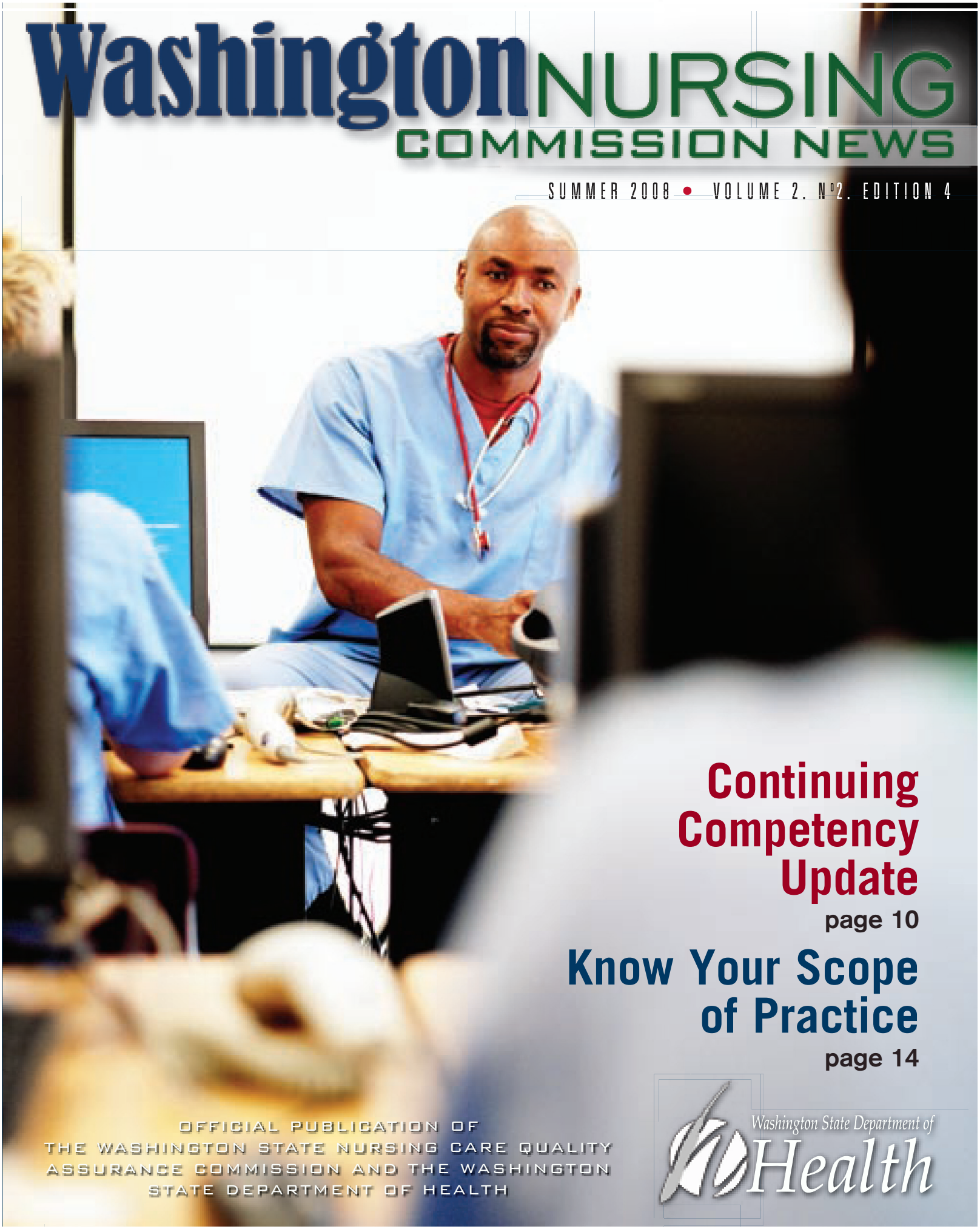
Washington NURSING COMMISSION NEWS

SUMMER 2008 • VOLUME 2, N°2, EDITION 4



Continuing Competency Update

page 10

Know Your Scope of Practice

page 14

OFFICIAL PUBLICATION OF
THE WASHINGTON STATE NURSING CARE QUALITY ASSURANCE COMMISSION AND THE WASHINGTON STATE DEPARTMENT OF HEALTH

Washington State Department of Health

YOU HAD ME, MOM.

A VACCINATION WON'T HURT AS MUCH.

GET YOURSELF VACCINATED. DON'T GIVE YOUR BABY A POTENTIALLY FATAL DISEASE.[1]

Pertussis, also known as whooping cough, can be a deadly disease to infants and is still a major problem. Even though babies are immunized against pertussis, they may not be fully protected until their third or fourth dose. And studies have found that when the source of pertussis has been identified, parents were the cause in nearly half of the infant cases.[2,3] That's why the Centers for Disease Control and Prevention (CDC) recommends a booster for everyone 11 through 64 years of age.[1,4] Getting yourself and your family immunized should be the first step in helping to protect your baby. Talk to your doctor and learn more about the importance of getting a pertussis booster at DoItForYourBaby.com

HEAR WHAT WHOOPING COUGH SOUNDS LIKE AT DoItForYourBaby.com

References: 1. Centers for Disease Control and Prevention (CDC). Preventing tetanus, diphtheria, and pertussis among adults: Use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine. *MMWR*. 2006;55(RR-17):1-27. **2.** Wendelboe A, Njamkepo E, Bourillon A, et al. Transmission of *Bordetella pertussis* to young infants. *Pediatr Infect Dis J*. 2007;26(4);293–299. **3.** Bisgard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: Who was the source? *Pediatr Infect Dis J*. 2004;23(11):985–989. **4.** CDC. Pertussis—United States, 2001-2003. *MMWR*. 2005;54(50):1283–1286.

Brought to you as a public health service by Sanofi Pasteur Inc.

MKT14678-1R 2/08 Printed in the USA

PUBLISHED BY
Washington State Nursing Care Quality Assurance Commission (NCQAC)
P.O. Box 47864
Olympia, WA 98504
Telephone: (360) 236-4700
FAX: (360) 236-4738
HTTPS://FORTRESS.WA.GOV/DOH/HPQA1/HPS6/NURSING/DEFAULT.HTM

Commission Members

Created by
Publishing Concepts, Inc.
David Brown, President
dbrown@pcipublishing.com
14109 Taylor Loop Road
Little Rock, AR 72223
501.221.9986
For advertising information contact:
Michelle Forinash at 501.221.9986 or 800.561.4686
mforinash@pcipublishing.com
www.thinkaboutitnursing.com

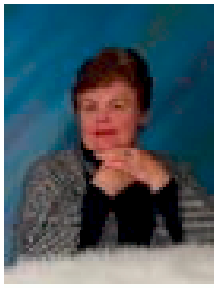
edition 4

THE WASHINGTON NURSING COMMISSION NEWS' CIRCULATION INCLUDES OVER 94,000 LICENSED NURSES AND STUDENT NURSES IN WASHINGTON.

Washington State Department of Health
DOH Pub 669-256

The Washington State Nursing Care Quality Assurance Commission regulates the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline.

Executive Director
Paula R. Meyer, MSN, RN
Editor
Terry J. West



Message from the Chair

By Judith Personett, Ed.D., CNAA, RN

Education expands our horizons into new areas of knowledge and expertise. The initial proof of competence to practice is the National Council Licensure Examination (NCLEX®) which allows entry into practice. I recently spoke with the senior class of Intercollegiate College of Nursing (ICN) in Spokane, most of who are striving through study and practice to pass the NCLEX®. At this point in time, they see the examination as the endpoint goal. While the initial proof of competence to practice is the NCLEX® which allows entry into practice, passage of the examination is only the beginning.

Continued learning engenders continued competence. Yesterday's practice is insufficient for today's challenges. For example, some of us practiced isolation techniques based on the type of infection. Color coded cards and signs directed staff and visitors to wear gowns and gloves, perhaps to add caps, all of which were stacked on carts outside the door of the infected patient. Universal precautions replaced that system. Nevertheless, containing infections continues to be a challenge.

As we move forward in our practice, nurse educators, nurse clinicians and nurse researchers partner to move standards of practice ever higher to ensure safe patient care based on excellence in practice. Because nurses work in complex health care systems, the challenge to involve all the players in the system must be confronted. The international nurse community has issued the following statement which reflects the global concern for education and continued competency of nurses: "Nurses must maintain their competence, and employers and governments need to facilitate this by providing access to suitable education." ICN-www.icn.ch.

We dedicate this issue to nurse regulation and education in a variety of forms. I hope you enjoy it. Your feedback is welcome.

Judith D. Personett, Chair
Nursing Care Quality Assurance Commission

Enhance your nursing career with a degree from UW Tacoma

The Nursing Program at the **University of Washington Tacoma** provides two degree opportunities for registered nurses:

- **Bachelor of Science in Nursing** (RN to BSN)
- **Master of Nursing (MN)** with study options in: Communities, Populations and Health; Leadership in Health Care; and Nurse Educator

UNIVERSITY OF WASHINGTON TACOMA

For more information:

(253) 692-4470

tacoma.washington.edu/nursing

Your touch. Your spirit.

Your life's work.

Children's Hospital & Regional Medical Center in Seattle is ranked **8th** among the "Top Ten" best children's hospitals in the nation by *U.S. News & World Report*. We bring together the best resources, technology, and most importantly, talent, to enhance the lives of children across the Pacific Northwest every day.

We welcome talented nurses to join our team. If you are an experienced RN with or without pediatric experience, consider a new role with Children's. Training is available for nurses with adult patient care experience.

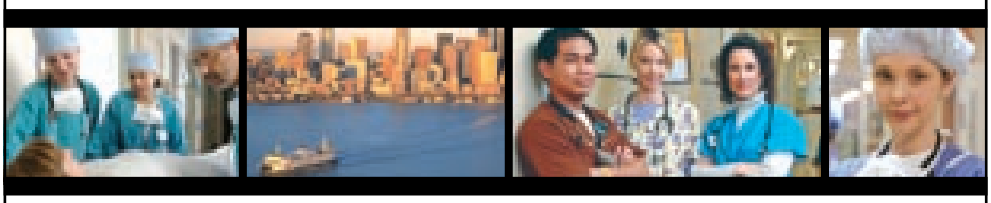
Pediatric nursing opportunities are available in the following areas:

ED•ICU•OR/PACU•Dialysis

We offer excellent pay and benefits, retirement plans, opportunities for career advancement, paid training days, certification pay and much more. For immediate consideration, apply online at **www.seattlechildrens.org/jobs** or call our **Nurse Recruiter** at **1-800-874-6691**. EOE.

