2016 NCSBN Discipline Case Management Conference - Remediating Practice Breakdown

Event
2016 NCSBN Discipline Case Management Conference

More info: https://www.ncsbn.org/8370.htm

Presenter
Rene Cronquist, JD, RN, Director of Practice and Policy, Minnesota Board of Nursing

- [Rene] I want to start first with managing expectations. I do not have a golden ticket. I don't have a secret formula to share with you to eliminate and banish practice issues forever more. So if that's what you thought this was going to be about, I'm sorry. I don't want to disappoint you. I do however have a few ideas about world peace. I'd be happy to share those with you. I do think that that's a little bit easier to handle. But, that's not what you came here for either. So what I am going to do is I'm going to describe one approach, one tool that we have used in Minnesota and we have found it helpful. I don't think, and I shared this with Cathy, I don't think that it's completely brand new so you may very well have experience with a similar kind of tool. So I absolutely welcome your feedback on how...your variation on that theme and of course any questions that you might have. To begin with, I just want to give you a little snapshot about what our caseload looks like in Minnesota so you can kind of maybe compare your reality with that. So here's our statistics about our number of nurses. So, as of last week, we had 122,000 registered nurses. In the last few days that might have gone up. Of that number, just over 7,000 of them are advanced practice nurses. And then we have nearly 23,000 LPNs. So with that group of licensees, we received about 1,500 complaints in fiscal year 2015. And if that number seems high to you, it might be that we consider a complaint anything that we've received in the door. So it isn't that it's already gone through a threshold. So you might be counting your complaints at a later point in the process. Surprisingly though, our number of complaints is down right now and we're glad of that, we don't really know why, but it is. So, you can see that about 28% of the complaints involve the provision of care and about 10% involve the impaired practice. So that previous slide showed that practice breakdown is one of the primary...it really is the number one category of complaint that we've received. But perhaps like your experience, it's not the number one basis for disciplinary action. So you can see of all the complaints we've received, probably about 30% resulted in some kind of a public action, be it disciplinary or corrective. And the majority of those, somewhat over half, actually removed the licensee from practice. And as you can imagine most of those that remove the licensee from practice did relate to impairment. But, about 10% of the actions had some requirements for the licensee to remediate their practice deficiencies. So again, if we reflect on it, practice issues are really kind of a small number of actions that are taken and we all know that the number of

actions taken is just a small fraction of our total population. With the recent passing of Muhammad Ali, I was kind of thinking and I was looking at some of his quotes and as you know, he was a quote-worthy individual. But this one I thought was on point, "It isn't the mountains ahead to climb that wear you out. It's the pebble in your shoe." And can we not all relate? And so my point there is the analogy would be, yeah, it's those impaired cases, the diversion that really get the headlines but it is the pebble in the shoe, it is the practice breakdown cases that, in the long term, can have really some significant effect. So, again like you, you get this complaint and you're gathering evidence, you are doing interviews, you're trying to get your hands around what is going on here. And so, even when there's nothing in the compliant that would suggest that you're dealing with a substance use disorder, it's still sometimes hard to get your head around what is the root cause? What was happening here in addition to what was going on with the system? What was going on with the individual? So, as I think about just culture, we're probably here in that category of human error, maybe reckless. So we know we've kind of...excuse me, human error, at risk. We'll probably put reckless off to the side. But even within that, there's a variety of reasons that error or the breakdown could have occurred. Some of the things that you might hear as you're talking to the nurse is, who's practice previously had been quite on point, that there were some personal stressors going on, that's something different in their personal life. Maybe there were some significant changes in their employment organization, some change in management or something like that. And so, again the point there is you're trying to get at the sense of, what's the root of it so you can hopefully identify what the appropriate remedy would be. So one of those remedies is what I'm calling here, "Individualize consultations, " or in our office we sometimes just call them "one-on-one consultations." And I'll talk more about what that is, but just to be clear, often times, it's a component of a disciplinary action. In our vernacular we would call it conditions on the license. And often, it's not the only condition that's being applied, it's not the only disciplinary action or...not the only piece of action. Often times, it can be used with continuing education. We often require the licensee to use the National Council videos, view them, take the course, the test and so forth. There might be some simulation exercises. So what the nurse needs to do, what the licensee needs to do will be clearly identified in their order. And with respect to this individualized consultation, we will outline what the topic or topics that need to be addressed are, and then we always indicate a minimum number of hours for the consultation. So, taking into consideration what needs to be addressed based on our past experience, we can think, "This is probably looking about four hours of consultation. There's really quite a bit here, we're probably looking at about six hours." That is stated as a minimum because we do leave it up to the consultant to re-evaluate that as they're going. They may find that that person is really having a hard time understanding this. Or conversely, we're kind of getting in a little bit deeper, we're exploring some more and so they may end up going beyond the required minimum number of hours. So, in terms of sort of how this happens, our board does maintain a list of potential consultants. And we also have criteria for pre-approval of a consultant. So that's always the preliminary step. It is the nurse's responsibility to obtain the consultant that they're going to use. So they contact the consultant, they do the contracting, and then they're responsible for the payment. What the licensee will do, though is they'll ask their potential consultant to submit his or her resume or curriculum vitae, something that reflects their credentials to the board for pre-approval. Essentially, the kinds of things that we're looking for is, does this individual have clinical expertise in the subject matter that the individual needs the consultation for? And additionally, we're looking for some education and training in teaching

