee to review with their employer and to have signed and returned to the Board for monitoring. It is the licensee’s responsibility to provide proof of completion for all coursework by the dates outlined in the plan. Failure to do so will result in termination of the program.

Q What are some types of practice issues that might be eligible for PREP participation?

A Exceeding scope of practice, medication errors, documentation deficiencies, and inappropriate verbal interaction with patient (not abuse) are some examples that are most commonly referred. If in doubt, please call and discuss with the PREP Coordinator.

Q What types of remediation are utilized?

A Online classes covering many different topics involving nursing practice are utilized. In addition, employers may be requested to provide on-site resources such as assigning a mentor to support the nurse’s learning, or asked for feedback in the form of work performance evaluations, and in some instances, supervised med passes may be included as indicated by the needs assessment.

Q Is there a charge to participate in the PREP program?

A The Board does not charge a fee for PREP participation; however the classes are fee based and are the responsibility of the nurse (not the employer). The contact hours gained can also be used to satisfy continuing competency requirements, if earned within the nurses’ renewal period.

Q How does PREP participation affect the nurse’s licensure status at the board?

A The Board views PREP participation as a voluntary remediation program and there is no negative association with the nurses’ license. PREP is separate from the complaint process and therefore would not be visible as such or be reported as such to any reporting body.

Q How effective has PREP been?

A Some samples of actual employer feedback:

- “Thank you for supporting Directors who really care about these nurses.”
- “There now is another avenue for staff vs. firing or potential license loss. Opportunity to move quicker with practice concerns.”
- “With the shortage of nursing and the amount of time it takes to orient new staff, the PREP Program is a very useful retention tool.”

Some samples of actual participant feedback:

- “I’m just so thankful I was given another opportunity.”
- “PREP provided me with excellent information and reminded me to think carefully before I act.”
- “Board staff went out of their way to be helpful and reassuring. I was seriously thinking of finding another profession before I talked to them.”

Analysis of data has found that less than 0.3% of participants have been subsequently reported to the Board for the same concerns.

Q I have heard that PREP can be used as a retention tool. What does this mean?

A In the past, employers have felt that termination of the nurse with the practice deficit was their only choice. However, when you consider the following, retention of the nurse (who is a safe practitioner) makes much more sense. Consider the following nurse retention benefits:

- Reduction in advertisement and recruitment costs
- Fewer vacancies and reduction in vacancy costs
- Fewer new hires and reduced orientation and training costs (some estimates place cost to orient new nurse between \$12,000 and \$30,000)
- Preserve organizational knowledge

Q How do I make a referral?

A The Referral form for the employer and the Licensee Information Form are located on the Board’s website (www.ncbon.com). Send both to: **Pamela Trantham, PREP Program Coordinator; email: Pamela@ncbon.com** • **Fax: 919-781-9461 (Attention: PREP)** Or mail to: **North Carolina Board of Nursing, P. O. Box 2129, Raleigh, NC 27602**

Migration to Online Nurse Aide II INITIAL AND RENEWAL APPLICATIONS

By Dacia Williams, Nurse Aide II Registry Coordinator

The North Carolina Board of Nursing converted to an online only application process for Nurse Aide II (NAII) initial and renewal listings effective December 1, 2011. The online applications are accessible on the Board of Nursing's website at www.ncbon.com.

The NAII application migration is an initiative of the Board's Strategic Plan which is to explore opportunities for improvement through increased use of technology in key processes and communication. This improvement streamlined the listing procedures for both NAII's and RN Supervisors of NAII's while providing for a more efficient, reliable and faster process. As of December 1, 2011, paper applications are no longer accepted. NAII's are required to complete both initial and renewal applications online.

Both the initial and renewal online application processes for NAII's consist of the

following two major steps:

Nurse Aide II Initial Listing

1. RN Nurse Aide II Program Instructor or the Nursing Program Director (for nursing students) must complete the online Nurse Aide II Program Completion Verification before the NAII applicant can proceed with the online application.
2. The Nurse Aide II applicant completes the online initial listing application within 30 business days of program completion.

Nurse Aide II Renewal Listing

1. Nurse Aide II completes online renewal application prior to expiration date.
2. RN Supervisor completes online Nurse Aide II Employment Verification before the application for renewal can be processed.

