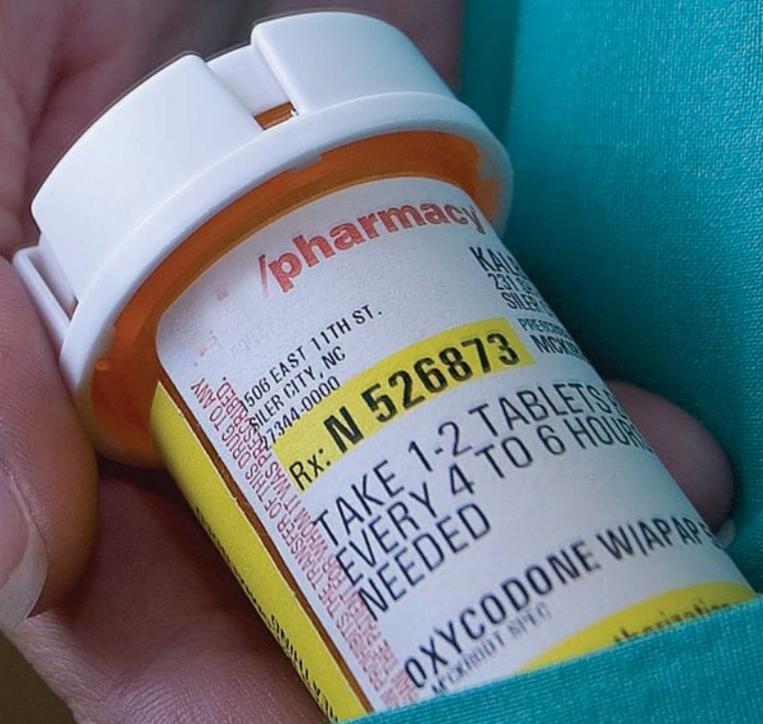


NURSING BULLETIN

WHAT COULD HAPPEN:

The Consequences
of “Practice Drift” ...
Is It Worth the Risk?

– page 6



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NC BOARD OF NURSING
Nursing Bulletin is the official
publication of the North
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Raleigh, NC 27607

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Office Hours

8 a.m. to 5 p.m.,
Monday through Friday

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Photography

DayMeetsNight Media Services

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from the **EDITOR**

Eyeing that slippery slope

I first want to congratulate new Board members, Lisa Hallman and Glenda Parker on their election efforts and the re-election of Sharon Moore to the 2017 Board of Nursing. I also want to thank departing Board members, Jennifer Kaylor, Cheryl Duke and Margaret Conklin for their hours of dedicated service on behalf of the Board. To read more about our incoming Board members see the article on Page 20.

The CE cover story on Page 6 highlights the issue of “Practice Drift.” In it, author Kathy Chastain, RN does a great job describing the “slippery slope” that licensees are known to take that eventually leads them to appear before the Board. I assure you this is NOT a work of fiction. We hear licensees describe these practices all the time — in defense of their actions. The article is a compelling read and will definitely help you identify problem areas where drift might occur.

Also in this issue is a short article, on Page 14, about the Foundation for Nursing Excellence (FFNE) and their efforts to report on steps that might be taken to address academic progression for LPNS. We have included a link to the report.

As 2016 comes to a close, I am already looking toward the future and a long session of the 2017 North Carolina General Assembly. I will keep you posted on Board of Nursing issues in the legislature.

David Kalbacker
Editor, NC Board of Nursing

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WHAT COULD HAPPEN: The Consequences of “Practice Drift”... Is It Worth the Risk?



Kathy Chastain, MN, RN, FRE and Linda Burhans, PhD, RN, FRE

Purpose:

To assist nurses in understanding and identifying practice drift and how to eliminate/mitigate effects.

Objective:

1. Explain “practice drift.”
2. Recognize factors that contribute to the occurrence of “practice drift.”
3. Discuss the impact of “practice drift,”
4. Create a plan to eliminate and decrease “practice drift.”



Have you ever...

1. Deviated from the procedure for safe medication administration?

- administered a medication prior to obtaining an order from a provider because you “knew” what the physician would order;
- borrowed a medication from another patient or used STAT orders to override the system as a workaround to bypass slow pharmacy services;
- administered a pain medication without completing a pain assessment because you were in a hurry;
- prepared medications simultaneously for more than one patient

because you were pressed for time and/or you were trying to save a few steps;

- carried medications in your pocket and wasted them at the end of the shift because there wasn't anyone available at the time to serve as a witness;
- signed as a witness to a narcotic medication waste you did not observe because you trusted your co-worker;
- left a patient's medications on the bedside table because he/she was on the phone;
- failed to check 2 identifiers when administering medication because you were in a rush;

- failed to scan the bar code on a medication because the scanner wasn't working;
- made assumptions when orders were incomplete or were illegible because you didn't want to bother the provider; or,
- hidden away unused medications from discharged patients for administration to other patients if needed in the future to avoid delays.

