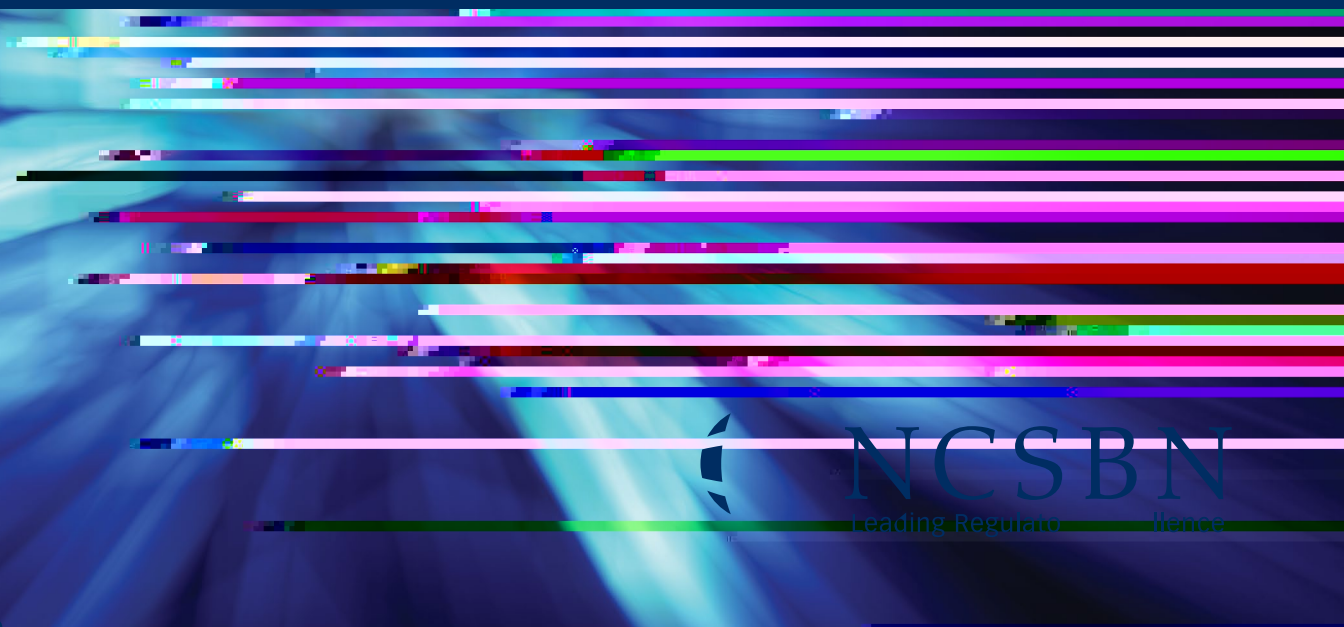
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Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases

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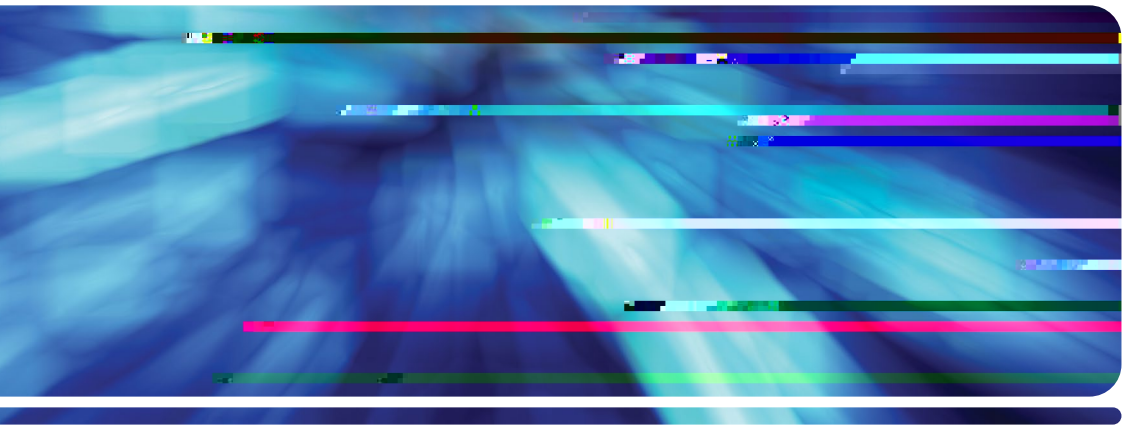


The purpose of this booklet is to provide boards of nursing (BONs) with practical guidelines in making decisions about sexual misconduct cases in their mission of public protection. This resource is not only pertinent, but timely.

In 2007, Halter, Brown and Stone reviewed the published empirical literature on sexual misconduct. This review provides details in the areas of: the prevalence of sexual misconduct, the impact on patients, factors associated with sexual boundary violations and themes for future research. The researchers drew the following conclusions from the studies they reviewed:

- Clear sexual boundaries are crucial to patient safety.
- Specific education about this subject, delivered in conducive environments, changes health care

EXTENT OF THE PROBLEM

In NCSBN's analysis of 10 years of Nur*sys*® data (NCSBN, 2009), 52,695 nurses were disciplined for 114,570 violations; of those violations, 659, or 0.57 percent, were included in the following categories: sexual misconduct—boundaries, other sexual misconduct, sexual abuse, sex with client or sexual language. Therefore, sexual misconduct is not a common complaint to a BON. The actual prevalence, however, is not known. Indeed, 38 to 52 percent of health care professionals report knowing of colleagues who have been sexually involved with patients (Halter et al., 2007).

The impact of sexual misconduct on patients is serious. The Council for Health Care Regulatory Excellence (2008) cites the following disorders and complaints as being resultant of sexual misconduct by a health care provider to a patient/client:

- Post-traumatic stress disorder and distress;
- Major depressive disorder;
- Suicidal tendencies and emotional distrust;
- High levels of dependency on the offending professional;
- Confusion and dissociation;
- Failure to access health services when needed;
- Relationship problems;
- Disruption to employment and earnings; and
- Use and misuse of prescription (and other) drugs and alcohol.

DEFINITIONS

Below are general definitions of sexual misconduct used by the BONs. The definitions below include language from BONs' laws and regulations and could be adapted by other BONs. See Case 2 at the end of this booklet to illustrate how definitions can be beneficial to BONs.

1. Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual; any verbal behavior that is seductive or sexually demeaning to a patient; or engaging in sexual exploitation of a patient or former patient.
2. A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people that a particular profession is intended to serve. Any and all sexual, sexually demeaning, or seductive behaviors, both physical and verbal, between a service provider (i.e., nurse) and an individual who seeks or receives the service of that provider (i.e., client), is unethical and constitutes sexual misconduct.
3. Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with, or in the presence of, a patient. For purposes of this subsection, an adult receiving psychiatrnr adultSc7itueay anposes

The following are more specific definitions of sexual misconduct designed for all health care providers:

1. A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client or key party* inside or outside of the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes, but is not limited to:
    a. Sexual intercourse;
    b. Touching of the breasts, genitals, anus or any sexualized body part, except as consistent with accepted community standards of practice for examination, diagnosis and treatment within the health care practitioner's scope of practice;
    c. Rubbing against a patient, client or key party for sexual gratification;
    d. Kissing;
    e. Hugging, touching, fondling or caressing of a romantic or sexual nature;
    f. Examination of, or touching, genitals without using gloves;
    g. Not allowing a patient or client privacy to dress or undress, except as may be necessary in emergencies or custodial situations;
    h. Not providing the patient or client with a gown or draping, except as may be necessary in emergencies;
    i. Dressing or undressing in the presence of the patient, client or key party;
    j. Removing a patient's or client's clothing, gown or draping without consent, emergent medical necessity or being in a custodial setting;
    k. Encouraging masturbation or other sex acts in the presence of the health care provider;
    l. Masturbation or other sex acts performed by the health care provider in the presence of the patient, client or key party;
    m. Suggesting or discussing the possibility of a dating, sexual or romantic relationship prior to the end of the professional relationship;
    n. Terminating a professional relationship for the purpose of dating or pursuing a

*Key party refers to immediate family members and others who play a role in health care decisions of the patient or client.

t. Posing, photographing or filming the body, or any body part of a patient, client or key party, other than for legitimate health care purposes; and

u. Showing a patient, client or key party sexually explicit materials, other than for legitimate health care purposes.

2. A health care provider shall not:

   a. Offer to provide health care services in exchange for sexual favors;

   b. Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;

   c. Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

3. A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client or key party within two years after the provider-patient/client relationship ends.

4. After the two-year period of time described in subsection (3) of this section, a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:

   a. There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or

   b. There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

5. When evaluating whether a health care provider is prohibited from engaging or attempting to engage in sexual misconduct, the regulator will consider factors including, but not limited to:

   a. Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;

   b. Transfer of care to another health care provider;

   c. Duration of the provider-patient relationship;

   d. Amount of time that has passed since the last health care services were provided to the patient or client;

   e. Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;

   f. Extent to which the patient's or client's personal or private information was shared with the health care provider;

   g. Nature of the patient or client's health condition during and since the professional relationship;

   h. The patient or client's emotional dependence and vulnerability; and

   i. Normal revisit cycle for the profession and service.

