MAINTAINING PROFESSIONAL BOUNDARIES IN NURSING

– page 6

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The North Carolina Board of Nursing has a record of leadership throughout the country. To maintain that legacy, we begin the New Year with a revised Mission, Vision and Values statement, a new four-year Strategic Plan and the enhanced Nurse Licensure Compact.

The full Board went through an extensive Strategic Planning process in 2017, to prepare the 2018 – 2021 Strategic Plan. Our work began in January 2017 and concluded at the January 2018 Board meeting where the full board voted on and approved the Strategic Plan that you see on pg. 22. As in years past, we solicited input from stakeholders on issues that may impact future nursing practice and regulation.

A special welcome to our new board members, Lori Ann Lewis, LPN and Pamela Edwards, RN. It is an exciting time for nurses in North Carolina and I am honored to have been elected by board members to serve in the role as Chair for a second term, in 2018.

Please note that the NCBON is actively looking for nurses to run for the Board in the 2018 election. Look for the nomination form on pg. 29. This year, we have 3 open positions including ADN/Diploma Nurse Educator, Staff Nurse and LPN. I encourage your consideration of this professional opportunity to serve the NCBON.

North Carolina has an extensive and distinguished history of nursing regulation, growth and innovation. In 2018, we look forward to continuing the advancement of nursing in our state with a focus on public protection, an eye for efficiency and a passion for innovation and quality. We are fortunate to have an excellent Board of Nursing in North Carolina.

Sincerely,
Pat Campbell, Public Member
NCBON Chair

Attention Nursing Program Directors and Nursing Faculty

Save the Date—April 9, 2018
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SPEAKER:
The keynote speaker is Carol Durham, EdD, RN, ANEF, FAAN, who will present on the topic of simulation.

Carol Durham is the Professor and Director of Education-Innovation-Simulation Learning Environment at the University of North Carolina at Chapel Hill School of Nursing.
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Introduction
Public protection through the regulation of the practice of nursing is the mission of the North Carolina Board of Nursing (Board). The Board has seen increasing trends regarding complaints associated with boundary violations and sexual misconduct. On June 1, 2017, an updated North Carolina Administrative Code (NCAC) rule that delineates various activities the Board considers a boundary violation went into effect. This legally-mandated Nursing Rule 21 NCAC 36.0217 (a)(23) indicates that “violating boundaries of a professional relationship including but not limited to physical, sexual, emotional, or financial exploitation of the patient or the patient’s family member or caregiver. Financial exploitation includes accepting or soliciting money, gifts, or the equivalent during the professional relationship” (NCAC, n.d.).

Definitions
Professional boundaries are defined by the National Council of State Boards of Nursing (NCSBN) as “the spaces between the nurse’s power and the patient’s vulnerability” (NCSBN, n.d.). Boundary violations can occur when there is uncertainty about the needs of the patient versus the needs of the nurse. Patients and family members are susceptible and you, as the nurse, are in a position of authority (NCSBN, 2014). It is important for the nurse to understand the continuum of professional behavior. No matter how the patient behaves, it is the legal and ethical responsibility of the nurse to maintain a therapeutic relationship. Both under-involvement and over-involvement jeopardize the nurse’s ability to provide safe, quality care. Under-involvement involves neglecting the patient, showing disinterest, and distancing yourself from the patient. Not talking with the patient even though you have entered the room multiple times is an example of under-involvement. Boundary crossing, boundary violations, and sexual misconduct are behaviors indicative of over-involvement (NCSBN, n.d.). Examples will be shared further in the article.

The continuum of professional behavior has no clear lines where the therapeutic relationship ends and

FIGURE 1
A CONTINUUM OF PROFESSIONAL BEHAVIOR

Every nurse-patient relationship can be plotted on the continuum of professional behavior illustrated above.

Outcome:
The purpose of this article is to provide information about various situations in which nurses can potentially risk crossing professional boundaries while providing patient care. A boundary violation is a violation of the Nursing Practice Act. This information will raise awareness of how professional relationships can move towards a boundary violation and why this must be prevented.

FIGURE 1
nursing leaders or your human resource department. It is your responsibility, as the nurse, to identify if the relationship is moving outside of the therapeutic nurse-patient range and take steps to correct it (College of Registered Nurses of British Columbia [CRNBC], n.d.).

Hall (2011) states there are four behaviors which are clearly problematic. These are: undue self-disclosure, secretive behavior, “super nurse” behavior, and special patient treatment. Self-disclosure, when used within the therapeutic relationship, should be limited and used with the intention of assisting the patient in a positive way. The information disclosed should be directly associated with what the patient is experiencing and brief in nature. However, in the majority of cases, self-disclosure is unnecessary. An example of self-disclosure is the nurse telling the patient she was treated for alcoholism in the past. The nurse does this not to cause harm, but with a mistaken belief that it will help the patient.

There should never be secrets between the nurse and the patient. An example of secretive behavior is the nurse texting the patient directly about being late for her assignment in the patient’s home, while not informing the employing agency. This could then potentially progress to the patient and nurse texting about personal topics and later to sexting, including sending photos of a sexual nature. In this situation, the nurse tells the patient their relationship is just between each other and no one can know.

