# THE EXAMINER

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## In This Issue

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The Mission of the Louisiana State Board of Nursing is to safeguard the life and health of the citizens of Louisiana by assuring persons practicing as Registered Nurses and Advanced Practice Registered Nurses are competent and safe.

## FROM THE EXECUTIVE DIRECTOR

**As the Louisiana State Board of Nursing (LSBN) prepares to celebrate the 30th anniversary of the Recovering Nurse Program (RNP) this month,** we have chosen to highlight articles focusing on substance abuse in healthcare providers and how LSBN works with this population in recovery. This division monitors Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs) and student nurses through confidential agreements and disciplinary orders. The RNP was developed to protect the consumers of health care in Louisiana while allowing RNs and APRNs recovering from chemical dependency and/or a medical, mental or physical condition to maintain licensure while being closely monitored by the Board through a structured agreement or order. Participants are allowed to join the program confidentially if they meet criteria outlined in L.R.S. 3419 or through a consent order with probation if ineligible for confidential entry. After completion of treatment and clearance to return to work by the RNP staff and treatment team, the individual is allowed to practice in a highly supervised setting. Monitoring includes, but is not limited to, frequent random drug screenings, reports from employers, and participation in aftercare and verified participation in support groups such as Alcoholics Anonymous. In contrast to some independent alternative programs, the RNP is housed within LSBN, therefore any non-compliance or relapse, once confirmed, is acted upon swiftly often resulting in either immediate return for treatment or automatic suspension of the nursing license. This process offers greater protection to the citizens of Louisiana from potentially impaired practitioners. The added structure and accountability of monitoring programs such as RNP have been linked to greater success in maintaining abstinence. Relapse rates for the general public following treatment for chemical dependency are 40%-60% (NIDA, 2009) whereas the relapse rate for RNP participants at LSBN in 2015 was 3.9% translating to a recovery rate of greater than 96%. We have over 1500 graduates and current enrollees in the RNP program and we are proud to be a national model for intervention and treatment with these nurses, assisting them through successful recovery to maintain their professional practice.

**The 2016 legislative session** was a particularly active one for LSBN. We engaged in both lawmaking, changing the composition of our board to include consumer members, and rulemaking throughout this year. The following rule changes and Nurse Practice Act changes became effective in the 2016 legislative season:

- HB1161 was signed by the Governor and becomes effective on 8/1/2016. The bill amends RS 37:914 (B)(1), 916, 917, and 927 (A) and enacts RS 37: 920 (B)(3) eliminating the two physician ex officio members replacing them with two consumer members appointed by the Governor; mandates that at least one member of the LSBN board represents an Associate Degree program in nursing if such person is nominated and said nomination is forwarded to the Governor's office; and delineates the fee for licensure as not to exceed $100/calendar year.
- HB1007 was signed by the Governor and became effective on June 5, 2016 amending and reenacting RS 40:978.2(C)(1) and (D) through (F) and enacting RS 40:978.2(G) and (H) to authorize the storage and dispensing of opioid antagonists under certain conditions; to authorize any person to possess an opioid antagonist; to provide for an effective date; and to provide for related matters.
- HR244: To urge LSBN and the Board of Practical Nurse Examiners to study feasibility and desirability of merging the two boards.
- HCR107: Request the Department of Children and Family Services to convene a consortium of emergency care facilities designated in the Safe Haven Law to create and maintain a registry.
- HR230: Requests the Department of Health to convene a study group of select healthcare workforce stakeholders to enhance access to healthcare services in HPSAs.
- SCR65: Creates a Task Force on meaningful oversight to assure compliance with Supreme Court's decision in North Carolina Dental Board case.
- LAC 46: XLVII. Chapter 35 on Undergraduate and Graduate Nursing Education Programs rule change became effective on June 20, 2016.
- LAC 46: XLVII. 4513 clarifying CRNAs as exempt from CPAs was finalized on April 20, 2016
- LAC 46: XLVII. 4507 giving the Board discretion in approving APRNs that are grandfathered was finalized on March 20, 2016.

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- LAC 46: XLVII.3324 relative to students who falsify their applications being prohibited from reapplying or being allowed to take the NCLEX-RN for 5 years became effective May 20, 2016.
- LAC 46: XLVII. 3307 and 3309 related to RNs and APRNs being authorized to delegate medication administration to unlicensed assistive personnel in outpatient clinic settings became effective May 20, 2016.

**Finally, as noted elsewhere in this newsletter, LSBN will be under construction** over the next 18 months as we expand our offices in order to better serve the increasing numbers of RNs, APRNs, students, and nursing education programs in our state. Staff have already been relocated to a temporary building in our parking lot, the Board Room or working at times from home. Disciplinary Hearing Panels and Board meetings have been moved to the Holiday Inn Baton Rouge South at 9940 Airline Highway. Construction officially begins July 25, 2016 and we hope that you will have patience with all of us as we attempt to meet our constituent needs during this challenging time. Enjoy the remainder of the summer and stay cool.

For the Public Trust,

Karen C. Lyon

Karen C. Lyon, PhD, APRN, ACNS, $NEA_{BC}$
Executive Director

## Announcements

The Louisiana State Board of Nursing welcomes our new board member **Tavell L. Kindall, DNP, APRN**.

Dr. Tavell L. Kindall is a board certified family nurse practitioner. He is currently employed by the Greater Ouachita Coalition Providing AIDS Resources and Education (GO-CARE) in West Monroe, LA, providing HIV primary and preventive care to adult clients. Dr. Kindall completed his doctoral work at the University of South Alabama College of Nursing and has practiced as a professional nurse in a variety of settings including medical/surgical nursing, critical care nursing, emergency nursing, air medical transport, nursing education, and advanced nursing practice over the course of the past 18 years. He is active locally and nationally in multiple professional organizations for nursing. In his free time, he enjoys church, sports, community service initiatives, traveling, and spending time with close friends and family.

