

PUBLIC HEALTH NURSING MANUAL
Revised March 2006

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CHILD ABUSE & NEGLECT

RSMo 210.109 - 210.183 is state legislation that was enacted for the purpose of mandating and encouraging the reporting of child abuse to proper authorities. It places duties on certain individuals to act when child abuse is suspected. The requirement is that when such an individual 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 that would reasonably result in abuse or neglect, a report must be made to the Children's Division (formally known as Division of Family Services). If there is evidence of sexual abuse or sexual molestation of any child, the Children's Division must be notified within 24 hours.

DEFINITIONS

Abuse is defined in Missouri 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" (RSMo, 210.110).

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, medical, surgical or any other care necessary for the child's well-being.

WHO MUST REPORT

- Physicians
- Dentists
- Chiropractors
- Optometrists
- Nurses
- Hospital and clinic personnel engaged in examination, care or treatment of persons
- Mental health professionals
- Social workers
- Day care center workers or other child care workers
- Juvenile officers
- Probation or parole officers
- Jail or detention center personnel
- Teachers
- Ministers, as provided by section 352.400, RSMo.
- Peace officers or law enforcement officials
- or other persons with responsibility for the care of children

HOW TO REPORT – Missouri Child Abuse & Neglect Hotline 1-800-392-3738

Reports to the Children's Division (formally known as Division of Family Services) should be made either orally or in writing and should include the following information:

- The name and address, present whereabouts, sex, race and birth date or estimated age of the reported child and any other children in the household.
- The name, address and telephone number of the person responsible for the child's care.
- Directions to the child's home when the child's address is general delivery, a rural route or only a town.
- Other means of locating the family.
- Parents' or alleged perpetrators' place of employment and work hours, if known.
- The full nature and extent of the child's injuries, including the reason for suspecting the child has been abused or neglected.
- Any event that precipitated the report.
- An assessment of the risk of further harm to the child and, if a risk exists, whether it is imminent.
- The circumstances under which the reporter first became aware of the injuries, abuse or neglect.
- The action taken, if any, to treat, shelter, or assist the child.
- Present location of the child.
- Whether the subject of the report is aware a report is being made.
- The reporter's name, address, work and home telephone number, profession and relationship to the child.

Any report of suspected abuse or neglect should be properly documented in the child's chart and reported to supervisors according to agency policy.

SUMMARY OF THE LAW

The child abuse/neglect legislation 210.109 to 210.183, RSMo, contains several statutes that deal with various aspects of reporting. The main points of the statutes are summarized as follows:

- It is required that when any person acting in an official capacity as a staff member of a medical institution, school facility or other agency suspects child abuse or neglect, those suspicions must be reported to the person in charge of the institution. It is then this person who becomes responsible for making or insuring that such report is made appropriately;
- The law does specifically exclude from suspected child abuse or neglect the situation where a child does not receive specified medical treatment by reason of the legitimate practice of the religious beliefs of the child's parents, guardian, or others legally responsible for the child. However, this does not preclude a court hearing on whether medical services should be provided to a child whose health requires it. It is incumbent upon the health care provider to petition the court in situations where the life or well being of a child is in danger to allow the court opportunity to act on behalf of the child;
- Whenever a staff member of a medical institution suspects child abuse or neglect, the physician in charge shall be notified immediately. Color photographs of physical trauma shall be taken and if indicated, x-rays. Reproductions of the photographs and/or x-rays shall be

sent to the Children's Division (formally known as Division of Family Services) as soon as possible. No consent is required for these actions taken pursuant to the statutes;

- If a physician, police officer, or other law enforcement official believes that a child is suffering from illness or injury, or is in danger of personal harm by reason of his surroundings, and that a case of child abuse or neglect exists, a request may be initiated that a juvenile officer take the child into protective custody. If it is perceived that the child is in imminent danger or suffering serious physical harm or a threat to his life, the physician, police officer or other law enforcement official may take or retain temporary protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care. Upon taking custody, the juvenile officer of the court shall be notified immediately and the Children's Division (formally known as Division of Family Services) must be notified. Reasonable attempts must be made to advise the parents, guardians, or others legally responsible for the child's care. The law provides what actions must be taken by the juvenile court for the protection of the child;
- If there is evidence of sexual abuse or sexual molestation of any child, the Children's Division (formally known as Division of Family Services) must be notified within 24 hours;
- Immunity from any liability, civil or criminal, is afforded to any person, official or institution in making of a report, the taking of photographs, the examination of a child by a physician, dentist or nurse practitioner, the making of x-rays, the removal or retaining of a child or in cooperation with the Children's Division (formally known as Division of Family Services), law enforcement agency, or the juvenile office in their activities. However, this immunity does not extend for intentionally filing a false report, acting in bad faith, or with ill intent or acting negligently with regard to the examination of a child;
- The provider-patient confidentiality privilege does not apply to situations involving known or suspected child abuse or neglect. It does not constitute grounds for failure to report as required or permitted, or to otherwise fail to cooperate with the Children's Division (formally known as Division of Family Services) and any of its activities pursuant to this legislation. No consent is required to release information to the Children's Division when investigating suspected abuse; and
- Any person violating any provision of these sections is guilty of a Class A misdemeanor, which is punishable by fine and/or imprisonment not to exceed one year.

REFERENCE

Sheryl Feutz-Harter. (1993). Missouri Statutes Affecting Nursing Practice. Professional Education Systems, Inc.

Colleagues for Children (2000), Child Abuse and Neglect, Volume 3, No. 2

Department of Social Services, Children's Division Staff (2004)

CODE OF ETHICS FOR NURSES

Ethics is an integral part of the foundation of nursing. Nursing has a distinguished history of concern for the welfare of the sick, injured, and vulnerable and for social justice. This concern is embodied in the provision of nursing care to individuals and the community. Nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, and communities. Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession, but also to embrace them as a part of what it means to be a nurse. The Code of Ethics for Nurses developed by the American Nurses Association (ANA) makes explicit the primary goals, values, and obligations of the profession.

The ANA Code of Ethics for Nurses serves the following purposes:

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

The Code of Ethics for Nurses is available from the American Nurses Association at <http://nursingworld.org/books/>

REFERENCE

American Nurses Association (ANA), (2001), Code of Ethics for Nurses, American Nurses Association, Washington, D.C.