A “super nurse” believes no one can take care of the patient better than him/her. An example of the “super nurse” is the nurse telling the patient she knows how to do his wound care better than the other nurses because she has more experience. She also provides special treatment by bringing him his favorite specialty coffee when she works. If the nurse believes no one can take care of the patient like he/she can or provides special treatment that is not given to other patients, not only is the appropriate therapeutic relationship destroyed but this behavior can impact professional relationships between the patient and other staff. The patient may become anxious believing no other nurse is qualified to provide his care, further promoting the inappropriate relationship.

The Minnesota Board of Nursing (2010) discusses four elements that are often seen in boundary violation situations. These include: role reversal, double bind, indulgence of professional privilege, and again, secrecy. Role reversal is a scenario in which the nurse uses the patient for gratification and satisfaction leaving the patient to take care of the nurse. Double-bind occurs when the patient wants to terminate the relationship but knows this will end receiving help from the nurse. The patient experiences fear of abandonment and feelings of guilt, so they allow the relationship to continue. Indulgence of professional privilege means the nurse takes information received while providing care to a patient and uses it for personal benefit. Lastly, secrecy includes keeping information inappropriately private between the patient and nurse.

Boundary violations and sexual misconduct can result in disciplinary action on the nurse’s license, including suspension of the privilege to practice. It is imperative that the nurse evaluates current nurse-patient relationships and takes the necessary steps to maintain the professional boundary and re-establish that relationship as necessary. It is imperative to avoid developing a ‘friends’ relationship with the patient and their family.

By the nature of care being provided, often on a long-term basis, some areas in which nurses practice are at higher risk for experiencing boundary violations. Some, but not all, of these areas include: private duty, home health, oncology, and correctional nursing. Check with your employer for policies addressing code of conduct.

Boundary Crossing

When a nurse briefly but unintentionally crosses professional lines in an effort to meet a particular need of the patient for a therapeutic purpose, this is considered boundary crossing. This puts the nurse at risk for escalating behaviors towards a boundary violation and, therefore, the nurse should not continue a pattern of boundary crossing (NCSBN, 2014). This may be something as simple as the nurse and the parent of a pediatric client becoming close and the parent asking the nurse to stop by the store to bring the client’s favorite ice cream when she comes to see the client.

Boundary Violation

Boundary Violations occur when there is confusion about the needs of the patient versus the needs of the nurse. Patients
and family members are susceptible and the nurse is in a position of authority (NCSBN, 2014).

Solicitation for Money, Gifts, or Favors/Financial Exploitation

The nurse must not sell anything to the patient or family. The nurse must not buy anything from the patient or family. The patient or family must not be asked to invest in any product or service, as this is financial exploitation. It is important to know your facility policy regarding receipt of gifts as this also creates a risk of being viewed as financial exploitation.

Financial exploitation can range from borrowing money from the patient to the nurse convincing the patient to make her the power of attorney or adding her to the patient’s will. Nurses should not share financial needs with the patient. Even if the patient or family members offer financial assistance, it cannot be accepted.

Fowler (2015) shares in the American Nurses Association (ANA) Code of Ethics, that the giving or accepting of gifts or favors is not appropriate. It is important to follow facility policy. The value of the gift along with the intent, cultural factors, nature, and timing should be considered. If uncertain, leadership should be consulted.

Social Media/Texting

Use of social media creates risk of boundary violations as well as breaches of patient confidentiality. The nurse does not have to be at work for this to occur. A common inappropriate behavior is sending messages or photos to a patient, family member, or a caregiver via social media or text.

It is the position of the International Nurse Regulator Collaborative (INRC) that the nurse not accept a “friend” request from patients on personal social media accounts. If the nurse engages in social media as a means to interact with patients, it is important to have a separate professional social media account from the personal one (INRC, n.d.).

Sexual Misconduct

Sexual misconduct is defined as “engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual; any verbal behavior that is seductive or sexually demeaning to a patient; or engaging in sexual exploitation of a patient or former patient (NCSBN, 2009, p.4).” Evans (2010) adds that the behaviors can be in the presence of a patient, not just with a patient. The author indicates sexual misconduct can include “using professional power, influence, or special knowledge to obtain sexual gratification from a patient” (Evans, p. 53).

The Council for Healthcare Regulatory Excellence (2008) discusses some of the consequences for when sexual boundaries are breached with a patient. The patient can experience significant and long lasting harm. The trust between the patient and health care professional is damaged. As a result, the patient’s decisions about seeking help from healthcare providers may be negatively affected. This can lead to serious outcomes for the patient’s mental and physical health.

Scenarios

Let’s examine some scenarios in which nurses unintentionally and intentionally violate boundaries.

Scenario # 1

The nurse is caring for a patient with newly diagnosed diabetes on a medical-surgical unit. The nurse has diabetes also and tells the patient and his family about her history and treatment, including suggestions about what medications may benefit the patient.

This is an example of boundary crossing. Speaking in general terms about the diagnosis for the patient’s benefit is acceptable. However, providing a detailed overview of the nurse’s personal experience with diabetes and suggesting medications is not acceptable, as every patient’s needs can be different. The nurse may perceive she is being helpful but this does not justify oversharing. Continuing to cross the boundary of the relationship can easily result in a boundary violation.

