Agency Mission: To protect and promote the welfare of the people of Kansas.

Kansas State Board of Nursing
Landon State Office Building
Board of Nursing Library, Room 1051
Investigative Committee Agenda
December 8, 2025

NOTE: The audience may attend in person or via Zoom. Link to access meeting to follow agenda.

Time: **9:00 a.m. – Until Finished**

Committee Members: Ruth L.M. Burkhart, DNP, MSN, MA, RN-BC, LPCC
Adri Gouldsmith, LPN, V. Chair
Brenda Sharpe, Public Member

Staff: Linda Davies, MSN, BSN, RN, Practice Specialist
Stephanie Wiley, Sr. Administrative Assistant

I. Quorum (minimum of 2 members present) – Yes or No

II. Call to Order

III. Review of On-Site packets

IV. Additions/Revisions to the agenda

V. Announcements

VI. Approval of minutes – September 4, 2025

Consent Item Agenda

VII. Unfinished Business
1. Legislative Review Plans and Sample Form Introduction
2. Statute Review Task Force Report
3. EVOKE Case Management Status Update

VIII. New Business
1. KNAP Statistical Summary
2. Just Culture in Nursing Regulation, NC BON Complaint Evaluation Tool
3. Disciplinary Statute Reviews

IX. Quasi-Judicial

X. Agenda for March 2026 Committee meeting

XI. Adjourn

Executive session if needed.

Committee Responsibilities:
To review and recommend revisions in investigative and discipline statutes and regulations. To conduct a review of cases opened by the legal department, determine what type of disciplinary proceeding, and recommend proceedings be initiated. To review and recommend changes to investigative and discipline policies and procedures. To maintain a structured system for monitoring impaired licensees; to review and recommend revisions to the impaired assistance program yearly contract.

Please Note: Additional items, which have come to the attention of the Board or Committee, will be handled as time permits. Agenda is subject to change based upon items to come before the Board. Handouts or copies of materials brought to the board or committees for discussion by committee members or visitors must be submitted to staff 30 calendar days prior to start of the meeting. Any items received after the 30th calendar day may be addressed at the meeting at the discretion of the President of the Board or chairperson of the committee.

You are invited to a Zoom webinar!
When: Dec 8, 2025 08:30 AM Central Time (US and Canada)
Topic: Kansas State Board of Nursing - Investigative Committee

Join from PC, Mac, iPad, or Android:
https://us02web.zoom.us/j/86868882454?pwd=12eJ6yvte9Lw4B8Ahj2jIwzVd4bhM5.1
Passcode:KsbnINVCom

Phone one-tap:
+13462487799,,86868882454#,,,,*2709397111# US (Houston)
+16694449171,,86868882454#,,,,*2709397111# US

Join via audio:
+1 346 248 7799 US (Houston)
+1 669 444 9171 US
+1 669 900 6833 US (San Jose)
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 646 931 3860 US
+1 689 278 1000 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 876 9923 US (New York)
Webinar ID: 868 6888 2454
Passcode: 2709397111
International numbers available: https://us02web.zoom.us/u/kcCprmuSug

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Introduction:

The following attachments list the statutes and regulations of the Kansas Nurse Practice Act (KNPA) approved by the Kansas Legislature listed by KSBN Committee in the order they appear in the KNPA.

Each statute and regulation has a hyperlink to the actual KNPA language to be reviewed by each committee in the next five years.

The column with "**Review Year***" needs to be reviewed for by each committee to agree are the **priorities for the next two years.**

The column with **"Quarter Review**"** needs to be reviewed for by each committee to agree are the **quarter scheduled for review for the next two years.**

NOTE: The majority of the information in this DRAFT Form will be automatically populated by KSBN Staff. Board Committees would be focus primarily on the ***four*** questions with a "*".

