

# NURSING BULLETIN

documentation PROBLEMS

social networking

IMPAIRMENT on duty

complaints

medication ERRORS



**Uh oh, the Board of Nursing  
called...Complaint Reporting  
and Resolution**

BREACH of confidentiality

DIVERSION



WINTER 2014 BULLETIN  
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4516 Lake Boone Trail  
Raleigh, NC 27607

**Mailing Address**

P.O. Box 2129  
Raleigh, NC 27602

**Telephone**

(919) 782-3211

**Fax**

(919) 781-9461

**Automated Verification**

(919) 881-2272

**Website**

[www.ncbon.com](http://www.ncbon.com)

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**Board Chair**

Dr. Peggy C. Walters, RN

**Executive Director**

Julia L. George, RN, MSN, FRE

**Editor**

David Kalbacker

**Photography**

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NC BOARD OF NURSING  
**NURSING  
BULLETIN**

# Table of CONTENTS

NC

VOLUME 10 { N° 2 } EDITION 29

**10** Uh oh, the Board of Nursing called...  
Complaint Reporting and Resolution



**18** Nomination Form for 2014 Election

**20** 2014 NCBON 11th Annual  
Nursing Education Summit

**22** Requirement vs. Professionalism

**24** PREP\*: A Fresh Look at Remediation

**26** CE Opportunities for 2014

**DEPARTMENTS:**

**4** From the Executive Director

**6** From the Board Chair

**19** Summary of Actions

**30** Classifieds



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Created by Publishing Concepts, Inc.  
David Brown, President • [dbrown@pcipublishing.com](mailto:dbrown@pcipublishing.com)  
**For Advertising info contact**  
Victor Horne • 800.561.4686 ext 114  
[vhorne@pcipublishing.com](mailto:vhorne@pcipublishing.com)

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from the  
Executive Director

## **“NOW IS THE WINTER OF OUR DISCONTENT”— WILLIAM SHAKESPEARE**



The winter of 2014 has brought some “discontent” and challenges with snow days for school children, but it has been far from a winter of discontent for the Board of Nursing. In fact, we are pleased to report in this edition of the Winter Bulletin a year of accomplishments and outreach.

We know from state and national data that the nursing workforce is aging and the population needing nursing care is increasing. Although North Carolina continues to increase our supply of new nurses, the overall supply is not keeping pace. For example, from 2010-2013, new RN licensees increased 13.7%, yet the overall workforce of RNs increased only 8.7%. Newly licensed LPNs increased 6.4%, yet the overall LPN workforce increased only slightly at 1.9%.

Now, more than ever, it is important that ALL licensed nurses practice to the full extent of their legal scope to provide affordable, accessible and safe care. Your Board of Nursing is committed to ensuring that our citizens are afforded the best nursing care possible.

Recently, the Education and Practice Committee of the Board reviewed and revised several position statements related to the role of the nurse in delegation to unlicensed assistive personnel. These revisions should serve to support nurses in practicing to their full scope and providing safe patient care.

In 2013, we moved ALL of our licensure applications online. We launched a new website and a new licensure system that include a “Nurse Gateway” portal for nurses to manage their communication with the Board in one single portal. We investigated 1,415 complaints and continue to have the shortest cycle time in the country for resolution of complaints.

In 2013, we presented 49 workshops related to nursing regulation throughout the state. Through our Bulletin, we provided three (3) free continuing education articles for professional development and continuing competence. We are particularly proud to have published a book on the history of our Board.

North Carolina has a long and distinguished history of nursing regulation, growth and innovation. We don't believe in having a winter of “discontent”. We always push forward with a focus on public protection, an eye on efficiency and a passion for innovation and quality.

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







from the Board Chair

## HISTORY HAS ARRIVED

"First in Nursing, A Journey of Regulatory Excellence: The North Carolina Board of Nursing 1903-2013" traces the history of the Board starting with its origin to today.

Dr. Shirley Toney has authored an outstanding

piece of literary work that will take you back in time, giving glimpses of what nursing was like and how it has evolved in North Carolina. Thank you, Dr. Toney, for your passion, time, and commitment to bring this book to fruition.

The book is full of happenings and describes

leaders, past and present, who have worked tirelessly to protect the public through the regulation of nursing. The timeline takes you through the decades of development and change. Two examples include the description of the 50s as "a period of bold and rapid changes in nursing" (p. 20) and the publication of the first Bulletin from the Board in 1959 that was titled the "News Bulletin" (p. 21).

Each chapter has information that holds the interest of the reader, whether it is the student, novice nurse, experienced nurse or those who have retired. The photos and documents

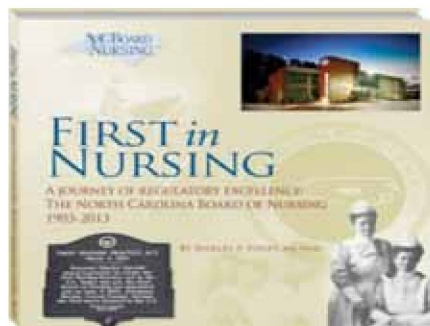
featured in the book bring out its rich history and lets some readers take a walk back in time remembering what our first nursing license looked like and whose name was on the signature line.

The book is more than history. The last chapters reflect what nursing in North Carolina looks like today. The graphs and charts are quick references to the demographics of the 140,241 currently licensed nurses and the 112,523 currently employed nurses in North Carolina. New roles, specialties and diversities are shared through the passing of time to reflect the current nurse in North Carolina.

By being the first to establish a Board of Nursing, the first to require licensure, the first to have a Nursing Practice Act, the first and only state to elect its members, and the first to give nurse practitioners the authority to prescribe medicines (p. 4.); North Carolina was and still is a leader in protecting the public - OUR MISSION.

It is a book that will serve nurses in North Carolina for years to come.

