Volume 20 • No. 2 May, June, July 2018

MISSOURI State Board of Nursing Newsletter

The Official Publication of the Missouri State Board of Nursing with a quarterly circulation of approximately 129,000 to all RNs and LPNs

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Message from the President

Anne Heyen, DNP, RN, CNE

I was privileged to attend my first National Council of State Boards of Nursing (NCSBN) meeting March 5-7, 2018 in Chicago. The meeting afforded me the opportunity to meet and network with presidents from other state boards of nursing. The NCSBN is a not-for-profit organization whose members include jurisdictional boards of nursing from jurisdictions around the world, including member boards in the 50 states, the District of Columbia and four U.S. territories. The membership also includes 30 associate members. Most recently, the creation of the exam user member category was approved by the 2017 Delegate Assembly. The first exam user members will be eligible to be voted in at the August 2018 Delegate Assembly.

NCSBN is the vehicle through which jurisdictional boards of nursing act and counsel together to provide regulatory excellence for public health, safety and welfare.

The mission of the NCSBN is to provide education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. Their vision is to advance regulatory excellence worldwide.

Their values are:

- *Collaboration*: Forging solutions through respect, diversity, and the collective strength of all stakeholders.
- *Excellence*: Striving to be and do the best.
- *Innovation*: Embracing change as an opportunity to better all organizational endeavors and turning new ideas into action.
- *Integrity*: Doing the right thing for the right reason through honest, informed, open and ethical dialogue.
- *Transparency*: Demonstrating and expecting openness, clear communication, and accountability of processes and outcomes.

NCSBN has a large communications library that you can access at https://www.ncsbn.org/communications-library.htm. There are many resources available free of charge, including brochures and posters on topics such as social media, professional boundaries and substance use disorder. Recently, the NCSBN published a booklet "NCSBN Welcomes you to the Nursing Profession" which is designed as a resource for newly licensed nurses to better understand nursing regulation and boards of nursing. I encourage you to look at the resources that are available to you and utilize them to help expand your knowledge about nursing and nursing regulation.

Executive Director Report

Authored by Lori Scheidt, MBA-HCM

Protect Your License

These practical tips will help you protect your license.

- If you have not already done so, you should enroll yourself in e-Notify by going to www.nursys.com/e-notify and select *"As a Nurse"* to complete the registration process. By enrolling in this free service, you will receive notifications any time your license status changes as well as receive license expiration date reminders. The e-Notify system also allows you to provide information about the nursing workforce in Missouri. The Missouri State Board of Nursing uses this information to gather important workforce data and uses the data to enhance Missouri's ability to plan for nurse supply and demand and ultimately, improve healthcare for all. As a reminder, you and your employer can verify your license at any time at www.nursys.com by clicking on Search Quick Confirm and following the instructions.
- Missouri does not issue a license card. Missouri has joined many other states in eliminating the issuance of license cards due to the fact that they can be forged, altered, misappropriated, can contribute to identity theft, and do not reflect recent disciplinary action. Fraud does not just occur by obtaining financial information or a social security number. It can happen with your nursing license record as well. You should search for your record using Licensure QuickConfirm at www.nursys.com. After you access your record, you can print a report that will show your license number, original issue date, expiration date, whether you have a multistate or single state license and discipline status. Please direct current or future employers to www.nursys.com to verify your license.
- RN licenses expire April 30th of every odd-numbered year. LPN licenses expire May 31st of every even-numbered year. When enrolling yourself in e-Notify, opt into the option to receive automated electronic reminders when you have a license that will be expiring within 30 days.
- Keep the board informed of your current name and address. A notification form can be found at www.pr.mo.gov/nursing. There are several reasons for this.
  - Licenses are suspended by operation of law for not filing or not paying state income taxes. If we do not have your current address, your license could be suspended without you receiving notification.
  - Failure to inform the board of your current address is cause to discipline your nursing license. You are required to inform the board of a change in your name and/or address within 30 days of the change.
  - Missouri is a member of the nurse licensure compact (NLC). This is similar to a driver's license where you are licensed in one state and can practice in other states that are members of the compact without having to obtain another license in that state. You can find an overview of the compact as well as a list of member states at www.ncsbn.org/compacts. The compact regulations also require that you keep your address updated. Whether you have a multistate or single state license depends on your primary state of residence.

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- Practice is where the patient is at the time nursing care is rendered. Know the state's Nursing Practice Act and rules before you practice. You can find the Missouri Nursing Practice Act on our web site. You can find links to other state boards of nursing at www.ncsbn.org

Legislative Session

The 2018 legislative session started January 3, 2018 and will go through May 18, 2018.

Several bills were filed regarding advanced practice registered nurses. Currently, a Missouri Advanced Practice Registered Nurse (APRN) is required to be in a written collaborative practice agreement with a physician. It is through this collaborative practice agreement that the physician delegates authority to administer or dispense drugs and provide treatment. The changes in the law, Section 334.104, RSMo, specify, among other things, that a collaborating physician cannot enter into a collaborative practice agreement with more than three full-time equivalent advanced practice registered nurses. It also specifies that the APRN and physician must maintain geographic proximity. The board of nursing and board of registration for the healing arts have joint rulemaking authority.

Many of the APRN bills have been amended to allow a collaborating physician to enter into a collaborative practice agreement with up to six full-time equivalent advanced practice registered nurses, licensed physician assistants, or any combination of those two professions. In addition, the board of nursing and board of registration for the healing arts have agreed to amend the collaborative practice rules to indicate that the collaborating physician and collaborating APRN shall practice within 75 miles by road of one another, except if the APRN is providing services pursuant to 335.175, RSMo. Missouri state law Section 335.175 is the utilization of telehealth by nurses law and specifies that an APRN providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the collaborating physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

The proposed changes to the law and the proposed rule change is not official as of the writing of this article.

You can keep up to date on the status of the collaborative practice rules on our web site pr.mo.gov/nursing.

You can find information about the status of bills and how to contact legislators at http://moga.mo.gov.

http://pr.mo.gov

Published by:
Arthur L. Davis Publishing Agency, Inc.

Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659v
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of April 1, 2018

Profession	Number
Licensed Practical Nurse	24,965
Registered Professional Nurse	108,438
Total	**133,403**

SCHEDULE OF BOARD MEETING DATES THROUGH 2018

May 23-25, 2018

August 8-10, 2018

November 7-9, 2018

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

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Education Report

Authored by Bibi Schultz, RN MSN CNE – Director of Education
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Nursing Faculty Shortage in Missouri – Review of the Literature and Call to Action!

While projections related to nursing shortages vary by source and geographical region, review of recently published nurse education literature clearly indicates the growing need for qualified nurse educators. As we reflect on Institute of Medicine recommendations (IOM, 2010) to double the number of nurses with doctoral degrees as well as to have 80% of the registered nurse workforce prepared at the baccalaureate degree level or higher by 2020, the necessity for well-prepared nurse educators is evident. Shortages in qualified nursing faculty are significantly impacting nursing school enrollments and have become one of the major barriers to nursing workforce development in Missouri as well as nationally. A recent report issued by the United States Bureau of Labor Statistics for the time span of 2012 to 2022 demonstrates concerning employment predictions for nurse educators. In order to meet projected demands across the country, it is estimated that by 2022 at least 34,200 new nurse educators will be needed (Laurencelle, Scanlan & Liners Brett, 2016).

For the academic year of 2014/2015 the American Association for Collegiate Nursing (AACN) reported 1,236 vacant nurse faculty positions in baccalaureate of science degree in nursing (BSN) programs across their membership. AACN data further suggested that in the same year pre-licensure BSN programs turned away an estimated 80,000 qualified applicants. AACN (2014) data indicated a 7.1% nursing faculty vacancy rate with 90.7% of openings in positions that required or preferred nurse educators prepared at the doctoral level. In 2015 an average age for nurse educators of 55 years was reported (Phoenix Bittner & Bechtel, 2017).

The Oregon Center for Nursing reports a notable shift of nurse educators to the age range between 45 and 59 years of age, which represents a significant increase in the number of educators nearing retirement from 17.9% in 2006 to 30.7% in 2015. National projections that up to 33% of nursing faculty currently teaching in pre-licensure BSN and graduate nursing programs may retire within the next ten (10) years are staggering. Data suggest that faculty ranks with doctoral preparation may be impacted the most. While historically the percentage of faculty prepared at the doctoral level has been below 50%; significant increase to 52.5% in 2015 is reported. This is at least partially attributed to the emergence of doctorate in nursing practice (DNP) programs as well as delayed retirements of faculty with research degrees (AACN, 2016). Fang and Keston (2017) further suggest beginning trends of recruitment of somewhat younger faculty; in turn it is noted that faculty in younger age groups are 12% less likely to pursue doctoral degrees, 21% less likely to hold senior professorial ranks, and 9% less likely to teach at the graduate level, which affirms concerning nurse faculty shortage projections (Fang & Kesten, 2017).

Phoenix Bittner et al. (2017) suggest that an already limited pool of faculty applicants with doctoral preparation is further strained by non-competitive faculty salaries, excessive faculty workload expectations as well as academic workplace environments that often fail to embrace new educators with the support and socialization necessary to make a successful and sustained transition to nursing education. While beginning trends may show that younger nurse educators are entering the field of academia, significant turnover rates especially in nurse faculty within their first few years of teaching are concerning. National League of Nursing (NLN) survey data published in 2014 showed that 45% of nurse educators were dissatisfied with faculty workloads; approximately 25% shared consideration to leave nursing education at that time. 2014 data suggested that 55% of nurse educators that responded to the survey experienced significant increase in workload demands due to growing faculty shortages (Phoenix Bittner et al., 2017).

The current AACN Nursing Faculty Shortage Fact Sheet (2017) indicates that for the 2016/2017 academic year, U.S. BSN and graduate nursing programs were unable to accommodate 64,067 applicants that met admission standards but could not be accepted due to a variety of reasons. While clinical placements, preceptor shortages, physical facility limitations and budget constraints seem to play a significant role, inability to find qualified nurse educators to fill vacant as well as new positions remains of greatest concern. AACN (AACN Fact Sheet, 2017) reports 1,567 faculty vacancies within BSN and graduate nursing programs in their membership. Data suggest that these programs project that at least 133 more faculty positions would have to be created, in addition to current vacancies, to meet current applicant and student demands. Significant increase in faculty vacancy rate to 7.9% for the 2016/2017 academic year is reported; 92.8% of those vacancies require or prefer a doctoral degree. AACN further reports that in 2016 an estimated 9,757 applicants deemed qualified to enter masters' degree in nursing programs as well as 2,012 applicants ready to start their doctoral studies had to be turned away. It is gravely concerning how quickly the U.S. nurse educator workforce is expected to dwindle in the coming years.

