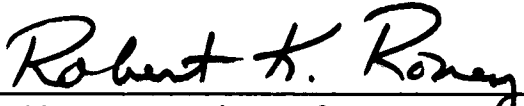
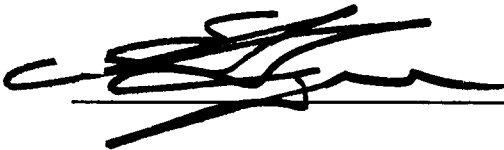


To the Graduate Council:

I am submitting herewith a dissertation written by Rachel Leona Orr entitled "A Profile of Disciplined Nurses in Tennessee, 1990-1992." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Educational Administration and Supervision.


Robert K. Roney, Major Professor

We have read this dissertation
and recommend its acceptance:







Accepted for the Council:


Associate Vice Chancellor
and Dean of The Graduate School

A PROFILE OF DISCIPLINED NURSES IN TENNESSEE

1990-1992

A Dissertation

Presented for the

Doctor of Education

Degree

The University of Tennessee, Knoxville

Rachel Leona Orr

May 1993

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DEDICATION

This study is dedicated to the hundreds of men and women in the healthcare field whose lives have been touched, or will be, by unfortunate professional and personal practices. May their lives be restored and made whole, and their practice healed.

ACKNOWLEDGEMENTS

I wish to thank God for allowing me the strength and wisdom to conduct and complete this study. At several points after my spinal cord injury I thought I would not be able to realize this goal. Its completion represents a milestone in my life.

This dissertation is the result of the interest, assistance, and support of several special people. I would like to express my appreciation to all of the members of my doctoral committee for their support and encouragement. Dr. Robert K. Roney, my major professor, has taught me much. He has challenged me as a doctoral student and encouraged me in a most positive way. He gave boundless time and attention to my work and always worked around my schedule. He readily emphasized my potential and not my physical handicap. He was patient and kind toward me. Dr. Sandra Thomas helped me to conceptualize a topic for research. Her friendly assistance and willingness to allow me to borrow materials from the Center for Nursing Research is warmly acknowledged. Dr. Charles Hamilton, as a teacher, stimulated my curiosity regarding public health care and demonstrated scholarship to help me learn. He has been a model teacher and administrator since my acquaintance with him and he was always considerate and caring toward me. Dr. Grady Bogue, since his committee membership, has been most supportive and suggestive of creative scholarship. He, too, has encouraged me to completion.

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ABSTRACT

Concern about the abuse of nursing standards in Tennessee by licensed nursing personnel served as a basis for this descriptive research. The purpose of the study was to describe the types and extent of disciplinary actions of licensed nurses by the Tennessee State Board of Nursing during the years from 1990 through 1992. The characteristics of these nurses as well as the actions taken against them were surveyed.

A census of 331 licensed and practical nurses who appeared before the Tennessee State Board of Nursing for nursing violations comprised the sample. Registered nurses and licensed practical nurses were represented in the sample. The instrument was based on the Disciplinary Report Form of the National Council of State Boards of Nursing and was modified and developed further for relevance to Tennessee.

Findings included a basically equal number of RNs (51.2 percent) and LPNs (49.8 percent) being disciplined during the three year period. It was found that the typical nurse violator who was disciplined is a white, 35.37 year-old, female RN who violated the Nurse Practice Act in the western, urban region of Tennessee in Shelby County or Davidson County or in the eastern, urban area in Knox County. The educational level of the violator represented an associate degree. The typical violator had held nursing license for 9.62 years. The typical nurse violator had previous disciplinary action in the area of drug abuse and drug diversion. Demerol was the

drug most often abused, followed by alcohol. The disciplinary action most often taken by the State Board of Nursing for violations was probation.

It is recommended that an educational effort incorporating the incidence and prevalence of the problem be put forth through the written and spoken media. It is also recommended that employers take additional measures to help monitor the profession to reduce the problem and provide further safety to patients.

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CHAPTER I

INTRODUCTION

BACKGROUND

Nursing exists only in its practice and its practitioners. The nurse is nursing and anything that undermines or destroys the practitioner undermines, wounds, and destroys the profession.

Leah Curtin

Editor, Nursing Management

Nurses in Tennessee are licensed for entry into practice by the State Board of Nursing as provided in the Tennessee Nurse Practice Act. The State Board of Nursing is the regulatory agency. Licensure defines a scope of practice and allows for disciplinary action as necessary. The Nurse Practice Act defines and limits the practice of nursing, hence, it determines what constitutes the unauthorized practice of nursing (or practice that exceeds the scope of authority) (Fiesta, 1990).

Nursing conduct and performance are held to certain standards. Some nurses for various reasons abuse that standard; therefore, they may be guilty of varying degrees of failure to practice at a satisfactory level. When the nurse perceives his or her professionalism within a narrow range of functioning, fails to see beyond the immediacy of a nursing act, or fails to assess the potential for harm in a given situation, violations occur. When the standards of health care delivery are violated, disciplinary action becomes necessary to protect the client, the nurse, the providing

agency and institution, and the profession. Violations of professional nursing conduct precipitate disciplinary action.

Luckenbill-Brett and Sluhler-Schlag (1987) indicated that Professional Boards of Nursing and other professionals consider mandatory reporting to be a necessary method to enable them to safeguard the public's welfare. The public health and safety of society warrant effective monitoring methodology.

Elliott and Heins (1987) discussed the purpose of the Boards of Nursing and the State Nurse Practice Acts. Individual state Boards of Nursing were created as a state agency to maintain the delicate balance between the rights of the individual and those of society. The Nurse Practice Acts regulate the practice of nursing in the United States, each state having its own respective Practice Acts. They are broadly rooted in the 10th Amendment of the United States Constitution. Their main purposes are to protect the health, safety, and welfare of the public. Boards of Nursing were created to carry forth this mandate and are sanctioned by the law to monitor nursing practice, to license qualified individuals, to create and modify rules and regulations, to approve nursing education programs, and to discipline the nurses of the state.

As health care becomes more complex and under greater scrutiny in our society, nurses, as the largest group of health care professional providers, are directly brought into the forefront of the health care system. Nurses are presently in short supply and their services are much needed in the dynamically, ever-changing health care delivery system. Ironically, nevertheless, nurses' behaviors are increasingly being disciplined by their State Boards of Nursing. Tennessee nurses are among those whose nursing

practices have been increasingly challenged and for whom disciplinary measures are taken for violation of the Tennessee Nurse Practice Act. No comprehensive, demographic, longitudinal statistics are available exclusively for the behavior of the Tennessee Nurse.

According to data from Certo-Guinan and Waite (1991), nationally, the majority of the disciplinary cases processed through the State Boards of Nursing are alcohol and/or drug related. There exists no available, reliable statistics on the number of chemically dependent nurses. Several reasons are purported for this lack of reliable statistics. There is difficulty in doing accurate research on a stigmatized illness characterized by denial. The persons affected, as well as their family and friends, often readily deny the disease. The profession of nursing, historically, has preferred not to recognize the chemical dependency problem (although peer assistance programs for impaired nurses are progressively changing this attitude). The numbers found in the literature, therefore, are estimates only and contain variation. Although estimates vary, it is thought that 5 percent of nurses are alcoholic based on the general population figures used for females as reported to the United States Congress in a special report by the Department of Health and Human Services (DeLuca, 1981). Drug addiction for the general population is 1 to 2 percent (Sullivan, 1988). The American Nurses Association (ANA) estimates that 6 to 8 percent of nurses have a substance abuse problem (Green, 1989).

Creighton (1988a) and Kelley (1982) described the scope of the discipline and impairment of nurses. Research shows that 10-20 percent of health care professionals

are impaired by alcohol or substance abuse. Sixty-seven percent of the disciplinary cases coming before State Boards of Nursing are drug related. Furthermore it has been reported in the literature and cited in numerous studies (Bissell & Jones, 1981; Booker, 1980; Certo-Guinan & Waite, 1991; Creighton, 1988a; Cronin-Stubbs & Schaffner, 1985; Greene, 1989; Hutchinson, 1986; Kraus, 1983; Sullivan, 1987) that 40,000 to 75,000 nurses in the United States are alcoholic, that narcotic addiction among nurses and physicians at any given time is 30 to 100 times greater than that of the general population at large, and that disciplinary action due to drug and alcohol abuse is a growing public health problem and major concern for health care professionals. The Florida Nurses Association (1983, p. 1) and Hutchinson (1986) reported that in Florida 80 percent to 93 percent of the disciplinary action cases brought before the Florida State Board of Nursing involved drugs with an annual cost of \$300,000. One in 10 Americans is chemically dependent, and nurses have a dependency rate which is 50 percent higher than non-nurses (Hutchinson, 1986; Kabb, 1984). According to figures supplied by Elliott and Heins (1987) and maintained by the National Council of State Boards of Nursing, of the 3400 disciplinary actions taken against nurses in 1986, 38 percent involved the use of drugs.

Disciplinary measures in nursing are not a new phenomenon even though publicity regarding the impaired health care professional has increased along with the violations during the past decade. Elliott and Heins (1987) indicated that nurses initially were disciplined mainly for drunkenness, moral turpitude, and violence. Murphy and Connell (1987) attributed the steady increase in disciplinary measures to

the increased consumer awareness movement, increased educational standards, and the professional duty and obligation to report violations of the Nurse Practice Act in the state.

Nurses are confronted with a wide spectrum of ethical and legal issues in their professional practice. Luckenbill-Brett and Stuhler-Schlag (1987) emphasized that social changes in health care have had an impact on nurses. Doing what is "right" is their concern when faced with the complexities of today's health care system. Doing that which is "right" is viewed as fundamental to ethical decision making. At issue is whether a nurse should focus only on his/her practice or, as a member of a health team, assume the responsibility to protect the patient from inappropriate practices of all members of the team. In either case, the ethical responsibility of the nurse is first and foremost to the patient.

The American Nurses Association (1976) developed the Code for Nurses and revised it in 1985. The Code for Nurses encourages nurses to participate actively in an ethical behavioral role. The Code identifies nurses' relationships to patients, the community, and other health care providers by incorporating state rules and regulations into a comprehensive code of conduct for practicing nurses. The Code for Nurses clearly states that a nurse's primary responsibility is to patient care and safety. To achieve this goal, the American Nurses Association directs that a nurse must be aware of his/her own professional behavior and that of others. It emphasizes that a nurse must be willing to take the appropriate measures necessary when aware of incompetent, unethical, or illegal behavior by other health care members.

Disciplinary actions require appropriate reporting to insure the public's safety. State Boards of Nursing act upon this reporting after sufficient proof of violation has been established.

Profiling the nurse violators is made more difficult because nurse managers, nurses, and those charged with the reporting and processing of nurse violators at the grassroots level often downplay or deny its existence or seriousness. Many times, the nurse is overwhelmed by the causative factors of the violation and may be too embarrassed to acknowledge or come forth and seek help, fearing that his or her license may be revoked. The nurse may not know where to turn for help until confronted by the State Board (Certo-Guinan & Waite, 1991). Green (1983) reported that there often appears to be a code of silence among nursing directors and staff that contribute to the disease of chemical dependency among the nursing employees. Excuses are made for their often inappropriate behavior. Leaves of absences are granted for these nurses, or, total denial of the problem is experienced. Many look the other way to avoid conflict. Administrators fail to report appropriate and timely information to the State Board. Based on the above information, the number of cases of nurses involved with alcohol or drugs at the level of the regulator boards is believed to be only the "tip of the iceberg" (Greene, 1989).

Violations of the Nurse Practice Act are generally outlined with the following seven types of disciplinary action based upon reportable activities or occurrences.

These are proof that a nurse:

- obtained a license through fraud, deception, or misrepresentation;

- engaged in gross negligence, malpractice, or incompetence;
- engaged in repeated acts of negligence, malpractice, or incompetence;
- engaged in professional or occupational misconduct as may be determined by the board.
- was convicted of any crime involving moral turpitude or any crime relating adversely to the activity regulated by the board;
- had his or her license revoked or suspended by any other state, agency, or authority for the above reasons; and
- is incapable, for medical or any other good cause, of discharging the functions of a license in a manner consistent with the public's health, safety, and welfare. (Luckenbill-Brett, et al., 1987, p. 34)

The Tennessee Nurse Practice Act clearly outlines the grounds for denial, revocation or suspension of a nursing license in the state of Tennessee as legalized by Tennessee Practice Act Regulation 63-7-115 (Appendix A).

STATEMENT OF THE PROBLEM

The literature review indicated that most unprofessional conduct in nursing resulting in disciplinary action by the State Board of Nursing was related to drug and alcohol abuse, although no comprehensive, longitudinal, published studies conducted with Tennessee nurses documented this claim. An unpublished study of nursing disciplinary action in Tennessee (Elliott & Heins, 1984) indicated 93 percent of all cases involving registered nurses (RNs) and 95 percent of all licensed practical nurses' cases related to drug and alcohol abuse.

Tennessee did not have statewide, current, published information in the form of profile information for the period of 1990-92 on nurse violators of the Tennessee

Nurse Practice Act. This research attempted to make that information available in a concise manner.

PURPOSE OF THE STUDY

The purpose of the study was to describe the types and extent of disciplinary actions of licensed nurses of the Tennessee State Board of Nursing during the years from 1990 through 1992. The characteristics of these nurses as well as the actions taken against them are summarized.

The overriding question to be addressed in this study is: What are the characteristics of nurses who have been brought before the State Board of Nursing for violation of the Tennessee Nurse Practice Act during the years from 1990 through 1992?

IMPORTANCE OF STUDY

Assessment of the nurse violations resulting in disciplinary action of the Tennessee State Board of Nursing has received limited attention from researchers. Increased emphasis on quality care and the welfare of patients makes it important that a profile be developed to identify problem areas and behaviors that might bring nurses' attention to the problem. Statistics on chemical dependency and alcohol use among nurses and health care professionals need to be tools for education of the profession and the public.

A research base needs to be established so further studies and follow-up surveys can be initiated. The future student nurse needs to know what risks and behaviors she/he faces as a licensed nurse. Advancement of nursing knowledge on which future

data bases may be compared is imperative. Tennessee nurses can benefit professionally from knowing about trends of fellow practitioners.

The Tennessee State Board of Nursing Executive Director, Elizabeth Lund, in a December 1992 interview, indicated a need for a study to enhance the work of the State Board and to show trends in violations and subsequent disciplinary action as communicated to the researcher. Zelma Stroud, Disciplinary Consultant at the Tennessee State Board of Nursing, endorsed the study as a means to comprehensively view the problem throughout the state (December 1992 interview). Dr. David Dodd of the Tennessee Medical Association and Chairman of the Tennessee Medical Peer Assistance Program/Abuse, Murfreesboro, Tennessee, indicated that research of this nature would be a first step in looking at the problem objectively and working with the health providers of this state to educate them of the need for more effective delivery of health care (March 1991 telephone interview). Douglas Arrington, former Chairperson of the Tennessee Nursing Peer Assistance Program, who previously worked with the nurse violators, indicated that a critical need for data and studies for Tennessee nurses existed. He further stated that this study would enhance the education process of the public as we face the rehabilitation of these professional people in the nineties (March 1991 telephone interview).

In 1992 the Tennessee State Board of Nursing endorsed a future fee increase for licensure of nursing to become effective in the near future. The funds shall be designated to help finance rehabilitation of impaired nurses through the Peer Assistance Program of the Tennessee Nurse Foundation. With this change, it was

important that leaders and practicing nurses have a profile of the scope of the problem of the disciplined nurse in Tennessee. Ms. Lund and Ms. Stroud were personally interviewed December 11, 1992, by the researcher at the State board of Nursing office in Nashville, Tennessee. Refer to Appendix B for supporting documentation.

ASSUMPTIONS

The study was based on the following assumptions:

1. The documented data obtained for the Tennessee State Board of Nursing were reported and recorded in an honest and accurate manner.
2. The variables chosen for study were valid for that purpose.
3. The procedures used when recording and retrieving data were appropriate and acceptable for collection of data for the study.
4. Disciplinary action was defined and measured.
5. The Tennessee Disciplinary Report Form is a valid and reliable instrument for recording disciplinary and demographic measures for nurses.
6. The reported cases were representative of the violations of the Nurse Practice Act throughout Tennessee.

LIMITATIONS

This study was:

1. limited to disciplinary actions taken by Tennessee Board of Nursing.
2. limited by information that was not available first hand.
3. limited by any incomplete files of data information at the State Board of Nursing.

DELIMITATION

The study was delimited to those cases of disciplinary actions of nurses that involve violations which were reported to the Tennessee State Board of Nursing and resulted in disciplinary action by the Tennessee State Board during the period from 1990 through 1992.

DEFINITION OF TERMS

An asterisk indicates the definition adopted by a four-stage Delphi survey of substance abuse experts conducted to help achieve greater clarity and uniformity in terminology associated with alcohol and other drug related problems. This multi-disciplinary group of experts was asked to reach a consensus on alcohol and other drug-related terms and definitions as reported in the Journal of the American Medical Association. Results produced an extensive list of abuse terms deemed important along with the most agreed on definition for each term (Rinaldi, JAMA, 1988, pp. 555-557).

For the purpose of this study, the following definitions were adopted:

Abstinence* is the cessation of use of a psychoactive substance previously abused, or on which the user has developed drug dependence.

Abuse potential* is the property of a substance that, by its physiological or psychological effects, or both, increases the likelihood of an individual's abusing or becoming dependent on that substance.

Addict (drug)* is a person who is physically dependent on one or more psychoactive substances, whose long-term use has produced tolerance, who has lost

control over his intake, and would manifest withdrawal phenomena if discontinuance were to occur.

Addiction (drug)* is a chronic disorder characterized by the compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm.

Administrative Procedure Act is written legal guidelines established by each state which regulate nursing practice in each respective state.

Alcohol abuse* is the use of ethyl alcohol in a quantity and with a frequency that causes the individual significant physiological, psychological, or sociological distress or impairment.

Alcohol addiction* is the physiological and psychological dependence on alcohol.

Alcohol dependence* is the chronic loss of control over the consumption of alcoholic beverages, despite obvious psychological or physical harm to the person. Increasing amounts are required over time, and abrupt discontinuance may precipitate a withdrawal syndrome. Following abstinence, relapse is frequent.

An alcoholic* is a person who has experienced physical, psychological, social, or occupational impairment as a consequence of habitual, excessive consumption of alcohol.

Alcoholics anonymous* is an international, nonprofessional organization of alcohol-dependent persons devoted to the achievement and maintenance of sobriety of its members through self-help and mutual support.

Alcoholism* is the chronic progressive, and potentially fatal biogenetic and psychosocial disease characterized by tolerance and physical dependence manifested by a loss of control, as well as diverse personality changes and social consequences.

Blackout* is the acute anterograde amnesia with no formation of long-term memory, e.g., a period of memory loss during which there is no recall for activities, resulting from the ingestion of alcohol and other drugs.

The Board of Nursing is the regulatory agency created by the state legislature to monitor and establish policy for the practice of nursing.

Chemical dependence* is the generic term relating to psychological or physical dependency, or both, on an exogenous substance, continuous use of mind-altering chemicals.

Dependence (drug)* is a generic term that relates to physical or psychological dependence, or both. It is characteristic for each pharmacological class of psychoactive drugs. Impaired control over drug-taking behavior is implied.

[According to Clark (1988, p. 12) the family, job and personal possessions (valued people and things) are sacrificed for the drug, which controls the person.]

Disciplinary actions are actions that are taken by the State Board of Nursing against nurses who are unable, or potentially unable, to meet acceptable standards of nursing practice because of chemical dependence or abuse, or who violate the Nurse Practice Act through other means.

Discipline is the type of sanction against a license.

Disease concept* is the recognition that chemical dependency is a chronic, progressive, and potentially fatal biogenetic and psychosocial disease characterized by tolerance and physical dependence manifested by a loss of control, as well as diverse personality changes and social consequences.

Diversion* is a diverting, or turning aside (from); distraction of attention; anything that diverts or distracts the attention; specifically a pastime of amusement. Diversion includes the theft of drugs for personal use and/or to give or sell to others.

Drug abuse* is the use of a prescription from a licensed physician or dentist for purposes other than that prescribed by the licensed physician/dentist or the use of alcohol regularly to attain a euphoric state.

[Drug abusers use drugs to avoid reality, to bolster one's ego, or to prove something. (Clark, 1988, p.12)]

Drug Free* is the ongoing disassociation from the use of any psychoactive substance.

Drug intoxication* is the changes in physiological functioning, psychological functioning, mood states, or cognitive processes, or all of these, as a consequence of excessive consumption of a drug; usually disruptive.

Drug use* is the use of a prescription from a licensed physician or dentist according to the physician's/dentist's directions or using alcohol in normal social drinking.

Drug misuse* is the use of a prescription from a licensed physician or dentist not according to the physician's/dentist's directions or occasionally drinking alcohol to excess. Any use of a drug that varies from a socially or medically accepted use.

[Drug use such as alcohol is for occasional and recreational purposes. It is predictable and intentional and not used as a means of problem solving. (Clark, 1988, p.12)]

Enabling behavior* is any action by another person or an institution that intentionally or unintentionally has the effect of facilitating the continuance of abuse or dependence.

An impaired nurse* is a nurse whose clinical conduct does not meet accepted standards of practice and whose conduct precipitated by alcohol-drug use, or psychiatric illness, or physical illness, or all three.

The Impaired Nurse Program is a program most often operated by a state nurses association to assist nurses who are chemically dependent.

Impairment is the inability to deliver competent patient care resulting from alcoholism or chemical dependency.

Intervention* is the act of interceding in behalf of an individual who is abusing, or is dependent on, one or more psychoactive drugs, with the aim of overcoming denial, interrupting drug-taking behavior, or inducing the individual to seek or initiate treatment.

Loss of control* is the inability to limit the use of substances via an internal locus of control.

A license is a legal document that permits a person to offer to the public his skills and knowledge in a particular jurisdiction where such practices would be unlawful without a license.

Over-the-counter drugs* are drugs which are available to the public for self-medication of minor problems. Also the physician or nurse practitioner may advise the client to use an over-the-counter drug for a variety of good reasons.

The Nurse Practice Act is the law passed by the state legislature to regulate the practice of nursing.

The NCSBN is the National Council of State Boards of Nursing. It serves as a national clearinghouse to provide professional data and licensure examinations for state boards of nursing.

The NCSBN Data Bank which is operated by NCSBN is the centralized source of information relative to disciplinary actions taken by State Boards of Nursing.

Physical dependence* is a physiological state of adaptation to a drug or alcohol, usually characterized by the development of tolerance to drug effects and the emergence of a withdrawal syndrome during prolonged abstinence.

Pilferage is stealing in small quantities.

Polydrug abuse* is the pharmaceutical or multi-concomitant use of two or more psychoactive substances in quantities and with frequencies that cause the individual significant physiological, psychological, or sociological distress or impairment.

Peer Assistance Program* is a network of peers who initiate intervention, monitor progress and offer continual support to a chemically dependent peer. Formal

programs usually include contracts for compliance with a prescribed treatment program and ongoing group support sessions.

Problem drinking* is drinking patterns that have resulted in serious disturbances of health, work, social adjustment, or other areas of functioning. This involves a pattern of alcohol consumption that does not satisfy all the criteria of alcoholism but that is characterized by sufficiently large intake to have generated problems of health or social functioning.

Psychological dependence* is the emotional state of craving a drug either for its positive effect or to avoid negative effects associated with its absence.

[Risk factors include the personal, environmental and societal conditions identified as predisposing factors to the development of chemical dependence. (Clark, 1988, p.12)]

Recovery* is the process of regaining a state of normalcy from the addiction to drugs.

A recovering alcoholic* is an alcoholic who is successfully abstaining; emphasizing the concept that no one is ever cured, and that recovery must be continuously worked out.

Rehabilitation* is the restoration of an optimum state of health by medical, psychological, social, and peer group support for a chemically dependent person and his significant others.

Relapse* is the recurrence of alcohol- or drug-dependent behavior in an individual who has previously achieved and maintained abstinence for a significant time beyond the period of detoxification.

Sobriety* generally refers to the state of complete abstinence from alcohol and other drugs of abuse in conjunction with a satisfactory quality of life.

Situational abuse is the frequent use associated with problematic situations, such as solving conflicts in family life or to cope with hurt, loss, rejection, or failure (Clark, 1988, p. 12).

The State Board of Nursing is an agency of state government charged with the responsibility for licensing individuals to practice nursing in the interest of the public's health, safety, and welfare.

A stay is the legal action in which there is a postponement of a legal decision.

Substance abuse* is the use of a psychoactive substance in a manner detrimental to the individual or society but not meeting criteria for substance or drug dependence.

Treatment* is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, or health injuring; or to restore appropriate levels of physical, psychological, or social functioning.

Tennessee Nurse Foundation (TNF) is the parent agency for the peer assistance program in Tennessee.

Unprofessional conduct is an act which is inconsistent with the standards of nursing practice. The definition differs from state to state.

Withdrawal* is the cessation of drug or alcohol use by an individual in whom dependence is established.

QUESTIONS

A profile was developed by seeking answers to the following questions through public records provided by the Tennessee Board of Nursing. These questions were divided into three categories: (1) Demographic (2) Professional (3) Relationships (between disciplinary action and violation).

1. Demographics

- A. Who were the violators? (RNs or LPNs)
- B. What type(s) of nursing degree did they possess?
- C. How many years in nursing did the nurse violator have?
- D. What were the personal characteristics of the disciplined nurses? (e.g., age, sex, race, marital status)
- E. Were the disciplined nurses' violations committed in the eastern region or western region of the state?
- F. Did the nurses commit their violations in rural counties or urban counties?

2. Professional

- A. What types of nursing violations occurred?
- B. What were the actions taken by the State Board of Nursing in Tennessee during 1990 through 1992?
- C. Were the disciplined nurses previously disciplined by a state board of nursing?
- D. Who was the employing agency for the disciplined nurse?
- E. Who reported the nurses most often for violation of the Nurse Practice Act?

F. Where in the state did drug abuse violators among nurses occur most often?

Inconsistent nursing practice? Medication administration abuse? Misconduct relating to the practice of nursing? Fraudulent conviction? Misdemeanor conviction?

3. Relationships (Between Disciplinary Action and Violation)

A. What disciplinary actions by the Tennessee State Board of Nursing were taken against nurses with various violations of the Nurse Practice Act, including substances abused?

B. What substance(s) were most abused by nurses which resulted in disciplinary action?

C. Which disciplinary action was taken most often against drug abuse? Drug diversion? Self administration? Use on duty? Writing illegal prescription?

ORGANIZATION OF THE STUDY

This study is organized in the following manner:

Chapter I is an introduction which consists of background, statement of the problem, purpose, and significance of the study. It includes research assumptions, limitations, and delimitations. Definitions and questions applicable to the study are also included.

Chapter II presents a review of related literature on the disciplinary actions of nurses. It covers the historical perspective of the disciplinary process. The incidence and prevalence of disciplined nurses is reviewed. The theoretical basis of chemical

dependence along with work-place factors are presented. In addition the legal issues surrounding disciplinary action are discussed.

Chapter III describes the procedures of the study. It includes the process by which the sample was selected, the data-gathering instrument process, and the statistical analysis of the data.

Chapter IV contains the findings of the study, an analysis and interpretation of the data, and a summary of significant findings.

Chapter V summarizes the research and findings, draws conclusions from the findings, and makes recommendations related to the disciplinary actions of nurses.

CHAPTER II

REVIEW OF RELATED LITERATURE

In the review of the literature, information is presented in the following categories:

1. Definition and historical perspective of disciplined nurses.
2. Incidence and prevalence of disciplined nurses.
3. Associated factors in nursing/violation disciplinary action.
4. Legal issues of disciplinary action.

DEFINITION AND HISTORICAL PERSPECTIVE OF DISCIPLINED NURSES

In our contemporary, complex society decision making in any profession, especially in the healthcare profession, can be very demanding and decisions may have awesome consequences. As a result, it is imperative for each person to be vested in his or her job—in the ultimate outcome of his or her work. This is especially true for nurses. Nurses deal with human interaction, relationships, nurturing, and medical treatment and their work outcome can impact life and death for the human being that is nursed. The impact of the nurse's ultimate outcome is paramount to life in most instances. Each nurse has a special responsibility and accountability that must become part of an employee's identity, commitment to life, and place in society. Ignoring the importance of that investment risks the integrity of the nurse and the life of the nursed, as well as the whole institution of the nursing profession.

Historically, the profession of nursing has had a "Professional Code of Ethics" as seen in the Florence Nightingale Pledge:

I solemnly pledge myself before God and in presence of his assembly; To pass my life in purity and to practice my profession faithfully.

I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself of those committed to my care. (Davis & Aroskar, 1978, pp. 12-13)

In 1976, the American Nurse Association (ANA) prepared a lengthy interpretative statement of the Florence Nightingale Pledge to clarify principles, called Code for Nurses, which stated among other principles that the nurse assumes responsibility and accountability for individual nursing judgments and actions to include:

- the right of nurses to regulate their own profession;
- specification of the nurse's role;
- accountability to the law rather than to physicians (creating an obvious conflict of duties); and
- peer evaluation and its consequent problems of enforcement. (ANA, Code for Nurses, 1976)

In a profession such as nursing, which requires licensure, the license is a legal document for the nurse. The license permits the practicing nurse to offer her skills and knowledge to the public in a certain jurisdiction that would otherwise be unlawful practice without a license. In every state the nursing profession requires that both RNs and LPNs be licensed to practice their skills and knowledge. This is done for the health, welfare, and safety protection of the public. Licensure rules in each state

were created by state statutes. The application of these statutes and the rules and regulations which govern the administrative agency (the State Board of Nursing) must be applied without regard to discrimination, improper pressure, or arbitrary action. The licensure of nursing personnel, when in conflict with the public protection, health, welfare and safety of patients, provides a legal foundation for disciplinary action (Creighton, 1981, p. 9; 1986).

Nursing licensure establishes the standards for entry into practice, defines a scope of practice, and allows for disciplinary action. The legal foundation for nursing licensure rests on the government's responsibility to protect the health, safety, and welfare of the public. The state legislative acts to protect the public from unqualified, unsafe practitioners are known as Practice Acts. Nurse Practice Acts define and limit the practice of nursing in each respective state. In so doing, they thereby determine what constitutes unauthorized practice, or practice which is beyond the scope of normal authority and practice.

Rules and regulations are published, in addition to the Nurse Practice Act, which tend to be more specific and provide more precise direction. Board rulings provide a third source of legal guidelines and scope of nursing practice in each state. Advisory opinions or rulings are often issued in response to a formal request by a nurse or facility for clarification of a clinical product or activity. In addition, the Board may submit a question to a particular state agency or department such as the Attorney General's department. Advisory opinions from the Attorney General's Office are not law; however, they are persuasive documents in a judicial proceeding.

