Lorie A. Brown, RN, MN, JD

LAW AND ORDER for NURSES

THE EASY WAY TO PROTECT YOUR LICENSE AND YOUR LIVELIHOOD

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THE REVIEWS ARE IN. READ WHAT YOUR COLLEAGUES ARE SAYING:

Lorie Brown's book, Law and Order For Nurses: The Easy Way To Protect Your License & Livelihood, is a delightful departure from a more usual approach to the integration of law into the practice of nursing. With her keen sense of humor and honesty, she provides the reader with an overview of the more pertinent legal issues that nurses face as they go about practicing nursing on a daily basis. The book is a treasure trove of actual experiences that Lorie and her clients have faced during Lorie's years of practice as a nurse, nurse attorney, and consultant. The reader can easily incorporate the insights she brings into their professional and personal life. Indeed, the book is filled with many GIFTS (Lorie's acronym that forms the basis of the theme for the entire book) that are easy to remember, easy incorporate into practice, and help the reader to achieve a more humane approach to the practice of nursing. The GIFTS also help the reader avoid unnecessary involvement in the legal system. That, in and of itself, is truly a gift.

Nancy J. Brent, RN, MS, JD | Nancy J. Brent Attorney At Law
"Brent's Law" Columnist at Nurse.com | Wilmette, Illinois

This is a "Knowledge is Power" book. The case situations and examples of nurse's getting into license violations and, the life-changing process that can follow, is quite sobering. Yet, the author follows the scenarios with systematic practical advice on how to take appropriate actions to protect your license and livelihood. This is a "must read" for every nurse.

Mevin R. Helmuth R.N.,M.N. Associate Professor of Nursing Goshen College and past President and Board Member of the Indiana State Board of Nursing

ABOUT THE AUTHOR

Lorie Brown is a Nurse Attorney, inspirational speaker, and author. Ms. Brown founded Brown Law Office in 1999 where she represents nurses and other health care providers before the licensing board. Ms. Brown is licensed in Indiana and Illinois and has co counsel relationships with other nurse attorneys nationwide.

For representation visit **www.brownlaw1.com**

Ms. Brown is also the founder of EmpoweredNurses.org where she is committed to giving nurses the tools that they can use to thrive in their profession so they can speak their mind, stand in their power and be a change agent to improve patient care all while legally protecting their license. By using these tools, nurses can rediscover the joy, passion and freedom that brought them into the profession that they slowly lose over time because of the current nursing culture.

For more information visit **www.empowerednurses.org**.

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The Easy Way to Protect your License License and Your Livelihood

LORIE A. BROWN,
R.N., M.N., J.D.

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To my children:

Evan, Jordan and Jillian for being my

best teachers. You have taught me how to love unconditionally,

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to create the changes in the nursing profession that I

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Preface: A Call to Help

Ever since I was a child, I wanted to be a nurse. When any of the other neighborhood kids had minor scratches, aches, pains, or boo-boos, I was the one they came to for help—they got attention and didn't have to cut their play time short with a visit home for their parents to patch them up. It wasn't something I planned or thought about, it was just me being me. I also was the regular babysitter, rescuer of stray animals, and I created an infirmary using all the toys in my basement.

My desire to help translated into visions of doing good things for others by studying and training to become a nurse. When I finally became a member of the noble nursing profession, I was ecstatic! I felt I could finally truly live my life's purpose—I could help people heal and feel better by giving the best care my training and enthusiasm could provide. However, shortly into my career, I sadly became disillusioned. I felt that I couldn't give the care I wanted to give, I couldn't because my hands were tied behind my back by things like rules, nursing culture, and even unit status quo—all things I didn't anticipate as an eager nursing student.

Regardless, I still wanted to help, so I continued my nursing education. I thought perhaps I could make a bigger difference as a Clinical Nurse Specialist or even by working in Administration. However, the same disillusioning problems followed me regardless of the position I was in. I even considered pursuing a doctorate in nursing, but was stopped with the questioning thought, "What was I going to do with the degree?" I really did not want to teach at that time, so why go after a doctorate? Instead, I made a turn and decided to go to law school. It's turned out that with that degree and my nursing experience, I still get to help people, only in a way different from what I expected.

As a professional woman, my identity is very much tied to my profession. There's a saying, "Once a nurse, always a nurse," and I find it apt. I naturally fell into representing nurses in need, usually malpractice matters and license defense. As I once felt passionately about being a nurse, it wasn't hard to empathize and imagine what these nurses were going through while their ability to practice nursing was in question.

So many nurses come to me and say, "I never thought I would get into trouble." Yet, there they are sitting across from me, crying with fear that they won't be able to continue doing what they love. Sometimes their stories are so compelling and heartbreaking that

it literally brings me to tears. Too many of the things these nurses face are never mentioned or taught in nursing school. Somehow, it is a rite of passage in a nursing career, and nurses are forced to learn these things the hard way and on their own.

I truly enjoy working with nurses and love helping them through difficult times. But, with so many of my cases, it also hurts me because I intrinsically know that I'm working with good nurses who care deeply about their patients. Too many of them shouldn't have to go through Board review or trials, but I know there's ultimately a reason, and what's on the other side will be better for them—they'll get a better job, or find a better work environment, or they'll end up do something making a change that will improve their lives and their future.

Don't get me wrong, not all nurses are created equal and not all of them are good; indeed, I have refused to represent my share of them. But most of my clients should not have been in trouble in the first place. However, under the law, "I don't know," is never a valid defense. With that in mind, I decided to write this book and share the stories and situations of some of the wonderful nurses I've represented and reveal the myriad ways in which nurses can slip into trouble. My hope is that you learn from these examples and never find yourself in an I-don't-know position that could

negatively affect your career.

One client told me, “I am so grateful that I have this job because it allows me to feed my daughter.” Nurses are not only the heart and soul of health care, but also of their families. By learning how to protect your license and your livelihood, you will avoid potential problems that could get in the way of you receiving the hard-earned living which allows you to house, feed, and care for yourself and your family.

This book is a culmination of more than two decades of my experience in representing nurses. However, I have no intention of going through each law, telling you what it is and how to comply with it—that’s long and tedious and won’t truly give you what you need. I tend to look at things differently, so I hope this book goes a little deeper than just written law. This book will take a look at some of the most common reasons nurses get into trouble and how they can protect themselves by avoiding problems in the first place. That way, you can focus on helping people and providing great patient care … after all, that’s why we all went into nursing in the first place.

~Lorie Brown, R.N., M.N., J.D.

Introduction: Oh, the Troubles I've Seen

I have over 30 years of combined experience as a Registered Nurse and an Attorney, and I've spent my entire career advocating for other nurses. I've seen a lot during those years and it breaks my heart when good nurses are unnecessarily disciplined, resulting in damaged careers and/or fewer good nurses taking care of us when we're ill. One common misconception is that only impaired nurses, ones who use controlled substances, appear before the Board. The vast majority of nurses I represent do not have these types of issues.

While, of course, protecting my clients' identities, I am able to share these stories with you because everything before the Nurse Licensing Board is public record. The Board actually files charges against a nurse who holds a license. These stories will surprise you and may even shock you. You may find yourself thinking, "How can anyone get in trouble for that?" Many of you may have even acted similarly and regularly apply the same practices, but have fortunately never gotten into trouble over it.

Remember, there are degrees of trouble. There are criminal mat-

ters in which jail time is a possibility and one's actual freedom is at stake, civil matters like medical malpractice where money damages is owed, and administrative matters where one's license and ability to practice nursing may be curtailed in some way. This book is going to focus primarily on the administrative matters before the Nurse Licensing Board (also called the Nursing Board, Board of Nursing, and Licensing Board … all the same administrative body regulating the practice of nursing.)

There are many scenarios in which nurses are incorrectly and unnecessarily disciplined. In the past 30 years I have seen nurses brought before the Board—or criminally charged—for reasons large and small.

I have seen nurses accused of *abuse* for:

- Speaking loudly to a hard-of-hearing patient.
- Encouraging a patient to walk ten feet to the bathroom after the nurse received orders by the doctor to encourage the patient to walk.
- Removing a patient's hand from a Foley catheter the patient was trying to yank out.

I have seen nurses accused of *neglect* for:

- Failing to answer another nurse's patient's light when the

nurse caring for the patient said *she* would get it.

- Having a patient die on their shift because the aide on duty did not give correct information to the nurse.
- Sending a patient to the morgue without cleaning up a BM she didn't notice, even though the other nurse in the room was aware of it and failed to take action herself (this other nurse was not accused.)

I have seen nurses *disciplined* for:

- *Practicing medicine without a license* when she received a telephone order instructing her to give a medication at a certain dosage which she misinterpreted even though that dose was still appropriate in the patient's case, and for which the patient benefitted from the medication and suffered no ill effects.
- Fraudulent Misrepresentation on their renewed license application because the nurse forgot to include past discipline for an attendance problem.
- Medication errors that were the result of the nurse being floated to a unit with which they were unfamiliar, and subsequently being required to accept an assignment for which they were not properly trained.
- Forgetting to renew their license on time because the Board

was no longer sending reminders.

I have seen nurses encounter licensing problems around *needed medications*:

- One nurse was ordered to cease taking Provigil—a medication used to treat narcolepsy—in order to have her probationary license status lifted. Seriously, would the Board rather have the nurse fall asleep on the job?
- Another had to stop taking Adderall, an ADHD medication that the nurse relied upon to maintain her focus while assisting in surgeries—not a place anyone should want an unfocused staff member! But it was required in order to have her probationary license status lifted.
- Another nurse had her license suspended for taking a narcotic medication to manage chronic pain, even though she worked from home on telephone wellness consultations and never performed hands-on patient care.

I have seen nurses *terminated* for:

- A HIPAA violation—another nurse's patient's medical record was on her computer screen for a total of 17 seconds.
- Being the most senior nurse on staff and earning the highest salary.
- Making suggestions that rocked the Unit culture or sta-

tus-quo boat.

I have seen nurses *criminally charged* for:

- Failing to give a patient an important medication; the case against her made it appear as if the nurse acted intentionally. (The nurse was acquitted of all charges in a criminal jury trial but the Board still took action against her license).

As you can see, I've dealt with a variety of situations and scenarios in which nurses are put under scrutiny, humiliated, disciplined, or even terminated for simple misunderstandings, small mistakes, trivial issues, and often things completely out of the nurse's control as well as situations in which a nurse acted wrongly and/or criminally (extenuating circumstances or not.) And the thing you must remember is that once any charges from the Nursing Board are filed, the case becomes public record and available for the whole world to see—and every potential employer to review.

I practice and represent nurses in Indiana, but I think the laws are similar in other states, as many are now following the Model Nurse Practice Act throughout the country. Keep in mind, this book is not meant to replace competent legal advice, but rather to empower you with answers, help you know when to ask questions

and/or get help, and prevent some of these troubles from happening to you so as to enable you to provide the best possible care for your patients.

For your copy of the Model Nurse Practice Act, go to http://www.lawandorderfornurses.com/resources.

Do I Know You? The Problem with Nurse Licensing Boards

Although I love my job helping nurses, it upsets me greatly when I find myself needing to represent nurses who have been charged in situations that could have been avoided or in which the Board should never have taken action. There is such a disparity in how nurses are treated before the various state licensing boards, that it can be difficult for a nurse to know when she's doing something that could jeopardize her license. Sometimes actions are obviously wrong, but sometimes it's not so clear. Here are some examples of sticky, tricky, and unclear situations:

- In Texas, if you get a DUI, the Board does nothing. However, if you get a second DUI, the Board will take disciplinary action.
- In Indiana, the Board wants to know the facts and circumstances surrounding the first DUI and then requires an evaluation to ensure you're safe to practice. If you get a DUI close to your license renewal, you will be treated differently than if

you received a DUI shortly after your last renewal and then went without problems. While I love that the board is cautious and wants to make sure nurses are safe to practice, I do have concerns about the methodology of their actions.