Enjoying History,  
Dr. Peggy Walters, RN  
Chair







# FIRST IN NURSING

A JOURNEY OF REGULATORY EXCELLENCE:

THE NORTH CAROLINA BOARD OF NURSING 1903-2013

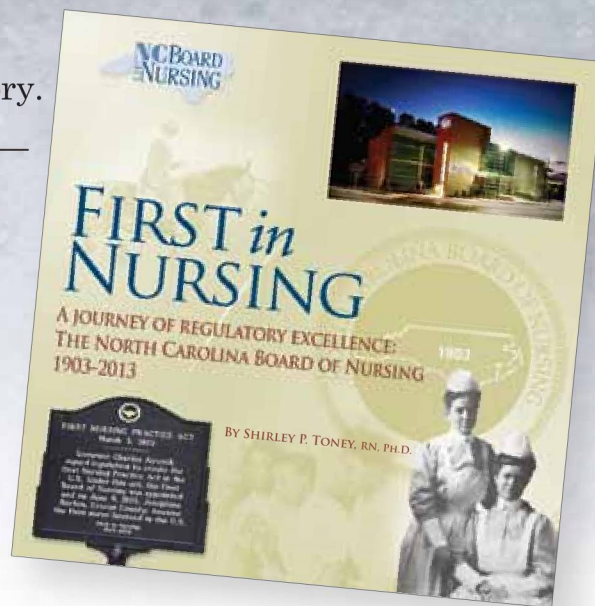


The NC Board of Nursing is proud of its history. Currently, licensing more than 145,000 nurses — providing care to the citizens of North Carolina.

*First in Nursing* is the history of America's original Board of Nursing — The North Carolina Board of Nursing from 1903 to 2013.

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# UH OH, THE BOARD OF NURSING CALLED... COMPLAINT REPORTING AND RESOLUTION



## Objective

The purpose of the article is to provide information about commonly reported issues which result in findings of violations of the Nursing Practice Act. This understanding will enhance the nurse's knowledge and facilitate safe practice.

## Introduction

The mission of the North Carolina Board of Nursing is to protect the public by regulating the practice of nursing. One aspect of public protection is the investigation of complaints involving licensed nurses. The Board receives complaints from either employers or members of the public, which may include coworkers, law enforcement agencies, other regulatory agencies, and self-reported occurrences. The allegations most commonly reported to the Board are discussed in this article, with the goal that licensed nurses will expand their knowledge concerning nursing regulation and in turn, enhance their practice by recognizing and avoiding potentially risky behaviors. Many nurses may have witnessed or been involved in scenarios similar to those described at some point in their practice.

The laws which govern nursing practice in North Carolina are collectively referred to as the Nursing Practice Act or NPA. The NPA addresses a variety of NC Board of Nursing (Board) duties and responsibilities including approval of nursing education programs, nursing licensure, licensure endorsement from other states, components of practice for

both the RN and LPN, Board composition, and disciplinary standards. Revisions to the NPA are passed by the NC General Assembly and enacted into law. The North Carolina Administrative Code (NCAC) includes rules which govern nursing practice and provide more specific details than the NPA. When licensed nurses are found violation of the NPA, the applicable laws and rules alleged to have been violated are clearly specified.

## Complaints

North Carolina is a mandatory reporting state. Anyone with reasonable cause to suspect that a violation of the NPA has occurred is required to report the allegations to the Board. While the Board accepts anonymous complaints, the ability to effectively investigate allegations when a complainant cannot be contacted may be impeded and the complainant does not receive feedback concerning the outcome of the case.

The majority of the complaints filed with the Board come from employers. Upon receipt of a complaint, the information is first reviewed to ensure that the Board has jurisdiction over the matter. In cases where the Board does not have jurisdiction, no action will be possible. Such a complaint may be referred to another agency if appropriate.

## Complaint Trends

A review of complaint data between 2010 and the first half of 2013 reveals that practice-related incidents represented the largest percentage of reported violations to the Board, followed by conduct issues and drug-related violations. For complaints received during 2010, just under half involved practice violations, primarily documentation errors and scope of practice issues. The data show similar results between 2011 and the first six months of 2013, with one

exception: treatment and medication errors and scope of practice issues were reported more than documentation errors in 2011. Documentation errors include both the failure to document appropriate information and deliberate false entries. Drug-related violations include driving while impaired (DWI), drug diversion, positive drug screens, and impairment while on duty. Conduct issues include those behaviors where the licensed nurse has made choices that contributed to the error or violation, such as criminal charges, theft, fraud, and inappropriate verbal or physical interaction with a patient. The Board participates in the National Council of State Boards of Nursing (NCSBN) Taxonomy of Error, Root Cause Analysis and Practice Responsibility Project referred to as TERCAP. The purpose of TERCAP is to identify factors which lead to or contribute to practice breakdown. North Carolina is one of 22 states participating in this project (NCBON Nursing Bulletin, Winter 2012). Data submitted by the NC Board since early 2011, shows that the majority of nurses reported for practice violations were employed in the setting where the practice breakdown occurred fewer than two years. Over one-half of the nurses had been previously disciplined by their employer for a practice issue. Consistent with national statistics, the most significant factor identified in NC practice breakdown was professional responsibility/patient advocacy. Sixty percent of nurses reported from all participating states had been previously disciplined by an employer or terminated and in 55% of the cases involving practice breakdown, the nurse had been employed in the setting less than two years. (Zhong and Thomas, 2012). Over one third of the NC practice cases reported since 2011 resulted in disciplinary action against the nurse.



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### **North Carolina Board of Nursing Complaint Evaluation Tool**

In 2008, the NCBON Complaint Evaluation Tool (CET) was developed to assist employers in determining which incidents should be reported to the Board. The CET is based on the Just Culture model, used as a methodology in assessing errors (Burhans, Chastain & George, 2012). In a Just Culture, the behavioral choices of the individual and level of risk are emphasized rather than the outcome of the error (Burhans, Chastain & George, 2012). The goal of the Just Culture model is to improve patient safety by establishing a system of shared accountability between

the individual and the system. The CET is scored based on five criteria: prior counseling or warnings for practice issues; knowledge level and experience; adherence to facility policies; standards or orders; conscious choice or decision making; and level of accountability.

The Just Culture premise is that everyone makes mistakes at some point, ranging from accidental errors, to at risk shortcuts, to reckless behavior. With the use of the CET, many factors including the identification of any system issues, are taken into consideration, rather than merely blaming the nurse who may have committed the error. A nurse's decision

making and choices are assessed as part of the investigation. The Board expects that nurse managers and leaders will utilize the CET to assist them in evaluating events and in making decisions about reporting to the Board. Conduct events such as theft, fraud, drug diversion, impairment on duty, sexual misconduct, physical/mental impairment, and confidentiality and boundary violations MUST be reported to the Board. Thus, the CET is not appropriate for use in assessing these types of incidents. During an investigation, Board staff also use the CET to evaluate the reported event. The Board's website ([www.ncbon.com](http://www.ncbon.com)) provides CET resources for the employer determining the

need to report.

