



Missouri Public Health Nursing Manual

Created by the

Missouri Council for Public Health Nursing



Public Health
Prevent. Promote. Protect.

Revised May 2016

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This manual is intended as a reference for Missouri Public Health Nurses. Regulations and legislation referred to herein reflect Missouri State Statutes; if you are practicing Public Health Nursing outside of Missouri, please refer to that state’s regulations and legislation.

Letter of Welcome

April 2016

On behalf of the Missouri Department of Health and Senior Services (DHSS) and the Missouri Council for Public Health Nursing (MCPHN), we are pleased to welcome you to the field of public health nursing.

In 2013, the American Public Health Association Public Health Nursing Section affirmed the 1996 definition of public health nursing as **“the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences”**. Public health nursing practice is directed toward a population and includes assessment and identification of sub-populations who are at high risk of injury, disease, threat of disease, or poor recovery. The goal of public health nursing is to improve the health of populations by working with and through the community.

There are many resources within the Missouri DHSS to assist you in learning about public health or specific programs. It is our hope that this manual will be a resource tool as you navigate your public health nursing career. **If you have additional questions about where to go for help or information, contact the Public Health Nursing Coordinator** in the Center for Local Public Health Services **at (573) 751-6170**.

Sincerely,

Missouri Council for Public Health Nursing

History of Public Health Nursing in Missouri

Public health nursing in the United States began in the late 1800's through the efforts of a few wealthy women in New York, Boston, Philadelphia, and Buffalo, who hired trained nurses to care for the poor in their homes. In 1880, New York City established a Division of Child Hygiene in the New York Health Department. This Division demonstrated that public health nurses could reduce infant mortality through home visiting and teaching. In 1898, Los Angeles became the first city to officially employ a nurse to care for the sick in their homes. By 1910, many of the urban visiting nurses had initiated preventive programs for school children, infants, mothers, and patients with tuberculosis.

In March 1883, a State Board of Health was created in Missouri. Its purpose was to protect citizens against the dreaded diseases of smallpox, typhoid, cholera, and other communicable diseases. Public health nursing began in Missouri in 1891 when the Ladies Society of Kansas City's First Congregational Church employed a graduate nurse to visit the poor in their homes. The following year, the Visiting Nurses Association of Kansas City was organized with this purpose:

“to provide skilled nursing care to the sick in their homes -- to teach health and the prevention of disease. By means of cooperation with allied social agencies, assistance was rendered in the solution of social and economic as well as health problems.”

In St. Louis, visiting nursing was initiated in 1895, and the Visiting Nurses Association (VNA) was incorporated in 1911. At this time, several insurance companies offered coverage of nursing care and partly subsidized the VNA.

Public health nursing in rural Missouri had its beginning in the post-war activities of the American Red Cross and the U.S. Public Health Service (1918-1919). The child health demonstrations sponsored by these agencies led to the passage of a bill by the legislature of 1919 that created a Division of Child Hygiene within the State Board of Health. The passage of the Federal Maternity and Infancy Act in 1921 made it possible for the State Board of Health, through the Division of Child Hygiene, to employ several public health nurses.

In 1919, an agreement was reached between the Missouri State Board of Health and the Southwestern Division of the American Red Cross Society, providing a director of the Division of Public Health Nursing of the Department of Health. The purpose of the division was to organize, coordinate, and supervise public health nursing activities in the rural sections of the state.

From the beginning, the State Board of Health made an effort to keep in touch with all local public health nurses, whether employed by private or official agencies, through letters, bulletins, and field visits. The nurses were encouraged to turn to the state for advice and help; and the Division of Child Hygiene supplied records, forms, literature, and clinic service free of charge to all local public health agencies. During the first few years, most of the local services were supported by county chapters of the American Red Cross. As the Red Cross funds were exhausted, the services were gradually taken over by the county courts or school boards. Beginning in 1923, the Division of Child Hygiene offered financial aid to counties employing public health nurses; and from 1923 to 1931, thirty counties availed themselves of this privilege.

In the 1940's the nursing division assisted in the development of regional educational conferences and offered scholarships to assist nurses to further their education. A plan for exchanging a rural nurse for an urban nurse was initiated with the Henry Street Visiting Nurses Association of New York City. Family case records were developed and an increase in tuberculosis and other communicable diseases occupied much of the field nurses' time. Hospitals also received nursing consultation under the emergency maternity and infant care program. Senior cadet nurses received four to six months of training in the rural and urban areas.

In 1945, the Missouri Constitution provided for the establishment of a department to correlate health and welfare activities; and Senate Bill 349 created such a department. The Department of Social Services was created in 1974 and included several divisions, including the Division of Health. The Department of Health was created in 1987. In August of 2001, the Division of Aging was moved from the Department of Social Services to the Department of Health which was then retitled as the Department of Health and Senior Services.

There was a division/bureau of nursing from 1931-1995 and a council of nursing met during some of this time. In 1997, the position of Public Health Nursing Liaison and the Council of Public Health Nursing were established. (Hoskins, 2014)

Missouri Council for Public Health Nursing

A policy creating a public health nursing council was published in the Department of Health (DOH) administrative manual in April 1997. The policy stated that the purpose of the council was to address issues common to public health nursing across divisional lines and authorities. Responsibilities included evaluating and making recommendations for issues related to public health nursing responsibilities and roles, standards, training, and recruitment. Members were one nurse from each DOH division and center, and two district nurses. In July 1997, the position of Public Health Nursing Liaison was created in the Center for Local Public Health Services. Duties of this position included implementation of the policy, development of the council, and serving as council chair. The first meeting of the Council of Public Health Nursing (CPHN) was in October 1997.

In 1999, the CPHN was restructured to include representatives from local public health agencies (LPHAs). Two standing committees were developed, one representing DOH and the other representing the LPHAs. The DOH committee was composed of one representative from each division, center, and district. The LPHA committee was composed of one LPHA nurse from each district. Members were asked to report CPHN activities to the areas they represent, and also to bring issues impacting public health nursing practice to the attention of the CPHN. The LPHA nurses were also asked to communicate with and organize meetings of local public health nurses in their district. The purpose of these meetings was to share information and provide opportunities for networking, support, and discussion of nursing issues.

In 2003, the CPHN was again restructured to include greater representation from LPHAs and the addition of nursing educators. The leadership was assigned to an executive committee with a chair from a LPHA. The Department of Health & Senior Services public health nursing liaison became an ex-officio member of the CPHN. At that time, the name was changed to Council for Public Health Nursing. The position of Public Health Nursing Liaison changed to Public Health Nursing Coordinator in 2007. In 2015, the name of the CPHN was updated to the Missouri Council for Public Health Nursing (MCPHN).

Resources

For more information about CPHN: <http://www.health.mo.gov/living/lpha/phnursing/cphn.php>

Definition of Public Health Nursing

In 2013, the American Public Health Association Public Health Nursing Section affirmed the 1996 definition of Public Health Nursing as “the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.”
(American Public Health Association, Public Health Nursing Section, 2013)

“Public health nursing is a specialty practice within nursing and public health. It focuses on improving population health by emphasizing prevention, and attending to multiple determinants of health. Often used interchangeably with community health nursing, this nursing practice includes advocacy, policy development, and planning, which addresses issues of social justice. With a multi-level view of health, public health nursing action occurs through community applications of theory, evidence, and a commitment to health equity. In addition to what is put forward in this definition, public health nursing practice is guided by the American Nurses Association *Public Health Nursing: Scope & Standards of Practice* and the Quad Council of Public Health Nursing Organizations’ *Core Competencies for Public Health Nurses*.”
(American Public Health Association, Public Health Nursing Section, 2013)

“Elements of Practice:

Key characteristics of public health nursing practice include:

- 1) a focus on the health needs of an entire population, including inequities and the unique needs of sub-populations;
- 2) assessment of population health using a comprehensive systematic process;
- 3) attention to multiple determinants of health;
- 4) an emphasis on primary prevention; and
- 5) application of interventions at all levels—individuals, families, communities and the systems that impact their health.” **(American Public Health Association, Public Health Nursing Section, 2013)**

Resources

American Public Health Association, Public Health Nursing Section (2013). The definition and practice of public health nursing: A statement of the public health nursing section.

<http://apha.org/~media/files/pdf/membergroups/phn/nursingdefinition.ashx>

Role of Public Health Nursing

“Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They translate and articulate the health and illness experiences of diverse, often vulnerable, individuals and families in the population to health planners and policy makers, and assist members of the community to voice their problems and aspirations. Public health nurses are knowledgeable about multiple strategies for intervention, from those applicable to the entire population, to those for the family and the individual. Public health nurses translate knowledge from the health and social sciences to individuals and population groups through targeted interventions, programs, and advocacy.

Public health nursing may be practiced by one public health nurse or by a group of public health nurses working collaboratively. In both instances, public health nurses are directly engaged in the inter-disciplinary activities of the Core Public Health Functions of assessment, assurance, and policy development. Interventions or strategies may be targeted to multiple levels depending on where the most effective outcomes are possible. They include strategies aimed at entire population groups, families, or individuals. In any setting, the role of public health nurses focuses on the prevention of illness, injury or disability, the promotion of health, and protection of the health of populations.” (American Public Health Association, Public Health Nursing Section, 1996)

Public health nurses provide a critical linkage between epidemiological data and clinical understanding of health and illness, as it is experienced in peoples’ lives. This understanding is translated into action for the public good. An illustration of this role is the surveillance and monitoring of disease trends within the community. Emerging patterns that potentially threaten the public’s health are identified and appropriate interventions planned, coordinated, and implemented. This is a role that public health nurses can do in any setting; however, it occurs mainly in the public sector. Public health nurses contribute to systems for monitoring crucial health status indicators such as environmentally caused illnesses, immunization levels, infant mortality rates, and communicable disease occurrence, in order to identify problems that threaten the public’s health and develop effective interventions.

❖ The Role of Public Health Nursing in Public Health Accreditation

The Public Health Accreditation Board (PHAB) is a voluntary national accreditation program designed to improve and protect the health of the public. PHAB accredited public health departments achieve this by advancing the quality and performance of their agency which becomes recognized nationally through a nonregulatory process.

“What is Public Health Department Accreditation?”

- The measurement of health department performance against a set of nationally recognized, practice-focused, and evidence-based standards.
- The issuance of recognition of achievement of accreditation within a specified time frame by a nationally recognized entity.
- The continual development, revision, and distribution of public health standards.

The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of tribal, state, local and territorial public health departments.” (PHAB, 2011)

In Missouri, local public health agencies are encouraged to seek voluntary accreditation. The first local public health agency was accredited in 2003 by the Missouri Institute for Community Health (MICH). In November 2005, the accreditation standards were revised to include the *Operational Definition of a Functional Local Health Department* created by the National Association of County and City Health Officials (NACCHO), along with the work of the national PHAB. The national accreditation standards focus on measurable outcomes that evaluate the capacity of public health departments to address the *Ten Essential Public Health Services*. In addition to the *Ten Essential Public Health Services*, PHAB included two other domains in which public health departments are peer-reviewed. These two domains are specific to management/administration and governance, respectively :

- “Maintain administrative and management capacity.”
- “Build a strong and effective relationship with governing entity.”

These PHAB standards, twelve in all, “define the expectation for all public health departments that seek to become accredited. National public health department accreditation has been developed because of the desire to improve service, value, and accountability to stakeholders.” (PHAB, 2011)

What is the role of public health nurses in the accreditation process?

Local public health nurses working within their agencies to attain accreditation will help to validate the quality and importance of the work they do to improve the health of our communities.

Public health nurses are uniquely qualified to participate in the PHAB accreditation process both by education and experience of their nursing practice. PHAB has incorporated the *Core Competencies for Public Health Professionals* within each of the standards. Since the PHAB standards are inclusive of the *Ten Essential Services of Public Health*, it is the Core Competencies that demonstrate the necessary skill set specific to public health practice. *The Quad Council Competencies for Public Health Nurses* (CCPHN) provides guidance on skill set specific competencies. Some examples of these public health practice skill sets for public health nurses include:

- 1) Participating on the public health department accreditation team to review, identify and select documentation that support PHAB standards and measures. (CCPHN Domain 8; PHAB Domain 9)
- 2) Participating in the local Community Health Assessment (CHA), as part of the core functions of public health including : a) collecting and analyzing data, b) mobilizing community partners, and c) disseminate findings to inform others for policy change. (CCPHN Domain 1, Domain 4, Domain 3; PHAB Domain 1, Domain 4, Domain 3)
- 3) Sharing information regarding the community determinants of health status, health needs, and community assets with community partners, staff, boards of health, and elected officials.(CCPHN Domain 3, PHAB Domain 3)

For more information on Public Health Accreditation:

Missouri Institute for Community Health <http://www.michweb.org>

National Association of County and City Health Officials

<http://www.naccho.org/programs/public-health-infrastructure/accreditation-preparation>

Public Health Accreditation Board

<http://www.phaboard.org/accreditation-overview/what-is-accreditation>

❖ The Role of Public Health Nursing in Disaster and Emergency Preparedness, Response, and Recovery

Preparing for, responding to, and recovering from disasters and emergencies is a public health priority. “Nursing and, specifically, public health nursing practice must remain a constant across the national planning framework: prevention, protection, mitigation, response, and recovery.” (Association of Public Health Nurses, 2014).

Public health nurses contribute specific skills in times of disaster. They not only serve as first responders to some events, but they also embrace a population-based vision, have the necessary skills and competencies to develop policies and comprehensive plans, and conduct and evaluate disaster response drills, exercises, and trainings.

Emergency preparedness and response services provided by public health nurses should be consistent with the scope of practice for the specialty or area in which the nurse is currently practicing. For example, public health nurses have the necessary skills to staff a congregate shelter that provides temporary housing for the general population with basic health needs. However, the acuity levels of persons housed in some special needs shelters require nursing skills which may not be consistent with the current scope of practice for public health nursing. One of the most exciting challenges for public health nurses, whether in the emergency management center or in a disaster shelter for hurricane victims, is to collaborate with other emergency workers from other disciplines to enhance the emergency response infrastructure at the local, regional, state, national, and global levels.

“Strong infrastructures, systems, and models are needed to maximize the utilization of first responders, health care professionals, and volunteers. Public health nurses can engage other nurses, such as those who are retired or unemployed, as well as students and volunteers, to assist with disaster prevention, planning, response, recovery, training, and exercises.” (Association of State and Territorial Directors of Nursing (ASTDN), 2007)

“If public health nurses do not practice these skills as part of their routine daily scope of practice, plans should be developed at the local, regional, and state levels to identify a pool of nurses with the necessary skills and ability to respond as volunteers or as paid workers when needed. However, the circumstances of any given disaster or emergency may unfold in ways that do not always assure the best match between the level of health care needs among victims and the level of skills among nurses available to respond. Therefore, emergency plans should provide for Just-In-Time Training to educate staff, both paid and volunteers, to update or learn the specific nursing skills needed in each situation.” (Association of State and Territorial Directors of Nursing (ASTDN), 2007)

“Public health nurses bring critical expertise to each phase of the disaster cycle: preparedness (prevention, protection, and mitigation) response and recovery.” “To clarify the relationship between PHN practice and phases of a disaster, Table 1, illustrates how each step of the nursing process is practiced during each phase of the disaster cycle” (Association of Public Health Nurses, 2014). To access this table *The Disaster Cycle Linked to the Nursing Process*, and the emergency-preparedness core competencies specific to public health nurses, see the APHN, 2014 Position Paper on [The Role of the Public Health Nurse in Disaster](#).