adult learners. Have they done something we can be confident that they have...they're an appropriate educator? Because we've, over time, developed a bit of a stable of consultants, we also get to know the quality of their reports and there are times when consultants have submitted reports and they haven't really addressed the issues that we needed to address and so we would not approve that consultant in the future. So again, we have this list of potential consultants that we can provide to the licensees and we'll give them the names based on their need and what the individual's expertise is. So again, the expectation is that the consultant develops a teaching plan for their work with the licensee: their methods, their schedule and so forth. When the consultation is completed, the consultant is going to submit a written report to the board outlining, again, what it is that they did, but most importantly, what they feel the licensee gained from this experience. Was it beneficial? Did they learn anything from doing this consultation with the expert? Of course, we want to have some indication, some evidence, that the licensee has learned something and so typically we'll ask them to demonstrate their learning via a written report. It would be atypical that we would do much...do something in person with that individual. The licensee, though, may be required to discuss or review their report with the consultants. So they finish the consultation, the licensee writes his or her report and then goes over it again with the consultant just to kind of make sure that they've hit all the points. In some cases, we'll ask the individual to review their report with their nurse manager, and for individuals who are in managerial roles, another possible outcome is they may be required to develop appropriate policies and procedures if that's part of what was lacking in the underlying practice problem. So, what kinds of things have we used consultations for? Often times, it's some kind of a knowledge deficit. In talking to the licensee, it appears that he or she really just did not know what the standard of practice was, what the standard of care was, what they should've done in the particular situation. And that could be a one time incident where they seemingly still haven't learned from their mistake if you will. Or, it's a repeated series of problems, perhaps of the same nature, frequent medication errors for example. Frequent calculation errors, lack of documentation, or it could be all of the above. So I just wanted to fit in with everybody else so I made sure that one of the knowledge deficits will be management of chronic pain, because that's our theme. But truly, that is a topic for which we have used individualized consultation. So it was an APRN who seemingly really was competent in other aspects of their practice, but they really were challenged in understanding how to properly manage chronic pain and perhaps had done some over-prescribing. And so, in that instance, of course the APRN is expected to...their consultation would be with another APRN, which of course sometimes is difficult to find. It's a small enough community, you need to make sure that they don't have a conflict of interest from a pre-existing relationship. We've had some things with maltreatment. Certainly nothing where there's been aggression or physical harm by the licensee toward a patient. But some instances where there were some failure to report. So that's kind of getting at the knowledge deficit. Then there can be those times where the individual can absolutely articulate what it is they should have done in that situation, they seem to know the right thing, but there's a gap. There's something that happens between what they know should have been done, and what they did. And perhaps even now they're having some difficulty grasping or identifying how they would do things differently. So we might call that issues with critical thinking. The other kinds of topics that we've used, probably even more often, would be minor boundary issues. So of course, I'm not talking about any kind of sexual contact, but again more minor boundary issues. I don't know about you guys, but we do get some issues with people not using social media in the most appropriate way. And sometimes