Missouri State Board of Nursing (MSBN) data compiled through annual reporting reiterates national nurse educator shortage trends at a more local level. 2016 annual reporting suggests at least 37 open full-time faculty positions across approximately 100 pre-licensure nursing programs across this state. The majority of unfilled positions are reported in BSN programs. 2016 data reflect that at least 162 Missouri nurse educators plan to retire within the next five (5) years; 95 of them currently teach in pre-licensure BSN programs. This is not surprising as the MSBN – Registered Nurse Age Range Report for 2017, accessible at http://pr.mo.gov/boards/nursing/maps/RN_Age_Range_Chart.pdf, shows that currently 33% (34,488) of registered nurses licensed in Missouri are at least 55 years old; this includes 22% (27,547) that are 60 years old or older. Furthermore, Missouri pre-licensure nursing programs estimated that 168 additional nurse faculty would have been needed to accommodate all applicants deemed eligible for admission in 2016; 91 of them at the pre-licensure BSN level. MSBN 2016 annual report data disclosed a significant pool of qualified applicants that were turned away. It is important to remember that this data may be somewhat skewed since students often apply to more than one program at a time and numbers may include applicants that have been tentatively accepted but have not yet started their program. Rolling admission processes may have also impacted the schools' reports. With that in mind, Missouri pre-licensure nursing programs reported that 1,856 applicants that met their admission standards in 2016 were not enrolled. Highest turn-away rates were at the baccalaureate (BSN) level: 928 applicants. Associate Degree in Nursing (ADN) programs reported 606 qualified applicants that could not be accommodated; Practical Nursing programs indicated 322 qualified applicants that were turned away (MSBN Annual Reports, 2016). The need for more nurse educators at all levels of Missouri pre-licensure nursing education is very real. Current and predicted shortages of nursing faculty at all levels of nursing education, but especially of those with doctoral preparation are sure to continue to impose rather significant challenges in years to come. Direct impact of such shortages on nursing workforce development in Missouri is undeniable. Innovative action is necessary to address this serious threat to nursing education and practice.

Phoenix Bittner et al. (2017) describe how a Massachusetts Action Coalition prepared to learn more and began to address the nurse educator shortage in their state. Massachusetts nurse educator survey data clearly show the need for extensive faculty mentoring and support and reiterate that nurse educators often feel ill prepared to deal with students in the classroom, especially at times when bad news have to be disclosed. Excessive faculty workloads are frequently listed as a deterrent to attract and keep nurses in nursing education. Reasons why nurses leave nursing education included retirements, non-competitive compensation, limitations in career advancements, insufficient opportunities to use practice skills and abilities, and lack of flexibility in work schedules. It is interesting to note that respondents indicate concerns that academic work environments

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sometimes lack cultural awareness and sensitivity resulting in significantly lower job satisfaction and inadvertently lower retention of culturally diverse nurse faculty. Findings indicate the likelihood that at least some institutions of higher learning may feel they are culturally sensitive, but in actuality are inconsistent in providing an inviting work environment for their educators. Findings also show a later-in-life transition of nurses to nursing education. It seems that nurses, at least within the reach of this survey, often waited to make the transition to the nurse educator role until after they were 40 years old or older. The necessity for more formal faculty preparation course work and long-term faculty mentoring programs, focused on role modeling by seasoned faculty as well as to support junior faculty in their endeavor to learn to teach and conduct research while actively engaged in practice/service activities, is of utmost importance. In turn the need for mentoring of senior nursing faculty by their junior colleagues in areas of technology skills/ innovative teaching methods is seen as essential to mutual success. Collaboration among PhD and DNP prepared faculty with shared vision to move the nursing profession forward in research as well as evidence-based practice is invaluable in the design of an academic infrastructure to optimally prepare nurses (Phoenix Bittner et al., 2017). These are interesting findings to consider since nurse workloads in the practice environment are often heavy, less than favorable news are frequently part of the job, and stressful work environments are nothing new to nurses; yet unfamiliarity and unpredictability of the academic work environment seem to majorly impact how nurses describe job satisfaction as nurse educators.

Gerolamo, Overcash, McGovern, Roemer and Bakewell-Sachs (2014) discuss strategies utilized in New Jersey to enhance and expand nurse educator resources in their state. Diversification of faculty populations as well as the importance to provide quality faculty preparation is emphasized. Goals of increased collaboration and resource sharing among schools of nursing to prepare and share nursing faculty are stated. Development of faculty preparation course work delivered through a school consortium, which in turn would share instructional loads and help provide student educators with new experiences and perspectives is recommended. Essentiality of clear expectations for student educators and experienced faculty mentors are discussed. Curriculum areas to be covered include creative teaching strategies, curriculum development and evaluation, evidence-based assessment of student learning, teaching competencies, actual teaching assignments and socialization to the faculty role. It is interesting to note that nurse educator feedback reveals that student educators least liked online learning modules. Feedback indicates that in-person interaction yields much stronger connection to the teaching environment and transitional support to the educator role (Gerolamo et al., 2014).

In a follow-up article Gerolamo, Conroy, Roemer, Holmes, Salmond and Polakowski (2017) indicate strong preference of new nurse educators to "mixed positions" that allow them to teach and practice nursing interchangeably. It is also to be noted that new faculty graduates with doctoral preparation tend to accept and stay in full-time faculty positions at a significantly higher rate than their masters prepared counterparts. Feasibility to add nurse educator course work to existing masters/ FNP programs is not recommended due to additional cost and already limited time to cover content. Major benefits of deliberate creation of collaborative, sustainable learning communities among student educators, their mentors and clinical partners are reiterated. The value of continued interaction among all participants with focus on competencies needed for nursing practice as well as innovative models of delivery that help prepare nurses for safe practice in clinical as well as academic settings is clear (Gerolamo et al., 2017).

Fang et al. (2017) suggest that succession planning is another area in need of attention. Professional faculty development specifically designed to prepare newer faculty for future challenges in administration as they move forward in their careers as nurse educators is seen as essential to prepare for a highly futuristic approach to nursing education (Fang et al., 2017). A recent article by Laurencelle et al., (2016) suggests additional measures to address looming nurse educator shortages. The need for more competitive compensation is emphasized. The essentiality of increased financial support for nurses to continue their nursing studies is clear. Great focus on innovative, individualized mentoring support and socialization to the academic environment is reiterated throughout the literature. The absolute necessity to embrace new nurse educators in an environment often described by them as scary and unsettling is a common theme. Exploration of tenure and alternatives to tenure as well as measures to increase flexibility in work schedules and focus on collegiality in the work place is suggested (Laurencelle et al., 2016).

Recently published articles by Summers (2017) and Gerolamo et al. (2017) recommend development of highly specialized nurse educator preparation programs that are specifically designed to foster transition from nursing practice to teaching in nursing. Deliberate transition of experts in nursing practice to faculty roles while these highly experienced clinical nurses continue to stay in practice creates a win-win situation for patients, students and faculty. The literature suggests a much more valuable and lasting transition to academia for nurses that remain engaged in clinical practice. In order to support successful transition to the faculty role, some major educational areas must be addressed; these include strategies to manage and motivate students, how to navigate student expectations, ways to accommodate different learning styles and to apply principles of adult education. New educators often need help to navigate an environment that seems to lack clear guidelines to manage their teaching roles, could present unrealistic workload expectations, and may lack structure that often accompanies their clinical jobs. Absolute necessity of sustained mentoring as well as continued help with socialization provided by experienced nursing faculty is reiterated (Summers, 2017 & Gerolamo, 2017).

Cooley and De Gagne (2016) as well as Jeffers and Mariani (2017) discuss essentiality of a combination of factors that must be in place to support developing competence for novice nurse educators. The importance of deliberate academic support through utilization of well-designed mentoring and internship programs is reiterated. Evaluation of nurse educator orientation programs show major deficiencies in scope, content and time allocated for new nurse educators to grasp their new responsibilities, make a lasting transition to the nurse educator role and to become effective teachers. Reports of new nurse faculty describing their role as exhausting, anxiety-provoking, intriguing as well as terrifying and overwhelming are repeatedly discussed. New educators report their struggle with insufficient time to perform their newly acquired duties, underestimation of necessary time with students and knowledge gaps to fulfill their academic responsibilities. Major emphasis on test development and exam analysis, preparation of hand-outs, and most effective ways to teach and reach students is noted. Lack of confidence to teach and less than optimal support in their new academic environment are common themes to why nurse educators leave their teaching positions. The sense of being alone in unfamiliar territory, to greater responsibilities with insufficient support as well as self-assessment of their own inexperience are described as major contributing factors to not stay in nursing education. Creation of a supportive, transformative learning environment for new faculty is essential. Submersion into major teaching events, such as teaching a nursing course as part of an internship with the support of experienced nurse faculty mentor(s) is recommended. Utilization of experienced nurse educators that are very close to retirement or may already be retired, but willing to work with novice nurse educators on a part-time or adjunct basis, has the potential to create win-win situations for new faculty, their senior colleagues as well as students. Crucial aspects of mentoring relationships described by Jeffers (2017) include collegiality among faculty, mutual respect, consideration of the knowledge and expertise gradient as well as a big dose of trust (Cooley et al., 2016 & Jeffers et al., 2017).

WHAT'S HAPPENING

CONNECTING WITH THE MILITARY *Board of Nursing*

The Missouri State Board of Nursing hosted its very first Military Connect meeting on February 23 to continue to further identify pathways for military personnel to obtain credit and licensure for their education, training and service.

In March 2017, the Missouri State Board of Nursing was the first state board to approve the Air Force's program. Bibi Schultz, the Director of Education for the Board of Nursing, represents Missouri on the Multi-State Collaborative on Military Credit Steering Committee (MCMC) and was instrumental in championing this action and this meeting.

Fifteen educators from all levels of nursing education programs and SMSgt Sherod Thompson from the United States Air Force attended the meeting.

> "We were pleased to host this meeting to brainstorm how to position Missouri as a leader in improving the lives of military families by providing a pathway to higher education and nurse licensure."
>
> Lori Scheidt, Director of the Boardof Nursing

Education Report

Reese and Brown Ketner (2017) reiterate the importance of formal training in principles and practices of adult education. Lack of formal training to prepare new nurse educators to assume academic roles is associated with frustration on the nurses' part, varying degrees of commitment to the teaching role, potentially negative impact on program and student learning as well as issues with application of program policies and evaluation of student performance, which all could directly impact program and individual student outcomes. Reese (2017) indicates how rule changes initiated by the North Carolina Board of Nursing in 2008 now require nursing faculty to attain certain qualification within their first three (3) years of teaching, such include general preparation in teaching and learning, principles in adult education as well as curriculum development, implementation and evaluation. Nurse educator competencies may be attained through completion of a Board-approved 45-contact hour continuing education course or similar course work. Required nurse educator certification may be attained at the state and/or national level. Nurse educator feedback strongly suggests that development of similar programs/ ways to acclimate to the nurse educator role is beneficial to new nurse educators and supports them in their endeavor to do well and to stay in nursing education. Just some of the major outcomes that are mentioned include better understanding and application of systematic program evaluation, improved utilization of instructional strategies especially in clinical teaching, development and application of measurable learning outcomes as well as utilization of greater variety of teaching strategies and methods (Reese et al., 2017).