Scenario # 2

The nurse accepts an assignment to provide care for a pediatric patient in the home. She quickly realizes she previously dated the father of the patient, but does not tell her agency. The nurse shares with the patient’s family that her spouse lost his job and she is having trouble paying the house mortgage. The patient’s mother begins to give the nurse gas money monthly and later wants to terminate the relationship because she cannot afford to continue to give the nurse money. However, the mother feels her daughter might not get the care she needs if she discontinues this financial assistance of the nurse.

This is a boundary violation. It is an example of role reversal because the patient’s family is taking care of the nurse as a result of the nurse’s undue self-disclosure. The nurse should not have accepted money directly from the client’s mother. Since the nurse had a prior relationship with the patient’s father, this nurse should have recognized this as a conflict of interest and made her employer aware. The nurse should have discussed the situation with her supervisor and declined to take this assignment once she realized the identity of the client’s father. In addition, this is a double bind. The mother does not
want to continue with the nurse, but is concerned about her daughter’s care.

Scenario #3

The nurse in an oncology clinic always asks to take care of a particular patient because she feels she has the most experience administering his type of treatment and feels no other nurse in the clinic is qualified to provide his care. While receiving daily outpatient chemotherapy treatments for a few weeks, the patient asks the nurse out on a date. The nurse accepts, becomes involved in a sexual relationship with the patient, and accepts an offer of marriage. This is sexual misconduct. The patient is in a vulnerable state and can construe the nurse’s caring attitude as something more. The National Council for Healthcare Regulatory Excellence (2008) indicates it is not uncommon for patients to begin to experience feelings for the nurse and sometimes this is expressed to the nurse in words or behaviors. It is always the legal and ethical responsibility of the nurse to maintain professional boundaries and to speak to leadership about changing assignments when signs of boundary drift first occur. This is also an example of “super nurse” behavior which often leads the patient to believe the other nurses are not qualified to provide his care.

Scenario #4

The nurse accepts a friend request on social media from the mother of a premature infant to whom the nurse is providing care for in the NICU on a regular basis. The nurse too had a premature infant a few months prior. The nurse and the mother exchange photos of their babies. The nurse also sees in the patient’s medical record the father owns a car dealership. She asks the mother to see if the father will give her a significant discount on a used car for her daughter. This is a boundary violation. The lines between the professional relationship and friendship have become blurred through the use of social media. The nurse has also indulged professional privilege by using information obtained from the patient’s chart for personal gain.

Scenario #5

The nurse is administering Methadone to a patient who is coming in for daily dosing at the clinic. The nurse gives the patient her phone number and says he can call if he needs any words of encouragement to prevent relapse or a ride to his narcotics anonymous meetings. They begin to text each other regularly to discuss his recovery. The nurse asked the patient to not tell anybody as it might impact him receiving his Methadone. This is a boundary violation. The sharing of personal contact information and the offer of personal assistance outside of the work environment is inappropriate. The nurse can no longer be objective regarding the patient’s care once this boundary is breached. The patient will likely begin to expect special treatment from the nurse. The nurse is using secrecy as well as creating a double bind in which she is setting the patient up to fear access to his medication should he try to end the relationship. In addition, this nurse’s actions are putting her at high risk for engaging in sexual misconduct if this behavior continues.

Scenario #6

An inmate has been flirting with a nurse during each medication administration telling her she is pretty. The nurse finds herself enjoying the attention and encourages the inmate to request a sick call for his asthma diagnosis so they can be in the clinic together. The nurse and the inmate engage in some inappropriate behaviors, including hugging one another. They begin to speak on the phone on the nurse’s days off work in a sexually explicit manner. The inmate asks the nurse to put money in his spending account which she does on a regular basis. The inmate may be truly attracted to the nurse or may manipulate the nurse intentionally by saying things that are ego building. Regardless of the inmate’s intent, it remains the responsibility of the nurse to maintain a professional, therapeutic relationship. The inmate is still considered vulnerable because the nurse is in the position of power. This is clearly sexual misconduct on the part of the nurse and the financial support of the inmate creates an aggravating circumstance related to the nurse’s violation of the Nursing Practice Act and Rules.

Scenario #7

While working in the Emergency Department, the nurse is assigned to a female patient who is overly friendly and compliments him on his bedside manner. He reads into this that the patient is attracted to him. While completing an EKG on the patient, the nurse intentionally fondles the breasts of the patient. The nurse also takes the patient’s cell phone number from the demographic section of the patient’s medical record and texts her a shirtless selfie. This is an example of sexual misconduct. No matter the patient’s words or actions, it is up to the nurse to maintain the professional boundaries. Physical contact outside the scope of treatment or examination must not occur. The nurse also breached patient confidentiality by obtaining the patient’s cell phone number for personal reasons without a healthcare related need to do so.

Scenario #8

The nurse practitioner develops a close relationship with an elderly patient. The nurse practitioner agrees to be the patient’s power of attorney while continuing to provide care to the patient. The patient’s family members are quite displeased and have concerns regarding the nurse’s intentions.
This is clearly a boundary violation. It is unprofessional conduct for the nurse practitioner to provide care at the same time as acting as the patient’s power of attorney. This is a significant conflict of interest, particularly when the nurse stands to potentially benefit financially. This could result in indulgence of professional privilege and also places the patient in a double-bind situation. The patient could fear that his care may be impacted if he requests for the nurse practitioner to no longer be his power of attorney.