The Nurse Practice Acts outline the grounds for disciplinary action. While the reasons differ from state to state, general categories usually include fraud and deceit, criminal acts, incompetence, and unprofessional conduct (Fiesta, 1990b). The Tennessee Nurse Practice Act clearly states the law concerning the grounds for denial, revocation, or suspension of certificate of license as stated in Tennessee General Statute 63-7-115 and the license revocation or suspension procedure (General Statute 63-7-116) (see Appendix A).

From a historical perspective, regulation in nursing has evolved in three phases. According to Danis (1985), the first phase of nursing licensure began in 1903. North Carolina, New Jersey, New York, and Virginia passed nurse registration acts. By the year 1923, all the states had passed similar laws. These nurse registration acts were not Nurse Practice Acts in the early law. Registered Nurses (RNs) were identified by their completion of an educational program and the passing of an examination. They were not specifically identified by their practice domain. The original goal of nursing licensure had been to restrict the right to use the title "nurse." Due to political considerations, however, the modifier "registered" was dictated. Anyone could practice nursing and use the title "nurse" but only certain licensed nurses could call themselves registered nurses.

The second phase of nursing regulation focused toward mandatory licensure and the delineation of the definition of nursing practice. The state of New York passed the first mandatory Practice Act in 1938, and over 40 states passed mandatory licensure laws during this phase in the history of nursing licensure and regulation. It

became illegal for unauthorized and unlicensed persons to practice nursing; thus, it became necessary to define nursing. The American Nurses Association adopted a model definition of nursing in 1955 (which has since been revised) which was very influential in limiting the scope of nursing practice. The definition stated that the practice of professional nursing "shall not be deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures." The prohibiting of diagnosis and therapeutic treatment became a barrier to practice when it was incorporated into many state practice acts (Danis, 1985, p. 213).

The current phase of nursing regulation and licensure has focused on removing barriers and expanding (or re-expanding) the legal scope of nursing practice. The third phase began in 1971 when Idaho revised its Nurse Practice Act authorizing diagnosis and treatment. By 1980, a total of 40 Nurse Practice Acts had provisions that facilitated an expanded nursing role, exemplified by nurse practitioners, nurse midwives, and nurse anesthetists. During the third phase, four strategies for expanding the role of nursing as a profession have been employed:

1. The basic definition of nursing has been expanded to include diagnosis and treatment.
2. "Additional Acts" provisions have been added, allowing certain specified types of nurses to practice in an expanded role.
3. The use of standardized protocols to delineate expanded functions has been allowed.
4. Physician delegation of diagnosis and treatment to nurses has been increasingly allowed.

Most states have selected either the expanded definition strategy for nursing or the additional-acts strategy. (Davis, 1985, p. 213)

As of 1991, nursing had expanded to include an extensive Manual of Nursing Diagnosis by Gordon (1989) and Nursing Diagnosis: Process and Application (Gordon, 1987). Conceptual word labels for diagnostic judgments were as commonplace as charting of the patient's condition and circumstances. Concise terms to describe a cluster of signs and symptoms exhibited by the client and the guidelines for diagnosis were readily a part of the nursing process. Nursing diagnoses were based on a nursing assessment. An overview of diagnostic judgment, the bridge between nursing diagnosis and treatment, and therapeutic judgement regarding intervention and outcome were encouraged in all aspects of the nursing process. The purpose was to describe professional nurse's diagnostic judgments about actual or potential patient health problems and health related conditions. Many types of judgments were made in nursing practice, but the term "nursing diagnosis" was reserved for patient conditions "which nurses by virtue of their education and experience were capable and licensed to treat" (Gordon, 1976, p. 1299). Nursing contemporary regulation has allowed diagnostic categories to be endorsed by the American Nurses Association as accepted by the North American Nursing Diagnosis Association (NANDA), an influential national nursing committee.

As complexity in the regulation and legislation of nursing rules and regulations became more pronounced, it is of significance to note that research in the literature indicates the incidence and prevalence of disciplinary actions involving nurses and

health workers increased. Drug abuse is a national health problem and drug abuse by health care professionals, including nurses, is a major concern of both colleagues and the public (Clark, 1988). "Society cringes from admitting that the hand that rocks the cradle may be shaky due to the use of alcohol and drugs" (Creighton, 1988a, p. 21). Interference with the ability of the nurse to make nursing assessment and diagnostic evaluations is of utmost concern to the public welfare.

INCIDENCE AND PREVALENCE OF DISCIPLINED NURSES

In order to understand the incidence and prevalence of disciplinary measures taken against nurses, basic information about nursing personnel in the United States is essential. In a national sample survey of registered nurses, funded by the Exxon Corporation and taken in 1988 by the federal government, characteristics of the RN population of the United States were documented by McKibbin (1990, pp. 2-3):

Employment and Earnings

More than 2 million (2,033,032) individuals held licenses as RNs in 1988; the total nurse population has increased some 45 percent since 1977.

Nearly 80 percent of RNs work in nursing--1,627,035 individuals. This is a remarkably high labor force participation rate for a profession that is predominately female (only 3.3 percent of RNs are males).

Among employed RNs, part-time work is prevalent; almost one-third (32.4 percent) of employed RNs work part-time.

Hospitals are the primary work site for registered nurses. More than two-thirds (67.9 percent) of RNs work in hospitals. [Some 100,000 more RNs worked in hospitals in 1988 than in 1984, although about two-thirds of employed RNs worked in hospitals in both of those years.] The other work areas in which 3 percent or more of employed RNs work are ambulatory care (7.7 percent), public/community health (6.8 percent), and nursing homes or extended care (6.6 percent)

About two-thirds of all employed RNs hold staff nurse positions, or "general duty" nursing jobs.

51,000 RNs (3 percent of all employed RNs) primarily work for temporary employment services. Another 37,000 RNs work for a temporary employer as well as holding another nursing job.

On average, RNs earn \$28,383. After removing the effects of inflation, real earnings increased only 9 percent between 1984 and 1988. Nurses employed in hospitals earned an average of \$29,160 in 1988, 17 percent and 15 percent more, respectively, than the average \$24,889 earned by RNs in ambulatory settings and the \$25,351 paid to nurses working in nursing homes.

Personal Characteristics and Education

Most registered nurses are white females. Among employed RNs, 3.3 percent are males, while 7.6 percent are from ethnic/racial minority backgrounds. The proportion of minority nurses has declined since 1984, when 11.5 percent of the employed RN population were members of minority groups.

By age group, the RN population is getting older. In percentage terms, between 1984 and 1988, the under-30 age group declined in size, while all older categories grew. More than one-third (34.4 percent) of RNs were between the ages of 30 and 39 in 1988. The average age of RNs is 39. The age distribution of the RN population mirrors the more general pattern of the "baby boom" generation.

Seventy percent of RNs are married, and the majority of married nurses (55 percent) have children at home. Most nurses, even those with children under age six at home, are employed in nursing, although married RNs with young children report much higher levels of part-time work than do other nurses.

The highest educational preparation of 40 percent of RNs is a nursing diploma; 25 percent hold associate degrees; 27 percent have baccalaureates (the balance hold higher degrees). These percentages compare to 67 percent, 11 percent and 18 percent, respectively, in 1977. About 125,000 RNs have master's degrees, up from 55,000 in 1977. Some 5,400 RNs hold doctoral degrees, more than double the 2,300 with doctorates in 1977 (McKibbin, 1990, pp. 2-3).

As of October, 1990, there were 45,023 active registered nurses in Tennessee and 1,935 inactive registered nurses. There were also 21,555 licensed practical nurses and 789 inactive practical nurses in Tennessee (Tennessee State Board of Nursing,

1990b). For the most up-to-date, revised figures for registered nurses and licensed practical nurses in Tennessee during the period of 1989-1992, refer to Table 1.

The process that leads to the disciplinary action taken against nurses is viewed by some in the profession as a liability to the profession rather than upholding the Nurse Practice Act. This results in nurse violators failing to be properly reported and disciplined. How extensive is the overall problem of disciplining nurses and for what infraction? The literature gives the reader a variety of statistics. Literature on this subject offers guesses of anywhere from 9 percent to 20 percent of health care professionals (including social workers, counselors, psychologists, priests, nuns, attorneys, doctors, nurses, teachers, dentists, veterinarians, pharmacists, airline pilots, and others) are impaired. Treatment experts think that the truth lies with the larger estimates, probably somewhere between 10 percent and 15 percent (Crosby & Bissett, 1989). However, not all of the impaired individuals receive discipline.

The truth of the extent of disciplinary measures taken is that no statistics of the percentage of nursing professionals afflicted or impaired have been accurately reported or consistently kept, historically. Many health care providers do not know what infractions are, how to recognize them, or how to report them. One truth is certain--not all impaired and incompetent professional health care providers, including nurses, are reported to their state professional boards for disciplinary action.

Secondly, when impaired professional nurses have undergone disciplinary action by licensing boards of nursing for such infractions and violations as unprofessional

Table 1. Number of Active and Inactive Registered Nurses and Licensed Practical Nurses in Tennessee 1989-1992 (Revised List*)

Year	Active Nurses	Inactive Nurses	Total Nurses
<u>Jan. 1989</u>			
RN	36,244	1,828	38,072
LPN	<u>21,469</u>	<u>898</u>	<u>22,367</u>
Total	57,713	2,726	60,439
<u>Sept. 1990</u>			
RN	45,023	1,935	46,958
LPN	<u>21,555</u>	<u>789</u>	<u>22,344</u>
Total	66,578	2,724	69,302
<u>Sept. 1991</u>			
RN	44,259	1,933	46,192
LPN	<u>23,445</u>	<u>786</u>	<u>24,231</u>
Total	67,704	2,719	70,423
<u>Jan. 1992</u>			
RN	44,812	1,912	46,724
LPN	<u>23,670</u>	<u>784</u>	<u>24,454</u>
Total	68,482	2,696	71,178

*Source: Figures given to researcher by Executive Director of Tennessee State Board of Nursing in January, 1993 by office files.

conduct, negligence, improper handling of controlled drugs, or diversion of controlled drugs for personal use, these disciplinary actions are recorded only under the broad, vague category of violation. It is not always clear as to what other violations were involved, including the use of drugs or alcohol. Thirdly, not all who are in trouble are caught; and even when they are, they may not be reported to proper regulatory boards. Fourthly, oftentimes nurses who are reported are not found guilty, even if they truly need behavior modification and regulation of their license. Reasons given include lack of proof, fear of litigation, fear of anger and retaliation, and commonly the attitude that "it's not my problem." It is controlled substances that usually are most reportable because they leave a detectable paper trail. With drugs such as cocaine or marijuana, which are more difficult to trace, there is greater difficulty.

Oftentimes, nurses are fired for alcohol/other drug usage, and oftentimes they move on to practice in another locale, even another state. Due to the fact that there is no central reporting, high-tech public health hazard registry tracking to safeguard against this relocation, and until disciplinary action can be brought against the nurse, the new area and locale of practice for the fired nurse will not have a record of the problem with the licensing board immediately (Crosby & Bissett, 1989)

Despite the lack of accurate figures on the number of chemically impaired professionals, the situation is critical. Various state agency reports of completed disciplinary actions taken relative to nursing licenses show alcohol and other drug use resulting in impairment.

It was reported by Connell and Murphy (1987) that measures to regulate the performance behaviors of professionals are being developed nationally. State Boards of Nursing are increasingly attempting to assume regulatory functions for the profession of nursing. The duty to report violations of a state's Nurse Practice Act has been legislated in most of the states as statutory mandates. Nursing professionals are only beginning to accept their professional responsibility of self-regulation and of peer review in the clinical practice setting.

Monitoring nursing practice is of a growing national interest because of such factors as rising health care costs, consumer awareness, AIDS (Auto Immune Deficiency Syndrome), and renewed emphasis on preventive health-maintenance and self-care and the state of health care in the present environment (Greenlaw, 1985). These factors have increased the self regulation of nursing activities in the profession, while the scope of nursing practice continues to expand. Nurses have begun to assume increased responsibilities as providers of excellence in health care at a lower cost to the consumer. States and disciplinary boards vary widely, however, in the degree to which they assume responsibility for regulating the nursing profession as of 1992.

The literature reflects that disciplinary regulations and violations are prevalent and serious in the entire nursing profession as reflected in the following statistics of prevalence and incidence. Review of the literature finds varied studies and statistics. Uniformity of record keeping and organization of case findings are not standardized in every state alike.

The American Nurses' Association estimates that six to eight percent of the registered nurse population has a drug or alcohol related problem (American Nurses Association, 1987). These estimates vary with other researchers, but are not significantly debatable. According to Lachman (1986), there are 40,000 alcoholic nurses in the United States; and one out of every three disciplinary cases handled by the National Council of State Boards of Nursing is drug related. It is obvious, therefore, that a problem involving drug abuse exists among nurses (Baywood, 1990, p. 40). In a study reported by Jefferson and Ensor (1982) involving 100 addicted nurses, it was found that they were well educated, honor students having finished in the top one-third of their classes, held advanced degrees, were ambitious workers who held responsible jobs, and were highly respected for excellent work. Reasons for drug abuse by nurses are explored in a later section of this chapter.

Beck and Buckley (1983) indicated in a study reported in Newsweek that nurses have a 50 percent greater chance of developing chemical dependency than other members of our society. Easy access to drugs by health care professionals puts them at increased risk for abusing drugs.

The number of actions taken against nurses' license for chemical dependence is known. Among the 37 of 58 member Boards of Nursing who responded to a survey done in one year by the National Council of States Boards of Nursing, 67 percent of 97 actions taken against nurses' license were for chemical dependency. The survey further reported that the loss of practice privileges resulted for 649 nurses in one year (Greene, 1984).

In a study of self regulation by the nursing profession composed of 100 records on file at a Board of Nursing office (state not disclosed), Connell and Murphy (1987) reported that 60 subjects were disciplined for some type of substance abuse while 40 subjects were disciplined while on duty in an agency. Demerol (meperidine) was the drug most often used by the disciplined nurse ($n=31$, 51.7 percent). The other most common drug was alcohol with 12 (20 percent) of the offenders being intoxicated, to some degree, while on duty. Nurse abusers are not as easily detected if they work at different hospitals. Unlike alcohol, drugs cannot be smelled on the breath, so a nurse can often continue to function without detection.

The type of incompetence reported by Connell and Murphy (1987) in their study of the 40 remaining subject nurses indicates that medication errors (including IV's, blood, and repeated errors) accounted for 47.5 percent, lack of technique and knowledge of procedure accounted for 17.5 percent, failure to maintain records 17.5 percent; soliciting drugs from patients 5.0 percent; stealing unsigned scripts and falsifying doctor's name 5.0 percent; physical abuse of patient, stealing from patient, and failure to supervise (2.5 percent each). Furthermore, it was found that the average, typical nurse who was brought before the Board for disciplinary action was between the ages of 30 and 39, female, divorced, had graduated within the last 10 years, worked in a medical-surgical nursing clinical area, and was employed by a hospital. The typical nurse presented before the Board for incompetency was between the age of 20 and 29, female, married, had graduated within the last 10 years, worked also in a medical-surgical clinical area, and was employed by a hospital. Connell and

Murphy (1987) report on research which showed that of all registered nurses disciplined for substance abuse, the most common drug was demerol.

Davee and Tranbarger (1990) reported the cost and devastating effects of chemical dependency in the work-place. Employees who abuse drugs, including alcohol, are very costly to employers. It is projected that such an employee who earns \$18,000 per year can cost an institution \$50,000 to \$75,000 per year in reduced job efficiency, sick leave abuse, unnecessary overtime, overuse of health insurance and workers' compensation claims resulting from injuries on the job, and training for personnel replacements and substitutes.

Kathryn Skinner, Nurse Counselor in charge of recruitment at Methodist Hospital of Memphis, Tennessee, stated that 6 percent of the nation's registered nurses are drug abusers based on the findings of the Chairman of the American Nurse's Association Committee on Impaired Nursing Practice. Suspicion of chemical dependency usually is thought to follow a single incident that alerts a manager to a problem (Skinner, 1990).

Due to the increased prevalence of chemical dependency in nursing, the American Nurses Association published a position paper in June of 1984 on Addictions and Psychological Dysfunctions in Nursing: The Profession's Response to the Problem. The publication provided an overview of the issue of impaired practice within nursing and offered suggestions and direction in calling attention to this problem (Naegle, Ensor, & Smith, 1984).

Research and similar reports by Kabb (1984), Hutchinson (1986) and Garb (1965) indicated that the vast majority of the disciplinary action cases of nurses are alcohol and drug related. The annual cost for disciplinary proceedings continues to spiral upward. Narcotics addiction has been the leading cause of disciplinary action and continues to be the major contributing factor.

In a study reported by Bissell and Jones (1981) and conducted in the mid 1970s to learn more about alcoholism among nurses, the subjects were white women. The criteria for the study included that the subjects (nurses) considered themselves to be alcoholic. They were members of Alcoholics Anonymous, and they had to have been completely abstinent for one calendar year or more prior to the interview. Ages ranged from 26 to 69, with a mean age of 44.6 years. They indicated that the range of abstinence from alcohol was from one to 20 years, with a mean of 4.8 years. Two were semi-retired and working only part-time, 67 were employed full-time as nurses, three worked full-time outside of nursing, and 28 were not employed (1 recent nurse graduate, 15 homemakers and mothers, and 8 volunteer workers). The results of the rates of addiction of the RNs were: alcohol only (65 percent); both alcohol and narcotics (1 percent); alcohol and non-narcotic drugs (21 percent); alcohol, narcotics and non-narcotic drugs (13 percent). The type of drugs of addiction reported other than alcohol included narcotics (14 percent); barbiturates (23 percent); amphetamines (16 percent); glutethimide (6 percent); meprobamate (13 percent); chlordiazepoxide (9 percent); Chloral Hydrate (6 percent); ethchlorvynol (placidyl) (3 percent); diazepam

(4 percent); terpin hydrate (4 percent); phenothiazine (6 percent); all other drugs (8 percent).

The institutional treatment for the alcoholism or alcohol-related illness among the 100 nurses indicated a total length of stay equivalent to 34 years with 67 percent of the RNs admitted one or more times. The medical complications included gastritis, peripheral neuropathy, severe malnutrition, fatty liver, gastrointestinal bleeding, duodenal ulcer, pancreatitis, cirrhosis, and esophageal varices. Several subjects reported more than one complication.

The legal sanctions taken against the subjects included 14 who were arrested, 12 who were jailed, and nine who reported the loss of their driver's license. The total number of arrests was 22, while the total number of jailings was 19. A number of the subjects experienced more than one sanction. The professional sanctions reported in this study included being admonished by colleagues (24 percent) and being warned by the state board of nursing (2 percent). Three percent lost their nursing license, while 74 percent were never sanctioned. Fifteen percent reported a period of unemployment due to drinking. Forty-four percent lost or quit their jobs due to drinking.

In a Health and Human Service federally supported research finding, Supples (1990) illustrated the high incidence of substance abuse in the nursing profession. The researcher emphatically stated that the incidence is high and growing. Indicating that there are 2.1 million registered nurses in the United States, she reported that from 1980 to 1986 there were 12,000 actions taken against licensees by State Boards

of Nursing, 60 percent of which involved drugs and alcohol. Supples also reported that the Surgeon General of the United States in a recent report, Healthy People, estimated that 10 percent of the general population will experience drug or alcohol problems some time in their lives.

Furthermore, at current estimates, it is possible to postulate that 10 percent of all nurses are affected to some degree by substance abuse while one in seven is at risk. No practice specialty or area is immune. Nurse anesthetists and their physician counterparts are known by the health care community to be more at risk than other personnel (Kabb, 1984).

From statistical records supplied by the National Council of the State Boards of Nursing, the latest statistics were compiled. Summaries of disciplinary actions by state boards from 1988 through 1990 in the areas of drug related cases are outlined in Table 2. Medication administration and inconsistent nursing practice cases are summarized in Table 3.

In 1990, the last year for which national statistics were processed and available at this writing, the disciplinary actions of State Boards continued to spiral upward. This may be due to more nurses working, especially through agencies, improved reporting mechanisms, less tolerance in the work-place for drugs, alcohol and incompetence, increased drug-testing programs, as well as an increase tendency in the society as a whole to abuse alcohol and other drugs.

Table 2. Drug-Related Disciplinary Cases Brought Against Nurses in the United States, 1988-1990

Violation	Year					
	1988		1989		1990	
	LPN	RN	LPN	RN	LPN	RN
Abuse						
No.	244	666	227	523	336	607
%	28.7	29.1	33.1	31.5	33.9	33.0
Diversion						
No.	248	630	189	439	238	480
%	29.2	27.5	27.6	26.4	24.0	26.1
Self Admin.						
No.	150	530	95	355	153	369
%	17.6	23.1	13.8	21.4	15.4	20.0
Use on Duty						
No.	78	200	56	122	56	127
%	9.2	8.7	8.2	7.3	5.7	6.9
Illegal Rx Writing						
No.	33	69	27	53	45	48
%	3.9	3.0	3.9	3.2	4.5	2.6
Other						
No.	97	195	92	170	163	210
%	11.4	8.5	13.4	10.2	16.4	11.4
Total						
No.	850	2290	686	1662	991	1841
%	100.0	100.0	100.0	100.0	100.0	100.0

Table 3. Medication Administration and Inconsistent Nursing Practice Cases Brought Against Nurses in the United States, 1988-1990

Medication Administration						
Violation	Year					
	1988		1989		1990	
	LPN	RN	LPN	RN	LPN	RN
Charting Errors						
No.	106	119	83	114	118	132
%	31.4	21.8	34.6	27.2	36.4	28.4
Follow Orders						
No.	63	79	46	68	60	88
%	18.6	14.4	19.2	16.2	18.5	19.0
Witness Waste						
No.	36	81	14	54	10	46
%	10.7	14.8	5.8	12.9	3.1	9.9
Document Admin						
No.	84	144	49	96	53	107
%	24.9	26.3	20.4	22.9	16.4	23.1
Other						
No.	49	124	48	87	83	91
%	14.5	22.7	20	20.2	25.6	19.6
Total						
No.	338	547	240	419	324	464
%	100	100	100	100	100	100

Table 3. (continued)
Inconsistent Nursing Practice

Violation	Year					
	1988	1989	1990	1988	1989	1990
Leave Station						
No.	34	20	25	27	38	15
%	11.8	5.2	8.5	5.8	8.8	2.7
Minimum Standards						
No.	123	149	108	180	149	205
%	42.9	38.5	36.7	38.5	34.5	36.7
Incompetent Practice						
No.	63	88	56	101	97	133
%	22.0	22.7	19.0	21.6	22.5	23.8
Other						
No.	67	130	103	160	148	206
%	23.3	33.6	35.7	34.2	34.3	36.9
Total						
No.	287	387	294	468	432	559
%	100	100	100	100	100	100

The major areas where RN and LPN cases are consistently near or over 25 percent for the three consecutive years in the drug-related disciplinary cases are the drug abuse and drug diversion categories. This is also reflected in the medication administration cases in the area of charting errors. This clearly confirms the literature finding that drug abuse and diversion are major problems in the nursing profession.

The major disciplinary category in the inconsistent nursing practice was in the area of maintaining minimum standards. The statistics reveal that in 1988 there were 123 LPNs disciplined for failure to maintain minimum standards (42.9%), the largest percentage of any violation. Incompetent nursing practice was a major, continuous focus of the inconsistent nursing practice category from 1988 through 1990. The charting of medicines incorrectly by nurses is clearly outlined as a major disciplinary area by state boards of nursing.

Dr. Sarah Mynatt, Professor of Nursing at Memphis State University, Memphis, Tennessee, surveyed nurses in the Tennessee Nurse Association Peer Assistance Program. She developed a profile of the chemically dependent nurse so as to make recommendations about how to identify the impaired nurse earlier so that policies could be recommended which would recognize the disease concept of chemical dependency. The study was developed around the concept of denial with denial being perceived as stronger in the early treatment period rather than later in recovery. Using a survey which maintained confidential identities and relied on voluntary participation with a sample of nurses in the Peer Assistance Program in Tennessee, a

personal history and characteristics of chemical use was gathered. Frequencies were calculated, and Chi Square was used to test differences in early and late recovery.

There was a 57 percent return of the survey, with 68 percent of the respondents having participated in the Peer Assistance Program for over one year. The most frequent area of specialty was medical/surgical with all types of educational preparation represented. Eleven percent held graduate degrees. The mean number of employers was 2.85 with 23 percent of the respondents being employed for three years by one employer. The results showed a considerable amount of drug usage. The drug usage history indicated that 50 percent of the respondents had experimented with chemicals before finishing high school; consumed chemicals before duty and while on duty; consumed orally or by injection; and concealed the chemical on themselves. The majority did not associate with impaired colleagues or share technical advice.

Findings of the study indicated that diversion and pilfering were common occurrences. The findings did not conclude that it was easier to divert chemicals on any particular day of the week or any particular work shift. The findings stated that few would have sought help without having been confronted. Only 36 percent had an employee assistance program which provided assistance to the nurse and most had sanctions imposed upon them. Feelings of worthlessness and being unloved were found to be significantly higher in the study in early recovery rather than later recovery.

The study concluded that in the chemically dependent nurse that self-reporting may not be an accurate method to identify the properties and characteristics associated

with the chemical dependency or the nurse's perception of his/her performance.

Nurses are able to work in an impaired condition for several years without being detected. Inadequate methods to identify and support the chemically dependent nurse exist. All mood-altering drugs are at risk for diversion. More employer support and educational programs for nurses and nursing students need to be developed.

Education should be targeted at developing a non-judgmental, non-moralist approach.

Confrontation strategies are extremely important to intervene into chemical dependency as a disease process (Mynatt, 1988).

Further research is being conducted regarding the impaired nurse in three regions of the state of Tennessee supported by a \$50,000 state grant which began in 1989. Preliminary results given to this researcher reveal that as many as one out of every five or six active nurses in the Memphis area show some degree of impairment (Personal conversation with Sarah Mynatt, Ph.D., May, 1991). Mynatt and Kelley (1990) have accessed the first database created by the peer assistance program for chemically dependent nurses in Tennessee through mailed questionnaires. The preliminary results indicated that nurses have a very complex problem involving alcohol and drugs with increasing concern for the growing numbers. The study results also indicated that stress, narcotics and other drugs, easy access to drugs, and the open opportunity to partake of them provides overwhelming evidence that nurses are a high-risk group for chemical dependency. Nurses at risk with certain personal crises coupled with stress, narcotics, access, and opportunity for use often exhibit maladaptive behavior. When this maladaptive behavior goes unnoticed in the same

environment, the result can be, and oftentimes is, drug abuse and chemical dependency (Mynatt & Kelley, 1990).

Robbins, a nursing consultant for impaired health care professionals, estimated that between 40,000 and 75,000 chemically impaired nurses were in the work force (Robbins, 1987). O'Conner (1985) estimated that approximately 12 percent of the entire work force have serious personal problems with half of these problems related to the use of alcohol or mood-altering chemicals. Through a monitored treatment program for impaired health care professionals, the serious, destructive process of chemical dependency (which has a staggering financial and emotional cost) can be reversed. If monitored, 90 percent can have a successful recovery while 85 percent can return to the work-place as productive employees (Robbins, 1987).

Kabb postulated that the problem of chemical dependency and alcoholism in the United States is endemic. One in four families has at least one member experiencing severe problems of chemical abuse. Conservative estimates as reported in Time Magazine (1983) indicate that one in ten Americans has an alcohol or chemical dependency problem. The scope of the problem is enormous (Kabb, 1984).

The Quinn-Larson and Pickard research (1989) noted a study on collegiate alcohol consumption in which approximately 80 percent of 300 undergraduate baccalaureate nursing students were current drinkers. The consumption of alcohol had interfered with work or school according to 13 percent of the sample. Greene (1984) in her research described traits common to nurses who become impaired. Those traits included graduating in the top third of their nursing class, holding an advanced degree, occupying a demanding and very responsible position, being greatly respected

by peer nurses, and coming from a home environment where one or both parents abused substances. These traits suggest that the nursing students who are high achievers might be more susceptible to chemical dependency.

In 1987, Nursing Life and Good Housekeeping conducted a comprehensive nationwide survey of almost 2000 nurses to inquire how deeply they have been affected by drug abuse, addiction, and alcoholism. Also, information was gained regarding the clinical practice of nursing for those using drugs and alcohol. The research was conducted in consultation with Madeline A. Naegle, RN, Ph.D., a highly respected nursing researcher and author. The response rate was 46 percent. Almost 2,500 nurses did not respond. The assumption was made that some of those who did not respond do abuse drugs and alcohol. People who abuse drugs or alcohol may be less likely than non-abusers to respond to surveys. Many may worry about confidentiality and fear repercussions, including loss of job, as this survey indicated. Most nurses felt uncomfortable examining this area of their lives. Also, it was indicated that when drug users do answer surveys about drugs and alcohol that they tend to minimize how much and how often they use them (Neagle, 1988).

Of the 1,811 nurses who responded to the survey, 98 percent were female in the age range of 25 to 39 years. Thirty-six percent held RN diplomas while 35 percent held either a BSN/BS/BA. Sixty-eight percent were employed in a hospital. Thirty-five percent were staff nurses. The years in nursing ranged from five to fourteen years. Forty-eight percent practiced in an urban setting and seventy percent of the respondents were married.

For an overall view of substance abuse among the respondents refer to Table 4. Findings indicated in the study reveal that very few of the nurses who responded to the survey were drug abusers. Nineteen percent said they never drank alcohol, but many respondents perceive alcohol abuse as a problem in the profession far greater than drug abuse. Men in the study drank alcohol and abused drugs more often than the female respondents. Females in the study had used street drugs more often and taken a prescription drug without a prescription more often than their male colleagues who responded. One of every two respondents reported that controlled substances in their workplaces were very accessible. Seventy-five percent reported that they were moderately to extremely stressed most of the time at work (Naegle, 1988, p. 44). These work-place stress findings agree with the work-place stress model put forth by Cherniss (1980) and Hardy (1978, p. 76). This comprehensive study has proven insightful into the hospital as an occupational hazard for nurses.

Helen Creighton, a leading and respected nursing legal expert, reiterated the scope of impairment in nursing as a considerable concern legally and professionally. As a basis of legal concern, Creighton cited Kelley's estimates that 10-20 percent of health care professionals in our nation are impaired by alcohol or substance abuse. Creighton cited Kabb's research that showed "one in ten Americans is chemically dependent, and nurses have a rate of dependency 50 percent higher than non-nurses" (Creighton, 1988a, p. 21).

Table 4. Nursing Life and Good Housekeeping Survey of the Frequency and Recency of Substance Use Among Nurses in 1987*

	Never took substance	In past only	Less than once a month over past year	Once a month or more over past year
Amphetamine-like drugs	91%	2%	<1%	<1%
Amphetamines	86%	7%	1%	<1%
Barbiturates	86%	7%	<1%	0%
Cocaine/crack	88%	6%	1%	<1%
Codeine	87%	3%	2%	1%
Darvon	86%	5%	1%	<1%
Demerol	92%	1%	<1%	0%
Hallucinogens	90%	4%	0%	0%
Heroin	93%	<1%	0%	0%
Marijuana/hashish	72%	20%	2%	2%
Morphine	93%	1%	<1%	0%
Percodan/Percocet	90%	2%	<1%	<1%
Quaaludes	91%	2%	0%	<1%
Tranquilizers	84%	6%	2%	<1%

* Percentages are based on answers given by all 1,811 survey respondents. Percentages in some categories may total more than 100% (due to multiple responses) or less than 100% (because some respondents failed to answer the question).