- If you take any controlled substance for a prolonged period of time rather than episodic use like after surgery or an injury, you may be put into a monitoring program and you will be required to get off all the controlled substances. I had one nurse who, while working surgery, took Adderall for ADHD. She needed the Adderall to help her focus to do her best job. The board's response essentially was "you cannot use controlled substances while in monitoring."
- In another matter, I represented a nurse who took Provigil for narcolepsy. Certainly, you would want your nurse to be awake and alert when she works her shift. But, again, the Indiana board requires adherence to a regulation demanding an abstinence-based monitoring program which prohibits a nurse from taking any controlled substance.

Nursing is an incredibly physically demanding and difficult profession. Many nurses end up experiencing chronic pain in their back, neck, etc., due to the heavy demands of the work—

especially older nurses who've been practicing for a long time. The only way they feel they can get through their day is to take controlled substances. Although medically a person's body can grow accustomed to taking controlled substances so that it doesn't have an impairing effect on their mentation, the Board, at least in my state, is very adamant on this topic, that no nurse should take controlled substances. And, if the nurse *does* take a controlled substance, the Board will require that the nurse go on monitoring. It's a double-edged sword that traps many nurses.

In the past, Nursing Boards allowed the facility for which the nurse works to manage whatever disciplinary actions they deemed reasonable and necessary and allowed them to rehabilitate nurses by providing whatever continuing education or help the facility thought was needed. However, lately the Nursing Boards have usurped the healthcare employers and now disciplines nurses directly, often requiring monitoring through probation, continuing education, or even both. Aside from impersonal treatment and punishments, another repercussion of the Board managing disciplinary actions is an increase in local and state taxes—when the Board is busier, it requires hiring more staff to work in the licensing area.

With the Boards acting as aggressive as they have been lately,

I am increasingly concerned that people will be dissuaded from becoming a nurse, or leave the profession because they are fed up with this type of "big brother" oversight. If smart and skilled people choose to opt out of pursuing a nursing career or continue to leave an established nursing career, who will take care of us when a nurse is needed in the future?

There is a fine line between ensuring that nurses are providing adequate care and invading the lives of perfectly good nurses because of simple misunderstandings. In at least 33 states, the Nursing Board is appointed by the Governor, whose ideas are often reflected in the makeup of the Board itself. If we have a conservative Governor, the Board tends to have conservative members. If our Governor is more liberal, the Board tends to allow the health care employers to do more of the discipline. Oftentimes, it is political influence or the public's outlook of the government that sways and determines how Nursing Boards conduct themselves—whether or not they allow the employers to deal with disciplinary situations in a manner appropriate for their facility and culture, or whether the Board will take on passing judgment on a nurse for whom they have no personal knowledge, but only what they've read in a report.

While I love helping nurses, I feel much frustration around

this situation. So instead of continuing to defend nurse after nurse individually in front of the Nursing Board, I want to empower all nurses to thrive in their own practice, and teach them the key laws they need to fully understand in order to effectively protect their nursing license I don't want to see any more good nurses disciplined for arbitrary misunderstandings or mistakes.

Nursing makes up the vast majority of the healthcare workforce yet has zero percent of the power. Why is this? Is it because we're a female-dominated profession? Or are there certain personality characteristics inherent in nurses that allow us to be treated as just another hospital employee rather than the skilled professionals we are?

I have found there are many commonalities in the nurses I've represented over the years. They tend to be very caring and dedicated to their profession, and every one of them, in one fashion or another, told me they never thought they would be brought before the Licensing Board.

In an attempt to determine why these nurses were getting into trouble, I sat down and made a list of those similarities. The pattern I saw was that there are certain ways of being that empower nurses and certain ways of being that allow nurses to get themselves into trouble-prone situations. I put these empowering ways

of being together and called them "GIFTS."

When empowered nurses use their GIFTS, they are able to stand in their power, speak their mind, and be a change agent to improve patient care. When empowered nurses do **not** use some or all of their GIFTS that is when they are more likely to experience a problem and get into trouble.

You're probably wondering, "What are these GIFTS and how can I get them?" Well, you are already in possession of them:

- **GIVING.** Empowered nurses not only give to their patients but they give to each other as well. They look for what is wanted and needed on the nursing unit and take care of it because they act like a team—everybody matters.
- **INTEGRITY.** Empowered nurses are authentic and are true to their word. If they say they are going to do something, they do it. They are honest with strong moral principles. They are a leader on their unit and their actions are conducted with the utmost integrity.
- **FOLLOW THROUGH and FOCUS.** When an empowered nurse performs a task—whatever that might be, large or small—she's focused on the details and will follow through to make sure everything is okay. For example, when

she gives a patient pain medication, she follows through to ensure it's effective. Empowered nurses follow through on everything they set out to do.

- **TRUST.** Empowered nurses are not only trustworthy, but they also "trust their gut", that little voice inside of them that says, "this patient doesn't look right … something is going on." And they listen to and act on that voice.
- **SOURCE.** Empowered nurses realize that they are the source of everything that happens on their unit. They realize they can create the positive things that happen on their unit as well as the negative. By being the source, they stand in their power to create positive changes.

Although you already inherently possess these GIFTS, it is like a muscle that needs to be developed through practice. It's easy for me to see in retrospect which GIFTS were not being used by my clients. Throughout this book I will refer to these GIFTS to show when nurses do not use their GIFTS, problems can occur.

Chapter 1:
You Mean Nursing Isn't What I Thought it Would Be?

I graduated from nursing school and took my California Boards (long before the National Council Licensure Examination (NCLEX).) After passing the Boards, I was fortunate to be invited to interview at seven different hospitals, and even more fortunate that each came with a different job offer. Each offer allowed me to pick the unit on which I wanted to work. I chose a medical/surgical unit at a hospital in Santa Monica, California.

Early in my career, I recall that a patient on the floor coded.

While the more experienced nurses responded to the code, I was assigned to watch the other patients on the floor. One nurse came out of the code room and asked me to get some items from Central Supply. I agreed and immediately went to the phone to call Central Supply and asked them to deliver the necessary equipment. The voice at the other end of the phone said, “We don’t deliver!” The answer shocked me—it was the last thing I expected to hear. I couldn’t believe that while a patient’s life was at stake, the necessary lifesaving equipment could not be brought up to the floor to help.

Evidently, my shocked disbelief caused me to speak in an unpleasant and undiplomatic way during the phone exchange and I found myself in the Head Nurse’s office the next day. She talked to me about my attitude and the overall manner of my phone conversation with Central Supply. I was then shocked again because I couldn’t believe I was getting in trouble for the phone conversation—our dialogue certainly, unpleasant or not, had no impact on the patient’s well-being.

The Head Nurse said that Central Supply doesn’t deliver and that’s just the way it is. Apparently all of the nurses in the hospital knew this except me. I was never told this when I was hired or trained. And all I could think was, why in the world would Central

Supply not deliver lifesaving equipment when no one else was available? And most importantly, why would the nurses put up with this grossly ineffective and potentially life-effecting arrangement?

Central Supply in that particular hospital was located in the basement. Administration, focused on their bottom line rather than the real logistics, evidently thought it more efficient to send a nurse down to Central Supply, rather than hire a tech, unit clerk, runner, or an orderly to run downstairs to do so, regardless of what the situation on the nurse's floor might be. A patient's life could be in danger, and this administration couldn't see that having the nurses run up and down to Central Supply and carry the equipment that could determine the fate of a patient might not be the most efficient way to go about it. Not to mention, registered nurses tend to have the highest-paid salaries in the hospital—not a good use of their time and skills.

This was one of my first "in trouble" learning experiences. It was the first real-life example that made it clear to me that things weren't quite right in nursing. In this particular incident, rather than give me the needed knowledge about the process, or pointing me toward a resource to help me better communicate with other departments, I was given a verbal warning and told to be more

pleasant and less demanding—regardless of whether or not a patient's life was on the line.

I must admit, at this point I became bitter, disheartened, and angry about the situation. I kept thinking, why aren't nurses treated better? Why are they given such menial tasks when they have trained so long to fulfill more pressing matters? It just didn't make sense to me. We'd never see a doctor take a patient to a room, or even take vital signs—it's always the nurse. Doctors come in, assess the patient, dictate orders, and then leave. When the patient returns for a follow up appointment, the doctor sees how his interventions worked or didn't, and evaluates the results. I mean no disrespect to doctors; I just wish people gave nurses the credit they deserve for all the work, care, and attention they provide.

It took me years to realize I was not using my GIFTS in my interaction with Central Supply. I was not *giving* to the person on the other end of the phone; she was just relaying to me what she'd been instructed to say. I was not in *integrity* because I violated my own moral principle of always treating others with respect and dignity. How could I *follow up* on my commitment to the other staff to get the supplies if I was getting nowhere on the phone? I was not *trusting* nor listening to my gut when it said I wasn't getting anywhere arguing with Central Supply and that it was time

to figure out another way to get the needed equipment. I was not the *source* of a solution to the situation: getting the equipment. Instead, I was spent my time reacting to the person on the phone rather than being focused on procuring the equipment. This was a recipe for disaster. Had I known to use my GIFTS, I'm sure I would have handled things differently. If I stepped into my power and became the source, I could have figured out another way to get the equipment at that moment, and then later dealt in a more powerful, effective way with the system-wide problem of Central Supply not delivering rather than arguing with the defenseless Central Supply employee who was just doing her job as instructed. Using your GIFTS to learn how to be an effective change agent takes practice, but the tools work if you use them and they can save you from getting into trouble.

I have been asked many times why I went from nursing to law. I went into law because I was disillusioned with nursing—too many issues needed common sense resolutions and too many nurses were wrongly being called before the Board. I now joke that as a nurse, doctors told me what to do; as an attorney, I tell the doctors what to do. But even in my law practice, I still perform the same process I was trained to do in nursing—assess, plan, intervene, and evaluate. When a patient is lying in bed and you only

have symptomatic information and history, assessment, planning, intervention, and evaluation are needed. There’s no neon sign over a patient’s head flashing, “Appendicitis,” “Subdural Hematoma,” or even a nursing diagnosis of “alteration in comfort”. Similarly, when clients come to me, they also don’t have that neon sign over their head flashing, “falsely accused,” “drug-addicted,” or “insufficient training.” I can’t judge anything about them or their case until I analyze the situation. It’s the same process as in nursing. Before anything else, I assess, plan, intervene, and evaluate!

LAW AND ORDER FOR NURSES

Chapter 2:

Stop Hurting Your Brothers and Sisters— The Issue of Nurse-to-Nurse Abuse

When I entered nursing more than three decades ago, I heard the disturbing phrase, "nurses eat their young." I was startled, to say the least. It's not as if I took it literally, but I thought this was a horrible thing to say about people who are committed to caring for others and doing good in the world—and what's more, almost every nurse I've talked to through the years knows this phrase. When starting this book, I "googled" the phrase to find out if it's still being used, and sadly discovered it is a pretty common saying

among nurses across the country. The phrase reflects the culture of senior nurses abusing new nurses on hospital floors, nursing homes, or in nursing schools. In fact, there's even a book on the matter entitled *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other* by Kathleen Bartholomew. Personally, I find this phrase and behavior puzzling. Call me an optimist, but I thought that nurses whose entire careers depend on teamwork and camaraderie would tend to be supportive of each other and be happy to assist their peers just as they do their patients … applying and living the *giving* part of the GIFTS. Instead, there is an unhelpful and damaging culture among many nurses. I'm continually amazed to see how some nurses consciously backstab, intimidate, and sabotage a new nurse on staff or the floor (who will inevitably make mistakes) rather than mentoring, encouraging, and properly training the new nurse. (I doubt this is you or you would not be reading this book.)

