Missouri Public Health Nursing Manual

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Missouri Public Health Association
Section for Public Health Nursing

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Table of Contents

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

History of the Section for Public Health Nursing in Missouri

The Council of Public Health Nursing (Council) was founded by the Missouri Department of Health and Senior Services (MODHSS) through a policy published in April 1997. The policy stated the purpose of the council was to address issues common to public health nursing across divisional lines and authorities.

Responsibilities included evaluation and making recommendations for issues related to public health nursing, responsibilities, roles, standards, training, and recruitment. Members consisted of one nurse from each MODHSS division and center, as well as 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 Missouri Council of Public Health Nursing was in October 1997.

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

In 2003, the CPHN was again restructured to include greater representation of LPHAs and the addition of nursing educators. Leadership of the Council was assigned to an executive committee with a chair from a LPHA. The MODHSS Public Health Nursing Liaison became an ex-officio member of the Council. At that time, the name was changed to Council for Public Health Nursing (CPHN). The position of Public Health Nursing Liaison changed to Public Health Nursing Coordinator in 2007. In 2016, the name of the CPHN was updated to the Missouri Council for Public Health Nursing (MCPHN).

In 2022, the MCPHN transitioned from the MODHSS to the Missouri Public Health Association. A Section for Public Health Nursing was created.

RESOURCE

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

Missouri Public Health Association Section for Public Health Nursing

The Section for Public Health Nursing (SPHN) was established within the Missouri Public Health Association (MPHA) to address issues that impact public health nursing.

You must be a member of MPHA to be a member of the SPHN and there are no additional fees. The SPHN makes recommendations on issues that affect public health nursing practice, standards, education, and recruitment. The SPHN uses the Community/Public Health Nursing Competencies set forth by The Quad Council Coalition (QCC) of the Public Health Nursing Organizations to define public health nursing practice.

The benefits of belonging to the Section are numerous. MPHA is affiliated with the American Public Health Association (APHA) and its Public Health Nursing Section. Educational offerings are included at each of our SPHN meetings and members are encouraged to present their work at conferences in Missouri and nationally. Also, there are several continuing education opportunities through APHA. Advocacy opportunities are also available through membership. We can present a united voice to legislators and public health entities about issues important to public health nursing.

Within the Section, you can serve on the board or ad hoc committees that design resources such as the Missouri Public Health Nursing Manual and the Public Health Nursing Preceptor Manual to advance the practice of public health nursing.

Public Health Nursing

Definition and Practice of Public Health Nursing

In 2023, the American Public Health Association Public Health Nursing Section affirmed the 1996 definition of public health nursing as "the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health services." (American Public Health Association, Public Health Nursing Section, 2013)

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

Elements of Practice

Key characteristics of public health nursing practice include:

1. a focus on the health needs of an entire population, including inequities and the unique needs of sub-populations;
2. assessment of population health using a comprehensive systematic process;
3. attention to multiple determinants of health;
4. an emphasis on primary prevention; and
5. application of interventions at all levels—individuals, families, communities, and the systems that impact their health. (American Public Health Association, Public Health Nursing Section, 2023)

RESOURCE

American Public Health Association, Public Health Nursing Section (2013). The definition and practice of public health nursing: A statement of the public health nursing section.
https://apha.org/~/media/files/pdf/membergroups/phn/nursingdefinition.ashx

Role of Public Health Nursing

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

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

Public health nurses provide a critical linkage between epidemiological data and clinical understanding of health and illness, as it is experienced in peoples' lives. This understanding is translated into action for the public good. An illustration of this role is the surveillance and monitoring of disease trends within the community. Emerging patterns that potentially threaten public health are identified and appropriate interventions planned, coordinated, and implemented. This is a role 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, to identify problems that threaten the public's health and develop effective interventions.

The Role of Public Health Nursing in Public Health Accreditation

The Public Health Accreditation Board (PHAB) is a voluntary national accreditation program designed to support health departments in their work to promote healthy communities. This is accomplished through accreditation and recognition, education, technical assistance, research, and evaluation. PHAB promotes evidence and innovation to support health departments in their delivery of services to drive performance improvement and strengthen infrastructure (Public Health Accreditation Board [PHAB], n.da).

Missouri Institute of Community Health (MICH) offers assistance with accreditation to LPHAs.

What is Public Health Department Accreditation?

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

The goal of national accreditation is to promote public trust and demonstrate an ongoing commitment to quality and performance improvement of tribal, state, and local public health departments (PHAB, n.db).

In Missouri, local public health agencies are encouraged to seek voluntary accreditation. The first LPHA was accredited in 2003 by MICH. In November 2005, the accreditation standards were revised to include the *Operational Definition of a Functional Local Health Department* created by the National Association of County and City Health Officials (NACCHO). In September 2011, the national public health department accreditation launched with the first version of the Public Health Accreditation Board Standards and Measures. The first public health agency in Missouri became PHAB accredited in 2013 (PHAB, n.dc).

In 2022, PHAB updated its standards to more closely align with the *Ten Essential Public Health Services*, increase emphasis on health equity considerations across the standards, and incorporate revised preparedness requirements based on lessons learned during the COVID-19 pandemic (PHAB, n.dd).

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

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

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

1. Participating on the public health department accreditation team to review, identify and select documentation that support PHAB standards and measures. (CCPHN Domain 8; PHAB Domain 9)
2. Participating in the local Community Health Assessment (CHA), as part of the core functions of public health including a) collecting and analyzing data, b) mobilizing community partners, and c) disseminate findings to inform others for policy change. (CCPHN Domain 1, Domain 4, Domain 3; PHAB Domain 1, Domain 4, Domain 3)
3. Sharing information regarding the community determinants of health status, health needs, and community assets with community partners, staff, boards of health, and elected officials. (CCPHN Domain 3, PHAB Domain 3, Domain 10)

4. Sharing information regarding the community determinants of health status, health needs, and community assets with community partners, staff, boards of health, and elected officials. (CCPHN Domain 3, PHAB Domain 3, Domain 10)
5. Investigating and addressing health problems and hazards affecting communities including preparedness and response to public health emergencies. (CCPHN Domain 1, PHAB Domain 2)

For more information on Public Health Accreditation:

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

National Association of County and City Health Officials
https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/accreditation-preparation/about

Public Health Accreditation Board
https://phaboard.org/

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

Preparing for, responding to, and recovering from disasters and emergencies is a public health priority. “Nursing and, specifically, public health nursing practice must remain a constant across the national planning framework: prevention, protection, mitigation, response, and recovery.” (Association of Public Health Nurses [APHN], 2025, p.4).

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

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

“The PHN (public health nurse) is also adept in collaborating with other experts, including environmentalists, epidemiologists, laboratorians, biostatisticians, physicians, social workers, and other nurses. Interprofessional practice is required to enhance preparedness, response, and recovery at the local, regional, state, national and global levels. Strong systems and models are needed to maximize the utilization of first responders, health care professionals, and volunteers.” (APHN, 2025, p.5).

"Public health nursing's abilities are critical for population-based care across the disaster cycle. Public health nurses are knowledgeable about the diverse community resources that are available, as well as what gaps may exist in community services, before, during and after a disaster. Thus, the PHN has a unique awareness of the vulnerable populations in the community, and who may be at heightened risk." (APHN, 2015, p. 6). To learn more about how each step of the nursing process is practiced during each phase of the disaster cycle, visit *The Disaster Cycle Linked to the Nursing Process* (APHN, 2015, p. 7-8).

In the Position Paper, the APHA states, "Public health must now, more than ever, expertly engage its internal and external partners, as well as its communities. No single discipline, agency, organization or jurisdiction can or should claim sole responsibility for the complex array of challenges associated with the disaster, whether caused by nature, humans, or some combination of both." (APHN, 2025 p.4). "Public health nurses possess the skills and knowledge to develop disaster policies and comprehensive plans, and to conduct and evaluate preparedness and response drills, exercises and trainings. They are integral members in response operations and command centers, in leadership and management roles, as well as in the field where they provide frontline population health and core public health services." (APHN, 2025, p.4-5). (Association of Public Health Nurses, 2024)

"Principles for PHN practice in a disaster:

1. Public health nursing roles in disasters are consistent with the scope of public health nursing practice and are articulated specifically in those standards and scope (ANA, 2013).
2. The components of the nursing process align with the National Planning Framework phases of preparedness (prevention, protection, mitigation), response, and recovery (ANA, 2010; FEMA, 2013).
3. Competencies provide a framework for defining PHN role and standards of practice across the disaster cycle and these competencies include those from public health nursing, disaster nursing, disaster public health, and competencies specific to public health nurses practice in disasters (ASPH, 2010; ICN 2009; Quad Council, 2011).
4. Public health nurses bring leadership, policy, planning and practice expertise to disaster preparedness, response and recovery." (APHN, 2015, p. 5).