Legal Consequences

Many behaviors related to boundary violations and sexual misconduct can also be reportable for possible criminal charges. Therefore, the nurse’s actions may not only impact the nurse’s license status and privilege to practice, but also result in legal implications.

Termination of the Professional Relationship

While establishing a professional nurse-patient relationship, understanding the necessity of terminating the relationship when patient care is no longer required is critical. Aston (2015) discusses the necessity of teaching nursing students about both establishing the relationship as well as working through the termination phase. If this is not understood, there is a greater risk of unintended boundary violations.

Potter et al (2017) discusses the importance of making the patient aware of when the helping relationship will be ending during the orientation phase of the relationship. The authors indicate the role the nurse plays, as well as the role the patient plays should also be established at this time along with including goal setting prior to the beginning of the working phase. During the termination phase, it is important to prepare the patient when the end of the professional relationship is approaching. Goal achievement should be evaluated along with reflecting back on the relationship. Lastly, the nurse separates from the patient by giving up responsibility for the patient’s care (p. 322).

Cultural Differences

The Council for Healthcare Regulatory Excellence (2008) shares that it is important to be aware that cultural differences can impact what is considered to be appropriate or intimate. Seeking the patient’s permission before touching the patient is essential. It is critical to be knowledgeable and respectful of cultural differences in order to preserve the patient’s dignity and avoid unknowingly violating a patient’s boundaries.

Your Responsibility

As a part of professional reflective practice, it is essential to self-evaluate your interactions and behaviors with all clients. Establishment and maintenance of a therapeutic relationship anchored appropriately in the continuum is an important part of that self-evaluation process regarding your clients. Your actions should always reflect the needs of the patient, not your own needs. Remaining a patient advocate to assure patient safety and quality of care is a primary goal. The ANA’s Code of Ethics for Nurses by Fowler (2015) is a valuable resource to guide the nurse in understanding the ethical obligations of being a nurse as well as practicing in a manner that results in quality patient care.

Strategies

Some examples the College of Registered Nurses of British Columbia website (n.d.) offers as strategies to maintain a therapeutic relationship include the following:

• Clearly share what your role and care limits are with the patient.
• Be aware of vulnerable patients such as those with mental health conditions, substance use or dependency disorders, cognitive impairment, or history of physical or verbal abuse.
• Keep personal and professional relationships separate. If you are in a situation where there are no alternatives than to care for someone you know personally, follow your agency policy. Make sure the patient consents and everyone knows you are working in a professional capacity at that point.
• Avoid interacting with patients on personal social media and use caution with former patients.
• When touching a patient, assure that it is in a manner that is appropriate in nursing practice.
• Do not overshare information about your personal life with the patient or family members, particularly if it is sexual in nature.
• Keep your actions with the patient and family members transparent.
• Be aware of your own emotional response to a patient. It may be necessary to dismiss yourself from providing care if you are unable to maintain objectivity.

It is also important to be aware of the actions of other health care providers and report any boundary violations or sexual misconduct. If you are unsure, speak with a member of leadership or consult with human resources. The behaviors may require a report to the Board as well as law enforcement.

If you, the nurse, are in need of professional assistance, seek it out. It is vitally important you do not use the patient or the patient’s family to meet your own needs.
Additional Education

It is valuable for nurses to receive education beyond nursing school on professional boundaries. Employers should consider providing additional education for staff. Some facilities include information in a Code of Conduct policy. Nurses can also seek out their own education. The National Council for State Boards of Nursing (NCSBN) offers a “Professional Boundaries in Nursing” video as well as an online course. NCSBN also offers a “Social Media Guidelines for Nurses” video. These can be located at https://www.ncsbn.org/professional-boundaries.htm.

The bottom line is: when in doubt, discuss your concerns with management or a human resources representative so that you can avoid crossing the professional boundary line while caring for your patients.

References

9. National Council of State Board of Nursing. (2014). Professional boundaries a nurse’s guide to the importance of appropriate professional boundaries

**EARN CE CREDIT**
Maintaining Professional Boundaries in Nursing (1 CH)

**INSTRUCTIONS**
Read the article and 21 North Carolina Administrative Code 36.0217(c) regarding investigations and disciplinary hearings. It is located at http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0217.pdf

**Situations for Reflection**
1. What would you do if you were working in a patient’s home and were asked to run errands for the family because their car did not work?
2. How would you handle if a patient asked for your cell phone number to text you if he/she has any questions about care after discharge?
3. What would you do if a patient offers to give you money to pet sit while he/she is in hospice care?
4. How would you approach the situation if an inmate you are caring for keeps engaging you in personal conversation and flatters you with daily compliments?
5. You start to grow particularly attached to a patient you are caring for daily who reminds you of your grandfather. You find yourself feeling strongly that no one else is as qualified as you to care for him. What are your next steps?

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

**RECEIVE CONTACT HOUR CERTIFICATE**

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

If you experience issues with printing your CE certificate, please email practice@ncbon.com. In the email, please provide your full name and the name of the CE offering (Maintaining Professional Boundaries in Nursing).

Registration deadline is 7-01-2018.

**PROVIDER ACCREDITATION**
The North Carolina Board of Nursing will award 1.0 contact hour for this continuing nursing education activity.