## LSBN Department Spotlight

In this edition of ***The Examiner***, we are introducing the team member of the ***General Counsel Department***. The department can be contacted at 225-755-7500.

**David Creighton Bolton** - The Louisiana State Board of Nursing is pleased to announce that Mr. David Creighton Bolton has accepted the position of General Counsel for the LSBN. Mr. Bolton began his work with the LSBN on April 21, 2016. Prior to joining the LSBN, Mr. Bolton worked in private practice, primarily medical malpractice defense for the Louisiana Patient's Compensation Fund, insurance defense work for Louisiana Farm Bureau, as well as, business and corporate formation and litigation. Mr. Bolton's litigation experience includes jury trials, first and second chair, and numerous arguments at the appellate level. Mr. Bolton comes from a family of RN's, including his mother and grandmother, and is honored to serve the people of Louisiana through his work for the LSBN. Mr. Bolton earned his Doctor of Jurisprudence degree from Mississippi College School of Law and Bachelor of Arts degree in History from Southeastern Louisiana University. Mr. Bolton has Bar admissions in Louisiana and admissions into the U.S. District Court Eastern District of Louisiana, U.S. District Court Middle District of Louisiana, U.S. District Court Western District of Louisiana and the U.S. Court of Appeals Fifth Circuit.

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# Drug Testing 101 for Healthcare Employers

by Barbara H. McGill, MSN, RN
Director, RNP/Monitoring

While I am not a Medical Review Officer (MRO), I did consult with two MROs, one of whom was instrumental in developing the MRO course, before embarking on this article. I wanted to share some things I have learned over the last 22 years about looking at drug screens for healthcare professionals. Why do we have drug screens in the workplace? Studies suggest that substance abuse—which includes drugs and alcohol—costs the United States an estimated $276 billion a year, with much of the cost resulting from lost productivity and increased healthcare spending.[1] Employees who use drugs are 2.5 times more likely than other non-abusing co-workers to be absent for eight or more days. Drug abusers are 3.6 times more likely to be involved in an accident at work and five times more likely to file a workers' compensation claim.[2] Forty-four percent of abusers have sold drugs to other employees. Eighteen percent have stolen from co-workers to support their habit.[3]

The term *drug testing* can be confusing because it implies that the test will detect the presence of all drugs. However, drug tests target only specific drugs or drug classes and can detect substances only when they are present above predetermined thresholds (cutoff levels). The term *drug screening* can also be deceptive because it is often used to describe all types of drug testing. However, *drug screening* is usually used in forensic drug testing to refer to the use of immunoassay tests to distinguish specimens that test negative for a drug and/or metabolite from positive specimens.[4]

First and foremost, we need to determine what substance is being tested for? If your hospital is using the National Institute of Drug Abuse (NIDA) 5, you are testing only for amphetamines (meth, speed, crank, ecstasy), tetrahydrocannabinol (THC) (cannabinoids, marijuana, hash), cocaine (coke, crack), opiates (heroin, opium, codeine, morphine), and Phencyclidine (PCP), angel dust).[4] The NIDA 5 does not test for synthetic opiates. Synthetic opiates include demerol, dilaudid, norco, lortab and others. Synthetic opiates are the most commonly abused drugs among the participants in the Louisiana State Board of Nursing Recovering Nurse Program (RNP). Approximately 47% identify opiates/synthetic opiates as their drug of choice. The RNP has received reports from hospitals indicating that they investigated a nurse for multiple narcotics errors involving dilaudid (number 1 drug of choice among nurses in the RNP). The hospital required a drug screen but it came back negative. The specimen was not tested for synthetic opiates. Even some collection sites have argued that the synthetic opiates are tested for, if the test says opiates, but that is not the case unless it says extended opiates or lists the opiates tested for. Fentanyl and propofol require special testing. It also would be appropriate for hospitals to use a medical professionals testing panel to include all the opiates and at lower cut-off levels than may be used in less "safety sensitive positions." Physicians, nurses, and other healthcare providers may cause patient harm if they are impaired. It is important to remember that persons can be impaired even if they have a legitimate prescription. The NIDA 5 also generally uses a detection level of 2000 ng/ml for opiates, well above the 300 ng/ml normally used in testing healthcare professionals.

Another thing to consider in drug testing is how the results get reported. LSBN recommends that organizations that employee nurses require the actual results of the test, not just the MRO determination. If the person being tested provides a prescription which covers a positive test, the MRO may report the screen as being negative. However, the Louisiana State Board of Nursing Advisory Statement Regarding Practicing While Taking Prescribed Narcotic Medication (September, 2010) sets forth guidelines for Registered Nurses who are taking prescribed controlled substances. The Advisory Statement encourages employers to develop drug free workplace policies which address the use of prescription medications. It includes that nurses should inform their employers if they are taking controlled substances. Employers may require certification from the prescriber that the prescription substance does not adversely impact fitness to do the job. Impairment at work due to prescribed medications is grounds for disciplinary action. If your hospital does not have a drug free workplace program, please consult the following website http://webapps.dol.gov/elaws/asp/drugfree/menu.htm for recommendations.[5]

Marijuana is still the most popular abused drug for non-healthcare workers. However, marijuana continues to be seen in pre-employment, random and post-accident drug screens in the healthcare workplace. The research that has been done on marijuana indicates that the metabolites are detected longer than most other drugs. Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that for single use of marijuana, the detection time in urine is 3 to 5 days. For moderate use (4 times per week), the metabolite is only detected for up to five days after the last use. For daily users, the metabolite is detected up to 10 days after the last use and for daily users using more than once per day, detection time may be up to 30 days or more.[4] Detection levels are generally set at 50 ng/ml. This level is used to avoid detection of passive inhalation. There are many synthetic marijuanas available today. If you are using a national laboratory, they can test for approximately 75 different types of synthetic marijuanas but the compounds change so frequently that the laboratories have a difficult time keeping up with new compounds.

