Advanced Practice Nursing in Arkansas

Arkansas State Board of Nursing
Outline

Section I  Regulations
Section II  Managing Your Practice
Section III  Violating the *Nurse Practice Act*
Section IV  Professional Boundaries in Nursing

This module meets 2 hours of pharmcotherapeutics as required for APRNs with prescriptive authority. You must complete a written exam to receive credit for this course.
Regulations

The first section of this presentation is a brief description of the statutes which passed in the Arkansas 90th General Assembly, 2015.

Rules were written in order to clarify the statues and delineate how these statues are to be carried out.
Objectives

The Learner will:

- Identify changes to APRN practice/prescribing as a result of the new statues (laws) from 2015.
- Modify APRN practice to incorporate new statutes.
- Identify process for prescribing Hydrocodone combination products.
- Identify changes with collaborative practice physician.
- Review process for establishing and utilizing Prescription Drug Monitoring Program.
- Review process for delegating access to Prescription Drug Monitoring Program in a clinical setting.
- Summarize new changes in rules for APRN practice.
Specific Acts of 2015 Impacting the Practice of Advanced Practice Registered Nurses

- Act 529
  - Prescribing hydrocodone combination products
- Act 824
  - Collaborative Practice Agreements
- Act 1208
  - Prescription Drug Monitoring Program
Prescribing of Hydrocodone Combination Products

DEA reclassified Hydrocodone Combination Products (HCP) from Schedule III to Schedule II on October 6, 2014.

• Arkansas Advanced Practice Registered Nurses (APRN)s are restricted by law to Schedule III-Schedule V.
• This impacted Arkansas APRNs greatly as they were no longer able to prescribe any HCP.
An APRN’s prescriptive authority shall extend only to drugs listed in schedules III-V, and only if expressly authorized by the collaborative practice agreement to those hydrocodone combination products (HCP) reclassified from Schedule III to Schedule II as of October 6, 2014.

ACA §17-87-310 (b)(2)
In order for an APRN licensed in Arkansas to prescribe HCPs, the Collaborative Practice Agreement (CPA) must include the following statement:

The above named APRN is authorized to prescribe drugs listed in Schedules III through V and hydrocodone combination products from Schedule II of the Controlled Substance Act.
1) The APRN must submit to the Arkansas State Board of Nursing (ASBN) a new CPA with the HCP language.

2) Once the updated CPA is approved, the ASBN will notify the APRN.

3) ASBN sends an approved list to the DEA on a weekly basis.

4) The APRN should send the following information to the DEA by email:
   • Primary practice site address,
   • APRN license number, and
   • DEA number.
5) After the DEA processes and updates the DEA registration to include Schedule 2, 3, 3N, 4, and 5, the APRN will be notified by email.

6) The APRN may begin prescribing HCPs **ONLY** after the DEA updates the registration on the DEA website.
APRN has a CPA with a practicing physician who is licensed under the Arkansas Medical Practices Act, §17-95-201, §17-95-207, §17-95-301, §17-95-305, §17-95-401, §17-95-411, and has training in scope, specialty, or expertise to that of the APRN.

Changes made to the statute:
- Added terms were “practicing” and “training”
- Deleted was “who has a practice comparable”

ACA §17-87-310 (a)(2)
What Does That Mean?

The collaborating physician:

• Must be in active practice; **Not retired**
• May have a different specialty than the APRN, but
  • Must have training in scope or expertise as that of the APRN.

This **Does Not** change the scope of practice for the APRN. Practice must remain within the educational background and certification regardless of the collaborating physician’s specialty.

**Example:** A Pediatric Nurse Practitioner can collaborate with a physician who specializes in family practice. The NP’s practice is restricted to pediatric patients.
Prescription Drug Monitoring Act

- Prescription Drug Monitoring Program (PDMP)
  - Created in 2011
- Purpose:
  - To combat prescription drug abuse, and
  - To provide a mechanism for reviewing controlled substance prescriptions.

ACA §20-7-607 et seq
Facts FYI:

• Legislation has been passed for PDMP reporting in all states except Missouri.

• New York requires all prescribers to check PDMP
  • Resulted in 75% decrease in patients utilizing multiple providers.