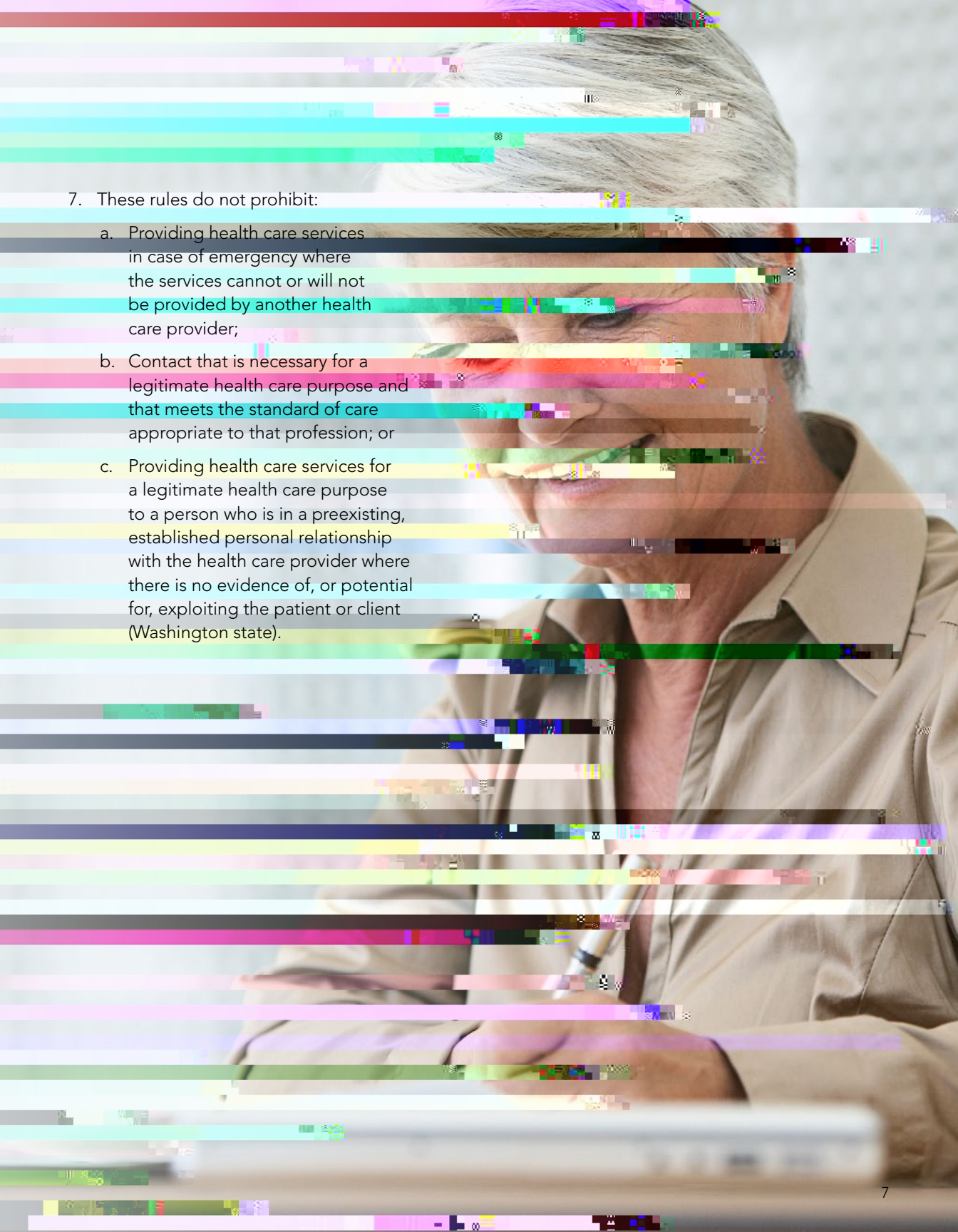
6. Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.

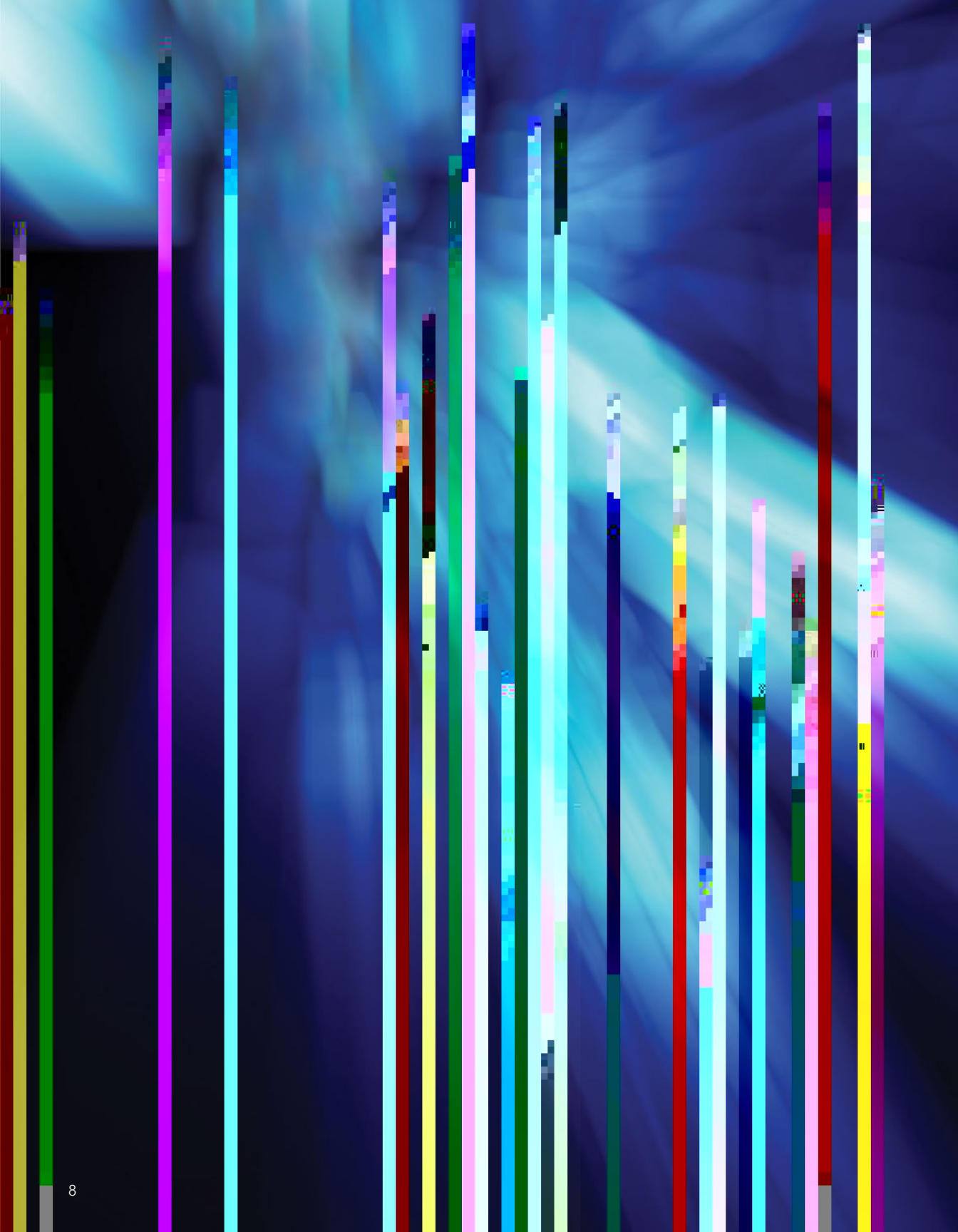
7. These rules do not prohibit:

   a. Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

   b. Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or

   c. Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client (Washington state).





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The term includes the following offenses:

1. Making sexually demeaning or sexually suggestive comments about or to a patient, including comments about a patient's body or undergarments.
2. Unnecessarily exposing a patient's body or watching a patient dress or undress, unless for therapeutic purposes or the patient specifically requests assistance.
3. Examining or touching genitals without the use of gloves when performing an otherwise appropriate examination.
4. Discussing or commenting on a patient's potential sexual performance, or requesting details of a patient's sexual history or preferences during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function, dysfunction or reproductive health care. Discussion of a patient's sexual practices and preferences shall be fully documented in the patient's chart.
5. Soliciting a date from a patient.
6. Volunteering information to a patient about one's sexual problems, preferences or fantasies.