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

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The following disclosure applies to the NCBON continuing nursing education article entitled “Maintaining Professional Boundaries in Nursing.”

Participants must read the CE article and additional reading(s) listed (if applicable) in order to be awarded CNE contact hours. Verification of participation will be noted by online registration. No financial relationships or commercial support have been disclosed by planners or writers which would influence the planning of learning outcomes and content of the article. There is no endorsement of any product by NCNA or ANCC associated with the article. No article information relates to products governed by the Food and Drug Administration.
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For the past few years, the U.S. has witnessed an alarming increase in reported instances of harm associated with use of drugs and alcohol. As reported in the Fall 2017 Bulletin (Lowery & Privette, 2017) death rates due to intentional or unintentional drug poisonings have increased significantly since 1998. The Centers for Disease Control and Prevention (CDC) reports that “nearly 2 million Americans abused or were dependent on prescription opioids in 2014” (CDC, 2018). Additionally, each day in the United States, there is one fatality every 51 minutes due to an alcohol-impaired driver (CDC, 2018).

It is estimated that 1 in every 10 people is experiencing Substance Use Disorder (SUD) and nurses are not immune to these statistics when it comes to the incidence of SUD (Kunyk, 2015). An individual whose judgment is clouded while using mood or mind-altering substances, including alcohol, may not always exhibit the physical signs and symptoms that we so often associate with impairment. When the individual experiencing SUD is employed in a safety-sensitive position such as nursing, there is concern for the health, safety and well-being of patients as well as the health, safety and well-being of the nurse.

The mission of the North Carolina Board of Nursing is to protect the public through the regulation of nursing practice. This brief article, the second in our series on SUD will focus on the nurse with a SUD. It addresses the regulatory aspects of the licensed nurse with an addictive disease including identification of risk factors and alternatives the nurse may consider, to provide safe nursing care in context of a SUD.

**Risk Factors**

There are many risk factors associated with the development of a SUD. (Darbro & Malliarakis, 2012). Physiologically, science has provided evidence of changes in the addicted individual’s brain. (NIDA 2016). The pleasure-seeking circuit of the brain becomes overstimulated by continued use of the abused substance(s) eventually resulting in the need to use more and more to achieve the same perceived pleasurable result. The addicted brain impacts an individual’s judgment, decision-making and overall performance. Despite these consequences, the impulse to use intensifies and the individual continues to repeat the behavior unless the cycle is disrupted with evidence-based treatment.

Genetics is known to play a role in the development of a SUD. (Gitlow, 2015). An individual is pre-disposed when a first-degree relative has a SUD and it is estimated that as much as 50% of the risk of addiction/dependence is due to genetics (NIDA, 2016).

Psychologically, a mental health disorder especially one that is left untreated such as depression or anxiety, is considered a comorbid condition and is often a contributing factor in the development and progression of SUD. It is when the nurse has poorly developed coping mechanisms and/or may be experiencing a chaotic life that he/she may begin to self-medicate with mood altering substances for relief of their distress.

Other risk factors include the social environment. (Gitlow, 2015). For example, an environment considered to be high-risk is one in which an individual is surrounded by family, friends or neighbors using drugs or alcohol. When the attitude of using drugs or alcohol for recreational purposes is more of a casual attitude than one of concern, this poses higher risks. The age at first use is also a factor, and in general, the younger the age at first use, the higher the risk of developing SUD.

The workplace is considered yet another risky environment for nurses. Few would argue that workplace environments are generally stressful and often chaotic. In most workplaces, nurses have access to controlled substances. A vulnerable nurse may begin down a path of self-medicating to manage stress, depression, anxiety or some other mood disorder. Self-medicating becomes unmanageable resulting in additional risk-taking behavior which poses a concern for the safety of the nurse and those under his/her care. These risk-taking behaviors (Figure 1) escalate as the disease progresses and may include but are not limited to:

- use of alcohol resulting in criminal convictions or impairment on duty
- diversion of drugs for personal use with or without impairment on duty
• falsification of records
• doctor shopping for controlled substances
• use of multiple pharmacies to pick up prescriptions for controlled substances, patterns of early refills
• abuse of their own legitimately prescribed substances
• “borrowing” prescribed controlled substances from others
• use of recreational or prescription drugs obtained through street purchase
• prescription drug forgery

It has been well-publicized that prescriptions for opioids have quadrupled in the US in the past two decades (Lowery & Privette, 2016)(CDC, 2018). Opiate-based medications have been more readily prescribed for the public and for hospitalized patients during this time, contributing in part to the crisis this country is experiencing today. Most nurses reported to the Board with SUD are diagnosed with an opiate dependency. It should be noted that according to the CDC, nearly 2 million Americans abused or were dependent on prescription opiates in 2014 (CDC, 2018).

Alcohol dependency is the second most commonly diagnosed SUD in the population of nurses reported. While not as common, an individual may present symptoms of a SUD and dependence on a non-controlled substance i.e. Diphenhydramine or Promethazine. In this example, even though the substance is non-controlled, the perceived pleasurable effects experienced by the user and the potential for impaired judgment and performance are no different than those abusing a controlled substance or alcohol.

