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INVESTIGATIVE QUESTIONNAIRE

ATTENTION:

TO BE COMPLETED BY BOARD STAFF

Nature of concern or complaint submitted against you:

(It is a violation of R4-19-403.25(a.) to fail to furnish in writing a full and complete explanation covering the matter reported pursuant to A.R.S. § 32-1664).

PLEASE COMPLETE AND RETURN THIS FORM BY:

I. RESPONDENT INFORMATION:

Name:

License No.:

Primary State of Residence (Where you vote, pay federal taxes, current driver's license): _____

Telephone Numbers:
Home: _____

Address: _____

Work: _____

E-Mail: _____

Cell Phone: _____

Have you ever been licensed in any other state?

Yes No

Where did you receive your nursing education?

If yes, list all states and current status of license:

I. RESPONDENT INFORMATION: (continued)

1. Indicate all degrees you hold and list the year of graduation and year of initial licensure, if applicable.

Degree(s)	Year of Graduation	Year of Graduation Unknown	Year of Initial Licensure	Year of Initial Licensure Unknown
Practical/Vocational		<input type="checkbox"/>		<input type="checkbox"/>
Associate Degree - LPN		<input type="checkbox"/>		<input type="checkbox"/>
Associate Degree - RN		<input type="checkbox"/>		<input type="checkbox"/>
Diploma – RN		<input type="checkbox"/>		<input type="checkbox"/>
Baccalaureate, Nursing		<input type="checkbox"/>		<input type="checkbox"/>
Masters, Nursing		<input type="checkbox"/>		<input type="checkbox"/>
Doctorate, Nursing		<input type="checkbox"/>		<input type="checkbox"/>
Bachelors, non- Nursing		<input type="checkbox"/>		<input type="checkbox"/>
Advanced Degree, non-Nursing		<input type="checkbox"/>		<input type="checkbox"/>
Other nursing		<input type="checkbox"/>		<input type="checkbox"/>
Degree Held by Nurse (Unknown)		<input type="checkbox"/>		<input type="checkbox"/>

2. Current licensure/certificate status? Check all that apply.

- LPN/VN RN APRN Licensure status unknown

<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Clinical Nurse Specialist
<input type="checkbox"/> Nurse Anesthetist
<input type="checkbox"/> Nurse Midwife
<input type="checkbox"/> APRN Category unknown

3. Is English your primary language?

- Yes No

II. EMPLOYMENT INFORMATION

A. Current Employer(s):

1. Employer: _____

Address: _____

Job title: _____

Supervisor: _____

Date of Hire: _____

Phone No.: _____

2. Employer: _____

Address: _____

Job title: _____

Supervisor: _____

Date of Hire: _____

Phone No.: _____

II. EMPLOYMENT INFORMATION (continued)

B. Previous Employer(s):

List all previous employers (full-time, part-time and registry employers) for the past five years. If a traveling assignment, list both facility and agency. **DO NOT ATTACH RESUME**

1. Employer: _____

Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment? Yes No

If yes, please explain or note your reason for leaving: _____

2. Employer: _____

Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment? Yes No

If yes, please explain or note your reason for leaving: _____

3. Employer: _____

Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment? Yes No

If yes, please explain or note your reason for leaving: _____

Were you terminated or did you resign in lieu of termination from **any** previous employment? Yes No

If yes, please provide an explanation: _____

IV. WITNESSES

List the witnesses you would like contacted regarding the incident(s). A witness is anyone who saw the alleged incident occur or otherwise had first-hand knowledge about the incident.

Name	Address	Phone No.	Work Relationship

V. ANALYSIS OF EVENT

Was a patient or patients involved in the reported event/events? Yes No

If the answer is **yes** please complete the remainder of this section to the best of your ability/knowledge. Even if more than one patient was involved please complete the remainder of this section for the patient that is the focus of the complaint.

If a patient or patients were not involved, please skip to section VI (page 14)

4. Length of time you worked in the patient care location (unit/department/area) where the reported event occurred. *Select one of the answers below.*

- Less than one month One - Two years More than five years
 One month - Eleven months Three - Five years Unknown

5. What type of shift were working at the time of the reported event?

Select one of the answers below or add your own.

- 8 hour On call
 10 hour Unknown
 12 hour Other please specify _____

6. Were you working in a temporary capacity (e.g., traveler, float pool, float to another unit, covering a patient for another nurse)?

- Yes No

7. How many direct care patients were assigned to you at the time of the reported event?

Number of patients _____ Unknown

8. Do you have a history of discipline by current or previous employer(s) for practice issues?

Select one of the answers below.

