

3rd AGENDA

BOARD OF NURSING

June 12, 2014 – 8:30 a.m.

Room 474 (Fourth Floor)

Heber M. Wells Building

160 E. 300 S. Salt Lake City, Utah

This agenda is subject to change up to 24 hours prior to the meeting.

ADMINISTRATIVE BUSINESS:

1. Sign Per Diem
2. Call Meeting to Order.
3. Review and approve April 10, 2014 minutes

BOARD BUSINESS:

8:45 a.m. - Connie Call, Compliance report, probationer requests/miscellaneous

9:30 a.m. - William Schwartz, review evaluations and practice plan

The evaluation review may result in a closed meeting in accordance with §52-4-205(1)(a).

10:30 a.m. - Nurse Practice Act Rule Hearing

11:00 a.m. - Diana Parrish/Deb Hobbins report on the NCSBN Discipline Conference

LUNCH: 11:30 a.m. – 12:30 p.m.

PROBATION INTERVIEWS:

Please note: The compliance report, report from Committees and probation interviews may result in a closed meeting in accordance with §52-4-205(1)(a).

	Group 1 Room 474	Group 2 Room 475
12:30 p.m.	Sara Swearingen, non-compliance	Rebecca Davis, her request
12:45 p.m.	Julie Porter, non-compliance	Kristina Withers, non-compliance
1:00 p.m.	Rachel Zimmermann, New Order	Kolby Andersen, New Order
1:30 p.m.	Jamie Partridge, New Order	Michelle Richman, New Order

BOARD BUSINESS:

2:00 p.m. – Informal Adjudicative Proceeding – Synthia Carter

2:30 p.m. – McKayla Brough, New Order

2:35 p.m. - Lori Wright, non compliance

3:00 p.m. - Rebecca McInnis, application review

3:30 p.m. - Cindy Lynn Carter, New Order

4:00 p.m. - Report from Committees

4:15 p.m. - Environmental Scan

-Discussion regarding sending evaluations for review prior to a meeting by a secure email.

NEXT MEETING: July 10, 2014

Meetings scheduled for the next quarter: August 21, 2014 and September 11, 2014

Note: In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify, Dave Taylor, ADA Coordinator, at least three working days prior to the meeting. Division of Occupational & Professional Licensing, 160 East 300 South, Salt Lake City, Utah 84115, 801-530-6628 or toll-free in Utah only 866-275-3675

REVISED CHECKLIST FOR PUBLIC MEETINGS

(Fill in the blanks to correspond to each respective board, commission, or committee.)

___ I am, PEGGY BROWN, chairperson of the BOARD OF NURSING.

___ I would like to call this meeting of the BOARD OF NURSING to order.

___ It is now (time) 8:35 (am / pm) on June 12, 2014.

___ This meeting is being held in room 474 of the HEBER WELLS BUILDING in SALT LAKE CITY UT.

___ Notice of this meeting was provided as required under Utah's Open Meeting laws.

___ In compliance with Utah's Open Meetings laws, this meeting is being recorded in its entirety. The recording will be posted to the Utah Public Notice Website no later than three business days following the meeting.

___ In compliance with Utah's Open Meeting laws, minutes will also be prepared of this meeting and will be posted to the Utah Public Notice Website. Appropriately marked "pending approval" minutes will be posted no later than 30 days after the close of the meeting and "approved" minutes no later than three business days after approval.

___ The following Board members are in attendance:

	YES	NO
<u>PEGGY BROWN</u> , Chairperson	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>RALPH PITTMAN</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>CECILEE RALL</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>MEGAN CHRISTENSEN</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>JAMIE JO CLINTON-LONT</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<u>DIANA PARRISH</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>CALVIN KREMIN</u>	<input type="checkbox"/>	Excused
<u>ALISA BANGERTER</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<u>(VACANT)</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>(VACANT)</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>(VACANT)</u>	<input type="checkbox"/>	<input type="checkbox"/>

___ The following Board members are absent: (Refer to the above list.)

___ The following individuals representing DOPL and the Department of Commerce are in attendance:

	YES	NO
<u>Mark B. Steinagel</u> , Division Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<u>Debra Hobbins</u> , Bureau Manager	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<u>Shirlene Kimball</u> , Board Secretary	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<u>Connie Call</u> , Compliance Specialist	<input checked="" type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

___ We welcome any visitors and interested persons at this time. Please be sure to sign the attendance report for the meeting and identify yourself before speaking.

___ As a courtesy to everyone participating in this meeting, at this time we ask for all cell phones, pagers, and other electronic devices to be turned off or changed to silent mode.

___ Board motions and votes will be recorded in the minutes.

___ Let us now proceed with the agenda.

___ (End of the Meeting) It is now (time) 5:13 (am / pm), and this meeting is adjourned.

Guests - Please sign

Date: 6/12/2014

BOARD OF NURSING

<u>NAME: (Please Print)</u>	<u>REPRESENTING</u>
Morgan Silva	Everest College: SLC
Brittany Lucaturo	Everest College: SLC
Sunnie Barlow	Everest College: SLC
Natasha Richards	Everest College
Amber Silva	Everest College
Taisha Corbett	Everest College, SLC
Katie Larsen	DATC
Camille Barnes	Everest College, SLC
Lorena Jimenet	Everest College SLC
Army Mayfield	Rocky Mountain University of Health Professions
Miranda Lamb	Everest College: SLC
Sharon Dingman	RN - DNP Rm u
Mark Davis	Rebecca Davis RN
Jolene Meltzer	Everest College: SLC
Rachel Zimmermann	RN. self.
Audrey Elliott	Rachel Zimmermann
Andrew Savas	Everest. college
Robyn Secondine	Everest College
MaryBeth Patton	Everest College
Che' Ague Ho	AG/ OAL
CAROL HUNTINGTON	HORI WRIGHT
Cady Carter	self
Todd Carr	

off 8:44 3:17
mc 9:27 3:46

**SWORN STATEMENT
SUPPORTING CLOSURE OF BOARD MEETING**

DOPL-FM-010 04/28/2006

I Marguerite Brown acted as the presiding member of the Nursing
Board, which met on June 12, 2014

Appropriate notice was given of the Board's meeting as required by §52-4-202.

A quorum of the Board was present at the meeting and voted by a _____
vote, as detailed in the minutes of the open meeting, to close a portion of the meeting to discuss the
following:

- the character, professional competence, or physical or mental health of an individual (52-4-205(1)(a))
- strategy regarding pending or reasonably imminent litigation (§52-4-205(1)(c))
- deployment of security personnel, devices, or systems (§52-4-205(1)(f))
- investigative proceedings regarding allegations of criminal misconduct (§52-4-205(1)(g))

The content of the closed portion of the Board meeting was restricted to a discussion of the matter(s) for which the meeting was closed.

With regard to the closed meeting, the minutes and recording of the open meeting include:

- (a) the date, time, and place of the meeting;
- (b) the names of members present and absent;
- (c) the names of all others present except where such disclosure would infringe on the confidentiality necessary to fulfill the original purpose of closing the meeting;
- (d) the reason or reasons for holding a closed meeting; and
- (e) the vote either for or against the proposition to hold such a meeting cast by each board member by name.

Pursuant to §52-4-206(5), a sworn statement is required to close a meeting under §52-4-205 (1)(a) or 52-4-205(1)(f), but a record by tape recording or detailed minutes is not required.

- A record was not made
- A record was made by: Tape Recording Detailed Written Minutes

Pursuant to §52-4-206(1), a record by tape recording is required for a meeting closed under §52-4-205(1)(c) or 52-4-205(1)(g), and was made.

- Detailed written minutes of the content of a closed meeting although not required, are permitted and were kept of the meeting.

I hereby swear or affirm under penalty of perjury that the above information is true and correct to the best of my knowledge.

Marguerite Brown
Board Chairman or other Presiding Member

June 12, 2014
Date of Signature

1. I have 9 years experience as a LPN in the school setting.
2. Developed IHP's in conjunction with the applicable students, parents, educators, and healthcare providers.
3. Developed and implemented methodical and specialized training to district staff, students, and family members.
4. Scheduled and administered vision/scoliosis screenings, and prepared state mandated reporting for evidence of completion.
5. Instructor of CPR, AED, First Aid emergency response for district staff, as well as small group trainings to address individual medical needs of students (e.g. G-tube, Epi-pen, insulin and glucagon emergencies, seizures, etc.).
6. Assessed and provided direction during a staff or student emergency, in person or remotely via phone contact.
7. Debriefed staff after emergency events to ensure accurate and detailed documentation.
8. Execute plans for staff wellness which includes administering annual flu shots and provides guidance on personal medical issues.
9. Meticulously documented, implemented, and maintained individualized health care plans for many students.
10. I am highly skilled in the unique ability to bring together disparate parties to forge relationships and create solutions for the higher good of the student's medical need.
11. I have the following certifications:
 - Licensed LPN for state of Utah (currently licensed LPN under Interstate Compact)
 - CPR, AED, First Aid Instructor
 - State of Utah vision screener
 - HANDS (Helping Administer to the Needs of the Student with Diabetes in School) Certified
 - Medical Pandemic Influenza Preparedness certification
 - Pediatric Patient with Gastrostomy and/or Tracheostomy in Home or School Setting Certified
 - IV Certified
 - Basic Cardiac Dysrhythmia Certified
 - Nasogastric Intubation Certified
12. Upon request I have multiple letters of recommendation from district administrators.

Thank you for your consideration,
Laura Upton-Bell LPN
Phone 435-619-3650

Santa Clara Elementary

Nadine Hancey
Principal

October 16, 2012

2950 West Crestview Dr
Santa Clara, UT 84765
Phone: (435) 628-2624
Fax: (435) 628-8785

To Whom It May Concern:

It is a pleasure to write this letter of recommendation for Nurse Laura Bell. Mrs. Bell has been a district nurse for many years and our school is one of many that she has worked with. She is one of the most dedicated and passionate people about her job that I have ever encountered. Even though she has the responsibility of being the nurse for many schools in our district, she finds the time to give the individualized care that many students and parents need.

One of the students we had at our school was a very medically fragile student . Throughout his elementary years, Laura built an excellent relationship with the student and his mother, trained paraprofessionals and resource teachers in the medical procedures, checked often to make sure the procedures were being followed, and responded quickly when we had an unusual situation with him. There have been other parents that have had questions or concerns and Nurse Bell was more than willing to call these parents to discuss their student's needs and help in anyway she could. I have never hesitated to have her visit with parents or students because she is caring and attentive to their concerns.

Her medical knowledge, her attention to detail, and her outgoing personality are all appreciated. I know Mrs. Laura Bell will be an asset to any organization.

Sincerely,



Nadine Hancey
Principal
Santa Clara Elementary



Washington County School District

121 West Tabernacle

St. George, Utah 84770

Telephone: (435) 673-3553

Fax: (435) 673-3216

SUPERINTENDENT MAX H. ROSE, Ph.D.

November 6, 2012

Personal Reference Letter for Laura Bell:

It is my pleasure to serve as a personal reference for Mrs. Laura Bell. I have been acquainted with Laura for the past 8 years as Laura has served as a School Nurse in Washington County School District. I have no reservations in regards to Laura's qualifications, dependability, and competence. She is an exemplary school nurse and valuable team member.

Laura has the ability to work with health care professionals, administrators, teachers, parents and students as she coordinates health trainings and services for the many schools in which she serves. She has the adaptability to work with a variety of ages and in various environments as she has worked with preschoolers, elementary, intermediate and middle school students. She has an excellent rapport with parents and handles parent meetings with professionalism and courtesy. She is an invaluable piece of the school education team and collaborates well with team members in coordinating health related services for students.

Laura is very organized and conducts vision and scoliosis screenings, flu shot clinics and maturation programs with attention to detail. She has a systematic and meticulous organization of health care plans. Her collaboration with all team members ensures a safe school environment and optimal learning opportunities by promoting health and safety for all students.

I would recommend Laura for any medical position for she has the knowledge and wisdom to make critical medical decisions. Laura would be an excellent employee and asset to any school or medical facility. Please contact me if you have any additional questions.

Sincerely,

Lee Ann M. Parkinson, M. Ed.

Special Education Cone Site Coordinator

Washington County School District

435 673-3553 x 5128



Washington County School District

121 West Tabernacle
St. George, Utah 84770
Telephone: (435) 673-3553
Fax: (435) 673-3216

SUPERINTENDENT MAX H. ROSE, Ph.D.

November 3, 2012

To Whom It May Concern:

It is a privilege for me to write a letter of recommendation for Mrs. Laura Bell. Laura has worked with Snow Canyon Middle School for the past eight years and has lived up to our expectations and served our school well. Laura is an innovative self-starter, who rarely requires supervision. She is punctual, manages stress well and is a true asset to our school.

Students who have a health issue such as asthma or diabetes need parents, teachers and the school health care personnel to work together to ensure their health and well-being. Laura makes sure everyone stays in good communication and keeps medical orders and medicines up-to-date at school. Our teachers and staff view her as a valuable resource. She quickly gains the confidence of the parents, students and her colleagues. Of worthy mention is Laura's ability to work with our team to resolve issues so health concerns minimally impact their learning environment. She is always working to help all students succeed.

It is rare to find such a caring individual. I would without reservation give Laura Bell my very strongest recommendation for any position that is available.

Sincerely,

Cheri Stevenson
Principal, Snow Canyon Middle School

Assist. Supt. Secondary Ed.
MARSHALL TOPHAM, M.S.

Assist. Supt. Elementary Ed.
REX WILKEY, M.ED.

Business Administrator
BRENT BILLS, M.B.A.

Dir. Human Resources
LYLE COX, M.B.A.

Dir. Special Ed.
JIM MCKIM, M.ED.

Dir. Career & Tech. Ed./Foundation
LARRY STEPHENSON, M.ED.

Dir. Assessment
BRAD FERGUSON, Ph.D.

Dir. Physical Facilities
N. CRAIG HAMMER, M.ED.

Dir. Professional Development
RICHARD HOLMES, M.ED.

Dir. Student Services
LUANNE FORREST, ED.D.