Children's Hospital & Regional Medical Center

One Team. One Passion. One Patient at a Time.



Team MedicineSM is a unique interdisciplinary approach which supports a collegial atmosphere. Our staff works together to provide Virginia Mason Medical Center's own brand of health care through mentoring, partnerships and communication. The result? Superior health care for every patient we treat and a workplace like no other.

At Virginia Mason, we know when you're recognized for your contributions, you're inspired to do even more. Join our nursing team, where you'll find an atmosphere of shared governance and respect. Staff and management nursing opportunities are available in a variety of areas.

Discover the power of teamwork by visiting us online at **www.VirginiaMason.org**. EOE/AAE.

TEAM MEDICINE™ VIRGINIA MASON
Seattle, Washington

COASTAL WASHINGTON STATE

Grays Harbor Community Hospital, a busy 96-bed full service acute care hospital, is located on the beautiful Olympic Peninsula in Washington State. Close to numerous recreational and cultural opportunities, we enjoy a moderate climate with warm summers and mild winters. We are recruiting experienced RNs to join us as we provide excellent patient care to our community. We offer a smoke free environment, no lift policy and patient care tech support.

Nurses are represented by the Washington State Nurses Association. Excellent salary and benefits provided. Relocation assistance and sign on bonus available.

For more info visit us at: www.ghchwa.org
Or contact: Jim Weaver, Recruiter, jweaver@whnet.org
(360) 537-5017
FAX (360) 537-5051
Grays Harbor Community Hospital
Aberdeen, WA. 98520

Grays Harbor COMMUNITY HOSPITAL

By Mary Selecky, Secretary of the Department of Health

HELPING PATIENTS WITH END-OF-LIFE DECISIONS

There are few things more personal than making decisions about our preferences at the end of our lives, and those decisions can be difficult to discuss even with those closest to us. While some people may have ideas about organ donation or instructions on whether to resuscitate, few actually write them down or share them with others.

As a health care provider, you may see patients who haven't told anyone and can no longer communicate their wishes. Without written instructions, you may have to help the patient's family sort through these very hard choices. To help with this difficult process, the Washington State Department of Health has created a secure, online living will registry to make it simple for people to put their final wishes in writing.

We hope the registry will make your job easier by providing quick access to your patient's living will so you can confidently follow their treatment wishes. The registry also stores emergency contact information to help you quickly contact the family or next-of-kin.

End-of-life decisions can be very difficult and emotional for the patient, loved ones, and health care providers.

People of all ages should have a living will. Please talk with your patients about the importance of recording their end-of-life preferences. You can help Washington residents learn more about the registry by visiting www.doh.wa.gov/livingwill. The Web site explains why and how to register and offers downloadable living will forms. You can help your patients take the simple steps needed to protect their final treatment wishes: complete the living will documents and registration agreement form, and mail them to the state Department of Health.

At the minimum, we recommend everyone complete a "health care directive" and a "durable power of attorney for health care." You can help your patients prepare these documents, or they can download the forms from the registry's Web site. The forms include:

- **Health Care Directive**—a legal document (sometimes called a Living Will or Advance Directive) that expresses a patient's wishes for end-of-life medical treatment.
- **Durable Power of Attorney for Health Care**—a legal document giving someone other than the patient permission to make medical decisions for them.
- **Physician Orders for Life Sustaining Treatment**—a specific plan created by a patient with a serious health condition and their doctor that states the patient's treatment wishes. It can be translated into medical orders.
- **Mental Health Advance Directive**—a legal document that allows a patient to express their preference for treatment should they become unable to communicate effectively due to mental illness.

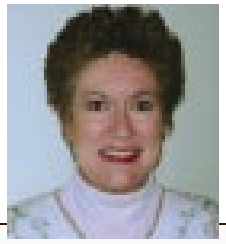
It's easy to register the documents — and it's free! Registered users will receive a confirmation letter in the mail; a unique registration ID number; and a wallet card and stickers to place on their driver's license, insurance card, or identification card. Once they're signed up, people can access or make changes to their living will at any time. They'll also automatically receive a letter annually asking them to update their information.

Health care providers working in hospitals, nursing homes, assisted living facilities, or in hospice and home health agencies can have access to the registry. All it takes is completing a simple application form and faxing it to us for approval.

I encourage you to apply today for a registry access code. Once your application is approved, you can access the registry 24 hours a day by entering your patient's name and birth date or registration identification number. Information about how you or your facility can apply for registry access is available online www.doh.wa.gov/livingwill/providerregistration.htm.

End-of-life decisions can be very difficult and emotional for the patient, loved ones, and health care providers. I hope you will inform your patients about this new tool and consider using it for yourself as well.

For more information or to request brochures to share with patients and others, contact Carol.Wozniak@doh.wa.gov or call 360-236-4369. Please remember to check the registry whenever you have a patient needing end-of-life care.



Message from the Executive Director

By Paula R. Meyer, MSN, RN, Department of Health

The 2008 legislative session was a busy one for nursing advocates. Several bills changed the scope of practice for ARNPs, RNs and nursing assistants.

Two bills changed ARNP practice:

HOUSE BILL 6267 removes the 72-hour limit on dispensing Schedule II-IV drugs. This change is effective June 12, 2008. This change will be reflected in the ARNP Rules that are open. ARNP prescriptive authority has evolved over the last ten years, and passage of this legislation gives ARNPs with prescriptive authority complete independence in their practice. In order to maintain current knowledge in medications, ARNPs need to attend 15 hours of continuing education in pharmacotherapeutics every two years. ARNP's prescriptive authority is tied to their specialty. For example, pediatric nurse practitioners prescribe medications to pediatric patients in appropriate doses according to diagnoses and contraindications.

A SAMPLE OF ALL LICENSEES WHO HAVE HAD PRIOR CHECKS DONE WILL BE CHOSEN EACH YEAR FOR A FEDERAL CRIMINAL BACKGROUND CHECK.

HOUSE BILL 6739 recognized the role of ARNPs in psychiatric treatment. Existing law related to mental health (Chapter 71.05 RCW) stated that physicians could commit patients to psychiatric care, prescribe medications when psychiatric patients refused psychiat-

ric medications, and participate in legal proceedings for involuntary commitment to psychiatric facilities. This bill adds the words 'Psychiatric Advanced Registered Nurse Practitioner' wherever the word physician is used in the law. By adding those words, psychiatric ARNPs can now fully use their scope of practice.

Additional legislation:

HOUSE BILL 3123 changes state law regarding evidence-based nurse staffing in hospitals. The legislation requires hospitals to form nurse staffing committees, write annual nurse staffing plans and post the plans. If the chief executive officer of the hospital does not accept the plan, the officer must provide a written explanation. The bill was the result of an agreement between the Washington State Nurses Association, Washington State Hospital Association, nursing executives and nursing unions.

HOUSE BILL 2668 allows RNs to delegate to nursing assistants, both registered and certified, insulin injections to patients in community-based care settings. The nursing assistant must complete training specific to insulin injections. The RN must train and assess the nursing assistant's ability to safely complete the tasks associated with insulin injections and must supervise the assistant at least weekly for a month. In community-based care settings, RNs may delegate certain nursing tasks to nursing assistants. Community-based care settings include adult family homes, homes for developmentally disabled residents, boarding homes and private homes. Eligible patients must have stable and predictable disease processes, and the patient must be willing to accept that a nursing assistant completes the task. Once the RN assesses the patient and assesses the nursing assistant's abilities to complete the task in a safe and accurate manner, the nursing assistant must be willing to accept completing the task.

HOUSE BILL 1103 changes licensure requirements in our state. Federal finger-print based background checks may be conducted in situations where an in-state check is not adequate. This may include instances where an applicant recently lived out of state or where an in-state check produced results. In addition, a sample of all licensees who have had prior checks done will be chosen each year for a federal criminal background check. Licensees must be contacted and informed of the results of the background check. House Bill 1103 gives the Nursing Care Quality Assurance Commission (NCQAC) and the Secretary of Health new abilities:

- **Application denial:** Currently, when someone applies for an RN or LPN license, they must provide documents that show they are qualified and are not a danger to patients. These documents include a Washington State Patrol background check, a check of a national data base for actions from other states, answers to personal data questions, a list of successfully completed educational requirements, and proof of passing an examination. In the past, when an applicant did not submit all of the required documents or they were questionable, the Department of Health and the NCQAC entered a legal process and formally charged the applicant. The charges included the outcomes of all the requirements. Under the new legislation, the Secretary of Health and the NCQAC will have the ability to deny the application up front. The applicant will still have the ability to appeal the denial.
- **Fines for not submitting documents during an investigation:** When there is an investigation of a complaint, it is up to the NCQAC to gather evidence to support the complaint. In the investigation, there are timelines that must be met in order to have valid evidence for a future hearing. Unreasonable delays in getting the documents that serve as evidence are unfair to all parties. Under the new law, documents or records must be produced within 21 days. The NCQAC can now issue a citation and fine the licensee for failing to respond to these requests.
- **Permanent revocation of a nursing license:** There are some cases where the NCQAC believes that the nurse is not able to ever practice nursing safely again. House Bill 1103 gives the NCQAC the ability to permanently revoke a license. The NCQAC will be able to use this power only in cases involving nurses who are not safe with patients and do not have the ability to be rehabilitated. The new law lists crimes that will automatically result in loss of a nursing license. These include murder and rape.

If you have questions about these bills, please go to www.leg.wa.gov. You can access all bills that were introduced this session. If you have questions on specific bills, you can contact our office at doh hsqa nursing@doh.wa.gov or (360) 236-4700.

BJ Noll, MSN, RN
Former Nursing Practice Advisor
Department of Health

Continuing Competency UPDATE

THE PUBLIC EXPECTS NURSES to provide effective and efficient care throughout their careers. That is why the Nursing Commission has made continuing competency an on-going priority.

The Continuing Competency Subcommittee, with the help of five advisory groups, is reviewing the literature and looking at other successful models. These can be found in other states, Canada, and the United Kingdom. This will help us craft the best possible system for Washington.

The commission proposed a nursing practice assessment model for current knowledge and skill. The model includes a tool to develop individual practice plans that cover implementation, documentation, and evaluation.

Ensuring professional nursing competency is not a new concept. In its 1992 report, the Citizen Advocacy Center asked, "Can the public be confident that health care professionals who demonstrated minimum level of competency when they earned their license continue to be competent years and decades after they have been in practice?"