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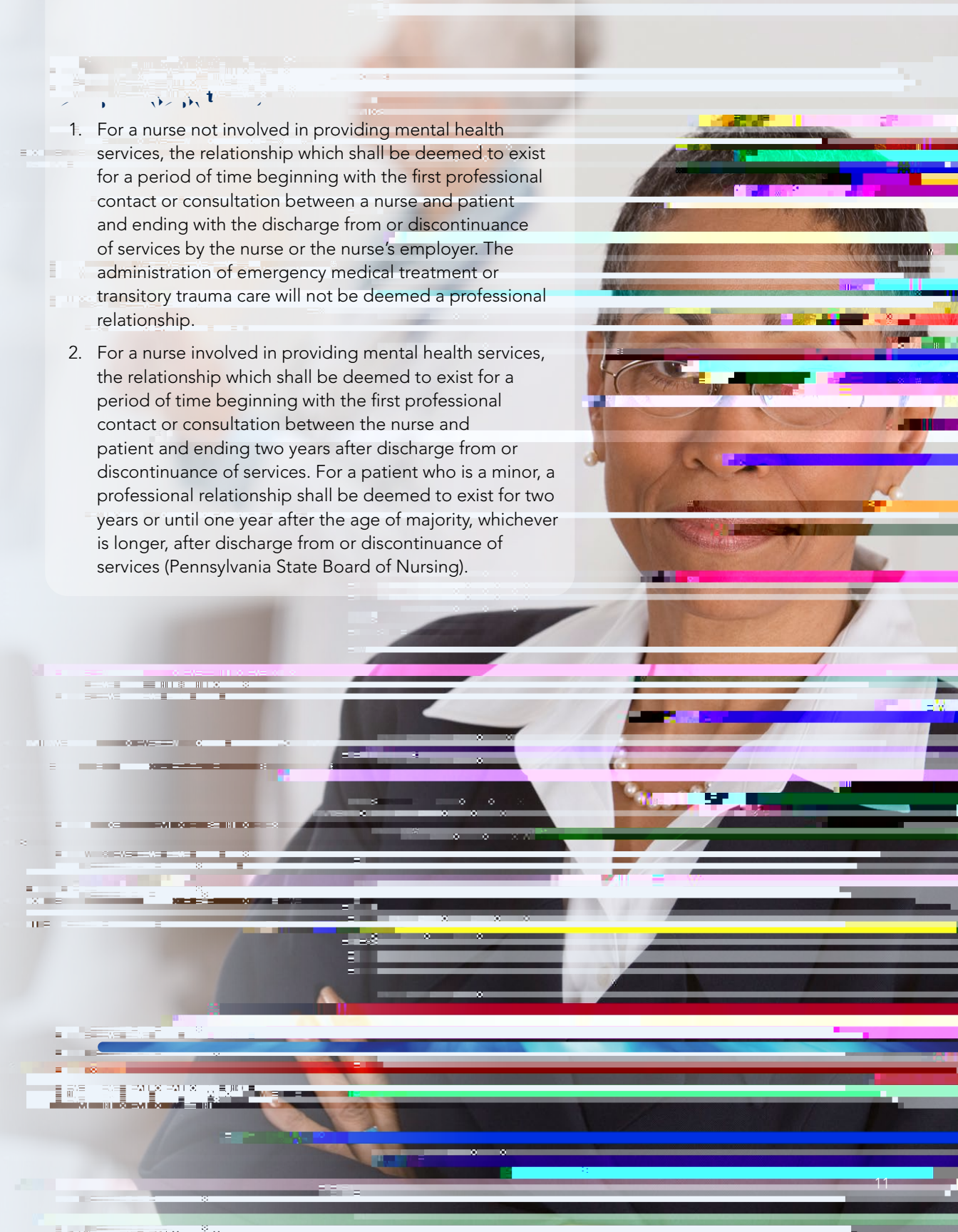
The term includes the following offenses:

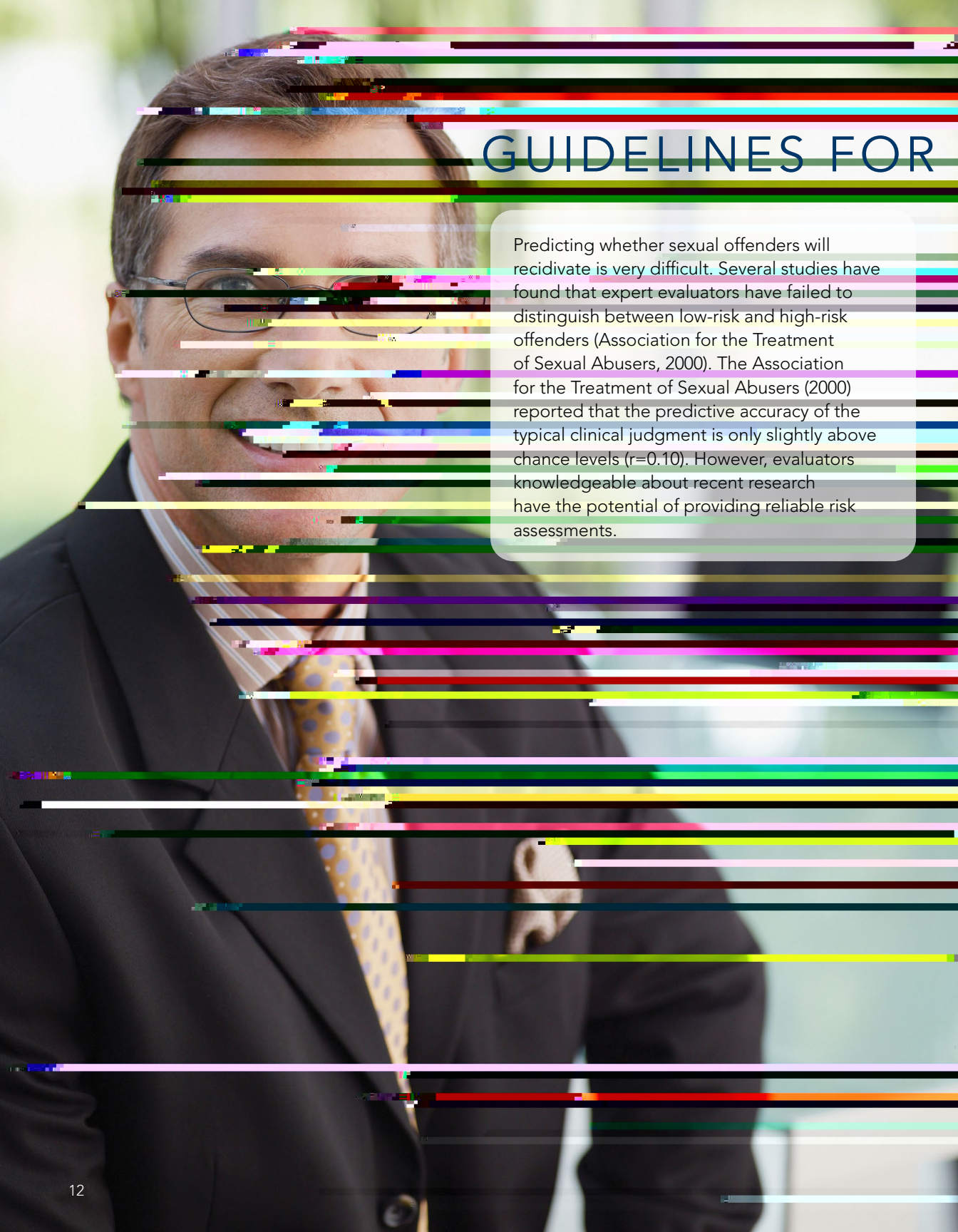
1. Sexual intercourse between a nurse and a patient during the professional relationship.
2. Genital-to-genital contact between a nurse and a patient during the professional relationship.
3. Oral-to-genital contact between a nurse and a patient during the professional relationship.
4. Touching of breasts, genitals or any other body part for any purpose other than appropriate examination or treatment.
5. Using prolonged or improper examination techniques or continuing examination techniques after the patient has refused or withdrawn consent.
6. Encouraging a patient to masturbate in the presence of the nurse or masturbating while a patient is present.
7. Providing or offering to provide drugs or treatment in exchange for sexual favors.
8. Using or causing the use of anesthesia or any other drug affecting consciousness for the purpose of engaging in conduct that would constitute a sexual impropriety or sexual violation (Pennsylvania State Board of Nursing).

OTHER RELEVANT DEFINITIONS:

1. A nurse or unlicensed assistive personnel (UAP) shall not engage or attempt to engage a former client, or former client's, immediate family member or significant other, in sexual or romantic conduct if such conduct would constitute abuse of the nurse-patient relationship. The nurse-patient relationship is abused when a nurse or nursing technician uses and/or benefits from the nurse's professional status and the vulnerability of the client due to the client's condition or status as a patient.
   a. Due to the unique vulnerability of mental health and chemical dependency clients,

1. For a nurse not involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between a nurse and patient and ending with the discharge from or discontinuance of services by the nurse or the nurse's employer. The administration of emergency medical treatment or transitory trauma care will not be deemed a professional relationship.
2. For a nurse involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between the nurse and patient and ending two years after discharge from or discontinuance of services. For a patient who is a minor, a professional relationship shall be deemed to exist for two years or until one year after the age of majority, whichever is longer, after discharge from or discontinuance of services (Pennsylvania State Board of Nursing).