• Arkansas prescribers are not mandated by law to access PDMP database prior to prescribing a controlled substance although it is highly recommended.
What the PDMP Can Do For APRN Practice

Prescribers are able to review:

- Their patient’s controlled substance history for instances of abuse or misuse in obtaining a controlled substance.
- Prescriptions for controlled substances which were filled under their name/DEA.
  - This allows for early identification of fraudulent prescriptions and possible errors by pharmacists.
  - If fraud is found the APRN should:
    - Notify the pharmacy,
    - Notify the DEA,
    - Notify the local police department, and
    - Notify the Board of Nursing.
PDMP Enrollment For Practitioners

• Website www.arkansaspmp.com
  • Select “Practitioner/Pharmacist”
  • Select blue hyperlink ‘Training Guide for Arkansas Practitioners and Pharmacists” You **CANNOT** skip this step
  • Your temporary ID and password are found here.
• Select the “Practitioner/Pharmacist Registration” tab and enter the temporary ID and password

• Complete the registration form and submit

• You will receive two emails with your permanent ID and PIN plus a temporary password that you can change.
Act 1208 of 2015

• Made many additions to PDMP

• The following slides will identify the change in statute followed by the corresponding change to Rule.

YOU ARE RESPONSIBLE FOR INCORPORATING ALL OF THESE CHANGES INTO YOUR PRACTICE.

ACA §20-7-604 et seq
ACT 1208

Permits an “alert” to be sent to the prescriber if his/her patient is being prescribed opioids by more than three prescribers within a 30 day period.

• This will be implemented when funding is available.

ACA §20-7-604(g)(2)
Defined chronic malignant pain as:
• Pain requiring more than three (3) consecutive months of prescriptions for:
  • An opioid written for more than the equivalent of ninety (90) tablets, each containing five (5) milligrams of hydrocodone; or
  • A morphine equivalent dose of more than fifteen (15) milligrams per day; or
  • Tramadol with a dose of fifty (50) milligrams or one hundred twenty (120) tablets.

ACA §20-7-702(2) and Rules, Chapter 4, Section XII(A)
Identified the following prescriber requirements for treating patients with chronic malignant pain:

- Patient treatment and evaluation
- Exceptions to the treating requirements

ACA §20-7-707(a)
Changes to the *Rules*

Prescribing for nonmalignant pain:

- **Patient Treatment and Evaluation**
  - The patient shall be evaluated at least one (1) time every six (6) months by a physician who is licensed by the Arkansas State Medical Board.
  - A current PDMP report shall be reviewed at least every six (6) months. The review shall be documented in the patient’s medical record.
  - A current pain contract with the patient shall be maintained and include, at a minimum, requirements for:
    - Random urine drug screens, and
    - Random pill counts.
Changes to the Rules

The requirements of this section shall not apply to the patient:

- Whose pain medications are being prescribed for a malignant condition;
- With a terminal condition;
- Who is a resident of a licensed healthcare facility;
- Who is enrolled in a hospice program; or
- Who is in an inpatient or outpatient palliative care program.

ACA §20-7-707 and Rules, Chapter 4, Section XII
Opioid prescribing guidelines of the Emergency Department (ED):

- Hospitals will draft and adopt guidelines for opioid prescribing for ED patients.
- Guidelines shall address, at a minimum:
  - Treatment of chronic nonmalignant pain and acute pain,
  - Limits on amounts and duration of opioid prescriptions,
  - Identification of situations where opioid prescription should be discouraged or prohibited.

ACA §20-7-703
Act 1208

Act 1208 allows prescribers to delegate the task of obtaining PDMP reports.

ACA §20-7-604(h)
Changes to the *Rules*

- Each APRN may delegate up to two (2) **licensed nurses per practice site** the task of running a PDMP report.
  - This task remains under the supervision of the APRN.

- The delegates must register with Department Human Services (DHS) prior to running a report. The nurse will sign up using a **delegated account** and will be assigned their own account and password.

*Rules, Chapter 4, Section VIII(K)(1)*
Delegation of PDMP Reports

The APRN **SHOULD NOT** under any circumstance give out his/her password for others to run PDMP reports.
Best Practice

Each facility should have a policy in place to determine the process for the delegated nurses to follow.

Example: if Chuck Norris has been on an opioid for three (3) months, the APRN can sign a “form” that delegates the nurse to run a PDMP report prior to each visit.
Process for Delegate Access

The APRN must first **activate their delegate account.**

- This account will be linked to your account so be sure you trust the nurse you are delegating to.
- Go to: [http://www.arkansaspmcp.com](http://www.arkansaspmcp.com)
- Select the “Delegate” link
- Select Practitioner and Pharmacist link
- Follow directions (pages 34-37) of the Training Guide
Act 1208

All prescribers licensed **AFTER** December 31, 2015 must obtain prescribing education within the first two (2) years of being granted a license.

ACA §20-7-704
Changes to Rules

All APRN’s issued a Prescriptive Authority Certificate (PAC) **AFTER 12/31/2015:**

• Shall obtain a minimum of **3 hours** of prescribing education which includes:
  • Information on maintaining professional boundaries, and the prescribing rules, regulations, and
  • Laws that apply to APRN’s in the state of Arkansas within **2 years** of issuance.

