

NURSING BULLETIN

BOARD ROOM



Getting to know your Licensing Board: the North Carolina Board of Nursing at a Glance PAGE 10



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Office Location

4516 Lake Boone Trail
Raleigh, NC 27607

Mailing Address

P.O. Box 2129
Raleigh, NC 27602

Telephone

(919) 782-3211

Fax

(919) 781-9461

Automated Verification

(919) 881-2272

Website

www.ncbon.com

Office Hours

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Board Chair

Dr. Peggy C. Walters, RN

Executive Director

Julia L. George, RN, MSN, FRE

Editor

David Kalbacker

Photography

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NC BOARD OF NURSING
NURSING BULLETIN

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Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
Victor Horne • 800.561.4686 ext 114
vhorne@pcipublishing.com

ThinkNurse.com

from the
EDITOR

Martha Ann Harrell, a business woman from Fayetteville, North Carolina, has been elected to the Chair of the North Carolina Board of Nursing beginning January, 2015. In the 111 year history of the Board, Harrell will break new ground in becoming the first non-nurse to hold the position of Board Chair. Harrell currently serves as the Board's Vice-Chair and has served on the Board's Finance Committee, Governance Committee and the Strategic Planning Committee, among others.

"I realize I have big shoes to fill. I also know that some people will be skeptical about my ability, as a non-licensee, to head up an occupational licensing board. However, the mission of the North Carolina Board of Nursing speaks directly to me. It plainly states that the Board's mission --- is to protect the public by regulating the practice of nursing. Well, I am the public --- and I am excited about the challenges ahead of me," said Harrell.

Jacqueline Ring, the Chief Operating Officer/Chief Nursing Officer at Johnston Medical Center in Clayton, was elected to serve as Vice-Chair of the Board beginning in January, 2015.

In recent Board of Nursing election news; Peggy Walters was re-elected as an ADN/Diploma Nurse Educator. Walters is the Director of Nursing Education at Duke Regional Hospital – Watts School of Nursing in Durham. Christina Weaver, a staff nurse in the adult emergency department for WakeMed in Raleigh, joins the Board for the first time and was elected in the RN-Staff Nurse position. Mary Jones was successful in her efforts to join the Board in the LPN position. Jones has experience in Rehab/Nursing and in home health settings. All candidates were elected for four years.

As we end one election, we start preparing for the next. On P. 28 note the nomination form. In 2015 we will be seeking nominations for a Nurse Administrator, a Nurse Educator – BSN/Higher Degree program and a LPN.

This issue's CE cover story, Getting to know your Licensing Board , P 10 is an introduction to the North Carolina Board of Nursing. This article will give you an excellent overview into the background and operations of the Board ---- America's original Board of Nursing!

In conclusion, as editor of the Nursing Bulletin, I am always open to suggestions on ways we can improve our publication. Should you have a suggestion, please contact me at: david@ncbon.com

Sincerely,
David Kalbacker
Editor and Dir. of Public Information

Nurses, Could This Happen To You?

Let me introduce myself. I am an experienced Licensed Practical Nurse (LPN) with an unblemished nursing license. I held a supervisor's position in an Adult Care Home and commonly worked in collaboration with outside agencies such as Mental Health, Home Health, and Hospice. Unexpectedly, I found myself before the Board of Nursing with allegations that I had exceeded my scope of practice. Given the circumstances, I am confident there are other nurses who could find themselves in the same position. I want to help you avoid this.

As any nurse who cares for hospice patients knows, there are multiple standing orders for medications and treatments. These orders often involve abundant latitude (e.g., morphine sulfate 2 – 4 mg intravenously [IV] every 1 – 4 hours as needed for shortness of breath) in anticipation of the patient's needs and allows the nurse to use her/his clinical judgment to determine the necessary dosing and frequency. This type of order for the hospice patient provides nursing discretion in treating a patient's progressive symptoms without requiring a delay in obtaining physician's orders.

Most physician orders are very clear: "Give one tablet every six hours as needed for pain." Other orders, however, appear vague at first glance: "Advance diet as tolerated." This "vague" order may be given specific meaning in post-operative patient care standards or policies. However, what about the order: "Alter diet as patient's condition deteriorates" in a hospice patient? That is where my interaction with the Board of Nursing started."

Patient A was an Adult Care Home patient with severe Alzheimer's disease. Her condition significantly deteriorated following an infection. After a lengthy discussion with her husband of almost fifty years, I contacted the physician to request an order for Hospice, which he verbally provided. The physician



personally evaluated Patient A in the facility as well and wrote the Hospice orders, including the order: "Alter diet as patient's condition deteriorates." Eating became more difficult and, based upon my experience; I decided that she became at-risk for choking/aspiration. I assumed a change to nothing by mouth (NPO) was within the "Alter diet as patient's condition deteriorates" order in a hospice patient and did not even think to contact the physician for an NPO order. In my experience, all hospice patients eventually became NPO, and I had never requested an NPO order for any of them. The Adult Care Home did not have a policy or standard established for this situation. The last thing I wanted to do was to force feed this lovely woman who was in the terminal stages of her ravaging disease. She had a living will stating she did not want this either. I wanted to respect her wishes not to be force fed or kept alive in this fashion.

The hospice registered nurse, also providing ongoing care for the patient, assessed and evaluated Patient A and her note supported that Patient A was

a choking/aspiration risk. However, unbeknownst to me, the hospice registered nurse requested an NPO order from the same physician who wrote the order to initiate Hospice services. Approximately, twenty-four hours later, he refused to write the order. A diet was restarted and the patient expired shortly thereafter.

What followed next almost destroyed me emotionally and professionally. Someone at my facility reported me to the NC State Division of Health Service Regulation and to the NC Board of Nursing for exceeding my scope of practice. The general allegation was that I made a patient NPO without a doctor's order. The specific issue was whether NPO in a hospice patient fit within the "Alter diet as patient's condition deteriorates" order provided by the physician. Obviously, the physician did not hold this opinion. He viewed an NPO order as an intervention he was not willing to order, as differentiated from a patient having reached the point of being unable to eat or drink. My employer provided no standards or protocols interpreting

“Do you have policies/ procedures or protocols to guide you regarding care delivery and/or ethical situations? If not, I urge you to initiate this process immediately. Otherwise, you might find yourself walking in my shoes – right into a conference room for an investigative interview at the Board of Nursing.