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, 4 CSR 200-4.200 Collaborative Practice (Nursing) or 4 CSR 150-5.100 Collaborative Practice (Healing Arts), specifies the practice boundaries of physicians and RNs or physicians and APNs engaged in written collaborative practice arrangements. You can access the Collaborative Practice Rule at <http://www.sos.mo.gov/adrules/csr/current/4csr/4c200-4.pdf>.

Collaborative practice arrangements (CPAs) are defined in state statute (334.104 RSMo) as written agreements, jointly agreed-upon written protocols, **or** written standing orders for the delivery of health care services. 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 (9) (a) through (e) RSMo]. If the RN, however, 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 collaborative practice arrangement 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 collaborative practice arrangement exists and the collaborative practice rule applies.

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) only of the collaborative practice rule (4 CSR 200-4.200). 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.

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. 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 collaborative practice arrangements, 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 collaborative practice arrangement. An example of this are several provisions regarding drug administration and dispensing behaviors in section (3) (I) of the Collaborative Practice Rule (4 CSR 200-4.200).

*NOTE: Dispensing of drugs is not authorized in the Nursing Practice Act. It is a delegated “medical act” which requires written authorization to perform. (See rule, 4 CSR 150-5.020 Nonpharmacy Dispensing which follows this section.) Either the traditional means described above, or a written collaborative practice arrangement may be used to document physician authorization to dispense.

REFERENCE:

Missouri State Board of Nursing (1998), Registered Professional Nurse/Advanced Practice Nurse Information Packet

4 CSR 150-5.020-Nonpharmacy Dispensing

4 CSR 200-4.200-Collaborative Practice Rule

Chapter 334.104-Collaborative Practice Arrangements

Chapter 335 RSMo-State of Missouri Nursing Practice Act

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. Two standing committees were developed, one representing DOH and the other representing the Local Public Health Agencies (LPHA). The DOH committee was composed of one representative from each division, center and district. The LPHA committee was composed of one local public health agency 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 LPHA nurses in their district by organizing meetings of LPHA 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 local public health agencies and the addition of nursing educators. The leadership was assigned to an

executive committee with a chair from a local public health agency. 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.

For more information about the CPHN go to
<http://www.dhss.mo.gov/LPHA/PHNursing/CPHN.html>.

DEFINITION OF PUBLIC HEALTH NURSING

Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.

Public health nursing is a systematic process by which:

1. The health and health care needs of a population are assessed in order to identify subpopulations, families and individuals who would benefit from health promotion or who are at risk of illness, injury, disability or premature death.
2. A plan for intervention is developed with the community to meet identified needs that take into account available resources, the range of activities that contribute to health and the prevention of illness injury, disability, and premature death. The plan is implemented effectively, efficiently and equitably.
3. Evaluations are conducted to determine the extent to which the intervention has an impact on the health status of individuals and the population.
4. The results of the process are used to influence and direct the current delivery of care, deployment of health resources, and the development of local, regional, state, and national health policy and research to promote health and prevent disease.

This systematic process is based on and is consistent with:

1. Community strengths, needs and expectations;
2. Current scientific knowledge;
3. Available resources;
4. Accepted criteria and standards of nursing practice;
5. Agency purpose, philosophy and objectives; and
6. The participation, cooperation, and understanding of the population.

Other services and organizations in the community are considered, and planning is coordinated to maximize the effective use of resources and enhance outcomes.

The title “public health nurse” designates a nursing professional with educational preparation in public health and nursing science with a primary focus on population-level outcomes. The primary focus of public health nursing is to promote health and prevent disease for entire population groups. This may include assisting and providing care to individual members of the population. It also includes the identification of individuals who may not request care but who have health problems that put themselves and others in the community at risk, such as those with infectious diseases. The focus of public health nursing is not on providing direct care to individuals in community settings. Public health nurses support the provision of direct care through a process of evaluation and assessment of the needs of individuals in the context of their population group. Public health nurses work with other providers of care to plan, develop, and support systems and programs in the community to prevent problems and provide access to care.

REFERENCE

American Public Health Association: *The definition and role of public health nursing: a statement of the APHA public health nursing section, March 1996 update*, Washington, DC, 1996, APHA.

DELEGATION

In order to meet the increasing need for accessible, affordable, quality health care, registered nurses (RN) 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 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.

DELEGATION DECISION-MAKING PROCESS

In delegating, the registered professional 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 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.

THE FIVE RIGHTS OF DELEGATION

1. RIGHT TASK

One that is delegable for a specific client.

2. RIGHT CIRCUMSTANCES

Appropriate patient setting, available resources, and other relevant factors considered.

3. RIGHT PERSON

Right person is delegating the right task(s) to the right person to be performed on the right person.

4. RIGHT DIRECTION/COMMUNICATION

Clear, concise description of the task, including its objective, limits and expectations.

5. RIGHT SUPERVISION

Appropriate monitoring, evaluation, intervention, as needed, and feedback.

