

| Volume 13 | Number 3 | Summer 2015 |

DAKOTA NURSE

C O N N E C T I O N



**Literature Review:
Nurse Fatigue Related
to Shift Length**

**South Dakota Board of Nursing
Implements New Registries for
Unlicensed Assistive Personnel**

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DAKOTA NURSE

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Dakota Nurse Connection circulation includes over 28,000 licensed nurses, hospital executives and nursing school administrators in North and South Dakota.



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The *Dakota Nurse Connection* is published by the South Dakota and North Dakota Boards of Nursing.
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A message from the Executive Director

Gloria Damgaard, RN, MS, FRE
South Dakota Board of Nursing

The South Dakota Board of Nursing extends our greetings to all of the readers of the Dakota Nurse Connection. We hope this summer edition of the Dakota Nurse Connection will be informative for you. Human trafficking is a timely and important issue for all of us. It is our hope that this article will raise awareness of the issue for nurses in South Dakota.

I also want to take this opportunity to announce an exciting new leadership development program for nurses. If you tuned in to Inside Keloland on Sunday, July 12, 2015, you may have already heard about the partnership established between the South Dakota Center for Nursing Workforce and EmBe of Sioux Falls. EmBe is the former YWCA organization. Empowering You to Be (EmBe) is the basis for the new name of the organization. Leadership is one of the core services offered by EmBe. Leadership development for nurses is also one of the key functions of the SD Center for Nursing Workforce which makes this new partnership a perfect fit.

The purpose of the partnership that has been formed is to facilitate leadership development of

nursing professionals by utilizing the experience and skills of established community leaders; to extend a hand-up to those who will follow. The Board of Nursing, as the lead agency for the SD Center for Nursing Workforce, is pleased to partner with EmBe to provide leadership development for nurses. As the CEOs of our own lives, leadership development is important whether you are at the bedside, in the boardroom or preparing yourself to take advantage of the next opportunity that knocks on your door. This program is specifically tailored for nurses, with opportunities to learn from leaders in nursing as well as other professions. This program offers the opportunity to learn and collaborate with nursing peers while developing as a leader.

The program begins with a

2-day retreat, followed by six training sessions over a five month time frame. The participants develop a personal leadership development plan that includes personal and professional goals and the means to achieve the goals. The training session topics include: Leading Authentically; Facts, Figures and Finances; Leadership Styles; Diversity and Inclusiveness in Leadership; and the Creation of Community Connections. All topics offer an exciting program that I would highly recommend to all nurses.

The inaugural program will take place in Sioux Falls, starting in January 2016. The intent is to replicate and offer the program in various locations throughout the state in future years. If you are interested in the program, applications are available at www.embe.org/leadership or by calling Erin Bosch at EmBe, 605-336-3660 or ebosch@embe.org.

Cost for the program is \$175 per participant. Class size is limited to 25 participants. I have included a portion of the program brochure for your review.

Enjoy the remaining summer months. I will be in touch with you again in the fall edition.

Sincerely,

Gloria Damgaard

The next step in your
leadership journey starts now!

SOUTH DAKOTA
Center for Nursing Workforce

Leadership
program
Presented by **EmBe**



The program is open to all nurses, men and women, who are interested in expanding their leadership potential. Accepted participants must hold an active South Dakota nursing license, or multi-state compact license, and be practicing in the role of a nurse in the state of South Dakota.

Applications are available at www.embe.org/leadership.
Contact Erin Bosch, at EmBe, for more information at 605-336-3662 ext 211 or ebosch@embe.org



A message from the Executive Director

Stacey Pfenning, DNP, APRN, FNP
North Dakota Board of Nursing

Greetings and welcome to the summer edition of the **Dakota Nurse Connection**, the official publication of the North Dakota Board of Nursing. This edition marks a time of historic celebration and momentous change at the North Dakota Board of Nursing.

On June 30th, Dr. Constance Kalanek, Executive Director since 1998, entered a new life adventure entitled “retirement”. Prior to her retirement, Dr. Kalanek was honored as recipient of the Founder Legendary Nurse Award for exceptional leadership in the development of the North Dakota Center for Nursing. On June 1st, the Board welcomed two new staff directors, Melissa Hanson and Tammy Buchholz. Melissa was named Associate Director for Discipline and Tammy was named Associate Director for Education.

In May, the North Dakota Board of Nursing celebrated 100 years of nursing regulation and licensure. Thanks to URL Radio and Kyle Martin of the Center for Nursing, reflections of nursing past, present and future aired during Nurse’s Week. These interviews can

be accessed on the NDBON website. To speak of *nursing past*, Estelle Tachenko, age 92, described nursing education and practice during the 1940s-1970s. During the interview, Estelle wore her original nursing cap and was accompanied by her daughter, Brenda, also a nurse. *Nursing present* emphasized the appreciation for advancements in healthcare equipment and technology, as well as the ability for nurses to work in a variety of specialties and in many capacities. The *nursing future* interview featured 3 nursing students completing degrees in North Dakota, as well as one high school student aspiring to be a nurse and preparing for the profession as early as 10th grade.

The celebration culminated in a once in a lifetime event entitled, “*Celebrating 100 Years of Nursing Excellence: Past, Present, and Future*,” which was held at the Bismarck Heritage Center on May 21st. This event, created through partnership with North Dakota Center for Nursing, honored generations of nurses, as well as past and present Board members and staff. The event provided

nurses with a silent auction, displays of historic nursing artifacts, and an evening gala. Marcus Engel, speaker and best-selling author of “The Other End of the Stethoscope” and “I’m Here”, provided an inspiring and empowering story highlighting the significance of nursing care from a patient point of view. Dr. Betty Rambur delivered the keynote presentation, and Dr. Kalanek provided a historic overview of nursing in the state. During the gala, the Center for Nursing honored 16 nurses as recipients of Legendary Nurse Awards. The overview of the awards and recipients can be viewed at the ND Center for Nursing Award site.

As the new Executive Director, I would like to express my sincere gratitude to Dr. Kalanek for her mentorship and support during this time of transition. I am excited to continue serving the North Dakota Board of Nursing in this new position.

Sincerely,
 Dr. Stacey Pfenning DNP
 APRN FNP



Mission
The mission of the North Dakota Board of Nursing is to assure North Dakota citizens quality nursing care through the regulation of standards for nursing education, licensure and practice.

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BOARD STAFF

E-MAIL ADDRESSES

Table with 2 columns: BOARD STAFF and E-MAIL ADDRESSES. Rows include Stacey Pfenning DNP, APRN, FNP, Executive Director; Tammy Buchholz, MSN, RN, CNE, Associate Director for Education; Melissa Hanson, MSN, RN, Associate Director for Discipline; Patricia Hill, BSN, RN, Assistant Director for Practice & Discipline; Julie Schwan, Adm Services Coord; Gail Rossman, Technology Specialist; Sally Bohmbach, Administrative Assistant; Kathy Zahn, Administrative Assistant.

NORTH DAKOTA BOARD OF NURSING 2015 BOARD MEETING DATES

July 16, 2015 Annual Meeting

As a service to the citizens of North Dakota, the Board of Nursing provides a PUBLIC FORUM during each board meeting. This is a time when anyone may address the board about any issue regarding nursing. Prior notification is not necessary. Individuals will be recognized in the order of their signature on a roster available at the board meeting. The time of the Public Forum for the 2014-2015 board meetings is 11:00 a.m. of the first day of each board meeting.

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Stacey Pfenning, DNP, APRN, FNP
Patricia Hill, RN, BSN

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Fee: \$100 per presentation plus mileage.

Contact Hours: One contact hour each, except Standards of Practice and Code of Ethics is 2.3 contact hours.

Delegating Effectively is 2 contact hours.

Approved by the North Dakota Board of Nursing.

NURSES Have you moved recently?