### Investigations

If the Board complaint reviewer determines that the reported allegations, if proven true, would constitute a violation of the NPA, the case is opened and assigned to a staff member for investigation. In almost all cases, the licensed nurse is contacted during the investigation and offered an interview opportunity to respond to the allegations. The employer is contacted to verify reported information and to obtain additional information or supporting documentation as needed. Depending on the length of tenure at the place of employment, a former employer may also be contacted to determine if there has been a pattern of similar concerns. In certain cases, witness accounts are important and witnesses are interviewed by Board staff.

The timeframe for case investigation and resolution depends upon the allegation(s), how many interviews are conducted, how much evidence is collected and reviewed, and the responsiveness of involved parties to

Board staff contacts and requests. An investigation can take as little as a week or as long as several months. If the alleged violation poses a potential risk or threat to the public during this period, the license is flagged on the Board's website to alert prospective employers of the investigation.

### Commonly Reported Practice Allegations

Common allegations fall into the categories of practice, conduct, and criminal convictions. Some of the practice allegations most frequently reported to the Board include:

- abandonment
- neglect
- documentation issues
- inappropriate delegation or supervision
- exceeding scope of practice
- unsafe practice/failure to maintain minimum standards
- withholding crucial information

### Abandonment

*Joanne, a home care nurse, is assigned to a pediatric private duty case and decides to leave the patient's home to run a quick errand*

*while the patient is asleep. The patient's parent, who works from home, is in the home but unaware that the nurse has left. The nurse informed the patient's teenage sibling that she was leaving, but not the parent. This would be considered abandonment as the teenage sibling was not a caregiver for the child and the nurse did not arrange for the continuation of care for the patient.*

Abandonment complaints are more commonly reported by long term care facilities and home care agencies than acute care settings. More nurses were reported for abandonment in the initial six months of 2013 than in either 2011 or 2012. Cases of abandonment frequently involve the licensed nurse leaving an assignment early, either with or without an attempt to notify their supervisor, or leaving the assignment temporarily, as in leaving the unit or premises without proper notification. Once a nurse accepts an assignment, there is an obligation to fulfill the duty until another nurse receives report and accepts the assignment. Failure to report to work, failure to accept an assignment, refusal to work overtime, or failure to give proper notice of resignation are not considered examples of abandonment and would be more appropriately dealt with as employment policy infractions. The Board has issued two related Position Statements on Staffing and Patient Safety and Accepting an Assignment, which can be found on the Board's website at [www.ncbon.com](http://www.ncbon.com).

### Neglect

*A patient undergoes a minor outpatient procedure and is transferred to the recovery area for monitoring. John, the assigned nurse, does not adequately monitor the patient's vital signs and pulse oximetry readings. Another nurse observes that the patient's pulse oximetry has dropped dangerously low requiring immediate intervention. Would you consider this as an example of neglect? Yes, the nurse neglected to appropriately monitor, assess, and intervene.*

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When the term neglect is mentioned, a common thought is that a patient has been left alone and uncared for. However, neglect significantly indicates the failure to do something or fulfill a responsibility. Nurses are reported for neglect for incidents such as not administering medications, not performing assessments or interventions such as dressing changes, sleeping on duty, and failure to make home visits in the home health setting. For nurses working in the home setting, failure to make assigned visits and sleeping on duty are the most prevalent allegations of neglect reported to the Board. In the long term care setting, neglect to administer medications is frequently reported. The failure to recognize a change in a patient's condition and respond appropriately is also considered neglect, including the failure to initiate CPR in a patient without a "Do Not Resuscitate" order.

### Documentation Errors

Joyce, a nurse working in a long term care facility, is assigned to the same hall that she has worked for past six months, basically taking care of the same group of patients. Her Saturday evening shift is particularly busy because of short staffing. She decides to sign off all of her meds in the medication administration record during her 4 p.m. rounds in order to save time. She figures that she can always go back and circle a medication if a patient refuses. Would you think of this as a documentation error? Yes, the Board does not consider this practice to be a safe or appropriate documentation practice.

Documentation allegations range from pre-documentation practices, such as documenting at the beginning of a shift or prior to performing the action, up to deliberate falsification of records. Omissions in documentation are also problematic. Since 2011, the Board has received more complaints regarding documentation errors from long term care providers than the acute care setting. The most commonly reported documentation complaints from long term care providers address pre-documentation of

tasks, including medication administration, or errors resulting from the nurse completing documentation only at the end of the shift. The timeliness of entries into the medical record is important and can be a critical component of ensuring continuity of care. During investigation, consideration is given regarding whether the documentation, or lack thereof, resulted in a change or potential change in the client's care or treatment plan. Timely and accurate documentation is an essential aspect of care delivery.

### Delegation

During report, Jeremy, the oncoming day shift nurse, is informed that a patient is experiencing swallowing difficulties and is awaiting evaluation by the physician. The patient requires a Nurse Aide to assist with feeding. Jeremy doesn't alter the assignment based on the information about the patient's swallowing problems. The Nurse Aide feeds the patient as usual and the patient aspirates and develops pneumonia. Should the nurse have altered the plan of care, particularly considering what tasks were delegated to the Nurse Aide? Yes, it was inappropriate for the nurse to delegate assistance with feeding to the Nurse Aide without further evaluation of the patient.

Delegation allegations involve licensed nurses delegating to unlicensed assistive personnel (UAP). The RN and LPN are ultimately accountable for both the decision to delegate and the supervision of delegated tasks in accordance with their legally designated scope of practice. On its website at [www.ncbon.com](http://www.ncbon.com), the Board provides a Decision Tree for Delegation to UAP to aid nurses in delegation and decision making. All delegation requirements specified in the decision tree are derived from the NPA and NCAC and must be met before tasks are delegated to UAP (including Nurse Aides I and II). In addition, the five criteria of appropriate delegation include: right task, right person, right circumstances, right directions and communications, and right supervision and evaluation.

### Scope of Practice

Justine is the nurse assigned to a patient exhibiting signs of anxiety and agitation. The patient had a physician's order for Ativan 1 mg IV every six hours as needed, which replaced a previous order for Ativan 2 mg. Justine administers 2mg because she thought the 1 mg dose would not be as effective. She did not contact the physician and receive a new order for the 2 mg dose. Did this nurse exceed her scope of practice? Yes, this would be an example of exceeding one's scope of practice.