GUIDELINES FOR

Predicting whether sexual offenders will recidivate is very difficult. Several studies have found that expert evaluators have failed to distinguish between low-risk and high-risk offenders (Association for the Treatment of Sexual Abusers, 2000). The Association for the Treatment of Sexual Abusers (2000) reported that the predictive accuracy of the typical clinical judgment is only slightly above chance levels (r=0.10). However, evaluators knowledgeable about recent research have the potential of providing reliable risk assessments.

The following are criteria that BONs might consider when selecting an expert evaluator to conduct an evaluation of the nurse accused of sexual misconduct. At a minimum, evaluators should be selected on the basis of their membership in and adherence to the practice and ethical standards espoused by professional associations and BONs, such as the Association for the Treatment of Sexual Abusers (ATSA) or the American Psychology-Law Society (AP-LS). In addition:

- Consider a senior practitioner in his/her field: a psychologist, nurse, social worker or psychiatrist who has experience evaluating health care professionals.
- Consider an evaluator who uses a multi-disciplinary approach to evaluating sexual misconduct cases. The multidisciplinary approach can include screening for co-morbid disorders, such as attention deficit hyperactivity disorder (ADHD), mood disorders, Axis II disorders, cognitive impairment, dementia, compulsivity, as well as any underlying physical disorder.
- Consider evaluators who are certified in performing neuropsychiatric testing.
- Look for demonstrated skill in setting up rehabilitation plans specifically for patients who are health care providers.
- addition:
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- Certified evaluator; and
- Licensed psychiatrist or licensed master's or doctoral level psychologist, social worker, counselor or marriage/family therapist.

- Must have attended 200 hours of formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders. A list of the qualifying scope of training is indicated in the SOCB administrative rules or may be requested from the SOCB.

- At least 2,000 hours of adult sexual offender treatment and evaluation experience within the preceding 10 years, including:
  - At least 250 hours of adult sexual offender evaluation experience; and
  - At least 250 hours of adult sexual offender treatment experience.

- Should have a thorough understanding and a broad knowledge of sexuality in the general population.
- Should also have a good understanding of basic theories and typologies of sexual offenders and sexual assault victims.

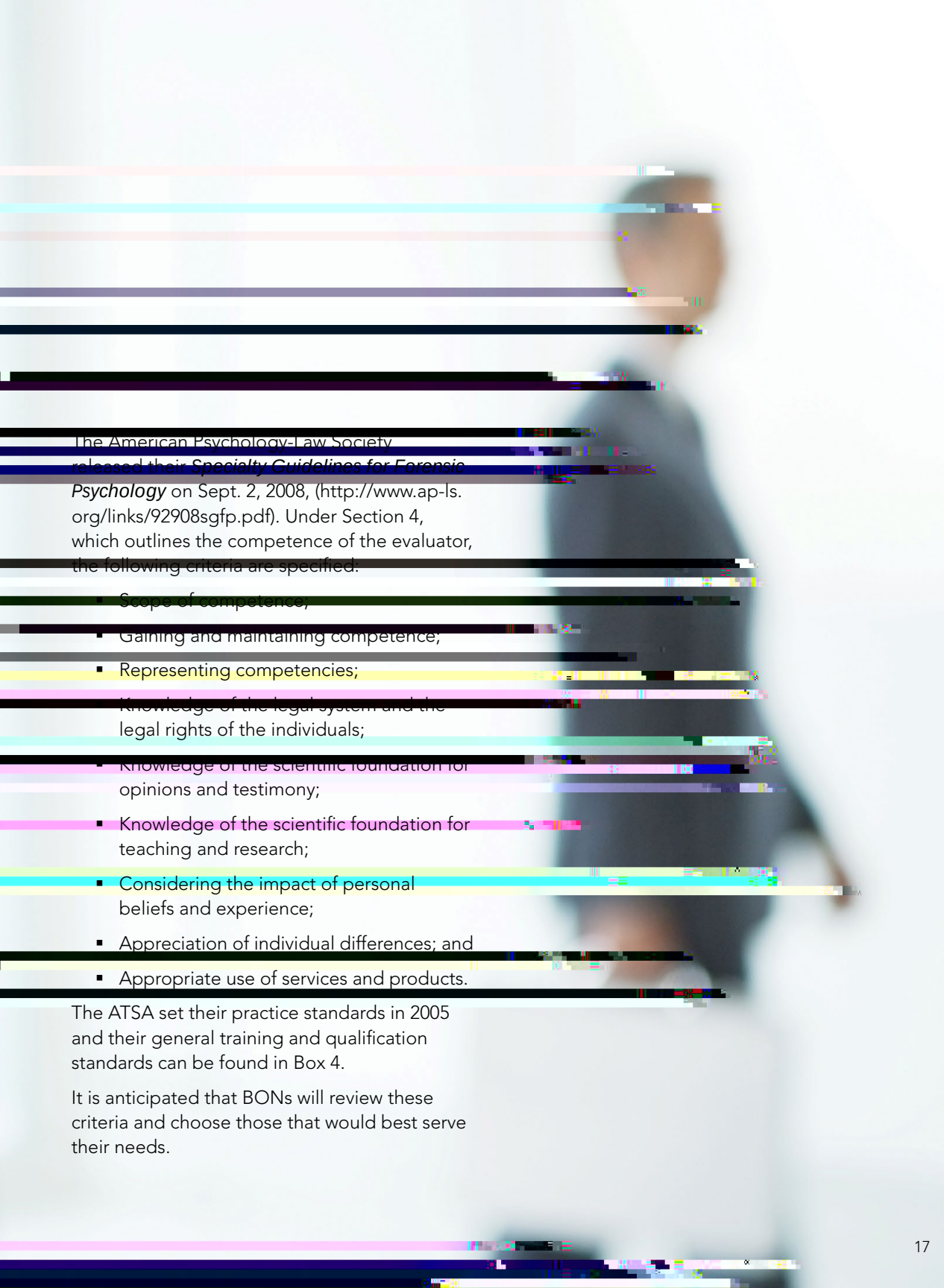
- Attendance of 40 hours at formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders within the preceding two years is required to maintain certification.
- Up to 10 of these hours may be obtained from online educational sources during a two-year period.

Please see Box 2 for the *Standards for Psychosexual Evaluations*, required by Idaho's Sexual Offender Classification Board website.

Outlined below are required areas of mental health sex offense-specific evaluations. It is minimally required that evaluators use some type of offense-specific psychological testing. No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sex offender and his/her risk to the community. Effective evaluations must include multiple risk factors. The evaluator should be cognizant that an offender's self-report is demonstrated by research to be the least reliable source of information during the evaluation and shall take steps not to rely solely on self-report information.

1. Accurate identification of the offender, including his/her current legal status and reason(s) for conducting the evaluation.
2. A list of all sources of information utilized in the evaluation.
3. Results of all psychological, physiological, medical testing, and examinations, including a summary of the clinical interview and a complete DSM-IV diagnosis.
4. Background information to include family; medical; educational; military; interpersonal development; sexual; occupational; recreational; criminal; and as applicable, institutional history.
5. Offense history to include: specific descriptions of the convicting offense(s) as explained by the offender and the victim(s) or the victim(s) representative; number of victims; characteristics of victim(s); relationship of offender to victim(s); number of violations of each victim; seriousness of offense(s); and predatory nature of offense(s).
6. A sexual history provided by the offender. Verification by polygraph is highly recommended.
7. Assessment of offender's sexual behavior, general characteristics, including sexual deviances, and personality profile.
8. Risk of reoffense, risk to the community, amenability to treatment, intent of offender upon release to the community, and the basis for the assessed risk.
9. Recommendation if offender is an appropriate candidate for future violent sexual predator review and rationale for the recommendation. For offenders being reviewed by the Board,

The Federation of Medical Boards has guidelines for selecting an evaluator to assess physicians who are accused of sexual misconduct, found in



The American Psychology-Law Society released their *Specialty Guidelines for Forensic Psychology* on Sept. 2, 2008, (http://www.ap-ls.org/links/92908sgfp.pdf). Under Section 4, which outlines the competence of the evaluator, the following criteria are specified:

- Scope of competence;
- Gaining and maintaining competence;
- Representing competencies;
- Knowledge of the legal system and the legal rights of the individuals;
- Knowledge of the scientific foundation for opinions and testimony;
- Knowledge of the scientific foundation for teaching and research;
- Considering the impact of personal beliefs and experience;
- Appreciation of individual differences; and
- Appropriate use of services and products.

The ATSA set their practice standards in 2005 and their general training and qualification standards can be found in Box 4.

It is anticipated that BONs will review these criteria and choose those that would best serve their needs.