- Yes No Unknown

9. Employment Outcome? *Check all that apply and/or add your own variant.*

- Still employed by same Employer My Employer terminated/dissmissed me
 I resigned as a result Unknown
 I resigned in lieu of termination Other - please specify _____

10. Do you have any previous discipline history by a board of nursing? *Select one of the answers below.*

Yes No Unknown

11. **Do you have any previous criminal convictions?** *Please pick one of the answers below.*

Yes No Unknown

12. **Patient Age:**

- | | |
|--|--|
| <input type="checkbox"/> Under 1 year | <input type="checkbox"/> 26 - 35 years |
| <input type="checkbox"/> 1 - 3 years | <input type="checkbox"/> 36 - 49 years |
| <input type="checkbox"/> 4 - 6 years | <input type="checkbox"/> 50 - 64 years |
| <input type="checkbox"/> 7 - 11 years | <input type="checkbox"/> 65 and above |
| <input type="checkbox"/> 12 - 18 years | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> 19 - 25 years | |

13. **Patient gender** Male Female Unknown

14. **Indicate the patient's diagnosis.** Check **no more than TWO diagnoses**, those that contributed to the reported situation.

- BLOOD AND BLOOD-FORMING ORGANS DISEASE/DISORDER (e.g. Anemias; Sickle Cell; Thrombocytopenia; Lymphadenitis; etc.)
- CANCER (e.g. Leukemia; Lymphoma; Breast Cancer; Uterine Cancer; Melanoma; Carcinoma; Sarcoma; etc.)
- DIGESTIVE SYSTEM DISEASE/DISORDER (e.g. Pancreatitis; Liver Failure; Hepatitis; Appendicitis; C-difficile; Intestinal Obstruction; G I Hemorrhage; Diverticulitis; Crohn's Disease/Irritable Bowel Syndrome; Nausea/Vomiting; etc.)
- ENDOCRINE, METABOLIC, AND IMMUNE SYSTEMS DISEASE/DISORDER (e.g. Diabetes; HIV/AIDS; Fluid and Electrolyte Disorders; Thyroid Disorder; Addison's Disease; Cushing's Disease; Lupus; Cystic Fibrosis; etc.)
- GENITOURINARY SYSTEM DISEASE/DISORDER (e.g. Acute/Chronic Renal Failure; Kidney Stones; Enlarged Prostate; Urinary Tract Infection; Endometriosis; STDs; etc.)
- HEART & CIRCULATORY SYSTEM DISEASE/DISORDER (e.g. Coronary Artery Disease; Heart Attack; Congestive Heart Failure; Hypertension; Aneurysms; Cardiac Dysrhythmias; Syncope; Stroke (CVA); Transient Ischemic Attack; etc.)
- INJURY/TRAUMA (e.g. Accidents; Falls; Motor Vehicle Accidents; Rape; Assault; gunshot; Electrocutation; Poisoning; etc.)
- MENTAL HEALTH CONDITIONS (e.g. Depression; Anxiety; Psychoses; Bi-Polar; Substance Use/Abuse/Dependency; Suicide/Attempt; Personality Disorder; Attention Deficit/Hyperactivity Disorder; Mental Retardation; etc.)
- MUSCULOSKELETAL SYSTEM DISEASE/DISORDER (e.g. Fractures; Arthritis; Back problems; Osteoporosis; etc.)
- NERVOUS SYSTEM OR SENSE ORGAN DISEASE AND DISORDER (e.g. Alzheimer's Disease and other Dementias; Parkinson's; Multiple Sclerosis; Seizures; Headache; Meningitis; Encephalitis; Glaucoma; etc.)
- PREGNANCY, CHILDBIRTH, and RELATED CONDITIONS/COMPLICATIONS (e.g. Normal/Abnormal Pregnancy and/or Delivery; Fetal Distress; etc.)
- RESPIRATORY SYSTEM DISEASE/DISORDER (e.g. Pneumonia; Chronic Obstructive Pulmonary Disease; Influenza; Upper/Lower Respiratory Infection; Asthma; Bronchitis; Pulmonary Embolism; Tuberculosis; etc.)
- SKIN DISEASE/DISORDER (e.g. Wounds; Burns; Cellulitis; Dermatitis; etc.)
- SYSTEMIC INFECTIONS/INFECTIOUS DISEASES (Bacterial, Viral, and Parasitic) (e.g. Septicemia; Lyme Disease; MRSA; VRE; E-coli; etc.)
- Unknown (If you select this option, do not select any other choices)

Other – please specify _____

15. Indicate whether the patient exhibited any of the following at the time of the reported event. Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Agitation/Combativeness | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Altered level of consciousness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Communication/Language difficulty | <input type="checkbox"/> Sensory deficits (hearing, vision, touch) |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Inadequate coping /stress management | <input type="checkbox"/> Unknown |

16. Type of facility or environment Please pick *one* of the answers below or add your own.

- | | | |
|---|---|--|
| <input type="checkbox"/> Ambulatory Care | <input type="checkbox"/> Home Care | <input type="checkbox"/> Physician/Provider Office or Clinic |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Hospital | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Critical Access Hospital | <input type="checkbox"/> Office-based surgery | _____ |
| | | _____ |

17. Patient Harm Please pick *one* of the answers below.

- No harm - An error occurred but with no harm to the patient
- Harm - An error occurred which caused a minor negative change in the patient's condition.
- Significant harm - Significant harm involves serious physical or psychological injury. Serious injury specifically includes loss of function or limb.
- Patient death - An error occurred that may have contributed to or resulted in patient death.