Matters involving scope of practice allegations typically arise when a nurse administers a medication that was not ordered; administers a different dose than what was ordered; or when a treatment or intervention is implemented or withheld without a physician's order. Additionally, nurses may be reported for practicing outside their scope when they perform activities, skills, or treatments that are not approved by their facility, approved only in certain settings, or approved only for nurses with specific qualifications. Scope of practice for RNs and LPNs is defined in the NPA and NCAC. For example, scope of practice violations for LPNs often include serving in a nursing managerial role, supervising RNs, or assuming responsibility for validating clinical staff competency. These responsibilities are beyond the legal LPN scope and are only appropriate for an RN. It is important for licensed nurses to recognize that because their scope of practice is legally defined, employers, physicians, and others cannot ever expand that scope. Scope of practice may, however, be limited by employer policy and procedure.

### Failure to Report

A Nurse Aide reports to Joseph, the nurse, that she is unable to obtain a blood glucose reading from a patient because the patient's sugar is too high. The nurse checks the patient's sugar and cannot obtain a reading either. The nurse administers the patient's scheduled dose of insulin along with sliding scale insulin and





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decides to recheck the patient later in the shift. By the time the nurse reassesses the patient, the patient is confused and is vomiting. The nurse faxes a note to the physician's office so the physician will see it first thing the following morning. Did the nurse appropriately report the abnormal finding? No, as there was no direct communication with the physician regarding the change in patient condition.

Failure to report crucial healthcare information arises as an allegation when a nurse does not report changes in a patient's condition to others with a need to know, such as charge nurse, physician, oncoming shift nurse, or nursing supervisor. The Board investigation explores whether or not the patient's care and treatment were impacted or modified based on the information that was withheld. Simply

leaving a voice mail for a physician or leaving a note on a chart does not in and of itself, meet the nurse's requirement for reporting a change in the patient's condition.

### **Commonly Reported Conduct Allegations**

The conduct allegations most frequently reported to the Board include:

- drug related issues, including DWI charges
- impairment on duty
- theft
- boundary violations
- breach of confidentiality and inappropriate access to patient information

### **Drug Related Issues**

A unit manager identifies that a nurse is administering more hydromorphone than her coworkers and begins further review of the nurse's practice. The manager also finds a high number of cancelled narcotic transactions, unwitnessed wastes, and several examples where the pain assessment indicated the patient was pain free immediately before the nurse administered hydromorphone. These are some examples of behaviors which could be indicative of drug diversion.

Drug diversion is defined as the unauthorized taking of a prescription medication for self or for other use. Allegations involving DWI charges and drug diversion are among the most frequently reported problems reported to the Board of Nursing and drug diversion is typically reported more by hospitals and long term care providers. Criminal charges related to drug or alcohol use can be grounds for action against a nurse's license.

Nurses can also be cited for documentation discrepancies related to controlled substances if their



documentation does not reflect proper handling of controlled substances. Examples include delayed or unwitnessed narcotic wasting, medications pulled but not documented as administered, delayed administration after medication was pulled, and pain assessment documentation does not support that the patient needed the medication.

Impairment on duty may be alleged due to the nurse being under the influence of drugs or alcohol, including medications legitimately prescribed for the nurse. Impairment can also result from a physical or mental condition, illness or disorder, or even fatigue, which renders the nurse unfit for duty.

Allegations of fraudulently obtaining prescriptions and of positive drug screens are also reportable to the Board and can result in disciplinary action. The Board offers programs for nurses with a chemical dependency which allow the nurse to gradually return to work in certain settings with close supervision while being monitored by the Board.

### Boundary Violations

*A pediatric nurse has become emotionally attached to a patient and family undergoing an extended hospitalization period. The nurse begins to purchase little gifts for the patient because she feels sorry for the child. The nurse decides to arrange a play date and bring her children to the hospital to visit the patient because her children are close in age to the patient. Would you consider this an appropriate and professional act? This would be considered a violation of nurse/patient boundaries and would be reportable to the Board.*

Boundary violations range from something as simple as purchasing groceries for a patient up to dating a patient. The professional relationship that a nurse has with a patient becomes strained when the nurse begins to do special things for a particular patient that he or she would not do for other patients. Likewise, the nurse may be the recipient of a favor from the patient or patient's family. When the

nurse begins to volunteer to have extra assignments with a particular patient or make special arrangements to spend more time with a patient, this can be the beginning of a slippery slope destructive to the nurse-patient relationship. If a nurse begins to discuss matters of a more personal nature with a patient that he or she would not want colleagues to know about, this also could signal a boundary concern. Certainly, most nurses are aware that romantic and intimate relationships with a patient are considered unacceptable, but the less egregious situations such as "friending" on social media sites, are often not recognized by nurses as a boundary violation.

### Confidentiality Issues

*A nurse posts a picture on social media of a patient care room and writes about her day with the patient who is dying from colon cancer. The patient's face cannot be seen in the picture, however, other personal items in the room are visible. The nurse has information on the social media site about where she works. A hospital staff member who lives in the patient's neighborhood views the post and realizes that their neighbor might be the colon cancer patient, although it is impossible to confirm. Would this be a confidentiality violation? If you answered yes, you are correct. There is enough information in the picture and on the posting which could allow the patient to be identified.*

Patient confidentiality violations arise when the nurse accesses a patient's medical record information for purposes other than a legitimate need for information to provide care and when information is inappropriately shared. The Board's investigation considers the intent or purpose for the nurse accessing the information, as well as what was done with the information. Appropriate uses of social media have to be taken into consideration as well. Nurses who post seemingly vague information about their patients or work may find themselves being reported to the Board for breaching patient confidentiality. When posting something online or sending

information, including pictures, via text message or email, the nurse should always ask themselves if the information would be appropriate to discuss verbally in the open with people not associated with the direct care of a patient.

### Non-reportable Allegations

Issues beyond the Board's jurisdiction are non-reportable. Nevertheless, the Board occasionally receives questions concerning the following:

- resignation without notice, no call/no show, attendance issues
- rudeness toward patient or staff
- nodding or momentary unintentional falling asleep
- refusal to accept an assignment
- failure to follow facility policy unless there is also a violation of the NPA

These concerns do not constitute a violation of nursing law and rules. They can be most appropriately addressed through employer policies and procedures.