NOTE: Statute requires a minimum of two (2) hours. The Rules require **three (3) hours.**

Rules, Chapter 4, Section VIII, 7
Renewal of PAC:

- Effective 01/01/2017 For **ALL** APRN’s with a PAC:
  
  - Two (2) of the five (5) hours of pharmacotherapeutic CEs must contain information related to:
    
    - Maintaining professional boundaries,
    
    - Prescribing rules and regulations, and
    
    - Laws that apply to the APRN’s in the state.

Rules, Chapter 4, Section III,F(7)
Changes to the *Rules*

**Reactivation of Prescriptive Authority**

- Prior to reactivation of prescriptive authority, the APRN shall complete:
  - Five (5) contact hours of pharmacotherapeutics continuing education in the APRN’s area of certification for each 12 months of non-prescribing activity.

- Two (2) contact hours shall include information on maintaining professional boundaries and the prescribing rules, regulations and laws that apply to the APRN’s in the state of Arkansas.

*Rules, Chapter 4, Section VIII(J)*
Changes to the Rules

The following prescribing language has been added:

• The APRN will keep accurate records to include:
  • The medical history,
  • Physical examination,
  • Other evaluations and consultations,
  • Treatment plan objective,
  • Informed consent,
  • Treatment and medications given, and
  • Agreements with the patient and periodic reviews.

Rules, Chapter 4, Section VIII(D)(6)
Changes to the *Rules*

The following prescribing language has been added:

- The APRN will periodically review the course of scheduled drug treatment of the patient and any new information about etiology of the pain. If the patient has not improved, the APRN may assess the appropriateness of continued prescribing of scheduled medications or dangerous drugs, or trial of other modalities.

Rules, Chapter 4, Section VIII(D)(7)
Changes to the *Rules*

The following prescribing language has been added:

- The APRN will obtain written informed consent from those patients he or she is concerned may abuse controlled substances and discuss the risks and benefits of the use of controlled substances with the patient, his or her guardian, or authorized representatives.

Rules, Chapter 4, Section VIII(D)(8)
Act 1208

Allows licensing agencies to require prescribers to run a PDMP report prior to prescribing opioids.

ACA §20-7-615
Changes to the *Rules*

All APRN’s with prescriptive authority, who are under a disciplinary order for a violation of the *Nurse Practice Act (NPA)* and/or Rules involving prescription drugs, shall review a current PDMP report (run within the past 30 days) prior to prescribing any opioids. Review of the PDMP report shall be documented in the patient’s medical record.

Rules, Chapter 4, Section VIII(K)(2)
References

• *Arkansas Nurse Practice Act* and *Rules*, Chapter 4 (Retrieved: www.arsbn.org)

• Arkansas 90th General Assembly (Retrieved: www.arkleg.state.ar.us)
Managing Your Practice
Objectives

The Learner will:

• Recognize required components of Collaborative Practice Agreements.
• Review protocol requirements for APRNs with Prescriptive Authority.
• Review requirements for all prescriptions written by an APRN.
• Identify necessary documentation requirements when prescribing medications.
• Compare continuing education requirements for APRNs applying for initial Prescriptive Authority with those who are renewing the Prescriptive Authority Certificate (PAC) and those who are seeking reactivation of the PAC.
• Discuss requirements for the termination of a Collaborative Practice Agreement.
Collaborative Practice Agreement

A Collaborative Practice Agreement (CPA) is only required if prescribing medications.

**THE CPA MUST CONTAIN:**

- Availability of the collaborative physician for consultation, referral or both,
- Methods of management which shall include use of protocols,
- Plans for coverage in absence of APRN or physician, and
- Provision for quality assurance.

Rules, Ch. 4, Section VIII (A)(5)
Prescriptive Authority

Prescribing of:

- Schedule III-V narcotics are permitted with an active DEA certificate.
- Hydrocodone combination products (Schedule II) permitted if:
  - Expressly authorized by the collaborative practice agreement, and
  - Approved by the DEA.

The above named APRN is authorized to prescribe drugs listed in Schedules III through V and hydrocodone combination products from Schedule II of the Controlled Substance Act.
Protocols for Prescriptive Authority

• All APRNs with Prescriptive Authority shall:
  • Have protocols available at the practice site which include the date the protocol was adopted or reviewed and
  • Review protocols at least annually.

• The protocols shall, at a minimum, include:
  • Indications for and classifications of legend drugs, controlled substances and therapeutic devices which will be prescribed or administered by the APRN.

Rules, Ch. 4, Section VIII (C)
Protocols

The APRN **CANNOT** prescribe outside of protocols unless:

- A specific written or verbal order is obtained from the collaborating physician, and
- There is documentation of the consultation with collaborating physician in client’s medical record.