Finally, I will close with just a few words about kratom, (Mitragyna speciosa korth). Kratom is a tropical tree indigenous to Thailand, Malaysia, Myanmar and other areas of Southeast Asia. Kratom has been used by natives of Thailand and other regions of Southeast Asia as an herbal drug for decades. Traditionally, kratom was mostly used as a stimulant by Thai and Malaysian laborers and farmers to overcome the burdens of hard work. They chewed the leaves to make them work harder and provide energy and relief from muscle strains. Kratom was also used in Southeast Asia and by Thai natives to substitute for opium when opium is not available. It has also been used to manage opioid withdrawal symptoms by chronic opioid users.[7] Kratom is sometimes used by healthcare workers and is gaining in popularity. There are urine drug screens available at some of the national labs. It currently is not a scheduled drug, but it is mood/mind-altering and addictive.

Nurses, physicians and other healthcare providers are entrusted with taking care of patients and if they are working while impaired, they could cause patient harm. The Louisiana State Board of Nursing and the Physicians Health Program have programs for nurses and doctors who develop the disease of addiction and in many cases these professionals can get help, be monitored and practice safely without disciplinary action against their license.

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# HEALING THE HEALERS

A series of conversations with Doctor C. on the brain disease of addiction

**Louis Cataldie, MD**
**Diplomate American Board of Addiction Medicine**

The Mission of the Louisiana State Board of Nursing is to safeguard the life and health of the citizens of Louisiana by assuring persons practicing as Registered Nurses and Advanced Practice Registered Nurses are competent and safe.

**Healthcare Cultures:** Healers hold a very special place in society. Of course we are not called "healers" anymore and nurses are not called "nightingales" anymore. Current society labels us as Health Care Providers (HCPs). We embrace and practice the art and science of helping people who have diseases and/or injuries. Registered Nurses are held in high esteem. They are also part of a healthcare culture that has been around since there were nurses.


Welcome to the Club: Years ago, when I was in medical school, I had the good fortune to train under the tutelage of a well-respected and very wise staff physician. During that time, he imparted several "pearls of wisdom" that have served me well over the years. One of those concerned the relationships that develop between members of the healthcare provider world.

> *"Son,"* He said sipping his pre-rounds coffee at 5 AM, *"You may have the ultimate responsibility for patient care but never think you run the hospital. Nurses run the hospital. And let me tell you something else. They can be your best friends or your worst enemies. They can make your life tolerable or they can make your life a living hell. And, if they say something is wrong with a patient, you better listen. Medicine is like an extended family. We may disagree and get angry but at the end of the day we are all about patient care."*

That was sound advice. From my years in various hospital settings, including being the Vice-President of Medical Affairs for a major multiple hospital system, I can attest to that truism. Indeed, I have passed it on to others. Physicians, nurses (including Nurse Practitioners and Certified Registered Nurses Anesthetists), physician assistants, and anyone else who provides life and death care to patients develop a special culture. We have our own esoteric language. We can communicate volumes to each other by a mere glance. We share common ethics and values. We work under the same stressful conditions. We hold ourselves to high performance standards. We worked hard to get where we are and we take pride in our professions and our achievements. We have purpose and we make a difference.

Nurses are the backbone of patient care and they do run the hospitals. Doctors know it, at least the savvy ones do. Administrators know it. Nurses know it. And most patients, and their family members, figure it out pretty quickly.

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Healthcare providers function within an ever changing, stressful, and often unforgiving environment in which 99% is considered a failing grade. You almost have to be in the healthcare field to understand some of those pressures. The price of failure is guilt and shame. Nurses develop a unique culture that bonds them together with other nurses and other providers.

**Carol C., RN, Pediatric ICU.** *"It is like you have to read each others' minds and anticipate the other person's next move. The stakes are high. As a matter of fact they are the highest in the world. We are talking about life or death decisions for a child. We better be able to trust each other and be a team."*

That culture extends beyond patient care. We tend to develop a sense of camaraderie and we tend to take care of each other. While this is a good thing, it can also be a bad thing.

**Why nurses become nurses:** There are multiple factors that make nursing an attractive profession. These include social prestige, financial security, expanding opportunities, and the satisfaction that comes with helping others. It takes a special type of person to become a nurse. When I ask nurses why they became nurses, the answers vary but the overwhelming majority rate patient care as number one. This is reflected in the level of care they give and the pride they take in their profession. Many of them were inspired by their own personal experiences with other nurses.

"I was impressed with the way the nurses cared for my mother."

"When I was sick in the hospital, the nurses made me feel safe."

"I wanted to make a difference in peoples' lives."

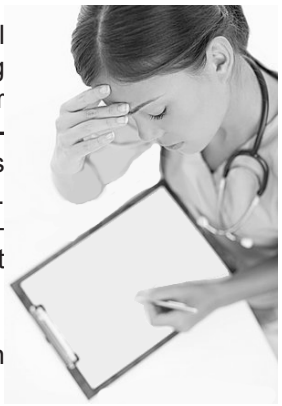
"My mother was a nurse and I wanted to be like her. It runs in the family."


Nursing is rewarding, but it is also a tough profession. And, like everyone else in the world, nurses get into problems with alcohol and drug dependency. Nurses have unique stressors and while they share some commonalities with other alcoholics and addicts, they have unique differences. This is about those issues.