18. Communication Factors Please check all that apply and/or add your own variant.

- | | |
|--|---|
| <input type="checkbox"/> Communication systems equipment failure | <input type="checkbox"/> Patient identification failure |
| <input type="checkbox"/> Interdepartmental communication breakdown/conflict | <input type="checkbox"/> Computer system failure |
| <input type="checkbox"/> Shift change (patient hand-offs) | <input type="checkbox"/> Lack of or inadequate orientation / training |
| <input type="checkbox"/> Patient transfer (hand-offs) | <input type="checkbox"/> Lack of ongoing education / training |
| <input type="checkbox"/> No adequate channels for resolving disagreements | <input type="checkbox"/> No communication factors involved |
| <input type="checkbox"/> Preprinted orders inappropriately used (other than medications) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Medical record not accessible | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Patient name similar/same | _____ |

19. Leadership/Management Factors *Please check all that apply and/or add your own variant.*

- | | |
|---|---|
| <input type="checkbox"/> Poor supervision/support by others | <input type="checkbox"/> Inadequate patient classification (acuity) system to support appropriate staff assignments |
| <input type="checkbox"/> Unclear scope and limits of authority/responsibility | <input type="checkbox"/> No leadership/management factors involved |
| <input type="checkbox"/> Inadequate/outdated policies/procedures | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Assignment or placement of inexperienced personnel | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Nurse shortage, sustained, at institution level | _____ |

20. Backup and Support Factors *Check all that apply and/or add your own variant.*

- | | |
|---|--|
| <input type="checkbox"/> Ineffective system for provider coverage | <input type="checkbox"/> Lack of adequate response by lab/x-ray/pharmacy or other department |
| <input type="checkbox"/> Lack of adequate provider response | <input type="checkbox"/> No backup and support factors involved |
| <input type="checkbox"/> Lack of nursing expertise system for support | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Forced choice in critical circumstances | <input type="checkbox"/> Other – please specify _____ |

21. Environmental Factors *Check all that apply and/or add your own variant.*

- | | |
|--|---|
| <input type="checkbox"/> Poor lighting | <input type="checkbox"/> Similar/misleading labels (other than medications) |
| <input type="checkbox"/> Increased noise level | <input type="checkbox"/> Code situation |
| <input type="checkbox"/> Frequent interruptions/distractions | <input type="checkbox"/> No environmental factors involved |
| <input type="checkbox"/> Lack of adequate supplies/equipment | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Equipment failure | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Physical hazards | _____ |
| <input type="checkbox"/> Multiple emergency situations | |

22. Other Health team members who contributed to the report event *Check all that apply and/or add your own variant.*

- | | |
|--|---|
| <input type="checkbox"/> Supervisory nurse/personnel | <input type="checkbox"/> Other support staff |
| <input type="checkbox"/> Physician (may be attending, resident or other) | <input type="checkbox"/> Patient |
| <input type="checkbox"/> Other prescribing provider | <input type="checkbox"/> Patient's Family/friends |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Unlicensed Assistive Personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks) |
| <input type="checkbox"/> Additional Staff nurse | <input type="checkbox"/> No health team members contributed |
| <input type="checkbox"/> Floating/temporary staff | <input type="checkbox"/> Unknown (<i>If you select this option, do not select any other choices.</i>) |
| <input type="checkbox"/> Other Health professional (e.g., PT, OT, RR) | <input type="checkbox"/> Other-please specify _____ |
| <input type="checkbox"/> Health profession student | _____ |
| <input type="checkbox"/> Medication assistant | |

23. Did staffing issues contribute to the reported event? *Check all that apply*

- | | |
|---|--|
| <input type="checkbox"/> Lack of supervisory/management support | <input type="checkbox"/> Lack of other health care team support |
| <input type="checkbox"/> Lack of experienced nurses | <input type="checkbox"/> None (<i>If you select this option, do not select any other choices</i>) |
| <input type="checkbox"/> Lack of nursing support staff | <input type="checkbox"/> Unknown (<i>If you select this option, do not select any other choices</i>) |
| <input type="checkbox"/> Lack of clerical support | <input type="checkbox"/> Other – please specify _____ |