IDENTIFY THE STATUTE, RULE AND REGULATION
Number
Article Title
Statute, Rule and Regulation Title
Type (new, amended)
Effective Date (history)
Authorizing KSA(s) and/or Related KAR(s)
Implementing KSA(s) and/or Related KAR(s)
Legislative History

KSBN STRUCTURE
KSBN Oversite Committee
Staff Review Owner
Review Year Cycle Number
Quarter of Review

PURPOSE: Briefly describe the public purpose of the statute, rule and regulation. (*limited to 400 characters)*

Environmental Assessment
Is KSBN operating in good faith and reasonable compliance with this statute, rule or regulation?

Is the statute, rule or regulation in agreement with current healthcare practice?

How does this statute, rule or regulation compare with other states, model legislation, or healthcare accreditation standards?

Have there been any changes in the National Licensure Compact, case law, statutes, rules or regulations that might impact this statute, rule or regulation?

*If changes are needed in statute, rule or regulation, what are the key elements of the substance of the revisions that need to be made?

NECESSITY (Primarily for Rules and Regulations)
*Is the rule and regulation necessary for the implementation and administration of state law, or could it be revoked? (*necessary/ could be revoked)*

Does the rule and regulation serve an identifiable public purpose in support of state law? *yes/no*

Is the rule and regulation broader than necessary to meet its public purpose? (*yes/no)*

TIES TO FEDERAL PROGRAMS (Typically not applicable to KSBN)
*Is the rule and regulation federally required for state participation in a federal program or authority? (*yes/no)*

Is the rule and regulation necessary for federal delegation of enforcement authority to the State?

If the rule and regulation is federally required, the state and federal program names and the federal agency name (*yes/no)*

Could federal moneys be in jeopardy under current law if the rule and regulation were repealed? (*yes/no)*

If federal moneys could be in jeopardy, the approximate amount received for the most recent fiscal year.

POTENTIAL FOR REVOCATION (Primarily for Rules and Regulations)
Briefly describe how revocation would affect Kansans. (*limited to 600 characters)*

If the rule and regulation is not in active use, would revocation require a change to the authorizing or implementing statute? (*in active use/ yes/ no)*

*If the rule and regulation is not in active use and revocation would require a change to the authorizing or implementing statute, which change(s)? (*limited to 400 characters)*

ADDITIONAL INFORMATION

Additional information necessary to understanding the necessity of this rule and regulation (*limited to 1,200 characters)*

SUMMARY OF REVIEW

Based on the summary of the information above, this KSBN Committee recommends

_____ no changes with review for another 5 years, or

_____ the Board develop a plan for revision and adoption as defined by Kansas laws.

Revisions need to address the key elements summarized in the Environmental Assessment.

Committee Reviewing:

Committee Chair:

Date of Meeting:

Date Presented to Board:

Board Chair:

Investigative Committee Legislative Review Schedule

Article Title	Review Year*	Quarter Review**
74-1110 - Civil fine.	2026	
65-1114 - Unlawful acts.	2026	
65-1120 - Grounds for disciplinary actions; proceedings; witnesses; costs; professional incompetency defined; criminal justice record information.	2026	
65-1120a - Reinstatement of revoked licenses; burden of proof; board of nursing report to legislature.	2026	
65-1121a - Judicial review of board's actions.	2026	
65-1122 - Misdemeanors; penalties.	2028	
65-1123 - Injunctions.	2028	
65-1127 - Reporting of malpractice incidents and other information; immunity from liability in civil actions for reporting, communicating and investigating certain information concerning alleged malpractice incidents and other information; conditions.	2027	
65-1135 - Complaint or information relating to complaint confidential; exceptions.	2026	
60-3-110. Unprofessional conduct	2026	
65-4209 - Grounds for disciplinary actions; proceedings; witnesses; costs; professional incompetency defined; criminal history record information.	2026	
65-4210 - Disciplinary proceedings; complaint; notice and hearing.	2026	
65-4211 - Judicial review.	2027	
65-4213 - Injunctions.	2028	
65-4214 - Violations; penalties.	2026	
65-4216 - Report of certain actions of mental health technician; persons required to report; medical care facility which fails to report subject to civil fine; definitions.	2027	
65-4217 - Immunity from liability in civil actions for reporting, communicating or investigating certain information.	2027	
60-7-106. Unprofessional conduct	2028	
60-7-111. Reporting of certain misdemeanor convictions by the licensee	2029	