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

Missouri Show-Me Response

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

Medical Reserve Corps

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

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

Think Cultural Health Respond Tool

The Think Cultural Health program in the Office of Minority Health, Department of Health and Human Services has a free, online program for disaster and emergency personnel called Cultural Competency Program for Disaster Preparedness and Crisis Response.
https://thinkculturalhealth.hhs.gov/education/disaster-personnel

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The Role of Public Health Nursing in Environmental Health

"Environmental health is the science and practice of preventing human injury and illness and promoting well-being by:

- Identifying and evaluating environmental sources and hazardous agents and
- Limiting exposures to hazardous physical, chemical, and biological agents in air, water, soil, food, and other environmental media or settings that may adversely affect human health" (National Environmental Health Association, n.d.).

The Agency for Toxic Substances and Disease Registry (ATSDR) has developed education and training. https://www.atsdr.cdc.gov/environmentaleducation.html

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

RESOURCES

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

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

National Environmental Health Association
https://www.neha.org/about

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Public Health Nursing Scope, Standards and Ethics

Scope of Practice

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

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

Decision Making Model

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

"All health care providers are accountable for their own actions: nurses, physicians, pharmacists, social workers, respiratory therapists, unlicensed assistive personnel, aides, technicians. Each is responsible for providing care within the appropriate standards of care for that provider. Health care providers are required to exercise independent judgments and utilize their knowledge within the scope of their profession or job when

caring for patients." (Feutz-Harter, 2012). Therefore, the use of sound judgement, current knowledge of their scope of practice, and their training must be the driving forces of any decision made.

Standards of Practice

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

The ANA has developed and published standards for nursing and nursing specialty practices, including the 2013 Public Health Nursing: Scope and Standards of Practice, 3rd Edition available from the ANA at http://www.nursesbooks.org.

Essential Services of Public Health

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

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

Assessment

- Assess and monitor population health status, factors that influence health, and community needs and assets.
- Investigate, diagnose, and address health problems and hazards affecting the population.

Policy Development

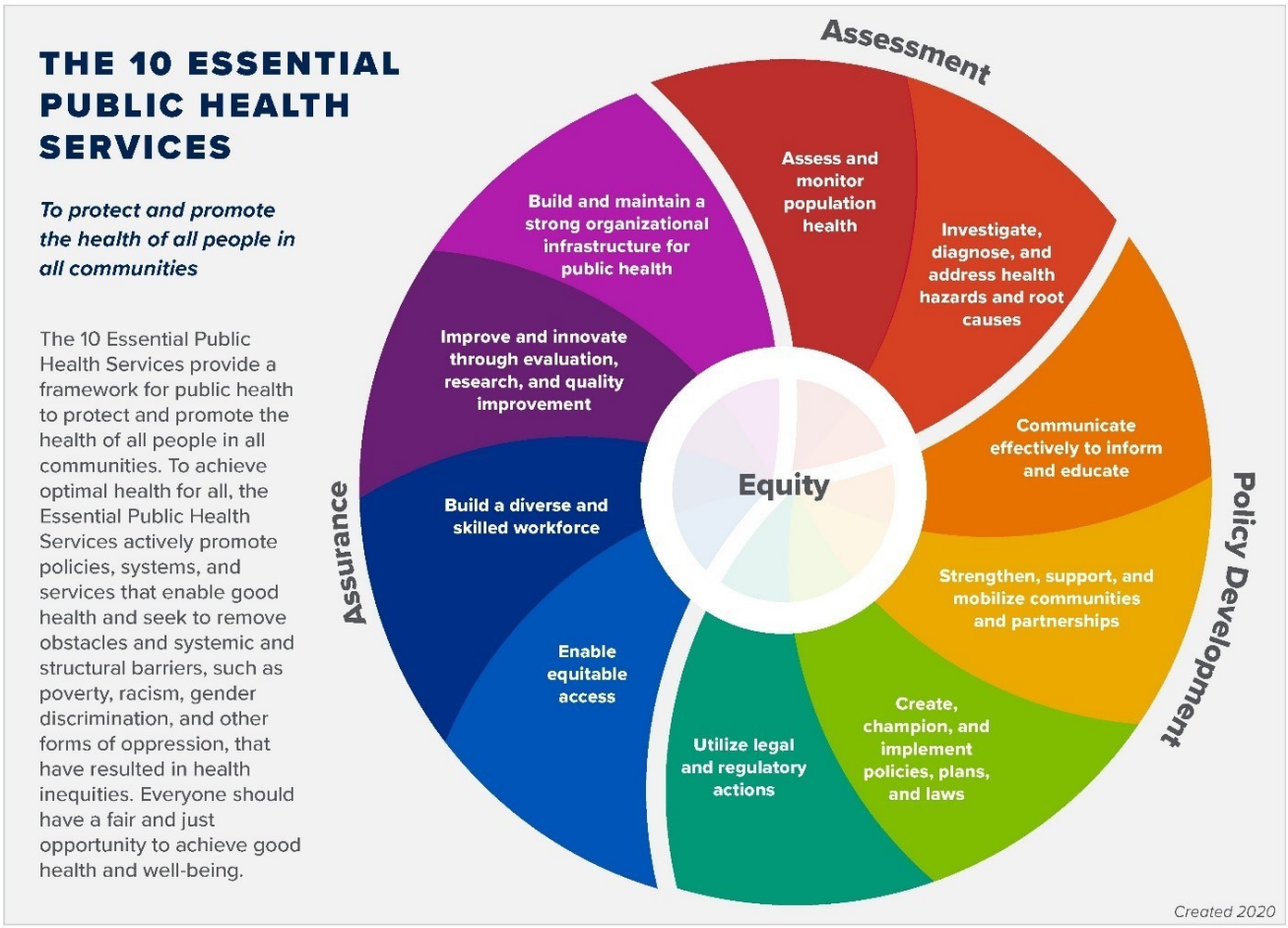
- Communicate effectively to inform and educate people about health, factors that influence health, and how to improve health.
- Strengthen, support, and mobilize communities and partnerships to improve health.
- Create, champion, and implement policies, plans, and laws that impact health.

Assurance

- Utilize legal and regulatory actions designed to improve and protect the public's health.
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
- Build and support a diverse and skilled public health workforce.

- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
- Build and maintain a strong organizational infrastructure for public health.

More information about the essential services can be found at CDC - 10 Essential Public Health Services - Public Health Infrastructure Center