To help find an answer, the National Council of State Boards of Nursing (NCSBN) issued a position paper in 1996. The paper defined "continuing competence" as "ongoing ability of a nurse to integrate knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and setting in accordance with the scope of nursing practice." The Council also supported research and state activities on continuing competency strategies.

The 1999 Institute of Medicine report "To Err is Human" brought medical errors to the public's attention. It raised concerns about substandard professional competency and the consequence for patient safety.

Our state's continuing competency journey started in 1994. The legislature directed the Nursing Commission to establish, monitor, and enforce continuing competency for its licensees (RCW 18.79.010). The work began in earnest in 2002. Victoria Fletcher, then chair of the Commission's Education Subcommittee, appointed a taskforce to solicit input from nurses, nursing organizations and other stakeholders on the project's scope and direction. Workshops were convened in 2005 and 2006.

The commission proposed a nursing practice assessment model for current knowledge and skill.

Building on the taskforce's work, the Continuing Competency Subcommittee was formed in January 2006 to create a system that is "user friendly" to nurses. Patient-care demands often leave little time to fill out forms.

The Subcommittee identified these tasks:

- Inform licensees of the importance of continuing competency.
- Gather input through state-wide workshops and other effective methods.
- Design the necessary instruments and methods of dissemination, collection and analysis.
- Establish sanctions for non-compliance.
- Promulgate necessary rules.
- Collect and analyze data regarding effectiveness.
- Provide technical assistance to assist nurses in complying.
- Monitor compliance.

You can become a part of this historical journey and help us improve and maintain your excellent nursing practice.

The best way to keep informed about this project is to sign up on our ListServ at http://listserv.wa.gov/cgi-bin/wa?A0=NURSING-QAC. You will receive dates, times, and locations for the activities. You can add or delete your name anytime.

We will also regularly report on continuing competency activities in our newsletter.

Meeting minutes and agendas for all meetings are available at www.doh.wa.gov/nursing; click on "Minutes and Agendas" in the site directory.

The Nursing Commission and subcommittee meetings are open to the public. The Continuing Competency Subcommittee looks forward to meeting and working with you.

NURSING COMMISSION SANCTIONING STANDARDS

By Paula R. Meyer, MSN, RN, Department of Health

One of the most important principles the NCQAC applies when considering disciplinary action is fair and equitable treatment. Several years ago, the NCQAC began to look at the actions it had taken on nurses' licenses and recognized that not all of the actions were the same for similar cases with similar facts. The NCQAC felt this needed improvement and developed Sanctioning Guidelines.

From Guidelines to Standards

The guidelines helped NCQAC members decide how to write orders when the nurse practice act is violated, for example, when a nurse makes repeated medication errors in a short-time period, incorrectly assesses patients or is guilty of drug diversion. The guidelines helped the NCQAC be sure that orders were consistent for all violations. Orders include what the nurse must do and how long the nurse has to complete the orders. Orders may include a fine.

After using the guidelines for several years, the NCQAC members were confident that the guidelines were fair, consistent and understood by the nurses. The NCQAC adopted the guidelines as standards and required all actions on a license to meet those standards. If the NCQAC chooses not to follow the standards in a given case, it must document the mitigating or aggravating circumstances that led it to make that decision.

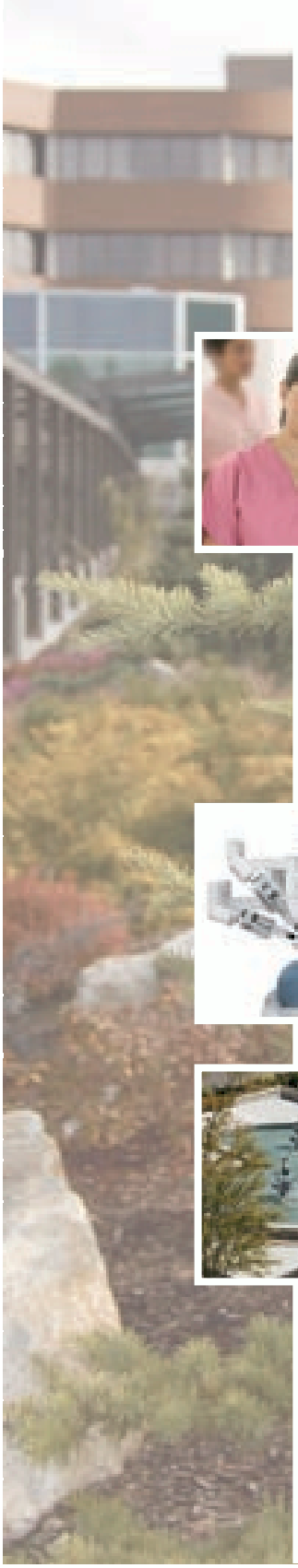
Mitigating and Aggravating Circumstances

Facts that justify deviations from the sanctioning guidelines are mitigating or aggravating circumstances. Mitigating circumstances are actions a nurse has taken to improve their performance. They could include course work completed after the error occurred, the employer required a preceptor, or the nurse voluntarily entered a drug treatment program. In these instances, the NCQAC has the ability to decrease the terms of the order, reduce a probationary period or reduce a fine. Aggravating circumstances are factors that raise additional concern. For example, the nurse made a serious medication error and fraudulently documented actions to cover up the error. The NCQAC can make the order more severe by increasing probation time, requiring a preceptor and a documentation course, requiring a medication course, or requiring direct supervision for a longer time.

Secretary of Health's Guidelines

The Secretary of Health adopted Sanctioning Guidelines for all health professions in our state. These guidelines apply to all health professions for the same purposes the NCQAC first adopted their sanctioning guidelines: fair, equitable treatment of all health professionals. You can access both the Secretary's Guidelines and the NCQAC Sanctioning Standards on the NCQAC Web page at https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm. On the menu on the left hand side of the page, you will see the link for Sanctions Guidelines and Nursing Sanctions Guidelines. If you have any questions on the sanctioning guidelines or standards, please contact us at 360-236-4700 or at doh hsqa nursing@doh.wa.gov.

Northwest Hospital & Medical Center



People value an excellent reputation, in themselves and in the professionals they trust with their health care. Northwest Hospital & Medical Center in north Seattle has a top-flight reputation on a number of levels, starting with:

Our people

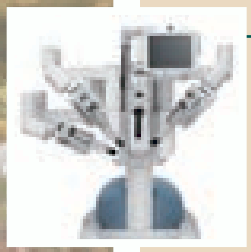
"My mother was a patient here, and she enjoyed her stay. She asked me, 'Why don't you apply at Northwest Hospital?'"

"Nurses want to work here because of family members who came here to give birth or for surgery; their families trust us."

"There's always someone to help you learn and expand your professional skill set."

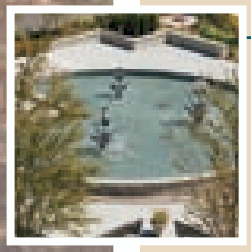
"You always have room for advancement, by learning new expertise on the job and getting tuition reimbursement for additional formal education."

"The retention at Northwest Hospital is excellent – people like what they do here and they have a strong commitment to the community they work in."



Our technology

Our staff uses the latest robotic surgery, featuring the da Vinci S Robot, which minimizes operating room time and speeds recovery; laparoscopic surgical techniques; a recently remodeled and expanded emergency room; a growing patient telemetry program that will soon include most Northwest Hospital in-patients; the Rapid Response Team; and many other evidence-based technical advances to assure the best in patient-centered care.



Our location

"The campus is very green and lush, and it reminds you that you're in the Pacific Northwest."

"The fountains and the landscaping give the medical center a relaxing feel. There are benches to sit down and talk. I like the way it's done."

"The hospital is beautifully landscaped: it's very pleasant for patients and their families, as well as the staff."

"Northwest Hospital is away from downtown, but very convenient – you can get there in a few minutes."

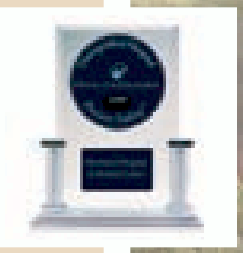
You've put everything into getting where you are. Northwest Hospital & Medical Center will take you further.

Our services

- Seattle Breast Center
- Women's Cancer Care of Seattle
- Sleep Medicine Associates
- Bariatric Surgery Program
- The Sports Medicine Clinic
- The Seattle Arthritis Clinic
- Urology Northwest
- . . . and many more!

Our awards

- 2007 and 2008 HealthGrades Distinguished Hospital Award for Patient Safety
- 2008 Award for Excellence in Stroke Care
- 2008 Award for Excellence in Back and Neck Care

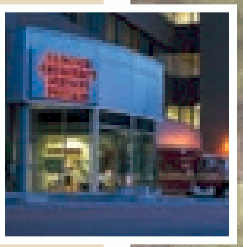


Our benefits

- Competitive salaries
- Specialty, training and residency programs
- Tuition reimbursement and scholarships for qualifying continuing education
- Flexible schedules
- On-site daycare
- Generous 401 (k) plan
- New on-site fitness center with incentive program and classes
- Transportation options, including free bus pass
- Easy commute, with on-site covered parking

Our opportunities

We're currently looking for emergency room, intensive care unit, telemetry, special care, medical-surgical float and critical care float nurses interested in working in a community-based hospital at the center of medical advancement.



For information on how you can become a part of the Northwest Hospital community, visit www.nwhospital.org/jobs.

KNOW YOUR SCOPE OF PRACTICE

By BJ Noll, MSN, RN, Former Nursing Practice Advisor, Department of Health

When was the last time you read the laws and rules that regulate your nursing practice? When you received your license to practice as a nurse in Washington, did you understand the responsibilities that come with it? This article will explain the Nursing Practice Act and describe scope of practice and competency.