2. Neglected a patient?

- failed to perform an assessment or treatment because the patient was sleeping;
- silenced a piece of equipment (bed alarm, IV pump, cardiac monitor, etc.) because it kept alarming for



- no apparent reason and you felt it was disturbing the patients; or,
 - failed to complete the “time out” in surgery because the surgeon was upset with how long it took to set up for his/her patient.
3. *Failed to maintain an accurate patient medical record?*
- pre-documented an assessment or care delivered to save time because the information was always the same;
 - pre-documented medication administration because you knew you would not have time later; or,
 - waited until the end of the shift to document all assessments and care rendered because you didn’t have time during the shift to get it done.
4. *Breached a patient’s confidentiality?*
- out of curiosity, looked up information on a patient you were not assigned to provide care;
 - posted pictures or comments about patients or family members on social media;
 - discussed patient information in a public setting (e.g., elevator or cafeteria) or commented on a patient’s condition to another patient or family member.
5. *Exceeded scope of nursing practice?*
- acted outside your scope of practice by writing “verbal orders” without actually speaking with the provider, believing they would be signed off at next rounds; or,
 - performed a procedure that was outside your scope of practice (e.g., rupturing membranes to induce labor) because the provider instructed you to do so.
6. *Inappropriately delegated a task to an unlicensed staff member?*
- directed a nurse aide (not appropriately educated and validated competent) to administer a medication or perform a simple dressing

- change because you were busy with another patient; or,
 - allowed unlicensed personnel to make assignments and delegate patient care tasks to others.
7. *Accepted an assignment when you knew you were not fit for duty?*
- worked while so fatigued that you were nodding off to sleep because you agreed to work an extra shift at the request of your manager; or,
 - worked an early shift while still “hung over” from a party that ended only a few hours before.

Chances are you have done some of these yourself, or if not, you have worked with someone who has! The multiple “at-risk” behaviors listed above all describe “practice drift.” The term “practice drift” is another way of describing a “work-around,” “shortcut,” or “rule-bending” done in order to accomplish an immediate goal, to meet a perceived expectation of another, and/or to promote efficiency (Collins, 2003). All of these incidents are types of practice violations which the NC Board of Nursing has investigated. Thankfully the vast majority of these incidents did not result in serious negative patient outcomes but each incident represents a “drift” from the standard of care and has the potential to jeopardize patient safety.

STOP READING: Make a list of work-arounds, shortcuts, and rule-bending in your practice setting. What variations from standards of practice or policies and procedures have you witnessed? Which variations have you used? How often does “practice drift” occur in your practice and that of your co-workers?

Behavioral research has shown that all humans are mentally programed to drift into unsafe habits, to lose perception

of the risk attached to everyday behaviors, or to mistakenly believe the risks taken to be justified. Decisions about what is important on a daily list of tasks are based on the immediate desired outcomes and over time, as perceptions of risk fade away, individuals try to do more with less and take shortcuts, drifting away from behaviors they know are safer (ISMP, June 2012).

Articles published by the Just Culture Community, have identified “at-risk” behaviors as the most common of the 3 types of errors (human, at-risk, reckless). Marx of Outcome Engineering (2005) explains,

“We all tend to lose perception of the risk attached to everyday activities, or mistakenly believe in some situations a risk is justified. Often our decisions to circumvent an evident or perceived workflow hindrance are based on immediate outcomes (time saver) in order to meet a goal or to achieve it more readily and do not consider the potential or uncertain consequence (patient harm) which is more remote.”

Studies have shown that once you have bent the rules and had a favorable outcome and/or a positive response from your peers and supervisors, you are likely to be tempted to do it again (Collins, 2003). If left unquestioned, the rule-bending action then tacitly becomes acceptable practice not only by that individual but may be adopted by others in the unit or facility and many times leads to what is referred to as a “cultural norm.” However, work-arounds and rule-bending are often just temporary fixes for bigger problems in the system and do not promote an environment supportive of safe patient outcomes.

STOP READING: Go back to your “practice drift” list. For each variation, list the reason(s) for those variations. Why do you and your co-workers use these work-arounds and shortcuts and bend established rules? What are you trying to achieve? What problems in the system or environment make it seem necessary to use these approaches?

Consider the following scenario:

Megan, a newly-employed Registered Nurse in the Operating Room of a small rural hospital, was assigned to circulate with another experienced nurse on a surgical case for Dr. S, a very impatient surgeon. The set up for the procedure was taking longer than expected because a specific piece of equipment that had been requested the day before could not be located. Dr. S voiced his frustration and threatened that he would cancel the surgery and “start taking his surgeries elsewhere” as they were never ready and always caused him to be behind in his schedule. The nurses rushed to finish the set up and due to the delays the experienced nurse instructed Megan that they would forgo doing the required “time out” to verify the patient, procedure, site, allergies, and antibiotics administered. Megan voiced concerns but was assured this was “common practice” for this surgeon to keep him happy as you never wanted to be on his bad side.

This example demonstrates how “practice drift” became a “cultural norm” for this facility. Based on extensive studies and the patient safety literature, the risk severity potential of omitting the “time out” procedure was high, but the probability of incident was incorrectly perceived by the nurses to be low as there had been no reports of wrong patient or wrong site surgeries in this hospital. The decision drivers

to “work-around” the rule included the intimidation the nurses felt due to the surgeon’s threats, the nurses’ desire to make up for lost time, and the time delay caused by the lack of preparedness in failing to verify the day before that the equipment was available. As described in this example, it is likely that this cultural norm will be perpetuated by the new nurse for whom this was identified as acceptable behavior. In addition, this cultural norm was reinforced again for all the nurses by the lack of untoward outcomes in this case.

STOP READING: Go back to your “practice drift” list. Highlight those variations that have become “cultural norms” in your setting. Is this “practice drift” so common that it is used routinely by all nurses? Is it used only by some of the nurses? If so, why do the other nurses not use these approaches?