Rules, Ch. 4, Section VIII (D)(4)
Prescription Format

All prescriptions written by the APRN **SHALL** contain:

- Name of client,
- APRN’s name, title, address, and telephone number,
- APRN signature with the initials “APRN”,
- Name of medication and strength,
- Dose,
- Amount prescribed,
- Directions for use,
- Number of refills, and
- APRN’s DEA number when controlled substance is written.

Rules, Ch. 4, Section VIII (E)
Best Practice - Written Prescriptions

• Ensure security of prescription pads.

• Include corresponding alpha characters when writing a number.
  • Sig: 10 (ten)

• Place a duplicate of each written prescription in the medical record.

• E-scripts must follow the same guidelines.
When prescribing medications ..........

Documentation must include:

- Medical history,
- Physical examination,
- Other evaluations and consultations,
- Treatment plan,
- Objective informed consent,
- Treatment and medications given, and
- Agreements with the patient including periodic reviews.

Rules, Ch. 4, Section VIII (D)(6)
When prescribing medications ..........

Periodically review the course of scheduled drug treatment and any new information about the etiology of the pain. If patient has not improved, the APRN may assess the appropriateness of continued prescribing of scheduled medications or dangerous drugs or trial of other modalities.

Rules, Ch. 4, Section VIII (D)(7)
When prescribing medications ..........

The APRN will obtain written informed consent from those patients he or she is concerned may abuse controlled substances and discuss the risks and benefits of the use of controlled substances with the patient, his or her guardian, or authorized representatives.

Rules, Ch. 4, Section VIII (D)(8)
Initial prescriptive authority issued after December 31, 2015 requires:

• Three (3) hours of prescribing education which includes information on maintaining professional boundaries and the prescribing rules, regulations and laws that apply to APRNs within two (2) years of issuance of prescriptive authority.

NOTE: This presentation meets two (2) hours of the above requirement.
RENEWAL: APRNs with prescriptive authority shall complete:

- Five (5) contact hours of pharmacotherapeutics continuing education in the APRN’s area of certification each biennium prior to license renewal.
- Two (2) of the five (5) hours must contain information related to maintaining professional boundaries and the prescribing rules, regulations and laws that apply to APRNs.

NOTE: This presentation meets the above requirement.
Reactivation of prescriptive authority: Prior to reactivation, the APRN shall complete:

- Five (5) contact hours of pharmacotherapeutics in the APRN’s area of certification for each twelve (12) months of non-prescribing.

- Two (2) of the five (5) hours shall include information on maintaining professional boundaries and the prescribing rules, regulations and laws that apply to APRNs.
Termination of a Collaborative Practice Agreement

If you leave your job you must notify the ASBN in writing within seven (7) days of the termination of your collaborative practice agreement.

- Your prescriptive authority will be inactivated until you have another approved collaborative practice agreement on file with the ASBN.

The next slide shows the termination form which can be found on the ASBN website.
TERMINATION OF A COLLABORATIVE PRACTICE AGREEMENT

It is important that the Arkansas State Board of Nursing (ASBN) have a copy of your current Collaborative Practice Agreement (CPA) that identifies your current collaborating physician/s. If you change jobs (or practice sites), have a new collaborating physician, etc., you will need to provide the Board with a new/updated CPA and Quality Assurance Plan. To terminate your previous CPA, please complete this form (may be submitted via mail, fax, or email). If you have more than one active CPA on file, please submit the one you wish to terminate along with this form. Please contact us if you have any questions. We appreciate your cooperation.

I, ______________________________ _____________, am notifying the Arkansas State Board of Nursing that I am terminating my Collaborative Practice Agreement & Quality Assurance Plan with the following physician(s) to be effective on ______/_____/_______.

____________________________, MD ____________________________, MD
____________________________, MD ____________________________, MD
____________________________, MD ____________________________, MD
____________________________, MD ____________________________, MD

I am submitting a new Collaborative Practice Agreement, which includes my collaborating physician/s and Quality Assurance Plan, to be effective on ______/_____/_______.

I understand that I cannot receive or prescribe medications or therapeutic devices until I have submitted the new Collaborative Practice Agreement and Quality Assurance Plan and that I have received verification that these items have been approved.

_______________________________ ____________________________
(Signature of APRN) (Date Signed)
SECTION III

Violating the Nurse Practice Act
Objectives

The learner will:

• Describe the process that nurses, employers, and the public should utilize when notifying the ASBN of illegal or unethical nurse behavior.
• Identify behaviors that are violations of the *Nurse Practice Act*. 
How to Report a Complaint to the ASBN

- All complaints must be in writing

- Website has online form and PDF form
  - [www.arsbn.org](http://www.arsbn.org)
  - Located under the Forms tab
(a) The Arkansas State Board of Nursing shall have sole authority to deny, suspend, revoke or limit any license or privilege to practice nursing or certificate of prescriptive authority ... upon proof that the person:

(1) Is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing or is engaged in the practice of nursing without a valid license;

Nurse Practice Act of the State of Arkansas, ACA §17-87-309
Examples of Fraud and Deceit

• Prescribing without an approved collaborative practice agreement on file with the Board.

