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Competent and Safe Practices: A Profile of Disciplined Registered Nurses

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Practice Issues

Competent and Safe Practice

A Profile of Disciplined Registered Nurses

Cheryl Delgado, MSN, RN, CANP

Nurses are monitored by state boards of nursing to answer the public demand for safe and competent practitioners. Initial competency is determined by successful completion of the NCLEX examination, and continued competency in most states is assured through continuing education requirements. Thus established, the right to practice nursing may be revoked or restricted if an individual is found to be in violation of the State Nurse Practice Act or convicted of certain state and federal laws. Grounds for disciplinary actions include fraud, criminal acts, substance abuse, mental incompetence, unprofessional actions, incompetent acts of care, negligence, and other willful misconduct such as the diversion of narcotics.[1,2] Revocation of licensure generally occurs for serious offenses that either threaten the health of consumers or represent a serious breach of law. Other disciplinary actions that could be imposed include temporary revocation, restriction of practice, or voluntary surrender of a license.

The majority of nurses practice within the boundaries of state practice acts, providing safe and competent care. According to the National Council of State Boards of Nursing, however, the number of disciplinary actions issued annually to registered nurses (RNs) has risen 21% in the last 5 years.[3] The causes of increasing numbers of disciplinary actions include the increasing complexity of the work role, staffing patterns, managed care constraints, and an increase in the willingness of employers and others to report offenses.[1] These stresses potentially affect all nurses, but only a small percentage is disciplined by the state board of nursing. The demographic characteristics of disciplined health providers in many states, including Ohio, has not been examined to identify at-risk groups or individuals. Such information may assist educators, managers, and state boards in taking proactive measures to minimize disciplinary actions.

States' Profiles

A review of the literature revealed only seven publications reporting demographic profiles of disciplined nurses from six states (Arizona, Colorado, Louisiana, New York, Tennessee, and Texas).[1,2,4-7] Two of those reports are over 10 years old and therefore have limited usefulness.[4,6] A review of the characteristics of disciplined nurses from states where profiles have been attempted produced interesting findings. One of the notable differences between disciplined and non-disciplined nurse profiles is a disproportionate representation of men in the disciplined group in all states where a profile is available.[4,6] Nurses whose highest level of education is an associate degree in nursing are also disciplined more often than diploma or baccalaureate prepared nurses.[6]

Ohio Data

Through a public records information request, I obtained information on disciplined nurses during fiscal year 2000 regarding age, gender, county of residence, type of license held, years since initial licensure, highest educational degree held, nature of violation, and type of disciplinary action invoked by the Ohio State Board of Nursing. This was compared to findings describing the current nursing workforce in Ohio from the report of the Data Task Force published in December, 2000.[8] Because information regarding marital status and race or ethnicity of disciplined nurses in Ohio is not available, these aspects could not be examined in this study.

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Disciplined Nurses

During the year studied, 43 RNs, including one advanced practice nurse, were disciplined. This represents 0.03% of the total number of RNs in the state of Ohio in 1999. Only 2.7% of Ohio RNs are men, but men accounted for 18.6% of the disciplined group. The average age of Ohio RNs is 47.5 years, slightly older than the disciplined Ohio RNs mean age of 42.6 years. The distribution of disciplined RNs in Ohio corresponds roughly to the distribution of the state's population, being concentrated in the northeastern greater Cleveland/Akron and central greater Columbus areas. Cincinnati was unusual in that only 4.6% of the disciplined nurse group resided in or near the county, despite its position as the third largest urban center in Ohio. Each of these urban centers has large university nursing programs.

Education

The educational preparation of Ohio RNs, according to the workforce study, has the following distribution: diploma graduates 34.8%, associate degree graduates 22.5%, baccalaureate degree graduates 31.8%, and master's degree or higher 10.8%. Disciplined Ohio RNs have a different distribution: 27.9% diploma graduates, 62.8% associate degree graduates, and 9.3 % baccalaureate degree graduates; no disciplinary actions were invoked against nurses with a master's degree or higher.