WASHINGTON COUNTY SCHOOL DISTRICT



June 7, 2014

Debra F. Hobbins, APRN
Bureau Manager
Utah Division of Occupational and Professional Licensing
160 E 300 S
Salt Lake City, UT 84111

Dear Mrs. Hobbins:

I understand that you are the contact person regarding the proposed changes to the Nurse Practice Act. With over 25 years in Special Education as a former Coordinator, Associate & Interim Director; and presently the new Student Services Director in Washington County School District (WCSD), I am seeking to make public comment in regards to the Utah State Bulletin; Number 2014-10; May 15, 2014. I am also seeking clarification between:

Subsection R156-31b-502(2): ... "nurse" was clarified as "registered nurse", the level of nurse education and licensure consistent with the requirements of and demands on a school nurse; and

Subsection R156-31b-102. Definitions:

(27) "Nurse" means:

- (a) an individual licensed under Title 58, Chapter 31b as:
 - (i) a licensed practical nurse;
 - (ii) a registered nurse;
 - (iii) an advanced practice registered nurse; or
 - (iv) an advanced practice registered nurse-certified registered nurse anesthetist; or...

WCSD appreciates the Board's efforts to reorganize the rules within the Nurse Practice Act and clean up existing language. R156-31b-703a Standards of Professional Accountability appears to encompass for LPN, RN and APRN licenses, many responsibilities which were previously divided; however, I find the new proposed R156-31b-703b somewhat limiting in comparison to the previous R156-31b-703. For example, an LPN in a school setting is very capable of the following responsibilities which have been eliminated: (2)(b) plan for episodic nursing care; (3)(a) function as a member of the health care team contributing to the implementation of an integrated health care plan; and (1)(f)(ii) delegating care for stable patients to unlicensed assistive personnel ... which implies that an LPN can and should also (new

scope RN) (2)(m) teach and counsel patient families **and unlicensed staff (proposed addition)**, regarding an applicable health care regimen, including general information about health and medical conditions, specific procedures, wellness and prevention.

It appears that these rules, as well as the Utah State Board of Education Special Education Rules, support school nurse services which are provided by a *qualified school nurse* (I'm assuming that means both RN and LPN consistent with R156-31b-102 above) and that health care services may be provided by either a qualified school nurse or other qualified person in order to assist a student with a disability to benefit from special education, etc. (I.E. Definitions (300.4-300.45)(34)(13)).

Washington County School District has functioned with RNs (some BSN, some Associate Degree), an LPN, as well as paraprofessionals. We are moving forward next year with the addition of a Lead Nurse (BSN); Nurse Trainer (our LPN), which in addition to serving students within the LPN Scope of Practice, will also be providing training to the paraprofessionals and to our new Health Assistants. Given the nature of the school/educational setting vs. clinical/medical setting, we hope that the Board and subsequent rule changes will support our comprehensive school model in serving all students along our broad continuum of health care services, as well as allowing for the utilization of a variety of qualified nursing personnel.

Thank you so much for allowing our input and for thank you in advance for providing us with further clarification.

Karen M. Bess

Director of Student Services
Washington County School District
121 W Tabernacle St.
St. George, UT 84770
Office: (435) 673-3553 ex. 5163/5164
Cell: (435) 668-7770
karen.bess@washk12.org



Shirlene Kimball <skimball@utah.gov>

Re: Nurse Practice Act

1 message

Debra Hobbins <dhobbins@utah.gov>
To: Amy Goeser <amygoeser@hotmail.com>
Cc: Shirlene Kimball <skimball@utah.gov>

Mon, Jun 9, 2014 at 7:55 AM

Dear Ms. Goeser:

Thank you for your email. I will made sure that it is presented at our Board meeting this week.

Warmest regards,

Deb

On Fri, Jun 6, 2014 at 3:19 PM, Amy Goeser <amygoeser@hotmail.com> wrote:
To Whom It May Concern:

I am writing this letter to address my concerns about the changes to the Nurse Practice Act.

I have had the pleasure of working with Laura Bell, an LPN for the Washington County School District, for 8 years regarding my sons health. She has helped him in times of emergency with professionalism and with the knowledge that any parent would be comfortable with when their child's well-being is at stake. She is very skilled in the nursing profession. I have been impressed with her knowledge about my son's conditions, as they are complicated.

She has written his 504 multiple times. She is extremely knowledgeable and competent in this area. She ensures that the dr. orders are followed to the letter. She makes sure that the school is aware of the 504 that is in place and also is willing to answer any questions/concerns that might come up. She also addresses the parents concerns and makes sure that they are completely comfortable with what is written in the 504. She also has worked with my son to address and issues that he might have with his 504 as well.

As an LPN, I know that she is knowledgeable and can do her job as well as an RN, if not better. I have dealt with other school nurses, and she is far above the standard that is required to work at any school. I would be extremely disappointed and upset, as would my son, if she was unable to do her job due to the proposed changes. If you do change the law, please keep any LPN nurses "grandfathered in" so that we don't lose these great assets to our schools.

I ask that you please consider my words carefully. It would be a great disservice to our school district to let these changes pass.

Thank you,
Amy Goeser
Ivins, Utah
435-313-9518



Shirlene Kimball <skimball@utah.gov>

Re: Changes to the Nurse Practice Act.

1 message

Debra Hobbins <dhobbins@utah.gov>
To: Nadine Hancey <nadine.hancey@washk12.org>
Cc: Shirlene Kimball <skimball@utah.gov>

Mon, Jun 9, 2014 at 4:40 PM

Dear Dr. Hancey:

Thank you for your email. I will take your email to the Board for discussion. Thank you for taking the time to contact us.

Regards,

Deb

On Wed, Jun 4, 2014 at 7:41 PM, Nadine Hancey <nadine.hancey@washk12.org> wrote:

Hello Debra,

I am a principal in Washington County School District. I just wanted to give my input to the changes being made to the Nurse Practice Act. I am hoping that any practicing LPN's can be grandfathered in to continue to work in schools. I have had the privilege of working with Laura Bell, LPN, as my school nurse. She is extremely valuable! She is particularly good with parents and on more than one occasion has kept us out of litigation by knowing the law and following it precisely. I feel she meets every qualification that we need in a school nurse and is one of the best school nurses I have had the privilege of working with in my 35-year career in schools. I would hate to see her not be able to continue to do what she does so well.

Thank you for the work that you do. I'm sure it is difficult trying to juggle everyone's opinions on the matter.

Sincerely,

Nadine Hancey

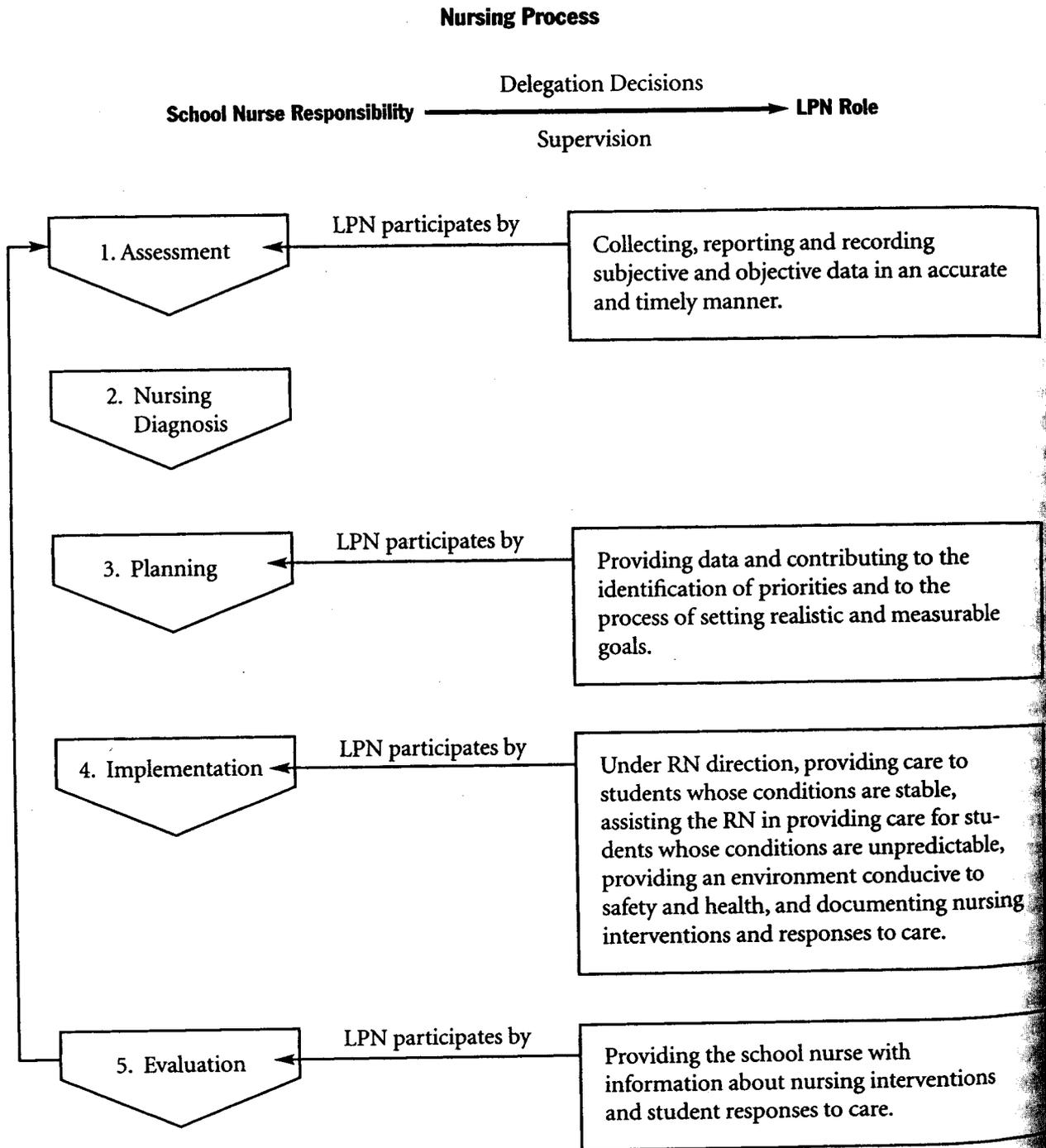
--

*Nadine Hancey
Principal
Santa Clara Elementary*

—
Debra F. Hobbins, DNP, APRN, LASUDC
Bureau Manager--Boards of Nursing, Midwifery, PT, OT, and Vocational Rehab
PHONE: (801) 530-6789
FAX: (801) 530-6511
E-MAIL: dhobbins@utah.gov

Figure 5-4. Conceptual Framework for RN Delegation of Nursing Functions to the LPN in School Health Services

In the school setting, as in any setting, the LPN must perform his or her nursing functions and **shared nursing responsibilities under the direction of a registered nurse**. As stated in the 1989 Connecticut Board of Examiners for Nursing Declaratory Ruling, the LPN is properly allowed to participate in all phases of the nursing process. The extent of this participation is portrayed in the model below.



**International Nurse Regulatory Collaborative Project
Risk Factors for Recidivism in Nursing Practice**

May 2014



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EXECUTIVE SUMMARY

This is the third report in a series for the International Nurse Regulatory Collaborative (INRC) research project initiated by eight nursing and midwifery regulatory agencies: Canada [Ontario (CNO) and British Columbia (CRNBC)], the United States (NCSBN), New Zealand (NCNZ), Australia (NMBA), Ireland (NMBI), the United Kingdom (NMC-UK), and Singapore (SNB). In the current report, we assessed possible risk factors associated with recidivism through a review of disciplinary records of 240 nurses who were put on probation (condition) in 2008 for practice violations from three countries and a Canadian province: *NCSBN (n=156)*, *NCNZ (n=57)*, *CNO (n=17)*, and *NMBI (n=10)*. The report is based on the aggregation set of all submitted data, resulting in a heavy weighting towards the U.S. as the U.S. submitted 65% of all cases.

Selected Findings

- Overall, 25% (*n*=61) of the nurses who were put on probation for practice-related violations in 2008 received subsequent disciplinary actions during 2009-2013. “*Violation of probation order/breach condition*” was the most common violation leading to subsequent disciplinary actions for all four jurisdictions that contributed data to this analysis (CNO, NCNZ, NCSBN, and NMBI).
- Thirty nurses (13%) recidivated with practice-related violations during 2009-2013: CNO (*n*=4), NCNZ (*n*=8), and NCSBN (*n*=18). NMBI reported that no disciplined nurses recidivated with practice-related violations.
- More than half of the recidivating nurses (83% for NCSBN, 100% for NCNZ, and 50% for CNO) received their subsequent disciplinary actions within the first two years after the initiation of the 2008 probation.
- NCSBN, NCNZ and CNO reported that nurses with certain histories are overrepresented among the recidivating nurses. These are:
 - Having a history of criminal conviction (23% versus 15% for NCSBN, 20% versus 0% for NCNZ, 25% versus 8% for CNO);
 - Having a previous discipline history by employers (89% versus 65% for NCSBN, 63% versus 50% for NCNZ, 50% versus 23% for CNO);
 - Having a previous discipline history by a regulatory agency (11% versus 4% for NCSBN, 38% versus 18% for NCNZ);
 - Termination by previous employers for practice-related issues (100% versus 38% for NCSBN, 50% versus 8% for CNO); and
 - Change of employers during probation (75% versus 28% for NCSBN, 86% versus 47% for NCNZ, 75% versus 20% for CNO).

OVERVIEW

This is the third report in a series for the International Nurse Regulatory Collaborative (INRC): Canada [Ontario (CNO) and British Columbia (CRNBC)], the United States (NCSBN), New Zealand (NCNZ), Australia (NMBA), Ireland (NMBI), the United Kingdom (NMC-UK), and Singapore (SNB). In the two previous collaborative studies initiated by the INRC group, it was reported that fewer than 1% of the nurses or midwives in their countries or provinces were disciplined during 2011-2012 (Internal INRC reports, 2012, 2013). In this study, the focus is on recidivism and potential risk factors.