24. Health care team *Check all that apply*

- | | |
|--|---|
| <input type="checkbox"/> Intradepartmental conflict/non-supportive environment | <input type="checkbox"/> Illegible handwriting |
| <input type="checkbox"/> Breakdown of health care team communication | <input type="checkbox"/> Lack of patient education |
| <input type="checkbox"/> Lack of multidisciplinary care planning | <input type="checkbox"/> Lack of family/caregiver education |
| <input type="checkbox"/> Intimidating/threatening behavior | <input type="checkbox"/> None (<i>If you select this option, do not select any other choices.</i>) |
| <input type="checkbox"/> Lack of patient involvement in plan of care | <input type="checkbox"/> Unknown (<i>If you select this option, do not select any other choices.</i>) |
| <input type="checkbox"/> Care impeded by policies or unwritten norms that restrict communication | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Majority of staff had not worked together previously | _____ |

25. Did the reported incident involve intentional misconduct or criminal behavior?

Check all that apply and/or add your own variant.

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes: Patient abuse (verbal, physical, emotional or sexual) |
| <input type="checkbox"/> Yes: Changed or falsified charting | <input type="checkbox"/> Yes: Criminal conviction |
| <input type="checkbox"/> Yes: Deliberately covering up error | <input type="checkbox"/> Yes: Other - please specify _____ |
| <input type="checkbox"/> Yes: Theft (including drug diversion) | <input type="checkbox"/> Unknown (if you select this option, do not select any Choices.) |
| <input type="checkbox"/> Yes: Fraud (including misrepresentation) | |

26. Did the reported event involve a medication error? Yes No

27. The type of medication error identifies the form or mode of the error, or how the error was manifested. Select the type of medication error. *Check all that apply and /or add your own variant.*

- | | |
|---|---|
| <input type="checkbox"/> Abbreviations | <input type="checkbox"/> Wrong dosage |
| <input type="checkbox"/> Drug prepared incorrectly | <input type="checkbox"/> Wrong drug |
| <input type="checkbox"/> Extra dose | <input type="checkbox"/> Wrong patient |
| <input type="checkbox"/> Mislabeling | <input type="checkbox"/> Wrong route |
| <input type="checkbox"/> Omission | <input type="checkbox"/> Wrong time |
| <input type="checkbox"/> Prescribing | <input type="checkbox"/> Wrong reason |
| <input type="checkbox"/> Unauthorized drug | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Wrong administration technique | <input type="checkbox"/> Other – please specify _____ |

28. If the wrong drug was involved in the reported event, please list the name of the drug

Drug ordered _____ Unknown

Drug actually given _____ Unknown

29. Was a documentation error involved? Yes No

- | | |
|---|---|
| <input type="checkbox"/> Pre-charting / untimely charting | <input type="checkbox"/> Charting on wrong patient record |
| <input type="checkbox"/> Incomplete or lack of charting | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> Charting incorrect information | |

30. Did the documentation error lead to the reported event? Yes No

OPTIONAL QUESTIONS

1. **Were the patient's family and/or friends present at the time of the reported event?** *Select only one*

- Yes No Unknown

2. **Type of Patient Event Related to Practice Breakdown** *Check all that apply and/or add your own variant.*

- | | |
|--|---|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Patient Fell |
| <input type="checkbox"/> Allergic/Anaphylaxis/Transfusion Reaction | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Equipment Failure | <input type="checkbox"/> Treatment Error/ Omission |
| <input type="checkbox"/> Healthcare Associated Infection | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Other-Please specify _____ |
| <input type="checkbox"/> Medication error | _____ |

3. **Type of community** *Select only one*

- Rural (lowly populated, farm, ranch land communities 10,000 or less)
 Suburban (towns, communities of 10,000 to 50,000)
 Urban (any city over 50,000)
 Unknown

4. **Facility size** *Select only one*

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> 5 or fewer beds | <input type="checkbox"/> 100-199 beds | <input type="checkbox"/> 500 or more beds |
| <input type="checkbox"/> 6-24 beds | <input type="checkbox"/> 200-299 beds | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> 25-49 beds | <input type="checkbox"/> 300-399 beds | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> 50-99 beds | <input type="checkbox"/> 400-499 beds | |

5. **Medical record system** *Select only one*

- | | |
|--|--|
| <input type="checkbox"/> Electronic documentation | <input type="checkbox"/> Paper documentation |
| <input type="checkbox"/> Electronic medication administration system | <input type="checkbox"/> Combination paper/electronic record |
| <input type="checkbox"/> Electronic physician orders | <input type="checkbox"/> Unknown |

6. **Did the nurse report completion of any continued competence activities or professional development activities in the last five years?** *Select only one*

- Yes No Unknown

7. **Work start and end times (based on a 24 hour clock) when the reported event occurred**