The cost of the process of disciplining nurses in an institution as well as the cost of nursing turnover incurs an economic loss for the employer. Johnston (1991) reported that the price associated with high turnover rates is staggering when all the related costs are calculated. Turnover of personnel incurs expenses of indirect overrun including termination costs, unused benefit payouts, exit interviews, and paperwork. The recruitment and orientation require financial budgeting to fill the vacant nursing positions. It is speculated that in excess of one million dollars annually in direct and indirect expenditures is spent just to replace the professional nursing staff. Fenner and Fenner (1989) reported that recruitment costs alone are estimated at \$2,500 to \$3,000 for a single registered nurse. The turnover costs per RN are calculated to average approximately \$25,000. This figure does not include the indirect costs from decreased productivity or the increased pressure on the other staff to assume additional workloads. These indirect costs increase when work behaviors due to drug abuse and/or incompetence are present.

ASSOCIATED FACTORS IN NURSING VIOLATIONS/DISCIPLINARY ACTION—TRENDS LEADING TO DISCIPLINE

The development of behaviors which lead to nursing violations and subsequent discipline are complex. Pressures exist in the nursing profession to strive for excellence and to approach perfection. The philosophy often internalized is "I am what I do." To admit deficiency is to be vulnerable in both personhood and in nursing. Often this work/life philosophy is a set-up for the use of mood-altering chemicals in order to cope, to keep going, and to relax. If the person has a genetic predisposition for chemical dependency, he or she is a time bomb waiting to ignite.

These issues and factors of overwork, perfectionism, and personal feelings lend insight into the behaviors leading to impaired practice and disciplinary action (Downing, 1990).

Social trends of alcohol and drug abuse among nurses parallel those of society. The use of drugs and alcohol in the American society is common and has been on an upward spiral since the 1960s, according to the American Nurse Association (1984). Two-thirds of the population drink alcohol on occasion, and of these one in ten develops an alcohol related problem (DeLuca, 1981). DeLuca further reported that 140 million individuals over the age of 18 use a variety of drugs, including prescription and recreational drugs such as marijuana, cocaine, inhalants, and stimulants. The trends and patterns of usage of particular significance are the increases in the non-medical use of prescribed drugs, the widespread use of marijuana, and the increasing rate of cocaine use, often in combination with alcohol (Mondanaro, 1989).

The National Institute on Drug Abuse reported that substance abuse is profoundly and negatively impacting the American work-place. They estimate that between 10 and 23 percent of all workers in the United States use dangerous drugs on the job, and many are under the influence of dangerous drugs when they arrive at work. Others use drugs so frequently outside the work environment that their health and judgment are impaired permanently (National Institute on Drug Abuse, 1987, p. 4). The annual employer losses due to alcohol and other drug abuse are estimated at \$80 billion (National Institute on Alcohol Abuse and Alcoholism, 1987). The unpleasant reality is that nurses and other Americans on any given day will comprise 8.9 million

to 16 million employees under the influence of drugs. It has been estimated these employees are performing at approximately 67 percent of capacity. It is, therefore, imperative to understand the basis for the behaviors in alcoholism and chemical dependency in the work-place, especially where the health and welfare of the public are at risk (Shibe, 1989, p. 14).

Since 96.7 percent of nurses are female (McKibbin, 1990), the basis for understanding alcoholism and drug addiction for nurses must be derived primarily from insights into women. With the use of alcohol increasing in general within the past 30 years, the woman alcoholic has become a more common phenomenon. Women become sicker faster, and they seek treatment earlier. It is not unusual for women to self-medicate frequently to alter their moods or adjust emotional states. Women who become addicted are often "poly-addicted", or addicted to more than one drug or drugs combined with alcohol (ANA, 1984, p. 3). Ineffective coping behaviors prevail in addicted women, thus they may be highly distressed; personal and psychological crises with accompanying anxiety and depression are often experienced (ANA, 1984).

Many social factors affecting women increase the distress and strain of role performance. Mental health problems arise. The strain complicates efforts to acknowledge the problem and obtain treatment. Women experience a divorce rate of nearly 50 percent, often with inconsistent support and maintenance payments. Women's salaries are disproportionately lower than salaries of men. These factors are not considered to be causes of drug problems, but they create strain for women,

especially those in multiple roles of parent and career woman or bread-winner (ANA, 1984).

Addressing violations of the impaired nurse has come somewhat more slowly than for professionals in business and industry in general. Why? The stance that health professionals must take in order to confront the problem(s) with immediate, prompt action ironically makes it more difficult to admit that the problem exists. Society would agree that health care professionals are often responsible for making decisions that have a vital impact on the lives and well-being of others. Ironically, though they recognize the seriousness of this responsibility, it is often the perception held by many health professionals that they are invulnerable to addiction themselves. As a product of their education and training, it is instilled into health care professionals that they should provide care to others, that they be physically, mentally, and emotionally strong under conditions of severe stress. By understanding the physiological consequences of drug and alcohol abuse, the perception is held that they can control their drug use. It is, however, ironic that due to their denial of emotional stress and/or unwillingness to admit mental and physical exhaustion, health care workers (of which nurses compose the majority) turn to readily available drugs or alcohol or both as a means of alleviating stress. These perceptions and behaviors complicate the acknowledgement by the health care professional that he/she may also need help (Brennan, 1991).

Impairment in nursing is widespread and universal. Alcohol and drug addiction certainly are not all inclusive signs of impairment and challenge. The nurse is impaired when personal or family crisis and job burnout influence patient care,

decision making, quality of care, and safety practices. The cumulative negative changes influencing behavior and associated with the troubled nurse may be a natural course toward impairment. "Health care deliverers impaired by alcoholism, chemical dependency, or mental illness have 'failed professionally and personally, to cope with stress.' Nurses, then, may be 'self-medicating to deal with the problems of living--with illness, stress, life, and work pressures'" (Cronin-Stubbs & Schaffner, 1985, p. 45).

When chemical misuse/abuse or dependence is suspected in a nurse, signs and symptoms of impairment usually surface. Three categories of impairment related to work performance are shown in personality and behavior changes, job performance changes, and time and attendance changes (Elliott & Heins, 1987). Personality and behavior changes vary with nurses who abuse alcohol versus another chemical substance. The alcohol-abusing nurse demonstrates mood swings, isolation, generally inappropriate response patterns and an unkempt appearance. The drug-addicted nurse demonstrates even more extreme mood swings which change more rapidly in addition to the other behaviors. A suspicious behavior pattern is a trademark of the nurse who is narcotic-addicted. Alcohol and other drug-addicted nurses demonstrate changes and alterations in job performance and productivity as well as attendance. Call-ins before or after weekends, holidays, or payday are commonplace. Absenteeism increases when nurses become addicted. Over a period of 3 to 6 months, these documented indications of declining job-related problems are objective evidence of a problem. These behavioral patterns indicate the decreased ability of the nurse to be at work or to perform his or her duties (R. Kelley, 1987).

Work performance indicators are often obvious in personality and attitude changes, job performance changes, and work schedule changes in the alcoholic and drug-addicted nurse. The alcoholic nurse who experiences personality and behavior changes usually is more irritable with patients and co-workers; withdraws; displays mood swings; goes to lunch alone; isolates herself/himself; wants to work nights; gives inappropriate responses to conversation; gives elaborate excuses for behavior; maintains an unkempt appearance; has blackouts; wants to be the medicine nurse frequently; and makes a lot of phone calls. The drug-addicted nurse usually displays extreme and rapid mood swings; usually wears long sleeves; has questionable and suspicious behavior concerning controlled substances; usually signs out more controlled drugs than anyone else; has frequent spills and breakage of controlled medicines; wants to wait until alone to open the narcotic cabinet; and constantly volunteers as a nurse who will pick up medicine from the pharmacy. Although these symptoms are often too vague to document, they cannot be ignored by other staffers. The documentation is anecdotal on these behaviors (M. Kelley, 1987).

THEORETICAL BASIS OF CHEMICAL DEPENDENCE

The theoretical cause of chemical dependence is shown to be diverse and multidisciplinary in nature in the literature, and falls within three basic categories: biological, sociocultural, and psychological. The literature indicates divergent thinking as to the cause without any one cause being mutually exclusive. It is well documented that chemical dependence (whether alcohol or drug induced) is a phenomenon with multiple causative factors.

Biological Chemical Dependence

The biological theories of chemical dependence concern themselves with the human body and its physiological functioning. Two major theories that are based on the biological concept are the Genetic Theory and the Opiate Receptor Theory.

The Genetic Theory is based on the postulate that humans are biologically predisposed to drug abuse. The research has been conducted mostly with alcoholics, but it is believed that genetic factors are the basis for any drug abuse (Schuckit, 1980). The Disease of Addiction Theory which is based on the Genetic Theory is the primary model of treatment of chemical dependence today. This model requires that abstinence as a condition is essential (Simon, 1980).

The Opiate Receptor Theory is based on the belief that within the human central nervous system there are specific areas or receptors where opiates tend to accumulate and create a euphoric effect. Endorphins, opiate-like substances, are linked to the development of tolerance to or dependence on opiates in humans (M. Kelley, 1987). The endorphin connection gives validation to the dependence/tolerance framework of the Opiate Receptor Theory, and it gives further credence to a biological basis for chemical dependence (Simon, 1980).

The view of habitual drinking as a form of illness is not new. Benjamin Rush, an eminent American physician of the eighteenth century wrote that drunkenness "resembles certain hereditary, family and contagious diseases" (Hughes, 1989, p. 1). The medical or disease perspective postulates that alcoholism and drug addiction occur in persons whose body chemistry makes them susceptible to addiction. In additional research, the evidence for genetic transmission comes from studies of

children reared apart from their alcoholic biological parents. Research reviews reflect that since the 1950s, studies have repeatedly shown that the likelihood of a person's developing alcoholism increases with the number of alcoholic relatives and the degree of genetic closeness to the alcoholic relative (Goodwin, 1976). Goodwin, Schulsinger, and Hermansen (1973) presented compelling information to support the theory of genetic predisposition in a study of 5,483 adopted sons of alcoholics in Denmark. The finding was that adopted sons whose biological fathers were alcoholic were more than three times as likely to become alcoholic as the adopted sons of non-alcoholics.

The basic tenets of the disease perspective of alcoholism as developed by a pioneer in the study of the disease concept of alcoholism, E. M. Jellinek, include the following:

1. alcoholics have predisposing characteristics that consistently differentiate them from non-alcoholics;
2. alcoholism is a progressive, inexorable process, progressing through identifiable stages;
3. alcoholics are unable to control their drinking in that once that they begin to drink, they are unable to stop;
4. treatment of alcoholics requires absolute abstinence. (Hughes, 1989, p. 1)

In summary, while the medical/disease producing theory remains the predominant model guiding alcoholism treatment, it remains controversial. The medical disease model is especially controversial in regard to loss-of-control and the necessity of abstinence for all alcoholics (Hughes, 1989; Jellinek, 1960).

Evidence of heredity predisposition and genetic factors in addiction to drugs other than alcohol are less researched than the alcohol linked research, thus they are more controversial (Hughes, 1989). Limited data do exist showing correlation between

drug use in groups of young men and drug problems among their parents (Annis, 1974; Tennant, 1976). Much of the research in the genetic factors relative to drug addiction (other than alcohol) concentrates on possible biochemical influences on drug addiction. The main focus has been on receptor-sites and neuro-transmitters. The central nervous system contains benzodiazepine and opiate receptors. The study of endorphins, which look and act like opiates, along with the receptor sites and neuro-transmitters, has led researchers to the hypothesis that people who become addicted (especially to narcotics) may have inborn abnormalities in the opiate receptor-endorphin systems (Hughes, 1989).

Physical problems (such as gastric and hepatic disorders, cardiovascular impairment, and neurological damage) can occur with continuous dependence on alcohol if left medically untreated. Central nervous system (CNS) depression caused by benzodiazepine can cause the following symptoms: daytime sleepiness, motor weakness and fatigue, motor incoordination, decreased cognition (thinking), decreased manual dexterity, and cerebellar symptoms such as involuntary rapid eye movement, imperfect articulation of speech, ataxia, and disinhibition of anger (Sullivan, Bissell, & Williams, 1988).

A study in 1984 by the National Institute on Drug Abuse indicated that alcohol and diazepam (a benzodiazepine) accounted for more emergency room visits due to ingestion of two or more drugs than did any other agents (Mondanaro, 1989). Sometimes the benzodiazepines have effects that are opposite from the anticipated outcomes and are exhibited in such behaviors as depression, confusion, excitement, extreme talkativeness, increased anxiety, increased hostility, agitation, toxic

psychosis, paranoid reactions, manic reactions, aggressive outbursts, and rage reactions. This behavior often parallels the observed behavior of chemically dependent nurses in the working environment.

A contrasting view of the biological theory exists. Fein (1990) disputed the theory that human behavior resulting in distress should be medicalized. He suggested that most feelings, thoughts, and behaviors resulting in anxiety, affective, dissociative, psychosexual, impulse, adjustment, and personality disorders are more the result of aspects of role problems than of diseases. The intense feelings and ultimate confusion result from the distress of failed role behavior or role change behavior. In the contrasting view of the biological theory, the intense feelings of distress do not have their primary source in a physical or functional illness. He further stated that when a person's dysfunctional behavior is a result of a genetic defect, an infection, a nutritional deficit, or an injury, it is proper and fitting to speak of disease. In contrast, when the primary evidence of disorder is the person's behavior itself, and particularly when there is reason to believe that the behavior has been socially induced, the concept of illness is misplaced and inappropriate (Fein, 1990).

Separate theoretical perspectives exist to explain addiction to alcohol, narcotics, and prescription drugs with only a few attempts having been made to explain addiction as a phenomenon, whatever the form of the addiction. The usefulness of the distinction between alcoholism and drug addiction is even more questionable when it is recognized that fewer and fewer substance abusers are abusers of only one chemical substance (Hughes, 1989). There is a continuous, ongoing debate among researchers as to whether alcohol and drug addiction, which lead to nurse impairment,

can be labeled a disease, a moral failing, a psychological disturbance, a personality disorder, a social problem, a dysbehaviorism, or a maladaptive coping mechanism (Hughes, 1989).

Psychological Chemical Dependence

Nursing professionals are not protected from the risks of addictive illness. It is well documented by many researchers that health professionals, including nurses, may be at a higher risk than the general population for the development of these difficulties (e.g., ANA, 1984; M. Kelley, 1987; Haack & Hughes, 1989; Twerski, 1982; Sullivan, et al., 1988). Attitude and accessibility contribute to the development of impaired nursing behavior. The nurse's attitude and belief in the use of drugs and medication as forms of healing contributes to "pharmacological optimism" (Naegle, et al., 1984, p. 4). It is furthermore held as a philosophy in medicine that drugs are an acceptable means of altering negative feeling states and conditions. This helps to diminish negative sanctions against their use. The nurse, then, as a health care provider self administers drugs for the relief of psychological pain as well as for relief in medical conditions. Drugs are accessible to nurses. Accessibility is often the initiator of drug and alcohol use with nurses, being readily available in health care facilities and office practice. Diversion of controlled drugs and tranquilizers is often the result of inadequate and insecure monitoring methods. Coupled with the socially acceptable and sanctioned use of alcohol in our society, drug accessibility gives nurses opportunities for diversion. Alcohol is legal and readily accessible. These factors, combined with social traditions and peer activities, can lead to questionable behavior (Naegle, et al., 1984).

The individual is the primary source of the problem, based on the psychological theory of chemical dependency. The nurse is responsible for his or her professional behavior. It is believed that the person is psychologically disturbed or is unable to cope with environmental factors which influence them (M. Kelley, 1987). Women are vulnerable to depression with accompanying low self-esteem. Research shows that women experience a higher rate of depressive [2:1 female to male ratio] symptomatology (Weissman & Klerman, 1977). It is possible that nurses--mostly female and wishing to help others--particularly when confronted with frustration in achieving professional, patient, and career goals, exhibit high levels of depression. Nurses are also prone to professional burnout. Burnout is characterized as a serious problem in the form of turnover rates, absenteeism, accidents, over-utilization of sick leave, and general deteriorating quality of nursing practice (Servellan, Soccorso, Palmero, & Faude, 1985). Burnout is defined by Pines and Maslach (1978) as "a syndrome of physical and emotional exhaustion involving the development of a negative self-concept, negative job attitude, and loss of concern and feelings for clients" (p. 233).

Nurse attitudes toward drug usage and the feelings of pain relief that can result when drugs are administered to human beings lend insight into developmental thinking regarding drug dependence. One theory holds that nurses believe they can stop self-medicating at any point without becoming addicted. Many nurses espouse "magical thinking" about their ability to control drug use (Winick, 1974, p. 161). Much curiosity regarding the observed responses of clients' relief and relaxation after the administration of pain killers appear to contribute to feelings of emancipation from the

potentiality of negative usage. Attitudes about analgesics are of key importance since the pattern of drug addiction is most frequently one of addiction to controlled analgesics such as demerol, dilaudid, talwin, and percodan (Winick, 1974, p. 157).

Accessibility of drugs through diversion in health care facilities is prevalent in the health care delivery system. Concealment of the problem from family and co-workers is common. Large quantities of controlled substances are easily accessible and may be withdrawn from floor supplies or obtained from emergency rooms and critical care units. Nurses, as well as society in general, can obtain prescription and recreational drugs on the street, although nurses are less likely to obtain their drugs in this manner (Winick, 1974). Another method of accessibility often used as diversional behavior for which disciplinary behavior can result is to obtain and complete prescription blanks (Naegle, et al., 1987)). Nurses, as well as other health care professionals, often become heavy users of prescription medicines for medical conditions. Many nurses visit multiple doctors and present false somatic complaints to obtain medicine in this manner. Physician colleagues are often too generous with prescriptions. These addictive methods predispose the nurse to impaired practice, to high risk potential for accidents and suicide, thus endangering self and the public safety of others (M. Kelley, 1987).

The nursing role has been theorized as contributing to the pattern of behavior which leads to impairment and disciplinary action. Nurses oftentimes view themselves as care givers and fail to see themselves as vulnerable to the problems that affect their patients. This denial is a central component and factor in the addictive disease process. It limits the recognition of the disease process and the seeking of

self-help. As a nurse has difficulty accepting illness, other health care professionals around the nurse may falsely reassure her that she does not have a problem, even when the nurse is exhibiting severe symptomatology (M. Kelley, 1987).

Socio-Cultural Theories of Chemical Dependency

Cultural values and environmental elements form the basis for the socio-cultural theory formation as to the cause of chemical dependency. These values and elements include family theory, subculture theory, and role theory (Burgess, 1985).

Family Theory has four major features according to Stanton (1980): traumatic loss, fear of separation, addict family context (close ties between chemically dependent persons and their families), and the family structure which reflects and involves an over-involved relationship between the chemically dependent person and the parent of the opposite sex. Stanton further postulated that when these four features exist, the family pattern produces children who have difficulty finding their own identity and establishing their self-esteem. M. Kelley (1987) agreed and added that the off-spring grow to adulthood without adequate coping skills and often are at high risk for becoming chemically dependent.

The Subculture Theory is another major socio-cultural theory in the cause of chemical dependence. The Subculture Theory espouses chemical dependency as the end product and value system of a norm group which allows chemical use, abuse, and dependence. The Subculture Theory is usually a part of the general cultural structure of the chemically dependent person but is chosen to allow for acceptance of a life-style which includes drug use. The Subculture Theory is based on a general theory of culture that groups people according to social values and norms. When society rejects

the values of the chemical dependent lifestyle, then a norming group is sought out that allows for and supports the chemically dependent life style (Burgess, 1985).

Role Theory as a major socio-cultural theory in chemical dependence is important to understanding impaired nurse behavior. Role Theory proposes that a certain status or position in society can be the precipitating factor in the emergence of chemical dependence. The issue of role strain is paramount in this theory, which occurs when a person perceives an inability to fulfill the expectation of the role in which he/she is engaged. Based on the Role Theory basis of chemical dependency, three factors promoting a high incidence of drug abuse are: access to dependence-producing substances, failure to use prescriptions for their intended therapeutic role, and role strain (Winick, 1980). The Role Theory provides the nurse with a possible rationale for the relapse phenomenon of the chemically dependent person whose professional role includes easy access to drugs in a high stress environment where role strain and role conflict are ever present (M. Kelley, 1987).

WORK-PLACE FACTORS

Work-related issues need to be considered when impaired practice occurs. Independent factors associated with the role of nursing may be theorized as contributing to the nurse's discomfort and continuous need to withdraw from painful circumstances. These factors include, but are not limited to, extreme fatigue, chronic colds and ulcers, emotional exhaustion, negative job attitudes, loss of commitment and concern for clients, decreased self-esteem and depression, withdrawal from clients (either physically or psychologically or both), increased mistakes, neglect of tasks, treatment of clients in dehumanized ways, tardiness, absenteeism, abuse of alcohol

and drugs, and leaving one hospital to find employment elsewhere. Work-related issues often impair nurses' mental and physical health and job effectiveness.

Situational and social stressors in the work setting often are related to intense occupational factors, the work environment, personal stressors, and lack of social support (Cronin-Stubbs & Schaffner, 1985).

Henry and Parrish (1988) enlighten the reader about substance abuse in the workplace with their research findings. The nature of the problem is extensive, even if reports by researchers and statisticians disagree about the extent. It is generally accepted, however, that two-thirds of adult Americans consume alcoholic beverages; and approximately one-fourth use illegal drugs or other substances on a regular basis (Elliott & Heins, 1984; Henry & Parrish, 1988). It is reported also that alcoholism affects an estimated 10 million Americans, and the drug addiction rate is estimated at two percent to three percent of the general population. The American Medical Association, as reported to the American Management Association, estimated in 1985 that more than 45,000 people were killed in automobile accidents in which alcohol played a role (Henry & Parrish, 1988). According to the National Institute on Drug Abuse, nearly two-thirds of people entering the work force have used illegal drugs, with 44 percent in the year previous to the report. Companies which have tested new applicants report that 15 percent of those applying for non-exempt positions and nine percent of those applying for exempt positions have been rejected because of positive drug test results (Henry & Parrish, 1988). In 1980, health service charges relating to substance abuse totaled approximately \$9 billion of which approximately \$3 billion was paid for by private third party individuals, including group health insurance

payers. Alcoholics also have an absenteeism rate of 3.8 to 8.3 times the non-alcoholic employee and are at two to three times greater risk of being involved in an industrial accident. Forty percent of industrial fatalities and 47 percent of industrial injuries can be attributed to alcohol abuse alone.

The health care work-place, as well, is seriously affected by substance abuse. Henry and Parrish (1988) indicated through their findings that alcohol and drug abuse rates among both physicians and nurses are comparable to those for the general population. It is estimated that 120,000 of the 2,400,000 registered and licensed practical nurses severely abuse alcohol and drugs, and 75,000 are believed to be chemically dependent at any given time. According to figures maintained by the National Council of State Boards of Nursing, of approximately 3,400 disciplinary actions taken against nurses in 1986, 38 percent involved the use of drugs (Elliott & Heins, 1987).

In job performance changes, documentation usually reflects the alcoholic nurse as experiencing difficulty in meeting deadlines, maintaining logical and neat charts, avoiding errors, and job fulfillment. The drug-addicted nurse engages in too much illogical and sloppy charting, medication errors, has excessive controlled drug spills or broken vials, and has difficult personal encounters at work with other personnel. The time and attendance changes of the alcoholic nurse are often observed by the nurse's increased absenteeism, long lunch hours, absence from the floor without explanation, calls to request compensatory time at the beginning of the shift, as well as frequent visits to the locker room. The drug-addicted nurse is frequently absent

from the nursing unit. The drug-addicted nurse comes to work early and stays late, likes to hang around, and uses sick leave lavishly (Kelley, M., 1987, p. 11).

Insufficient social support from supervisors and co-workers are negative contributing factors for job stress. Often unmet expectational goals and outcomes become significantly negative stressors which lead to poor adjustment and coping strategies, stress, anxiety, and disillusionment. These become cumulative negative factors for social work-related issues. Reality shock from the clash of naive or incorrect expectations with reality is realized. Inadequate socialization experiences because of the work load coupled with ambiguity and uncertainty of patient outcome and treatment add to the depth of the stressful environment.

Cherniss (1980) developed a model to account for work experiences of human service professionals, including nurses, in their early career which resulted over time in negative personal change (psychological burnout). The model proposes that particular characteristics of the work setting such as the workload and scope of client contacts interact with individual characteristics such as career orientation, extra-work demands, and supports. Together, these factors result in particular sources of stress being experienced in varying degrees by human service professionals, including nurses. Cherniss, in the model, identified five sources of experienced stress by professionals in human services which include nurses:

1. doubts about competence referred to concerns that the professional was falling short of expected goals;
2. problems with patients referred to difficult and ungrateful recipients of care and assistance with no positive reinforcement;
3. bureaucratic interference referred to rules, policies and procedures which interfere with getting the work completed on a timely basis;

4. lack of stimulation and fulfillment referred to feelings of routine, boredom and monotony which decreases productivity, and
5. lack of collegiality referred to little social support from work colleagues and further role conflicts and isolation.

These work stressors, in turn, were predicted by Cherniss to lead to psychological burnout. Empirical studies by Burke, Shearer, and Deszca (1984) and Burke (1987a) lend support to the Cherniss model. Cooper and Payne (1988) further reinforce the difficulty compounded by the multifaceted manifestations of stress in the work-place with work strain related issues being of a cognitive, physiological, health, organizational, behavioral, and subjective nature as described here-to-fore. One must note, however, that stress is not a unique feature of nurses nor of chemically dependent nurses.

Chemical dependency in the work-place in nursing is a growing concern among nurses in Tennessee. The Tennessee Nurses Association, in its Tennessee Nurse (June, 1991), published a focused review of how to spot the chemically dependent nurse. It noted the diminished skills of observation and communication, along with the delayed reaction times and impaired abilities that a nurse experiences when under the influence of drugs and alcohol. It noted the danger signals to be aware of when attempting to delineate the problem. The areas recommended include employment history/performance, preference in assignment, absenteeism, time on unit, disappearance, decreasing effectiveness on the job, charting and reports, health history, and appearance (Appendix C). The implication for the broadened focus on the chemically dependent nurse is heightened awareness as to the universal effects of

the problem and its effect on the chemical dependent nurse, fellow employees, the employer, the patient, and society (p. 33).

Working nurses are exposed to a number of occupational health hazards in their professional career. The majority of nurses are employed in a hospital environment. Hospitals are high risk work-places, and the range of hazards in the average hospital may supersede that of any other work setting. Hazardous substances in the work environment are generally classified into five major categories including biologic, chemical, environmental, biomechanical, physical, and psychosocial agents (Rogers & Travers, 1991). For a categorical listing of potential or actual occupational hazards under these five areas, see Appendix D.

The risk factors for which nurses are most susceptible are the psychosocial hazards in the work-place. Role stress was described by Hardy (1978, p. 76) as "a condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet." Hardy further defined role strain as the "subjective state of distress experienced by a role occupant when exposed to role stress." This definition of role strain is parallel with that given by Goode (1960) in his early work on role strain as being "the felt difficulty in meeting role obligations" (p. 483). Role stress and role strain are complex, multidimensional in scope, and have been associated with various negative work-related outcomes including job dissatisfaction, decreased commitment, job short tenure, and decreased productivity (Mobily, 1991). Personal characteristics of the nurse and the environment are implicated in the role strain and role stress which subsequently contribute to nurse impairment and necessary disciplinary action. For guidelines for employers with nurses who abuse drugs, see Appendix E.

The origins of stress which contribute to impairment were addressed by Haack (1988). Contributing to the stress associated with the profession are the psychologically demanding nature of the clinical environment and the technical tasks which are carried out by nurses. The lack of recognition of professional and social expertise often contribute to feelings of alienation and frustration. These sources coupled with the additional sources of stress which include, but are not limited to, frequent shift changes, physically labor-intense work, inadequate staffing, inadequate support systems, frequent encounters with life and death crisis, low status and low pay contribute to extreme stress (ANA, 1984).

The indirect-inactive type of coping strategy often used in dealing with the work stressors such as drinking or using drugs, getting ill, and collapsing which compounds the problem are well described by Lazarus (1974). The psychosocial hazard aspect of the nursing environment is reinforced in writings by Haack (1988). Unsatisfactory measures taken in dealing with the professional stress in nursing often force the nurse to resort to the indirect-inactive strategy of coping. Drinking and using drugs may be palliative but can lead to dependency. Through the feelings of powerlessness and helplessness associated with being inactive and indirect, depression can result.

The perception of events which cause stress can help determine the effects of that stress on human behavior. Abramson, Seligman, and Teasdale (1978) postulated in their research that when individuals are confronted with an uncontrollable outcome, they will make an attribution relative to its cause. If the cause is viewed as internal to the person and is stable over a period of time, the person is thought to formulate

behaviors dependent on the controllable outcome. Controlled expectancies can be treated as an outcome of a stressful encounter or a series of such encounters.

Learned helplessness and an inability to cope with stress results in depression, long-term dissatisfaction, and low morale. It is, therefore, recognized that objective stress, when coupled with certain psychological characteristics, may strongly focus and lend individuals to burnout, depression, or substance abuse. When the person discovers that certain responses and their outcomes are independent, attributions about the causes of the responses occur. When a negative outcome is thought to be a result of the person's effort (internality), there will be a loss of self-esteem and a greater likelihood of depression than if the outcome is seen as the result of external factors. The outcome of these perceptions results in learned helplessness for the nurse. Furthermore, Maslach and Jackson (1984) noted that a failure to perceive events as caused by internal factors, not under one's control, will lead to feelings of helplessness. It is not merely a person's history that counts but how events are construed and over which personal control is exercised. Nurses often do not feel in control and subsequently impairing behaviors ensue.

Gillmore (1990) indicated that the occupational health risks for hospital nurses are of significant concern for administrators. The most significant aspect of the workplace as asserted by House and Cottington (1986) is the psychosocial environment as evidenced by the level and scheduling of work loads, interpersonal relationships, responsibility for people and property, worker control, and relationships between work and non-work life. The psychosocial risk creates excess stress and consequently

impacts health. The organizational work environment and/or the characteristics of the individual employee impact on the hospital nurse's ability to cope.