### Case Resolution

Cases are resolved through various means. Some nurses may be ordered to participate in remedial coursework either online or with one-on-one meetings with a Board-approved instructor. This may be appropriate for some documentation errors and for those exceeding scope to a minor degree. In contrast, investigations involving drug diversion and impairment more frequently result in discipline against the license, which may include some level of license suspension. Nurses may have probationary conditions placed on their license for a defined period of time, which allow the nurse to continue in or return to practice while being closely supervised by a registered nurse in a structured environment. Typically a nurse working under probationary conditions would not be allowed to practice in a setting where there is no direct supervision or limited resources, such as home care or on a night shift in a long term care facility.

During the investigation, a nurse's



license to practice is not usually affected. However, in certain situations where there may be some risk to the public, a license is flagged during the investigation to alert future employers that there is a significant matter under investigation by the Board. Whenever the license is flagged for a pending investigation and when discipline is issued, the Board is required to report such information to national databanks, including NURSYS, which is maintained by the National Council of State Boards of Nursing. Once a nurse has received disciplinary action, their licensure status will reflect the history of disciplinary action for an indefinite period of time.

### What Does this Mean for Me?

*How does a nurse protect his or her license to practice and ensure the delivery of safe and competent care?*

Laws and rules vary from state to state. Nurses are legally responsible to not only be familiar with the Nursing Practice Act, Administrative Code Rules, components of practice, position statements, and other state requirements, but also to understand the impact of these on their practice. Particularly when moving into a new state the nurse must seek out resources to ensure that he or she knows and understands the nursing regulations and policies that apply. The NC Board's website has a wealth of resources, including continuing education opportunities for nurses seeking to enhance their knowledge and practice.

Additionally, nurses must be well informed regarding specific protocols and procedures established by their employer. Even when changing departments within a facility, the nurse is responsible to know and understand the changes applicable in the new practice setting. A facility may choose to restrict a nurse's scope of practice by not allowing the nurse to perform certain tasks, even

when those tasks would be allowed by the Nursing Practice Act. An employer, physician, or other professional may not ever, however, expand a nurse's scope of practice.

So, to avoid that telephone call from the Board, practice your profession in a thoughtful, safe manner. If in doubt about any component of practice or employer expectation, seek resources and ask questions to clarify your appropriate legal scope and responsibilities. But, if that call comes from the Board, respond immediately and follow up timely with requests for information and documentation. Board staff will inform you about the process and about your rights and responsibilities during an investigation.

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**Registration deadline is February 1, 2016**

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Board Chair



Cheryl Duke



Sarah Griffith



Deborah Herring



Takela Jeffries



Jennifer Kaylor



Bobby Lowery



Sharon Moore



Robert Newsom



Martha Ann Harrell  
Board Vice-Chair



Jacqueline Ring



Carol Wilson

# 2014 NC BOARD OF NURSING

# NOMINATION FORM FOR 2014 ELECTION

Although we just completed a successful Board of Nursing election, we are already getting ready for our next election. In 2014, the Board will have three openings; one ADN/Diploma Nurse Educator, one Staff Nurse and one LPN. This form is for you to tear out and use. This nomination form must be completed on or before April 1, 2014. 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](http://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](mailto: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, 2014.

### 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. (The certificate number appears on the upper right-hand corner of the license.)
- 4. Names and certificate numbers (for each petitioner) must be legible and accurate.
- 5. Each petition shall be verified with the records of the Board to validate that each nominee and petitioner holds appropriate North Carolina licensure.
- 6. If the license of the nominee is not current, the petition shall be declared invalid.
- 7. If the license of any petitioner listed on the nomination form is not current, and that finding decreases the number of petitioners to fewer than ten, the petition shall be declared invalid.
- 8. The envelope containing the petition must be postmarked on or before April 1, 2014, for the nominee to be considered for candidacy. Petitions received before the April 1, 2014, deadline will be processed on receipt.
- 9. Elections will be held between July 1 and August 15, 2014. Those elected will begin their terms of office in January 2015.

*Please complete and return nomination forms to 2014 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 2014

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):

- ☐ ADN/Diploma Nurse Educator      ☐ Staff Nurse      ☐ License Practical Nurse

Address of Nominee: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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

TO BE POSTMARKED ON OR BEFORE APRIL 1, 2014

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

Please complete and return nomination forms to 2014 Board Election, North Carolina Board of Nursing, P.O. Box 2129, Raleigh, NC 27602-2129.



# 2014 NCBON 11th Annual Nursing Education Summit

## April 7, 2014

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

**Presenters and topics include:**

Nancy Spector, PhD, RN  
NCSBN Director, Regulatory Innovations  
Quality and Safety Education for Nurses (QSEN) from a  
Regulatory Perspective

Carol Fowler Durham, EdD, RN, ANEF  
Clinical Assoc. Professor and Director of the Clinical  
Education and Resource Center

UNC-Chapel Hill  
Using Simulation-Based Education to Make Patient  
Safety Connections

Lourdes Lorenz, RN, MSN, NEA-BC, AHN-BC  
Director of Integrative Healthcare  
Memorial Mission Hospital System-Asheville  
Self-Care for Nurses

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



# SUMMARY of ACTIVITIES

## ADMINISTRATIVE MATTERS

- Approved 2014 Strategic Plan Roadmap
- Approved proposed amendments to 21 NCAC 36. 0228 Clinical Nurse Specialist Practice. The Clinical Nurse Specialist (CNS) role has not been regulated in North Carolina. Currently, individuals may seek recognition voluntarily. The proposed rule change will require nurses who practice at the Advanced Practice Registered Nurse (APRN) level in the CNS role to meet standardized qualifications consistent with the National Council State Boards of Nursing (NCSBN) Consensus Model for APRN Regulation.

A Public Hearing on the proposed changes will be scheduled in May. 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.

## INVESTIGATION AND MONITORING ACTIONS

Received reports and Granted Absolutions to 3 RNs and 0 LPN.

Removed probation from the license of 25 RNs and 3 LPNs.

Accepted the Voluntary Surrender from 2 RNs and 0 LPNs.

Suspended the license of 5 RNs and 2 LPNs.

Reinstated the license of 18 RNs and 4 LPN.