In summary, current nursing literature indicates a variety of recommendations to help develop a strong, expanded nurse educator workforce. The necessity of formal professional development especially designed to meet the challenges of academia is a common theme. Some of the major points to be gleaned and should be considered include the following strategies:

1. Deliberate assessment of the academic workplace – emphasis on socialization to the educator role, strong, long-term mentoring relationships, collegiality, cultural awareness and sensitivity for students and faculty as well as exploration of opportunities for career progression, flexibility in work schedules and compensation scales.
2. Exploration of "mixed" faculty positions – clinical experts that teach while remaining actively engaged in clinical practice.
3. Development and implementation of specialized nurse educator programs with collaboration and resource sharing among schools of nursing.
4. Financial support in form of scholarships and grants to continue in graduate/doctoral studies.
5. Purposeful socialization to the academic environment – creation of a collaborative learning community for new faculty to interact and work with seasoned colleagues and clinical partners.
6. Long-term mentoring support for new faculty (9 month to several years) and reasonable workload expectations especially within the first few semesters of teaching.

As indicated throughout this writing, development of a very specialized curriculum is essential to help nurses make successful, sustained transitions to the nurse faculty role. Recommendations for curriculum development for nurse educator preparation courses (NEPC) should include, but are certainly not limited to the following content areas:

1. Principles of adult education
2. Accommodation of different learning styles
3. Teaching competencies/creative teaching strategies
4. Curriculum development and evaluation
5. Exam item writing and test analysis
6. Evidence-based assessment of student learning
7. Strategies to manage and motivate student behavior
8. Navigation of student expectations
9. Actual teaching assignments/teaching internships
10. Active socialization to the faculty role and mentoring

While pondering the current state of nursing education, actual and projected faculty shortages as well as strategies to safeguard and support continued development of a highly competent nursing workforce, it is important to remember that qualified, well-prepared nurse educators are the essential link to preparing new nurse graduates for safe clinical practice. It is therefore necessary to bring the focus on quality nurse educator preparation, active collaboration among schools of nursing, clinical partners, nurses, nurse educators and regulators. New and renewed strategies are necessary to innovatively expand the pool of qualified nurse educators that are optimally prepared and ready to take nursing education forward while supporting patient safety through deliberate preparation of their students and graduates for safe clinical nursing practice.

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Missouri Board of Nursing Awards Grants to Five Nursing Programs

Since 2011, over $5 million has been invested in nursing education

Jefferson City, Mo – In 2011, legislation was passed that authorized the Missouri Board of Nursing to provide funding for the Nursing Education Incentive Program. This allowed any institution of higher education accredited by the Higher Learning Commission of the North Central Association that offered a nursing program to apply for grants. Grant award amounts could not exceed $150,000 and no campus could receive more than one grant per year. The board awarded grants in 2011, 2012, 2013 and 2017. They are awarding the grants again this year, bringing the total investment in nursing education programs to $5,333,194.

At the Board's Feb. 28-Mar. 2, 2018 meeting, they approved grant funding for these five nursing programs:

- Columbia College — $150,000
- Goldfarb School of Nursing — $150,000
- Missouri State University — $148,233
- St. Luke's College of Health Sciences — $95,750
- State Fair Community College — $149,370

State Board of Nursing Executive Director Lori Scheidt said, "I'd like to thank our legislators for approving the grant authority so we can help nursing programs increase their physical and educational capacity. I am proud of our team. We have successfully kept our licensure fees the lowest in the nation while also maintaining our ability to offer this grant funding. Nursing programs generally operate on very lean budgets and these grants allow programs to increase the number of nurse graduates and make other improvements to improve the quality of education."

Adhering to the grant requirements, this year's grant recipients plan to utilize their awards to increase enrollment through the addition of nursing faculty, enhance simulation resources, utilize technology to augment student learning, and for development of an adjunct faculty academy. Grant recipients are required to provide periodic updates to the Board related to the utilization and impact of the funding awarded to them.

About the Missouri Department of Insurance, Financial Institutions & Professional Registration

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) is responsible for consumer protection through the regulation of financial industries and professionals. The department's seven divisions work to enforce state regulations both efficiently and effectively while encouraging a competitive environment for industries and professions to ensure consumers have access to quality products.

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

☐ RN ☐ APRN ☐ LPN

Missouri License Number _____ Last 4 Digits of Social Security Number _____

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed) _____ First Name (Printed) _____

NEW INFORMATION

Last Name _____ First Name _____ Middle Name _____

(_____)_____ (_____)_____ _____

Daytime Telephone Number Alternate Phone Number E-mail Address

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ I declare _____ as my primary state of residence effective _____.
(primary state of residence) (effective date)

☐ I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

Information on the Nurse Licensure Compact can be found at www.ncsbn.org/nlc.htm
In accordance with the Nurse Licensure Compact **"Primary State of Residence"** is defined as the state of a person's declared fixed, permanent and principal home for legal purposes; domicile. Documentation of primary state of residence that may be requested (but not limited to) includes:

- Driver's license with a home address
- Voter registration card displaying a home address
- Federal income tax return declaring the primary state of residence
- Military Form no. 2058 – state of legal residence certificate
- W-2 from US Government or any bureau, division or agency thereof indicating the declared state of residence

Proof of any of the above may be requested.

When your primary state of residence is a non-compact state, your license will be designated as a single-state license valid only in Missouri.

When your primary state of residence is a compact state other than Missouri, your Missouri license will be placed on inactive status and you can practice in Missouri based on your unrestricted multi-state license from another compact state.

I solemnly declare and affirm, that I am the person who is referred to in the foregoing declaration of primary state of residence; that the statements therein are strictly true in every respect, under the pains and penalties of perjury.

→ _____ _____
Signature ***(This form must be signed)*** Date

Complete, SIGN and Return to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 Or Fax to 573-751-6745 or Scan and Email to nursing@pr.mo.gov

Moments with Marcus

Marcus Engel

The Cost of Caring

Has anyone else wondered if the cost of caring for the greater good has cost you way too much in your personal life? If so, how do you balance this one?

This was a question posted by an ER nurse friend, Kelly. Then, this exchange happened:

Kelly's friend, Tim: *Sounds like you need a new job.*

Kelly: *Being a nurse is akin to breathing for me. I think that's part of the issue; seeing other nurses treat it like a job instead of as a calling.*

Wow. Just wow. Two people, two questions, four sentences… and enough content to unpack for a year's worth of Moments articles.

So, let's look at Kelly's original question: Has anyone wondered if the cost of caring for the greater good has cost you way too much in your personal life?

Ah, the cost of caring for the greater good. It would be nice if nursing (or caregiving of any kind) didn't interfere with personal lives. It'd be great if a nurse never had to miss her daughter's soccer game. It'd be nice if she came home after work, flipped off an internal switch and was able to leave work at work… not sad, distressed and anxious about the amount of human suffering he witnessed on the last shift. It would be nice if illness, injury and disease took a day off so caregivers could always be home and present with family on the holidays.

That would also be a world with rainbows and unicorns and zero calorie junk food.

The concept is subjective, of course, but without a doubt, there is a cost of caring… Wouldn't you agree?

You don't have to look very far to discover a nurse who has a work-related injury, who has been assaulted on the job, who has had to miss once-in-a-lifetime events in order to do the greater good.

There IS a sacrifice to nursing, if nothing more than the simple witnessing of people suffering. Nursing isn't retail or manufacturing or accounting. It requires nurses to get up close and personal with the sick and dying. It means getting home and immediately dropping one's scrubs in the wash and stepping into the shower to get rid of whatever microscopic nastiness may have been picked up at work. It's not easy. There is a cost.

Caring for the greater good is inherent in every nursing shift and in every interaction. At least, I hope it is. After all, it's the choice to put aside one's own needs and pay close attention to the suffering of another. To listen intently, to comfort, to witness. To provide skill and compassion simultaneously…this is nursing. Oh yeah, and to be juggling a variety of tasks and duties behind the scenes. That's nursing, too.

Naturally, passion for the job may wax and wane. Any human being doing repetitive tasks can risk burnout. But when that burnout first begins to rear its ugly head, stop. Take a breath and acknowledge the investment nursing requires. Appreciate the gift you are giving and the work you are doing.

Simply acknowledging that nursing can be difficult is the first step. Second step? Return to step #1.

Just acknowledge it. Don't try to change it, don't try to erase it, don't try to ignore it.

When you give yourself the compassion of recognition, I hope you'll begin to see that there is a cost, but it's one you can choose to wallow in, or it can be something you purposefully and intentionally explore.

Occupational licensing has no effect on wages, but does increase access to occupations

by Beth Redbird

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Occupational licensure creates a right to practice, legislatively carving out tasks that can only be performed by authorized practitioners and reserving an occupational title for the sole use of those practitioners. The authority to practice can be obtained only from the state, and unauthorized practice can result in criminal and civil penalties.

Over the past few decades, occupational closure – most often through occupational licensing – quietly became the norm for a broad swath of American occupations. Where only a small set of 'traditional' professions once determined entry through regulation, today the practice governs a much wider range of occupations, from doctors to engineers, carpet layers to massage therapists, agricultural inspectors to wilderness guides, and fortune tellers to legal document assistants.

The most substantial growth in occupational licensing has been in blue-collar occupations.

Many occupational licensing boards are made up of senior professionals in that field. Thus, architects draft guidelines for other architects; standards for hairdressers are styled by instructors in cosmetology schools; and frog farmers must leap over barriers imposed by fellow amphibious agriculturalists.

Because not every worker who wants a license can obtain one, licensure is thought to raise wages for licensed workers by artificially restricting supply. If true, this would mean that licensed workers benefit at the expense of consumers.

This article presents a new examination of licensure-wage effects, relying on two important innovations.

First, it is the largest study to date, examining more than 4.5 million workers over 30 years, and across 500 occupations. This allows for more complex statistical modeling. By tracking licensing legislation across all fifty states, through an exhaustive search of statutes and administrative codes, licensed hairdressers in one state are compared to unlicensed hairdressers in another state, within that same year, licensed occupational therapists are compared to unlicensed occupational therapists, and so on.

