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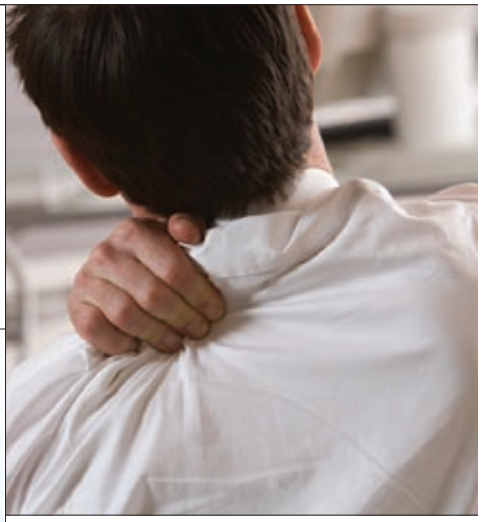
Nancy Herrin, *Editor*

50,000 copies are addressed and mailed statewide to every nurse of every degree in the state of Mississippi plus every nursing student, hospital administrator and nursing school administrator in Mississippi four times a year at no cost to the nurses or citizens of the state of Mississippi.

MISSION...

The mission of the Mississippi Board of Nursing is to protect the public through the process of licensure and regulation of nursing.



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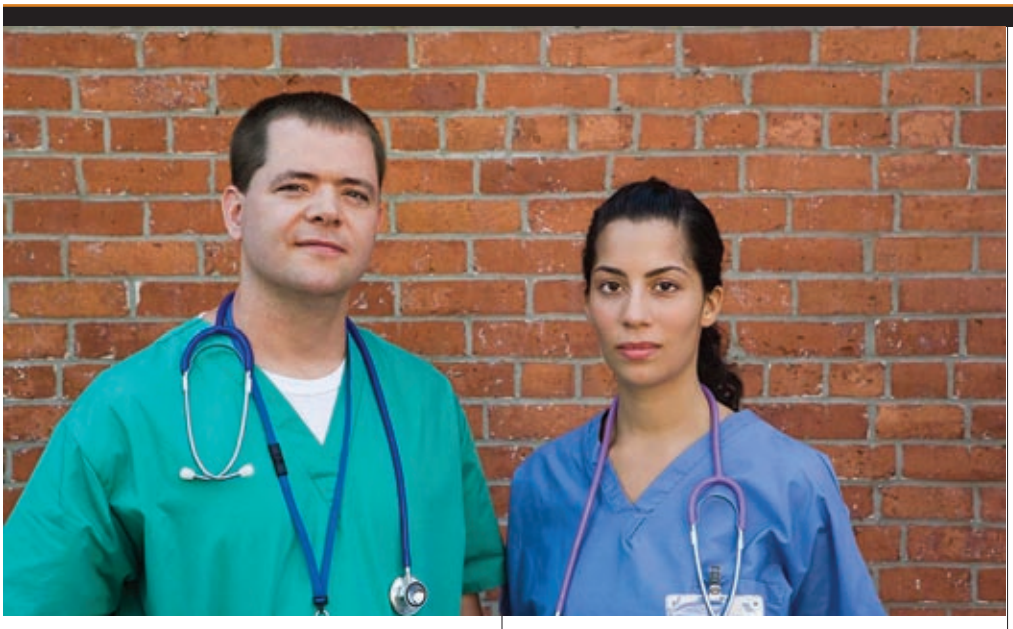
LETTER from the **EXECUTIVE DIRECTOR**

MELINDA RUSH, DSN, FNP

PROFESSIONAL BOUNDARIES



Professional boundaries are increasingly becoming an issue for nurses and for the disciplinary and investigative offices of boards of nursing. Many nurses lack knowledge of the definition of professional boundaries. Professional boundaries are defined as: the limits of the professional relationship that allows for a safe therapeutic connection between the professional, the nurse, and the client or patient (NCSBN, 1996). There is a fine line between the professional caring relationship and one that crosses the line. The concern must be that the professional is in a position of power and the patient is in a position of vulnerability. Many times this crossing of the line is due to the nurse's needs and not those of the patient's. The consequences can be harmful for the patient and eventually damaging for the nurse. The nurse is responsible for maintaining the professional relationship and guarding those boundaries.

The issue of professional boundaries is not unique to Mississippi, but is a problem nationwide. The National Council of State Boards of Nursing (NCSBN) has published a helpful guide to understanding what constitutes professional boundaries and what violates professional boundaries. Following is that article.

PROFESSIONAL BOUNDARIES
A NURSE'S GUIDE TO THE IMPORTANCE OF APPROPRIATE PROFESSIONAL BOUNDARIES

As a health care professional, a nurse strives to inspire the confidence of clients, treat all clients and other health care providers professionally, and promote the clients' independence. Clients can expect a nurse to act in their best interests and to respect their dignity. This means that a nurse abstains from obtaining personal gain at the client's expense and refrains from inappropriate involvement in the client's personal relationships.

Professional boundaries are the spaces between the nurse's power and the client's vulnerability. The power of the nurse comes from the professional position and the access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client's needs.

Boundary violations can result when there is confusion between the needs of the nurse and those of the client. Such violations are characterized by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. Boundary violations can cause distress for the client, which may not be recognized or felt by the client until harmful consequences occur.

Boundary crossings are brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a special therapeutic need. Boundary crossings can result in a return to established boundaries but should be evaluated by the nurse for potential client consequences and implications. Repeated boundary crossings should be avoided.

Professional sexual misconduct is an extreme form of boundary violation and includes any behavior that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the client. Professional sexual misconduct is an extremely serious violation of the nurse's professional responsibility to the client. It is a breach of trust.

A Continuum of Professional Behavior

A zone of helpfulness is in the center of the

professional behavior continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client is on the right side of the continuum; this includes boundary crossings, boundary violations and professional sexual misconduct. Under-involvement lies on the left side; this includes distancing, disinterest and neglect, and it can also be detrimental to the client and the nurse. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, is a gradual transition or melding.This continuum provides a frame of reference to assist nurses in evaluating their own and their colleagues' professional-client interactions. For a given situation, the facts should be reviewed to determine whether or not the nurse was aware that a boundary crossing occurred and for what reason. The nurse should be asked: What was the intent of the boundary crossing? Was it for a therapeutic purpose? Was it in the client's best interest? Did it optimize or detract from the nursing care? Did the nurse consult with a supervisor or colleague? Was the incident appropriately documented?