Number of Participants in the Alternative Program for Chemical Dependency: 158 RNs and 7 LPNs (Total = 165)

Number of Participants in the Chemical Dependency Program (CDDP):

96 RNs, 10 LPNs (Total = 106)

Number of Participants in Illicit Drug and Alcohol/ Intervention Program:

23 RNs, 1 RN compact, 8 LPNs. (Total = 32)

## EDUCATION MATTERS:

Summary of Actions related to Education Programs

Ratification of Full Approval Status – 5 programs

Determination of Program Approval Status –

Initial Approval – 1 program

ACEN/CCNE Accreditation Decisions – 7 programs



# REQUIREMENT vs. PROFESSIONALISM

There is a legal requirement that an individual that is engaged in the practice of nursing must hold a current, valid license to practice nursing. But why do we have a license? Is it simply to collect money from nurses? No, licensure is the way by which the public can be assured that those individuals engaged in the practice of nursing have met certain educational guidelines; have successfully completed the licensure exam; have passed certain core requirements (CBC, etc.); and that the individual is safe and competent to practice. The license is a quick and easy way for the public to distinguish “the nurse” from other care givers.

But licensure is much more than just a requirement. Maintaining a valid license is also about professionalism. Maintaining a valid license speaks to the pride and accountability that one has about being a nurse. It is about the privilege of ownership we should all have in being called a nurse.

Yet something so important is often neglected. Each year dozens of nurses receive discipline action from the Board because the nurse failed to renew the license in a timely manner. A license is valid for two (2) years and always expires the last day of the licensee’s birth month. Approximately sixty (60) days before the license expires, the nurse is sent a postcard reminding them of the renewal date. Often this is where the first kink in the process occurs.

The postcard is “undeliverable” because the licensee moved and failed to notify the Board of their new address. It is the responsibility of the nurse to keep the Board apprised of address changes. The postcard is a courtesy, but failure to get the card does not absolve the nurse of the responsibility for renewing in a timely fashion.

The postcard also provides additional valuable information. The postcard

lets the nurse know if the nurse will be audited related to continuing competency requirements. The nurse has until midnight, the last day of their birth month, to renew the license. There is NO grace period that allows the nurse to

continue to work in a licensed position after that time.

If the nurse fails to renew by the expiration date, and the nurse continues to work, the nurse may then be subjected to the discipline process of the Board. It



is a violation of the Nursing Practice Act to engage in the practice of nursing without a license (G. S. 90-171.44 {3}). If the nurse fails to renew and continues to work in a licensed position, that might also subject the Chief Nursing Officer (CNO) or their designee to the Board's discipline process for employing an unlicensed person to engage in the practice of nursing (G. S. 90-171.44 {5}).

Discipline action may involve the issuance of a Reprimand; a requirement to take a course; or a denial to reinstate the license. In rare instances, a case may be directed to the Board and the Board makes the decision of disposition on a case-by-case basis.

Go online today! Check to see when you last renewed your license. Make yourself a reminder for your next renewal date. Remember to always notify the Board if you change addresses! Licensure is one of the fundamental pillars for being called a profession. Maintaining a valid license is NOT just a legal requirement, but speaks to the individual and the pride and accountability that is taken by being a member of a time honored profession.



# PREP\*: A Fresh Look at Remediation

“Remediation focuses on quality improvement and is non punitive.” Andrew D. Harding, MS, RN, CEN, NEA-BC, FAHA, FACHE - Mark W. Connolly, JD

Remediation, whether justified or not, often provokes a negative reaction, especially when it pertains to nursing practice. The Free Dictionary’s (2014) definition of remediation is, “the act or process of correcting a fault or deficiency.” While correcting a fault or deficiency is, in and of itself, a positive step, nurses are not easily forgiven for a “fault”, much less a “deficiency”. The Free Dictionary’s The-saurus expands on remediation as, “the act of offering an improvement to replace a mistake; setting right.” The essence of remediation in nursing practice is “setting right.” Perhaps, framed in this manner, even doubters might view remediation in a positive light.

Remediation in nursing is not a new concept; however it is one not widely utilized until recent years. Harding and Connolly (2012) wrote, “There is a difference between incompetence and negligence. Incompetence is not performing at an expected level or not acting effectively. Negligence is the failure to act as a reasonably prudent registered nurse in a given situation. Therefore, it is possible to act incompetently without being negligent, as long as the registered nurse acts in good faith and is not imprudent or reckless” (pg. 49).

“Nurses in management roles are responsible and accountable for providing safe, high-quality patient care and thereby establishing internal nursing practice standards” (Harding & Connolly, 2012, pg. 48). North Carolina is a mandatory reporting state, meaning any suspected violation of the Nursing Practice Act must be reported to the Board of Nursing. This reporting most commonly becomes the responsibility of the nurse manager. However, the Board’s practice remediation program, named PREP, may be an alternative to filing a formal complaint in certain circumstances. To be eligible for a PREP evaluation, the practice deficit

identified must be minor in nature and must not involve conduct or drugs. The nurse’s continued practice must not pose a risk to public safety and the nurse must be motivated to improve his/her practice.

PREP\* (Practitioner Remediation Enhancement Partnership) is a collaborative approach to addressing deficits in practice. Information obtained from the nurse and nurse employer is used to tailor a remediation plan specific to the nurse’s needs. Consideration is given to the nurse’s preferred learning style and his/her level of technical ability. Many types of remediation are utilized, such as: online courses, chart audits, mentoring (if employer has resources), med pass audits, reflective papers, presentations to co-workers (if nurse is willing), and sometimes a Performance Evaluation conducted by the employer in a few months to evaluate improvement. All three parties (nurse, employer and Board) have a vested interest in the nurse’s success.

We are often asked, “When is the best time to make a PREP referral?” Consider PREP:

- If a deficiency is noted during the orientation period
- During performance review when strengths/weaknesses are evaluated
- When the nurse expresses frustration or difficulty with performing skills or demonstrates a knowledge deficit
- When a minor event occurs related to a deficiency in knowledge or skills
- At the time of counseling or written warning related to knowledge or skills deficit

The 2013 PREP statistics show that the average participant was a female RN aged 46 to 55, who exceeded scope of practice or had minor documentation errors. The good news is that the majority of those nurses referred to PREP remained employed. In the past, many employers chose to terminate rather than retain nurses and invest in their future.

The 2012 PREP statistics show that for all prior years, only 0.4% of past participants were reported with a subsequent confirmed violation of the Nursing Practice Act of the same nature. The success of PREP is attributed, in part, to the collaborative effort that takes place, creating a lasting relationship of open communication and trust.

