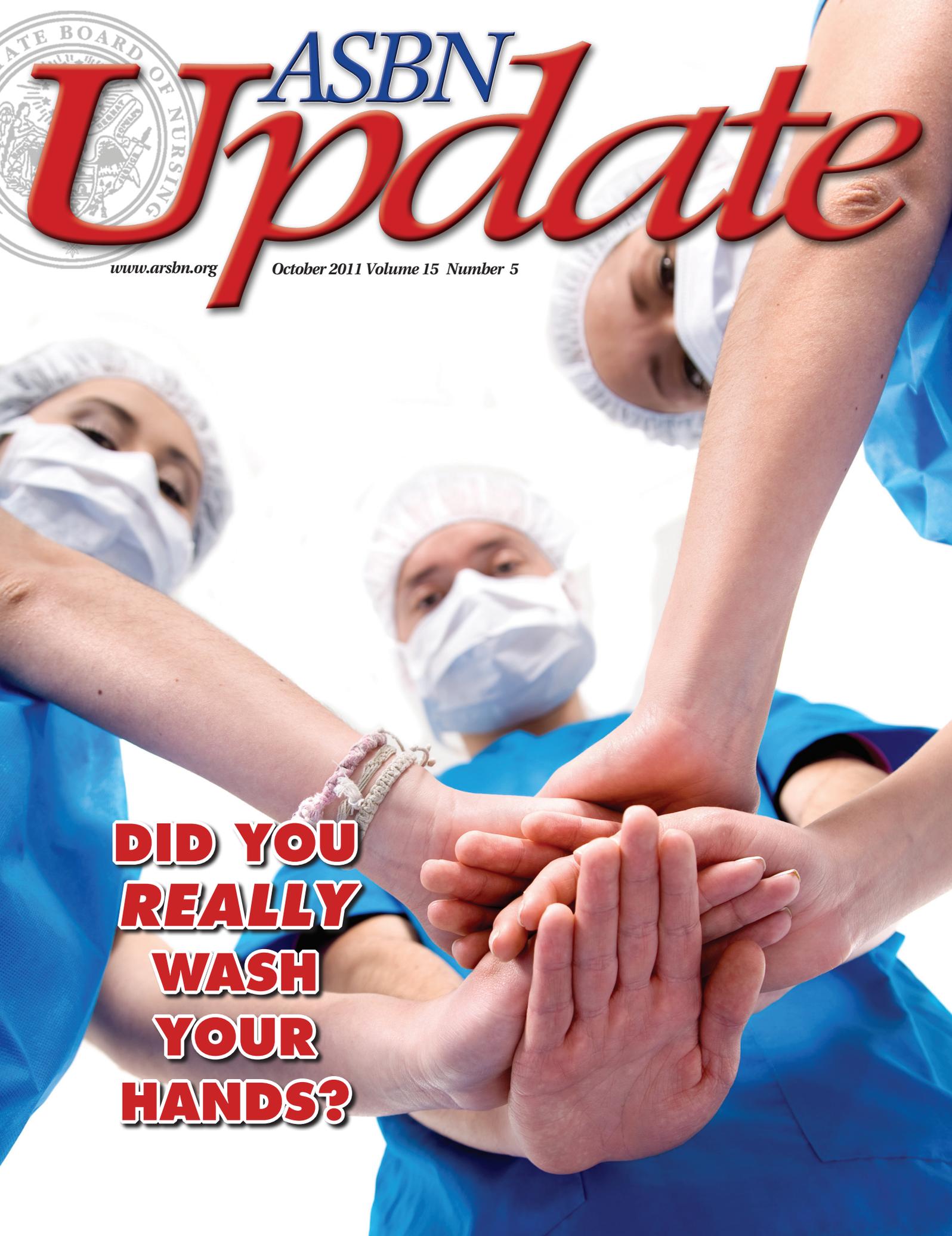




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October 2011 Volume 15 Number 5



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The mission of the Arkansas State Board of Nursing is to protect the public and act as their advocate by effectively regulating the practice of nursing.

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C o n t e n t s

Executive Director's Message • 4

President's Message • 6

Board Business • 7

Staff Directory • 8

Down the Rabbit Hole • 10

Bullying: Confront or Condone • 12

Hospice and Long Term Care
Partnership • 14

Quality Improvement:
Whose Job Is It Anyway • 18

Quality assurance plans for the APNs
with prescriptive authority • 20

NCLEX® Pass Rates • 22

Did you really wash your hands? • 25

Disciplinary Actions • 27

Name and address changes:
A requirement for licensure • 29

The ASBN Update circulation includes over 48,000 licensed nurses and student nurses in Arkansas.





When Was the Last Time You Read the Nurse Practice Act?

I am glad you are taking a couple of minutes to read this article, but I hope the question, "What is the Nurse Practice Act?" is not going through your head.

However, I will take a few minutes to refresh your memory. The *Nurse Practice Act* is a collection of the statutes — otherwise known as laws — that outline the practice of nursing in Arkansas. These statutes must be followed just as we follow every other law. An additional guideline that further defines the practice of nursing is the *ASBN Rules*. The rules are written in language that is easier to understand and apply to the work setting. The Board of Nursing has also issued official position statements on various issues, including IV Conscious Sedation (94-1), Pronouncement of Death (06-1), Telenursing (00-2) and Transmission and Acceptance of Verbal Orders (95-2). The practice of nursing varies to some degree in other states, and anyone practicing in Arkansas as a nurse, regardless of state of licensure, must follow the Arkansas regulations.

I believe all nurses begin their career with the belief that they will never do anything to jeopardize their license and career. The two most common reasons that disciplinary action is taken against a nurse are unprofessional conduct and fraud and deceit. We all know coming to work under the influence of drugs or alcohol is unprofessional conduct. A few other behaviors considered unprofessional conduct include:

- failing to assess and evaluate a patient's status
- violating the confidentiality of information related to a patient
- improperly delegating duties
- failing to supervise
- failing to conform to universal precautions
- failing to wear a name badge
- providing inaccurate or misleading information regarding employment history to an employer

Review Chapter 7 of the ASBN Rules for the full definition of unprofessional conduct.

Unfortunately, fraud and deceit occur often. On the initial application for licensure as well as on the renewal application, there are questions that ask for self-disclosure of convictions, drug use/treatment, past discipline, completion of continuing education, etc. Failure to be honest when answering these questions is considered fraud and deceit in the process of obtaining/renewing a nursing license. The excuses we hear most often for not disclosing requested information are "I forgot," or "I didn't think you meant ..." Well, neither these excuses — nor any other excuse — will prevent disciplinary action from being taken against the nurse or applicant. Usually the disciplinary action is not severe, such as a Letter of Reprimand. However, there have been several instances where an individual was denied licensure and other instances where a license was revoked, which is permanent in Arkansas.

If you have not read the *Nurse Practice Act*, the *ASBN Rules* and the ASBN Position Statements recently, stop what you are doing and read them. You can find them on the ASBN website, www.arsbn.org, under the Laws and Rules tab. It is your responsibility to be informed on the Arkansas *Nurse Practice Act*, the *ASBN Rules* and Position Statements. You don't want to find your name among the disciplined nurses listed in the back of this magazine!

RESERVED AD SPACE



OUR LEGACY

Back to school. This phrase evokes various reactions: excitement, fear and sadness for students, happiness for parents and reality for educators. Back to school gives us all a new start and a clean slate. To a nursing educator, the beginning of a school year brings fresh, hopeful faces and new challenges. Just when you have pushed, pulled, prodded and groomed a class full of these “hopefuls” into competent nurses, it’s time to begin bed baths and bed making once more. Being a nurse educator is one of the most challenging, rewarding undertakings. With all due respect to other types of instructors, I have often said should I teach ceramics, for example, I would find a way for every student to succeed. After all, beauty is in the eye of the beholder when it comes to art. However, in the art and science of nursing, the stakes are way too high.