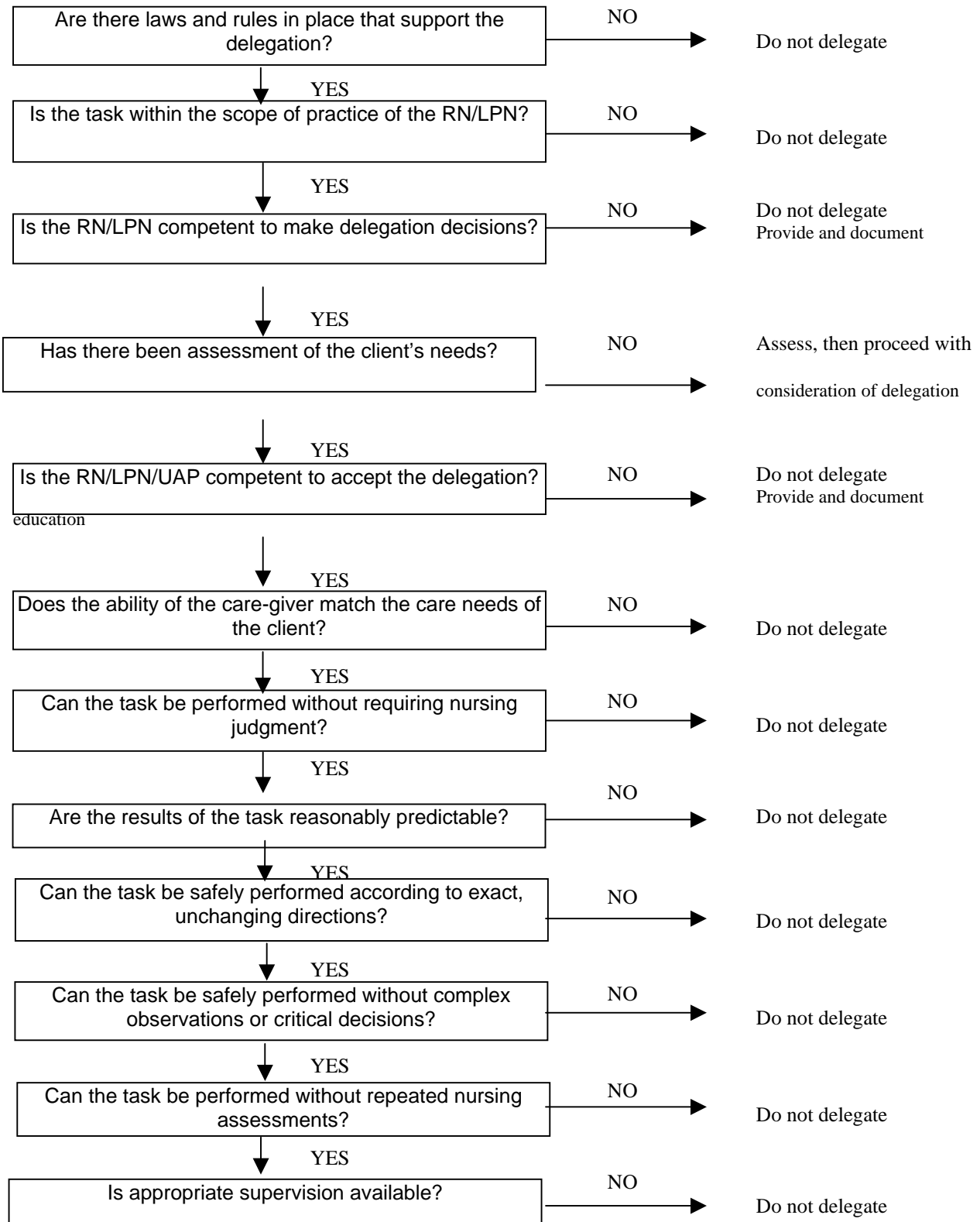
REFERENCES

American Nurses Association. (1995). The ANA Basic Guide to Safe Delegation. American Nurses Publishing Company. Washington, DC.

National Council of State Boards of Nursing. (1997). Delegation: Concepts and Decision-Making Process

Delegation Decision-making Tree

Adapted from the Delegation Decision Tree developed by the Ohio Board of Nursing



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 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, to engage in the practice of professional nursing.

Registered Professional Nurse Certification--A nurse who has met requirements for clinical or functional practice in a specialized field; pursued education beyond basic nursing preparation; and passed a written examination based on nationally recognized standards of nursing practice.

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 nurse anesthetist, nurse midwife, nurse practitioner, or clinical nurse specialist. An individual who meets the requirements to be an advanced practice registered nurse is recognized by the Missouri State Board of Nursing within a specific advanced practice nursing clinical specialty area and role. The specific advanced practice nursing clinical specialty area and role is identified on a "Document of Recognition" sent to the licensed registered professional nurse. The "Document of Recognition" is not a license.

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

stabilized chronic illnesses. Current nurse practitioner specialties for which certification is available are pediatric, school, family, adult, Ob/Gyn, neonatal, and gerontological.

Clinical Nurse Specialist--An advanced practice registered nurse with a graduate degree, master's or doctoral, in nursing who has become expert in a defined area of nursing knowledge and practice. The primary emphasis of the clinical nurse specialist is on client-centered practice that is defined by a select client population and practice setting such as cardiac, cancer, community health or mental health. Currently, clinical nurse specialist certification is available in the areas of psychiatric and mental health (adult), psychiatric and mental health (child), medical-surgical, gerontological, and community health.

Certified Nurse Midwife--An advanced practice registered nurse who has completed specialized education in nurse midwifery and who has received certification through the American College of Nurse Midwives. Nurse midwives provide primary care in the area of women's health including gynecologic, prenatal, delivery, and postpartum care.

Certified Registered Nurse Anesthetist--An advanced practice nurse who has 2 to 3 years of formal education beyond a Bachelor of Science degree in nursing and who has received certification from the Council of Certification of Nurse Anesthetists. Nurse anesthetists administer anesthesia to patients in a variety of settings, including hospital operating rooms, ambulatory surgical settings, and dentist's offices.

REFERENCES

- ANA Congress of Nursing Practice. (1992). "Working Definition -- Nurses in Advanced Practice."
- American Nurses Association. (1993). "Nursing Facts -- Advanced Practice Nursing: A New Age in Health Care."
- Code of State Regulations. (1996). 4 CSR 200-4.200, Collaborative Practice Rule.
- Marion, Lucy and Williamson, Geraldine C. (1985). The Scope of Practice of the Primary Health Care Nurse Practitioner. American Nurses' Association.
- Missouri State Board of Nursing. (1990). The Missouri Nurse 59. 5. "Advanced Registered Professional Nursing Position Statement."
- RSMo Chapter 335. (1995). State of Missouri Nursing Practice Act.
- Sanders, Melinda Dolan. (1993). The Missouri Nurse 62. "Your Nursing Practice."
- Sparacino, Patricia and Durand, Barbara A. (1986). Council of Primary Health Care Nurse Practitioner Newsletter. "Specialization in Advanced Nursing Practice." American Nurses' Association.

DISPENSING MEDICATIONS

The following guidelines should be followed when dispensing medications.

DEFINITIONS

Dispense

The act of dispensing includes the selection and labeling of prepackaged medications ordered by the physician or advanced practice nurse to be self-administered by the client. Medications may only be dispensed by a physician, pharmacist, or registered nurse.

Administer

The act of administering medication involves giving the client a single dose of prescribed medication. All personnel who are licensed to do so may administer medications.

Nursing Protocol

Describes the steps to be taken in the nursing management of specific health problems. Includes strategies for obtaining historical and physical assessment data and plans of action. Nursing protocols do not need to be signed by a physician.