Further questions about PREP?  
Pamela Trantham, PREP Coordinator  
Pamela@ncbon.com

## Additional Board resource for Nurse Managers/Administrators to consider:

**Orientation Session for Administrators of Nursing Services and Mid-Level Nurse Managers (4.6 CHs):** This interactive information session is offered at the Board office quarterly. The functions of the Board of Nursing and how these functions impact the roles of the chief nurse administrator and mid-level nurse manager in all types of nursing service settings are discussed. Practice Regulation Consultants provide tips on conducting an effective investigation and what documents are needed to submit to Board. An overview of the PREP program, as well as the Alternative Program for the Chemically Dependant Nurse is provided. There is \$40.00 fee and lunch is provided. <http://www.ncbon.com/dcp/i/nursing-education-continuing-education-board-sponsored-offerings>

## References:

1. A. Harding & M. Connolly. (2012). Remediation: A Necessary function for employers to correct incompetence regarding clinical professional registered nurse practice. JONA’s Healthcare Law, Ethics and Regulation, 14, (2), pp. 48-52.
2. The Free Dictionary. Remediation. <http://www.thefreedictionary.com/remediation>. Accessed January 21, 2014.



# NCSBN Update

**The NCSBN Board of Directors (BOD)  
voted on Dec. 10, 2013, to raise the  
passing standard for the NCLEX-PN  
Examination beginning April 1, 2014.**



Chicago – The National Council of State Boards of Nursing (NCSBN) Board of Directors (BOD) voted on Dec. 10, 2013, to raise the passing standard for the NCLEX-PN Examination (the National Council Licensure Examination for Practical Nurses). The passing standard will be revised from the current logits\* -0.27 to -0.21 logits beginning April 1, 2014, with the implementation of the 2014 NCLEX-PN Test Plan. The new passing standard will remain in effect through March 31, 2017.

After consideration of all available information, the NCSBN BOD determined that safe and effective entry-level licensed practical/vocational nurse (PN/VN) practice requires a greater level of knowledge, skills, and abilities than was required in 2010 when NCSBN implemented the current standard. The passing standard was increased in response to changes in U.S. health care delivery and nursing practice that have resulted in the greater acuity of clients seen by entry-level PN/VNs.

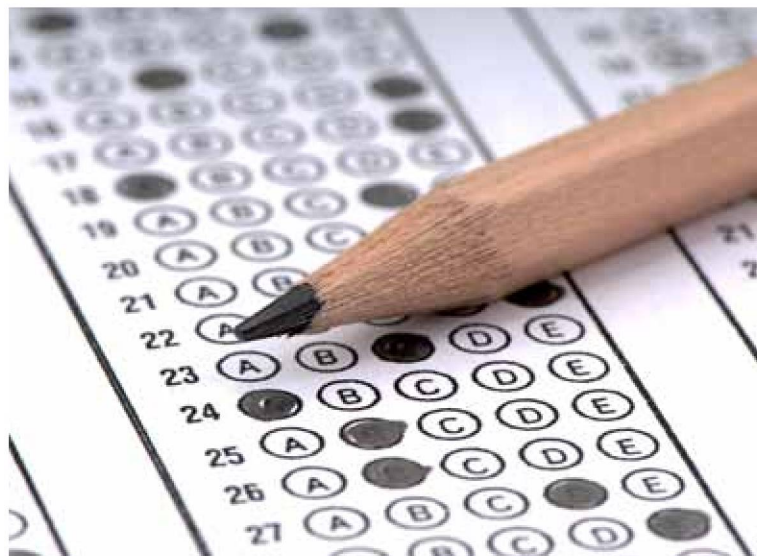
In their evaluation the BOD used multiple sources of information to guide its evaluation and discussion regarding the change in passing standard. These sources include the results from the criterion-referenced standard-setting workshop, a historical record of the NCLEX-PN passing standard and candidate performance, the educational readiness of high school graduates who expressed an interest in nursing, and the results from annual surveys of nursing educators and employers conducted between 2011 and 2013. As part of this process, NCSBN convened an expert panel of 13 subject matter experts to perform a criterion-referenced standard-setting procedure. The panel's findings supported the creation of a higher passing standard. NCSBN also considered the results of national surveys of nursing professionals, including nursing educators, directors of nursing in acute care settings and administrators of long-term care facilities.

In accordance with a motion adopted by the 1989 NCSBN Delegate Assembly, the NCSBN BOD evaluates the passing standard for the NCLEX-PN Examination every three years to

protect the public by ensuring minimal competence for entry-level PNs. NCSBN coordinates the passing standard analysis with the three-year cycle of test plan evaluation. This three-year cycle was developed to keep the test plan and passing standard current. The 2014 NCLEX-PN Test Plan is available free of charge from the NCSBN website.

Media inquiries may be directed to the contact listed above. Technical inquiries about the NCLEX examination may be directed to the NCLEX information line at 1.866.293.9600 or [nclexinfo@ncsbn.org](mailto:nclexinfo@ncsbn.org).

\*A logit is defined as a unit of measurement to report relative differences between candidate ability estimates and item difficulties.





# CE Opportunities 2014



## Online Bulletin Articles

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

**Social Networking and Nurses (1 CH)**  
No fee required

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

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

**Competency Validation: What Does it Mean for You? (.75 CH)**  
No fee required.

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

**Incivility in Nursing (1 CH)**  
No fee required.

More offerings on website

## Webcasts

**Understanding the Scope of Practice and Role of the LPN (1 CH)**  
Provides information clarifying the LPN scope of practice. An important course for RNs, LPNs, and employers of LPNs.  
No fee required.

**LEGAL SCOPE OF PRACTICE (2.3 CHs)**  
Provides information and clarification regarding the legal scope of practice parameters for licensed nurses in North Carolina.

**\$40.00 Fee.**

**Questions:**  
Pamela Trantham  
919-782-3211 ext. 279  
[Pamela@ncbon.com](mailto:Pamela@ncbon.com)

## Orientation Session

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

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

**Session Dates**  
April 9, 2014  
September 17, 2014  
November 6, 2014

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

**Register online at [www.ncbon.com](http://www.ncbon.com).**  
Registration at least two weeks in advance of a scheduled session is required.