In the Position Paper, the Association of Public Health Nurses states,

“Public health must now, more than ever, expertly engage its internal and external partners, as well as its communities. No single discipline, agency, organization or jurisdiction can or should claim sole responsibility for the complex array of challenges associated with the disaster, whether caused by nature, humans, or some combination of both.” (Association of Public Health Nurses, 2014)

“Public health nurses possess the skills and knowledge to develop disaster policies and comprehensive plans, and to conduct and evaluate preparedness and response drills, exercises and trainings. They are integral members in response operations and command centers, in leadership and management roles, as well as in the field where they provide frontline population health and core public health services. The PHN is also adept in collaborating with other experts, including environmentalists, epidemiologists, laboratorians, biostatisticians, physicians, social workers, and other nurses. Interprofessional practice is required to enhance preparedness, response, and recovery at the local, regional, state, national and global levels. Strong systems and models are needed to maximize the collaboration of first responders, health care professionals, and volunteers.” (Association of Public Health Nurses, 2014)

“Principles for PHN practice in disaster:

1. Public health nursing roles in disasters are consistent with the scope of public health nursing practice and are articulated specifically in those standards and scope (ANA, 2013).
2. The components of the nursing process align with the National Planning Framework phases of preparedness (prevention, protection, mitigation), response, and recovery (ANA, 2010; FEMA, 2013).
3. Competencies provide a framework for defining PHN role and standards of practice across the disaster cycle and these competencies include those from public health nursing, disaster nursing, disaster public health, and competencies specific to public health nurses practice in disasters (ASPH, 2010; ICN 2009; Quad Council, 2011).
4. Public health nurses bring leadership, policy, planning and practice expertise to disaster preparedness, response and recovery.” (Association of Public Health Nurses, 2014)

This APHN Position Paper provides excellent recommendations for competencies for disaster response, as well as a discussion of recommended Performance Goals for disaster response.

Missouri Show-Me Response

Show-Me Response is Missouri’s Emergency System for Advanced Registration for Volunteer Health Professionals, which is a federal directive through the U.S. Department of Health and Human Services to support more efficient intrastate, state-to-state, and state-to-federal health care volunteer response. It is a web-based management system that allows health care and non-medical professionals to preregister on-line and become volunteers in the event of a major disaster or public health emergency. Show-Me Response provides readily available, verifiable, up-to-date information regarding a volunteer’s identity, professional license verification status, and employment information, as well as tools to notify and manage the activation of volunteers. For more information and how to register, go to <https://www.showmeresponse.org>. Also, [Show-Me Response Disaster Call for Heroes. Answer the Call](#) provides more information about this important program.

Medical Reserve Corps

The Medical Reserve Corps (MRC) is a national network of local groups of volunteers committed to improving the health, safety, and resilience of their communities. The MRC program was founded following President Bush's 2002 State of the Union Address when he asked all Americans to volunteer in support of their country. MRC volunteers include medical, non-medical, and public health professionals who are interested in strengthening the public health infrastructure and improving the preparedness and response capabilities of their local jurisdiction. For more information visit: <http://health.mo.gov/emergencies/ert/volunteer.php>

More information on disaster and emergency planning is available at the Missouri Department of Health and Senior Services website at <http://health.mo.gov/emergencies/index.php>

Think Cultural Health Respond Tool

The Think Cultural Health program in the Office of Minority Health, Department of Health and Human Services has developed the [Respond Tool: Culturally Competent History Taking in a Crisis](#). The following is a summary of that tool:

- R** – Rapport: Build *rapport* with the individuals you are reaching.
- E** – Explain: *Explain* the purpose of your conversation. Establishing clear intentions and expectations about the nature of the conversation will go a long way in making communication more efficient and effective.
- S** – Services: Identify what community-based *services* are available to community members to help them re-establish their lives. In addition, be aware that many individuals might not understand that these services are available, let alone that they are often offered at no cost to them.
- P** – Proactive: Encourage individuals to be *proactive* in seeking help and identifying their needs.
- O** – Offer: *Offer* assistance for individuals in the affected communities by helping them identify their needs as much as you are able.
- N** – Negotiate: *Negotiate* what was “normal” prior to the disaster to help an individual identify his or her needs as much as you are able.
- D** – Determine: Finally, *determine* what the next steps are for that individual, as people affected by a disaster are likely to feel increasingly vulnerable. Providing them with the security of structure and normalcy can improve their ability to recover more quickly. (Office of Minority Health, 2015)

Resources

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❖ The Role of Public Health Nursing in Environmental Health

“Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours. It encompasses the assessment and control of those environmental factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments. This definition excludes behaviour not related to environment, as well as behaviour related to the social and cultural environment, and genetics”. (World Health Organization (WHO), 2015) http://www.who.int/topics/environmental_health/en

The Agency for Toxic Substances and Disease Registry (ATSDR) has developed the national Environmental Health Nursing Initiative (EHNI) to increase environmental health capacity in nursing research, education and practice. The EHNI is a collaborative effort with representatives of federal agencies, university nursing programs, nursing organizations, state and local health departments, and grass roots organizations working together to increase and sustain environmental health knowledge and skills among nurses.

The CDC has a National Environmental Public Health Tracking Program which is the ongoing collection, integration, analysis, interpretation, and dissemination of data from environmental hazard monitoring, and from human exposure and health effects surveillance. It can provide the local public health agency with current data on a multitude of environmental issues. It also provides avenue for a two-way exchange of information about local environmental issues.

Resources

Agency for Toxic Substances and Disease Registry.
<http://www.atsdr.cdc.gov/emes/public/index.html>

CDC National Environmental Public Health Tracking Program
<http://ephtracking.cdc.gov/showHome.action>

Scope of Practice

As changes occur in the structure of agencies, technology, issues, and programs, nurses often ask the question “Is this within my scope of practice?” The answer to the question is not simple. Basic parameters of the scope of practice are defined by basic licensure preparation and advanced education. There is not a list of specific tasks, functions, or responsibilities nurses may or may not do. If there were such a list, it would need to be limited to the minimal skills every nurse must possess when they graduate. As the profession of nursing evolves and technology changes, all licensed nurses continue to share a common base of responsibility and accountability that is defined as the practice of nursing. In addition, nurses who are actively practicing are expected to keep current and increase their skills and expertise. This may be achieved by continuing formal education, in-services, reading professional journals, or other educational opportunities. Therefore, the scope of practice of individual nurses may vary according to the type of basic preparation, practice experiences, and professional development. Each nurse is responsible, both professionally and legally, for determining his or her own personal scope of practice.

When deciding if a task falls within their scope of practice, the nurse has several options. The nurse can decide to accept the assignment, making the nurse legally accountable for its performance. Or, the nurse may learn the skills required for the new task. If the decision is made to learn new skills, the nurse will need to notify their employer that they need additional education to be competent and make sure there is documentation in their personnel file validating this additional education. The third option is to refuse to perform the task. If this decision is made, it is important for the nurse to document the concerns for patient safety, as well as the process that was followed to inform the employer. The nurse should be aware that if the employer requires a task to be performed that the nurse is uncomfortable with, even if the nurse has legitimate concerns, the employer has the legal right to initiate employee disciplinary action.

Decision Making Model

To help nurses make decisions about scope of practice, the Missouri State Board of Nursing has adopted the Scope of Practice Decision Making Model. The [Missouri State Board of Nursing Scope of Practice Decision Making Tool](#) allows the nurse to use their judgment, skill, and knowledge to determine if they may perform an activity according to acceptable and prevailing standards of nursing. This tool will help nurses make informed decisions about their scope of practice. (Missouri State Board of Nursing, 2006)

“All health care providers are accountable for their own actions: nurses, physicians, pharmacists, social workers, respiratory therapists, unlicensed assistive personnel, aides, technicians. Each is responsible for providing care within the appropriate standards of care for that provider. Health care providers are required to exercise independent judgments and utilize their knowledge within the scope of their profession or job when caring for patients.” (Feutz-Harter, 2012). Therefore, the use of sound judgement, current knowledge of their scope of practice, and their training must be the driving forces of any decision made.

Standards of Practice

The Scope and Standards of Practice developed by the American Nurses Association (ANA) provide guidelines for nursing performance. They are a standard of what it means to provide competent care. The registered professional nurse is required by law to carry out care in accordance with what other reasonably prudent nurses would do in the same or similar circumstances. Thus, provision of high quality care consistent with established standards is critical.

The ANA has developed and published standards for nursing and nursing specialty practices, including the 2013 Public Health Nursing: Scope and Standards of Practice, 2nd Edition available from the ANA at <http://www.nursesbooks.org>.

Essential Services of Public Health

Essential to any public health practice are the three core function and 10 essential services of public health. The 10 essential services serve as a framework for public health systems. Public health nursing practice includes all 10 essential services An individual public health nursing position may not utilize all 10 essential services, but every public health nursing position should include the core functions

The 10 essential services can be categorized into the three core functions as follows.

Assessment

- Monitor health status to identify and solve community health problems.
- Diagnose and investigate health problems and health hazards in the community.

Policy Development

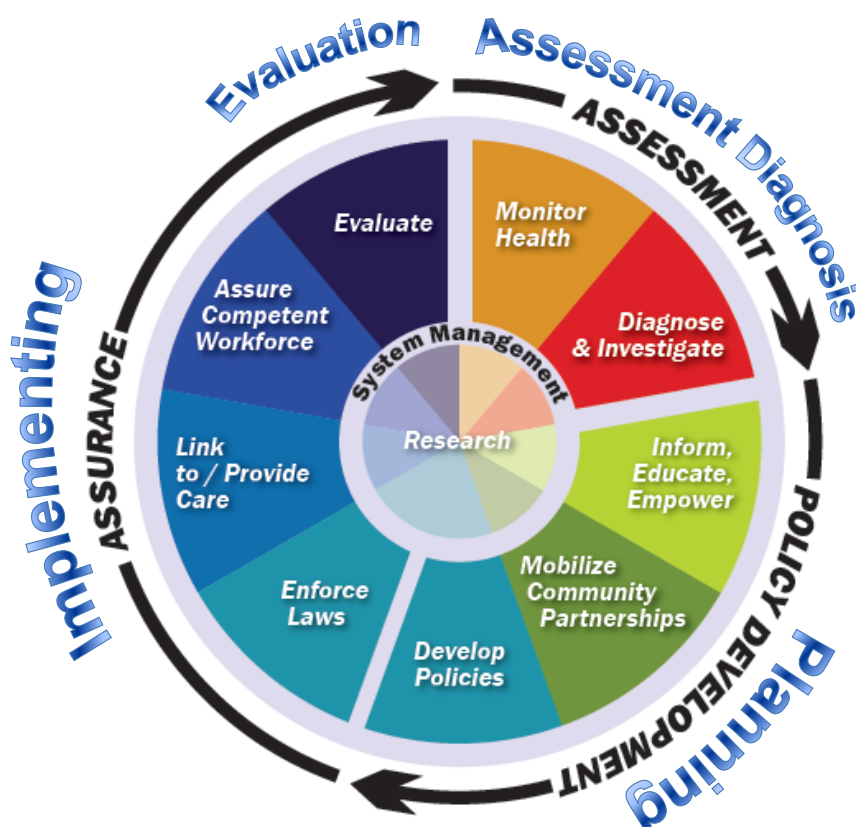
- Inform, educate, and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.

Assurance

- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure competent public and personal health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

More information about the essential services can be found at

<http://www.cdc.gov/nphpsp/essentialServices.html>.



The essential services reflect closely the nursing process (assessment, diagnosis, planning, implementing, and evaluation). Assessment includes (1) monitor health. Diagnosis includes (2) diagnosis & investigation. Planning includes the policy development steps: (3) inform, educate, empower; (4) mobilize community partnerships; and (5) develop policies. Implementation includes three of the assurance steps: (6) enforce laws; (7) link to/provide care; and (8) assure a competent workforce. The final step in both processes is evaluation.

Public Health Nursing Competencies

In 2011, the Quad Council of Public Health Nursing (QCPHN) Organizations revised their Core Competencies for Public Health Nursing to be used at all levels and in a variety of practice settings. These competencies can be useful for agencies/organizations employing public health nurses (PHNs), educational institutions, and other agencies engaged in educating PHNs.

The QCPHN recognizes eight domains spanned by three tiers of practice to “demonstrate core competencies for public health professionals at all three levels: the basic or generalist level (Tier 1), the specialist or mid-level (Tier 2), and at the executive and/or multi-systems level (Tier 3).” (Quad Council of Public Health Organizations, 2011) These domains are:

- Domain 1. Analytic and Assessment Skills
- Domain 2. Policy Development/Program Planning Skills
- Domain 3. Communications Skills
- Domain 4. Cultural Competencies Skills
- Domain 5. Community Dimensions of Practice
- Domain 6. Public Health Sciences Skills
- Domain 7. Financial Planning and Management Skills
- Domain 8. Leadership and Systems Thinking Skills

(Quad Council of Public Health Organizations, 2011)

Further discussion about these domains and their relationship to the various levels of public health nursing can be found at:

<http://www.achne.org/files/quad%20council/quadcouncilcompetenciesforpublichealthnurses.pdf>.

Code of Ethics

A professional code of ethics provides guidelines for ethical decision making and establishes basic principles and standards. ANA has established a code of ethics for nurses, which is available at <http://www.nursebooks.org>. For a summary of the provisions in the code of ethics you can go to: <http://www.nursingworld.org/codeofethics>. The American Public Health Association (APHA) has also established a code of ethics for public health professionals, which can be found at https://www.apha.org/~media/files/pdf/about/ethics_brochure.ashx. In addition to these two resources, there are a number of topic specific recommendations that reflect ethical standards for public health nurses; a sample of some of these topics are discussed below.

❖ Professional Boundaries

“A nurse must understand and apply the following concepts of professional boundaries:

1. Professional boundaries are the spaces between the nurse’s power and the patient’s vulnerability.
2. Boundary crossings are brief excursions across professional lines of behavior that may be inadvertent, thoughtless or even purposeful, while attempting to meet a special therapeutic need of the patient.
3. Boundary violations can result when there is confusion between the needs of the nurse and those of the patient.
4. A nurse’s use of social media is another way that nurses can unintentionally blur the lines between their professional and personal lives.
5. Professional sexual misconduct is an extreme form of boundary violation and includes any behavior that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the patient.

The nurse’s challenge is to be aware, be cognizant of feelings and behaviors, be observant of the behavior of other professionals, and always act in the best interest of the patient.” (National Council of State Boards of Nursing, 2014)

For additional information about Professional Boundaries visit www.ncsbn.org.

The National Council of State Boards of Nursing. (2011), provides resources and documents, including the full brochure *A Nurse’s Guide to Professional Boundaries* available for download <https://www.ncsbn.org/professional-boundaries.htm> or to request a hard copy at no charge, visit <https://www.ncsbn.org/3757.htm>

❖ Reporting Incompetent, Unethical, or Illegal Practices

Reporting Responsibilities and Guidelines

A nurse's practice and behavior is expected to be safe, competent, ethical and in compliance with applicable laws and rules. Any person who has knowledge of conduct by a licensed nurse that may violate a nursing law or rule or related state or federal law may report the alleged violation to the state board of nursing where the situation occurred.

If you believe that there is a problem with a nurse, ask yourself if the nurse's practice and/or behavior is:

- Unsafe
- Incompetent

- Unethical
- Affected by the use of alcohol, drugs or other chemicals
- Affected by a physical or mental condition
- Is in violation of a nursing or nursing-related law or rule

Most states require a written and signed description of the practice or behavior. Many states have complaint forms available on their websites or you may call the board office to request information on filing a complaint. The board needs enough information to be able to determine:

- If the individual is a nurse licensed by the board or a licensure applicant.
- If the alleged practice or behavior is a violation of a board law or rule that the board has the authority to enforce.

[Contact your state board of nursing](#) for questions regarding confidentiality and how you, the complainant, may be involved in the process. Complaints should not be sent to NCSBN, as we have no authority over individual nurses. (National Council of State Boards of Nursing, 2016).

❖ Responsibilities of the Missouri State Board of Nursing

The mission of the Missouri State Board of Nursing is to protect the public by development and enforcement of state laws governing the safe practice of nursing.

Disciplinary Grounds

The Missouri Nurse Practice Act (335.006 2. RSMo) provides grounds to deny license or discipline the license of an RN or LPN. The list can be found in [RSMO 33.006.2](#).

The Board's disciplinary responsibilities include:

1. Reviewing and investigating complaints concerning licensed nurses, nurses in the licensure process, and nurse impostors;

The State Board of Nursing must receive and process each complaint made to them. Any member of the public or profession, state or local official may make a complaint to the Board.

Complaints must be made in writing and mailed or delivered to the Executive Director of the Missouri State Board of Nursing. A complaint may be made based upon personal knowledge or upon information and belief, reciting information received from other sources. All complaints must fully identify the complainant by name and address.

Each complaint received shall be acknowledged in writing and the complainant will be informed as to whether the complaint is being investigated and of any disciplinary action taken. The complaint and any information obtained as a result of the investigation of the complaint are not available for inspection by the general public. (adapted from State Regulation: **20 CSR 2200-4.030 Public Complaint Handling and Disposition Procedure**)

How to File a Complaint

[Click Here for Complaint Report Form](#)

Anyone may file a complaint against the license of a Registered Professional Nurse or a Licensed Practical Nurse. Please refer to the Public Complaint Handling and Disposition Procedure, 20 CSR 2200-4.030.3. The complaint must be in writing.