Dr. Van Sell (2012), noted that nurses will engage in a reasoned, intentional rule bending behavior to solve an immediate problem and not realize the potential negative consequences. Factors such as staffing levels, patient acuity, workload, time constraints, interruptions/emergencies, lack of access to providers, lack of input in design of workflow and procedures, familiarity and trusting relationships with providers, and lack of proper working equipment/supplies/medications are just some of the challenges nurses face every day when trying to do what needs to be done to provide effective patient care.

Work-arounds develop in response to factors that:

- are perceived to prevent or undermine nurses’ care for their patients;
- are not considered in the best interests of the patient;
- make performance of their job difficult; or

- potentially threaten professional relationships.

Now, can you identify “practice drift” in the following scenario?

Cindy, a Licensed Practical Nurse, has worked on the evening shift in a long term care skilled nursing facility for a number of years. The facility does not have an on-site pharmacy; therefore, all ordered resident medications are obtained from a pharmacy in a neighboring town. On the date of this incident, a new resident was transferred from the hospital to Cindy’s unit. They were understaffed, which was not an uncommon occurrence on that unit. That evening Cindy was falling behind with all the tasks she was assigned to complete. She completed the admission assessment but failed to review the orders. The Unit Secretary transcribed all the medication orders onto the Medication Administration Record (MAR) for Cindy to verify. Cindy was preparing to do her first medication pass for the shift. She took the Medication Administration Record (MAR) without verifying the orders because she had no doubts that it was accurate. She proceeded to pre-pour all scheduled medications for all residents for the entire shift and place them into individual baggies which she labeled with the residents’ room numbers. At the same time, she documented that all medications poured had been administered at the times noted in the MAR. She believed these practices to be safe. She had worked with these residents for a long time and knew who they were as well as what medications they took. Throughout the shift, she completed the medication passes which she had pre-poured and pre-documented.

The new resident had an order for an oral antibiotic which had not been delivered. Cindy knew another resident on the unit was taking this same medication so she “borrowed” one dose because she didn’t have time to wait on the pharmacy. She failed to check the new resident’s allergies, thus failing to see that there was a documented allergy to the antibiotic she had

administered. The resident had an allergic reaction resulting in the resident having to be transferred back to the hospital.

While trying to take care of the transfer arrangements for the above resident, a nursing assistant (who is currently in nursing school) informed her that another resident was requesting her pain medication. Cindy reviewed the MAR and noticed the medication was ES-Tylenol. She poured the medication and handed it to the nursing assistant directing her to take it to the resident. In addition, a nurse arrived at 8:30pm to assist with medication administration but left and went back to her own unit when she reviewed the MAR and saw all medications had already been administered through 10:00pm doses. The relief nurse reported to the supervisor that there was a discrepancy related to medication administration.

The above scenario involved multiple “practice drifts.” How many did you find?

- Insufficient staff on the unit contributed to Cindy’s decisions to “cut corners.” She did not request assistance because she “knew” it would not be available, leaving the supervisor unaware of the unit status.
- She rationalized that she did not have to check the orders and MAR because she trusted the secretary and believed she would not make an error in transcribing.
- She failed to consider that the unit secretary was not educated in clinical nursing and pharmacology and would not likely identify the problem between the resident’s allergies and the medication ordered.
- In her rush to complete the medication pass, she omitted the safety

check of reviewing the allergies as well.

- Instead of waiting on the pharmacy or calling to see why the resident’s medications had not been delivered, Cindy decided to bypass policy and borrow the medication from another resident. Had she called the pharmacy she would have been informed that there was a question regarding the order. This third safety mechanism would have prevented an error.
- Cindy believed that pre-pouring all the medications at once would save her time and be more efficient. Because she knew the patients, she believed that she could label the baggies with room numbers only. She chose to ignore all patient safety policies and procedures.

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- Cindy’s decision to pre-document all the medications that were scheduled to be administered on her shift ultimately resulted in confusion as to what medications had been administered when another nurse came to assist. Notification of the supervisor resulted in an internal investigation into Cindy’s medication administration practices and resulted in a report to the Board. As a result of this action, Cindy’s credibility was called into question causing her employer to question if she falsified patient records routinely.
- Finally, Cindy inappropriately delegated medication administration to an unlicensed nursing assistant. This, too, was a violation reported to the Board.

Ultimately, Cindy’s actions on this shift demonstrated extreme “practice

drift.” Her overall intent was to provide the best care possible with limited resources. However, the time Cindy thought she was saving by using short-cuts, bending rules, and implementing work-arounds, resulted in compromised patient care, damage to her professional reputation and credibility, a potential loss of her job, and a potential sanction of her nursing license.

It is not uncommon for any one of us, when faced with having to do more with less or when pushed for time, to find ways to use work-arounds and take shortcuts. In a busy work environment, particularly one that is understaffed, rule-bending may seem like the only solution. But none of these influence substantive change and they only provide a temporary fix when what is needed is a change in the underlying condition that made work-arounds, short-cuts or rule bending necessary.

“Practice drifts” operate as adaptations to inefficiencies and have the potential to both subvert and augment patient safety. Occasionally, workarounds operate as localized acts of resilience, are at times crucial to the delivery of services, place the patient’s best interests at the forefront, operate as adaptations to inefficiencies, and provide opportunities for improvement. When operating in this manner, they are used as unique, short-term solutions and the opportunities for improvement are immediately addressed. More frequently, however, because rule-bending, work-arounds, and shortcuts circumvent safety blocks, mask environmental and operational deficiencies, and undermine standardization they have the potential to jeopardize patient safety as well as your career. When a patient is injured because you deviated from the standard of care, there is little defense to be found (HPSO, 2016).