Not only must we hold nursing students to high academic standards, we must teach professionalism. In today’s age of freedom of choice and individual expression, we must insist on conforming in personal appearance and demeanor. The amount of material to learn can be overwhelming and moves at a lightning pace. In the first few weeks, some decide they don’t really want to be nurses after all; we decide some don’t need to be nurses. Others try their very best and still fall short in spite of all our best efforts. Nurse educators are still nurses (although many of our students think we never endured the agonies of nursing school), and by our very nature, we are compassionate, nurturing and caring. We want all our students to be successful. When an educator has taught for several years, it is nice to see many of the students you knew didn’t admire you very much during training come back to thank you. The audience laughs and you smile when a student speaks at a graduation ceremony and thanks you for being a “hard” teacher. All’s well that ends well, and between orientation and pinning, somehow both students and instructors survive and become lifelong friends. To know your influence will touch thousands of lives through your students makes the salary bearable.

I recently welcomed 20 new students for orientation, and our journey begins. My love of teaching has brought me to a very difficult and sad decision — the decision not to reapply for a board appointment. Serving on the Board of Nursing for the past four years has been a wonderful experience for me. Working with the other board members, serving my profession and the people of our state, and learning about the regulation of nursing practice have all been both rewarding and enjoyable. Arkansas can be proud of this state agency and be assured its mission is carried out diligently and faithfully. Serving as president for the past year has been an honor.

I encourage every nurse, whatever your role, to be knowledgeable about the Board of Nursing and its mission. Get involved. Wherever you practice, become a teacher and mentor to our students. *They are our legacy.*

BOARD DATES

October 12

Hearings

October 13

Hearings

November 9

Hearings

November 10

Hearings

November 17

CE Workshop – NURSING TODAY: Ethics, Leadership, Social Networking and More, Baptist Health School of Nursing, Little Rock

January 11

Hearings

January 12

Business Meeting

February 8

Hearings

February 9

Hearings

March 12-14

NCSBN Midyear Meeting, Chicago, IL

April 11

Hearings

April 12

Hearings

May 9

Board Retreat

May 10

Business Meeting

Granted continued full approval to

- North Arkansas College's Associate Degree registered nurse program until the year 2016
- University of Central Arkansas' Bachelor of Science in Nursing degree program until the year 2016
- Northwest Arkansas Community College Associate of Applied Science in Nursing degree program until the year 2016

Granted prerequisite approval to Arkansas Tech University – Ozark Campus' Associate of Applied Science in Nursing degree program

Approved curriculum revisions proposed by the College of the Ouachitas Associate of Applied Science in Nursing degree program to be implemented in January 2012

Approved curriculum revisions proposed by the Southern Arkansas University Tech – Camden Practical Nurse program to be implemented in January 2012

Accepted the response for the first year of low pass rates on the NCLEX-RN® from

- Arkansas Northeastern College Associate of Applied Science in Nursing degree program
- Harding University Bachelor of Science of Nursing program
- University of Arkansas at Fort Smith Associate of Applied Science in Nursing degree program
- University of Arkansas at Monticello Associate of Applied Science in Nursing degree program
- University of Arkansas for Medical Sciences Bachelor of Science in Nursing degree program

Accepted the response for the first year of low pass rates on the NCLEX-PN® from Arkansas State University – Newport Practical Nursing program

Placed Henderson State University Bachelor of Science in Nursing degree program on conditional approval until two consecutive years of a 75 percent pass rate is achieved or until the Board withdraws approval status for noncompliance with the education standards

Accepted the Fourth Year Low Pass Rate report of the University of Arkansas at Pine Bluff Bachelor of Science in Nursing degree program

Accepted the Interim Progress Report, dated August 2011, of the University of Arkansas at Pine Bluff Bachelor of Science in Nursing degree program

Moved that the Board continue conditional approval of the University of Arkansas at Pine Bluff Bachelor of Science in Nursing degree program as identified in July 2010 with clarification of existing conditions, as specified in the meeting and following review of documents and testimony provided



The Board elected new officers for 2011-2012 during the September Business Meeting.

They are: Seated (L to R) President – Sandra Priebe, RN; Treasurer - Cynthia Burroughs, Consumer representative; Standing (L to R) Vice president – Richard Spivey, LPN; Secretary – Gladwin Connell, Rep. of Older Population



Executive Director Sue Tedford presented a plaque to off-going Board Member and President Brenda Murphree

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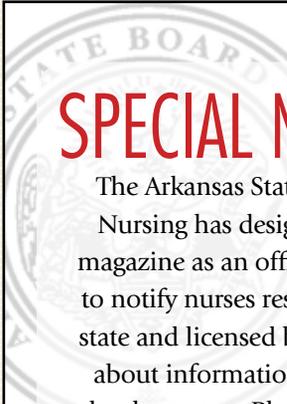
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The Arkansas State Board of Nursing has designated this magazine as an official method to notify nurses residing in the state and licensed by the Board about information and legal developments. Please read this magazine and keep it for future reference as this magazine may be used in hearings as proof of notification of the ASBN Update's contents. Please contact LouAnn Walker at the Board office (501.686.2701) if you have questions about any of the articles in this magazine.

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The following names appear on the ASBN records for checks returned to the ASBN due to insufficient funds. If practicing in Arkansas, they may be in violation of the Nurse Practice Act and could be subject to disciplinary action by the Board. Please contact Gail Bengal at 501.686.2716 if any are employed in your facility.

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DOWN THE RABBIT HOLE

“Who are you?” said the caterpillar...

“I – I hardly know, Sir, just at present,” Alice replied rather shyly, “at least I know who I was when I got up this morning, but I think I must have changed several times since then.”

(Carol, 1965)

After following the white rabbit down the rabbit hole, Alice confronted a multitude of wildly complex and chaotic adventures in wonderland that personified the constant nature of change. She was propelled through mystical and bizarre encounters — haphazardly relying on various characters for a multitude of unclear directions.

I was reminded of Alice’s predicament during a recent conversation with a nurse colleague. We were chatting about noteworthy trends and issues in nursing. I enthusiastically mentioned the Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*. Although it was released in 2010, I still consider this a stimulating topic for conversation. It was obvious that my colleague viewed the IOM report as less than thought-provoking as she wrinkled her nose (just like a rabbit) and asked why she should be concerned with a report that did not have anything to do with her. Pardon my surprise as I choked on my tea! I could visualize my colleague standing at the fork in the road — like Alice allowing happenstance as guide.

Who are you? When asked the same question as Alice, many of us would respond, “I am a nurse.” We are part of a profession that dramatically changes. The health care system is increasingly complex as

practice evolves and the profession advances; change continues to be omnipresent.

A key stimulus for preparing for the change that will continue to transform us as we consider the profession’s future is the IOM report. The work, sponsored by the Robert Wood Johnson Foundation, resulted from the Initiative on the Future of Nursing. It includes several key messages that are further clarified with evidence-based recommendations to meet respective initiatives. It explores in-depth how nurses’ roles and responsibilities should advance to keep pace with demands that will be created by the health care reform.

The key messages reflect the IOM’s vision for the nursing profession and form the basis for the report:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training, through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other health professionals, in redesigning health care in the United States. (IOM, 2010).

So, as my colleague stands at the fork in the road — without a clear direction — how can we take a more determined path? Yes,

the report continues to create quite a stir as the profession attempts to come to terms with potential impact of the recommendations. There are more opportunities for practicing nurses to obtain leadership roles in all settings; and become knowledgeable regarding issues that affect future practice. Participate in professional organizations and read the IOM report at <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>

If nurses do not participate in leading the change, it will be led for us.