Protect yourself and your patients by being proactive.”

this type of order. However, all of my prior hospice patients had the same diet order. In all of my experience no hospice patient ever required an NPO order when it was clear they were no longer able to eat. I learned a lot from the ensuing investigation and Board interview. I want to be certain I share my knowledge with you so you won't find yourself in this same position.

There are ethical differences in the field of hospice and you may face opposition from your staff, co-workers, and community during the patient's dying process. Understanding the limits of your scope of practice and recognizing the importance of collaboration can make all the difference in situations such as this.

It is essential that all nurses perform activities within their appropriate Scope of Practice (RN or LPN). The LPN performing in a health care capacity must have RN supervision (even if they, themselves, are the facility administrative supervisor. It is imperative that all nurses clarify any

order that is not specific and clear. Be certain your hospice organizations, as well as your employers, have specific parameters or guidelines in place to guide you in determining of the limits of any “vague” order. Had hospice, or the facility, had a protocol or standard that defined orders that are routinely written for a hospice patient, including but not limited to, “Alter diet as patient's condition deteriorates,” I would not have found myself in this position. I will always clarify an order that has any ambiguity. Also, documentation is increasingly important in these situations to memorialize all conversations the nurse has with family and other health care professionals.

Do you have policies/procedures or protocols to guide you regarding care delivery and/or ethical situations? If not, I urge you to initiate this process immediately. Otherwise, you might find yourself walking in my shoes – right into a conference room for an investigative interview at the Board of Nursing.

Protect yourself and your patients by being proactive.

Anonymous LPN

FROM THE BOARD:

What the Licensed Practical Nurse did right:

- She consulted with the physician requesting a Hospice order.
- She recognized the patient was having difficulty swallowing and was a high risk for choking/aspiration.
- She collaborated with the Hospice Registered Nurse to validate her assessment and participated in needed revisions to the Hospice plan of care.

Thoughts and considerations:

- Orders must provide clear directives unless the agency has policies/procedures/protocols to provide consistent guidance to staff.
- Unanticipated changes in condition, (e.g., choking/aspiration risk), must be reported to the

medical provider to determine if changes are needed in orders and plan of care.

- Changes to the medical plan of care are made by the medical provider and changes to the nursing plan of care are made by the registered nurse. The LPN participates in planning nursing care by identifying needs and making recommendations to the RN.
- Patient/family members must be informed of available treatment options to be able to make informed decisions. This conversation should be documented.
- Ethical decisions such as discontinuing basic needs (food/fluids) should include multidisciplinary communication (including the patient and family). The patient/family may need time to process the information before a decision is made to implement the order.
- Accurate and thorough documentation cannot be over emphasized. Information that should be documented includes: assessment of patient's condition, identification of individuals contacted regarding changes and needs, rationale for changes in plan of care, options discussed and decisions.
- Adult Care Settings are facilities that provide for the personal care needs of residents. In these settings, health care needs of residents are considered incidental to their personal care needs and licensed nursing staff are not required by law. When health care needs exist, supervised nursing care may be indicated. Nurses working in these settings must be clear regarding their supervisory and/or clinical responsibilities and limitations.
- Nurses are accountable for functioning within their licensed Scope of Practice (RN or LPN).

Getting to know your Licensing Board: the North Carolina Board of Nursing at a Glance

Purpose:

To provide an overview of the role of the N.C. Board of Nursing in Public Protection.

Objective:

1. Describe the primary functions of the Board
2. Demonstrate Utilization of the Board's web site for access to resources and information

“No person shall practice or offer to practice as a registered nurse or licensed practical nurse, or use the word ‘nurse’ as a title for herself or himself, or use an abbreviation to indicate that the person is a registered nurse or licensed practical nurse, unless the person is currently licensed as a registered nurse or licensed practical nurse...”§ 90-171.43.

Consider for a moment what health-care would look like if the providers entrusted to care for your loved ones had no standard basic education requirements, no established scope of practice and no measures by which to remove an incompetent professional. Frightening thought? It should be! Professional licensing boards exist solely to protect the public from harm by unscrupulous and incompetent persons engaging in practice. Citizens have the right to expect each professional licensing board to advocate for the public welfare in the execution of its duties. Licensing a professional sends

a clear message to the public that the individual holding a license has satisfied necessary academic requirements and has met minimum entry-level standards of competency before being approved to practice in that profession. In addition, licensing assures the public of oversight of the professional discipline by holding its members accountable for minimum standards of competency. The focus of licensing boards is different than that of professional organizations. It is a common misconception that professional regulatory boards are professional advocacy groups. Licensees should be aware that the mission of their regulatory board is public protection while the role of their professional organization is advocacy for the profession.

This article provides an overview of the North Carolina Board of Nursing's (Board) structure, function and legal authority. Throughout the article specific statutes (laws) from the NC Nursing Practice Act (NPA) are cited as references. Further, the author provides “helpful hints” to give the reader additional supporting information on specific topics discussed herein.

In 1903, NC enacted the country's first NPA for the purpose of regulating the practice of Nursing. These laws provide the foundation for every function and duty carried out by the Board. The NPA requires licensing of any person representing themselves as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) and defines the legal scope of practice for nurses practicing within the state [§90-171.20 (7)(8)]. The NPA laws are further clarified through NC Administrative Code Rules which are developed by the Board and provide the details necessary to support implementation of and adherence to the laws. (Both Laws and Rules are published on

the Board website). Together laws and rules are designed to protect the public as described in the Board's mission statement (below).

“The Mission of the North Carolina Board of Nursing is to Protect the Public by regulating the practice of Nursing”

Each state has legislatively enacted an NPA. While there are variations in statutory language among the states, they all have a common mission of public protection. When employed in a licensed position in North Carolina (NC) or in any other state, a nurse is governed by and held accountable for the NPA standards of that state or jurisdiction. This applies, likewise, to nurses working on a Privilege to Practice (PTP) in a participating Compact State [§90-171.83]. For example, a nurse whose primary or “home” state of residence is NC, holds a NC multi-state license as long as that license is in good standing. This multi-state privilege means that the nurse may be employed in any of the other 23 Compact member states, referred to as “party states”, without having to apply for licensure in those states. If the nurse changes the primary or “home” state of residence, then the nurse is required to apply for licensure in the new “home” state. A nurse relocating to NC and declaring NC as the new primary or “home” state must notify the Board within 90 days of relocation. Nurses residing in non-Compact states must hold single-state licenses in all states in which they work. Whether working under the multi-state PTP or a single state license, the nurse is held to the standards set forth in the NPA in the state where the client (patient) is located at the time of practice.