that spills over into HIPAA violations. You can have your social media issues with or without HIPAA violations. A really challenging issue that we're focusing on a bit more is this interpersonal communication and that was touched on yesterday in one of the sessions. And our board of nursing looks at that pretty seriously. You know we're not just talking about the individual who sort of woke up on the wrong side of the bed and went to work with a crabby face. We're talking about the individual who consistently and often times in more than one practice setting, just really seems really unable to get along with their colleagues. And we know that even if it hasn't directly impacted the patient, that is in other words, they're reasonably appropriate with patients and patient family members, we do know that it's disrupting the dynamic of the care team. And so that sometimes can be the focus of it. That can also be called just professionalism, you know? Using appropriate language, not cursing, that sort of thing. We also have individuals who may have been educated abroad and are really having some difficulty acculturating to some of the cultural norms. And we find that that one-on-one consultation is beneficial for that because it helps get past any defensiveness. It isn't necessarily to say your world view or your point of view is wrong, it's just we want to help you understand how this is coming across to others. How this is coming across to your patients? Kind of related to that is again the impact of body language. Some people just don't understand that...this is kind of a negative defensive attitude. So, again, that individualized consultations seems to be pretty beneficial for things of that nature. And then finally, we have things that can be specific to the setting where the individual worked. Home care, assisted living, schools, they're such sort of unique practice settings. In particular we find in the home care and assisted living, that many times people have come there from another... They've had years of experience perhaps in a nursing home or something, and they go to the assisted living arena and it's very different. They're used to having much more hierarchy, they're used to having more pre-established policies and procedures and they sometimes don't realize that actually if you're the only nurse, you just became the DON and so that policy procedure development and whatnot is now on you. And of course both...home care, as are many areas of nursing practice, is highly regulated. And so sometimes the individuals aren't as familiar with those specialized regulations as they need to be. And for those kinds of things, there are some courses that are on point, but, you know, they're not always available. So, sometimes that individual consultation is the way to go with that. So I think I've kind of touched already on what we perceived to be some of the benefits of this. Clearly, the instruction is tailored to the licensee's needs. There's the opportunity for dialogue, immediate feedback and modification of the teaching plan. So clearly the consultant, when they're creating their teaching plan, has not spent much time talking to the licensee. They have a copy of the licensee's orders so they can see what led to the discipline. So they have that. But once they get to talk to the licensee, it may be a rather different picture. Again, that opportunity for immediate feedback, if they're realizing that the licensee is not comprehending what they're talking about at the moment, they can redirect them and that sort of thing. Again, as I alluded to earlier, we think that there's a greater opportunity for the licensees to express maybe more fully, maybe more in depth his or her understanding of the issues. We know that coming into what we call a conference setting where the licensee may or may not be represented by their choice. They come in and they're meeting with myself or one of my colleagues. And we have a board member present and we always have our attorney there. And sometimes it isn't perhaps that they don't know it, they just can't get it out. And so when they have that opportunity for one-on-one, they can more fully express their understanding. As I noted, they're both prior to and after the instruction. The

other piece that I alluded to earlier is, the consultant is there to benefit them. They're there to support the licensee and obviously at times, they have to both point out reality and say, "Hmm, no, I'm not sure that's quite correct," but they can do so in a sort of more personalized sort of way. Potentially, you have greater flexibility in scheduling. So I mentioned the specialized courses in home care for example. If they're only offered two times a year and you want this person to have some remediation more quickly than that, this can be a good alternative. It's more likely, you know, that if the nurse works the night shift, maybe the prime time for them to get their instruction is from 5 to 8 p.m. Well, CEs might or might not be offered at that time. Some of the drawbacks to these individualized consultations is sometimes our licensees really do have a difficult time finding a consultant that has the necessary expertise, that is available, that we can approve, that they can afford and that is anywhere near them. So our folks in the more rural areas, they do sometimes have a harder time. The folks with a really unique issue, again the APRNs, our certified nurse-midwives, finding somebody that has the expertise that isn't having a conflict of interest, that really can be challenging for some of our licensees. I alluded to the quality of the consultants. Many times, the individual is known to us and if they're not we're making our judgments based on their prior experience as documented in their CV, but how's that going to translate in terms of the quality of the consultation and the quality of the report? And then cost can be a factor. That is something that the board takes into consideration when shaping the whole order. So, if it's a case where the board might think about assessing a civil penalty, they may reduce the amount of that or eliminate it altogether when they're considering that the licensee is probably looking at at least $100 an hour to $200 an hour for their consultation. So doing the math, it can be rather expensive for some individuals, particularly if their practice breakdown was such that they were terminated from employment and they may not have secured subsequent employment. We do of course give a time frame for when this has to happen. We give them a pretty clear timeline. You know, you need to submit your consultant's credentials for pre-approval by a certain date. You need to have the consultation within X number of days after that. And we need to get the consultant's report X number of days after that. Having said that, we can have some flexibility with this. So if they say, "I'm really having some difficulty finding a consultant or I have found a consultant, going to be perfect, going to be spot on but they're going on a month-long vacation." Again, we have some flexibility with that. So, the ultimate question and where we all were hoping to get, that secret formula or that golden ticket was, does it work? And I think that's the ultimate question in all of our remediation, whether it's for impairment, whether it's for ethical violations, whether it's for practice breakdown, it really is ultimately a very difficult question to answer. And using our individualized consultations is no different. What we use as our proxy, I guess, is the majority of the individuals who complete one-on-one consultations, we do not receive subsequent complaints about them. So not very many of them are, what I'm calling here, "repeaters." The notable exception are those for whom the allegations really had the whiff of diversion. But there wasn't sufficient evidence to meet the burden of proof so we're not able to...and then the licensee's denying this so the board isn't able to take action concluding that this individual diverted controlled substances. So what we're left with are there deficiencies in medication, storage, administration, documentation, things of that nature. And so we really would focus their consultation on that with the belief that if things are as they appear and you complete this remediation, that should hopefully address our underlying problem. But in those instances where, in fact, the individual has been diverting and they return to that, that habit, that practice, we often times do get a subsequent complaint on them. And then in terms of