Needs to be reviewed by committee to agree

* These are the **priorities for the next two years.**

** on the **quarter scheduled for review for the next two years.**

Kansas Nurses Assistance Program
Statistical Summary

Reporting Period: 7/1/2025 - 9/30/2025

Participants Entered Into Program: **17**

Referral Source:

Board:	8
Employer:	0
Co-Worker:	0
Self:	9
Family-Friend:	0
Other:	0

Reasons for Referral:

Alcohol:	6
Drugs:	5
Alcohol & Drugs	3
Mental Health:	1
Diversion	5

Released from Program:

Successful:	6
Non-Compliant:	3
Voluntary Withdrawal:	1
Death:	0
No Diagnosis:	0

State of Residency:

MO	4
KS	85

Contract Length:

5 Year's	1
3 Year's	66
1 Year	22

Active Cases

Total Number in Program: **89**

Type of License:

ARNP	3
CRNA	3
LPN	19
RN	64

Board:

Known:	74
Un-Known:	15

Gender:

Male:	14
Female:	75

Age:

20's:	12
30's:	26
40's:	34
50's:	15
60's:	2

Nursing Employment Status:

Employed:	67
Unemployed:	11
Outside Profession:	11

Nursing Employment Settings:

Hospital:	22
Nursing Home/Long Term Care:	21
Medical Office/Clinic:	21
School:	1
Administrative:	2
Other:	

North Carolina Board of Nursing (NCBON)
COMPLAINT EVALUATION TOOL (CET)

Allegation(s): _____ **Licensee Name:**

_____

	Criteria	Human Error	At Risk Behavior			Reckless Behavior		Score
		0	1	2	3	4	5	
G	General Nursing Practice	No prior written counseling for practice issues.	Prior written counseling for single non-related practice issue within last 12 months.	Prior written counseling for single related practice issue within past 12 months	Prior written counseling for various practice issues within the last 12 months	Prior written counseling for same practice issue within last 12 months	Prior written counseling for same or related practice issue within last 6 months with minimal to no evidence of improvement	
U	Understanding / level of experience	Has knowledge, skills, and ability. Incident was accidental, inadvertent or oversight.	Limited understanding of correct procedure. May be novice < 6 months experience in nursing or with current event / activity.	Limited understanding of options / resources. Aware of correct procedure but in this instance cut corners. May be advanced beginner – 6 months to 2 years experience in nursing or with current event / activity.	Aware of correct action / rationale but failed to apply in this incident. Did not obtain sufficient information or utilize resources before acting. May be competent > 2 years experience in nursing or with current event / activity.	In this instance there was intentional negligence or failure to act / not act according to standards. Risk to client outweighed benefits. May be In a position to guide / influence others. May be proficient > 5 years in nursing or with current event / activity.	In this instance there was intentional gross negligence / unsafe action / inaction. Licensee demonstrated no regard for client safety and harm almost certainly would occur. May hold a leader / mentor position. May be expert performer > 5 years in nursing or with event / activity.	
I	Internal policies / standards / orders	Unintentional breach or no policy / standard / order exists.	Policy / standard / order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy / standard / order was misinterpreted.	Policy / standard /order clear but nurse deviated in this instance as a time saver. Failed to identify potential risk for client. No evidence of pattern.	Aware of policy / standard / order but ignored or disregarded to achieve perceived expectations of management, client, or others. Failed to utilize resources appropriately. May indicate a pattern.	Intentionally disregarded policy / standard / order for own personal gain.	Intentional disregard of policy / standard / order with understanding of negative consequences for the client.	
D	Decision / choice	Accidental / mistake/ inadvertent error.	Emergent situation – quick response required to avoid client risk.	Non-emergent situation. Chose to act / not act because perceived advantage to client outweighed the risk.	Emergent or non-emergent situation. Chose to act / not to act without weighing options or utilizing resources. Used poor judgment.	Clearly a prudent nurse would not have taken same action. Unacceptable risk to client / agency / public. Intentional disregard for client safety.	Willful egregious / flagrant choice. Put own interest above that of client / agency / public. Intentionally neglected red flags. Substantial and unjustifiable risk.	
E	Ethics / credibility / accountability	Identified own error and self reported. Honest and remorseful.	Readily admitted to error and accepted responsibility when questioned. Identified opportunities and plan for improvement in own practice.	Reluctantly admitted to error but attributed to circumstances to justify action / inaction. Cooperative during investigation and demonstrated acceptance of performance improvement plan.	Denied responsibility until confronted with evidence. Blamed others or made excuses for action / inaction. Failed to see significance of error. Reluctantly accepted responsibility and denied need for corrective action.	Denied responsibility despite evidence. Indifferent to situation. Uncooperative, insubordinate and / or dishonest during investigation.	Took active steps to conceal error or failed to disclose known error. Provided misleading information during investigation or destroyed evidence. May have inappropriately confronted others regarding investigation.	