During the May 2013 INRC meeting in Melbourne, Australia, all regulatory agencies from the INRC Group agreed to undertake this collaborative research project. Researchers from CNO, CRNBC, NMBI, NCNZ, NCSBN, SNB and NMC-UK were appointed by their agencies to participate in the study and all contributed to the design and proposal development (See Appendix A). The research team determined that a review of practice-related “probation” or “discipline with conditions” (hereinafter referred to as probation) cases would provide data to identify recidivism risk factors. The research team chose to review probation cases because it is a common disciplinary action taken by nurse regulators internationally.

Methods

Research Questions

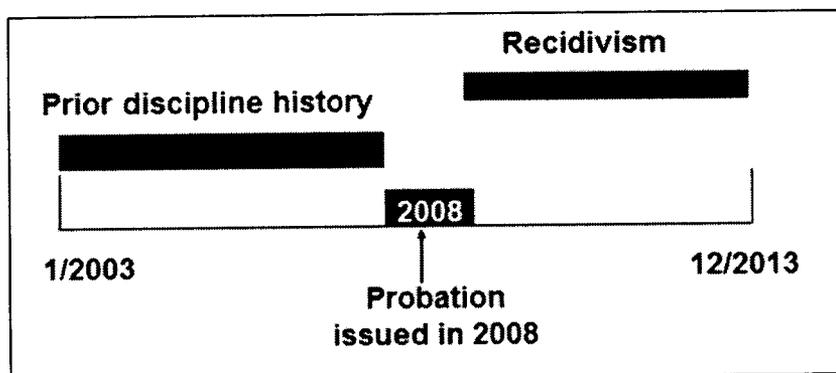
1. What is the demographic profile of nurses who were placed on probation in 2008 for practice-related violations?
2. What are the common violations committed by nurses who were placed on probation in 2008?
3. What are the potential risk factors that may be associated with recidivism in nurses placed on probation for practice-related violations during 2008-2013?

This is a retrospective study of RNs, licensed practical nurses (LPNs)/vocational nurses (VNs)/registered practical nurses (RPNs), enrolled nurses (ENs), advanced practice registered nurses (APRNs)/nurse practitioners (NPs), as well as certified midwives who were placed on probation from nursing and midwifery regulatory agencies for various practice violations related to patient care in 2008.

This is an examination of practice-related probation cases from the year 2008. The purpose of the study is to determine characteristics of nurses who were disciplined during 2008 and identify potential risk factors associated with recidivism. Regulators participating in the project were asked to submit and analyze all their jurisdiction’s 2008 practice-related probation cases using a tool specifically designed for this study (see Appendix C). The analysis included identifying disciplinary actions for 4 years prior to 2008 (2003-2007) as well as subsequent discipline from 2009–2013. Figure 1 shows the basic research design. The data collection tool asked the regulators submitting cases to examine each case and indicate whether the nurse being disciplined had a history of any factors the research team identified as possible risk factors for recidivism. These factors included: criminal history, discipline by an employer for practice-related issues, previous discipline by a regulatory agency, termination by an employer for a practice-related incident(s), a change of employer during probation, a history of substance abuse,

and a history of mental illness. All jurisdictions that contributed probation cases were asked to send a matching number of non-disciplined nurses for the control group.

Figure 1. Research Design



Case Selection Criteria

All cases, from the countries/provinces participating in the study, which involved a nurse being placed on probation in 2008 for a practice-related violation(s) were eligible to be included in the analysis. Cases that involved substance abuse without violations involving patient care were excluded.

Instrument Development

The research team developed the data collection instrument. It was based on a literature review which revealed six potential risk factors for recidivism: (1) history of criminal conviction (Zhong, Kenward, Sheets, Doherty, & Gross, 2009); (2) discipline history by employers for practice issues (Zhong & Thomas, 2012); (3) discipline history by regulatory agencies (Zhong et al., 2009); (4) termination by previous employer for practice issues (Zhong & Thomas, 2012); (5) changing employers during probation (Zhong et al., 2009; Zhong & Thomas, 2012); (6) history of substance abuse (Wanek, Spetz, & Keane, 2011). A seventh risk factor, history of mental illness, was added by the research team to learn whether this might also be a possible risk factor for recidivism.

The data collection instrument included questions related to demographics, the seven risk factors for recidivism and the underlying violation(s) which led to the discipline. A control group data retrieval form including demographic information on level of practice, gender and year of birth was also created (Appendix C).

The regulatory bodies participating in the study identified cases that met the criteria and filled out a data collection instrument for each case they contributed. These were aggregated and analyzed.

RESULTS

Six regulatory bodies (CNO, CRNBC, NCNZ, NCSBN, NMBI, and SNB) contributed data to the study. A total of 240 discipline cases that met the case selection criteria for the current study were submitted by the following: NCSBN ($n=156$; 65% of cases), NCNZ ($n=57$; 24% of cases), CNO ($n=17$; 7% of cases), and NMBI ($n=10$; 4% of cases). Seven states from the U.S. participated in the study: Idaho, Iowa, Missouri, Massachusetts, Washington, Texas, and Nevada. Because NCSBN collected the data, the aggregate data from these seven states will be referred to as “NCSBN”. SNB and CRNBC reported no probation cases met the case selection criteria during this time period.

A control group of 307 nurses that did not receive any discipline during 2008 were randomly selected by the six participating groups to determine demographic information of the general nursing workforce: NCSBN ($n=150$), NCNZ ($n=30$), CNO ($n=17$), NMBI ($n=10$), CRNBC ($n=50$), and SNB ($n=50$).

1. What is the demographic profile of disciplined nurses who were placed on probation in 2008 for practice-related violations?

Sex and Age

The majority of disciplined nurses were female (86%, $n=207$). CNO and NCNZ reported a higher percentage of male nurses in the probation group compared to in the control group (24% vs. 6% for CNO and 12% vs. 6% for NCNZ). Based on the current sample, NCSBN and NMBI reported similar proportions of male nurses in the discipline and control groups (14% NCSBN, 10% NMBI).

At the time of being placed on probation for practice-related issues, all of the four participating agencies reported an average age of the nurses in the discipline group as 47 to 48 years old. There are no significant differences in age between the discipline and control group nurses for all countries/provinces. SNB and CRNBC reported average ages of the control group nurses as 38 years old ($SD=12.7$, $N=50$) and 39 years old ($SD=11.3$, $N=50$) respectively. However, CNO, NCNZ, NCSBN, and NMBI reported that the average ages of the control group nurses ranged from 44 to 50 years old. This finding is consistent with our previous INRC reports. Table 1 presents the age distribution of study subjects.

Table 1. Age Distribution of Study Subjects in 2008

<i>Agency</i>	<i>Group</i>	<i>Percent Age 20-29</i>	<i>Percent Age 30-39</i>	<i>Percent Age 40-49</i>	<i>Percent Age ≥50</i>
CNO	Discipline	--	17.6% (n=3)	41.2% (n=7)	41.2% (n=7)
	Control	5.9% (n=1)	11.8% (n=2)	23.5% (n=4)	58.9% (n=10)
CRNBC	Discipline	--	--	--	--
	Control	26.0% (n=13)	24.0% (n=12)	24.0% (n=12)	26.0% (n=13)
NCNZ	Discipline	5.3% (n=3)	21.1% (n=12)	22.8% (n=13)	50.9% (n=29)
	Control	6.7% (n=2)	26.7% (n=8)	43.3% (n=13)	23.3% (n=7)
NCSBN	Discipline	11.6% (n=18)	15.5% (n=24)	29.0% (n=45)	43.9% (n=68)
	Control	8.7% (n=13)	24.0% (n=36)	20.7% (n=31)	46.7% (n=70)
NMBI	Discipline	--	30.0% (n=3)	30.0% (n=3)	40.0% (n=4)
	Control	10.0% (n=1)	30.0% (n=3)	20.0% (n=2)	40.0% (n=4)
SNB	Discipline	--	--	--	--
	Control	32.0% (n=16)	22.0% (n=11)	24.0% (n=12)	22.0% (n=11)
Total	Discipline	8.8% (n=21)	17.6% (n=42)	28.5% (n=68)	45.2% (n=108)
	Control	15.0% (n=46)	23.5% (n=72)	24.1% (n=74)	37.5% (n=115)

Education

The majority of the disciplined/probation nurses held diplomas or various certificates as the highest level of education at the time of their initial licensure. Two nurses, disciplined in the U.S. (1%) held a masters' degree. While CNO and NCSBN reported 6% to 8% of the disciplined nurses held baccalaureate nursing degrees in nursing, NCNZ reported the highest proportion of disciplined nurses who held a baccalaureate degree (35%). The other educational preparation held by the disciplined nurses included different types of diplomas. Previous U.S. studies demonstrated that nurses who held lower educational degrees were at a higher risk for being disciplined (Carruth & Booth, 1999; Zhong & Kenward, 2009).

Among the 240 disciplined nurses, 9% (n=21) received entry-level nursing education from a country outside their current country of residence. This information is unknown for 13% (n=30) of nurses.

Level of Nursing Practice

The majority of the disciplined nurses were RNs including registered general nurse (RGN) and registered psychiatric nurse (RPN). Only 8 (3%) disciplined nurses are APRNs or midwives. Both CNO and NCSBN reported a slightly higher percentage of the practical nurses in the discipline group compared to that in the control groups (31% versus 18% for CNO, 51% versus 27% for NCSBN). This finding is consistent with previous reports (McGovern, 2009; Zhong & Kenward, 2009). NCNZ and NMBI reported no LPN/VN discipline cases that met the case selection criteria.

Number of Years since Initial License at Time of 2008 Probation

Overall, nurses licensed for 10 years or less (40%, n=92) were the most frequent group of nurses with probation in 2008. This information is unknown for 8 nurses. The number of years since initial licensure at time of 2008 probation is presented in Table 2.

Table 2. Number of Years since Initial Licensure at 2008

<i>No. of Years Since Initial Licensure</i>	<i>CNO</i>	<i>NCNZ</i>	<i>NCSBN</i>	<i>NMBI</i>	<i>Total</i>
0-5 years	(n=2)	24.6% (n=14)	23.7% (n=35)	(n=3)	23.3% (n=54)
6-10 years	(n=4)	14.0% (n=8)	16.9% (n=25)	(n=1)	16.4% (n=38)
11-15 years	(n=2)	15.8% (n=9)	23.7% (n=35)	--	19.8% (n=46)
16-20 years	(n=3)	8.8% (n=5)	10.1% (n=15)	(n=1)	10.3% (n=24)
21-25 years	--	8.8% (n=5)	5.4% (n=8)	(n=1)	6.0% (n=14)
Above 25 years	(n=6)	28.1% (n=16)	20.3% (n=30)	(n=4)	24.1% (n=56)

Employment Settings and Status

At the time when the incidents resulting in the 2008 probation occurred, 84% (194 out of 232) of the disciplined nurses were employed in long-term care facilities or hospital settings. Other settings included, but were not limited to, office settings (clinical office/clinic, nurse staff agency, nursing registry), mental health centers, correctional facilities (jail, prison, correctional facility, house of corrections), group (school, adult family home, secured juvenile offender facility, adoption services) or one-on-one care (residential care), etc.

Among the 142 disciplined nurses with known employment status, 87% (n=124) worked full-time when the incident occurred. This information was unknown for 41% (n=98) of the nurses.

2. *What are the common violations committed by the nurses who were placed on probation in 2008?*

Violations that Led to the 2008 Probation

“Breakdown in professional responsibility (for example, practice beyond scope)” was reported as the most common violation or basis for disciplinary actions that led to the 2008 probation for CNO and NCSBN, while “inappropriate clinical reasoning (for example, failure to recognize patient’s signs and symptoms, failure to access or intervene)” and “documentation error” were cited as common violations for NCNZ and NMBI (Table 3). The “other” violation category specified violations which included breach of boundary issues, failure to fulfill responsibilities, or failure to display a level of competency. Overall, 48% (n=108) of the disciplined nurses committed more than one violation (for example, both documentation and medication errors) during 2008. The violations were unknown for 14 (6%) nurses.

Table 3. Violations that led to the 2008 Probation

	<i>CNO</i>	<i>NCNZ</i>	<i>NCSBN</i>	<i>NMBI</i>	<i>Total</i>
Documentation error	14.3% (n=5)	17.6% (n=18)	14.9% (n=37)	19.2% (n=5)	15.8% (n=65)
Medication error	8.6% (n=3)	22.5% (n=23)	10.1% (n=25)	7.7% (n=2)	12.9% (n=53)
Inappropriate clinical reasoning	17.1% (n=6)	27.5% (n=28)	11.7% (n=29)	7.7% (n=2)	15.8% (n=65)
Breakdown in professional responsibility	31.4% (n=11)	9.8% (n=10)	16.5% (n=41)	15.4% (n=4)	16.1% (n=66)
Inadequate attentiveness or surveillance	--	2.9% (n=3)	13.3% (n=33)	11.5% (n=3)	9.5% (n=39)
Missed or inadequate nursing intervention	5.7% (n=2)	2.9% (n=3)	6.9% (n=17)	11.5% (n=3)	6.1% (n=25)
Lack of standard prevention measures	--	3.9% (n=4)	2.0% (n=5)	--	2.2% (n=9)
Drug/alcohol impairment or substance abuse	--	1.0% (n=1)	1.6% (n=4)	11.5% (n=3)	2.0% (n=8)
Intentional harm or other criminal behavior	8.6% (n=3)	7.8% (n=8)	7.3% (n=18)	--	7.1% (n=29)
Violate probation order/breach condition	2.9% (n=1)	1.0% (n=1)	2.4% (n=6)	--	2.0% (n=8)
Other	11.4% (n=4)	2.9% (n=3)	13.3% (n=33)	15.4% (n=4)	10.7% (n=44)

Violations that Led to Subsequent Disciplinary Actions: After the 2008 probation, a comparatively lower percentage of nurses committed violations related to “*breakdown in professional responsibility*” during 2009-2013. However, “*violation of probation order/breach condition*” became a common basis for discipline for 41 (45%) cases. This violation reflects procedural violations related to the disciplinary conditions themselves. In addition, we found three of the specified “*other*” violations were related to falsified license application in a different state (U.S.) and unpaid taxes, which are not directly related to patient care (Table 4).