“What should I do?” asked Alice as she reflected on her situation.

“Read the directions and directly you will be directed in the right direction,” replied the doorknob.

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- Carol, L. (1965). *Alice’s Adventures in Wonderland*. New York: Random House.
- Institute of Medicine of the National Academies (2010). *The future of nursing: focus on education*. Retrieved from <http://iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Report-Brief-Education.asp>

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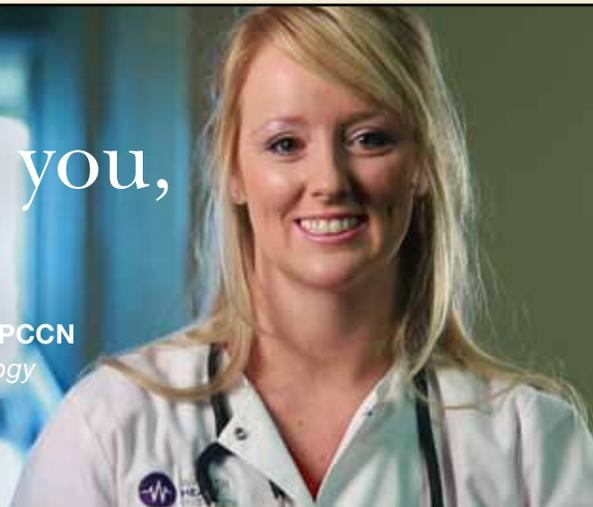
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BULLYING: CONFRONT OR CONDONE

What are your first thoughts when you hear the word “bullying?”

- 11-year-old boy who has his glasses knocked off his face everyday.
- 13-year-old girl who is taller than any other class member and gets comments of “get off your stilts.”
- 16-year-old girl who gets fabricated comments on her Facebook page about her sexual habits.

There are basically four forms of bullying.

- Physical: any unwanted physical contact.
- Psychological: any form that caused damage to a victim’s psyche and/or emotional well-being.
- Verbal: any slanderous statement that causes the victim undue emotional distress.
- Cyber: any bullying done through the use of technology. Cyber bullying can be an anonymous form of bullying since the bully can pose as someone else.

Bullying stops when you graduate from high school — or does it?

As a registered nurse or licensed practical nurse, does bullying appear in the workplace?

Bullying is an act of repeated aggressive behavior to intentionally hurt another person physically, mentally, verbally, or through social networking. Bullying is characterized by an individual behaving in a certain way to gain power over another person.⁽¹⁾ Bullying is associated with a perceived imbalance of power. Research indicates that adults who bully have personalities that are authoritarian, combined with a strong need to control or dominate.⁽²⁾ According to the Workplace Bullying and Trauma Institute, workplace bullying is “repeated, health-harming mistreatment, verbal abuse, or conduct that is threatening, humiliating, intimidating, or sabotage that interferes with work, or some combination of the three.”⁽³⁾

- Giving report on a typical day of work and the RN assigned to take over your

patients keeps questioning the care you provided. The nurse asks, “Why didn’t you address the Hgb and Hct? Did you call the doctor?” No matter what you do, he/she finds fault in the care you have provided for your patients, is rude, and repeats the act of rudeness each day you give report.

In a care plan meeting, any suggestions or recommendations you give are questioned by a fellow nurse. So, you might decide to stop making recommendations. However, only your recommendations are questioned, which leads to silence instead of collaboration; and that affects the quality of patient care.

- In meetings when you don’t agree, the co-worker points his or her finger and gets in your face in an attempt to force you to agree with his or her point of view.
- On the nursing unit when you ask the experienced nurse a question about care, he/she says, “You should know that. Every nurse knows that. Where did you go to nursing school? That school must not have taught you how to properly take care of patients.”

An unwise belief is: “When I put you down, I make myself feel superior.” It is sad when relationships are not “give and take.” They can become a one-up-man-ship in the form of bullying. And bullying is clearly disruptive behavior in any clinical setting.

It is very hard to stop the cycle of bullying. Some tips that may help include:

- Confront the person by using any of the following responses;
- “Let me give your report. Then we can discuss any issues you believe are left undone ...”
- “You have so much knowledge. Teach me how to address _____, but wait until after report.” Give positive attention to the bully. Then she may not need to bring attention to herself by putting others down.

Report the bullying behavior to your superior and/or Human Resources of your organization with a follow-up written occurrence report. Bullying takes many forms in the workplace—from putdown and negative remarks to performing a co-worker’s jobs instead of her own job because the workplace bully believes she can do it better. When you confront a bully, the bullying will stop, but you may have to confront the person more than once. Confronting a bully takes courage whether you are 11 years old or 61 years old.

Nurses in the workplace may not report bullying behavior because of the fear of retaliation. However, you cannot take action against a workplace bully if the bullying activity is not confronted and/or reported to the supervisor or Human Resources department. Many times, repeated bullying behavior will occur. When this happens, make a written report of the instances, which will support your reporting to a supervisor or Human Resources. Most hospitals, long-term care facilities and clinics have a policy on Workplace Harassment and Nonretaliation. The Joint Commission issued Leadership Standard .02.04.01, effective January 1, 2009, that calls for a formal process of managing conflict in the workplace to protect the quality and safety of care.⁽⁴⁾

Remember that confronting the behavior is the first step in stopping the bully, and when you don’t confront the bully, you are condoning the behavior. Take courage in confronting.

1. Besag, V.E.; *“Bullies and Victims in Schools”*; Milton Keynes, England: Open University Press.
2. Sylvester, Ruth; *“Teacher as Bully: Knowingly or Unintentionally Harming Students,”* *Morality in Education*, 2011:42-45.
3. Namie, Gary and Ruth; *Workplace Bullying Institute Definition*.
4. *The Joint Commission, Leadership Standard .02.04.01*

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HOSPICE AND LONG TERM CARE PARTNERSHIP

Hospice care is a growing part of long-term/nursing home care. The partnership between these organizations will continue to grow in importance. It is estimated that by 2040, 40 percent of deaths will occur in nursing homes. In 1982, Congress adopted legislation allowing payment for hospice care for terminally ill Medicare beneficiaries, and in 1986, this benefit was extended to nursing homes. In 2000, 14 percent of Medicare beneficiaries who died in nursing homes elected the Medicare hospice benefit.^{1,9} From 2001-2006, there was a 60 percent increase in nursing home patients enrolled in hospice.^{1,5,9}

Studies have shown the benefit of hospice care for patients in nursing homes. These benefits include improved pain control and symptom management at the end of life, less fragmented care, and avoidance of inpatient hospital deaths. Despite the benefits, there are barriers that may delay patient enrollment in hospice when the patient is in the long-term care setting.^{5,8} About 52 percent of nursing home hospice referrals have a length of stay less than 14 days, which means referrals are occurring closer to time of death.¹⁴

Hospice and nursing homes have common goals for patients who are approaching the end of their lives. Nursing homes are the primary care provider to their residents at the end of their lives. The facility and staff play a prominent role for patients and families, and they often serve as extended family and patient advocates. Nursing home goals are to maintain function and medically supervise patients to benefit their quality of life.⁵ They also strive to preserve patient autonomy and dignity. Although hospice goals are primarily comfort, because medical stability is often not obtainable, preserved patient autonomy and dignity are also part of the hospice charge. Although hospices and nursing homes have common goals and the benefits for patients are clear, the partnership at times can be difficult. I use the case of Mrs. P to illustrate issues that come up and how hospices and nursing homes can be resources to each other as they partner in

providing patient care.