Experience

The mean length of time the RN license was held was used to estimate years of experience, although an active license could be held when an RN was inactive in the nursing workforce. It is therefore possible to overestimate years of experience using this measure. It is also possible that this measure may underestimate years of experience, in that the workforce study notes that 4.1% of Ohio RNs hold both RN and LPN licenses, indicating greater experience in the nursing field than is reflected by looking at years as an RN alone. The length of time a RN held a license was inversely related to the percentage of disciplinary actions.

Reasons for Discipline

The most common causes of disciplinary action for Ohio RNs (37.2%) were practice-related issues, including competency. Consistent with findings from other state studies of disciplined nurses, many Ohio nurses were disciplined for drug/chemical dependency (34.9%). Eight nurses (18.6%) had licenses permanently revoked, indefinitely suspended, or voluntarily surrendered their license after conviction on criminal charges, not necessarily related to nursing. All three RNs (7%) who were charged with patient abuse either voluntarily surrendered their license or had licenses permanently revoked. Reprimands, the least punitive measure, were given to three RNs (7%) for practice violations.

Sex

Male nurses, over-represented in the disciplined group, were 33.3% of the subgroup disciplined for patient abuse, 37.5 % of the subgroup disciplined for criminal activity, and 26.7% of the subgroup disciplined for drug problems. Men in the Ohio disciplined nurses group had no practice issue violations. All were associate degree or diploma graduates.

Discussion

The results of this survey indicate that Ohio is not different from other states in that the profile of disciplined nurses reveals a higher-than-expected number of male nurses and associate degree-prepared nurses. The disciplined Ohio nurse profile also showed a higher than expected percentage of nurses with less than 10 years of experience. A commonality among these three seemingly disparate groups could be problematic socialization to the nursing role. Nurses in these groups may not have full understanding and acceptance of nursing roles due to deficiencies in educational preparation, gender issues, or lack of experience. Associate degree nurses, who have a higher than expected representation in the disciplined group, also have the shortest educational preparation. Therefore, they have less formal examination of the nursing role and a shorter time to adapt to the nursing culture. Their preparation for practice is oriented to technical skills and procedures, and may not contain the theoretical and ethical content and concentration of a baccalaureate nursing program.

Male nurses struggle with these problems, and are additionally burdened with the challenge of integration in a predominantly female professional culture. They may face questions of gender identity because of their interest in nursing, and possibly a lack of understanding and support for their unique problems from the nursing profession itself. Several researchers have noted that men and women use different coping strategies under stress.[9] It may be that nursing educators and employers have not recognized that male nurses may need special support in identifying and selecting coping strategies that are role appropriate for nursing.

Nurses with less experience were more often disciplined in Ohio. As with both other groups, they have had less time to learn, understand, and adapt to the nursing culture. There may be an element of reality shock and difficulty in making the adjustment from student to practitioner in their early years after graduation. Nurse educators should research how to prepare students for the transition from student to practitioner role, perhaps through mentoring and preceptored senior year clinical experiences. Nursing educators who are employed by a medical center or health care institution desiring to improve retention rates for nursing staff during a nursing shortage could explore the support novice nurses receive through apprenticeship assignments during orientation to the workplace.[10]

A weakness in this profile is the limitation imposed by the lack of data from public records on other subgroups. Other at-risk demographic groups, based on socioeconomic factors or ethnicity, might have been identified if more complete information had been available. Future stud-

ies could be directed at understanding the stressors inherent in nursing, how the stressors may vary by gender, and how these stressors may interact with other difficult life situations. Resources that are both available and effective could be identified for nurses coping with stress. How to effectively include such information in nursing education needs to be explored. The correlation between educational preparation and disciplinary actions might support arguments for a standardized entry level to practice at the baccalaureate level. Associate degree and diploma schools could re-examine their programs to determine if adequate emphasis and time are allowed for understanding and adapting to the nursing culture. Nursing education has the challenge of preparing students for the practice of professional nursing. Are we doing enough, and are we doing it well enough? Failure in practice has consequences much more severe than a failure in the classroom.[11]

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