Update your address on the N.D. Board of Nursing Web site: www.ndbon.org Choose Demographic Updates under Nurse Licensure

NORTH DAKOTA BOARD OF NURSING "CARDLESS" FOR PUBLIC SAFETY Wallet licensure cards are no longer issued for:

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LICENSURE VERIFICATION

North Dakota License Verification Options

The North Dakota Board of Nursing provides the following options for individuals attempting to verify a ND nursing license:

- North Dakota Board of Nursing Website - go to www.ndbon.org. and choose "Verify."
• Nursys® Nurses' Verification. For participating states, go to www.nursys.com. Choose Licensure QuickConfirm.
• E-notify - database for verification of licensure at nursysenotify@ncsbn.org

NORTH DAKOTA BOARD HIGHLIGHTS

May 2015

- Approved the management of the following accounts:
 - Kirkwood Bank - main checking, Pfenning, Hill, Hanson, and board treasurer
 - Kirkwood savings: Pfenning and board treasurer
 - Bank of North Dakota - NEL checking & savings: Pfenning and board treasurer
 - Bank of North Dakota – merchant account – Pfenning and board treasurer
 - Dakota Community Bank, BND, BNC, and Kirkwood Bank - investment/reserve funds – Pfenning
 - On-line banking transfers - KBT safety deposit box – Pfenning, Schwan, Rossman
- The Finance Committee recommended the board continue Brian Bergeson’s \$3000 retainer fee per month and accept Bergeson’s proposal for an increase in hourly fee rates for other matters when charged from \$130 to \$140 effective 7/1/2015.
- The Finance Committee recommended the board include funding for revisions to and adoption of the Nurse Licensure Compact and Advanced Practice Licensure Compact.
- The Finance Committee recommended the board approve the proposed 2015-2016 budget of \$1,448,865 projected income and \$1,455,400 budgeted expenses, which includes \$82,500 designated for Nursing Education loans and \$277,050 designated for the ND Center for Nursing.
- Ratified Merry Foyt’s request for permission to practice in ND under the nurse licensure compact privilege while under an encumbered license in NE.
- Denied the UAP/Surg Tech application for David Peterson based on NDCC 43-12.1-14 (1)(4)(5); and NDAC 54-02-07-01.1(12).
- The Nursing Education Committee recommended the board accept the University of Mary’s notification of major programmatic changes for the BSN program as the program has full approval from the ND Board of Nursing and the programmatic changes are in compliance with NDAC 54-03.2-06-02.
- The Nursing Education Committee recommended the board accept the ND State College of Science’s notification of major programmatic change to offer their practical nurse program in the Fargo area as the program has full approval from the ND Board of Nursing and the programmatic changes are in compliance with NDAC 54-03.2-06-02.
- The Nursing Education Committee recommended
- that the board approve the compliance report from TMCC AASPN program and require a compliance report with the 2014-2015 Annual Nursing Education report addressing partial compliance with NDAC 54-03.2-02-05. Nursing program evaluation.
- Accepted the 2013-2014 CE Audit Report as presented.
- The Nursing Practice Committee recommended the board support the recommendations from the ND Department of Health’s guidance on administration of immunization entitled “responding to parental refusals or delays of immunization of children.
- The Nursing Practice Committee recommended to the board to not support the expansion of the dialysis technician role based on “guidelines for role of dialysis technician.”
- Appointed Stacey Pfenning to ND Center for Nursing Board of Directors.
- Appointed Paula Schmalz as an alternate to ND Center for Nursing Board of Directors.



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Melissa Hanson

Melissa Hanson Hired as Associate Director for Discipline

Melissa Hanson RN has been hired as the Associate Director for Discipline for the North Dakota Board of Nursing.

Melissa received a BSN from North Dakota State University (NDSU) and a Master's of Science in Nursing from the University of Mary. She has 22 years of nursing experience in various roles. Melissa was an Assistant Professor of Practice in Nursing at North Dakota State University at Sanford Health in Bismarck (formerly Sanford College of Nursing, formerly Medcenter One College of Nursing) for the past 9 years.

Melissa was recently awarded the 2015 Higher Education Outstanding Teacher of the Year Award by the Bismarck-Mandan Chamber of Commerce. She was nominated for this award by her students and peers.

She has held numerous professional memberships and was most recently an appointed Board Member for the Board of Nursing. Melissa was also a member of the Board of Nursing, Nursing Practice Committee for 4 years prior to her Board Membership.

Melissa has co-authored one article, published in a national nursing journal, and a second co-authored article has recently been accepted for publication. She has also presented at a regional nursing conference at the University of Minnesota in Minneapolis, MN.

Tammy Buchholz Hired as Associate Director for Education

Tammy Buchholz RN has been hired as the Associate Director for Education for the North Dakota Board of Nursing.

Tammy received an ASN from Casper College, Casper WY, a BSN and a

Master's of Science in Nursing from the University of Mary. Tammy most recently was the Nursing Research Coordinator for Sanford Health Bismarck and prior to that was an Assistant Professor of Nursing at Sanford College of Nursing in Bismarck (formerly Medcenter One

College of Nursing) for 9 years. She has 24 years of nursing experience in various roles. She currently holds a position with the Birthcenter at Sanford Health Bismarck as a staff nurse.

Tammy recently earned the designation of certified nurse educator (CNE) from the National League for Nursing (NLN).

Tammy has held numerous professional memberships and currently is the Vice President of Membership Services for the North Dakota Nurses Association (NDNA). Tammy was the NDNA representative member for the Board of Nursing, Nursing Practice Committee and was selected to serve on the Advisory Committee representing ND for the Code of Ethics for Nurses Revision and the Workplace Violence and Incivility ANA Professional Issues Panels. She is active on the North Dakota Center for Nursing Evidence Based Practice Resource subgroup and the Practice and Policy Group.

Tammy has presented locally and at regional nursing conferences in Grand Forks as well as nationally at the Nurse Educators Conference in the Rockies in Breckenridge, Colorado. She has also contributed numerous articles for publication for the NDNA newsletter.



Tammy Buchholz

1/3 ad to come



Stacey Pfenning

Dr. Stacey Pfenning Assumes Executive Director for North Dakota Board of Nursing

Education and Advanced Practice since 2012. This position allows for collaborations with nursing programs, as well as active contribution to policy and regulation related to health care, nursing education, and advanced practice in ND and nationally.

As a FNP, Dr. Pfenning practices at Dakota Eye Institute in Bismarck and National Medical Resources, a locum organization covering areas in need of health care providers in North Dakota. Formally, Dr. Pfenning served the community through 11 years of FNP practice at a local emergency & trauma center.

As an educator, Dr. Pfenning recently acted as program coordinator and associate professor during the team development and implementation of a FNP track for a DNP program at Rocky Mountain

University of Health Professions (RMUoHP).

Dr. Pfenning's organizational involvement includes: National Council of State Boards of Nursing networks and committees; ND Prescription Drug Monitoring Advisory Council since 2012; ND Center for Nursing Evidence-Based Practice (EBP) and Preceptorship Committees; St. Alexius Institutional Review Board for research since 2007; RMUoHP Institutional Review Board for research since 2008; past ND Nurse Practitioner Association member-at-large and Vice President.

Dr. Pfenning received the 2015 Center for Nursing Legendary Nurse Award for EBP. Dr. Pfenning has published and presented on numerous nursing topics, locally and nationally.

1/2 ad to come

Frequently Asked Questions

Related to Discipline, Investigations, and Complaints

Who can file a complaint against a nurse?

Anyone, including a public citizen, patient, family member, co-worker, employer, facility, other regulatory agencies, and even the Board, may file a complaint against a licensed nurse for alleged violations of the Nurse Practices Act. Any person who has knowledge of conduct by a licensed nurse that may have violated a nursing law or rule in North Dakota may report the alleged violation to the North Dakota Board of Nursing.

However, as stated in the Nurse Practices Act (NDCC 43-12.1-11), the law mandates licensees to report to the Board any knowledge of the performance by others those acts or omissions that are violations of the

Nurse Practices Act or grounds for disciplinary action set forth in NDCC 43-12.1-14.