The risk factor of enabling has profound professional, ethical, and legal significance. An enabler is a person who, through action or inaction, assists the chemical user to continue the habit. Both peers and supervisors can be enablers (Clark, 1988). Major difficulty exists in the helping professions in determining how to handle fellow members who are alcoholic (Bissell & Jones, 1981). Peer enabling has been attributed to five factors: professional bonding, denial of the magnitude of the problem, hope that the colleague would seek help, misplaced loyalty, and fear that the nurse will lose both job and license. It is not uncommon for work performance, productivity, and deficiencies of the nurse to be assumed by fellow nurses. Nurse managers are perceived as enablers when they fail to confront the problem and intervene with the nurse regarding her performance. Often the nurse is terminated for unsatisfactory performance, and the path of the impaired nurse leads to another work environment without a report being made to official federal or state agencies.

Tennessee State Board of Nursing (1990a) which regulates nursing requires that violations of the Nurse Practice Act (including drug or alcohol abuse) be reported. Failure to do so can be reason for disciplinary action. In addition, the American Nurses Association Code for Nurses requires registered nurses to take definite action to safeguard both patients and public against "incompetent, unethical, or illegal practice of any person" (Pinch, 1990, p.9).

The societal impact of the related work-place expenses both in economic and in personal terms is multifaceted. Such economic losses as the social and personal

expense of chemical dependence work-related accidents, auto accidents and traffic violations, homicides, suicides, property crime, and damage exact a toll on the criminal justice system as well as social service programs, fire protection, highway safety, and the productive loss of a much needed employee. This places society at risk. The personal economic loss is enumerated in the form of the loss of income, medical expenses, legal fees, cost of unused or unfinished education, unemployment, cost of treatment and counseling, and lost opportunity. Boards of Nursing suffer economic loss of funds after a complaint is filed against a chemically dependent nurse due to the cost of investigators, attorneys, staff, hearing officers, court reports, and expenses incurred by Board members to attend disciplinary hearings. The incalculable cost of the disciplinary process comes in the form of the personal anguish, shame, and grief experienced by the nurse and with those with whom she comes in contact (M. Kelley, 1987).

Greene (1989) indicated that as the nursing shortage intensifies, increased stress and demands on nurses worsen. Role strain can exacerbate the problem. As nurses exercise more assertiveness and assume more accountability for their actions, role strain may occur and intensify stress. Male nurses, who work in a predominately female profession, can experience special role strain. Sullivan, et al. (1988) reported an unusually high incidence of chemical dependency in male nurses, compared with their actual numbers in the profession (p. 12). Nurses are educated to suppress feelings and, instead, listen and maintain their self control to the detriment of expressing feelings. This inability to express emotions is often seen in chemical

dependency. Nurses frequently work rotating schedules which may disrupt sleep patterns and encourage the use of sedatives or stimulants (Greene, 1989).

Alcohol and drug usage is common in society. The same variables that encourage drinking and the accompanying problems for the general population are applicable to the nursing profession. These include relative affluence and the financial ability to purchase the drug or alcohol, exposure to the sophisticated contemporary urban environment, shunning abstinence-oriented religious choices, and social settings in which drinking is accepted and often expected (Greene, 1989). This researcher notes from personal observation and general personal interaction and contact among nursing peers that within the last four years nurses' income has increased. Salaries have risen to a respectable level from previous low pay in the 1980's. Nursing salaries continue to spiral upward in the work-place, mostly due to short supply and high demand. Earlier review of literature did not reflect this financial trend.

For nurses, the orientation to drinking in excess often begins in nursing school as described by Haack (1988) in a study of nursing students and stress. Haack (1987) and R. Kelley (1987) indicated that student nurses did not differ from other female college students in their drinking behaviors or their drug use. Approximately 14 percent of nursing students report problems in work or school as a result of use of drugs or alcohol. It was, in addition, reported that social support to student nurses in the form of being cared for and frequent interaction with peers also negates some of the destructive and negative consequences of stress.

To summarize, there are associated risk factors that predispose nurses to initial and continuing drug use. Clark (1988) conducted a literature search from 1898 to

1984 which examined case studies, self-reports by impaired nurses, research reports, and writing experts from 302 citations. Risk factors were identified and placed in seven categories: role strain (67), problems of daily living including role deprivation (53), enabling by peers and managers (53), attitudes toward drugs and drug use (53), lack of education regarding chemical dependency (35), lack of controls (31), and physicians' practices (10).

LEGAL ISSUES OF DISCIPLINARY ACTION

The public, the patient, the employing agency, and the nurse has the right to protection and due process when a nurse's behavior and functioning are scrutinized and called into professional question. A regulatory Board of Nursing must maintain a legal balance; the public must be protected from incompetent health care delivery practitioners while the constitutional rights of the licensee must be preserved by the application of due process. The public has a constitutional right to expect protection from harm by the police power of the state. In addition, the public has a right to information necessary to make informed decisions about health care modalities and providers (M. Kelley, 1987; Creighton, 1986, 1988a; Fiesta, 1990a,b). The regulatory boards provide this protection.

The legal basis for nursing licensure and certification lies with the State Board of Nursing or Board of Nurse Examiners, depending on the state. The states have a compelling interest in the licensure issuance and revocation because it is the government's responsibility to protect the health, safety, and welfare of the public. The legislative acts enacted to protect the public from unqualified, unsafe

practitioners are known as Practice Acts (Naegle, 1985b). Tennessee has a State Board of Nursing which is a regulatory board.

Fiesta (1990b) noted that licensure established standards for entry into practice, defined the scope of practice, and allowed for disciplinary action. The Nurse Practice Acts define and limit the practice of nursing and subsequently determine what constitutes unauthorized practice or practice that exceeds the limits of the authority. In addition, rules and regulations may be published by the states providing more specific rules and further direction. Nursing scope of practice is also given by Board rulings. Advisory opinions or rulings by Boards are given for clarification of a clinical product activity. The State Board of Nursing may submit questions to specific state agencies or departments for advisory opinions which are not law but can be persuasive in judicial proceedings (Fiesta, 1990b).

The basis for a disciplinary action is rooted in the Nurse Practice Acts, which generally include fraud and deceit, criminal acts, incompetence, substance abuse, mental incompetence, and unprofessional conduct. The grounds for denial, revocation, or suspension of certificate or license in Tennessee is found in TCA Regulation 63-7-115 and the procedure to follow is 63-7-116 as shown in Appendix A. Unprofessional conduct, negligence, and habits or other causes that can result in disciplinary action by the State Board are listed in Regulation 1000-2-13 as shown in Appendix A.

When the State Board of Nursing receives a complaint, the Board must investigate and decide whether the disciplinary process should be carried forth. The National Council of State Boards of Nursing outlines the authority of the Board's

Administrative Procedure Act (APA) in each state based on the Uniform APA: proper notice to all parties involved; opportunities for all parties to respond to present evidence and arguments and cross examine on all issues involved; a proper record of the proceedings; recorded or written final order or discussion, including finding of fact and conclusions of law; and a review and appeal of the State Board's decision and orders (M. Kelley, 1987). It is mandatory that the due process of law be allowed and followed without arbitrary and capricious action.

After legislative enactment, the courts determine on a case-by-case basis how the laws should be interpreted. Each state defines what grounds may result in disciplinary action by the Board. The interpretation of what constitutes "unprofessional conduct" is often difficult. The scope of the court review of cases includes three issues: whether the agency acted within its powers conferred upon it by law and the constitution, whether its decision is supported by substantial evidence, and whether the agency decision is reasonable and not arbitrary. The court does not pass upon the wisdom of the decision of the agency (Fiesta, 1983; Feutz-Harter, 1991).

In Livingston v. Nyguist (1976), nurse Livingston was found guilty of unprofessional conduct, and her license to practice was suspended for five years because she obtained large quantities of a controlled drug by the unauthorized use of her father's Bureau of Narcotics number. She had injected the drug in patients as part of a weight reduction program without order from a physician and without maintaining medical records of these treatments.

In Davin v. New York State Board of Regents (1977), nurse Davin was charged with fraud and deceit in nursing, addiction to drugs, unprofessional conduct, and being habitually drunk resulting in diversion of certain controlled substances and prescriptions from her place of employment. She admitted unlawfully removing narcotics and the court determined that she was addicted. Substantial evidence existed to support the finding of fraud and deceit in the practice of nursing. Her license was revoked.

In Scott v. State (1976), nurse Scott was denied her application for licensure after being issued a temporary permit. She was denied on the basis of poor work performance, work attitude, and conduct. The court reiterated the definition of "unprofessional conduct" as that "conduct which violates those standards of professional behavior which through professional experience have become established, by the consensus of the expert opinion of the members, as reasonably necessary for the protection of the public interest" (Feutz-Harter, 1991, p. 315). It established that certain acts which constitute unprofessional conduct may be established by the testimony of qualified experts.

In Lunsford v. Board of Nurse Examiners for the State of Texas (1983), nurse Lunsford was found guilty of unprofessional conduct for failing to assess and evaluate a patient's status, inform the attending physician of the life-death nature of patient's instability, and take appropriate measures to stabilize the patient's condition or prevent complications.

In Ward v. Oregon State Board of Nursing (1973), nurse Ward allowed her daughter to practice as an RN without licensure. The Oregon State Board established

that an expert testimony is not needed to establish that aiding and abetting another to hold oneself out as a registered nurse is a violation of the standards of professional nursing.

Willful misconduct is defined as an intentional designed act without a justifiable excuse (Feutz-Harter, 1991, p. 325). In McCarl v. Commonwealth of Pennsylvania State Board of Nurse Examiners (1979), the state concluded that McCarl willfully violated a regulation of the State Board by administering anesthesia without the presence of a directing physician and by falsely documenting the action. It ruled that nurse McCarl was aware of his non-compliance with the applicable regulation and was guilty of willful misconduct.

Inappropriate use of alcohol and drugs constitute the majority of disciplinary actions against nurses. In Jordan v. Department of Professional Regulation (1988), nurse Jordan had his license revoked after the misuse of demerol on himself, the misuse of demerol on his patient's family without a physician's order, and after using controlled substances obtained through fraudulent prescriptions. Jordan had a history of dependency on the narcotic drug, demerol. Jordan's actions were viewed by the court as a failure to conform to acceptable and prevailing nursing standards. He was charged with committing fraud and deceit in the practice of nursing.

In Petition of Johnson (1982), certain criteria were offered for consideration when a defense of the nurse was raised:

1. the accused was affected by alcoholism;
2. alcoholism caused the misconduct;
3. the accused was recovering from alcoholism and any other disorders that may have caused or contributed to the misconduct;

4. recovery had arrested the misconduct and the misconduct was not apt to re-occur.

These criteria are useful to Boards of Nursing in making decisions regarding chemically dependent nurses.

The National Council for the State Boards of Nursing notes that the nurse has personal rights. The right to continued licensure is a property right. The nurse's right to privacy, as well as the right to seek employment in another state, is often of legal concern. None of these are, however, absolute when a violation has occurred.

As outlined in the Fourteenth Amendment to the United States Constitution, which reads, in part, "nor shall any state deprive any person of life, liberty, or property without due process of law . . .," the nurses are guaranteed that property cannot be taken from their persons without just cause and without due process of law establishing just cause. The property right concept is considered relevant to continued licensure in a state and, consequently, relevant to the disciplinary situation which threatens the continuation of nursing licensure (M. Kelley, 1987).

The due process of the property right clause protects a nurse with a license from arbitrary state action. The due process clause, however, does not prevent the Board of Nursing from taking action to protect the public from unsafe nursing practice, including that of a chemically dependent nurse. Proper administrative procedure is needed (Reaves, 1985). Fiesta (1983) outlined the due process rights as including a written notice of charges being made or reasons for denial, an opportunity for a hearing, a relatively impartial body to conduct the hearing, an opportunity to produce

evidence and witnesses, a written notice of the hearing body's recommended decision along with the reasons for the decisions, and the opportunity to appeal the decision.

Ashley and O'Rourke (1980) in their writing about health care ethics noted the right to freedom from invasion of privacy. The Fourth Amendment of the United States Constitution protects individuals from unwarranted intrusion into their private lives. The nurse's right to privacy must be considered when investigating allegations of misuse or diversion of a controlled substance. "Nevertheless, the right of privacy has limits set by the rights of other persons." (p. 117). This right of privacy for the nurse is not absolute and becomes subordinate to the state's right to enact laws promoting the health, safety, and welfare of the public. This is true even if the laws invade the offender's right of privacy (Creighton, 1985).

The property right does not apply to initial licensure in any state. The United States Supreme Court ruled that there is a liberty interest in the right "to contract to engage in any of the common occupations of life." This liberty interest can include the right to seek licensure but not necessarily to be licensed in another state. The concept of freedom to seek licensure is important because chemically dependent nurses are known to move from state to state. The Board of Nursing from which the nurse seeks licensure is entitled to be given as much information as is legally permissible about the nurse's chemical dependency in order to make an informed decision about licensure of the chemically dependent nurse. In Judge v. Rockford Memorial Hospital (1958), the court declared that when reports to other agencies include only direct observations and are made through proper channels, and when the person reporting does not knowingly make false statements to harm the chemically

dependent nurse, attempts to bring a defamation lawsuit will be denied (M. Kelley, 1987; Fiesta, 1990a).

The prevailing public action of making available to consumers the names of those nurses who have had disciplinary actions taken against them does not violate the right to privacy. Its basis is to allow the public the information necessary to make an informed choice.

Eason and Quick (1986) asserted that the consumer has a right to information (name and disciplinary action taken) in order to make an informed choice regarding health care providers. This indicates that the profession is committed to delivering the safest possible care. The revelation of the identity of the nurse who is disciplined provides a mechanism for protecting the public against persons who are unsafe providers of nursing care. The nurses are accountable for their practice and the public has a right to know when nurses are found guilty of violating the Nurse Practice Act. It is viewed as a possible motivating force to cause chemically dependent nurses and incompetent and negligent nurses to seek help before their practice deteriorates to unsafe levels. Perhaps this will increase public willingness and obligation to report violations unknown to agencies and open the door for further consumer involvement and responsibility (Eason & Quick, 1986).

As a counterpoint on this legal and ethical issue, it is noted that making the disciplinary action public violates the respect, worth, and dignity of the individual. It may prohibit individual nurses from admitting problems and seeking treatment. Eason and Quick, in their counterpoint, explain the view that if the nurse has been disciplined and has an assured rehabilitation plan in effect or completed, with the

license reinstated, the nurse is capable of delivering an acceptable level of nursing care. It is agreed by both authors that if the nurse at any time begins using drugs or alcohol, or if the nursing performance deteriorates, the information must be reported to the Board of Nursing for reconsideration of disciplinary action (Eason & Quick, 1986).

Does a chemically dependent rehabilitated nurse have a place in the profession? Should a nurse be denied the opportunity to return to the profession? Federal law has required some employers to hire former chemically dependent nurses who have rehabilitated themselves if they are "otherwise qualified." This situation developed in a Veterans Administration hospital in Kansas with a former chemically dependent, otherwise impeccably credentialed, nurse. This nurse, Nurse Wallace, had been "clean" for nine months and applied for a position in I.C.U.

As a result of the V.A. hospital's refusal to hire her, Nurse Wallace alleged discrimination in violation of the Rehabilitation Act of 1973 which was to "promote and expand employment opportunities in the public and private sectors for handicapped individuals" (Regan Report, 1988, p. 2). The law prohibits the exclusion "solely by reason of their handicap" of "otherwise qualified individuals" from government agencies or recipients of federal funds.

In Wallace v. Veterans Administration (1988) the court found that Nurse Wallace had established a case whereby she was clearly qualified as an RN for I.C.U. In addition, the court found that Nurse Wallace suffered from a handicap—drug addiction—which prevented her from meeting a "physical" requirement for

employment. She was granted back pay, back benefits, attorney's fees, and the next available R.N. position at the hospital (Regan Report, 1992, p. 2).

The Rehabilitation Act of 1973 is the precursor to the Americans with Disabilities Act (ADA). No case law studies yet exist regarding the impact of the Americans with Disabilities Act (1991) on nurses who are impaired and disabled because of alcohol and drug usage. The potential impact of this legislation upon the healthcare profession as well as the nursing profession is yet to be litigated in a court of law.

The Disability Act covers services and employment. It sets up a reasonable accommodation standard for employers. The new Disability Act will affect nursing by providing impaired, disabled nurses, who are otherwise qualified for employment unless they pose a significant risk to the health, welfare, and safety of the public, a reasonable accommodation standard. Factors to be weighed in future litigation determination will include the nature, duration, and severity of the risk to the public. Handicapped persons must be reasonably accommodated to enable them to qualify for services or employment (Overlock, p. 29).

The profession of nursing has yet to affiliate with the National Data Bank for Healthcare Practitioners required for other health care practitioners. In 1986, congress passed the Health Care Quality Improvement Act (HCQIA) in order to regulate professional (peer) review actions. It set up a sanction and malpractice information clearinghouse (data bank). Health Care Quality Improvement Act of 1986 requires that any time a peer review action involving a physician's or dentist's license is undertaken, then hospital staff privileges may be affected. The professional society membership may be adversely affected or sanctioned; however, certain due

process rules must first be followed. Once a sanction is invoked, or avoided by a plea agreement, a report must be forwarded to the Data Bank. All malpractice judgments and settlements of any amount must be reported. It is designed to improve the quality of medical care nationwide through professional peer review. Restriction of the healthcare provider to move from state to state without proper disclosure or discovery of previous disciplinary actions, damaging and incompetent performance, is the goal (Overlock, 1992).

The Council of the State Boards of Nursing is working toward availing the nursing profession of this data bank clearinghouse service. The applications and goals for nursing will be synonymous with the physician and dental data-gathering process (telephone interview with Vickie Sheets, December, 1992).

SUMMARY

The literature review regarding the disciplinary actions taken by the State Boards of Nursing clearly emphasized the nursing profession's growing problem. The magnitude of the problem among various researchers and professionals has been well documented.

Reports of the exact incidence and prevalence of the problem varied among researchers. Consensus was reached, however, on two critical factors in the literature. First, there is a problem with alcohol and drug abuse among nurses which continues to exist, creating a need for disciplinary action by the State Boards of Nursing. Second, the process by which nurses violate the Nurse Practice Act is usually a slow-paced, multifaceted, and costly pathway.

The impairment of nurses due to chemical dependency has only been addressed within the past decade or so. Prior to this time it has been largely ignored or hidden. Overwhelming evidence suggests that nurses are a high-risk group of professionals for chemical dependency because of their accessibility of drugs. Nurses are often placed in role conflict regarding impaired peers. There exists professional conflict as to whether impairment should be viewed as a disciplinary issue as opposed to a personal employee-assistance problem. Numerous stress factors and variables related to the practice of nursing contribute to the problem of substance abuse and subsequent chemical dependence which lead to impaired behavior. These variables include, but are not limited to, such things as rotating shifts, nursing shortages, consistent crisis resolution, family problems, a labor-intensive environment, and exposure to drugs.

Classic symptoms exist for identifying the impaired and incompetent nurse. Changes in behavior such as absenteeism, isolation, a change from doing good work to doing the minimum, inability to meet schedules, excessive errors, increased medication administration, and incorrect narcotic counts are signals for the need for safety precaution for patients as well as the public (Jefferson & Ensor, 1982).

Theories of etiology of chemical dependence as reviewed in the literature involved biological, sociocultural, and psychological factors. A diversity of views and research results has led to divergent thinking on the issue. The biological theories of chemical dependency are described in the literature as the Genetic Theory and the Opiate Theory. These involve an insidious process that occurs as the result of genetic and body chemistry predisposition. The psychological theory emphasized the attitudes that nurses assign toward the value of drug relief which can contribute to drug

dependency. Accessibility to drugs can also contribute to the vulnerability toward drug dependency. Coupled with burnout and emotional stress and depression, these factors are thought to contribute to a trajectory of drug dependence and impaired behaviors. The sociocultural theory of drug dependency is the result of a process external to the individual (that is, the actions and reactions of family, friends, coworkers, supervisors, and society). Cultural values and environmental elements constitute much of this theory.

The work-place is a high risk environment for nurses. Role strain is commonplace. How a nurse perceives the work-place events in relation to role strain is as important in developing chemical dependency as the other contributing factors mentioned heretofore. Impairing behaviors result when nurses feel that they have lost control and are in a state of helplessness in coping with life. The work-place allows enablers to extend the impaired behavior rather than confront it. Peer enabling by nurses, although illegal, has been attributed to various factors including professional linkage, denial, hope that the nurse will seek help on her own, misplaced loyalty, and fear that the nurse will lose both job and license. Much literature review surrounds the topic of allowing impaired colleagues to work and the potential implications, both legal and personal, that colleagues struggle with when confronted with the problem.

Many references are made in the literature review regarding the legal aspects of disciplinary actions of State Board of Nursing. A legal balance must be maintained by the State Board when disciplining nurses. The public must be protected from incompetent health care delivery practitioners, while the constitutional rights of the nurse licensee must be preserved by due process of the law. It was often noted in the

research and legal cases that a nurse's right to practice nursing was at stake.

Historically, case review in the literature reveals that states have a compelling interest in the licensure issuance and revocation because it is the government's responsibility to protect the health, safety and welfare of the public.

CHAPTER III

METHODS AND PROCEDURES

This chapter explains the procedures utilized to describe the types and extent of disciplinary action of nurses in Tennessee. The following is a presentation of the sample, the instrument utilized, the data collection procedures, and a description of the analysis of those data.

SAMPLE

The sample was composed of 331 registered and licensed nurses who were disciplined by the Tennessee State Board of Nursing from the period of January, 1990 through December, 1992. The final sample included eleven nurses who were each disciplined in 1990 through 1992 two or more times before the Tennessee State Board of Nursing for violations and were each counted only as a single nurse violator for sample purposes. The actions brought against them were calculated each time in the study. Nine nurse records were unavailable to the researcher due to legal work pending in another department and/or the inability to locate the file. Two potential sample subjects who were disciplined by the State Board were unlicensed imposters, one posing as a RN scrub nurse. They did not meet the sample criteria. Of the 331 disciplined nurses, 17 were licensed in states in addition to licensure in Tennessee but were disciplined for violations in Tennessee.

The records for these cases were on public file in Nashville, Tennessee, at the Tennessee Board of Nursing office and the Department of Health and Environment Office. Criteria for inclusion in the sample included:

1. All who were registered nurses and licensed practical nurses licensed to practice in the state of Tennessee from 1990 through 1992 who were brought before the Tennessee State Board of Nursing.
2. Study subjects who had been charged with and received disciplinary action because of violation of the Tennessee Nurse Practice Act.
3. Investigation of the subjects' records were closed by the Tennessee State Board of Nursing and concluded in regard to the action taken by the Tennessee State Board of Nursing in order to assure protection of human rights and due process.
4. The subject's records were of a public nature. (Such files were, and currently are, considered legally open to the public; hence, permission to examine data was not required.)
5. The records used for data collection were limited to the past three years in order to show the disciplinary action patterns of Tennessee nurses since the beginning of the 90s decade (1990-1992).
6. The information, where available, was obtained in accordance with the required information sheet of the National Council of State Boards of Nursing Disciplinary Report Form (Appendix F). The researcher used a modified version adapted for information specific to Tennessee nurses (Appendix G).
7. Other identifying information was obtained as available—such as marital status, basic education status, etc.

INSTRUMENTATION

The Tennessee State Board of Nursing did not have an exclusive, standardized form for gathering data regarding disciplinary action by the Tennessee State Board. It used the Disciplinary Report Form which was supplied by the National Council of State Boards of Nursing to report data. This researcher requested and received a sample of this instrument used at the state level (Appendix F). The National Council of State Boards of Nursing deemed the instrument valid and reliable, although this agency was in the process of modifying the instrument as of February, 1993.

A modified form of the Disciplinary Report Form was created by the researcher to gather information that was inclusive of the required information of the National Council of the State Board of Nursing but that was more exclusive for use in Tennessee for obtaining state level data of local reporting agencies. The modified form was entitled Tennessee Disciplinary Report Form (Appendix G). The modified form included space for identifying the region of the state, urban/rural status, age of offender, race, marital status, and the drug/s involved, if any, along with years in nursing, employing agency, and reporting source.

The Tennessee Disciplinary Report Form was approved by the Director of Public Policy for the National Council of State Board of Nursing, Vicky Sheets (refer to letter in Appendix B). Verbal and written approval was also given to the instrument by Elizabeth Lund, Director of the Tennessee State Board of Nursing and Zelma Stroud, the Disciplinary Board of Nursing after lengthy review of the document in December, 1992. Written approval from the Tennessee State Board of Nursing is included in Appendix B.

The Tennessee Disciplinary Report Form contains several categories for data-collection which require the following explanations:

1. **The Date of Violation** category is the date on which the violation resulting in this particular disciplinary action occurred. If several violations occurred over several months resulting in a disciplinary action by the Tennessee State Board of Nursing, then the initial date of the violation which resulted in disciplinary action was recorded. If several continuing actions had been previously taken by the State Board regarding the initial violation of the nurse, the date on which the State Board of Nursing found it necessary to continue the action of the violator was recorded in this section.
2. **The Age At Time of Violation** represents the age of the nurse violator at the time the violation under study was being disciplined,
3. Under the **Nurse Status** category, the certified registered nurse anesthesists and nurse midwives were included under the RN classification. They represented RNs with advanced training.
4. Under **Code of County** category, the code of county where the violation took place was recorded and not necessarily the county where the violator was employed or resided.
5. The **Employing Agency** category represented the place of employment when the violation occurred and not when the action was taken.
6. The **Years in Nursing** represented the number of years, if any, the nurse violator had engaged in nursing when the violation took place rather than when the action by the State Board of Nursing was taken.

7. The category, **Referred to Tennessee Nurse Foundation Program** indicates the State Board of Nursing action in which violators were disciplined by being referred to the Peer Assistance Program or after-care programs and their rehabilitation requirements and efforts. Under this category, violators who volunteered to undergo self-referral in the Peer Assistance Program were calculated as a "yes."
8. The category **Action Taken in Other Jurisdiction** represented criminal or nursing action taken by other states. Actions taken by state boards of nursing other than Tennessee are included in this category.

DATA COLLECTION

Using the Tennessee Disciplinary Report Form, the researcher obtained the data through manual search of records in the offices of the Tennessee State Board of Nursing and Health Related Boards in Nashville, Tennessee. Data collection began in early 1993. The staff of the State Board of Nursing provided the file numbers for data gathering. The researcher obtained the actual files from the stacks of files stored at the State Board Office and refiled them numerically. An individual form was used for each disciplined nurse with only the license number recorded for the purpose of cross reference of records. No individual names were recorded nor used in the tabulation of data analysis or in the written report.

DATA ANALYSIS

The usable data were coded for computer entry, with variables described and labeled. Coding was checked and accuracy verified. The results of the investigation were tabulated using a computer program so as to present various facets of the profile

of the disciplined nurse in Tennessee during 1990 through 1992. Data analysis allowed the researcher to describe the sample, compile descriptive data, and compare for relationships among variables. Since the sample actually was a census for the years studied, no inferential statistics were called for nor were inferences made beyond the data collected.

The sample size was determined by the number of disciplinary actions taken by the State Board of Nursing from 1990 to 1992. The total number of cases was 331. Every case which was brought before the State Board during the designated time frame, regardless of disposition, was reviewed as a potential subject. Data were incomplete or unavailable for nine cases. The entire record regardless of the number of violations or actions taken constituted one case or subject.

The demographic characteristics of nurse violators were analyzed. The age, marital status where available, sex, type of nursing licensure (RN or LPN), county where the discrepancy was reported, region of state (east or west), and rural or urban area were calculated. The type of employing agency was compiled. The basic nursing education status of the nurse was tabulated and discussed. Frequency distributions and percents were used. The nurse violators who had licensure in other states were noted. The number of previous disciplinary actions by the State Board were contained in the frequency distribution. These obtained frequency distributions were represented through tabular displays and/or descriptive presentation of data.

Each action taken by the State Board of Nursing was grouped and displayed using percentage of total population. Each action taken was compared to the demographic information of age, marital status, county, region, rural/urban area, employing

agency, educational status, and previous disciplinary action, as well as the number of other states in which licensure was active.

The reason for the disciplinary action (Case Description Section D of instrument) of the nurses by the State Board was displayed by appropriate tables when data allowed, showing frequency of occurrence. This was done for the case description (Section D of instrument) usage of drugs, inconsistent nursing practice, administration of medications, misconduct relating to the practice of nursing, and conviction status. The variables in the case description section of the instrument (Section D of instrument) as listed above were compared to the action (Section C of instrument) showing numbers and percentages. The researcher, therefore, described the reason for the disciplinary action and the action taken by sample frequencies and compared the results. The case descriptors (Section D of instrument) were compared to the demographic characteristics of the disciplined nurses.

The action variables (Section C of instrument) were compared to the actual substances that were abused, where applicable, to show what occurred to the nurse violator who used certain substances. Also, the substance abused was compared with the demographic variables as listed above to show relationships. The years in nursing were shown in relationship to action, case description, substance abused, as well as to the basic nursing education status and sex and nurse status. The reporting agency of the violator was compared to the age of the nurse and the years in nursing practice, as well as to the variables of the case description.

CHAPTER IV

FINDINGS, ANALYSIS AND INTERPRETATION OF THE DATA

The purpose of this study was to describe the types and extent of disciplinary actions of licensed nurses of the Tennessee State Board of Nursing during the years from 1990 through 1992. Chapter IV contains the findings of the study, an analysis and interpretation of the data and a summary of significant findings. The questions for which the data sought answers were divided into three categories:

(1) Demographic (2) Professional (3) Relationships.

DEMOGRAPHIC QUESTIONS

Who Were the Violators? (RNs or LPNs)

The sample of disciplined violators was composed of 331 different RNs and LPNs. Of these nurses, 165 (49.8 percent) were LPNs and 166 (51.2 percent) were RNs. In 1990 and 1991, RNs were disciplined more often as compared to 1992 when LPNs were more often disciplined. A summary of the total number and percentage of disciplined nurse violators is found in Table 5. Also included is a breakdown of the years in which the violations occurred for which nurses were disciplined in 1990-1992. Of significance to note is that through 1989, 160 of the nurses in this study had five or more violations, some dating to 1979. These violations of the various years form the basis for the disciplinary actions taken by the Tennessee State Board of Nursing.

Table 5. Violators and Year of Violation of Tennessee Nurse Practice Act (1990-1992) and Number of Violations

Violator	YEAR						TOTAL
	1990		1991		1992		
	LPN	RN	LPN	RN	LPN	RN	
Male							
No.	6	24	7	16	10	19	82
%	4.29	17.14	7.07	16.16	10.86	20.65	24.77
Female							
No.	56	54	41	35	45	18	249
%	40.00	38.57	41.41	35.35	48.91	19.56	75.23
<u>Total</u>							
No.	62	78	48	51	55	37	331
%	44.29	55.71	48.48	51.51	59.77	40.21	100%

No. of Violations	YEAR			
	Through 1989	1990	1991	1992
0	84	235	271	314
1	42	37	20	13
2	21	12	9	0
3	16	1	7	0
4	8	7	1	1
5 or more	160	39	23	3

What Types of Nursing Degree Did Nurse Violators Have?