Second, for the first time, the effect of licensing can be studied over time. Using a longitudinal approach, this study examines wages in the years following enactment and see exactly how they change when a law is passed.

Does licensing raise wages?

The short answer is: no. The typical weekly wage declines by between 0.19 percent and 1.23 percent due to licensure – in other words, for most people, not at all. In the years following enactment, wages will fluctuate, but even twenty years after enactment there is no long-term change in wages.

So why don't wages increase?

The modern view of occupational closure as monopolistic derives from the earliest views on the subject. However, the occupational regulation that pervades today's legislative and economic landscape only marginally resembles the structures envisioned by Adam Smith and other early critics.

Licensing restructures methods of entering an occupation.

The enactment of a licensing law promotes the development of other institutions in the state, such as vocational schools specifically designed to train applicants for the new license. Licensees have access to support systems specific to their occupations, such as exam-oriented coursework, licensure application assistance, career counseling, job fairs, and networking opportunities, all of which are designed to make licensure requirements and employment outcomes manageable and attainable.

Overall, the major flaw in past research has been the assumption that, in an unlicensed environment, all prospective entrants have an equal opportunity to enter any given occupation. In reality, informal barriers pervade the labor market.

In a licensed state, workers can use the license as a state-endorsed signal of quality, which shows prospective employers that they meet basic qualifications, and can help overcome problems of 'fit,' such as a race, gender, or age mismatch. Workers can rely on support from subordinate institutions to help find and get a job.

Unlicensed workers, on the other hand, have a hard time obtaining their first job without a standardized way to prove credibility and competence, and will most likely be chosen (or not) based on social networks or employer tastes. Workers who lack social connections may be left out in the cold.

Licensed applicants also take advantage of a codified path of entry, following a publicized set of steps that, by state law, lead to licensure. The would-be practitioner can refer to the appropriate publication or contact the licensing authority for the 'official' requirements.

Results of the study show that, after licensing, the number of workers in the occupation increases by an average of more than seven percent over original levels.

Licensing may be advantageous for women and minority workers

Because licensing requirements necessitate the expenditure of resources (frequently money and time), traditional theory suggests that the effect of supply restrictions should be most easily detectable among populations that are traditionally excluded.

Results show that this is not true. After enactment, the composition of licensed occupations shifts as more women and minorities enter the population. The proportion of women working in the occupation increases by approximately two percent and the proportion of black workers increases by more than three percent.

The new institutions that develop around licensing might be particularly helpful for historically-excluded groups, allowing them to bypass informal barriers. Increased supply, particularly among traditionally disadvantaged groups, is thus an understandable outcome from licensure.

Licensing may have other consequences

In addition to changing how workers enter an occupation, licensing may also create broader changes that social scientists have yet to investigate.

For as long as it remains legitimate, the license will continue to function as an important signal and may insulate practitioners against shifts in the market. States codify the appropriate content and level of training necessary to be the 'right' type of practitioner, and thus free licensed workers to obtain only the specified level of education, while workers in unlicensed jurisdictions continue to compete along educational lines.

Through the lens of licensure, occupational elites can define the 'proper' way to practice, since license requirements are essentially comprehensive lists of ways to be excluded or removed. However, this may also limit innovation, reduce experimentation, and perhaps hinder growth in knowledge. While practitioners in unlicensed markets are free to compete on all aspects of their occupations, licensed workers must obey legal limitations on both *what* they do and *how* they do it.

On a broader scale, this formalization may rigidify the reward structure of an occupation, solidifying wage inequality. Ongoing research suggests this might be the case. Current research into wage gaps shows that, while more women enter licensed occupations, licensing also tends to increase the wage gap as it reduces mobility for women. As a result, women tend to be clustered at the low-end of the earnings spectrum in their occupation.

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Maintaining Professional Boundaries in Nursing

Introduction

The North Carolina Board of Nursing has granted permission to reprint this article by Ruth Ann Go, M.Ed., RN, Regulation Consultant, North Carolina Board of Nursing. The Missouri State Board of Nursing, similar to the North Carolina Board of Nursing, has the responsibility of protecting the public's health and safety through the regulation of nursing education, licensure and practice. 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 Nurse Practice Act. This information will raise awareness of how professional relationships can move towards a boundary violation and why this must be prevented.

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 behavior 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 under-involvement and over-involvement begin. The transition from one to another can be gradual. The nurse's behavioral choices may start out professionally sound, but as the care and therapeutic relationship continues, the nurse may become too comfortable. When providing care for the patient, particularly over a long term basis, the topics of conversation, although well-intentioned, may become less professional and more personal. This can occur not only with the patient but with the family members as well.

While some boundaries are clear, others make it necessary for the nurse to use professional judgement. If you are unsure, seek out the guidance from 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 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 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 in 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 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 enough to do it. 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 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 not to 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

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Maintaining Boundaries continued from page 9

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 Nurse Practice Act.

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 professional boundaries. Physical contact outside the scope of treatment or examination must not occur. The nurse also breached the 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 and include goal setting prior to the beginning of the work 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.

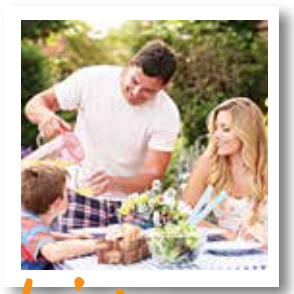
Your Responsibility

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 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.


Live.


Work.


Play.

- Keep personal and professional relationships separate. If you are in a situation where there are no alternatives other 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 healthcare 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 of Nursing 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 of 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.

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Thank you to the North Carolina Board of Nursing and Ruth Ann Go, M. Ed., RN for sharing this article.

Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

The Board of Nursing is requesting contact from the following individuals:

Jodi Michelle Bell – PN 2015036780
Kristal Marie Benjamin – PN 2004019189
Brian Neal Davy – RN 2011026749
Jeri Lyn Eubanks – RN 2011024991
Maurita SheRee Francis – PN 2008007246
Amanda Carla Franz – PN 2014004807
Christine Michelle Johnson – PN 2005009292
Tiffany Nichole Meyers – PN 2005041268
Melanie Elaine Moore – PN 2004009598
Lisa Marie Pasley – RN 2002025791
Lisa Marie Reynolds – RN 2007015364
Cassandra Lynn Wilmes – RN 201002609

If anyone has knowledge of their whereabouts, please contact Kristi at 573-751-0082 or send an email to nursing@pr.mo.gov

CENSURE

Crowder, Crystal Lynn
Myrtle, MO
Licensed Practical Nurse 2002022808
Licensee practiced nursing in Missouri without a license from June 1, 2016 to November 27, 2017.
Censure 02/13/2018

Hoff-Nygard, Danyelle Rene
Collinsville, IL
Registered Nurse 2006021102
On May 27, 2016, Licensee called a pharmacy in St. Louis, Missouri and requested a prescription for Ativan be filled, on behalf of a co-worker using Dr.'s DEA number and address. The pharmacy contacted the prescribing physician, Dr., regarding the prescription. Licensee violated hospital policy as she did not have the authorization from Dr. to call in the prescription of Ativan for her co-worker. When questioned by hospital officials, Licensee admitted that she had not received authorization from Dr. to call in a prescription for her co-worker.
Censure 02/17/2018

Kidd, Lisa Anttranet
Kansas City, MO
Licensed Practical Nurse 2010033533
Licensee practiced nursing in Missouri without a license from June 1, 2016, to September 1, 2017.
Censure 12/13/2017

Irwin, April Dawn
Deepwater, MO
Registered Nurse 2012027812
Licensee practiced nursing in Missouri without a license from May 1, 2015, to May 19, 2016.
Censure 01/23/2018

PROBATION

Stepp, Amy S
O Fallon, IL
Registered Nurse 2005007603
On December 22, 2016, during her shift, Licensee was observed by co-workers exhibiting unusual behavior, slurring her words, using profanity more than normal, appearing disheveled, and making frequent trips to the restroom with her backpack. Licensee's coworkers observed Licensee to not perform required checks on her patient during the December 22, 2016 shift. Administrators observed a bottle of vodka in Licensee's backpack, which was left open on a couch in the break area. Licensee consented to submit a sample for a breathalyzer blood alcohol test. Licensee's breathalyzer test results revealed Licensee had a blood alcohol level of .216 and .201 at 2:05 am and 2:22 am, respectively.
Probation 12/22/2017 to 12/22/2022

Nagle, Peggy Sue
Cameron, MO
Registered Nurse 2005028646
On August 1, 2016, Respondent's supervisor requested that Respondent provide a urine sample for a for cause drug screen. On August 22, 2016, facility staff received the report that the sample Respondent submitted for testing was confirmed positive for amphetamine and methamphetamine. Respondent did not have a prescription for, or a lawful reason to possess, amphetamine and methamphetamine. Respondent's employment with the facility was terminated on August 24, 2016, due to her positive test for amphetamine and methamphetamine.
Probation 12/22/2017 to 12/22/2022

Nance, Katrina Nicole
Blue Springs, MO
Registered Nurse 2014005207
On or about February 19, 2017, a compliance audit was performed on patient records. The audit revealed that two of Licensee's patients did not have a signed admission consent form in their patient record. The admission consent form is to be signed by each patient at the time