- Professionals providing clinical service, who do not have graduate or professional degrees, have had specific training and experience in working with individuals who sexually offend and are under the direct supervision of a qualified mental health professional.
- Professionals providing clinical services participate in a minimum of 2,000 supervised hours of face-to-face clinical contact with individuals who sexually offend before providing unsupervised clinical services.
- Professionals obtain and document annual continuing education in the field of sexual abuse. Continuing education includes courses, seminars, conferences, workshops, and other training experiences.
- Professionals have education, training, and experience in the evaluation, treatment, and management of individuals who sexually offend. Members working with a specialized population have education, training, and experience specific to that population (for example, clients with developmental disabilities, or clients with mental illness).
- Professionals complete courses, training, and/or gain experience in order to become knowledgeable about the following areas (the order does not indicate priority):
    - Assessment and diagnosis;
    - Cognitive therapy;
    - Counseling and psxr Tf-o1.316 Td(training experiences.)Tj/Span<</ActualText<FEFF0009>>BDC -0.806
    - Cognitive therapy;

GUIDELINES FOR ESTABLISHING SANCTIONS FOR SEXUAL ABUSERS

The expert evaluator that the BON hires will consider a range of risk factors. No single risk factor can be linked to recidivism of sexual offenders. the Association for the Treatment of Sexual Abusers (2000) reports on the strongest predictors of sexual offense recidivism, as obtained from a meta-analysis by Hanson and Bussière (1998). All of these factors have been replicated in at least four studies, thereby providing evaluators with some evidence upon which to base their decisions. The single strongest predictor was sexual interest in children as measured by phallometric measurement (r=0.32, with total sample size of 4,853 and a total of seven studies). While the correlations are weak, the following are also identified as risks, in descending order:

- Any deviant sexual preference (r=0.22; sample size 570; five studies)
- Prior sexual offenses (r=0.19; sample size 11,294; 29 studies)
- Treatment drop out (r=0.17; sample size 806; six studies)
- Any stranger victims (r=0.15; sample size 465; four studies)
- Antisocial personality (r=0.14; 811 sample size; six studies)
- Any prior offenses (r=0.13; sample size 8,683; 20 studies)
- Age of accused (young) (r=0.13; sample size 6,969; 21 studies)
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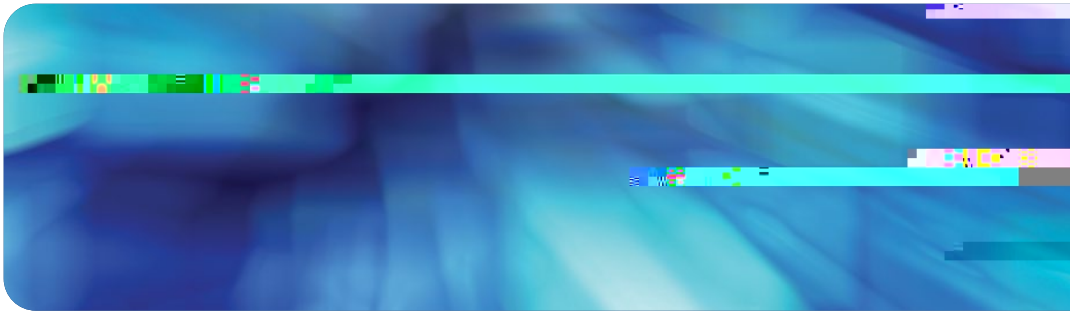
FITNESS FOR PRACTICE GUIDELINES

BONs must make difficult decisions about whether nurses are fit to practice after they've successfully completed a treatment program for sexual offenders. The following are some guidelines they might consider. See Case 3 to illustrate how these guidelines might be applied to a case. Carr (2003) suggests elements for professional sexual misconduct monitoring with physicians. Those have been adapted in Box 5 as possible elements of monitoring contracts with nurses.

Box 5

- Agreement for sexual abstinence outside of the primary relationship.
- Agreement for abstinence from any form of cybersex, including, but not limited to: accessing pornographic websites; soliciting sex from the Internet; texting sexual messages; taking inappropriate sexual photos; and e-mailing, blogging, Facebooking, Tweeting, Skyping, webcamming, instant messaging, posting, etc., sexual messages on the Internet.
- Abstinence from mood-altering drugs/alcohol, if indicated, with drug screens.
- Workplace monitoring with regular reports.
- Nurse's physician and therapist, if indicated, acceptable to the BON.
- Couples therapy, if indicated.
- Compliance with any prescribed medications.
- Mandates for ongoing training, such as ethical boundaries, if indicated.
- Notification of appropriate staff in the workplace of past issue(s). These personnel should not act as detectives, but should report concerns promptly.
- Patient surveillance forms disguised to look like patient satisfaction forms, if indicated.
- Use of informed, licensed chaperones.
- Group therapy with other professionals, if indicated.
- Sex Addicts Anonymous groups, if indicated.
- Other 12-step groups, as indicated.
- Relapse prevention plan.
- Peer practice monitor.
- Agreement for support and encourage recovery for spouse/significant family and other family.
- Agreement for targeted practice, if limited.
- Agreement for provisions for portability if nurse should move.
- Agreement to submit to polygraph, if warranted.
- Agreement to allow free exchange of information between all involved, including the BON.



Box 6 presents some possible general guidelines, gleaned from the substance abuse literature, that the expert evaluator will consider when deciding if the rehabilitated sex offender is fit for practice. Before considering fitness for practice guidelines, the following should have been documented to the BON:

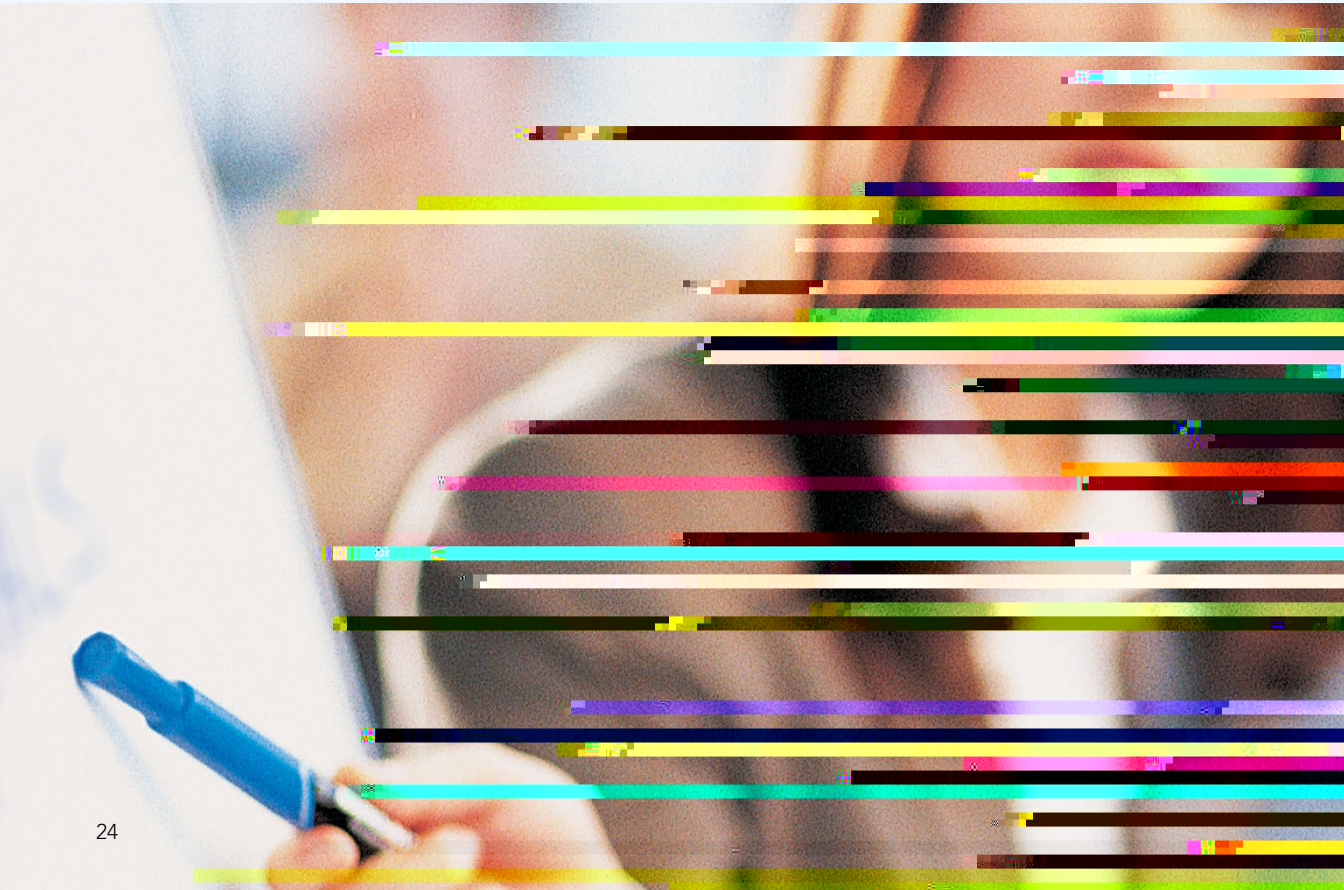
- The nurse must have successfully participated in a treatment process;
- A specific relapse plan should be designed; and
- The nurse must provide the BON with documentation of adherence to the treatment plan.