<http://www.sos.mo.gov/adrules/csr/current/20csr/20c2200-4.pdf>

According to the State of Missouri Nursing Practice Act (335.066 7., RSMo), anyone who makes a complaint and does so in good faith SHALL NOT be subject to civil damages because of the allegation made. **RSMo 335.066**

If you wish to file a complaint against the license of a nurse, please PRINT A COPY OF THE **[Complaint Report Form](#)**, fill it out, and mail it to:

Missouri State Board of Nursing
P. O. Box 656
Jefferson City, MO 65102

Should you have any questions regarding this process, please call the Board office at (573) 751-0070 or send an e-mail to: **nursing@pr.mo.gov**

2. Determining disciplinary action after cause for discipline has been established;

The following actions may be taken by the Board:

Non-disciplinary

- **No Further Action**: no disciplinary action taken against the nurse's license. A copy of the complaint and action taken kept in licensee's file;
- **Letter of Concern**: no disciplinary action taken against the nurse's license. A letter is sent to the nurse expressing their concern about the alleged behaviors in violation of Nurse Practice Act. Copy of complaint and action taken kept in licensee's file.

Disciplinary

DISCIPLINARY ACTIONS AVAILABLE TO THE BOARD

The Board of Nursing may take disciplinary action against a licensee for violation of the Nursing Practice Act. The Board is authorized to impose any of the following disciplines singularly or in combination: censure, probation, suspension, and revocation. For further reference see: [RsMO 335.066.3](#)

CENSURE:

This is the least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.

PROBATION:

The imposition of probation places terms and conditions on the licensee's license. The licensee must comply with the terms and conditions throughout the probationary period, which may extend up to five years.

SUSPENSION:

The imposition of suspension requires that the licensee cease practicing nursing for a period not to exceed three years.

REVOCATION:

This is the most restrictive discipline. The imposition of revocation mandates that the licensee immediately loses his/her license and may no longer practice nursing in Missouri. Once a license is revoked, the individual may not apply for relicensure for at least one year from the date of revocation. Upon application, the individual may be relicensed at the discretion of the Board after compliance with all the requirements relative to a new applicant, including, but not limited to, retaking the licensure examination.

3. Monitoring disciplined licensees.

<https://www.nursys.com/>

For questions related to disciplinary matters, contact the Missouri State Board of Nursing. <http://www.pr.mo.gov/nursing>

Resources

Missouri State Board of Nursing (2008). [Complaint Brochure](http://pr.mo.gov/boards/nursing/publications/brochures/Resolving%20a%20Complaint%20Brochure.pdf)
<http://pr.mo.gov/boards/nursing/publications/brochures/Resolving%20a%20Complaint%20Brochure.pdf>

American Nurses Association. (2015). *Guide to the Code of Ethics for Nurses with Interpretive Statements*. Silver Spring, MD. Nursesbooks.org

Missouri State Board of Nursing, Nursing Practice Act and Rules
<http://pr.mo.gov/boards/nursing/npa.pdf>

Use of Social Media

The use of social media and other electronic communication is expanding. While it can be valuable in reaching target audiences with strategic, effective and user-centric health interventions, and provide various forums for professional and personal communication with others, it can pose a risk to nurses and the nursing profession. Employer policies typically do not address the nurse's use of social media outside of the workplace. It is in this context that the nurse may face potentially serious consequences for inappropriate use of social media. (Adapted from *A Nurses' Guide to the Use of Social Media*, NCSBN)

- “With awareness and caution, nurses can avoid inadvertently disclosing confidential or private information about patients. The following guidelines are intended to minimize the risk of using social media: Nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.
- Nurses are strictly prohibited from transmitting by way of any electronic media any patient related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.
- Nurses must not share, post or otherwise disseminate any information or images about a patient or information gained in the nurse/patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligations to do so.
- Nurses must not identify patients by name, or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.
- Nurses must not refer to patients in a disparaging manner, even if the patient is not identified.

- Nurses must not take photos or videos of patients on personal devices, including cell phones. Nurses should follow employer policies for taking photographs or videos of patients for treatment or other legitimate purposes using employer provided devices.
- Nurses must maintain professional boundaries in the use of electronic media. Like in personal relationships, the nurse has an obligation to establish, communicate, and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient. Nurses must consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.
- Nurses must promptly report any identified breach of confidentiality or privacy.
- Nurses must be aware of and comply with employer policies regarding use of employer owned computers, cameras and other electronic devices, and use of personal devices in the workplace.
- Nurses must not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic, or other offensive comments.
- Nurses must not post content or otherwise speak on behalf of the employer unless authorized to do so and must follow all applicable policies of the employer.”
(National Council for State Boards of Nursing, 2014)

(excerpted from the NCSBN, “*A Nurse’s Guide to the Use of Social Media.*”)

For NCSBN resources and documents, including the full brochure, [*A Nurse's Guide to the Use of Social Media*](#), available for download or to request hard copies at no charge, visit <https://www.ncsbn.org/3739.htm> .

The National Council of State Boards of Nursing (NCSBN) has developed guidelines for using social media responsibly. NCSBN has collaborated with the American Nurses Association (ANA) on the professional use of social media. NCSBN has endorsed ANA’s principles of using social media, and ANA has endorsed NCSBNs guidelines. Additionally, NCSBN and ANA have collaborated on the development of videos to provide guidance in the use of social media. <https://www.ncsbn.org/347.htm>

The ANA’s *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse* is a resource to guide nurses and nursing students in how they maintain professional standards in new media environments and on using social networking media in a way that protects patients’ privacy and confidentiality and maintains the standards of professional nursing

practice. The six essential principles are relevant to all registered nurses and nursing students across all roles and settings. The *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse* can be purchased from the ANA at www.Nursesbooks.org.

To assist in the planning, development, and implementation of social media activities, the CDC has developed guidelines to provide critical information on lessons learned, best practices, clearance information, and security requirements. Although the guidelines have been developed for the use at CDC, they may be useful materials for other federal, state, and local agencies as well as private organizations to reference when developing social media tools. The CDC's Social Media Tools for Consumers and Partners, Guidelines for Best Practices are available at <http://www.cdc.gov/SocialMedia/Tools/guidelines/> and includes [The Health Communicator's Social Media Toolkit](#).

Resources

American Nurses Association (ANA), (2011), [Principles for Social Networking and the Nurse: Guidance for the Registered Nurse](#), American Nurses Association, Silver Spring, Maryland.

Centers for Disease Control and Prevention, The Health Communicator's Social Media Toolkit, (2011) http://www.cdc.gov/socialmedia/tools/guidelines/pdf/socialmediatoolkit_bm.pdf

Cultural Competencies

The U.S. Department of Health and Human Services, Office of Minority Health has developed the following Cultural Competency in Health Care and the National Standards for Culturally and Linguistically Appropriate Services (CLAS). This information is directly referenced from the U.S. Department of Health and Human Services and can be accessed in its entirety from www.ThinkCulturalHealth.hhs.gov.

❖ Center for Linguistic and Cultural Competency in Health Care

The Office of Minority Health established the Center for Linguistic and Cultural Competency in Health Care to address the health needs of populations who speak limited English. Its mission is to collaborate with federal agencies and other public and private entities to enhance the ability of the health care system to effectively deliver linguistically appropriate and culturally competent health care to populations who speak limited English.

<http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>

❖ National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards)

“The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance

health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. The National CLAS Standards include a collective set of mandates and guidelines that inform, guide, and facilitate both required and recommended practices related to culturally and linguistically appropriate health services.” (U.S. Department of Health and Human Services, Office of Minority Health, 2013)

“The National CLAS Standards were developed by the Health and Human Services Office of Minority Health in 2000, and updated in 2013 in partnership with a team of subject matter experts and the public. The Enhanced National CLAS Standards reflect the tremendous growth in the fields of cultural and linguistic competency since 2000 and address demographic trends and changes. The Enhanced National CLAS Standards also ensure relevance with new national policies and legislation, such as the Affordable Care Act.” (U.S. Department of Health and Human Services, Office of Minority Health, 2013)

The history and purpose of the CLAS program is described in the National CLAS Standards Fact Sheet:

<https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf>

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. The Blue Print for the CLAS Standards is provided below:

<https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf>

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (U.S. Department of Health and Human Services, 2013)

Additional information specific to culturally and linguistically appropriate services (CLAS) can be obtained by accessing: www.ThinkCulturalHealth.hhs.gov.

Resource

World Health Organization, 2012

http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

Description of Registered Nurse Titles

Professional Nursing- The performance for compensation of any act which requires substantial specialized education, judgment, and skill-based knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:

- (a) Responsibility for the teaching of health care and the prevention of illness to the patient and his/her family;
- (b) Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured, or experiencing alterations in normal health processes;
- (c) The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments;
- (d) The coordination and assistance in the delivery of a plan of health care with all members of a health care team;
- (e) The teaching and supervision of other persons in the performance of any of the foregoing.

Registered Professional Nurse or Registered Nurse- A person licensed under the provisions of sections 335.011 to 335.096, RSMo, (“The Nursing Practice Act”) to engage in the practice of professional nursing.

Advanced Practice Registered Nurse- A registered professional nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for an advanced practice registered nurse established by the board of nursing. The board of nursing promulgates rules specifying which professional nursing organization certifications are recognized as advanced practice registered nurses, and sets standards for education, training, and experience required for those without such specialty certification to become advanced practice registered nurses.

The term advanced practice registered nurse applies to a registered professional nurse as defined in Section 335.016(2), RSMo, who is a certified registered nurse anesthetist, certified nurse midwife, certified nurse practitioner, or certified clinical nurse specialist. An individual who meets the requirements to be an advanced practice registered nurse must demonstrate current certification in their respective advanced nursing clinical specialty area by a Missouri State Board of Nursing (MSBN) approved nationally-recognized certifying body. The specific advanced practice nursing clinical specialty area and role is identified on a “Document of Recognition” granted by the Missouri State Board of Nursing, and sent to the licensed registered professional nurse. The “Document of Recognition” is not a license. (CSR 2200-4.100).

Nurse Practitioner- An advanced practice registered nurse who is prepared through a formal nursing educational program to provide a full range of primary health care services. Most nurse practitioner programs currently confer a master's degree. The nurse practitioner, utilizing a broad knowledge base, focuses on health promotion, prevention of disease/health problems, early diagnosis and treatment of common acute minor illnesses and injuries, and management of stable chronic illnesses. Current nurse practitioner specialties certification is available in acute care, adult psych/mental health, family psych/mental health, pediatric, women's health, family, adult, neonatal, and gerontology. (20CSR 2200-4.100)

Certified Clinical Nurse Specialist- “A registered nurse who is currently certified as a clinical nurse specialist by a nationally recognized certifying board approved by the board of nursing.” (335.016 (5), RSMo Definitions).

Certified Nurse Midwife- “A registered nurse who is currently certified as a nurse midwife by the American College of Nurse Midwives, or other nationally recognized certifying board approved by the board of nursing.” (335.016 (6), RSMo Definitions).

Certified Registered Nurse Anesthetist- “A registered nurse who is currently certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or other nationally recognized certifying body approved by the board of nursing. (335.016 (8), RSMo – Definitions)

Nationally recognized certifying bodies currently acceptable to the Missouri State Board of Nursing include those listed in Appendix A of this document.

Collaborative Practice Rule

The State Board of Nursing's and State Board of Registration for the Healing Arts' joint rulemaking activity on collaborative practices by physicians with registered professional nurses (RNs) or registered professional nurses who are advanced practice nurses (APNs), became law on September 30, 1996. This rule, 20 CSR 2200-4.200 Collaborative Practice (Nursing) or 20 CSR 2150-5.100 Collaborative Practice (Healing Arts), specifies the practice boundaries of physicians and RNs or physicians and APNs engaged in written collaborative practice arrangements (CPA). The Nursing Practice Act and Rules can be accessed through the Missouri State Board of Nursing at <http://pr.mo.gov/boards/nursing/npa.pdf>

CPAs are defined in state statute (334.104.1., RSMo) as... "written agreements, jointly agreed-upon written protocols, **or** written standing orders for the delivery of health care services." The state statute can be viewed at <http://www.moga.mo.gov/mostatutes/stathtml/33400001041.html> or for more information from the Missouri State Board of Nursing on CPAs and the APN: <http://www.pr.mo.gov/nursing-advanced-practice-collaborative-practice.asp>

Through a CPA, a physician may delegate:

- To an RN who is not an APN the authority to administer or dispense drugs and provide treatment within the RN's scope or practice and consistent with the RN's skill, training, and competence; and
- To an RN who is an APN the authority to administer, dispense, and prescribe drugs and provide treatment.

An RN does not need to engage in a CPA with a physician **nor** require physician oversight to perform "nursing acts" the RN has the specialized education, judgment, and skill to perform [335.016 (15) (a) through (e) RSMo]. However, if the RN is to perform delegated "medical acts" (e.g., dispensing of drugs*), a physician-RN or physician-APN relationship must clearly and defensibly be in place.

A professional relationship between a physician and RN or APN can be established and exercised through the traditional means of specific, and later cosigned, verbal orders from a physician or written orders, possibly in the form of protocols or standing orders, generated and signed by a physician and carried out by an RN or APN. In this case, the relationship is not based on a jointly agreed-upon practice arrangement and therefore, would not constitute a CPA and the collaborative practice rule would not apply.

On the other hand, a physician-RN or physician-APN relationship can also be established and exercised through one or more of the jointly agreed-upon physician and RN or physician and APN written means described above. In this case, a written CPA exists and the collaborative practice rule applies. (Missouri State Board Of Nursing, 2015)

Collaborating physicians and collaborating RNs or APNs practicing in association with public health clinics providing specific population-based health services must abide by the

statute provisions in 334.104 RSMo and sections (1) and (5) of the collaborative practice rule 20 CSR 2150-5.100. The specific services are as follows: immunizations; well child care; HIV and sexually transmitted disease care; family planning; tuberculosis control; cancer and other chronic diseases and wellness screenings; services related to epidemiological investigations and related treatment; and prenatal care. (20 CSR 2150-5.100 Collaborative Practice, 2010)

If services provided in public health clinics include diagnosis and initiation of treatment of any other disease or injury than those listed above, then all other rule provisions [sections (2), (3), and (4)] apply (20 CSR 2150-5.100 Collaborative Practice, 2010). Although collaborating professionals whose practice activities meet the above population-based health services are not bound to address all the rule provisions in their written CPAs, they may find inclusion of other rule provisions to be in the best interest of reasonable, prudent, and defensible practice.

Additionally, some rule provisions are required practices pursuant to other state or federal laws whether or not one is in a written CPA. An example of this are several provisions regarding drug administration and dispensing behaviors in section (3) (G) of the Collaborative Practice Rule, 20 CSR 2150-5.100.

*NOTE: Dispensing of drugs is not authorized in the Nursing Practice Act. It is a delegated “medical act” which requires written authorization to perform. (20 CSR 2150-5.020 Nonpharmacy Dispensing, 2010). Either the traditional means described above, or a written CPA may be used to document physician authorization to dispense.

Resources

20 CSR 2200-4.100 Advanced Practice Registered Nurse

20 CSR 2200-4.200 Collaborative Practice

<http://s1.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2200-4.pdf>

20 CSR 2150-5.020 Nonpharmacy Dispensing

20 CSR 2150-5.100 Collaborative Practice

<http://s1.sos.mo.gov/cmsimages/adrules/csr/previous/20csr/20csr0712/20c2150-5.pdf>

RSMO 334.104 Collaborative Practice Statutes

<http://www.moga.mo.gov/mostatutes/stathtml/33400001041.html>

Missouri State Board of Nursing, Nursing Practice Act and Rules

<http://pr.mo.gov/boards/nursing/npa.pdf>

Physician Orders

General Guidelines

According to the Nursing Practice Act (Chapter 335 RSMo), the scope of practice of the professional nurse includes administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments. (Missouri State Board of Nursing, 2014)

Telephone orders for medical treatment and medications are to be taken and recorded only by a licensed nurse. It is the right and responsibility of the nurse to question orders the nurse deems inappropriate and to verify the validity of any order. Although telephone orders need to be verified by a physician's signature, there are no statutes or rules defining the time frame for obtaining the physician's signature. Third party reimbursement sources such as Medicaid or Medicare do have requirements for receipt of the physician's signature for drugs and treatments. When third party reimbursement is not an issue, the public health nurse will need to establish a protocol for time frames for obtaining physician signatures on telephone orders or establish protocol for the actions to be taken for obtaining physician signatures. One way to minimize the time it takes to obtain physician signatures is to fax the physician the telephone order for his signature.