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Rules: we can't live without them, but there is probably not a day goes by when we don't break or bend one. Rule-bending, work-arounds, and shortcuts are all reflective of the "practice drift" used to achieve specific outcomes. They often seem like the only solution to fixing what is wrong. They become part of the culture and the need to identify and address the root cause of the issue is hidden. We fail to see that we have institutionalized a temporary, inadequate fix. In many cases, it is not until an adverse event requires deeper examination that the underlying conditions that led to unsafe "practice drift" are identified.

Nurses, according to the Gallup Poll, have ranked as the most trusted profession for the last 14 years (ANA, 2015). Nurses strive to do a good job and to provide safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice may begin to drift in an attempt to find ways to accomplish more with less or to do something "faster" or "better." We lose sight of the risk inherent in the resulting deviations from established standards of care, policies, and procedures. We assume that risk through the behavioral choices we make. When a patient is injured because we deviated from the standard of care, we bear that responsibility.

The NC Nursing Practice Act (Law) and Rules provide clear direction concerning the variables that determine the responsibilities or assignments that can be safely accepted by an RN or LPN. Likewise, specific criteria designate considerations when assigning or delegating to others. Nurse manager and administrator responsibilities for staff, unit environment, and nursing systems are also spelled out.

STOP READING: Explore the NC Nursing Practice Act (<http://www.ncbon.com/dcp/i/laws-rules->

[nursing-practice-act-nursing-practice-act](http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-administrative-code-rules)) and Administrative Code Rules (<http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-administrative-code-rules>) to identify sections relevant to this discussion.

All nurses must strive to uncover and address the underlying causes of rule-bending, work-arounds, and shortcuts to affect substantive change. Nurses, nurse managers, and administrators must work together to identify and address the underlying issues in each work environment – both chronic and acute – which influence "practice drift." Nurses must speak out to identify the "practice drift" they and their peers are using; specifically identify the underlying reasons: short staffing, inadequate supplies, unresponsive pharmacy services, inadequate education, etc.; and collaborate with managers and administrators to identify effective, evidence-based solutions. It is essential that safe solutions to underlying problems be implemented. Patient safety and well-being is the ultimate shared goal.

NOW: Go back to your "practice drift" list and make a plan to address at least one variation! How will you alter your own practice to move away from at-risk behavior? How will you communicate the risks of "practice drift" to your co-workers? How will you address the underlying system changes with your manager and administrator?

IN THE FUTURE: Prioritize your "practice drift" list and address one at a time. Enlist support and involvement from your co-workers and manager. Patient safety and well-being is your ultimate shared goal!

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LPN-BSN ACADEMIC PROGRESSION IN NORTH CAROLINA

Challenges and Recommendations Report

As part of our efforts to increase both the diversity and educational preparation of our nursing workforce in NC, the Foundation for Nursing Excellence (FFNE) convened a small workgroup of nursing program leaders as well as representatives from the NC Area Health Education Centers program, the NC Board of Nursing and NC Community Colleges System to lead a feasibility study and, based on findings, make recommendations for future actions that North Carolina might take in addressing academic progression for LPNs. Information related to current LPN-BSN academic interest and/or initiatives to help build the nursing workforce of the future was gathered from a variety of stakeholders including LPNs

licensed in NC, nurse educators at PN, ADN and BSN levels as well as employers from across the state, and nurse leaders from other states. We are pleased to share a link to our September 2016 LPN-BSN Feasibility Workgroup Report, LPN-BSN Academic Progression in North Carolina: Challenges and Recommendations, for your review and consideration of the recommendations for action. We also ask that you distribute the link to this report at <http://ribn.org/library/library/other-resources/2016-lpn-bsn-feasibility-report.pdf> to your colleagues in both the practice and education communities who are committed to academic progression for all levels of nursing in North Carolina.

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TELEHEALTH/TELENURSING

Position Statement for RN and LPN Practice

Issue:

Licensed nurses (RN and LPN) may practice nursing using telehealth/telenursing modalities, provided required criteria are met.

The NCBON has determined that nursing practice occurs at the location of the client at the time services are being provided.

Licensed nurses practicing and providing client care via telehealth/telenursing modalities are required to be licensed or hold the privilege to practice in the state(s) where the client(s) is located. Licensed nurses must practice in compliance with the laws, rules, and standards of practice of the state(s) where the client(s) is/are located.

Definition: Telehealth/telenursing (alternatively termed telemedicine) is the practice of healthcare within a professionally designated scope of practice using electronic communication, information technology, or other means between a licensee in one location and a client in another location with or without an intervening healthcare provider.

RN Role: Telehealth/telenursing includes assessing (including triaging) clients; planning, implementing, and evaluating client care; teaching and counseling clients; managing and supervising the delivery of care;



teaching nursing personnel/students; administering nursing services; collaborating; and consulting.

LPN Role: Must be supervised by an RN, physician, nurse practitioner, physician assistant, or other person authorized by state law to provide the supervision.