CASE

Mrs. P is a 92-year-old female who resides at home with her daughter, who works nights and cares for her three grandchildren at home. Mrs. P is incontinent and bedbound with a past medical history of Alzheimer's dementia, hypertension, congestive heart failure, left side middle cerebral artery infarct with right-sided hemi paresis who is hospitalized with aspiration pneumonia. Since starting treatment for her pneumonia, she is awake and alert. She recognizes her daughter and follows one-step commands. Her speech evaluation showed she is an aspiration risk and recommends an alternate route of feeding. Her medical teams think this would not be in her best interest. This is her fourth hospitalization in six months. She has lost 15 lbs in the last three months. Her living will states she would not want life prolonging measures including a feeding tube. The primary team recommended hospice to her daughter who is her health care Power of Attorney. The daughter had been considering nursing home placement. Mrs. P's social worker is going to contact nursing homes and wants to know what makes Mrs. P a hospice candidate?

The primary diagnoses for the majority of patients entering hospice from nursing homes are dementia, debility, and failure to thrive versus cancer diagnosis. Health care providers are charged with referring patients who have a prognosis of six months or less in keeping with Medicare guidelines.¹⁰ Cancer has a sharp steady decline on which the six-month prognosis was based. The disease trajectories for dementia, debility, and failure to thrive diagnoses can have an undulating course and it can make prognostication for them difficult even for experienced hospice and palliative care providers.^{6,7}

Medicare uses the Functional Assessment Staging or the FAST scale for patients with dementia to guide eligibility for admission to hospice. However, several studies evaluating this criterion have shown that Medicare guidelines that use the FAST scale 7C as a cutoff do not accurately predict the six month survival of patients

with dementia — especially for patients whose disease does not follow a typical course. Susan Mitchell et al. published a study comparing the Advanced Dementia Prognostic Tool (ADEPT) developed from the Minimum Data Set (MDS) with the current Medicare guidelines and found a modest advantage over the Medicare guidelines (FAST 7C). Strict adherence to both guidelines could potentially exclude patients who could benefit from services. The accuracy of the ADEPT was 67 percent and Medicare hospice eligibility criteria using FAST scale was only 55 percent in determining which patients with the diagnosis of dementia would expire within six months.¹⁰

Many variables factor into the survival of patients in the terminal phases of dementia, which include nutritional status, slow gradual decline, co-morbidities, functional status, and type of dementia to name a few.^{7,11} It can be difficult for health care providers to always identify and agree on appropriate patients. Hospice consultation can serve as a resource to nursing home staff to help identify appropriate patients. Nursing home staffs are valuable resources for hospice staffs to help them understand the disease trajectory and history of a specific patient when the course of their disease does not follow an ordinary pattern. Nursing home staff can be a better judge of a patient's decline because of the daily care. Prognostication with dementia, adult failure to thrive, and debility are difficult and tools we have are helpful but are not a substitute for clinical judgment.^{10,11} For patients who are appropriate but may fall out due to the guidelines, health care providers' documentation of co-morbid conditions and medical reasoning is important supportive documentation.

Also, nursing homes and hospices should take into account patients and/or a surrogate decision maker's goals of care. Nursing homes that have good working relationships with hospices have shown improved end-of-life symptom management — even for patients who choose

Continued on page 16

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not to enroll. This is because hospice provides palliative education to nursing home staff, which helps them better care for residents. Patients may appear comfortable, but that does not imply stability. The patient may be receiving a life prolonging benefit second to the supportive care that hospice provides.^{8,9}

CASE

Mrs. P's daughter asks her social worker, "Hospice sounds OK, but I was going to place Mom in a nursing home. Should I do nursing home or hospice? What could a hospice provide in the nursing home?"

One barrier for patients and families choosing hospice in a nursing home can be loss of the skilled Medicare benefit in nursing homes, which covers room and board for the patient as long as there is a skilled need or rehabilitation is taking place. Both hospice and Medicare skilled nursing days are paid for by Medicare Part A and a patient cannot have both. For patients whom the decline is abrupt and placement after hospitalization is required, using the skilled days may not be financially viable. These patients can still receive palliative care under Medicare skilled benefit in the nursing home if the service is available. Palliative care programs in long-term care facilities are growing but they are not standardized.

The hospice benefit in the nursing home mandates that hospices provide the same services offered to a patient as if they were in their private home, however, with new health care legislation this may change. For now, hospices provide durable medical equipment, medications related to diagnosis, nursing assistants, RN, hospice physician, social worker, chaplain, volunteers, respite and any other ancillary services hospice provides their community-based patients. In the nursing home, hospice can serve as support and a resource to assist the nursing home staff in providing palliative care. All patients are care-planned by the hospice interdisciplinary team. Hospice can also provide access to the continuous care services in the nursing home as they can in a patient's home for uncontrolled symptoms. Hospices can provide general inpatient services for patients who require aggressive symptom management when comfort is not being achieved in the patient's current setting.

CASE

Mrs. P's daughter and the hospital social worker find a nursing home which has a Medicaid long-term bed and contracts with hospice. Her daughter requests hospice "A." The social worker calls to arrange this but the nursing home states, "We only use hospice B." The social worker asks "Can't the family pick the hospice they want to use?"

Nursing homes can choose which hospice they contract with and may do so exclusively. Many nursing homes have multiple contracts with hospices to accommodate patients and families but nursing homes with multiple contracts may face some difficulties, i.e. expectation of different hospices, different charting systems, varying practice styles, and communication difficulties. Nursing home concerns with hospice can cause barriers to enrollment and care.² Other barriers could include disagreement on plans of care and having to carry out treatment plans they do not have a hand in making, variation in hospice corporate practices and staff practices, inconsistent care plan documentation and perception of Office of Long Term Care requirements.^{8,9,12}

Even if a patient is in hospice, nursing homes are still held to the same standards of care as for patients not in hospice. They are required to address weight loss, wounds, falls, recurrent infections, and dysphasia. Nursing homes may perceive and/or receive pressure from regulatory agencies to prevent weight loss and wounds even for the terminally ill.^{1,4,5} Federal regulation expectation is that a care plan is made. Conflicting goals of care between hospices and nursing home can arise especially if organizational care plans are made in isolation.

Hospice may have difficulties practicing in the nursing homes setting. Ersek et al identified barriers hospices encounter which include inadequate/inconsistent follow through on symptom management treatment plan, frequent staff turnover, under reporting of changes in patient clinic status, unrealistic expectation of hospice services, difficulties with contract negotiations, resistance to changes in goals of care, and negative attitudes towards hospice and palliative care.⁵ Wowchuck et al identified common barriers inherent in the nursing home setting to providing hospice comfort care are staff attitudes about death and dying

privacy for dying patients and families, staffing time limitations for providing care to dying residents, family expectations of care, and lack of physician support.¹³ Nursing home administrator and staff can feel that they provide adequate end-of-life care and may not see the benefit of hospice.²

Lack of mutual communication and education are at the core the difficulties these two organizations face when working together. In 2010, Susan Miller, Ph.D., identified strategies nursing home and hospices that have successful partnerships use⁽⁹⁾:

- Goals of care and organization philosophies are aligned
- Open and frequent communication between hospice and nursing home and they develop joint plans of care
- Mutual respect for professional boundaries
- Organizational roles and expectations of service are realistic and clearly defined to each other and families
- Creation of nursing home/hospice liaison who facilitates communication and the relationship between nursing home, hospice, and patients; assist with conflict resolution
- Nursing homes have formal/informal mechanisms to identify referrals
- Palliative Care consults were allowed in nursing homes for patients without having to waive the Medicare nursing skilled care
- Hospices develop nursing home teams with staff that may have experiences in nursing home; they provide emotional and bereavement support to staff
- Hospices provide one on one education for staff, have a visible presence in the nursing home, provide 24 hour supportive care, and attend care plan meetings
- Hospices assist nursing homes with their Medicare and state surveys; they provide documentation of a patient's disease process and expected decline

Despite some of the inherent difficulties in providing hospice care in nursing homes the above strategies have been modeled successfully. Trust and respect must exist between the hospice and the nursing home in order for the relationship to be successful.