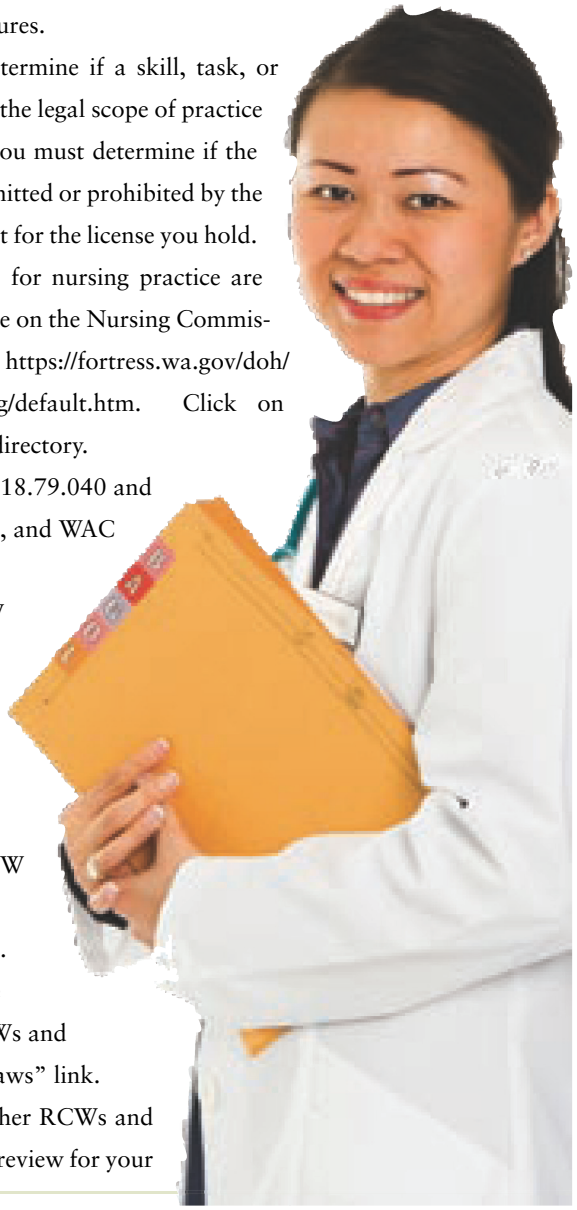
The laws enacted by the Washington State legislature are collected in the Revised Code of Washington (RCW). The rules that agencies develop to implement the RCW are found in the Washington Administrative Code (WAC). The Nursing Commission writes the rules used to implement the nursing statutes (the RCWs). Rules carry the force of law.

The nursing state laws (RCWs) and rules (WACs) form the Nursing Practice Act. Some of you may have received a copy of the Nursing Practice Act in nursing school or maybe from your first employer. Did you really understand what the Nursing Practice Act meant to you and your nursing practice? Then on your first day of work, as a new nurse, did any of you say, "Wow—I didn't learn that in nursing school."

As the Nursing Practice Advisor, part of my job is to provide technical support for the more than 90,000 licensees under the jurisdiction of the Nursing Care Quality Assurance Commission (Nursing Commission). The questions I receive the most involve scope of practice. Some want to know why the Nursing Practice Act does not describe what a nurse can do. My answer is that it would be impractical, and limiting for nursing practice, to have the Nursing Practice Act contain all the specific skills, tasks, and procedures that every nurse in every nursing setting must possess.

It would also be impractical for the Nursing Practice Act to describe all the duties that nurses are permitted to perform. Doing so would restrict the evolution of nursing practice. Nursing practice and technology are rapidly changing. Nursing knowledge is expanding, and nurses practice in many and varied settings. Nurses should not be restricted from acquiring and using new skills that are not yet identified as nursing practice.

Employers also define nursing practice in their policies and procedures. An employer may define nursing practice within their organization, and this is not prohibited by the Nursing Practice Act provided that the practice does not exceed what is established in nursing law or rule. Employers may choose to limit a certain skill to RNs, or not to practice a certain skill at all. To practice legally and safely, nurses must know the nursing laws and rules and follow employer policies and procedures.



How do you determine if a skill, task, or procedure is within the legal scope of practice for nurses? First, you must determine if the act is expressly permitted or prohibited by the Nursing Practice Act for the license you hold. The laws and rules for nursing practice are on-line and available on the Nursing Commission Web site at: https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm. Click on "Laws" in the site directory.

- **RNs:** See RCW 18.79.040 and RCW 18.79.260, and WAC 246-840-700.
- **LPNs:** See RCW 18.79.060 and RCW 18.79.270, and WAC 246-840-700.
- **ARNPs:** See RCW 18.79.050 and RCW 18.79.250.

You will also see many other RCWs and WACs in the "Laws" link.

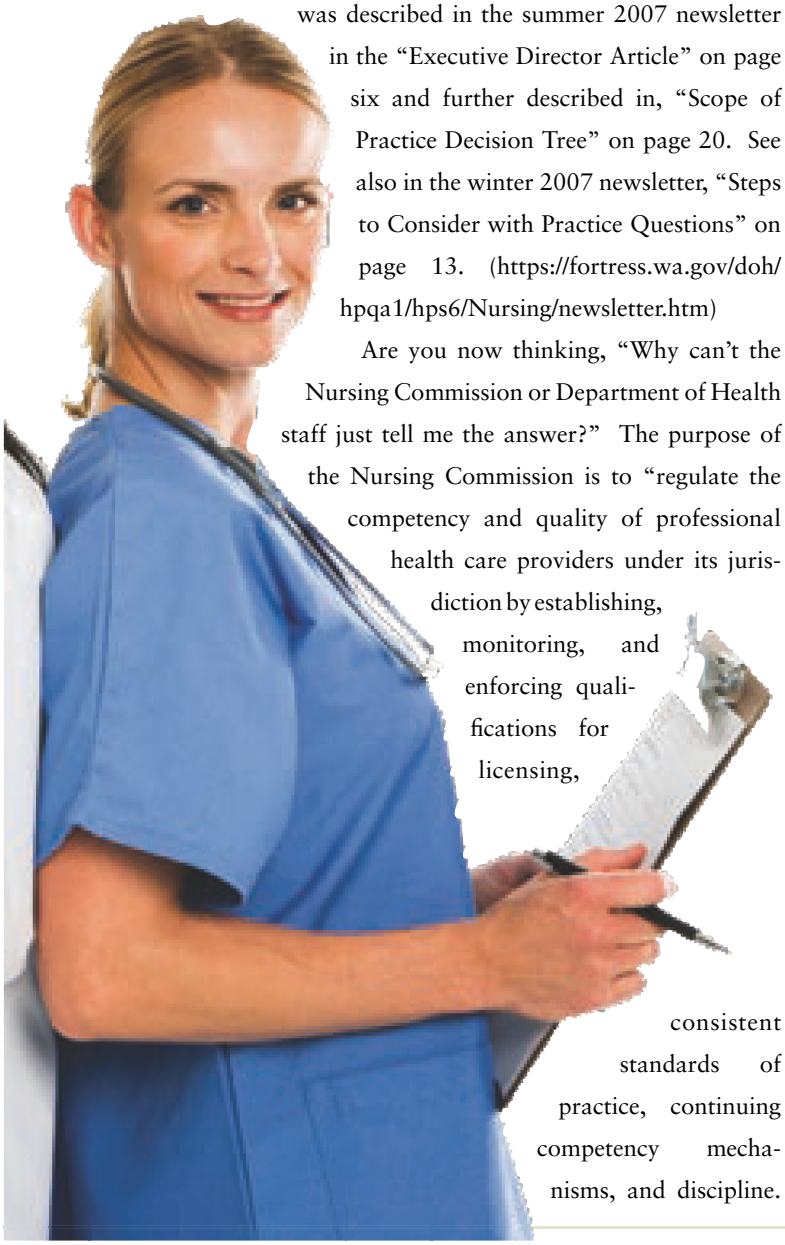
You may find other RCWs and WACs beneficial to review for your

current or future nursing practice. Look in the site directory for links to practice information, previous newsletters, and Nursing Commission meetings and minutes.

If the laws and rules do not answer your question, check national nursing organizational standards or nursing literature and research. If you find a standard for the nursing act, then you must personally possess the depth and breadth of knowledge to perform the act safely and effectively. Formal education and training programs may be needed and required.

You must also personally possess current clinical skills. Next, you must determine if performance of the act is within an accepted standard of care for nursing. Perform the act with a valid order when necessary and in accordance with agency policies and procedures.

Ultimately, you must be prepared to accept the consequences of your actions. The thought process described in the two preceding paragraphs is the Scope of Practice Decision Tree. The Decision Tree was described in the summer 2007 newsletter in the "Executive Director Article" on page six and further described in, "Scope of Practice Decision Tree" on page 20. See also in the winter 2007 newsletter, "Steps to Consider with Practice Questions" on page 13. (https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/newsletter.htm)



Are you now thinking, "Why can't the Nursing Commission or Department of Health staff just tell me the answer?" The purpose of the Nursing Commission is to "regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington" (RCW 18.79.010).

Commission members and staff are not allowed to answer specific clinical scope of practice questions either on the telephone, via e-mail, or in writing. However, Nursing Commission office staff are available to listen to your questions and provide appropriate materials or direction to help you decide how to best proceed with your particular situation.

In some cases, the Nursing Commission may decide to determine or not determine nursing scope of practice. This requires submission of a written request for an advisory opinion. This is a very long process, and it may take up to 18 months for the commission to reach a decision. The Nursing Commission makes its decisions at regularly scheduled business meetings.

Another important requirement and component of scope of practice is competency. WAC 246-840-700(4) speaks to competency and states that: "(b) The registered nurse and the licensed practical nurse shall be responsible and accountable for his or her practice based upon and limited to the scope of his/her education, demonstrated competence, and nursing experience consistent with the scope of practice set forth in this document; and (c) The registered nurse and the licensed practical nurse shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or procedures which are in his/her scope of practice."

You can find articles on continuing competency in the winter 2007 newsletter "Continuing Competency" on page 24; the winter 2008 newsletter has three articles on competency: "Message from the Chair" on page four, "Message from the Executive Director" on page eight, and "Continuing Competency Update" on page 18. There is another continuing competency update in this edition of the newsletter.

Nurses are the largest number of health care professionals and are at the forefront of patient care. Understanding scope of practice and competency are essential to helping you protect the health and safety of the people of Washington State.

"Each individual, upon entering the practice of nursing, assumes a measure of responsibility and public trust and the corresponding obligation to adhere to the professional and ethical standards of nursing practice. The nurse shall be responsible and accountable for the quality of nursing care given to clients. This responsibility cannot be avoided by accepting the orders or directions of another person" (WAC 246-840-700).

Please continue to read future Nursing Commission newsletters and nursing practice articles. This will further your knowledge and understanding of your scope of practice.

NURSING COMMISSION OR NURSING ASSOCIATION?

What's the difference between the Nursing Care Quality Assurance Commission (NCQAC) and the Washington State Nurses Association (WSNA)?

NCQAC and WSNA are two Washington State organizations that play a critical role in the career of every nurse. These organizations frequently share common agendas and agree on similar policy issues. However, the role and function of each organization is very different. Frequently there is a great deal of confusion about the differences between the two organizations. Nurses contact one organization when they really need to make contact with the other. The following is intended to help you understand differences between the two organizations.