Telehealth/telenursing by the LPN includes participating in assessing, planning, and evaluating client care, implementing client care according to an established health care plan, and collaborating with other healthcare providers in compliance with nursing law and rules (G.S. 90-171.20 (8) and 21 NCAC 36.0225). LPN supervision of others is limited by state laws and rules. It is beyond the scope of LPN practice to perform complex, independent decision-making, such as that potentially required to triage client care needs via telehealth/telenursing modalities.

Both RN and LPN Role:

1. Report and record nursing care provided.
2. Accept responsibility and accountability for client care via telehealth/telenursing modalities only if possess the documented education and validated competence necessary to deliver nursing services safely.
3. Accept orders for medical interventions via telehealth/telenursing from Physicians, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants authorized to make medical diagnoses and prescribe medical regimens.
4. Standing orders and protocols for care must meet requirements as stated in the NCBON Standing Orders Position Statement for RN and LPN Practice available at www.ncbon.com.
5. Employing agency's policies and procedures address telehealth/telenursing services and are available in the facility.

References:

- G.S. 90-171.20 (7) & (8) – Nursing Practice Act
- 21 NCAC 36.0224 - RN Rules
- 21 NCAC 36.0225 - LPN Rules
- NCBON Standing Orders Position Statement for RN and LPN Practice
- RN Scope of Practice – Clarification
- Position Statement for RN Practice
- LPN Scope of Practice – Clarification
- Position Statement for LPN Practice

Approved: 5/2016

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COMPLEMENTARY THERAPIES

Position Statement for RN and LPN Practice

Issue:

Complementary therapies refer to a broad range of modalities such as, but not limited to, massage therapy, therapeutic touch, biofeedback, magnet therapy, reflexology, imagery, hypnosis, aromatherapy, and acupuncture. Some of these therapies are inherent in basic nursing practice while others require additional education/training prior to performing them. Complementary therapies are intended to be used in conjunction with the existing treatment plan, not to replace it.



Both RN & LPN Roles:

- A. It is within scope of practice to perform complementary therapies provided licensee has:
 - 1. Documented knowledge, skill, and competency necessary to carry out the therapy in a safe manner,
 - 2. Employing agency's policies and procedures support nurse's use of complementary therapies.
- B. When complementary therapy is used as a nursing intervention; this should be:
 - 1. Reflected in the patient's plan of care, and

- 2. Documented in the patient's medical record consistent with requirements for reporting and recording

Notes:

- 1. Any state or local laws, which require licensure to perform the complementary therapy, must be followed. For example, massage may be utilized as a nursing care intervention but a massage license is required to offer, provide, or practice massage in a broader context.
- 2. Acupuncture can only be performed if the individual is licensed to perform this modality in North Carolina consistent with NC GENERAL STATUTES 90, Article 30 (Practice of Acupuncture).
- 3. Licensed nurses are held responsible and accountable for practicing at all

times within the scope associated with their highest level of active licensure. Refer to "Practicing at Level Other Than Highest Licensure/Approval/Recognition Position Statement for RN, LPN, and APRN Practice" available at www.ncbon.com for more detail.

References:

- G.S. 90-171.20 (7) (b & h) and (8) (b & f) – Nursing Practice Act
- 21 NCAC 36.0224 (d) and (f) - RN Rule
- 21 NCAC 36.0225 (d) and (f) - LPN Rule

Approved: 5/2001

Revised: 4/2006, 4/2007, 5/2009, 11/2009, 5/2016

Reviewed: 2/2013

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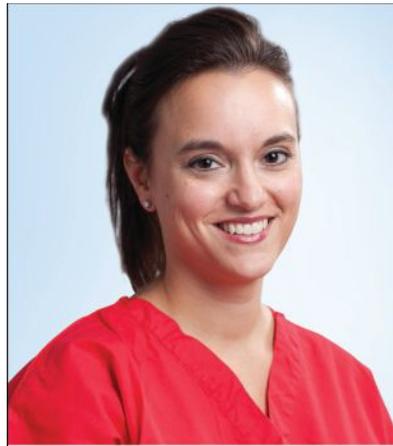
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SUMMARY of ACTIVITIES

Administrative Matters:

- Approved proposed amendments to rules related to revocation, suspension or denial of license. The current rule places a greater procedural burden and more restriction on the Board of Nursing than is required by the Administrative Procedures Act and fails to capture needed nursing practice. Amendments include technical changes throughout the rule and the creation of new violations in section (a) where a need was seen to capture acts previously outside the Board's disciplinary jurisdiction. Lastly, deletions were made of provisions in the rule that are covered in law pursuant to the North Carolina General Statutes or that generally place unnecessary burden not required by law on staff during the enforcement/disciplinary process.
- Approved proposed amendments to rules related to annual renewal, continuing education and prescribing authority for Nurse Practitioners. Amendments include language to clarify requirement for maintaining national certification for annual renewal, establishing continuing education hours in prescribing practices in accordance with Session Law 2015 – 241 Section 12 F16(b) and clarifying language regarding authorized prescription refills.
- A Public Hearing on the proposed amended Rules is scheduled for November 17 at 1:00 pm. Visit our website at <http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-proposed-rule-changes> for specific details as they are available. Additional information will also be published in subsequent issues of the magazine.