Table 4. Violations that Led to Subsequent Disciplinary Actions After 2008

	<i>CNO</i>	<i>NCNZ</i>	<i>NCSBN</i>	<i>NMBI</i>	<i>Total</i>
Documentation error	(n=1)	23.8% (n=5)	6.8% (n=4)	--	11.0% (n=10)
Medication error	--	23.8% (n=5)	3.4% (n=2)	--	7.7% (n=7)
Inappropriate clinical reasoning	--	14.3% (n=3)	5.1% (n=3)	--	6.6% (n=6)
Breakdown in professional responsibility	(n=3)	4.8% (n=1)	3.4% (n=2)	--	6.6% (n=6)
Inadequate attentiveness or surveillance	--	--	--	--	--
Missed or inadequate nursing intervention	(n=1)	--	1.7% (n=1)	--	2.2% (n=2)
Lack of standard prevention measures	--	--	--	--	--
Drug/alcohol impairment or substance abuse	--	9.5% (n=2)	3.4% (n=2)	--	4.4% (n=4)
Intentional harm or other criminal behavior	(n=1)	--	3.4% (n=2)	--	3.3% (n=3)
Violate probation order/breach condition	(n=2)	23.8% (n=5)	55.9% (n=33)	(n=1)	45.1% (n=41)
Other	(n=2)	--	16.9% (n=10)	--	13.2% (n=12)

A comparison of the types of violations committed by disciplined nurses before and after the 2008 probation demonstrates that only 11% (n=6) of the nurses received subsequent disciplinary actions for the identical violation(s), 28% (n=15) of the nurses received subsequent disciplinary actions for different violations, and 61% (n=33) of the nurses committed partially identical violations (e.g., a nurse commits a different violation in addition to the original one). Such information was not available for seven nurses (11%).

Characteristics of Recidivism (2009-2013)

In the current study, recidivism is defined as a nurse receiving a discipline subsequent to the 2008 probation for the same or different type of violations related to patient care during 2009-2013. Therefore, 31 nurses involved in “*violation of board order/breach condition*” and “*other*” violations not directly related to nursing practice reported in Table 4 were removed for the following recidivism analysis. In summary, a total of 30 nurses who met this definition of recidivism were evaluated in the following analysis.

When Recidivism Occurred

More than half of the recidivating nurses (100% for NCNZ, 83% for NCSBN, and 50% for CNO) received the subsequent disciplinary actions within the first two years following the 2008 probation (Table 5).

Table 5. Timing of the Subsequent Disciplinary Actions Issued

<i>Discipline Year</i>	<i>CNO</i>	<i>NCNZ</i>	<i>NCSBN</i>	<i>NMBI</i>	<i>Total</i>
2009 (1 year)	(n=2)	(n=3)	27.8% (n=5)	--	33.3% (n=10)
2010 (2 years)	--	(n=5)	55.6% (n=10)	--	50.0% (n=15)
2011 (3 years)	--	--	5.6% (n=1)	--	3.3% (n=1)
2012 (4 years)	--	--	11.1% (n=2)	--	6.7% (n=2)
2013 (5 years)	(n=2)	--	--	--	6.7% (n=2)

3. What are the risk factors associated with recidivism in nurses that were placed on probation for practice errors from 2008-2013?

Possible Risk Factors Associated with Recidivism

Each disciplined nurse in the sample (n=240) was evaluated according to seven risk factors for recidivism: (1) history of criminal conviction; (2) disciplinary history by employers for practice issues; (3) history of discipline by a regulatory agency, (4) termination by previous employer for practice issues; (5) changing employers during probation; (6) history of substance abuse, and (7) history of mental illness. In Tables 6-12 the disciplined nurses were divided into two groups: (1) recidivism group: 30 nurses who recidivated with practice-related violation during 2009 to 2013 and (2) non-recidivism group, including the 210 nurses who did not receive subsequent disciplinary actions for practice-related violation after the 2008 probation.

History of criminal conviction. Among the nurses for whom data on criminal conviction history were available (62%, n=149): 23% of the nurses presented with a history of criminal conviction versus 10% of those without such history recidivated (Table 6).

Table 6. History of Criminal Conviction

	<i>Group</i>	<i>Criminal Conviction History</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	25.0% (n=1)	75.0% (n=3)	--
	Non-recidivism	7.7% (n=1)	92.3% (n=12)	--
NCNZ	Recidivism	20.0% (n=1)	80.0% (n=4)	37.5% (n=3)
	Non-recidivism	--	100.0% (n=36)	26.5% (n=13)
NCSBN	Recidivism	23.1% (n=3)	76.9% (n=10)	27.8% (n=5)
	Non-recidivism	15.4% (n=12)	84.6% (n=66)	43.5% (n=60)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0% (n=10)

History of discipline by employers for practice-related violations. Overall, 71% of the disciplined nurses with previous discipline history by employers for practice-related violations recidivated versus 50% of the disciplined nurse without such history. This information was unknown for 139 (58%) nurses (Table 7).

Table 7. Previous Discipline History by Employers Prior to the 2008 Probation

	<i>Group</i>	<i>Discipline History by Employer</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	50.0% (n=2)	50.0% (n=2)	--
	Non-recidivism	23.0% (n=3)	76.9% (n=10)	--
NCNZ	Recidivism	62.5% (n=5)	37.5% (n=3)	--
	Non-recidivism	50.0% (n=22)	50.0% (n=22)	10.2% (n=5)
NCSBN	Recidivism	88.9% (n=8)	11.1% (n=1)	50.0% (n=9)
	Non-recidivism	65.2% (n=15)	34.8% (n=8)	83.3% (n=115)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0% (n=10)

Previous discipline by regulatory agencies. Among the 240 nurses who were placed on probation for practice violations in 2008, 9% (n=21) received disciplinary actions before the 2008 probation. Overall, a higher percentage of the disciplined nurses who received disciplinary actions prior to the 2008 probation recidivated (17%) versus the first-time offenders in 2008 (8%) (Table 8).

Table 8. Previous Disciplinary Actions by Regulatory Agencies Prior to the 2008 Probation

	<i>Group</i>	<i>Discipline History by Regulatory Agencies</i>		<i>Total</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	--	100.0% (n=4)	4
	Non-recidivism	15.4% (n=2)	84.6% (n=11)	13
NCNZ	Recidivism	37.5% (n=3)	62.5% (n=5)	8
	Non-recidivism	18.4% (n=9)	81.6% (n=40)	49
NCSBN	Recidivism	11.1% (n=2)	88.9% (n=16)	18
	Non-recidivism	3.6% (n=5)	96.4% (n=133)	138
NMBI	Recidivism	--	--	--
	Non-recidivism	--	100.0% (n=10)	10

Termination by previous employers for practice issues. A higher percentage of the disciplined nurses who were terminated by their employers for practice issues, prior to the 2008 probation, recidivated (54%) versus those without that history (15%) (Table 9).

Table 9. Termination by Previous Employers Prior to the 2008 Probation

	<i>Group</i>	<i>Termination by Previous Employers</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	50.0% (n=2)	50.0% (n=2)	--
	Non-recidivism	7.7% (n=1)	92.3% (n=12)	--
NCNZ	Recidivism	--	100.0% (n=4)	50.0% (n=4)
	Non-recidivism	7.7% (n=3)	92.3% (n=36)	20.4% (n=10)
NCSBN	Recidivism	100.0% (n=5)	--	72.2% (n=13)
	Non-recidivism	37.5% (n=6)	62.5% (n=10)	88.4% (n=122)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0% (n=10)

Changing employers during probation. Nurses who changed employers during probation were more likely to recidivate compared to those who remained working with the same employer (78% versus 34%, Table 10).

Table 10. Change of Employers during the 2008 Probation

	<i>Group</i>	<i>Change Employers during Probation</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	75.0% (n=3)	25.0% (n=1)	--
	Non-recidivism	20.0% (n=2)	80.0% (n=8)	23.1% (n=3)
NCNZ	Recidivism	85.7% (n=6)	14.3% (n=1)	12.5% (n=1)
	Non-recidivism	46.7% (n=21)	53.3% (n=24)	8.2% (n=4)
NCSBN	Recidivism	75.0% (n=9)	25.0% (n=3)	33.3% (n=6)
	Non-recidivism	28.0% (n=21)	72.0% (n=54)	45.7% (n=63)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0% (n=10)

History of substance abuse. Among the 141(59%) disciplined nurses for whom substance abuse histories were available, 30% of the disciplined nurses with history of substance abuse versus 13% of those without such history recidivated (Table 11).

Table 11. History of Substance Abuse

	<i>Group</i>	<i>History of Substance Abuse</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	50.0% (n=1)	50.0% (n=1)	50.0% (n=2)
	Non-recidivism	100.0% (n=1)	--	92.3% (n=12)
NCNZ	Recidivism	50.0% (n=2)	50.0% (n=2)	50.0% (n=4)
	Non-recidivism	14.3% (n=5)	85.7% (n=30)	28.6% (n=14)
NCSBN	Recidivism	21.4% (n=3)	78.6% (n=11)	22.2% (n=4)
	Non-recidivism	11.8% (n=10)	88.2% (n=75)	38.4% (n=53)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0.0% (n=10)

History of mental illness prior to probation. The current data revealed that a very low number of nurses (5%, n=12) reported a history of mental illness prior to their 2008 probation (Table 12). This information was unknown for 88 nurses (37%).

Table 12. Reported Mental Illness Prior to the 2008 Probation

	<i>Group</i>	<i>Mental Illness</i>		<i>Missing Data</i>
		<i>Yes</i>	<i>No</i>	
CNO	Recidivism	--	(n=2)	50.0% (n=2)
	Non-recidivism	--	(n=6)	53.9% (n=7)
NCNZ	Recidivism	(n=2)	(n=3)	37.5% (n=3)
	Non-recidivism	(n=9)	(n=32)	16.3% (n=8)
NCSBN	Recidivism	--	(n=14)	22.2% (n=4)
	Non-recidivism	(n=1)	(n=83)	39.1% (n=54)
NMBI	Recidivism	--	--	--
	Non-recidivism	--	--	100.0% (n=10)

Suggestions Regarding Remediation and Strategies to Reduce Recidivism

Comments were also solicited from the participating regulatory bodies on which elements of their probation programs they considered to be the most effective for remediation and reducing recidivism. Representatives from CNO, NCSBN, NMBI, and SNB shared their comments and experiences. The detailed comments are listed in Appendix B.

- *Most effective remediation components:* Education has been cited as one of the most effective elements for remediation. Providing these nurses additional education to improve their professional skills could lead to positive remediation outcomes.
- *Most effective strategies suggested for reducing recidivism:* Timely follow-up and monitoring disciplined nurses and collaborating with other health care team members and regulators.

Limitations

The submission of data to the INRC research project was voluntary. Missing data and low case numbers limit this study and preclude the drawing of solid conclusions. In addition, differences across countries/provinces related to regulations and reporting of discipline may affect the results.

Furthermore, data is not available to determine whether all of the nurses who were put on probation continued their nursing practice after being subject to the 2008 probation action. We cannot exclude the possibility that some could have stopped practicing after being disciplined. The recidivism rate could be potentially higher if these nurses were in practice. Finally, considering the amount of work required to retrieve a 10-year record from the data archives, we cannot guarantee that 100% of cases that met the case selection criteria have been included and every single incident was retrieved.

DISCUSSION

Overall, a very small number of nurses ($n=240$) were put on probation for practice-related violations in 2008 in the participating jurisdictions. CRNBC and SNB did not have any cases that met the case selection criteria. Among the probation group, however, a relatively high percentage recidivated with practice-related violations (13%, $n=30$) during the five year post-probationary period (2009-2013) compared to the annual discipline rates reported in these agencies (<1%). Early identification of this group of higher risk nurses may be helpful for developing more efficient risk-limiting strategies. Although the current study, as previously noted, is heavily weighted towards the U.S. due to the inherent composition of the dataset, several potentially meaningful risk predictors are suggested:

Links between previous histories and a nurse's future practice: The current data revealed a potential link between a nurse's previous criminal conviction/discipline history and a nurse's future practice (Tables 6-8). Comprehensive tracking and careful screening of a nurse's previous criminal and discipline history may be useful.

Negative impact on change of employers during probation: The current data suggest that nurses who changed employers during probation are at a higher risk for recidivism. A higher percentage of nurses who changed employers during probation recidivated compared to those who remained working with the same employer (75% versus 28% for NCSBN, 86% versus 47% for NCNZ, and 75% versus 20% for CNO). Therefore, changing workplaces may not be an optimal option for disciplined nurses to get a new start. Thus, instead of thinking that a change in employer will prevent future practice errors, these disciplined nurses, with the help of their employers, should make every effort to improve their professional skills and their work attitudes to achieve positive change in their current work place.

Vulnerable time for subsequent discipline actions: Current data show that disciplined nurses who recidivated tended to do so soon after initial disciplinary actions were imposed. A majority of recidivating nurses received subsequent disciplinary action during the first two years following the 2008 probation (83% for NCSBN, 100% for NCNZ and 50% for CNO). Previous studies have reported that nurses and physicians who have been disciplined for misconduct face a greater likelihood of making further errors and more frequent instances of suboptimal patient care due to

increased stress at work (LaDuke, 2000; Williams, Manwell, Konrad, & Linzer, 2007). Helping disciplined nurses better cope with the stress caused by the discipline process should be a goal of workplaces and nursing regulators.

Noncompliance and subsequent disciplinary actions: All four regulatory agencies that contributed probation cases reported a considerable proportion of disciplined nurses who violated probation orders (Table 4). The underlying causes of probation order violations are unclear and need further clarification. This raises a concern to the nurse regulators regarding how to more efficiently design and implement future remediation programs. If disciplined nurses fail to comply with probation orders developed by regulatory agencies, these remediation programs will not benefit the disciplined nurses or the public's health and safety.