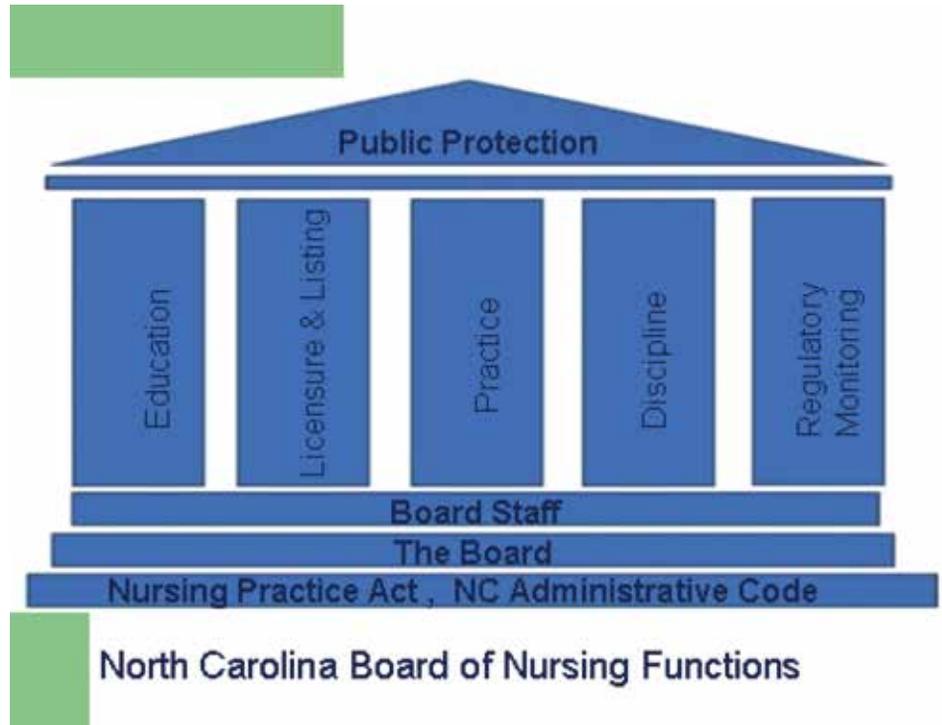
Helpful hint: General information on the compact is published on the Board's website under the tab Verify License: Verify a compact license.

Licensing Boards vary in size but are generally inclusive of members of the specific professional discipline and members of the public, unaffiliated with the profession. The NC NPA provides for the creation of an independent 14 member board [§90-171.21]. Members include 8 RNs; 3 LPNs and 3 public members appointed to serve by the Governor and the NC Legislature. The NC Board is recognized nationally as the only state board of nursing that elects its nursing (RN and LPN) members. Each year, the Board holds elections to fill vacancies occurring when a sitting RN/LPN's term has expired. Every RN and LPN holding a current license in NC has the opportunity to vote for members to fill anticipated vacancies.

The results of the most recent election have been announced. The new 2015 Board members include Christina Weaver, MSN, RN who will fill the vacant RN staff nurse position and Mary Jones, BSc, LPN who will fill the vacant LPN position. Peggy Walters, MSN, MEd, EdD, RN was reelected as the ADN/Diploma nurse educator and currently serves as the Board Chair.

To support its many and varied duties, the Board employs a staff led by an Executive Director (ED) [§90-171.24]. Julia George, MSN, RN was named ED in 2008. In her role as ED, Ms George serves as liaison to the Board in daily operations and regulation of practice. Regulation is defined as the process of interpretation, implementation, and enforcement of laws, rules and policies designed to ensure minimum standards of nursing competency and public protection. Ms George oversees the staff in the implementation of the strategic plan and in supporting the functions of the Board

Education: The Board establishes standards for pre-licensure nursing education programs and the qualifications for nursing faculty [§90-171.38]. Each request to develop a new program requires approval from the Board prior to operation. The approval process includes



There are 5 primary functions of the Board as depicted in the model (above). The foundation for the existence of the Board and the authority for its functions and operations are grounded in the NPA with a clear legislative mandate for Public Protection.

submission of an application providing evidence that the program can meet the minimum standards for pre-licensure education necessary to ensure their graduates have the education necessary to practice as an RN or as an LPN in a safe and competent manner. Following receipt of the application and supporting evidence, a site visit is conducted by designated Board staff before initial program approval is granted by the Board. A second site visit following graduation of the first class leads to full approval status by the Board if all requirements are met. Once approved, all pre-licensure nursing programs are continuously monitored for quality and formally reviewed at least every 8 years. In situations where a program is unable to show evidence of meeting minimum standards, the Board holds the authority to place the program on warning status until such time as evidence is submitted to demonstrate correction of deficiencies. The Board publishes a list on its web-site of each pre-licensure program in the state along with their approval status. Trended scores on the National Council Licensure Examination

(NCLEX) for RNs or PNs is one measure used by the Board in its ongoing efforts to monitor a program's quality. NCLEX results are published and available on the Board's website.

The Board frequently receives questions related to the requirements for a Refresher Course. A Board approved course is mandatory if the NC nursing license has been inactive, retired or lapsed for five years or more and the nurse has not been licensed in another state during the last five years. The nurse must satisfactorily complete the Refresher Course prior to reactivating or reinstating the NC license. The nurse must then apply for reinstatement within one year of completing the approved course. On the other hand, if the nurse has maintained an active NC license and had not been employed in a licensed position for an extended period of time, a Refresher course is not mandatory. Many nurses in this situation voluntarily seek this level of preparation prior to returning to active practice, however it is not required by the law.

The Board also has the authority for

granting approval of continuing education programs designed to enhance nursing practice by teaching skills not generally included in the basic educational preparation of the nurse (RN or LPN). A request for the implementation of such an educational program requires the requestor to demonstrate need and to show evidence of the quality of the curriculum, faculty and the practicum. Prior to granting approval, the Board will determine that upon satisfactory completion of the educational program, the nurse can be expected to carry out those procedures in a safe and competent manner. Examples of such advanced skills include those which may be performed in an emergency situation by an RN during critical care transport; by an RN who has completed the requirements for the Sexual Assault Nurse Examiner, or by an LPN Nurse who has demonstrated competency in selected advanced skills [§90-171.42].