Start time _____ am/pm End time _____ am/pm

Time of incident _____ am/pm Unknown

8. **Length of time the nurse had worked for the organization where the practice breakdown occurred**
Select only one

- | | | |
|--|---|---|
| <input type="checkbox"/> Less than one month | <input type="checkbox"/> One - Two years | <input type="checkbox"/> More than five years |
| <input type="checkbox"/> One month - Eleven months | <input type="checkbox"/> Three - Five years | <input type="checkbox"/> Unknown |

9. Length of time the nurse had been in the specific nursing role at the time of the practice breakdown *Select one of the answers below.*

- | | |
|--|---|
| <input type="checkbox"/> Less than one month | <input type="checkbox"/> Three - Five years |
| <input type="checkbox"/> One month - Eleven months | <input type="checkbox"/> More than five years |
| <input type="checkbox"/> One - Two years | <input type="checkbox"/> Unknown |

10. Days worked in a row at the time of the practice breakdown (include all positions/employment) *Select one of the answers below.*

- | | |
|--|---|
| <input type="checkbox"/> First day back after time off | <input type="checkbox"/> Six or more days |
| <input type="checkbox"/> Two - Three days | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Four - Five days | |

11. Assignment of the nurse at time of the practice breakdown *Select one of the answers below.*

- Direct patient care
- Non-patient care
- Unknown

12. How many staff members was the nurse responsible for supervising at the time of the practice breakdown?

Number of Staff _____ Unknown

13. How many patients was the nurse responsible for overall (counting direct care patients and the patients of the staff the nurse was supervising at the time of the practice breakdown)?

Number of Patients _____ Unknown

14. Nurse's reported perception of factors that contributed to the practice breakdown.

Check all that apply and/or add your own variant.

- Nurse's language barriers
- Nurse's cognitive impairment
- Nurse's high work volume/stress
- Nurse's fatigue/lack of sleep
- Nurse's drug/alcohol impairment/substance abuse
- Nurse's functional ability deficit
- Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
- No rest breaks/meal breaks
- Nurse's lack of orientation/training
- Nurse's overwhelming assignment(s)
- Nurse's lack of team support
- Nurse's mental health issues
- Nurse's conflict with team members
- Nurse's personal pain management
- Lack of adequate staff
- None (If you select this option, do not select any other choices)
- Unknown (If you select this option, do not select any other choices)
- Other - please specify _____

15. Supervisor or employer's perception of factors that contributed to the practice breakdown.

Check all that apply and/or add your own variant.

- Nurse's language barriers
- Nurse's cognitive impairment
- Nurse's high work volume/stress
- Nurse's fatigue/lack of sleep
- Nurse's drug / alcohol impairment/substance abuse
- Nurse's functional ability deficit
- Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
- No rest breaks / meal breaks
- Nurse's lack of orientation/training
- Nurse's overwhelming assignment(s)
- Nurse's lack of team support
- Nurse's mental health issues
- Nurse's conflict with team members
- Nurse's personal pain management
- Lack of adequate staff
- None (If you select this option, do not select any other choices)
- Unknown (If you select this option, do not select any other choices)
- Other - please specify _____

16. Terminated or resigned in lieu of termination from previous employment

Select one of the answers below.

- Yes No Unknown

17. Select which factors contributed to the medication error. *Check all that apply and/or add your own variant.*

- | | |
|--|---|
| <input type="checkbox"/> Blanket orders | <input type="checkbox"/> Leading/Missing zero |
| <input type="checkbox"/> Brand/generic drugs look alike | <input type="checkbox"/> Measuring device inaccurate/inappropriate |
| <input type="checkbox"/> Brand names look alike | <input type="checkbox"/> Medication available as floor stock |
| <input type="checkbox"/> Brand names sound alike | <input type="checkbox"/> Monitoring inadequate/inappropriate |
| <input type="checkbox"/> Calculation error | <input type="checkbox"/> Non-formulary drug |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Non-metric units used |
| <input type="checkbox"/> Computer entry | <input type="checkbox"/> Packaging/container design |
| <input type="checkbox"/> Computerized prescriber order entry | <input type="checkbox"/> Patient identification failure |
| <input type="checkbox"/> Computer software | <input type="checkbox"/> Performance (human) deficit |
| <input type="checkbox"/> Contra-indicated in disease | <input type="checkbox"/> Performance deficit |
| <input type="checkbox"/> Contra-indicated in pregnancy/breastfeeding | <input type="checkbox"/> Prefix/Suffix misinterpreted |
| <input type="checkbox"/> Contra-indicated, drug/drug | <input type="checkbox"/> Preprinted medication order form |
| <input type="checkbox"/> Contra-indicated, drug allergy | <input type="checkbox"/> Procedure/Protocol not followed |
| <input type="checkbox"/> Decimal point | <input type="checkbox"/> Pump: failure/malfunction |
| <input type="checkbox"/> Dilutant wrong | <input type="checkbox"/> Pump: improper use |
| <input type="checkbox"/> Dispensing device involved | <input type="checkbox"/> Reconciliation – Admission |
| <input type="checkbox"/> Documentation inaccurate/lacking | <input type="checkbox"/> Reconciliation – Discharge |
| <input type="checkbox"/> Dosage form confusion | <input type="checkbox"/> Reconciliation material confusing/inaccurate |