How do I know what to include with my complaint?

The complaint form may be obtained from the North Dakota Board of Nursing website at www.ndbon.org; click on forms, then Potential Violation Report. When submitting a complaint to the Board of Nursing, complete the form in the most complete manner possible and include a written synopsis of the nature of the complaint with as much detail as possible.

What happens once a complaint is filed?

- When a request for investigation is received by the North Dakota Board of Nursing, the information is reviewed to determine whether jurisdiction exists and whether the alleged practice or behavior, if true, violates the law or regulations that govern the licensee's practice. Once these two conditions are met, an investigation is initiated.
- The nurse is notified of the complaint and asked to submit a written response to the board.
- The pending matter is investigated, interviews are conducted, records are obtained, and evidence is reviewed.
- The completed investigation is reviewed by the Disciplinary Review Panel of the North Dakota Board of Nursing to determine if evidence exists to support a violation of the Nurse Practices Act.
 - Cases that are dismissed due to lack of evidence to support a violation of the Nurse Practices Act are resolved at this level.

- If the evidence obtained during the investigation support the allegations of a violation of the Nurse Practices Act, a disciplinary settlement may be discussed with the licensee, outlining the facts of the violations and the appropriate sanctions.
- All disciplinary actions must be taken to the Board of Nursing for final action.

What disciplinary sanctions can the Board of Nursing impose against a licensee?

The Board can impose various disciplinary sanctions against a nurse for violations of the Nurse Practices Act, including, reprimand, probation, suspension, revocation, surrender, and emergency suspension. Additionally, penalty fees for each separate violation may be imposed against the licensee following any disciplinary action. And, costs and disbursements, including witness fees, and reimbursement of the board's expenses in any administrative hearing or other proceeding, may be recovered from the licensee following any disciplinary action.

How long will it take to resolve a complaint?

Depending on the complexity and nature of the case, availability of information, coordination and cooperation of witnesses and the licensee, the disciplinary process, including the investigation, proceeding, and disposition of a case, can take anywhere from a few weeks to several months to a year or more. Each case is unique and needs to be considered on its own merits. On average, cases are resolved within 45-60 days from

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the date they are received in the board office until the date the investigation is completed and the matter is resolved.

Can a nurse continue to practice nursing while there is a pending investigation against him/her?

The ability to continue nursing practice during an investigation is permissible as long as the nurse who is under investigation maintains a current nursing license and there is no evidence of immediate threat to patient safety.

Is there a timeframe requirement to file a complaint?

The North Dakota Board of Nursing does not have a time limit to file a complaint. However, complaints that are not submitted in a timely manner may be more difficult to investigate.

Will the nurse know who submitted the complaint?

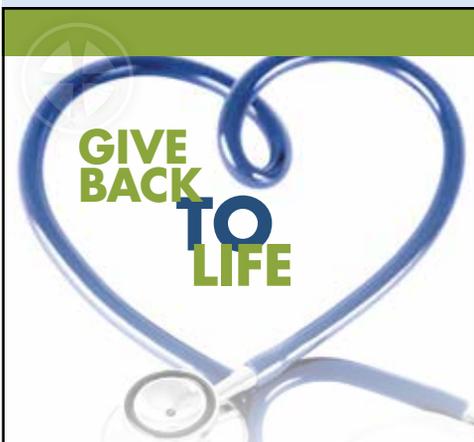
The person named in the allegation may be given a copy of the Potential Violation Report in order for the Respondent to submit a written response to the allegations. Such document may be an open or public record under NDCC 44-04-18. However, if disclosure of the identity of the complainant poses a risk to the person making the complaint, the complainant's identifying information may be redacted.

What may happen to the nurse?

The mission of the North Dakota Board of Nursing is to protect the public. The disciplinary staff aims to accurately and efficiently investigate every complaint in a fair and appropriate manner. If the Board determines that the nurse who has engaged in activities with the potential for

endangering the health, safety, and welfare of the public needs to be monitored or separated from nursing practice, a variety of actions may be initiated, taking into consideration the potential risk of harm to patients as well as mitigating and aggravating circumstances in the nursing care delivery system. Most disciplinary cases are resolved with an informal stipulated settlement. This type of settlement agreement between the nurse and the Board eliminates the need for an administrative hearing. However, if the nurse contests the charges, a formal complaint is filed and an administrative hearing is scheduled before an administrative law judge. Following the hearing, the administrative hearing officer makes a recommendation to the Board with the final decision made by the Board of Nursing.

Reviewed/Revised 04/14



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Literature Review: Nurse Fatigue Related to Shift Length

Reprinted with permission from Deborah Maust Martin, DNP, MBA, RN, NE-BC, FACHE.

The issue of nurse fatigue is of increasing concern to nurses and healthcare organizations. Evidence to document the fatigue issue continues to emerge and provide more specific data and insights for the healthcare community. The relationship of fatigue to patient safety and risk of self-injury is documented in several sources. The purpose of this literature review is to present the most recent evidence and recommendations specific to nurse fatigue for nurses and their managers in understanding these relationships.

Symptoms of fatigue include, but are not limited to decreased alertness, irritability and sleepiness. The Occupational Safety and Health Administration (OSHA)¹ cautions against working more than 8-hour shifts as longer shifts may result in reduced alertness. Fatigue is correlated to nurse performance and chronic fatigue is related to the number of hours worked.²

Health care workers are not alone in shift work and working long hours. The Department of Transportation regulates the number of hours of service for those in aviation, highway, rail and nautical professions.³ Not only are shift times regulated; some have restrictions on weekly and monthly work allotments. Sleep and rest are noted to be

important for those in the rail industry,⁴ airline industry,⁵ and the forest industry.⁶

Long working hours may have an impact on errors as well as near errors,⁷ and decrease the nurse's vigilance in critical care.⁸ Research conducted by Barker and Nussbaum (2011) found that acute fatigue resulted from long hours of work, and that fatigue was negatively correlated with performance.

It was identified that an increased number of shifts worked by nurses in the prior 72 hours were significantly associated with hypoglycemic events in ICU patients receiving insulin infusions.⁹ Documentation of patient care can also be impacted by working longer hours;

there were 26 percent less charting errors with fewer call hours in the surgical setting.¹⁰

In addition to patient clinical outcomes, a correlation exists between hospitals where nurses worked 13 hours in length or longer and patient dissatisfaction with communication, pain control and help when they wanted it.¹¹ Nurses working long shifts were more likely to be burned out, dissatisfied with their job and intended to leave their job within the year.¹¹

¹² Shifts scheduled for 12 hours often exceed that timeframe, as many as 40% of the work shifts logged for their study exceeded 12 hours.⁷

Nurse's personal safety related to longer worked hours is also a concern. Extended work hours are a contributing factor in needle stick injuries among nurses,¹³ and rates of nurses driving drowsy doubled when they worked more than 12.5 hours.¹⁴ In a study that examined the impact of a 9-hour shift compared to an 8-hour shift, the nurses working the 9-hour shift had more health issues, were not as satisfied and had more fatigue.¹⁵ In variables associated with worker injury, those working 12-hour shifts had a higher medical cost per injury than those who worked 8-hour shifts.¹⁶ Findings in a simulated environment demonstrated older people were not able to perform as well as younger people.¹⁷ This is important for the health care industry to consider as the nursing workforce ages and there is a need to retain them through improved job attributes.¹⁸

If shorter shifts are not available, planning to decrease the effects of fatigue can include regular and frequent breaks,^{1, 7, 19, 20} meal breaks,^{1, 7, 19} staff getting enough sleep or naps,^{21, 22, 19,} ²³ limiting caffeine,^{19, 23} eating well and exercising¹⁹ and limit the number of shifts worked in a row.² Additional options include avoiding double back shifts such as an evening shift followed

by a day shift with less than eight hours between, limit on-call hours, and allow sleeping during the night shift. Implementation of a formal fatigue countermeasures program for nurses has provided evidence of improvement in nurse fatigue.²⁴ With consecutive 12-hour shifts, nurses were not able to recover between shifts and used caffeine as a possible mechanism to improve alertness.²⁵