A registered professional nurse, or licensed practical nurse under the direction of a registered professional nurse, may carry out orders from a physician licensed by any state regulatory board to prescribe medications and treatments. [(RSMO335.016 (15)(C)] It is important to note that some prescribers have limited scopes of practice, such as podiatrists and ophthalmologists and can only prescribe medications and treatments for illness and injury within their scope. (Missouri State Board of Nursing, 2014)

A physician order is not needed for a registered nurse to perform independent nursing acts, as long as the nurse defensibly has the required specialized education, judgment, and skill.

The Missouri State Board of Nursing has issued an opinion (March, 2000) that registered professional nurses, and licensed practical nurses under the direction of registered professional nurses, may perform finger sticks and heel sticks for assessment purposes without an order from a physician. This opinion means that obtaining a blood sample using a finger stick or heel stick is considered an assessment act and is included in the specialized education, judgment, and skill of the registered professional nurse identified in the Nursing Practice Act. However, determining what should be done based on the sample, including treatment decisions, interventions and follow-up, is the province of the physician; therefore, appropriate standing orders, protocols, or CPA should be in place for such actions.

Standing Orders

Standing orders are appropriately used in a local public health agency for some services (e.g., immunizations, sexually transmitted disease (STD) screening, tuberculosis (TB) testing).

As an example, standing orders may include (adapted from the *Oregon State Board of Nursing, Board Policy, Standing orders used by RNs and LPN's*):

“Components of Standing Orders should include:

1. Conditions (symptoms) or situation in which the standing order will be used;
 2. Assessment criteria;
 3. Objective and/or subjective finds which allow the nurse to apply the nursing process;
 4. Plan of Care including:
 - a. Medical treatment/pharmaceutical regimen if subjective and objective findings as listed above are present and meet criteria set forth in the standing order
 - b. Nursing actions, and
 - c. Follow-up or monitoring requirements
 5. Inclusion and exclusion criteria or circumstances for which the Licensed Independent Practitioner (LIP) is to be consulted, specifying criteria for routine, urgent or emergent consult;
 6. Date written and last reviewed; and
 7. Signature of the LIP”
- (Oregon State Board of Nursing, 2012)

All standing orders should be reviewed and revised as needed, or at least once a year.

All staff who carry out standing orders should review the orders and document that the review has occurred.

Each agency should have policies and procedures to implement all standing orders, including assessment of the patient and emergency treatment.

Resource

Oregon State Board of Nursing, Board Policy, Standing Orders used by RN's and LPN's February, 2012. http://www.oregon.gov/OSBN/pdfs/policies/standing_orders.pdf

Delegation

In order to meet the increasing need for accessible, affordable, quality health care, nurses working in public health agencies must coordinate and supervise the delivery of nursing care. This may include the delegation of nursing tasks to licensed and unlicensed health care personnel. The registered nurse (RN) maintains the ultimate responsibility and accountability for the management and provision of nursing care.

Acceptable Use of The Authority to Delegate

The delegating nurse is responsible for an individualized assessment of the patient and situational circumstances, and for ascertaining the competence of the licensed or unlicensed health care worker before delegating any task. A registered professional nurse must complete the functions of assessment, evaluation, and nursing judgment. Supervision, monitoring, evaluation, and follow-up by the RN are crucial components of delegation. The licensed or unlicensed health care worker is responsible for accepting the delegated task and for his/her own actions in carrying out the task.

“The Missouri State Board of Nursing recognizes that activities of unlicensed health care personnel need to be monitored to protect the health, welfare, and safety of the public. Registered professional nurses may teach, delegate, and supervise licensed practical nurses and unlicensed health care personnel in the performance of certain nursing care tasks [335.016(15)(e), RSMo; 20 CSR 2200-5.1010 Definitions]. Under the direction/supervision of registered professional nurses or persons licensed by a state regulatory board to prescribe medications and treatments, licensed practical nurses may teach, delegate, and supervise unlicensed health care personnel in the performance of specific nursing care tasks [335.016(14), RSMo; 20 CSR 2200-5.1010 Definitions].” (Missouri State Board of Nursing, 2007)

Delegation Decision-Making Process

In delegating, the nurse must ensure appropriate assessment, planning, implementation, and evaluation. The following model describes the decision-making process, which is continuous:

I. Delegation criteria.

- A. Nursing Practice Act
 - 1. Permits delegation
 - 2. Authorizes task(s) to be delegated or authorizes the nurse to decide delegation
- B. Delegator qualifications
 - 1. Within scope of authority to delegate
 - 2. Appropriate education, skills, and experience
 - 3. Documented/demonstrated evidence of current competency

Provided that this foundation is in place, the registered nurse may enter the continuous process of decision-making.

II. Assess the situation.

- A. Identify the needs of the patient, consulting the plan of care
- B. Consider the circumstances/setting
- C. Assure the availability of adequate resources, including supervision

If patient needs, circumstances, and available resources indicate patient safety will be maintained with delegated care, proceed to III.

III. Plan for the specific tasks to be delegated.

- A. Specify the nature of each task and the knowledge and skills required to perform the task
- B. Require documentation or demonstration of current competence by the delegate for each task
- C. Determine the implications for the patient, family, and significant others

If the nature of the task, competence of the delegate, and implications indicate patient safety will be maintained with delegated care, proceed to IV.

IV. Assure appropriate accountability.

- A. As delegator, accept accountability for performance of task(s)
- B. Verify that delegate accepts the delegation and the accountability for carrying out the task correctly

If delegator and delegate accept the accountability for their respective roles in the delegated patient care, proceed to V.

V. Supervise performance of the task(s).

- A. Provide directions and clear expectation of how the task(s) is/are to be performed
- B. Monitor performance of the task to assure compliance to established standards of practice, policies, and procedures
- C. Intervene when necessary
- D. Ensure appropriate documentation of the task(s)

VI. Evaluate the entire delegation process.

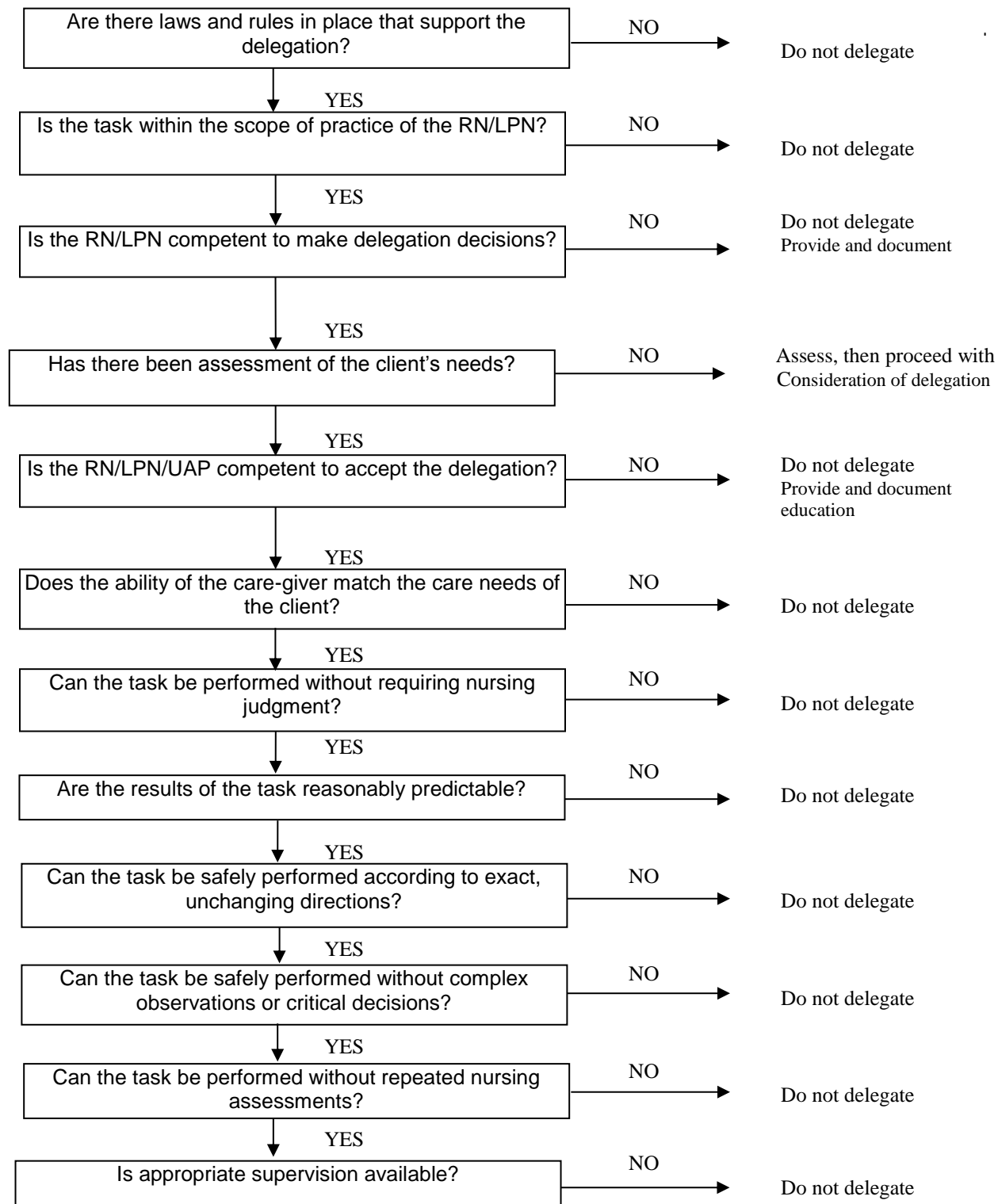
- A. Evaluate the client
- B. Evaluate the performance of the task(s)
- C. Obtain and provide feedback

VII. Reassess and adjust the overall plan of care as needed

Table 1 Missouri State Board Decision Making Tree

(Missouri State Board of Nursing, 1997)

The Missouri State Board of Nursing provides [delegation resources](#) and a [delegation decision making tree](#) on its website for review:



Resources

Missouri State Board of Nursing, (2007) Position Statement: Utilization of Unlicensed Health Care Personnel.

<http://pr.mo.gov/boards/nursing/positionstatements/Utilization%20of%20Unlicensed%20Health%20Care%20Personnel.pdf>

Missouri State Board of Nursing, (1997) Delegation Decision Making Tree

<http://pr.mo.gov/boards/nursing/delegationtree.pdf>

Other resource models available on delegation decision making can be found at the National Council of State Boards of Nursing <https://www.ncsbn.org/1625.htm>

American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) Joint Statement on Delegation (2005)

https://www.ncsbn.org/Delegation_joint_statement_NCSBN-ANA.pdf

Documentation

Documentation should primarily be according to organizational policy and include any regulatory, accreditation, and professional organization standards. Organizations should also consider contractual or grant requirements for documentation if indicated.

Nursing documentation serves many purposes beyond the basic responsibility to record an assessment, plan, implementation, and evaluation around a client's care. Documentation is routinely used for: communication among care team members; insurance reimbursement; verifying accreditation standards; and legal defense in the case of litigation. It is important that documentation is timely, accurate, standardized, and complete.

General Guidelines for Documentation

- All documentation should be factual, complete, accurate, contain observations, clinical signs and symptoms, client quotes when applicable, nursing interventions, and patient reactions. Be specific.
- Do not include opinions or document for another person. If documenting comments from others document the source and use quotes as appropriate.
- All documentation should indicate the time documented and be signed. Late entries should also note the time events actually occurred.
- Use correct grammar, spelling, and punctuation. Only use organizationally approved abbreviations.
- When documenting on paper “close” all white spaces when documentation is complete. On the last line of documentation draw a line from the last word to the right side of the page. When a page will contain no more documentation but there is white space left at the bottom, draw a perpendicular line across the space to prevent further documentation in the future.
- Always verify you are documenting in the right client chart by verifying at least two forms of patient identification (i.e. name, date of birth, chart number). Paper documentation should have at least two forms of patient identification including the client's full name on each page.
- Document errors according to your organization's policy. Never erase, obliterate, or “white out” documentation. One common practice for paper charting is to strike out the words needing corrected with a single line, ensuring it is still readable, and marking with “mistaken entry”.
- Always document actions taken when documenting a client issue, such as pain.
- Remember the nurses golden rule on documentation: If you didn't document it, it didn't happen.
(Kopf, 1993)

Electronic Medical Records (EMR)

The standards for documenting in an EMR are the same as for paper charting. Electronic charting has some advantages, but also may require you to review previous policies to ensure they cover both paper and electronic documentation guidance.

The United States Department of Health and Human Service program, HealthIT.gov lists the following benefits to the Electronic Medical Record:

An EMR is more beneficial than paper records because it allows providers to:

- **Track** data over time
- **Identify** patients who are due for preventive visits and screenings
- **Monitor** how patients measure up to certain parameters, such as vaccinations and blood pressure readings
- **Improve** overall quality of care in a practice
(HealthIT.gov, 2014)

Although many venues for health care are adopting some form of electronic medical records, the LPHA should thoroughly research the different products in use and assure that they are HIPAA compliant. More information about the requirements for EMRs, including guidelines for how to implement EMR's, can be found at the Health IT.gov website.

ANA has published a position statement, Electronic Health Record (EHR) which addresses implementation of an EHR.

Resources

American Nurses Association (ANA) Position Statement. Approved 12/11/2009
<http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Electronic-Health-Record.html>

HealthIT.gov. What is an Electronic Medical Record (EMR). <http://www.healthit.gov/providers-professionals/electronic-medical-records-emr>

American Nurses Association. (2010). ANA's Principles for Nursing Documentation Guidance for Registered Nurses. Nursesbooks.org.

College of Registered Nurses of Nova Scotia. (2012). Documentation Guidelines for Registered Nurses. <http://crnns.ca/wp-content/uploads/2015/02/DocumentationGuidelines.pdf>

Dispensing Medications

The following guidelines should be followed when dispensing medications

Prescription

“The terms, ‘perscription’ or ‘prescription drug’ order are hereby defined as a lawful order for medications or devises issued and signed by an authorized prescriber within his scope of practice which is to be dispensed or administered by a pharmacist or dispensed or administered pursuant to section 334.104 to and for the ultimate user.” (RSMo 338.095.1.) (Note: section 334.104 is the Collaborative Practice statute)

Collaborative Practice Agreement (CPA)

A written agreement that acknowledges jointly agreed upon protocols or written standing orders for the delivery of health care services. A CPA may delegate to a registered professional nurse the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the registered professional nurse and is consistent with that nurse's skill, training, and competence. (334.104.1. RSMo)

Protocol

A predetermined, written medical care guideline, which may include standing orders; Section 190.100.1 subsection 34 Missouri Revised Statutes.

Responsibilities of the RN when Dispensing Medications

Except those public health agencies that employ a licensed pharmacist, public health agencies store, dispense, and administer only those medications that are necessary for the public’s health such as immunizations, tuberculosis treatment, prenatal care, etc. The statutes that govern the practice of pharmacies and pharmacists (RSMo 338 and 20 CSR 2200-2) can serve as a guide for the proper dispensing of medications. The pharmacy practice regulations treat written, faxed, or electronically communicated physician orders the same - all must meet the standards for content and security. It is suggested that the RN verify the license of a physician or collaborative practice nurse prior to carrying out treatment or drug orders from an unknown physician or nurse in a collaborative practice.

1. Check Order

Verify presence of a current, complete, and signed physician’s order in the client record or protocol in the agency. Physician’s orders and/or protocols must be rewritten or reviewed, signed, and dated at least yearly, or more often if indicated.

The content of individual medical orders to dispense medication as outlined in the pharmacy regulations (20 CSR 2220-2.018) must contain:

- Client’s name, if the order is not written on client’s record;
- The date the order is written;

- The prescriber's name if an oral prescription, or written or electronic signature if written or faxed, or electronically written prescription;
- Name, strength, dose, and the directions for use;
- Method of administration;
- Number of refills (if applicable);
- The quantity prescribed in weight, volume, and number of units; and
- An indication whether generic substitution has been authorized by the prescriber

Telephone orders:

- Should be accepted only under unusual circumstances;
- May be taken by an RN or LPN;
- Must be documented in the client record;
- Must be signed by the nurse taking the order;
- Requires a signed copy of the order from the physician; and
- May not be refilled if the physician's order is not signed.