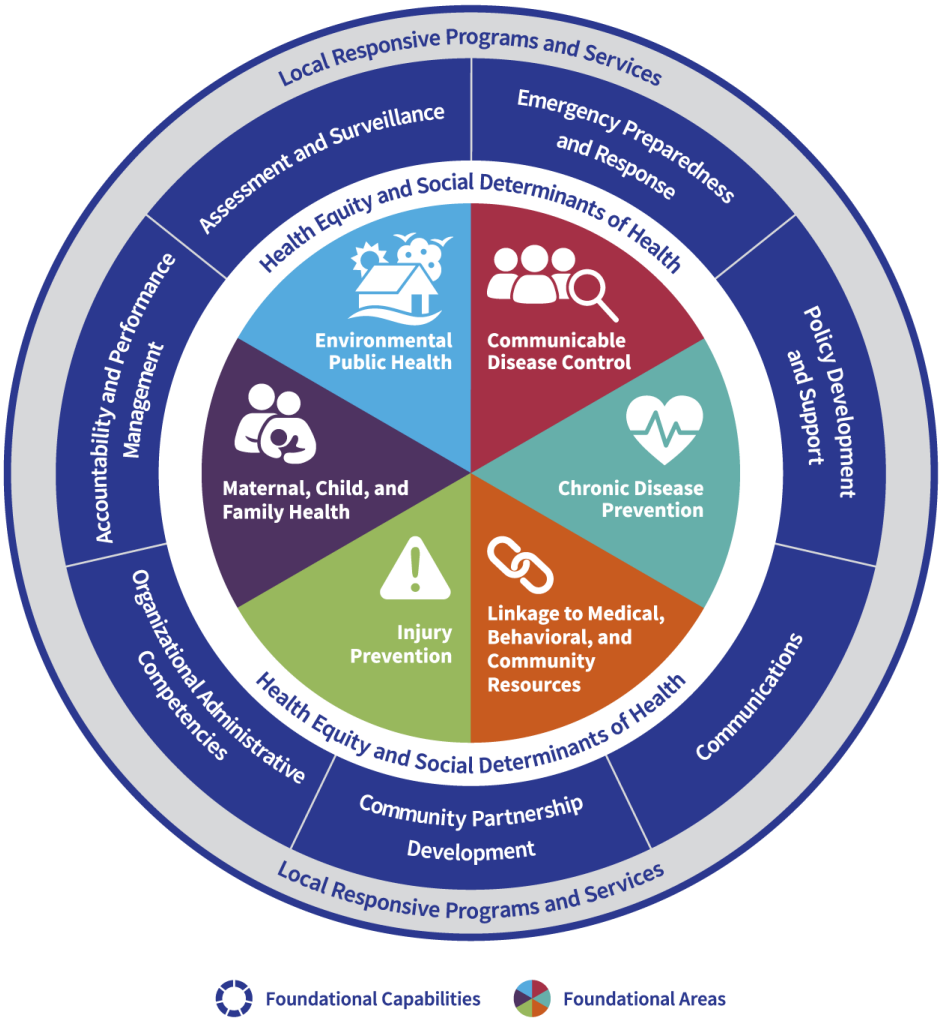


The essential services reflect closely the nursing process (assessment, diagnosis, planning, implementing, and evaluation). Assessment includes (1) monitor health; Diagnosis includes (2) diagnosis & investigation; Planning includes the policy development steps (3) inform, educate, empower; (4) mobilize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

Missouri's Foundational Public Health Services Model

The Missouri Foundational Public Health Services (FPHS) model is a framework designed to ensure essential public health services are provided consistently and equitably across the state. The model focuses on creating a robust public health system by defining a core set of services that all LPHAs should deliver. These services are considered "foundational" because they form the basis of a functioning public health system and are crucial for protecting and promoting the health of all Missourians. The outcome is a greater capacity to deliver care and resources that are centered on the needs of individuals and communities, empowering people to overcome obstacles, and achieve their optimal health. With well-functioning systems, we have more flexibility to operate in a way that respects and honors the dignity and value of every individual.

More information about Missouri's Foundational Health Services Model can be found at #HealthierMO.



Public Health Nursing Competencies

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

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

Domain 1. Analytic and Assessment Skills

Domain 2. Policy Development/Program Planning Skills

Domain 3. Communications Skills

Domain 4. Cultural Competencies Skills

Domain 5. Community Dimensions of Practice

Domain 6. Public Health Sciences Skills

Domain 7. Financial Planning and Management Skills

Domain 8. Leadership and Systems Thinking Skills

(Quad Council of Public Health Organizations, 2011)

Further discussion about these domains and their relationship to the various levels of public health nursing can be found at: QCC-C-PHN-COMPETENCIES-Approved_2018.05.04_Final-002.pdf (cphno.org)

Code of Ethics

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

Professional Boundaries

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

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

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

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

The National Council of State Boards of Nursing. (2011), provides resources and documents, including the full brochure. A Nurse's Guide to Professional Boundaries | NCSBN.

Reporting Incompetent, Unethical, or Illegal Practices

Reporting Responsibilities and Guidelines

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

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

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

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

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

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

Responsibilities of the Missouri State Board of Nursing

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

Disciplinary Grounds

The Missouri Nurse Practice Act (**Statutes: § 335.006.2, RSMo**) provides grounds to deny license or discipline the license of an RN or LPN. The list can be found in Public Health Nursing Manual | Local Public Health Agencies | Health & Senior Services (mo.gov).

The Board's disciplinary responsibilities include:

- Reviewing and investigating complaints concerning licensed nurses, nurses in the licensure process, and nurse impostors.
- The Missouri State Board of Nursing must receive and process each complaint made to them. Any member of the public or profession, state or local official may make a complaint to the Board. Complaints must be made in writing and mailed or delivered to the Executive Director of the Missouri State Board of Nursing. A complaint may be made based upon personal knowledge or upon information and belief, reciting information received from other sources. All complaints must fully identify the complainant by name and address.
- Each complaint received shall be acknowledged in writing and the complainant will be informed as to whether the complaint is being investigated and of any disciplinary action taken. The complaint and any information obtained as a result of the investigation of the complaint are not available for inspection by the general public. (adapted from State Regulation: 20 CSR 2200-4.030 Public Complaint Handling and Disposition Procedure).

How to File a Complaint

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

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

According to the State of Missouri Nursing Practice Act (335.066 7. RSMo), anyone who makes a complaint and does so in good faith SHALL NOT be subject to civil damages because of the allegation made. If you wish to file a complaint against the license of a nurse, please PRINT A COPY OF THE Complaint Report Form, fill it out, and mail it to:

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

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

The following actions may be taken by the Board:

Non-disciplinary

1. 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.
2. Letter of Concern: no disciplinary action taken against the nurse's license. A letter is sent to the nurse expressing their concern about the alleged behaviors in violation of Nurse Practice Act. Copy of complaint and action taken kept in licensee's file.

Disciplinary

Disciplinary Actions Available to the Board

The Board of Nursing may take disciplinary action against a licensee for violation of the Nursing Practice Act. The Board is authorized to impose any of the following disciplines singularly or in combination: censure, probation, suspension, and revocation.

- **Censure:** This is the least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.
- **Probation:** The imposition of probation places terms and conditions on the licensee's license. The licensee must comply with the terms and conditions throughout the probationary period, which may extend up to five years.
- **Suspension:** The imposition of suspension requires the licensee cease practicing nursing for a period not to exceed three years.
- **Revocation:** This is the most restrictive discipline. The imposition of revocation mandates the licensee immediately loses his/her license and may no longer practice nursing in Missouri. Once a license is revoked, the individual may not apply for relicensure for at least one year from the date of revocation. Upon application, the individual may be relicensed at the discretion of the Missouri State Board of Nursing after compliance with all the requirements relative to a new applicant, including, but not limited to, retaking the licensure examination.

Monitoring Disciplined Licensees

https://www.nursys.com/

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

RESOURCES

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

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

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

Use of Social Media

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

> With awareness and caution, nurses can avoid inadvertently disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risk of using social media:

- Nurses must recognize they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.
- Nurses are strictly prohibited from transmitting by way of any electronic media any patient related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy or otherwise degrade or embarrass the patient.
- Nurses must not share, post or otherwise disseminate any information or images about a patient or information gained in the nurse/patient relationship with anyone unless there is a patient care-related need to disclose the information or other legal obligations to do so.
- Nurses must not identify patients by name, or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.

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

  (National Council for State Boards of Nursing, 2014, excerpted from the NCSBN, *"A Nurse's Guide to the Use of Social Media."*)

For NCSBN resources and documents, including the full brochure visit Nurse's Guide to Use of Social Media.

The National Council of State Boards of Nursing (NCSBN) has developed guidelines for using social media responsibly. NCSBN has collaborated with the American Nurses Association (ANA) on the professional use of social media. NCSBN has endorsed ANA's principles of using social media, and ANA has endorsed NCSBNs guidelines. Also, NCSBN and ANA have collaborated on developing videos to provide guidance in social media use. Video: Social Media Guidelines for Nurses

The ANA's *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse* is a resource to guide nurses and nursing students in how they maintain professional standards in new media environments and on using social networking media in a way that protects patients' privacy and confidentiality and maintains the standards of professional nursing practice. The six essential principles are relevant to all registered nurses and nursing students across all roles and settings. The *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse* can be downloaded for free on the ANA website along with the fact sheet "Navigating the World of Social Media."

Website: Principles for Social Networking and the Nurse: Guidance for the Registered Nurse

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge (cdc.gov). HIPAA says what kind of patient information can be shared, who can see it, and when. This includes anything about a patient's physical or mental health that could identify them. It is important to know because breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. For example, nurses might accidentally share too much on social media, like describing a patient in a way that others could figure out who they are, saying mean things about them, or even sharing pictures or videos of them without permission.

If a nurse misuses social media or electronic platforms, it can be reported to the Missouri State Board of Nursing (BON). Each jurisdiction has different laws about what actions can lead to disciplinary measures by the BON. Depending on the laws in a particular area, the BON might investigate reports of inappropriate sharing on social media sites. If it is confirmed that the accusations are accurate, the nurse could be disciplined by the Board of Nursing. This discipline might involve a warning, a monetary fine, or a temporary or permanent loss of their nursing license (Nurses Guide to the Use of Social Media).