- Global Assessment Functioning (GAF) of at least 70.
- Has adequate control of emotions (such as sadness, anxiety, anger, fear, etc.).
- Has adequate energy to perform eight hours of work per day.
- Has adequate cognitive capacity (in terms of ability to focus, concentrate, remember things and organize material).
- Has reached a comfort level in interpersonal interactions.
- Is not abusing substances or engaging in compulsive behaviors of any kind (overspending, overeating, sexual addictions, alcohol, gambling, etc.).
- Has reached a comfort level in coping with circumstances that led up to treatment.
- Is agreeable to transition into work hours and responsibilities (such as part-time work for the first one to two weeks).
- Has achieved competence to handle ethical and professional responsibilities.
- Is willing to participate in posttreatment surveillance (i.e., feedback forms from coworkers and patients, polygraphs).

Some further guidelines for regulators include:

- Ask the sexual abusers what they have learned to stop the behavior.
- What specific steps they are going to take to prevent it from ever happening again?
- Let the abusers know that they do not get credit for leaving themselves in harm's way.
- The abusers should be able to recognize and avoid the red flags (J. Tallant, personal communication, April 8, 2009).

There is evidence to support that health care professionals who violate sexual boundaries can successfully return to work without recidivism (Abel, Osborn, & Warberg, 1998). Abel, Osborn, & Warberg (1998) report that of the cases treated at the Behavioral Medicine Institute of Atlanta, 47.7 percent returned to practice with a recidivism rate of less than 1 percent in seven years. With the selection of an expert evaluator (Boxes 1-4) and when the offending nurse receives expert treatment, the BONs can use the information in Boxes 5 and 6 for ongoing surveillance of the offending nurse, in their very difficult job of protecting the public in sexual misconduct cases.

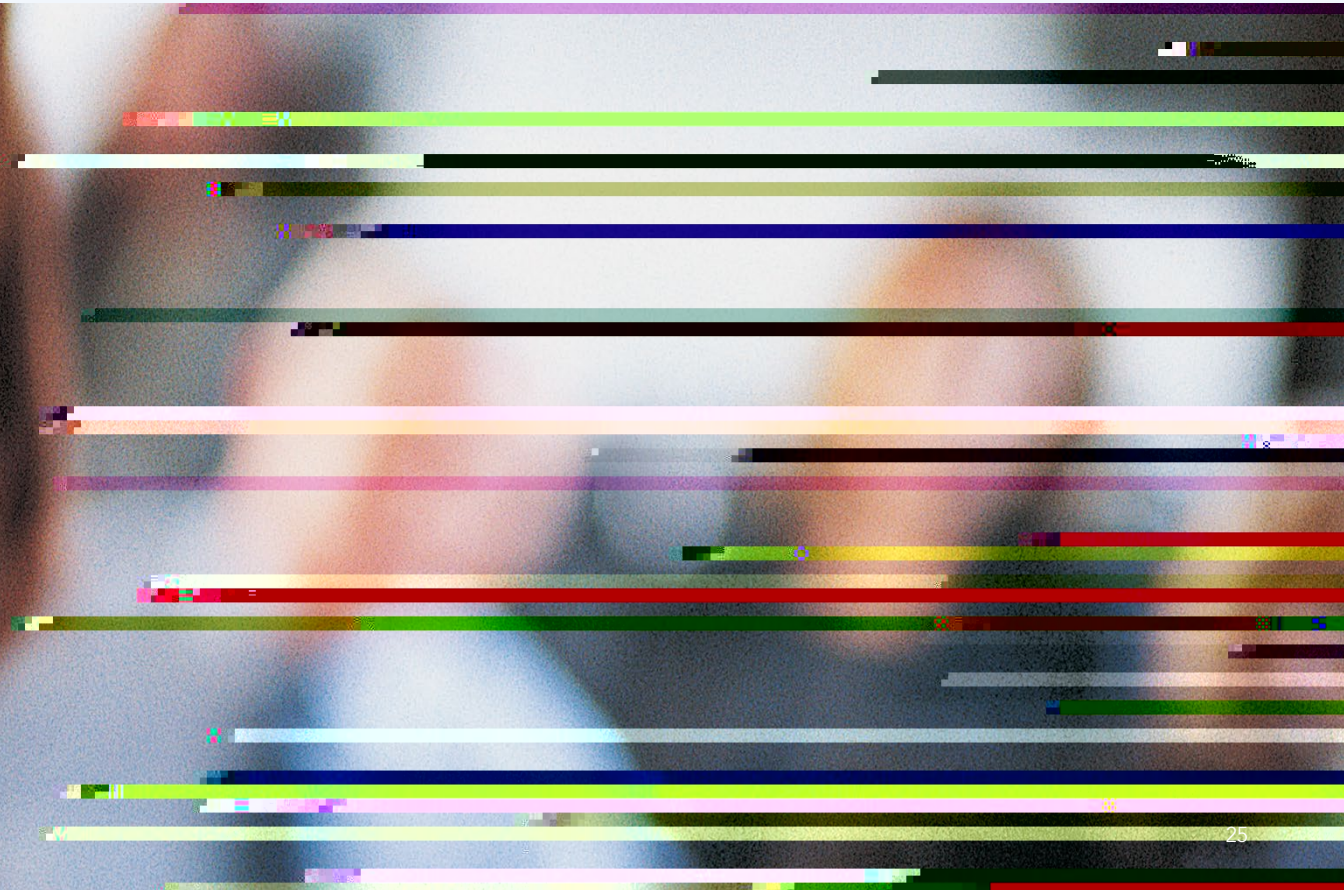


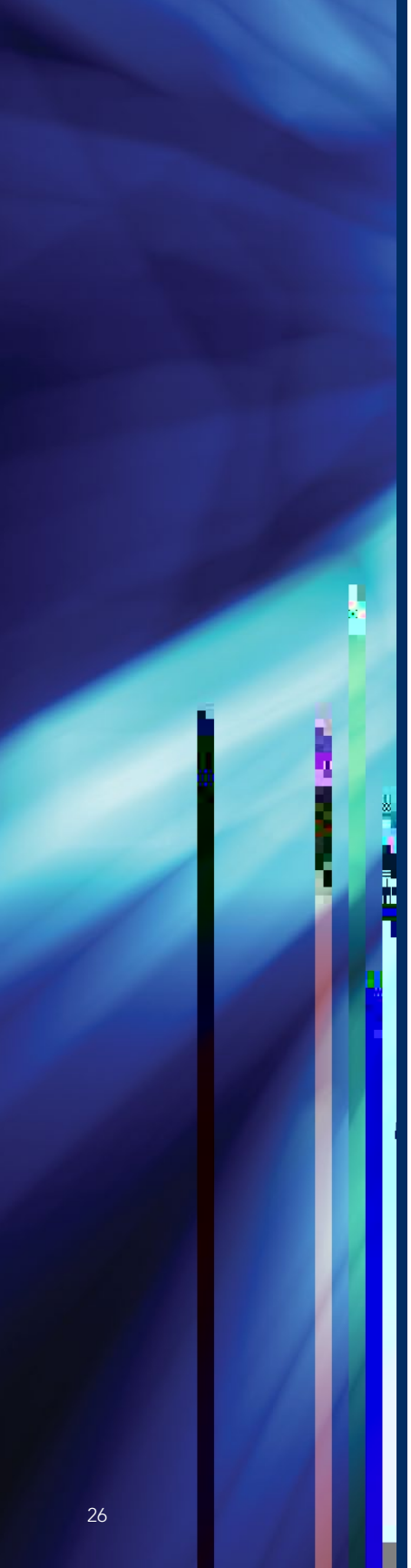
FRAMEWORK FOR DECIDING WHEN/HOW TO TAKE ACTION IN SEXUAL MISCONDUCT CASES

This comprehensive framework will be valuable to BONs as they review complaints of sexual misconduct. See Cases 1 and 3 at the end of this booklet to illustrate how this framework might be used.

FIRST CONSIDER: Should the complaint be opened for investigation in the first place? If it should, decide what priority it should be given (e.g., any potential emergency action is priority A and all other sexual misconduct is priority B).

- How egregious is the misconduct alleged?
- Were there aggravating circumstances that warrant higher priority, such as force, intimidation, stalking or highly vulnerable patient (e.g., mental health patient, comatose)?
- What is the source of or nature of the complaint?
- Is it anonymous or possibly biased? Is it rumor and hearsay versus observation (e.g., "I heard that …")?





- What is the alleged victim's condition/diagnosis? Is there any indication of cognitive impairment, temporary (postoperative) or otherwise (such as dementia)?
- Is there a history of similar allegations against other staff?
- Do we know anything about the alleged perpetrator? Is there any prior history such as an allegations in another place?

NEXT CONSIDER: Once opened for investigation, can we develop the case and when will we have a case worth charging (*prima facie case*)? Where is the evidence located? What can I get? Where can I find it?