Protocol or Standing Orders for medications:

There are many online resources for the development of protocols or standing orders. These include *A Standard Guide for Nursing Protocols* developed by the University of Wisconsin and *Guidelines for Nurse Protocols* developed by the Georgia Department of Health. At a minimum, protocols or standing orders should address:

- Name of medication;
- Strength of medication (as per age, weight, condition, etc.);
- Frequency medication is to be taken (as per condition, etc.);
- Exact dosage (as per age, weight, condition, etc.);
- Quantity of medication;
- Method of administration (as per age or condition, etc.);
- Permission to refill;
- Condition for which the medication would be dispensed. Example: for client who has positive gonorrhea culture (GC);
- Date signed;
- Signatures, name, address, and telephone number of the collaborating physician and the collaborating RN;
- In most instances, it is recommended that standing orders be reviewed/renewed at least once a year.

The copies of the applicable protocol or standing orders should be available at each clinic and in the health unit office for immediate reference. The original should be kept in a permanent file.

2. Assess Client

Assess the client's condition including:

- Need for medication;
- Contraindications, i.e., allergic reactions;

- Signs and symptoms of side effects; and
- Compliance with treatment.

Medication should NOT be provided if in the registered nurse's judgment:

- Client's condition contraindicates further medication until the nurse has conferred with the physician;
- The patient's/family's ability to be responsible for a quantity of medications is highly questionable. The physician should be consulted;
- The label is inaccurate on pre-labeled medications. In this case, the nurse should consult with the person who dispensed the medication;
- The physician's order is unclear, incomplete, or questionable. The nurse should consult with the physician to clarify order before making the decision whether to provide the medication or refer to the physician;
- Medication is outdated, obviously contaminated, or otherwise compromised; and
- Medication has not been stored properly.

3. Label Medication

The Missouri Nurse Practice Act (20CSR 2200-4.200 (2) (G)2.) requires that nurses in a collaborative practice arrangement follow the pharmacy statute RSMo339.05 for the labeling of medications being dispensed.

It states that the label must contain:

- Date medication dispensed;
- Sequential number;
- Client name;
- Prescriber's direction for usage including frequency and route of administration;
- Prescriber's name;
- Name and address of the agency dispensing;
- Name and strength of the drug dispensed;
- Quantity dispensed; and
- Number of times refillable, if appropriate or the words "no refill."
- When a generic substitution is dispensed, the name of the manufacturer or an abbreviation thereof shall appear on the label or in the pharmacist's records as required in section 338.100.

The label must be checked against the order and manufacturer's label on package and affixed by an R.N., physician, or pharmacist.

EXAMPLE

Agency.....	
Address.....	
Ph. No.....	Seq. No.....
Client's Name.....	
Medication & Strength.....	
Date dispensed.....	No. Disp.....
Dr.....	
Directions.....	
	Refill x 1 (if applicable)
KEEP OUT OF REACH OF CHILDREN	

A label must be affixed to each individual container to be given to the client. If a bottle is in a box, the label must be affixed to the bottle. When blister packets are dispensed, the label may be attached to envelope or box. It is recommended that the label also be reinforced with transparent tape. The label must be affixed so the name of the manufacturer and the manufacturer's expiration date are visible.

All medications should be dispensed in childproof containers. Blister packets are considered childproof.

4. Document In Dispensing Record

The Missouri Nurse Practice Act (20CSR 2200-4.200 (2) (G)6.) requires that nurses in a collaborative practice arrangement have “retrievable dispensing logs for all prescription drugs dispensed and shall include all information required in state and federal statutes, rules and regulations”. State regulations 20 CSR 2220-2017 outlines the requirements that must be followed for dispensing medications by pharmacists, but provide a guide to the local public health agency for dispensing medications. Any RN dispensing medications should maintain required records for security, storage, and accountability. This includes:

- Date the medication was prescribed and the date of initial dispensing
- A unique sequential labeling number
- If applicable, a unique readily retrievable identifier
- Name of the patient
- Prescriber's name
- Name, strength, and dose of the drug
- The number of refills authorized
- Quantity dispensed
- Date of refill, if any
- The RN responsible for reviewing the accuracy of the data on each original prescription
- The identity of the RN reviewing the final product prior to dispensing

- Whether generic substitution has been authorized by the prescriber
- Any changes or alterations made to the prescription based upon contact with the prescriber.

All medications dispensed from a local public health agency should be kept in a secure location, labeled, sequentially numbered, and logged.

Medication Log

A log is to be established as a continuous record for accountability of all medications dispensed to clients of the health unit;

Each page of the log must be retained for five years from the last entry date on the page;

A separate log may be established for clinics held away from the health unit or that are held simultaneously;

All logs are considered confidential information and should be handled accordingly;

The log for STD medications should be handled with the same confidential procedure as other STD records; and

When separate logs are kept, a central record should be kept on where the logs are located and what groups are recorded in each log.

The log shall contain:

- Sequential number;
- Client's name;
- Name of medication;
- Manufacturer and lot number;
- Strength and quantity of medication;
- Name of dispensing medication; and
- Date medications dispensed

5. Provide Information To Client

The following information should be given to the client family:

- Condition for which the medication has been prescribed;
- Effects of medication, expected and untoward actions;
- How, when, what, and amount of medication to take;
- Other factors as indicated by client need and type of medication;
- When, who, and where to contact in case of an adverse reaction;
- Other appropriate interventions as indicated by the assessment; and
- Warning to keep the medications out of the reach of children.

5. Check Medication

Before the client/family leaves with the medication, check the following:

- The medication manufacturer's label, including expiration date, against the physician's written order;
- The sequential number and medication have been logged; and

- The label is complete and correct.

6. Document In Client's Record

The following must be recorded in client's record:

- Findings of assessment which indicate or contraindicate need for medication. If medication is not dispensed, the reason why;
- Reference to medical order. Individual orders are to be kept in the client record. Protocols or standing orders are to be kept on permanent file with updates and changes. The protocol should be referenced in the client record documentation or a copy of the protocol be included in the record;
- Name of medication dispensed, strength, dose, route, frequency, and amount dispensed;
- Sequential number (optional);
- Signature of registered nurse dispensing medication; and
- Current date

7. Electronic Record Keeping

The Pharmacy statutes at 20 CSR 2220-2.080 define the requirements for maintaining prescription data in an electronic system. It is recommended that the LPHA follow these requirements to the extent that they are applicable in the public health setting. In part, it requires the following information concerning the original filling or refilling of any prescription:

- A A unique, sequential prescription label number;
- B Date the prescription was prescribed;
- C The date the prescription was initially filled and the date of each refill;
- D Patient's full name;
- E Patient's address
- F Prescriber's full name;
- G Name, strength and dosage of drug, device or poison dispensed, and any directions for use;
- H Quantity originally dispensed;
- I Quantity dispensed on each refill
- J Identity of the pharmacist responsible for verifying the accuracy of prescription data prior to dispensing on each original prescription (editor's note: for the LPHA, an RN can fulfill this activity for certain medications);
- K Identity of the pharmacist responsible for reviewing the final product prior to dispensing, on each original and refill prescription if different from the pharmacist verifying the prescription data (editor's note; for the LPHA, an RN can fulfill this activity for certain medications);
- L The number of authorized refills and quantity remaining;
- M Whether generic substitution has been authorized by the prescriber;
- N The manner in which the prescription was received by the pharmacy (editor's note: or LPHA) (e.g. written, telephone, electronic, or faxed); and

- O Any other change or alteration made in the original prescription based on contact with the prescriber to show a clear audit trail. This shall include, but is not limited to, a change in quantity, directions, number of refills, or authority to substitute a drug.

Resources

20 CSR 2150-5.020-Nonpharmacy Dispensing

<http://s1.sos.mo.gov/cmsimages/adrules/csr/previous/20csr/20csr0712/20c2150-5.pdf>

20 CSR 2220-2.080 Electronic Prescription Records

www.sos.mo.gov/cmsimages/adrules/main/agency/20csr/20c2220-2.doc

20 CSR 2200-4.200 Collaborative Practice Rule, Chapter 335 RSMo-State of Missouri Nursing Practice Act <http://pr.mo.gov/boards/nursing/npa.pdf>

Student Nurse Recommended Guidelines

❖ Responsibilities of the Local Public Health Agency as Clinical Experience

Determine if the request to provide student experience is reasonable and appropriate. The educational objectives, focus of the nursing program, type of experience, and resources of the LPHA should be considered when making the decision.

1. Educational Objectives and Purpose

An appropriate learning experience should meet the objectives and purpose of the program and occur at an appropriate place in the curriculum. The LPHA and the faculty of the nursing program should work together to determine the most appropriate type of experience for the level of students and curriculum objectives. For instance, if the objective is to acquaint the student with the functions of the LPHA, an hour presentation and tour of the agency may be a better choice than an observational experience.

2. Types of Nursing Programs

There are various types of nursing education programs. Each type of program has specific focus for the preparation of students.

- Licensed Practical Nurse (LPN): focus is on commonly occurring health problems with predictable outcomes.
- Diploma: focus is on illness-related care.
- Associate Degree in Nursing (ADN): focus is on care of well-defined health problems of an individual.
- Bachelor of Science in Nursing (BSN): focus on the wellness-illness continuum of an individual, family, and community. Curriculum includes information about concepts of public health, epidemiology, community assessment, and health promotion.
- Master of Science in Nursing (MSN): focus on critical thinking, research, and expanded role of nurse. Students in these programs may be studying to be nurse practitioners.

3. Type of Experience Requested

There are several types of experiences the LPHA may provide for a nursing education program:

- **Clinical Experience:** The student has client contact and assumes nursing care responsibilities. A clinical experience requires a memorandum of agreement between the nursing program and the LPHA. This type of experience is most appropriate for students in BSN or MSN programs.
- **Observation Experience:** The student observes a particular function of the LPHA. This experience usually does not last more than three days. The student observes while the nurse or other staff performs specific activities. A written cooperative agreement is not necessary. In general, students should not be permitted into sensitive situations, or have access to the client's record. A statement of

confidentiality should be signed before the observation and the clients should be asked if they object to being observed.

- **Classes and Consultation:** The LPHA provides information about public health and public health nursing or services provided by the agency.

4. **Resources Available**

- Resources such as willingness of LPHA staff to work with students, skills and competencies of staff, services being provided in the LPHA, and ability of health department to participate in education while continuing to provide quality services to community should be considered.
- Provide orientation about policies and programs of the LPHA to the nursing program faculty.
- Provide competent and qualified supervisory and professional nursing personnel to assist with agreed upon guidance, supervision, and evaluation of students.
- Have written policies and procedures in place. Students are required to follow the policies of the LPHA.
- Assure students have been informed about HIPAA confidentiality requirements and have signed confidentiality statements.
- Collaborate with the faculty member in selection of specific educational experiences.
- Provide agreed upon physical space for the faculty member and students to have conferences and workspace.

❖ Responsibilities of the Nursing Program

- Provide the LPHA with information about the nursing program and educational objectives of the student experience.
- Provide adequate supervision, guidance and evaluation of students by faculty member who is oriented to the LPHA, and collaborate with LPHA staff to select experiences for students.
- Meet with LPHA staff before, during, and following the educational experience to evaluate the learning experience and plan for the future. Agreement should be reached regarding the number of students and assigned schedule.
- Provide documentation that the students and faculty have professional liability insurance coverage.
- Advise the LPHA as to the plan for student's emergency medical care while assigned to the LPHA.

❖ Memorandums of Agreement between LPHA and Nursing Programs

The purpose of a memorandum of agreement with a nursing program is to define lines of authority and the professional responsibilities of the involved parties. The agreement is written and signed and should be reviewed annually. The agreement should include:

- Parties involved in the agreement;
- Responsibilities of the educational institution;
- Responsibilities of the local agency;
- Responsibilities of the students;
- Joint responsibilities;
- Liability coverage of faculty and students independent of the health agency;
- Confidentiality guidelines;
- Notice necessary to terminate the agreement; and
- Any other items needed for the protection of the client/family, students, local agency, and nursing program.

The Missouri Public Health Nursing Preceptor Handbook (2006) can provide more information and sample resource materials available for preceptor, agency, and educational institution at: [Public Health Nursing Preceptor Handbook](#)

Resources

The Missouri Public Health Nursing Preceptor Handbook
<http://health.mo.gov/living/lpha/phnursing/preceptor.pdf>

Guidelines for Reducing Liability Risk

Maintain open, honest, respectful relationships and communication

- Do not offer opinions if someone asks what you think is wrong; you may be accused of making a medical diagnosis
- Do not make a statement that may be interpreted as an admission of fault or guilt
- Do not criticize health care providers or their actions
- Maintain confidentiality

Maintain competence in your specialty area of practice

- Attend relevant continuing education classes
- Expand your knowledge and skills
- Read professional literature

Know legal principles and incorporate them into everyday practice

- Know your nursing practice act and other laws that affect nursing practice; function within those constraints
- Follow established standards of practice
- Keep up-to-date on your agency's policies and procedures
- Use the ANA's *Code of Ethics for Nurses* to solve an ethical dilemma

Practice within the bounds of professional licensure

- Perform only the skills allowed under your scope of practice and that you are competent to perform.
- Always document your actions as they apply to your practice setting.
- Know who to contact and what to do if licensed or unlicensed practitioners violate the nurse practice act. Remember, you have an obligation to uphold the state nurse practice act and to see that others likewise uphold the act.
- Delegate appropriately. You must consider the task being delegated, the patient, and the person being delegated to. You can delegate a task, but not nursing assessment or judgment. (Croke, 2003)

Recommended Policies

Local public health agencies should have written comprehensive policies and procedures. There should be policies and procedures for clinical activities, as well as other issues. Each agency should determine what policies are necessary to manage specific problems and issues. The following nursing related policies are recommended to be included in each local public health agency policy manual.

- ❖ **Medical Procedures/Services:** All medical services provided should include a policy and procedure. Include how the agency will handle orders from other licensed providers such as nurse practitioners or physician assistants.
- ❖ **Admission and Discharge of Clients:** Procedure to follow when admitting clients or discharging clients from service.
- ❖ **Documentation:** Policy regarding requirements for documentation in client record, including who must document, what should be documented, where documentation is made, format of documentation, time limits, and approved abbreviations and acronyms. For agencies with electronic health records (EHRs), specific policies regarding the use of **EHRs** should be included.
- ❖ **Emergency Response Requirements:** The policy should include what is expected of nursing staff when responding to a public health emergency within the county, in support of other counties, and participation in the Show-Me Response registry.
- ❖ **Informed Consent:** Policy stating when to obtain informed consent and procedure to follow within the agency. This activity must be in compliance with HIPAA statutes and regulations.
- ❖ **Job Descriptions:** There should be a job description for each employee and volunteer in the agency, outlining the specific duties of the position.
- ❖ **Liability Insurance:** A written policy outlining the liability protection provided to nursing staff through the insurance policy of the agency, any requirement for nurses to purchase individual malpractice insurance, and how documentation of malpractice insurance will be maintained.
- ❖ **Protection of Staff with Direct Patient Contact:** The policy should include information on universal precautions including the utilization of personal protective equipment, education on safety issues, handling and packaging of specimens, infection control within the agency, and education required by Occupational Safety & Health Administration (OSHA) guidelines.
- ❖ **Professional Development:** Guidance on the expectation for nursing staff regarding participation in continuing education and documentation of continuing education

- activities. The type of acceptable continuing education, any amount of continuing education, and any financial support for academic (for example degree completion) continuing education, as well as more traditional continuing education activities such as attendance at conferences, should be included.
- ❖ **Release of Information:** Policy stating when to obtain release of information and procedure to follow within the agency.
 - ❖ **Reporting of Abuse and Neglect:** Procedure to follow when staff suspects a child or adult is the victim of abuse and/or neglect. Policy needs to follow current state statute (RSMo210.115)
 - ❖ **Reporting Incompetent, Unethical, or Illegal Behavior:** Procedure to follow to report incompetent, unethical, or illegal behavior of co-worker.
 - ❖ **Risk Management:** Procedure to follow when a risk situation such as needle stick, medication errors, or an injury or accident occurs.
 - ❖ **Services Provided by Agency:** Procedure/guidelines for determining if requested services will be provided by the agency. Includes things such as level of care or type of service required, skills and competencies of staff, and type of reimbursement available.
 - ❖ **Social Media:** There should be policies governing employee use of electronic and social media in the workplace.
 - ❖ **Patient Confidentiality:** There must be written policies and procedures that are consistent with the HIPAA Privacy Rule. This includes, but not limited to, workforce training, mitigation of the effect caused by disclosure of protected health information, safeguards for written and electronic health data, addressing complaints, etc.
 - ❖ **Student Nurses:** Policy regarding students working in agency, including responsibilities of staff, confidentiality statements, and responsibility of faculty.
 - ❖ **Verification of Nurse Licenses:** Missouri is now part of the Nurse Licensure Compact, which recognizes licensure from other compact states and no longer provides a licensure document with an expiration date. A policy should outline who is responsible for the required verification of licensure, when the verification will be conducted, and how the documentation will be maintained. This verification can be done automatically at Nursys.com.