Drug Order or Prescription

A physician has the independent legal authority to administer or dispense drugs. This authority is delegated to another person through an order, prescription, standing orders, protocols, or collaborative practice agreement. An order is generally considered to be written on the client's record. A prescription generally refers to an order written on a separate piece of paper. For simplicity, the word "order" will be used throughout this document.

Medical Protocol

Describes the medical treatment to be included in the plan of care for a specific condition. This includes prescription medications and treatments that require a physician's signed order.

Standing Order

Often used interchangeably with the term "medical protocol." A standing order is usually narrower in focus and consists of physician orders only (i.e., Immunization Standing Order).

Collaborative Practice Agreement

A written agreement that states jointly agreed-upon protocols or written standing orders for the delivery of health care services.

RESPONSIBILITIES OF THE RN WHEN DISPENSING MEDICATIONS

1. CHECK ORDER

Verify presence of a current, complete, 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.

Individual medical orders to dispense medication must contain:

- Client's name, if the order is not written on client's record;
- Name of medication;
- Strength, dosage and frequency of medication;
- Quantity of medication to dispense;
- Method of administration;
- Date order written;
- Number of refills (if applicable); and
- Physician's original signature (stamps are not acceptable).

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 must include:

- Medical order for the medication;
- 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 GC culture;
- Signatures of physician(s) and registered nurse(s) implementing the protocol; and
- Date signed.

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

4 CSR 150-5.020 and 4 CSR 200-4.200 outline the requirements for labeling of all medications.

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."

Labels may be filled in by a clerk, but 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.....	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

State regulations (4-CSR 150.5.020, 4 CSR 200-4.200) outline the requirements that must be followed for dispensing medications. Any RN dispensing medications must maintain required records to guarantee security, storage, and accountability. 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 sexually transmitted disease 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 RN dispensing medication; and
- Date medications dispensed.

Sequential Numbering

Sequential numbers are assigned to medications (Tuberculosis medications have sequential numbers assigned by the state - contract pharmacy, and should not be relabeled. The sequential number should be logged.)

Determine what the beginning number will be, and as each new medication is dispensed, the next number in sequence is assigned and recorded on the label.

Example: 100 -- Mary Smith -- Pramilets
 101 -- Mary Smith -- Ferrous Gluconate
 102 -- John Brown -- Tetracycline

When a refill is made, the same sequential number is retained, but an R is placed behind the number.

Example: 100-R
 100-R2

When the same drug is reordered or the prescription rewritten, a new sequential number is assigned.

If there are separate record books for logging the numbers, a number code should be designated for each book.

Example: STD record book - all 1000 numbers
 prenatal record book - all 2000 numbers

OR

 STD record book - all S1000
 prenatal record book - all P1000

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.

6. 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.

7. 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.

REFERENCE

4 CSR 150-.5.020-Nonpharmacy Dispensing
4 CSR 200-4.200-Collaborative Practice Rule
Chapter 335 RSMo-State of Missouri Nursing Practice Act
Physicians Desk Reference

DOCUMENTATION

GENERAL DOCUMENTATION GUIDELINES

1. Contents of a medical record must meet all regulatory, accrediting, and professional organization standards. Common requirements specific to nursing documentation include, but are not limited to: the nursing assessment and care provided; informed consent for any/all procedures; teaching provided either to the client directly or to his/her family; and response and reaction to teaching.
2. Use black permanent ink for entries.
3. Date, time, and sign all entries. Use first initial, last name and title. Full signature and title must be on file in agency.
4. Entries are to be legible with no blank spaces left on a line or in any area of the documentation. If a space is left on a line, draw a line through the space to the end of the line. For large areas not used on a form or page, use diagonal lines to mark through the area.
5. For errors, draw a line through the error, write error, initial and date the line. Do not attempt to erase, obliterate or “white out” the error.
6. Entries are to be factual, complete, accurate, contain observations, clinical signs and symptoms, client quotes when applicable, nursing interventions, and patient reactions. Do **not** give opinions, make assumptions, or enter vague, meaningless statements (e.g., “is a good parent”). Be specific.
7. Use correct grammar, spelling and punctuation.
8. Write client’s name and other identifying information on each medical record page.
9. Be sure to use only those abbreviations approved by your agency/facility.
10. Always record a client’s non-cooperative/non-compliant behavior.
11. Never document for someone else or sign another nurse’s name in any portion of the medical record.
12. Documentation should occur as soon after the care given as possible. Note problems as they occur, resolutions used and changes in client’s status.
13. When leaving messages, document time, name, and title of person taking message, and telephone number you called.

14. Record client assessment before and after you administer medications or other treatments.
15. Document any discussion of questionable medical orders, and the directions the doctor gave. Include the time and date of discussion and your actions as a result of the discussion and consequent directions given.
16. Chart an omission as a new entry. Do not backdate or add to previously written entries.
17. When an unusual incident occurs, document the incident on a special incident or occurrence report form. Do not write “incident report” filed in the medical record. Do write what happened to the client and actions taken to assure the client’s well-being in the medical record.
18. Record only your own observations, actions. If you receive information from another care giver, state the source of the information.
19. Record the date, time, and content of all telephone client-related communications.
20. REMEMBER, if you didn’t document it, it didn’t occur.

REFERENCES

Brent, Nancy. (1997). Nurses and The Law. W. B. Saunders Company.
Kopf, Randi. Are Your Medical Records a Legal Asset or Liability? Legal Documentation Guidelines. Journal of Nursing Law. 1, (1).

Other Resources:

Missouri State Board of Nursing. (1996). Documentation/Charting Information Packet.

GOOD SAMARITAN LAW

Sections 537.037, RSMo, (1988) of the Missouri Statutes is 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.

REFERENCE

Sheryl Feutz-Harter. (1993). Missouri Statutes Affecting Nursing Practice. Professional Education Systems, Inc.

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 or both.
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.

\REFERENCES

Cummings, Constance. Keeping Written Policies Up-to-Date. Maginnis & Associates Publication.

Feutz-Harter, Sheryl. (1993). Nursing and The Law. Professional Education Systems, Inc.