The Board is the determining authority to identify those nursing care activities which may be delegated to unlicensed personnel, regardless of title. The Nurse Aide I is educated to perform basic nursing skills and personal care activities. The Nurse Aide II is educated to perform more complex nursing skills with emphasis on sterile technique in elimination, oxygenation, and nutrition. The Board also establishes Medication Aide training program requirements to support safe medication administration and improve client, resident, and patient outcomes. It establishes standards for faculty and applicant requirements. Medication Aides must hold a NA I certificate in order to satisfy requirements for the Medication Aide certificate and listing on the registry. They are limited to performing only the technical tasks of medication administration in a skilled nursing facility (long term care).

It is important for employers to be knowledgeable of and to differentiate between the Board approved program and the Division of Health Services Regulation (DHSR) Medication Aide program (separate from the Board). The entry level education for the DHSR program is a high school diploma however some NAs may elect to complete the program. Upon successful completion of this DHSR program, the Medication Aide is limited to performing tasks in an Assisted Living facility.

Because there is variation in education and training requirements between the Board and the DHSR programs, NAs completing one may not cross-over and work as a Medication Aide with the other client population.

Licensure & Listing: The Board requires initial entry to licensed practice through standard examination (NCLEX) [§90-171.30]. Foreign graduates or graduates from other jurisdictions who have not completed the NCLEX may be considered for endorsement to NC when there is verification that requirements of the pre-licensure program were deemed to be equivalent to those required of NC and that in the opinion of the Board, the applicant is able to meet the minimum standards set forth in the NPA. Applicants for licensure are required to submit a criminal background check which is reviewed prior to issuance of the initial license [§90-171.48].

Following initial licensure, the Board requires a nurse to renew the license every two years (birth month). At the time of renewal the licensee attests to meeting minimum continuing competency requirements and reports any adverse incidents, including criminal charges or convictions which may have occurred since the date of last renewal.

Employers are required to verify the license or listing of a prospective new nurse or Nurse Aide II employee using the Board's licensure verification system through www.ncbon.com. Further, the employer maintains ongoing accountability for assuring that each licensed or listed employee remains in current, active status throughout employment [§90-171.30].

DHSR has primary responsibility for "listing" of the Nurse Aide I (NA I) and Medication Aides (MA) on the respective registries. NA Is and Medication Aides are not licensed, rather they hold a certificate. Medication Aides are "listed" on both the Nurse Aide Registry as NA Is and the Medication Aide Registry with DHSR. The role of the Medication Aide is limited to long term care where they are supervised by a licensed nurse in performance of their duties.

The NPA provides for a Nurse Aide II (NA II) option. Current NA Is completing a specific training program can be "listed" as NA II with the Board. The Board approves listed NA IIs to perform specific

tasks beyond those skills approved in the basic NA I training program. Jurisdiction over NA disciplinary issues can be confusing. The responsibility for all disciplinary action and jurisdiction in all matters related to NAs (I and II) is addressed under the NA I listing status by DHSR rather than under the NA II listing status by the Board.

Helpful hints: It is the responsibility of every licensee to maintain a current address with the Board and to renew the license prior to its expiration. A nurse is in violation of the NPA by practicing without a valid license. The license expires the last day of the birth month every 2 years. While the licensee has until the last day of the month to complete the application, renewal will be delayed IF the licensee is audited or IF the application is incomplete. There is no grace period. Licensure Renewal on the Board's web site is under the tab: Licensure & Listing

Likewise, it is the responsibility of every NA II to maintain a current address and to re-list (vs renew) as a NA II (with the Board) and NA I (with DHSR).

Employers may wish to explore information on the Employer Notification System, (ENS) through the Board's web site under the tab: Verify a License. This subscription service automatically provides the employer with real-time, up to date information and verification on the current status of the licensed RNs, LPNs, and Advanced Practice Registered Nurses (APRN) and of the listed NA IIs employed in their agency.

Practice:

The Board, provides staff consultative services and education to nurses, employers, physicians, and others making an inquiry regarding clinical practice issues or interpretation of the law and rules as they relate to the RN (including the APRN) or LPN scope of practice. The staff remains abreast of research and evolving nursing practice trends locally and nationally. A myriad of tools are available to licensees and employers in guiding practice. These tools, grounded in best practice, laws, and rules include information on the



License Verification



Name: Jane Doe
License #: 123456789
Nurse Type: RN Permanent License
Confirmation #: 123ABC123

LICENSE STATUS



- No license due to discipline **OR**
- Chemical Dependency Discipline Program **OR**
- Probationary Conditions **OR**
- Under Investigation

Charges/Discipline Against License/Privilege: YES

CHARGES/DISCIPLINE INFORMATION FOR THIS LICENSE/PRIVILEGE

Effective November 2006, the NC Board of Nursing began displaying public documents for charges and/or disciplinary actions taken against a license. For public documents prior to November 2006 for this licensee, please call (919) 782-3211 ext. 273, during normal business hours.

[Click here to display available public documents](#)

Screen View 1

scope of practice for the RN, APRN, and LPN, Delegation Decision Trees, Position Statements, and Joint Statements. A list of frequently asked questions (FAQs) is also available and is a helpful adjunct to the published materials.

Helpful hint: Decision Trees, Position Statements, Joint Statements and FAQ's are available on Board's website and found under the tab: Nursing Practice

Discipline:

“Any person who has reasonable cause to suspect misconduct or incapacity of a licensee or who has reasonable cause to suspect that any person is in violation of this Article... shall report the relevant facts to the Board...Any person making a report pursuant to this sections shall be immune for any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false” [§90-171.47].