**Colleen W., RN, Med-Surg:** Some nurses, like Colleen, get into trouble with mood altering substances before becoming nurses. Here is her story: *"I never was much of a drinker or a drugger for that matter. I had pretty good grades in high school, as a matter of fact I was in the top 10% of my class and I really did not have to study that much. I figured it would be just as easy in nursing school. Boy, was I wrong. I made a low "C" on my first test and went into panic mode. I was lucky enough to get in with a pretty good study group and that is when I got introduced to Adderall. Everybody was taking it. They told me about this Nurse Practitioner who was handing it out like Halloween candy. I went to her and answered a few questions that I had been prepared for by my friends. I walked out of there with a prescription and I would just go back whenever I needed more. She also gave me some Ambien for sleep. If I got too amped up on the Adderall and was out of the Ambien, I learned to take a drink or two to come down and sleep. I also found out that I could drink alcohol and not get too drunk if I took an Adderall before I went out. I guess that sort of led me into trying other stuff. Adderall really did help me study. It also helped me work extra shifts to pay off my student loans. I got to where I relied on the Adderall to work and the Ambien to sleep."*

The Board of Nursing referred Colleen to treatment due to the fact that she had diverted Ambien at work. She had been a Registered Nurse for six months at the time. Her supervisor confronted her due to medication discrepancies and when they insisted on a drug test, she confessed.

Colleen is certainly responsible for her behavior but she is also a casualty of "academic doping". According to numerous studies, use of Adderall in this type of situation increases risk for other drug use. Up to 96% of persons who use Adderall for non-medical purposes (academic doping is a non-medical purpose) use other illicit drugs.

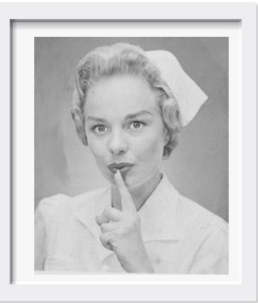


Colleen also exemplifies some basic tenets of drug abuse. She was made **aware** of Adderall academic doping by her peer group. There was definitely an atmosphere of **acceptance** among the student nurses in her study group. Her **assessment of the risk** from using was very low. Her peers were using it and all they reported were positive results. And, the drug was readily **available**. Once she used a controlled drug for non-medical purposes, she became a drug abuser. This also set the stage for her to continue the using behavior and to rationalize drug diversion (theft). After all, she used Adderall and Ambien before and got away with it, which means she could obviously handle it and those warnings were meant for people less knowledgeable than her. Why not divert that PRN Ambien that Mrs. Jones decided not to take?

The transition from non-medical use to diversion is often a subtle one. In Colleen's case, it started with her first dose of "academic dope".

**Drug Dependency is almost an occupational hazard** in nursing. The easy access and the fund on knowledge about the effects of medications can make nurses more susceptible to thinking they can "control it." Some areas of nursing are more high risk than others. Anesthesia is one of those areas.

**Gerald D., CRNA:** *"I went into nursing with the goal of becoming a CRNA and I made it. I love everything about it and now I may have thrown it all away behind my drug addiction. I should say my opiate addiction. I only use opiates. I rarely drink because I just do not like the feeling. But I loved that damn Fentanyl. I guess I loved all of it. When I was in high school, I fractured my femur and was given a prescription for hydrocodone. I really like it. Opioids energize me. It is like I can go forever. But, once the bone healed I got off the stuff and that was that. I am a good CRNA. Which means I am in demand. I took on another job at another hospital and I was burning the candle at both ends. I remembered how the opioids energized me. So I shot up a small amount of Fentanyl at work and I was off to the races. I could work 24 hours without any problems. At least that is what I thought. Then I started relying on it. I knew I was going to have to detox myself because when I got off I had withdrawal symptoms. I had it planned out but I got called out to work and I had to go in. So I hit up a little to get me by. But it was not enough and I started detoxing at the hospital. I decided to hit up between cases and they found me passed out in the bathroom. They gave me Narcan and that of course put me into acute withdrawal and now I am here in treatment. People at work were really surprised to find out I was a drug addict. I hid it well."*



Gerald may have hidden his addiction well. Nurse addicts are loners and nurses are smart. He became quite adept at deflecting questions from his peers.

*"I admit I came in looking pretty rough a few times but I just told everyone I was working too many shifts back to back. That was something we all understood. One time I was having some detox signs and I played it off like I had the flu."*

Gerald probably had some help hiding out. Nurses tend to cover for each other and they tend to discount obvious signs of addiction in their peers. They may not be comfortable confronting their suspicions. They may have a misplaced sense of loyalty. They may minimize any signs of impairment.

One of his co-workers later indicated that she was concerned about this behavior but thought he was just going through a bad time. She had covered up a couple of drug errors she caught and made it her duty to watch out for any "mishaps". She did not want to report him because she knew he was the sole support of his family and his aging mother. In short, she was enabling him through her silence.

Gerald also presents with another facet of addiction that may seem strange to some people. The opioid drugs energize him. They make him feel good and give him the energy to work long hours. The majority of people who take opiates medically for acute pain often report the opiates knock them out. People who get energized by opioids are obviously at high risk for opioid addiction.

Nurse anesthetists are not the only nurses getting into opioids. Where there are opioids, there is opportunity. If opioids are on the unit, the danger of diversion exists. But, you do not have to be a hospital nurse to be around opioids. Home hospice nurses and home care nurses are exposed to prescription opioids on a regular basis.

Plus, there is the ubiquitous "hallway consult" in which a physician quickly scribbles out a prescription on request from a nurse. If that does not suffice, the nurse can always try to forge a prescription. That behavior often turns out badly.

While nurses have access to various addictive drugs, they also have access to alcohol just like everyone else.

**Rita S, RN, Obstetrics:** *"I am here (in treatment) because my supervisor smelled alcohol on my breath. I had been drinking the night before and I did not stop soon enough. I knew I should not have gone in but I already had several absences and I know they were getting suspicious. I have gone in with a hangover and the shakes before. I take a 0.5 Xanax for the shakes and I can function pretty well. I just screwed up this time. I know I need to stop drinking but I cannot afford to be out of work. I am the breadwinner in my family. I am not like these other nurses. I do not divert drugs I do not take drugs except as prescribed. So I do not need inpatient treatment. All I need is outpatient or just monitoring. I tried to stop before but this time I have learned my lesson. You do not have to worry about ever seeing me here again."*

Rita has a long list of work problems. She comes in late or she calls in at the last minute. She has mood swings and has "snapped out" at patients. She is employed in a hospital that is short staffed and has difficulty getting nurses so there is the possibility that there has been some professional enabling by her supervisor. She is obviously fearful for her license but still wants to bargain her way out of inpatient treatment even though two facilities have recommended it. She does not see herself as an impaired nurse. The Board of Nursing disagrees with her.