GUIDELINES FOR REDUCING LIABILITY RISK

Maintain open, honest, respectful relationships and communication

- Don't offer opinions if someone ask what you think is wrong; you may be accused of making a medical diagnosis
- Don't make a statement that may be interpreted as an admission of fault or guilt
- Don't 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 American Nurses Association'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

REFERENCE

Croke, Eileen (2003). Nurses, Negligence, and Malpractice. American Journal of Nursing. Vol.103, No. 9, p 54-64

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 Nurse 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 Nurse 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 4-6 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 title, public health nurse was changed to community health nurse in 1976. The Department of Health was created in 1987.

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.

REFERENCES

Buhler-Wilkerson. (1985). Public Health Nursing: In Sickness or in Health. 75 (10), 1155-1160.
Bureau of Community Health Nursing. (1985). Community Health Nursing Manual.

NEGLIGENCE AND MALPRACTICE

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

Negligence is:

- A general term that denotes conduct lacking in due care;
- Carelessness; and
- A deviation from the standard of care that a reasonable person would use in a particular set of circumstances.

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

Malpractice a more specific term that looks at a standard of care as well as the professional status of the caregiver. To be liable for malpractice, the person committing the wrong must be a professional.

The courts define malpractice as the failure of a professional person to act in accordance with the prevailing professional standards, or failure to foresee consequences that a professional person, having the necessary skills and education, should foresee.

The same types of acts may form the basis for negligence or malpractice.

- If performed by a non-professional person the result is negligence;
- If performed by a professional person the acts could be the basis for a malpractice lawsuit.

In order to prove negligence or malpractice, the following elements must be established:

- Duty owed the patient;
- Breach of duty owed the patient;
- Foreseeability;
- Causation;
- Injury; and
- Damages.

There are different levels of responsibility or liability for malpractice.

- An individual is accountable for acts of negligence personally committed;
- The manager or supervisor may be held liable for the acts of the nurse if there has not been appropriate delegation of duties or adequate supervision;
- An employer may be liable for the acts of its employees for failing to do the following:
 - hire staff who has the qualifications and skills to perform the necessary functions;
 - provide opportunities for the professional growth of the staff such as workshops and seminars;

- provide adequate library services;
- provide opportunities for exchange of ideas;
- provide adequate and sufficient equipment and supplies and maintaining them; and
- ensure that managers and supervisors carry out their duties competently.

REFERENCES

Brent, Nancy J. (1997). Nurses and the Law. W.B. Saunders.
Feutz-Harter, Sheryl. (1993). Nursing and the Law. Professional Education Systems, Inc.
Wacker Guido, Ginny. (1988). Legal Issues in Nursing. Appleton and Lange.

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 Nursing Practice Act is found in the State of Missouri Statutes RSMo 335. You can access the statute <http://www.moga.state.mo.us/STATUTES/C335.HTM>.

REFERENCE

Brent, Nancy. (1997). Nurses and The Law, A Guide to Principles and Applications.
W.B.Saunders Company.

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 (physician). Therefore, the Missouri Department of Health and Senior Services (DHSS) recommends physician orders should be obtained for administration of all medications and treatments.

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. Telephone orders should be sent to the physician for signature within 24 hours. If not returned within 72 hours, the physician should be contacted. If not returned in the next 72 hours, notify physician of orders being discontinued. One way to avoid the problem of telephone orders is to have a signed order FAXED.

Registered professional nurse or licensed professional 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.

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 professional 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 collaborative practice agreement 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, STD screening, TB testing).

The DHSS recommends that, at a minimum, standing orders should include:

- The geographic area to be served by the public health agency (XY County or YZ City);
- Process for the review of services by the physician and nurse (Evaluation of the standing orders protocols and implementation should be on a predetermined time schedule. The scope of the evaluation will vary widely, dependent upon the services to be provided);

- Full name of the patient or group of individuals who will receive treatment such as, “persons presenting themselves for immunizations” or “persons presenting themselves for TB testing;”
- Date the order is written by the physician;
- The name of the test, medication or treatment to be administered;
- Dosage of the drug or reference to established guidelines such as CDC, DHSS or Advisory Committee on Immunization Practices (ACIP);
- Method of administration of medication or treatment;
- Signature of the physician.

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. See Section 300.05 for guidelines for developing policies and procedures.

REFERENCES

Missouri State Board of Nursing. (1996), Physician Orders/Relaying of Orders Information Packet.

Missouri State Board of Nursing. (1998), Registered Professional Nurse/Advanced Practice Nurse Information Packet

Chapter 334.04, RSMo, 1994
4CSR 200-4.200.

PROTECTIVE SERVICES FOR ADULTS: ELDER ABUSE

SECTIONS 660.250 – 660.295, RSMo

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.

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.

“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.

“Likelihood of serious physical harm” is defined as one or more 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.

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 and include the following:

- Name, age and address of the adult;
- Name and address of any person responsible for the adult's care;
- Nature and extent of the adult's condition;
- Information regarding the nature of the abuse or neglect; and
- Other relevant information.

SECTIONS 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.

MANDATED REPORTERS

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:

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 or 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
Pharmacist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Probation or Parole Officer
Psychologist
Social Worker

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.

MANDATED REPORTERS

The following professionals are mandated under state law to report if 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:

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 or 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
Pharmacist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Probation or Parole Officer
Psychologist
Social Worker

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.

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.

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.

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.

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 notify 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.

MANDATED REPORTERS

The following professionals are mandated under state law to report if he/she has reasonable cause to believe that a resident of a facility has been abused or neglected:

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 or 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
Pharmacist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Probation or Parole Officer
Psychologist
Social Worker

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.

WHAT TO INCLUDE IN REPORT

Reports will contain the following:

- Name and address of the facility;
- Name of the resident;
- Information regarding the nature of the abuse or neglect;
- Name of the complainant; and
- Other helpful information.

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. It is recommended, the following nursing related policies are developed in each local public health agency:

Risk Management: Procedure to follow when a risk situation such as needle stick, medication errors or an injury to accident occurs.

Actions Requiring an Order From a Physician: Identification of activities that can be done without an order from a physician. such as home visits.

Reporting of Abuse and Neglect: Procedure to follow when staff suspects a child or adult is the victim of abuse and/or neglect.

Reporting Incompetent, Unethical, or Illegal Behavior: Procedure to follow to report incompetent, unethical, or illegal behavior of co-worker.

Professional Development: Policy stating the requirements for continuing education of professional nurses.

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.

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.

Release of Information: Policy stating when to obtain release of information and procedure to follow within the agency.