Use of the Board's Complaint Evaluation Tool (CET) is recommended in determining whether an incident is a reportable

event. Board staff practice consultants are available to assist the employer in making the appropriate determination. Can the event be classified as normal human error? Is it indicative of unintentional risk-taking behavior? Could it be intentional risk-taking behavior? Or, is it deemed reckless behavior? The answers will determine reportable events from those able to be managed at an organizational level. In some cases, after consultation, the employer and the Board consultant reach an opinion that the most appropriate resolution in a matter is determined to be the licensee's completion of a Practitioner Remediation Enhancement Program (PREP), a non-disciplinary resolution in a particular matter designed to address an issue with a licensee before it becomes a violation of the NPA and a reportable event. It should be noted that incidents related to confidentiality, fraud, theft, drug abuse, impairment on duty, drug diversion, failed drug screen, boundary issues, sexual misconduct, and mental/physical impairment are not appropriate for evaluation using the CET. These events/

issues are conduct and health-related issues, not practice incidents or events, and they MUST be reported to the Board. All complaints received are reviewed and analyzed. Board staff investigators conduct inquiries into reports submitted from the public, patients, employers, healthcare organizations, law enforcement or from other states alleging a violation of the NPA. If, following initial review of a complaint, there is information suggesting a potential violation of the NPA, a formal investigation is initiated. Investigators evaluate the infraction and assess the level of the licensee's culpability in the matter and the risk to the public as a result of the reported behavior.

The Board has the power and authority to take action on a license when it determines that there is evidence that the nurse is in violation of the NPA [§90-171.37]. The licensee is advised of their rights at the onset of an investigation and informed that reaching a resolution in the matter could take up to 4 to 6 months. In general, while a nurse is under investigation, the license remains active although it is flagged to denote the investigation is underway (see licensure verification screen view 1). Prior

to action against the license, the nurse is granted an opportunity to be interviewed and to review the evidence in the matter. The role of the investigator is to establish the facts in the case. They are authorized, after consultation with a Board staff attorney, to communicate with the licensee and offer resolutions when it has been determined that the incident reported constitutes a violation. Options for resolution may be disciplinary and published or non-disciplinary and non-published. In situations where there is published discipline, including a request to voluntarily surrender during or immediately following an investigation; the license has a permanent flag displayed when the license is verified through the Board's license verification system. Documents related to the violation and subsequent action are also published on the website (see screen view 1) and all public documents should be reviewed by the prospective employer (note arrow in screen shot pointing to "click here to display available public documents").

This sample screen view 1 depicts a "caution flag" which is displayed on the license of a nurse whose license is suspended; encumbered in a drug monitoring program or probation; or who may be under investigation. Public documents related to Board action are viewed by clicking the link in "Charges/Discipline Information for this License/Privilege".

Following loss of a license through voluntary surrender or suspension for a disciplinary matter, the nurse is required to petition the Board for reinstatement, a process which requires documented evidence to support that he/she is safe to return to practice. It should be noted that a nurse may not request to "retire" the license or "lapse" the license while there is a matter under investigation with the Board. At the conclusion of an investigation, if it is determined that there is no evidence to substantiate the allegation, the case is closed. On the other hand, if the outcome of the investigation results in disciplinary action, the Board reports such action federally to the National Council of State Boards of Nursing (NCSBN); the National Practitioner Data Bank (NPDB) and the Office of Inspector General (OIG), and at the state level to the DHSR. It should be noted that with disciplinary action on the



license, any continuing nursing education may be disrupted or delayed until the matter has been resolved. Consistent with the Board's mission, any and all outcomes of investigations are thoughtfully processed with the goal of public safety and quality improvement. Once any disciplinary action taken by the Board has been resolved, the caution flag on the verification system will be removed. The system will continue to reflect that there has been prior disciplinary action and all public documents related to the action will continue to be available to any person or entity verifying the license.

Some criminal convictions may result in action against the nursing license. [§90-171.48 (a)(1)(2)]. Driving While Impaired (DWI) is the most commonly reported conviction. At the time of license renewal, nurses are required to report any criminal convictions (felony or misdemeanor) and any pending criminal charges that have not been previously reported to the Board. Failure to disclose this information or falsely answering the questions asked is considered falsification of the application for initial licensure or renewal. Pre-licensure convictions may result in denial of licensure until the applicant has petitioned the Board and appears before a licensure panel.

Helpful hints: Through its research on the subject, Board staff has developed a Complaint Evaluation Tool (CET)

to assist the nurse leader in evaluating practice events or errors. Staff has also researched and developed an instruction booklet called "Just Culture in Nursing Regulation" (Burhans, Chastain, & George, 2012).

These resources provide valuable education on complaint evaluation and examples of reportable and non-reportable events for licensees and for employers. This booklet and the CET are available at no cost on the Board's website under tab: Discipline and Compliance.

Information on the PREP program is on the Board's website under tab: Discipline and Compliance

Licensee Rights during an investigation and a description of the investigation process are published on the Board's website under tab: Discipline and Compliance.

Information on Charges/Disciplinary Action against a license is available by clicking on the link: "Click here to display available public documents"

Regulatory Monitoring: "The Board is empowered to establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities

and programs for monitoring such nurses for safe practice: establish programs for aiding in the remediation of nurses who experience practice deficiencies [§90-171.23 (b)(18)(a)].

When the Board has determined that a licensee is in violation of the NPA, appropriate measures are employed to enhance competency and quality of nursing practice as they relate to the mission of public protection. Many of these measures require close monitoring of the licensee through a Disciplinary or Non-Disciplinary Consent Order. Nurses diagnosed with a substance use disorder/chemical dependence are typically monitored by Regulatory Compliance monitoring staff for a period of 3 years of employment. Some nurses in violation of the NPA may require monitoring for a period of 1 year of employment. Yet, others may simply be required to complete mandatory training/education program and show evidence of satisfactory completion of the program. Regulatory Compliance monitoring staff is assigned to engage the licensee at the time they enter into an agreement with the Board and until such time as the conditions of the Order are satisfied. The Regulatory Compliance monitor serves as the interface between the licensee, the employer and the Board and serves as the primary contact for both the licensee and the employer for the duration of the period of the Order.

Helpful hint: The National Council of State Boards of Nursing has resources available on Substance Use Disorders in Nursing; www.ncssbn.org

The public places its trust and confidence in professional regulatory boards, and as such deserves assurance that the standards established to assure their safety, well-being, and health are upheld. The citizens of North Carolina can be assured that in the execution of their fiduciary responsibilities, Board members avoid conflicts of interest and effectively serve in the interest of the public. From establishing nursing education standards, setting minimum standards of competence, and regulating professional practice, through enforcement of the NPA and Rules, all functions, duties and

actions taken by the Board are done so with this mission in mind.