Seating is limited. There is usually a waiting list for this workshop. If you are unable to attend and do not have a substitute to go in your place, please inform the NCBON so someone on the waiting list can attend.

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

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

[www.ncbon.com](http://www.ncbon.com) Click on:



to the right of the homepage.

**Questions on Online Bulletin Articles**

**Contact::** Linda Blain  
919-782-3211 ext. 238 [LindaB@ncbon.com](mailto:LindaB@ncbon.com)

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

## PRACTICE CONSULTANT AVAILABLE TO PRESENT AT YOUR FACILITY!

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

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

Standard presentations offered are as follows:

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

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



*Naomi Goldston (right) of Durham, was presented a book by history team member Kay McMullan. Goldston was the oldest holder of a current LPN license in North Carolina when the history book went to press*

## NORTH CAROLINA BOARD of Nursing Calendar

### **BOARD MEETING**

May 29-30, 2014

### **LICENSURE REVIEW PANELS**

April 10, 2014

May 8, 2014

June 12, 2014

### **ADMINISTRATIVE HEARINGS**

May 29, 2014

July 24, 2014

### **EDUCATION/PRACTICE COMMITTEE**

March 19, 2014



# Five N.C. Health Care Trends to Watch for 2014

There are a lot of changes happening all at once in the health care system; sometimes it's difficult to keep up. Last year was a big year because of the rollout of the federal Affordable Care Act, but plenty happened that's unique to North Carolina too. And once the state legislature reconvenes in mid-May for the "short" session (which is supposed to run only until July 1, but can often go much longer), there'll be even more changes happening.

So, here are some of the big topics that will be in play this coming year:

## 1. The state of North Carolina's Medicaid system

Under the federal Affordable Care Act, states were given the option to expand Medicaid to cover more low-income people, specifically those who fall under 135 percent of the federal poverty level. Estimates are that from 360,000 to 500,000 people in North Carolina would have been made eligible for the program.

But the Medicaid budget has been a problem over the past few years, posting multimillion-dollar overruns annually, even as North Carolina's care-delivery program, Community Care of North Carolina, received national kudos for efficiency, reduced cost and improved outcomes. Opinions on the causes of those overruns differ: Was it a forecasting problem? Is Medicaid "out of control" and "broken"? Did lawmakers allocate too little to the annual budget?

Questions aside, the General Assembly chose not to expand Medicaid, claiming that the program needed to be "fixed" before expansion could take place.

Very quickly, Gov. McCrory tasked the state Department of Health and Human Services to study reforms to Medicaid. At the time of publication of

this article, that plan had not been announced; but no matter what the plan is, expect a lot of political wrangling about what North Carolina Medicaid will look like in the future.

## 2. North Carolina's mental health system continues its pattern of constant change.

North Carolina's mental health system is organized into 10 regional agencies which have been tasked by the General Assembly to act like mini-insurance companies (managed care organizations) to coordinate mental health services. They don't provide the mental health care, only coordinate its delivery by private providers. The transition to becoming MCOs took place quickly and by mid-2013, all of the state's mental health management entities were operating as MCOs.

Advocates for people with mental illness and developmental disabilities say the changes have happened too quickly. Lawmakers like MCOs because it means that the state has a set budget for the year, giving legislators some control over finances. But advocates worry that this limitation on funds is an incentive to ration care.

Advocates are also critical of the fact that treatment and management for mental health problems are not coordinated with care for physical health problems – and given that mental and physical health are often closely intertwined, they have a point. Some lawmakers agree, which means the governance and reimbursement for mental health are likely to be tweaked again during the legislative session.

Now, DHHS is asking those MCOs to consolidate down to four regionally-based mental health managed care organiza-

tions, more change in a system that has seen constant change over the past decade.

There's also some great news in mental health: There are some really creative solutions to helping manage the care for people who are acutely mentally ill that are being piloted in the state that could make care much better. Those solutions include initiatives such as critical time intervention, a program that helps people transition out of inpatient care and into their communities more effectively, and new initiatives for managing mental health crises. Those trends are worth watching.

## 3. Continued consolidation in the hospital and health care industry.

The recession has not been kind to North Carolina hospitals, particularly those in rural areas of the state. Even though big hospitals such as Duke and UNC Hospitals look prosperous, officials from the North Carolina Hospital Association will tell you that one in three hospitals in the state runs a deficit and another third just about break even.

On top of long-running financial pressure, state lawmakers' decision not to expand Medicaid means that many folks in poorer communities remain uninsured – but those folks will keep showing up at hospital emergency departments, increasing the financial pressure.

Those factors are driving consolidation, in particular the trend of smaller hospitals to look to affiliate with larger systems, something that will only continue. N.C. Hospital Association officials estimate that only about 20 of North Carolina's 135 hospitals remain unaffiliated.

The trend has positives: Affiliating with a larger hospital system can give



small rural hospitals a measure of financial security and access to specialties such as oncology or cardiology, which have been difficult for smaller hospitals to provide in the past.

On the negative side, people in rural communities mourn the loss of local control. They don't like the big bureaucracies and consolidation has a real potential to raise prices. That loss of local control has led to the closing of one hospital in Hyde County, and people in other communities where money-losing hospitals have affiliated with a large urban system are watching that situation closely.

**4. The role of nurses will continue to evolve and expand.**

As the health care system looks to find more effective and cost-effective solutions to providing care, nurses are emerging as some of the most important care providers. Sections of the Affordable Care Act that emphasize primary care have created opportunities for nurse-led initiatives in prevention and managing chronic conditions. More nurse-led programs and services are emerging that creatively manage care for sometimes difficult-to-serve patients, such as transitional-care protocols to help patients as they are discharged from the hospital to the community, pregnancy counseling for women who have been sexually abused or nurses providing case management in patient-centered medical homes.

The law also opened up opportunities for advanced-practice nurses to bill for their services.

Advanced-practice nurses have also had several pieces of legislation moving through the General Assembly in the past year. At the time of this writing, lawmakers are considering improving the practice environment for certified nurse-midwives. Last year, lawmakers introduced a bill to limit the autonomy of certified registered nurse anesthetists; that bill is still alive in the legislature, but is parked in a committee process.

Nurses are the largest single group of workers in the U.S. health care system, and as former U.S. Health and Human Services Sec. Donna Shalala told North Carolina nurses last year, nurses are approaching a “golden age” in how they practice and collaborate to provide care. But that can only happen if nurses take those opportunities and get creative.









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