Rita's life is chaotic. Her 17-year-old daughter wants to drop out of school and she is using marijuana. Her 13 year-old-son stays away from the house as much as possible. She admits feeling guilty about passing out on the couch instead of interacting with the children. Rita and her husband argue about almost everything including money. He drinks but not as much as she does. She gets very angry when he tells her to tone the drinking down. Her husband has been laid off and the family is in financial trouble. Without Rita's income, the family would be broke. Her relationship with her mother is turbulent. Rita's mother says Rita does not remember phone calls that she makes late at night. Her mother thinks she is depressed and needs to see a psychiatrist.

Rita fulfills all the criteria for a simple alcohol dependency screening tool called the **CAGE**:

**C** – People around her are expressing **concern** about her drinking.
**A** – She gets **angry** when confronted about her drinking.
**G** – She has **guilt** about her drinking behavior.
**E** – She needs an **"eye opener"** at times to ward off alcohol withdrawal. In her case, she takes a Xanax.

Rita's life has been falling apart for a couple of years. By the time a nurse displays alcohol or other drug induced dysfunction at work, the addiction has progressed to a significant level of severity. She needs treatment.

Signs of Addiction in the Workplace: There are many clues that a peer may be suffering from the brain disease of addiction. Unfortunately, co-workers often do not put all these clues together" until after some sort of crisis brings the nurse's addiction to the forefront. Here are some signs of addiction:

- Absence from the unit for extended periods of time
- Frequent trips to the bathroom
- Arrive late & leave early
- Excessive mistakes
- Medication errors
- Narcotic discrepancies
- Large amounts of narcotic wastage
- Frequent reports of inadequate pain relief by nurse's patients
- Offers to medicate co-worker's pain patients
- Altered verbal or phone medication orders
- Changes in appearance
- Diminished alertness
- Memory problems
- Abnormal pupil size
- Unexplained or unusual bruising
- Hand tremor
- Irritability
- Inappropriate verbal or emotional responses
- Isolation from peers
- Works at multiple facilities
- Jumps from one facility to another

**Treatment Issues in Nurse Recovery:** The number one barrier a nurse faces when confronted with the need for treatment is the fear of "loss of license." This is a real fear but it is not based upon sound fact. Boards of Nursing in many states have alternative programs. An alternative program refers to the fact that the Board allows the nurse to get help and be monitored rather than go through a disciplinary process. This is not a free pass. Alternative programs are in place to help the nurse as well as the public because these programs combat the conspiracy of silence phenomenon.

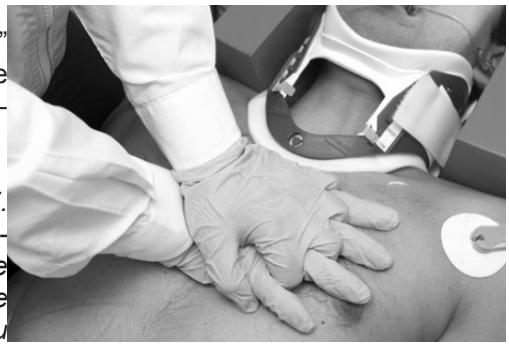
For example, the Louisiana State Board of Nursing has an alternative process that results in a 90% recovery rate for participants in its Recovering Nurse Program. If a nurse comes forward as a self-report, she/he may qualify for a confidential agreement. This generally calls for an evaluation, possibly treatment, and a monitoring process for several years. It is a win-win situation. The nurse gets help and the Board safeguards the public.

**Special Treatment Needs:** The addictive behaviors of nurses are generally not like those of non-medical addicts. As stated earlier, nurse addicts are loners. They are not in the "drug culture." They hide their addictions and they use in secret. Rationalization and intellectualization are generally prominent defense mechanisms. They also present with a great amount of guilt and shame, including professional shame.

One, criticism I have heard from uninformed people, including some therapists, is that special treatment programs tend to make healthcare professionals feel they are better than other addicts. In reality, the opposite is true.

I think this nurse's statements deflate that criticism.

**Jason H., trauma nurse:** *"It's not that I think I am better than other addicts, it's that I think I am worse. I knew I was doing wrong. I was in way over my head. But, I was afraid to reach out for help. I tried so hard to control it myself. I betrayed everything I stood for. I felt like I was betraying my patients because that is what I was doing. I was lying to my co-workers and my family. I was always afraid of getting caught so I kept others away. I kept telling myself that I am smarter and better than this. I am not."*



Jason is a good nurse and he is experiencing "ego deflation at great depth." He has violated a sacred code of ethics. He has violated the Nurse Practice Act and he has diverted narcotics, which is a felony. He, like many other nurses, has also practiced under extraordinarily stressful situations.

**Shirley P., RN, Emergency Department:** *"I remember my first CODE. We all do. I remember most of them prior to Ambien. If we were successful, a positive attitude permeated the unit. But, if we were unsuccessful, the team just sort of drifted away. Some of us would get together later at the local pub to decompress but we often avoided really talking about it. You know? It was not supposed to really get to us. You know? There was not room for self-doubt on our team. Or at least that was the unspoken rule. We would avoid the pain with alcohol and bravado. That did not work out well for many of us. Some of us ended up in treatment and some were not so fortunate.*

*I would go home and I could not sleep, especially with shift work. That is when the Ambien started. I became a zombie with that stuff. One of my biggest fears is that I hurt someone while I was numbed out on that crap. There is so much I simply do not remember."*

**Self-Medication:** Nurses who try to self-medicate negative emotional states, such as job related grief, are at high risk for addiction. Part of treatment is learning to deal with that pain and learning healthy ways to cope. That is best accomplished in healthcare specific groups in which others can relate to such unique stressors.