Floor nursing can be a truly difficult position. Nurses are asked to work ever-changing shift schedules, holidays, and of course, long hours. Stable patients can become unstable in seconds. Doctors show up unexpectedly, throwing off established routines and processes, and staff absences require nurses on the floor to pick up the slack and care for the absent nurse's patients—and still pro-

vide good care for their own assigned patients.

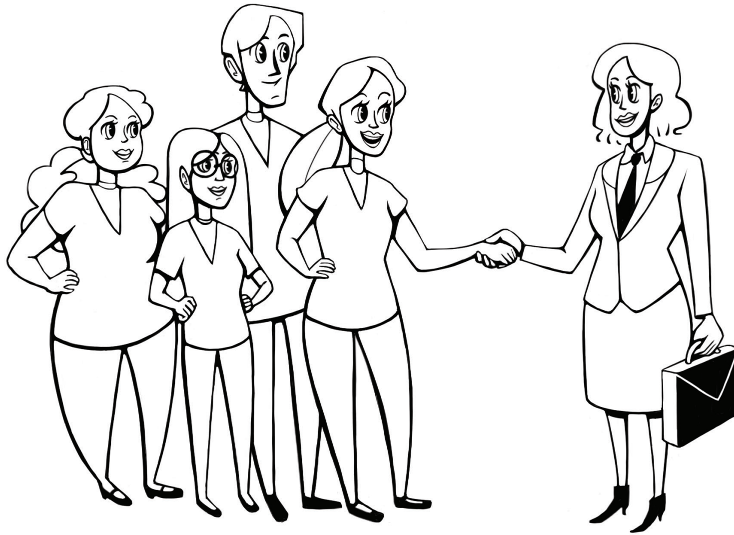
Regardless of how difficult nursing is, it's unbelievable to me how many nurses continually harass each other, and so few have the courage to speak up against the abusive harassment, which speaks to the *integrity* part of GIFTS—possessing the moral character to stand up and speak up when you see a problem that can be hurtful to someone else. It's unfortunate, but statistically speaking, most nurses won't think twice about one nurse mistreating another. We'd never remain silent if it were patients being abused, so it begs the question, why do nurses mistreat each other and allow themselves to be harassed this way?

I liken nurse-to-nurse abuse to what often happens in high school—as the new, young freshman, it's hard to understand why the senior upperclassmen viewed us with such disdain, yelling, "Fresh meat!" as we pass in the halls, or worse. But then a few years later, along comes our own senior year and suddenly, messing with the new freshmen just seems right. I can only surmise that the nursing environment must be functioning the same way. But by allowing such misconduct over the years, all we've done is foster an environment and culture that not only accepts abusing the newer nurses, but makes it okay.

So how can we change and reverse the nurse-to-nurse abuse

culture? Well, first we have to change the nursing environment by fostering relationships and work places in which nurses can happily practice and thrive alongside one another, and be treated with both dignity and respect. The following chapters will begin to give you some ideas—in the act of empowering yourself to protect your license, you'll learn how to use your GIFTS and become an agent of change.

LAW AND ORDER FOR NURSES



Chapter 3:
A Second Chance—Why All Nurses Deserve Representation

One common misconception about nurses who are called before the Nursing Board is that they are all abusers of drugs or alcohol. Now I know, of course, that there are some nurses called before the Board for drug use or abuse, but by no means is it all encompassing. Initially, I actually refused to represent those who were “impaired”, in other words, nurses who were in trouble for inappropriate drug or alcohol use. These nurses still deserved representation, but at the time I just didn’t think I could help them.

My viewpoint is that when I defend a nurse, I am pledging my own word that the nurse I represent will never be called before the Board again for a similar issue. My thoughts were that if I attempted to always keep this promise, it could cause problems if nurses I previously represented continued to get into trouble for the same exact issue. All I could think was, how could the Board trust me in the future, especially when looking at nurses who I truly believed would never make the same mistakes, yet did anyway?

However, I soon realized my own misjudgment. Most nurses called before the Board for a substance use or abuse problem are willing to change. So, as the years went by, I grew more and more willing to help nurses who showed they were willing to help themselves. Just by virtue of reading this book you show a willingness to help yourself, and in turn, help the profession and your patients.

Don't Walk the Plank Alone—
Why Nurses Need Attorneys

I am greatly concerned by the fact that there are nurses who appear before the Board who do not hire an attorney. Most nurses would never think to hire an attorney. Why? Because the Board is composed of nurses and they would understand the accused nurses. Appearing before the Nursing Board is a legal proceeding resulting when formal charges are filed, and everything that takes place is documented by a court reporter. The Board acts as a tribunal to determine the future of your nursing license; in other words, the Board determines the fate of your career, and your very livelihood is at stake. If you had criminal charges pending against you, would you defend yourself? If your freedom was at stake, you would never consider not hiring an attorney. In fact, I'd wager you would more likely be planning to do anything and everything within your power to keep your freedom. If I was in that position, I know I'd want the best attorney I could find, and I'd willingly follow any advice he/she offered which would help me. Would you do different?

Sometimes a nurse will say to me, "Why should I hire you if the outcome is going to be the same as if I didn't?" No outcome can ever be guaranteed, but I do know that an attorney can hold your hand, walk you through this difficult process, and help ensure the best possible outcome.

A nurse who represents herself has a fool for an attorney! Believe me, I speak from experience. I have needed to represent myself in the past, and rued the decision to attempt it on my own. Not necessarily because of the outcome (don't forget, unlike most nurses before the Board, I AM an attorney!) but because of the stress and the toll self-representation took on me. Hiring an attorney to guide you through the process is crucial. Not only do attorneys take care of the complicated legal aspects and develop a strategy, they'll be there to tell you exactly where to go, what to expect, how to dress, what you will be asked, what documents you need, etc. An attorney can make a scary, unfamiliar, and intimidating process much easier and much less stressful. And just as you wouldn't want an OB/GYN operating on a brain tumor, the same is true of attorneys. You want an attorney that regularly practices before the Nurse Licensing Boards. To find a nurse attorney in your state, check out The American Association of Nurse Attorneys at www.TAANA.org.

There are several very common reasons why nurses get into trouble (see Chapter 8), but most nurses who hire me aren't "frequent fliers"—they're not getting into trouble over and over again. *Almost every nurse I have represented has learned from the process and is now better off than they were before.* After working with me, they now know how to avoid similar problems in the future and they absolutely know exactly how to protect themselves so they will not find themselves defending their license again in front of the Board.

When you find yourself in a bad and challenging situation, you can look at it in one of two ways. You can choose to be a victim and see yourself as cursed by poor circumstances, moping around wondering how the world can be so cruel. Or (and I sincerely hope you choose this way) you can come to terms with the fact that inevitably in life and in our nursing careers a difficult situation or crisis will arise—it happens to the best of us. This allows you to look at the situation as a learning experience—something that by no means will be fun, but instead, will allow you to improve your nursing practice, and come out as a stronger individual and nurse than you were before.

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Chapter 4:
Has High Tech Put Your Gut Instinct on Auto Pilot?

Case Study:
How Distraction Can Destroy Lives and Careers

Officer William Phillips, age 32, was killed Thursday, September 30, 2010 at 12:45 a.m. when a vehicle struck his bicycle while he was training with two other officers along U.S. 40 near Knightstown, Indiana. The riders were wearing reflective helmets and gear. The person whose vehicle hit Officer Phillips fled the scene.

It turns out that the person who hit the officer was a nurse who turned herself in to the Greenfield Police Department the next day. She was charged with leaving the scene of an accident causing death.

What struck me about this matter is that the woman who fled the scene was a critical care nurse. She struck the police officer because she was distracted trying to keep her 4-years old son from waking her 15-month-old twins. It's sad and tragic that she didn't stop to help the police officer—it certainly would have resulted in fewer criminal charges.

What is most compelling to me about this event, however, is how this one second decision to focus on her children while she was driving will affect her entire life. She must live with the fact a man died because of her. She now faces criminal charges. She will face an emergency suspension by the Nursing Board and quite possibly lose her nursing license. (At the time of this publication, her license had been indefinitely suspended.) We all are human and make mistakes—large and small, tragic and inconsequential—but we still need to be accountable. Had this nurse stopped and assisted the victim, she may have been able to avoid some of the criminal charges, would certainly be facing less severe charges, may have helped avoid the officer's death, and might have been able to

save her nursing license.

One second can change your life. As humans, we often run on autopilot and/or are reactive to events and circumstances rather than proactively keeping our eye on the task at hand—in this example, driving. We would make fewer mistakes if we remembered to be present in each moment and conscientious about what we were doing. Being conscientious is the f "follow through" and focus. It's always easier said than done, but in a profession in which a life is at stake—such as nursing—it's critical.

Moral of the story: Remember your GIFTS—*Trust* your gut and stay present (*follow through and focus*) to avoid auto-pilot mistakes—it's critical!

In my nursing days, back in the 80s and 90s, everything about a patient's case was written in the patient's medical record—there wasn't an option to use a computer. Hospitals, doctor's offices, and other medical facilities didn't have the fancy electronic equipment available now, and which we take for granted. Nurses took oral temperatures with mercury thermometers, felt for a pulse and counted it against an analog watch with a second hand. We used blood pressure cuffs that were attached to the wall requiring us to manually pump, watch, and listen as the dial decreased to get the

correct blood pressure reading.

High-tech invasive devices such as pulmonary artery Swan Ganz catheters used to be reserved for the ICU or the patients on telemetry needing continuous heart monitoring—only then were these automatic devices used to capture pulse and blood pressure data. But today, nurses don't even have to read a mercury thermometer; instead the electronic thermometer is put under a patient's tongue, on the forehead, or in the ear and a digital number pops up on the device. To get a pulse, you need not feel for it, you just put a small device on the patient's fingertip and the number appears. Regarding blood pressure, a cuff is put on the wrist or arm, it inflates itself and the number magically appears.

Unfortunately, what all these fancy electronic devices do, beyond their convenient auto-measurement, is damage a nurses' ability to "use her gut" t "*trust* your gut", and instinctively know when looking at a patient whether they are stable or unstable. Although it seems the modern electronic devices would make our nursing lives easier and leave less room for error, what we are now realizing is quite the opposite—we are actually seeing MORE errors. And the reason seems to lie at the foot of nurses relying too heavily on the electronic devices. In other words, we're on "autopilot."

There are two parts of the brain: the conscious and the sub-

conscious. The conscious brain really does very little of the work required to successfully run our body. Can you imagine what it would be like if you had to consciously force yourself to breath every five to ten seconds to get oxygen to your cells? Our entire conscious mind would be taken up by just running our body. Instead, we don't need to think about it at all—all of these functions run on autopilot; they are part of the subconscious mind.

Driving a car is a great example. My son, Evan, began driving last year. At first, it was hard for him to transition from sitting in the passenger seat with no need to focus on anything, to driving in which he had the wheel, two pedals, and an entire array of buttons to worry about, not to mention the whole rest of the road and every other car on it. However, with a lot of practice, it became almost second nature to him and he passed his driving test on the first try. But now he's encountering another problem; he's become so used to the mechanics of driving that he goes on autopilot. He just drives along, not consciously thinking about anything related to it. I can't count the amount of times he's passed our house, or swerved in at the last second to turn onto our street because his mind didn't need to concentrate (focus) as much as it did before.