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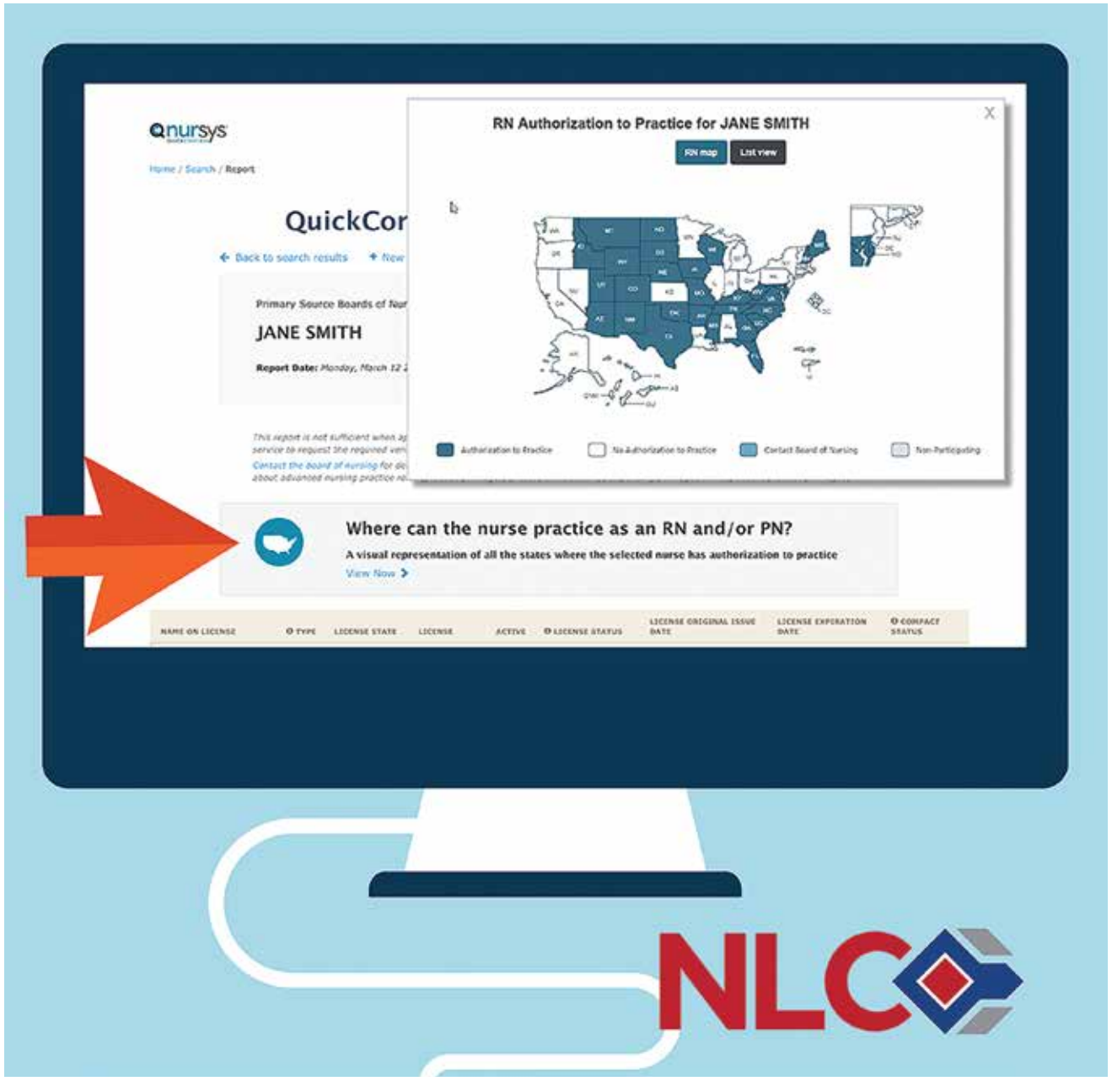

Disciplinary Actions**

of the nurse visit. On February 20, 2017, it was noted that both patient records in question contained signed consent forms; however, the forms were signed six to seven hours after the nurse visit performed by Licensee. When questioned about the discrepancies, Licensee admitted to signing the signature of both patients in the electronic medical record without either patient's knowledge.
Probation 12/22/2017 to 12/22/2018

Aubuchon, Brenda G
Afton, MO
Licensed Practical Nurse 037718
On September 14, 2016, a pharmacy manager called the nursing home to verify a prescription, which had been called in for Licensee the previous day, under the DEA registration number of T.J., FNP. The nursing home's office coordinator informed the pharmacy manager that Licensee was a nursing home employee and not a patient of T.J., FNP. Licensee admitted to nursing home administrators and the Board's investigator that she had called in the prescriptions for hemorrhoid cream, a duo-nebulizer, and clindamycin for herself using the DEA registration number of T.J., FNP. T.J., FNP, did not give Licensee authorization to call in the prescriptions or to use her DEA registration number.
Probation 12/12/2017 to 12/13/2017

Odom, Janice Lee
West Plains, MO
Registered Nurse 2009033027
On or about August 4, 2017, Licensee was asked to submit to a random drug screen, which returned negative for the presence of drugs. On or about August 14, 2017, officials received information from a co-worker of the Licensee that the Licensee had not submitted her own urine for the drug screen on August 4, 2017. On or about August 18, 2017, Licensee was asked to submit to a for-cause drug screen, which was positive for marijuana. Licensee admitted to the Board investigator that she smoked marijuana prior to the August 4, 2017 and August 18, 2017, drug screens. Licensee admitted to the Board investigator that she had used her granddaughter's urine for the August 4, 2017 drug screen because she knew her urine would be positive for the presence of marijuana. Licensee additionally admitted to ingesting her husband's hydrocodone.
Probation 01/23/2018 to 01/23/2023

Kasen, Susan L
Saint Louis, MO
Registered Nurse 2001007407
On June 2, 2014, licensee reported to work and staff members reported she appeared to be under the influence of alcohol. Licensee was asked to provide a breath sample for screening. The results of the test indicated that Licensee tested positive for alcohol, with two different results, both of .126 BAC.
Probation 02/14/2018 to 02/14/2020

Vogel, Heather Anne
Ballwin, MO
Registered Nurse 2009023100
Licensee reports in her "stop-working statement" that on or about October 18, 2017, Licensee learned her license had expired when she was notified by a healthcare facility at which she had placed an order for a patient that her license was not current. Licensee further claimed that she did not receive any notifications that her license had expired as she had moved. She further claimed that she thought her license expired in 2018. The Board's records indicate that the Board received a Request for RN Renewal Notice from Licensee dated May 25, 2017. Board staff called and left a message for Licensee informing her that the last day to complete the renewal was May 30, 2017, and that Licensee could come to the Board office to complete the process or that Licensee would need to complete a Petition for License Renewal, pay the renewal fee, and complete a background check. Licensee's address was updated at that time and Board staff mailed a Petition for License Renewal to Licensee's new address. When questioned about the discrepancy between her earlier phone call and her written statement to the Board, Licensee stated that she was under the impression that she only had to update her address and complete a background check in order to renew her license. Licensee worked as a nurse in Missouri without a license from May 1, 2017 until October 18, 2017.
Probation 12/07/2017 to 12/18/2017

Blue, Deborah L
Saint Louis, MO
Registered Nurse 142649
On August 21, 2007, Licensee pled guilty to the class A misdemeanor of DWI - Alcohol - Prior Offender. On February 4, 2014, Licensee pled guilty to the class C felony of DWI - Alcohol - Aggravated Offender. Licensee reports she has been receiving counseling and treatment since July 2016. Licensee was diagnosed with Alcohol Abuse in Remission. She reports her sobriety date is December 3, 2016.
01/27/2018 to 01/27/2022

Rector, Christopher L
Union, MO
Registered Nurse 2009021819
On or about February 11, 2017, Licensee arrived to work two hours late. Licensee was observed by co-workers to be acting disoriented and was seen falling asleep at the medication cart. The Director of Nursing at the nursing home asked Licensee to submit to a for-cause drug and alcohol screen due to Licensee's unusual behavior. Licensee refused to submit to the drug screen and stated that he would test positive for marijuana. Licensee admitted to smoking marijuana.
Probation 02/23/2018 to 02/23/2023

Rotich, Philip K
Overland Park, KS
Registered Nurse 2006035383
On April 24, 2015, the Administrative Hearing Commission entered a Decision finding that the Board had cause to discipline Respondent's nursing license pursuant to Sections 335.066.2 (5) and (12) RSMo. On May 28, 2010, Respondent received a counseling memo, called a Performance Improvement Form (or "PI"), alleging that he violated various hospital policies by failing to respond appropriately when asked by a female phlebotomist to stay in a patient room with her while she conducted a blood draw on a potentially dangerous patient. On November 16, 2010, and March 10, 2011, Respondent received Pls related to controlled substance documentation errors he made. In order to track the flow of controlled substances, the nursing staff and pharmacy used a form called a controlled substance administration record ("CSAR"). On October 13, 2011, Respondent took over the narcotics box key when he went on duty at 7:00 p.m. He took part in the count with the outgoing nurse and signed the bottom of the CSAR. Although both Respondent and the outgoing nurse agreed to a count of seven (7) tablets of Xanax 0.5 mg at the shift change, Respondent failed to notice that the record beginning inventory at the top of the CSAR form listed eight (8) tablets. This caused the overnight narcotics count for Xanax 0.5 mg to be off by one tablet. There were seven (7) tablets in the box, but eight (8) tablets were listed in the beginning inventory. Respondent administered two (2) Xanax 0.5 mg during his shift, both to patient P.A., for which he withdrew two (2) tablets at 22:01 (10:01 p.m.) and 6:58 a.m. After he administered the first, he wrote "7" in the space for the Xanax 0.5 mg count on the CSAR, and after he administered the second, he wrote "6." The next morning, Respondent and the oncoming day shift nurse conducted the narcotics box inventory at about 7:00 a.m. They discovered there were only five (5) Xanax 0.5 mg in the narcotics box. Respondent did not know what had happened to the missing tablet, and his first thought was that a tablet might have been dropped. Impulsively, he wrote a "C" in the "Dosage wasted" column, indicating the dose had been dropped on the floor, by the 22:01 entry in which he had indicated he had withdrawn a Xanax 0.5 mg tablet for P.A. Respondent asked nurse to help document the waste or destruction of a Xanax 0.5 mg tablet, but nurse declined to sign the CSAR as a witness to the waste of the 0.5 mg tablet because she had not actually seen the tablet wasted. When nurse supervisor questioned Respondent about the count discrepancy, he quickly responded that he had dropped one of the Xanax tablets in a patient room, which would have accounted for a missing tablet, but it was not a true statement. Nurse supervisor said she would accompany Respondent back to the patient room to help him look for the missing tablet of Xanax so it could be accounted for and wasted in accordance

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with hospital policy. Respondent then said he had not dropped a tablet after all. Respondent then went back to the medication room and lined all the way through the 22:01 CSAR entry. He did not change the electronic medical record for patient P.A., however, which showed that Respondent administered the 0.5 mg tablet of Xanax at 10:04 p.m. and had gone back 30 minutes later to document its effect on P.A.'s condition. Respondent then made a late entry for a 22:02 (10:02 p.m.) withdrawal of the Xanax tablet.
Probation 02/16/2018 to 02/16/2019

Goessele, Lovena Estella
Kansas City, MO
Registered Nurse 2014016345
On or about September 7, 2016, hospice administrators received a complaint from a patient's family regarding Licensee's attitude during a visit. The patient's family also stated that Licensee destroyed the patient's discontinued medications by flushing them down the toilet without a witness. Licensee was asked to submit to a for-cause drug screen due to destroying the medications without a witness. On September 9, 2016, Licensee's drug test result was returned positive for marijuana.
Probation 02/28/2018 to 02/28/2021

Biddle, Morgan Le Anne
West Plains, MO
Registered Nurse 2012003651
Respondent did not attend the meeting or contact the Board to reschedule the meeting. The Board did not receive an employer evaluation or statement of unemployment by the quarterly due date of August 24, 2017. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by August 22, 2017. The Board did not receive proof of any completed hours.
Probation 12/18/2017 to 12/18/2018