Informed Consent: Policy stating when to obtain informed consent and procedure to follow within the agency.

Student Nurses: Policy regarding students working in agency, including responsibilities of staff, confidentiality statements, and responsibility of faculty.

REPORTING INCOMPETENT, UNETHICAL, OR ILLEGAL PRACTICES

The *Code for Nurses with Interpretive Statements* (ANA, 1985) states that nurses as client advocates act “to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice by any person.” Incompetent nursing practice is measured against nursing standards, unethical practice is evaluated by the Code for Nurses, and illegal practice is identified in terms of violations of the law.

REPORTING RESPONSIBILITIES AND GUIDELINES

If a nurse is aware of inappropriate or questionable practice in the provision of health care, concern should be expressed to the person carrying out the questionable practice. If indicated, the practice should then be reported to the appropriate authority within the agency or larger system. There should be an established process for reporting and handling incompetent, unethical or illegal practice within each employment setting so that such reporting can go through official channels without causing fear or reprisal. Written documentation of the observed practices or behaviors must be available to the appropriate authorities. If the incompetent, unethical or illegal activity is not corrected within the employment setting and continues to jeopardize the client's welfare and safety, the problem should be reported to other appropriate authorities such as the Missouri State Board of Nursing.

RESPONSIBILITIES OF THE MISSOURI STATE BOARD OF NURSING

The law provides fourteen grounds to deny license or discipline the license of an RN or LPN:

- Impairment from alcohol and/or other drug use;
- Criminal prosecution;
- Use of fraud, deception, misrepresentation, or bribery in securing certificate of registration of license;
- Incompetence, misconduct, gross negligence, fraud, misrepresentation, or dishonesty in the performance;
- Obtaining or attempting to obtain composition by fraud, deception or misrepresentation;
- Violation of, or assisting or enabling any person to violate provisions of practice act;
- Impersonation of any person holding a certificate of registration or license, or allowing another person to use your license;
- Disciplinary action against the holder of a license granted by another state;
- Judged insane or incompetent by court;
- Assisting or enabling any person to practice who is not eligible;
- Insurance or license based upon inaccurate fact;
- Violation of professional trust or confidence;
- Use of advertisement or solicitation which is false, misleading or deceptive;
- Violation of the drug laws.

The Board's disciplinary responsibilities include:

- Reviewing and investigating complaints concerning licensed nurses, nurses in the licensure process, and nurse impostors;
- Determining disciplinary action after cause for discipline has been established;
- Monitoring disciplined licensees.

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. Forms are available from the Board by request.

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.

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

- Censure: Letter sent to nurse indicating there has been a violation of the Nursing Practice Act. Copy of letter kept in licensee's file;
- Probation: Nurse allowed to practice but must meet certain conditions and terms;
- Suspension: The nurse is prohibited from practicing nursing for a period of time not to exceed three years;
- Revocation: The nurse loses his or her license and can no longer practice in the State of Missouri;
- Other: The board may impose the above disciplines singularly or in combination.

For questions related to disciplinary matters, contact the State Board of Nursing. (see resource section)

REFERENCES

American Nurses Association. (1985). Code for Nurses with Interpretive Statements. American Nurses Association Publishing Company.

American Nurses Association. (1994). Guidelines on Reporting Incompetent, Unethical, or Illegal Practices. American Nurses Association Publishing Company.

Chapter 335, RSMo-State of Missouri Nursing Practice Act.

Missouri State Board of Nursing. (1997). Discipline Information Packet.

ROLE OF PUBLIC HEALTH NURSES

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 maintenance of the health of populations.

Examples of Public Health Nursing Activities

Examples of public health nursing activities include the following:

1. Evaluating health trends and risk factors of population groups and helping to determine priorities for targeted interventions.
2. Working with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities.
3. Participating in assessing and evaluating health care services to ensure that people are informed of available programs and services and assisted in the utilization of those services.
4. Providing essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups.
5. Providing health education, care management, and primary care to individuals and families who are members of vulnerable population and high-risk groups.

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.

REFERENCE:

American Nurses Publishing. (2000). *Scope and Standards of Public Health Nursing Practice*

American Public Health Association, Public Health Nursing Section. (1996)

SCOPE OF PRACTICE

DECISION MAKING MODEL

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 and even if the nurse has legitimate concerns, the employer has the legal right to initiate employee disciplinary action.

To help nurses make decisions about scope of practice, the Missouri State Board of Nursing has

adopted the Scope of Practice Decision Making Model. This 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. The tool can be found at http://pr.mo.gov/boards/nursing/MODecision_Making_Model.pdf. This tool will help nurses make informed decisions about their scope of practice.

REFERENCE: Adapted from Missouri State Board of Nursing Newsletter, Volume 8 No. 1, February, March, April 2006

STANDARDS OF NURSING PRACTICE

Standards of nursing practice developed by the American Nurses' Association (ANA) provide guidelines for nursing performance. They are the rules or definition 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.

As defined by the American Nurses' Association (ANA), standards of nursing practice consist of three components:

1. Professional standards of care define diagnostic, intervention, and evaluation competencies.
2. Professional performance standards identify role functions in direct care, consultation, and quality assurance.
3. Specialty practice guidelines are protocols of care for specific populations.

The ANA has developed and published standards for clinical nursing practice and specialty practice including public health nursing. A list of the standards of public health nursing are available at the American Public Health Association-Public Health Nursing Section website <http://www.csuchico.edu/~horst/about/standards.html>.

Copies of the scope and standards documents can be ordered from American Nurses Association at <http://nursingworld.org/books/>.

REFERENCES

Brent, Nancy. (1997). Nurses and The Law, A Guide to Principles and Applications. W.B. Saunders Company.

STUDENT NURSE GUIDELINES

RECOMMENDED GUIDELINES FOR STUDENT NURSES USING LOCAL PUBLIC HEALTH AGENCY FOR CLINICAL EXPERIENCE:

RESPONSIBILITIES OF THE LOCAL PUBLIC HEALTH AGENCY

1. 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.

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.

Type of nursing program

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

- Licensed Practical Nursing (LPN): focus is on commonly occurring health problems with predictable outcomes.
- Diploma: focus in on illness-related care.
- Associate Degree in Nursing (ADN): focus is on care of well-defined health problems of an individual.
- Baccalaureate 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.

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 3 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.