Some Guiding Principles for Determining Professional Boundaries and the Continuum of Professional Behavior

- The nurse's responsibility is to delineate and maintain boundaries.
- The nurse should work within the zone of helpfulness.
- The nurse should examine any boundary crossing, be aware of its potential implications and avoid repeated crossings.
- Variables such as the care setting, community influences, client needs and the nature of therapy affect the delineation of boundaries.
- Actions that overstep established boundaries to meet the needs of the nurse are boundary violations.
- The nurse should avoid situations where the nurse has personal or business relationship, as well as a professional one.
- Post-termination relationships are complex because the client may need additional services and it may be difficult to determine when the nurse client relationship is truly terminated.

REGARDING PROFESSIONAL BOUNDARIES AND SEXUAL MISCONDUCT QUESTIONS AND ANSWERS

What if a nurse wants to date or even marry a former patient? Is that considered sexual misconduct?

The key word here is former, and the important factors to be considered when making this determination are:

- What is the length of time between the nurse-client relationship and the dating?
- What kind of therapy did the client receive? Assisting a client with a short-term problem, such as a broken limb, is different that providing long-term care for a chronic condition.
- What is the nature of the knowledge the nurse has had access to and how will that affect the future relationship?
- Will the client need therapy in the future?
- Is there risk to client?

What if a nurse lives in a small community? Does this mean that he or she cannot interact with neighbors or friends?

Variables such as the care setting, community influences, client needs, nature of the therapy provided, age of the client and degree of involvement affect the delineation of behavioral limits. All of these factors must be considered when establishing boundaries, and all contribute to the complexity of professional boundaries.

The difference between a caring relationship and an over-involved relationship is narrow. A professional living and working in a remote community will, out of necessity, have business and social relationships with clients. Setting appropriate standards is very difficult.

If they do not relate to real life, these standards may be ignored by the nurse or simply may not work. However, the absence of consideration of professional boundaries places the client and nurse at risk.

Do boundary violations always precede sexual misconduct?

Boundary violations are extremely complex. Most are ambiguous and difficult to evaluate. Boundary violations may lead to sexual misconduct, or they may not. In some cases, extreme sexual misconduct, such as assault or rape, may be habitual behavior, while at other times, it is a crime of opportunity. Regardless of the motive, extreme sexual misconduct is not only a boundary violation, it is criminal behavior.

Does client consent make a sexual relationship acceptable?

If the client consents, and even if the client initiates the sexual conduct, a sexual relationship is still considered sexual misconduct for the health care professional. It is an abuse of the nurse- client relationship that puts the nurse's needs first. It is always the responsibility of the health care professional to establish appropriate boundaries with present and former clients.

How can a nurse identify a potential boundary violation?

Some behavioral indicators can alert nurses to potential boundary issues, for which there may be reasonable explanations. However, nurses who display one or more of the following behaviors should examine their client relationships for possible boundary crossings or violations.

- **Excessive Self-Disclosure** - The nurse discusses personal problems, feelings of sexual attraction or aspects of his or her intimate life with the client.
- **Secretive Behavior** - The nurse keeps secrets with the client and/or becomes guarded or defensive when someone questions their interaction.
- **"Super Nurse" Behavior** - The nurse believes that he or she is immune from fostering a nontherapeutic relationship and that only he or she understands and can meet the client's needs.
- **Singled-out Client Treatment or Client Attention To the Nurse** - The nurse spends inappropriate amounts of time with a particular client, visits the client when off-duty or trades assignments to be with the

client. This form of treatment may also be reversed, with the client paying special attention to the nurse, e.g., giving gifts to the nurse.

- Selective Communication - The nurse fails to explain actions and aspects of care, reports only some aspects of the client's behavior or gives "double messages." In the reverse, the client returns repeatedly to the nurse because other staff members are "too busy."
- Flirtations - The nurse communicates in a flirtatious manner, perhaps employing sexual innuendo, off-color jokes or offensive language.
- "You and Me Against The World" Behavior- The nurse views the client in a protective manner, tends not to accept the client as merely a client or sides with the client's position regardless of the situation.
- Failure to Protect Client - The nurse fails to recognize feelings of sexual attraction to the client, consult with supervisor or colleague, or transfer care of the client when needed to support boundaries.

What should a nurse do if confronted with possible boundary violations or sexual misconduct?

The nurse needs to be prepared to deal with violations by any member of the health care team. Client safety must be the first priority. If a health care provider's behavior is ambiguous, or if the nurse is unsure of how to interpret a situation, the nurse should consult with a trusted supervisor or colleague. Incidents should be thoroughly documented in a timely manner. Nurses should be familiar with reporting requirements, as well as the grounds for discipline in their respective jurisdictions and they are expected to comply with these legal and ethical mandates for reporting.

What are some of the nursing practice implications of professional boundaries?

Nurses need to practice in a manner consistent with professional standards. Nurses should be knowledgeable regarding professional boundaries and work to establish and maintain those boundaries. Nurses should examine any boundary-crossing behavior and seek assistance and counsel from their colleagues and supervisors when crossings occur.

THE NURSE'S CHALLENGE

- Be aware.
- Be cognizant of feelings and behavior.
- Be observant of the behavior of other professionals.
- Always act in the best interest of the client.

For additional information about the National Council of State Boards of Nursing (NCSBN®), visit their Web site at www.ncsbn.org.

ANN RICKS, RN, BSN

DIRECTOR of **INVESTIGATIONS**

THE "GRASS" IS NOT ALWAYS GREENER...

We are often asked to identify the most frequently reported types of allegations or complaints received against nurses. By far, allegations involving drugs and/or alcohol top the list of most frequently reported offenses. In the past six months alone, the investigative division received approximately 500 allegations of which about 200 or more were involving drug/alcohol related offenses. These allegations included an assortment of scenarios either criminal in nature or a combination of criminal and poor nursing practice. The Board routinely receives allegations of nurses receiving a charge/conviction of driving under the influence of alcohol or other chemical substance, prescription forgery for controlled substances, positive drug screens, impairment of nursing practice related to consumption of mind and mood altering substances or stealing narcotics from patients for the nurse's personal use or to give to friends or family members.

The number of nurses testing positive for marijuana when drug screened is alarming. Of the 18 positive drug screens reported to the board in the past 6 months, 14 were confirmed positive for marijuana. **Consuming marijuana whether it is smoked as a form of tobacco (joint, nail, bong, blunt), brewed in tea or mixed in food is illegal.** Over the years, various nurses have made gallant yet unsuccessful attempts to provide explanations of how they tested positive in error. The more common whimsical explanation is "it must be from second hand smoke" breathed while the nurse attended a party where "other people" were smoking it. One nurse stated while attempting to resolve her positive screen, "I thought the brownies tasted funny". Yet another claimed that her cigarette must have been contaminated with marijuana when she used the same ashtray that had previously been used by marijuana smokers.