Knuckles, Elizabeth A
Dittmer, MO
Registered Nurse 151065
On April 18, 2015, Licensee arrived one (1) hour late for her shift at facility. During this shift, Licensee was observed by facility co-workers displaying erratic behavior, which included hand tremors, refusing to make eye contact, difficulty communicating, and the constant exaggerated scratching of her legs. Licensee stayed three (3) hours after this shift to complete documentation; however, it was discovered later that three (3) of Licensee's four (4) patients still had incomplete documentation. On April 19, 2015, Licensee did not show up for her scheduled shift until four (4) hours after the shift began. Licensee was asked to complete the documentation on the patients from the previous shift; however, Licensee failed to complete the documentation. On April 20, 2015, Licensee was observed displaying erratic behavior again. Licensee stayed four (4) hours after this shift to complete documentation; however, documentation was still incomplete on five (5) patients. Licensee failed to document the vital signs for three (3) patients and she failed to document the administration of medication and a neurological examination for two (2) patients. According to the Pyxis report, Licensee withdrew 20 mg of oxycodone at 2019 and documented administering 5 mg at 0154, but 15 mg of oxycodone was not documented as administered or wasted. Additionally, according to the Pyxis report, Licensee withdrew two (2) tablets of Percocet at 2205, but failed to document the administration or waste of the medication.
Probation 01/17/2018 to 01/17/2023

Walker, Krystle Rose
Frontenac, KS
Registered Nurse 2008019014
The pharmacy ran an audit for Tramadol usage and discovered that Tramadol was missing and discrepancies related to Respondent's Tramadol withdrawals. Respondent was questioned regarding her Tramadol usage. Respondent admitted to withdrawing Tramadol from the Pyxis and keeping it for her personal use. Respondent provided a sample for screening on July 11, 2014, and the sample which Respondent submitted returned positive for Tramadol.
Probation 12/19/2017 to 12/19/2022

Scott, Karissa Ann
Arnold, MO
Registered Nurse 2004021517
On August 8, 2017, Respondent pled guilty to the class C felony of Possession of a Controlled Substance Except 35 Grams or Less of Marijuana.
Probation 12/22/2017 to 12/22/2022

Gomez, JaCey Beth
Savannah, MO
Licensed Practical Nurse 2009029700
Suspended 11/21/17-12/05/17; Probated 12/06/17-12/06/19
On December 1, 2016, Licensee was informed by a Certified Nurse's Aide (CNA) that Resident GS refused to shower. Licensee told the CNA to make the resident bathe. In route to the shower resident GS questioned who was making her shower. Licensee raised her voice to resident GS to state that it was her that was making the resident shower. Licensee got into a verbal altercation with resident GS. Further, on December 1, 2016, resident SV spoke with the Administrator of the nursing home regarding Licensee. Resident SV informed the Administrator that Respondent told him that he could not bother the doctors that day or she would take away his electric wheelchair. Additionally, on December 1, 2016, Licensee made resident CM get up and go to breakfast even though resident CM did not want to. Resident CM

Disciplinary Actions**

had informed Licensee that she had been up late and did not want to go to breakfast.
Probation 12/06/2017 to 12/06/2019

Shelby, Karen Ann
Salem, MO
Licensed Practical Nurse 2011016092
On or about November 16, 2015, Licensee pled guilty to two (2) counts of Making a False Statement. The Virginia Board of Nursing disciplined Licensee's privilege to practice in that State upon grounds for which revocation or suspension is authorized in this State.
Probation 01/17/2018 to 01/17/2020

Noble, Ronda C
Stanberry, MO
Registered Nurse 148364
Licensee's Missouri nursing license was originally issued on September 3, 1997, and was current and active until the license expired on April 30, 2017. On or about October 5, 2017, Licensee learned her license had expired when her employer informed her that her license had lapsed. Licensee worked as a nurse in Missouri without a license from May 1, 2017 until October 5, 2017. This is the second time that Licensee has worked without a license, having done so previously from May 1, 2011 until July 14, 2011.
Probation 12/07/2017 to 12/07/2018

Kelly, Lacie Rose
Liberty, MO
Registered Nurse 2015026471
In April 2016, a Proactive Diversion report showed that Licensee had withdrawn narcotic medications in greater quantities than her peers in March 2016. A chart audit was performed and it was discovered that Licensee was not appropriately following the medication administration and medication waste policies. On April 29, 2016, Licensee met with her supervisor and discussed the medication administration process. After hospital administrators reviewed the report, Licensee received a verbal warning on May 6, 2016, concerning sloppy documentation of narcotics. In July 2016, a Proactive Diversion report revealed concerns regarding Licensee's narcotic access and documentation for June 2016. The Proactive Diversion report for June 2016 indicated that Licensee failed to properly document the administration, waste, or return of Hydromorphone and Fentanyl which she withdrew. Hospital administrators met with Licensee on July 15, 2016 to review the findings of the June 2016 Proactive Diversion report. Hospital administrators requested that Licensee submit a sample for a for-cause drug screen. Licensee told her employers that she might test positive for marijuana because she had smoked marijuana earlier in July and Licensee opted to not submit a sample for testing. Licensee later spoke with an investigator with the Board and admitted that she had smoked marijuana on July 4, 2016.
Probation 02/03/2018 to 02/03/2021

Voyles, Sabrina Mashell
Kansas City, MO
Licensed Practical Nurse 2003014344
On February 3, 2009, Applicant pled guilty to the class B misdemeanor of DWI - Alcohol. On May 19, 2009, Applicant pled guilty to the class A misdemeanor of Driving While Revoked. On April 9, 2010, Applicant pled guilty to the class C felony of Arson 2nd Degree. On March 28, 2017, Applicant pled guilty to class A misdemeanor of Theft/Stealing. She was diagnosed with alcohol abuse and amphetamine abuse and has a history of alcohol use disorder and methamphetamine use disorder.
Probation 01/17/2018 to 01/17/2023

Cazier, Malisa Halona
Nixa, MO
Licensed Practical Nurse 2014044587
Respondent failed to complete the contract process with NTS. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the due date of September 12, 2017.
Probation 12/22/2017 to 12/22/2022

Webb, Shianne Michelle
Lees Summit, MO
Registered Nurse 2010018151
Count I
During 2014, hospital officials conducted an investigation into Licensee's drug-dispensing activities for her patients and found her to have a high variance rate; she was pulling both IV and oral narcotics at the same time, she was not "scanning" her medications at an acceptable rate, and she had a higher than average dispense rate for oral narcotics. As a result of the investigation, hospital officials asked Licensee to submit to a for-cause drug screen. On July 16, 2014 Licensee submitted a sample for a for-cause drug screen. The sample Licensee submitted July 16, 2014 returned positive for marijuana. Count II: On or about April 9, 2016, Licensee was witnessed by a coworker exhibiting impaired behavior, including slurring her speech and difficulty keeping her eyes open. The oncoming nurse spoke with an alert patient who requested pain medication. The electronic medication administration record (EMAR) indicated the patient had been administered two NORCO just prior to the request. The patient stated he had not received any pain medication that day. The EMAR showed that Licensee had administered two NORCO to the patient at 9:10 a.m., 12:53 p.m., and 6:57 p.m. On or about April 15, 2016, the Patient Care Supervisor observed the Licensee exhibiting impaired behavior of being "a little foggy or dazed." An audit was performed of patients the Licensee had administered medication

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Disciplinary Actions**

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to on that day. Three (3) alert patients stated they had not received medication, though the EMAR showed the patients had been administered Norco by Licensee. A narcotic audit was conducted for the Licensee by the hospital for the period of March 15, 2016 through April 12, 2016. On April 8, 2016, for patient 419956990: a. 2 Percocet were pulled from the PYXIS at 1642; administered at 1700. b. 5 Percocet were wasted in the PYXIS at 1654. c. 1 Percocet pulled from the PYXIS at 1655; Licensee did not document the administration or waste of the narcotic. On March 24, 2016, for patient 419885405: a. 2 Norco pulled from the PYXIS at 0827; administered at 0750. b. Patient received another dose of Norco at 1726. Licensee was the only nurse to give the patient pain medication during her hospital stay. On April 12, 2016, for patient 420033904: a. Chlor-Hydrocodone 5 ml suspension pulled at 0854; not documented as given until 1031. b. Norco pulled from PYXIS at 0855; administered at 1034. On April 14, 2016, for patient 419984448: a. 2 Norco pulled under separate PYXIS pulls 1055; Licensee did not document the administration or waste of these pulled narcotics. b. 2 Norco pulled at 1538; Licensee did not document the administration or waste of these narcotics. Due to impaired behavior of thick speech, restricted pupils, white tongue, and slow and pronounced blinking during Licensee's meeting with hospital officials, Licensee was asked to submit for a for-cause drug screen. Licensee declined to submit a sample for the for-cause drug screen for the hospital officials. Count III: On or about July 25, 2016, Licensee was witnessed by coworkers exhibiting impaired behavior. Licensee appeared tired, lethargic, her speech was slow, and was witnessed falling asleep while working. Subsequently, Licensee was asked to submit for a for cause drug screen. On August 1, 2016, Licensee's drug screen was confirmed positive for marijuana.
Probation 02/02/2018 to 02/02/2023

Hunter (Boren), Bonnie Marie
Poplar Bluff, MO
Licensed Practical Nurse 2017042343
From 2005 until 2012, Boren abused alcohol and pain medication such as hydrocodone (brand name Vicodin). At first Boren had prescriptions for pain medication, but sought refills sooner than she should have and went to more than one doctor for prescriptions for hydrocodone and Percocet. Boren also purchased controlled substances as a "street purchase." When Boren did not have a prescription, she began diverting medication from her employer, a hospital. She stole Demerol and Vicodin. From 2008 to 2011, Boren was drinking a fifth to a fifth and a half of hard liquor a day. Boren entered into a settlement agreement with the Board on January 12, 2011. The Board placed Boren's license on probation for three years with conditions, including random drug and alcohol testing. Boren failed to undergo the drug testing because she was still abusing alcohol and pain medication. Boren has not consumed alcohol or illicit drugs since 2012.
Probation 12/05/2017 to 12/05/2020

Zweifel, Kristina A
Hillsboro, MO
Licensed Practical Nurse 2006033387
Licensee was employed as an agency nurse at several facilities in St. Louis, Missouri. Only one facility reported concerns regarding Licensee's handling and administration of medications. On two occasions, Licensee documented the administration of one (1) Hydrocodone/APAP 5/325mg tablet too early and contrary to the doctor's orders. In both cases, Licensee believed the patient was in pain and believed she could administer pain medication every two (2) hours, but did not check the patient's orders. During narcotic count, it was noted that one (1) Oxycodone/APAP 5/325mg was missing from its bubble card that Licensee had been responsible for had been popped. Licensee later located the missing Oxycodone pill on the ground underneath the narcotic count table. Both Licensee and another LPN wasted the pill and documented the waste. Licensee's employment with the agency was terminated on November 9, 2016. Licensee submitted to a drug screen after her termination, which was negative.
Probation 01/23/2018 to 01/24/2018