**Alternative to Discipline**

Treatment for a SUD is effective and recovery is possible. Nurses experiencing a SUD are encouraged to proactively seek help before they violate the Nursing Practice Act (NPA). However, when the SUD is manifested in the workplace, the employer is required by law [§ 90-171.47] to report suspected misconduct to the Board. Allegations reported to the Board may or may not directly involve a patient. When a nurse is initially reported to the Board with allegations of a violation of the NPA related to abuse of drugs and/or alcohol, he/she is offered an option to enter a monitoring program. Through the NPA, the Board is granted authority to “establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse…” [§ 90-171.23 (b)(18)]. In NC, nurses have an opportunity to participate in the Alternative Program (“AP”), a structured and comprehensive approach to rehabilitation and recovery and it involves monitoring by the Board for a period of three (3) to five (5) years. The nurse signs a legally binding Non-Disciplinary Consent Order (NDCO) with the Board and agrees to a list of conditions including but not limited to receiving treatment, continuing care and random drug screens all monitored by a Board Staff Regulatory Compliance Coordinator assigned to work with the nurse for the duration of the monitoring period.

At the time the nurse accepts the NDCO for participation in the AP, he/she must cease practice for a minimum period of three (3) to four (4) months and until they have received treatment and an evaluation by a physician specializing in addictions medicine. The addictionologist must deem the nurse sufficiently stable in recovery and fit to re-enter practice. Upon approval to return to practice, the nurse is required to share a copy of the NDCO with the prospective employer prior to the first day of new employment or return to employment.

With knowledge of the stress of the healthcare environment and knowledge that the healthcare environment may be a trigger for relapse and return to old behaviors, the AP provides a graduated
re-entry into full, unrestricted practice. Known high-risk areas i.e. Emergency Department, ICU and Home Health are precluded from options for employment in the first year following return to practice. Further, the nurse is restricted from directly handling or having any accountability for processing any controlled substances for the first year of employment following approval to return to practice. The nurse in recovery is supported by the presence of a worksite monitor who has knowledge of the NDCO and restrictions on practice. Gradually, over the course of participation in the AP, all conditions are removed and the nurse may return to full, unrestricted practice. Nurses are held accountable for complying with the conditions articulated in the NDCO and upon successful completion of the AP, there is no evidence of any discipline action by the Board.

Summary

Just as one would manage a chronic medical condition such as diabetes or hypertension, the nurse must recognize the diagnosis of a substance use disorder as a chronic health condition and make their recovery a life-long commitment. While nurses are no longer required to submit to drug screens and no longer monitored by the Board after successful completion of the AP, they are encouraged to continue to remain active in the recovery community and to avoid environments and individuals which may pose a risk to their recovery.

The following published resources are available for nurses and nurse leaders seeking additional information on SUD and the Board’s Alternative Program:

North Carolina Board of Nursing (NCBON) website: www.ncbon.com
- Discipline & compliance tab: Chemical Dependency Resources.
  — https://www.ncbon.com/discipline-compliance-chemical-dependency-resources-warning-signs
  — https://www.ncbon.com/discipline-compliance-chemical-dependency-resources-suspected-impairment-checklist
- Discipline & Compliance tab: Drug monitoring Programs.

National Council of State Boards of Nursing (NCSBN) website: www.ncsbn.org
• Resources & Tools: Substance Use Disorder in Nursing
  — https://www.ncsbn.org/333.htm

References
The Enhanced Nurse Licensure Compact (eNLC) Updates
Unlocking Access to Nursing Care Across the Nation

A new era of nursing licensure began on January 19, 2018, when the eNLC was implemented by the Interstate Commission of Nurse Licensure Compact Administrators, the eNLC governing body. On the eve of implementation, Colorado and New Mexico also joined the eNLC making them the 28th and 29th states, respectively.

So what does this mean for you?
The eNLC, which is an updated version of the original Nurse Licensure Compact (NLC), allows for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to have one multistate license, with the ability to practice in person or via telehealth in both their home state and other eNLC states. All applicants for a multistate license are required to meet the same licensing requirements, which include federal and state criminal background checks.

On Jan. 19, 2018, nurses with eNLC multistate licenses may begin practicing in the 29 eNLC states, listed below. In original NLC states that have enacted eNLC legislation like North Carolina, a nurse who holds a multistate license on or before July 20, 2017, will be grandfathered into the eNLC and will be able to practice in other eNLC states beginning on the implementation date. You do not need to take any action unless you move to another state. If you do move to another state that is a member of the eNLC, you will need to meet the Uniform Licensure Requirements (ULRs) in order to obtain a multistate license. Likewise, all nurses applying for licensure and declaring North Carolina their home state will need to meet the ULRs. The URLs may be found at https://www.ncsbn.org/eNLC-ULRs_082917.pdf

A nurse residing in a state that is new to the eNLC will be able to practice in other eNLC states contingent upon the board of nursing issuing the nurse a multistate license.

The current states in the eNLC include: Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. Work will continue toward the ultimate goal of having all 50 states in the compact.

Additionally, beginning January 19, 2018, a nurse with a multistate North Carolina license will no longer have multistate privileges in Rhode Island. Also, if you are a North Carolina licensee who was issued a single state license, or if you have any stipulation on your license which limits your practice to North Carolina only, you will not be eligible for a multistate license or multistate licensure privileges.