In nursing, we have similar experiences. At first, it's difficult trying to organize our workload and assignments. But, after

you've been doing it for a while, it becomes second nature—especially if you have the same patients. We become accustomed to the routine of the tasks required of us, so much so that we occasionally go on autopilot. We lose follow through and focus. In this state of mind, we're not consciously thinking about what we're doing, so we're not always paying close attention and we miss the cues we might otherwise notice. In the autopilot state, the subconscious mind can't recognize those cues for what they are—it's as though our mind is simply not capable of processing thoughts and information; it's almost as though it just turns off.

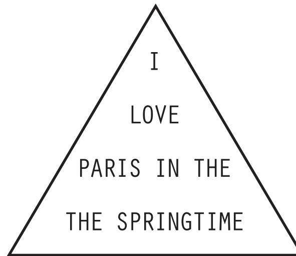
Although the high-tech devices we now rely upon and use every day are designed to help us, they actually eliminate our ability to consciously process the information—both obvious and subtle. Still not convinced how easily this can happen? Let me give you an example. How many times does the letter "f" appear in this sentence?

"Finished files are the result of years of scientific study combined with the experience of years?"

Most people think there are only three "fs" but, there actually are SIX! Go back and take a closer look. You were probably read-

ing on "autopilot" and skimmed right passed the ever-present "of" missing the extra "fs"!

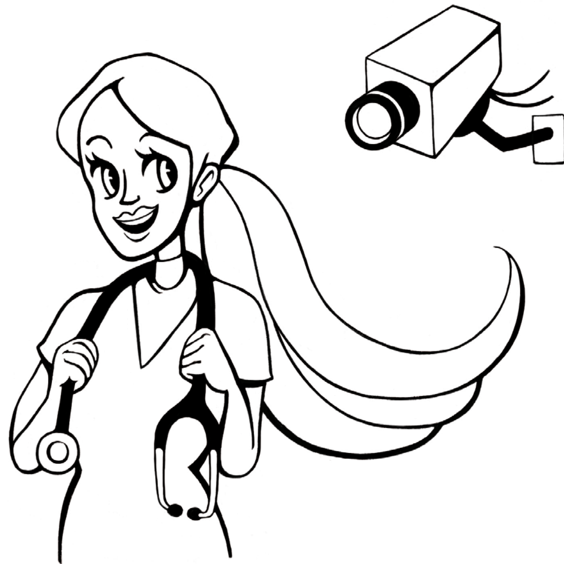
Read this:



Did you read "I LOVE PARIS IN THE SPRINGTIME"? If so, you are wrong! Look again and see what is really written in that sentence. Our eyes tend to ignore the second "the" and we read what we expect to read.

If focus on a task is required from the beginning, we are much more likely to uncover cues and signs when we're applying our attention in a slow, conscious, and concentrated manner throughout. But when that effort is no longer required, such as in tasks we're very familiar with like reading, riding a bike, or interpreting the data our high-tech nursing machines spit out, we're much more likely to ignore and/or miss the subtle, underlying signs a patient or situation may be giving us.

LAW AND ORDER FOR NURSES



Chapter 5:
Smile, You're on Camera!

Statistics now show that in large cities such as Boston or New York, an average person can be caught on camera anywhere between 8 to 12 times a day and, in some cases, as high as 75 times a day. In Britain, where cameras are all over the streets, the average person is caught on camera **300** times a day! Recently, I became aware of three cases before the Nursing Board in which a video was critically involved in determining outcome.

Case Study:
Video Can Catch a Liar

The first case was from a video on a psychiatric unit. The nurse delegated 15-minute checks to a Psychiatric Technician. The technician did not comply with the request and, in fact, lied to the nurse and reported on the charts that he did perform the requested 15-minute checks. However, the unit video in fact revealed that he did not do the checks as required. The nurse checked on her patient at the beginning of the shift and a couple of times during her shift. At the end of her shift, she found her patient had committed suicide. The technician AND the nurse were both terminated. Never forget that nurses' actions are almost always under surveillance and scrutiny, even if you can't see it taking place. The nurse admitted after the fact that she should have checked on the patient more often instead of relying on the tech; the patient was her responsibility and she didn't *follow through*.

Moral of the Story: Remember, you are the *source* of what happens to your patient. It is your responsibility, not a tech, to follow through and ensure your patient's wellbeing.

Case Study:
Actions and Inactions Caught on Video

In the second situation involving video, a nurse was providing home care for a child. While she was supposed to be supervising the child, the nurse watched TV, talked on her cell phone, and there were even periods of time when she was out of the room leaving the child alone—the nurse had little to no interaction with the child under her care. She was also seen handling the child inappropriately; she moved the child by lifting her by her limbs rather than her torso which is safer and less likely to cause injury. At one time, the video revealed that the IV pole almost fell on the child. All her actions—and inactions—were caught on camera. And, of course, only the most incriminating portions of the video were shown to the Board. As nurses, we should always stand on our ethics and be in integrity and never do something so horrible as to take advantage of our patients. Even little things with seemingly small consequences—like talking on your cell phone while working—should be avoided if you want to keep a clean record; you never know when you're being watched.

Moral of the story: Keep your GIFTS in mind; behave in *integrity* and hold your own strong moral principles close at all times.

Case Study:
Video May Show Only Part of Story—
and It Can Still Get You Fired

The third case involved an alarm on a ventilator in a subacute facility. When a ventilator alarm goes off, the light over the patient's door flashes in short bursts and an alarm sounds at the nurses' station, which is different from when a patient pushes a call light to signal a nurse. On the video surveillance, it appeared that all three nurses sitting at the Nurses' Station ignored the light. In reality, each of the nurse asked the nurse assigned to the patient whose alarm was sounding if she needed help. Her reply was, "No" yet the light continued to flash and blare. However, all three nurses were terminated for what appeared to be negligence—ignoring the alarm light—and all three were called before the Nursing Board. None of these nurses stepped outside of the initial inquiry to *give* a little extra effort to the nurse whose patient was having the problem.

Moral of the story: We need to *give* our time, effort, and attention to all patients and staff on the unit—not just to the ones assigned to us. Even if the nurse says they do not need help, do not ignore the patient.

We all take short cuts, every one of us. There are times when I don't wash my hands for the recommended full twenty seconds. And I certainly don't always brush my teeth for the full two to three minutes that four out of five dentists recommend. When you're cooking for your family, think about how often you taste the food you've prepared, and then use the same spoon to serve the dinner. What about when the light turns yellow, do you go through the intersection or do you stop? Do you always come to a *complete* stop at every stop sign? None of us is perfect, but if we think our actions were being caught on camera, what would we want other people to see? I'd bet we'd all take a second look at our overall conduct.

So, as you go about your day, take a few minutes and think about what would happen if somebody was watching what you did on camera. Would you do things differently? Would you treat your patient with more respect? Would your actions and handling of your patient be done with more love, care and gentleness? Would your verbal interactions be a little more reassuring and compassionate? Would you double and triple check medications and orders? Think about it.

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Chapter 6:
Let's Not Play the Blame Game

When dealing with mistakes, we can choose to take action from two different paths: blame or responsibility (*source*.) In our society, it does seem as though everyone is always trying to blame someone else for anything that goes wrong—courts are full of people accusing each other of all sorts of things. There is a lot of time and money being spent on figuring out the answer to 'who is the bigger victim?' Is it the defendant who claims the light was green, or the other driver who said the light was red? What about the doctor who reports the patient died due to a complication of

care, or the patient's family who claim the doctor was negligent? Even in my own daily life, shifting responsibility can easily happen if I let it—it's easy to find an excuse for being late, or if I've misplaced something, or blame the school if my child didn't get a good grade. However, when I shifted my thinking to come from a place of responsibility or source, without applying fault or blame, I soon realized that placed me in a stronger, more ethical and moral position.

When you learn to be accountable and take responsibility for your own actions, it teaches and trains you to be proactive in your activities. You learn to analyze situations and seek ways to improve. Other people are, and always will be, a loose and uncontrollable variable; their actions can never be predicted or anticipated. You can only ever change your own actions. A natural consequence of being proactive is that problems will occur less often because you've anticipated what actions you needed to take ahead of time to minimize any possible negative outcomes.

In nursing, all too often it seems the regular scenario is that everyone blames each other: "If *they* had told me in report about patient A, I would have done Y." or "If *they* had counted correctly, the medication would not be missing." Or "If we had this piece of equipment, then that would not have happened." Or "If I had

support from my supervisor, I would have done better." Or "If we had more staff, then I would have able to complete my workload in a timely manner." The excuses and the blame go on and on and on. In reality, what purpose does blame serve? It serves none. It doesn't make us feel better, and if it involves another person, it only serves to make that person feel bad. What happened, happened. Whatever it was is now in the past—it can't be changed, and it can't be erased.

What can be even more devastating is when nurses blame themselves. At first glance, it would appear that this is taking responsibility, but it's not. Taking responsibility mustn't be blame based; if it is, it keeps nurses inside a victim mentality. Nurses can be hardest on themselves, but remember that beating yourself up serves no purpose.

If you keep finding yourself in a similar situation, look at the common denominator; it's you. But the good news is you can embrace your GIFTS and become a change agent for your own life and nursing career. The first step of stopping the pattern is awareness; recognizing the situation. The second step is to make a decision that things will be different. The third step is to act on your decision and create the life and career you want.

A powerful position in which to stand is to be a *source* of re-

sponsibility for what happens in your life—especially at work. This is as simple as making the decision to be the *source*. I have seen so many nurses who blame circumstances or someone else, including the Board, for why they are being called before the Board. For example, many nurses misinterpret the renewal questions, and consequently, do not give a positive response to one of those questions; then they blame "not knowing" as their excuse. But in truth, they simply failed to be proactive and ask for clarification ahead of time. Instead of standing in the blaming mentality of, 'well, it's their fault for not asking a clear question,' nurses need to choose the proactive mentality of, 'I don't understand this question, so I should ask the Board for clarification.' What possible harm could be caused by a nurse calling the Board or an attorney and saying, "I don't understand this question, am I supposed to respond 'yes' if this happened?" No harm at all. It's simply being the source and taking responsibility.

Nurses often find themselves in the situation of arriving at work only to discover there's not enough staff for the workload. At this point, there isn't much you can do and blaming will serve no purpose. If you feel overwhelmed and decide to leave your shift, it's considered patient abandonment and you'll likely get fired unless your state has a law that allows you to refuse a patient

assignment if you do not feel adequately trained to undertake the assignment. If your state does not have such a law, my suggestion would be for you to write a note to your supervisor telling him or her that you are extremely concerned about the number of staff given the acuity of the patients. Add that you are committed to providing the best care you can, but will have limited time with each patient, and request more staff should a similar situation arise again. Give the note to your supervisor, but make sure to keep a copy for yourself—and absolutely, ***make sure you date it!*** That way, if anything negative does happen, you'll have documentation that the unit was short-staffed. But, more importantly, instead of focusing on the negative of being short staffed, you've turned your focus to how to do the best job you can given the staff shortage; you're focused on figuring out how to complete your work as efficiently as possible while providing the best care given the number of patients. This focused action is the third step of creating what you want. Again, this puts you in the much more powerful position of being an accountable, responsible, and proactive nurse—this garners respect and leaves you feeling good.