In summary, while substantially limited by low case numbers submitted by regulatory agencies outside the U.S., the current study nevertheless suggests that probationary requirements imposed by participating regulatory agencies, to some extent, seem to be effective in the reduction of the same type of violations that led to the 2008 probation. Work is needed to further reduce the overall recidivism rates. A closer evaluation of a nurse's previous discipline/job history could be useful in identifying a small group of nurses who are at risk for recidivism. Therefore, special attention can be given to those disciplined nurses which may prevent or reduce future errors.

An in-depth understanding of the current discipline process used by the nursing regulators and the continued collaborative research on the development of a more comprehensive and standardized lexicon on nursing regulation could allow detailed research could be highly useful to the development of remediation strategies to further reduce recidivism.

This study does indicate there is much similarity between the countries involved in the study. This research may assist regulators around the world in developing new strategies for remediation as a part of discipline and the prevention of recidivism to better fulfill the mission of public protection.

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APPENDIX A: INRC Recidivism Study Research Team

The following individuals appointed by INRC agencies comprised of the research team:

CNO

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Measurement and Evaluation Coordinator

Information Management

Knowledge Management Department

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Director, Professional Conduct

CRNBC

Natasha Dookie, CHRP, BA, LL.B.

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Research Analyst

Corporate Governance

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Evidence and Research Manager

Corporate Governance

SNB

Kwek Puay Ee (Ms)

Executive Secretary

APPENDIX B: Comments from Representatives

Representatives from CNO, NCSBN, NMBI and SNB shared comments about the most effective remediation components and effective strategies in reducing recidivism. The following are selected comments and excerpts from representatives of the participating agencies.

I. Most Effective Probation Requirements

The elements for successful probation programs includes, but are not limited to: an individually designed agreed settlement addressing a particular offense, monitored and continued practice after coming to the board's attention, participation in education courses, and working with employers and requiring employer reports. Most of the participants believe that the most effective element of remediation is the increased emphasis on remediation, not punishment. Collaboration with employers and other stakeholders is recommended. The detailed comments are listed below:

Focus on remediation and education

- Remediation and notification to employers. Include specific nursing courses, with the requirement for a nurse to review the applicable standards of practice and participate in a facilitated reflection with a regulatory expert. The nurse is required to complete any preliminary activities assigned by the nurse expert and participate in 2-3 meetings focused on practice reflection and application of learning to future practice. The nurse is responsible for the cost.
- Educational course(s) aimed at the identified area of practice deficit. Didactic learning and experiences involving in-person (not on-line), monitored practice, and employer evaluation.
- Conditions relating to participation in and/or completion of an education program have been effective in addressing competence issues, e.g., a nurse/midwife may be required to complete a medication management program where the Fitness to Practice Committee has found that the nurse did not administer medication in accordance with national guidelines. Where a nurse/midwife has a substance abuse or addiction problem, she is more likely to benefit from participation in a drug or alcohol rehabilitation program if she has some insight into her problem and is reasonably well disposed to participating.

Collaboration with employers and monitoring practice

- Notify all employers of the disciplinary finding and provide them with a copy of the decision. The employer must confirm in writing that they have been notified and received the documents.
- For drug/substance abuse cases, random body fluid screen testing, treatment reports, limitation of controlled substance access when appropriate and employer reports.
- Continued clinical practice under supervision and participation in an educational experience.

II. Most Efficient Strategies for Reducing Recidivism

The participating agencies shared the following comments regarding how to more efficiently reduce recidivism: (1) close monitoring and timely follow up of non-compliance issues, (2) collaboration between the regulator and other stakeholders and educators, and (3) the use of discipline action to prevent future errors. The following are some strategies suggested by the participating agencies.

Communications with licensee and follow-up compliance monitoring

- Just simply being named in a board complaint and knowing the board is monitoring is helpful in establishing a positive remedial outcome and reducing recidivism.
- Ability for staff to meet one time with a licensee to counsel if there are concerns identified regarding practice or non-compliance. Efficiency of board staff response to licensee non-compliance.
- Clear, detailed initial communication with licensee regarding expectations of board. This empowers most licensees to take responsibility and be accountable.
- Length of sanction (i.e., 6 months, or 1 year) must be satisfied while licensee is working in a licensed position. It is not for just a calendar year. Practice performance must be monitored to satisfy license.
- Advancements by the board to be more customer friendly by providing more information and documents on Websites.

“Zero Tolerance”

- It has been suggested that a “zero tolerance” policy on substance abuse by the regulator may be most effective in reducing recidivism, particularly in relation to substance abuse.

Collaboration with the regulator and other stakeholders

- It may also be of greater benefit to the individual nurse/midwife (and those supporting personnel) to be temporarily “struck off” the register sooner rather than later, in that the impaired nurse may seek treatment and/or rehabilitation sooner. Development of appropriate guidance for individual practitioners and managers could be effective.
- Collaboration with hospitals, educational institutions providing nursing education and other healthcare providers to enhance education on areas pertaining to professional conduct and code of ethics for nursing. A basis for continuing education, self-evaluation and peer review.

Use of regulatory power

- Use the full board/regulatory power of suspension and put on a stay-suspension agreement when in need.
- Suspension of license is an efficient way to reduce future errors.

APPENDIX C: Data Collection Package

Data Collection Instruction

This study intends to identify risk factors for recidivism. To better assist you in completing the instrument, below are instructions and definitions.

Definition

(1) Probation (Condition)

In this study, “probation/condition” is defined as “to impose conditions and terms upon a license either consensually agreed on or mandatorily imposed.” Other synonymous terms include: *attachment of conditions to retention in the register, provisional registration/enrollment, terms, or conditions and limitations, or conditional license.*

(2) Recidivism

“Recidivism” refers to a tendency to lapse into a previous pattern of offenses (either the same or different infractions) and being sanctioned more than once during 2008-2013. If a nurse was disciplined in 2004 and was put on probation in 2008, and no additional complaints were filed against this nurse and no additional disciplinary actions were imposed during the five-year post-probationary period of time (2008-2013), the nurse is not defined as a recidivist in the current study.

Criterion for Case Selection

(1) Discipline case collection.

Probation (condition) cases selected for study participation must involve a practice violation related to patient care and the disciplinary action should be issued in the calendar year of 2008. We do not need the cases where no discipline actions were taken or any cases solely related to substance abuse without violations related to patient care. Also excluded are the disciplinary cases that lead to termination of an individual’s license or prohibition to practice because no recidivism pattern can be tracked for those cases.

(2) Control group data collection.

A control group of a matching number of non-disciplined nurses is randomly selected. These nurses must hold a valid nursing license/registration in 2008 and **did not** receive any discipline actions **nor** attended an alternative program during that time. To minimize the extra work from the participating agencies for retrieving data, only demographic information on level of practice (types of license/registration), age and gender will be collected from the non-disciplined nurses.

If you have any additional questions, contact Elizabeth H. Zhong, PD, associate, Research, NCSBN (ezhong@ncsbn.org, tel: 312-525-3636).

**International Nurse Regulator Collaborative Data Collection Form for Recidivism Study
(Discipline Data)**

We are seeking information on disciplined nurses who were put on probation for practice violation related to patient care in the calendar year of 2008. Please fill out a form for **each probation case** in your 2008 records, excluding any cases that were solely related to substance abuse without direct violation related to patient care. *Please put an X in the box next to the answer that best describes the situation and write your answer in the space provided.*

Demographic Information of Disciplined Nurse

1. ID (an identification number assigned by your agency to keep track of cases) _____
2. Gender: Male Female
3. Year of Birth _____
4. What was the highest level of education for the disciplined nurse at the time of initial licensure?

Degrees/Academic Qualification	Nursing	Non-nursing
Diploma	<input type="checkbox"/>	<input type="checkbox"/>
Associate	<input type="checkbox"/>	<input type="checkbox"/>
Baccalaureate	<input type="checkbox"/>	<input type="checkbox"/>
Master's	<input type="checkbox"/>	<input type="checkbox"/>
Doctorate	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>Specify</i> _____)	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>

5. Did the disciplined nurse receive their entry-level nursing education from a foreign country? Yes No Unknown

Practice

6. At the time when the incident that led to the 2008 probation occurred, which license/registration did the disciplined nurse hold? Please check all that apply and indicate the year of initial licensure/registration in that role.

Types of License/Registration	Year of Licensure/Registration
<input type="checkbox"/> Registered Nurses (RN)	_____
<input type="checkbox"/> Licensed Practical /Vocation Nurse (LPN,VN, EN, RPN)	_____
<input type="checkbox"/> Advanced Practice Nurse (APRN, NP, CRNA, CNM, CNS)	_____
<input type="checkbox"/> Midwife	_____

7. In what employment setting did the incident occur that resulted in probation in 2008?
(Check all that apply)
- Hospital
 - Long-term care
 - Home health care
 - Unknown
 - Other _____
8. At the time when the incident leading to the 2008 probation occurred, what was the employment status of the nurse?
- Full-time
 - Part-time
 - Unknown

Personal Record of Disciplined Nurse

	Yes	No	Unknown
9. Did the disciplined nurse have a history of criminal conviction?			
10. Did the disciplined nurse receive any disciplinary actions by an employer for practice issues <i>prior to the incident leading to the 2008 probation?</i>			
11. Was the disciplined nurse terminated from previous employment for practice issues <i>prior to the incident leading to the 2008 probation?</i>			
12. Did the disciplined nurse change employers <i>during the 2008 probationary period?</i>			
13. Did the disciplined nurse have a history of substance abuse?			
14. Had the disciplined nurse ever reported any mental illness <i>prior to the incident leading to the 2008 probation?</i>			

Discipline Grounds for Discipline Actions Taken During 2003-2013

15. Check the records of the nurses who were *put on probation for practice violation related to patient care in 2008* and retrieve all of their discipline grounds during *2003-2013*, not just for probation actions. Please use the scales listed below and place a letter in each cell under the year that the disciplinary action took place for each disciplined nurse. If multiple discipline grounds were taken, please use a comma to separate the types of violation.

Discipline Grounds

- A. Documentation error
- B. Medication error
- C. Inappropriate clinical reasoning (for example, failure to recognize patient's signs and symptoms, failure to assess or intervene)
- D. Breakdown in professional responsibility (for example, practice beyond scope)
- E. Inadequate attentiveness or surveillance (for example, the nurse did not observe a patient for five hours)
- F. Missed or inadequate nursing intervention

- G. Lack of standard prevention measures (for example, the nurse left her side rails of bed down-causing the patient to fall out of bed)
- H. Drug or alcohol impairment or substance abuse
- I. Intentional patient harm or other criminal behavior
- J. Violate probation order/breach condition
- K. Other (*Please specify*_____)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Discipline Grounds											

16. What were the dates of probation ordered by your agency *in 2008*?

Probation Dates	MM	DD	YYYY	Through	MM	DD	YYYY
Original dates ordered by your agency							
Actual dates the nurse was on probation							

Please email, mail or fax the completed forms NO LATER than January 15, 2014 to:

Elizabeth H. Zhong, PhD
 NCSBN Research Department
 111 E. Wacker Drive, Suite 2900
 Chicago, IL 60601-4277
 Fax: (312) 279-1032.
 E-mail: ezhong@ncsbn.org

Thank you in advance for your time and participation!

**International Nurse Regulator Collaborative Data Collection Form for Recidivism Study
(Control Group)**

Randomly pick a matching number of nurses who **did not** receive any discipline actions from your agency **nor** attended an alternative program in 2008, and fill out their level of practice, gender and age information in the table below. If needed, please insert additional lines.

Case	Level of Practice			Gender		Year of Birth
	RN	LPN/VN/EN/RPN	APRN*	Female	Male	
1						
2						
3						
4						
5						
6						
7						
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** APRNs include: certified nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) and clinical nurse specialist (CNS).*

Comments:

1. Based on your experience, which components of your probation requirements are **most** effective?

2. How can a regulatory agency more efficiently reduce recidivism?

Please email, mail or fax the completed forms NO LATER than January 15, 2014 to:

Elizabeth H. Zhong, PhD
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 111 E. Wacker Drive, Suite 2900
 Chicago, IL 60601-4277
 Fax: (312) 279-1032.
 E-mail: ezhong@ncsbn.org

Thank you in advance for your time and participation!

Criminal Background Check (CBC) Guidelines

Biometric state and federal criminal background checks (CBCs) provide the most comprehensive information available for determining whether a nurse applying for a license has a history of criminal activity. CBCs are relatively inexpensive for the applicant and can readily be performed using various methods allowing a state board of nursing (BON) quick access to information that is vital to protecting the public. While some applicants have violations that are misdemeanors, the result of youthful indiscretions or one-time occurrences, there are cases where criminal history is insight into a pattern of thinking and behavior that might endanger the public. For this reason, NCSBN encourages all BONs to incorporate state and federal biometric CBCs into their requirements for licensure. The following, however, can be used by all jurisdictions, regardless of the means by which they collect CBC information.

In 2012 NCSBN convened a task force to develop a method that would assist BONs in the interpretation of a criminal conviction history. This task force consisted of two BON executive officers, a forensic and police psychologist, a criminologist, a parole officer and NCSBN staff members. The goal of this task force was to provide BONs with an evidenced-based, consistent and fair approach to the interpretation of CBC information that protects the BON and the public.

Anti-discrimination Law Challenges to CBC Policies

BONs have inquired whether the use of CBCs may subject them to claims of violating Title VII. As explained below, the appropriate use of CBCs does not violate Title VII or federal anti-discrimination laws.

Title VII Does Not Apply to Licensure Decisions by BONs

Title VII applies only to discrimination in employment. BONs generally do not employ licensure applicants and, therefore, Title VII does not apply to BON licensure decisions. There have been a few court decisions that expanded Title VII's reach to licensure or other actions (e.g., granting of hospital privileges) on the theory that licensure or privileges is necessary to obtain employment; however, the great majority of decisions have consistently held over time that Title VII does not apply to state licensure decisions. See *Birla v. New Jersey Board of Nursing, et al.*, 2013 WL 2156255 (D.N.J. May 17, 2013), which rejected a Title VII challenge to the BON's use of criminal background checks.