Unfortunately, like most of the general population, some nurses consider using marijuana as being a harmless form of recreation. The effects of marijuana use can negatively impact a nurse's ability to practice nursing safely. In addition, a confirmed positive drug screen for marijuana or any other illegal drug can result in the nurse facing grave consequences in regards to his/her licensure for a violation of the Mississippi Nurse Practice Law. Please refer to § 73-15-29 (h) of the Mississippi Nurse Practice Law and Chapter II section 1.2(e)(q) of the Rules and Regulations located on our web site at www.msbn.state.ms.us.

In the past six months alone, the investigative division received approximately 500 allegations of which about 200 or more were involving drug/alcohol related offenses. These allegations included an assortment of scenarios either criminal in nature or a combination of criminal and poor nursing practice.

According to the National Institute on Drug Abuse, also known as NIDA, (http://www.nida.nih.gov/researchreports/marijuana/Marijuana3.html), the acute effects of intoxication of marijuana can include impairment of one's short term memory and ability to pay attention. Coordination and balance can be altered. The ability to make sound judgments can be impaired along with compromised cognitive functions. After acute intoxication subsides, marijuana use may continue to impair memory and the ability to learn. Cumulatively, potentially permanent effects

of chronic marijuana use can lead to addiction, chronic lung conditions and an increased risk of cancer.

A nurse who abuses marijuana may demonstrate a threat to the safety of his/her patients in providing substandard care. Poor memory and the inability to concentrate may manifest for example, in the form of medication errors and faulty documentation. The impaired nurse may demonstrate the inability to make sound nursing judgments in situations which would otherwise be considered routine and elementary such as the inability to interpret a sliding scale insulin order.

Consumption of marijuana can have serious negative consequences for patients under the care of an impaired nurse as well as for the individual nurse. If a nurse manager or nursing co-worker has substantial knowledge and justification to believe that a nurse is practicing nursing while impaired, the manager or co-worker has the duty and responsibility to report known facts to the Mississippi Board of Nursing. The following are recommendations of actions to be considered when faced with an impaired nurse:

- **Ensure patient safety** by removing the nurse from patient care assignments until it is determined that the nurse is safe to practice in accordance with the health care facility's established policies and procedures.
- Respect the dignity and rights of the suspect nurse during an investigation by collecting evidence as discreetly as possible.
- Obtain a drug screen specific to the type of drug of suspicion in accordance with the health facility's policies and procedures. All drugs may not be detected by certain screens. Alert the laboratory of the specific drug of suspicion and confirm that the specimen will be screened appropriately to detect the drug of suspicion. For example, if a nurse is suspected to have misappropriated Demerol, the laboratory should confirm that the screen requested is sensitive to the detection of Demerol.
- Obtain a complete and accurate chain of custody of the specimen. Keep a copy for your records.
- Ensure the laboratory confirms the drug screen, through for example, gas chromatography-mass spectrometry (GC-MS) confirmation.
- Collect copies of all other components of evidence including copies of medical records, interview witnesses and obtain witness statements regarding the suspect nurse's behavior and actions. Obtain photos of concrete evidence. For example, if a nurse is suspected of tampering and removing controlled substances from a blister pack of Lortab, a photo of the blister pack could be a key piece of evidence.
- Document all findings of an investigation. Withhold personal opinions or comments from investigative findings.
- Ensure that investigative findings are reported to the appropriate entity in accordance with the facility's policies and procedures and applicable reporting laws.

The Mississippi Board of Nursing is formally charged with protecting the public by ensuring there are safe, ethical and competent nurses practicing. This is achieved through the licensing and regulation process compounded by cooperation of those in the nursing field. The regulatory actions of the Board regarding impairment of nurses and those nurses abusing illegal substances such as marijuana is not intended to be punitive in nature but directed at whatever measures necessary to ensure the safety of the health care recipients in Mississippi. In jest, the old saying that the "grass is always greener" dose not hold true in the case of marijuana use.

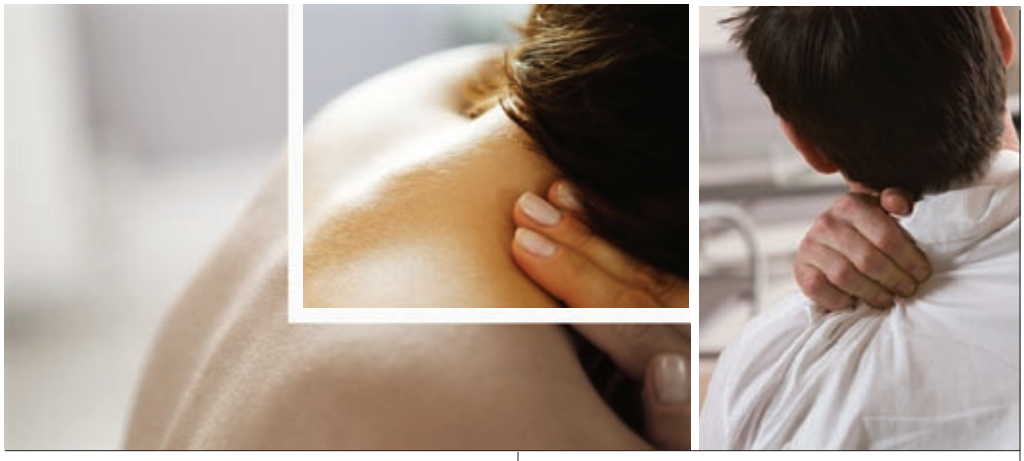
According to the National Institute on Drug Abuse, also known as NIDA, (http://www.nida.nih.gov/researchreports/marijuana/Marijuana3.html), the acute effects of intoxication of marijuana can include impairment of one's short term memory and ability to pay attention. Coordination and balance can be altered. The ability to make sound judgments can be impaired along with compromised cognitive functions.

LINDA SULLIVAN, DSN, FNP-BC, PNP-BC

DIRECTOR of ADVANCED PRACTICE

WHAT A PAIN IN THE NECK!

UNDERSTANDING THE ROLE OF THE APRN IN PAIN CLINICS



Chronic or acute pain are problems that have plagued man from the start of time. Our forefathers had some interesting remedies for pain which included leeches, potions and even drilling into people's skulls. As recently as the 1950s there were many interesting and sometimes smelly concoctions that momma always said worked. I wonder how many of you are old enough to remember the old Mustard Plaster? Now there was a pain treatment! In fact we have always sought to treat pain in ways that were both efficient and effective and caused no problems either for the prescriber or the patient.