To assist in the planning, development, and implementation of social media activities, the CDC has developed guidelines to provide critical information on lessons learned, best practices, clearance information, and security requirements. Although the guidelines have been developed for the use at CDC, they may be useful materials for other federal, state, and local agencies as well as private organizations to reference when developing social media tools. CDC Digital & Social Media

REFERENCES

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

Centers for Disease Control and Prevention, HIPAA Privacy Rule and Public Health, Guidance from CDC and the U.S. Department of Health and Human Services, (May 2, 2003). https://www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm

Centers for Disease Control and Prevention, Digital and Social Media, (July 3, 2023). https://www.cdc.gov/digital-social-media-tools/index.htm

National Council of State Boards of Nursing (NCSBN), (2018), A Nurse's Guide to the Use of Social Media, National Council of State Boards of Nursing, Chicago, IL

Use of Artificial Intelligence (AI) in Public Health Nursing

According to the American Nurses Association (ANA) position statement, The Ethical Use of Artificial Intelligence (AI) in Nursing Practice (ANA, 2022), the appropriate use of AI in nursing practice supports and enhances the core values and ethical obligations of the profession. The ANA also clarifies the use of advanced technologies, including AI, does not replace the nurse's decision-making, critical thinking, nursing skills, or assessment skills and it is the nurse's responsibility to be informed and ensure AI is being used appropriately to optimize the health and wellbeing of those in their care (ANA, 2022).

The following guidelines may help when using AI in the healthcare setting:

- Keep up to date with the latest AI developments and their applications in healthcare.
- Participate in training sessions and workshops on AI tools relevant to public health.
- Recognize what AI can and cannot do. Understand AI is a tool to assist, not replace, nursing judgment.
- Ensure the data used for AI applications is accurate and comprehensive.
- Protect patient data and ensure it is used ethically. Follow HIPAA guidelines and other relevant regulations.
- Be aware of potential biases in AI algorithms and work to mitigate them.
- Participate in developing policies and guidelines for the ethical use of AI in your public health setting.
- Use AI to identify areas for improvement in public health initiatives and interventions.
- Ensure the use of AI leads to better health outcomes and enhances patient care.

AI has the potential to significantly enhance the nursing practice, but it must be used responsibly and ethically. Adherence to established standards and guidelines ensures AI tools contribute to improved patient outcomes while maintaining the trust and integrity of the nursing profession. Please familiarize yourself with the policies and procedures of your Public Health Department and adhere to them when seeking additional information regarding the use of AI.

RESOURCES

ANA

ANA AI Position Statement 2022

National Council of State Boards of Nursing (NCSBN)

NCSBN AI Statement 2024

BMC Public Health; Priorities for successful use of AI by public health-lit review

Fisher & Rosella (2022)

Cultural Competencies

Cultural Competencies

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Center for Disease Control and Prevention, 02/23/24).

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

CLAS are respectful of and responsive to the health beliefs, practices, and needs of diverse patients. CLAS are a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity (U.S. Department of Health and Human Services, Office of Minority Health).

The National CLAS Standards

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. (U.S. Department of Health and Human Services, Office of Minority Health, 2023)

National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice can be accessed by clicking on this link:
https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

PDF Download of National Standards:
https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care are listed below.

Principal Standard

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

Governance, Leadership, and Workforce

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

Communication and Language Assistance

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

Engagement, Continuous Improvement, and Accountability

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

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

A free, four-hour e-learning program *Culturally and Linguistically Appropriate Services (CLAS) in Nursing* is offered through the Think Cultural Health website and can be accessed at this link: https://thinkculturalhealth.hhs.gov/education/nurses

RESOURCES

Centers for Disease Control and Prevention (CDC) National Prevention Information Network (NPIN). (n.d.). Cultural Competence in Health and Human Services. Retrieved from https://npin.cdc.gov/pages/cultural-competence-health-and-human-services

U.S. Department of Health and Human Services (HHS) Office of Minority Health. (n.d.). Think Cultural Health: Advancing Health Equity at Every Point of Contact. Retrieved from https://thinkculturalhealth.hhs.gov/

Collaborative Practice

Description of Registered Nurse Titles

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

a. Responsibility for the promotion and teaching of health care and the prevention of illness to the patient and his/her family;
b. Assessment, data collection, nursing diagnosis, nursing care, evaluation, 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 determination and 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 **Statutes: § 335.011 to 335.096, RSMo** (The Nursing Practice Act) to engage in the practice of professional nursing.

Advanced Practice Registered Nurse (APRN): a registered nurse who is licensed under the provisions of Chapter 335 RSMo to engage in the practice of advanced practice nursing and is currently certified by a nationally recognized certifying body approved by the board of nursing and licensed as a certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.

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 (APRNs), became law on September 30, 1996. This rule, 20 CSR 2200-4.200 Collaborative Practice (Nursing) or 20 CSR 2150-5.100 Collaborative Practice (Healing Arts), specifies the practice boundaries of physicians and RNs or physicians and APRNs engaged in written collaborative practice arrangements. The Nursing Practice Act and Rules can be accessed through the Missouri State Board of Nursing at Rule 334.104.

Collaborative practice arrangements are defined in state **Statutes: § 34.104.1, RSMo** as, "written agreements, jointly agreed-upon written protocols, or written standing orders for the delivery of health care services." The state statute can be viewed at, or for more information from the Missouri State Board of Nursing on collaborative practice arrangements and the APRN. APRN Collaborative Practice

Through a collaborative practice arrangement, a physician may delegate:

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

An RN does not need to engage in a collaborative practice arrangement with a physician *nor* require physician oversight to perform "nursing acts". The RN has the specialized education, judgment, and skill to perform **Statutes: § 335.016(16) (a) through (e), RSMo**. However, if the RN is to perform delegated "medical acts" (e.g., dispensing of drugs*), a physician-RN or physician-APRN relationship must clearly and defensibly be in place.

Collaborating physicians and collaborating RNs or APRNs practicing in association with public health clinics providing specific population-based health services must abide by the statute provisions in **Statutes: § 334.104, RSMo** and sections (1) and (5) of the collaborative practice rule 20 CSR 2150-5.100. The specific services are as follows: immunizations; well-child care; HIV and sexually transmitted disease care; family planning; tuberculosis control; cancer and other chronic disease and wellness screenings; services related to epidemiological investigations, and prenatal care. (20 CSR 2150-5.100 Collaborative Practice, 2023)

If services provided in public health clinics include diagnosis and initiation of treatment of any other disease or injury than those listed above, then all other rule provisions [sections (2), (3), and (4)] apply (20 CSR 2150-5.100 Collaborative Practice, 2023). 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) (G) of the Collaborative Practice Rule, 20 CSR 2150-5.100.

***NOTE:** Dispensing of drugs is not authorized in the Nursing Practice Act. It is a delegated "medical act" which requires written authorization to perform. (20 CSR 2150-5.020 Nonpharmacy Dispensing, 2023). Either the traditional means described above or a written collaborative practice arrangement may be used to document physician authorization to dispense.

RESOURCES

20 CSR 2200-4.100 Advanced Practice Registered Nurse
20 CSR 2200-4.200 Collaborative Practice
Missouri Code of Regulations

20 CSR 2150-5.020 Nonpharmacy Dispensing

20 CSR 2150-5.100 Collaborative Practice

Missouri Code of Regulations

Statutes: § 334.104, RSMo Collaborative Practice Statutes

Revised Statutes of Missouri

Missouri State Board of Nursing, Nursing Practice Act and Rules Division 2200

Missouri State Board of Nursing

Physician Orders

General Guidelines

According to the Nursing Practice Act (Chapter 335 RSMo), the scope of practice of the professional nurse includes administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments. (Missouri State Board of Nursing, 2023)

A registered professional nurse, or licensed practical nurse under the direction of a registered professional nurse, may carry out orders from a physician licensed by any state regulatory board to prescribe medications and treatments. [(**Statutes: § 335.016 (15)(C), RSMo**] It is important to note that some prescribers have limited scopes of practice, such as podiatrists and ophthalmologists and can only prescribe medications and treatments for illness and injury within their scope. (Missouri State Board of Nursing, 2023)

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 supports the philosophy that a nurse's scope of practice is based upon his/her documented education, experience, skill, training, knowledge, and/or competency. A facility/employer must support the practice with policy/procedures and/or protocols approved by a physician or the appropriate medical staff committee. An employer, another regulatory body and/or third-party payer may further restrict this practice. Continued competency must be documented.