CASE

Mrs. P has been residing in the nursing home for five months and during that time she became more engaged with staff and her daughter. She was able to maintain her weight within five lbs with oral supplement and the nursing home feeder program. However, two nights ago she became unresponsive after an episode of aspiration. She has also developed a stage III-IV wound on her sacrum. Her daughter is committed to continuing comfort care. Mrs. P has begun have copious airway secretions and diarrhea. The doctor has ordered a bedside suction, low air loss mattress. A frustrated nursing home Certified Nursing Assistant who has cleaned up Mrs. P for the third time in the last two hours asks, "Her hospice aide will be here in 30 minutes, why do I have to do it?" Her nurse comments "This is my third dying patient this week...I thought she was getting better."

Nursing home staff must continue to provide the same care to a hospice patient as any other patient. Hospices are there to provide support but they are not able to substitute for the primary care giver. However, hospice staff availability is a positive factor in nursing home hospice relations. Hospice service can help shoulder some of the burden of care especially for patients with complicated medical and psycho social issues. Patients should see the care as seamless and should not get the impression from either organization "that's not my job." If a patient has symptoms which are difficult to control, initiating continuous care or offering GIP services is appropriate in the nursing home. Nurses are asked to carry out treatment plans that are medically justified but they may not have fully reconciled either emotionally or ethically.⁵ This is, perhaps, even more the case for the nursing assistant who is usually not privy to the justification of certain treatment courses chosen at the end of life adding to the physical demands of the job. Nursing home staff may be the caregiver who needs support just as hospice would provide support for a home-based caregiver.

The number of patients residing in nursing homes is likely to increase. This will mean an increase in patient eligibility for the Medicare hospice benefit. Studies have shown the benefit to nursing home patients enrolled in hospice at the end of their life. The service can also be

valuable to nursing home staff as well. As with all partnerships, there are barriers and inherent sources of conflict. Through open communication, education and teamwork, we can overcome these barriers to provide our patients with the best supportive care.

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ONLINE NURSING

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QUALITY IMPROVEMENT: Whose Job Is It?

As nurses, we have all filled out forms that ask for our area of practice. They list med-surg, OB/gyn, cardiac, surgery, and many others. They instruct us to choose the one that is most applicable. The area name that has always given me pause is “quality.” Does choosing one of the other areas mean I don’t practice quality?

Quality improvement has historically been treated as a separate function in health care, but this is changing. A national focus on health care reform and patient safety makes all of us more aware of our role in and accountability for providing patient-centered, quality health care. An organization’s quality improvement professional may be the one who facilitates the improvement process, but the front-line staff and those most involved in the processes of care are key to creating systems that allow for the best outcomes.

STEPS OF IMPROVEMENT

How does one approach improving processes? There are many models of the steps in quality improvement, but they are all similar. If you are a nurse, you have been exposed to those steps—while learning about the scientific method, the nursing process or other topics. We gather information, we analyze it, we draw conclusions, we implement interventions, and we review or study the results.

The Plan-Do-Study-Act (PDSA) method is common in the health care community. As health care providers, we often identify opportunities where systems do not work or need improvement. Quality improvement begins here. It may be a situation where there is a threat to patient safety, redundancy in the work performed, gaps in achieving expected positive outcomes or waste of resources. An individual perspective is not enough. A team of individuals who are connected to the process is the best way to gather information and data as well as confirm there is an opportunity for improvement. This team begins with the **Plan** phase of improvement. The team’s role is to identify the gaps, identify the changes each person believes will make an improvement, and the best way to implement those changes.

They then move on to the **Do** phase. It is

really important to make changes in a small way first so you can determine whether the changes elicit the results you expect. There are many examples of an organization rolling out a form, a policy, etc. that was not tested first. Making changes first on a small scale minimizes the number of people affected if the changes do not have a positive result. It also allows for adaptations to improve the results before going large scale. Testing changes can increase organizational buy-in and validate for others in the organization that the changes are needed.

The third phase, **Study**, actually begins during the Do implementation phase. In this phase, the team examines the results of the small-scale implementation and determines if the desired outcomes were achieved. This may be done through gathering quantitative and/or qualitative data related to the implementation. This phase sets the direction of the final stage.

The **Act** phase is where decisions are made

to complete the improvement. After studying the implementation, the team has three basic directions from which to choose. The team may decide the change achieved is exactly what was desired and the “new” process should be adopted. This is where larger-scale implementation occurs. The team may decide the change almost achieved what was desired, and the “new” process should be adapted. If the process is adapted, it should be tested once again on a small scale and the PDSA steps repeated. The team may decide the change did not achieve the desired outcome and the “new” process should be abandoned. If this occurs, the team again uses the PDSA process to decide what to do next.

Nurses in any setting and in any area of practice are an integral part of the quality improvement process. As health care continues to become more patient-centered, quality and safety evolve from a separate function to an embedded part of our day-to-day job performance.

The University of Arkansas Community College at Batesville is **seeking a full-time nursing instructor** for the Associate of Applied Science RN program.

A master’s degree in nursing is required and teaching experience in medical/surgical with clinical work is desired. A bachelor’s in nursing will be considered if currently enrolled in a master’s in nursing program.

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Act, 2009 (P.L. 111-5), Title XIII.*

**Community College Consortia
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Analysis of The Office of the National Coordinator for
Health Information Technology

RESERVED AD SPACE

QUALITY ASSURANCE PLANS FOR APNs WITH PRESCRIPTIVE AUTHORITY

Do I have to have a Quality Assurance (QA) Plan? What must be included in a QA Plan? How often must it be reviewed? Does it need to be signed by the APN and the Collaborating Physician? Is there an example I can look at to help me build a QA Plan? These are frequently asked questions about the QA Plan that we have received.

Advanced practice nurses (APNs) with prescriptive authority must submit a Collaborative Practice Agreement (CPA) and Quality Assurance (QA) Plan upon initial application for Prescriptive Authority and at renewal of their APN license. For renewals, if the CPA and QA Plan are still exactly the same as previously submitted, you may fax in the previously signed Collaborative Practice Agreement and QA Plan without getting new signatures. However, if there are changes, you must submit a new original CPA and QA Plan. You will then receive a letter stating that your CPA and QA Plan have been approved or need revision.

Many APNs are unclear as to what should be included in a QA Plan. The purpose and goal of a QA Plan are to evaluate the APN's patient care for quality and compliance with the protocols for prescribing authority. There are four essential guidelines that must be addressed in a QA Plan. These guidelines can be found on the ASBN's website under the Advanced Practice tab.

The guidelines include that: **The plan must**

- be specific to the practice area (regarding APN certification specialty and patient population being served).
- be reviewed, signed, and dated annually by the APN and the collaborating physician(s).
- include a written plan for corrective action; if indicated, how the follow-up will be handled.
- include evidence of compliance to be available to the ASBN upon request.

Please understand that the above four guidelines must be addressed, but that the Arkansas State Board of Nursing does not govern other items added to the QA Plan. Some APNs and physicians choose to include what types of charts will be reviewed (i.e., complex diseases and treat-

ment plans or just random selection). It is also up to the APN and physician how many charts (or percentage of charts) will be reviewed and how often (i.e., monthly, quarterly, annually). Something that newly licensed APNs may want to consider is having a higher percentage of their charts reviewed more frequently (as opposed to a seasoned APN who may not need a large number of their charts reviewed often). The frequent chart checks will help catch any issues early on so that correction and follow-up can occur.

Another item that some QA Plans contain is patient interviews to determine patient satisfaction of the APN's care provided. It is also a good idea to include, address, and follow-up on patient complaints in the QA Plan. Some facilities include the QA Plan as part of the facility's case management protocols.