Being first thought of as a punishment from God, pain is now recognized as the most common problem reported by patients and often requires both pharmacological and non-pharmacological intervention. Ancient healers recognized the dangers associated with pain medications and sought other means of treating pain that did not involve drugs or herbs as used in those times. However, in the 1600s the drugs of choice were opium and a mixture of opium and sherry called Laudanum for pain relief. While effective in dealing with pain, these were highly addictive treatments and thus quickly fell into disfavor among health care providers and patients. The question however still exists today: how does one treat the pain and spare the patient from addiction or other harmful effects of pharmacological interventions?

Management of pain has long been a concern among health care providers and patients alike and more than likely will continue to be a challenging aspect of care for all health care providers. In humans, pain is often considered the "fifth vital sign" that all health care providers must assess, but an accurate and correct assessment is a complicated and often elusive task.

Despite the fact that pain is the oldest medical problem documented we continue to have misunderstandings related to the physiology of pain. In the mid 17th century Rene Descartes was the first to propose a link between the mind-body connection associated with pain. Melzac and Wall (1965) challenged the notion of a hard wire connection between mind and body and suggested that pain resulted from the integration of information from a variety of sources which can be modified by both emotional and behavioral information. This information may then be interpreted within the spinal cord and taken to the brain for further interpretation.

Pain is a complex clinical problem. Assessment is dependant in part on verbal reports of the patient and often these physical perceptions may be modified by cognitive and affective factors. The prevalence of pain as a problem in its own right has grown since 1945 and new therapeutic alternatives have developed from research and from new theoretical perspectives. The birth of pain centers throughout the country is a relatively new phenomenon not being noted until around 1984-86. This explosion requires the attention of health care providers and their licensing boards so as to ensure the safety of the patients and provide assurance that care is being delivered in these facilities at the highest level, resulting in the best possible outcomes. Currently there are approximately 2000 pain management programs, clinics and centers in the country. Only about one-half of these are nationally accredited. Accrediting bodies include the American Academy of Pain Management and the Commission on Accreditation of Rehabilitation Facilities (CARF).

The current concerns regarding Pain Management Centers are multifaceted. The first is, "Are the health care providers prepared appropriately?" The second is "What standards of care are the treatment regimes based on and how does one determine pharmacological versus non-pharmacological treatment plans?" The next concern would be "When is the appropriate time for a referral to

As recently as the 1950s there were many interesting and sometimes smelly concoctions that momma always said worked. I wonder how many of you are old enough to remember the old Mustard Plaster?

be made to a Pain Center?" Other concerns include, "How are drug seekers identified in these clinics?", "How long is too long to stay on a pharmacological controlled substance?" "How often and by whom should the patient be re-evaluated?" And lastly, "What is the role of the advanced practice registered nurse in these clinics?"

To answer these questions, one has to consider many aspects of the pain care spectrum. Assessments and treatment plans can best be done when the health care provider has the appropriate education and training. Currently anesthesiologists are trained in many aspects of pain management and the Advanced Practice Registered Nurse (APRN) in many cases is working collaboratively with these physicians. What the APRN's employed in these settings need to acknowledge is that they too need expanded training and education. Therefore it is appropriate, and perhaps it should be mandatory, that all APRN's in pain clinics not only have a certain percentage of their continuing educational courses related to pain management but can demonstrate additional technical or "hands on" training in these areas. In many states APRN's that work in these settings have a mandatory participation in a National Association for Pain Management or the American Academy of Pain Management.

The importance of both continuing education and establishing appropriate collaborative agreements with those who are also experts in the area are critical to the success of the utilization of the APRN in pain management and can in fact add to the success of any pain management facility. Knowledge of the latest and most appropriate tools in this arena is paramount to efficacious treatment of all patients. To this end, the development of policies that guide the practice of pain management are critical and experts agree that these need to be clearly delineated and followed. National certification should be considered an indicator that there is a greater likelihood of having qualified providers but again the lack of oversight in these areas makes gauging this marker difficult.

When a patient first arrives at a health care facility, whether it is a family practice or a pain clinic, it is important for the health care provider to gather information related to the past history of this problem. Asking questions about what has been done to date regarding these problems is essential and obtaining test results done prior to the visit to your clinic assists the health care provider in creating the most appropriate plan of care. Health providers should conduct a thorough assessment of pain experienced by a patient on a regular basis, according to a written protocol established by the health care facility or health care provider. Pain shall be assessed in all patients using a combination of patient's self report, an assessment, and/or a pain intensity tool. This self report includes answers to the questions related to when the pain started, location, duration, intensity and what makes it better and what makes it worse. A pain intensity tool addresses the location, duration, onset, and characteristics of pain, the patient's goals, and alleviation of causative factors. These may b used but again are subjective in nature and not necessarily accurate. The first visit should also include an inventory of what medications are currently being used and a determination of the effectiveness of these drugs. Appropriate studies that can support both the diagnosis and treatment plan should be ordered to validate the findings of these tools. Physical examinations shall be conducted as indicated. All these finding should be recorded in the patient's record and be documented in a complete and thorough fashion.

All patients should be re-assessed on a regular basis for pain level and changes in pain recorded according to a written protocol established by the health care facility or health care provider. All pain assessments and re-assessments shall be documented in the patient's clinical record. More than one pain intensity tool may be used by the health care facility or health care provider. At least annually, health care facilities shall ensure competency in pain assessment among appropriate clinicians as designated by the health care facility. This can be accomplished by continuing education and peer evaluation.

Given the complexity of the problems associated with the management of pain it is imperative that the Advanced Practice Registered Nurse is knowledgeable in the area of pain management so as to be considered a credible practitioner with expertise in this area if they choose to practice in the pain arena. The importance of both continuing education and establishing appropriate collaborative agreements with those who are also experts in the area are critical to the success of the APRN in pain management and can add to the success of any pain management facility.

Currently, there are no clear guidelines for the APRN in Mississippi related to practice in the area of pain management. With an eye towards preventing establishment of the local "candy store," concern exists that lack of guidelines may give birth to the indiscriminate prescribing practices that exist in these "candy stores." In an effort to standardize practices and provide information to practitioners in the ever growing area of pain management, the Board of Nursing is seeking to provide clear and comprehensive guidelines for those practitioners who wish to engage in this practice avenue. To ensure that these guidelines are comprehensive and accurate the Board wishes to establish an Ad Hoc committee to assist in developing guidelines for the Practice of Pain Management and you are invited to participate in this. If you or your collaborating physician would like to assist in this task you are invited to contact Dr. Linda Sullivan at 601-944-4851.