- Drug devices
 - Drug distribution system
 - Drug shortage
 - Equipment design confusing/inadequate
 - Equipment (not pumps) failure/malfunction
 - Fax/Scanner involved
 - Generic names look alike
 - Generic names sound alike
 - Handwriting illegible/unclear
 - Incorrect medication activation
 - Information management system
 - Knowledge deficit
 - Label - Manufacturer design
 - Label - Your facility's design
 - Repackaging by other facility
 - Repackaging by your facility
 - Similar packaging/labeling
 - Similar products
 - Storage proximity
 - System safeguard(s) inadequate
 - Trailing/terminal zero
 - Transcription inaccurate/omitted
 - Verbal order
 - Workflow disruption
 - Written order
 - Unknown
 - Other (Specify) _____
-

VI. ARRESTS/CITATIONS/CHARGES

Have you ever been arrested, cited or charged? Yes No

If yes, please complete pages 15 and 16 of this questionnaire.

VII. Attach any other documentation related to the complaint you would like reviewed.

If no response is received, the Investigative Report will proceed and your case will be presented at a future Board of Nursing meeting for discussion and recommendations. Be advised that failing to cooperate with the Board by not furnishing in writing a full and complete explanation covering the matter reported pursuant to A.R.S. § 32-1664 is considered unprofessional conduct and is grounds for disciplinary action.

I verify that the above information provided by me is true, complete and correct to the best of my knowledge and belief.

Signature

Date

Thank you for your assistance. Please return to:

Attention:
Arizona State Board of Nursing
1740 W. Adams Street, Suite 2000
Phoenix, Arizona 85007-2607

ARREST/CHARGE/CITATION QUESTIONNAIRE

Instructions:

- A completed questionnaire MUST BE submitted for EACH arrest, charge, or citation you have ever received, regardless of age or outcome (excluding civil traffic. DUIs, Reckless Driving, or Hit and Run incidents are not considered civil traffic). This means incidents must be disclosed even if they were ultimately dismissed.
- Make as many copies of the questionnaire as you need in order to submit a separate questionnaire per incident.
- Please print neatly or type. Read each question carefully and answer every question. "See attached" is not an acceptable answer.
- **Complete and submit ALL pages of the questionnaire, sign and date the last page, and attach the required police and court records as well as your detailed written statement.** Processing of your case will be delayed and additional questionnaires will be sent if this required information is not submitted with each questionnaire and for every arrest, charge, or citation, regardless of age or outcome. Failure to provide the required documents may be considered failure to cooperate with the Board investigation and may constitute a violation of the Nurse Practice Act.

1. Demographic Information:

Full Name: _____
First Middle Last

All Other/Former Names Used or Aliases (maiden, prior married names): _____

Social Security Number: _____ Date of Birth: _____

Address: _____
Street City State Zip

Home Phone Number: _____ Cell/Mobile Number: _____

2. Arrest/Charge/Citation Information:

Fill in the following information regarding the agency which arrested or cited you.

Name of law enforcement agency or sheriff office: _____

Address of agency: _____
Street City State Zip

Date arrested/charged/cited: _____

For what offense(s) were you arrested, charged or cited? _____

Was the arrest/charge/citation for: misdemeanor felony

I have requested from this law enforcement agency and am submitting with this questionnaire, as applicable, ALL required police records listed below:

- Arrest/booking report, complaint, citation/ticket if applicable AND
- Officer narrative, arrest/incident department report. The narrative explains why the officer made contact with you and what occurred during that contact AND
- All supplements or additions to the report, including results of testing, additional information, etc.

I am submitting with this questionnaire my detailed written (or typed) statement regarding the circumstances surrounding this arrest, charge or citation.

When submitting a written explanation, be sure to be as specific as possible and address the "who, what, when, where, why and how" of the circumstances regarding the incident. This is your opportunity to tell the Board what happened in your own words. Failure to provide a *detailed* statement regarding each incident is a violation of the Nurse Practice Act.

3. Court Information:

Fill in the following information regarding the court where your case was heard or where your charges were submitted, if applicable.