Guidelines for Developing Policies and Procedures

The performance of clinical procedures is “governed” by written policies. Policies outline the steps you should follow in a particular situation and usually provide an explanation of why it is important to proceed in the outlined manner.

The format of policies and procedures is usually a policy statement which states the agency’s belief regarding a specific issue and a procedure portion which states what action is to be taken, who is responsible, and what documentation is necessary. Procedures should be written to provide for discretions to be exercised by nurses as they consider the facts of specific situations and are not absolute rules.

1. Write the policy as clear as possible. Use consistent terminology and define terms to ensure clarity. i.e., is a nurse an RN, LPN, etc.
2. Base the policy and procedure on current and accurate knowledge and national standards.
3. Avoid using the words “responsible for” as that may impose strict or automatic liability even when it is appropriate to delegate a task to another. Better language is: “The RN or a designee...” This permits the RN to delegate a task to another individual.
4. Review each policy periodically and ensure that the written statement is consistent with the current practice within your agency. Policies should be dated to reflect when they became effective and when any revisions were made. Outdated policies should be maintained for the same period of time in which other medical records are kept for purposes of potential legal actions.
5. Make it clear that the written policy cannot be overridden by verbal changes. All changes should be in writing and approved by the appropriate people.
6. Make sure all involved staff are advised of policy changes, and review all policies on a routine basis.
7. Make sure policies are available to all staff at all times.
(Feutz-Harter, 2012)

HIPAA

DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES [45 CFR 164.512(b)]

The following information is available from the U.S. Department of Health and Human Services <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

Background

The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

How the Rule Works

General Public Health Activities. The HIPAA Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(1)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CFR 164.512(b)(2).

A “public health authority” is an agency or authority of the United States government, a state, a territory, a political subdivision of a state or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501. Examples of a public health authority include state and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and OSHA.

Generally, covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual’s authorization, or for disclosures that are required by other law. See 45 CFR 164.502(b). For disclosures to a public health authority, covered entities may reasonably rely

on a minimum necessary determination made by the public health authority in requesting the protected health information. See 45 CFR 164.514(d)(3)(iii)(A). For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of protected health information that may be disclosed for such purposes. See 45 CFR 164.514(d)(3)(i). All covered entities must:

- Develop and implement written privacy policies and procedures that are consistent with the HIPAA Privacy Rule.
- Designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.
- Train their workforce, including employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity). A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violated its privacy policies and procedures or the HIPAA Privacy Rule.
- Mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the privacy rule.
- Maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the HIPAA Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.
- Have procedures for individuals to complain about its compliance with its privacy policies and procedures and the HIPAA Privacy Rule. The covered entity must explain those procedures in its privacy practice notice.
- May not retaliate against a person for exercising rights provided by the HIPAA Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the HIPAA Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.
- Must maintain, until six years after the latter of the date of their creation or last effective day, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the HIPAA Privacy Rule requires to be documented.

Other Public Health Activities. The HIPAA Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Accordingly, the rule permits covered entities to disclose protected

health information, without authorization, to such persons or entities for the public health activities discussed below.

Child abuse or neglect. Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the HIPAA Privacy Rule would permit a covered entity to report such cases to that authority without obtaining individual authorization. Likewise, a covered entity could report such cases to the police department when the police department is authorized by law to receive such reports. See 45 CFR 164.512(b)(1)(ii). See also 45 CFR 512(c) for information regarding disclosures about adult victims of abuse, neglect, or domestic violence.

Quality, safety, or effectiveness of a product or activity regulated by the FDA. Covered entities may disclose protected health information to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to,:

- Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
- Tracking FDA-regulated products;
- Enabling product recalls, repairs, replacement, or lookback (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of lookback); and
- Conducting post-marketing surveillance.

See 45 CFR 164.512(b)(1)(iii). The “person” subject to the jurisdiction of the FDA does not have to be a specific individual. Rather, it can be an individual or an entity, such as a partnership, corporation, or association. Covered entities may identify the party or parties responsible for a FDA-regulated product from the product label, from written material that accompanies the product (known as labeling), or from sources of labeling, such as the Physician’s Desk Reference.

Persons at risk of contracting or spreading a disease. A covered entity may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations. For example, a covered health care provider may disclose protected health information as needed to notify a person that (s)he has been exposed to a communicable disease if the covered entity is legally authorized to do so to prevent or control the spread of the disease. See 45 CFR 164.512(b)(1)(iv).

Workplace medical surveillance. A covered health care provider who provides a health care service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of state laws having a similar purpose. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(1)(v).

You can find additional information at:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

Good Samaritan Law

Sections 537.037, RSMo, (1988) of the Missouri Statutes are commonly referred to as the “Good Samaritan Law.”

This legislation applies to physicians, surgeons, registered professional nurses, licensed practical nurses, and licensed mobile emergency medical technicians in situations when aid is given in an emergency or accident and occur outside of a health care setting.

When any of the above health care providers render, in good faith, emergency care or assistance at the scene of an emergency or accident, no liability may be imposed for any civil damages arising from acts or omissions in rendering such emergency care. There is no protection, however, for gross negligence or willful or wanton acts or omissions. Thus, it should be noted that this legislation is only applicable if the care is rendered without compensation.

This law further protects the rendering of emergency care or assistance to any minor involved in any accident, injured in competitive sports, or affected by any other emergency at the scene of an accident without first obtaining the consent of a parent or guardian. Again, there is no protection from civil liability for gross negligence or willful or wanton acts or omissions. (Section 537.037.1 RSMo, 2015)

Resources

Sheryl Feutz-Harter. (2012). Legal & Ethical Standards for Nurses. Professional Education Systems, Inc. Health Care Manual

Nursing Practice Act & Code of State Regulations

Nurses, like other licensed professionals, are regulated by various state laws. One important state law that directly affects the practice of nursing is the Nursing Practice Act. Nursing practice acts originated to protect the public from unsafe and unlicensed practice, by regulating nursing practice and nursing education. Nursing practice acts define nursing, set standards for the nursing profession, and give guidance regarding scope of practice issues. As such, the state Nursing Practice Act is the **single most important piece of legislation affecting nursing practice.**

Nursing practice acts are not checklists. They contain general statements of appropriate professional nursing actions. The nurse must incorporate the Nursing Practice Act with his or her educational background, previous work experience, institutional policies, and technological advancements. The main purpose of nursing practice acts is to protect the public from unsafe practitioners, and the ultimate goal is competent, quality nursing care provided by qualified practitioners.

Nurses have an ethical and legal responsibility to maintain the currency of their practice in today's changing health care system and to be familiar with the Nursing Practice Act.

The Missouri State Board of Nursing provides access to the Missouri Nursing Practice Act and Rules (2014) at <http://pr.mo.gov/boards/nursing/npa.pdf>

Resources

Brent, Nancy. (2001). Nurses and The Law, A Guide to Principles and Applications. W.B.Saunders Company.

Missouri State Board of Nursing, Nursing Practice Act and Rules (2014)
<http://pr.mo.gov/boards/nursing/npa.pdf>

Negligence and Malpractice

The terms negligence and malpractice are frequently used interchangeably. However, there is a difference in the two terms.

Negligence is:

- “Legal cause of action involving failure to exercise the degree of diligence and care that a reasonable and ordinarily prudent person would exercise under the same or similar circumstances.” (Feutz-Harter, 2012)

Anyone, including non-medical persons, can be liable for negligence.

Malpractice is:

- “Professional negligence. In medical terms, malpractice is the failure to exercise that degree of care as is used by reasonably prudent health care providers of like qualification in the same or similar circumstances. The failure to meet this acceptable standard of care must cause or contribute to the patient injury to result in liability.” (Feutz-Harter, 2012)

Neglect and malpractice apply both to the person providing the care and to those supervising. This means malpractice can include duties that were delegated by the nurse. Organizations and management can also be liable if appropriate supervision, policies, procedures, and training are not in place.

Neglect and malpractice are torts under civil law. In a tort claim, the plaintiff must prove four elements: duty, negligence/malpractice, causation of injury, and damages.

- Duty - Duty refers to the establishment of a nurse-patient relationship. Duty is assumed in a number of ways including assignment, awareness of need for an unassigned patient, or observation of inadequate/inappropriate care. (See the Good Samaritan law for exceptions/protections related to duty.)
 - Neglect/malpractice – Nurses are held to the current established standards of care. Examples of standards of care include documents like ANA’s *Nursing Scope and Standards of Practice*, accreditation standards, national organizations standards, and organizational policies.
 - Causation of injury - Injury must be caused by the alleged act or omission in order to establish neglect/malpractice.
 - Damages - Damages can be physical, financial, or emotional, and include both past and future losses.
- (Feutz-Harter, 2012)

Missouri Statutes to be aware of related to malpractice include:

- RSMo 538.225.1 – Plaintiff’s requirements for an affidavit by a health care provider.
<http://www.moga.mo.gov/mostatutes/stathtml/53800002251.html?&me=538.225.1>
- RSMo 516.105.1 – Actions against health care providers (medical malpractice), statute of limitations.
<http://www.moga.mo.gov/mostatutes/stathtml/51600001051.html?&me=516.105.1>
- RSMo 537.037 – Good Samaritan Law
<http://www.moga.mo.gov/mostatutes/stathtml/53700000371.html?&me=537.037>

Nurse Licensure Compact

Missouri's Nurse Licensure Compact (NLC) became effective on June 1, 2010. Missouri Legislature passed Senate Bill 296, the Nurse Licensure Compact Act, during the 2009 legislative session. The Nurse Licensure Compact is a mutual recognition model of nurse licensure that allows a nurse to have one license, issued by the state in which the nurse claims primary residence, and to practice (physical or electronic) in all states that have entered into the interstate compact (multi-state licensure). This model of mutual recognition was developed by the National Council of State Boards of Nursing (NCSBN) to facilitate practice and regulation.

Similar to a driver's license, a multi-state nursing license allows a nurse who is licensed in one compact state (called a home state) to legally practice in another compact state (called a remote state). The NLC requires the nurse to adhere to the practice laws and rules of the state in which the patient(s) receive care.

The NLC includes registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVNs). The NLC does not include Advanced Practice Registered Nurses (APRNs) or IV authority for LPNs/LVNs.

- All APRNs who want to practice in Missouri must obtain a Missouri document of recognition.
- All LPNs who want to practice IV therapy in Missouri must obtain IV authority from the Missouri State Board of Nursing.

Twenty-four (24) states as of 2015 belong to the NLC: Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. Contact information for compact states and to view a map of compact states, visit www.ncsbn.org/nlc.

Employers should verify whether a nurse's license is designated as a single-state or multi-state license. Nurses working in Missouri under a multi-state license are not required to notify Missouri State Board of Nursing, so verification for nurses working in Missouri under licenses from compact states should be verified through NURSYS at www.nursys.com, rather than the Missouri State Board of Nursing. There is NO fee for this service. Employers can verify a nurse's license and receive a Licensure Quick Confirm report which will contain the nurse's name, jurisdiction, license type, license number, compact status (multistate/single state), license status, expiration date, discipline against license, and discipline against privilege to practice.

335.075 RSMo Missouri requires verification of nursing licenses:

1. Before hiring a registered nurse, licensed practical nurse, or advanced practice registered nurse in Missouri, an employer shall verify that the applicant has a current, valid license to practice nursing under chapter 335. This section shall not apply for employment which does not require the possession of a current, valid license to practice nursing.

2. Employers shall have a process in place to verify licensure status of each registered nurse, licensed practical nurse, or advanced practice registered nurse coinciding with the license renewal.

For information regarding nursing licensure and practice in the state of Missouri, go to the Missouri State Board of Nursing at: <http://pr.mo.gov/nursing.asp>

Reporting Child Abuse and Neglect

Child Abuse/Neglect Reports by Mandated Reporters

Reporting Requirement (210.115.1 – 210.115.3 RSMo)

“210.115. 1. When any physician, medical examiner, coroner, dentist, chiropractor, optometrist, podiatrist, resident, intern, nurse, hospital or clinic personnel that are engaged in the examination, care, treatment or research of persons, and any other health practitioner, psychologist, mental health professional, social worker, day care center worker or other child-care worker, juvenile officer, probation or parole officer, jail or detention center personnel, teacher, principal or other school official, minister as provided by section 352.400, peace officer or law enforcement official, or other person with responsibility for the care of children has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report to the division in accordance with the provisions of sections 210.109 to 210.183. No internal investigation shall be initiated until such a report has been made. As used in this section, the term "abuse" is not limited to abuse inflicted by a person responsible for the child's care, custody and control as specified in section 210.110, but shall also include abuse inflicted by any other person.

2. If two or more members of a medical institution who are required to report jointly have knowledge of a known or suspected instance of child abuse or neglect, a single report may be made by a designated member of that medical team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter immediately make the report. Nothing in this section, however, is meant to preclude any person from reporting abuse or neglect.

3. The reporting requirements under this section are individual, and no supervisor or administrator may impede or inhibit any reporting under this section. No person making a report under this section shall be subject to any sanction, including any adverse employment action, for making such report. Every employer shall ensure that any employee required to report pursuant to subsection 1 of this section has immediate and unrestricted access to communications technology necessary to make an immediate report and is temporarily relieved of other work duties for such time as is required to make any report required under subsection 1 of this section.” (Section 210.115.1 RSMo, 2015)

Reasonable cause to suspect means a standard of reasonable suspicion, rather than conclusive proof. When a person is required to report in an official capacity as a staff member of a medical institution, the person in charge shall be notified. That person in charge becomes responsible for immediately making or causing a report to be made. This is not meant to relieve anyone of their responsibility from making a report. A report may also be made to any law enforcement agency or juvenile office, although this does not take the place of making a report to the Child Abuse/Neglect Hotline.

Section 210.109.3, RSMo, states mandated reporters may not make child abuse/neglect (CA/N) reports anonymously provided the reporter is informed that reporter information will be held as confidential.

Abuse is defined as: "...Any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse."

Neglect is defined as; "...Failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for the child's well-being."

Those responsible for the care, custody, and control of the child are defined as: "...Those included but not limited to the parents or guardian of a child, other members of the child's household, or those exercising supervision over a child for any part of a 24 hour day. It shall also include any adult, who, based on the relationship to the parents of the child, members of the child's household or the family, has access to the child."
(Section 210.110 RSMo)

Reporting Procedure/Child Abuse/Neglect Hotline Unit Response

Reports are to be made immediately to the 24 hour, 7 day a week Child Abuse/Neglect Hotline telephone number (1-800-392-3738 & TDD 1-800-669-8689) maintained by Children's Division. The hotline is staffed by trained Children's Service Workers whose responsibility is to accept the information and make the determination that the information constitutes a child abuse/neglect report. The screening will determine that:

- The alleged victim is a child (less than eighteen (18) years-old) at the time of the hotline call;
- Whether or not the person who is alleged to have abused the child was "responsible for the care, custody, and control" of the child at the time of the incident;
- The alleged abuse or neglect is having an adverse effect on the child;
- The incident occurred in Missouri;
- The report meets the definition of abuse or neglect as defined by law; and
- Identifying information is available to locate the child/family.