HELEN AMOS, LPN, PRESIDENT
LINDA W. SHOWS, RN, BSN, MS, EXECUTIVE DIRECTOR

MISSISSIPPI LPN ASSOCIATION

As a critical and integral component of the nursing team, the licensed practical nurse (LPN) represents the second largest segment of licensed healthcare providers in Mississippi, with over 13,000 licensees. These nurses participate in the planning, implementation, and evaluation of nursing care in all settings. The Mississippi LPN Association, Inc., (MLPNA) is the only professional membership organization representing LPNs exclusively. MLPNA and its affiliate association, the National Federation of Licensed Practical Nurses, Inc. (NFLPN), work for the improvement of patient care through the support and encouragement of professionalism in nursing practice.

The MLPNA has a rich heritage. The original incorporation documents were destroyed during a Gulf Coast hurricane, but its history was reconstructed through research of state records and verbally from current and former members. A group of LPNs, meeting informally for several years, decided to pursue a more formal approach to providing services to LPNs in Mississippi and formed a group who petitioned for charter from the NFLPN. The NFLPN issued a charter to the fledgling organization on October 13, 1970. Two years later on June 28, 1972, the organization sought and received a certificate of incorporation from the State of Mississippi. The board of directors included Jewel Worthy, Senie Fortenberry, Jackie Neely, Florence Hollingsworth, Hattie Evans, Rose Mary Stewart, Alfreeda Fridland and Elsie McMinn. In recent years under the leadership of many dedicated members and officers such as the late Jim Blackledge, Mae Blackledge, Emily Pharr, Opal Ezell, Cathy Walker, Cleo Summers and numerous others, the organization has grown and been active in advocating for LPNs in Mississippi.

The year of 2006 was pivotal in the growth of MLPNA as the association sought and explored ways to increase membership and participation from the LPN community. Changes within the association in 2007 included greater participation of LPN students within the association and the addition of an Executive Director, Linda Shows; development of a web-site; and the formation of LPN school chapters who were granted charters through NFLPN.

MLPNA sponsors an annual convention, generally in April, where contact hours of continuing education are offered in areas relative to current nursing needs. Through this venue, LPNs may explore current issues in nursing practice and education; monitor legislative developments at the state and national level; relay important health news; and channel concern of issues related to the LPN. LPN members continued to have three days of intense training offered by leading healthcare professionals from throughout the state. For the past 15 years the association has provided 10 quality CEU hours for LPNs requiring recertification in IV therapy. Student activities were expanded to include three days of educational sessions, NCLEX review and scholastically oriented competitive events.

The rewards garnered from the 2006/2007 mission change has led to increased membership and greater participation by LPNs following graduation and increased mentoring by seasoned LPN members. Sponsorship of the organization by vendors and other organizations has increased with the awareness of the larger audience reached through MLPNA.

MLPNA will celebrate its 40th anniversary in 2010. It proudly acknowledges its role in providing training for LPNs and students, advocating for the nurses of Mississippi, partnering with other allied health organizations, providing qualified applicants to the Governor for members on the Mississippi Board of Nursing, granting monetary scholarships for students, and being the voice for LPNs to state legislative bodies in matters affecting them.

The mission of MLPNA/NFLPN beyond 2010 is to foster high standards of nursing care and promote continued competence through education/certification and lifelong learning, with a focus on public protection. MLPNA is committed to quality and professionalism in the delivery of nursing care; working with other organizations and groups in a cooperative, progressive spirit; and to build strong professional and public relationships. MLPNA aspires to be the professional organization of choice for Mississippi LPNs dedicated to quality driven decisions that elevate the profession of practical nursing in Mississippi.

MLPNA has worked diligently to maintain a supportive relationship with the Board of Nursing. We continue to seek their support and offer our assistance wherever needed as we go forward.

Mississippi LPN Association
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www.mslpn.org

"To cure sometimes, to relieve often, to comfort always."
-Anonymous

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The Growing Need for Geriatric and Psychiatric Nurse Practitioners

MECSAPN makes new advanced practice tracks accessible through five Mississippi universities

The Mississippi Educational Consortium for Specialized Advanced Practice Nursing (MECSAPN), is a consortium of five leading Mississippi universities. The purpose of this unique collaboration is to improve access to quality health-care in two medically underserved – and vulnerable – health-care populations: older adults and persons with mental health issues.

Gerontological and Psychiatric nursing are specialties where demands for advanced practice nurses are increasing at a rapid rate, particularly in rural areas throughout Mississippi. Nurses who choose a career path in one of these two specialized programs can expect strong growth and rewarding career growth.

Geriatric Nurse Practitioners (GNPs)

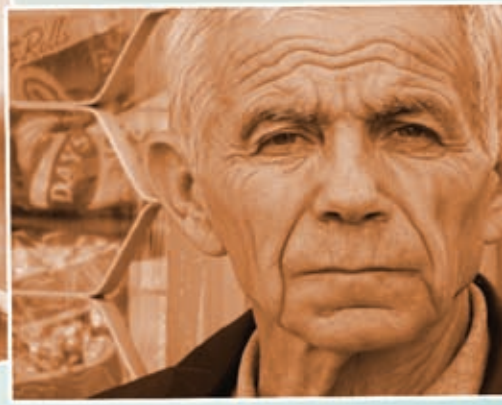
The distribution of the elderly population is biased four-to-one rural over urban settings* (add as footnote - U.S. Census, 2001). Rural older adults are the oldest old, poorest, and have more chronic illnesses than any other segment of the population. This group also faces transportation challenges and often, an overall lack of accessibility to quality health-care facilities.

GNPs provide direct health-care services to young-old, old, old-old, well, frail, and demented adults. They practice independently and collaboratively in multiple rural and urban settings, including ambulatory care (geriatric, medicine, and family practice clinics), acute care (hospitals and rehabilitation facilities), long-term care (nursing homes and assisted living facilities), and home care (home health and hospice agencies).

Psychiatric Mental Health Nurse Practitioners (PMHNPs)

Although the demand for mental health services, especially after Hurricane Katrina, has escalated, access to mental-health care in Mississippi, especially in rural, medically underserved areas, is severely limited or totally non-existent.