A blank (not completed) QA Plan should be submitted to the Board and signed by both the

APN and the Collaborating Physician(s). The reason for the signatures on a "blank" Plan is to ensure that both the APN and the Collaborating Physician(s) understand that a QA Plan is in place and must be utilized. We do not need the completed QA Plans submitted unless we ask for them. The completed QA Plans need to be kept in a safe place (i.e., in the APN's file) in the case there is a complaint filed against the APN or if they are selected for a random audit - in other words, be sure there is sufficient documentation on the QA Plan to prove that it was followed and reviewed annually (evidence of compliance).

In addition to the CPA example on the www.arsbn.org website (select the Adv. Practice tab), we have added three examples of Quality Assurance Plans. APNs are welcome to use these examples, making changes accordingly to the specific guidelines agreed upon between the APN and the Collaborating Physician(s).



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We hope to have nominees from every county and every medical facility in Arkansas. From approximately 48 finalists, we will choose two "Runners Up" and finally, one nurse will be named Arkansas' Most Compassionate Nurse at a special ceremony. The nurses will be recognized in the *ASBN Update* magazine and the Winner will be featured inside and on the cover. Watch for more details coming soon!

Send or email your nomination to:
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2011 Nursing Compassion AWARD

2010 Nursing Compassion Award Winner Elaine Peterson, RN



NCLEX® Pass Rates

Tammy Claussen, MSN, RN, CNE
ASBN Program Coordinator



The annual pass rate for the National Council Licensure Examination (NCLEX) is calculated based on a fiscal year (July 1-June 30) for each nursing program in Arkansas. The Arkansas State Board of Nursing (ASBN) Rules requires that each program achieve at least a 75 percent annual pass rate. Programs that do not achieve this standard must submit documentation to the ASBN analyzing all aspects of their program. The report must identify and analyze areas contributing to the low pass rate and include a resolution plan that must be implemented.

REGISTERED NURSE PROGRAMS

July 1, 2010 – June 30, 2011

PROGRAM	NUMBER TAKING	NUMBER PASSING	PERCENT PASSING
Arkansas Rural Nursing Education Consortium (ARNEC)	112	107	95.5
Arkansas State University - ADN	103	93	90.2
Arkansas State University - BSN	81	67	82.7
Arkansas Northeastern College – Blytheville	84	62	73.8
Arkansas Tech University	58	47	81.0
Baptist Health School of Nursing	179	147	82.1
East Arkansas Community College	17	16	94.1
Harding University	30	22	73.3
Henderson State University	23	15	65.2
JRMC School of Nursing	20	16	80.0
National Park Community College	53	48	90.5
North Arkansas College	28	21	75.0
Northwest Arkansas Community College	95	90	94.7
College of the Ouachitas	33	28	84.8
Phillips County Community College/U of A	36	29	80.5
Southeast Arkansas College	20	17	85.0
Southern Arkansas University	52	49	94.2
U of A Community College – Batesville	57	51	89.4
University of Arkansas at Fayetteville	74	71	95.9
University of Arkansas at Fort Smith - ADN	74	49	66.2
University of Arkansas at Fort Smith - BSN	32	29	90.6
University of Arkansas at Little Rock - ADN	90	84	93.3
University of Arkansas at Monticello – BSN	25	19	76.0
University of Arkansas at Monticello – ADN	10	7	70.0
University of Arkansas at Pine Bluff	15	3	20.0
University of Arkansas for Medical Sciences	100	74	74
University of Central Arkansas	69	65	94.2

PRACTICAL NURSE PROGRAMS

July 1, 2010 – June 30, 2011

PROGRAM	NUMBER TAKING	NUMBER PASSING	PERCENT PASSING
Arkansas Northeastern College – Burdette	37	36	97.3
Arkansas State University – Mountain Home	40	32	80.0
Arkansas State University – Newport	27	20	74.0
Arkansas State University Beebe – Searcy	40	38	95.0
Arkansas State University Technical Center	57	49	85.9
Arkansas Tech University – Ozark	47	38	80.8

PRACTICAL NURSE PROGRAMS

July 1, 2009 – June 30, 2010

PROGRAM	NUMBER TAKING	NUMBER PASSING	PERCENT PASSING
Baptist Health School of Practical Nursing	131	120	91.6
Black River Technical College	7	7	100
Cossatot Technical College	27	24	88.8
Crowley's Ridge Technical Institute	15	15	100
National Park Community College	31	27	87.1
North Arkansas College	32	32	100
Northwest Technical Institute	41	41	100
College of the Ouachitas	63	57	90.4
Ozarka Technical College	55	50	90.9
Phillips Community College U of A - Dewitt	20	19	95.0
Pulaski Technical College	37	35	94.5
Rich Mountain Community College	25	24	96
Southern Arkansas University – Technical	14	13	92.8
Southeast Arkansas College	43	39	90.7
SouthArk Community College	47	43	91.4
St. Vincent's School of Practical Nursing	17	16	94.1
Univ. of AR Community College – Batesville	59	55	93.2
Univ. of AR Community College – Hope	28	27	96.4
Univ. of AR Community College – Morrilton	34	32	94.1
Univ. of AR at Fort Smith	17	17	100
Univ. of AR Monticello College of Technology – Crossett	8	8	100
Univ. of AR Monticello College of Technology – McGehee	11	11	100

POSITION STATEMENT 98-2

INSERTION OF INTRAUTERINE PRESSURE CATHETER

The Arkansas State Board of Nursing has determined that it is not within the scope of practice of the registered nurse, licensed practical nurse, and licensed psychiatric technician nurse to insert intrauterine pressure catheters.

Adopted May 14, 1998

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8:30 a.m.	ASBN 101
9:00 a.m.	What's So Social About Social Networking?
10:00 a.m.	Break
10:15 a.m.	Extreme Makeover of Your Leadership Abilities
11:00 a.m.	The Disciplinary Process: From Investigation to Resolution
12:00 p.m.	Lunch
12:45 p.m.	Nurses Beware: Ethical Issues
1:30 p.m.	Protecting Your Privilege to Practice
2:30 p.m.	Break
2:45 p.m.	NCLEX®

REGISTRATION FEE: \$45.00 (includes lunch)
Pre-registration required. Fees are non-refundable.



2011 Dates and Locations

February 17	Baptist Health School of Nursing 11900 Colonel Glenn Road, Little Rock
March 10	Sparks Regional Medical Center 1001 Towson Avenue, Fort Smith
September 27	University of Arkansas Community College at Batesville 2005 White Drive, Batesville
November 17	Baptist Health School of Nursing 11900 Colonel Glenn Road, Little Rock

This continuing education sponsored by the Arkansas State Board of Nursing is awarded 6.0 contact hours. Participants who leave immediately prior to the NCLEX presentation will receive 5.0 contact hours. E-mail info@arsbn.org if you have questions.

This continuing education activity was approved by Arkansas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Provider Code 09-31-EA

Register online at
www.arsbn.org

REGISTRATION FORM

Mail completed registration form and \$45.00 registration fee (in-state check or money order) to ASBN, 1123 South University, Suite 800, Little Rock, AR 72204. Registration must be received one week prior to workshop.

Check date you plan to attend: [] November 17

NAME _____ LICENSE NUMBER _____

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DID YOU REALLY WASH YOUR HANDS?



As nurses, we do know the essentials of an effective infection control program (i.e. policies/procedures, surveillance/investigation, monitoring, prevention and education). However, it never hurts to remind you that the single most effective means for preventing healthcare acquired infections (HAIs and formerly called nosocomial infection) is proper hand hygiene.