The list of unique stressors can seem overwhelming:

- **Shift work** –Inefficient sleep takes a heavy toll on many nurses. There are acute and chronic adverse effects to disrupting normal circadian rhythms, not the least of which is depression.
- **Burnout** – Nurses can suffer from all sorts of "Battle Fatigue" such as decision fatigue, compassion fatigue, and alarm fatigue.
- **Patient Load** - Between a nursing shortage and financial constraints, patient loads appear to be increasing.
- **Perfectionism** – Nurses are expected to give one hundred percent 24/7. It is an unrealistic expectation but a lot of nurses buy into it.
- **People Pleasing** – Being caretakers, some nurses fall into the trap of trying to please everyone. Since this is impossible, especially with disruptive patients' relatives, the nurse may feel inadequate. The need to "people please" may be related to family of origin issues such as being raised in an alcoholic family.
- **Administration** – There seems to be constant friction between the "bean counters" and the caregivers. Nurses often cast themselves in the roles of defending patients against the perceived "evils" of the administrators.
- **Disruptive Physicians** – Feeling powerless to deal with abusive physicians creates a hostile work environment. These doctors should be reported but they may also be protected by administration, especially if they are major admitters to the hospital.
- **Technological Advances** – The implementation of advances, including Electronic Health Records has proven to be very stressful for many healthcare providers.
- **Pain** - According to the American Nurses Association, 52% of all nurses suffer from back pain. Many of these nurses are prescribed narcotic analgesics. Some of them become dependent and some become addicted.

**Sara Jeanne A., RN, Physical Rehab:** *"I injured my back a couple of times but I did not let that stop me from working. The first time I was trying to transfer this big guy from his bed to a wheelchair on my own. The aides were tied up, because we are chronically short staffed. I knew better and I paid for it. I felt my back pop when he almost fell. I started taking Nonsteroidal anti-inflammatory drugs (NASAIDs) like I was eating M&Ms. Then I did it again on a very large woman. The orthopedist recommended surgery but I was afraid of that. He put me on some Norco and Flexeril. I could not sleep on the Norco so he added some Xanax at night. Then I was tired from shift work so my Primary Care Physician (PCP) put me on Nuvigil. I would take all that and go to work. I admit that on rare occasions I would have to take an extra Norco or a Tramadol that I got from my PCP, for the pain. I thought my work was fine but I fell asleep at work and they said I needed an evaluation for addiction. I am not an addict. I just did what I had to do to keep working. I am a single mom with three kids. You can do the math. I do not have time for surgery and rehab for myself."*

**Assets and Liabilities in Treatment:** Nurses are smart people. They have the ability to grasp concepts quickly. That can be a definite asset in treatment for addiction. It can also be a liability that presents in the form of intellectualization and "analysis paralysis". It is much easier to be objective rather than subjective early in the treatment process.

**Cathy M, Telemetry** (two months into treatment) addressing **Theresa B., NICU** (newcomer) in nurses' group: *"I did the same thing you are doing Terry. I would pick this brain disease concept apart and look for why I was not an addict. I would also over-analyze everything told to me in group. And I would want to debate it. We are comfortable living in our heads. Applying treatment to ourselves can be another matter. For me it was all part of my denial."*

**Compassion and Rescuing:** Nurses are trained to step in and rescue people. When someone is in distress, they try to make things better. That is a definite asset in the world of medicine but it can be a liability in a recovery group setting. There are times when other group members need to recall life events and behaviors that cause emotional pain. This is part of a process that allows the person to resolve painful issues that if not addressed act as triggers to relapse. Interfering with that process by trying to rescue the person from pain is non-therapeutic. In "mixed groups" (composed of non-healthcare professional patients), other group members may cast the nurse into the role of "co-therapist. It is "natural" for the nurse to accept this role. Subsequently, the nurse does not get the benefit of the group process.

**Secrets Kill:** Nurses are trained in confidentiality and they know how to keep things to themselves. They also are reluctant to share certain professional issues in "mixed groups". Indeed, there are things that should not be shared in mixed groups. Issues related to violations of patient care will be understood among peers. One of the prices of societal prestige is higher societal expectations and harsher societal response of failure to fulfill those expectations. Nurses entering recovery are generally filled with fear and shame. They are very unforgiving of self at times and they do not need to be pelted with more negative judgmentalism. They also need to be in treatment with other nurses who are progressing though the stages of recovery. This not only promotes bonding into the group but also instills hope.

**Understanding of Disease:** Nurses have the foundation to understand pathology. They can understand the brain disease of addiction. Like any other addict giving up their love object (alcohol or other drugs), nurses go through a grief process. But they grasp disease concepts and understand treatment plans. Addiction is a primary, progressive, destructive, and chronic illness. Once they apply these concepts to their own addictions and approach addiction in the context of chronic disease management, they achieve sobriety. About 90% of nurses do this and enjoy a life free of addiction.

If you are a nurse and have concerns that you may have a problem with alcohol and or other drugs I strongly encourage you to reach out for help. Addiction is a progressive illness and the consequences tend to worsen over time. Alternative to discipline programs exist to allow you to get help before experiencing some professional crisis.

If you are concerned about a nurse who needs help, I encourage you to educate yourself about addictions and to explore ways to help that nurse get help.

Check out the Recovering Nurse Program (RNP) on the Louisiana State Board of Nursing (LSBN) Website: http://www.lsbn.state.la.us

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# Continuing Education Requirements for 2017 Registered Nurse License Renewals

by Cynthia York, RN, MSN, CGRN
Director, RN Practice and Credentialing Department

Registered Nurse (RN) license renewal season begins in early October, 2016.

Now's the time to review the nursing continuing education (CE) you've obtained this year to ensure you have sufficient contact hours accredited by the American Nurses Credentialing Center (ANCC) or a specific U.S. State Board of Nursing (BON) that meets Louisiana State Board of Nursing (LSBN) CE requirements.