Appropriately Used, CBCs Do Not Violate Equal Protection Rights Under the 14th Amendment

Although BONs are not subject to Title VII, their licensure decisions are subject to challenge as discriminatory under the equal protection clause of the 14th Amendment to the U.S. Constitution. To state a claim under the 14th Amendment however, a licensure applicant would have to demonstrate that a BON used CBCs to intentionally discriminate against protected groups of licensure applicants. Demonstration of disparate impact alone is insufficient to make a claim of denial of equal protection under the 14th Amendment. Rather, an applicant would have to show that the BON used CBCs in a manner intentionally designed to exclude minority applicants and that the use of the CBCs was unrelated to a proper state regulatory interest. This is a very high bar to achieve.

It is self-evident that CBCs serve a legitimate regulatory purpose. Further, a BON can ameliorate any risk of claims of intentional discrimination (or "disparate treatment") by ensuring that the BON applies its CBC policy consistently in a similar manner in similar situations regardless of the

applicant's race, religion, sex or national origin. A BON can further minimize any risk of a legal challenge to the use of CBCs by fashioning its policy to consider such factors as the length of time since any conviction, the nature and gravity of the offense, the relationship of the offense to safe nursing practice, and demonstration of rehabilitation. In this regard, a BON may wish to consult the guidelines published by the Equal Employment Opportunity Commission (EEOC) on the use of conviction background checks (http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm#VIII). Strictly speaking, these guidelines pertain only to Title VII, but the guidelines provide an indication of the federal government's preference for tailoring the use of CBCs to regulatory needs.

In addition to federal anti-discrimination laws, some states have laws that cover professional licensure.

Licensing an Applicant with a Positive Criminal History

The following guidelines were developed to assist BONs with the interpretation of CBC information.

Step One: The Application

In accordance with the NCSBN Uniform Licensure Requirements (ULRs), all applications for nursing licensure should include a question asking the applicant about any past criminal history. This is in addition to requiring the biometric CBC. The application should state that all applicants must report all misdemeanors, felonies or plea agreements. Any applicants with a positive history should also provide a personal statement describing the nature of any/all offenses. The personal statement should include the following information: date of offense(s), circumstances surrounding the offense(s), court findings, court documents and the current status of the case(s).

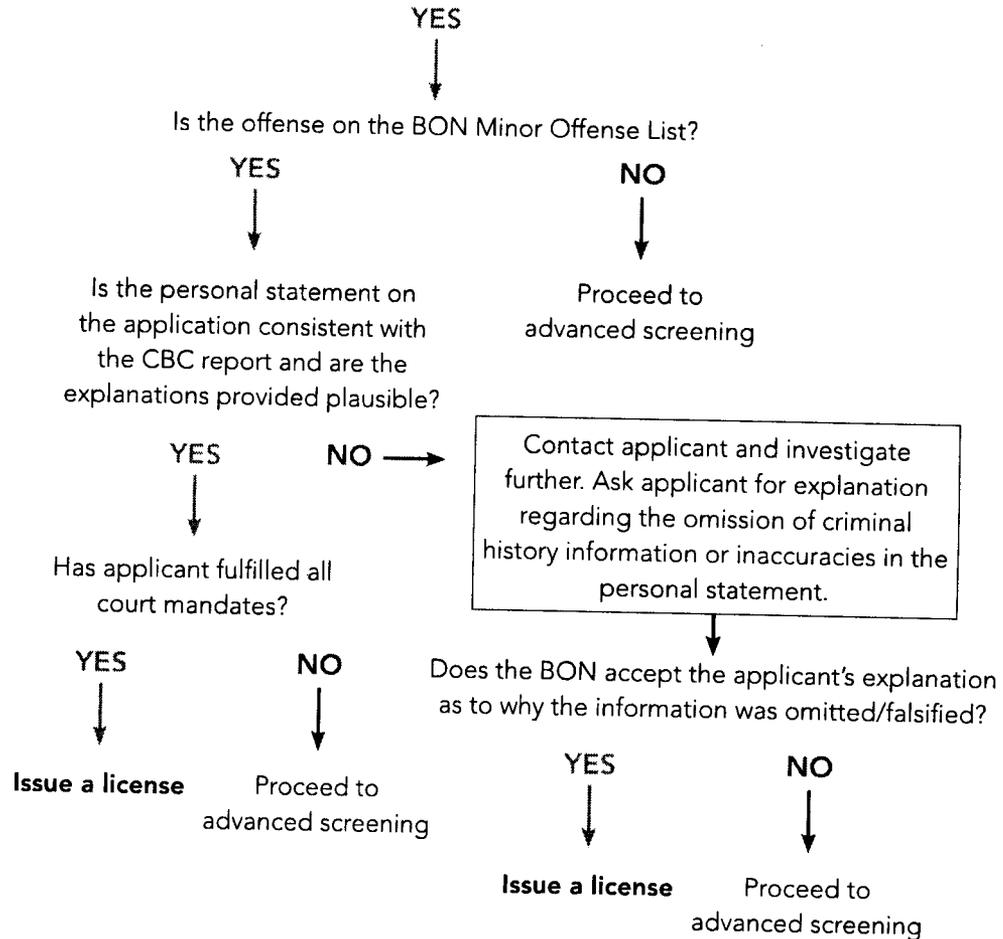
Step Two: Minor Offense List

The BON should create a Minor Offense List, which should consist of misdemeanors that are not applicable or relevant to safe nursing practice. Examples of these may include loud noise violations, a minor in possession of tobacco, littering or fishing without a permit.

Step Three: Initial Screening

Take applications through the following steps:

DOES THE CBC REVEAL A POSITIVE CRIMINAL HISTORY?



Step Four: Advanced Screening

While minor offenses can be addressed by BON staff, the BON or special CBC committee/task force designated by the BON should review applicants that go on to advanced screening. Advanced screening is for:

1. Minor offenses with a lack of honest disclosure; explanation on personal statement is incongruent with the CBC report or other documents;
2. Serious offenses (including a series of misdemeanors or those that suggest that the individual has a pattern of behavior, or any misdemeanor that the BON feels warrants further investigation);
3. Crimes of a sexual nature; and
4. A history of substance use.

Crimes of a Sexual Nature

Is the crime of a sexual nature?

If so, require a psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the BON identifies sexual behavior of a predatory nature, deny licensure.

Substance Use

Does the crime involve substance use?

If so, require a substance use disorder evaluation and proceed with the board's routine policies and procedures for handling individuals with substance use disorder.

All Other Serious Offenses/Minor Offenses with Incongruent Explanations

The BON (or a designated committee/task force) should gather all information regarding the applicant's criminal history and consider the following:

- The nature and seriousness of the crime;
- The relationship of the crime to the type of activity the applicant will be engaged in (nursing care);
- The extent to which the license might further the opportunity to engage in the criminal activity;
- Time lapse since the last offense;
- Conduct and activity of the applicant since the offense; and
- Any additional information regarding the crime:
 - Multiple or repeat violations/patterns of related offenses;
 - Criminal mistreatment of children or vulnerable adults;
 - Murder, felonious assault, kidnapping or other crimes of violence; and/or
 - Demonstrated lack of rehabilitation.

After evaluating these criteria, the decision to issue a license may be evident. However, if the BON or CBC committee/task force is still uncertain about whether to license a particular applicant, a further evaluation should be done to determine if the applicant demonstrates criminal thinking and would pose a threat to public safety if licensed as a nurse.

Step Five: Risk Assessment

Does this person demonstrate criminal thinking and thereby pose a threat to public safety if hired as a nurse?

If the BON is uncertain about the decision to license an applicant, a psychological evaluation/risk assessment is recommended. The purpose of this is to systematically and objectively assess risk to public safety and use data to make an informed and fair decision about licensure. By including risk assessment in the licensure evaluation process, the profile of the applicant becomes multidimensional and more in-depth. BONs will be better equipped to determine risk to public safety and avoid potential bias against an applicant.

Referral/Resources for Risk Assessment

The BON or CBC committee/task force should refer the applicant to a psychologist trained in forensics and/or risk assessment. These psychologists are available in every state and BONs should consider building relationships with a psychologist or group practice in their state. Below are websites that will be useful in locating an appropriate professional:

American Psychological Association: www.apa.org

- Click on "Find a Psychologist"
- Type in your city or zip code
- Select "Forensics" from pull-down menu
- Specify distance reasonable for the applicant to travel

American Academy of Forensic Psychology: www.aafp.com

- Click on "Diplomat Directory"
- Then "Locate a Board Certified Forensic Expert"
- Search by name or state

American Academy of Clinical Psychology: www.aacpsy.org

- Click on "Resources"
- Then "Member Directory"
- Search by name or by state

Sample Referral Questions

The BON should help guide the assessment by supplying the psychologist with a statement or referral question. For example:

"Conduct a brief risk assessment using a personality and psychopathology measure to assess risk to patient safety."

"Is this applicant a risk to patient safety if licensed to be a nurse?"

"What level of risk does this applicant post to patient safety – high, medium or low?"

Additional Information

It is very important for a psychologist to have as much relevant information about the applicant as possible. Provide background information, including criminal history and court mandates. Also include notes from conversations with the applicant and any letters of recommendation.

Testing

A two-test battery is recommended along with a clinical interview:

- One measure of personality; and
- One measure of psychopathology.

Ensure tests/assessment instruments comply with any applicable state constitutional and statutory privacy rights protections. Below are a number of tests/assessments that measure personality and psychopathology. They are psychometrically sound and EEOC and ADA compliant. It is recommended that you review the websites and discuss with the forensic psychologist the best test to use for the evaluation you are requesting.

Measures of Personality

16 Personality Factors (16-PF): www.ipat.com

- Assesses traits that describe and predict behavior in a variety of contexts.

California Psychological Inventory (CPI): www.cpp.com

- Leading nonclinical personality inventory test.
- Evaluates interpersonal behavior and social interaction.

Measures of Psychopathology

Personality Assessment Inventory (PAI): www4.parinc.com

- Screens for levels of psychological distress, including impulse control problems.

- Has two indicators of potential harm to self or others.
- Interpersonal scales assess relationships and interactions.

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)/MMPI-2RF: www.pearsonclinical.com

- Identifies suitable candidates for high-risk public safety positions.
- Evaluates substance use disorder.
- Reports can be tailored to present information for specific settings.

PsychEval Personality Questionnaire (PEPQ): www.ipat.com

- In-depth normal personality assessment and a quick screen for psychopathology-related patterns of behavior.
- Screening of applicants for high-risk positions.
- Fitness-for-duty evaluations.

Other tests are available and may be used as well. It is important to have a relationship with a psychologist that the BON trusts to choose the appropriate tests. The tests herein are considered extremely accurate and can provide the BON with valuable insight into the applicant that they would not otherwise have.

The Decision to License

The results of the assessments and the recommendation of the psychologist should be considered by the BON or designated committee/task force and integrated with the information from the BON investigation, including:

- Applicant explanation of criminal history;
- Arrest records;
- Court documents; and
- Letters of recommendation.

A decision can now be made about licensure.

The Cost of Risk Assessments

The cost of undergoing a risk assessment can range anywhere between \$150 and \$400, depending on the number of tests deemed necessary and the overall extent of the evaluation.



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Nursys Data Analysis: An Overview of NCSBN Member Board Data as Submitted to Nursys (2003-2013)

Introduction

In the current study, we conducted a review of 2003-2013 discipline cases from the NCSBN Nursys database aiming to extract data on demographics and trends in discipline among nurses.

Aims and Significance

This study aims to

1. Examine trends in discipline.
2. Examine whether there have been changes in disciplinary violations or board actions over the last ten years.
3. Provide a description of the demographic characteristics of nurses disciplined from 2003-2013.
4. Provide information about the type of data that can currently be extracted and analyzed from Nursys.

Research Questions:

1. What are the demographic characteristics of nurses who were disciplined during the years 2003-2013?
2. What are the most frequent violations and board actions entered into Nursys from 2003-2013?
3. Have the discipline rates, violations or board actions of BONs changed over the ten year period (2003-2013)?

Definitions:

Discipline case: a dated Nursys record of disciplinary action imposed on a nurse by her/his BON. A discipline case includes one or more violations and one or more disciplinary actions. (Discipline cases may include revision to actions; however, in this study only initial actions are reviewed.)

Discipline Rate: the total number of disciplined licenses by the total number of licenses in the nursing workforce.

Unique ID Numbers: Numbers assigned to a licensee when the license is entered into the Nursys database.

Methods:

Research Design and Data Analysis: This is a retrospective study of all disciplined nurses including registered nurses (RNs), licensed practical nurses/vocational nurses (LPNs/VNs), and advanced practice registered nurses (APRNs) entered into the NCSBN Nursys database between January 2003 and November 2013. Data were analyzed using standard statistical

methods. Because the datasets contain missing information, each analysis has a different number of subjects or cases (n) and this is noted within each section of the results.

Case Selection Criteria: In the current report, data from 2003-2013 is reviewed using three datasets from Nursys: (1) individual demographic information (licensure database); (2) disciplinary violations; (3) disciplinary actions (initial actions only). Revisions to actions are in a separate dataset and were not included in this analysis.

Confidentiality: Although the licensure and discipline data for a particular licensee is publicly accessible via Nursys Licensure Quick Confirm and many BON websites, this report presents data in aggregate form only.

Results:

Demographic Characteristics of Disciplined Nurses

Total Sample (N=109,239 nurses)

A review of individual data from Nursys demonstrated that from 2003 through 2013, 109,239 nurses (as identified by Nursys unique ID numbers) were disciplined by 56 BONs. (Does not include data from Mariana Islands, Guam and American Samoa)

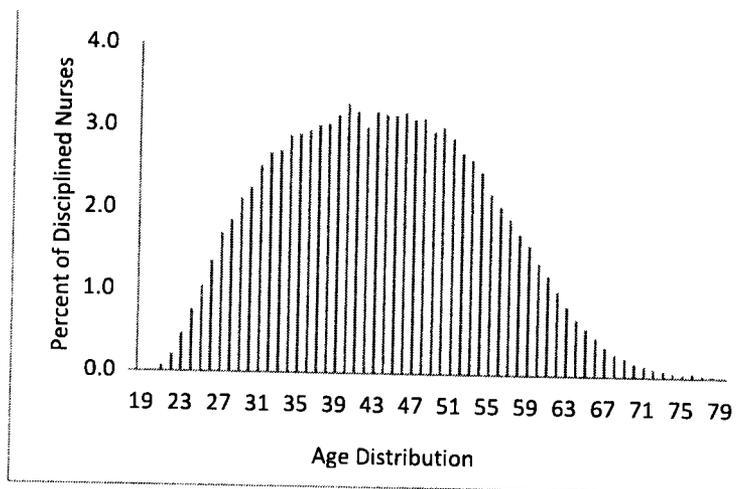
Gender (N=109,239 nurses)

The majority of the disciplined nurses (83% of gender data available) were female (n=80,064), while 17% (of gender data available) were male (n=15,880). Despite the lower percentage of discipline for male nurses, they were over-represented in the disciplined group compared to the proportion of male nurses in the general nursing workforce (less than 9%) (Health Resources and Services Administration, 2013).