It is a legal and ethical obligation to educate the nursing staff about the effects of long work hours.²⁶ It is important for senior management to be aware of the impact of working longer shifts.²⁷ The Institute of Medicine (IOM)²⁸ recommends limiting the number of hours worked in a day by nurses as a patient safety precaution. They find the evidence to be "very strong" (p. 236) related to prolonged work hours and worker fatigue. Recommendations are that health care organizations establish policies and practices to limit hours worked in a shift as well as the number of hours worked in a week,^{11, 28} that the "routine use of twelve-hour shifts should be curtailed"⁷ (p. 210), and that overtime after a 12-hour shift should be eliminated.⁷ Another recommendation is to decrease shift length to allow recovery time between shifts.²⁹ Health care workers in the United States often work 12-hour shifts prompting Lockley³⁰ to state "hours routinely worked by health care providers in the United States are unsafe" (p. 14). The American Nurses Association³¹ notes that in addition to employee accountability regarding fatigue, employers are obligated to provide adequate staffing to care for patients. It is not the individual nurse's responsibility to cover all shifts by working extra hours.

The evidence is compelling that long shift lengths are correlated with negative outcomes for both patients and nurses. Patients are impacted by errors in their care and are more

dissatisfied when nurses work longer shifts. For the nurse, the outcomes of working longer shifts can be injury to self and intent to leave their job. Injuries may happen on the job such as needle sticks or strains; or on the way home if in an accident caused by driving while drowsy.

A literature review revealed that shift length has been correlated with nurse fatigue and has become a growing concern in the United States with the routine shift length of 12 hours.

Outcomes correlated to shift length and fatigue includes errors or near errors in patient care. In addition to concerns in patient care outcomes, the impact of fatigue on the nurse is also noted.

Nursing is a profession, and as a profession, we need to be self-regulating. If we are not able to mitigate the impact of fatigue, it could become regulated as with other industries such as transportation, logging and nuclear power workers.

Acknowledgement: A special 'thank you' to Kathy Malloch, PhD, MBA, RN, FAAN who encouraged me to take the leap and go back to school for a DNP in Innovation Leadership at ASU and for recognizing the importance of this topic to the nursing profession.

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Updated 6/15



TERCAP

Taxonomy of Error, Root Cause Analysis and Practice-responsibility

Ten Years After the Institute of Medicine (IOM) Recommendation to NCSBN: Highlights of the Findings from the NCSBN National Nursing Adverse Event Reporting System – TERCAP®

A decade has passed since the publication of the 2004 Institute of Medicine (IOM) report “Keeping Patients Safe: Transforming the Work Environment of Nurses,” in which the IOM recommended that “The National Council of State Boards of Nursing [NCSBN], in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their applicability by state boards of nursing and other state regulatory bodies having authority over nursing” (Institute of Medicine, 2004).

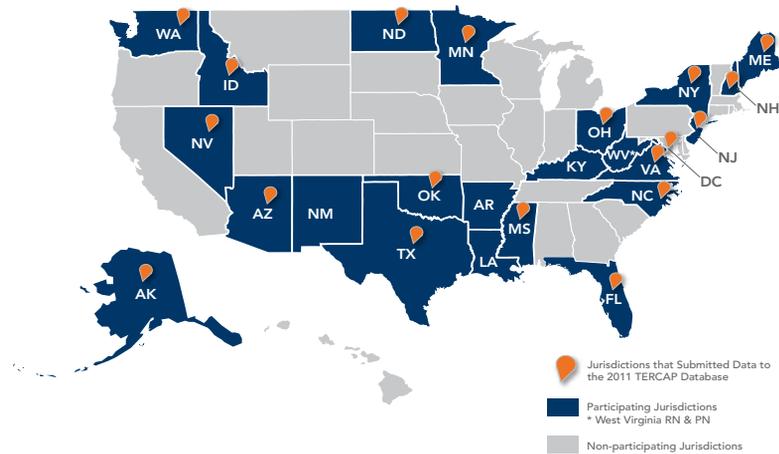
To systematically track and evaluate the causes of adverse events from both individual and system perspectives, and enable the development of proactive interventions to protect patient health and safety, NCSBN initiated the Taxonomy of Error Root Cause Analysis of Practice-responsibility (TERCAP®) project. Practice breakdown is defined as the disruption or absence of any of the aspects of good nursing practice and the term “practice breakdown” is used in this context because it broadens the categorization of events reported to TERCAP.

The TERCAP database, developed in 2007 in consultation with nursing regulators, researchers, and educators nationwide, is a direct response to the IOM’s concerns. It is designed for boards of nursing (BONs) to collect standardized, comprehensive and consistent information regarding nursing practice breakdown during investigations and

report practice breakdown cases to NCSBN for analysis of error trends.

Based on 3,075 practice breakdown cases submitted by 25 BONs, NCSBN completed the 2014 TERCAP report, which examined all components involved

Figure 1. BONs Contributing to TERCAP®



in the TERCAP model by evaluating the contributing factors associated with practice breakdown from nurses, patients’, and system perspectives. Figure 1 shows the BONs that have contributed data to TERCAP.

Highlights of the 2014 TERCAP Report Nature of Practice Breakdown and Contributing System Factors

- 73 percent of the practice breakdown cases submitted to TERCAP involved unintentional errors.
- While 56 percent of the practice breakdown did not cause harm, 44 percent did cause harm to patients.
- The most frequently reported practice breakdown categories include a lack of professional responsibility and/or patient advocacy, defined as a nurse

failing to act responsibly in protecting patient vulnerabilities (73 percent), lack of clinical reasoning (49 percent), and lack of intervention (48 percent).

- Miscommunication (38 percent) and health care team conflicts (39 percent) were the most frequently reported system factors contributing to practice breakdown.

Characteristics of Patients and Practice Breakdown

- 66 percent of the patients involved in a practice breakdown were 50 years or older.

- Patients 65 years or older are more likely to be affected by lack of intervention compared to patients 18 years of age or younger (56 percent versus 39 percent).
- At the time of the practice breakdown, 62 percent of patients up to 18 years of age were accompanied by their family or friends, while only 22 percent of patients aged 65 and above were accompanied by family or friends.

Characteristics of Nurses Contributed to Practice Breakdown

In line with previous NCSBN studies (E. H. Zhong, Kenward, Sheets, Doherty, & Gross, 2009; E.H. Zhong & Thomas, 2012), the 2014 TERCAP report showed that nurses with a previous negative job

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(discipline or termination for practice issues by employers) or discipline history were more likely to commit practice breakdown. In addition, male nurses and licensed practical nurse (LPNs) or vocational nurses (VNs) are over represented in the group of nurses who committed practice breakdown.

- 38 percent of the nurses had been previously disciplined by their employers for practice issues.
- 9 percent of the nurses had been disciplined by BONs before the current incident, while the average annual discipline rate by BONs in the general nursing workforce is less than 0.3 percent.
- 5 percent of the nurses had a criminal conviction history while less than 3 percent of the non-disciplined nurses had such a history.
- 15 percent of the nurses were male, compared to 9 percent of the national nursing workforce.
- 37 percent of the nurses held LPN/VN licenses, compared to 20 percent of the nursing workforce.

The Initial Trend Reviews (2008-2014)

The proportion of types of practice breakdown reported to TERCAP remained consistent over the past seven years.

There was a slight decrease in the proportion of cases related to a lack of professional responsibility and/or patient advocacy from the 2008-2011 reporting period (78 percent) compared to the 2011-2014 reporting period (71 percent), and a slight increase in cases related to a lack of prevention, from 23 percent to 29 percent.

There was a slight decrease in the proportion of cases involving system factors reported to TERCAP since 2011 (Figure 2). This positive tendency could be a result of a group effort from BONs and other health care members in improving the health care system.