Organization:	Nursing Care Quality Assurance Commission Phone: (360) 236-4700 Fax: (360) 236-4738 E-mail: doh hsqa nursing@doh.wa.gov website: www.fortress.wa.gov//doh/hpqal/hps6/Nursing/default.htm	Washington State Nurses Association Phone: (206) 575-7979 Fax: (206) 575-1908 E-mail: membership@wsna.org website: www.wsna.org
Structure:	Legally constituted State of Washington regulatory agency within the Department of Health	Professional association for all Registered Nurses; a constituent member of the American Nurses Association (ANA)

Members:

Judith D. Personett, Ed.D., RN, Chair
Susan Wong, MBA, MPA, RN, Vice Chair
Linda Batch, LPN
Erica Benson-Hallock, Public Member
Richard Cooley, LPN
Williams J. Hagens, Public Member
Rev. Ezra D. Kinlow, Public Member
Darrell Owens, Ph.D., ARNP
Jacqueline Rowe, RN
Robert Salas, RN
Diane M. Sanders, MN, RN
Rhonda Taylor, MSN, RN
Mariann Williams, MPH, MSN, ARNP
Susan L. Woods, Ph.D., RN
Laura Yockey, LPN

Board of Directors:

Kim Armstrong, BSN, RN (Pres)
Stasia Warren, MN, RN
Ed Dolle, RN
Pam Pasquale, MN, RN
Tim Davis, BSN, RN
Judith Turner, RN
Jean Pfeifer, BSN, RN
Verlee Sutherlin, M.Ed., RN
Jeanne Avey, RN
Susan E. Jacobsen, RN
Sharon L. Bradley, MSN, RN

Nursing Commission or Nursing Association? (continued)

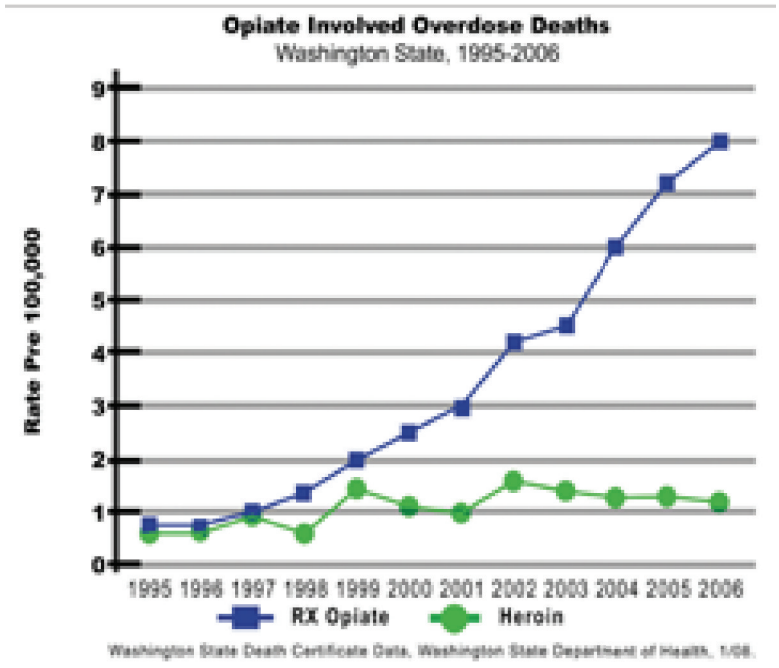
Mission Statement:	Section 18.79.010 of the Revised Code of Washington describes the purpose of NCQAC as: to regulate the competency and quality of professional health care provides under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington	WSNA mission statement: The Washington State Nurses Association provides leadership for Registered Nurses and the nursing profession and promotes quality health care for consumers through education, advocacy, and influencing health care policy in the state of Washington. WSNA vision statement: The Washington State Nurses Association is the collective and leading voice, authority, and advocate for the nursing profession in the state of Washington. (Approved 3/7/07)
Leadership:	Members of the commission are appointed by the Governor for up to four year terms. Membership consists of fifteen members including: seven RNs, two ARNPs, three LPNs, and three public members.	Members of the board are elected by current members of WSNA through a democratic voting process.
Membership:	Mandatory licensure to practice as an RN, LPN, or ARNP (original education, examination, renewals, and endorsements).	Voluntary membership through application and dues; mandatory membership through various collective bargaining contract agreements.
Role:	Protects the public health, safety and welfare from unqualified or unsafe practitioners.	Informs nurses in WA State about issues and trends that affect their professional practice. Promotes the professional development and advances the economic and general welfare of all nurses.
Policy:	Adopts rules and regulations to implement its functions; issues interpretations on practice related issues as relevant to statues, rules and regulations.	Adopts position statements and resolutions that advance the profession and the organization's mission.
Practice Standards:	Establishes minimum standards for nursing education and practice.	Promotes ANA standards of nursing practice; works to ensure adherence to ANA's Code of Ethics for Nurses.
Education:	Develops reasonable and uniform standards for nursing practice and education. Approves and renews approval for nursing education programs that meet the Washington Administrative Code requirements.	Develops, promotes, and approves continuing nursing education as authorized by the American Nurses Credentialing Center.
Workforce Advocacy:	Investigates complaints regarding nurses; issues discipline and monitors disciplinary actions. (Discipline may include stipulations, revocations, suspensions, denial of license or limitations on scope of nursing or nursing related practice activities.)	Promotes occupational safety for nurses. Provides workforce advocacy program for nurses, including addressing workplace issues, e.g., staffing, safe lifting, hazardous exposure, workplace violence.
Government Affairs:	Administers Nurse Practice Act and adopts rules and regulations for its implementation.	Acts and speaks for nursing profession related to legislation, governmental programs, and health policy. Reviews all bills introduced in the Washington State Legislature for impact on nurses, nursing and the health care of the public.
Revenue:	Establishes and collects licensure fees pursuant to legislative rules.	Membership dues established by members; percentage may go to ANA.

Adapted from: "Board or Association?" (September, October, November, 2007) *Nebraska Nurse*. 20-21.

NEW OPIOID DOSING GUIDELINES ADDRESS RISE IN POISONING DEATHS

By Gary M. Franklin, M.D., and Jeffery Thompson, M.D.

In little more than a decade, Washington's overdose deaths from opiate-related prescription drugs increased 17-fold, going from 24 deaths in 1995 to 475 in 2006.[4] This dramatic jump is evident nationwide. Poisoning is now the nation's second leading cause of injury death. Only motor vehicle accidents kill more.[5] The vast majority of poisoning deaths are from unintentional opioid overdoses.



There are several tools available to help health providers prescribe the right doses of these painkillers. The state Medical Quality Assurance Commission has published Guidelines for Pain Management.[6] Another tool for safer and more effective opioid-related care is the Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain.

Medical directors from six Washington State agencies[7] published the opioid interagency guideline last year. It does not apply to the treatment of acute pain, cancer pain or hospice care.

Agency staff worked with practicing pain management specialists to translate their expertise into clear and easy to use information. The interagency guideline is a resource for primary-care treatment. It is the focus of a year-long educational campaign.

The guideline does not dictate dosages. It recommends that the daily dose of opioids generally should not exceed 120 milligrams of morphine or its equivalent. If a patient's dose moves up to 120 milligrams without improvement in both pain and function, the guideline calls for a second opinion from a doctor experienced in pain management. If

both pain and function are improved from baseline, dosages above 120 milligrams per day are viewed as appropriate.

The guideline is available at www.agencymeddirectors.wa.gov. This site also provides a calculator to help doctors set dosages of combinations of different opioids. The Web site has had visitors from as far away as New Zealand and Greece.

[4] Washington State Death Certificate Data, Washington State Department of Health, December 2007.

[5] Paulozzi, Leonard J, "The Epidemiology of Prescription Drug Overdoses in the United States," from Congressional testimony, 2005 update, presentation on March 12, 2008.

[6] This is on the Web at https://fortress.wa.gov/doh/hpqa1/hps5/Medical/pain-mgmt.htm.

[7] This group includes the medical directors from the Departments of Corrections, Health, Health Care Authority, Labor and Industries, Social and Health Services, and Veterans Affairs. Together, those six agencies provide health care to 1.3 million Washington State residents each year.

THANK YOU TO GARY M. FRANKLIN, M.D. AND JEFFERY THOMPSON, M.D.
ON BEHALF OF THE WASHINGTON STATE AGENCY MEDICAL DIRECTORS GROUP.

Commission members pictured above are listed in order. In the top row: Robert Salas, Linda Batch, Todd Herzog, Ezra Kinlow. In the middle row: Rhonda Taylor, Susan Woods, Judith Personett, Mariann Williams, Erica Benson-Hallock. In the front row: Susan Wong, Rick Cooley, Jacqueline Rowe.

The Nursing Commission meets in person every other month. All business meetings and workshops are open to the public. Nurses and students are strongly encouraged to attend a meeting to learn about issues addressed by the commission. We place an agenda for each meeting on the Web site at www.doh.wa.gov/nursing two weeks prior to each meeting. Topics range from rules, advisory opinions, and school approvals to sub committee reports. Business meetings have set agendas and include opportunity for public comment. Workshops include training opportunities for commission members. We hope to see you at a future meeting.

2008 Nursing Commission Meeting Dates

DATES	LOCATIONS
July 10, 2008, workshop – 8:30 a.m. July 11, 2008, business meeting – 8:30 a.m.	Department of Health 310 Israel Road SE Tumwater, WA 98501
September 12, 2008, business meeting – 8:30 a.m.	Colville, WA Location to be determined
November 13, 2008, workshop – 8:30 a.m. November 14, 2008, business meeting – 8:30 a.m.	Department of Health 310 Israel Road SE Tumwater, WA 98501

By Paula R. Meyer, MSN, RN,
Department of Health

NEW LICENSURE FEES

WILL PROVIDE NURSES WITH ON-LINE ACCESS

Everything done by the Nursing Care Quality Assurance Commission (NCQAC) is paid for by nursing license fees. There is an application fee, a renewal fee and a reactivation fee. The fees cover costs for everything from copying materials to staff salaries. At times, special fees are added to the licensing fees for specific reasons. A good example of this is the recent addition of a fee to provide a new on-line service for nurses.

In 2007, the legislature approved a fee for the University of Washington to make an on-line library available to certain health professions, including nurses. This fee will be added to the nursing fees this year. Once the on-line library, named the HEAL-WA portal, is developed, every nurse in the state will have access to the on-line library.