Preventing HAIs is our professional responsibility. The Centers for Disease Control and Prevention estimates 88,000 Americans per year may die of HAIs.¹ HAIs not only have the personal toll of inflicting suffering and death but also have the very public cost to the United States of almost \$5 billion each year due to the extra days or weeks of hospitalization needed to treat the infection (McKibben, 2005). Patients in nursing homes and in-home care are also at risk for developing HAIs—particularly if they have invasive medical devices, such as urinary catheters or central venous catheters. Nearly 1 million infections occur annually in nursing homes.²

Would it surprise you to know more than 30 studies have shown the average rate of compliance with hand hygiene guidelines among health care workers is only 40 percent?³ A recent observational study of hand washing practices

for a group of Australian doctors revealed they self-reported a 73 percent hand hygiene compliance rate. During that same observation period, the deputized nurse spies recorded the doctors' actual hand hygiene rate as 9 percent. That study demonstrated a huge discrepancy between what we believe we do versus what we actually do.⁴

Proper hand hygiene includes both washing with soap and water and using alcohol-based hand hygiene (ABHH) products.

- If hands are visibly soiled, wash with soap and water using friction for at least 15 seconds. Sing "Happy Birthday" twice.
- Wash hands with plain soap or alcohol-based product after touching blood, body fluids, and contaminated items whether or not gloves are worn.
- Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated.
- Wash hands as appropriate and necessary between tasks and procedures on the same patient to prevent cross-contamination of different body sites.
- Avoid unnecessary touching of surfaces near the patient to prevent contaminating clean hands and to prevent transmission of pathogens from contaminated hands to surfaces.

ABHH products are acceptable over soap and water when hands are not visibly soiled.

Alcohol-based products have the following benefits:

- They kill the germs better.
- They leave skin in better condition.
- They are quicker and easier to use, so people use them more.

While ABHH products are considered equal to soap and water that is only true when the product is used correctly. What is correct usage?

- Use only on dry hands.

- Use enough of the product so hands are dry again in 15 seconds, and rub hands together until they are completely dry.⁵

The third week in October is National Infection Control Week. Chances are your workplace will provide educational activities related to the essential elements of infection control, so take the time to refresh your knowledge with a new commitment to prevention. Gerberding suggests we adopt a paradigm shift in our thinking for HAIs from infections being inevitable with some being preventable to each infection being potentially preventable unless proven otherwise.⁶

References:

1. Centers for Disease Control and Prevention (CDC). (2008). Campaign to Prevent Antimicrobial Resistance in Healthcare Settings. Retrieved August 11, 2011 from <http://www.cdc.gov/DRUGRESISTANCE/healthcare/ltc.htm>.
2. McKibben L, et al. (2005). Guidance on public reporting of healthcare-associated infections: Recommendations of the healthcare infection control advisory committee. *American Journal of Infection Control* 33(4).
3. Centers for Disease Control and Prevention (CDC). (2008). Campaign to Prevent Antimicrobial Resistance in Healthcare Settings. Retrieved August 11, 2011 from <http://www.cdc.gov/ncidod/eid/vol7no2/pittet.htm>
4. SuperFreakonomics: YouTube Interview Dubner and Levitt. Retrieved August 11, 2011 from <http://www.youtube.com/watch?v=AeK0mn5hjFU>
5. Centers for Disease Control and Prevention (CDC). (2002). Guidelines for Hand Hygiene in Healthcare Settings. *MMWR* 51(RR-16):13. Retrieved August 11, 2011 from http://www.cdc.gov/ncidod/dhqp/gl_hand-hygiene.html.
6. Gerberding, J.L. *Ann Intern Med* 2002; 137:665-670.

RESERVED AD SPACE

The full statutory citations for disciplinary actions can be found at www.arsbn.org under *Nurse Practice Act*, Sub Chapter 3, §17-87-309. Frequent violations are ACA §17-87-309 (a)(1) "Is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing or engaged in the practice of nursing without a valid license;" (a)(2) "Is guilty of a crime or gross immorality;" (a)(4) "Is habitually intemperate or is addicted to the use of habit-forming drugs;" (a)(6) "Is guilty of unprofessional conduct;" and (a)(9) "Has willfully or repeatedly violated any of the provisions of this chapter." Other orders by the Board include civil penal-

ties (CP), specific education courses (ED), and research papers (RP). Probation periods vary and may include an impaired-nurse contract with an employer and/or drug monitoring and treatment programs.

Each individual nurse is responsible for reporting any actual or suspected violations of the *Nurse Practice Act*. To submit a report use the online complaint form at www.arsbn.org, or to receive additional information, contact the Nursing Practice Section at 501.686.2700 or Arkansas State Board of Nursing, 1123 South University, Suite 800, Little Rock, Arkansas 72204.

PROBATION

Bennett, Nancy Elaine Alsop
R44774, L22251 (exp), Harrison
A.C.A. §17-87-309(a)(6)
Probation - 1 year
Civil Penalty - \$500.00

Chronister, Danielle Nicole
L45516, Waldron
A.C.A. §17-87-309(a)(6)
Probation - 1 year
Civil Penalty - \$1,000.00

Culberson, Rita Corinea
T01580, Little Rock
A.C.A. §17-87-309(a)(6)
Probation - 1 year
Civil Penalty - \$500.00

Curtis, Steven Douglas
R44879 (expired), Hot Springs
A.C.A. §17-87-309(a)(4)&(6)
Probation - 3 years
Civil Penalty - \$1,000.00

Douglas, Angela Marie
R79283, Wynne
A.C.A. §17-87-309(a)(6)
Probation - 1 year
Civil Penalty - \$500.00

Hartwick, Nexie Nicole Johnston
Sweeten
R66110 (exp), L37718 (exp),
Quitman
A.C.A. §17-87-309(a)(2),(4)&(6)
Probation - 2 years
Civil Penalty - \$1,000.00

Jackson, Sarah B.
L49301, Tuckerman
A.C.A. §17-87-309 (a)(6)
Probation - 1 year
Civil Penalty - \$1,700.00

Meador, Cortney Ellen
R77475, Green Forest
A.C.A. §17-87-309(a)(2),(4),(6)&(9)
Probation - 2 years
Civil Penalty - \$2,000.00

McGill, Nicholas R.
L44231 (exp), Little Rock
A.C.A. §17-87-309(a)(4)&(6)
Probation - 2 years
Civil Penalty - \$500.00 plus prev bal

McKay, Shelley L.
R63853 (expired), Little Rock
A.C.A. §17-87-309(a)(4)&(6)
Probation - 2 years
Civil Penalty - \$1,000.00

McQuay, Amanda Lee Gamblin
R82224, Jonesboro
A.C.A. §17-87-309(a)(6)
Civil Penalty - \$1,000.00

Miller, Jeannie Leigh
R84850, Bentonville
A.C.A. §17-87-309(a)(4)&(6)
Probation - 3 years
Civil Penalty - \$1,500.00

Morin, Erin Rae Jameson
R67700, Springdale
Probation Non-Compliance
Probation - 2 ½ years
Civil Penalty - \$1,500 plus prev bal

Rowland, Josh John
R89584, Little Rock
A.C.A. §17-87-309(a)(2)&(4)
Probation - 1 year

Smith, Devon Lea Elam
L52166, Benton
A.C.A. §17-87-309(a)(2)
Probation - 1 year

Swaim, Vicki Elaine Coombe
R84511, L44514, Fort Smith
A.C.A. §17-87-309(a)(6)
Probation - 1 year
Civil Penalty - \$500.00

Vaughn, Ronald Glenn
A03061 (exp), R68371 (exp),
PAC 2962 (surrendered), Paragould
A.C.A. §17-87-309(a)(6)
Probation - 2 years
Civil Penalty - \$3,200.00

Young, Mildred Speed
R37342, L16693 (exp), Maumelle
A.C.A. §17-87-309 (a)(6)
Probation - 1 year
Civil Penalty - \$500.00