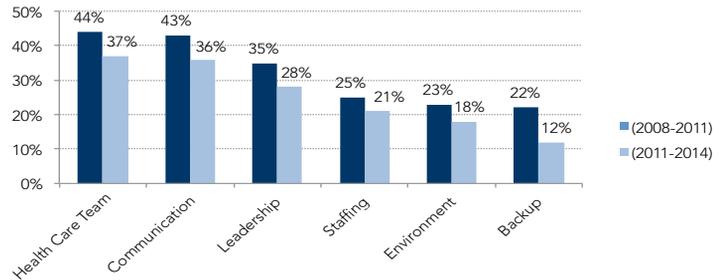
Facility Issues

The current report examined the distribution of registered nurses (RNs)

and LPN/VNs by employment setting compared to the national composition. At the time of practice breakdown, 16 percent of RNs and 56 percent LPN/VNs worked in long-term care (LTC) facilities, while the HRSA U.S. Nursing Workforce

- were dismissed by BONs
- 49 percent of the LTC cases versus 57 percent of the cases from hospitals resulted in disciplinary action by BONs.

Figure 2. Proportion of Cases Involving System Factors Reported during 2008-2011 and 2011-2014



report showed that nationally only 7 percent of RNs and 31 percent of LPN/VNs worked in nursing care facilities (HRSA, 2013). Conversely, 52 percent of RNs and 8 percent of LPN/VNs worked in hospital settings when the practice breakdown occurred; however, nationally, 63 percent of RNs and 29 percent of LPN/VNs worked in hospital settings (HRSA, 2013). The underlying causes for higher reporting of practice breakdown in LTC facilities compared to hospital settings are unclear. A further analysis on the cases reported from LTC facilities and hospitals showed the following :

- 85 percent of LTC nurses versus 3 percent of the hospital nurses were assigned more than 10 direct care patients.
- 80 percent of the LTC patients and 37 percent of the hospital patients were 65 years or older.
- 67 percent of the LTC facilities versus 20 percent of hospitals used paper documentation record systems.
- 28 percent of the LTC cases versus 17 percent hospital cases claimed that a staffing issue contributed to the practice breakdown.
- 32 percent of the LTC cases versus 25 percent of the hospital cases reported that leadership contributed to the practice breakdown.
- After BON investigations, 14 percent of the LTC cases versus 10 percent of the hospital cases

Summary

The proportions and types of practice breakdown reported to TERCAP remained consistent over the past seven years.

Unintentional errors were the predominant cause (73 percent) of cases submitted to TERCAP, with less than half of the reported breakdowns involving harm to patients. Practice breakdowns occurred more frequently in LTC facilities, as compared with hospitals, and involved older patients at a higher frequency than younger patients. The TERCAP data supports existing evidence that nurses with a history of disciplinary action or reported violation experienced more practice breakdowns, particularly in male nurse and LPN/VN populations.

Future Plans

- NCSBN will continue the TERCAP data collection and further promote the TERCAP project at the state and national levels with the goal to increase participation of all BONs.
- NCSBN will monitor the possible trend changes after the implementation of the Affordable Care Act within a two- year time frame.

With the establishment and refinement of the TERCAP database, along with the release of the 2011, 2013 and 2014 TERCAP reports,

NCSBN has fulfilled the IOM request of designing uniform processes for BONs to follow. With broader participation from BONs, additional analysis can be performed to further investigate the causes of practice breakdown and move the TERCAP project to the next level – development of rational strategies to prevent and reduce practice breakdown.

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Next scheduled Board of Nursing Meetings, to be held in Sioux Falls, South Dakota:

Meeting date: Agenda items due:

Sept. 10 & 11, 2015 Aug. 27, 2015

Nov. 19 & 20, 2015 Nov. 5, 2015

All licensure forms, the Nurse Practice Act and contact information is available on the South Dakota Board of Nursing Website at www.sdnursing.gov

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DISCIPLINARY ACTIONS TAKEN BY THE SOUTH DAKOTA BOARD OF NURSING

APRIL 17, 2015

- Valerie Lynn Arens, R041585..... Probation
- Jimmi Denell Ashley, P009106..... Voluntary Surrender
- Craig Robert Davelaar, IA RN116986... Probation on Iowa Privilege to Practice in South Dakota
- Candie Lynn Dirth, P009747..... Probation
- Nicole Marie Ernst, R042137..... Letter of Reprimand – Appealed
- James Michael Hand, R024764..... Voluntary Surrender
- Julie Ellen Hansen, P008042..... Letter of Reprimand
- Mary Ellen Hudson, P010566..... Probation
- Nichole Kristine Solomon, R033973..... Probation
- Karmyn Brianna Gluhm, R041875..... Summary Suspension

South Dakota Board of Nursing Meeting Highlights April & June 2015

Practice:

- The South Dakota Board of Nursing granted a motion at their February 2015 meeting to accept the Unlicensed Diabetes Aide (UDA) Registration and Training Policy as presented. The policy establishes a process to develop a final exam for the purpose of registering UDAs using a deliberate process to ensure a consistent, reliable and valid exam that measures the minimum competence and proficiency of UDAs.
- The South Dakota Board of Nursing granted a motion at their June 2015 meeting to accept the proctor policy for unlicensed assistive personnel online exams for the registration of Medication Aides and UDAs as presented. The policy establishes a process to use approved proctors for the administration of the South Dakota Board of Nursing's on-line examinations.
- The South Dakota Board of Nursing granted a motion at their April 2015 meeting to appoint Kay Foland, CNS, CNP and Lynn White, CNS to the Advanced Practice Registered Nurse (APRN) Committee. The Committee assists the Board of Nursing in evaluating APRN care standards and regulation.
- The South Dakota Board of nursing reviewed the South Dakota Center for Nursing Workforce 2015 South Dakota Nursing Workforce Supply and Employment Characteristics report at their April meeting. The report may be accessed at: <http://doh.sd.gov/boards/nursing/RandP.aspx>.

Education:

- The South Dakota Board of Nursing granted a motion to accept the 2014 South Dakota Annual Education & Narrative Reports and moved to continue RN and PN program approval. The report may be accessed at: <http://doh.sd.gov/boards/nursing/RandP.aspx>
- The South Dakota Board of Nursing granted a motion for Full Approval status for the LPN-AAS program at Southeast Technical Institute.
- The South Dakota Board of Nursing granted a motion to accept the NCLEX Improvement Plan for NAU's generic baccalaureate nursing program.

Pursuant to SDCL 36-9-17, the Board is required to meet annually and as often as may be necessary to transact its business. The Board of Nursing generally meets a minimum of five times each year. The following webpage can be accessed for a listing of scheduled board meetings <http://doh.sd.gov/Boards/nursing/Calendar.aspx>

Individuals interested in attending should check the Board website for dates, location, and time of upcoming meetings. The agenda will be posted onto this website 24 hours prior to the Board Meeting. All agenda items are due to Jill Vanderbush (jill.vanderbush@state.sd.us) at the Board no later than two weeks prior to a scheduled meeting. Minutes from a transacted Board meeting can be found on the Board website: <http://doh.sd.gov/Boards/nursing/Minutes.aspx>

Meetings are open to the public, however SDCL 1-25-2 allows a public body to close a meeting for discussing employee or legal matters. For more information on open meeting law, please go to <http://atg.sd.gov/LinkClick.aspx?fileticket=37WWjqBso3c%3d&tabid=324&mid=811>



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** (U.S. Department of Labor, Bureau of Labor Statistics, Jan. 8, 2014)



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South Dakota Board of Nursing Implements New Registries for Unlicensed Assistive Personnel

Medication Aide Registration

The South Dakota Board of Nursing is pleased to announce the implementation of a Medication Aide Registry as of May 1st, 2015. New rules adopted in ARSD 20:48:04.01 in July 2014 require the Board to maintain a registry listing unlicensed individuals who completed a Board approved 20-hour medication administration training program.