I remember when I was in my undergraduate program and had to go to the library to access articles. Way back then, we had to ask reference librarians to complete our searches. It took at least a week to get the results, and then we ordered the articles. By the time I was in graduate school, I had access to some of the world's finest libraries, and I was able to do some of the searches by myself, get the articles by myself, and use most of them within the week.

With the HEAL-WA portal, all nurses in our state will be able to use the system without visiting the Seattle campus. This is a great way to read the most recent articles on diabetes, congestive heart failure, and other patient care topics. Research databases and text books will also be available through the portal. The fee will go into effect in August 2008, and will be an additional $20 per year. The HEAL-WA portal will be operational in January 2009.

By Linda Tieman, RN, MN, Executive Director, Washington Center for Nursing

Washington Center for Nursing PROGRESS

The Washington Center for Nursing (WCN) is the statewide nursing workforce center of the Washington Nursing Leadership Council. It was started in 2004. Our mission is to contribute to the health of Washington State by ensuring that there is a sufficient supply of nurses to care for our citizens now and in the future.

Our work focuses on:

- Improving nursing's image.
- Building the database on our workforce.
- Transforming nursing education.
- Solving retention challenges in all settings where nurses work.
- Collaborating with others in the workforce world.

WCN is private, non-profit, and governed by a board of nurses from many care and education settings across the state. We've been busy! Here are the highlights.

MINORITY NEW RN GRADUATE STUDY

Principal Investigator Kathy Hare, RN, MN, worked over 18 months to complete this survey of all Washington acute care hospitals. The survey helped us learn about the unique strategies in place to help minority new RN graduates transition into their first professional role. We also documented the numbers of new RN graduate "residencies," "internships" or "special orientations" in our state. The survey was funded by a Department of Health grant and the Group Health Community Foundation.

We learned that those acute hospitals with special transition programs have a 90 percent retention rate of their new RN graduates after one year of employment. Programs vary in length and format. There is opportunity for employers to deepen their understanding of all new RN graduates' needs, especially those from minority and under-represented groups.

Retention of new RN graduates is critical. It helps organizations provide the care promised to patients. Retention strengthens our profession overall and builds the confidence and competence of new graduates. The entire study is downloadable from our Web site, www.WACenterforNursing.org, under "FAQ."

MASTER PLAN FOR NURSING EDUCATION

For more than two years, research, discussions, and development have been underway on a Master Plan for Nursing Education. The plan addresses major issues such as professional competence, an adequate supply of nurses, access and distribution of educational programs, and diversity of our nursing and nursing educator population.

More effective collaboration, partnering, planning, communication, and leadership are themes in the work. This transformation will require significant time and funding, and many changes at every point in our systems.

As this edition goes to print, we are working on several additional pieces. These include a master plan and recommendations, a timetable and projected costs and continued review of feedback. Send your suggestions to Linda Tieman, Executive Director, at tiemal@spu.edu or call 206-281-2634.

OTHER INITIATIVES

- We are planning a summit to explore the issues specific to the LPN providers whose numbers have remained static for the past five years.
- "Minority Recruitment and Retention" best practices study.
- Study of models of care that enhance nurse and patient safety and satisfaction, and achieve quality goals measures.
- We are planning for the 2009 "Johnson & Johnson Promise of Nursing for Washington" gala to raise money for student scholarships, faculty fellowships, and nursing school capacity expansion grants.

The Public Member on Licensing Boards and Commissions

By Commissioners Hagens, Benson-Hallock, and Kinlow

Public or "consumer" members have become a common feature of today's boards and commissions. They play a prominent role in the field of health care regulation. In Washington, at least one public member is required on all 16 of the state's health licensing boards.

The number of public members on the boards is as follows:

ONE MEMBER: Massage therapy, occupational therapy, physical therapy, optometry, podiatry, osteopathic medicine, and veterinary medicine.

TWO MEMBERS: Dentistry, pharmacy, denturists, and psychology.

THREE MEMBERS: chiropractic, speech and hearing, mental health counselors, and (our own) nursing.

FOUR MEMBERS: nursing home administrators.

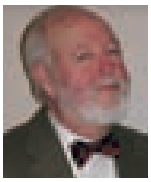
SIX MEMBERS: medical (allopathic) physicians

Nursing regulation in this state dates back to 1909. However, public members were not required on the board of registered nursing until 1973 and on the board of practical nursing until 1983. The two boards were consolidated in 1994 as the current Nursing Commission. The Nursing Commission had two public members until 2005, when the total was increased to three.

Here are your Nursing Commission public members:

Rev. Ezra Kinlow of Spokane – Term expires 6/30/08. For the past 26 years, I have been the Minister of the Holy Temple Church of God in Christ located in Spokane, Washington. I am a retired Technician of the IBM Corporation. I have served as the President of the Spokane Ministerial Alliance for the past two years. I am in my eighth year as a public member with the Nursing Commission. My term with the Nursing Commission ends in June of this year. This has been a tremendous education and experience. Thanks for the opportunity to serve.

Erica Benson-Hallock of Spokane – Term expires 6/30/10. I serve as the President and CEO of the United Way of Washington on statewide issues such as early learning, financial stability and 2-1-1. Previously, I worked for the California State Association of Counties in the legislative unit focusing, again, on health and human services. I also staffed a gubernatorial advisory committee on children's issues in California. Finally, during summers in college, I had the pleasure of working for the Los Angeles County Public Health Department.



Bill Hagens of Tacoma – Term expires 6/30/09. I retired in 2004 from the Washington Department of Social and Health Services, where I was Executive Health Policy Adviser to the Secretary of Social and Health Services for two years. For two years prior, I was a deputy insurance commissioner. I spent most of my career (25 years) as the Senior Analyst for the State House Health Care Committee. Until this year, I served as a clinical professor at the University of Washington School of Public Health and Community Medicine, where I taught health policy for over 25 years.

The Rise of Public Membership on Licensure Boards

Health provider regulation goes back to the 1820s. Understanding that history helps explain the emergence of the public member. In that decade, a big increase in voter eligibility and direct election of presidents drove a major expansion of public involvement in politics.

One change in this new political landscape was the demise of early forms of occupational regulation. This older regulation was viewed as inherently undemocratic because it imposed restrictions on how a person could earn a living. Deregulation resulted in the emergence of medical diploma mills that granted credentials to those with little or no medical preparation.

The proliferation of the diploma mills and increase in numbers of poorly prepared graduates alarmed state medical societies. They feared a physician surplus and, assumedly, were concerned for patient safety. In response, these societies adopted codes of conduct and practice standards. This resulted in expulsion of non-compliant members. While this "seal of approval" exposed incompetent physicians, it did little to exclude charlatans who were not society members from practicing. Doing so required the power of law.

To address this concern, legislatures invoked the state's police power. To protect the public, they required a license to practice medicine. To regulate the profession, government granted the powers to the profession itself—thus creating the self-regulating board.

But over the years, the expansion of board influence and unbridled autonomy raised concerns among the public and policy makers. They feared this unchecked authority might protect the provider at the expense of public safety. To create a check, the government began appointing public members to professional licensing boards.

Public member qualifications

There is no requirement to have specific knowledge of the health profession. Statutory qualifications actually suggest otherwise. For example, the Nursing Commission's law, which is similar to other licensure bodies, reads like this:

> "Public members of the commission may not be a member of any other health care licensing board or commission, have a fiduciary obligation to a facility rendering health services regulated by the commission, or have a material or financial interest in the rendering of health services regulated by the commission." RCW 18.79.070 (6)

Public and nursing members are appointed by the Governor for four years. They don't serve at the pleasure of the Governor, such as political appointees and non-civil services employee. However, they can be removed "for neglect of duty, misconduct, malfeasance or misfeasance in office, or for incompetency or unprofessional conduct" (RCW 18.79.080).

Public and Nursing members, along with their counterparts on the medicine, dentistry and chiropractic commissions, are compensated at the highest level permitted by law for part-time regulatory bodies: $250 per day of work, plus necessary expenses.

Public Member Duties

For the most part, public member duties are identical to those of nurse members, including:

- Reviewing and adjudicating professional discipline matters, which constitute the commission's primary focus.
- Attending six business meetings and three workshops annually.
- Representing, from time to time, the Commission at public meetings and conferences.
- Serving on at least one of three policy subcommittees addressing issues of "Licensing & Discipline," "Continuing Competency," and "Education & Standards."
- Promulgating rules.

Public member roles are distinct from those of nurse members, but are not fully expressed. The law is precise on qualifications, but it is less clear on specific duties. The exception is a broad charge to represent the public in commission proceedings.

If you have suggestions on how we can better serve the public, we'd love to hear from you. Contact any or all of us at: doh hsqa nursing@doh.wa.gov.

Becoming a Commission Member

If you would like to become a member of the Nursing Commission or one of the over 180 state boards and commissions, Governor Gregoire would like to hear from you.

The best way to start is to visit the Governor's Boards and Commissions Web site at shttp://www.governor.wa.gov/boards/default.asp. You will find a list of all vacancies, eligibility requirements, and ways you can apply. Good luck. We have all found this experience to be incredibly rewarding.

Certificate Program:
COMPLEMENTARY & ALTERNATIVE MEDICINE / HEALTHCARE (CAM): AN INTEGRATIVE APPROACH

UNIVERSITY OF WASHINGTON SCHOOL OF NURSING

Learn more about CAM by taking individual courses or enrolling in the 18-credit graduate certificate program. Over 1/3 of adults and up to 15% of children use a form of CAM, but CAM use is rarely assessed or discussed in mainstream healthcare. Our courses provide nurses with the skills to:

- Obtain accurate information from patients about CAM use
- Understand CAM modalities, the evidence base for their efficacy and safety, and how they are used to treat common conditions
- Provide guidance in patients' decision-making about CAM use
- Understand wellness and health promotion strategies

Coursework and the certificate are 100% distance accessible throughout Washington State. There are optional laboratory sessions and experiential learning at Bastyr University campus in whole foods production and application, botanical medicines, qi gong, and reflexology.

Check our website for more information:

www.son.washington.edu/eo/cam/about.asp

Or email: **sondl@u.washington.edu**

Funded by Division of Nursing, Bureau of Health Professions, U.S. Department of Health & Human Services. Health Resources & Services Administration. Advanced Education Nursing Grant Program, Grant #D09HP07358

By Judith Personett, Ed.D., RN, Chair

Champion of Nurses Retires
JOAN GARNER, RN, MSN

Joan Garner recently retired from the Washington State Nurses Association in her position as the Director of Nursing Practice, Education and Government Relations. She is known as a champion of nurses. Joan believes that if you don't participate in the process, someone else will be making the decisions. Therefore, Joan Garner is well known to our legislators as well as to the members of the Nursing Commission as a spokesperson for the nurse.