Grayson, Daryl Lynn
Kansas City, MO
Registered Nurse 153782
From January 27, 2017 until the filing of the Complaint on September 25, 2017, Respondent failed to check in with NTS on two (2) days: to-wit, March 26, 2017 and July 30, 2017. On July 13, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana. Respondent admitted to the medical review officer, Dr. Greg Elam, that she had smoked marijuana the day prior to the test.
Probation 12/22/2017 to 12/22/2019

Jawadi, Al Mehdi Mostafa
Columbia, MO
Registered Nurse 2011006812
The Board did not receive an employer evaluation or statement of unemployment by the quarterly due date of July 17, 2017; however, Respondent submitted a statement of unemployment in May 2017, which he believed would satisfy the July 17, 2017 due date. An evaluation meeting the requirements of both a mental health evaluation and a chemical dependency evaluation was received by the Board on June 13, 2017. The evaluation was completed on or about June 6, 2017, and recommended further treatment, including therapy for mental health and chemical use/abuse issues. The Board did not receive an updated chemical dependency evaluation submitted on Respondent's behalf by the quarterly due date of July 17, 2017. The Board did not

Disciplinary Actions**

receive an updated mental health evaluation submitted on Respondent's behalf by the quarterly due date of July 17, 2017.
Probation 12/22/2017 to 12/22/2020

Fuller, Traci L
Saint Joseph, MO
Registered Nurse 092443
On August 19, 2016, Licensee's coworkers observed Licensee falling asleep while charting on the computer. On her August 21, 2016 through August 22, 2016 shift, Licensee's coworkers observed Licensee falling asleep and slurring her speech during her shift. Licensee was observed falling asleep while reporting off on her patients and was unable to provide a full report on all of her patients. It was also discovered that Licensee had failed to chart the administration of medications to patients and Licensee had failed to document the withdrawal of controlled substances for her patients. Licensee failed to document what she had done with narcotic medications for her patients. While Licensee was attempting to report off on her patients, it was discovered that several bottles of liquid Lorazepam were missing. The bottles were later found but a total of 13.5 ml of Lorazepam was unaccounted for. Licensee was impaired on the August 21, 2016 through August 22, 2016 shift and was unable to provide appropriate care to her patients. Licensee had previously received a verbal counseling for failure to report abuse to nursing management or administration on March 1, 2015. Further, Licensee received a written warning on August 14, 2015, for failing to follow job functions by not signing out that she had given medications to a resident from July 1, 2015, through July 7, 2015. On this incident the medication was discontinued on July 8, 2015, at which time the nurses charted that she had given the medication the week prior. On September 25, 2015, Licensee received a written warning for taking an order to change a Coumadin dose; however, there was no telephone order written, no fax or call to the Pharmacy, and no update documented on the Coumadin tracking sheet. Licensee was terminated for failing to submit to a for-cause drug screen.
Probation 12/12/2017 to 12/12/2020

Jackson, Susan Renee
Columbia, MO
Licensed Practical Nurse 2008026793
On or about October 23, 2016, Licensee was present when a co-worker was interacting inappropriately with a patient. Licensee failed to report the co-worker's inappropriate interactions. Licensee was also heard during this encounter sharing personal health information about herself and other co-workers. On November 22, 2016, Licensee received an Unacceptable Conduct Notice for failing to provide proper wound care to a patient on or about October 25, 2016. The Unacceptable Conduct Notice stated that Licensee cared for a patient's exposed and infected wound without properly washing her hands before or after the procedure, nor wearing gloves during the procedure. A video additionally showed Licensee coughing into her hands while caring for the patient's wound.
Probation 12/16/2017 to 12/16/2018

Barnett, Kristina Maria
Lebanon, MO
Licensed Practical Nurse 2010005295
On or about July 24, 2017, Licensee pled guilty to the class C felony of Possession of a Controlled Substance except 35 grams or less of Marijuana. On or about April 26, 2017, Licensee underwent a chemical dependency evaluation. The evaluator concluded that Licensee is in remission of early middle stages of chemical dependency, primarily methamphetamines. Licensee reported to the evaluator that she started using methamphetamines "near daily" after the birth of her son, whom she reported as then being two years old, until she was arrested in January 2016. Licensee reports her date of sobriety is January 22, 2016.
Probation 01/23/2018 to 01/23/2022

Dzyban, Steven Mathew
Ballwin, MO
Registered Nurse 2016037436
The Missouri State Board of Nursing received information from the Tennessee Board of Nursing via the NURSYS website that the Tennessee certificate to practice as an advanced practice registered nurse and nursing license of Respondent were suspended in an Agreed Order, which was made a Final Order on February 22, 2017. The suspension was stayed and his certificate and license were placed on probation.
Probation 12/22/2017 to 12/22/2022

Bahler, Michele Noelle
Hollister, MO
Registered Nurse 2006023341
On or about May 2, 2017, Licensee pled guilty to the class A misdemeanor of Stealing Leased or Rented Property, in the Circuit Court of Adair County, Missouri, in case number 16AR-CR00067-01. Licensee was sentenced to two (2) years of supervised probation and ordered to pay restitution in the amount of $13,981.83.
Probation 01/29/2018 to 01/29/2020

Probation continued on page 18

Disciplinary Actions**

Probation continued from page 17

Chesnut, Trevor E
Kansas City, MO
Registered Nurse 2011037225
On or about December 9, 2015, Licensee pled guilty to the offense of OWI - 3rd in the Circuit Court of Dodge County, Wisconsin. On October 13, 2016, the Wisconsin Board of Nursing issued its Final Decision and Order indefinitely suspending the privilege to practice of Licensee.
Probation 02/01/2018 to 02/01/2022

Urhahn, Tiffany L
Morse Mill, MO
Registered Nurse 2004022395
On September 23, 2016, Licensee was asked to submit a sample for a for-cause drug screen. The sample which Licensee submitted returned positive for Marijuana.
Probation 12/12/2017 to 12/12/2019

Fasce, Stacie Ann
High Ridge, MO
Registered Nurse 2003005384
In November 2014, the hospital Manager investigated claims that Licensee had failed to administer medication to a patient when Licensee had documented that she had administered the medication. The Nurse Manager spoke to the patient, and the patient stated that she had not received the medication. The Nurse Manager took a closer look at Licensee's narcotic usage and patient care and discovered that Licensee was pulling more Norco than other nurses, Licensee was printing off duplicate patient wristbands which are used for tracking patient medication administration, and Licensee was scanning medications and patient wristbands in rooms where the patients were not located. On or about December 3, 2014, Licensee was questioned by hospital administrators regarding patients not receiving medications and discrepancies in Licensee's documentation and administration of narcotics. Licensee admitted to several instances of not following proper procedures for scanning medication and patients' wristbands, and also to diverting Norco for personal use.
Probation 02/23/2018 to 02/23/2021

Leisinger, Jeri L
Columbia, MO
Licensed Practical Nurse 030323
Applicant's guilty pleas and findings of guilty to multiple offenses of driving while intoxicated constitute offenses involving moral turpitude. Applicant's history demonstrates that she has habitual intoxication or a dependence upon alcohol. Applicant has not demonstrated that she has rehabilitated herself. Applicant has not demonstrated that she has the requisite moral character for licensure in Missouri.
Renewal Denied 01/17/2018

REVOKED

Weaver, Dinorah L
Saint Joseph, MO
Registered Nurse 134614
Respondent pled guilty to the offense of Willful Failure to Collect or Pay Over Taxes.
Revoked 12/18/2017

Jensen, Julie Marie
Saint Louis, MO
Registered Nurse 2009005952
Respondent pled guilty to the class C felony of Stealing a Controlled Substance. Respondent stole eight (8) Percocet pills from a patient for whom she was caring in a home health care position. When police asked Respondent to go outside and speak with them, she threw the Percocet pills in the garbage in the breakfast area of the hotel because she was scared the police would find them on her.
Revoked 12/18/2017

Cox, Denise L
Buffalo, MO
Licensed Practical Nurse 042450
The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of April 14, 2017 and July 14, 2017.
Revoked 12/18/2017

Sturgis, Jennifer Leigh
Saint Joseph, MO
Registered Nurse 2013021000
Respondent pled guilty to the offense of False Statements on a Tax Return.
Revoked 12/18/2017

Langlais, Dawn C
Saint Joseph, MO
Registered Nurse 095704
Respondent pled guilty to the offense of Willful Failure to Collect or Pay Over Taxes.
Revoked 12/18/2017

Cameron, Rosalind Sherron
Springfield, IL
Licensed Practical Nurse 2007015007
The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of July 5, 2017. The Board did not receive an application to renew Respondent's nursing license, the required fees, and criminal background check by the due date of May 31, 2017. Respondent was required to obtain continuing education hours by July 17, 2017. As of September 21, 2017, the Board had not received proof of completion for any completed continuing education classes; however, Respondent submitted proof of completion of four (4) of the required classes that she completed on October 9 and 10, 2017. She did not complete Sharpening Critical Thinking Skills.
Revoked 12/18/2017

Smith, Lisa A
Malden, MO
Licensed Practical Nurse 054821
Respondent failed to check in with NTS on eight (8) days. On three separate occasions, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. The Board had not received proof of any completed continuing education hours.
Revoked 12/18/2017

DiLorenzo, Stephanie Renee
Prairie Village, KS
Registered Nurse 2009017308
Respondent and the Kansas Board of Nursing entered into a Consent Agreement and Final Order (Order) which became effective on July 20, 2017. In the Order, Respondent and the Kansas Board of Nursing stipulated that Respondent currently has a medical condition that interferes with her ability to safely practice nursing.
Revoked 12/18/2017

Disciplinary Actions**

Layton, Lisa Ann
Dexter, MO
Licensed Practical Nurse 2001019752
Respondent was employed as a home health licensed practical nurse with an agency in Sikeston, Missouri. On January 28, 2016, Respondent arrived at a patient's home to provide in-home care. The patient's mother witnessed Respondent exhibiting concerning behavior, such as the inability to recall whether she had administered medication to the patient. The patient's mother contacted the agency due to her concerns regarding Respondent's behavior. An agency official came to the patient's home and witnessed Respondent acting fidgety, unable to focus on the conversation, having scattered thoughts, standing up and sitting down repeatedly, turning in circles, and telling the same information multiple times. Respondent was also unable to recall whether she had administered medication to the patient to the agency official. Respondent admitted to the agency official that she had consumed alcohol until 2:00 a.m. and reported six (6) hours later to her 8:00 a.m. shift on January 28, 2016. Respondent also admitted to the agency official that she had ingested a Vicodin, which she did not have a prescription for, a few days prior to January 28, 2016. The Board investigator sent a letter regarding the complaint to Respondent on March 3, 2016 to the address Respondent had provided to the Board. The letter was returned to the Board as unable to forward; Respondent had moved from that address and had not provided the Board with her current address. The Board investigator failed to reach Respondent at the telephone number she provided, due to this number being disconnected.
Revoked 12/18/2017