Newly Elected and Re-Elected Members

- Newly Elected: Glenda Parker, RN and Lisa Hallman, RN
- Re-elected to 2nd term: Sharon Moore, RN

Chair and Vice Chair for 2017

- Chair: Pat Campbell, Public Member
- Vice Chair: Deborah Herring, RN

Regulatory Compliance Matters:

- Removed probation from the license of 11 RNs and 1 LPNs.
- Accepted the Voluntary Surrender from 9 RNs and 1 LPNs.
- Suspended the license of 14 RNs and 0 LPNs.
- Reinstated the license of 5 RNs and 1 LPNs.
- Number of Participants in the Alternative Program for Chemical Dependency: 146 RNs and 10 LPNs (Total = 156)
- Number of Participants in the Chemical Dependency Program (CDDP): 95 RNs, 11 LPNs (Total = 106)
- Number of Participants in Illicit Drug and Alcohol/Intervention Program: 28 RNs, 15 LPNs (Total = 43)

Education Matters:

Ratification of Full Approval Status

- University of North Carolina Wilmington - BSN

Ratification to Approve the Following Expansion in Enrollment

- Southwestern Community College – ADN, increase of 28 for a total 80 beginning August 16, 2016

Initial Approval for New Program

- Mayland Community College - PN

ELECTION RESULTS FOR 2016

New Members

Glenda Parker, Family Nurse Practitioner for Minute Clinic, from Concord, NC, was elected as RN – Advanced Practice Registered Nurse to the NC Board of Nursing. Mrs. Parker comes to serve on the Board with more than 37 years of nursing experience.

Lisa Hallman, Nurse Manager at Johnston Correctional Institution

with the Department of Public Safety is from Raleigh, NC and was elected as RN – Staff Nurse to the NC Board of Nursing. Mrs. Hallman has more than 21 years of nursing experience.

Sharon Moore, was re-elected to the Board in the position of Nurse Educator – PN, to serve another 4 year term. Mrs. Moore is the

Department Chair for Practical Nursing at Forsyth Technical Community College.

Chair & Vice Chair Elections

Pat Campbell, public member and 2016 Vice Chair, was elected to Chair the Board for 2017.

Deborah Herring, RN – At Large, was elected as Vice Chair for 2017.

Executive Director Nationally Recognized with Highest Award in Nursing Regulation

Julia L. George, MSN, RN, FRE, Executive Director, North Carolina Board of Nursing, was honored with the prestigious R. Louise McManus Award. Individuals receiving this award have made sustained and significant contributions through the highest commitment and dedication to the mission and vision of The National Council of State Boards of Nursing Inc. (NCSBN).

NCSBN recognized dedicated and exceptional membership at its annual awards ceremony during the NCSBN Annual Meeting and Delegate Assembly, held in Chicago, IL, August 18, 2016.

In addition to receiving the R. Louise McManus Award, George was also elected as President-Elect to the NCSBN Board of Directors. This is a 4-year commitment, serving 2 years as President-Elect and 2 years as President.

NCSBN was founded March 15, 1978, as an independent not-for-profit organization and was created to lessen the burdens of state governments and bring together boards of nursing (BONs) to act and counsel together on matters of

common interest. NCSBN's membership is comprised of the BONs in the 50 states, the District of Columbia, and four U.S. territories – American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also 27 associate members that are either nursing regulatory bodies or empowered regulatory authorities from other countries or territories.

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LITERATURE REVIEW

Nurse Fatigue Related to Shift Length

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The issue of nurse fatigue is of increasing concern to nurses and healthcare organizations. Evidence to document the fatigue issue continues to emerge and provide more specific data and insights for the healthcare community. The relationship of fatigue to patient safety and risk of self-injury is documented in several sources. The purpose of this literature review is to present the most recent evidence and recommendations specific to nurse fatigue for nurses and their managers in understanding these relationships.

Symptoms of fatigue include, but are not limited to decreased alertness, irritability and sleepiness. The Occupational Safety and Health Administration (OSHA)¹ cautions against working more than 8-hour shifts as longer shifts may result in reduced alertness. Fatigue is correlated to nurse performance and chronic fatigue is related to the number of hours worked.²

Health care workers are not alone in shift work and working long hours. The Department of Transportation regulates the number of hours of service for those in aviation, highway, rail and nautical professions.³ Not only are shift times regulated; some have restrictions on weekly and monthly work allotments. Sleep and rest are noted to be important for those in the rail industry,⁴ airline industry,⁵ and the forest industry.⁶

Long working hours may have an impact on errors as well as near errors,⁷ and decrease the nurse's vigilance in critical care.⁸ Research conducted by Barker and Nussbaum (2011) found that acute fatigue resulted from long hours of work, and that fatigue was negatively correlated with performance.

It was identified that an increased number of shifts worked by nurses in the prior 72 hours were significantly associated with hypoglycemic events in ICU patients receiving insulin infusions.⁹ Documentation of patient care can also be impacted by working longer hours; there were 26 percent less charting errors with fewer call hours in the surgical setting.¹⁰

In addition to patient clinical outcomes, a correlation exists between hospitals where nurses worked 13 hours in length or longer and patient dissatisfaction with communication, pain control and help when they wanted it.¹¹ Nurses



working long shifts were more likely to be burned out, dissatisfied with their job and intended to leave their job within the year.^{11, 12} Shifts scheduled for 12 hours often exceed that timeframe, as many as 40% of the work shifts logged for their study exceeded 12 hours.⁷