Joan began her career as a graduate of St. Joseph's Creighton Memorial Hospital School of Nursing, Omaha, Neb., in 1960. The health care system was an altruistic one, meaning that the nurses and others had the best interests of the patient at heart. Health care costs were often based on a sliding scale that was income dependent and insurance was minimal.

Advances in health care were astounding with new surgeries, hemodialysis, and the advent of the Intensive Care Unit. To meet the challenges in nursing care, Joan earned her Baccalaureate of Science in Nursing in 1971 and then a Masters in Nursing in 1973 from the University of Oregon. She worked as a Nurse Clinical Specialist in Cardio-Vascular. During the next eight years, she taught at the University of Portland and set up the Master's Program while working weekends in the Intensive Care Unit at Immanuel. During the early 1970's, transitions in nursing education challenged the clinical competency of the college-educated BSN nurse as opposed to the hospital-trained diploma nurse, and Joan Garner faced those challenges.

In 1981, she joined the Oregon Board of Nursing as the Assistant Director of Nursing Practice and Discipline. Her interest in legislation and health policy grew during these years. She returned to her role as Nurse Clinical Specialist as the Supervisor of the Intensive Care Units at the Veterans Administration Hospitals in Portland and Seattle. As Health Care Systems changed from altruistic systems into profit oriented systems, Joan worked at Providence Hospital from 1988 until 1993. She experienced every day in her nursing practice the impact of changing legislation in nursing practice.

In 1993, she joined the Washington State Nurses Association as the Nurse Practice Specialist, but in 1994, became the Director of Nurse Practice, Education and Government Relations. Collective bargaining was a highly controversial issue coupled with the nurses right to strike that Joan struggled with daily. Her commitment to the right of nurses to control their practice has motivated her to work with the legislative processes to codify that right into law. The struggles continue even as Joan retires.

Joan Garner leaves us with a message, "It is the responsibility of every nurse to give something to the profession for its advancement." Joan, we salute you for all you have given.

Have you MOVED?

Please send your address changes to: Department of Health, HPQA Customer Service Center, PO Box 47865, Olympia WA 98507-7865 • email: hpqa.csc@doh.wa.gov

License address change request • Please change the address to:

Name: _____

License Number: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

By Marc Defreyn, Supervising Staff Attorney,
Washington State Department of Health

DISCIPLINARY MATTERS

Every attorney secretly turns to the back of BarNews magazine each month to read the "Disciplinary Notices" section. It makes for some juicy reading and reminds us that with our license comes a responsibility to faithfully obey the rules of professional conduct. If that isn't enough, it also reminds us that our license to practice law, issued by the state, can be revoked.

This article does not address the entire disciplinary process. It focuses on two main themes: the standard of proof required in an administrative hearing and the sanction guidelines used when discipline is warranted.

The Washington Legislature passed the Uniform Disciplinary Act in 1984 to strengthen and consolidate regulation of the state's licensed health care professionals. It is codified in Chapter 18.130 of the Revised Code of Washington (RCW). In 1994, the Legislature passed Chapter 18.79 RCW – "Nursing Care." This established the Nursing Care Quality Assurance Commission. It directed the commission to enforce the provisions of the Uniform Disciplinary Act.

The Nursing Commission serves as the disciplining body when licensed practical nurses, registered nurses and advanced registered nurse practitioners break laws that govern the nursing profession.

STANDARD OF PROOF

Courts and finders-of-fact in administrative matters must make findings based on a "standard of proof." A standard of proof guides us on how strong the evidence must be for us to make a particular finding. There are three primary standards of proof:

Preponderance of the Evidence: Evidence shows that the elements of the case are more likely than not to be true.

Clear, Cogent and Convincing Evidence: Evidence shows that the elements of the case are "highly probable."

Evidence Beyond a Reasonable Doubt: The evidence leaves little room for doubt about the elements of the case. This standard has been equated to near moral certainty.

In 2001, the Washington Supreme Court determined there needed to be clear, cogent and convincing evidence of unprofessional conduct to revoke the license of a physician.[1] Faced with different types of licenses, however, the courts reached varied conclusions. For example, engineer discipline was subject to the clear, cogent and convincing standard, while real estate appraiser discipline was subject to the preponderance of the evidence standard. The Department of Health and the various boards and commissions, including the Nursing Commission, had to decide what standard of proof to apply.

> **Option 1:** Limit the clear, cogent and convincing standard to medical physician cases only.
>
> **Option 2:** Limit the clear, cogent and convincing standard to all physician cases, including osteopathic and podiatric.
>
> **Option 3:** Use the standard in all cases, but also evaluate by the preponderance standard.

They chose option 3.

In 2006, the Washington State Supreme Court gave further guidance. Ongom v. Dept. of Health[2] is a case involving a registered nursing assistant that worked at an Alzheimer's care facility. An employee said she saw Ms. Ongom throw a dish at a patient, slap the patient's hands and kick the patient's leg. Ms. Ongom denied doing those things. A third witness did not testify at hearing, but submitted a written statement supporting Ms. Ongom's story.

The department charged Ms. Ongom with abuse of a patient, and a Health Law Judge concluded that although the department met the preponderance standard on the abuse charge, its proof did not meet the clear, cogent, and convincing evidence standard.

On appeal, the state Supreme Court opined that an individual's interest in a professional license is profound and that more than money is at stake. The Ongom court concluded that discipline is not a civil matter. Discipline has some criminal attributes to it because it is for public protection and may have punitive results.

As a result, the Ongom court concluded that procedural safeguards are not a substitute for the standard of proof. The court said "[w]e must determine whether proof by a preponderance of the evidence in a professional license disciplinary proceeding satisfies due process…We conclude that due process requires clear and convincing proof."

Thus, the matter was resolved. Disciplinary matters under the Uniform Disciplinary Act must apply the clear, cogent and convincing evidence standard. Under this standard, the risk of public harm can be reduced by impressing key players with the importance of both individual rights and public protection.

SANCTION GUIDELINES

There are two basic steps in the disciplinary process: the disciplining authority must decide if the allegations have been proven by clear, cogent and convincing evidence and, if so, what level of discipline should be imposed.

On May 11, 2007, the Nursing Commission formally adopted the Department of Health's Sanction Guidelines. The guidelines help the Nursing Commission ensure the disciplinary process is fair, equitable and consistent. They provide a framework for discipline and consider a range of activity within certain types of conduct. This makes outcomes more predictable for both parties.

The Sanction Guidelines help impose consistent sanctions for similar conduct, both within each profession and among the different professions. Although the guidelines refer to a limited category of conduct, stated principles apply to any violation of the Uniform Disciplinary Act (see the grids below).

The Washington Legislature passed the Uniform Disciplinary Act in 1984 to strengthen and consolidate regulation of the state's licensed health care professionals.

HOW THE GUIDELINES WORK

The guidelines include a grid, or worksheet, for seven categories of conduct. These categories account for about 80 percent of disciplinary actions across all health professions. The seven categories are sexual contact, abuse, drug diversion, felony convictions, practice below standard, misuse of drugs and alcohol and noncompliance with a previous disciplinary order. Sanctions are based on the severity of the conduct. They consider aggravating or mitigating circumstances. When making a decision, the Nursing Commission:

- Starts with the guiding principles.
- Considers the type of conduct.
- Evaluates the severity of that conduct.
- Identifies other factors, including prior disciplinary history and possible aggravating or mitigating circumstances.

For example, in a case where a nurse diverts drugs – and the allegation is either proven at a hearing or resolved through a settlement – the Nursing Commission must apply a sanction for the violation. The Nursing Commission would turn to the Sanction Guidelines to determine what sanction is appropriate. In this case, the guidelines look as follows in chart on the next page.

The Nursing Commission, acting as the disciplining authority, first seeks to establish the severity of the alleged drug diversion. It then considers the level of conduct. The Nursing Commission considers the presence of aggravating or

mitigating circumstances. It finds an appropriate sanction range and duration for the conduct.

Rest assured that the Nursing Commission takes seriously its task of balancing protection of the public with the rights of the nurse. While Nursing Commission members have many responsibilities, I am always impressed by how genuinely committed each and every commission member is to the fairness and consistency of the disciplinary process.

The goal is not discipline for the sake of discipline or exoneration for the sake of the profession. When a standard of care, conduct or practice is violated, the Nursing Commission will ensure a fair disciplinary process is followed. When a violation is committed, it wants the punishment to fit the crime.

[1] Nguyen v. Department of Health, 144 Wn.2d 516,534,Cert. denied, 533 U.S.904(2002)

[2] Ongom v. Department of Health, 159 Wn.2d 132(2006)

Severity	Tier/Conduct	Sanction Range		Duration
		Minimum Not subject to stay	Maximum	
Least ↑ ↓ Greatest	A – Diversion for self without patient harm	Reprimand or conditions	Probation, conditions or suspension for 5 years	0 - 5 years
	B – Diversion creating harm or risk of harm or for distribution	Probation or suspension for 2 years	Suspension for 7 years or revocation	2 - 7 years unless revocation
	C – Diversion with patient harm or for substantial distribution to others	Suspension for 5 years	Indefinite suspension or permanent revocation	Minimum 5 years

Aggravating Circumstances:	Mitigating Circumstances
- Diversion for profit - Patient harm or risk of harm - Prior history of discipline for substance abuse or diversion - Other concurrent findings of unprofessional conduct - Work setting - Extensive diversion for distribution to others, including intent to sell - Concurrent substance abuse	- No patient harm or risk of harm - Under influence of legitimate prescription - Legitimate medical condition - Self-remediation effort or corrective action - In treatment and compliant

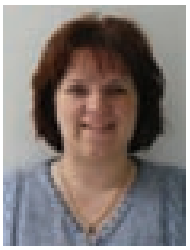
New Commission Members Appointed

Governor Christine Gregoire recently appointed two new commission members. Thank you to outgoing members, Lorrie Hodges, LPN, and Todd Herzog, ARNP, for their years of service and dedication to the public and Nursing Commission. Welcome to the two new members.