Paris, Mary E
Kansas City, MO
Registered Nurse 113368
Suspended 12/19/17-06/19/18; Probated 06/20/18-06/20/23
The Missouri State Board of Nursing received information from the Kansas Board of Nursing via the NURSYS website that the nursing license of Respondent was suspended in a Consent Agreement and Final Order (Order) dated May 24, 2017. Specifically, the Order states the following agreed findings of fact: a. Respondent was working as an RN on the night shift at Saint John's Hospital, Leavenworth, KS from on or about September 11, 2015 through September 12, 2015. b. During the shift, other staff noticed that Respondent was not acting normally, had slow, slurred speech, an unsteady gait, and was emotionally unstable. Management asked Respondent to take a UDS [urine drug screen] due to her altered behavior. c. Respondent refused to take a UDS and became physically and verbally belligerent. Hospital security was called and Respondent struck one of the security officers. d. On or about September 12, 2015, Respondent was terminated from St. Johns for failure to submit to drug/alcohol testing pursuant to the facilities [sic] drug and alcohol policy. e. Respondent received a copy of St. John's drug and alcohol policy prior to the above events. f. During a phone interview with a KSBN [Kansas State Board of Nursing] investigator, Respondent stated she had been in inpatient treatment in May 2015 for a month for alcohol treatment. g. The Board referred Respondent to the Kansas Nurses Assistance Program (KNAP) on March 2, 2017. h. Respondent had a drug and alcohol evaluation and it determined that she had an impairment and needed monitoring. Respondent enrolled in a three-year monitoring program with KNAP on April 14, 2017. f. On October 5, 2017, Respondent's Kansas nursing license was suspended after she attempted to submit "fake" urine for a random drug test because she had taken hydrocodone without a prescription.
Suspension 12/19/2017 to 06/19/2018

VOLUNTARY SURRENDER

Schwoeppe, Linda M
Marthasville, MO
Registered Nurse 074964
On January 22, 2016, Licensee was observed at work in an intoxicated condition. Licensee smelled of alcohol, had slurred speech, and an unsteady gait. Licensee submitted a breath sample for a breathalyzer blood alcohol test, which returned positive with a .206% blood alcohol level. Licensee was given a one-time referral to the Employee Assistance Program (EAP) in lieu of termination. Licensee did not comply with the EAP and her employment with the hospital was terminated on March 17, 2016, for violating the facilities Drug and Alcohol-Free workplace policy.
Voluntary Surrender 02/14/2018

Brown, Melanie Alison
Columbia, MO
Registered Nurse 2015005377
On February 17, 2016, a routine audit of the Licensee's narcotic administration was performed and discrepancies were found in Licensee's documentation of medications which she administered and wasted. On January 20, 2016, Licensee withdrew 2 mg of Alprazolam from the Pyxis for patient GS, at 0823 and again at 1031. Licensee documented the administration of the 2 mg of Alprazolam at 0825 and again at 1033. According to orders, the patient was to receive 2 mg of Alprazolam every 6 hours. On January 25, 2016, Licensee withdrew 5 mg of diazepam from the Pyxis at 0756 for patient TB. Licensee failed to document the administration, waste, or return of the diazepam. On February 1, 2016, Licensee withdrew 15 mg of oxycodone from the Pyxis at 0823 for patient AB. Licensee failed to document the administration, waste, or return of the oxycodone. On February 15, 2016, Licensee withdrew 0.5 mg of lorazepam from the Pyxis at 1702 for patient IA. Licensee documented that the patient refused the medication at 1700. Licensee did not return the medication to the Pyxis until February 17, 2016. Licensee failed to properly document the administration and wasting of medications.
Voluntary Surrender 01/29/2018

Smith, Matthew John
Saint Louis, MO
Registered Nurse 2011032687
Licensee admitted to the Board's investigator that he had diverted Dilaudid, Percocet, oxycodone and morphine from the hospital for personal consumption and his diversion had increased during the months of April and May 2014.
Voluntary Surrender 12/19/2017

Lutz, Sherri Marie
Wentzville, MO
Registered Nurse 2011021776
Licensee pled guilty to the class B felony of Conspiracy to Commit Murder and the class B felony of Distribution of a Controlled Substance.
Voluntary Surrender 12/18/2017

Mccrae, Ida J
Doniphan, MO
Registered Nurse 086500
Licensee surrendered her Missouri nursing license effective January 8, 2018.
Voluntary Surrender 01/08/2018

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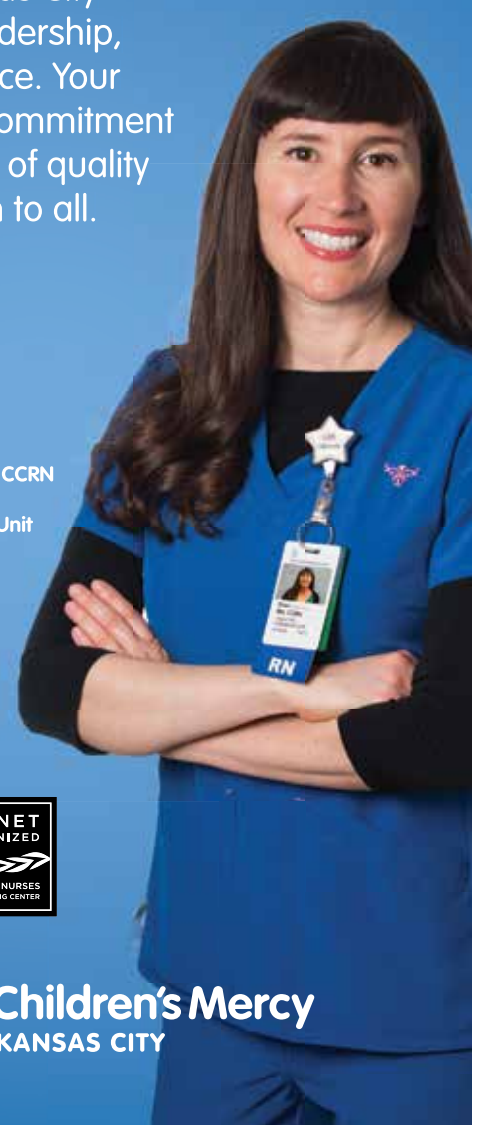

Shak Hensley, MSN, RN, CCRN
Critical Care Staff Nurse
Pediatric Intensive Care Unit

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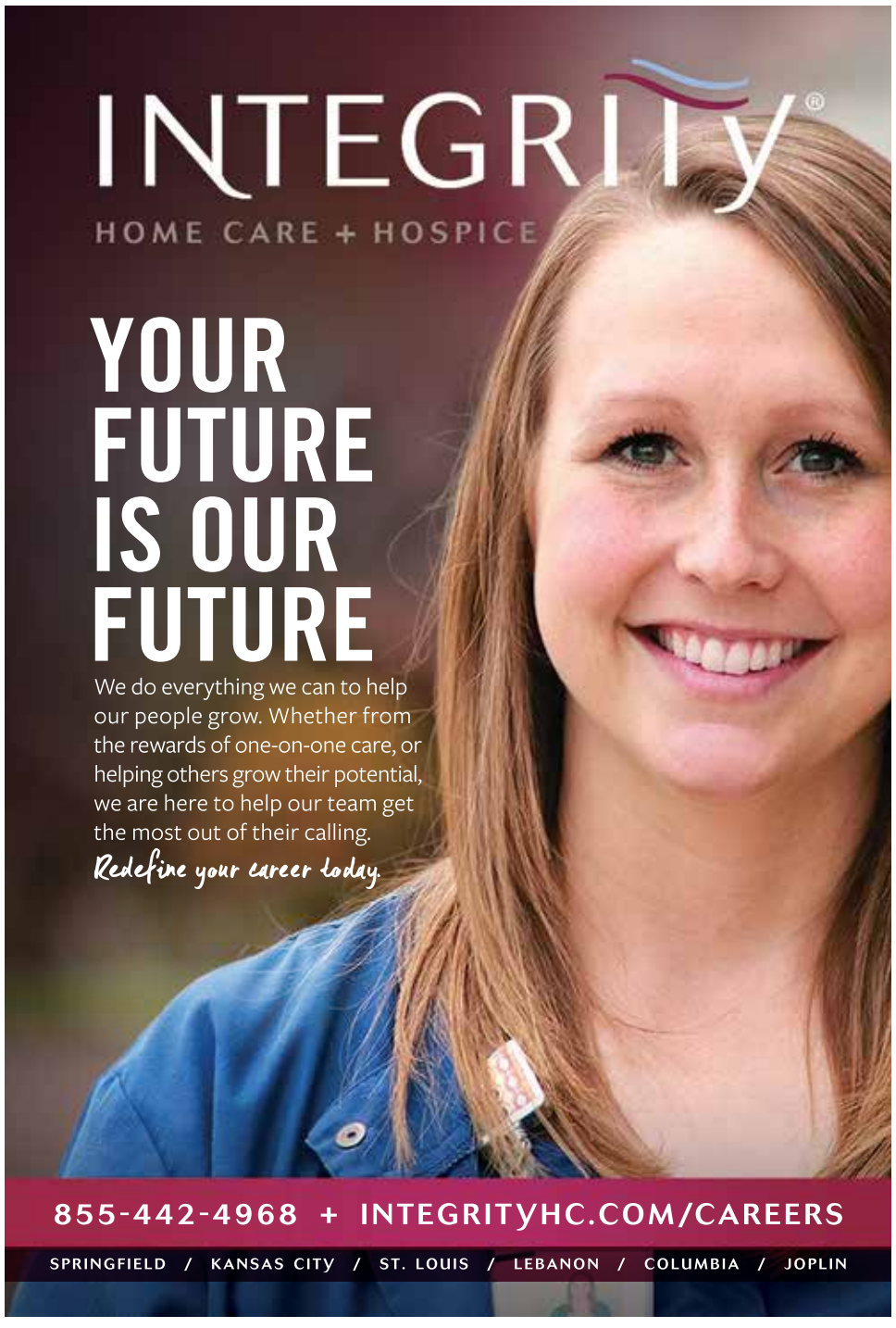

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