Age at Initial Discipline (N=108,732 nurses)

Figure 1, illustrates the distribution of ages at initial discipline. Note the highest number of nurses receiving initial discipline falls between the ages of 39 and 49.

Figure 1. Age at First Discipline Action, Among Disciplined Nurses



Number of Years since Initial Licensure at Time of First Discipline Action (N=86,753 nurses)

Table I indicates that 29% of those disciplined had a nursing license for 5 years or less, and another 22% held their license for 6-10 years. Thus, a little over 50% of the disciplined nurses were licensed 10 years or less.

Table I. Number of Years Since Initial Licensure at Time of First Discipline Action (N=86,753)

<i>No. of Years Since Initial Licensure at the Time of Discipline</i>	<i>N</i>	<i>Percentage</i>
0-5 years	25.376	29.25
6-10 years	19.118	22.04
11-15 years	15.058	17.36
16-20 years	10.385	11.97
21-25 years	6.570	7.57
Above 25 years	10.246	11.81

License Types (N=109,239 nurses)

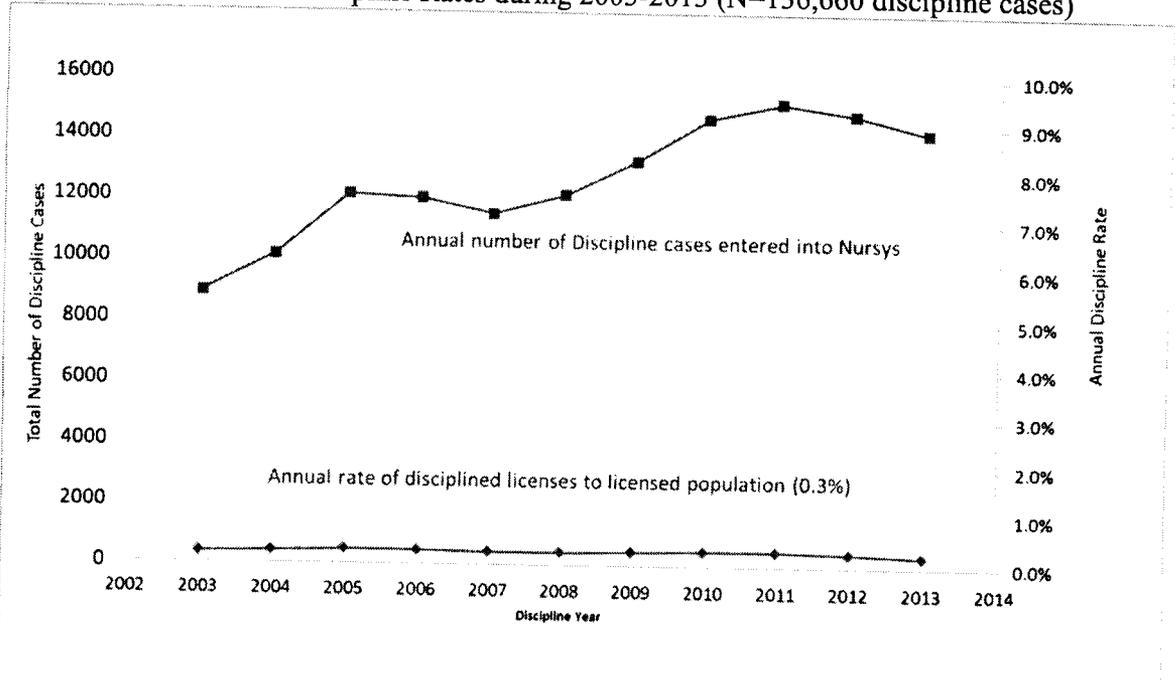
More than 50% of the disciplined nurses practiced as RNs, 42% as LPN/VNs, and 1% held an APRN license. The NCSBN licensure statistics demonstrate, on average, the proportion of nurses who held LPN/VN licenses was approximately 20% of the nursing population (NCSBN, 2003-2013). Therefore, the LPNs/VNs are over-represented in the disciplined population. This finding is also consistent with previous discipline studies which were based on Nursys-independent datasets (Zhong, Kenward, Sheets, Doherty, & Gross, 2009; Zhong & Thomas, 2012). Overall, 7% of the disciplined nurses held more than one type of license (e.g., RN and LPN/VN, or RN and APRN).

Overview of 2003-2013 Discipline Trends

Discipline Rates

Over the ten year period (2003-2013), the number of discipline cases BONs entered annually increased by 33%, from 8,927 cases in 2003 to 11,865 cases in 2013. However, according to HRSA (2013), the nursing population also grew during this time period (RNs: 24.1% growth and LPNs: 15.5% growth). The actual rate of discipline cases remained constant over the ten year period. As depicted in Figure 2, over the ten year period, the annual discipline case rate remained consistently low at 0.31% or less. Figure 2 depicts the annual total numbers of discipline cases reported to Nursys from all jurisdictions and the annual discipline rate.

Figure 2. Overview of Discipline Rates during 2003-2013 (N=136,660 discipline cases)



Discipline Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Discipline Rate (%)	0.22	0.25	0.29	0.28	0.26	0.26	0.29	0.31	0.31	0.28	0.23

Common Violations Committed by Disciplined Nurses

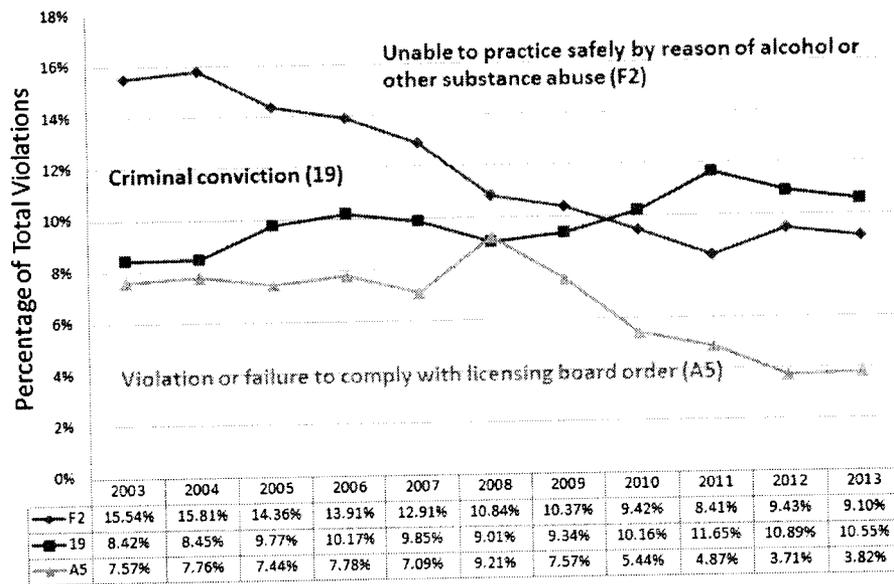
A review of disciplinary cases showed that 109,043 nurses (identified by unique identifiers) committed 72 different types of violations based on the National Practitioner Data Bank (NPDB)/Nursys codes recorded in Nursys. Alcohol or other substance use remained the most frequently reported type of violation that resulted in disciplinary action by BONs. The actual percentage of these substance use disorder (SUD) violations in Nursys (11.45%) is artificially low due to the fact that many nurses with SUD are enrolled in alternative to discipline programs and not reported to Nursys. Table II lists the most frequently reported violations recorded in the Nursys database.

Table II. Most Common Violations (Total=208,064 violations)

<i>NPDB/ Nursys Code</i>	<i>Types of Violations</i>	<i>Frequency N</i>	<i>Percent %</i>
F2	Unable to Practice Safely by Reason of Alcohol or Other Substance Abuse	23,828	11.45
19	Criminal Conviction	20,725	9.96
A5	Violation or Failure to Comply with Licensing Board Order	13,330	6.41
F6	Substandard or Inadequate Care	11,306	5.43
H6	Diversion of Controlled Substance	11,205	5.39

The data in Figure 3 indicates the percentage of discipline cases related to alcohol or other substance abuse decreased 41% and cases related to violation of board order decreased 50% during this time period. However, the percentage of criminal conviction cases increased by 25%. The decrease in the substance use cases may be due to a rise in the number of nurses enrolled in alternative to discipline programs.

Figure 3. Percentage of the Most Common Violations Reported in Nursys by Year (2003-2013)



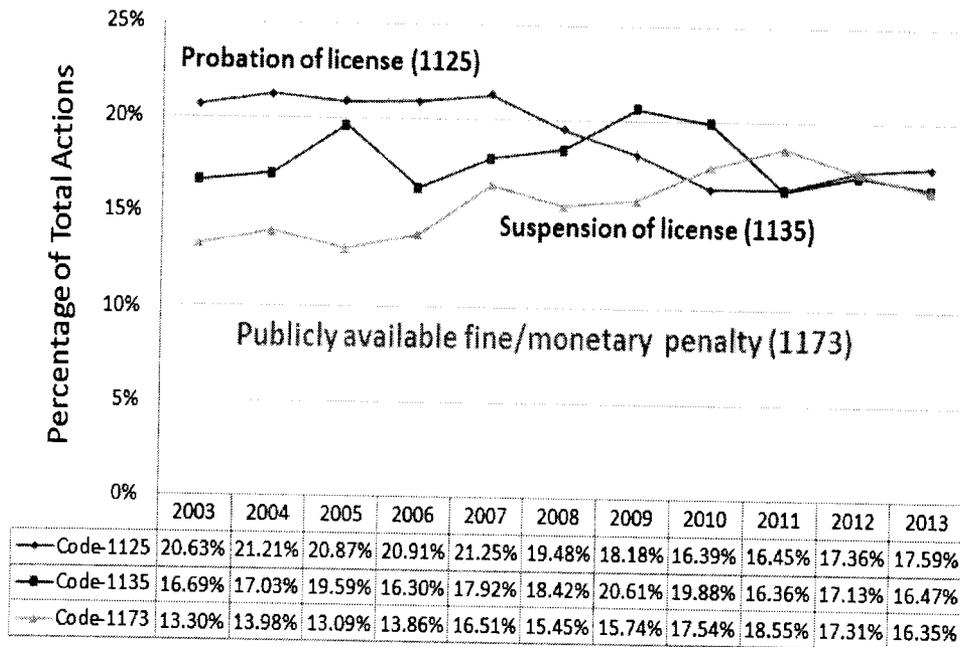
Common Disciplinary Actions Issued by BONs

The three most common disciplinary actions imposed by BONs and recorded in Nursys for this ten year period are: “Probation of license” (19%), “Suspension of license” (18%), and “Fine/monetary penalty” (16%) (See Table III).

Table III. Most Common Disciplinary Actions Taken by BONs Over 10 Years (Total=186,416 actions)

<i>NPDB/ Nursys Code</i>	<i>Discipline Actions</i>	<i>Frequency</i>	<i>Percentage</i>
1125	Probation of License	35,231	18.90
1135	Suspension of License	33,376	17.90
1173	Publicly Available Fine/Monetary Penalty	29,495	15.82
1140	Reprimand or Censure	22,933	12.3
1110	Revocation of License	17,008	9.12
1145	Voluntary Surrender of License	14,288	7.66

Figure 4. Percentage of the Top Three Most Common Disciplinary Actions to the Total Number of Actions Taken by BONs (2003-2013)



Discipline Actions Taken on the Common Violations

Table IV presents the five most frequent violations and the most common disciplinary actions taken as a result of those violations.

Table IV. Disciplinary Actions Taken on Common Violations

<i>Violations</i>	<i>Discipline Action Taken</i>	<i>Percent/ (N)</i>
Unable to practice safely by reason of alcohol or other substance abuse <i>Total Action: (N=31,215)</i>	Suspension of license	26.2 (8,192)
	Probation of license	20.8 (6,482)
	Voluntary surrender of license	12.4 (3,878)
	Revocation of license	11.4 (3,560)
Criminal Conviction <i>Total Actions: (N=27,807)</i>	Probation of license	24.6 (6,842)
	Revocation of license	14.6 (4,069)
	Suspension of license	14.3 (3,987)
	Fine/monetary penalty	12.9 (3,582)
Violation or Failure to Comply with Licensing Board Order <i>Total Actions: (N=18,541)</i>	Suspension of license	32.2 (5,965)
	Revocation of license	14.1 (2,617)
	Fine/monetary penalty	13.7 (2,543)
	Probation of license	12.4 (2,294)
Substandard or Inadequate Care <i>Total Actions: (N=16,313)</i>	Probation of license	23.4 (3,818)
	Reprimand or censure	19.3 (3,152)
	Other license action (unclassified)	18.5 (3,009)
	Fine/monetary penalty	10.5 (1,714)
Diversion of Controlled Substances <i>Total Actions: (N=14,757)</i>	Suspension of license	24.4 (3,593)
	Probation of license	20.2 (2,982)
	Revocation of license	14.1 (2,080)
	Voluntary surrender of license	13.7 (2,019)

The Nursys Dataset as the Basis for a Study on Recidivism

Recidivism is a problem in a subset of the nursing workforce who have discipline on their license. We attempted to review recidivism trends using the Nursys datasets. In order to do this, specific criteria and a protocol were developed to ensure accuracy of the analysis.