Please encourage medication aides to complete the Board of Nursing's application process and become registered! Medication aides, trained in a BON approved 20-hour training program*, will be grandfathered onto the registry and are not required to take the new South Dakota Board of Nursing's approved medication aide exam. To become registered the medication aide must **submit a completed application*** to the South Dakota Board of Nursing office. The application is located at: <http://doh.sd.gov/boards/nursing/MATPApproval.aspx>. *Individuals grandfathered onto the registry will not be required to take the Board's exam.*

**Medication aides trained to work in group homes and community settings licensed by the Division of Developmental Disabilities, Department of Human Services must complete a BON-approved medication administration training program to be placed onto the Board of Nursing's medication aide registry. For questions, contact Stephanie.orth@state.sd.us*

Following receipt and review of a completed application, the Board of Nursing will place the individual on the registry. Medication

aides, employers, and nurses may then verify a medication aide's registry status at www.sduap.org/ verify at no cost. **Please allow 5-7 business days for processing of the application.**

Keep in mind that medication aides trained before the end of 2015 and who are currently working in the role of a medication aide will **not** be required to take the Board's medication aide exam. However individuals wanting to grandfather onto the registry **must apply and be registered prior to December 30, 2015.** Those individuals **not** grandfathered will be required to pass the Board of Nursing's new exam. The exam is projected to be implemented and required for new medication aides as of January 1, 2016.

Be advised that as of January 1st, 2016, RNs and LPNs may only delegate medication administration to medication aides that are listed on the Board's registry.

Additionally, it is important that nurses and employers recognize that this registry only provides assurance that individuals listed have met minimal criteria including the completion of required training and testing to allow them to accept the delegated task of medication administration from a licensed RN or LPN while under nurse supervision. **Registry status does NOT imply that an individual has met moral, ethical, or legal standards and should not take the place of an employer's hiring screening process or background check.**

Visit the Board of Nursing's website <http://doh.sd.gov/boards/nursing/> for more information and to locate application information. If you have additional questions regarding

registration of medication aides please contact the Board of Nursing office at 605-362-2760.

For information on grandfathering or the medication aide registry, contact: stephanie.orth@state.sd.us

Unlicensed Diabetes Aide Registration

The South Dakota Board of Nursing is now registering Unlicensed Diabetes Aides (UDA) as required in new rules in ARSD 20:48:04.01, adopted July 2014. The rules allow RNs to delegate the administration of subcutaneous insulin to a registered UDA while under the RN's supervision. An RN, that has completed the Board's self-paced UDA RN Train-the-Trainer Course, may delegate insulin administration to a trained and registered UDA only when a licensed RN or LPN is not available to administer the insulin and only in accordance with the South Dakota Board of Nursing's **Approved Protocol**. The protocol lists training requirements for the UDA and RN and includes RN supervision requirements.

The new rules require the Board to maintain a registry that lists those individuals that completed the Board's approved 10-hour diabetes medication administration training program and passed the Board's online UDA exam. The training and exam are offered at no cost.

Additionally, it is important that nurses and employers recognize that this registry only provides assurance that individuals listed have met minimal criteria including the completion of required training and testing to allow them to accept the delegated diabetes care tasks and insulin administration from a licensed RN while under supervision. **Registry status does NOT imply that an individual has met moral, ethical, or legal standards and**

should not take the place of an employer's hiring screening process or background check.

Visit the Board of Nursing's website <http://doh.sd.gov/boards/nursing/uda.aspx> to locate the Approved Protocol and for more information on the RN and UDA training and application process.

For information contact: Linda.young@state.sd.us

Dialysis Technician Registration

The South Dakota Board of Nursing is also registering Dialysis Technicians in accordance with a new requirement in ARSD 20:48:04.02:04, effective July 31, 2014. Registration as a dialysis technician permits the registrant to continue to accept delegated nursing tasks to perform basic clinical and technical tasks in the care of clients with end stage renal disease. These tasks may only be delegated by a licensed nurse that

is physically present in the dialysis unit and according to rules provided in ASRSD 20:48:04.05. *(Exception: an unregistered/uncertified dialysis technician employed for less than 18 months may accept delegated tasks).*

Please encourage dialysis technicians to complete the Board of Nursing's application process and become registered before November 1, 2015. The application and registry information is located at: <http://doh.sd.gov/boards/nursing/Dialysis.aspx>. After November 1st the Board expects that licensed nurses delegate dialysis care tasks to technicians registered with the South Dakota Board of Nursing.

Nurses and employers will be able to verify the registration status of a dialysis technician on the Board of Nursing's website at no cost, www.nursing.sd.gov.

For information contact: Linda.young@state.sd.us

Watch Your Mailbox!

2015 National Nursing Workforce Survey

The National Council of State Boards of Nursing (NCSBN) and The National Forum of State Nursing Workforce Centers is conducting the 2015 National Nursing Workforce Survey. This is a nationally randomized survey that is sent to 260,000 licensed nurses chosen from the approximately 4.5 million nurses in the United States.

Examining the current supply of nurses provides valuable insight into preparing to meet our county's future nursing demand. If you are selected and receive this survey, please take a moment and complete the survey! Your responses, along with the those from many other nurses, will provide valuable information critical to examining the current nursing workforce supply for our country and will help to promote and ensure a future workforce prepared to deliver quality care for individuals and communities.

Please remember to watch your mailbox and if you receive the survey please participate! Your responses will contribute to this valuable national study and will also help your state center for nursing workforce examine their own state supply as well.

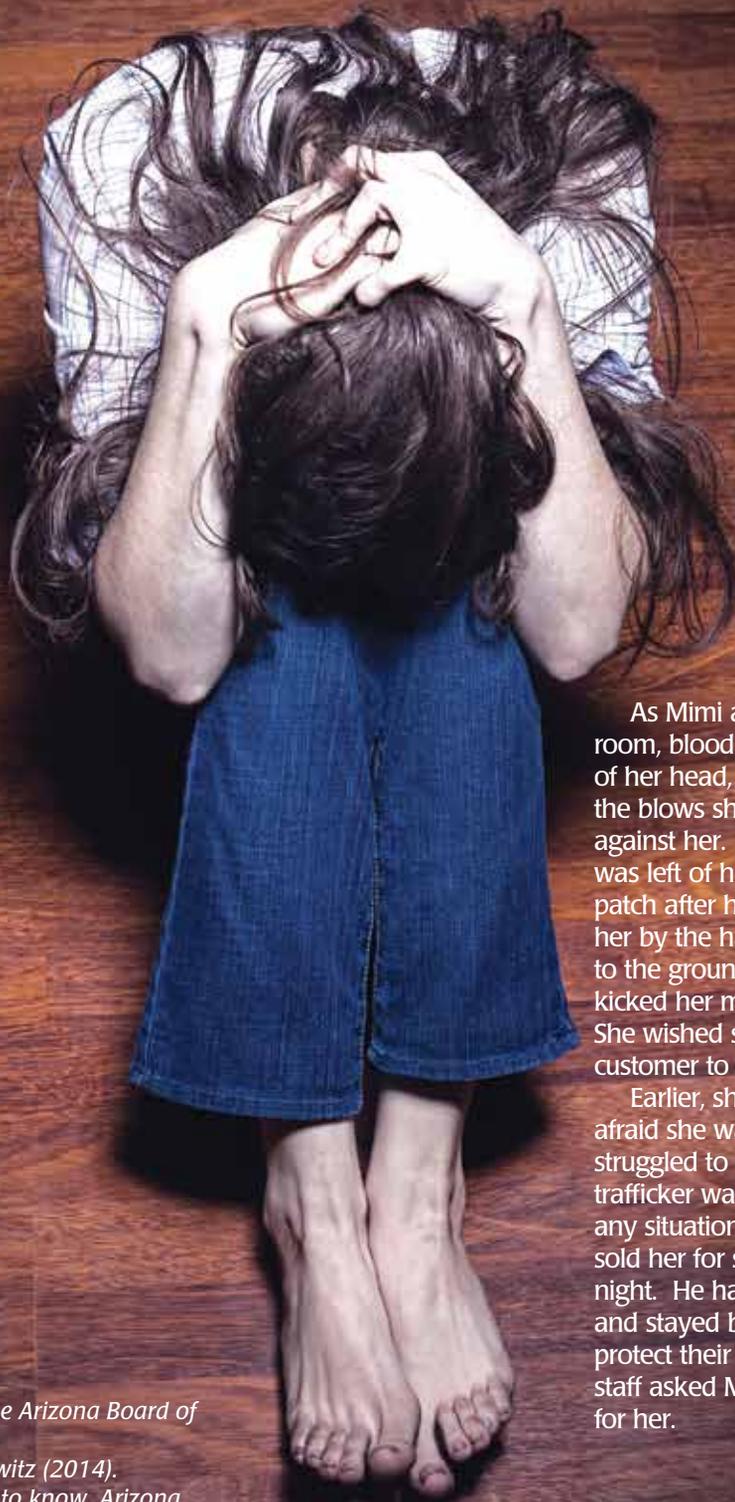
Thank you!