**What is my CE requirement to qualify to renew my Louisiana RN license for 2017?**
All Louisiana licensed RNs, except those issued a 1st time Louisiana license in the 2016 calendar year, **must** be in compliance with LSBN rules regarding annual nursing CE requirements that are accredited by either the ANCC or a specific State BON prior to renewing his/her RN license online.

A random CE audit is conducted each year in which 3 percent of all active licensees are selected to demonstrate compliance with the nursing CE requirement. Failure to respond or successfully pass the CE audit can result in the inactivation of the nurse's license and/or disciplinary action. Maintaining LSBN accepted nursing CE documentation for at least five (5) years is the responsibility of the individual nurse.

**How many nursing CE contact hours do I need each year to renew my Louisiana RN license?**

| Nursing Practice Level for Year | ANCC/State BON accredited CEs Needed |
|---|---|
| **Practiced nursing 1600 hours (or more)** within the calendar year. The 1600 hours is equivalent to 10 consecutive months of nursing employment at 40 hours per week | **Minimum of 5 contact hours** of **ANCC** or **State BON** accredited nursing continuing education required annually for license renewal |
| **Practiced nursing at least 160 hours, but less than 1600 hours.**<br>160 hours is the equivalent of 4 weeks at 40 hours per week | **Minimum of 10 contact hours** of **ANCC** or **State BON** accredited nursing continuing education required annually for license renewal |
| **Practiced nursing less than 160 hours** during the calendar year. This level includes nurses who are retired from active practice, had unverified nursing employment, self-employed, and/or had not worked during the year – but still wish to renew their nursing license for next year. | **Minimum of 15 contact hours** of **ANCC** or **State BON** accredited nursing continuing education required annually for license renewal.<br>**NOTE** - Nurses with 15 or more ANCC/BON accredited nursing contact hours do not need to provide proof of nursing practice hours verified by their employer if later selected for the CE audit. |

**What documentation do I need to obtain and verify before I renew my RN license?**

A certificate of completion for each nursing CE topic/course that includes all of the following information:

a. name of the CE provider/source
b. title of CE topic/training indicating it was nursing related
c. your name
d. number of contact hours awarded for completing the topic/training
e. date the contact hours were awarded in 2016
f. clear printed statement that the nursing CE was accredited by either the **ANCC** - *or* – by a specific **U.S. State BON**.

Click here to view sample CE certificates.

**Does training obtained through my place of employment count?**
Sometimes training obtained through your nursing employer may qualify, but do not assume. Look at each CE certificate of completion carefully for the information required to meet LSBN nursing CE requirements as explained previously.

An employer has the right to require certain training as a condition of employment, but only nursing CE that shows accreditation by the **ANCC** or a **State BON** on the certificate may be counted toward the contact hours needed each year to renew your Louisiana RN license. If you need to obtain additional ANCC/State BON accredited CE this year, you may find resources on LSBN's website by clicking here.

**Are there other ways to meet the annual CE requirement for license renewal?**
Yes – there are two (2) other methods by which you could qualify to renew your RN license:
1. If you attended school this year for a **post-secondary nursing degree** and were awarded academic credit in 2016 for coursework specific to nursing practice. To qualify for this option, the nurse must obtain an official paper transcript obtained directly from the school *prior* to renewing and be able to supply it to LSBN upon request if notified later that you've been selected to be audited. Student summary print-outs, electronic and/or 3rd party transcripts are not acceptable verification. One (1) academic semester hour in a nursing course documented on an official paper transcript is equivalent to fifteen (15) contact hours of ANCC/BON accredited nursing continuing education for annual license renewal.

2. If you hold a certification in a nursing specialty from one of the national organizations recognized by LSBN for CEs ***and*** the certification was current for the full 2016 calendar year, you may utilize the certification toward your CE requirement for license renewal. If notified that you've been selected to be audited, you would submit the letter (or card) from the national organization that includes your name, certification number, nursing specialty, date certification was issued/renewed and expiration date. A list of the national nursing certifying organizations accepted is available at the LSBN website under **Education / Continuing Education / National Nursing Certification Recognized by LSBN for CEs** or click here. Only the nursing certifications on this LSBN list may be utilized for license renewal in lieu of **ANCC** or **State BON** accredited contact hours.

**I was previously selected for the CE audit. Can I be selected again?**
Yes. Since all nurses must meet their annual mandatory CE requirements per LSBN rules prior to renewing, any nurse who has renewed his/her Louisiana license is eligible to be selected later by random audit. There is no limit to the number of times an individual can be audited for his/her CEs.

**My email and/or mailing address changed since 2016 licensure/relicensure. Can I update this information online?**
Once the 2017 renewal season officially opens in October, you will be able to update contact information during the online RN Renewal Application. If you have new contact information ***prior*** to the start of annual renewal, click here for the **'Address/Contact Change Form'**. Please complete the form and fax to LSBN for staff to update your contact information. Processing time is approximately 10 business days from receipt.