All licensed practical nurse violators were graduates of a one year program. Registered nurse violators were found to have a higher percentage of graduates from an associate degree, two year program. Of the 166 RNs in the study, 104 (62.7 percent) held associate degrees. In this study, the nurse violators with the least amount of education were most disciplined by the State Board of Nursing. The higher the education of the nurse, the less frequently that level of graduate was disciplined. Refer to Table 6 for a summary of the types and percentages of RN nurse violators and their educational status.

Table 6. Nursing Education Level of RN Nurse Violators (1990-1992)

Degree	n	%	% of Total
Associate Degree	104	62.7	31.4
Diploma	45	27.1	13.6
Bachelor Degree-Nsg	15	9.0	4.5
Bachelor Degree-Other	0	0	0
Masters Degree Nursing/Other	1	< 1	< 1
Other	1	< 1	< 1

How Many Years in Nursing Did Nurse Violators Have?

The nurse violators' years in nursing ranged from 38 years to those licensed nurses who were brought before the State Board of Nursing with no years of experience, who were granted initial licensure with stipulation. The violations of these 20 nurses (< 1 percent) resulted from crimes committed prior to graduation or falsification of the initial licensing process. The average years in nursing for the disciplined nurse was 9.62 years as a graduate. The year range with the highest amount of RNs was 1-5 years in nursing while the LPN high year range was 6-10 years in nursing. These data appear in Table 7.

Table 7. Years in Nursing of Nurse Violators, RNs and LPNs (1990-1992)

Number of Years	0	1-5	6-10	11-15	16-20	21-25	26-30	30+
RN Violator	11	69	48	12	10	6	5	5
LPN Violator	9	42	49	34	18	9	4	0
Total	20	111	97	46	28	15	9	5

What Were the Personal Characteristics of Nurse Violators?

The personal characteristics of the nurse violators who were disciplined in this study included the age, sex, race, and marital status. These data gave a more complete profile of the nurses.

The mean age for RN and LPN nurse violators was 35.37 years. LPN male nurses were older than RN male nurses. Female RNs were older than female LPN violators. The male LPN represented the oldest group with a mean age of 39.5 years of age. The median age for the nurse violators was 33 years of age, with an age range of 19 to 62 years of age. The age most represented in the sample was 32. Refer to Table 8 for an outline of the ages.

The sex of the nurse violators was outlined in Table 5. Males in the sample represented 24.8 percent while females represented 75.2 percent of the sample. In the year of 1990 female RNs and LPNs were presented to the State Board for violations more often than in the other two years in this study. In 1990 more RN males were presented to the board than in other years. In 1992 more male LPNs were disciplined by the board than in other years under study. More male and female RNs and LPNs were disciplined by the Tennessee State Board of Nursing in 1990 than in the other years under study.

The marital status of the nurse violator was only obtainable on 125 subjects (37.8 percent) of the population under study. This information is not required on the chart and is consistently lacking in the nurse file. Those whose marital status was available represented nurses who were married (66.4 percent of total obtained) as occurring most often.

Table 8. Age/Marital Status at Time of Violation, RNs and LPNs (1990-1992)

Nurse Violator	Mean Age
<u>RN</u>	
Male	30
Female	34.17
<u>LPN</u>	
Male	39.50
Female	32.78
LPN/RN Violator	35.37

Median (LPN and RN)	33
Mode (LPN and RN)	32 (n=24)
Range (LPN and RN)	19-62 years of age

Marital Status of Tennessee Nurse Violators (1990-92)*
(n=125)

<u>Status</u>	<u>No.</u>	<u>%</u>
Married	83	66.4
Single	19	15.2
Divorced	<u>23</u>	<u>18.4</u>
Total	125*	100.0*

*Note: These numbers only represent the number of nurses whose marital status was available.

The racial groups are outlined in Table 9. The Caucasian race was overwhelmingly represented with a sample size of 270 (81.58%). No data exist for comparison as to how the racial make-up of this study compares to the racial make-up of all licensed nursing personnel in Tennessee.

Table 9. Racial Group of Tennessee Nurse Violators (1990-1992)

Racial Status	N	%
Caucasian	270	81.6
Afro-American	35	10.6
Asian	2	0.6
Native American	0	0.0
Hispanic	3	0.9
Other/Not Available	21	6.3
Total	331	100.0

What Were the Regions of Tennessee Where Nursing Violations Occurred?

Nurses who were disciplined by the Tennessee State Board of Nursing during 1990 through 1992 represented all regions of Tennessee. More violators were from the western region (64 percent) than the eastern region (36 percent). The eastern region with the largest number of nurse violators was Region II. Knoxville is located within Region II. The western region with the largest number of nurse violators was Region

IX. Shelby County whose area includes Memphis is in this region. It is followed by Davidson County in Region V whose area includes Nashville.

The urban region most represented was the Shelby County region of Memphis with 24.2 percent of the violations. The rural region most represented was Region II of East Tennessee with 7.0 percent. Refer to Table 10 for a summary of the regions of Tennessee in which nursing violations occur which resulted in disciplinary 1990-1992.

PROFESSIONAL QUESTIONS

Types of Nursing Violations

Various violations of the Tennessee Nurse Practice Act occurred by licensed nurses and resulted in disciplinary action by the Tennessee State Board of Nursing. Nursing violations dealt with drugs, inconsistent nursing practice, administering medicines, misconduct and convictions.

Drugs were abused, diverted from employer and patient, self-administered, and used while on duty. Illegal prescriptions were written by nurses with unauthorized forged physician signatures. Legal prescription pills were abused. Nurses violated the professional Code of Conduct by being addicted to chemicals and alcohol, often without any attempt at seeking help. Nurses replaced narcotics with another substance in tubex or vial, diverting patient medication. Some violations came in the form of nurses reporting to work under the heavy influence of alcohol and/or drugs.

Nurses violated patient safety standards various ways. Some were charged with leaving the nursing station during a shift without any licensed personnel present to care for patients. Failure to maintain minimum, reasonable standards of the

Table 10. Regions of Tennessee in which Nursing Violations Occurred Resulting in Disciplinary Action (1990-1992)

	n	%
<u>Eastern Region</u>		
I	20	6.4
II	55	17.5
III	29	9.2
IV	9	2.9
Total (East)	113	36.0
<u>Western Region</u>		
V	75	23.9
VI	15	4.8
VII	10	3.2
VIII	15	4.8
IX	86	27.4
Total (West)	201	64.0
Total East and West	314	100.0%
<u>Urban Region</u>		
II A	41	13.1
III A	24	7.6
V A	65	20.7
IX	76	24.2
Total (Urban)	206	65.6
<u>Rural</u>		
I	15	4.8
II	22	7.0
III	5	1.6
IV	8	2.5
V	20	6.4
VI	17	5.4
VII	9	2.9
VIII	12	3.8
Total (Rural)	108	41.4
*Total (Urban & Rural)	314	100.0%

*The 17 disciplined nurses from outside Tennessee constitute the difference between total region (n=314) and total sample (n=331).

profession was cause for several disciplinary measures. Incompetence, both mental and/or nursing, accounted for various violations. The failure to maintain accurate records of the patient's condition and status caused nurses to be brought before the State Board of Nursing, especially when nurses falsified vital signs and treatment modalities. Nurses who failed to follow physicians' orders were disciplined. Nurses who engaged in unprofessional conduct as a result of other violations or by having a single violation were disciplined. Nurses were disciplined for delegating responsibilities to unlicensed or unqualified personnel. Some were disciplined by falsifying home health visits and charges where none were completed.

Charting errors where failure to maintain accurate records caused patient harm in administering medications were often disciplined. Nurses who failed to follow physician orders and became their own medicine ordering agent were violators. When nurses failed to have narcotic dosage wastage witnessed and recorded on a consistent on-going basis, they were reported to the Tennessee State Board of Nursing for disciplinary action. When nurses failed to record in a consistent and timely manner the administration of medicine, they were brought before the Board of Nursing. Nurses often forged names and dates of medicines to unassigned or nonexistent patients.

Misconduct related to the practice of nursing was prevalent as nursing violations. Practicing beyond the scope of nursing and fraudulent practice were among the nursing violations. Failure to renew licensure, thus working on a lapsed license, accounted for some violations. Nurses falsified application renewal forms and failed to acknowledge former crimes. Probation measures previously taken by the

Tennessee State Board of Nursing were violated. Nurses exhibited impaired behavior on the job. Medicines and hospital supplies were pilfered by nursing personnel who were caught and reported. Few nursing personnel were disciplined for sexual misconduct. Table 11 contains a year-by-year breakdown of the violations committed, categorized as given above by RN and LPN status.

Convictions resulting in felonies and misdemeanors by disciplined nurses were widespread. Other jurisdictions (states) where crimes were committed by nurses were reported to the Tennessee State Board of Nursing for disciplinary action. A list of the violations by nurses resulting in felony and misdemeanor charges are listed in Table 12. They represent major crimes such as drug trafficking, Medicare fraud, murder, sexual misconduct, criminal trespassing, bomb threats and larceny, to name a few. The crimes listed here represent the major crimes found in any typical state and society, but atypical of professional conduct in the healthcare arena.

The violations of drug abuse, diversion, self administration, and use on duty along with chemical and alcohol addiction and unprofessional conduct were the major violations. Drug abuse ranked number one with chemical and alcohol addiction the number two cause of disciplinary action. There was no non-prescription abuse surveyed. The least violation surveyed was the falsification of home health visits by nurses to patients who were home bound.

Actions Taken by Tennessee State Board of Nursing

The Tennessee Board of Nursing exercised the power to deny license application to applicants (by reciprocity or otherwise); to permanently or temporarily withhold issuance; to suspend; to limit or restrict a license for such time and manner as the

Table 11. Types of Nursing Violations for Which Tennessee Nurses were Disciplined (1990-1992)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
<u>Drugs</u>						
Drug Abuse						
No.	33	47	31	32	25	25
%	23.24	33.10	31.31	32.32	28.09	28.09
Drug Diversion						
No.	33	37	24	23	21	22
%	23.24	26.06	24.24	23.23	23.60	24.72
Self-Admin.						
No.	22	26	14	15	7	13
%	15.49	18.31	14.14	15.15	7.87	14.61
Use on Duty						
No.	21	23	15	15	5	12
%	14.79	16.20	15.15	15.15	5.62	13.48
Illegal Presc.						
No.	5	6	2	2	4	2
%	3.52	4.23	2.02	2.02	4.49	2.25

Table 11. (continued)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Presc. Abuse						
No.	4	1	0	1	1	0
%	2.82	0.70	0	1.01	1.12	0
Non. Presc. Abuse						
No.	0	0	0	0	0	0
%	0	0	0	0	0	0
Chem/Alc Addict						
No.	26	49	27	26	29	26
%	18.31	34.51	27.27	26.26	32.58	29.21
Replace Narc.						
No.	7	6	4	3	4	1
%	4.93	4.23	4.04	3.03	4.49	1.12
Under. Infl.						
No.	3	8	1	2	2	3
%	2.11	5.63	1.01	2.02	2.25	3.37
<u>Inconsistent Nsg. Practice</u>						
Leav. Nsg. Stat.						
No.	4	1	7	2	4	1
%	2.82	0.70	7.07	2.02	4.49	1.12
Failure Mim. Std.						

Table 11. (continued)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
No.	10	9	22	14	13	10
%	7.04	6.34	22.22	14.14	14.61	11.24
Incompet.						
No.	12	9	18	12	18	12
%	8.45	6.34	18.18	12.12	20.22	13.48
Fail-Nsg Record						
No.	2	2	4	2	3	3
%	1.41	1.41	4.04	2.02	3.37	3.37
Fail Dr. Orders						
No.	2	3	6	2	3	3
%	1.41	2.11	6.06	2.02	3.37	3.37
Unprof. Conduct						
No.	62	74	45	49	47	41
%	43.66	52.11	45.45	49.49	52.81	46.07
Improper Deleg.						
No.	2	1	5	2	4	0
%	1.41	0.70	5.05	2.02	4.49	0

Table 11. (continued)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Falsified Visits						
No.	2	1	1	3	0	1
%	1.41	0.70	1.01	3.03	0	1.12
<u>Admin. Medicine</u>						
Charting Errors						
No.	20	24	17	16	12	14
%	14.08	16.90	17.17	16.16	13.48	15.73
Failure/ Orders						
No.	10	6	8	7	4	5
%	7.04	4.23	8.08	7.07	4.49	5.62
Wastage Witness						
No.	4	10	3	2	1	5
%	2.82	7.04	3.03	2.02	1.12	5.62
Fail. Doc. Adm.						
No.	4	5	5	7	4	1
%	2.82	3.52	5.05	7.07	4.49	1.12
Forging Names/ Dates						
No.	13	15	7	10	9	14
%	9.15	10.56	7.07	10.10	10.11	15.73

Table 11. (continued)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Narc. Chart. Disc.						
No.	16	14	13	13	10	15
%	11.27	9.86	13.13	13.13	11.24	16.85
<u>Misconduct</u>						
Beyond Scope						
No.	2	2	6	5	2	2
%	1.41	1.41	6.06	5.05	2.25	2.25
Fraud. Pract.						
No.	3	0	7	5	4	4
%	2.11	0	7.07	5.05	4.49	4.49
Work/Lapsed Lic.						
No.	5	3	3	2	4	1
%	3.52	2.11	3.03	2.02	4.49	1.12
Falsify Appl./ Renewal						
No.	7	3	7	6	5	6
%	4.93	2.11	7.07	6.06	5.62	6.74
Probation Viol.						
No.	12	8	9	14	6	6
%	8.45	5.63	9.09	14.14	6.74	6.74

Table 11. (continued)

VIOLATION	YEAR					
	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Impaired Beh.						
No.	23	17	19	17	15	21
%	16.20	11.97	19.19	17.17	16.85	23.60
Pilfering						
No.	3	2	2	2	2	5
%	2.11	1.41	2.02	2.02	2.25	5.62
Sexual Miscond.						
No.	0	1	1	1	1	0
%	0	0.70	1.01	1.01	1.12	0
<u>Conviction</u>						
Felony						
No.	7	8	8	10	10	8
%	4.93	5.63	8.08	10.10	11.24	8.99
Misdemeanor						
No.	10	14	8	15	3	5
%	7.04	9.86	8.08	15.15	3.37	5.62
Action/ Other Juris.						
No.	3	4	2	3	2	3
%	2.1	2.8	2	3	2.24	3.4

*One case missing in 1990 data.

Table 12. Violations Resulting In Felony and Misdemeanor Convictions Which Impacted Disciplinary Actions of Tennessee Nurses (1990-1992)

Violation	Type of Conviction
Aided/abetted husband to escape from jail	Felony
Aided/abetted patient escape from penitentiary (who threatened nurse)	Felony
Bad check charges	Felony
Breach of trust	Misdemeanor
Called in bomb threat and started fires at place of employment	Felony
Carried weapon to judicial proceedings	Felony
Carrying weapon with drug possession	Felony
Conspiracy related to sale of controlled drugs	Felony
Contempt of court	Misdemeanor
Contributing to delinquency of minor in exchange for dilaudid	Felony
Contributing to delinquency of minor	Felony
Credit card abuse and conspiracy	Felony
Criminal trespassing	Misdemeanor
Disorderly conduct Resisting arrest	Misdemeanor

Violation	Type of Conviction
Driving on revoked license	Misdemeanor
Driving under influence	Misdemeanor
Drug diversion	Felony; misdemeanor
Drug abuse	Felony; misdemeanor
Falsification of renewal application	Misdemeanor
Forgery of checks	Felony
Forging prescriptions	Misdemeanor
Gambling	Misdemeanor
Grand larceny	Felony
Imposter	Misdemeanor
Ingesting cocaine	Misdemeanor
Leaving scene of accident	Misdemeanor
Medicare fraud	Felony
Murder (2nd degree)	Felony
Possession of controlled substance for resale	Misdemeanor
Possession of alcohol/drugs/marijuana	Misdemeanor
Possession of marijuana	Misdemeanor; Felony
Possession of drug paraphernalia	Misdemeanor
Public drunkenness	Misdemeanor

Violation	Type of Conviction
Purchasing dilaudid	Felony
Receiving, concealing, retaining stolen property	Felony
Sale of cocaine	Felony
Self-medication	Misdemeanor
Sexual perpetration	Felony
Sexual abuse/assault on own child; 1st degree sodomy/ 4 counts of criminal abuse; 21 counts of 2nd degree sodomy; rape	Felony (85 yr. sentence)
Shoplifting	Misdemeanor
Stealing demerol (petty larceny)	Misdemeanor
Stealing drugs	Federal court misdemeanor
Substituting one medication in lieu of pain medicine	Felony
Use on duty	Misdemeanor
Willfully taking controlled drugs by fraud/charting	Felony

Tennessee Board of Nursing determined; to take such disciplinary action as they deemed proper; and to permanently revoke a license.

The Board of Nursing exercised the power to assess a civil penalty as they saw fit. A penalty of not more than \$1,000 for each separate violation of a statute, rule, or order of the Board of Nursing was sometimes levied. The penalties were in three categories: (1) Type A Civil Penalty (2) Type B Civil Penalty (3) Type C Civil Penalty.

A Type A Civil Penalty was imposed when the nurse willfully and knowingly practiced nursing without a permit, license, or on a revoked license to such an extent that there was, or likely would be, imminent, substantial threat to the health, safety, and welfare of an individual patient or the public. Type A Civil Penalties were assessed for not less than \$500 or more than \$1,000.

A Type B Civil Penalty was imposed when the Board of Nursing found the licensed nurse guilty of a violation of the Nursing Practice Act and the rules and regulations of the board as they directly impacted on the care of patients or the public. Type B Civil Penalties were assessed for not less than \$100 or more than \$500.

A Type C Civil Penalty was imposed when the licensed nurse was found to be guilty of a violation of the nursing Practice Act but that violation was neither directly detrimental to the patients nor the public. Type C Civil Penalties were assessed for not less than \$50 or more than \$100.

Other actions taken by the Tennessee State Board of Nursing as reflected in this study include required assessments for chemical abuse or addiction or psychological assessment. Psychiatric or psychological assessments were required to show nurse stability to return to practice, especially in the area of narcotic administration. Mental competence assessments were also required.

Courses were required for some violators before they could return to practice. Pharmacology, courses in how to delegate to others, and basic nursing procedures were required. Proof of completion were required before action was cleared on the nursing record.

Nurses who violated drug administration privileges, resulting in abuse, diversion, use on duty, or self-administration, were required by their employer to be closely supervised if they were allowed to continue to practice nursing. Often nurses were not allowed to administer narcotics if drug usage had occurred.

The Board of Nursing required some nurses who were chemically dependent/addicted to successfully complete a Peer Assistance Program before applying for relicensure. Relicensure was contingent upon successfully undergoing and completing every phase of the program. Drug-free urine screens, reports, and continuous contact with an advocate are some components of this program.

In some cases where the breach of public trust and safety had been quite jeopardized as in cocaine use on duty, the Board of Nursing took actions as deemed appropriate in addition to requiring the nurse to appear in person before the State Board when reapplying. The State Board of Nursing requests this stipulation in order

to assure the satisfactory completion of the disciplinary action and therapy recommended. The State Board questions nurse violators as to their ability to safely re-enter the profession.

Table 13 summarizes the actions taken by the Tennessee State Board of Nursing during 1990 through 1992. There were 620 actions taken by the State Board of Nursing against nurse violators in this study.

Table 14 gives a breakdown of the violations and the resulting actions taken by the Tennessee State Board of Nursing during this study. A discussion of these findings will be found in the Relationship Question section, later in this chapter.

Were Disciplined Nurses Previously Disciplined by a State Board of Nursing?

Many of the nurses in this study had been previously disciplined. The previous disciplinary actions were taken by either the Tennessee Board of Nursing or another state board where the violation occurred.

There were 485 previous disciplinary actions taken on the sample in this study. RNs had 274 previous actions taken and LPNs had 211 previous actions. For RNs, drug and alcohol abuse, and addiction, diversion, misdemeanors, violation of probation terms and demerol use were the major indicators of previous disciplinary actions. For LPNs, drug and alcohol addiction, drug diversion, felonies, and hallucinogens (including marijuana usage) were the major indicators of previous disciplinary actions. These nurse violators had been previously disciplined six times for cocaine usage. Refer to Table 15 for a summary of previous disciplinary actions for these nurse violators.

Table 13. Disciplinary Actions Taken By Tennessee State Board of Nursing (1990-1991)

ACTION	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Licensure Denied						
No.	0	0	0	1	0	1
%	0	0	0	1.01	0	1.12
License Limited						
No.	0	0	0	0	0	1
%	0	0	0	0	0	1.12
Licensure Revoked						
No.	13	12	18	8	21	13
%	9.15	8.45	18.18	8.08	23.60	14.61
Volunt. Surr.						
No.	1	0	0	1	0	1
%	1	0	0	1	0	1
Summary Susp.						
No.	0	2	0	6	1	2
%	0	1.41	0	6.06	1.12	2.25
Suspension						
No.	12	9	5	14	10	6
%	8.45	6.34	5.05	14.14	11.24	6.74

Table 13. (continued)

ACTION	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Probation						
No.	32	45	22	31	22	21
%	22.54	31.69	22.22	31.31	24.72	23.60
Fine						
No.	0	0	10	8	14	6
%	0	0	10.10	8.08	15.73	6.74
Reprimand						
No.	4	3	5	4	3	2
%	2.82	2.11	5.05	4.04	3.37	2.25
Other						
Assesment Req.						
No.	7	8	2	7	4	2
%	4.93	5.63	2.02	7.07	4.49	2.25
Course						
No.	3	2	1	5	5	4
%	2.11	1.41	1.01	5.05	5.62	4.49
Req. Supv.						
No.	1	11	4	1	0	3
%	0.70	7.75	4.04	1.01	0	3.37
PAP Prog.						
No.	6	4	1	3	3	3
%	4.23	2.82	1.01	3.03	3.37	3.37

Table 13. (continued)

ACTION	1990 (n=142)*		1991 (n=99)		1992 (n=89)	
	LPN	RN	LPN	RN	LPN	RN
Spec. Reinst.						
No.	2	1	1	5	0	0
%	1.41	0.70	1.01	5.05	0	0
Action Cleared						
No.	20	37	3	6	0	4
%	14.08	26.06	3.03	6.06	0	4.49
Reinstate						
No.	18	14	4	7	6	5
%	12.68	9.86	4.04	7.07	6.74	5.62
Reinstate. Denied						
No.	0	0	0	1	0	0
%	0	0	0	1.01	0	0

*One Case missing in 1990 data.

Table 14. Actions Taken Against Tennessee Nurse Violators (1990-1992)

ACTIONS	VIOLATIONS														REMARKS
	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	Licenses	
Violations	1	0	58	2	8	38	112	16	2	41	31	13	6	15	11
No.	1	0	58	2	8	38	112	16	2	41	31	13	6	15	11
%	<1	0	17.5	<1	2.4	11.5	33.8	4.8	<1	12.4	9	3.9	1.8	4.5	3.3
Drug Abuse															
No.	1	0	51	2	6	28	94	13	3	35	14	13	5	14	9
%	<1	0	15.4	<1	1.8	8.5	28.4	3.9	<1	10.6	4.2	3.9	1.5	4.2	2.7
Drug Diversion															
No.	1	0	51	2	6	28	94	13	3	35	14	13	5	14	9
%	<1	0	15.4	<1	1.8	8.5	28.4	3.9	<1	10.6	4.2	3.9	1.5	4.2	2.7
Self-Adm.															
No.	0	0	26	2	4	21	58	8	2	26	13	5	3	10	5
%	0	0	7.9	<1	1.2	6.3	17.5	2.4	<1	7.7	3.9	1.5	<1	3	1.5
Use on Duty															
No.	0	0	26	2	4	20	52	7	1	19	2	8	2	8	2
%	0	0	7.9	<1	1.2	6	15.7	2.1	<1	5.7	<1	2.4	<1	2.4	<1

Table 14. (continued)

A C T I O N	L i c e d	L i c e d	L i c e d	V o l u m e	S u m m e r i z e d	S u p p l y m e n t s	P r o b l e m s	F i n e a n c e s s a r y	R e p r e s e n t a t i o n	C l e a r e d a n d	R e c i s s e s s e s	A s s e s s e s	C o u r s e s	C l o s e s	P a p e r s	S p e c i a l i z e d	
Illegal Presc.																	
No.	0	0	6	0	1	5	11	3	1	6	0	3	1	1	0	1	0
%	0	0	1.8	0	<1	1.5	3.3	<1	<1	1.8	0	<1	<1	<1	0	<1	0
Presc. Abuse																	
No.	0	0	3	0	0	1	4	0	0	2	0	2	0	0	1	0	0
%	0	0	<1	0	0	<1	1.2	0	0	<1	0	<1	0	0	<1	0	0
Non. Presc. Abuse																	
No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chem/Alc/ Addict																	
No.	0	0	54	2	7	36	108	15	2	34	32	13	4	0	13	4	1
%	0	0	16.3	<1	2.1	10.9	32.6	6	<1	10.3	9.7	3.9	1.2	0	3.9	1.2	<1

Table 14. (continued)

A C T I O N	L i c e D e n i c e d	L i c e L i c e m i t c e d	L i c e R e v e r r	V o l u m e	S u m m e r s e p p e r	S u s p e n d e n c e	P r o b a b i l i t y	F i n e a n c e	R e p r e s e n t a n c e	C l e a r e d t e n t e	R e i n s u r e n c e	A s s e s s e n c e	C o u r s e	C l o s e	P A P	S p e c i a l i z e d	R e s u l t
No.	0	0	9	0	0	6	13	3	1	10	1	0	3	16	0	1	0
%	0	0	2.4	0	0	1.8	3.9	<1	<1	3	<1	0	<1	4.8	0	<1	0
Under Infl.																	
No.	0	0	4	0	0	3	11	1	1	4	4	1	0	1	0	0	0
%	0	0	1.2	0	0	<1	3.3	<1	<1	1.2	1.2	<1	0	<1	0	0	0
Inconsistent Nursing Practice																	
Leav. Neg Stat.																	
No.	0	0	5	0	0	6	7	3	5	0	2	0	3	2	7	0	0
%	0	0	1.5	0	0	1.8	2.1	<1	1.5	0	<1	0	<1	<1	2.1	0	0
Failure Mim. Std.																	
No.	0	1	22	1	1	16	36	15	9	9	10	12	11	0	5	1	0
%	0	<1	6.7	<1	<1	4.8	10.9	4.5	2.7	2.7	3	3.6	3.3	0	1.5	<1	0

Table 14. (continued)

A C T I O N	L i c e n c e d	L i c e v	L i c e v	V o l u m e	S u m m e r y	S u s p e n d	P r o b l e m s	F i n a n c e	R e p r e s e n t a t i o n	C l e a r i n g	R e s u l t s	A s s e s s m e n t	C o u r s e	C o u r s e	P a r t i c i p a n t	S p e c i f i c	
Incompetence																	
No.	0	1	26	1	2	19	33	15	10	7	11	11	12	2	1	1	0
%	0	<1	7.9	<1	<1	5.7	10	4.5	3	2.1	3.3	3.3	3.6	<1	<1	<1	0
No. Nsg. Record																	
No.	0	1	8	1	0	3	2	2	3	1	1	2	3	3	0	0	0
%	0	<1	2.4	<1	0	<1	<1	<1	<1	<1	<1	<1	<1	<1	0	0	0
Fail Dr. Orders																	
No.	0	1	9	0	0	3	5	3	1	2	1	1	5	0	20	0	0
%	0	<1	2.7	0	0	<1	1.5	<1	<1	<1	<1	<1	1.5	0	6	0	0
Unprof. Conduct																	
No.	2	1	82	3	11	56	168	42	21	65	51	30	19	0	20	9	1
%	<1	<1	24.8	<1	3.3	16.9	50.8	12.7	6.3	19.6	15.4	9	5.7	0	6	2.7	<1

Table 14. (continued)

A C T I O N	L i c D e n i e d	L i c L i m i t e d	L i c R e v	V o l S u r	S u m m S u s p	S u s p	P r o b	F i n e	R e p r i m a n d	C l e a r e d	R e i n s t a t e	A s s e s s	C o u r s e	C l o s e	P A P	S p R e q	D e n
Improper Delegation																	
No.	0	0	2	0	0	5	4	2	7	0	2	1	4	18	0	0	0
%	0	0	<1	0	0	1.5	1.2	<1	2.1	0	<1	<1	1.2	5.4	0	0	0
Falsified Visits																	
No.	0	0	1	0	0	1	6	3	0	2	0	1	0	0	0	2	0
%	0	0	<1	0	0	<1	1.8	<1	0	<1	0	<1	0	0	0	<1	0
Administ. Medicine																	
Charting Errors																	
No.	0	0	36	0	2	16	53	12	3	25	22	10	8	0	8	2	0
%	0	0	10.9	0	<1	4.8	16	3.6	<1	7.6	6.7	3	2.4	0	2.4	<1	0
Failure/fol Orders																	
No.	0	1	11	0	1	7	19	9	3	8	6	4	3	5	3	2	0
%	0	<1	3.3	0	<1	2.1	5.7	2.7	<1	2.4	1.8	1.2	<1	1.5	<1	<1	0

Table 14. (continued)

A C T I O N	L i c e D e n i e d	L i c e L i m i t e d	L i c e R e v	V o l u m e	S u m m e r	S u s p e n d	P r o b e	F i n e	R e p r i m a n d	C l e a r e d	R e i s s e s	A s s e s s	C o u r s e	C l o s e	P a p e r	S p e c i f i c	R e s u l t
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Wastage Witness Failure	No.	0	0	6	0	2	1	12	1	3	7	3	3	2	3	3	1	0
%		0	0	1.8	0	<1	<1	3.6	<1	<1	2.1	<1	<1	<1	<1	<1	<1	0
Fail Doc. Adm.	No.	0	0	11	0	1	4	10	4	3	4	5	2	5	2	3	1	0
%		0	0	3.3	0	<1	1.2	3	1.2	<1	1.2	1.5	<1	1.5	<1	<1	<1	0
Forging Names/ Dates	No.	0	0	20	0	1	15	39	5	3	15	12	5	3	2	5	1	0
%		0	0	6	0	<1	4.5	11.8	1.5	<1	4.5	3.6	1.5	<1	<1	1.5	<1	0
Narc. Chart Disc.	No.	0	0	27	0	2	15	44	7	4	17	16	6	4	4	6	2	0
%		0	0	8.2	0	<1	4.5	13.3	2.1	1.2	5.1	4.8	1.8	1.2	1.2	1.8	<1	0

Table 14. (continued)