Patricia Moulton, PhD
Executive Director, North Dakota Center for Nursing Workforce

Linda Young, RN, MS, FRE, BC
Program Director, South Dakota Center for Nursing Workforce
Nursing Practice Specialist, South Dakota Board of Nursing

1/3 v ad to come

Sex Trafficking: What Nurses Need to Know



As Mimi arrived in the emergency room, blood was trickling down the side of her head, which already ached from the blows she sustained in the attack against her. Blood soaked through what was left of her hair. She had lost a large patch after her assailant had grabbed her by the hair and slammed her face to the ground in the gravel alley, then kicked her multiple times in the stomach. She wished she hadn't taken this violent customer to such a private spot.

Earlier, she had stumbled to her feet, afraid she was badly hurt. She had struggled to get to the street where her trafficker waited. He was her help for any situation—as well as the one who sold her for sex multiple times every night. He had driven her to the hospital and stayed by her side, as pimps do, to protect their merchandise. As hospital staff asked Mimi questions he answered for her.

Reprinted with permission from the Arizona Board of Nursing Regulatory Journal.

Citation: Hickle, K. & D, Roe-Sepowitz (2014).

Sex trafficking: What nurses need to know. Arizona Board of Nursing Regulatory Journal (10),2, 6-11.

Although Mimi’s story was relayed by another (Sabella, 2011), it is typical for victims of the sex slave trade (U.S. Department of State, 2011). Often traffickers identify themselves as a loving family member, boyfriend, or employer who is simply trying to help. Victims also may identify traffickers in these ways. For the trafficker, this is a financial decision. Mimi was a great source of income to her pimp. For those unfamiliar with sex trafficking, most don’t realize that girls working the streets keep none of the money they receive for sex. All monies—100% including tips, is given to the pimp. Her pimp considers her his property and source of income.

The well-intentioned nurses, physicians, and other staff who cared for Mimi didn’t question why this young girl, wearing excessive makeup, was out so late in scantily clad clothing on a cold night. Additionally, no one seemed to realize the need to separate her from the man who accompanied her. If Mimi had been questioned alone, the truth may

have been uncovered (Belles, 2012).

What is sex Trafficking?

Sex Trafficking and terms like “modern day slavery” usually conjure images of young girls being sold to sex tourists in faraway countries. Movies and documentaries feature scenes of tourists being kidnapped and forced into sexual servitude. Sex trafficking is a real and growing problem all over the world, including here in the United States. It defies stereotypes and experts continue to build new knowledge about the issue.

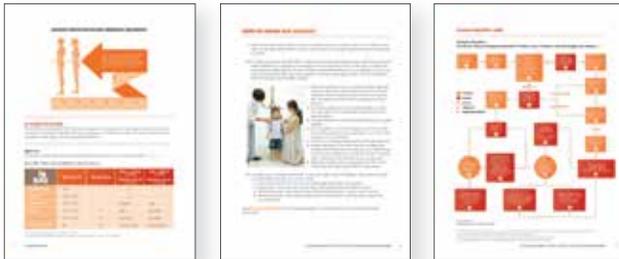
The sex trafficking market is driven by the laws of supply and demand. As long as there remains a demand for a commercial sex industry, there will remain a supply of individuals willing to profit from its sale. Sex trafficking is a highly profitable criminal enterprise generating several billion dollars annually, second only to illegal arms trafficking and the drug trade (FAS, 2000). Sex trafficking is a high profit, low risk business where the commodity, a human

body, can be sold repeatedly, unlike drugs or weapons, where the product can only be sold once.

Along with a means to recruit victims, traffickers use technology to reach a wide client base for prostitution services. The perceived anonymity of online transactions has emboldened traffickers to openly recruit, buy and sell their victims via the internet (Boyd, 2012). Consequently, those looking to profit will continue to recruit, abduct, and exploit young people for the purpose of supplying the demand (Harris, 2012).

Although there is limited data to quantify the exact number of human trafficking incidences, we know that the sex trafficking of minors happens and has devastating physical and mental health consequences on victimized youth. It can be difficult to detect unless people who interact with victims are trained to recognize the signs.

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- Obesity coding information



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Front-line health care settings where a victim may present for services include the emergency room, urgent care, primary care clinics, obstetrics/gynecology clinics, school nurse's office, community health centers, mobile clinics, Planned Parenthood and dental clinics. Common public health concerns often co-occurring with sex trafficking victimization include domestic violence, child abuse and neglect, HIV and other Sexually Transmitted Infections, unwanted pregnancies, unmet preventative healthcare needs, drug and alcohol abuse and addiction (Williamson et al., 2009).

Unfortunately, the majority of nurses have a limited understanding of the issue of sex trafficking and how it may present with their patients. The reality is that trafficked victims often endure physical violence and neglect, and are likely to present for medical care at some point during their abuse. In fact, nurses are one of the few

groups of professionals who interact with victims while they are still under the control of their abuser or the person profiting from their abuse (Issac, Solak & Giardino, 2011).

WHO ARE THE VICTIMS?

While there is no commonly accepted profile for victims of minor sex trafficking, certain populations are more vulnerable than others. Pimps/traffickers target runaway or "throwaway" teens or those who are having trouble at home. Runaway and homeless youth are at increased risk for predators as they have few resources, may not be old enough to legally get a job, and are often running away from difficult situations.

It is common for these adolescents to trade sex to meet their basic survival needs of food, clothing or shelter. According to a recent survey of homeless youth in New York, of those engaged in commercial sex, they said they did it for shelter because they needed someplace to stay (Bigelsen, 2013).

How do individuals become victims of trafficking?

- Recruitment by "Romeo/boyfriend" pimps who convince them that they love and care for them.
- Kidnapping by "gorilla pimp" and forced into the life.
- Gang related prostitution.
- A parent or family member pimps their child for drugs or money.
- Running away and living on the streets and are forced to exchange sex for survival.

MISSED OPPORTUNITIES

Despite chances for intervention, nurses can easily fail to identify victimized youth. With increased knowledge about the topic, and new screening tools and intervention strategies, you can begin to ask the right questions and help your clients

avoid further exploitation and abuse.

Vulnerable youth can be lured into prostitution and other forms of sexual exploitation using promises, psychological manipulations, provision of drugs and alcohol, and violence. The trafficker's main purpose is financial gain and will make every effort to establish trust and allegiance by wooing the victim in what feels like a loving and caring relationship.

TARGETED Pimps "shop" for their victims online, in shopping malls, bus stops, schools, after school programs, foster homes and other places where teens gather.

TRICKED Pimps invest a lot of time and effort in forming a bond with their victim. They often buy gifts, provide a place to stay, and give affection before revealing their true intent to sexually exploit them. Traffickers use a powerful technique pioneered by religious cults known as "love bombing" in which a girl is showered with affection as a means of manipulating her (Dorais & Corriveau, 2009).