Criteria Score _____

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updated 11.3.2020; updated 9.8.2021; updated 9.8.2022; updated 2.3.2023; updated 3.27.2024; updated 7.22.2024; 032025; 072025

North Carolina Board of Nursing (NCBON)
COMPLAINT EVALUATION TOOL (CET)

	Mitigating Factors -check all identified		Aggravating Factors - check all identified	
	Communication breakdown (multiple handoffs, change of shift, language barrier		Took advantage of leadership position	
	Limited or unavailable resources (inadequate supplies / equipment)		Especially heinous, cruel, and / or violent act	
	Interruptions / chaotic environment / emergencies – frequent interruptions / distractions		Knowingly created risk for more than one client	
	Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet agency needs		Threatening / bullying behaviors	
	High Work volume / staffing issues		Disciplinary action (practice related issues) in previous 13 – 24 months	
	Policies / procedures unclear		Vulnerable client: geriatric, pediatric, mentally / physically challenged, sedated	
	Performance evaluations have been above average		Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet personal needs	
	Insufficient orientation / training		Other (identify)	
	Client factors (combative / agitated, cognitively impaired, threatening)			
	Non-supportive environment – interdepartmental conflicts			
	Lack of response by other departments / providers			
	Other (identify)			
	Total # mitigating factors identified		Total # aggravating factors identified	

Criteria Score from page 1 _____

No Board Contact Required	A Report May Be Required. Board Consultation Suggested	Board Report Required
Contact with NCBON is not required if: ○ 3 or more criteria in green OR ○ Criteria score of 6 or less	Consult with NCBON if: ○ 3 or more criteria in yellow OR ○ Criteria score 7 – 15 Call: 984-238-7681 Email: practice@ncbon.com	Mandatory report to NCBON if: ○ 2 or more criteria in red OR ○ Criteria score 16 or more OR ○ Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment. Go to website: (www.ncbon.com)

CET Completed by: _____ Facility Name: _____

Contact Number & Email address: _____

Date of Consultation with NCBON _____ NCBON Consultant: _____ Action Taken: _____

Guide to the Just Culture Algorithm

The Just Culture Algorithm

www.justculture.org

Event Investigation The Five Rules

Rule 1
Causal Statements should clearly show the "cause and effect" relationship.

Rule 2
Negative descriptions (e.g. poorly, inadequate) should not be used in causal statements.

Rule 3
Each human error should have a preceding cause.

Rule 4
Each procedural deviation should have a preceding cause.

Rule 5
Failure to act is only causal when there was a pre-existing duty to act.