A review of the first two months of online

Nurse Aide II Renewal Listings reflects a significant delay in receiving RN Supervisor Employment Verifications. As required by 21 NCAC 36.0404(g)(1) . . . *to be eligible for renewal, the nurse aide II must have worked at least eight hours for compensation during the past 24 months performing nursing care activities under the supervision of a Registered Nurse.*

The Board is asking RN Supervisors for assistance in completing the online Nurse Aide II Employment Verification in a more timely manner. This will enable the improved process to operate as designed resulting in renewal of NAII listings within a one hour cycle time. For additional information or clarification regarding the NAII initial or renewal listing processes, contact Dacia Williams, Nurse Aide II Registry Coordinator at (919) 782-3211 ext. 245 or dwilliams@ncbon.com.

**NOW
AVAILABLE!**



Providing Public **PROTECTION** *while minimizing risks*



Employer Notification System *for RN, LPN License and NA II Listing*

Employer Notification System provides license verifications both permanent and temporary, with "real time" notifications of any status changes or expirations.

Employer Notification System (ENS) is an annual subscription service providing license/listing verification and notification for the following:

- Permanent and Temporary RN/LPN
- NA II
- Nurse Practitioner, CRNA, Midwife, CNS (APRN)
- RN/LPN working in North Carolina on another compact state license

How can ENS benefit you?

- Provides accurate licensure information
- Saves staff time
- Ensures organization protection via "real time" alerts such as suspensions, probation and reprimands
- Provides public protection via timely and critical nurse licensure information

Who can benefit from ENS?

Hospitals, educational institutions, nursing homes, staffing agencies, and others can rely on ENS for verification of nursing license status.

Subscribe today!

View	License #	Type	Expiration	Status	Exp Date	Notes	Last Change
APPLICATE, JAMES ROBERT	21669	RN	NC	ACTIVE	04/30/2010		07/31/2011
BARTON, MELBA LYNETTE	21669	RN	NC	MULTISTATE	10/01/2011		ACTIVE
BENNER, ELIZABETH ANN	43488	RN	NC	MULTISTATE	02/28/2010		02/19/2011
BENJAMIN, AMERICA S	933285	RN	MD		03/21/2010		
BURGOME, CARRIE ANGELO	221488	RN	NC	MULTISTATE	04/30/2012		04/21/2011
CARROLL, MELBA STEWART	1202	RN	NC		03/01/2010		
CLERSON, DEBRA EMER	221917	RN	NC		04/30/2010	EXPIRED	
COYNE, PRISCILLA ANTOINETTE	98029	RN	NC		03/28/2011		03/01/2011
DARTON, ROBERTO MELISSA	54038	LPN	NC		06/01/2010	INACTIVE	06/09/2010
HAUGSTAD, MONIQUE B	85736	LPN	NC	MULTISTATE	12/01/2011		ACTIVE
HANNA, HEATHER LF	334329	RN	NC		04/30/2010	EXPIRED	
KIRBY, PHYLLIS REBECCA	227351	RN	NC	MULTISTATE	02/28/2012		ACTIVE
KIRKLAND, JENELL SUEANNE	334504	RN	NC	MULTISTATE	04/30/2010		04/15/2011
LEWIS, ANNE ANGELA	87900	LPN	NC	MULTISTATE	12/31/2011		ACTIVE
LIND, SARA EDDIE	33825	LPN	NC		10/31/2004		
MADEN, PAMELA LUCILLE	47126	RN	NC	MULTISTATE	03/31/2011		02/24/2011
MALCONSON, SHARON LORNE	78679	RN	NC		01/14/2010	INACTIVE	
MENASTREL, KATHY BARBARA	45236	RN	NC	MULTISTATE	02/29/2012		ACTIVE
MENELL, ROCKWELL L	108916	RN	NC	MULTISTATE	02/28/2010		03/01/2011
MERRITT, LESLIE H	164721	RN	NC	MULTISTATE	04/30/2012		ACTIVE
MORTON, ELIZABETH ANN	21669	RN	NC	SINGLE STATE	07/01/2011		ACTIVE
MURKIN, SHARON H	128416	RN	NC	MULTISTATE	04/30/2010		03/08/2011
MURPHY, RICHARD L	222349	RN	NC		03/01/2012		
ROBINSON, ANTOINETTE SUEANNE	87934	RN	NC	MULTISTATE	02/28/2010		02/02/2011
RUSTICKY, BARBARA ANN	48678	RN	NC	MULTISTATE	02/28/2010		03/01/2011

FOR MORE INFORMATION

Contact: Gail Marshall
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