- Is there forensic evidence (e.g., a rape kit)? Were there medical reports?
- If it occurred at a facility, was an internal investigation conducted? Can we get a copy of the report? (Note: has an initial investigation by the facility had a dilatory effect on our investigation?) We may have to obtain a subpoena.
- Were there witnesses to the incident or other relevant observations beyond the victim? Oftentimes people don't see the incident, but they may see other things, such as someone running out of the room, closing the door, etc.
- How credible are the alleged victim's allegations? Is the story consistent to various parties? Was there appropriate postincident behavior? Sometimes victims wait awhile and it might be appropriate, but the investigators must know about it. Did the victim report to someone right after the episode or provide credible reasons why not? How does the victim present as a witness generally?
- Consider the state's duty to report requirements. If none, consider contacting law enforcement anyway (see Law Enforcement Coordination section).

ALSO CONSIDER:

What is the licensure status of the alleged perpetrator?

- Is the alleged perpetrator still working at the facility?
- If he/she is fired or on administrative leave, is there a chance he/she is working elsewhere?
- Ask the licensee about work status when you interview him/her, as this is relevant to making an argument for imminent danger justifying a summary action.

How should you best approach alleged victims/witnesses when it is appropriate to investigate?

- Interview the victim separately in a safe environment whenever possible.
- Ask questions in a neutral, objective and nonjudgmental fashion.
- If possible, record the interview.
- A phone interview may be all that is available.
- Get the victim's statement in writing.
- Take notes as to what he/she says, transpose and go over the notes with him/her.
- Make sure victims/witnesses agree with every aspect of content and then have him/her sign the statement.
- Consider composing a memo to file by the investigator as to what he/she observed/heard, in addition to the alleged victim's statement; this is often helpful because subsequent legal review by the attorney will be used to aid the BON in determining sufficiency.
- It is beneficial to have two investigators. One investigator should ask questions – preferably this investigator is the same sex as the victim and has a calming disposition, if appropriate. The other investigator can record impressions, take careful notes of content and make accurate and detailed observations as to how well the victim presents as a potential live witness.

Are you legally barred from disseminating preconviction data?

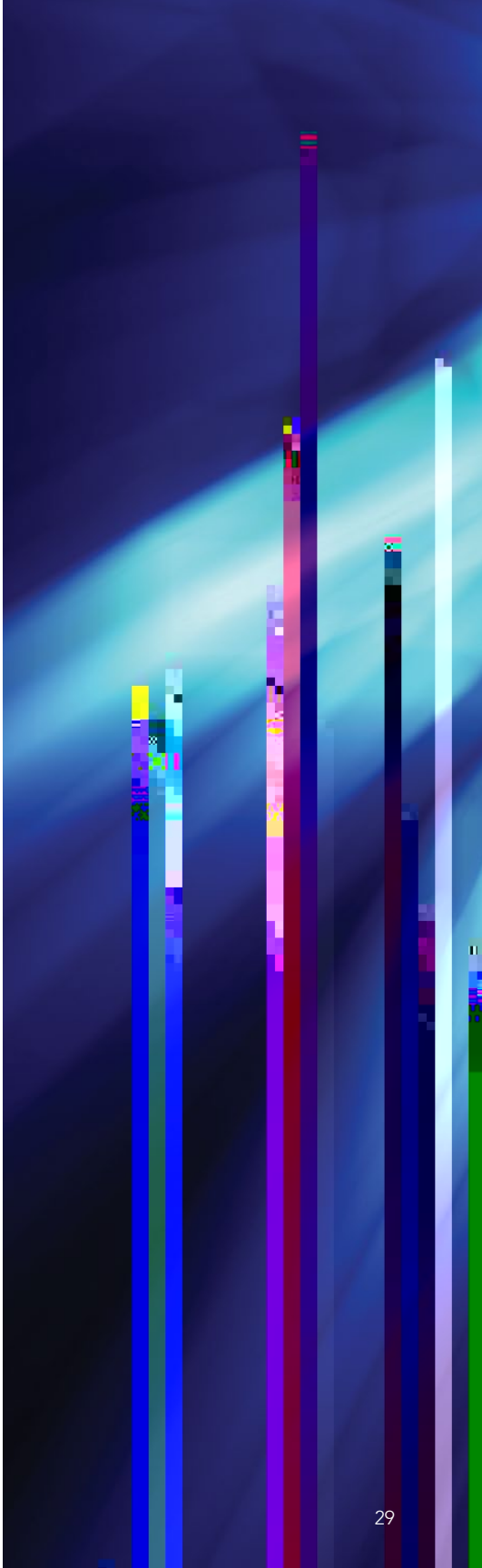
- If you are charging the licensee while he/she is still being investigated by the police or in the case of a deferred prosecution, take steps to bar further release of all preconviction data to the public, since you are relying on this information.
- Move for a protective order regarding the evidence and keep the fact the licensee is being investigated out of your pleadings or discussions with the media.
- Once criminal charges are filed, however, the licensee is entitled to discovery and usually gets most of the police report.
- If the authority is opposed to your BON getting ahead of the criminal matter, ask whether they would still be willing to share their investigative results so that you can prepare your case. Then once the local authorities are ready to file their charges, you can do the same in your forum.

If we are barred from using police investigation materials or it's not advisable, can we, and when should we, develop our own investigation? Will this result in impeachable evidence?

- The more you document the alleged victim's or other witnesses' story, the more you create opportunities for opposing counsel to point out inconsistencies.
- If you go to hearing before the prosecuting attorney does, do you create the risk that the defense counsel gets to pretry the criminal matter and test the case in advance to find weaknesses?
- Can you be sure fragile witnesses can stand two full hearings?
- What is the greater goal, taking the license or incarcerating the predator?

Is the licensee incarcerated?

- Arrested and released without charges or bail? Then the nurse is still free to practice and the law enforcement investigation remains nonpublic.
- Arrested, charged and on bail? The criminal information is public. Ask the prosecutor to request that the judge restrict the licensee from practicing, pending trial.
- In jail and has not posted bail? How high is bail set? They only need to come up with 10 percent of the bail amount and there is no way of knowing when he/she might post bail. How soon is the trial?



ANTICIPATE

- Has the incident gone public or might it go public? Arrests/charges are a matter of public information; witnesses could go to the press at any point.
- Prepare a media release in anticipation.
- Consider developing, in every such case, a standard report sent from the frontline staff up the organization's hierarchy so that upper management won't be blindsided by outside inquiries or media reports.
- Rapid response to media Tf1.263 0des or media rep he pSpaal; you.9 dsided

HIGH-PROFILE CASE ON SEXUAL MISCONDUCT

The following cases are based upon real incidents adjudicated by BONs. Some information has been changed to protect the anonymity of those involved.

The investigator received a complaint that a male nurse (Mr. A) had been accused of a rape in a neighboring state. Mr. A had allegedly raped the wife of the complainant while Mr. A was hosting a swingers' party. The complainant attached nude photos of Mr. A and his wife (also an RN) from the Internet. The couple was active on a proswinger website and had elicited contact with other swingers.

The complainant noted that at the party, Mr. A had penetrated the complainant's wife while in the hot tub. He stated that it was discussed prior to the party that the rules forbid any sexual intercourse with others' spouses. The complainant went on to discuss specifics of swinger parties and rules that are laid out in advance.

The complainant also noted that his wife was given some liquor from Mr. A's bar that he believes was spiked with a narcotic. His wife complained of being drugged prior to the incident with Mr. A in the hot tub.

A police report had been filed, but the police noted that they did not have a criminal case. Members were at the party as swingers, they were in various stages of dress and there was noted alcohol use. The complainant stated he understood that there would probably not be criminal charges, but insisted his wife was raped by Mr. A and that the BON should monitor his behaviors.

The BON investigator continued to investigate these complaints and gathered police reports.

The BON was then contacted by a hospital in their state and told that Mr. A was being charged with rape of a patient. The patient claimed that Mr. A had drugged her with morphine and then forced her to have oral sex with him. The facility police reported that the bed sheet had been secured and sent for DNA testing. They had to get a court order to have Mr. A provide a DNA specimen and were able to get an oral swab from him.

Issues for the BON to consider:

- The nurse has an active license and he can still work; yet, he is facing possible first-degree felony charges.
- There are no charges against him. The police want to wait for the DNA results before charging him with a crime.
- There are very serious accusations, but the BON cannot go public with these because the police will not give them the report until the prosecutor releases it.
- The nurse also has licensure in an adjoining state.

1. What can you do while the police are awaiting the results of the DNA results? In this case, the DNA is delayed because the state crime lab has a backlog of cases to complete. Contact the nurse and ask him to voluntarily go inactive. If he refuses to go inactive, the BON might order a mental health evaluation.
2. What should you do if you hear he is working at another hospital in the area as an agency nurse? Contact them and ask if he is working there, though you may be unable to tell them why you are asking.
3. Contact local facilities (hospitals, nursing homes) and local nursing agencies asking if he is employed with them. He could be connected to several other agencies. If you locate any employers, point them to available public records (such as court actions or police reports). Contact his agency, though he could be connected with another nursing agency and could be working elsewhere.