The Response to An Event

Single Human Error
- Console employee
- Conduct Human Error Investigation

At-Risk Behavior
- Coach employee
- Conduct At-Risk Behavior Investigation

Reckless Behavior
- Counsel employee
- Use remedial action to change behavior, where appropriate
- Use disciplinary action to change behavior

Repetitive Errors or At-Risk Behaviors
- Investigate to determine source of repetitive errors or at-risk behaviors
- If source resides in system, change the system
- If source is within employee, consider remedial and then punitive action to address risk

Definitions

Knowingly – practically certain that conduct will cause harm

Impossibility – condition outside of employee's control that prevents duty from being fulfilled

Counseling – a first step disciplinary action: putting the employee on notice that performance is unacceptable

Human error – inadvertently doing other than what should have been done; a slip, lapse, mistake

At-risk behavior – behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified

Substantial and unjustifiable risk – a behavior where the risk of harm outweighs the social utility associated with the behavior

Purpose – conscious objective to cause harm

Social utility – the societal benefits derived from a behavior: the value the judging body puts on the behavior

Coaching – supportive discussion with the employee on the need to engage in safe behavioral choices

Reckless behavior – behavioral choice to consciously disregard a substantial and unjustifiable risk

Punitive action – punitive deterrent to cause an individual or group to refrain from undesired behavior

Remedial action – actions taken to aid employee including education, training, assignment to task appropriate to knowledge and skill

System Investigation

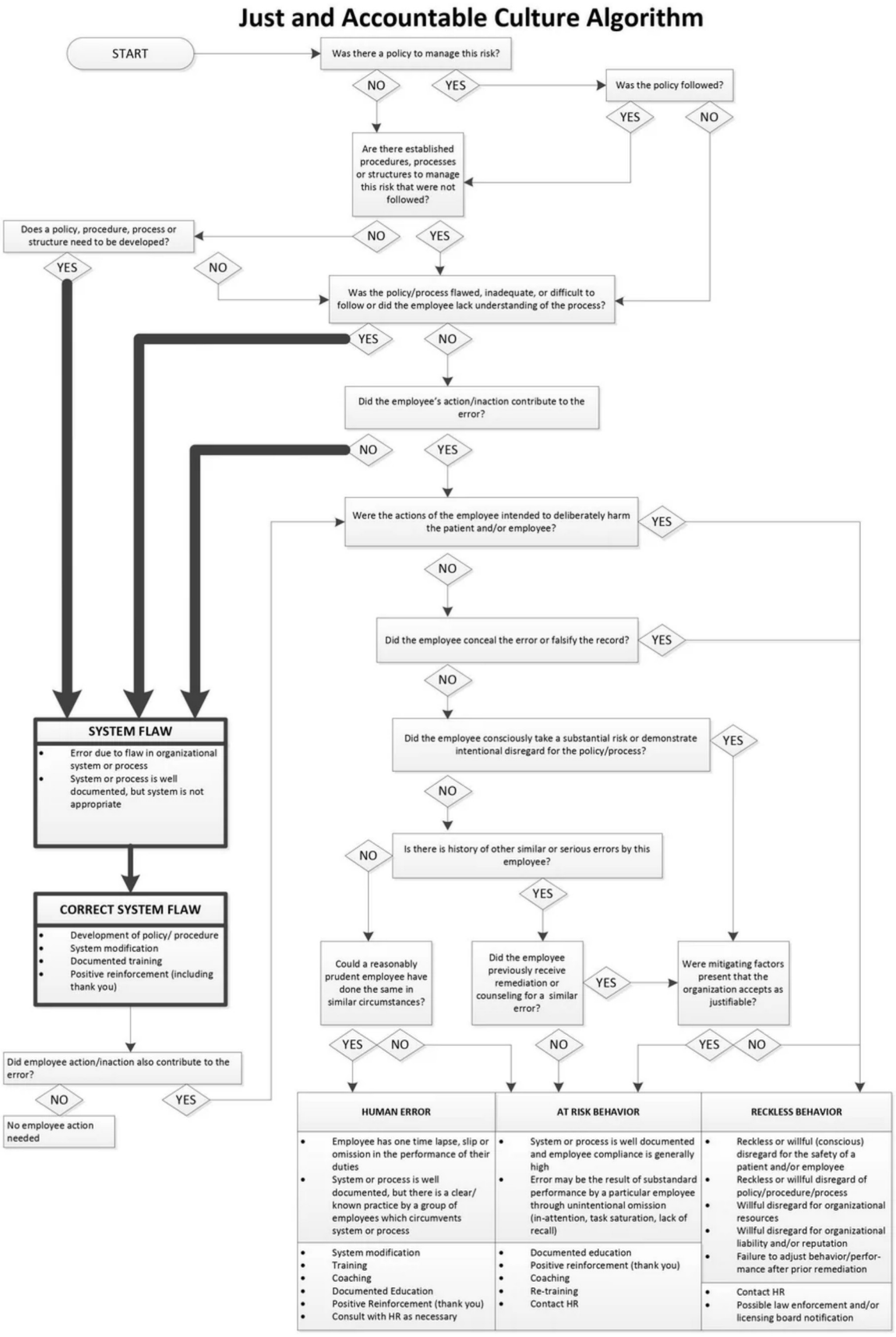
How was the risk being managed ahead of the event?
- Employee to manage personal risk?
- Organizational control of performance shaping factors?
- Organizational control of skill/competency?
- Organizational maintenance of high perceptions of risk?
- Barriers put in place to prevent error?
- Recovery to catch error before becoming a critical outcome
- Redundancy to allow success through multiple paths?