I used to work with a nursing agency that had me working in various units at different hospitals throughout Indianapolis—I never knew what type of situation I was walking into. I didn't

know what constituted understaffing for any given hospital because it varied across town and units. So, in order to keep myself in a strong position, I decided I would do the best I could with whatever situation was given to me. I would much rather hold the belief in my head that I am the source of what happens in my life and responsibly create the environment in which I want to work and serve in rather than blame others for any shortcomings I encounter.

In fact, when my nurse clients appear before the Board, I always encourage them to accept responsibility and be remorseful for what happened without blaming others. I want to show the Board that my clients are accountable and responsible by showing that my clients either took action to remedy the situation themselves, or took continuing education on the issue so as to increase their knowledge of the subject for the future.

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Chapter 7:
Live with Integrity

Living in *integrity* (remember, the I in GIFTS), means not settling for less than what you know you deserve—in all facets of your life. This means asking for what you want and need from others in all your relationships and always speaking your truth even though it might create conflict or tension. It requires behaving in a way that is in harmony with your personal values … in other words, making choices based on your core beliefs and values rather than allowing the beliefs of others to dictate your actions.

Remember, you are a nurse 24/7. Your actions and behav-

ior are observed by the public, and if they know you're a nurse, the observation can be intense. This is not to say that you can't "let your hair down", go out and have some fun, but be appropriate because people will notice. Being a nurse requires integrity, and simply put, integrity means being honest and working from a strong moral and ethical foundation. This translates into a few key actions for nurses:

- **License Renewal Application:** Answer all questions with absolute honesty. If you don't understand something, or need to discuss an aspect of the application, it's much better to contact the Board or an attorney to get those questions answered beforehand than lie, gloss over, or omit information. "I misunderstood the question" is not a defense. If the Board discovers you didn't disclose something that you should have, that can be considered fraud and possible grounds for disciplinary action against your license.
- **Employment Applications:** These also require complete honesty. If you have been terminated from any prior position, you must disclose that. You cannot omit the job. You do not have to give details or the reason in an application, but state you'll discuss the reasons in an interview—this reveals a level

of honesty most employers desire from their nurses. However, if you aren't forthright on the application and your employer finds out you were terminated from a previous position and kept the information from them, you could easily lose your new job, and possibly be called before the Board because it's considered fraud in obtaining a license.

- **Documentation:** Always be honest in all your documentation. I've had nurse clients come to me saying the Department of Health or Joint Commission on Accreditation of Healthcare (JAHCO) is coming in and there are things missing in the charts that their employer wants them to add. If you don't remember doing something, *don't document it*. However, if you're sure of an accurate memory and you do document something late or after the fact, be sure to write it as a late entry—your facility should not require you to break the law. Make sure you know and follow your facility's policy for a late entry.
- If you see a co-worker being dishonest, say something—use your judgment on whether it's directly to the co-worker, giving her a chance to set things right, or a supervisor. It is up to each and every one of us to police our profession and uphold the strong ethics that year after year allow nursing to be considered one of the most trusted professions.

It is so important to live with *integrity*; I firmly believe that not doing so causes ongoing stress which can ultimately lead to disease(s), negative feelings, and bad decisions. Living outside of our core values causes our lives to consistently be out of balance, which creates more stress—it becomes a self-perpetuating problem. However, nurses are employees—who, within the language of the law, are actually still referred to as being in a *master/servant relationship*—and many do not feel as though they can speak their mind without getting into trouble. So many get stuck in a place or situation that has them living in a way that violates their core values—constantly creating stress and essentially living without integrity. The next chapter discusses the main ways this manifests and provides suggestions for avoiding them.

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Chapter 8:
Avoid the Top Three Reasons Nurses Get Fired

As I looked at all of the clients that I've helped over the years who have been terminated from their jobs and had to report that to the Nursing Board, I noticed there were three key areas they had in common: (1) the "squeaky wheel" nurse, (2) the nurse with the longest tenure and highest pay, and (3) cultural differences between the nurse and the institution for which she worked.

Case Study:
Choosing Integrity over Status Quo

A nurse called me recently to complain about an illegal practice she'd observed in the ICU in which she worked—the other nurses regularly bolused their patients with additional fentanyl without a physician's order (the patients were already on a fentanyl drip.) By doing this, the other nurses were essentially practicing medicine without a license, leaving them open to losing theirs. Additionally, if any patient experienced an adverse outcome from receiving too much fentanyl, that quickly becomes a law suit waiting to happen. And last, but not least, if someone was diverting the fentanyl, there would be no way to tell which nurse was diverting, therefore, all the nurses would be to blame. Smartly, the nurse who called me refused to take part of this illegal practice and jeopardize her license—she's choosing to live with integrity. However, because she refused to follow this practice and complained, she was seen as a "squeaky wheel" because she would not comply with the culture of the Unit. Consequently, she was assigned to another Unit. There are always ways to get your point across without reverting to becoming a Unit's problematic "squeaky wheel." Ask yourself: Who are the decision makers on the unit? Who would be in the best position to stop this incorrect

practice? Does the nurse manager condone this practice? If my client had gone to Risk Management—who are in the best position to address this type of problem—there may have been a different outcome. The illegal practice could have been addressed by someone with authority without the nurse being stuck in the middle and being labeled a "squeaky wheel."

Moral of the story: Live with *integrity*, but learn how to communicate your concerns effectively to the proper people.

(1) Oiling the Squeaky Wheel

Employers—and coworkers—generally don't like a nurse who is a "squeaky wheel," by which I mean someone who constantly criticizes or complains about the way things are done. We all have our personal comfort zone from which we operate. We've already talked about how most of our day-to-day activities are done on "auto-pilot" and our mechanism for staying in our comfort zone is similar. Think of your comfort zone like a thermostat. If it is set at 72 degrees and it gets too hot, the air conditioner kicks in to cool it back down to 72. If the temperature turns too cool, the heat kicks in and warms it back up to 72 degrees. The same is true in our life. No one likes discomfort—unconsciously we're wired to always seek out events and situations in which we can feel comfortable, even if we have to manufacture solutions to "fix" what we perceive as a problem.

But this can create problems for both the nurse and the Unit in which she works. If a nurse constantly criticizes and complains about how things are run, that essentially disrupts the Unit's overall harmony—a comfort zone which exists whether the processes

or situations actually work or not—which in turn, can cause the manager to want to get rid of the nurse who's making things uncomfortable for everyone.

Another version of the "squeaky wheel" is the know-it-all nurse. This is someone who insists that things must be done a certain way or touts that she has the answer to the problem if only management would listen. The problem with a know-it-all nurse is the way in which suggestions are made. The know-it-all nurse makes suggestions with her employer based on ego and with an attitude of "I'm right," rather than making her suggestion with a win-win, team attitude. Again, this ego-based behavior upsets the status quo because it creates discomfort.

But take note: there ARE ways to create change without abruptly disturbing the existing comfort zone. There are ways to speak your mind that ultimately can bring about change but in such a way as to be so gradual and automatic that it becomes the ***new*** comfort zone. You can learn to speak your mind without it being simply a complaint or criticism—voice your thoughts in a solution-based way so as you are not seen as a "problem child" or "squeaky wheel."

If you need to address concerns in your work environment, take careful note of what you perceive is the problem, but then

take the time to think of potential viable solutions, especially solutions that involve small steps along the way (easier for the Unit to adopt). This way, you can approach the manager or supervisor with a solution to the problem—you're not simply dumping the problem in his/her lap to solve. The manager may/may not accept your assessment and solution, but you've presented yourself as a problem solver allowing you to live and work with integrity without garnering a squeaky wheel or know-it-all nurse reputation.

Another thing to consider is that if you are concerned about the safety of your patients and the overall care provided, your current situation may not be a good fit for you. You may instead want to find a position in an environment which provides care aligned with the way you believe good nursing is practiced. If you continue to allow poor care in your work environment, what does that ultimately say about you and your nursing practice? If poor care is prevalent in your environment—not necessarily by you, but in essence tolerated by you—what are you allowing in your life? If you tolerate behavior and accepted practices that are outside of your personal integrity boundaries, this sets you up for a malpractice suit or a potential license claim.

(2) Long Service + High Pay + Profit Problems = Possible Termination

Case Study:
Is Attention to Detail Enough or Is a New Environment Required?

One example in particular was a nurse terminated for an alleged HIPAA violation because her computer had displayed information on a person not her patient for a whole 17 seconds. Evidently, the patient was a VIP (a fact the nurse didn't know), creating a situation that was a perfect setup to terminate the nurse with longevity and high pay. In this situation, she was up against the administration's need to eliminate her salary … it was only a matter of time before something happened. However, knowing her situation, she could see what was happening and took steps to find the right environment, and is now happier and thriving in her practice at a different facility.

The second area in which I see a lot of nurses getting terminated is when they have worked for an institution for a long time

and are subsequently the highest paid. Unfortunately, there is not much that can be done to change this situation. You deserve to be compensated for your years of service and experience—you're earning what you are worth. However, I have had nurses at the top of their game get fired for the silliest of reasons. It upsets me when hospitals put their profits before their patients and cut experienced nurses due to budget concerns. If you're a nurse in this situation, you need to be especially careful to adhere to best practices.

Over the years, I've heard many nurses say in retrospect they knew what was coming, but they didn't want to leave their patients. This is a perfect example of nurses staying in their comfort zone as we talked about earlier. It seems perfectly reasonable to want to stay in a position in which you are comfortable, but you need to truly assess the situation. If keeping your position and license safe is simply a matter of being extra careful, then that is one answer. But, if the proverbial handwriting is on the wall, you need to step outside your comfort zone and begin submitting applications to find yourself a new position in order to avoid the potential career-impacting problems.

(3) Culture …

The third top reason—that I see—causing nurses to get fired is that they are simply not a good fit for the environment in which they're working. Some nurses work better in a nursing home environment which provides them with the consistency of routine found when caring for the same patients every day. These nurses feel fulfilled and achieve satisfaction by being an important figure in the last few years of these patients' lives; they often can feel part of their patients' families. Other nurses will work much better in an ICU or ER. They thrive under adrenaline-ridden conditions, enjoy the quick pace, the constant change, and find fulfillment in the idea of really making a difference for these patients and their families in their acute situation.

Environment matters and often determines whether we happily thrive or constantly struggle. We are who we are. A fish can't live out of water, and a human cannot live under the sea, just as a flower can't grow in Antarctica—we can only survive in the environment conducive to our good health. Metaphorically speaking, if you are a go-with-the-flow "round" individual forcing yourself to work in

a rigid “square” environment, you will not survive—your round peg is just not going to fit into that square hole. But, it is often a good way to find yourself before the licensing Board or involved in a medical malpractice case. Working in an environment that doesn’t fit your personality type, doesn’t meet your professional needs, or doesn’t fulfill you or bring you professional satisfaction, leaves you vulnerable to becoming the Unit’s “squeaky wheel” or going on autopilot and making serious mistakes—all of which could land you before the licensing Board or in a malpractice case.

I frequently need to argue before the Nursing Board that a nurse was in a situation that wasn’t a good fit, resulting in a problem or issue. A Board cannot restrict and/or dictate the type of environment in which a nurse ought to work unless your license is on probation. It’s our personal responsibility to find the right environment for us. If you are a proverbial round peg squishing yourself into a square hole, *stop*. Go find the round hole in which you fit so you can thrive and do well in your practice. When you are in the right environment, you can flourish and grow while providing the best care and making the greatest difference for your patients, because ultimately, that’s why you went into nursing in the first place, right?