• Allowing APRN certification to expire and continue to practice as an APRN (prerequisite for APRN licensure).

• Falsification of application for licensure, prescriptive authority or renewal.

• Failure to maintain an active RN license (co-requisite for APRN license).
What to Report to the ASBN

(2) Is guilty of a crime or gross immorality;
   • Found guilty, pled guilty, pled nolo contendere, or have imposition of sentence for any crime
   • Examples: DWI, public intoxication, possession of a controlled substance, battery

(3) Is unfit or incompetent by reason of negligence, habits, or other causes;

ACA §17-87-309
What to Report to the ASBN

(4) Is habitually intemperate or is addicted to the use of habit-forming drugs;
   • Positive drug screen

(5) Is mentally incompetent;

(6) Is guilty of unprofessional conduct;

ACA §17-87-309
What Constitutes Unprofessional Conduct?

(a) Failing to assess & evaluate/failing to intervene

- Example: Patient comes in with a complaint of back pain - you ask a few questions and send them off with a prescription for NSAIDs and muscle relaxer. You never performed physical assessment.

(b) Inaccurate or false documentation / reporting

(c) Failing to document or falsely documenting

(d) Misappropriation or meds, supplies, equipment or personal items of the patient or employer

Rules, Chapter 7, Section IV(6)
What Constitutes Unprofessional Conduct?

(e) Medication/Treatment errors

- It is not a question of will a nurse make a mistake, but when. An important factor that affects how severely your license is disciplined is what you do about the mistake.
  - Do you take steps to report and correct error?
  - Do you cover up and/or ignore?

Rules, Chapter 7, Section IV(6)
What Constitutes Unprofessional Conduct?

(f) Performing/attempting to perform procedures that nurse is untrained to do

- The days of “see one”, “do one”, “teach one” are over. Training with competency check off is necessary. This also includes practicing outside your scope of practice.
  
  Example: Adult-Gero Nurse Practitioner cannot see pediatric patients.

(g) Violating confidentiality

(h) Causing suffering or allowing physical/emotional injury

  Example: A nurse gave a nursing home resident a meal tray with plastic food to eat. The nurses sat back and watch the frustrated patient.

Rules, Chapter 7, Section IV(6)
(i) Leaving nursing assignment without notifying appropriate personnel

- There is a difference in abandonment from the employers’ point of view (job abandonment) and the Board of Nursing’s point of view (patient abandonment).

- **Job Abandonment**
  - Facility policy issue - Facilities can take action on employment

  *Example:* You quit your job effective immediately. Never reported to work.

Rules, Chapter 7, Section IV(6)
What Constitutes Unprofessional Conduct?

Patient Abandonment: Leaving your nursing assignment without notifying the appropriate personnel.

- Who does the facility policy require the nurse to inform? (Chain of Command)
- Who if anyone did the nurse inform?

Example: You leave your job in the middle of the shift without informing appropriate individuals.

*ASBN only gets involved with patient abandonment.*

Rules, Chapter 7, Section IV(6)
(j) Failing to report to the Board within a reasonable time of the occurrence, any violation or attempted violation of the *Nurse Practice Act* or duly promulgated rules or orders.

- Disciplinary action can be taken against you if you know another nurse is violating the *Nurse Practice Act* and you ignore the behaviors and do not report them to the Board.

Rules, Chapter 7, Section IV(6)
Now Everyone is a Mandatory Reporter

In the 2015 General Assembly ACA §17-80-117 was added. This section is the substance abuse reporting act.

• The act states required reporters (facilities that employ or contracts with healthcare professionals to provide healthcare services) shall report to the appropriate licensing authority:

  • A final disciplinary action taken against a healthcare professional as a result of the diversion, misuse, or abuse of illicit drugs or controlled substances.., and

  • The voluntary resignation of any healthcare professional against whom a disciplinary action arising from the diversion, misuse, or abuse of illicit drugs or controlled substances ... if disciplinary action is pending.
What Constitutes Unprofessional Conduct?

(k) Inappropriate delegation

Example: Asking the medical assistant to administer an injection in the clinic where you practice. Nurse may not delegate the administration of medications to any unlicensed individual.

(l) Failing to supervise delegated tasks

Rules, Chapter 7, Section IV(6)
What Constitutes Unprofessional Conduct?

(m) Practicing when unfit
   Example:
   • You are on call and had a glass of wine for dinner and were called to come into work.
   • You cannot make decisions due to physical, psychological, or mental impairment.