At- Risk Behavior Investigation

- What type of at-risk behavior?
  - Error in risk v. utility decision?
  - Failure to make risk v. utility decision?
- Why was the decision made?
  - Incentives to cut the corner?
  - Perceptions of risk?
- How prevalent is the behavior?
  - Individual or group?
  - Rate?

Human Error Investigation

Explain human errors by identifying the performance shaping factors:
- Information
- Equipment/tools
- Job / task
- Qualifications / skills
- Individual factors
- Environment/facilities
- Organizational environment
- Supervision
- Communication



Investigative 15

Just Culture Decision Support Tool

STEP 1: Choose the column that best describes the employee's action. Read down the column for recommended responses.

The employee was impaired by illegal or legal substances.	The employee wanted to cause harm.	The employee makes or participates in an error while working appropriately and in the patient's best interest.	The employee made a potentially unsafe choice. Faulty or self-serving decision making may be evident, or short cuts, or routine rule violations.	The employee knowingly violated a rule and / or made a dangerous or unsafe choice. The decision appears to have been made with little or no concern about risk.
IMPAIRED JUDGEMENT	**MALICIOUS ACTION**	**HUMAN ERROR**	**AT RISK Behavior**	**RECKLESS Behavior**
• Discipline is warranted if illegal substances were used. • The employee's perfomance should be evaluated to determine if a temporary work suspension is helpful. • Help should be actively offered to the employee.	• Discipline and/or legal proceedings are warranted. • The employee's duties should be suspended immediately.	• The employee is not accountable. • The employee should be consoled. • The employee should be interviewed and consulted during any systems level analysis.	• The employee is accountable and should receive coaching. • The employee may participate in teaching others the lessons learned.	• Discipline may be warranted. • The employee is accountable and should receive re-training/coaching as necessary. • The employee should participate in teaching others the lessons learned.

NCPS®
VA National Center for Patient Safety

Safer Systems • Safer Care

Adapted from: Leonard, M.W.,Frankel, A., The path to safe and reliable healthcare. Patient Educ Couns. 2010 Sep;80(3):288-292.