Procedure

1. Recidivism was operationally defined as: a new disciplinary case (violation and board action) entered into Nursys after a nurse received discipline for a prior violation.
2. Violation codes that did not directly pertain to recidivism were eliminated. Sixteen violations were identified that would not pertain to or indicate recidivism. These were eliminated from the dataset. These included Code 39, *license revocation, suspension or other disciplinary taken by a federal, state or local licensing authority*.
3. Twenty test cases were randomly drawn from the dataset and were manually examined to ensure the current methodology was accurate and would allow for analysis of recidivism cases that met the study criteria.

4. Upon examination of the test cases, it was determined that reciprocal actions, taken because another state took action on the respondent's license, are recorded by BONs in varying ways. Because of these variations, there is no way to accurately distinguish recidivism cases from reciprocal actions without examining all cases manually and reading the case entry and narrative.

As a result of these findings, rates of recidivism cannot be reported at this time.

Limitations

This is a descriptive study based on data submitted to Nursys by boards of nursing. The demographic data reported may be limited due to missing data in the Nursys database. For example, date of initial licensure was missing in 20% of cases and gender information was missing in 12% of the cases.

Conclusions

1. What are the demographic characteristics of nurses who were disciplined during the years 2003-2013?

Nurses who are disciplined from 2003-2013 were predominantly:

- Female; however, a disproportionate number of males were disciplined (i.e. the percentage of male nurses disciplined was higher than the percentage of males in the nursing workforce).
- Licensed 10 years or less
- Between the ages of 39 and 49
- Held LPN licenses

2. What are the most frequent violations and board actions entered into Nursys from 2003-2013?

- Most frequent violations were related to the following:
 - Alcohol or substance use
 - Criminal conviction
 - Violation of board order
- Most frequent board actions were:
 - Probation of license
 - Suspension of license
 - Fine/monetary penalty

3. Have the discipline rates, violations or board actions of boards of nursing (BONs) changed over the ten year period (2003-2013)?

- This review shows that overall discipline rates in nursing practice remained consistently low over the past decade ($\leq 0.31\%$).
- The review also shows there is a decrease in the percentage of violations related to substance use; however, this most likely is due to enrollment in confidential non-disciplinary alternative programs. The percentage of “Violation or Failure to Comply with Licensing Board Order” violations decreased and an increase in the percentage of violations related to criminal convictions was observed.
- The types of board actions taken have remained consistent over 10 years.

In summary, the Nursys database is a rich data source for the study of discipline. Currently, the usefulness of the data is constrained by the inherent issues described in this report. More consistent disciplinary data entry by all jurisdictions would allow more detailed research and firmer conclusions that could be highly useful to nursing regulation.

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With Billions on the Line, Congress Starts to Love

Telemedicine

House bills expand Medicare coverage

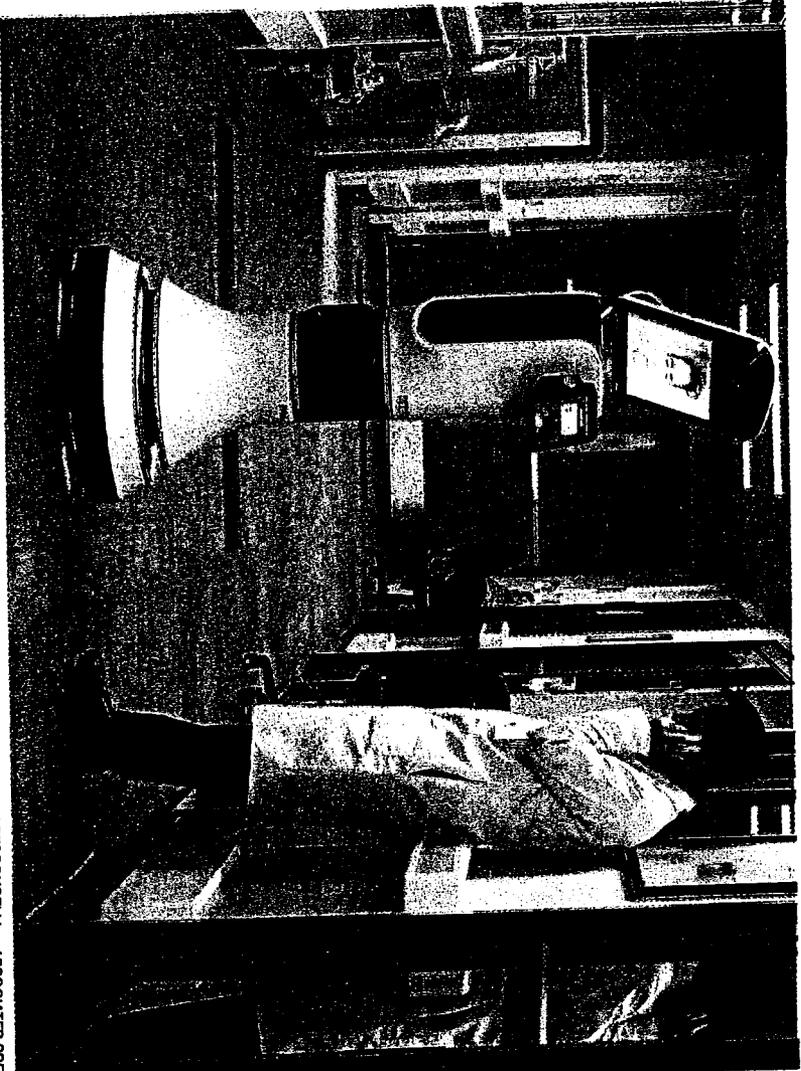
By DAVID PITTMAN

Telemedicine is the new buzzword in Washington's health policy circles, and billions of dollars are keeping it on people's lips.

Congress, which for years paid scant attention to the issue, is pushing legislation to spur its use by expanding Medicare coverage. Lobbyists are diving in, pushing the notion that high-tech, high-value telemedicine fits snugly in the new world of affordable care.

"Though there have been lots of people working on this issue for a very long time, it seems to be now reaching a crescendo," said Krista Drobac, executive director of the Alliance for Connected Care, a lobbying group created earlier this year by former Senate Majority Leaders Tom Daschle (D-S.D.) and Trent Lott (R-Miss.) and former Sen. John Breau (D-La.). "We hope that we can turn it into something good."

Medicare pays for telemedicine services only when care is provided in a rural, underserved area, occurs in a health facility and is a live communication between a provider and a patient. The agency's payments for the service amounted to about \$12 million last year. Outside Medicare, the annual market is about \$240 million. Assuming that Medicare expands its coverage, spending on telemedicine



Alan Shatzel, medical director of the Mercy Telehealth Network, is displayed on a monitor as he waits to confer with Alex Nee at Mercy San Juan Hospital in Carmichael, California. Congress is looking at expanding payments that cover telemedicine.

payments for home health services that use the technology and allow doctors to provide care across state lines through telemedicine. Both are House bills, but Sen. John

Caremark are members of the coalition and are funneling money into its coffers. Those companies stand to see a bigger slice of the Medicare pie

that it won't create another hole in the hull of the Medicare ship. In a survey of research he produced for the Alliance for Connected Care last month, University of Michi-

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payments." A May 29 study in JAMA Ophthalmology showed that nearly a quarter of veterans who received remote eye exams later showed up at a VA eye clinic for care, with costs running to \$1,000 per patient.

The Medicare Payment Advisory Commission hasn't seriously addressed the issue yet. Lobbyists like the Alliance for Connected Care hope to sit down with MedPAC and and the Congressional Budget Office to convince them of the potential savings the technology can produce. Advocates believe that tech advances are helping their case as well.

The proliferation of broadband has made the service possible in more areas. Also, the number of people and conditions for which it can be used continues to increase, with specialists such as psychiatrists showing increased interest.

"There's more and more consumers using telehealth for primary care," said Drobac, who most recently oversaw the health division of the National Governors Association and previously spent time at the Centers for Medicare & Medicaid Services. "I think that's probably why it's getting more attention in the industry now."

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Medicare pays for telemedicine services only when care is provided in a rural underserved area, occurs in a health facility and is a live communication between a provider and a patient. The agency's payments for the service amounted to about \$12 million last year. Outside Medicare, the annual market is about \$240 million. Assuming that Medicare expands its coverage, spending on telemedicine could balloon to nearly \$2 billion by 2018, according to one market research firm.

Expansion will require some changes in law and tradition. Backers of the technology want to allow doctors in one state to be able to treat a patient in another through telecommunication — something that has generally been forbidden to doctors who aren't licensed to practice in the state where the patient resides. Others want Medicare to pay for consults and interactions delivered through telemedicine regardless of whether the patient lives in a rural area or a city.

During a recent Capitol Hill event hosted by the Alliance for Connected Care, Sen. Ron Wyden (D-Ore.) vowed to make Medicare policies friendlier to telemedicine while he's chairman of the powerful Senate Finance Committee. House Energy and Commerce Committee Chairman Fred Upton (R-Mich.) said last month that his committee will make the issue a priority "over the next few years as we work towards fostering innovation that will lead to more treatments and cures." He called for industry and others to provide guidance to the committee by June 16.

Bipartisan groups of lawmakers have pushed their own bills — the Telehealth Enhancement Act and the TELEmedicine for MEDicare Act — both of which would enhance

payments for home health services that use the technology and allow doctors to provide care across state lines through telemedicine. Both are House bills, but Sen. John Thune (R-S.D.) has backed similar legislation in the upper chamber.

Telemedicine is grabbing Congress' attention now "because members are looking for health care-related issues that they're able to work on collaboratively," said Neal Neuberger, executive director of the Institute for e-Health Policy. "If the vehicles are there — and there is a high level of interest in several bipartisan telehealth-related bills introduced this session — I think that this could be a big year for moving the ball further down the field."

Telemedicine owes its improving fortunes to some recent research indicating it could save taxpayer money — and to a concerted lobbying effort.

Since Daschle, Lott and Breaux launched the Alliance for Connected Care earlier this year, the group has spent \$120,000 on lobbying, with Patton Boggs and DLA Piper doing the work. Companies like Verizon, WellPoint and CVS

Caremark are members of the coalition and are funneling money into its coffers.

Those companies stand to see a bigger slice of the Medicare pie should Congress ease the restrictions on reimbursements. For example, WellPoint, one of the nation's largest health insurers, recently expanded its two-way video consulting service nationwide after success in California and Ohio. If the company could bill Medicare for these services, its market would rapidly expand, since seniors are envisioned as major consumers of telemedicine.

In previous years, lawmakers feared that removing barriers to Medicare funding of telemedicine would swell the federal budget and make Medicare more insolvent by increasing utilization and thus overall costs. The telemedicine industry has tried to convince Washington budget hawks that the technology can save money in the long run by substituting remote care for expensive in-person visits to clinics or hospital emergency departments. Advocates believe there is enough evidence from its years of use to convince policymakers

that it won't create another hole in the hull of the Medicare ship. In a survey of research he produced for the Alliance for Connected Care last month, University of Michigan professor Rashid Bashshur, a former president of the American Telemedicine Association, found no evidence that wider use of telemedicine would increase utilization or drive spending.

Not everyone is convinced this is the case. Ateev Mehrotra, policy analyst at the RAND Corp. and associate professor at the Harvard Medical School, cautioned lawmakers at a hearing last month that while telemedicine could lead to lower costs per clinical encounter, it might increase the number of such encounters.

"If the primary goal of telehealth is to reduce societal health care spending, then telehealth options that focus on eliminating high-cost medical events such as hospital admissions or specialty referrals are more likely to be effective," Mehrotra said in his testimony. "This possibility of overutilization can be tempered through payment reforms being considered by Congress that focus on bundled

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Alan Shatzel, medical director of the Mercy Telehealth Network, is displayed on a monitor as he waits to confer with Alex Nee at Mercy San Juan Hospital in Carmichael, California. Congress is looking at expanding payments that cover telemedicine.

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"There's more and more consumers using telehealth for primary care," said Drobac, who most recently oversaw the health division of the National Governors Association and previously spent time at the Centers for Medicare & Medicaid Services. "I think that's probably why it's getting more attention in the policy space."

With 20 states and the District of Columbia now requiring private insurance companies to cover telemedicine at the same rate they do in-person care, Washington lawmakers are looking to bring Medicare into the 21st century. When the Social Security Act was amended almost 15 years ago to mention telemedicine, the technology was envisioned to serve rural patients. But people everywhere are using it today.

The uptick in interest around telemedicine is directly related to the health care focus on value rather than volume, said Bill Fera, principal at EY, formerly Ernst and Young.

"From an overall care standpoint, it makes all the sense in the world," Fera said. "The idea that you need to be in the same room as somebody to affect their care is just antiquated."

For all the attention telemedicine is receiving these days, watchdogs are pushing back, reminding policymakers that technology can't be a substitute for a real person.

Common ailments such as sore throats and infants' ear infections can't be diagnosed solely through telemedicine, noted Greg Billings, executive director of the Center for Telehealth and eHealth Law.

"It isn't a matter of safe telemedicine," Billings said. "It's a matter of safe medicine."

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Krista Drobac
Executive director, Alliance for Connected Care

From: Synthia Carter RN

2009-355

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DIRECTOR
STATE OF UTAH

JUN 11 2014

STATE OF UTAH

In response to Notice of Informal Agency Action

#7- I did fail to meet with the Board of Nurses on March 27, 2014.

I was unaware of this meeting. I did not receive any letter via mail as I always have in the past, nor did I respond and confirm the meeting as usually required upon receiving the letter. On April 19, 2014, when looking thru my personal email yahoo account, I found an email sent from Connie Call on March 18, 2014 stating I had a meeting with the Board on March 27, 2014. I immediatly responded to her stating I was unaware of this meeting, and did not receive any messages via mail, or Affinity, which is our daily route of communication. In the past 5 years, I have communicated to Connie Call via my yahoo email account 3 times, due to problems with my affinity account. The last email sent via my yahoo accout was March 19, 2013.

#8- I did fail to submil a urine sample on 2/7/2014. I was on my way home from East Carbon, Utah, to test at my usual testing site, when unexpectedly my care broke down in Spanish Fork Canyon. By the time I was able to get transportation home, It was too late to test.