Psychiatric mental health (PMH) nursing is focused on persons with diagnosed psychiatric disorders, or those vulnerable individuals or populations at risk of mental-health disorders. In addition to psychotherapy, PMHNPs may have prescriptive authority, inpatient admission privileges, 3rd-party reimbursement, and other specific privileges for mental health care. They may specialize in either Adult Psychiatric Mental Health (i.e., adolescent, adult, and older adult) or Family Psychiatric Mental Health.



MECSAPN is comprised of the following Mississippi universities. For more information on advancing your career as a Gerontological or Psychiatric Mental Health Nurse Practitioner, contact one of the following nursing programs:

Alcorn State University
1000 ASU Drive #359
Alcorn State, MS 29096-7500
601.304.4303
www.alcorn.edu
Ms. Meg Brown/Ms. Debbie Redford

Delta State University
1003 W. Sunflower Rd; PO Box 3343
Cleveland, MS 38733
662.846.4264
www.deltastate.edu
Dr. Shelby Polk/Ms. Cheryl Oleis

Mississippi University for Women
1100 College St., MUW-910
Columbus, MS 39701-5800
662.329.7320
www.muw.edu
Dr. Patsy Smyth

Supported by HRSA grant D09HP09062, Dr. Kaye Bender, PI The University of Mississippi Medical Center

2,038 GNPs are licensed nationwide, only 7 are licensed in Mississippi
2,636 PMHNPs are licensed nationwide, only 46 are licensed in Mississippi

MECSAPN

MECSAPN provides specialized advanced practice nursing clinical tracks that are accessible through all of the university graduate programs in the state. Students choosing these tracks are admitted, take core curriculum courses, and graduate from the NP programs of ASU, DSU, MUW, UMMC, or USM.

The courses for the specialized clinical tracks are taught via distance learning by UMMC faculty. Graduates of BSN programs complete the MSN with an emphasis in Geriatric NP or Psychiatric Mental Health NP roles. Core courses can be taken at any consortium school.

University of MS Medical Center
2500 North State St.
Jackson, MS 39216-4505
601.815.4134
www.umc.edu
Dr. Cynthia Luther/Ms. Rachel Thrash

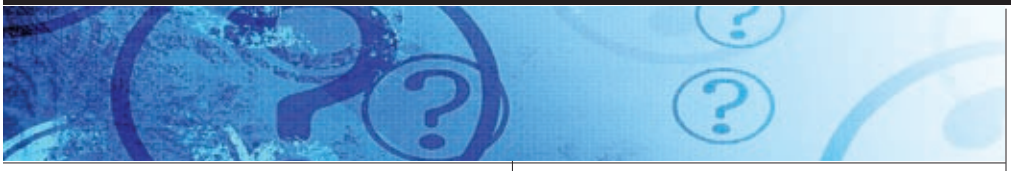
University of Southern MS
118 College Dr.; PO Box 5095
Hattiesburg, MS 39406
601.266.5457
www.usm.edu
Dr. Sheila Davis

MECSAPN
ASU - DSU - MUW - UMMC - USM

DIRECTOR of LICENSURE AND PRACTICE

LATRINA GIBBS MCCLENTON, RN, BSN, MPH

NURSING PRACTICE Q & A



Q. Can a RN administer Ephedrine IV push to hypotensive maternity patients?

A. On October 3, 2008, the Nurse Practice Committee revised its position as follows:

It is within the scope or practice of the appropriately prepared RN to administer Ephedrine IV push for maternal hypotension provided:

1. The RN is educated and competent in the procedure. This education and competence must be documented initially and on an ongoing basis;
2. There is a medical order for the agent and for the patient;
3. The RN practices according to accepted standards of practice;
4. All necessary resources must be readily available; and
5. The facility has policies and procedures addressing all aspects of the issue.

Q. Is it within the scope of practice of the RN to work on an ambulance?

A. It is within the scope of practice of the RN to function as a RN on an ambulance provided:

1. The RN is educated and competent in the care necessary for the patient and knowledgeable regarding the use of available equipment. This education and competence should be documented initially and on an ongoing basis;
2. There is a medical order, emergency protocol or standing orders directing the care of the patient;
3. The RN practices according to accepted standards of practice;
4. The ambulance provider/facility has policies and procedures in place addressing all aspects of the issue.

Q. Does the Mississippi Board of Nursing require TB skin test certification in order to administer or read results?

A. The Board of Nursing does not have specific regulations or require special certification for the administration or reading of a TB skin test. The appropriately prepared registered nurse or licensed practical nurse may perform this procedure provided:

1. The nurse is educated and competent in the procedure. This education and competence must be documented initially and on an ongoing basis;
2. There is a medical order for the procedure;
3. The nurse practices according to accepted standards of practice; and
4. The facility has policies and procedures in place regarding all aspects of this issue.

However, it should be noted that some state and federal regulatory agencies including, but not limited to, the Mississippi State Department of Health (MSDH) and the Occupational Safety and Health Administration (OSHA) require nurses to be certified in the administration and reading of TB skin tests in order for such tests and results to be considered valid.

Q. What is the appropriate nurse/patient ratio?

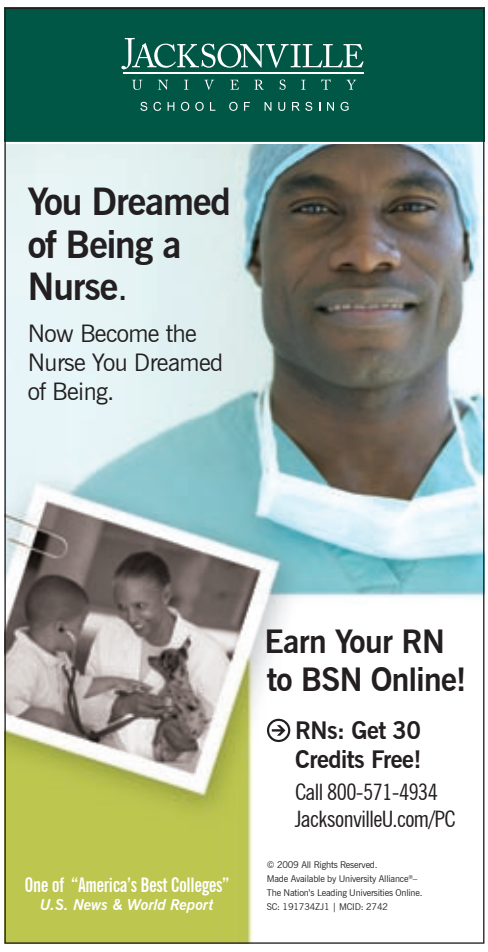
A. The Board of Nursing does not determine or mandate nurse/patient ratios. The number of patients a nurse may care for with reasonable skill and safety should be determined by evaluation of several factors including but not limited to: the nurses' educational preparation, experience and competencies; acuity of the patients; layout of the facility and equipment and other resources available for care of the patient.