Standing Orders

Standing orders are appropriately used in a LPHA for some services (e.g., immunizations, sexually transmitted infections (STI) screening, tuberculosis (TB) testing). As an example, standing orders may include (adapted from the *Washington State Board of Nursing, Advisory Opinion: Standing Orders*):

1. Identify the patient population or condition to be treated according to the standing orders, including exceptions or contraindications.
2. Specify which acts require any level of experience, training, education, or certification.
    - Conditions, symptoms, or situations in which the standing order will be used;
    - Assessment criteria;

- Objective or subjective findings;
- Plan of care including medical and pharmaceutical treatment based on
- assessment criteria;
- Nursing actions;
- Follow-up or monitoring requirements.

3. Specify those who may perform the actions required using standing orders.
4. Delineate under what circumstances the actions may be performed.
5. Specify the scope of supervision required (if any).
6. Identify special circumstances under which the person implementing the standing order is to immediately communicate with the medical provider.
7. Identify limitations on the practice setting (if any).
8. Provide a method of maintain a written record of those authorized to use standing orders.
9. Establish a method for initial and continuing evaluation of the competence of those authorized to use standing orders.
10. Use generic names of medication/biologics, exact dosages, and routes of administration. The NCQAC recommends following the Institute of Safe Medication Practices (ISMP) Institute for Safe Medication Practices (ISMP) Guidelines to avoid error-prone abbreviations, symbols, and dose designations.
11. Specify documentation requirements.
12. Specify authentication requirements considering state facility laws/rules and federal laws/rules (such as CMS requirements), and accreditation standards such as Joint Commission.
13. Provide a method of periodic review of standing orders.
14. Specify authentication requirements considering state facility laws/rules and federal laws/rules (such as CMS requirements), and accreditation standards such as Joint Commission.
15. Delineate inclusion and exclusion requirements for which the nurse must consult with a medical practitioner for routine, urgent, or emergent situations including the communication process between the nurse and medical practitioner as appropriate.
16. Identify diagnostic, procedural, and billing coding requirements.

RESOURCE

Washington State Board of Nursing, Advisory Opinion: Standing Orders, Revised, November 2023. Washington State Board of Nursing

Delegation

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

Acceptable Use of The Authority to Delegate

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

Delegation Decision-Making Process

Refer to the Missouri Board of Nursing and (NCSBN)

Missouri Board of Nursing Decision Tree

NCSBN

RESOURCES

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

Missouri State Board of Nursing Decision Tree

National Council of State Boards of Nursing Delegation Decision Making

NCSBN Delegation Decision Making

American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) Joint Statement on Delegation (2019)

NCSBN and ANA Position Paper on National Guidelines for Nursing Delegation

Documentation

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

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

General Guidelines for Documentation

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

Electronic Medical Records (EMR)

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

The United States Department of Health and Human Service program, HealthIT.gov lists multiple benefits to the Electronic Medical Record. An EMR is more beneficial than paper records because it allows providers to:

- Achieve practice efficiencies and cost savings
- Improve care coordination
- Improve diagnostics and patient outcomes
- Improved patient care
- Increase patient participation

(HealthIT.gov, 2017)

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

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

RESOURCES

American Nurses Association (ANA) EHR Position Statement
ANA EHR Position Paper

HealthIT.gov. What is an Electronic Medical Record (EMR). EMR

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

Dispensing Medications

The following guidelines should be followed when dispensing medications:

Collaborative Practice Agreement

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

Prescription

"The terms 'prescription' or 'prescription drug' order are hereby defined as a lawful order for medications or devises issued and signed by an authorized prescriber within his scope of practice which is to be dispensed or administered by a pharmacist or dispensed or administered pursuant to **Statutes: § 334.104, RSMo** to and for the ultimate user." **(Statutes: § 338.095.1, RSMo**)

Protocol

A predetermined, written medical care guideline, which may include standing orders **Statutes: § 190.100(33), RSMo.**

Responsibilities of the RN when Dispensing Medications

Except those public health agencies that employ a licensed pharmacist, public health agencies store, dispense, and administer only those medications that are necessary for the public's health such as immunizations, tuberculosis treatment, prenatal care, etc. The statutes that govern the practice of pharmacies and pharmacists (**Statutes: § 338, RSMo** and 20 CSR 2200-2)

can serve as a guide for the proper dispensing of medications. The pharmacy practice regulations treat written, faxed, or electronically communicated physician orders the same - all must meet the standards for content and security. Follow your agency's standing orders if they require the nurse to verify the license of a physician or collaborative practice nurse prior to carrying out treatment or drug orders from an unknown physician or nurse in a collaborative practice.

1. Label Medication

The Missouri Nurse Practice Act (20CSR 2200-4.200 (2) (G) requires nurses in a collaborative practice arrangement follow the pharmacy **Statutes: § 338.059, RSMo** for the labeling of medications being dispensed.

The statute states the label must contain:

- Date the prescription is filled;
- Sequential number or other unique identifier;
- Patient's name;
- Prescriber's direction for usage;
- Prescriber's name;
- Name and address of the pharmacy dispensing;
- Exact name and dosage of the drug dispensed;
- One line under the information provided stating, "Refill" with a blank line or squares following or the words, "no refill."; and
- The label of any drug or biological product with is sold at wholesale in this state and which requires a prescription to be dispenses at retail shall contain the name of the manufacturer, expiration date, if applicable, batch or lot number and national drug code.

When a generic substitution is dispensed, the name of the manufacturer or an abbreviation thereof shall appear on the label or in the pharmacist's records as required in **Statutes: § 338.100, RSMo**.

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 an envelope or box. It is recommended 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.

2. Document In Dispensing Record

The Missouri Nurse Practice Act (20CSR 2200-4.200 (2) (G)6) requires nurses in a collaborative practice arrangement have "retrievable dispensing logs for all prescription drugs dispensed and shall include all information required in state and federal statutes, rules and regulations". State regulation 20 CSR 2220-2.017 outline the requirements that must be followed for dispensing medications by pharmacists but provides a guide to the LPHA for dispensing medications. Any RN dispensing medications should maintain required records for security, storage, and accountability. This includes:

- date the medication was prescribed and the date of initial dispensing, if different;
- a unique sequential prescription label number;
- if applicable, a unique readily retrievable identifier;
- name of the patient;
- prescriber's name;
- name, strength, and dose of the drug;
- the number of refills authorized;
- quantity dispensed;
- date of refill if any;
- the RN responsible for reviewing the accuracy of the data on each original prescription;
- the identity of the RN reviewing the final product prior to dispensing;
- whether generic substitution has been authorized by the prescriber;
- any changes or alterations made to the prescription based upon contact with the prescriber; and
- the address of the prescriber.

All medications dispensed from a LPHA should be kept in a secure location, labeled, sequentially numbered, and logged.

3. 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.

4. Electronic Record Keeping

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

- a unique, sequential prescription label number;
- if applicable, a unique readily retrievable identifier;
- date the prescription was prescribed;
- the date the prescription was initially filled and the date of each refill;
- patient's full name;
- patient's address;
- prescriber's full name;
- prescriber's address;
- name, strength and dose of drug, device or poison dispensed and any directions for use;
- quantity originally dispensed;
- quantity dispensed at each refill;
- identity of the pharmacist responsible for verifying the accuracy of prescription data prior to dispensing on each original prescription (editor's note: For the LPHA, an RN can fulfill this activity for certain medications);
- the number of authorized refills and quantity remaining;
- whether generic substitution has been authorized by the prescriber;
- the manner in which the prescription was received by the pharmacy (Editor's note: or LPHA) (e.g., written telephone, electronic or faxed); and
- any other change or alteration made in the original prescription based on contact with the prescriber to show a clear audit trail. This shall include, but is not limited to, a change in quantity, directions, number of refills, or authority to substitute a drug.

RESOURCES

20 CSR 2150-5.020-Nonpharmacy Dispensing
https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2150-5.pdf

20 CSR 2220-2.080 Electronic Prescription Records
https://www.sos.mo.gov/CMSImages/AdRules/csr/current/20csr/20c2220-2.pdf

20 CSR 2200-4.200 Collaborative Practice Rule
Missouri Secretary of State: Code of State Regulations (mo.gov)

Policies

Guidelines for Reducing Liability Risk in Nursing

Proper Communication and Documentation

- Ensure your documentation is complete and accurate, free of errors, or missing information that can impact patient outcomes.
- Ensure your communication is honest, and respectful of relationships.
- Refrain from offering opinions if asked about a medical diagnosis to avoid potential accusations of practicing medicine without a license.
- Avoid making statements that might be interpreted as admissions of fault or guilt.
- Steer clear of criticizing healthcare providers or their actions.
- Always uphold confidentiality.