The following information, if available, should be provided when making a report:

- The name, address, present whereabouts, sex, race, and birth date or estimated age of the reported child or children and of any other children in the household;
- The name(s), address(es), and telephone number(s) of the child's parent(s), or other person(s) responsible for the child's care;
- The name(s), address(es), and telephone number(s) of the person(s) alleged to be responsible for the abuse or neglect, if different from the parent(s);
- Directions to the home, if available, when the child's address is general delivery, rural route, or only a town;

- Other means of locating the family;
- Parents'/alleged perpetrators' place of employment and work hours, if known;
- The full nature and extent of the child's injuries, abuse, or neglect, and any indication of prior injuries, including the reason for suspecting the child may be subjected to conditions resulting in abuse or neglect;
- Any event that precipitated the report;
- Adverse reactions to the child(ren);
- An assessment of the risk of further harm to the child and, if a risk exists, whether it is imminent;
- If the information was provided by a third party, or if there were witnesses, the identity of that person(s);
- The circumstances under which the reporter first became aware of the child's alleged injuries, abuse or neglect;
- The action taken, if any, to treat, shelter, or assist the child;
- Present location of the child;
- Whether the subjects of the report are aware a report is being made;
- The name, address, work and home telephone numbers, profession, and relationship to the child of the reporter;
- When was the child last seen by the reporter;
- Whether other children are in the home.

If the call is accepted as a child abuse/neglect report, the information is transmitted electronically to the county Children's Division office within a designated circuit, and an investigation or family assessment is begun immediately or initiated within 24 hours, depending on the severity of the allegations. If educational neglect is the only concern, the investigation shall be initiated within 72 hours. For the vast majority of reports, the child is seen within 24 hours.

Only juvenile officers, law enforcement or physicians can take protective custody of a child. Law enforcement officers and physicians may detain a child for 12 hours, whereas juvenile officers may detain a child for 24 hours. Immediate notification of protective custody shall be made to the juvenile court. A child is removed from the home only when the child's safety cannot be assured.

The worker completing the investigation or family assessment will contact the reporter in order to ensure that full information has been received, to obtain any additional information, and to determine the safety of the child. The mandated reporter shall be contacted when the report is sent to the county office or within 48 hours of receipt of the report. If the worker is unable to contact the reporter, the investigation or family assessment will be initiated by seeing the child. The worker shall also contact the identified Public School District Liaison in the district the alleged victim child attends school. The Public School District Liaison shall be designated by the superintendent of each school district. Investigations and family assessments are completed in 30 days. The name of the reporter is never revealed to the person named as the alleged perpetrator or to family members of the child (Section 210.150 RSMo).

Immunity/Penalties (Section 210.135 RSMo)

The law provides immunity from civil or criminal liability to those who are required to make reports with CD, any law enforcement agency, or the juvenile office in the completion of an investigation/family assessment. Immunity is provided regardless of the outcome of the investigation/family assessment; however, it does not apply if a person intentionally files a false report.

Failure to report is a Class A misdemeanor for a person who is required under the law to report. Filing a false report is also a Class A misdemeanor.
(Missouri Department of Social Services, Children's Division, 2013)

Resources

[Guidelines for Mandated Reporters of Child Abuse and Neglect](#). Missouri Department of Social Services, Children's Division.

Department of Social Services, Children's Division <http://www.dss.mo.gov>

Reporting Elder Abuse or Neglect

Vulnerable Adults

State legislation mandates protection for vulnerable adults in Missouri. Eligible adults include persons over the age of 60 who are unable to protect their own interests or adequately perform or obtain services necessary to meet essential human needs, or adults with disabilities between the ages of 18 and 59 who are unable to protect their own interests or adequately perform or obtain services necessary to meet essential human needs. Adult Protective Service laws are intended to provide a mechanism for state intervention and protection to eligible adults when it has been reported that there is a likelihood of serious physical injury or harm. Any person who has reason to suspect an eligible adult may be facing situations that present a likelihood of serious harm shall report such information to the Department of Health and Senior Services. (Section 660.250, RSMo).

The department maintains a toll-free telephone number (1-800-392-0210) for the receipt of these reports. Reports of abuse, neglect, misappropriation, or falsification of in-home clients by in-home employees are investigated by department staff. All reports and investigative findings are confidential.

If, during the initial contact, another person prevents department staff from gaining access to the alleged victim, the court may issue a warrant for entry. Eligible adults may refuse intervention or protective services; however, in determining whether or not to proceed, the department staff shall attempt to determine the decisional capacity of the reported adult. Adults with questionable capacity to consent may warrant legal intervention and the department can involve mental health professionals, physicians, law enforcement, or other professionals to assist with intervention and protection.

Definitions:

“**Abuse**,” the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm or corporation. (Section 660.250, RSMo)

“**Neglect**,” the failure to provide services to an eligible adult by any person, firm or corporation with a legal or contractual duty to do so, when such failure presents either an imminent danger to the health, safety, or welfare of the client or a substantial probability that death or serious physical harm would result. (Section 660.250, RSMo)

“**Likelihood of serious physical harm**” is defined as one or more of the following: A substantial risk that physical harm will:

- Occur because of the failure or inability of the person to provide for essential human needs. This is evidenced by acts or behaviors that have caused such harm, or which give another person probable cause to believe that such harm will be sustained.

- Be inflicted by the adult upon himself, as evidenced by recent credible threats, acts, or behaviors which have caused such harm, or which place another person in reasonable fear that the adult will sustain such harm.
- Be inflicted by another person upon the adult as evidenced by recent acts or behaviors which have caused such harm, or which give another person probable cause to believe the adult will sustain such harm.
- Occur to the adult who has suffered physical injury, neglect, sexual or emotional abuse, or other maltreatment, or use of financial resources by another person. (Section 660.250, RSMo)
- Primarily for use by prosecutors, the “Crime of Elder Abuse,” establishes three degrees of criminal abuse, including respective criminal penalties.

Who Must Report

State law requires that any person having reasonable cause to believe that there is a likelihood that, without protection, serious physical harm may occur to an eligible adult shall report information to the department.

Where statute mandates certain professionals (see below) to report, failure to report known information or filing a false report can be prosecuted as a misdemeanor offense. Likewise, a reporter (who has not participated in or benefited from mistreatment) has immunity from civil and criminal prosecution for filing a report or participating in an investigation in good faith. Anyone who makes a report pursuant to any of these laws, or who testifies in any administrative or judicial proceeding arising from the report, is immune from any civil or criminal liability, unless the person acted negligently, recklessly, in bad faith or with malicious purpose, or committed perjury.

How to Report

Report should be made to the department orally (1-800-392-0210), or in writing. The reporter should be prepared to answer the following questions to the best of his or her ability:

- The alleged victim’s name, address, telephone number, sex, age and general condition;
- The alleged abuser’s name, address, sex, age, relationship to victim and condition;
- The circumstances which lead the reporter to believe that the older person is being abused, neglected or financially exploited, with as much specificity as possible;
- Whether the alleged victim is in immediate danger, the best time to contact the alleged victim, if he or she knows of the report, and if there is any danger to the worker going out to investigate;
- The name, daytime telephone number, and relationship of the reporter to the alleged victim;
- The names of others with information about the situation;
- If the reporter is not a required reporter, whether he or she is willing to be contacted again; and
- Any other relevant information

(Missouri Department of Health and Senior Services, 2011)

Resources

Missouri Department of Health and Senior Services. *Abuse, Neglect and Financial Exploitation of Missouri's Elderly and Adults with Disabilities It is a Crime.*
<http://health.mo.gov/safety/abuse/pdf/FY11CryingEyeAR.pdf>. 2011

Reporting Concerns About In-home Services

Section 660-300.RSMo - Recipients of in-home services have added statutory protection from mistreatment by agencies authorized to provide services to them in their home. Any in-home services employee or home health employee who knowingly abuses or neglects an in-home services client shall be guilty of the crime of Elder Abuse and be subject to criminal prosecution under 565.180, 565.182, or 565.184, RSMo. Penalties of incarceration range from 15 days to life imprisonment and fines may range from \$300 to \$20,000.

Definitions

“In-home services client,” an eligible adult who is receiving services in his/her private residence through any in-home services provider agency.

“In-home services employee,” a person employed by an in-home services provider agency.

“In-home services provider agency,” a business entity under contract with the department, or with a Medicaid participation agreement which employs persons to deliver any kind of services provided for eligible adults in their private homes.

“Home health agency,” the same meaning as such term is defined in section 197.400, RSMo. (In 197.400, RSMo, home health agency is defined as “a public agency or private organization or a subdivision or subunit of an agency or organization that provides two or more home health services at the residence of a patient according to a physician’s written and signed plan of treatment.”)

“Home health agency employee,” a person employed by a home health agency.

“Home health patient,” an eligible adult who is receiving services through any home health agency.

Abuse of Services

Section 660.305, RSMo - Any in-home services provider agency or in-home services employee who puts to his/her own use or the use of the agency, or otherwise diverts from the client’s use any personal property or funds of the client, or falsifies any documents for service delivery, shall be guilty of a Class A misdemeanor.

Who Must Report

Any person having reasonable cause to believe that property or funds of an in-home

services client has been misappropriated, or has knowledge that documentation that verifies service delivery has been falsified, may report such information to the department.

Anyone who makes a report pursuant to any of these laws, or who testifies in any administrative or judicial proceeding arising from the report, is immune from any civil or criminal liability unless the person acted negligently, recklessly, in bad faith or with malicious purpose, committed perjury, or participated in or benefited from the misappropriation of funds/property.

Abuse of Funds or Property

Section 660.315. RSMo - Employees who are finally found to have abused, neglected, misappropriated funds or property, or falsified time sheets which verify service delivery for recipients of in-home services are placed on a list that prohibits employment in specific agencies within the health care industry for a period of time that is determined by the director of the Department of Health and Senior Services, or the director's designee, and will be based on several factors, such as whether the person acted recklessly or knowingly, the severity of the incident, and/or whether the person has previously been listed on the employee disqualification list. The department maintains "The Employee Disqualification List" (EDL), which contains the names of persons who have been finally determined by the department to have recklessly, knowingly, or purposely abused or neglected an in-home services client, home health patient, or facility resident, misappropriated any property or funds of an in-home client or facility resident, or falsified any documents for service delivery of an in-home services client.

This EDL is provided to other state departments upon request and to any person, corporation, or association that is licensed in Missouri as a hospital, ambulatory surgical center, home health agency, skilled nursing facility, residential care facility, intermediate care facility, or adult boarding facility, provides in-home services under contract with the department, employs nurses and nursing assistants for temporary or intermittent placement in health care facilities, or is approved by the department to issue certificates for nursing assistants' training. No person, corporation, or association who receives the EDL shall knowingly employ any person who is on the list.

Facilities

Section 198.070, RSMo - Similar statues exist to protect residents of residential care facilities, intermediate care facilities, or other nursing facilities. Reports are also registered by the department and investigations initiated within twenty-four hours. As soon as possible during the course of the investigation, department staff notifies the resident's next of kin or responsible party of the report and the investigation, and upon conclusion of the investigation, notify them whether the report is substantiated or unsubstantiated. These reports are confidential.

Any person who knowingly abuses or neglects a resident of a facility shall be guilty of a Class D felony.

What to Include in Report

Report should be made to the department orally (1-800-392-0210), or in writing and include the following:

- Name, age, address, telephone number, sex, and general condition of the adult;
- Name and address of any person responsible for the adult's care;
- Alleged abuser's name, address, sex, age, relationship to victim, and condition;
- Why the reporter believes the person is abused, neglected, or financially exploited;
- Does the alleged victim know of the report, is the danger immediate, and if there is a threat of danger for the investigator:
- Name, telephone number, and relationship of the reporter to the alleged victim; (the identity of a reporter is protected)
- Names of others with information about the situation (if possible); and other relevant information.

Required Information

In addition to information required for all reports, in-home services reports include:

- Name and addresses of the in-home services provider/home health agency;
- Name of the in-home services/home health employee;
- Name of the complainant;
- Names of any witnesses; and
- Other helpful information.

(Missouri Department of Health and Senior Services, 2011)

Mandated Reporters

Section 565.180-565.190, RSMo - Primarily for use by prosecutors, the crime of Elder Abuse, “establishes three degrees of criminal abuse, including respective criminal penalties.”

Anyone who makes a report pursuant to any of these laws or who testifies in any administrative or judicial proceeding arising from the report is immune from any civil or criminal liability unless the person acted negligently, recklessly, in bad faith or with malicious purpose, committed perjury, or perpetrated the abuse or neglect.

The following persons are mandated under state law to report elder abuse if

- He/she has reasonable cause to suspect, or has observed a senior being subjected to abuse or neglect.
- He/she has reasonable cause to believe that an in-home services client is being abused or neglected as a result of the services being provided to him/her at home.

Who Must Report

Adult Day Care Worker
Chiropractor
Christian Science Practitioner
Coroner
Dentist
Embalmer
Employee of the Department of Social Services
Employee of the Department of Mental Health
Employee of the Department of Health and Senior Services
Employee of a local Area Agency on Aging
Employee of an organized Area Agency on Aging Program
Funeral Director
Home Health Agency or Home Health Agency Employee
Hospital and Clinic Personnel engaged in examination, care, or treatment of persons
In-Home Services Owner, Provider, Operator, or Employee
Law Enforcement Officer
Long-Term Care Facility Administrator or Employee
Medical Examiner
Medical Resident or Intern
Mental Health Professional
Minister
Nurse
Nurse Practitioner
Optometrist
Other Health Practitioner
Peace Officer

Person with responsibility for the care of a person 60 years of age or older or an eligible adult

Personal Care Attendant

Pharmacist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Probation or Parole Officer

Psychologist

Social Worker

Consumer Directed Services Vendor

(Missouri Department of Health and Senior Services, 2011)

Resource

Missouri Department of Health and Senior Services. *Abuse, Neglect and Financial Exploitation of Missouri's Elderly and Adults with Disabilities It is a Crime.*

<http://health.mo.gov/safety/abuse/pdf/FY11CryingEyeAR.pdf>. 2011

The Future of Nursing

In 2008, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. A committee was formed with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing. The committee considered the obstacles all nurses encounter as they take on new roles in the transformation of health care in the United States. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act.

The Institute of Medicine (IOM) released its report in 2010, entitled *The Future of Nursing: Leading Change, Advancing Health*. This report emphasizes that if we are to end up with both better health as a nation and a better health care system, the involvement of registered nurses is essential. The IOM report formed the basis of *The Future of Nursing: Campaign for Action*, an initiative led by the RWJF and the American Association of Retired Persons (AARP) to implement the goals identified in the IOM report. The campaign envisions a health care system where all Americans have access to high-quality care, with nurses contributing to the full extent of their capabilities. The campaign seeks active participation from states, national organizations and individuals from health care, business, education, government, and philanthropic sectors to ensure that the recommendations are translated into actions that result in improved patient-centered care. Detailed information and updates about the *Campaign for Action* can be found at the website www.thefutureofnursing.org.

The IOM report has four key messages and seven recommendations.

Key messages:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Recommendations:

1. Remove scope of practice barriers.
 2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
 3. Implement nurse residency programs.
 4. Increase the proportion of nurses with a baccalaureate degree to 80% by 2020.
 5. Double the number of nurses with a doctorate by 2020.
 6. Ensure that nurses engage in lifelong learning.
 7. Prepare and enable nurses to lead change to advance health.
- (The Institute of Medicine (IOM), 2010)

For more information visit [The-Future-of-Nursing-Leading-Change-Advancing-Health](#)

More than 80 health care and nursing, business, and consumer organizations share the Centers to Champion Nursing in America's goal to transform health care through nursing. They know that nurses are instrumental to a health care system that provides seamless, accessible, quality care for every American.

There are a number of barriers preventing nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. However, to improve the current regulatory, business, and organizational conditions, the power rests not solely with nurses; government, businesses, healthcare organizations, professional associations, and the insurance industry, all must play a role. Working together, these diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes.

The Association of State and Territorial Directors of Nursing's, now the Association of Public Health Nurses, position statement endorses the recommendations in *The Future of Nursing: Leading Change, Advancing Health* and encourage all of its members to become actively engaged in the implementation of the Action Plan, including being actively involved in existing or developing Regional Action Coalitions in their states. (Association of State and Territorial Directors of Nursing (ASTDN), 2011)

Missouri was selected as an Action Coalition in September 2011, by the Future of Nursing: *Campaign for Action*, coordinated through the Center to Champion Nursing in America (CCNA). The Missouri Action Coalition, initiated by the Missouri Nurses Association, Missouri League for Nursing, and Missouri Health Advocacy Alliance, is charting a course for healthcare in Missouri. Working together, many diverse parties can help ensure the healthcare system provides seamless, affordable, quality care that is accessible for all Americans.