If you feel like you are walking on eggshells every day that

you work your shift, that is an excellent indication that the environment isn't good for you. Stress or simple mistakes can lead to a license matter or a malpractice claim, so take some time and think about what defines the cultural context of the environment in which you work. In other words, what are the prevailing attitudes and beliefs? Do they align with your core values, beliefs, and how you like to work? If you are working in an environment with a cultural context that does not support your values and beliefs, you will not survive and thrive. You will either need to find a new environment or transform the existing one. This is why I think it is so important that nurses consciously create their environment by bringing a positive, upbeat, team player attitude to their work. And the good thing is environments ***can*** change when nurses bring this attitude to their practice. Negative environments can evolve into a supportive, caring, and have-each-other's-backs context so that nurses can thrive. It's just a matter of changing the cultural context of the environment to create a new environment. This may seem simplistic, and it may take time, but it can be done.

To learn more about how to empower yourself as a nurse, please visit: http://www.empowerednurses.org.

LAW AND ORDER FOR NURSES

Chapter 9:
Silence Equals Trouble: Speak Up and ASK FOR HELP

Time and time again, I see nurses getting into trouble when they don't speak up or ask for help. One of my nurse clients provides the perfect example in this chapter's first case study.

Case Study:
Staying Silent is NOT the Answer

My nurse client was working a New Year's Eve shift in the emergency room, with a full moon outside, when she began to

develop a migraine. But, given the night, she was too afraid to let anyone know she wasn't feeling well because after all, who would come in and cover for her? Also, she feared the other nurses would be angry and end up completely buried after inheriting all her duties. She also feared that the perception would be she just wanted to go out on New Year's Eve and had found a convenient way to do it.

So, instead of saying anything, she took some medication, toughed it out and stayed—but ended up making a horrible mistake that night. Consequently, she was drug tested and, of course, narcotics were found in her urine. She was fired and disciplined by the Nursing Board. This will affect the rest of her nursing career—she's required to disclose her termination on all job applications, and the discipline against her license is public record for all to see. Had she related her medical condition to her supervisors, she could have avoided the incident entirely.

There are a number of proactive ways to deal with this type of situation, specifically, informing a coworker, the charge nurse, supervisor, or one of the physicians. In fact, as with any emergency room, there were plenty of doctors available, and she could easily have told one of them, "I'm having this problem, can you help me? I really want to complete my shift, but I'm not feeling

well and I'm afraid it will affect my ability to provide good care." But, she was afraid to speak her mind. If she had, she could have received the medical care and help she needed. She likely would have been sent to employee health, where she would have received the help she needed, rested for a bit, and then possibly returned to work once she felt better, or arrangements could have been made for someone else to have come in.

Moral of the Story: ***Ask for help.*** In this instance, the nurse was not *giving* to herself and not trusting her gut when it was saying she needed to take care of herself.

We need to remember to always ask for help when it's needed. We are so afraid to appear vulnerable or as though we can't do the job that we withhold vital information that needs to be disclosed. In the end, we only suffer more for it.

Another scenario in which I see nurses getting into trouble is when they normally work in one unit, and end up floating in another to help out.

Case Study:
Assuming is Potentially Dangerous and Deadly

My nurse client normally worked on a medical surgical unit,

but was floated to the emergency department. He was assigned to a patient who complained of abdominal pains, so doctors ordered a "GI cocktail" and to discharge. GI cocktails are not given on medical surgical units, so the nurse had no idea what it was.

The nurse actually did what was proper—he asked the charge nurse, "What is a GI cocktail?" In that hospital, the GI cocktail consisted of an antacid (Maalox) with viscous Lidocaine. The charge nurse pointed to the Pyxis machine, which visibly contained the Maalox and the viscous Lidocaine, but he thought she had pointed to Mylanta and Vecuronium. Rather than verbally confirm which drugs by asking, "Are you telling me to give Mylanta and Vecuronium?" he assumed he understood. On top of his assumption, he never questioned why this patient would be getting Vecuronium.

Vecuronium is a paralytic agent used mostly to relax the trachea and larynx prior to intubation. When the patient, who was supposed to be discharged, was found lying paralyzed and unable to breathe, it was clear something was very wrong. A search of the Pyxis revealed the exact cocktail the nurse had given the patient. Fortunately, the patient survived but required an overnight inpatient hospitalization in the ICU.

This mistake occurred because the nurse was floated to an un-

familiar unit and was not oriented to that unit, but most importantly, he didn't speak up when he was unfamiliar with the combination of meds in a GI cocktail and did not question why the charge nurses had pointed to what he thought was Vecuronium. His assumptions and silence resulted in him having a discipline on his license.

Moral of the Story: Speak up! This nurse didn't f*ollow through*; he failed to ask the nurse specifically what she was pointing to and gave meds without knowing their effects. As a *source* of responsibility, a nurse must know what meds she/he is giving to have the best outcome for the patient.

The lesson here is again, you need to speak up. If you are floated to a unit with which you are unfamiliar, you can find yourself between a rock and a hard place. If you refuse to accept the assignment, it could be considered patient abandonment.[1] However, if you accept the assignment and make a mistake, it's your fault. It's much better to question, confirm, and express your concerns than risk a mistake such as the one in the above example. If you find yourself in a similar scenario, I suggest you speak your mind, and then write a dated note to the supervisor, keeping a copy for yourself, stating that you were floated to a unit for which you

were not properly trained and do not feel comfortable. This way, if anything happens, you will have a record that you voiced your concerns.

If you are asked to use equipment on a patient that you do not know how to use, *it is imperative that you be properly trained before using it*—and it's up to you to request the training. I know of a nurse who was floated to a unit with ventilators but she didn't know how to properly care for the machine and inadvertently turned the machine off. No alarms went off to alert the staff that the patient was not getting the necessary oxygen and tragically the patient died. The nurse was terminated, her license disciplined, and a malpractice suit was filed.

Now, you may think to yourself, "Oh, I would NEVER make such a mistake!" But, I promise you, they DO happen. You need to always be wary of unfamiliar territory and equipment and be ready to ask for assistance and instruction when needed. And with T, *trust* your gut, I bet your gut would be blaring "don't send me to that unit."

Fuzzy Policies & Procedures Mean *Always* Ask!

Surgery on the wrong site has been a problem in operating rooms across the country, i.e., a surgeon performs an arthroscopic knee surgery on the right knee when it was the left knee that was symptomatic. Because of this problem, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now mandates time out procedures in all surgical suites prior to surgery on each patient. Prior to this mandate, retrospective studies show that in almost every situation in which surgery was performed on the wrong site, someone had questions on whether the physician was about to operate on the wrong site *but said nothing*. These health care providers allowed the patient to be cut, and surgery to be performed on the wrong site because they were afraid to open their mouth and express their concern—they were afraid to speak their mind and voice their questions because what if they were wrong? But the real question ought to be, what if they were right? Voicing their concern would have saved those patients the unnecessary surgery, the permanent scar, and the accompanying pain and suffering.

Case Study:
Question and Communicate to Avoid Serious Error

In August of 2012, in Toledo, Ohio, Susan Fudacz was prepped for a surgery that would provide her the kidney her younger brother, Paul Fudacz, Jr., was donating. They were a perfect match, and Susan was excited to get a new lease on life with her brother's gift.

When Susan woke from anesthesia, she noticed that she had no incision. It turns out that a nurse mistakenly tossed the organ that was sitting in a temperature controlled slush machine into the garbage before it could be transplanted. The surgical nurse who was to be part of the team left on her lunch break and her place was covered by the circulating nurse. When the surgical nurse returned from her break, she thought the kidney was medical waste and, therefore, discarded it. Unfortunately with that action, the perfect-match kidney her brother donated was unable to be used.

I'm not saying that what the nurse did was right, but it was a shame how the media vilified the nurses—there certainly were system and procedural problems that allowed this event to occur.

1. According to the news articles, the nurse who left on break did not give proper report to the circulating nurse who covered for

her—but there were no policies and procedures in place for this scenario.

2. The nurse who discarded the slush thought the viable kidney was in the recipient's room because that is what usually happens in this type of scenario, so she thought the kidney in the slush machine was medical waste.
3. Also, in the room at that time were a physician and a scrub nurse, both of whom should have seen the nurse walking out with the slush and the kidney but they never said anything.
4. Additionally, the approved process for emptying the slush machine was not followed as it is usually done by a perioperative tech or a surgical scrub tech instead of the nurse.

Up until this event occurred, there was no policy in place at the facility for when a surgical patient is handed off to another nurse and what communication must take place. There is now.

Afterward: Just to let you know what has happened since this incident, Susan did receive a kidney the following November. Regardless, Susan and her family filed a lawsuit this past July against the facility in which the erroneous events occurred.

Moral of the Story: Communicate, **Communicate**, and **COMMUNICATE** some more! *Follow through*—check, double

check, and then triple check to make sure everyone knows what is going on with your patient.

The lesson from this story is never assume and *always ask*! Make sure that your facility has policies and procedures regarding communication when you go and return from break—and that you know what they are. If they don't, speak up and suggest it. If you ever see something that does not look quite right, say something. And, if you are not sure of something, don't assume, always ask!

Don’t Go It Alone

The other important area for nurses to speak up is to ask for additional staff or help. I can’t tell you how many cases I’ve seen in which a patient was supposed to be a two-person assist and only one nurse was available. For example, one nurse proceeds to walk the two-assist patient alone to the bathroom and then the patient falls. Obviously, such nurses on duty are reprimanded and some are even suspended for not doing what was in the best interest of the patient, incurring a consequence which could easily have been avoided if another staff member was asked or had been present.

In another situation, an ICU of eight patients called for regular staffing of four nurses—two patients for each nurse. However, on this particular night, the acuity was extremely high. The nurses knew it, but not one asked for help because they thought it would be futile. One of the patients coded and most of the nurses were kept busy with the resuscitation. During that time, the other seven patients weren’t receiving the care they needed. The condition of one of the other patients deteriorated but went unnoticed,

and he also ended up coding—and he was unable to be resuscitated.

As nurses, we have an obligation to speak up and ask for help when we have concerns about patient safety. If your facility is constantly short-staffed, leaving you unable to complete your required work, and you find your manager unsympathetic to your needs, the best option is for you to search for a different work facility. Your license is too important! If situations arise in which an area is understaffed and you make a mistake, regardless of the circumstances, you will be blamed and reported.

Case Study: Overworked and Stressed Leads to Mistakes

One of my clients worked 120 hours in a two-week period because two other nurses had quit. She worked in a small community nursing home where it was difficult to get more staff. She also felt confident that she knew her patients and could provide the best care for them rather than bringing in another nurse who would be unfamiliar with the patients, or the policies and procedures at the nursing home.

After her lengthy stretch, one of the patients was sent to the hospital with a blood clot in her leg. The facility audited her

med box and found extra Lovenox. They accused the nurse of not providing the patient with the ordered medication. After having worked at the facility for 15 years, the nurse was fired and had criminal charges filed against her, as well as charges against her nursing license.

Only after a jury trial was she found not guilty and acquitted of all charges. She maintained her freedom and was able to avoid serving prison time. However, the discipline still remains on her license. The publicity of the criminal trial put her name out there and everyone knows her in that small town—her career is forever hampered in that community. If she had looked past her pride and told her employer, "Look, I can't work this much. It is dangerous to me and my patients," another nurse might have caught the mistake before it occurred, or better yet, she might have been less stressed from the workload and the mistake would never have happened in the first place.

Moral of the story: Communicate when stress and exhaustion are at potentially dangerous-mistake levels. *Give* to yourself by *trusting* your instinct when it says you need help.

If you do not feel like you are physically or mentally able to work a shift, you need to say something. Don't put your pa-

tients in jeopardy to be the hero—working when no one else can or because you're afraid that you will be fired, all you do is put yourself and your patients at risk.