SUSPENSION

Cunningham, Lakresha Doretha
L38261, Sherwood
Suspension - until terms of LOR met
September 14, 2011

Edmonds, Ruth Jeanne
Michaels Sakmar
L27651, Mabelvale
Suspension - until terms of LOR met
September 14, 2011

Holt, Judy Jenette
R56681 (exp), L30081 (exp),
T01664 (exp), Benton
Suspension - until terms of LOR met
September 14, 2011

McCandless, Michele Marie
Pominville Williams
L39702, Walnut Ridge
Suspension - until terms of LOR met
September 14, 2011

Thomas, Sandy Kay Smith
L38977, Texarkana
Suspension - until terms of LOR met
September 14, 2011

VOLUNTARY SURRENDER

Ahrent, Jonathan Nicholas
L50793, Augusta
August 30, 2011

Cook, Lindsay Nicole DeSalvo
L49492, Jonesboro
September 13, 2011

Dailey, Kimberly Ann
R34391, Texarkana, TX
September 6, 2011

Decker, Patricia Naoma
Vandenbiggelaar Barnett
R64958, Tulsa, OK
July 20, 2011

Hamilton, Christina Gay Cockrill
R72698, Cabot
August 9, 2011

Hilton, Donna Sue
L39875, West Memphis
August 15, 2011

Hunter, Heidi Lynette Allen
R70351, Bella Vista
September 13, 2011

James, Meagan Elizabeth
L49493, Strawberry
August 25, 2011

Kalinka, Deborah September
L24738, Little Rock
August 25, 2011

Lee, Kelly Ann Byus Mitchell
L44692, Pine Bluff
September 9, 2011

Mahaffey, John Michael
R66724, Texarkana
August 4, 2011

McFarlin, Leigh Ann
L46110, Jonesboro
August 16, 2011

Pitts, Paula Karen Johnson Linton
R20745, Benton
August 30, 2011

Pruett, Alyson Jean
L50065, Bryant
August 23, 2011

Spinks, Kathy Renee Powell
R70601, L28118, Batesville
August 4, 2011

Woodall, Brinda Carrol Davis
R43586, Amity
August 8, 2011

REINSTATEMENTS WITH PROBATION

Charleville, Kelly Marie Winter
R76848, L41217 (exp), Redfield
August 4, 2011

Dudley, Donna Lynn Dudley
Vano Dudley
R22701, Maumelle
August 9, 2011

REINSTATEMENTS

Hildebrand, Rebecca Lynn Baker
R45075 (exp), L27923 (inact.),
North Little Rock
August 16, 2011

REPRIMAND

Alaman, Sayward Mary Allen
L36087, Searcy
August 8, 2011

Funmaker, Brandi Jeanne
R78452, Van Buren
July 6, 2011

Houston, Tamara Lynn
L36618, Barling
September 14, 2011

Jones, Kristin Lea Wheeler
L41290, Harrison
July 13, 2011

Paxson, Shirley Ann Peters Loftin
R54662, L12790 (inact.), Mulberry
July 7, 2011

Penne, Jennifer Johanna Fritz
R72401, Fayetteville
July 20, 2011

Wilmoth, Beverlee Rene Gardner
L21830, Jonesboro
July 20, 2011

continued on page 28

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Disciplinary Actions - September 2011,
continued from page 27

PROBATIONARY STATUS REMOVED

Butler, Margaret Marie Murphy
R44998, Benton
August 5, 2011

Carroll, Janet Marie Hallmark
R52484 (exp), L21854 (exp), Jonesboro
July 22, 2011

Deaton, Danna Lynn Scott
A01771, R55269, Manila
August 15, 2011

DeLong, Cheryl Lynn Long Medford
R36160, Van Buren
July 21, 2011

Gassaway, Brenda Louise Millican
R37108, Van Buren
July 21, 2011

Harris, Courtney Leigh Cavitt
L41032, Tyrone
July 21, 2011

King, Linda Lee Rudolph
R63382, L22696 (exp), Paragould
July 21, 2011

Morgan, Traci D. Booth
R66968, El Dorado
July 21, 2011

Huddleston, Jaclyn Rebecca
L50376, Fayetteville
July 21, 2011

Looney, Elsie Renee
L48838, Rogers
July 21, 2011

Shanahan, Danny George
R80083, Bella Vista
August 8, 2011

Speed, Pamela Ruth Long
A01068, P01164 (exp), R40612, PAC 0176,
Heber Springs
July 21, 2011

Wilkins, Gregory Steven
R84149, Rohwer
August 8, 2011

WAIVER GRANTED

Amiker, Shala Marie Ray
RN Applicant
September 14, 2011

Jeter, Sikangila Wyki
PN Applicant
September 14, 2011

Meyer, Robert
PN Applicant
September 14, 2011

Mitchell, Bobbie Ann
PN Applicant
September 14, 2011

Stephens, Ashley Elyse
RN Applicant
September 14, 2011

The Employment EXPERTS

Teresa Waters
President

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Little Rock, Arkansas 72211
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Nurses are required to use the name on file with the Board of Nursing when practicing nursing. The nurse must continue to use and sign the name on file until they submit the appropriate documents to change the name in the Board of Nursing's database. A copy of the marriage certificate, divorce decree or court document changing the name is to be sent with the change of name form. The Board of Nursing does not charge a fee to change

the name in the database, and the corrected name will be reflected on the ASBN registry. Replacement cards with the current name can be purchased if desired.

It is important to notify the Board of Nursing of name and/or address changes, not only because it is a requirement of licensure, but

ary action. If current information is not on file with the Board of Nursing, staff will make recommendations for disciplinary action based upon the information that is available. If disciplinary action is taken against a nurse's license without a current address, the nurse may not know about the action until the em-

Has your name or address changed? It is important to notify the Board of Nursing of name and/or address changes, not only because it is a requirement of licensure, but you never know when the Board staff may be trying to contact you.

you never know when the Board staff may be trying to contact you. An address change can be completed on the Board of Nursing's website or by submitting a written request to change the address. If a complaint is received regarding a nurse's practice, the staff may attempt to contact the nurse for information regarding the complaint or pending disciplin-

employer inquires about a flagged license, the nurse is not able to renew the license online, they read their name in the ASBN Update, or they are scheduled for a hearing due to discipline non-compliance.

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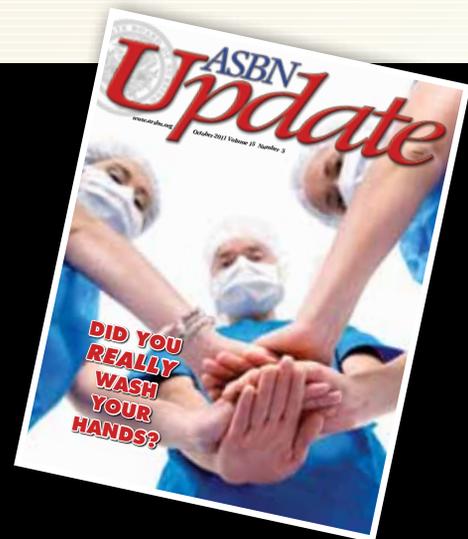
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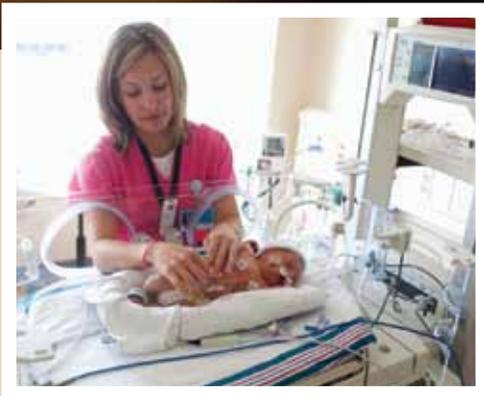
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