Mr. A is arrested and charged with a first-degree felony. The BON investigator contacts him again and asks him to go on inactive status. He agrees to go inactive, but states he must contact an attorney. Mr. A still insists he is innocent and

TYPICAL CASE STUDY IN SEXUAL MISCONDUCT: LONG-TERM CARE SETTING

An allegation was received from an administrator of a long-term care facility (Facility A) regarding inappropriate behavior of an LPN employee. The allegation was that the nurse had followed a female coworker into a medication room, closed the door, and started hugging and kissing her. She pushed him away and left the room. The nurse resigned before being terminated from Facility A for inappropriate sexual advances toward a coworker.

Upon investigation, there were no practice issues identified, the nurse denied the allegation and there was insufficient evidence for the BON to take action. The female coworker, however, did provide a statement that the offender trapped her in a corner, started hugging and kissing her, and told her that she was denying her needs for him. She stated that she kept pushing him away and was frightened by his behavior. She asked for an escort to her vehicle that evening when leaving the facility because she was concerned that he would continue to pursue her.

A second allegation was received from a long-term care facility (Facility B) that the nurse was terminated after two residents complained of sexual misconduct. The allegations, however, could not be substantiated by internal investigations.

The first alleged incident occurred in April 2006. Resident T claimed the nurse felt all over her body looking for a Duragesic patch. When she informed him it was on her back, he allegedly asked her "What are you going to do for me since I did something for you?" Resident T had a history of Guillian-Barré syndrome, drug and alcohol abuse, and frequently made unfounded allegations against staff, particularly about not getting medication that she was supposed to have gotten. Resident T was asked to make a statement; she made an initial statement the next morning and then gave a second, very detailed statement. When contacted, her husband said she often has hallucinatory episodes, hears voices and makes accusations about not getting her medication.

Upon interview, the nurse said Resident T got angry because she alleged that the medication was not administered. Even though the nurse stated that he was trying to change a patch, he did not sign out a patch to administer.

Further investigation showed that Resident T had an order for a Duragesic patch to be changed every 72 hours; it had been applied earlier that morning and was not due to be changed. Resident T also had an order for Xanax four times

The facility was instructed by their corporate office to terminate the nurse, who was still on probation, and to report the allegations to the BON.

Upon further investigation, the following information was provided:

1. A criminal background check that was done by Facility B came back with an arrest for rape in 1984, but the district attorney dropped the charges when the victim was unavailable.
2. The nurse applied for employment at a third long-term care facility (Facility C). Review of his application for employment at Facility C showed that he had failed to include his employment at Facility B on his work history. When interviewed, the nurse stated he was afraid he would not find employment because of false accusations, so he left his employment at Facility B off the application. He insisted that the allegations of sexual misconduct were unfounded. He said that the 1984 allegation of rape was made by

A review of work history indicated the following:

April 2005–September 2005: resigned, failed to work out notice.

September 2005–January 2006: resigned before being terminated for inappropriate sexual advances toward a female nurse.

May 2006–June 2006: terminated after two residents complained of sexual misconduct. Review of application showed he claimed to work at a facility from 2000 through 2005 that closed in 1995.

August 2006: terminated for falsifying application.

At this point, the nurse's license was temporarily suspended based on the complaint by his female coworker and complaints of two residents, the falsification of employment application and signing out the Xanax at 6 am without an order. He was scheduled for an administrative hearing.

Further information was provided from the Department of Health by a health facility surveyor. The Department of Certification and Licensure had conducted a site survey and reported the following:

> As part of the survey process, they request to hold a group session with residents cognizant enough to be interviewed.

At the administrative hearing, testimony that was provided by the female coworker who was trapped in the medication room by the nurse was revealed by an investigator who had interviewed both residents and by two Department of Health facility surveyors who had conducted the group session with residents.

The BON's hearing panel found the nurse guilty of all charges and revoked his nursing license.

Issues to Consider:

- Employer/employee issue of charges by coworker of sexual harassment;
- Work history shows many short-term positions;
- Seeks vulnerable patients with credibility issues, history of dementia, substance abuse, difficulty with communication;
- Incidents occur at times when he is the only nurse on unit and is assigned to residents in question;
- Stories of victims are very similar in nature;
- Physically imposing presence, seeks to intimidate victims;
- Collaboration with other state agencies; and
- Based on a criminal background check, his story about why charges were dropped is different from what the record reflects.

There was no specific language about sexual misconduct in law, so charges were based on:

- Engaging in conduct likely to harm the public (three complaints of sexual misconduct);
- Making incorrect entries or failing to make essential records (falsified employment application); and
- Administering medication except as legally directed (signed out Xanax at time not ordered).

A specific definition would have assisted the BON in this case. This booklet has several definitions for BONs to review and they might either select one of them or they might use one as a starting point for developing their own definition. There are two very detailed definitions and three more general ones. One of the detailed definitions would have probably been useful for this BON.

The BON received a report from a local hospital indicating they had terminated one of their nurses based on allegations by four female patients that this same male nurse had inappropriately touched them during their hospitalizations. The reported incidents occurred during the period June 29, 2005, to Oct. 30, 2006.

The 50-year-old male nurse, against whom the allegations were made, had been licensed as an RN

her, "Does this feel good?" ES began to cry and the nurse left the room. On interview, the nurse admitted that he gave ES thigh massages that night and that his hand may have brushed against her pubic area where the drain lines and catheter lines had become tangled. ES adamantly denied that the Jackson-Pratt drain line and her Foley catheter had in any way become entangled that night. ES reported the incident to hospital administration shortly after it occurred. Following this incident, the hospital terminated the nurse's employment and reported him to the BON.

Following receipt of the hospital report, a fourth patient, AG, contacted the hospital to report an incident that had occurred following her admission through the hospital emergency room when she experienced a transient ischemic attack (TIA). On her transfer from the emergency room to the floor, the same nurse gave her two pills for her complaint of a headache. During the night, AG awoke from a sound sleep to find the nurse sitting on her bed holding her left hand. The curtain was pulled around her bed. AG reported that she was very frightened by his unexplained presence in her room with the curtain drawn. She did not report the incident until she was later completing a patient satisfaction form received from the hospital.

Following receipt of the report from the hospital, the BON had received a call from AC, the nurse's niece, who reported that her uncle (the nurse under investigation) had sexually abused her as a child. That incident occurred when she lived in the nurse's home in 1991, at 11 years of age. The BON received police reports of the investigation into these allegations and was aware that the police had not pursued the case because of the length of time that had passed since the time of the alleged incidents.

All four women patients testified at a hearing that they were scared and upset by the nurse's conduct. The hearing officer for this case indicated that during the hearing, the testifying patients were still visibly upset when they described what had happened to them. The allegations made by the niece, AC, were not considered in the administrative hearing on this case.

1.

A VULNERABLE PATIENT

Mr. R is a 32-year-old male who was diagnosed as mentally ill with a schizoaffective disorder. Mr. R was also diagnosed with post-traumatic stress disorder related to physical and sexual abuse endured as a child, and has a history of suicidal ideation and gestures. He was incarcerated in a residential health care unit of a state prison for attempted murder. In this particular residential health care unit, the state can accommodate up to 32 prisoners, while offering a full range of hospital services.

For about three months Mr. R was having explicit sexual conversations with a nurse while she was on duty in the unit. The nurse, Ms. B, talked about sexual experiences and watched Mr. R masturbate. Eventually, the two masturbated with each other and kissed. One of the custodial staff observed this behavior and reported it to the nursing supervisor.

In this particular state any employer of a nurse must report potential violations of the rules and law to the state board of nursing (BON).

The nursing supervisor, along with the state police, who are responsible for investigating any criminal activity in state prisons, reported the complaint to the BON. Eventually, after receiving permission from the courts, Mr. R was set up with a wire to record a conversation with Ms. B, which he did, thus confirming the sexual misconduct.

Ultimately, Ms. B admitted discussing sexual experiences with Mr. R, masturbating with him and kissing him. She denied ever touching his penis. The police concluded that although an inappropriate relationship occurred, there was insufficient evidence to charge her with sexual battery. However, the expert witness used by the police stated that there has been serious emotional harm done to this patient because the nurse took advantage of her powerful position. Ms. B was prosecuted for patient abuse and was terminated from her job. After a full investigation by the BON and a review of all the evidence, Ms. B's license was permanently revoked.

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SUMMARY OF THE NCSBN'S 2009 SURVEY ON SEXUAL MISCONDUCT

In January 2009 a survey was electronically sent to those individuals listed on NCSBN's Discipline Knowledge Network. The survey was sent to executive officers of BONs in jurisdictions where no contact was listed. The purpose of the survey was to find out the needs of BONs related to their work with sexual misconduct cases. There were 26 boards that responded, and of those, 46 percent were definitely satisfied with how their BON handles sexual misconduct cases; 50 percent were somewhat satisfied; and
four percent (one BON) was not satisfied at all. The following are direct responses taken from these surveys offering some specific reasons BONs were satisfied:

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- It depends on the administrative law judge who is assigned to the case. Some have standards with which we disagree. Also, if the petitioner seeks a writ, the superior court judge may rule on technicalities that are not favorable to consumer protection from our perspective.
- We do not have experts in sexual misconduct to whom we can refer licensees for evaluations, if the licensee has not already been evaluated.