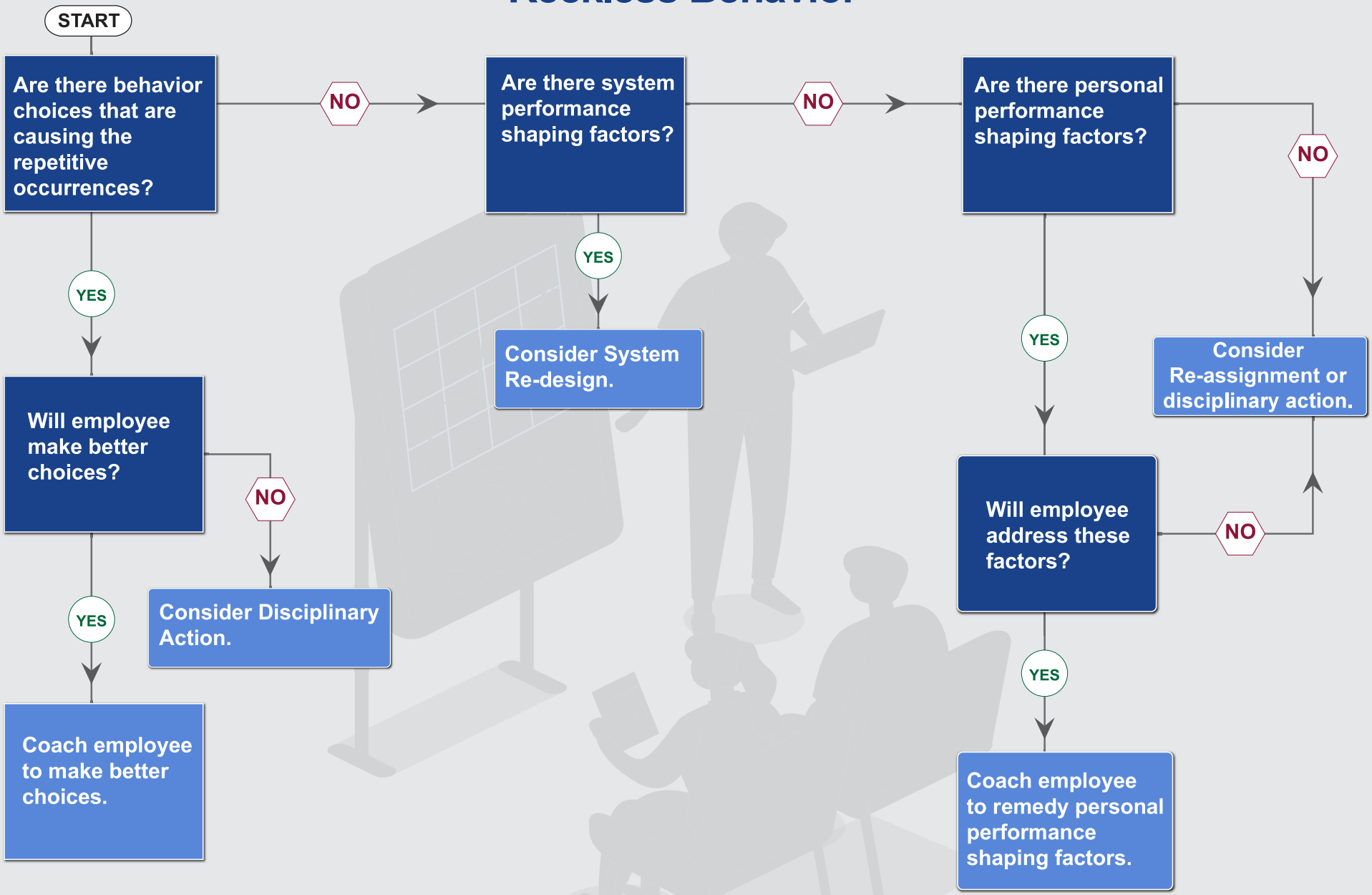
Revised May 2021

STEP 2: Would 3 other employees with similar skills and knowledge do the same thing in similar circumstances? If YES proceed below.

The system and/or culture supports error and requires improvement and/or redesign. Leaders are accountable and should apply error management in the system via human factors-based improvements.	The system and/or culture supports risky action and requires improvement and/or redesign. The employee is probably less accountable for the behavior. Leaders share accountability with the employee.	The system and/or culture supports reckless action and requires improvement and/or redesign. The employee is probably less accountable for the behavior. Leaders share accountability with the employee.

STEP 3: If there are repeated errors, or occurrences of at-risk behavior, further evaluation is warranted. Response may involve further coaching, transfer (employee may be in the wrong position), or disciplinary action. See reverse side of this card for general guidance.

Repetitive Occurrences of: Human Error / At Risk Behavior / Reckless Behavior



Adapted from Just Culture Training for Managers - Healthcare edition. Adapted and modified from: Outcome Engenuity 2012