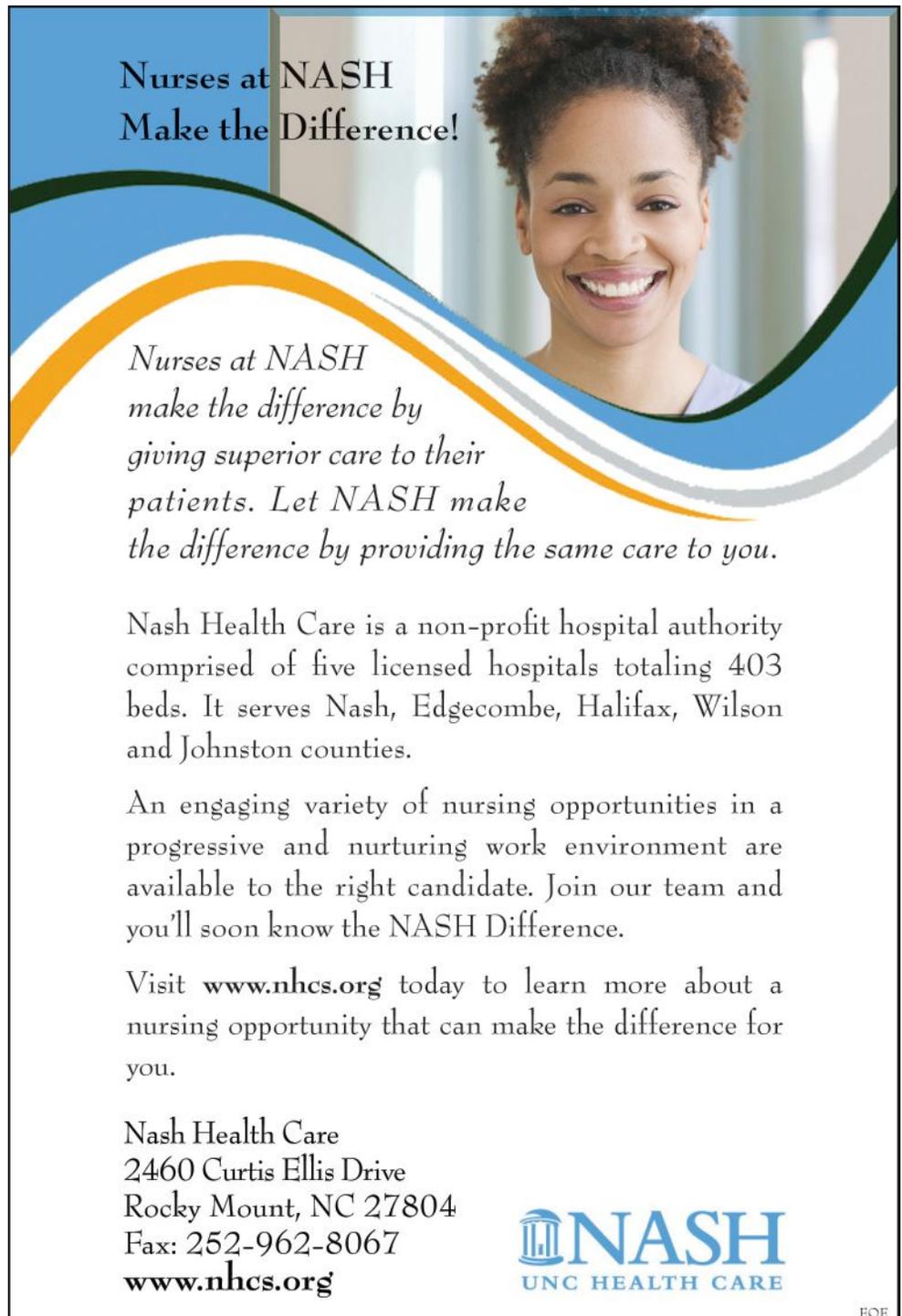
Nurse's personal safety related to longer worked hours is also a concern. Extended work hours are a contributing factor in needle stick injuries among nurses,¹³ and rates of nurses driving drowsy doubled when they worked more than 12.5 hours.¹⁴ In a study that examined the impact of a 9-hour shift compared to an 8-hour shift, the nurses working the 9-hour shift had more health issues, were not as satisfied and had more fatigue.¹⁵ In variables associated with worker injury, those working 12-hour shifts had a higher medical cost per injury than those who worked 8-hour shifts.¹⁶ Findings in a simulated environment demonstrated older people were not able to perform as well as younger people.¹⁷ This is important for the health care industry to consider as the nursing workforce ages and there is a need to retain them through improved job attributes.¹⁸

If shorter shifts are not available, planning to decrease the effects of fatigue can include regular and frequent breaks,^{1, 7, 19, 20} meal breaks,^{1, 7, 19} staff getting enough sleep or naps,^{21, 22, 19, 23} limiting caffeine^{19, 23} eating well and exercising¹⁹ and limit the number of shifts worked in a row.²⁰ Additional options include avoiding double back shifts such as an evening shift followed by a day shift with less than eight hours between, limit on-call hours, and allow sleeping during the night shift. Implementation of a formal fatigue countermeasures program for nurses has provided evidence of improvement in nurse fatigue.²⁴ With consecutive 12-hour shifts, nurses were not able to recover between shifts and used caffeine as a possible mechanism to improve alertness.²⁵