You must keep in mind that your nursing practice takes place where the patient is located. If the patient is located in another state, you need to be licensed to practice in that state. A multistate license helps to facilitate that, but you must still adhere to the laws and regulations of the state in which you are practicing, whether that be in person or via telehealth. The practice of nursing is not limited to patient care and does include all nursing practice, as defined by state practice laws of the state in which the patient/client is located.

If you need to practice in a state that is not a member of the eNLC, you will need a single-state license, issued from that state regardless of the laws in the state in which you are practicing.

Additional information about the eNLC can be found at https://www.ncsbn.org/enhanced-nlc-implementation.htm or www.nursecompact.com. For the latest information, follow the eNLC on Twitter or Facebook.
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Celebrating the Role of the Foundation for Nursing Excellence in North Carolina’s Journey Toward Excellence in Healthcare

In 2017, the Foundation for Nursing Excellence (FFNE), wrapped up more than 15 years of service aimed at improving the health of our state through enhancing the practice of nursing, and officially closed its doors. During that time the FFNE faced many challenges within the healthcare community to create a more accessible and cost-efficient delivery system as well as a better prepared workforce to provide the highest quality of care to those we serve. The Foundation focused its efforts on nursing workforce development through a variety of initiatives at both the academic preparation and practice levels of our profession to include the following achievements:

1. Developed on-line Nurse Preceptor Training Development modules and simulation tools to support the competence and confidence development of newly licensed nurses entering the nursing workforce.
2. Coordinated the Regionally Increasing Baccalaureate Nurses (RIBN) project which offers an economically feasible BSN educational track through partnerships between community colleges and universities. Detailed information re. RIBN is available at www.ribn.org.
3. Co-led the NC Future of Nursing Action Coalition with NC AARP and the BSN & Higher Degree Taskforce with NC AHEC from 2011-2016. Further information is available at https://campaignforaction.org/state/north-carolina/
4. Convened a Nurse Practitioner Transition to Primary Care Practice initiative to identify key elements needed in a transition to practice program for North Carolina.
5. Convened an LPN-BSN Feasibility Workgroup to assess current pathways for LPNs to transition to RNs as well as determine the need and interest in creating more streamlined pathway(s) for qualified LPNs to progress to a BSN degree. View the full report at http://ribn.org/library/library/other-resources/2016-lpn-bsn-feasibility-report.pdf. Visit www.ffne.org for more information on the projects that we have undertaken in our commitment to improving the health of all North Carolinians.

The FFNE must give credit to the many organizations and individuals across the state who partnered with our organization to create and implement more innovative ways to enhance the education and practice of our current and future nursing workforce. Individuals, from academic program directors and faculty to executive leaders and clinicians within the practice community, gave countless hours of their time and expertise to this work. And none of this work could have occurred without the financial support we received from leading state and national health-related and philanthropic organizations as well as from individuals committed to our Mission and Vision.

Now that the Foundation has completed its more than 15 years of service to North Carolina, our Board and staff want to say to all of our partners and friends… Thanks for your support of FFNE and your commitment to improving the health of those we serve!

Polly Johnson, RN, MSN, FAAN
CEO Retired
North Carolina Nurses Association Awards NCBON Board Member “Nurse Educator of the Year”

*As reported in the 2017 Fall edition of the Tar Heel Nurse*

NCBON Board Member and NCNA Member, Peggy Walters, EdD, MSN, Med, NEA-BC, was awarded the 2017 NCNA Nurse Educator of the Year award. She has worked at Duke Regional Hospital — Watts School of nursing since 1980 and currently oversees the application process for offering baccalaureate nursing degrees and helped develop the nurse manager simulation program, among many other professional accomplishments.

For several years in a row, 96% of Watts graduates have been hired within six months and nearly two-thirds of the graduates from her program are still employed in healthcare after five years. A true testament to the quality of the nurses she has helped prepare!

Walters has served on the NCBON since 2014 and previously served for a term from 1999 – 2001. Peggy brings over 40 years of nursing and nursing education experience to the board, including 2 years as Board Chair.

*Congratulations Peggy Walters!*
North Carolina Board of Nursing
2018 – 2021 Strategic Plan

Vision Statement
Exemplary nursing care for all.

Strategic Initiative #1:
Enhance public protection through the Board’s proactive leadership

• Objective A: Ensure equitable, efficient, and effective regulatory processes.
• Objective B: Achieve legislative change that advances the mission and vision.
• Objective C: Ensure adequate resources to fund programs, services and operations through maintaining a strong financial position.
• Objective D: Increase the visibility and impact of the organization.

Strategic Initiative #2:
Advance best practices in nursing regulation

• Objective A: Conduct and utilize research that expands evidence for regulation.
• Objective B: Facilitate innovations in education and practice.
• Objective C: Ensure current and evolving roles and responsibilities of nursing align with regulation.
• Objective D: Identify and address issues regarding the opioid crisis.

Strategic Initiative #3:
Foster mobility and facilitate access to safe nursing care

• Objective A: Implement the enhanced Nurse Licensure Compact (eNLC).
• Objective B: Facilitate the safe and effective practice of nurses using telehealth and emerging technologies.
• Objective C: Conduct and disseminate a supply and demand workforce study.

Core Values
Professionalism, Accountability, Commitment, Equity

Mission Statement
Protect the public by regulating the practice of nursing.