A C T I O N	L i c e n s e d	L i c e n s e d	L i c e n s e d	V o l u n t e e d	S u m m e r i z e d	S u p p l y i n g	P r o b l e m s	F i n e a n c e s s e s	R e p r e s e n t a t i o n	C l e a r i n g	R e i n s u r a n c e	A s s e s s m e n t	C o u n t e r p a r t	C l o s e d	P a r t i c i p a n t	S p e c i f i c	R e n e w a l
conduct																	
Beyond Scope																	
No.	0	0	3	0	1	3	10	5	3	1	5	3	3	5	0	0	0
%	0	0	<1	0	<1	<1	3	1.5	<1	<1	1.5	<1	<1	1.5	0	0	0
Fraud. Pract.																	
No.	2	0	8	1	1	3	7	9	3	3	1	0	0	0	1	2	0
%	<1	0	2.4	<1	<1	<1	2.1	2.7	<1	<1	<1	0	0	0	<1	<1	0
Work/ Lapsed Lic.																	
No.	0	0	5	0	0	3	5	4	2	0	4	2	0	1	0	1	1
%	0	0	1.5	0	0	<1	1.5	1.2	<1	0	1.2	<1	0	<1	0	<1	<1
Falsify Appl. Renewal																	
No.	2	0	12	1	1	9	12	7	2	3	6	3	1	0	1	2	0
%	<1	0	3.6	<1	<1	2.7	3.6	2.1	<1	<1	1.8	<1	<1	0	<1	<1	0

Table 14. (continued)

A C T I O N	L i c e D e n i c e d	L i c e L i m i t e d	L i c e R e v	V o l S u r r	S u m m S u s p	S u s p	P r o b	F i n e	R e p r i m a n d	C l e a r e d	R e i n s t a t e	A s s e s s	C o u r s e	C l o s e	P A P	P A P	S p e c i f i c	R e s u l t
Probation Violation	No.	0	1	21	2	4	12	27	6	0	9	8	2	2	0	5	3	0
	%	0	<1	6.3	<1	1.2	3.6	8.2	1.8	0	2.7	2.4	<1	<1	0	1.5	<1	0
Impaired Beh.	No.	1	0	41	0	5	23	55	13	5	16	9	14	4	3	9	2	0
	%	<1	0	12.4	0	1.5	7	16.6	3.9	1.5	4.8	5.7	4.2	1.2	<1	2.7	<1	0
Pilfering	No.	0	6	0	0	4	8	2	1	3	3	4	2	1	5	0	1	0
	%	0	1.8	0	0	1.2	2.4	<1	<1	<1	<1	1.2	<1	<1	1.5	0	<1	0
Sexual Misconduct	No.	0	4	0	1	0	0	2	0	0	0	0	0	0	1	0	0	0
	%	0	1.2	0	<1	0	0	<1	0	0	0	0	0	0	<1	0	0	0

Table 14. (continued)

A C T I O N	L i c	L i c	L i c	V o l	S u m	S u p	P r o b	F i n e	R e p r e m a n d	C l e a r e d	R e i n s t a t e	A s s e s s	C o u r s e	C l o s e	P A P	S p R e i n s t q	D e n
<u>Conviction</u>																	
Felony																	
No.	0	1	14	5	9	24	9	0	8	8	11	5	4	3	2	4	0
%	0	<1	4.2	1.5	2.7	7.3	2.7	0	2.4	2.4	3.3	1.5	21.2	<1	<1	1.2	0
Misdemeanor																	
No.	0	0	13	1	8	35	6	1	12	12	13	4	2	5	7	2	0
%	0	0	3.9	<1	2.4	10.6	1.8	<1	3.6	3.6	3.9	1.2	<1	1.5	2.1	<1	0
Action Other Juris.																	
No.	0	3	9	3	4	13	4	2	8	8	9	4	1	3	2	0	1
%	0	<1	2.7	<1	1.2	3.9	1.2	<1	2.4	2.4	2.7	1.2	<1	<1	<1	0	<1

Table 15. Previous Disciplinary Action of Disciplined Nurse Violators (1990-1992)

Previous Action	RN (n)	LPN (n)	Total Prev. Violations
Drug Abuse/Alc. Abuse	58	29	87
Diversion	31	24	55
Self-Administration	11	10	21
Use on Duty	11	7	18
Writing Illegal Presc.	2	2	4
Failure Maintain Std	1	2	3
Pilfering	3	1	4
Forging Names/Medrec.	6	5	11
Nar/Cons. Sub/Chart. Dis.	8	5	13
Misdemeanor	17	8	25
Felony	14	12	36
Lapsed License/Fal. App.	4	7	11
Violation Prob.	13	10	23
Sexual Misconduct	2	1	3
Doc. Chem. Depend. Behavior	15	10	25
Impairment Behav.	4	9	13
Narc/Cont. Sub. Disc.	1	1	2
Demerol	15	10	25
Cocaine	5	1	6
Hallucinogen	14	19	33
Fraudulent Pract.	0	2	2
Fail Wit. Wast.	1	1	2
Incompetent Pract.	2	4	6
Charting Errors (Meds)	3	2	5
Improper Deleg.	0	1	1
Alcohol	12	5	17
Talwin	1	0	1
Fail. Follow Dr. Order	2	1	3
Percodan	1	0	1
Dilaudid	1	1	2
Morphine	3	1	4
Pract. Beyond Scope	1	0	1
Prescription Abuse	1	0	1
Under Infl./Work	2	2	4
Fail. Doc. Adm./Drugs	0	1	1
Multi Pharm.	8	7	15
Falsified Home Visits	1	0	1

Who Was the Employing Agency of the Disciplined Nurse?

Nurses in this study worked in typical areas of nursing practice. They were employed in hospitals, nursing homes, nursing pool registries, schools, doctor's offices, and home health agencies. Five were unemployed. Some were employed by private patients as sitters, while two others were employed by jails. Information regarding the employer on eight nurse violators was not available. In 17 cases, the employer of the nurse violator from states other than Tennessee was unavailable. Twenty nurse violators who were recent graduates had no employer when violation charges were brought before the Board of Nursing. These were listed in the non-applicable category.

The major employing agency for nurse violators was the hospital for both RNs and LPNs, followed by nursing homes and home health agencies. Nurse violators also were sometimes employed at another healthcare agency at the same time that the nursing violations occurred.

Refer to Table 16 for the size of the employer where nurse violators worked where there was a bed capacity in the institution or agency. The nurse violators were most often employed in institutions (hospitals and nursing homes) with 500 or more beds when the nursing violations occurred. The bed capacity in Table 16 represents hospitals, nursing homes, registry assignments in hospital or nursing homes, jails, and a outpatient surgery center.

Table 17 gives a breakdown by nurse status and employer described in numbers and percentages.

Table 16. Bed Capacity of Employer of Nurse Violators (1990-1992)

Beds	Nurse Violators (n=259)	%
1-50		6.6
50-100	35	13.5
101-200	71	27.4
201-300	30	11.6
301-400	18	6.9
401-500	4	1.5
500+ beds	8	32.4

Table 17. Major Employer of Disciplined Nurse at Time of Nursing Violation (1990-1992)

Employing Agency	LPN		RN	
	n	%	n	%
Hospital	67	20.2	117	35.3
Nursing Home	49	14.8	17	5.1
Registry	3	0.90	2	0.60
School	0	0	1	0.30
Dr. Office	1	0.30	0	0
Home Health	3	0.91	9	2.7
Unemployed	1	0.30	4	1.2
Private Pt.	2	0.60	0	0
Other	4	1.2	2	0.60
Out pt/surg ctr	0	0	2	0.60
Jail	2	0.60	0	0
Not appli/avail	33	9.7	12	3.6
Total	165	49.51	166	51.49

Who Reported Nurses Most Often?

Table 18 reflects the person or agency who reported the nurse violator to the Tennessee State Board of Nursing. The sample numbers in this chart exceed the sample number in this study due to more than one person or agency reporting the nurse violator to the Tennessee State Board of Nursing. For example, when illegal prescriptions were written it followed that the pharmacist, the law, and the employer reported the violation to the Tennessee State Board of Nursing.

The employer was the most common reporting agency who communicated the violation to the State Board of Nursing. Law officers, charged with reporting crimes for the safety and welfare of the public, were next most responsible in reporting to

Table 18. Who Reported Tennessee Nurses to State Board of Nursing Resulting in Disciplinary Action (1990-1992)?

Reporter	n*	%
Employer	256	77.3
Fellow Nurse/Worker	14	4.2
Law/Police	74	22.4
Citizen of Community	0	0
Peer Assist. Program	28	8.5
Anonymous	6	1.8
Self	14	4.2
Spouse	0	0
Board of Nursing	51	15.4
Pharmacy	15	4.5
Other	7	2.1

* Number exceeds sample size due to multiple reportings of one nurse violator.

the State Board of Nursing. The State Board of Nursing was listed as the reporting agency 15.4 percent of the time. When nurses violated their Peer Assistance Program contract with the State Board of Nursing the disciplinary personnel charged with monitoring this contract were authorized to intervene. Also, the State Board of Nursing was made aware of violations in other states by nurses through a quarterly list which was supplied to them. This alerted them to those nurses who were out-of-state who applied for licensure through reciprocity.

Where in the State did Drug Abuse Violations Among Nurses Occur Most Often? Inconsistent Nursing Practice? Medication Administration Abuse? Misconduct Relating to the Practice of Nursing? Fraudulent Conviction? Misdemeanor Conviction?

Refer to Table 19 for the counties where nursing violations, including substance abuse, occurred. Table 20 gives a breakdown of the regions of Tennessee where nursing violations occurred in terms of east/west and urban/rural categories.

The major areas for nursing violations in the state overall were in Shelby County, Davidson County, Knox County and Hamilton County. This was consistent with drug abuse, and diversion violations. Shelby and Davidson counties ranked first and second, respectively, for the number of alcohol/drug addiction violators. Hamilton County ranked third in this category and Knox County ranked fourth. Nurses replaced narcotics with other substances more often in Knox County than elsewhere.

Table 19. What Were the Counties Where Nursing Violations Occurred Most Often by Disciplined Nurses (1990-1992)

NURSING VIOLATION THAT WAS DISCIPLINED	COUNTY OF OCCURRENCE 1st, 2nd, 3rd Rank
<u>Drugs</u>	
Drug Abuse	Shelby; Davidson; Knox
Drug Diversion	Shelby; Davidson Knox
Self-Administration	Shelby, Davidson (19 each); Knox; Hamilton
Use on Duty	Shelby; Davidson, Hamilton
Writing Illegal Presc.	Shelby; Montgomery, Knox; Hamilton
Replace. Narc/Other Subst.	Knox; Davidson; Hamilton
Chem. Add./Alcoh. Dep.	Shelby; Davidson; Hamilton
Reported Under Infl.	Davidson; Shelby; Sullivan, Knox
<u>Inconsistent Nsg. Practice</u>	
Leaving Nursing Station	Davidson; Bedford, Hamilton, Jefferson, Knox; Shelby
Incompetence	Davidson; Knox; Shelby
Fail Maint. Nsg. Rec.	Shelby; Knox; Davidson, Hamilton
Unprofessional Conduct	Shelby; Davidson; Knox
Improper Delegation	Knox; Davidson; Hamilton
Falsifying Visits	Davidson, Bedford; Hamilton; Jefferson
Fail. Fall. Med. Ord	Davidson; Shelby; Knox
<u>Administering Medications</u>	
Charting Errors	Davidson, Shelby; Knox; Hamilton
Fail. Waste/Witness	Davidson; Shelby; Hamblen, Hamilton
Fail. Doc. Adm.	Davidson; Shelby; Knox
Forging Names/Dates	Shelby; Davidson; Knox
Narc. Chart. Discrep.	Shelby; Davidson; Hamilton
<u>Misconduct</u>	
Fraud. Pract.	Davidson; Knox; Shelby
Work Lapsed Lic.	Shelby; Hamilton; Knox
Falsified App./Renewal	Davidson; Knox; Shelby

Table 19. (continued)

Prob. Violation	Shelby; Davidson; Knox
Impaired Behavior	Shelby; Davidson; Hamilton, Knox
Pilfering	Shelby; Knox; Davidson
Sexual Misconduct	Davidson; Knox; Montgomery
<u>Conviction</u>	
Felony	Davidson; Shelby; Knox
Misdemeanor	Shelby; Davidson; Knox
<u>Substances</u>	
Alcohol	Shelby; Davidson; Knox
Demerol	Shelby; Davidson; Knox
Dilaudid	Davidson; Shelby; Hamilton
Percodan	Shelby; Hamilton; Knox
Talwin	Shelby; Putnam; Davidson
Valium/Xanax	Shelby; Davidson, Knox; Bedford
Cocaine	Shelby; Hamilton; Knox, Davidson
Hallucinogens	Shelby; 14 others had 1 ea.
Multi-Pharm.	Knox; Shelby; Davidson
Morphine	Shelby; Davidson; Hamilton
Darvon/Darvocet	Shelby; Hamilton; Davidson
Vicoden	Shelby; 1 ea in Smith, Lewis, Hamilton, Hamblen, Blount
Phenergan	Hamilton; Davidson; Shelby, Hamblen
Mepergan Fortis	Shelby; Lawrence; Putnam
Codeine-Related	Shelby; Davidson; Hamilton, Knox
Marijuana	Shelby; Davidson; Hamilton, Knox, Sullivan
Lortab	Montgomery; six others had 1 ea.
Benzodiazepines	Shelby; Knox; Hamilton
Sedative/Hypnotic	Davidson; Hamilton; Knox, Shelby
Oxycodone	Hamblen; Knox; Loudon, Shelby
Pain Medicine	Davidson; Shelby; Knox
Miscellaneous Drugs	Shelby, Davidson; Knox; Hamilton

Table 20. Region of State Where Nursing Violations Occurred Resulting in Disciplinary Action (1990-1992) (n=314)

Violation	East	West	Urban	Rural
<u>Drugs</u>				
Drug Abuse				
No.	72	110	116	66
%	22.9	35	36.9	21
Drug Diversion				
No.	60	93	97	56
%	19.1	29.6	30.9	17.8
Self-Admin.				
No.	39	55	59	35
%	12.4	17.5	18.8	11.2
Use on Duty				
No.	32	56	51	37
%	10.1	17.8	16.3	11.7
Illegal Presc.				
No.	10	10	12	8
%	3.1	3.1	3.8	2.6
Presc. Abuse				
No.	4	3	4	3
%	1.3	1	1.3	1

Table 20. (continued)

Violation	East	West	Urban	Rural
Non Presc. Abuse				
No.	0	0	0	0
%	0	0	0	0
Chem/Alc/Addict				
No.	67	107	113	61
%	21.3	34.1	36	19.5
Replace Narc				
No.	14	11	13	12
%	4.5	3.5	4.1	3.8
Under Influen.				
No.	6	12	12	6
<u>Inconsistent Nsg. Practice</u>				
Leav. Nsg. Stat.				
No.	7	12	12	7
%	2.2	3.8	3.8	2.2
Failure Mim. Std.				
No.	27	49	51	25
%	8.6	15.6	16.2	7.9
Incompetence				
No.	30	48	54	24
%	9.6	15.3	17.2	7.6
No. Nsg. Record				
No.	6	10	13	3
%	1.9	3.2	4.1	1

Table 20. (continued)

Violation	East	West	Urban	Rural
Fail. Dr. Orders				
No.	9	9	15	3
%	2.9	2.9	4.8	1
Unprof. Conduct				
No.	109	193	197	105
%	34.7	61.4	62.7	33.4
Improper Deleg.				
No.	7	7	9	5
%	2.2	2.2	2.9	1.6
Falsified Visits				
No.	2	6	6	2
%	1	2	1.9	1
<u>Administ. Medication</u>				
Charting Errors				
No.	33	67	70	30
%	10.5	21.3	22.3	9.6
Failure/Orders				
No.	15	25	28	12
%	4.8	8	8.9	3.8
Wastage Witness				
No.	6	18	16	8
%	1.9	5.7	5.1	2.6
Fail. Doc. Adm.				
No.	12	14	19	7
%	3.8	4.5	6	2.2

Table 20. (continued)

Violation	East	West	Urban	Rural
Forging Names/Dates				
No.	20	44	49	15
%	6.4	14	15.6	4.8
Narc. Chart. Disc.				
No.	26	52	52	26
%	8.9	16.6	16.6	8.2
Misconduct				
Beyond Scope				
No.	6	13	16	3
%	1.9	4.1	5.1	1
Fraud. Practice				
No.	9	13	15	7
%	2.9	4.1	4.8	2.2
Work/Lapsed Lic.				
No.	5	13	14	4
%	1.6	4.1	4.4	1.3
Falsify Appl./Renewal				
No.	12	19	19	12
%	3.8	6	6.1	3.8
Probation Violation				
No.	18	36	38	16
%	5.7	11.5	12.1	5.1

Table 20. (continued)

Violation	East	West	Urban	Rural
Impaired Beh.				
No.	42	66	68	40
%	13.4	21	21.7	12.8
Pilfering				
No.	4	13	12	5
%	1.3	4.1	3.8	1.6
Sexual Misconduct				
No.	1	3	3	1
%	4	1	1	1
<u>Conviction</u>				
Felony				
No.	14	36	30	20
%	4.5	11.5	9.6	6.4
Misdemeanor				
No.	21	31	30	22
%	6.7	9.9	9.6	7
Action/Other Juris.				
No.	0	0	0	0
%	0	0	0	0

Nurses reported to work under the influence of drugs and alcohol in Davidson County, Shelby County, Sullivan County and Knox County more often than in other locations. Nurses forged prescriptions most often in Shelby, Montgomery and Knox, and Hamilton County in that order. Nurses in rural counties of Jefferson and Bedford most often falsified home health visits, while this violation occurred most often in the urban counties of Davidson and Hamilton. Sexual misconduct by nurses occurred most in Davidson County, Knox County and Montgomery County.

Davidson County accounted for the most felony convictions by nurse violators. Shelby County ranked second. Convictions for misdemeanors occurred most often in Shelby with Davidson ranking second. Knox County ranked third in felony and misdemeanor convictions of nurse violators. Table 19 reflects the three top ranking counties where these occurred most often. Of the 22 categories listed, Shelby County ranked first 15 times as the number one county where the substance category was abused. Davidson ranked first on four substances; Knox County ranked first on one substance as did Hamilton, Montgomery and Hamblen. Knox County ranked first in the area of multi-pharmaceuticals where nurses used various substances as opposed to a major substance in violation of the Nurse Practice Act. Davidson County ranked first in nurses reporting to work under the influence of drugs, leaving nursing station and thus abandoning patients, and incompetent nurses.

Demerol, the number one drug of abuse in this study, was abused most often in Shelby County (32 nurses), followed by Davidson County (18 nurses), and Knox County (14 nurses). Shelby County had almost twice as many demerol violators as

Davidson County and three times as many as Knox County. One tenth of the nurses disciplined were demerol violators from Shelby County. Another 10 percent is represented by the combined demerol violations in Davidson and Knox County. The three counties combined represented 20 percent of all demerol violations in this study.

Hamilton County, an urban, eastern region of the state ranked second, only after Shelby County in the number of cocaine-use violations. The same is true for Hamilton County in darvocet/darvon violations.

The rural western county of Bedford ranked third in valium/xanax abuse. Lawrence County, a western rural region, and Putnam County, an eastern rural region, ranked second and third, respectively, in nurse violators using the narcotic mepergan fortis. Montgomery County, a western, rural region ranked first in the misuse of lortab by nurses. Hamblen County, a rural, eastern county ranked first in nurses using oxycodone (tylox, percocet).

RELATIONSHIP QUESTIONS

What Disciplinary Actions Were Taken for Various Violations, Including Substances Abused?

Disciplinary action was taken by the Tennessee State Board of Nursing in an open-forum public meeting in Nashville, Tennessee, every three months during this study (1990-1992). Action was taken in different forms, based on the individual charges, proof, evidence, and circumstances of the nurse violator. The actions taken could be in conjunction with previous action. Other times, nurses had new action brought against them, sometimes two or three actions for the violation for which they

were charged. Nurses frequently committed more than one violation for which they were charged. More than one action was frequently given to the violator during the meeting of the State Board of Nursing for violations of the Nurse Practice Act.

Reference is made to Table 14 and Table 21 to follow the relationship of the violation and action in each violation category. Listed are each violation in which nurses were disciplined. The individual categories of substances abused are also listed with the actions taken as a result of their usage. Individual drugs abused are listed in Appendix I. Table 21 displays the disciplinary actions taken against Tennessee nurses who abused chemical substances and were disciplined for that abuse during the period 1990 through 1992.

Drug abuse was disciplined more often than other drug related violations. It is the main subcategory of violation. Unprofessional conduct was treated as a universal category when coming before the State Board of Nursing. Therefore, this behavior was treated as having been assigned to each person appearing before the Board of Nursing. All behaviors in this study did constitute unprofessional conduct as described in Appendix A relative to T.C.A. 63-115 and 1000-2-.13. Even those who received only reprimands exercised unprofessional conduct in their behavior relative to the practice of nursing.

Table 21. (Continued)

SUBSTANCES		A	L	L	L	V	S	S	P	F	R	A	C	C	P	S	C	R	R
		C	i	i	i	o	u	u	r	i	e	s	o	l	A	p	i	e	e
		T	c	c	c	l	m	s	o	n	p	s	u	o	P	e	c	i	i
		I					m	p	b	e	r	e	r	s		c	a	n	n
		O	D	L	R	S	S		a		i	s	s	e			r	s	s
		N	c	i	e	u	S		t		m	s	e			R	e	t	t
			n	m	v	r	u		i		a	m				e	d	a	
			i	i	o	r	s		o		n	e				i			D
			e	t	k	r	p		n		d	n				n			e
			d	e	e	d						t				s			n
			d	d	d											t			
Valium/ Xanax																			
No.		0	0	11	0	1	6	19	2	0	0	4	0	1	2	1	9	4	0
%		0	0	3.3	0	<1	1.8	5.7	<1	0	0	1.2	0	<1	<1	<1	2.7	1.2	0
Cocaine																			
No.		0	0	6	0	1	3	17	2	0	0	1	3	2	2	0	7	6	0
%		0	0	1.8	0	<1	<1	5.1	<1	0	0	<1	<1	<1	<1	0	0	1.8	0
Hallucinogens																			
No.		0	0	1	0	1	2	5	0	1	1	1	0	1	0	0	2	4	0
%		0	0	<1	0	<1	<1	1.5	0	<1	<1	<1	0	<1	0	0	<1	1.2	0
Multi-Pharm.																			
No.		0	0	13	0	2	8	18	3	2	4	4	1	2	4	1	5	9	0
%		0	0	3.9	0	<1	2.4	5.4	<1	<1	<1	1.2	<1	<1	1.2	<1	1.5	2.7	0

Table 21. (Continued)

SUBSTANCES		A	L	L	L	V	S	S	P	F	R	A	C	C	P	S	C	R	R
		L	L	L	L	V	S	S	P	F	R	A	C	C	P	S	C	R	R
		i	i	i	i	o	u	u	r	i	e	s	o	l	A	S	I	e	e
		c	c	c	c	l	m	s	o	n	p	s	u	s	P	P	e	i	i
		c	c	c	c	S	m	p	b	e	e	s	r	e	P	e	a	n	n
		D	L	R	R	S	S	t	a	i	m	s	s	e		R	r	s	s
		e	i	e	e	u	S	i	t	o	a	s	s			e	e	t	t
		n	m	v	m	r	u	i			n	m	s		S	R	e	a	a
		i	i	o	r	r	s				d	c	u	p		i	d	t	t
		e	t	k	e		p					n		v		n			D
		d	d	e								i				s			e
																t			n
Morphine																			
No.		1	0	18	1	4	6	28	3	2	2	7	4	3	5	1	13	6	0
%		<1	0	5.4	<1	1.2	1.8	8.5	<1	<1	<1	2.1	1.2	<1	1.5	<1	3.9	1.8	0
Darvon/ Darvocet																			
No.		0	0	10	0	1	4	9	1	1	1	2	1	1	2	0	2	6	0
%		0	0	3.2	0	<1	1.2	2.73	<1	<1	<1	<1	<1	<1	<1	0	<1	1/8	0
Vicoden																			
No.		0	0	5	0	0	3	5	0	4	4	1	1	1	0	2	2	2	0
%		0	0	1.5	0	0	<1	1.5	0	1.2	0	<1	<1	<1	0	<1	<1	<1	0
Phenergan																			
No.		0	0	5	0	1	6	11	3	1	1	1	0	1	2	0	1	5	0
%		0	0	1.5	0	<1	1.8	3.3	<1	<1	<1	<1	0	<1	<1	0	<1	<1	0

The disciplinary action most often rendered for drug abuse was probation and revocation of licensure, 33.8 percent and 17.5 percent, respectively. Only two nurses involved in drug abuse volunteered to surrender their license. Thirty-eight nurse violators, or 11.5 percent of those abusing drugs, were suspended from practice. Two were reprimanded by the State Board of Nursing. Forty-one (12.4 percent) were finally cleared of their action during this study. Thirty-one were reinstated which indicated a degree of compliance with action taken. Thirteen (3.9 percent) drug abuse violators were required to undergo a psychiatric assessment for chemical dependency. Sixteen violators who engaged in drug abuse were levied fines.

Nurses also diverted drugs from their place of employment as well as from the patient's stock of medicines. These substances were mainly controlled substances, but not exclusively. Ninety-four (28.4 percent) of probation actions were taken against nurses for diverting drugs. Drug diversion violations accounted for 51 (15.4 percent) revocations of licensure. Nurses who diverted drugs were required to be assessed, take classes, and be closely supervised by employers.

Nurses self-administered narcotics to themselves resulting in 51 (15.4 percent) license revocations. Thirteen of the 26 nurse violators whose licenses were revoked for this violation were reinstated. Twenty-six nurse violators' records were eventually cleared by fulfilling responsibility of action taken.

The main disciplinary actions taken against nurses who were chemical or alcohol addicted was probation, revocation, and suspension of license. Thirteen of those with the addiction problem underwent a mandatory Peer Assistance Program before being

reinstated. Those charged with replacing narcotics were most often disciplined by requiring close supervision by employer in conjunction with probation.

Eleven people who reported to work under the influence of alcohol were placed on probation while four had revocation of license actions taken. The main action taken against nurses who were involved with failure to witness wastage, forging of signatures and dates, and charting violations was probation of license.

The fraudulent practice of nursing was disciplined mainly by fines and revocation of license. Holding oneself up as being more qualified than credentials show is seen as a serious violation with safety factors considered for public welfare. License revocations and suspension of license for falsifying application/renewal were the main disciplinary action taken.

Violation of probation terms was disciplined in most circumstances by extending probation (27 times) and by revocation of licensure (21 times).

Those nurses who were involved in pilfering materials or drugs from the hospital were most often disciplined by suspension, though this was in conjunction with another violation, usually a controlled substance violation.

Those nurse violators involved with felony convictions were most often disciplined by being suspended or having their license revoked. Of those felons, compliance with terms of disciplinary action was met by 11 who were reinstated and eight of them eventually had their action cleared. Five felons were required to undergo a psychiatric assessment. The same is true with those charged with a misdemeanor. Thirty-five nurse violators had their license suspended for misdemeanors, and 13 had

them revoked. Thirteen of these individuals were reinstated during this study and 12 had their action cleared through compliance. Five of these nurse violators were required to undergo psychiatric evaluation assessments.

In summary, substances abused by nurses in this study involved every major category of drugs. Refer to Table 22 for reference to the number and percentage of substances abused which accounted for disciplinary actions being brought upon the nurses who abused them. The use of these substances were in violation of the Tennessee Nurse Practice Act. Nurses often abused these drugs in combination with each other.

The drug most often abused was demerol with 123 nurse violators representing 17.6 percent of all substances abused and 37.2 percent of the sample population. Alcohol was the second most often abused drug by nurses representing 17.6 percent of all drug violations and 20.5 percent of the sample population. Morphine was the third most frequently used drug representing 8.2 percent of all substances abused and 17.2 percent of the sample population. Cocaine and marijuana, illegal Class I drugs, accounted for 28 and 31 nurse violations, respectively. Together they represented 18.8 percent of the population and 8.9 percent of the drugs abused.

Pain medications (multiple), not listed in Table 21, but referred to in Appendix I, accounted for 60 violations. The violations represented 8.6 percent of all drugs abused and 18.1 percent of the sample population.

Table 22. Number and Percent of Substance/Chemical Abuse by Nurses Who Were Disciplined by Tennessee State Board (1990-1992)

<u>Substance</u>	<u>(n)</u>	<u>%</u>	<u>% of Drugs Abused</u>
Alcohol	68	20.5	9.8
Demerol	123	37.2	17.6
Dilaudid	28	8.5	4.0
Talwin	4	1.2	.6
Percodan	14	4.2	2.0
Valium/Xanax	34	10.3	4.9
Cocaine	28	8.5	4.0
Hallucinogens			
Other than Marijuana	8	2.4	.1
Multipharmaceutical (5 or more)	34	10.3	4.9
Morphine	57	17.2	8.2
Darvon/Darvocet	23	6.9	3.3
Vicoden	14	4.2	2.0
Phenagan	15	4.5	2.2
Marijuana	31	9.4	4.4
Mepergan Fortis	10	3.0	1.4
Codeine-related	31	9.4	4.4
Lortab	10	3.0	1.4
Benzodiazepine	24	7.3	3.4
Sedative/Hypnotic	22	6.6	3.2
Oxycodone (Tylox, Percocet)	5	1.5	.7
Pain Meds (multiple)	60	18.1	8.6
Misc. Drugs (multiple)	54	16.3	7.7

Which Disciplinary Action Was Taken Most Often Against Drug Abuse? Drug Diversion? Self Administration? Use on Duty? Writing Illegal Prescriptions?

The disciplinary action taken most often against those charged with drug abuse was probation. This action was followed by license revocation and suspension. Forty-one violators were eventually cleared by meeting the standards set forth by the Tennessee State Board of Nursing. Fifty special actions, either independently or collectively, were taken by State Board in form of assessment courses required, close supervision by employer, required completion of Peer Assistance Program or special reinstatement hearing.

The nurses charged with drug diversion were likewise disciplined as those who were drug abusers. Probation was the highest ranked means of discipline followed by licensure revocation and suspension. Thirty-five violators were eventually cleared by meeting the standards set forth by the State Board of Nursing. Forty-three special actions were added to the regular board actions of the drug diversion violators in the form of assessment, courses, close supervision, required Peer Assistance Program, or special request and appearance before the State Board of Nursing before the violator was reinstated.

Self-administration of drugs, usually through muscular or intravenous injection, was a source of much nursing violation. The action most often taken by the Tennessee Board of Nursing for self-administration was probation, followed by license revocation and license suspension. Twenty-six nurses involved in self-

administration met the standards set forth by the State Board of Nursing and eventually were cleared to return to nursing.

Drug use on duty involved ninety-one nurses. The action most often taken by the Tennessee Board of Nursing for violators who used drugs on duty was probation. Drug abuse, diversion, and use on duty were disciplined by license probation, license revocation, and license suspension, in that respective rank order. Twenty-two special other actions involving assessments, courses, close supervision by employer, required completion of Peer Assistance Program, and a special request before reinstatement were also disciplinary measures taken. Nineteen nurses in this study (who used drugs on duty) met the standards and had their actions cleared to resume nursing practice in this study.

The same rank order of disciplinary action for nurse violators existed as with drug abuse, diversion, self-administration, and use on duty. Five nurses were given additional disciplinary actions as assessments, courses, close supervision by employer, required Peer Assistance Program, and special request for supervision.