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.

2. Provide orientation about policies and programs of the LPHA to the nursing program faculty.
3. Provide competent and qualified supervisory and professional nursing personnel to assist with agreed upon guidance, supervision and evaluation of students.
4. Have written policies and procedures in place. Students are required to follow the policies of the LPHA.
5. Assure students have been informed about HIPAA confidentiality requirements and have signed confidentiality statements.
6. Collaborate with the faculty member in selection of specific educational experiences.
7. Provide agreed upon physical space for the faculty member and students to have conferences and workspace.

RESPONSIBILITIES OF THE NURSING PROGRAM

1. Provide the LPHA with information about the nursing program and educational objectives of the student experience.
2. 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.
3. 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.
4. Provide documentation that the students and faculty have professional liability insurance coverage.
5. 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.

TENETS OF PUBLIC HEALTH NURSING

The Quad Council of Public Health Nursing Organizations (1997) developed the following eight tenets of public health nursing to advance the public health nursing goal of promoting and protecting the health of the population.

1. **Population-based assessment, policy development, and assurance processes are systematic and comprehensive.** The client or unit of care is the population. Each process includes consideration of the community capacity, personal or lifestyle health practices, human biology, health services, and social, economic, physical, and environmental factors as they affect the population's health.

The assessment process includes a review of the needs, strengths, and expectations of all of the people and is guided by epidemiological methods. Policies are derived from assessment, are developed with a view toward the priorities set by the people, and consider subpopulations or communities where health is at greatest risk, as well as the effectiveness of interventions and program options in influencing the health goals of the people. Interventions and programs are assured through direct provision of services by public health nurses, through regulation, or by encouraging the actions of other health care professionals or organizations, and focus on availability, acceptability, access, and quality of services.

2. **All processes must include partnering with representatives of the people.** This assures that the interpretation of the data, policy decisions, and planning of intervention strategies reflect the perspectives, priorities, and values of the people. By emphasizing representation from multiple communities, decisions are made with consideration of what is in the best interest of all.
3. **Primary prevention is given priority.** Primary prevention includes health promotion and health protection strategies. The practice of public health nursing places emphasis on primary prevention in all assessment, policy development, and assurance processes.

4. **Intervention strategies are selected to create healthy environmental, social, and economic conditions in which people can thrive.** Although all nurses are concerned about the environment in which individual clients live, public health nurses concentrate on interventions aimed at improving environments to benefit the health of the population. Interventions include education, community development, social engineering, as well as policy development and enforcement strategies. Interventions tend to emerge from the political or community participation process and result in governmental policies and laws, administrative rules, and budget priorities. Interventions also emerge from policy and resource control mechanisms within public or private organizations. Some interventions will support functions and systems that promote health, whereas others will protect the health of the people by prohibiting harmful practices.
5. **Public health nursing practice includes an obligation to actively reach out to all who might benefit from an intervention or service.** Often, those most likely to benefit are those who are the most marginal recipients. Because risk factors are not randomly distributed in the population, the health of some subpopulations may be more vulnerable to the development of disease and disability, or they may have more difficulty accessing and using interventions or services. These high-risk subpopulations or communities may need special outreach or programs so they can achieve an improvement in their risk status or health. Public health nursing focuses on the whole population and not solely on those who present themselves for services.
6. **The dominant concern and obligation is for the greater good of all of the people or the population as a whole.** Because the unit of care for this specialty is the population, consideration of what is in the best interest of the whole takes priority over the best interest of an individual or a group. Public health nurses also promote the health of individuals, but this responsibility is secondary to their obligation to promote the health of the population. Public health nurses recognize that it may not be possible to meet identified individual needs when those needs conflict with other priority health goals that benefit the whole population.
7. **Stewardship and allocation of available resources support the maximum population health benefit gain.** This includes providing information to members of the population and leaders for the optimal use of available resources for the best overall improvement in the health of the entire population. Information should include scientific data on potential outcomes of various policy decisions, as well as the cost benefit or cost effectiveness of potential intervention strategies.
8. **The health of the people is most effectively promoted and protected through collaboration with members of other professions and organizations.** Creating conditions in which people can be healthy is an extremely complex, resource-intensive process. Public health nurses join with appropriate experts from multiple professions and organizations in efforts to improve population health.

Public health nursing practice includes providing leadership to assure that all of the people have their collective and individual nursing needs met. This includes (a) collaborating with other nurses in developing public policies that assure an adequate supply of well-prepared nurses to work in all health settings, (b) developing and enforcing public and organizational policies that assure access to quality nursing services, and (c) supporting nursing research and evaluation to promote quality of care by all nurses. Public health nurses also assure the availability of care to

individuals and families in the community (community-based care) when their health condition creates a risk to the health of the population. In this situation, community-based care is a public health nursing strategy that directly benefits the whole population by reducing exposure to risk factors.

REFERENCE

American Nurses Publishing. (2000). Scope and Standards of Public Health Nursing Practice

RESOURCES

LIST-SERVS RELATED TO PUBLIC HEALTH NURSING

Missouri Public Health Nursing List-Serv (MO-PHN-L)

The Missouri Department of Health and Senior Services, in partnership with Missouri Nurses Association and Central Missouri State University, has created a new list-serv for public health nursing. The list-serv, Missouri Public Health Nursing (MO-PHN-L), is open to everyone and includes information about resources, announcements, educational opportunities, and questions for other subscribers.

To Subscribe:

Go to <http://listsrv.cmsu.edu> (notice no "e" in listsrv)

You will get a screen that says-Welcome to LISTSERV.cmsu.edu

Click on the heading-Information and Commands on Available Mailing Lists

Click on MO-PHN-L (the names are in alphabetical order)

You will get a screen that has commands

Click on Subscribe to MO-PHN-L

Type in your e-mail address and hit OK

Environmental Health (EH- Nurse List-Serve)

The EH-Nurse electronic mailing list is dedicated to supporting nursing professionals seeking accurate, timely and credible scientific information on environmental health and nursing. The ultimate goal is to prevent environmental disease by increasing the numbers of nursing professionals who can recognize environmental etiologies and risk factors of disease, promote health through risk reduction and control strategies and empower individuals, families and communities through partnering, advocacy and education.

To Subscribe:

Send an e-mail to listproc@list.umaryland.edu

Leave subject blank

Type subscribe eh-nurse in the subject line

Delete your signature before you send

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>

MCH Alert

The MCH Alert list-serv 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.