Stay informed by maintaining competence in your area of practice

- Regularly review the Missouri Nurse Practice Act and other pertinent laws governing nursing practice, ensuring compliance within legal parameters.
- Adhere to established standards of practice applicable to your area of nursing.
- Stay informed about your agency's policies and procedures, incorporating them into your daily routines.
- Utilize the American Nurses Association's (ANA) Code of Ethics for Nurses https://www.nursingworld.org/coe-view-only as a guide for resolving ethical dilemmas.
- Continuously expand your knowledge and skill set through learning opportunities and stay aware of advancements in nursing.
- Stay updated on professional literature to remain informed of current best practices and trends.

Practice within the bounds of professional licensure

- Limit your practice to only those skills permitted within your scope of practice and for which you possess competency.
- Thoroughly document all actions undertaken within your practice setting to maintain accurate records.
- Be aware of the appropriate channels to contact and steps to take if licensed or unlicensed practitioners violate the Nurse Practice Act. Upholding the Nurse Practice Act is a professional obligation.
- Delegate tasks appropriately, considering factors such as the nature of the task, the patient's condition, and the competence of the individual being delegated. Remember, while tasks can be delegated, nursing assessment and judgment remain the responsibility of the licensed nurse. [ANA, 2015; Croke, 2003; Hankey, 2023.]

Recommended Policies

Local public health agencies should have written comprehensive policies and procedures. There should be policies and procedures for clinical activities, as well as other issues. Each agency should determine what policies are necessary to manage specific problems and issues. The following nursing-related policies are not an inclusive list, but suggestions of policies that should be considered when creating a LPHA policy manual.

Client Services and Procedures

- **Admission and Discharge of Clients:** Procedure to follow when admitting clients or discharging clients from service.
- **Documentation:** Policy regarding requirements for documentation in client records, including who must document, what should be documented, where documentation is made, the format of documentation, time limits, and approved abbreviations and acronyms. For agencies with electronic health records (EHRs), specific policies regarding the use of EHRs should be included.
- **Emergency Response Requirements:** The policy should include what is expected of nursing staff when responding to a public health emergency within the county, in support of other counties, and participation in the Show-Me Response registry.
- **Informed Consent:** Policy stating when to obtain informed consent and procedure to follow within the agency. This activity must comply with HIPAA statutes and regulations.
- **Medical Procedures/Services:** All medical services provided should include a policy and procedure. Include how the agency will handle orders from other licensed providers such as nurse practitioners or physician assistants.
- **Release of Information:** Policy stating when to obtain release of information and procedure to follow within the agency.
- **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.

Staff and Personnel

- **Job Descriptions:** There should be a job description for each employee and volunteer in the agency, outlining the specific duties of the position.
- **Liability Insurance:** A written policy outlining the liability protection provided to nursing staff through the insurance policy of the agency, any requirement for nurses to purchase individual malpractice insurance, and how documentation of malpractice insurance will be maintained.
- **Protection of Staff with Direct Patient Contact:** The policy should include information on universal precautions including the utilization of personal protective equipment, education on safety issues, handling and packaging of specimens, infection control within the agency, and education required by Occupational Safety & Health Administration (OSHA) guidelines.

- **Professional Development:** Guidance on the expectation for nursing staff regarding participation in continuing education and documentation of continuing education activities. The type of acceptable continuing education, any amount of continuing education, and any financial support for academic (for example degree completion) continuing education, as well as more traditional continuing education activities such as attendance at conferences should be included.
- **Reporting Incompetent, Unethical, or Illegal Behavior:** Procedure to follow to report incompetent, unethical, or illegal behavior of a co-worker.
- **Student Nurses:** Policy regarding students working in an agency, including responsibilities of staff, confidentiality statements, and responsibility of faculty.
- **Verification of Nurse Licenses:** Missouri is now part of the Nurse Licensure Compact, which recognizes licensure from other compact states and no longer provides a licensure document with an expiration date. A policy should outline who is responsible for the required verification of licensure, when the verification will be conducted, and how the documentation will be maintained. This verification can be done automatically at Nursys.com.

Ethics and Confidentiality

- **Patient Confidentiality:** There must be written policies and procedures that are consistent with the HIPAA Privacy Rule. This includes, but is not limited to, workforce training, mitigation of the effect caused by disclosure of protected health information, safeguards for written and electronic health data, addressing complaints, etc.
- **Reporting of Abuse and Neglect:** Procedure to follow when staff suspects a child or adult is the victim of abuse and/or neglect. Policy needs to follow current state **Statutes: § 210.115, RSMo**.
- **Risk Management:** Procedure to follow when a risk situation such as a needle stick, medication error, or an injury or accident occurs.
- **Social media:** There should be policies governing employee use of electronic and social media in the workplace.

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 CDC provides guidance on policy development that should be considered throughout the process, including two domains, *Stakeholder engagement and education and Evaluation* that should be considered throughout the process and five development domains:

1. Problem Identification
2. Policy Analysis
3. Strategy and Policy Development
4. Policy Enactment
5. Policy Implementation

Developing effective public health policies and procedures involves a systematic approach.

- **Define the Problem**: Collect, summarize, and clearly articulate the issue or problem in terms of its impact on population health.
- **Evaluate Readiness for Policy Development**: Assess the feasibility and appropriateness of policy development.
- **Develop Goals, Objectives, and Policy Options**: Set specific goals and objectives for the policy.
- **Identify Influencers and Decision-Makers**: Identify key stakeholders, decision-makers, and influencers.
- **Build Support for the Policy**: Develop partnerships and communicate findings and evidence related to the policy.
- **Revise the Policy Draft**: Continuously refine the policy based on feedback and new information.
- **Implement the Public Health Policy**: Put the policy into action.
- **Evaluate and Monitor the Policy:** Regularly assess the policy's impact on population health.

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 discretion to be exercised by nurses as they consider the facts of specific situations and are not absolute rules.

1. Write the policy as clearly as possible. Use consistent terminology and define terms to ensure clarity. i.e., is a nurse an RN, LPN, etc.
2. Base the policy and procedure on current best practices, 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 on a routine basis and ensure 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. Make sure all involved staff are advised of policy changes and they are always available to all staff.
5. Make it clear the written policy cannot be overridden by verbal changes. All changes should be in writing and approved by the appropriate people.
6. Outdated policies should be maintained for the same length of time in which other medical records are kept for purposes of potential legal actions. [Centers, 2012, Feutz-Harter 2012]

Health Information Portability and Accountability Act

Disclosures for Public Health Activities [45 CFR 164.512(b)]

The disclosure for public health activities provides information about the HIPAA Privacy Rule related to Public Health. The Health & Human Services webpage that hosts the disclosure was last reviewed on February 9, 2023. Listed below is a summary of the disclosure to read the full document go to https://www.hhs.gov/hipaa/for-professionals/special-topics/public-health/index.html

Background: The document emphasizes the need for public health authorities to access protected health information to perform their duties effectively.

General Public Health Activities: Entities can disclose public health information without authorization to public health authorities for purposes like controlling disease, injury, or disability.

Public Health Authority Definition: A public health authority is defined as an agency with a legal mandate for public health matters. Which can include federal, state, local, or tribal agencies.

Minimum Necessary Information: Disclosure of information should be limited to the minimum necessary to fulfill public health purposes, except when authorization is given or required by law.

Other Public Health Activities: The rule also allows disclosure for other public health activities, such as reporting child abuse or neglect, FDA-regulated product issues, notifying persons at risk of spreading diseases, and workplace medical surveillance.

FAQs and Further Information: Provides further information and additional resources for more detailed information on the privacy rule. [Office, 2023]

REFERENCES

American Nurses Association: (2025). *Code of ethics for nurses.* https://www.nursingworld.org/coe-view-only Retrieved May 2024.

Center for Disease Control and Prevention, Office of Policy, Performance and Evaluation. (2012). Policy Process. Retrieved May 2024 https://www.cdc.gov/policy/paeo/process/index.html#print

Croke, E. (2003). Nurse, Negligence, and Malpractice. *American Journal of Nursing, 103(9), 54-64.*

Hankey, L. (2023). *Proper documentation protects patients and your license. American Nurse Journal.18(8).* Doi:10.51256/ANJ082328

Missouri State Board of Nursing. (2024, April). *Missouri State Board of Nursing, Nursing Practice Act and Rules.* Retrieved from https://pr.mo.gov/nursing-rules-statutes.asp

Legal Issues

Good Samaritan Law

Statutes: § 537.037, RSMo of the Revised Statutes of Missouri (RSMo), (2023) of the Missouri Statutes are commonly referred to as the "Good Samaritan Law."