LAW AND ORDER FOR NURSES

Chapter 10:
Do You Know Your Nurse Practice Act?

Your nursing license, like your driver's license, is a privilege, not a right, and we have to take privileges seriously and protect them. When you drive a car, there are certain rules of the road just as there are certain laws that govern nursing practices. There are risks in getting behind the wheel of a car and there are risks in practicing nursing.

Each state's nursing regulatory function in issuing and supervising a license focuses on two points: to make sure that a nurse is safe to practice and to protect the citizens of the state. Al-

though the Board is composed of nurses, their job is not to support the nurse but to protect the public. It is unfortunate that the Nursing Board, at least in my state of Indiana, is much more aggressive than the Medical Board. If a physician did some of the things for which some nurses find themselves before the Nursing Board, the Medical Board would probably either do nothing, sweep the issue under the rug, or slap the physician on the wrist and say, "don't do that again." The Nursing Board has a much more rigorous approach.

All states have some form of a Nurse Practice Act. In fact, the American Nurses Association has published a Model Nurse Practice Act to guide states. Each state passes laws regarding the nursing profession, but since lawmakers are not nurses, it is difficult for them to enact legislation with specificity to regulate the practice. Therefore, the Nursing Board is empowered with the authority to develop administrative rules and regulations to assist in the regulation of the practice. Each Nurse Practice Act includes the following areas[2]:

- Definitions
- Authority
- Power

- Composition of the Board of Nursing
- Educational program standards
- Standards and scope of nursing practice
- Types of titles and licenses
- Protection of titles
- Requirements for licensure
- Grounds for disciplinary action
- Other violations
- Possible remedies

It is important that you know and understand the standards and scope of nursing practice for your state's Nurse Practice Act because anybody can file a complaint against your license. This includes patients and their families, co-workers, physicians, administrators, and even former spouses!

Once a complaint is filed, there is an initial review of the complaint and an investigation is performed. If there's a question regarding a violation of the Nurse Practice Act, then the case will proceed to the Board and a hearing will be held. The hearing will be public, and unlike civil or criminal proceedings, which limit the evidence that can be used, such as hearsay, all evidence is admissible. And, unlike a criminal matter in which the defendant is

innocent until proven guilty, Board matters seem to operate from the opposite—presuming the nurse is guilty until she/he proves innocence.

At that time, the Board can do several things: impose a fine, require you to take a continuing education class, refer you to a Practice Monitoring Program for drug or alcohol abuse or dependence, give a public reprimand, place your license on probation, or suspend or even revoke your nursing license. Any action that the Board takes will be public record, *even if the matter is ultimately dismissed*. Should the Board take action on your license, it will be reported to a federal data bank called the National Practitioner Data Bank (NPDB; the Healthcare Integrity and Protection Data Bank (HIPDB) merged with the NPDB in May of 2013.)

This federal data bank was designed primarily for physician regulation. If a physician had several malpractice cases in one state, she/he could not go to another and get licensed to practice without the medical board, insurance companies, and health care facilities knowing about her/his past issues. It is not as much of a concern for nursing. If you are reported to the NPDB, you will have the right to submit your version of the facts regarding the matter.

Any complaint or violation of regulated issues that will have

you reported to the Nursing Board and can be grounds for charges against your license include:

1. Competence to practice
2. Drug related issues
3. Inappropriate boundaries
4. Sexual misconduct
5. Physical, mental, or emotional abuse or neglect of a patient
6. Fraud or misrepresenting the truth on:
    a. a license or job application
    b. charting after the fact
    c. a person's identity, money or possessions
7. Criminal conduct
8. Discipline in another state

In addition, if the action taken against your license involved a Medicare or Medicaid recipient, you may be reported to the federal Office of the Inspector General (OIG). For example, if a nurse inadvertently didn't give medication to a Medicare or Medicaid patient, and Medicare or Medicaid was billed for it by the facility, this can be considered fraud. If you are reported to the OIG, you will most likely not be able to work in a traditional setting that

provides care for Medicare or Medicaid recipients, and placed on an exclusion list, preventing you from taking care of Medicare and Medicaid patients for a period of five years. The government does not want to pay for services not provided; it wants to make sure that a person who violates the law regarding a Medicare or Medicaid patient is no longer allowed to take care of those patients for that five year exclusion period.

If you have questions or would you like a copy of your state's Nurse Practice Act, visit: http://lawandorderfornurses.com/resources.

Critical Knowledge: Your Facility's Policies & Procedures

Not only is it important for you to know the Nurse Practice Act in your state, it is also critical you know your facility's policies and procedures. They are the standard of care under which you work—what you are supposed to do or not to do in certain situations. I cannot stress enough how important it is to review your facility's policies and procedures. Just as you cannot claim you didn't know to stop at the stop sign when you get pulled over for driving through it, "I don't know" is not a viable defense in a nursing matter. If you are under oath and an attorney asks, "What is your fall-prevention policy?" and you do not know, the Board isn't going to look favorably upon you. You are not only required to know your facility's policies and procedures but *you are expected and required to follow them*. If you don't follow them, that could be grounds for termination or it could lead to a medical malpractice action, or even lead to you losing your license.

Please take your nursing license as seriously as you take your driver's license, if not more so! Again, your license is a privi-

lege, not a right, so it is important to treat it as such. Knowing your facilities' policies and procedures as well as your State's Nurse Practice Act can go a long way to helping protect your valuable asset—your nursing license and your livelihood.

Avoiding HIPAA Violations

As every nurse knows, we have a duty to keep patient information confidential. This has always been a practice, but with the advent of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it's become a critical part of healthcare—and one that can jeopardize your license if you don't always strictly adhere to the HIPAA rules and regulations.

Computers are arguably the main record keeping source today, and have also provided the easy means of getting into trouble with the HIPAA rules and regulations. For instance, should you accidentally pull up a chart belonging to the wrong patient that could be considered a HIPAA violation. One of my clients was terminated because her facility had a zero-tolerance policy, even though all she did was accidently pull up the wrong patient's chart and it was only on her computer screen for 17 seconds. She, herself doesn't recall any details—nor could she retain any or review much information in such a brief amount of time, but it's irrelevant. With computerized charting, facilities can do random audits and see every record that you've opened based on your

log-in information; in her case, it meant termination. Therefore, it is critical to NOT share your log-in information with anyone. It's also equally important to consistently log-out every time you leave the computer. This allows you—and everyone around you on the unit to keep in *integrity*.

In my years representing nurses, I've learned of some facilities that allow sloppy habits around patient confidentiality. For example, there was a facility in which only one nurse worked in the nursery and she left herself logged-in to her computer constantly during her shift. This created a situation in which whatever patient information she accessed was visible to anyone who happened by the computer screen. This type of practice is particularly dangerous if someone else does have access to that computer and does something under your log-in—if something happens, whomever is logged-in will be the one in trouble.

Also, be careful about discussing patient information in open areas like hallways, elevators or the cafeteria. Any time you discuss a patient's medical situation with anyone outside of the patient's health care team it is a HIPAA violation—the patient's identity and information must be protected at all times. For example, one of my nurse clients had tried all day to reach a certain doctor and finally ran into him in a crowded elevator as she was

leaving her shift. Unfortunately, she chose that moment and place to relay the information she had been trying to get to him all day. The exchange should never have happened in the elevator and consequently, she was disciplined for her indiscretion.

Even in cases of a patient wanting a copy of some part of their medical record, it is imperative you do NOT give it to the patient or a family member. Such requests must go through the proper channels and a release needs to be signed to get whatever information they seek—otherwise, you and the facility are vulnerable to being accused of violating the patient's privacy rights. Use common sense and of course, integrity—protect your license. Follow the policies and procedures of the health care facility each and every time when it comes to privacy and medical records.

LAW AND ORDER FOR NURSES

Chapter 11: Under the Influence

I didn't think this book would be complete without sharing information about impaired nurses. Many nurses incorrectly believe that the only ones who end up before the Board are impaired, and this simply is not true. Yes, there are a fair number of impaired nurses, but they are not the only ones who have issues with their license and appear before the Board. But, for the sake of this chapter's information, let's look at what constitutes an impaired nurse: an impaired nurse is someone who uses alcohol or a controlled substance *on a regular basis* and to an extent that it in-

terferes with their work. Keep in mind, each state has a slightly different definition of an impaired nurse.

And here's a sad fact: many of these nurses don't know they have a problem at all. I do believe alcohol or drug use is a medical problem that causes a chemical reaction in the mid-brain so powerful that it creates an intense desire for the substance that cannot be sated with anything else. This intense desire causes someone to act in ways in which he or she normally would not so as to feed the craving and achieve the desired chemical reaction in the mid-brain.

In the course of my career, I have heard of nurses forging prescriptions, writing prescriptions for a family member for their own use, and even putting on scrubs and a mask and going to the surgery unit to steal medications from the Pyxis—an impaired nurse will go to any length to get the desired medication. I also believe that genetics must be involved—how else do you explain the fact that some people can discontinue their use of controlled substances and not have any problem, while others have serious withdrawal symptoms?

Where I live in Indiana, our state law says that if you use or abuse controlled substances, you are a candidate for the Indiana State Nurses Assistant Program (ISNAP). The program is avail-

able to help any nurse with a chemical use or dependency issue. An INSPECT (Indiana Scheduled Prescription Electronic Collection and Tracking Report) can be accessed by Licensing Boards, the Attorney General's Office (for investigative purposes), law enforcement officers, and health care providers and it will show any controlled substances for which you may have had a valid prescription in the past year. INSPECT also shares data with neighboring states. If you are using any controlled substances, even with a valid prescription for longer than an acute event, the Board may consider that a problem if you are actively practicing nursing. In fact, the Board may be concerned even if you were to drink alcohol the night before a shift.

Many nurses erroneously believe that if they're arrested for a DUI and consequently enter into a diversion program, they do not need to disclose this on their license renewal application. This is still a conviction in which you pled guilty; you are still required to disclose this on your license renewal application.

The American Nurses Association advocates for alternative-to-discipline programs or peer assistance activities; most, if not all, state Boards of Nursing offer these types of programs. These programs also provide comprehensive monitoring and support to assist the nurse in safely returning to work.

Although some states do allow self-reporting to an alternative-to-discipline program in order to get assistance with a chemical dependency, some Boards believe that discipline is in order and the public has a right to know that a nurse has or had a chemical dependency problem. The Boards that discipline nurses for substance use create a situation in which nurses would rather hide their problem than get help, for fear of endangering their license.

It used to be that self-reporting to a comprehensive monitoring program working with your Board of Nursing would protect your license, however, that does not seem to be the case lately. I think this causes a chilling effect for nurses who would like to report and would like to get help but fear that they will be found out and lose their job. However, I still always encourage nurses to get the help they need. I think it is important for nurses to get and be healthy for themselves because if they are not, then how can they help patients in need?

According to the American Nurses Association, it is estimated that 6-8% of nurses use drugs or alcohol to the point that it substantially impairs their judgment. Although this statistic is not different from the general population, it is unique because nurses have greater access to drugs in their work environments.

Additionally, many nurses are afraid to report concerns they

may have about a co-worker. Not only do they feel as if they would be "tattletales," but they also don't report concerns because they fear they may be wrong. The way I look at it, if you suspect a nurse has a chemical dependency problem, your actions can only help them. Look at your organization's policies and procedures for employee substance abuse and at their Employee Assistance Program so you know what actions you can take. You do have a moral and ethical duty to patients, colleagues, and the nursing profession, as well as to the community to take action. You actually are doing them a favor by helping them get the help that they need now rather than allowing them to spiral downward as the disease progresses.