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9. NCBON Just Culture in Nursing Regulation Complaint Evaluation Tool (CET) Instruction Booklet. Retrieved from www.ncbon.com on September 5, 2014.
10. Russell, K.A. (2012). Nursing practice acts guide and govern nursing practice. *Journal of Nursing Regulation*, 3(3) 36-40.

EARN CE CREDIT

“Getting to Know your Licensing Board: the North Carolina Board of Nursing at a Glance”

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 encouraged.

RECEIVE CONTACT HOUR CERTIFICATE

Go to www.ncbon.com and scroll over “Nursing Education”; under “Continuing Education” select “Board Sponsored Bulletin Offerings”, scroll down to the link, “Getting to know your Licensing Board: the North Carolina Board of Nursing at a Glance.” Register, be sure to write down your confirmation number, complete and submit the evaluation, and print your certificate immediately.

PROVIDER ACCREDITATION

The North Carolina Board of Nursing will award 1.0 contact hours for this continuing nursing education activity.

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

NCBON CNE Contact Hour Activity Disclosure Statement

The following disclosure applies to the NCBON continuing nursing education article entitled “Getting to know your Licensing Board: the North Carolina Board of Nursing at a Glance.”

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

Clinical Agencies Providing Clinical Sites for Pre-licensure Nursing Education Students

Questions to Ask When Considering Student Clinical Placement

Crystal Tillman DNP, RN, CPNP



Clinical experiences for pre-licensure nursing students are a critical part of the learning and competence development process. The North Carolina Board of Nursing members and board staff appreciate the partnership that clinical agencies form with nursing education programs to meet the mutually beneficial goals of preparing safe, competent entry-level nurses. Clinical sites for pre-licensure nursing education students are at a premium in North Carolina, and board staff members are frequently asked if clinical agencies are required to accept nursing students. The North Carolina Board of Nursing (NCBON) has no jurisdiction in the number of pre-licensure nursing education students an agency will or can accept. That decision remains entirely with the agency based on the number of nursing education students that can be safely accommodated for effective clinical experiences. The Board encourages clinical agencies to weigh the many benefits of student placements against the potential challenges.

Clinical agency decision-makers may want to consider the following questions in determining their ability to

provide experiences essential for student learning and competence development.

1. In collaboration with faculty, understand outcomes to be met relative to the level of student and course content:
 - How will the outcomes be achieved through the clinical experience?
 - Will this be a faculty-supervised or a precepted experience for focused client care experience? If precepted, what is the availability of the program faculty?
 - What is the faculty experience/competency in this clinical area?
2. Evaluate and determine:
 - Is there any major agency event or project occurring or predicted that will negatively impact students or staff if students are present?
 - Do the available experiences and average patient census support the curriculum and the outcomes of

the course in which the students will be enrolled during the clinical experience?

- Do the nurses understand and function within the legal scope of practice?
 - Are there sufficient registered nurses available for mentoring and/or role identification?
 - Are nurses appropriately performing in the role for which the student is preparing to function as a graduate?
 - Do agency policies address supervision of the LPN and unlicensed assistive personnel, delegation, nursing assessment, care planning (including evaluation of patient response to interventions/ progress toward meeting established goals), and medication administration/security?
3. Resolve any scheduling conflicts with current and potential new nursing education program clinical requests:

- Are there sufficient experiences available without causing patient or staff fatigue?
 - Can the staff keep the student type (RN, LPN), level in program, and course outcomes straight if multiple programs or student levels will be in one area?
 - If you are unable to provide the requested experience, is there another option you can offer that might partially or fully meet the requested need?
4. Agree on terms of the experience including:
- Responsibility for patient care
 - Responsibility for students, including supervision and evaluation
 - Number of students and for which semesters
 - Communication of student scheduling
 - Availability of the nursing faculty (on-site versus on call)
 - Requirements for immunizations or

special training required

- Right of denial of individual students at the clinical site based on criminal background checks
- Are students permitted to chart in the documentation system?
- Do the faculty members need to co-sign student documentation?
- Who is responsible to assure regulation specific requirements are met?

The education consultants at the NCBON are available to assist in a consultative role as you determine the appropriateness of the clinical agency for nursing education students. The NCBON, nursing education programs, and clinical agencies are united in striving for the same outcome of educating safe and competent nurses for our future.

Board's Interpretation of current NC Laws and Rules regarding delegation to Unlicensed Assistive Personnel (USP)



Following a one year evaluation, the North Carolina (NC) Board of Nursing at its May 2014 meeting authorized clarification of the Board's interpretation of current NC laws and rules regarding nursing delegation to Unlicensed Assistive Personnel (UAP).

Specifically, the Board clarified that NC nursing laws and rules permit the Registered Nurse (RN) and Licensed Practical Nurse (LPN) to delegate the technical task of medication administration to UAP. The technical task of medication administration is defined solely as giving a medication to a client via the appropriately ordered route and is permitted ONLY with careful consideration of applicable laws, rules, standards, agency policies and procedures, and after using all components of the NCBON Decision Tree for Delegation to UAP including education, competency validation, and appropriate supervision.

Before delegating the technical task of medication administration to UAP, the RN and LPN are accountable for understanding the laws, rules, standards, and agency policies and procedures applicable to medication administration in their specific practice setting. If delegation of the technical task of medication administration to UAP is permitted by all applicable laws, rules, standards, and agency policies and procedures, then all nursing laws and rules apply.

Appropriately ordered routes for medication administration are: Oral, Sublingual, Buccal, Ophthalmic, Otic, Nasal, Inhalant, Transdermal, Vaginal, Rectal, and Topical. (Note: Delegation of the application of Topical medication to UAP for the purpose of wound debridement is NOT permitted within current standards of practice.)

In addition, the technical task of medication administration to UAP via injectable [i.e., intradermal (ID), subcutaneous (SQ), or intramuscular (IM)] routes is permitted ONLY with careful consideration of applicable laws, rules, standards, policies, procedures, and application of all components of the NCBON Decision Tree for Delegation to UAP.

The licensed nurse is prohibited from delegating medication administration to UAP via the intravenous (IV), epidural/caudal, intrathecal, intraosseous, intraoral, cranial intraventricular, or body cavity/organ routes since delegation of these routes for medication administration are not permitted within current standards of practice.