Darrell Owens, Ph.D., ARNP

Dr. Owens was appointed to the Commission in January 2008. He is the current director and founder of the Palliative Care Service at Harborview Medical Center in Seattle. Darrell started his nursing career in 1981 when he completed Hospital Corps training in the U.S. Navy at age 17. He obtained a Bachelor of Science in Nursing from Emory University in Atlanta, a Master of Science in Health Services Administration and a Master of Science in Nursing. He also completed a post-master's certification as an adult and geriatric nurse practitioner, a Doctor of Philosophy in Health Administration, and is a post-doctoral graduate of the Harvard Medical School Center for Palliative Care Faculty Scholar Program.

He is a board certified adult health and palliative care nurse practitioner and former Hospice and Palliative Nurses Association board member. He is currently the Associate Editor for the ***Journal of Hospice and Palliative Nursing***. After spending two years working in emergency and critical care nursing, he has spent the past 16 years working to improve the quality of care received at the end of life. Darrell hopes to continue to improve care at the end of life through his work on the Commission.



Laura Yockey, L.P.N.

Mrs. Yockey graduated from Clover Park Technical College in July of 1993. After gaining ten years experience in different areas of the nursing field, Mrs. Yockey has found her love of pediatric nursing.

She was appointed to the NCQAC in January 2008. She looks forward to contributing to the rewarding work that is done by the commission.

DISCIPLINARY LEARNING LESSONS

By Terry J. West, Adena Nolet, and Mary Dale, Department of Health

The Nursing Commission acts on a wide variety of complaints. This article describes actual disciplinary cases to illustrate the kinds of issues the commission considers, the actions it takes and the range of sanctions it applies.

How to avoid disciplinary sanctions:

- Read and know the rules and statutes regulating the practice of nursing.
- Read the rules on sexual misconduct, boundary issues and guidelines on medication administration.
- Self-refer into a monitoring program for alcohol and substance abuse issues, if you have a problem.
- Know the procedures for proper documentation.
- Follow the rule on mandatory reporting.

The following ten summaries represent a sample of cases decided in 2007. The cases are public record. However, for the purpose of education, names were removed.

CASE 1: Nurse A failed to complete the 24-hour medication administration record check for several patients. She also failed to assess patients' conditions and made several medication administration and documentation errors. The Nursing Commission placed Nurse A's RN license on probation for 12 months. She was required to:

- Pay a $500 cost reimbursement.
- Make sure her employer received a copy of the document placing her license on probation.
- Have her employer submit quarterly performance reports to the commission.
- Abide by employment restrictions, such as not working nights, not working as the only RN, and not functioning as a supervisor, head nurse or charge nurse.
- Complete 40 hours of coursework in medication administration and documentation and 20 hours of supervised clinical practice in medication administration.

CASE 2: Nurse B was assigned to care for an elderly patient. Nine days after the patient's ARNP discontinued the patient's nitroglycerin, the nurse administered two doses of nitroglycerin at five-minute intervals. The patient's blood pressure dropped from 90/50 to 54/30. Paramedics transported the patient to the hospital, where she was stabilized. A Statement of Charges was issued, and the nurse waived her right to a hearing. An Order was issued indefinitely suspending her RN license.

CASE 3: Nurse C practiced beyond the scope of practice as an ARNP. She prescribed or approved refills of prescriptions for Schedule II-V substances prior to becoming authorized to do so. She was issued a Stipulation to Informal Disposition, which required her to:

- Undergo monthly prescriptive practice audits by an approved practitioner.
- Pay a cost reimbursement of $1,000.

CASE 4: While employed as an LPN, Nurse D communicated with a patient in a verbally abusive and insensitive manner. The Nursing Commission and Nurse D entered into an Agreed Order, which required Nurse D to:

- Obtain commission-approval for all health care employment.
- Have her employer submit quarterly reports to the Commission.
- Pay a fine of $250.
- Complete a total of 36 hours of coursework in legal issues, communication, and stress management.

CASE 5: Nurse E diverted Toradol for her own personal use. She requested and allowed a coworker to administer the drug to her without a physician's order. On another occasion, Nurse E again diverted Toradol for her own personal use. She requested and allowed a nursing student that she supervised to administer the drug to her without a physician's order. Nurse E was issued a Stipulation to Informal Disposition which placed her license on probation. The Stipulation required her to:

- Seek a substance abuse evaluation through the Washington Health Professional Services.
- If recommended by the above, enter and comply with the program.
- Write a research report.
- Pay a $1,000 cost reimbursement.
- Complete eight hours of coursework in medication administration and eight hours in nursing ethics.

CASE 6: Nurse F was employed at an assisted living facility. After the facility discovered that food stamps and electronic benefit transfer (EBT) cards were missing from a locked cabinet, Nurse F was videotaped making grocery store purchases using food stamps and EBT cards. Nurse F admitted using these items belonging to residents. She was found guilty of theft in the third degree, a gross misdemeanor. The Nursing Commission issued a Statement of Charges to Nurse F's last known address. When she failed to respond to the Statement of Charges, a default order followed, suspending her LPN license. After 60 months, she may ask for reinstatement of her license if she pays a fine of $1,500.

CASE 7: Nurse G submitted a pre-employment drug screen which was positive for cannabinoids. A Department of Health Nursing Commission investigator sent Nurse G a letter requesting a written explanation. The nurse failed to respond to the investigator. The Nursing Commission issued a Statement of Charges to Nurse G's last known address for the possible misuse of a controlled substance and for failing to cooperate with the disciplining au-

In 2007, the Nursing Commission received 1,228 reports or complaints. Of those, 631 went to investigations for more information. Some were closed after investigation, and others resulted in disciplinary action. Reports may be closed before investigation for several reasons:

- The commission does not have jurisdiction over the issue.
- The reported conduct is considered "below threshold," which means there is little or no risk to the public.
- The issue is not a violation of law or rule.
- There is insufficient information to convince the panel to open an investigation.

thority. After failing to respond to the Statement of Charges, a default order was issued, indefinitely suspending her RN license.

CASE 8: Nurse H was issued an LPN license in October 1993. Nurse H's license expired in July 2006. When he applied for re-licensure in 2007, Nurse H indicated that, in the past ten years, he had not been found guilty in a criminal, civil, administrative agency, professional association or certifying agency proceeding. In 1987, Nurse H was convicted of three counts of indecent liberties. The Nursing Commission issued a Statement of Charges to Nurse H's last known address. Because Nurse H failed to respond to the Statement of Charges, a default order was issued which revoked Nurse H's license. After ten years, Nurse H may ask for reinstatement if he undergoes a psychosexual evaluation.

CASE 9: While employed as the Director of Nursing (DON), Nurse I failed to meet the standard of DON nursing practice. He failed to provide a sufficient evaluation of an RN employee's current clinical competency. The director did not evaluate the RN's ability to practice nursing with reasonable skill and safety after returning to acute care following years in administration. Nurse I also failed to adequately supervise the RN employee and to recognize a pattern of nursing errors and deficiencies. Lastly, Nurse I failed to develop and implement a comprehensive and continuing plan to provide adequate supervision, remedial education and training for the RN employee. An Agreed Order was signed, placing his license on probation for 18 months. Nurse I was required to ensure his employer received a copy of his order, pay a $1,000 fine, complete six hours of coursework in nursing communication, write a research report, and comply with employment terms such as not functioning as a supervisor and working under direct supervision.

CASE 10: Nurse J failed to supervise staff adequately to ensure that the safety precautions in a patient's care plan were in effect that day. Consequently, the patient fell from his wheelchair twice and then fell from his bed, sustaining injuries. The Nursing Commission issued a Stipulation to Informal Disposition to Nurse J, requiring her to complete coursework in nursing leadership skills and complete 120 hours of supervised clinical practice.

new computer system

Terry J. West, Deputy Executive Director, Department of Health

On February 19, 2008, the Department of Health implemented a new licensing computer system making available better reporting, tracking and more options. Here are some things to note about the current system:

- The Provider Credential Search allows you to search for any person, facility or hospital regulated by the Department of Health. Please take a minute to check your license on the Provider Credential Search to ensure we have the correct data. The Web address is https://fortress.wa.gov/doh/providercredentialsearch/.
  If anything needs to be corrected, please contact us at (360) 236-4700 or hpqa.csc@doh.wa.gov.
- ARNPs may have new numbers. The new system allows a separate license for each specialty. The old system could only produce one license, but kept track of the different specialties. Now ARNPs will have a separate license for each specialty, and the specialty will be clearly indicated on the license.
- Early next year, the system will begin allowing on-line applications and on-line renewals. The department has already installed credit card access at the front counter. The credit card option on-line will be installed next year with the on-line applications and renewals.
- Renewals, once processed, are reflected on the Provider Credential Search within minutes. You no longer need to wait 24 hours to check on someone's status. If you are an employer, be sure you have prospective employees download the most current application form on the Web site. Throw away any outdated application forms. Forms with dates prior to May 2008 will not be allowed and will delay someone's licensure if used. Application forms can be downloaded at https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/forms.htm for nursing applicants or https://fortress.wa.gov/doh/hpqa1/hpqa_forms_links.htm for all other health care licenses.

Washington State Nursing Care Quality
Assurance Commission (NCQAC)
P.O. Box 47864
Olympia, WA 98504

PRESORTED STANDARD
U.S. POSTAGE PAID
LITTLE ROCK, AR
PERMIT NO. 1884

Imagine

Nursing the way it used to be...

Less stressful and less physically demanding.

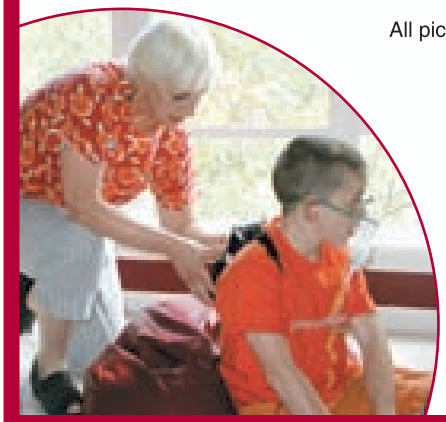
Orientation to each patient until you feel ready.

Working with one patient and making a real difference.

At Avail you can still enjoy nursing the way it used to be.

- One-to-one patient care
- Case specific orientation
- Personal schedules designed to meet your individual needs

- 6-12 hour shifts, full-time and part-time
- RNs and LPNs
- New graduates welcome



Home Health Care as a career path truly embodies a passion for nursing and a love of patient care.

Avail
Home Health, Inc.
"Serving Washington Since 1981"

1-800-637-9998

www.availhome.com

CELEBRATING 27 YEARS OF CARE & COMFORT

For career opportunities in your area, please call or visit us on-line today!