The purpose of the Missouri Action Coalition is to familiarize Missouri nurses and other stakeholders with the recommendations in the IOM Future of Nursing Report and develop strategies on how to make these recommendations a reality in our state, transform the healthcare system, and improve health outcomes.

In addition to the five existing teams, RN Practice, Advanced Practice, Education, Leadership, and Workplace/Workforce, two new teams have been added for Diversity and Sustainability. Consider joining one of these teams. Visit <https://mocenterfornursing.org> for more information, to join a team, and to get the schedule for conference calls and webinars.

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Missouri State Board of Nursing recognized certifying organizations

American Academy of Nurse Practitioners (NP):

<http://www.aanpcert.org>

- Adult NP
- Family NP
- Adult-Gerontology Primary Care Nurse Practitioner

American Association of Critical Care Nurses:

<http://www.aacn.org>

Specialty Certifications

- [CCRN – Acute/Critical Care Nursing \(Adult, Neonatal & Pediatric\)](#)
- [CCRN-E – Tele-ICU Acute/Critical Care Nursing \(Adult\)](#)
- [PCCN – Progressive Care Nursing \(Adult\)](#)
- [CNML – Nurse Manager and Leader](#)

Subspecialty Certifications

- [CMC – Cardiac Medicine \(Adult\)](#)
- [CSC – Cardiac Surgery \(Adult\)](#)

Advanced Practice Consensus Model Based Certifications

- [ACNPC-AG – Acute Care Nurse Practitioner \(Adult-Gerontology\)](#)
- [ACCNS – Clinical Nurse Specialist; Wellness through Acute Care \(Adult-Gerontology, Pediatric & Neonatal\)](#)

Advanced Practice Certifications

- [ACNPC – Adult Acute Care Nurse Practitioner \(Adult\)](#)
- [CCNS – Acute Care Clinical Care Nurse Specialist \(Adult, Neonatal & Pediatric\)](#)
- Acute Care Clinical Nurse Specialist (CNS)

American Nurses Credentialing Center:

<http://www.nursecredentialing.org>

Nurse Practitioner Certifications

[Acute Care NP](#)

[Acute Care NP Adult - Gerontology Primary Care NP](#)

[Adult Psychiatric–Mental Health NP](#)

[Family NP - Gerontological NP](#)
[Pediatric Primary Care NP](#)
[Psychiatric–Mental Health NP](#)
[School Nurse Practitioner](#)
Specialty NP
[Emergency NP](#)

Clinical Nurse Specialist Certifications

[Adult Health CNS](#)
[Adult-Gerontology CNS](#)
[Adult Psychiatric–Mental Health CNS](#)
[Child/Adolescent Psychiatric–Mental Health CNS](#)
[Gerontological CNS](#)
[Home Health CNS](#)
[Pediatric CNS](#)
[Public/Community Health CNS](#)

Specialty Certifications

[Ambulatory Care Nursing](#)
Cardiac Rehabilitation Nursing*
[Cardiac-Vascular Nursing](#)
Certified Vascular Nurse*
College Health Nursing*
Community Health Nursing*
Diabetes Management – Advanced*
[Faith Community Nursing](#)
Forensic Nursing
Advanced General Nursing Practice*
[Advanced Genetics](#)
Advanced [Gerontological Nursing](#)
[Hemostasis Nursing](#)
Home Health Nursing*
[Informatics Nursing](#)
[Medical-Surgical Nursing](#)
[Nurse Executive](#)
Advanced [Nursing Case Management](#)
[Nursing Professional Development](#)
[Pain Management Nursing](#)
[Pediatric CNS](#)
Perinatal Nursing *
[Psychiatric–Mental Health Nursing](#)
Advanced Public Health Nursing*
Advanced [Rheumatology Nursing](#)
[School Nursing*](#)

*Exam retired. New applications not accepted. The credential can be renewed.

National Certification Corporation:

<http://www.nccwebsite.org>

Core certification

- [Inpatient Obstetric Nursing](#) (RNC-OB)
- [Maternal Newborn Nursing](#) (RNC-MNN)
- [Low Risk Neonatal Nursing](#) (RNC-LRN)
- [Neonatal Intensive Care Nursing](#) (RNC-NIC)

Nurse Practitioner certification

- [Neonatal Nurse Practitioner](#) (NNP-BC)
- [Women's Health Care Nurse Practitioner](#) (WHNP-BC)

Subspecialties

- [Electronic Fetal Monitoring](#) (C-EFM)
- [Neonatal Pediatric Transport](#) (C-NPT)

Pediatric Nursing Certification Board:

<http://www.pncb.org>

- Pediatric Nurse
- Pediatric Emergency Nurse
- Pediatric Nurse Practitioner Primary Care
- Pediatric Nurse Practitioner Acute Care
- Pediatric Primary Care Mental Health Specialist

American Midwifery Certification Board:

<http://www.amcbmidwife.org>

- Certified Nurse Midwife
- Certified Midwife
- Certified Professional Midwife

Council on Certification of Nurse Anesthetists:

<http://www.nberna.com>

- Certified Registered Nurse Anesthetist

Resources

Missouri State Board of Nursing. (2010). APRN Certifications for New Applicants. Retrieved from Professional Registration: July, 2013:

<http://pr.mo.gov/boards/nursing/APRN%20RECOGNIZED%20SPECILITIES.pdf>

American Nurses Association, Advanced Practice Nurses:

<http://www.nursingworld.org/EspeciallyForYou/AdvancedPracticeNurses>

American Nurses Association, Scope of Practice for APRNs:

<http://www.nursingworld.org/EspeciallyForYou/AdvancedPracticeNurses/Scope-of-Practice-2>

Resources

❖ Professional Development for Public Health Nurses

1. **Heartland Center Learning Management System** (free online enrollment)

<http://www.heartlandcenters.com/>

Catalog Topic areas related to public health:

- Community Assessment/Community Health Improvement
- Emergency Management/Preparedness
- Epidemiology/Disease Investigation
- Infectious Disease/Immunization
- Leadership/Crisis Leadership
- Policy Development & Law
- Public Health Administration/Management
- Public Health Agency Accreditation/Quality Improvement
- Public Health Nursing
- Public Health Practice

1. **Environmental Public Health Tracking Online Training**

The [Centers for Disease Control and Prevention](http://www.cdc.gov) (CDC), in partnership with the National Environmental Health Association, offers education to users about environmental public health tracking. **Environmental Public Health Tracking Online Training:** (www.neha.org/tracking.html).

2. **International Nursing Coalition for Mass Casualty Education (ICMCE)**

<http://www.nursing.vanderbilt.edu/incmce/overview.html>

4. **Federal Emergency Management Agency online training courses:**

<http://www.training.fema.gov>

Topic areas related to public health include:

- National Incident Management System (NIMS)
- Centers for Domestic Preparedness (CDP)
- Emergency Management Institute (EMI)

5. **MCH Navigator:** <http://navigator.mchtraining.net>

The MCH Navigator seeks to enhance access to currently available public health MCH learning resources by “matching” learner needs with learning paths. This initiative is intended to complement, and not be a substitute for, formal institutionally-based undergraduate or graduate education programs in maternal and child health.

❖ Free Mobile Application Tools for Public Health Nurses

HEALTH AND SAFETY

Centers for Disease Control and Prevention-Main Directory

<http://www.cdc.gov/mobile/mobileapp.html>

Centers for Disease Control and Prevention – Vaccine Schedule

<http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html>

HHS’s Find a Health Center- http://findahealthcenter.hrsa.gov/Search_HCC.aspx

– *Help clients find access to health care near by (not an app-website access)*

AIDS Info- <http://aidsinfo.nih.gov/apps>

– *Stay up to date on HIV data including outbreaks, etc.*

AHRQ ePSS- <http://epss.ahrq.gov/PDA/index.jsp>

– *Allows for searching or browsing the US Preventive Services Task Force (USPSTF) Clinical Preventative Services*

OSHA Heat Safety Tool- https://www.osha.gov/SLTC/heatillness/heat_index/heat_app.html

– *Provides the heat index for work sites and precautions to prevent heat illness*

LANGUAGE TRANSLATOR

Google Translator- <http://www.google.com/mobile/translate>

– *Translate words and phrases between more than 60 languages*

ENVIRONMENTAL HEALTH

Environmental Protection Agency’s My Green Applications-

<http://www.epa.gov/mygreenapps/>

– *Over 290 apps to help understand and protect the environment*

EMERGENCY PREPAREDNESS

Red Cross- <http://www.redcross.org/prepare/mobile-apps>

Several applications for natural disaster (tornado, hurricane, earthquake) readiness, find a shelter, and first aid

Federal Emergency Management Agency (FEMA)

<https://www.fema.gov/smartphone-app>

– *Contains preparedness information for different types of disasters, an interactive checklist for emergency kits, a section to plan emergency meeting locations, and information on how to stay safe and recover after a disaster.*

HEALTH PROMOTION

American Heart Association Walking Paths-

<http://www.startwalkingnow.org/WalkingPathApp.jsp>

- *Find and keep track of walking paths near you*

Centers for Disease Control (CDC) – Health Information

<http://www.cdc.gov/mobile/applications/cdcgeneral/promos/cdcmobileapp.html>

National Heart, Lung, and Blood Institute (NHLBI) Body Mass Index (BMI) Calculator-

<http://origin.apps.usa.gov/bmi-app.shtml>

- *Allows quick assessment of body mass index*

National Cancer Institute

- *Smoking Cessation (QuitPal)-* <http://smokefree.gov/apps-quitstart>
- *Breast Cancer Risk*
- *Colorectal Cancer Risk*

American Cancer Society, Tools and Calculators

<http://www.cancer.org/healthy/toolsandcalculators/index>

- *Exercise Calculator*
- *Calorie Counter*
- *Cigarette Calculator*

Best and Promising Practices in Public Health

- 1. Association of Maternal and Child Health Programs (AMCHP)** provides a searchable database of evidence-based best practices through “Innovation Station” that can be queried <http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/Pages/default.aspx>

Additionally, AMCHP includes other organizations’ best practice programs and topics as resources

<http://www.amchp.org/programsandtopics/BestPractices/Pages/Resources.aspx>

- 2. National Association of County and City Health Officials (NACCHO)** provides a searchable database of model best practices <https://eweb.naccho.org/eweb/DynamicPage.aspx?site=naccho&webcode=mpsearch>

- 3. The Community Toolbox** provides a resource listing of other organizations’ promising practice programs and topics as resources http://ctb.ku.edu/en/promisingapproach/Databases_Best_Practices.aspx

- 4. National Institute of Health Care Management, Promising Practices in MCH Searchable Database.** This database allows you to learn more about the MCH activities and priorities of health plans from across the country by discovering innovative programs the National Institute for Health Care Management (NIHCM) has identified over the past six years under projects funded by the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB). <http://nihcm.org/maternal-child-and-adolescent-health/promising-practices>

E-mail Lists Related to Public Health Nursing

1. Immunization Action Coalition (IAC) Express

Immunization and hepatitis A and B news you can use, published by the Immunization Action Coalition and Hepatitis B Coalition.

To Subscribe:

Go to <http://www.immunize.org/genr.d/ntn.htm>

2. MCH Alert

The MCH Alert e-mail list provides weekly updates of a broad range of resources including journal articles, recently released reports, new federal programs and initiatives, and conferences affecting the maternal and child health community. The MCH Alert is available free to anyone who is interested in current issues in maternal and child health news and policy. The MCH Alert is distributed each Friday via e-mail.

To Subscribe:

Send an e-mail message to MCHAlert-request@list.ncemch.org with SUBSCRIBE in the subject line. You do not need to enter any text in the body of your message. You will receive confirmation that the subscription is being processed and you will receive your first issue of the MCH Alert within the next week.

3. Nursing and Environmental Health

This e-mail list was created to provide nurses a forum to discuss emerging topics and pose questions regarding environmental health and nursing. You can expect to see announcements relevant to “Environment, Health and Nursing”, including: conferences, new educational materials (books, curricula, videos, etc.), continuing education programs, funding “Request for Proposals (RFPs)”, and federal and state initiatives, regulations, policies and resources (websites, organizations), as well as experiences and helpful tips to address environmental health issues in your practice setting.

To Subscribe:

Send e-mail message to listserv@listserv.cdc.gov with the text message: Subscribe Environmental Health - Nursing [*your name*].

4. Environmental Public Health Tracking Online Training

The [Centers for Disease Control and Prevention](http://www.cdc.gov) (CDC), in partnership with the National Environmental Health Association, offers education to users about environmental public health tracking. **Environmental Public Health Tracking Online Training:** (www.neha.org/tracking.html).

Nursing Organizations

American Nurses Association

8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910-3492
(301) 628-5000
fax (301) 628-5001
<http://www.nursingworld.org/>

Association of Public Health Nurses

<http://www.phnurse.org>

American Public Health Association

Public Health Nursing Section
800 I Street NW
Washington, DC 20001-3710
(202) 777-APHA
<http://www.apha.org>

Missouri Association of School Nurses (MASN)

<http://www.missourischoolnurses.org/home/homepage.htm>

Missouri League for Nursing, Inc. (MLN)

604 Dix Road
P.O. Box 104476
Jefferson City, MO 65110-4476
(573) 635-7908
<http://mlnmonursing.org>

Missouri Nurses Association (MONA)

1904 Bubba Lane
P.O. Box 105228
Jefferson City, MO 65110
(573) 636-4623
(888) 662-MONA
<http://www.missourinurses.org>

Missouri State Board of Nursing

3605 Missouri Boulevard, P.O. Box 656
Jefferson City, MO 65102-0656
(573) 751-0075
e-mail: nursing@pr.mo.gov
<http://pr.mo.gov/nursing.asp>

National Association of School Nurses

1416 Park Street, Suite A

Castle Rock, CO 80109

1-866-627-6767

(1-866-NASN-SNS)

(303) 663-2329

Fax (303) 663-0403

nasn@nasn.org

<http://www.nasn.org/Default.aspx>

National League for Nursing (NLN)

61 Broadway

New York, NY 10006

(800) 669-1656

e-mail: ninweb@nlm.org

<http://www.nln.org>

National State Boards of Nursing

676 N. St. Clair Street, Suite 550

Chicago, IL 60611-2921

(312) 787-6555

<http://www.ncsbn.org>

Sigma Theta Tau International

Honor Society of Nursing

550 West North Street

Indianapolis, IN 46202

(317) 634-8171

<http://www.nursingsociety.org/default.aspx>

Ready Web References

Licensed nurses' practice is directed by statutes and rules/regulations within their respective state; however, there may be other laws than those in Chapter 335 or 4 CSR 200 which may pertain to current licensed nurse practice activities and thereby warrant review:

- ❖ **Revised Statutes of Missouri (RSMo)**
<http://www.moga.mo.gov/mostatutes/statutesAna.html>
- ❖ **Missouri Rules/Regulations Missouri Secretary of State's Office**
<http://www.sos.mo.gov/adrules/csr/csr.asp>
- ❖ **Secretary of State Office (SOS)**
<http://www.sos.mo.gov/>
Provides access to current (code of state regulations -- csr) and proposed (Missouri register) rules/regulations
- ❖ **Missouri State Government**
<http://www.mo.gov/>
Provides access to executive, legislative, judicial, and state department information
- ❖ **Office of the Missouri State Governor**
<http://governor.mo.gov/>
Provides gubernatorial information and pertinent links
- ❖ **Professional Registration (PR)**
<http://pr.mo.gov/>
Provides access to all regulated professions in Division of Professional Registration and includes searchable directories — e.g., RN, LPN, APN
- ❖ **Missouri State Board of Nursing (MSBN)**
<http://pr.mo.gov/nursing.asp>
Includes “focus on practice” button and “advanced practice” button, along with nurse practice act and other pertinent information
- ❖ **National Council of State Boards of Nursing (NCSBN)**
<http://www.ncsbn.org>
Provides information on other state boards of nursing and has pertinent information on topics important to nursing and nursing practice
- ❖ **Prevention and Control of Communicable Diseases. A Guide for School Administrators, Nurses, Teachers, Child Care Providers, and Parents or Guardians.**
http://health.mo.gov/living/families/schoolhealth/pdf/Communicable_Disease.pdf
- ❖ **Nursing Practice Act and Rules for Missouri**
<http://pr.mo.gov/boards/nursing/npa.pdf>