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

When any of the above health care providers render, in good faith, emergency care or assistance, without compensation, 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 this legislation is only applicable if the care is rendered without compensation.

This law further protects the rendering of emergency care or assistance, without compensation, 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.

Any other person who has been trained to provide first aid in a standard recognized training program may, without compensation, render emergency care or assistance to the level for which he or she has been trained, 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, however, there is no protection form civil liability for gross negligence or willful or wanton acts or omissions.

Any mental health professional, as defined in **Statutes: § 632.005, RSMo**, qualified counselor, as defined in **Statutes: § 631.005, RSMo** practicing medical, osteopathic, or chiropractic physician, certified nurse practitioner, or physicians' assistant may in good faith render suicide prevention intervention at the scene of a threatened suicide, and no liability may be imposed for any civil damages for acts or omissions. There is no protection from civil liability for gross negligence or willful or wanton acts or omissions.

RESOURCES

Statutes: § 537.037, RSMo – Good Samaritan Law
https://revisor.mo.gov/main/OneSection.aspx?section=537.037#:~:text=Any%20other%20person%20who%20has,damages%20for%20acts%20or%20omissions

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

Nurse 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 Nurse Practice Act. Nurse practice acts originated to protect the public from unsafe and unlicensed practice, by regulating nursing practice and nursing education. Nurse practice acts define nursing, set standards for the nursing profession, and give guidance regarding scope of practice issues. As such, the state Nurse Practice Act is the **single most important piece of legislation affecting nursing practice.**

Nurse practice acts are not checklists. They contain general statements of appropriate professional nursing actions. The nurse must incorporate the Nurse Practice Act with his or her educational background, previous work experience, institutional policies, and technological advancements. The main purpose of nurse 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 Nurse Practice Act.

The Missouri State Board of Nursing within the Missouri Division of Professional Registration provides access to the State Board of Nursing's rules and regulations at https://pr.mo.gov/nursing-rules-statutes.asp. Statutes that apply to "Nurses" in Missouri are found in the State of Missouri Nursing Practice Act, Chapter 335, also accessible on the Board of Nursing webpage. A list of statutes found in other chapters of the Revised Statutes of Missouri that may also apply to the practice of registered professional nurses and licensed practical nurses and/or be of interest to nurses is accessible at https://pr.mo.gov/nursing-focus-differentiating-statutes.asp

RESOURCES

Brent, Nancy. (2000). Nurses and The Law, A Guide to Principles and Applications. W.B.Saunders Company.

Missouri State Board of Nursing, Rules and Statutes. https://pr.mo.gov/nursing-rules-statutes.asp

Negligence and Malpractice

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

Negligence is:

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

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

Nursing negligence, as defined by the American Journal of Nursing, often takes one of six forms:

- failure to follow established standards of care;
- failure to use equipment in a responsible manner;
- failure to communicate;
- failure to document;
- failure to monitor and assess; or
- failure to act as a patient's advocate.

Malpractice is:

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

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

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

Duty refers to the establishment of a nurse-patient relationship. Duty is assumed in a number of ways including assignment, awareness of need for an unassigned patient, or observation of inadequate/inappropriate care. (See the Good Samaritan law for exceptions/protections related to duty.)

Neglect/malpractice: Nurses are held to the current established standards of care. Examples of standards of care include documents such as ANA's Nursing Scope and Standards of Practice, accreditation standards, national organizations standards, and organizational policies.

Causation of injury: Injury must be caused by the alleged act or omission in order to establish neglect/malpractice.

Damages: Damages may be physical, financial, or emotional, and may include both past and future losses. (Feutz-Harter, 2012)

Missouri Statutes related to malpractice include:

- **Statutes: § 538.225, RSMo** – Plaintiff's requirements for an affidavit by a health care provider. https://revisor.mo.gov/main/OneSection.aspx?section=538.225
- **Statutes: § 516.105, RSMo** – Actions against health care providers (medical malpractice), statute of limitations. https://revisor.mo.gov/main/OneSection.aspx?section=516.105

- **Statutes: § 537.037, RSMo** – Good Samaritan Law https://revisor.mo.gov/main/OneSection.aspxsection=537.037#:~:text=Any%20other%20person%20who%20has,damages%20for%20acts%20or%20omissions
- **Statutes: § 538.205, RSMo** – Tort Actions Based on Improper Health Care https://revisor.mo.gov/main/OneSection.aspx?section=538.205

Nurse Licensure Compact

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

Nurses holding a multistate license are allowed to practice in other NLC states and territories, without obtaining additional nursing licenses, while maintaining their primary state of residence (PSOR). The multistate license is issued in the PSOR but recognized across states lines, similar to a driver's license. Nurses are eligible for a multistate license if the PSOR is a member of the NLC and they meet the uniform licensure requirements. https://www.nursecompact.com/how-it-works/applying-for-licensure.page#uniform-licensure-requirements

The NLC enables nurses to practice in person or provide telenursing services to patients across the country without obtaining additional nursing licenses, including allowing nurses to quickly cross state borders and provide vital services in the event of a disaster. The NLC requires the nurse to adhere to the practice laws and rules of the state in which the patient(s) receive care.

The NLC includes registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVNs). The NLC does not include IV authority for LPNs/LVNs. The NLC APRN Compact allows advanced practice registered nurses (APRNs) to have one multistate license with the ability to practice in all compact states.

- A practical nurse who is currently licensed to practice in Missouri and who is not Intravenous (IV)-Certified in Missouri can obtain IV-Certification upon the successful completion of a board-approved venous access and intravenous infusion treatment modalities course. (https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2200-6.pdf)
- A new NLC Rule requires nurses moving from one compact state to another compact state to apply for licensure in their new PSOR within 60 days.

Forty-one (41) states belong to the NLC (April 2024). A map showing all participating states and jurisdictions and access to each state/jurisdiction's board contact information is available on the National Council of State Boards of Nursing website at https://www.nursecompact.com/.

Missouri **Statutes: § 335.075, RSMo** requires employers to verify possession of a current, valid license to practice nursing prior to hiring a registered nurse, licensed practical nurse, or advanced practice registered nurse, unless the employment does not require the possession of a current, valid license to practice nursing. A

process shall be in place for employers to verify licensure status of each registered nurse, licensed practical nurse, or advanced practice registered nurse.

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

Full information regarding the Nurse Licensure Compact (NLC) and APRN Compact is accessible at https://www.ncsbn.org/compacts

For full information regarding nursing licensure and practice in the state of Missouri, visit the Missouri State Board of Nursing website at https://pr.mo.gov/nursing.asp

Reporting Child Abuse and Neglect

Child Abuse/Neglect Reports by Mandated Reporters
Reporting Requirement (Statutes: § 210.115.1 – 210.115.3, RSMo)

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

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

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

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

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

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

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

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

Reporting Procedure/Child Abuse/Neglect Hotline Unit Response

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

- the alleged victim is a child (less than eighteen (18) years-old) at the time of the hotline call;
- whether or not the person who is alleged to have abused the child was "responsible for the care, custody, and control" of the child at the time of the incident;
- the alleged abuse or neglect is having an adverse effect on the child;
- the incident occurred in Missouri;

- the report meets the definition of abuse or neglect as defined by law; and
- identifying information is available to locate the child/family.

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

- the name, address, present whereabouts, sex, race, and birth date or estimated age of the reported child or children and of any other children in the household;
- the name(s), address(es), and telephone number(s) of the child's parent(s), or other person(s) responsible for the child's care;
- the name(s), address(es), and telephone number(s) of the person(s) alleged to be responsible for the abuse or neglect, if different from the parent(s);
- directions to the home, if available, when the child's address is general delivery, rural route, or only a town;
- other means of locating the family;
- parents'/alleged perpetrators' place of employment and work hours, if known;
- the full nature and extent of the child's injuries, abuse, or neglect, and any indication of prior injuries, including the reason for suspecting the child may be subjected to conditions resulting in abuse or neglect;
- any event that precipitated the report;
- adverse reactions to the child(ren);
- an assessment of the risk of further harm to the child and, if a risk exists, whether it is imminent;
- if the information was provided by a third party, or if there were witnesses, the identity of that person(s);
- the circumstances under which the reporter first became aware of the child's alleged injuries, abuse or neglect;
- the action taken, if any, to treat, shelter, or assist the child;
- present location of the child;
- whether the subjects of the report are aware a report is being made;
- the name, address, work and home telephone numbers, profession, and relationship to the child of the reporter;
- when was the child last seen by the reporter; and
- whether other children are in the home.