what we hear from the nurses and from the consultants. They're largely very positive about it. We don't very often get negative feedback about this experience. We've heard from both licensees and consultants specifically saying their own version of, the nurse really didn't get it at the beginning, but over time you really could see a progression, you really could see that they were understanding the issues much better toward the end. And again, we've heard that from licensees who have sent, you know, "I kind of thought that you guys were completely off base. I saw no need for this." And I'm thinking particularly of some of our boundary issues. And then, when they've had this opportunity to talk about it and get the input from the consultant, they really have a different view of it. Similarly, the consultants have reported similar things. We have received some reports from consultants who at the end have said, "We completed everything, we did everything you said. There are some remaining concerns." And then we really scrutinize the individual's self report, when that comes in. The report of their learning and we're looking to see are they reflecting something indicating knowledge has been gained, and sometimes that's not there. But nonetheless, as I said, we really haven't received very many repeaters so we feel good about that. As I said at the beginning, I'm sure many of you have experience with something like this and so, please offer your comments if you have. Or any questions that you might have. - [Woman] Could you give a couple examples of who you're asking...an issue and a consultant that you might seek out, because I'm a little unclear. - Can you repeat the question? - Could you give a couple examples of a situation or an issue and what type of consultant are you seeking out? - Well, I'll give you an easy example first and then maybe a more nuanced one. The example that first comes to mind are the nurse who, again, really quite a bit of experience, but they get into the home care arena. And they're now in that position. And in addition to it being a new practice site for them, what we hear is sometimes the nurse is supervised by a non-nurse, the building or the facility is owned by a non-nurse. And so, there can be some conflict between the nurse describing what they believe to be necessary for a safe nursing practice and the non-nurse manager or owner. And so, sometimes as a result the nurse doesn't assert him or herself and really say, "No, we're not equipped to take this kind of client. We need something more." Or again, quite frankly, sometimes they don't realize that it is their responsibility to do those assessments. And again, that's where we have found that there are a number of nurses who have really great expertise in home care and assisted living and in fact, they do a lot of consultations themselves with the settings, and we have found that very effective. So that's kind of a simple example. The other, again, would be the myriad of boundary issues where the nurse has gone beyond the nurse-patient relationship and has started down the slippery slope and is doing things like essentially befriending the client. Maybe they're scheduled to work and they don't have childcare and so they bring their child with them on the home visit. And they sort of can't see the error of that, their ways there. They think, "Gosh, I was in such a... I couldn't abandon my client and then I had this issue with my child and..." "Oh, okay. So, maybe that wasn't..." And then maybe the nurse's child gets along with the client's children and soon they're playmates or something. So that would be maybe another example that we've done. And there are a number of nurses who have some good expertise in ethics and in professional boundaries. We really appreciate when our boundary consultants are nurses. We've got some clinical nurse specialists and nurse practitioners who have a really good expertise in that and have done a really good job. Anything else? All right. With that, I will say thank you for your attention.