One nurse involved in drug abuse, diversion, self-administration, chemical/alcohol addiction, and use on duty was denied reinstatement. This nurse was an out of state nurse violator. This was not part of the action brought against any nurse violator who wrote illegal prescriptions. Six nurse violators who wrote illegal prescriptions met the State Board of Nursing standards and were cleared to return to practice. Five special action measures were taken with this relative to assessment, course requirements, and close supervision by employment.

What Substances Were Most Abused Which Resulted in Disciplinary Action?

Demerol, a controlled narcotic, Schedule II drug, was the drug most often abused. Licensure probation, license revocation, and license suspension were the main disciplinary actions taken against nurses involved in demerol usage. No nurse violators with a demerol charge voluntarily surrendered their license.

Alcohol abuse violators were placed on probation as their main disciplinary measure. Among the 68 nurses whose violations included alcohol abuse, nineteen were reinstated and eighteen met compliance standards and had their actions cleared.

Pain medicines, those abused individually on a much smaller scale than demerol, dilaudid, and morpine, were highly abused, collectively. The main disciplinary measure taken against pain-med violators was probation (11.2 percent), license revocation (4.8 percent) and suspension (3.6 percent). Twelve had their license suspended for use of pain meds followed by license revocation (4.8 percent). Only one nurse voluntarily surrendered her license who was involved in pain-med violations. Thirteen violators had their records cleared during this study who abused pain-meds. Refer to Appendix I for a listing of substances abused.

Morphine, a common hospital Schedule II narcotic, was associated with license denial. A person denied the license had a violation involving demerol and morphine. The action taken most often regarding the misuse of morphine was probation of license followed by license revocation. Compliance and rehabilitation by morphine users is indicated by the reinstatement of nurses and the actions cleared by the Tennessee State Board of Nursing.

Miscellaneous drugs, those not found in categories elsewhere in this study, were commonplace among abusers. Licensure probation was the main disciplinary action taken by the State Board of Nursing for those who abused these drugs. Probation, as the number one disciplinary measure, was followed by licensure revocations and suspension. Twelve people received reinstatement.

Multipharmaceuticals, the category where nurses violated a Nursing Practice Act by using five or more drugs, was disciplined mainly by probation, followed by license revocation and licensure suspension. Nine violators had their licensure reinstated with probation, and five met the conditions for having their probation cleared.

Valium/Xanax, an anti-anxiety drug, was among the main drugs abused. Disciplinary action was most often taken with probation and license revocation.

Dilaudid, a very potent controlled Schedule II narcotic, was abused by 28 nurses with the main disciplinary action that of probation and licensure revocation.

Cocaine, an illegal Schedule I drug, was used by 28 nurse violators in this study. Probation was granted as the most frequent disciplinary measure by the State Board of Nursing, followed by license revocation. Cocaine violators were charged with a felony or misdemeanor. Six violators who use cocaine were granted reinstatement with probation. Seven cocaine users' records were cleared during this study.

Hallucinogens, mind and mood altering illegal drugs, were used by nurses in this study. The action category with most violators was that of probation.

The other medications, including vicoden, phenergen, mepergan fortis, codeine-related, marijuana, benzodiazepine, and oxycodone had as their main disciplinary

action that of license probation followed by revocation. An exception to this disciplinary trend was the nurse violators who used lortab. Those associated with lortab had as their main disciplinary action that of suspension. Those who abused the sedative/hypnotic category of medicine were most often disciplined by fines.

Overall, the main disciplinary actions, taken in rank order of occurrence, were probation, revocation of license, and suspension. Limiting license was the action taken least often.

No fines were levied by civil penalty in 1990 by the Tennessee State Board of Nursing with violators in this study. In 1991, \$46,600 was levied by civil penalties against nurse violators in this study ranging from \$15,000 to \$100 per individual. In 1992, \$12,350 was levied in fines ranging from \$1,000 to \$250. In summary, refer to Table 23 for the disciplinary actions taken and the average length in months.

Summary of Important Findings

This chapter presented an analysis of the data obtained from the Tennessee Disciplinary Report Form on 331 nurse violators who were disciplined by the Tennessee State Board of Nursing from 1990 through 1992. Several findings are of practical importance to the nursing profession in Tennessee.

1. Of the 331 nurse violators in the sample, 165 (49.8 percent) were LPNs and 166 (51.2 percent) were RNs.

Table 23. Disciplinary Actions and Length of Time of Nurse Violators (1990-1992)

Action	Average Length
Denial of License	60 months
Limit License	12 months
Revoke License	13.27 months
Voluntary Surrender	36 months
Summ. Suspension	10 days to 3 months
Suspension	9 months
Probation	23 months

2. Of the 331 nurse violators 160 of the sample had 5 or more violations for which they were disciplined.
3. Of the 166 registered nurses in this study, 104 (62.7 percent) held a two-year associate degree as their highest education.
4. Twenty nurses were disciplined by the State Board of Nursing after graduation but before being credentialed. This action was for violations previously committed for which the State Board of Nursing monitored.
5. The average number of years in nursing by the nurse violator in this study was 9.62 as a graduate.
6. The mean age of the nurse violator in the study was 35.37 years.
7. The gender of the nurse violators in the study included 24.8 percent of males and 75.2 percent of females.

8. The marital status of the group was partially unavailable. Available data indicated that nurse violators were married 66.4 percent of the time.
9. The racial grouping of the sample indicates that the nurse violators in this study were primarily of the Caucasian race.
10. The violators in this study represented all regions of the state, with the western region and the urban regions most often represented.
11. The violation of the Nurse Practice Act most often committed by the nurse in the sample was drug abuse.
12. Drug and alcohol addiction, usage, and diversion by nurse violators in this study accounted for previous disciplinary action by the State Board of Nursing.
13. The largest employing agency for the nurse violator was the hospital with 500 or more beds.
14. The employer of the nurse violator was most often the reporting agency for the nurse violator to the State Board of Nursing.
15. Shelby County, a western, urban region of the state was the county in which nursing violations occurred most often. Davidson County, a western, urban county followed in number of violations. In third place was Knox County, an eastern, urban county. These are the three largest population counties in the state.
16. Shelby County ranked in first place in fifteen out of twenty-two categories of substances abused by nurses in this study.

17. Demerol, the drug most often abused drug in this study, was abused most frequently in Shelby County.
18. Davidson County accounted for the most felony convictions of nurse violators in this study.
19. Shelby County accounted for the most misdemeanor convictions of nurse violators in this study.
20. The main disciplinary actions taken against nurses by the Tennessee State Board of Nursing for violations of the Tennessee Nurse Practice Act was probation of license, revocation of license, and suspension of license in that order. This was true for the main substance abused, demerol, as well.
21. Newly graduated nurses were found to have committed illegal acts leading to disciplinary measures for initial licensure in 20 nurse violator subjects.

Other Findings

The data obtained from the survey in this study revealed several other interesting findings. Forty-seven RNs and 29 LPNs in the study held licenses in other states with Florida most often represented, followed by Arkansas. Of the nurses involved in any form of drug abuse or chemical dependency, 66.3 percent were referred to the Tennessee Nurses Foundation Peer Assistance Program. Of this number 17 percent were already affiliated with some form of rehabilitation for drug and alcohol chemical dependency program. Those not referred to the Tennessee Nurse Foundation Peer Assistance Program (33.3 percent of drug violators) were nurse violators who failed to appear at the Board of Nursing for charges without an agreed order. The Board of

Nursing held these people in default and generally revoked their license. With a revoked license, a nurse may not request reconsideration for reinstatement for at least 12 months unless special conditions of rehabilitation are most favorable and special requests are submitted.

The State Board of Nursing gave consideration in their disciplinary action to drug use violators who acknowledged their problem and sought rehabilitation through the Peer Assistance Program or another aftercare agency.

The states where action by another jurisdiction resulted in charges being brought against Tennessee nurses varied widely. Florida, Alabama, Kentucky, Arkansas, Ohio, Mississippi, and Texas led in rank order. Eighty-seven percent (288) of those nurses who violated the Nurse Practice Act in this study were licensed initially in Tennessee.

The average length of time from the initial date of each violation which was disciplined in this study until the State Board took action on that violation was 17.2 months. This time lapse included the reporting of the violation, the processing of it, and assigning an investigator to the case. Information was then gathered through verification of records, and the State Board disciplinary team (nurses and General Counsel) prepared the case to be presented to the State Board.

The four months in which the nursing violations occurred most often were, in order, June, September, March, and December. Each one of these months represents the end of a season, and three of these months are inclusive of holidays.

Certified Registered Nurse Anesthesists accounted for five of the nurse violators. They most often left patients unattended during surgery and used narcotics of versed, demerol, and nubain while on duty. They also had violations of impairment by alcohol while on duty.

Anecdotal documentation of the impaired Tennessee nurse indicated personality and behavior changes consistent with that reported in the literature by M. Kelley (1987). A listing of these behaviors by Tennessee violators is given in the conclusions.

The major felony conviction by a nurse violator during this study was that of sexual misconduct. A male nurse sexually abused his children, and was convicted for the crime. He had his license revoked, and is now serving 85 years in prison without parole. Other felony and misdemeanor crimes by nurse violators in this study are as outlined in Table 12.

One male nurse violator in the study who had multiple violations of alcohol abuse and disciplinary action died during his last probationary period.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The final chapter of this study presents a summary of the research and findings, draws conclusions from the findings, and makes recommendations for educating nurses about the Tennessee Nurse Practice Act and monitoring nurses who have violated the Nurse Practice Act.

SUMMARY

Although the Tennessee Nursing profession has been concerned about the nursing violations committed by licensed nurses for many years, prior to this study no multi-year overview of the characteristics of the disciplined nurses had been undertaken. Tennessee did not have statewide, current profile information. This study sought to determine the characteristics of nurses who were brought before the Tennessee State Board of Nursing from 1990 through 1992 for violation of the Tennessee Nurse Practice Act.

An instrument was created by the researcher to gather data from the public files of the Tennessee nurse violator. Space was included for identifying the region of the state, its urban/rural status, age, sex, marital status, and the drug(s) involved, if any, along with years of nursing, employing agency, reporting source, violation, and resulting action taken.

The sample consisted of a census of 331 licensed practical nurses and registered nurses who were disciplined by the Tennessee State Board of Nursing from 1990 through 1992 for violations of the Tennessee Nurse Practice Act.

Data analysis revealed that nurses disciplined from 1990 through 1992 represented an approximately equal number of RNs and LPNs. Consistent with the numbers working in nursing, more females were disciplined than males. Most nurses in the study were employed by hospitals. Violations were most often committed by nurses who worked in facilities with 500 or more beds. The employer most often reported the violator. Nurse violators, on an average, had more than nine years of experience. The western region had more nurse violators in comparison to the east. Urban areas had more nurse violators than the rural regions. Shelby County, the state's largest population center, led the state in nursing violators. Drug abuse and demerol abuse were more often committed by nurses in Shelby County. The major nursing violation was drug abuse, alcohol and chemical dependency, and drug diversion. Demerol was the substance most often abused. The main disciplinary actions taken by the Tennessee State Board of Nursing were probation (average 24 months), revocation, and suspension of license.

DISCUSSION OF FINDINGS

Findings of the study, which examined the characteristics of the Tennessee disciplined nurse from 1990 through 1992, will now be discussed in relation to relevant conceptual and research literature.

The findings of this study support the idea that disciplinary cases brought before the State Board of Nursing were relevant to drug and alcohol abuse. Drug abuse by nurses is a major concern of both colleagues and the public (Clark, 1988). The literature reflects that ten percent of the people in the general population develop an alcohol related problem (DeLuca, 1981). In this study, the percentage exceeded that at 17.6 percent of those afflicted with alcohol abuse.

The literature gives insight into nurse violators admitting deficiency in their ability to cope. This is reflected in the study in two ways. Nurses in the study were very reluctant to surrender voluntarily their nursing license and not practice nursing while heavily abusing drugs. They were, however, in somewhat larger measure (17 percent substance abusers) enrolled in a Peer Assistance Program when appearing before the Tennessee State Board of Nursing during the years under study, although some were noncompliant with standards.

It was found that the average, typical nurse who was brought before the Tennessee State Board of Nursing for disciplinary action was between the ages of 30 and 39, (average 35.7 years old) had graduated within the last 10 years (9.62 years in this survey), worked in a medical-surgical nursing clinical area, and was employed by a hospital. This is consistent with research findings conducted by Connell and Murphy (1987). Of all licensed and registered nurses disciplined for substance abuse, the most common drug was demerol. This is consistent with the research findings and report by Connell and Murphy (1987). This is reaffirmed by Kabb (1984), Hutchinson (1986) and Garb (1965) research.

Pilfering and drug diversion were common violations by nurses in this study. This finding reaffirms a study finding conducted by Dr. Sarah Mynatt of the Tennessee Peer Assistance Program in 1988. Also reaffirmed by this study was Mynatt (1988) finding that nurses were able to work in an impaired condition for several years without being detected.

Anecdotal behaviors and personality changes in the Tennessee nurse violator were noted in this study. They were relevant to alcohol and drug abuse and were consistently noted. They included irritability, withdrawal, mood swings, isolation, sleeping on duty, inappropriate responses to conversation, elaborate excuses for behavior, blackouts, questionable and suspicious behavior concerning controlled substances, and being more generous with controlled substances than anyone else. The drug addicted nurse had more frequent spills and breakage of controlled medicines than others. The nurse violator fails to have narcotics wastage witnessed. Documentation showed also that the drug nurse abuser was continuously administering drugs to other nurses' patients without proper protocol as indicated by charting errors. These behaviors are consistent with literature relevant to this survey finding (M. Kelley, 1987).

Although nursing violations monitoring, especially drug and alcohol abuse, continue to be a major thrust of the Tennessee State Board of Nursing, the number of cases decreased in this study from a high in 1990 to a low in 1992. This may be due to cases being delayed and rescheduled; however, the awareness of the Tennessee Peer Assistance Program may be impacting on the nursing profession. This trend in

Tennessee is inconsistent with available research statistics on the national level (Supples, 1990; National Council of State Boards of Nursing, 1988-1990).

Disciplinary nursing actions taken by the Tennessee State Board of Nursing most often include probation, revocation, and suspension of license. Patient abuse and diversion of patient medication for self use using replacement substances were disciplined more stringently.

The Tennessee State Board of Nursing consistently attempted to fill in education gaps through psychiatric assessments and courses that would remediate the violator in the area of weakness. They required nurses to successfully complete Peer Assistance Programs in cases where the Board deemed that, otherwise, the public would be unsafe. Narcotic restrictions by employers were mandated for nurses who had abused and diverted multiple drugs on a consistent, ongoing, long-term basis.

When nurses were requested to appear before the State Board of Nursing and they did not, they were consistently held in default. This failure to exercise a "good faith effort" to deal with the nursing violation problem resulted in revocation of license and generally a special appearance before the Board of Nursing prior to asking for reinstatement. New graduates had disciplinary action concurrent with their initial licensure. This occurred with 20 subjects and is indicative of initial drug abuse and alcohol use in nursing school. This finding is congruent with the Quinn-Larson and Pickard research (1989).

The State Board of Nursing, through its disciplinary actions, speaks to the protection of the public welfare and safety of its citizens through monitoring nurse

violators. Though they exercised extended effort with many nurse violators to work conjointly with them to rehabilitate their illegal habits, they speak firmly through their actions and recommendations.

Registered nurse anesthetists, according to Kabb (1984) are known to be more at risk for abusing drugs and becoming addicted to drugs than other practicing nurses because of the availability of addicting drugs. In this study, five nurse anesthetists were charged with violations and disciplined by the State Board of Nursing. They used the narcotics of versed, demerol, and nubain while on duty. Two nurse anesthetists left patients unattended while undergoing surgery. One was under the heavy influence while on duty. This behavior is consistent with violations of this group when drug addicted.

Among the strengths of the study were: (1) the comprehensiveness of the target sample obtained through files at the Tennessee Board of Nursing; (2) development of an instrument which was consistent with the data sought; (3) selection of relevant categories of nurse violations and actions taken by the board accounting for a broad scope of data.

CONCLUSIONS

Based on the findings in this study, the following conclusions may be drawn:

1. All types of nurses may be susceptible to problems which may lead to a need for disciplinary action by the State Board of Nursing.
2. Nurses in all settings may be vulnerable, but those in large institutions in urban areas may be most at risk.

3. While the large majority of nurses are stable and highly professional, a continuing problem exists for a small proportion of the profession, often leading to reliance on drugs.
4. Access to drugs and the opportunity to obtain them in the workplace make this "solution" to personal and professional stresses a temptation.
5. Many nurses who are in violation of the Nurse Practice Act have continuing problems even after their first disciplinary action.
6. Disciplinary actions of the State Board of Nursing are not effective for some nurses.
7. Nurses are often able to move from one state to another to avoid disciplinary action.
8. The Peer Assistance Program is not always an effective remedy for the nurse violators.
9. Close supervision of persons trained to identify the symptoms of drug use, pilferage, and diversion leads to early identification of the problems of nurse substance abusers.
10. Effective, easily accessible records of nurse violators within Tennessee and among all states are not available. Data retrieval through computer-assisted information systems is essential for tracking and trending nurse violators on an on-going, continual basis.

11. Educational programs for nurses may, in many cases, be lacking in preparing student nurses for the stresses and problems which may later lead to violations of the Nurse Practice Act and eventually to disciplinary action.

RECOMMENDATIONS

These findings and conclusions lead to the following recommendations:

1. More concerted efforts need to be made at early identification, reporting and remediation for nurses who violate the Nurse Practice Act.
2. Nursing administrators and supervisors should be trained in the identification of the symptoms of the nurse violator.
3. Nursing administrators should be required to have an internal monitoring system and procedure for checking license and permits in order to reduce the number of nurses working on a lapsed or revoked license. They, too, should be held accountable. Other states presently discipline this violation.
4. Nursing administrators should be encouraged more by the Tennessee State Board of Nursing through written communication to educate the nurses within their institution regarding the violation problem of nurses.
5. Nurses should be openly encouraged to ethically report other nurses who are abusing drugs rather than ignoring the situation.
6. In order to move the problem of chemical dependency to the forefront in nursing and seek a decrease in its occurrence, a strong educational effort must be undertaken to provide workshops and seminars to nurses and health care providers.

7. A code should be established by the Tennessee State Board of Nursing on the license of every nurse at renewal time indicating disciplinary status. Employers would be better able to monitor those with certain codes. None presently exist.
8. The nurses whose license are revoked, suspended, denied, or summarily suspended by the Tennessee State Board of Nursing should not be allowed to work in areas of direct patient care in a healthcare agency. Example: working as a nursing assistant.
9. It is recommended that the nursing profession soon become a part of the network of the National Practitioner Data Bank to monitor sanctions imposed on nurse violators and decrease employment mobility of nurse violators.
10. The public needs to be better informed regarding the problems that exist with nurse violators so as to have a better informed consumer. Mini media slots are encouraged.
11. The awareness of problems with chemical dependency and alcohol abuse along with other violations of the Tennessee Nurse Practice Act should be encouraged at nurse orientation in every Tennessee health care institution employing licensed nurses.
12. Special diligence and security measures should be taken in institutions to protect against drug pilferage and diversion.
13. It is recommended that nursing students have information regarding types of nursing violations and the Nurse Practice Act incorporated into the curriculum of

each nursing school in Tennessee. Proof of this curriculum instruction would be contingent on state approval by the Tennessee Board of Nursing.

14. Tennessee student nurses should be required sometime during their basic nursing education to attend a State Board of Nursing meeting on a day when disciplinary cases are being heard.
15. Every effort should be made by disciplinary process of the State Board of Nursing to insure that the nurse violator has had at least two opportunities to receive a returned "Notice of Charges" when addresses are in question so that no nurse who had potential for help goes unhelped by the State Board of Nursing.
16. Repeat offenders of the Nurse Practice Act should be removed from the profession unless or until their problems can be shown to be corrected, if possible.
17. Nursing fines should be aggressively pursued after being levied by the Tennessee State Board of Nursing in order to fund a position of drug education at the Tennessee State Board level.
18. The State Board of Nursing should continue trending the disciplinary actions of nurse violators when their computer and information system comes on line. This could add to the body of nursing knowledge regarding the chemical and drug problem in Tennessee.
19. Random drug testing should be done in the healthcare workplace as in other work settings.

20. Due to the increasing work load and documentation required for monitoring Tennessee nurse violators, another full-time employee is needed in this area if future trending and education efforts are to be realized.
21. Information regarding the Tennessee Peer Assistance Program should be communicated in writing to every licensed practical and registered nurse in Tennessee.
22. The Peer Assistance Program should be reviewed for those in non-compliance, evaluated, and improved, if needed, on a regular basis.
23. The workplace could be better served by providing inservice to nursing personnel in the form of education targeted at developing a non-judgmental, non-narcotic approach. It is recommended that nurses develop confrontation strategies to intervene into chemical dependency as a disease process.
24. Future research should build on this initial study by looking at the different nursing violations and their relationship to the individual substances abused, and the resultant actions.
25. Future research should include a breakdown of countries where the nurse worked and where the nurse violated the Tennessee Nurse Practice Act, and their relationship.
26. Future research should include the grade point average of the nurse violators to ascertain if they were above average achievers in nursing school.
27. Future research should include the number of attempts at passing the State Boards and their relationship to drug abuse tendency.

28. Future research should include a survey of the nurse violator administered by the nurse administrator at the institution in which the violation of the disciplined nurse occurred in order to gain insight into social, professional, and personal attitudes and feelings related to drug and alcohol abuse and addiction. These variables may be insightful into developing future rehabilitation efforts in the Peer Assistance Program of the Tennessee Nurse Foundation.

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APPENDICES

APPENDIX A

TENNESSEE NURSE PRACTICE ACT

TCA 63-7-115 AND 1000-2-.13

TENNESSEE NURSE PRACTICE ACT

63-7-115. GROUND FOR DENIAL, REVOCATION, OR SUSPENSION OF
CERTIFICATE OR LICENSE.--(a)(1) The board shall have power to deny, revoke or

suspend any certificate or license to practice nursing or to otherwise discipline a licensee upon proof that the person:

- (a) Is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing;
- (b) Is guilty of a crime;
- (c) Is unfit or incompetent by reason of negligence, habits, or other cause;
- (d) Is addicted to alcohol or drugs to the degree of interfering with nursing duties;
- (e) Is mentally incompetent;
- (f) Is guilty of unprofessional conduct; or
- (g) Has violated or attempted to violate, directly or indirectly or assisted in or abetted the violation of, or conspired to violate, any provision of this chapter or any lawful order of the board issued pursuant thereto.

(2) This section shall also supply to members of the board.

- (b) The board shall have concurrent enforcement power, pursuant to 63-1-122, with the division, to revoke or suspend any certificate of fitness of a nurse practitioner who has been issued a certificate of fitness pursuant to 63-1-104, or to otherwise discipline such person in accordance with the provisions of this section.

63-7-116. License revocation or suspension procedure--Reissuance.--(a) Any person may prefer charges against a nurse for violation of any grounds of discipline mentioned in 63-7-115. The charges shall be in writing and submitted to the board unless they originate with the board or a member thereof.

- (b) Unless the charges are dismissed without a hearing by the board as unfounded or not warranting further investigation, the board shall, within ninety (90) days

from the date on which the charges are preferred, set a time, date and place for a hearing on the charges. The date on which the charges are preferred.

(c) A copy of the charges, together with the notice of the time and place of hearing, shall be furnished to the accused, which may be done by registered mail directed to the address furnished the board at the time of registration, at least thirty (30) days before the date fixed for the hearing.

(d)(1) The chairman or the vice chairman of the board shall have the power to administer oaths, issue subpoenas, and enforce the attendance of witnesses and the production of books, records and papers at any hearing on any matter which the board has power to investigate.

(2) If any witness fails or refuses to obey a subpoena issued by it, the board is authorized to make application to any court of record in this state within the jurisdiction of which the witness is found or resides, and the court shall have power to attach the body of the witness and compel him to appear before the board and give testimony or produce books, records, or papers as ordered, and any failure to obey the court order may be punished by the court issuing the order as a contempt.

(3) Each witness who appears before the board by order of the board shall receive for his attendance the compensation provided by law for attendance of witnesses in a court of record, which shall be paid from the funds of the board in the same manner as all other expenses of the board are paid.

(e) At the hearing the accused shall have the right to appear personally and by counsel, to cross-examine witnesses, to produce evidence and witnesses and shall also have the right to have subpoenas issued by the board to compel the attendance of all witnesses considered by the parties to be necessary to a full and complete hearing.

(f) After the hearing if a majority of the members of the board present vote in favor of finding the accused guilty of any of the charges, the board shall suspend or revoke the certificate of registration of the accused as in its judgment the offense deserves.

(g) Review of the action of the board in suspending or revoking any license shall be pursuant to 27-9-101 - 27-9-114.

(h) The board may reissue any license which it has revoked if a majority of the members of the board present vote in favor of the reissuance of the license for reasons the board may consider sufficient.

(Tennessee Board of Nursing, April, 1990a, pp. 9-10)

1000-2-.13 UNPROFESSIONAL CONDUCT AND NEGLIGENCE, HABITS OR OTHER CAUSE.

- (1) Unprofessional conduct, unfitness, or incompetency by reasons of negligence, habits or other causes, as those terms are used in the statute, is defined as, but not limited, to the following:
 - (a) Intentionally or negligently causing physical or emotional injury to a patient;
 - (b) Failure to maintain a record for each patient which accurately reflects the nursing problems and interventions for the patient;
 - (c) Abandoning or neglecting patient requiring nursing care;
 - (d) Making false or materially incorrect, inconsistent or unintelligible entries in any patient records or in the records of any health care facility, school, institution or other work-place location pertaining to the obtaining, possessing or administration of any controlled substance as defined in the Federal Controlled Substances Act;
 - (e) Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any health care facility, school, institution or other work-place location;
 - (f) The use of any intoxicating beverage or the illegal use of any narcotic or dangerous drug while on duty in any health care facility, school, institution, or other work-place location;
 - (g) Being under the influence of alcoholic beverages, or under the influence of drugs which impair judgment while on duty in any health care facility, school, institution or other work-place location;
 - (h) Impersonating another licensed practitioner;
 - (i) Permitting or allowing another person to use his or her license for the purpose of nursing the sick or afflicted for compensation;
 - (j) Revocation or suspension of a license to practice nursing by another state or territory of the United States for any act or omission which would constitute grounds for the revocation or suspension of a license in this state;

- (k) Practicing practical nursing in this state on a lapsed (state) license or beyond the period of valid temporary permit;
 - (l) Assigning unqualified persons to perform functions of licensed persons or delegating nursing care functions and tasks and/or responsibilities to others contrary to the Nurse Practice Act or rules and regulations to the detriment of patient safety;
 - (m) Failing to supervise persons to whom nursing functions are delegated or assigned;
 - (n) Aiding, abetting, assisting or hiring an individual to violate or circumvent any law or duly promulgated rule intended to guide the conduct of a nurse or any other licensed health care provider;
 - (o) Exercising undue influence on the patient including the promotion of sale of services, goods, appliances, or drugs in such a manner as to exploit the patient for financial gain of the nurse or of third party;
 - (p) Discriminating in the rendering of nursing services as it relates to race, age, sex, religion, national origin, or the condition of the patient.
 - (q) Violating confidentiality of information or knowledge concerning the patient, except when required to do so by a court of law;
 - (r) Failing to take appropriate action in safeguarding the patient from incompetent health care practices;
 - (s) Failing to report, through proper channels, facts known to the individual regarding incompetent, unethical or illegal practice of any health care provider;
 - (t) Performing nursing techniques or procedures without proper education and practice;
 - (u) Engaging in acts of dishonesty which relate to the practice of nursing.
- (Tennessee Board of Nursing, March, 1988, pp. 35-36)

APPENDIX B

SUPPORTING DOCUMENTS



STATE OF TENNESSEE
BUREAU OF MANPOWER AND FACILITIES
HEALTH RELATED BOARDS
283 PLUS PARK BLVD.
DEPARTMENT OF HEALTH
NASHVILLE, TENNESSEE 37247-1010

December 31, 1992

Ms. Rachel Leona Orr, R.N., M.S.N., CRNAA
857 Spinnaker Drive
Knoxville, TN 37922-4761

Dear Ms. Orr:

It was a pleasure to meet you on Friday, December 11, 1992 in my office at Nashville. I am most pleased to be able to work with you in your efforts to research the disciplinary actions of the Tennessee State Board of Nursing from 1990 through 1992. I am writing to you to reaffirm my complete endorsement of your research and my willingness to cooperate with you in your data collection.

The profile of the nurses disciplined by the Tennessee State Board of Nursing will certainly bring together the individual variables in a comprehensive, compiled manner. Your choice of this study topic was a well thought-out plan based on your prepared materials and presentation to Ms. Stroud and myself. Since the period in March, 1991, that you initially contacted the State Board of Nursing to discuss the research and request permission for consideration of data collection at our agency, I have looked forward to working with you. A study of this type is indicated to enhance the work of the Tennessee State Board of Nursing as well as the nurses in Tennessee. This data will show trends in violations and subsequent disciplinary action. A comprehensive profile of Tennessee disciplined nurses will allow our agency to begin to construct a data base of the 90's on which future monitoring can be built and enhanced. It is hoped that other nurses can reference this data in the future and add to it for the advanced knowledge of nursing in this ever-growing occurrence among the nursing profession.

Again, best wishes for your study and rest assured that I welcome you to our agency to research your much sought-after data. I shall look forward to seeing you soon.

Professionally yours,

Elizabeth Lund /z

Elizabeth Lund, R.N., M.S.N.
Executive Director
Tennessee State Board of Nursing

EL/G2212366

cc: Ms. Zelma Stroud
State Board of Nursing

Dr. Robert Roney
Chairman, Doctoral Committee for
Rachel Orr at University
of Tennessee



National Council
of State Boards of Nursing, Inc.

676 North St. Clair Street
Suite 550
Chicago, Illinois 60611-2921

312 787.6555
FAX 312 787.6898

December 8, 1992

Rachel Orr, BSN, MSN, EDS, CRNAA
857 Spinnaker Drive
Knoxville, Tennessee 37922

Dear Ms. Orr:

Thank you for sharing your draft data collection instrument which you have based on the National Council of State Boards of Nursing Disciplinary Report form. This letter documents permission to use a modified version of the Disciplinary Report form, with proper acknowledgement to the National Council, to obtain data for your research.

As you indicated in your letter dated December 8, 1992, we are in the process of revising our reporting form as part of our database conversion. I anticipate beginning to use the new form early in the new year.

Good luck as you complete your research and write your doctoral dissertation. I would be most interested in your findings regarding disciplined nurses in Tennessee.