In situations regarding consistent understaffing, the nurse should be aware of federal and state regulations regarding the facility's responsibility to assure safe staffing and avenues to report this situation when the nurse feels that it endangers the patient's health and safety. A Condition of Participation in the Code of Federal Regulations (CFR) §482.12, governing hospital services mandates that the "hospital have an organized nursing service that provides 24 hour nursing services." The CFR §482.12, further states that the director of nursing services "is responsible for the operation of the service including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital." Nursing administration

continued on page 18

duties include a review of nursing staffing and making adjustments for absenteeism, as necessary." The federal regulations also mirror the Nursing Practice Law by stating the "registered nurse must assign the nursing care of each patient to other personnel in accordance with the patient's needs and the specialized qualifications and competencies of the nursing staff available." State regulations for hospitals state that the facility must provide nursing services for each unit sufficient to meet the needs of the patients. There are similar state and federal regulations for other health care facilities.

The Mississippi State Department of Health (MSDH) is responsible for enforcement of federal and state regulations for healthcare facilities. Consistent understaffing which endangers the health and safety of the patient should be reported to the MSDH at 601-364-1100.



RICKI GARRETT, EXECUTIVE DIRECTOR

MISSISSIPPI NURSES ASSOCIATION

It is a privilege to have the opportunity to write a column for the publication of the Mississippi Board of Nursing. As the professional association for the 37,000 registered nurses in our state, we have an excellent working relationship with the regulatory board of the profession as well as with many other constituencies of nursing. I am not sure that we fully appreciate how invaluable that collaboration is in our state, particularly in light of the fact that in many states it does not exist. In attending national meetings, I often hear of friction and competition among the various nursing groups, not to mention other healthcare professions, so we are very fortunate in our state.

While the Board of Nursing provides important regulation of the profession in order to protect the public, the Mississippi Nurses Association is your advocate for your practice and your profession. For the small price of $23.00 a month, MNA represents you at regulatory meetings of the Board of Nursing, the Board of Medical Licensure and the Board of Health. Both your MNA executive director and your contract lobbyist are also working constantly with the legislature and with other policy makers in the state to assure that your practice is not only protected but enhanced. As the legislature continues to wrestle with budget issues, MNA is lobbying for funding to develop a simulation lab project in our state that will benefit schools of nursing as well as hospitals. Legislation has already been approved to protect the title "nurse" and to put the regulation of nurse practitioners solely under the control of the Board of Nursing.

In this time of heightened focus on healthcare delivery, please join us as we work to make sure that nurses and nursing are at the forefront of the decision-making process.

Mississippi Nurses Association
31 Woodgreen Place
Madison, MS 39110
www.ms.nurses.org

MARIANNE R. WYNN, BA

MONITORING COUNSELOR of RECOVERING NURSE PROGRAM

We are pleased to share with you an article based on a letter written by Charles Les O-Neal, RN, and printed in the May 2009 issue of the *ASBN Update* entitled Fish Swim, Birds Fly and Addicts Lie. Excerpts from the article are presented below in quotations. Paraphrases and changes have been made to reflect details of the Mississippi Board of Nursing's monitoring program.

"Dealing with impaired addicted nurses, what a job! No thank you. This is when the nurse has gotten caught and more times than not, this behavior has been going on for quite some time. The individual is angry, resentful, scared, ashamed, devastated, in denial and very manipulative. This individual is typically broke, busted and disgusted. When I say broke, I mean more than financially. Broken in spirit, out of control, bewildered at what has happened to them. Often times, the addict is the last to know that he or she is an addict. We addicts have to learn that denial is not a river in Egypt; denial is in our mind, and it is a strong delusion."

This is where the counselors and monitors of impaired nurse programs enter the picture. They talk to people every day who are desperate and trying to minimize the damage of drug use and will lie if it serves their purpose. Confrontation is required, and is usually met with resentment and more lies. Then the worst case scenario is made real; the nurse is faced with the fact that he or she will need to get help or face the possibility of losing their license or privilege to practice.

In the Mississippi Recovering Nurse Program (RNP), the first step is meeting with the monitors and demonstrating a willingness to cooperate with the process. The next step is an assessment by an addiction specialist, and depending on the results of that assessment, some form of treatment, or a referral for disciplinary action other than RNP, or a closing of the case. For the nurse that is chemically dependant, they are given the option to participate voluntarily. Participation normally involves signing an affidavit with the board which restricts and monitors their practice for a period up to five years, attending the indicated treatment, random drug screening with daily calling, attendance of three twelve step meetings weekly, an employee agreement, therapeutic groups at the board office and reporting in writing monthly.

Of all of the consequences that participating nurses face, it is the prejudice, disgrace and mistrust from themselves, co-workers, administrators and supervisors that cut the deepest. "And the intangibles, the looks you receive in public, fear of rejection with job interviews, feelings of I'm less than a good nurse, less than a trustworthy nurse, just not good enough." Once the restrictions have been imposed, nursing jobs are not always easy to obtain. Healthcare facilities don't always want to hire nurses that can't work alone, have narcotic restrictions or have papers to prove that they have been guilty of having a disease called addiction.

Mr. O'Neal asks if the Arkansas Board of Nursing is too hard on those who have found themselves addicted and responds, "No, absolutely not." Boards of nursing have a "responsibility to the public to make sure the people who are privileged to be called nurses are not impaired." "…it takes a lot to recover from addiction, and recovery is not going to happen with a letter of concern or a slap on the wrist." Boards of nursing monitoring programs are often the catalyst for needed and wonderful changes in the lives of nurses, their families, their co-workers and their patients.

In his article, Mr. O'Neal further states: "I am one grateful recovering addict, who is appreciative of what the disciplinary nurses program did for me and for the often thankless job they do to help nurses to recover and regain their careers. I have found recovery to be the best thing in my life, and the spiritual growth has been priceless. I have completed my probationary status and currently have 1,693 consecutive days completely clean and sober by the grace of God. Do I wish this had not occurred to me? Do I wish to shut the door on this chapter of my life? NO. It took what it took; I am a stronger person and a better person who has learned the full meaning of hope, faith, and love. I feel I can use this experience to help and understand others and that is exactly why I became a nurse. Do I recommend this road of addiction for others? Absolutely not!"