NORTH CAROLINA BOARD OF NURSING
CALENDAR OF EVENTS

Board Meeting:
May 25, 2018

Administrative Hearings:
May 24, 2018
July 26, 2018

Education/Practice Committee:
March 14, 2018

Hearing Committee:
March 29, 2018
April 26, 2018
June 28, 2018

Licensure Review Panel:
March 15, 2018
April 12, 2018
May 10, 2018
June 14, 2018
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SUMMARY of ACTIVITIES

Administrative Matters:
• Approved 2018–2021 Strategic Plan (pg. 22)

Education Matters

Ratification of Full Approval Status:
• College of Albemarle, Elizabeth City – ADN
• Sampson Community College, Clinton – ADN and LPN

Ratification to Approve the Following Enrollment Expansion:
• Bladen Community College, Duplin — ADN, increase in 20 for a total of 70 students beginning in Spring 2018.
• Cabarrus College of Health Sciences, Concord — ADN, increase in 75 for a total of 250 students beginning in Fall 2018.

Notification of Alternate Scheduling Options:
• Bladen Community College — EMTP to ADN Option
• Lenoir Community College — EMTP to ADN Option
• Surry Community College — LPN to BSN and ADN to BSN RIBN Options
• Winston-Salem State University — LPN to BSN Option

Notification of Program Closing:
• Carteret Community College, Morehead City — LPN, Fall 2017 no students

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The North Carolina Board of Nursing is committed to communicating with the nurses and public of North Carolina. In order to keep you updated and informed about nursing regulation in our state, the NCBON uses a variety of communication tools to reach you, including our website, this magazine, email marketing and just recently we’ve added social media to the mix.

The NCBON joined Facebook in November 2017 and we’re happy to report that over 5,000 people have liked and followed our page to remain engaged with nursing in our state. We routinely post updates about the new enhanced Nurse Licensure Compact (eNLC), regulation affecting your license, license renewal reminders, updates on Board Meetings, office closures, nursing in the news and much more!

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An NCBOON education & practice consultant is available to provide educational presentations upon request from agencies or organizations. To request an education & practice consultant to speak at your facility or via webinar, please complete the Presentation Request Form online (https://generic/az1.qualtrics.com/jfe/form/SV_19Mmb2bv8ILkFy) and submit it per form instructions. The NCBOON will contact you to arrange a presentation. A minimum of 30 participants are required for presentations.

Standard presentations offered are as follows:

- **Continuing Competence (1 CH)** — 1 hour — Presentation is for 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 webinar.

- **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 webinar.

- **Nursing Regulation in NC (1 CH)** — 1 hour — Describes Board authority, composition, vision, function, activities, strategic initiatives, and resources.

- **Introduction to Just Culture and NCBOON 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 NCBOON CET, consultation with NCBOON about practice errors, and mandatory reporting. Suggested for audience NOT familiar with Just Culture.

- **Introduction to the NCBOON 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 NCBOON about practice errors, and mandatory reporting. Suggested for audience already familiar with Just Culture.

**ONLINE BULLETIN ARTICLES**

- **Maintaining Professional Boundaries in Nursing (1.0 CH).** No fee.
- **What Nurses Need to Know about Informatics, Social Media, and Security (1.9 CHs).** No fee.
- **Regulatory Intelligence: A Necessary Competency for Advanced Practice Nurses (2 CHs).** No fee.
- **What Could Happen: The consequences of “practice drift”… Is It Worth the Risk? (1.5 CHs).** No fee.

More offerings on www.ncbon.com

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

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November 7, 2018

$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 NCBOON 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/1/news-resources-podcasts (No CH provided)
Although we just completed a successful Board of Nursing election, we are already getting ready for our next election. In 2018, the Board will have three openings: Nurse Educator: ADN/Diploma, Staff Nurse, LPN. This form is for you to tear out and use. This nomination form must be completed on or before April 1, 2018. 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, Executive Assistant, 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, 2018.

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, 2018, for the nominee to be considered for candidacy. Petitions received before the April 1, 2018, deadline will be processed on receipt.
9. Elections will be held between July 1 and August 15, 2018. Those elected will begin their terms of office in January 2019.

Please complete and return nomination forms to 2018 Board Election, North Carolina Board of Nursing, P.O. Box 2129, Raleigh NC 27602-2129.
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- Shared decision-making structure
- Tuition & specialty certification reimbursement
- On-site bachelor’s and master’s degree programs
- Continuing education and career advancement opportunities

At WakeMed, we put patients first in all we do. If you have a passion for providing exceptional patient care, we want to hear from you.

Learn more at www.wakemed.org/experiencednurses
Opportunities for a Lifetime

LIFE AS A DUKE NURSE IS EXHILARATING.

Our nurses have unparalleled opportunities to grow and develop throughout their careers, with residency, mentoring and precepting programs, a robust clinical ladder, and a supportive environment for lifelong learning and academic progression.

Duke Nurses take pride in raising the standards of nursing excellence through research and performance improvement projects. They are valued leaders and members of interprofessional teams focused on fulfilling the Duke Health mission of “Advancing Health Together.”

Duke Nurses experience many intrinsic rewards in their professional practice, and are compensated with competitive pay and valuable benefits, including:

- Pension plan
- Generous paid time off
- Comprehensive health and wellness benefits
- Nursing school loan forgiveness
- Tuition assistance
- Community discounts

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