Nursing and Environmental Health

This list-serv 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 “RFPs,” and federal and state initiatives, regulations, policies and resources (websites, organizations), as well as experiences and helpful tips to addressing 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.

Public Health Nursing Discussion and Information

An unmoderated discussion list designed to provide discussion and exchange of information among nursing professionals who provide public health services and other interested parties.

To Subscribe:

Send e-mail message to listproc@u.washington.edu

Leave subject line blank. In the body of the message type SUBSCRIBE PHNURSES your name.

NURSING ORGANIZATIONS

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

Association of State & Territorial Directors of
Nursing
<http://www.astdn.org>

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

International Nursing Coalition for Mass
Casualty Education (ICMCE)
[http://www.mc.vanderbilt.edu/nursing/coalitions/
INCMCE/index.html](http://www.mc.vanderbilt.edu/nursing/coalitions/INCMCE/index.html)

Missouri Association of School Nurses
www.missourischoolnurse.org

Missouri League for Nursing, Inc. (MLN)
604 Dix Road
P.O. Box 104476
Jefferson City, MO 65110-4476
(573) 635-7908
<http://www.monursing.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 Public Health Association (MPHA)
P.O. Box 126
Jefferson City, MO 65102-0126
(573) 634-7977
e-mail: mopublicha@aol.com
<http://www.mopha.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
U.S.A.
1-866-627-6767
(1-866-NASN-SNS)
303-663-2329
Fax 303-663-0403
nasn@nasn.org
<http://www.nasn.org>

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://nursingsociety.org/>

READY WEB REFERENCES

The following information is reprinted with permission from the May-June-July 2001, Missouri State Board of Nursing Newsletter, Practice Corner by Rita Tadych PhD, RN, Practice Administrator.

For assistance with negotiating the State of Missouri environment of statutes (RSMo); current and proposed rules (SOS); Missouri State Board of Nursing (MSBN) website; other licensees' web pages and laws (PR); other government entities (Missouri State Government); legislation (Missouri State Government); and so forth, use this document, "Ready Web References".

❖ REVISED STATUTES OF MISSOURI (RSMo)

<http://www.moga.state.mo.us/STATUTES/STATUTES.HTM>

PROVIDES ACCESS TO CURRENT STATUTORY LAWS

❖ 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.state.mo.us>

PROVIDES ACCESS TO EXECUTIVE, LEGISLATIVE, JUDICIAL, AND STATE DEPARTMENT INFORMATION

❖ OFFICE OF THE MISSOURI STATE GOVERNOR

<http://www.gov.state.mo.us>

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 DOWNLOADABLE 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

Since licensed nurses’ practice may be influenced or directed by statutes and rules/regulations
 other than those in Chapter 335 or 4 CSR 200, I have included, below, other laws which may
 pertain to your current practice activities and thereby warrant your review:

OTHER STATUTES OF INTEREST TO NURSES

To view all of the Missouri Revised Statutes, go to:

<http://www.moga.state.mo.us/homestat.htm>

Abortion	Chapters 188, 197, and 565
Abuse and Lose Law (Driver’s License)	Chapter 577
Acupuncture	Begins at 324.475, RSMo
Administration of Medication or Health Services in Schools	167.621, RSMo
Adult Abuse, Eighteen and over	Chapter 455
Adult Abuse Protection, age 60 and over and disabled persons	Chapters 660 and 198
Blood Tests of Pregnant Women	210.030, RSMo
Board of Pharmacy Statutes	Chapter 338
Breath, blood, saliva, or urine tests, consent implied	577.020 – 577.041, RSMo; 577.206 – 577.208, RSMo;577.211, RSMo
Civil Immunity For Providing Information to Board of Nursing	335.066.6, RSMo
Collaborative Practice Arrangements	334.104, RSMo
Confidentiality of HIV Testing	Begins at 191.650, RSMo
Consent to Surgical or Medical Treatment, Who May Give, When	431.061, RSMo
Contracts, Legal Age For	431.055, RSMo
Controlled Substances, Administering and Dispensing of	195.070, RSMo
Controlled Substances, Who may Prescribe	195.070, RSMo
Criminal Background Checks	660.317, RSMo;see also Chapters 565, 566, and 569

Day Care Centers for Children	Chapters 210 and 313
Death, Legal Definition of	194.005, RSMo
Declarations, Life Support	459.010, RSMo
Department of Mental Health	Chapter 630
Department of Social Services (Includes Division of Aging)	Chapter 660
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OTHER RULES OF INTEREST TO NURSES

To view all of the Missouri Rules/Regulations, go to:

<http://www.sos.mo.gov/adrules/csr/csr.asp>

Advanced Practice Nurse	4 CSR 200-4.100
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Controlled Substances, Schedules of	19 CSR 30-1.002
Bureau of Narcotics and Dangerous Drugs (BNDD) Number, Requirements for Nurses who Dispense Controlled Drugs to Obtain	19 CSR 30-1.066

Department of Health and Senior Services Entity Licensing Rules/Regulations:	
Definitions Related to Hospitals	19 CSR 30-20.011
Administration of Hospital Licensing Program	19 CSR 30-20.015
Organization and Management for Hospitals	19 CSR 30-20.021
Administration Standards for Rehabilitation Hospitals	19 CSR 30-22.020
Administration Standards for Psychiatric Hospitals	19 CSR 30-24.020
Definitions and Procedures for Licensing Ambulatory Surgical Centers	19 CSR 30-30.010
Hospice Program	Starts in Title 19, Division 30, Chapter 35
Comprehensive Emergency Medical Services Systems	Starts in Title 19, Division 30, Chapter 40
License-Exempt Child Care Facilities Health Requirements	19 CSR 30-60.060;
Health Care Licensing Rules for Family Day Care Homes	19 CSR 30-61.185; see also 19 CSR 30-61.125
Health Care Licensing Rules for Group Day Care Homes and Child Day Care Centers	19 CSR 30-62.192; see also 19 CSR 30-62.122
Perinatal Substance Abuse Forms for Health Care Providers	19 CSR 40.6.010
Generic Drug Formulary	4 CSR 220-3.011
Nonpharmacy Dispensing	4 CSR 150-5.020
Prescription Requirements	4 CSR 220-2.018
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