In my role as a monitoring counselor for the Mississippi Board of Nursing, I meet with nurses every week who express the same sentiments of gratitude as the nurse who wrote this article. It is my privilege to work with them, to witness the changes in their nursing practice, their family lives, their spiritual lives, and the contributions they make to medical institutions and society.

disciplinary SUMMARY

The following disciplinary actions were taken at hearings conducted by the Mississippi Board of Nursing April 1-2, 2009, or reflect actions accepted by the licensees or applicants by agreed order. All information contained in this summary is public.

NAME	LICENSE #	ACTION	VIOLATION OF THE NURSING PRACTICE LAW
APRIL 1-2, 2009			
Bailey, Mary	P-164895	Reprimand, Fine, and Education	Acted in manner inconsistent with the health and safety of patients:
Bierdeman, Beverly	P-289724	Restricted Licensure for a minimum of (6) months	Engaged in conduct likely to deceive defraud or harm the public
Bigham, Charles	P-315002	Restricted Licensure for a minimum of (12) months/ Formal Reprimand/Legal Aspects of Nursing Workshop/ Documentation Program	Falsified or made incorrect entries on records
Bradley, Bobbie	P-225703	Restricted Licensure for a minimum of (24) months	Addicted to or dependent on alcohol or other habit-forming drugs
Demby, Remonia	R-865377	Reinstatement of Nursing License Denied with Drug Related Recommendations	Violated an order, rule or regulation of the Board
Dukes, Felicia	P-324149	Formal Reprimand	Engaged in conduct likely to deceive defraud or harm the public
Crystal Jean Edgeston	P-319296	Revocation	Obtained or attempted to obtain controlled substances by unauthorized means
Gault, Vanessa	P-320101	Restricted Licensure for a minimum of (6) months/ Formal Reprimand/ Legal Aspects of Nursing Course	Falsified or made incorrect entries on records
Gordon, Leila	P-314346	Revocation	Violated an order, rule or regulation of the Board
Goss, Amy	R-869981	Restricted Licensure for a minimum of (12) month's Formal Reprimand/ Legal Aspects of Nursing Course Documentation Course	Falsified or made incorrect entries on records
Grant, Stacey	P-318549	Revocation	Acted in manner inconsistent with the health and safety of patients: / Falsified or made incorrect entries on records
Hammack, Debra	P-246026	Voluntary Surrender	Violated an order, rule or regulation of the Board
Hammond, Christy	P-319463	Revocation	Addicted to or dependent on alcohol or other habit-forming drugs
Herrington, Mary	R-881795	Formal Reprimand	Engaged in conduct likely to deceive defraud or harm the public
Hogan, Darren	P-273141	Voluntary Surrender	Violated an order, rule or regulation of the Board
Huff, Tara	P-322214	Voluntary Surrender	Obtained or attempted to obtain controlled substances by unauthorized means
Hunt, Debbie	R-692646	Reinstatement of Nursing	Violated an order, rule or regulation License with Drug Related of the Board Stipulations
Ingle, Shelly	R-869962	Voluntary Surrender	Violated an order, rule or regulation of the Board
Jackson, Deidra	R-856679	Voluntary Surrender	Obtained or attempted to obtain controlled substances by unauthorized means
Lee, Michelle	RN Endorsement Applicant	Appeal of Administrative Denial Application for RN Endorsement Decision Affirmed	Falsified or made incorrect entries of on records
McKinney, Dana	R-858611	Reinstatement of Nursing License with Drug Related Stipulations	Violated an order, rule or regulation of the Board
Nelson, Patricia	R-871508	Formal Reprimand/ Medication Administration	Acted in a manner inconsistent with the health or safety of patients
Nolen, Brittany	R-880833	Restricted Licensure for a minimum of (6) months With Modified Drug Stipulations	Engaged in conduct likely to deceive defraud or harm the public of the Board
Odom, Candance	R-863229	Legal Aspects Workshop Formal Reprimand	Acted in a manner inconsistent with the health or safety of patients
Palmer, Nina	P-322120	Voluntary Surrender	Possessed, obtained, furnished or administered drugs except as legally directed
Patricks, Susan	R-822187	Voluntary Surrender	Violated an order, rule or regulation of the Board
Peters, Jacqueline	R-872358	Formal Reprimand/Legal Aspect of Nursing/Documentation Course	Falsified or made incorrect entries on records
Porter Lashandria	P-321848	Formal Reprimand	Engaged in conduct likely to deceive defraud or harm the public

NAME	LICENSE #	ACTION	VIOLATION OF THE NURSING PRACTICE LAW
Rawlings, Shelley	R-860732	Formal Reprimand	Acted in a manner inconsistent with the health or safety of patients
Shields, Diane	P-316770	Residents Right and Dignity and Boundaries Course	Engaged in conduct likely to deceive defraud or harm the public
Smith, Fredrick	R547514 CRNA	Voluntary Surrender	Addicted to or dependent on alcohol or other habit-forming drugs
Stewart, Marianne	R-854298	Reinstatement of Nursing License with Drug Related Stipulations	Violated an order, rule or regulation of the Board
Stubbs, Bernard	R-852975	Voluntary Surrender	License or privilege to practice suspended or revoked in anothe rjurisdiction
Thompson, Cynthia	P-321963	Formal Reprimand/ Legal Aspects of Nursing	Acted in a manner inconsistent with the health or safety of patients
Thompson, Michael	R-813668	Reinstatement of Nursing License with Drug Related Stipulations	Violated an order, rule or regulation of the Board
Whitehead, Deborah	R-590525, FNP	Suspension of Controlled Substance Prescriptive Authority/Restricted Nurse Practitioner Certification for a minimum of (36) months /Pharmacology Course/ Management of Patients with Chronic Pain Syndrome Course	Acted in a manner inconsistent with the health or safety of patients
Williams, Debra	R-761103	Reinstatement of Nursing License with Drug Related Stipulations	Violated an order, rule or regulation of the Board
Willis, Kevin	R-860529	Voluntary Surrender	Violated an order, rule or regulation of the Board

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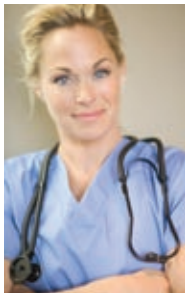


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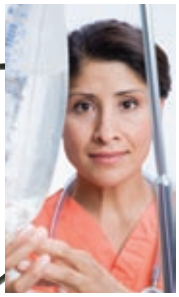


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