Sincerely,

Vickie R. Sheets, RN, JD

Vickie R. Sheets, RN, JD
Director for Public Policy,
Nursing Practice and Education

March 2, 1991

12401 Union Road
Knoxville, Tennessee 37922

Dr. Jennifer Bosma, Director
National Council of State Boards of Nursing
676 North St. Clair Street
Suite 550
Chicago, Illinois

Dear Dr. Bosma:

I am a doctoral student at the University of Tennessee. I am presently working on my dissertation research which shall deal with the topic of disciplined nurses in Tennessee, looking at quantitative data.

The purpose of this letter is to request written approval from you to adapt the "Disciplinary Report Form" that you have, so that I can use it in modified format as a data instrument tool to gather information for my dissertation. I plan on adding some demographic variables and deleting some variables as deemed satisfactory by the Tennessee State Board of Nursing and my academic committee.

Thank you for your consideration in this professional endeavor.

Professionally yours,

Rachel Orr, BSN, MSN, ED.S., CRNAA
Doctoral Student
University of Tennessee, Knoxville

APPENDIX C

SPOTTING THE CHEMICALLY DEPENDENT NURSE

SPOTTING THE CHEMICALLY DEPENDENT NURSE

EMPLOYMENT HISTORY/PERFORMANCE

Alcohol: Exhibits frequent moves, job changes--attempts a "geographical cure" of starting over. Explains these by family needs, problems, transfers.

Drugs: May also exhibit frequent job changes but is more selective in jobs. Eager to begin work before references or out-of-state licensure are checked.

PREFERENCE IN ASSIGNMENT

Alcohol: may transfer to less demanding an/or more independent or isolated role--such as from E.R. to nursery or public health. Does not volunteer for additional or difficult assignments.

Drugs: Prefers areas with high volume use of their drug of choice, decreased patient awareness, and lack of supervision--prefers orthopedics, anesthesiology, nursing homes, or large/busy surgical units over pediatrics, dialysis, or small ambulatory units. Often volunteers for 3-to-11 or 11-to-7 shifts to decrease contact with others.

ABSENTEEISM

Alcohol: Above average rate, especially following days off. Apt to call at the last minute to extend time off. Use of sick time at the beginning of the shift--can't get to work on time because of a hang-over.

Drugs: Exhibits "workaholic" syndrome--volunteers to work extra, shortens vacation to obtain the drug supply.

TIME ON UNIT

Alcohol: Late arrival from hangovers/early departure to hurry home to drink.

Drugs: Often arrives early, stays late, skips lunch and breaks--may appear at unusual hours or on unassigned units to visit, assist, or borrow meds.

DISAPPEARANCES

Alcohol & Drugs:

Frequent, longer breaks; trips to the bathroom & lunch alone. Declines offers for meals or breaks with peers--eats on the unit, skips meals, or goes alone to use drugs or alcohol.

DECREASING EFFECTIVENESS ON THE JOB

Alcohol & Drugs:

Inconsistent or erratic performance. Failure to meet deadlines or schedules. Increase in complaints from staff about carrying the workload. Increase in complaints from patients and family. Has difficulty conceptualizing.

CHARTING AND REPORTS

Drugs:

Discrepancies between patients' and nurse's reports, especially regarding pain meds. Patients complain of incomplete relief from medications recorded as give or not requesting meds given for "c/o pain." Errors in narcotic count. Unwitnessed or excessive loss--breakage, waste. Above average number of the nurse's signature of the narcotic sign-out sheet, especially prior to days off. Patients receiving more PRNs on nurse's shift than others. Signing out several PRNs at once--"I'm going to get all my pre-ops ready now" or "I know he's going to need it all this shift." Evidence of tampering.

Alcohol & Drugs:

Handwriting is noticeably affected in charting. Quality of notes diminished. Failure to file reports. Discrepancies exist between oral and written reports.

HEALTH HISTORY

Alcohol & Drugs:

Excessive use of insurance coverage. Reluctance to submit to initial physical exam without advance warning.

APPEARANCE

Alcohol:

Odor of alcohol lingers on breath, through skin to clothing. Blood shot eyes-red, bleary. Spider veins, especially around the nose. Face wrinkled-Flushed, puffy. Leathery skin. Weight slightly higher on frame than obesity.

Drugs:

Always wears uniforms with pockets, long sleeves, or sweaters. Band-aids on hands, arms. Pupils constricted-narcotics. Pupils dilated--stimulants. Runny eyes or runny nose with clear mucous drainage.

Alcohol & Drugs:

Unkempt, hair lacks luster. Avoids eye contact. Premature aging. Fatigue. Thin-rarely athletic or physically fit. Malnourished, anorexic, signs of fluid and electrolyte imbalance. Keeps large purse or satchel in view or locked.

(Tennessee Nurse, July, 1991, p. 33)

APPENDIX D

OCCUPATIONAL HAZARDS

OCCUPATIONAL HAZARDS

Categories of Potential or Actual Occupational Hazards

1. **Biologic--Infectious Hazards--Infections--**biologic agents such as bacteria, viruses, fungi, or parasites that may be transmitted via contact with infected patients or contaminated body secretions or fluids.
* HIV virus, which can lead to AIDS, falls under this category.
2. **Chemical Hazards--**Various forms of chemicals that are potentially toxic or irritating to body systems, including medications, solutions, and gases.
3. **Environmental--Mechanical Hazards--**Factors encountered in work environments that cause or potentiate accidents, injuries, strain, or discomfort (e.g., poor equipment of lifting devices, slippery floors).
4. **Physical Hazards--**Agents within work environments, such as radiation, electricity, extreme temperatures, and noise that can cause tissue trauma.
5. **Psychosocial Hazards--**Factors and situations encountered or associated with the job or work environment that create or potentiate stress, emotional strain, interpersonal problems.

(Rogers & Travers, 1991, p. 487)

APPENDIX E

**GUIDELINES FOR EMPLOYERS WITH NURSES
WHO ABUSE DRUGS**

**SUGGESTED GUIDELINES FOR EMPLOYERS AND
INDIVIDUALS REPORTING
NURSES INVOLVED IN SUBSTANCE ABUSE**

**A Comparison of Functions of the TNA Impaired Nurse
Program and the Tennessee Board of Nursing**

<u>TNA Impaired Nurse Program</u>	<u>Tennessee Board of Nursing</u>
1. <u>Authority:</u> Voluntary Program	Tennessee Code Annotated (63-7-115)
2. <u>Structure:</u> A program developed and sponsored by the Tennessee Nurses' Action	An agency of state government within the Department of Public Health
3. <u>Purpose:</u> To assist the impaired nurse and protect the public	To protect the public health, safety, and welfare
4. <u>Who to Report:</u> Any licensed nurse believed to be <u>personally</u> impaired by drug and/or alcohol abuse in the practice setting.	All licensed nurses believed to be in violation of the Nurse Practice Act. The Following are grounds for disciplinary action by the Board (63-7-115): 1. Fraud or deceit in procuring or attempting to procure a license to practice nursing 2. Guilty of a crime 3. Unfit or incompetent by reason of negligence, habits or other cause 4. Addicted to alcohol or drugs to the degree interfering with nursing duties 5. Mental incompetence 6. Unprofessional conduct 7. Violation of any Board rules.

5. Who may file a report:

Anyone

Anyone

6. Who to call to file a report:

Impaired Nurse Program

Telephone: (615)321-0455

Tennessee Board of

Nursing

Telephone: (615)741-7256

7. Investigative Process

Case is immediately assigned to a Nurse Confronter and documentation collected. The nurse is then immediately contacted by the confronter and offered assistance. The nurse must agree to discontinue the practice of nursing and enter treatment. The Impaired Nurse Program works closely with the reporting agency (or individual) to assure that the nurse is not in practice and remains in treatment. If the nurse refuses to discontinue the practice of nursing and enter treatment, a report is made to the Tennessee Board of Nursing.

An investigator from the Division of Health Related Boards is assigned to the case and documentation collected. An investigative report is completed and reviewed by Attorneys in the Office of General Counsel. If evidence supports an alleged violation of the Nurse Practice Act, a notice of hearing and charges is mailed to the nurse. The Tennessee Board of Nursing then hears the case and determines whether the nurse is innocent or guilty based on finding of law. If found guilty the Board determines appropriate disciplinary action. If the nurse is found innocent, the charges are dismissed.

The Tennessee Board of Nursing has endorsed the Impaired Nurse-Peer Assistance Program sponsored by the Tennessee Nurses' Association. Therefore, the Impaired Nurse Program is recognized by the Board as an appropriate channel to report nurses who are personally impaired due to substance abuse. This is to emphasize and clarify the fact that individuals or employers may file a report regarding a nurse personally involved in substance abuse with the TNA Impaired Nurse Program and/or the Tennessee Board of Nursing. We hope that the

aforementioned guidelines will assist individuals and agencies in the evaluation of specific cases involving substance abuse.

However, we do wish to emphasize that cases regarding nurses who are not personally impaired and cases related to other ground for disciplinary action outlined in the Nurse Practice Act (identified in this document under Tennessee Board of Nursing, Section 4) should be reported immediately to the Tennessee Board of Nursing by the employer or consumer.

(Tennessee Board of Nursing, 1992)

APPENDIX F

**DISCIPLINARY REPORT FORM OF NATIONAL COUNCIL OF
STATE BOARDS OF NURSING**

NATIONAL COUNCIL OF STATE BOARDS OF NURSING
DISCIPLINARY REPORT FORM

1. _____
Last Name First Name Middle Name Maiden Name
2. _____
Address
3. _____ 4. _____
Date of Birth Social Security Number
5. _____ 6. _____
State of Original license and license number Other states of licensure
7. _____ 8. RN ☐ LPN ☐ _____
Jurisdiction Reporting Permanent Number of
License Being Disciplined
(If 2 licenses are disciplined, submit two forms.)
9. _____
Date of Action

10. Type of Action (check as many as necessary and indicate duration)

		Stayed	Duration
☐	Licensure Denied		
☐	Limitation		
☐	Probation		
☐	Reinstatement		
☐	Reinstatement Denied		
☐	Revocation		
☐	Summary		
☐	Suspension		
☐	Suspension		
☐	Voluntary		
☐	Surrender		
☐	Other (Fine, Reprimand)		

11. Case Description (Check as Many as Necessary)

	Action involving drugs: abuse, diversion, self-administration, use on duty, writing illegal prescriptions, etc.
	Action determined to be inconsistent with good nursing practice: leaving duty station without authorization, failure to maintain minimum standards of nursing practice, incompetence, etc.
	Misconduct related to nursing practice: practicing beyond the scope of the license, fraudulent practice, practicing without a valid license, etc.
	Action involving administering medications: charting errors, poor charting practices, failure to have wastage witnessed, failure to follow medical orders, failure to document administration, etc.
	Conviction of a felony or misdemeanor
	Action in another jurisdiction
	Other: (Please Describe.)

12. Final Disposition

Date	Action	Signature
_____	Action Cleared	_____
_____	Reinstatement	Title
_____		_____
Signature		Date
_____		_____
Title		

Date		

Permission is hereby given to the National Council of State Boards of Nursing, Inc. for the release of this information to interested parties.

APPENDIX G

TENNESSEE DISCIPLINARY REPORT FORM

A

Tennessee Disciplinary Report Form*

License # _____			VIOLATION OCCURRENCES		DATE OF ACTION		
Date of Violation			Date	# of Violations	Year	Month	Day
94	Month	Day	Year		41	1990	
					42	1991	
					43	1992	

Circle Correct Information

AGE AT TIME OF VIOLATION		MARITAL STATUS		RACE		SEX		NURSE STATUS	
01	Under 20	11	Married	17	Caucasian	23	Male	31	R.N.
02	20-24	12	Single	18	Afro-American	24	Female	32	L.P.N.
03	25-29	13	Divorced	19	Asian				
04	30-34	14	Separated	20	Native American				
05	35-39	15	Widowed	21	Hispanic				
06	40-44	16	No Response	22	Other				
07	45-49								
08	50-54	COUNTY WHERE DISCREPANCY REPORTED		Code of County		REGION OF STATE		Urban/Rural	
09	55-59					AA I		JJ IIA	
10	60+					BB II Eastern		KK IIIA Urban	
						CC III		LL VA	
						DD IV		MM IX	
						EE V		NN I	
						FF VI		OO II	
						GG VII Western		PP III	
						HH VIII		QQ IV Rural	
						II IX		RR V	
								SS VI	
								TT VII	
								UU VIII	

EMPLOYING AGENCY		BASIC NURSING EDUCATION STATUS		ORIGINAL LICENSE		OTHER STATES OF LICENSURE	
51	Hospital	61	Licensed Practical Nurse	Juris		70	1.
52	Nursing Home	62	Associate Degree Program	No			RN ☐
53	Registry	63	Diploma Program				PN ☐
54	School	64	Bachelor Degree Nursing				
55	Dr. Office	65	Bachelor Degree- other area			80	2.
56	Home Health	66	Master's Degree Nursing				RN ☐
57	Unemployed	67	No Response				PN ☐
58	Other						

REPORTING AGENCY		SUBSTANCE(S) ABUSED				
B	YEARS IN NURSING	2000	Employer			
		2100	Fellow Nurse/Worker			
		2200	Law/Police			
		2300	Citizen of Community			
		2400	Peer Assistance Program			
		2500	Anonymous			
		2600	Self			
		2700	Spouse			
	2800	Bd. of Nursing/Dept. of Health	900	None	970	Cocaine
	2900	Pharmacist	910	Alcohol	980	Hallucinogens
	3000	Other (describe)	920	Demerol	985	Multipharmaceutical
			930	Dilaudid	990	Morphine
			940	Talwin	995	Other (Describe)
			950	Percodan		
			960	Valium/Xanax		

C

ACTION	YEAR	LENGTH (MONTHS)	PREV. DISCIPL. ACTION	
110 ☐ Licensure Denied			210	Yes If so, for what?
120 ☐ Licensure Limited			220	No
130 ☐ Licensure Revoked				
140 ☐ Voluntary Surrender				
150 ☐ Summary Suspension				
160 ☐ Suspension				
170 ☐ Probation				
180 ☐ Fine (Amount)				
190 ☐ Reprimand				
200 ☐ Other				
810 ☐ Action Cleared		Referred to Tennessee Nurse Foundation Program		
820 ☐ Reinstatement		3000 3100		
830 ☐ Reinstatement Denied		Yes No		

HOSPITAL SIZE OF EMPLOYER IN BEDS (WHERE APPLICABLE)			
315	1-50	355	301-400
325	50-100	365	401-500
335	101-200	375	500+
345	201-300		

D Case Description (Check All Applicable)

DRUGS	INCONSISTENT NURSING PRACTICE
310 ☐ Abuse	410 ☐ Leaving Nursing Station
320 ☐ Diversion	420 ☐ Failure to Maintain Minimum Standards
330 ☐ Self-Administration	430 ☐ Incompetent Practice
340 ☐ Use on Duty	440 ☐ Failure to Maintain Nursing Record
350 ☐ Writing Illegal Prescription	450 ☐ Failure to Follow Doctor's Orders
360 ☐ Prescription Abuse	499 ☐ Other (Describe)
370 ☐ Non-Prescription Abuse	
399 ☐ Other (Describe)	

ADMINISTERING MEDICATIONS	MISCONDUCT RELATING TO THE PRACTICE OF NURSING
510 ☐ Charting Errors	610 ☐ Practice Beyond the Scope of Nursing
520 ☐ Failure to Follow Medical Orders	620 ☐ Fraudulent Practice
530 ☐ Failure to Have Wastage Witnessed	699 ☐ Other (Describe)
540 ☐ Failure to Document Administration	
599 ☐ Other (Describe)	

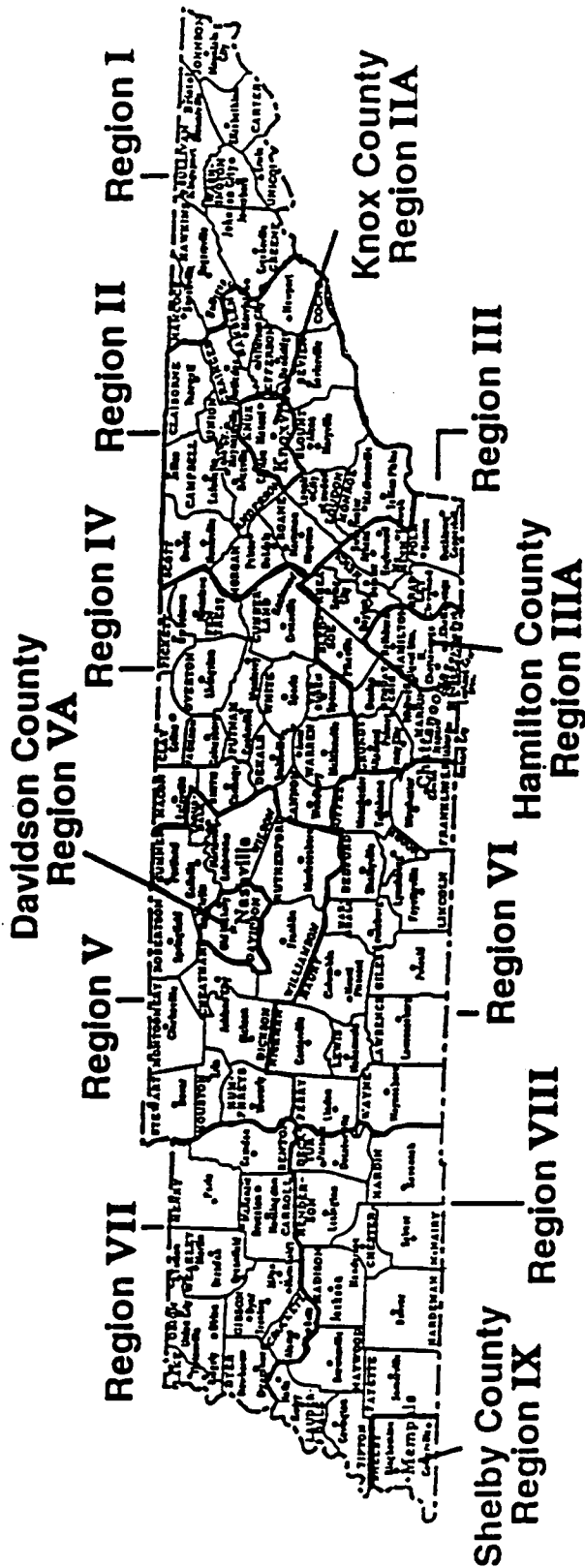
CONVICTION OF
710 ☐ Felony
720 ☐ Misdemeanor
799 ☐ Action Taken in Other Jurisdiction (Specify)

*"Document Modified with Permission (12/92) from "Disciplinary Report Form"
of National Council of State Records of Nursing- Chicago, Illinois*

APPENDIX H

MAP OF COUNTIES OF TENNESSEE BY REGION

Tennessee by Region



Urban Regions: Region IIA, Region IIIA
 Region VA, Region IX

Rural Regions: Region I, Region II, Region III
 Region IV, Region V, Region VI
 Region VII, Region VIII

Eastern Regions: Region I-Region IV

Western Regions: Region V-Region IX

As per Tennessee Board of Health, March, 1991
 Map and Regional Location of Tennessee
 Department of Health-
 Serving Regional Agencies and Eastern and Western Counties/
 Rural and Urban Counties

TENNESSEE COUNTIES

<u>County</u>	<u>Eastern/Western</u>	<u>Rural/Urban</u>
Anderson	Eastern	Rural
Bedford	Western	Rural
Benton	Western	Rural
Bledsoe	Eastern	Rural
Blount	Eastern	Rural
Bradley	Eastern	Rural
Campbell	Eastern	Rural
Cannon	Eastern	Rural
Carroll	Western	Rural
Carter	Eastern	Rural
Cheatham	Western	Rural
Chester	Western	Rural
Claiborne	Eastern	Rural
Clay	Eastern	Rural
Cocke	Eastern	Rural
Coffee	Western	Rural
Crockett	Western	Rural
Cumberland	Eastern	Rural
Davidson	Western	Rural
Decatur	Western	Urban
Decatur	Western	Rural
Dekalb	Eastern	Rural
Dickson	Western	Rural
Dyer	Western	Rural
Fayette	Western	Rural
Fentress	Eastern	Rural
Franklin	Western	Rural
Gibson	Western	Rural
Giles	Western	Rural
Grainger	Eastern	Rural
Greene	Eastern	Rural
Grundy	Eastern	Rural
Hamblen	Eastern	Rural
Hamilton	Eastern	Urban
Hancock	Eastern	Rural
Hardeman	Western	Rural

Hardin	Western	Rural
Hawkins	Eastern	Rural
Haywood	Western	Rural
Henderson	Western	Rural
Henry	Western	Rural
Hickman	Western	Rural
Houston	Western	Rural
Humphreys	Western	Rural
Jackson	Western	Rural
Jefferson	Eastern	Rural
Johnson	Eastern	Rural
Knox	Eastern	Urban
Lake	Western	Rural
Lauderdale	Western	Rural
Lawrence	Western	Rural
Lewis	Western	Rural
Lincoln	Western	Rural
Loudon	Eastern	Rural
McMinn	Eastern	Rural
McNairy	Western	Rural
Macon	Eastern	Rural
Madison	Western	Rural
Marion	Eastern	Rural
Marshall	Western	Rural
Maury	Western	Rural
Meigs	Eastern	Rural
Monroe	Western	Rural
Montgomery	Western	Rural
Moore	Western	Rural
Morgan	Eastern	Rural
Obion	Western	Rural
Overton	Eastern	Rural
Perry	Western	Rural
Pickett	Eastern	Rural
Polk	Eastern	Rural
Putnam	Eastern	Rural
Rhea	Eastern	Rural
Roane	Eastern	Rural
Robertson	Western	Rural
Rutherford	Western	Rural
Scott	Eastern	Rural

Sequatchie	Eastern	Rural
Sevier	Eastern	Rural
Shelby	Western	Urban
Smith	Eastern	Rural
Stewart	Western	Rural
Sullivan	Eastern	Rural
Sumner	Western	Rural
Tipton	Western	Rural
Trousdale	Eastern	Rural
Unicoi	Eastern	Rural
Union	Eastern	Rural
Van Buren	Eastern	Rural
Warren	Eastern	Rural
Washington	Eastern	Rural
Wayne	Western	Rural
Weakley	Western	Rural
White	Eastern	Rural
Williamson	Western	Rural
Wilson	Western	Rural

Location Source: Tennessee Board of Health, March, 1991 supplied map with counties and regional status.

APPENDIX I

**NAME AND CLASSIFICATION OF SUBSTANCES ABUSED BY NURSES
WHO WERE DISCIPLINED BY TENNESSEE STATE BOARD
OF NURSING, 1990-1992**

Name and Classification of Substances Abused by Nurses

Who Were Disciplined by Tennessee State

Board of Nursing 1990-1992

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u>
Acetaminophen	Non-narcotic analgesic	--
Adrenalin	Adrenergic (Broncho-dilator)	--
Alcohol	Depressant	--
Alupent	Bronchodilator	--
Amobarbital (Amytal)	Sedative/Hypnotic	II
Amphetamines	Speed	sched; unsched
Aspirin	Analgesic	--
Atarax	Anti-Anxiety	--
Ativan	Anti-anxiety	IV
Benzocaine	Topical numbing agent	--
Benzphetamine	Amphetamine	III
Buprenex	Narcotic Analgesic	V
Buspar	Anti-Anxiety	--
Chlordiazepoxide (Libri-tab)	Anti-anxiety	IV
Cocaine	Hallucinogen	I

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u>	227
Codeine	Narcotic Analgesic	II	
Cylert	Cerebral Stimulant	IV	
Dalmane	Sedative Hypnotic	IV	
Darvocet	Narcotic Analgesic	IV	
Darvon	Narcotic Analgesic	IV	
Demerol	Narcotic Analgesic	II	
Desyral	Anti-Depressant	--	
Didrex	Cerebral stimulant	IV	
Dihydrocodeine	Narcotic Analgesic	III	
Dilaudid	Narcotic Analgesic	II	
Dimetapp Elixir	Antihistamine	--	
Diphenhydramine (Benadryl)	Antihistamine	--	
Elavil	Antidepressant	--	
Fentamyl Injection	Narcotic Analgesic	II	
Fiorinal	Analgesic	III	
Flexeril	Skeletal Muscle Relaxant	--	
Fluothane	Inhaled gas	Controlled	
Halcion	Sedative	IV	
Haldol	Antipsychotic	--	
Heroin	Hallucinogen	I	

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u>	228
Hydrocodone	Narcotic Analgesic	III	
Indomethacin	Non-steroidal anti-inflamm.	--	
Lorcet/Lorcet Plus/Lortabs	Narcotic Analgesic	--	
Librium	Anti-anxiety	IV	
Lioresal	Skeletal Muscle Relaxant	--	
Lorazepan	Anti-anxiety	IV	
Marijuana	Hallucinogen	I	
Mellaril	Antipsychotic	--	
Mepergan Fortis	Narcotic Analgesic	II	
Meproamate	Anti-anxiety	IV	
Methaqualone	Illegal amphetamine	I	
Morphine	Narcotic Analgesic	II	
Noctec (chloral hydrate)	Sedative/Hypnotic	IV	
Nubain	Non-narcotic Analgesic	II	
Opiods	Narcotics	II, III	
Oxycodone	Narcotic Analgesic	II	
Paragoric	Antidiarrheal	III	
Pentobarbital (Nembutal)	Sedative/Hypnotic	II	
Percocet	Narcotic Analgesic	II	
Percodan	Narcotic	II	

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u>	229
Phendimetrazine (Prelu-2)	Cerebral Stimulant	IV	
Phenergan	Antihistamine	--	
Phenmetrazine (Preludin)	Cerebral Stimulant	III	
Phenobarbital	Anticonvulsant	IV	
Phenophen/Codeine	Narcotic analgesic	III	
Phenothiazine	Antipsychotic	--	
Placidyl	Sedative/Hypnotic	IV	
Prednisone	Cortico-Steroid	--	
Prescription drugs	all classes	sched; unsched	
Proventil	Bronchodilator	--	
Restoril	Sedative Hypnotic	IV	
Scheduled Drugs	I, II, III, IV, V	scheduled	
Secobarbital	Sedative Hypnotic	II	
Seconal	Sedative/Hypnotic	II	
Seldane	Antihistamine	--	
Skelaxin	Skeletal/Muscle Relaxant	--	
Soma	Skeletal/Muscle Relaxant	--	
Stadol	Narcotic Analgesic	--	
Stimulants (speed)	Amphetamine	sched; unsched	
Sublimaze	Narcotic Analgesic	II	

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u> 230
Talacen	Narcotic Analgesic	II
Talwin	Narcotic Analgesic	IV
Theophylline	Bronchodilator	--
Thorazine	Antipsychotic	--
Tigan	Anti-Emetic	--
Tranxene	Anti-anxiety	IV
Triavil	Antidepressant	--
Tricyclics	Antidepressants	--
Tylenol (No. 2, 3, 4)	Narcotic Analgesic	II
Tylox	Narcotic Analgesic	II
Unspec. Barbiturates	Barbiturates	Sched; Unsched.
Unspec. Narcotics	all classes	Sched; Unsched.
Unspec. Intoxicants	Depressant	--
Unspec. Benzodiazepine	Anti-anxiety	II, III, IV
Unspec. Depressants	Depressants	--
Valium	Anti-anxiety	IV
Versed	Sedative/Hypnotic	IV
Vicodin (Hyphen, Cogesic)	Analgesic	III
Vistaril	Anti-anxiety	--
Wygesic	Analgesic	--

<u>Substance Abused</u>	<u>Classification</u>	<u>Scheduled Drug</u>	231
Xanax	Anti-anxiety	IV	
Zantac	Anti-Ulcer	--	
Zinc Oxide	Topical Analgesic	--	

Key to Scheduled Substances Categories

- I. Heroin, LSD, peyote, Marijuana, Mescaline. Illegal. Great potential for abuse.
- II. High Potential for Abuse. Use may lead to severe physical or psychological dependence. Prescriptions must be written in ink, or typewritten and signed by the practitioner. Verbal prescriptions must be confirmed in writing within 72 hours, and may be given only in a genuine emergency. No renewals are permitted.
- III. Some potential for abuse. Use may lead to low-to-moderate physical dependence or high psychological dependence. Prescriptions may be written or oral. Up to five renewals are permitted within six months.
- IV. Low potential for abuse. Use may lead to limited psychological or physical dependence. Prescriptions may be oral or written. Up to five renewals are permitted within six months.
- V. Subjects to state and local regulation. Abuse potential is low; a prescription may not be required.

Source: Physicians Desk Reference (1993).

VITA

Rachel Leona Orr was born in Robbinsville, North Carolina, on November 8, 1951. She attended school in the Graham County School System through her junior year at Mountain View School. It was a rural school which is now closed. She graduated from Robbinsville High School in May, 1969.

Rachel attended Western Carolina University where she received her Bachelor of Science in Education Degree in 1972. She taught in the Graham County School System until 1975, during which time she attended Western Carolina University at night and on Saturdays. These efforts resulted in her receiving both her Master's of Science Degree in Education in 1973 and Educational Specialist Degree in Educational Administration in 1975.

After having taught for several years, Rachel moved to Cullowhee, North Carolina where she supervised student teachers for Western Carolina University from Franklin to Charlotte, North Carolina. She finished her nursing component of the nursing curriculum and obtained a Bachelor of Science Degree in Nursing in 1977 from Western Carolina University where she graduated with highest honors in her nursing class and gave a speech at graduation ceremonies. She was the Assistant Superintendent of Instruction of the Roanoke Rapids School System from July 1977 to September 1980. In December 1982, Rachel received her Master's Degree in Nursing from East Carolina University, in Greenville North Carolina. She received an assistantship at Duke University Medical Center where she worked and attended

nursing classes at Duke Medical Center. She taught nursing classes at Atlantic Christian College in Wilson, North Carolina and worked as her schedule allowed at Pitt Memorial Hospital in Greenville, North Carolina, and Tarboro General Hospital in Tarboro, North Carolina, while attending graduate nursing school.

In December 1982, Rachel moved to Knoxville, Tennessee, where she worked as Nurse Manager on the medical floor at Park West Hospital and became Director of Nursing there in 1983. She has served various hospitals as a nursing consultant for administrative matters. In 1983, she entered the doctoral program in Educational Administration and Supervision within the College of Education at the University of Tennessee, Knoxville. Her major emphasis of study included the curriculum of higher education and public health.

In late 1985, Rachel was involved in a motor vehicle accident and received severe spinal injuries which has limited her nursing functions since that time. She completed this dissertation in reduced, intermittent intervals as her schedule, rehabilitation, and condition allowed, working on it as her activity-rest cycle permitted.

Throughout her educational and nursing career, Rachel has belonged to professional organizations and conducted much public and private service to organizations and individuals, respectively. She has been honored numerous times with awards and distinguished recognitions for her efforts and scholarship. Rachel holds advanced certification from the American Nurses Association Credentialing Center. She is certified as an Administrator-Advanced practitioner.

In May, 1993, Rachel graduated from the University of Tennessee with a Doctorate of Education degree in Educational Administration and Supervision with collaterals in higher education administration and public health.