Substance abuse can be a costly, career-changing situation. Nurses who fall prey to substance abuse and are brought before the Board will inevitably have to contend with the cost of treatment and rehabilitation, as well as substantial legal fees for criminal, civil, and Board matters. An impaired nurse's life can change over something seemingly insignificant—she/he doesn't have to steal large doses of a controlled substance. One hospital turned a nurse over to the prosecutor's office for stealing a $0.25 syringe, and criminal charges were filed.

The Indiana Board, which I suspect is similar to other state's

Boards, believes that any nurse who takes any controlled substance for a prolonged period of time, rather than episodic use like after surgery or an injury, is an impaired nurse. That nurse may be put into a monitoring program which is abstinence based and be required to get off all controlled substances, even if medically necessary. For example, remember I previously mentioned my client who took Adderall for ADHD while working surgery. She needed the Adderall to help her focus to do her best job, however, the board's response essentially was, "you cannot use controlled substances while in monitoring."

Remember the client who took Provigil for narcolepsy? Certainly, you would want your nurse to be awake and alert when she works her shift. But, again, the Indiana board required adherence to a regulation demanding an abstinence-based monitoring program which prohibits a nurse from taking any controlled substance. These two nurses weren't impaired, but because the drugs are controlled substances, they couldn't take them and work.

Unfortunately, these are the cold hard facts of our profession. But, you can be part of the solution rather than the problem by helping your co-workers get the help that they need. Again, if you see something suspicious, say something—it's only going to help the person and the nursing profession.

Many of my clients who have overcome addictions and substance abuse say that they learned so much from the process. They feel better about themselves both physically and emotionally. They receive a greater enjoyment out of life and their profession than they did before. They also learn tools to help cope in stressful situations. Oftentimes we only see the negative side of substance abuse but not the positive part that comes after overcoming the addiction.

I have many great examples of success stories of nurses overcoming addiction and finding greater joy and career satisfaction. One example is a client who was addicted to Vicodin. As part of her recovery, she was not allowed to work around controlled substances, so she became an MDS Coordinator in a nursing home. Throughout her recovery process she was able to move up the corporate ladder and is now the Corporate Risk Manager for a large extended-care company over the state of Indiana and fully enjoying her career. Additionally, she also started a Caduceus group in her hometown in Indiana. (Caduceus groups are support groups for impaired health care providers like AA (Alcoholics Anonymous) or NA (Narcotic's Anonymous.)

Chapter 12:
When Mistakes Become Nursing Malpractice

We all make mistakes; we're human beings. However, as nurses we need to ask the question, 'When does a nursing mistake become nursing malpractice?' As opposed to a Board matter which is administrative, a malpractice suit is a civil matter conducted in a regular court.

Malpractice[3], noun:

law : careless, wrong, or illegal actions by someone (such as a doctor) who is performing a professional duty

1. a dereliction of professional duty or a failure to exercise an ordinary degree of professional skill or learning by one (as a physician) rendering professional services which results in injury, loss, or damage
2. an injurious, negligent, or improper practice: malfeasance

Malpractice is simply a word for **negligence regarding a professional**. Negligence is considered a civil wrongdoing. Negligence can occur in two ways, with either an omission—a failure to do something you were supposed to do, or a commission—doing something that should not have been done.

What constitutes malpractice?

Some states' nurse license renewal applications require you to disclose if you've ever been involved in a malpractice action. A malpractice action can also result in disciplinary action against your license. There are four elements of malpractice and each element must be proven to have a case:

1. **Duty.** Duty is the standard of care which is what those acting under same or similar circumstances would do.
2. **Breach.** There must be a breach of that duty. You must do something or fail to have done something that others would have done acting under same or similar circumstances.
3. **Cause.** The breach of the duty must cause the fourth element to occur.
4. **Harm.** Harm must have occurred, otherwise, it's not malpractice, but only negligence.

As a nurse, you must comply with the standard of care, which is determined and defined by nurses—what another nurse would

or would not do in a given situation (the average person in the United States knows there's a duty to stop at a stop sign, but is not likely to understand what a nurse ought or ought not to do in a situation, so we wouldn't want anyone but nurses determining standards of care.) Standards are also found in a facility's Policies and Procedures (again, I must stress how important it is to know your employer's policies and procedures!), National Nursing Organization Guidelines, and published, authoritative peer-reviewed articles.

As previously stated, malpractice is negligence and negligence is a civil wrong. We all as licensed drivers have a duty to stop at a stop sign. If we do not and instead drive through it, hit another car and cause harm to the people in the car, this scenario fills all the requirements of negligence. However, if we run a stop sign, but don't hit anything, then we breached our duty as drivers, but because we didn't cause any harm, it therefore is not considered negligence.

For an example in the nursing context, nurses have a duty to administer the proper medication. If the nurse gives Ampicillin instead of Aminophylline as the ordered medicine, the nurse breached duty. But, if the patient does not have a reaction to the Ampicillin, there is no harm and thus, no negligence; it is simply

a medication error. However, if the patient does have a reaction to the incorrect medication, all of the elements of malpractice have been met; the nurse was therefore negligent.

Should I Have My Own Malpractice Insurance?

Whether or not to have your own malpractice insurance is a personal choice. One clear benefit of having your own malpractice insurance is that it gives you the right to have your own attorney present at a deposition and trial. In Indiana, if you choose to have malpractice insurance, it is imperative that you become a qualified healthcare provider under the Indiana Patients Compensation Fund. The Indiana Medical Malpractice Act, created by the State of Indiana and upheld by the Indiana Supreme Court, states that in order for a healthcare provider to have liability limited to $1,250,000 that healthcare provider must voluntarily participate and be qualified under the Indiana Patients Compensation Fund pursuant to the Indiana Medical Malpractice Act ("the Act"). If your state has caps or a catastrophic fund for excess damages, be sure your policy provides you the protections of your state's caps and Fund. This may require that your insurance company pay an additional premium so as to qualify you under the Act. Nursing malpractice insurance is relatively inexpensive; however, although it is more expensive to be covered by the Indiana Act, you must

remember that the Indiana Medical Malpractice Act gives you the certain benefit of limiting your liability so that there is no personal exposure. It also requires that your case be presented to a medical review panel before it can proceed in court. You do not get these protections if you are not qualified under the Act. If you live in another state, you want to make sure you get the most protection and any additional benefits your state has to offer.

It is also advisable to have your own attorney if the hospital's interests are different than yours. If your position was terminated over the malpractice incident or you feel like the hospital will not support you in the case or the care that you provided, I would strongly recommend that you have your own attorney. In any event, it is always advisable to seek the advice of an attorney should you be named in a suit or be asked to give a deposition because your testimony will be under oath—and it can be given to the Indiana State Board of Nursing for further action if the Board deems it necessary.

The best defense is a strong offense. By practicing defensive nursing care—charting thoroughly and being proactive—it will save you a lot of time and potential trouble in the future. After a long day it is difficult to have the energy to sit down and chart, but imagine picking up a chart two or three years after the malpractice

occurred and trying to remember what happened—it's not likely you'll remember details. I would challenge each one of you to pick up a chart that you wrote on six months ago and see how good your recollection is and see how well your notes protected you. It's better to be proactive, *give* yourself the time, *follow through* and chart what needs to be recorded.

If you have questions, or would like to listen to an audio recording of an interview with a physician attorney, Greg Kauffman, MD, JD, who specialized in medical malpractice, please visit: http://lawandorderfornurses.com/resources.

Conclusion

As I conclude this book, I know I have given you some sobering facts about the nursing profession and illustrated how nurses are treated before the Nurse Licensing Board. However, I strongly believe that forewarned is forearmed—knowledge is power and if you know how the Board works, you can protect yourself.

With every nurse that walks through my door seeking help, I can see which of the GIFTS she/he was not using when trouble occurred. Even though we all possess these GIFTS, it takes practice to use them and become an empowered nurse. The best way to practice is to develop a consciousness about our GIFTS and continually think about them in our daily practice until they become second nature.

Are you *GIVING* to your patients, coworkers, and yourself? If you are more concerned about other people in a given situation, it's likely that when you need assistance in some way, other people would be there for you. For example, if you wanted a cup of coffee, you would have everyone on your unit helping you get a cup of coffee.

Are you living and working in *INTEGRITY*? Are you making extra effort to not cut corners? Do you fully express how you feel and what you are thinking? Are you honest and upfront even if it creates tension and some conflict? This was hard for me to learn—societally, I was taught to value being nice; I wanted to be liked. But being in integrity means you have to be true to yourself. And none of us can control what others think of us.

Do you FOLLOW THROUGH? Are you present in the moment and focused on the situation at hand? This one is especially difficult because as nurses we are always thinking ahead and what is next. We need to practice focusing on the moment.

Do you TRUST your gut? When you get the unique feeling in your stomach that signals to you that your patient does not look right, do you dismiss it or do you say something? Too often our logical brain tries to talk us out of trusting our gut feelings because it doesn't seem rational, but that inner voice is often right, despite seeming evidence to the contrary.

Are you the SOURCE of what happens at work and in your life? This one is the hardest to practice because you truly own your responsibility and are accountable for what happens. This isn't from a position of fault or blame but from a strong position from which to stand. If you are the source, you can do some-

thing about the situation rather than only reacting and becoming the effect. As the source of our profession, we have the power to become agents of change and do something about the ways nurses are treated by the Board, and how to help nurses who get in trouble.

Because you have read this book, I know you really care about the nursing profession and want to make a difference. But in order to improve your career and the nursing profession we need to use all our GIFTS. The Board is simply a reflection of the nursing profession and how we treat each other. Until we each make changes, and nurses universally treat each other with respect and dignity, the Board will not change how it treats nurses; how nurses are treated at work will not change. It is up to each and every one of us, and if not now, when?

If you would like to learn more about out how implement your GIFTS and learn how to thrive in your nursing practice, visit www.empowerednurse.org.

Endnotes

1. Check your state's regulations. Some states allow a nurse to refuse a patient assignment if you have not completed competency validation. http://www.rn.ca.gov/pdfs/regulations/npr-b-21.pdf
2. List from The Journal of Nursing Regulation, Vol. 3, Issue 3, October 2012 by Kathleen A. Russell, J.D., M.N., R.N., p. 37. https://www.ncsbn.org/2012_JNR_NPA_Guide.pdf
3. Mirriam-Webster Dictionary

About the Author

Lorie Brown is a Nurse Attorney, transformational leader, inspirational speaker, author and entrepreneur. Ms. Brown graduated from Indiana University School of nursing with a BSN in 1982 and became a staff nurse on a medical surgical floor at St. John's Hospital in Santa Monica. She then attended the University of California at Los Angeles School of nursing to obtain a master's degree. During her schooling, she continued to practice nursing. Upon graduation, she became a nurse manager to make a bigger impact on the profession. She then moved back to Indianapolis and became a manager of a busy neurosurgery unit at the county hospital. After a divorce, she decided to attend law school at Indiana University School of Law in Indianapolis. Ms. Brown combined her love of nursing and law by representing health care providers in medical malpractice cases and before the licensing Board throughout the state of Indiana. Ms. Brown founded Brown Law Office in 1999 where she represents nurses and other health care providers before the licensing board in Indiana.

Ms. Brown is also the founder of EmpoweredNurses.org where she is committed to giving nurses the tools that they can use to thrive in their profession so they can speak their mind, stand in their power and be a change agent to improve patient care all while legally protecting their license. By using these tools, nurses can rediscover the joy, passion and freedom that brought them into the profession that they slowly lose over time because the current nursing culture.

For more information, for representation visit www.brownlaw1.com or to thrive in your nursing practice, visit www.empowerednurses.org