Name of Court: _____

Address of Court: _____

Street

City

State

Zip

Of what offense(s) were you convicted? _____

Date of conviction: _____

Was the conviction: misdemeanor felony undesignated

Did you plead: guilty nolo contendere no contest

What was the sentence? (Include all fines, courses, counseling or group sessions, restitution, probation/parole, community service, etc)

If the conviction was for a felony or undesignated offense, what was the date of completion of all probation requirements, including payment of court fines and restitution (You must include proof of completion of probation/court requirements/payment in full)? _____

Has there been any change in the designation of your conviction since the original sentencing (Examples: reduced to a misdemeanor, set aside, dismissed, expunged, deferred)?

No Yes

If yes, what was the change? _____

Are you currently on probation or parole? No Yes

If yes, when is your anticipated probation or parole end/discharge date? _____

Name of your probation/parole officer (PO): _____

Probation/parole officer phone number: _____

Were you ever found in violation of your probation or was a warrant ever issued? No Yes

If so, describe the circumstances of the violation: _____

Was your sentence modified as a result of your probation violation? No Yes

Explain: _____

I have requested from this court and am submitting with this questionnaire, as applicable, ALL required court records listed below:

- Notice of charges, complaint, indictment. This will show the Board what you were originally charged with; AND
- Pre-sentence screening, report or referral, pre-sentence report AND
- Plea agreement/s if applicable AND
- Sentencing, probation order/judgment. This will show the requirements imposed by the court AND
- Dismissal, probation release, court discharge.

4. Document Requirements

Check off the boxes below to ensure you have provided all documentation required to be submitted with this questionnaire.

- A **Detailed Written (or Typed) Statement.**
- ALL **Police, Sheriff, or Law Enforcement Records.**
- ALL **Court Documents.**

4a) If no formal court charges resulted from the arrest or citation, you must still include the police report. However, in place of the court records listed above, please provide:

- Documentation or letter from the police department or court stating that no charges were filed or that prosecution was declined.

4b) If the arrest, citation or charge occurred several years ago and police or court records have been purged or are no longer available, a document on letterhead from the police department and court stating that the files on your case no longer exist, will be required and acceptable if it includes the following:

- Your name, date of birth, social security number (used by the agency to conduct the search).
- The type of charge (what the arrest was for) and the date and year the arrest transpired.
- Name/phone number of the police department or court contact person.

I verify that the above information provided by me and answered within this questionnaire is true, complete and correct, and I have disclosed each of my arrests, citations and charges, for felonies and misdemeanors, including incidents that did not ultimately result in convictions.

Signature

Date

Complaint or Self-Report Process

<http://azbn.gov/faqs/discipline-complaints/submitting-a-complaint-faqs/>

1. What happens with the complaint?

When a complaint or self-report is received by the Board, it is first reviewed to determine jurisdiction. If the Board has jurisdiction, an investigator and a case number are assigned. Notification letters are sent to the complainant and to the subject of the complaint and the investigative process begins. The subject of the complaint (“Respondent”) is made aware of the specific allegations and is required to respond in writing. The investigator collects objective information from a number of sources, interviews the complainant, witnesses, and Respondent. The information is compiled into an investigative report to present at a board meeting for the Boards’ review and decision. The board meeting is open to the public. The complainant and Respondent may choose to be present and make a statement to the Board but neither is required to do so. The board meeting is not a hearing but rather is forum for the Board to determine, based upon the investigative findings, if probable evidence exist that a license or certificate holder has violated the Nurse Practice Act.

2. Can the subject of the complaint (“Respondent”) obtain legal representation?

At any stage of the investigative process, the subject of the complaint (“Respondent”) may obtain independent legal representation.

3. How long does the investigative process take?

Several factors weigh into how long an investigation may take before the case is presented to the Board. The Board considers the severity of the risk to the public first and foremost and prioritizes accordingly. Some case are much more complex than others and take longer to process. If the allegation meets the criteria for case opening, both the complainant and Respondent receive notification that an investigation is in process and provided with contact information for the assigned investigator. We encourage you to stay in contact with the investigator throughout the process to facilitate the investigation.

4. Can the license/certificate holder or applicant work while they are under investigation?

The ability to work as a nurse, LNA or CNA is unrestricted during the investigation as long as the license or certificate remains active. However, applicants are not issued a license/certificate until the conclusion of the investigation and therefore cannot work until a license/certificate has been issued.

5. What can the subject of the complaint (“Respondent”) or people making the complaint (“Complainant”) do to assist in the investigative process?

If you are the subject of the complaint (“Respondent”): keep the board apprised of any changes in your address and phone number, and respond promptly to any requests for information or documents. You will be required to submit a written response to the complaint and will be requested to meet with the assigned investigator for an interview and to review information obtained during the course of the investigation. Your input and participation is important in understanding what occurred.