TRAUMATIZED The pimp's use of psychological manipulation, physical violence and rape can make the victim feel trapped and powerless. The "trauma bond" is very difficult to break and may require intensive long term treatment and counseling (National Center for Missing and Exploited Youth, 2014).

THERE IS NO SUCH THING AS A WILLING CHILD PROSTITUTE

The Federal Trafficking Victims Protection Act (TVPA) defines the crime of trafficking as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act where such an act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age. The most important thing to understand from the federal definition is that anyone under the age of 18 who is induced



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to perform a commercial sex act is automatically a trafficking victim.

Victims are often reluctant to come forward because they have been taught by their victimizer that if they attempt to seek help, no one will believe them, and they will be treated like a criminal and a prostitute (Bigelsen, 2013). It is helpful to understand that there are many similarities in victimization between intimate partner violence and sex trafficking. Victims of sex trafficking and domestic violence tend to hide their situations and both victim groups are hesitant to disclose their victimization in medical or clinical settings (Roe-Sepowitz et al, 2013).

Nurses can apply their knowledge about domestic violence, trauma and sexual abuse to better understand a trafficking victim's fear and reluctance to leave the relationship. In addition, common myths and stereotypes about sex trafficking can affect judgment and response. Common myths include "that only happens abroad" or "it was consensual." The more health care providers know about this population, including the mindset of a victim, the better equipped they will be to identify victims and focus on prevention strategies.

UNDERSTANDING THE MINDSET OF A VICTIM

- Victims often do not see themselves as victims.
- Victims may feel shame, self-blame and feelings of unworthiness of a better life.
- Victims may be coached to lie to nurses and other health professionals and often give fabricated histories with scripted stories.
- Victims are often fearful and distrust law enforcement and government services due to fear of arrest.
- Victims often fear for their own safety and the safety of their loved ones due to threats of violence

- Victims may have formed a trauma bond with their exploiter and may have deep loyalties and positive feeling for their abuser.
- Drugs often play a role in sex trafficking situations – sometime as a way to cope or victims sometime enter "the life" to support a drug habit.

POSSIBLE PHYSICAL SEX TRAFFICKING INDICATORS

- Evidence of sexual trauma
- Cigarette burns
- Fractures
- Bruises and or contusions
- Tattoos found on the body may serve as a "brand" that the victim belongs to a certain trafficker
- Respiratory infections
- Drug related health issues such as asthma, Hepatitis C, skin infections
- Tension headaches, back pain, stomach pains
- Malnutrition and poor diet
- Dehydration
- Unexplained scars
- Injuries to head and mouth
- Bladder damage, injury or infection
- Temporal Mandibular joint problems from oral sex
- Bite marks
- Stab or gunshot wounds
- Hearing loss from head trauma
- Traumatic Brain Injury (TBI)
- Bald patches from having hair pulled
- Dental problems

(Dovydaitis, 2010; Sabella 2010 & 2013)

RED FLAGS

- Discrepancy in reported age and apparent age
- Resistance to gynecological exam
- Homelessness
- Chronic runaway
- History of abuse

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- Traveling with an older male
- Presence of an older “boyfriend” or older peer
- Unusual tattoos or branding marks
- Involvement with the juvenile justice system through truancy, curfew violations and other status offenses
- Companion who refuses use of an interpreter
- Use of street lingo with references to “the game” “the life”
- Lack of identification
- Dominating or controlling “boyfriend” or companion in the room who refuses to leave
- Claim that the patient is “just

visiting” the area and unable to provide a home address

Randy Christensen, founder and director of a mobile health clinic for homeless youth in Phoenix, Arizona shares many stories of interacting with victims of sex trafficking in his book, “Ask Me Why I Hurt: The Kids Nobody Wants and the Doctor Who Heals Them.”

In one case, Dr. Christensen reports seeing both vaginal and rectal tearing from a violent rape. The victim didn’t want to call the police for fear they would not believe her because she thought there was no such thing as raping a prostitute. His nurse commented, “Whatever happens to her she thinks she deserves it.”

Some excerpts from the book:

“Oh, I’m eighteen. We’re always eighteen, unless you want me to be twelve, a lot of “Johns” (customers) do.”

“She was physically there, but not emotionally present at all. I learned what I had read about sexual abuse victims and how they learned to disassociate from their bodies. Reading about it was different than actually patient on my exam table, a child who lay there like a defenseless puppet.”

“These kids have built fortresses around their hearts. They seemed so shut down that I wasn’t sure if anyone could reach them. I wondered if it would be possible to act professional yet also connect as a caring adult.”

DID YOU KNOW

Between 244,000 and 325,000 American youth are considered at risk for sexual exploitation, and an estimated 199,000 incidents of sexual exploitation of minors occur each year in the United States (Estes & Weiner, 2001).

The average age at which girls first become exploited through prostitution is 12–14 years old (US



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Department of Health and Human Services, 2013).

Minors in sex trafficking nearly always have a pimp – someone who they view as their protector but who in fact is managing and benefitting from the sexual exploitation of the child (Shared Hope International, 2009).

Adolescent boys and lesbian, gay, bisexual, transgendered and queer/questioning (LGBTQ) can also be victims. According to a recently released study, boys make up almost half of the victim population (Bigelsen, 2013).

THE ROLE OF TRAUMA

Instead of asking
WHAT'S WRONG WITH YOU?" or
"WHY ARE YOU DOING THIS?"

ask

"WHAT HAS HAPPENED TO YOU?"

This change reduces the blame and shame that some people experience when being labeled. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing.

Sex trafficking victims have endured a high level of trauma and require services and interventions that do not inflict further trauma such as physical restraint, isolation or harsh verbal interrogation. Traumatic experiences can be dehumanizing, shocking or terrifying and often include a loss of safety and the betrayal by a trusted person or institution (National Center for Trauma-Informed Care, 2013).

If you suspect your client could be a victim of sex trafficking, the first step is to get them alone in a confidential location for an interview. If the client is in immediate danger, call 911.

Sample messages to use with a victim to gain trust:

- "You can trust me."
- "I am here to help you."
- "My first priority is your safety."
- "We will give you the care you need."
- "We can help you find a safe place to stay."
- "No one has the right to hurt you or make you do things against your will."

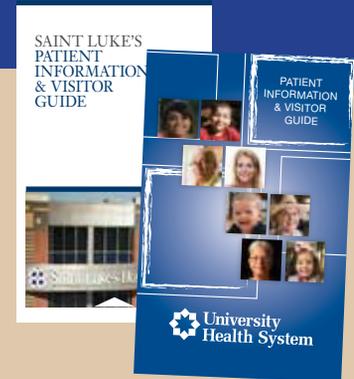
Screening questions to ask:

- "Can you come and go as you please?"
- "Has anyone ever paid someone else to have sex with you (like a boyfriend, boss, manager, etc)."
- "Tell me about that tattoo."
- "Do you have to work to contribute money to your 'family'?"
- "Do you have a boyfriend? If so, how old is he and what do you like to do together?" "Where did you meet?"
- "Have you ever run away from home? If so, where did you stay and who did you stay with?"
- "Have you ever had to do things in order to stay somewhere that you did not want to do?"
- "Has anyone ever taken pictures of you and put them on the internet?"
- "Have you been physically harmed in any way?"
- "Where are you staying?"
- "Are you or your boyfriend a member of a gang?"

(Ohio Human Trafficking Task Force Human Trafficking Screening Tool, 2013)

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AFTER VICTIM IDENTIFICATION, WHAT DO I DO?

If the victim is under 18, it is mandatory under state and federal law to report sexual exploitation of children. Notify the police and Child Protective Services.

Call the National Human Trafficking Resource Center to report the incident and ask for help.

The center's phone number is 1-888-3737-888.

WHERE CAN I GET MORE INFORMATION?

www.endsextrafficking.az.gov

<https://ssw.asu.edu/research/stir>

www.polarisproject.org

www.sharedhope.org

The information contained in this Article is from **What You Need to Know, Sex Trafficking and Sexual Exploitation: A Training Tool for Health Care Providers** written by:

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