It is a legal and ethical obligation to educate the nursing staff about the effects of long work hours.²⁶ It is important for senior management to be aware of the

impact of working longer shifts.²⁷ The Institute of Medicine (IOM)²⁸ recommends limiting the number of hours worked in a day by nurses as a patient safety precaution. They find the evidence to be "very strong" (p. 236) related to prolonged work hours and worker fatigue. Recommendations are that health care organizations establish

policies and practices to limit hours worked in a shift as well as the number of hours worked in a week^{11, 28} that the "routine use of twelvehour shifts should be curtailed"⁷ (p. 210), and that overtime after a 12-hour shift should be eliminated.⁷ Another recommendation is to decrease shift length to allow recovery time between shifts.²⁹ Health



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care workers in the United States often work 12-hour shifts prompting Lockley³⁰ to state “hours routinely worked by health care providers in the United States are unsafe” (p. 14). The American Nurses Association³¹ notes that in addition to employee accountability

A literature review revealed that shift length has been correlated with nurse fatigue and has become a growing concern in the United States with the routine shift length of 12 hours. Outcomes correlated to shift length and fatigue includes errors or near errors in patient care.

regarding fatigue, employers are obligated to provide adequate staffing to care for patients. It is not the individual nurse’s responsibility to cover all shifts by working extra hours.

The evidence is compelling that long shift lengths are correlated with negative outcomes for both patients and nurses. Patients are impacted by errors in their care and are more dissatisfied when nurses work longer shifts. For the nurse, the outcomes of working longer shifts can be injury to self and intent to leave their job. Injuries may happen on the job such as needle sticks or strains;

or on the way home if in an accident caused by driving while drowsy.

A literature review revealed that shift length has been correlated with nurse fatigue and has become a growing concern in the United States with the routine shift length of 12 hours. Outcomes correlated to shift length and fatigue includes errors or near errors in patient care. In addition to concerns in patient care outcomes, the impact of fatigue on the nurse is also noted.

Nursing is a profession, and as a profession, we need to be self-regulating. If we are not able to mitigate the impact of fatigue, it could become regulated as with other industries such as transportation, logging and nuclear power workers.

Acknowledgement:

A special ‘thank you’ to Kathy Malloch, PhD, MBA, RN, FAAN who encouraged me to take the leap and go back to school for a DNP in Innovation Leadership at ASU and for recognizing the importance of this topic to the nursing profession.

Author:

Deborah Maust Martin received her Master’s degrees in nursing and business administration from West Virginia University and is currently employed by Banner Health as the System Director of Professional Practice. She has served on various local and national boards in an effort to strengthen the profession of nursing. One of these was the Congress on Nursing Practice and Economics with the American Nurses Association where she contributed to the Scope and Standards of Practice (2010) and the Principles for Nurse Staffing (2012). Deborah is currently enrolled in a doctoral program at Arizona State University.

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NORTH CAROLINA BOARD OF NURSING CALENDAR

Board Meeting:
January 20, 2017

Administrative Hearings:
December 1, 2016
February 23, 2017

Education/Practice Committee:
~~November 30, 2016~~
Canceled

Hearing Committee:
January 26, 2017

Licensure Review Panel:
December 8, 2016
January 12, 2017
February 9, 2017

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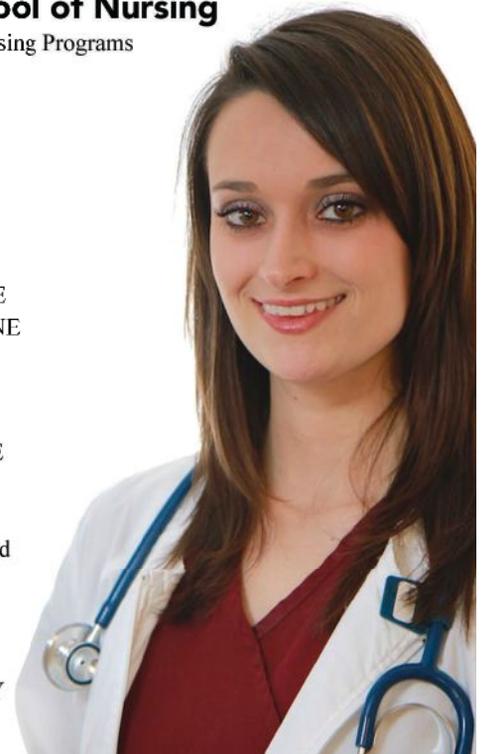
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NOMINATION FORM FOR 2017 ELECTION

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

Instructions

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

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

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

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

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

Guidelines for Nomination

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

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

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

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

RN – At Large LPN

Address of Nominee: _____

Telephone Number: (Home) _____ (Work) _____

E-mail Address: _____

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

TO BE POSTMARKED ON OR BEFORE APRIL 1, 2017

NAME	SIGNATURE	CERTIFICATE NUMBER
_____	_____	_____
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Standard presentations offered are as follows:

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

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

ONLINE BULLETIN ARTICLES

- **What Could Happen: The consequences of "practice drift"...Is It Worth the Risk?** (1.5) No fee.
- **Development of Sanctioning Guidelines for Public Discipline in Nursing Regulation: The North Carolina Board of Nursing Journey** (1 CH) No fee.
- **Who's Your Supervisor or Manager? Nursing Practice: The Management and Supervision of Nursing Services** (1 CH) No fee.
- **Getting to Know your Licensing Board: the North Carolina Board of Nursing at a Glance** (1 CH) No fee.

More offerings on www.ncbon.com

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

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Session Dates

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

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

WEBCASTS

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

PODCASTS

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

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