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## Major Motions and Other Actions Taken at the February 18, 2016 Board Meeting

**EDUCATION**

**Accepted** the Consent Agenda Motions

1. Louisiana Tech University – ACEN Follow-up Report
2. Intercollegiate Consortium for a Master of Science in Nursing – Post Master's Certificate Program
3. Schools of Nursing 2013-2014 Annual Reports

    1. Baton Rouge Community College
    2. Baton Rouge General Medical Center – Diplomas
    3. Bossier Parish Community College – ASN
    4. Delgado Community College – ASN
    5. Fletcher Technical Community College – ASN
    6. Louisiana College – BSN
    7. Louisiana Delta Community College – ASN
    8. Louisiana State University Alexandria – ASN
    9. Louisiana State University Eunice – ASN
    10. Louisiana State University Health Sciences Center – BSN
    11. Louisiana Tech University – ASN.
    12. Nicholls State University – BSN
    13. Northwestern State University – ASN and BSN
    14. University of Our Lady of Holy Cross – BSN
    15. Our Lady of the Lake College – BSN
    16. Southeastern Louisiana University – BSN
    17. South Louisiana Community College – ASN
    18. University of Louisiana at Lafayette – BSN
    19. University of Louisiana at Monroe – BSN
    20. Grambling State University – MSN
    21. Intercollegiate Consortium for a Master of Science in Nursing – MSN
    22. Loyola University – MSN
    23. Louisiana State University Health Sciences Center – MSN
    24. Northwestern State University – MSN
    25. Our Lady of the Lake College – MSN
    26. Southern University Baton Rouge – MSN
    27. University of Louisiana at Lafayette – MSN

**Accepted** the ANNUAL REPORT of the baccalaureate degree in nursing program at Dillard University and continue on conditional approval for a third consecutive year for noncompliance with LAC46XLVII.3523B.
And further, that the Board instruct Dillard University to submit interim progress reports to be reviewed at 2016 LSBN Board meetings.

**Accepted** the *ANNUAL REPORT* of the baccalaureate degree in nursing program at Grambling State University.

**Accepted** the *ANNUAL REPORTS* of the associate and baccalaureate degrees in nursing programs at McNeese State University and continue full approval for associate program and restore full approval to the baccalaureate program.

**Accepted** the *ANNUAL REPORT* of the baccalaureate degree in nursing program at Southern University at Baton Rouge and continue conditional approval for a second year for non-compliance with LAC46XLVII.3523B, and request that the Board conduct a site visit.

**Accepted** the *ANNUAL REPORT* of the associate degree in nursing program at Southern University at Shreveport and restore full approval.

**Accepted** the letter of intent from SOWELA Technical Community College, approve Step II and request to begin Step III for initiation of an Associate of Science Degree in Nursing education program.

**Accepted** the closing report submitted by Grambling State University to the Accreditation Commission for Nursing Education (ACEN).

**Did not approve** the University of Cincinnati to offer graduate clinical experiences in Louisiana for Adult Gerontology Primary Care Nurse Practitioner (MSN, PMC and DNP) pending licensure and credentialing of Adult Nurse Practitioner faculty.

**OFFICE OF THE EXECUTIVE DIRECTOR**

**Accepted** the LSBN Strategic Initiatives 2016-2019

**Accepted** the 2016 Directors Performance Metrics Dashboard Dr. Lyon has created

**NURSE PRACTICE ISSUES**

**Approved** for Board staff to proceed with rule-making for section LAC 46: XLVII:4513 including the substantive changes.

## Major Motions and Other Actions Taken at the April 14, 2016 Board Meeting

**EDUCATION**

Accepted the Consent Agenda Motions
1. LSBN Staff Program Status Reports
    1. NCLEX Report
    2. Accreditation Reports
2. LSBN Staff Visit Reports
    1. Dillard University - Focused Site Visit
    2. Baton Rouge Community College - 5 Year Accreditation Site Visit
    3. Sowela Technical Community College - Initial Site Visit
3. Accreditation Reports from Approved Programs
    1. Louisiana College - SACSCOC Action
    2. Louisiana Delta Community College - ACEN Corre spondence
    3. University of Louisiana Monroe - CCNE Progress Improvement Report

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4. Requests for Continuing Education Providership
    1. LA-MS Hospice & Palliative Care Organization - CE Approval
5. Requests for Continuing Education Providership
    1. Loyola University- Major Curriculum Change
6. Education Announcements
7. South Louisiana Community College Administrative Change

**Accepted** Dillard University's report and action plan regarding conditional approval status of the Baccalaureate of Science in Nursing education program.

**Accepted** Southern University Baton Rouge's report and action plan regarding conditional approval status of the Baccalaureate of Science in Nursing education program.

**Approved** status and approve the request of Herzing University to offer graduate clinical experiences in Louisiana until April 9, 2017 for the following roles and populations:

Family Nurse Practitioner (Master of Science in Nursing)

**Approved** Step II in establishment of a Master of Science Degree in Nursing Program for the role and population of Family Nurse Practitioner from Our Lady of the Lake College and permit progression to Step III .

**Accepted** South Louisiana Community College's request to withdraw

**Approved** Board staff to proceed with rulemaking for section LAC 46: XLVII Chapter 35 Undergraduate and Graduate Nursing Education Degree Programs.

**Accepted** the Declaratory Statement adding staff explore with legal counsel the issue of broader protection considering statutory relationship to what currently exists. The effective date of this would be April 14, 2016

**ADVANCED PRACTICE**

**Approved** Mr. Shinskie applicant for licensure by endorsement as CRNA.

**ADMINISTRATION**

**Accepted and Approved** LSBN Board Resolution to amend contract for legal services with Shows, Cali & Walsh, LLP as prosecuting attorney.

**RNP MONITORING**

**Approved** a change in length of the initial RNP contractual agreement from three to five years

## Disciplinary Matters

LSBN took a total of 27 actions at the March 9, 2016 hearing panel. For a complete listing click the link below:
March 9, 2016

LSBN took a total of 32 actions at the April 13, 2016 hearing panel. For a complete listing click the link below:
April 13, 2016

LSBN took a total of 97 actions at the June 15, 2016 hearing panel. For a complete listing click the link below:
June 15, 2016

## LSBN Construction

Please pardon our progress while LSBN enters a remodel phase for the next 12-18 months. At times we may have limited parking. We appreciate your patience during this construction phase.


## 2016 State Holiday Schedule

| | |
|---|---|
| Labor Day..... | September 5 |
| General Election Day..... | November 8 |
| Veterans Day..... | November 11 |
| Thanksgiving Day..... | November 24 |
| Christmas Day..... | December 26 |

## Future Board Meeting Dates

August 11, 2016
October 13, 2016
December 15, 2016