(n) Failing to use Standard Precautions

(o) Inaccurate or misleading employment history

(p) Failing a drug screen

(q) Acts of dishonesty related to practice of nursing
   Example: Use of the doctor title in the clinical setting - ACA§ 17-80-110-113
   Rules, Chapter 7, Section IV(6)
What Constitutes Unprofessional Conduct?

(r) Failure to wear name tag w/insignia
   - must have name and title clearly visible to patients and families

(s) Failure to repay ASBN Nursing Student Loan Fund
Nurse Practice Act and Rules do not regulate how this is completed, but reasonable judgment is expected in order to not be considered patient abandonment.
Terminating the APRN - Client Relationship

Best practice:

• Provide the client with 30-day notification in writing
• Provide medication refills during this 30-day transition
• Provide a list of local providers and a statement of your willingness to provide them (or the client) with the client’s medical records.
(7) Has had a license, privilege to practice, certificate, or registration revoked or suspended or has been placed on probation or under disciplinary order in any jurisdiction;

(8) Has voluntarily surrendered a license, privilege to practice, certification, or registration and has not been reinstated in any jurisdiction;
What to Report to the ASBN

(9) Has willfully or repeatedly violated any of the provisions of the *Nurse Practice Act or Rules.*

ACA §17-87-309
What happens if a complaint is filed against a nurse?

• All complaints must be in writing
  • No verbal or phone complaints are accepted.
  • May be anonymous.

• ALL complaints are reviewed by the ASBN Executive Director.
  • An investigation will be opened and assigned to an investigator to begin the investigatory process.

• The nurse is notified of the complaint filed against them and asked to provide the ASBN with a letter of response.
  • This letter may also include supporting evidence or documentation to defend themselves.
  • (HIPAA regulations are waived for licensing agencies that are conducting investigations for violations of the law).
What happens if a complaint is filed against a nurse?

- All evidence is reviewed; if no violation of the *Nurse Practice Act* or *Rules* is substantiated, case is closed without action and investigative flag is removed.

- If evidence supports a violation of the *Nurse Practice Act* or *Rules*, disciplinary action is taken.
Potential Disciplinary Actions

If a violation is found, action will be taken, based on the severity of the incident and circumstances.

- **Letter of Warning**
  - Not disciplinary action but puts the nurse on notice that the behavior is unacceptable and if it continues, may result in disciplinary action.

- **Letter of Reprimand**
  - Lowest level of disciplinary action and issued for minor violations such as falsification of an application, medication errors, documentation errors, etc.
What happens if a complaint is filed against a nurse?

• **Consent Agreement**
  • Legal agreement with specific terms related to probation. May or may not include a period of suspension.

• **Board appearance and subsequent discipline**
  • Occurs when the violation is of very serious nature or the nurse declines to enter into a consent agreement. Board has the ability to issue discipline from a Letter of Reprimand to Revocation of the license.

• **Voluntary Surrender**
  • The nurse chooses to surrender the license(s). Usually for a minimum of one year.
What happens if a complaint is filed against a nurse?

- **Cease and Desist**
  - An order by the Board to stop nursing practice in Arkansas. Usually used for nurses working on the privilege to practice and for imposters.

- **Summary Suspension**
  - An emergency action by the board to suspend a license without due process.

- **Revocation**
  - Loss of licensure which is permanent in the state of Arkansas.
Licensure is a privilege, not a right.
SECTION IV

PROFESSIONAL BOUNDARIES IN NURSING
Objectives

The learner will:

• Identify interactions with clients that are boundary violations.
• Describe the continuum of professional behavior.
• Discuss factors that might place a nurse at risk for crossing boundaries.
• Describe warning signs of a boundary crossing.
PROFESSIONAL BOUNDARIES

- The space between the nurse’s power (including prescriptive power) and the client’s vulnerability.

- The establishment of boundaries is the responsibility of the NURSE, not the client.
Risk Factors

- Vulnerability of client
- Has a nursing care need
  - The more physical and/or emotional distress the client is experiencing, the greater the risk.

Clients are reliant upon and trusting of the nurse.
Risk Factors

• Professional factors

  • Level of training; professional ability (prescribing)
    • The greater the educational level of the nurse, the less likely to cross the boundary.

  • Personal and professional stress levels
    • Increased levels of stress increase the likelihood of crossing the boundary.
Risk Factors

• Opportunity
  • Nature of nursing care
    • Close physical contact can make it difficult to maintain appropriate boundaries
  • Setting (homecare)
    • Little to no supervision
  • Long-term relationships with clients
Continuum of Professional Behavior

ZONE OF HELPFULNESS

Under-Involved

- Distancing
- Disinterest
- Neglect

Over-Involved

- Boundary crossing
- Boundary violation
- Sexual misconduct

Source: National Council of State Boards of Nursing, 2016 (NCSBN)
Zone of Helpfulness

Zone of helpfulness is where most interactions should occur

Under-Involved  ZONE OF HELPFULNESS  Over-Involved
Under Involvement

• Distancing
  • You attend to the client needs at a minimum level. You do the basics but there isn’t any additional interactions between you and the client.