One new Position Statement – Delegation of Medication Administration to UAP and revised Position Statements related to this clarified interpretation are available on the Board's website. These Position Statements are designed to assist RNs and LPNs in understanding their roles and responsibilities when delegating the technical task of medication administration to UAP.

Teaching modules are available on the website to assist the RN when teaching UAP the technical task of administering a medication and validating UAP competency. While use of these specific modules is not required, they provide information regarding routes of administration, forms of medication, and steps required to successfully complete this task, all of which the RN must cover when providing medication administration education and training for UAP.

References:

1. NCBON Position Statement "Delegation of Medication Administration to UAP"
2. NCBON Decision Tree for Delegation to UAP (Both available at www.ncbon.com > Nursing Practice > Position Statements and Decision Trees.)

CE Opportunities 2014



Online Bulletin Articles

Getting to Know your Licensing Board: the North Carolina Board of Nursing at a Glance (1 CH)
No fee required.

Uh oh...the Board of Nursing called...Complaint Reporting & Resolution (1 CH)
No fee required

Social Networking and Nurses (1 CH)
No fee required

Delegation: What are the Nurse's Responsibilities? (2 CHs)
No fee required

Continuing Competence Self Assessment: Have You Met Your Professional Responsibility? (1 CH)
No fee required

Public Protection Through Safe Nurse Staffing Practice (.85 CH)
No fee required.

More offerings on website

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
February 18, 2015
April 23, 2015
September 16, 2015
November 5, 2015

\$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
paulette@ncbon.com

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 on Online Bulletin Articles
Contact:: Linda Blain
919-782-3211 ext. 238 lindab@ncbon.com

For Webcasts and Orientation Session see bottom of columns for contact info.

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 (2.0 CHs)** – 2 hours – Defines and contrasts each scope, explains delegation and accountability of nurse with unlicensed assistive personnel, and provides examples of exceeding scope. Also available as webcast.
- **Understanding the Scope of Practice and Role of the LPN (1 CH)** – 1 hour – Assists RNs, LPNs, and employers of nurses in understanding the LPN scope of practice. Also available as webcast.
- **Documentation and Medication Errors (1 CH)** – 1 hour – Explains purpose, importance, and desirable characteristics of documentation; describes relationship between nursing regulation and documentation; identifies practices to avoid and those that may violate NPA; and identifies most common medication errors and contributing factors.
- **Nursing Regulation in NC (1 CH)** – 1 hour – Describes Board authority, composition, vision, function, activities, strategic initiatives, and resources.
- **Introduction to Just Culture and NCBON Complaint Evaluation Tool (1.5 CHs) – 1 hour and 30 minutes** – Provides information about Just Culture concepts, role of nursing regulation in practice errors, instructions in use of NCBON CET, consultation with NCBON about practice errors, and mandatory reporting. Suggested for audience NOT familiar with Just Culture.
- **Introduction to the NCBON Complaint Evaluation Tool (1 CH)** – 1 hour – Provides brief information about Just Culture concepts and instructions for use of the NC Board of Nursing's Complaint Evaluation Tool, consultation with NCBON about practice errors, and mandatory reporting. Suggested for audience already familiar with Just Culture.

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.

CNS Proposed Rule Changes Working through Rulemaking Process

Proposed amendments to 21 NCAC 36 .0228, CLINICAL NURSE SPECIALIST PRACTICE will make recognition by the NC Board of Nursing REQUIRED for practice at the advanced practice clinical nurse specialist (CNS) level. This means that CNSs who currently have voluntary recognition from the Board of Nursing and all those who wish to practice as a CNS will need to apply and qualify under the new requirements. If approved, the new requirements will go into effect on July 1, 2015.

The Board of Nursing would like to develop a database of CNS email addresses so that CNSs may be notified of application requirements and deadlines should the proposed changes become final. To have your email address included in this database, please send an email to aprnpractice@ncbon.com with “add my email address to the CNS database” in the subject line.

To learn more about these rule changes, please visit www.ncbon.com, select “Laws & Rules” from the website banner, then select “Proposed Rule Changes” on the right side.



“HELP! ONE OF OUR NURSES HAS SLURRED SPEECH AND WE ARE MISSING SOME CONTROLLED SUBSTANCES. WHAT DO WE DO NOW?” UPDATE FOR EMPLOYERS: ANSWERS TO FAQs REGARDING DRUG TESTING

Brandi Griswold, BA, CI, Regulatory Compliance Coordinator
Brian Stewart, BSCJ, Lead Investigator

Drug testing is a valuable tool used in the investigation of diversion of controlled substances and/or for the assessment of a Licensee’s fitness for duty. The results of a drug test should be used in conjunction with other information gathered during the employer’s investigation to determine the action that must be taken. A negative drug test result, however, cannot definitively rule out diversion nor can it assure a Licensee’s ability to practice safely.

The following list of questions can assist employers in developing agency policies and/or procedures related to drug testing.



Q: What are some signs and symptoms of impairment?

A: Signs of impairment may include the Licensee appearing sleepy, nodding off, displaying unsteady gait and slurred or rambling speech. The North Carolina Board of Nursing (the “Board”) offers a “Suspected Impairment Checklist” on our website that provides detailed information regarding signs of impairment.

Q: What procedures should be followed when impairment is suspected?

A: Be familiar with your facility policy. Usually a member of management is consulted to assist in confirming the reported behavior. All behaviors should be documented immediately.

If it is determined that a “for cause” drug test is necessary, the test should be administered as soon as possible after the suspected impairment is observed. The Board recommends that a drug test be directly observed by a same-sex collector and that a split specimen be obtained. The Licensee suspected of being impaired should be escorted by management, human resource staff, employee health staff or security at all times. Specifically, the Licensee should not be permitted to go to the locker room, a patient’s room or any other area without an escort. If impairment is suspected the Licensee should not be allowed to drive home. Cab

services or a family member should be called to transport Licensee.

Q: Do standard urine drug tests test for all commonly abused drugs?

A: No. When drug testing a Licensee who is suspected of diversion, it is of the utmost importance to direct the lab to test the specimen for the specific drug(s) of concern. Synthetic and Semi-Synthetic Opiates are the most commonly abused prescription drugs. However, these drugs are not typically included on standard drug testing panels. Synthetic Opiates include Fentanyl, Demerol, Methadone and Tramadol. Semi - synthetic

Opiates include Hydrocodone, Hydromorphone and Oxycodone.