If you have filed a complaint (“Complainant”): submit all written documentation regarding your concerns, observations and impressions concerning the incident. Providing detailed information at the onset is important in assisting the Board to understand risk of harm and in facilitating the investigative process.

6. What happens when the case is presented to the Board?

The board meeting is an open public meeting where investigative reports related to complaints that have been received and investigated by staff are reviewed by the Board members to determine, based upon evidence in a case, whether there is probable evidence of a violation of the Nurse Practice Act. Board members will deliberate and make a motion, stating what action should occur.

7. Who can address the Board members?

If you have submitted a complaint (“Complainant”) or you have had a complaint submitted against your application or your license/certificate (“Respondent”), you are welcome to attend the board meeting to hear the discussion and Board decision. The board meeting is not a hearing but you may choose to give a verbal presentation (up to 5 minutes), providing information you feel is pertinent for the Board to consider. You may also choose to just be available to respond to their questions, or you may be present and not speak at all. Information that is relevant to the complaint and investigation should have been provided to the assigned investigator in advance of the board meeting.

8. What are the possible Board members decisions or actions?

Board actions are categorized as: Dismissal, Non-disciplinary Action, Disciplinary Action, and Administrative Violations. Once the case has been reviewed by the Board and the Board votes for discipline, the licensee/certificate holder/applicant status is updated to reflect "complaint-outcome pending" or if final, the disciplinary action taken.

Dismissal	Dismissal – Evidence does not support there has been a violation of the Nurse Practice Act.
Non-Disciplinary	Letter of Concern – A letter from the Board expressing concern that a licensee, certificate holder or applicant may have been engage in questionable conduct that is considered low risk or harm to the public. A letter of concern issued by the Board is non-discipline and is not an appealable agency action
Disciplinary Actions	Civil Penalty – A monetary fine issued by the Board, not to exceed \$1,000, given singly or in combination with any disciplinary action for a violation of the Nurse Practice Act. Decree of Censure – This is an official discipline by the Board that the individual’s conduct violated the Nurse Practice Act but does not represent a continued risk to the patient/public. Probation – This action allows the nurse to continue working during the period of probation subject to compliance with the terms and conditions. During the period of probation the nurse must be supervised in their practice and complete certain requirements which are aimed at rehabilitation or educating and remediating the nurse in his/her area(s) of practice deficit. For example, a nurse with a substance abuse issue may be required to enter and complete treatment, attend AA/NA meetings, abstain from

alcohol and other drug use along with other requirements. A nurse who lacks sufficient knowledge of medications or safe administration may be required to take a pharmacology course, etc.

Suspension – A person who has been suspended may not practice during the period of suspension. A person who has been suspended has terms and conditions which must be fulfilled during the period of suspension and before being allowed to resume practice. Examples of terms and conditions may include completing a refresher course, psychological or substance abuse treatment in addition to other requirements. A licensee/certificate holder that has been suspended often has a period of probation or monitoring following successful completion of the terms of suspension.

Revocation – This action prohibits the nurse/certificate holder from practicing for a minimum of five years, pursuant to A.A.C. R4-19-404. When a license/certificate has been revoked, the applicant for re-issuance must provide detailed information to the Board that the reason for revocation no longer exists and that the issuance of a license/certificate would no longer threaten the public health or safety. A.A.C. R4-19-404 or R4-19-815) The individual whose license/certificate has been revoked may not practice or otherwise indicate to the public that they hold a license/certificate.

Denial – A person (applicant) who has been denied a license/certificate may not practice and is not eligible to reapply to the Board for a period of five years.

Voluntary Surrender – A Consent Agreement has been signed in which an APRN, RN, LPN, LNA, CNA has voluntarily surrendered their license or certificate.

**Administrative
Violations**

Administrative Penalty – A penalty/fine given to a licensee or certificate holder who has worked on an expired license/certificate, or failed to notify the Board of an address change within 30 days. It is not reportable to NCSBN or other national data centers.

9. When is the Board decision final?

For discipline to be final and in effect, a Respondent must either consent to the discipline as voted upon by the Board by signing a “Consent Agreement” or if not signed, the Respondent has had an opportunity for a hearing. Hearings are conducted at the Office of Administrative Hearings and the person conducting the Hearing is an Administrative Law Judge (ALJ).

Following the hearing and based upon the evidence presented, the ALJ submits recommended “Findings of Fact, Conclusions of Law and Order” to the Board. Transcripts of the hearing are reviewed by the Board members prior to voting on the appropriate disciplinary actions (if any) to be taken. The Board has final authority to determine discipline and can adopt, modify or reject the ALJ recommendation. If discipline is determined to be appropriate by the majority of the Board Members, a “Board Order” is issued. If the Respondent disagrees with the outcome, a request for rehearing must be filed within 30 days of the mailing of the Board’s decision and Order, otherwise, the matter is final.