  EXAMPLE: You administer the medications and fail to ask if the client needs anything else

• Disinterest
  • Not concerned with the issues at hand.

  EXAMPLE: Client isn’t eating anything at meal time and you make no attempt to find out why.
• Neglect
  • To omit, fail, or forbear to do a thing that can be done, or that is required to be
done. Also an absence of care or attention in the doing or omission of a given
act.

EXAMPLE: Failure to follow-up on diagnostic test order for a
patient.

(Black’s Law Dictionary)
Over Involvement

• Occurs when the professional exploits the relationship to meet his/her personal needs rather than the client’s needs

• There are three types of over involvement:
  • Boundary Crossing
  • Boundary Violation
  • Sexual Misconduct
What is a Boundary Crossing?

Brief excursion across a boundary with a return to the established limits of the professional relationship.

- Most common type of over involvement
- No long-term effects
- May be intentional or inadvertent
- May begin as a simple act of kindness or courtesy
EXAMPLE: Tommy, who is 18 years old, was admitted to the hospital with 3\textsuperscript{rd} degree burns of both hands. He feels bad about the way his hands look and believes that no girl will ever want to date him, much less hold hands with him. You spend a lot of time with him trying to cheer him up. He is refusing to attend physical therapy so you buy him an Atlanta Braves baseball cap since you know it is his favorite team. You make him promise to go to PT and you will give him the cap. He tells you he would do anything for you.

Is this OK?
Boundary Crossing

This was an brief intentional boundary crossing. This situation did not appear to benefit the nurse in anyway nor harm the client. This would be ok if:

- The nurse did not keep the hat a secret
- Did not give a gift of substantial value
- Did not withhold any information from the parents

Yes, in this situation
An intentional decision to deviate from an established boundary can enhance the therapeutic alliance in certain circumstances.

• CONTEXT IS EVERYTHING. What is appropriate behavior in one context may not be in another.

• The nurse must use appropriate professional judgment when intentionally crossing boundaries.
Boundary Violation

Characterized by:

- Role reversal
- Secrecy
- Meeting of nurse’s needs rather than client’s
Boundary Violation

Occurs when there is confusion of the professional’s needs and the patient’s needs.

- Implies harm to the patient
- Never acceptable behavior
EXAMPLE: An Arkansas school nurse, Jennifer, was arrested for supplying liquor to one of her students. She would meet the student at her house after school and drink.

• Instead of being an authority figure – she was trying to be his friend.
• Her nursing license was REVOKED
Sexual Misconduct

Often begins with an inappropriate comment or a touch to test the waters.

- Overt or covert expression of erotic or romantic thoughts/feelings/gestures.
- Early detection is critical.
- This is the extreme of over-involvement.
Types of Sexual Misconduct

• Harassment
• Sneaky Sex
• Sex by Fraud
• Romantic involvement
• Rape/Sexual abuse
Harassment

• Use of sexual language
• Unwanted touch

EXAMPLE – A patient stated:
• One time I was getting dressed in the whirlpool room when Mark came in to give me a shot. That is when he told me I had beautiful breasts.
• When he gave me a shot in the hip, he’d run his hand over my bottom and tell me how nice my skin tone was.
Sneaky Sex

Gratification obtained through:

• Illicit touch (frotteurism), or
• Secretive observation (voyeurism)

EXAMPLE: Paul was a CRNA who worked at different facilities. In 2009 a patient noticed a camera in the bathroom which was pointed at the commode. A search of Paul’s house revealed hundreds of videos from the bathroom camera and of him sexually assaulting patients while under anesthesia – at times with others in the operating room.
Sex by Fraud

Sexual gratification disguised as treatment

EXAMPLE: Unnecessary breast exams, pelvic exams, touching the genitals and improper examinations
Romantic involvement

May be consensual. Even if the client initiates the sexual conduct, a sexual relationship is still considered sexual misconduct.
Rape/Sexual abuse

May involve an anesthetized patient, use of drugs or hypnosis to diminish ability to resist, or forcible assault.

Example: Jose worked at a long term care facility. One resident, Carol had lost most of her memory from Huntington’s Disease. However she reported Jose raped her. Jose denied the allegations and the case was closed due to her mental capacity. Six months later DNA results came back which proved he raped her.
Are these ever right?

- Giving/Receiving Gifts
- Hugging a Client
- Loaning a Client Money
- Telling a Client About a Personal Experience
- Giving a patient your cell phone number instead of the medical exchange #
- Treating a member of your family

Good practice is NO

Depends on context of the situation

NEVER

Depends on context of the situation
The Nurse Practice Act and Rules do not specifically address this other than the APRN would still have to follow the law regarding documentation of care/prescription in the medical record.