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

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

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

Immunity/Penalties (Statutes: § 210.135, RSMo)

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

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

RESOURCES

Guidelines for Mandated Reporters of Child Abuse and Neglect. Missouri Department of Social Services, Children's Division.

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

Reporting Elder Abuse or Neglect

Vulnerable Adults

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

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

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

Definitions

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

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

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

1. 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.
2. 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.

3. 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.
4. 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. **Statutes: § 660.250, RSMo**
5. Primarily for use by prosecutors, the "Crime of Elder Abuse," establishes three degrees of criminal abuse, including respective criminal penalties.

Who Must Report

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

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

How to Report

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

- the alleged victim's name, address, telephone number, sex, age, and general condition;
- the alleged abuser's name, address, sex, age, relationship to victim and condition;
- the circumstances which lead the reporter to believe the older person is being abused, neglected or financially exploited, with as much specificity as possible;
- whether the alleged victim is in immediate danger, the best time to contact the alleged victim, if he or she knows of the report, and if there is any danger to the worker going out to investigate;
- the name, daytime telephone number, and relationship of the reporter to the alleged victim;
- the names of others with information about the situation;
- if the reporter is not a required reporter, whether he or she is willing to be contacted again; and
- any other relevant information (Missouri Department of Health and Senior Services, 2011)

RESOURCE

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

Reporting Concerns About In-home Services

Statutes: § 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 **Statues: 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 **Statutes: § 197.400, RSMo**. (In **Statutes: § 197.400, RSMo**, home health agency is defined as “a public agency or private organization or a subdivision or subunit of an agency or organization that provides two or more home health services at the residence of a patient according to a physician’s written and signed plan of treatment.”)

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

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

Abuse of Services

Statute: § 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 the property or funds of an in-home services client has been misappropriated or has knowledge that documentation that verifies service delivery has been falsified, may report such information to the department.

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

Abuse of Funds or Property

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

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

Facilities

Statutes: § 198.070, RSMo - Similar statues exist to protect residents of residential care facilities, intermediate care facilities, or other nursing facilities. Reports are also registered by the department and investigations initiated within twenty-four hours. As soon as possible during the course of the investigation, department staff notifies the resident's next of kin or responsible party of the report and the investigation, and upon conclusion of the investigation, notify them whether the report is substantiated or unsubstantiated. These reports are confidential. Any person who knowingly abuses or neglects a resident of a facility shall be guilty of a Class D felony.

What to Include in Report

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

- name, age, address, telephone number, sex, and general condition of the adult;
- name and address of any person responsible for the adult's care;
- alleged abuser's name, address, sex, age, relationship to victim, and condition;
- why the reporter believes the person is abused, neglected, or financially exploited;
- does the alleged victim know of the report, is the danger immediate, and if there is a threat of danger for the investigator;

- name, telephone number, and relationship of the reporter to the alleged victim; (the identity of a reporter is protected); and
- names of others with information about the situation (if possible) and other relevant information.

Required Information

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

- name and addresses of the in-home services/home health provider agency;
- name of the in-home services/home health employee;
- name of the in-home services client;
- information regarding the nature of the abuse or neglect;
- name of Complainant; and
- any other information which might be helpful in an investigation.

(**Statutes: § 192.2475, RSMo**)

Mandated Reporters

Statutes: § 565.180-565.190, RSMo: Primarily for use by prosecutors, the crime of Elder Abuse, "establishes three degrees of criminal abuse, including respective criminal penalties."

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

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

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

Who Must Report

- Adult Day Care Worker
- Chiropractor
- Christian Science Practitioner
- Coroner
- Dentist
- Embalmer
- Employee of the Department of Social Services
- Medical Examiner
- Medical Resident or Intern
- Mental Health Professional
- Minister
- Nurse
- Nurse Practitioner
- Optometrist

- Employee of the Department of Mental Health
- Employee of the Department of Health and Senior Services
- Employee of a local Area Agency on Aging
- Employee of an organized Area Agency on Aging Program
- Funeral Director
- Home Health Agency or Home Health Agency Employee
- Hospital and Clinic Personnel engaged in examination, care, or treatment of persons
- In-Home Services Owner, Provider, Operator, or Employee
- Law Enforcement Officer
- Long-Term Care Facility Administrator or Employee
- Other Health Practitioner
- Peace Officer
- Person with responsibility for the care of a person 60 years of age or older or an eligible adult
- Personal Care Attendant
- Pharmacist
- Physical Therapist
- Physician
- Physician's Assistant
- Podiatrist
- Probation or Parole Officer
- Psychologist
- Social Worker
- Consumer Directed Services Vendor

(Missouri Department of Health and Senior Services, 2011)

RESOURCE

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

Resources and Websites

Best Practice Sites

Association of Maternal and Child Health Programs
Innovation Hub MCH Innovations Database - AMCHP

National Association of County and City Health Officials (NACCHO)
https://eweb.naccho.org/eweb/DynamicPage.aspx?site=naccho&webcode=mpsearch

The Community Toolbox
http://ctb.ku.edu/en/promisingapproach/Databases_Best_Practices.aspx

Certifications

Nursing

American Nurses Credentialing Center (ANCC)
American Nurses Credentialing Center (ANCC) Certifications | ANA (nursingworld.org)

Public Health

National Board of Public Health Examiners (NBPHE)
About the Certification in Public Health (CPH) - NBPHE

Manuals and Reference Material

Communicable Disease Investigation Reference Manual – MODHSS
Communicable Disease Investigation Reference Manual | Health & Senior Services (mo.gov)

Prevention and Control of Communicable Diseases: A Guide for School Administrators, Nurses, Teachers, Child Care Providers, and Parents or Guardians – MODHSS
http://health.mo.gov/living/families/schoolhealth/pdf/Communicable_Disease.pdf

The Future of Nursing 2020-2030
The Future of Nursing 2020-2030 - National Academy of Medicine (nam.edu)

Nursing and Public Health Organizations

Missouri

Missouri Association of School Nurses (MASN)
Home - Missouri Association of School Nurses (missourischoolnurses.org)

Missouri League for Nursing, Inc. (MLN)
http://mlnmonursing.org

Missouri Nurses Association (MONA)
http://www.missourinurses.org

Missouri State Board of Nursing
e-mail: nursing@pr.mo.gov
http://pr.mo.gov/nursing.asp

Missouri Immunization Coalition
https://moimmunize.org/

National

Association of Community Health Educators
ACHNE - The Association of Community Health Nursing Educators

American Nurses Association
http://www.nursingworld.org/

American Public Health Association
http://www.apha.org

Association of Public Health Nurses
http://www.phnurse.org

National Association of School Nurses)
http://www.nasn.org/Default.aspx

National League for Nursing (NLN)
http://www.nln.org

National State Boards of Nursing
http://www.ncsbn.org

Phone Applications

CDC Vaccine Schedule
https://www.cdc.gov/vaccines/hcp/imz-schedules/app.html#cdc_generic_section_2-download-the-app

Federal Emergency Management Agency (FEMA)
https://www.fema.gov/smartphone-app

Google Translator
http://www.google.com/mobile/translate

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

Smoking Cessation – quitSTART
quitSTART | Smokefree

Statutes and Rules/Regulations

Revised Statutes of Missouri (RSMo)
Missouri Revisor of Statutes - Revised Statutes of Missouri, RSMo, Missouri Law, MO Law, Joint Committee on Legislative Research

Code of State Regulations Missouri Secretary of State's Office
http://www.sos.mo.gov/adrules/csr/csr.asp

Missouri State Government
http://www.mo.gov/

Missouri Division of Professional Registration (PR)
http://pr.mo.gov/

Missouri State Board of Nursing (MSBN) Nurse Practice Act
http://pr.mo.gov/boards/nursing/npa.pdf

Training and Professional Development

Agency for Toxic Substances and Disease Registry
Environmental Health and Toxic Substances Education
ATSDR - Resources for Health Professionals (cdc.gov)

Federal Emergency Management Agency online training courses
NTED | National Preparedness Course Catalog (firstrespondertraining.gov)

Heartland Center Learning Management System (free online enrollment)
http://www.heartlandcenters.com/

HIV/AIDS Education and Training Center Program

National HIV Curriculum (uw.edu)

Immunization Education and Training – Centers for Disease Control and Prevention

Vaccine Education and Training for Healthcare Professionals | CDC

MCH Navigator

MCH Competencies | MCH Navigator

Public Health 101 – Centers for Disease Control and Prevention

Public Health 101 | Public Health 101 Series | CDC

Note: This is not an exhaustive list of resources or websites.