Q: Do standard urine drug tests test for alcohol?

A: No. If impairment on alcohol is suspected it is generally recommended by drug testing professionals that a breath alcohol and/or a blood alcohol test be completed in addition to a urine test. It is important to obtain breath alcohol, blood alcohol and urine drug tests as soon as possible following the incident or report of behavior.

Q: A drug test sent to the lab was cancelled due to collector error. What kinds of issues can cause a drug test to be cancelled?

A: A drug test must be completed using a “chain of custody” protocol. This means that the specimen does not leave the Licensee’s sight until the specimen container is sealed. The Chain of Custody form is completed by the collector and includes fields such as the name and employee identification number of the Licensee, date of the test and the type of test. The form must be signed and dated by the collector and the Licensee. The Chain of Custody form must be completed (without omission) or the test may be cancelled. If a test is cancelled, request that the Licensee submit another drug test, if possible. If diversion or impairment is suspected, submit a complaint to the Board even if the drug test is cancelled or deemed negative. The Employer Complaint form and information regarding the complaint process is located on the Board’s website.

Q: Is it really necessary to have our drug test results reviewed by a Medical Review Officer?

A: Yes. All positive drug tests must

be reviewed by a Medical Review Officer (MRO). The MRO is a licensed medical doctor or doctor of osteopathy who is authorized to verify the integrity of the collection process and review and interpret laboratory results.

Q: A Licensee was observed to be impaired on duty, but the Licensee has prescriptions for all of the medications that showed up on the drug test. Should we still report the Licensee to the Board of Nursing?

A: Yes, a Licensee can be impaired on his or her prescribed medication. In order to protect the public, all alleged impairment while on duty cases must be reported to the Board for further investigation whether or not there is evidence of diversion, abuse of prescription medication or illicit drugs.

Q: Once a Licensee is reported to the Board for diversion, impairment and/or a positive drug test, what happens next?

A: Once a drug related complaint is received at the Board office, it is routed to Board Regulatory Compliance staff. Staff will contact the Licensee and explain all options for resolution. The options include a full Board investigation after which a Licensee may request a hearing before the Board; the surrender of the license for a minimum of one year; or entrance into a Board drug monitoring program. Entrance into a Board program may require a three month period of time during which the Licensee is unable to work in a licensed position. Once reinstated the Licensee may have conditions and restrictions on the license.

Employer Drug Testing: Important Tips

1. Always specify the drugs you are looking for. If the Licensee is suspected of diverting Dilaudid and

Fentanyl, specify that the drug screen should test for these drugs.

2. Make certain that the mode of testing makes sense given the drug suspected. If impairment on alcohol is suspected do a blood test and/or a breathalyzer in addition to a urine test.
3. Make certain the chain of custody protocol is followed and the Chain of Custody form is complete. Consult with Employee Health and Human Resources.
4. Have all positive test results reviewed by a Medical Review Officer (MRO).
5. When submitting drug testing information to the Board include copies of the actual drug test result, Chain of Custody form, MRO report, witness statements, Behavior Observation Checklists, and any evidence of diversion, such as patient records, Pyxis reports, or video or photo evidence, if applicable.

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3. Public Policy Statement on The Role of Medical Review Officers (2005) American Society for Addiction Medicine, Inc. Retrieved from www.asam.org on 4/28/14.
4. United States Department of Transportation, DOT Rule 49, CFR Part 40, Section 40.121, Subpart G – Medical Review Officers and the Verification Process. Retrieved from www.dot.gov on 5/9/14.
5. Veskrna, Les (2012) Urine Drug Testing in Chronic Pain. Retrieved from Lincoln Family Medicine Program, www.lfmp.com on 5/1/14.

SUMMARY of ACTIVITIES

ADMINISTRATIVE MATTERS

Administrative Matters for October issue of Bulletin:

- Approved designation of funds

REGULATORY COMPLIANCE ACTIONS

Received reports and Granted Absolutions to 5 RNs and 2 LPNs.

Removed probation from the license of 15 RNs and 2 LPNs

Accepted the Voluntary Surrender from 16 RNs and 2 LPNs

Suspended the license of 5 RNs and 4 LPNs

Reinstated the license of 12 RNs and 2 LPN

Number of Participants in the Alternative Program for Chemical Dependency: 161 RNs and 8 LPNs (Total = 169)

Number of Participants in the Chemical Dependency Program (CDDP): 98 RNs, 10 LPNs (Total = 108)

Number of Participants in Illicit Drug and Alcohol/Intervention Program: 30 RNs, 13 LPNs. (Total = 43)

EDUCATION MATTERS:

Summary of Actions related to Education Programs

Ratification of Full Approval Status – 2 programs

Ratification to Approve Expansion in Enrollment – 2 programs

Notification of Programs Not Admitting Students – 1 program

FYI – Program Closures – 1 program

FYI – Voluntary withdrawal from ACEN Accreditation – 1 program

Determination of Program Approval Status:

Program Non-compliance with 21 NCAC 36.0318 Faculty – 1 program

Attention: Advanced Practice Registered Nurses, RNs, and LPNs New NC Medical Board Policy on the Use of Opioid Medication for the Treatment of Pain

At the NC Medical Board's May 2014 meeting, a new policy on the use of opioid medications for the treatment of pain was adopted. The effective date is June 1, 2014. The policy provides guidelines and information regarding the expectations for patient management. All advanced practice registered nurses who prescribe controlled substances for the treatment of pain should become familiar with this policy as it contains detailed clinical guidelines and information about the expectations for patient management. Since nurse practitioners are jointly regulated by the Board of Nursing and the Medical Board, they are directly covered by this policy. Nurses who do not prescribe opioids may find this policy helpful in their work with clients taking these medications.

"The challenges faced by North Carolina Medical Board licensees who care for patients taking opiates for pain are significant. The North Carolina Medical Board is committed to helping its licensees meet those challenges successfully. By doing so the Board and its licensees will help promote public health and the individual well-being of citizens of our state." (Excerpt from

the Introduction of the new policy)

To obtain a copy of the policy, go to www.ncbon.com and look under News and Announcements on the homepage.





P.O. Box 2129
Raleigh, NC 27602-2129