**Best Practice:**
Have another provider treat them, especially when prescribing medications or controlled substances. Maintaining objectivity is far more difficult when treating ourselves and/or family members.

*Could you prove objective decision-making to a jury?*
Who is harmed by boundary crossing?

• CLIENT
  • Varies from embarrassment to depression, even suicide
  • Breach of trust is often more harmful than the act itself

• PROFESSIONAL
  • Loss of job
  • Disciplinary action by the Board of Nursing
  • Ruined career
Who is harmed by boundary crossing?

- **PROFESSION**
  - Negative publicity
  - Weaken the ethics of care
  - Altered perception of the profession

- **PUBLIC**
  - Erosion of confidence in the profession
  - Criminal offense
Warning Signs of a Boundary Crossing

• Excessive self-disclosure
  • The nurse discusses personal problems, feelings of sexual attraction or aspects of his or her life with the client

• Secretive behavior
  • The nurse keeps secrets with the client and/or becomes guarded or defensive when someone questions their interaction
Warning Signs of a Boundary Crossing

• **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**
  • 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 (giving gifts to the nurse, dressing up for the nurse, or waiting around to see the nurse)
Warning Signs of a Boundary Crossing

• Me and you against the world thinking
  • 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 the client
  • The nurse fails to recognize feelings of sexual attraction to the clients.
What to do if you suspect ....

- Consult with trusted supervisor.
- Document incidents.
- Be familiar with legal requirements for reporting to your Board of Nursing.

CLIENT SAFETY MUST BE THE FIRST PRIORITY
Prevention

• Identify high risk situations:
  • Isolated work environment.
  • Lack of direct supervision.
  • Long and intense nurse-client interactions.
  • Client fear brought on by illness.
Ask Yourself.....

- Whose need is being met by this intervention?
- Can I document this in the client’s record?
- Is this something I can openly and honestly discuss with a coworker or supervisor?
Ask Yourself.....

- Is this what other nurses do?
- Do I spend the same quality and quantity of time with other patients?
- Would I provide nursing service to other clients in this location?
- How does this look to others?
  (peers, family, supervisors)
Ask Yourself.....

• Does the gift giving create a sense of obligation on the part of the recipient?

• Is the gift of a personal nature, given to one nurse or a general gift to a group of caregivers?
GOLDEN RULE

Do or say nothing in private or public that cannot be documented in the patient's record.
Best Prevention is:

- **Be aware** - boundaries are the limits that allow for a safe relationship with a client. A relationship should meet the client’s needs. It is the duty of the professional to establish and maintain boundaries.

- **Be reflective** - an effective way to do this is through reflective practice, thinking about your professional relationships and learning from them. Use the continuum of therapeutic relationships to analyze practice situations.
Best Prevention is:

• Respect your “dis-ease” - if you are feeling uncomfortable with a client relationship, this is a good time to counsel with a trusted colleague, mentor, or supervisor

• Keep your client’s needs paramount - your client’s needs must always come first
What if....

Katie Smith, RN spends her day off running errands, cleaning house and preparing food for her home care clients, Mr. & Mrs. Higgins. They pay her a small hourly wage directly for this work.
Patty Brown, LPN, has been seen kissing Ben, a 26 year old quadriplegic patient. When asked about it she states he asked her to kiss him.
What if ....

Timmy Sky, RN needs help with his tax returns. He doesn’t understand the new tax laws. He asks his client, Ted Thompson, a CPA for assistance.
What if ...

Jon Keller, LPN, has been taking care of Cindy, an 8-year-old ventilator dependent girl, for the past 4 years. Cindy’s parents think Jon is the best nurse Cindy has. To express their appreciation they give Jon 2 tickets to the Super Bowl game.
Olivia Grace, APRN, offers to give John Gilbert a ride home because it is raining and he doesn’t have an umbrella. John is a client at the clinic where Olivia works.
Sheila Wells, RN, took care of Paul Kite while he was in the hospital. Paul always flirted with her. Three days after discharged, Paul called Sheila and asks her out on a date.
Cooling-off Period

The interval between the end of the professional relationship and the beginning of a business or personal relationship with the client.

Best practice is a cooling-off period of one-year
Additional Tips

- Limit physical contact to that which is therapeutic
- Limit social contact to on-duty time
- Avoid financial/legal dealings
- Limit self-disclosure to superficial information
- Avoid making your patient’s problems your own
Additional Tips

• Never engage in communications with patients that could be interpreted as flirtatious or which employ sexual innuendos, off-color jokes, or offensive language.

• Be aware of any feeling of sexual attraction to a client and NEVER act or discuss these with the client.


